Leadership Message | Natalee Hill

In this month’s newsletter the role of technology in health care is a common theme. Whether as a tool for improving an individual’s health outside of the provider office, a tool for better care coordination inside the provider office, or a tool for recruiting the highest quality providers and staff to the Hudson Valley.

We all know that technology has transformed every part of our lives and health care, one of the most important parts of our life, is no exception. One of the major benefits of DSRIP has been the access to critical resources and partnerships that make the best use of the innovative technology available to the health care sector. A great example has been the state resourced Regional Health Information Organizations (RHIO) which have given our partners a centralized “hub and spoke” model of information flow that benefits care management and patient experience. We are proud that all contracted members of the MHVC network have either connected, or have signed agreements to connect, with the RHIO.

It’s exciting to see MHVC partners harnessing that opportunity to move through many of the traditional barriers to great care providers have faced in the Hudson Valley.
MAX Results: How the Health Quest Care Management Team Changed to Change Lives
Patient success stories from the MAX Series

Thanks to the MAX Series, when Chanel Artist, RN, Community Care Manager and Certified Case Manager at Health Quest, tells the story it is far from a chart recitation. “Elderly female with a complex medical history” becomes “our case conference really worked and the team understood how to help.”

Health Quest started the Community Care Manager (CCM) program in 2015 with two case managers funded through Vassar Brothers Medical Center (VBM). The goal was to minimize avoidable admissions. “We were having a hard time identifying patients that needed the help -- frequent readmissions. We were working with some but not enough to make an impact,” said Artist. “The MAX Series helped us restructure how we identify patients and their drivers of utilization.”

CCMs are a team of Registered Nurse Case Managers whose primary focus is to identify, assess, connect and reduce readmissions at VBM. CCMs collaborated with the MAX Series program to restructure and enhance the identification of the hospital’s high-risk patients. Health Quest put together a core action team including community partners and skilled nursing facilities (SNFs) -- keys to deferring many high-utilizer admissions. “In the past, we would refer a patient to resources from our individual assessments, but now, after team-based meetings with nursing homes, we are able to collaborate to accomplish a more comprehensive plan to reduce readmissions,” said Artist.

Another outcome of the MAX Series was the development of a data tool, called the Flash Report, which identifies high-utilizers and is generated daily. With this report, CCMs can assess the patient barriers and formulate interventions to decrease utilization. At the team-based meetings, patients are identified from the report and the team then collaborates with resources, such as nursing home leaders. Before MAX, the processes were not as efficient or consistent.

“The result is that the patient is better managed in the community,” said Manav Surti, MHVC Performance Management Specialist for the MAX Series. The CCMs work with patients who have heart failure, COPD, and multiple disease processes. For example, the CCMs provide scales to patients for weight management and to know when to call a clinician for diuretic management, an office or emergency room visit, if necessary. They also teach heart failure education -- all to reduce readmissions. Transition of care calls are placed within 24-72 hours post-discharge to reduce the risks for readmissions. The paramedic program performs hospital follow-up visits in patients’ homes and collaborates with the CCMs for advocacy, education, and continuity of care.

“This team approach and the ability to follow up changed the way we deal with complex patients,” said Artist. The patient in Artist’s story had over five inpatient hospitalizations in the past year and her caregiver was unable to manage her needs without additional support. The caregiver became engaged during the discharge planning discussion, and a teach-back focused on education for her diagnoses. The patient was referred to homecare, long-term care services, and a community pharmacy that delivered pre-poured medication. After close monitoring from the CCM program, it became clear that the patient would be better-managed in a local skilled nursing facility. Since her last inpatient admission (more than three months ago) there have been no inpatient and/or emergency room visits.
"Elderly female with a complex medical history' is just one of many examples of how our newly restructured team assisted a patient to a good outcome," said Artist. "We consider that a real MAX success story."

MHVC Out Front | Leading initiatives and collaborations in the region

When Co-Location is Not Enough: How Astor and CMG Created a Seamless Process
MHVC BH Learning Collaborative facilitated collaboration, development of templates

Before DSRIP, Astor Clinics of Ulster and Dutchess County moved into the Children’s Medical Group building, anticipating that co-location would be the future of providing care for their mutual clients. Astor was in the building almost five years, but although they were co-located, some of the clinicians were still siloed while others had good relationships.

