November | December 2016

Leadership Message | Allison McGuire

2016 has been an extraordinary year – at times exhilarating, at other times challenging. Over this past year we have transitioned from our initial focus on infrastructure development to our current focus on project implementation. With learning collaboratives, team training, MAX action teams and the launch of project toolkits we have seen the real fruits of our labor. Several stories in this edition of our newsletter call out those successes.

2016 was also an election year. As in any election year, the results have an impact on the work each of us does for our patients and communities of care. The age old adage is true, the only constant in the health care industry is change. Regardless of the result, local, state and federal elections always mean new policies and different opportunities. Of course, 2016 is no exception. To me the result tells us all what we likely already knew – that our shared commitments to our patients and our communities have never been more important. As we head into 2017, I join each of you in redoubling our efforts to improve care, improve health and lower costs for the Hudson Valley and its residents.

Since this newsletter will serve as our closing note for 2016, I wish each of you a happy holiday season and a happy and healthy new year. Thank you for your continued partnership.

In This Issue
- Leadership Message
- DSRIP News
- MHVC Out Front
- Around MHVC
- Partner Portal
- Working It
- Partner Spotlights
- Contact Us

DSRIP News | Network and State Activities
Success Stories from the MAX Series

The first round of the Medicaid Accelerated Exchange (MAX) Series ended in September, with three MHVC teams participating. Since there will be future rounds of MAX projects, we want to share the innovative and collaborative work of the MHVC partners who participated in the first round.

From the MHVC point of view, the goals were for each MAX team participant to find value in the work; to achieve a new level of collaboration; to break down internal and external barriers; and to achieve better outcomes for patients. Judging from the responses of the participants and their results, those goals were met and exceeded, leading to the opportunity for long-term change and sustainability.

MHVC teams participated in two projects: managing care for frequent utilizers of the Emergency Department (super-utilizers), and integrating primary care into a behavioral health facility (DSRIP behavioral health integration, Model 2). MHVC was the only PPS MAX team to do Model 2 (co-location of PCPs in BH settings) for an adult population, making the results even more significant for MHVC and providers around the state. The two super-utilizer teams were from St. Luke’s Cornwall Hospital (including representatives from Cornerstone, Access: Supports for Living and Horizons Medical Group) and St. Joseph’s Medical Center; the Behavioral Health Model 2 team was composed of Access: Supports for Living and HRHCare.

These teams have already accomplished a great deal and created exciting models for the network. The articles below contain more detail on all of the great work happening now. We thank all of the MAX teams for their enthusiasm, commitment and passion.

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Super-Utilizers, Super Success
Creating alignment between internal and external stakeholders

St. Joseph’s Medical Center, Yonkers, NY

St. Joseph’s Medical Center in Yonkers fully accepted the challenge and commitment of the MAX Series and learned how to improve care and work innovatively. “The MAX project focused us on how to work well together, both internally and externally,” said Lisa Hanrahan, St. Joseph’s Vice President for Quality and Risk Management. “We now know what services each department can provide for this population, and we can foster relationships externally. These are long-lasting benefits.” There was also immediate success with St. Joseph's seeing a 20% reduction in ED visits and an 88% reduction in admissions among the patients participating in the program.

The team embraced the fast-paced and intense schedule. KPMG, the MAX Series consultant, provided guidance during site visits and weekly calls, reminding the team to identify and solve the smaller, incremental problems. “The initiative established a structure that was easy to follow and was one of the key differentiators that enabled our success,” said Hanrahan. “We were able to focus our processes on this finite group of super-utilizers.”

The team identified a cohort of patients who had four inpatient visits and ten emergency department visits per year. Gathering the data was a painstaking process of truly understanding the whole person -- not just the medical diagnosis. "We realized the group was not medically complex,
but individually complicated with chronic conditions such as homelessness or the inability to keep an appointment.” The team developed a tracker for each patient: Do they have a case manager in common? Can we get this information quickly to physicians? “This led to a bunch of ‘aha’ moments and patterns,” said Hanrahan.

Getting to the root cause resulted in surprising and valuable collaborations with outside partners. For example, hemodialysis patients in the cohort were missing appointments or had failed catheters. This led to new relationships between the hospital and hemodialysis centers and vascular surgeons for transfers, appointments, or observation for more appropriate care and to avoid ED admissions. “We could proactively identify patients and get them the right help at the right time,” said Hanrahan, “even to solve a problem as simple as not being able to get prescriptions or refills.”

The MAX project also fosters internal change. “Looking at a cohort also forced us to create a tighter medical environment,” continued Hanrahan. “We are weaving a safety net for this population,” which means using their resources of social workers and also their health home to help patients who live in residences with no support for their medical needs.