This was the perfect project for Michelle Blackmore, PhD, Project Director at the Montefiore Medical Center’s Care Management Organization, which leads the Behavioral Health Integration Learning Collaborative (BHLC) for MHVC. Working with Amie Adams, LCSW-R, Regional Director of Outpatient Clinics for Astor Clinics of Ulster and Dutchess County, and Dr. David Fenner, President of the Children’s Medical Group (CMG), the BHLC helped foster collaboration and communication, launching new interactions and work flows between these two partners.

"We brought them to the table and they talked about their mutual and separate needs and frustrations," said Blackmore. "Simple yet profound actions resulted, from developing health assessment templates that allowed medical and behavioral health providers to update each other on shared patients, to just having a meet-and-greet with each other’s new staff to begin collaboration.” MHVC and Blackmore, as part of the BHLC, now have monthly calls with the teams, but they are mostly brief check-ins and an opportunity to brainstorm through any challenges as the teams advance their integration efforts. "We have been so impressed with what they were able to do in such a short time," said Blackmore. "Many changes didn’t necessarily require expense or infrastructure transformation, just caring and care coordination on each side."

"The BHLC got leadership to the table and we were able to identify meaningful and realistic changes," said Adams. "We could also address the basics, such as, ‘In the pediatric world, this is how we function’ and ‘in the behavioral health world, this is how we do things.’" Astor and CMG implemented a liaison protocol on each side.

The model is so successful that MHVC and the BHLC are now introducing it to other partners. The health care assessment template is a tool to help medical and behavioral health providers communicate and collaborate on shared patients. It is used instead of a chart, providing a more efficient way to share patient information, treatment plans, progress, etc. "Reviewing a full chart isn't always practical, so without the assessment template, providers weren't sharing information regularly," said Blackmore.
The template creates a 1-2 page summary with vitals, chief complaint, scales, etc., and makes it much easier and efficient to obtain and share client information. The key points are in narrative form, very user-friendly, and easy to get into the electronic health record and send out to the liaison. Since Astor represents the behavioral health (BH) side, and CMG pediatrics, there are two complementary forms -- the BH Assessment Form and the Medical Assessment Form.

**Summary of BHLHC Health Care Assessment Template**

- Used instead of a full chart
- Creates a 1-2 page summary with vitals, chief complaint, scales, etc.
- Key points are in narrative form
- User-friendly
- Easy to get into the electronic health record

"When we know we are going to collaborate on a patient or client, we can quickly fill out the form and get it to the right clinician -- and CMG can do the same," said Adams. Astor has two full-time clinicians in the CMG Hyde Park location, and one full-time clinician in Rhinebeck, five days a week. Both offices are fully co-located with CMG: they share a front door at Hyde Park, and have an office in the pediatrician’s office in Rhinebeck. "Nurses often walk families over to Astor—a warm handoff,” said Adams.

Astor provides outpatient mental health services for ages 2-21. It is an open access model, so families can walk into its Hyde Park office from 9 AM-5 PM, and crisis appointments during working hours prevent trips to the emergency department. “Importantly for this population, the collaboration of mental health and pediatrics should be physically prominent in a child’s health care,” said Adams.

That is the joint goal of Astor and CMG, according to Dr. Fenner, a pediatrician. "A lot of people present in our primary care offices. In some cases, we refer to a therapist and there is never communication back and forth. With Astor in some of our offices, we have that communication and so much more." The CMG Care Coordinators and Astor act as "matchmakers" between providers. Astor and CMG started with simple questions: If CMG has providers on site Tuesday, Thursday, Friday, and the Astor therapist is there on Wednesday, how and when do they speak? “We asked, 'What is our work flow? Their work flow? How does it work with a busy primary care doctor and a busy therapist?’” "The goal is to create times for meaningful, deliberate communication,” said Fenner. "We schedule a call -- it is not ad hoc and in the middle of my primary care appointment."