**St. Luke’s Cornwall, Newburgh, NY**

“The focus on assembling and mobilizing teams of the right people, doing the right things, at the right times, was one of the great aspects of the MAX experience,” said Kathleen Sheehan, RN, Director of Emergency and Respiratory Services for St. Luke’s Cornwall. “We had to decide who on the team was critical at different stages, and that involved both internal and external partners,” she said, including an external “quarterback”, an entity to lead care for each patient. Three other organizations also played critical roles: Cornerstone Family Health, Horizons Medical Group, and Access: Supports for Living.

As team leader, St. Luke’s did a lot of pre-work before convening the team. “IT did the critical infrastructure work that helped us define a manageable cohort,” said Sheehan. Analyzing 2015 data, the project identified 91 patients with six inpatient and three ED visits. Working with this data, a strategy was developed over the course of three workshops with KPMG, MHVC, and the team. The results were quick and exciting, showing a 33% reduction in ED utilization among the patients participating in the program.

“We needed to know when these patients came in,” said Sheehan. IT created a “red flag,” turning the patient’s name red in the computer system, to alert all internal team members. “A lot of this work is simple,” Sheehan continued, “but we needed a process such as the PDSA cycle to work it through and engage everyone we needed. We are now using our staff more wisely,” and have a robust team to implement changes, including two Care Transition Nurses, care plans for each patient in the cohort, and more options for the ED staff. Sheehan is now looking beyond this project to another cohort of patients with ten ED visits in the past year.

Organizationally, “We were energized to work together, and we created new teams that made sense for us and for our patients.” The project taught them different ways to achieve the goal of decreasing ED visits. “People were not always coming in for medical reasons, so we had to recognize the drivers and connect them to an external ‘quarterback’ in the community.” Addressing the social determinants of health had
immediate impact. “We partnered with a local food bank, since most of the patients are hungry,” said Sheehan, and they continue to find out about agencies they didn’t know, even in their close-knit community. “We learned that we can’t and shouldn’t do everything,” Sheehan said, “but now we know how we can help make it happen.”

Using MAX to Accomplish the “Impossible” in Model 2
MAXimizing both physical and care changes in a short amount of time

When the state designated behavioral health integration as a MAX Series cohort, it set the stage for making the difficult -- bringing primary care into a behavioral health facility -- possible. “This has been on our wish-list for years,” said Amy Anderson-Winchell, President and CEO of Access Supports for Living, which spearheaded the project. “We understood the complexity of implementing the project since we didn’t have the appropriate licenses. The attention given to MAX expedited approvals and helped make it happen.”

The process was far from simple, requiring physical plant renovations, combining two practice cultures, process changes, and government approvals at all levels. Accomplishing these changes in eight months took commitment and collaborative efforts of the project team, MHVC, the MAX program and its consultants, and local and state governmental entities. The model included partnership with primary care partner HRHCare. The results came quickly. Access and its partners saw a 38% reduction in ED use among the patient cohort along with a 16% uptick in primary care visits and a nearly 60% improvement in blood pressure within range.

The team chose an Access facility in Middletown, NY, where it could integrate an HRHCare primary care nurse practitioner into a facility serving people with significant behavioral health complexities. Access and HRHCare were already strong partners; providing the nurse practitioner gave them the chance to impact outcomes at a direct-service level. “The problem was getting patient engagement,” said Allison Dubois, MPH, Chief Operating Officer of HRHCare, “and we knew that a highly-qualified nurse practitioner would be the key.”

The team tried a number of strategies. The one that worked was having the Access Behavioral Health Registered Nurse and Care Manager go into the waiting room to talk one-on-one with patients and introduce those needing primary care to the HRHCare Nurse Practitioner. The team asked questions such as, “Who is your primary care provider? When is the last time you saw them?” These and other questions showed patients that perhaps they were not taking care of their real underlying health problems.

The MAX structure helped the team identify a cohort of diabetes patients, and the clinical actions to improve. They went through a process of setting baselines and goals. “Some moved quickly,” said Dubois, “but, frankly, it wasn’t all smooth sailing. It was a learning process.” One challenge was dealing with barriers to the work flows and figuring out what worked and what didn’t. “We needed to take time to prepare and to
keep the inter-organizational and cross-organizational work going,” she added.

“For all of our success, we still have a way to go to reach financial sustainability,” observed Anderson-Winchell. “The big question is, ‘How do we get to an enrollment level that is sustainable?’ Even given large start-up costs, she is confident of financial stability once there is full utilization. “We believe completely in this model and we hope that others will replicate it, benefiting from our groundbreaking efforts.”

**New York State Releases Mid-Point Assessment for Public Comment**

On November 29th the New York State Independent Assessor (IA) released its long awaited Mid-Point Assessment of the DSRIP program. There are two main takeaways from the IA’s assessment:

1) MHVC is successfully implementing DSRIP and engaging partners in the Hudson Valley region.