This high level of collaboration and coordination has allowed CMG and Astor to address critical problems together. “There is so much need for mental services for kids,” said Fenner. Child and adolescent mental health needs and ways to deliver it are different from those of adults, just as the pediatric world differs from adult primary care. "Working with Astor, we ask ourselves, 'How do we integrate child and adolescent mental health with the pediatric world?'"
Gas-up for GASO: Are You Ready for the “Great American Smokeout”?
Center for a Tobacco-Free Hudson Valley breaking down barriers this month and beyond

The Great American Smokeout (GASO) may be on the calendar for November, but tobacco dependence treatment can save lives all year round. “Tobacco use is a public health issue,” said Didi Raxworthy, Director of the Center for a Tobacco Free-Hudson Valley. “This year marks the 40th anniversary for the Great American Smokeout, and we now know so much more about how to best help people to quit smoking. Four decades of research proves that medical and behavioral health professionals have the most impact with this process by combining counseling and quit-smoking medications.”

The Center is a program of the American Lung Association funded by the NYS Department of Health Bureau of Tobacco Control program. It works collaboratively with health care provider organizations, the NYS Smokers’ Quitline, and community groups, to implement sustainable tobacco dependence treatment policies dedicated to reducing smoking rates within underserved populations that continue to suffer from higher smoking rates. Evidence shows that successful quit rates nearly double, particularly for high-risk populations, when medical providers systematize their tobacco dependence treatment protocols. Therefore our focus is helping organizations write strong policies aligned with the Public Health Service Guidelines to outline tobacco dependence treatment work within existing care,” says Raxworthy. Ideal protocols support tobacco treatment coaching, motivational interviewing techniques, and seamless prescribing. “In order to do this, the Center offers coaching tips and techniques with scripting, along with comprehensive sample policies and pharmacotherapy guides. There are many success stories in the Hudson Valley: This is hard work and takes a policy-driven team focus from the provider, but it can be done,” emphasized Raxworthy.

A great part of the Center’s work is provider education to break down barriers and arm clinicians with tools to help their patients and clients quit smoking. “The December 2016 New York Medicaid benefits expansion eliminates barriers for providers and support the realities that smokers face with quitting a strong nicotine addiction,” Raxworthy continued. (Link here to the Medicaid document, with changes on page 7.) “There are no longer restrictions on the number of times the prescription benefit can be ordered during a year. In support of the evidence that combination therapy increases quit rates by 50-70%, two different nicotine replacement therapies can now be prescribed together.” explained Raxworthy.

“Having this information helps build confidence and add efficiencies to processes, enabling providers to be more effective in assisting patients and clients to quit,” said Dr. Damara Gutnick, MHVC’s Medical Director. “Didi Raxworthy and the Center are a great resource for our MHVC partners and I encourage organizations to reach out for guidance and support to develop strong tobacco cessation policies and protocols.” said Gutnick. For more
There's an App for That: Using Technology to Improve Behavioral Health

MHVC offers app and interactive voice system to partners

The future of health care is now being piloted with members of MHVC’s Behavioral Health/Primary Care Learning Collaborative in partnership with Montefiore Medical Center’s Care Management Organization (CMO).

"The project offers partners access to two telehealth platforms, a smartphone application and an interactive voice response system (IVR) -- automated check in call -- to enhance collaborative care for patients with common behavioral health conditions in primary care and behavioral health settings," explained Michelle Blackmore, PhD, Project Director at the Montefiore Medical Center’s Care Management Organization, which leads the Behavioral Health Integration Learning Collaborative (BHLC) for MHVC. "MHVC will now offer this technology to partners who have established an integrated care foundation and are looking to improve patient symptom monitoring, engagement in care, and self-management, while maximizing provider and staff resources."

"The preliminary results are impressive," said Blackmore. "Patients using the smartphone application had a threefold increase in their number of contacts with their health care team per month compared to those patients not using the application. With IVR, over 50% of patients answering the calls completed symptom scales, allowing their health care team to more closely monitor progress throughout treatment. Most patients using the app or IVR also report that they feel more connected to their care team, contributing to the evidence that technology can help increase patient satisfaction in their health care experience."
This technology was previously piloted as part of a Health Care Innovation Award from the Center for Medicare and Medicaid Innovation to Montefiore Medical Center for the Behavioral Health Integration Program. Eligible patients were offered treatment through the collaborative care model, including short-term, evidence-based behavioral health treatment and/or medication management, case supervision, and enhanced “between visit” care (e.g., psychoeducation, behavioral activation, motivational interviewing). Patients were given the option to enroll in their choice of the smartphone application or IVR system to assist in between-visit, patient-provider contact.

The smartphone application, by Valera Health, offers a comprehensive and interactive care management experience, including a secure chat and video capability to connect with providers off-site, automated appointment and medication reminders, symptom and function scales, goal setting features/reminders, and self-management education. Passive data can also be collected to inform treatment plan adherence and alert the health care team if a patient becomes behaviorally inactive (the app can track the steps a patient takes each day as well as map their geo-location) or demonstrates poor sleep hygiene (e.g., ambient light sensor). IVR can be used to collect information on patients’ depression and anxiety symptoms between visits, as well as provide educational tips on topics related to whole health (e.g., behavioral activation, sleep hygiene, nutrition, self-care, etc), and even offers a breathing relaxation exercise. During the call, patients also are asked if they have questions about their medication or health to help ensure more timely responses from the health care team when needed.

"With the smartphone application, patients are more comfortable letting us know through the chat feature when they are having difficulty adhering to their treatment goals or need to reschedule an appointment -- patients can then get more timely feedback and coaching and stay engaged in their health care," said Blackmore. "They can also access psychoeducational and mindfulness materials and videos, which they are able to read and use in the privacy of their home or when it is convenient for them."

Montefiore’s partnering smartphone vendor assured patient accessibility to the app across a variety of devices, including any Android or iOS operating systems. Patients without a smartphone have the option of using the IVR automated check in calls on any type of cell phone or landline. "Not only does the technology automate a lot of patient follow-up without creating additional work for providers or patients, it also empowers patients to take a more active role in the management of their health," said Blackmore.

The care team uses all aspects of the technology platforms and reports high satisfaction. Clinical Care Providers (PCPs and BH clinicians) can utilize the cloud-based dashboard to better manage and more closely monitor the patients in their caseload. Blackmore cites one example. "In one case, an alert notified a care manager that a patient had not left home in 72 hours, based on tracked geo-location activity. The care manager reached out to the patient and identified worsening depression. The technology allowed for more immediate intervention, rather than having to wait until the next face-to-face visit which may have taken a month or more. The care manager told us that she has a much better sense of what is happening with the patient and feels more connected."

The success of this new direction for health care is countering the belief that all interactions have to be face-to-face. "Over 87% of patients find the technology
easy to use and would recommend it to a friend, so if patients continue to use it, they likely will be more engaged with their care team and have better outcomes,” said Blackmore. “Even as providers identify more patients in need of services and continue to manage larger caseloads, this technology can help them provide a higher quality of care and stay better connected with their patients.”

Around MHVC | Partner activities

Catholic Charities Receives $2 MM in Federal Funding to Fight Opioid Crisis
Partnership with NYS OASAS will address prevention, treatment, recovery

MHVC partner, Catholic Charities Community Services of Orange and Sullivan (CCCSSOS), will receive a share of $25.2 million in federal funding awarded to the New York State Office of Alcohol and Substance Abuse Services (OASAS), through the Opioid State Targeted Response grant program administered by the Substance Abuse and Mental Health Services Administration, a branch of the U.S. Department of Health and Human Services. The goal of the grant is to increase access to treatment, reduce unmet need for related treatment services, and reduce overdose-related deaths in 16 New York State counties identified as having a high need for response to the problem of opioid use disorder.

Catholic Charities of Orange and Sullivan will receive $2 million a year for two years to increase access to treatment through initiatives including expanded peer services, telemedicine (the use of telecommunication and information technology to provide clinical health care from a distance), and mobile treatment services in identified high-need areas of Sullivan and Ulster Counties. “These much-needed funds will allow us to expand and enhance access to prevention, treatment, and recovery services in those hard-to-reach communities where the need is high,” said Dr. Dean Scher, CEO of CCOS.

Through this grant-funded State Targeted Response (STR) program, Catholic Charities is now an OASAS-designated Center of Treatment Innovation. As a Center, Catholic Charities will strive to enhance access to treatment and recovery supports in the under-served communities of Sullivan and Ulster Counties utilizing peer supports, clinical services and emerging technology to empower opioid dependent individuals toward recovery. Services will include assessment and treatment referrals, telemedicine and medication assisted treatment, individual, family, and group therapy, peer advocates for recovery support, and case management.