2) There were no identified areas that required corrective action. MHVC was only one of four PPSs to receive no corrective recommendations (Maimonides, NYP-Queens, and Staten Island are the others).

MHVC is very pleased with the IA report. The process fostered internal alignment of program requirements across MHVC. MHVC will build off of that structure to create successful translation to a population health model of care. For those interested in learning more about the Mid-Point Assessment, or reading the reports, more information can be found here: [http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/index.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/index.htm).

**CMS Extends NYS DOH Medicaid Redesign Team Waiver**

On December 7, DOH announced that the Centers for Medicare and Medicaid Services (CMS) have approved New York’s request to extend its Medicaid Section 1115 waiver, the Medicaid Redesign Team (MRT) Demonstration, through March 31, 2021. This extension extends the necessary authority for New York to continue to operate its demonstration with modest modifications. This includes extensions for the DSRIP program through March 31, 2020. MHVC will continue to monitor the impact of the waiver on the DSRIP program. The New York 1115 waiver renewal letter and Standard Terms and Conditions (STCs) have been posted to the MRT website here: [http://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm](http://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm)

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**MHVC Out Front | Leading initiatives and collaborations in the region**

**Lessons from the Behavioral Health Learning Collaborative Learning Session 1**

*High energy, immediate results, and valuable team time*

On November 1, 110 participants joined clinical co-leaders, Dr. Henry Chung and Dr. Damara Gutnick, for the first learning session of the MHVC Behavioral Health Learning Collaborative. The full-day event in Tarrytown was a rich mix of overview topics, team building, and breakout groups that addressed some of the challenges faced by behavioral health integration teams, including training for depression screening, integrating primary care and work flows, and adopting and using a registry.

The session helped attendees take a step back and look at their projects and workstreams on a smaller scale, encouraging incremental, manageable steps. Techniques such as Plan-Do-Study-Act (PDSA) were discussed, with very practical applications: How do you do PDSAs? And once you do them, how do you implement and study the results? How do you integrate these into your workflow? How do you work SMART (Specific, Measurable, Achievable, Relevant, Time-oriented)?

The focus was on practical, sustainable, and immediately applicable learning. As a measure of success, 90% of respondents said they would be able to apply the knowledge/skills they learned to their work in coming weeks. Survey respondents emphasized their appreciation of the group activities and having the time for team discussions with their teams. Most cited “team-building and getting everyone on the same page,” “group interaction,” and “collaborative problem-solving through PDSA” as benefits from the day. To reinforce the lessons, there was a follow-up Webinar for participants on November 15 to answer questions and support the momentum.

“The energy of the attendees was fabulous,” said Dr. Chung, “It was very gratifying to see the high level of engagement.” One of the most effective aspects of the day was peer leadership at the breakout sessions. “They are going through the same thing as participants,” said Dr. Chung, “walking the walk, and talking the talk.” Learning from peers who have the same or similar experiences, and are perhaps at the same point in the process or only slightly ahead, was extremely helpful for attendees.

Breakout sessions were led by MHVC partners including Allison DuBois and Dr. Daniel Miller (HRHCare); Katarina Hoass (Access); Dr. Alissa Mallow, Dr. Thomas Betzler, Evelyn Figueroa, and Maritza Casillas (Montefiore); and Dr. Michelle Blackmore, Dr. Sally Ricketts, and Kelly Carelton (CMO).

The MHVC Behavioral Health Integration Learning Collaborative is a 12-16 month learning experience comprising learning sessions, Webinars, and workshops. With the help of feedback from Learning Session 1 attendees, MHVC will improve and expand the offerings for Learning Session 2, which will be held in Spring/Summer of 2017. For more information, contact MHVC@montefiore.org.
Patient Engagement: Tips for Primary Care Teams
Half-day session in Suffern on January 13

Join us for this highly-interactive session designed for the clinical team in a primary care setting. Attendees will leave with skills and tools that they can implement into their busy practices immediately to engage patients and to support self-management. The session is designed for all members of the primary care clinical team, including PCPs (MDs, NPs, PCAs), RNs, Care Managers, Social Workers, Medical Assistants, Health Coaches, Pharmacists, etc. The agenda will touch on patient engagement strategies, teamwork, and skills development that can easily be applied to practice. It will include a brief introduction to motivational interviewing, tips to improve adherence, and introduce valuable connections to health homes and community resources.

The session will be held at the Crowne Plaza, Suffern, NY, from 8:00 AM-12:30 PM, on Friday, January 13, 2017. A flyer with information and a registration link will be sent to network members. For more information, contact montefiorehvc@montefiore.org.

NYC RING Convocation features Duke University Keynote
Themes include using data to target at-risk populations

On October 18, the New York City Research and Improvement Networking Group (NYC RING) held its 2016 annual convocation. NYC RING is a practice-based research network focused primarily on urban, low-income, minority primary care patients, and is sponsored by the Albert Einstein College of Medicine Department of Family and Social Medicine. Montefiore Medical Center hosted the growing annual convocation, which highlighted and encouraged collaboration among a wide variety of community-based research and quality improvement initiatives. It also featured 54 poster presentations. Several MHVC partners were part of the 150 total NYC RING attendees.

The 2016 annual convocation keynote speaker was Dr. J. Lloyd Michener, Professor and Chairman of the Department of Community and Family Medicine at Duke University. Dr. Michener discussed strategies to address social determinants to rapidly improve health outcomes. Several other individuals, including Dr. Damara Gutnick, Medical Director of MHVC, also presented. A common theme among all speakers was the use of technology or data analytics to inform targeted population-based outreach. Notably, organizations such as MHVC and South Bronx Rising Together are using data to geo-map clusters of patients diagnosed with asthma for intervention initiatives. MHVC will take this learning and explore its application to Hudson Valley hot-spots. Consistent with Dr. Michener’s message, MHVC is excited to use the asthma data analytics to efficiently use resources, properly identify initiative partners, and quickly improve population health outcomes for residents of the Hudson Valley.

MHVC looks forward to further collaborating with NYC RING given our mutual focus on improving public health through targeted, evidence-based community engagement.
The Organization Tab: Learning to Use "Activity History"

Never miss an MHVC email

It seems simple enough: The Organization tab of the Partner Portal displays the information that MHVC has on file for your organization. This includes organization details, a current contact list, and committee participation for all contacts in the organization. However, this tab also includes "Activity History," a feature that can potentially simplify your digital life -- at least your digital life relative to MHVC.

The Activity History box displays an inventory of all email communications to your organization that MHVC deems important, including contract information and reporting. Why is this important? MHVC communications are sent to both organizational email addresses and to the Partner Portal's Activity History, where they are logged in. Since most of us receive a large volume of emails every day with varying levels of importance, there is always the chance that one may be overlooked, deleted, or put in the wrong folder and never seen again.

When MHVC logs that same email into Activity History, it will always be there so you can access it any time. Once an email is logged in, users have access to the full email by clicking the subject. You can view the original email communication, who it was sent to (including others in your organization), and any attachments distributed with the email. Your view of the Activity History area is related to your role on the project and your position in the organization: You can easily scan to see who else received the same communication, which is very helpful for team efforts.

Activity History ensures that you will never lose or misplace an important MHVC communication. By understanding the benefits of this feature, we hope you will use it more frequently. If you have any questions, contact us at partner.portal@montefiore.org.

Update on "Train the Trainer"

As part of its ongoing commitment to offering training programs for its partners, MHVC has developed a Brief Action Planning and Motivational Interviewing Train the Trainer Program. On October 27, MHVC held a BAP training as part of the Self-Management Program training series with 25 attendees representing multiple partners throughout the Hudson Valley. Participants learned the skill of using Brief Action Planning and how the spirit of motivational interviewing provides the foundation of BAP. Selected participants also completed a three-day Brief Action Planning Train-the-Trainer course (BAP TTT) on November 29, November 30, and December 1 in Tarrytown, NY.

We are looking forward to reporting on how partners are using TTT. The
January 2017 newsletter will have a major article on “Uptake of Training,” sharing applications of the training from the partner perspective. If you have a story of how TTT has worked for your organization and how it can help other partners, let us know.

April Lawrence (CCMI) facilitating the BAP training in Valley Cottage, NY

Partner Spotlights

On December 5th, Nyack Hospital broke ground on the largest project undertaken in the hospital’s over 100 year history. The expansion and redesign of the Hospital’s Emergency Department and addition of a Medical Village will facilitate initiatives designed to reduce hospitalizations, improve access to disease management programs and preventative services and encourage community involvement in health and wellness through an integrated health care system.
Partner Posters and Presentations

On December 15th, Dr. Bruce Rapkin and Iliana Garcia of MHVC and the Einstein School of Medicine/Montefiore Medical Center presented a poster entitled, Assessment of Organizational Readiness and Capacity to Implement Tobacco Cessation Services in a DSRIP Performing Provider System, at the 9th Annual Conference on the Science of Dissemination and Implementation held in Washington, DC.

The MAX Series team from St. Joseph's Medical Center in Yonkers is excited to announce that they had a track presentation accepted to the National Association for Healthcare Quality's Annual Conference in September 2017 entitled, Managing "Super Utilizers": Decreasing Inpatient and ED Utilization -- a DSRIP Project.

Send us your Spotlights! The MHVC Partner Relations team wants to feature you in upcoming newsletters. Send your highlights and photos (with captions) to montefiorehvc@montefiore.org.

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