In addition, Catholic Charities is one of ten agencies throughout New York State to receive $100,000 in funding to deliver evidence-based prevention services for underserved, hard-to-reach youth and other at-risk populations in Sullivan County. Catholic Charities provides a variety of school, community, and peer-based prevention programs for youth of all ages; family and community outreach programs, including NARCAN training, are also available.
Orange County’s Addiction Treatment Process Improvement Event, featuring Cory Waller, MD

Creating a clear path for our health care system to identify, engage, and treat substance use is essential to resolving this public health emergency. Starting on October 16th, MHVC supported and participated in a week-long community-wide effort in Orange County to improve care for patients with high-needs who experience poor outcomes despite extreme patterns of hospitalizations or emergency care. Dr. Cory Waller, MD, of the Camden Coalition facilitated the development of the future Orange County Substance Use System built on the 3C’s of competency-capacity-consistency: competency challenges us to use addiction science and data; capacity requires us to have effective services at levels commensurate with need; and consistency is needed throughout our system in the form of a singular assessment tool, treatment pathways, and metrics. Based on the 3C’s, a substance use treatment care path was created including the ASAM assessment tool and corresponding treatment offerings across levels 0-5. Look for the full article in our November MHVC newsletter.

Dr. Cory Waller facilitated the discussion for the event.

December is Flu Awareness Month

If you have special events or activities around flu awareness or immunization, let us know so we can feature them in our upcoming newsletters and post them on our MHVC website. Contact us atMontefioreHVC@montefiore.org.

Go to MHVC Website
Boomers, Millennials, and Staffing Strategies in the Hudson Valley

Recruitment Roundtable shares perspectives on Diversity & Inclusion, attracting and retaining talent

One size does not fit all when it comes to recruitment, whether it is a hospital versus a small nonprofit, or a Baby Boomer versus a Millennial. On October 4, 2017, MHVC convened over 30 participants in Pomona, NY, to discuss the common -- and different -- challenges at its first Recruitment Roundtable furthering relationships with new and existing partner recruiters.

"When we designed this recruitment roundtable we wanted to acknowledge the diversity not just of our partners, but of the workforce we are trying to attract," said Joan Chaya, MHVC Director of Workforce Development and Management. "We are looking forward to learning from this event and hosting other roundtables in different parts of our MHVC region."

The half-day session was moderated by Dan Bengyak, Vice President, Administrative Services, St. Luke's Cornwall Hospital, and Marc J. Leff, Esq., Vice President of Human Resources, St. John's Riverside Hospital. Three panelists made presentations and led the breakout sessions: Dorcas Lind, MPH, a diversity and inclusion (D&I) professional presented on the challenges that recruiters face with D&I; Theresa Forget, SHRM-CP, Senior Director of Human Resources for Montefiore New Rochelle, Montefiore Mount Vernon and Schaffer Extended Care Center, reviewed an RN turnover case study; and Joan Chaya discussed trends in supply and demand and emerging roles. Following the panelist presentations the participants joined one of two table breakout discussions: emerging roles and internal recruitment strategy, or external recruitment strategy and managing Millennials.

Feedback from participants helped frame the impact of the event. Ashley Richards, HR Business Consultant, White Plains Hospital, and Jim Morris, Recruiting Team Leader, Access: Supports for Living (ASFL), both shared how they each found value in the roundtable.

The MHVC Hudson Valley Jobs portal (link here) was new to Richards, and she will bring that back to her team and think of ways to integrate it into their work. However, the big takeaway for Richards was the RN turnover discussion. "We compete with the city, so we need to develop other recruitment strategies," said Richards. "Employees leave after two years, then go to the city for five years, and then might come home." Richards continued, "How can we retain new graduate nurses when the city pays more? We have to tell a different story: stay close to home, save the commuting time, have a better quality of work/life balance." The discussion focused on how to cater to Millennials to get them to stay past three years, versus Baby Boomers who stay longer. The group discussed creating internal mobility strategies to keep Millennials engaged. "It was a relief to know that this is a common struggle in health care across the board," said Richards, "and we are not alone."

Networking and sharing stories with colleagues was also the highlight for Morris, who does not often get the opportunity to deal with HR professionals who do the same type of work as ASFL. "Hospitals have a different salary structure and we can't compete with them. Those of us in nonprofits are doing the same work, and it was great to share stories and tips that help us all to do a better job." Morris was especially enthusiastic about the MHVC Jobs portal, saying, "More people should take advantage of it since it helps us all." ASFL
recruits for 70+ sites, including day programs and 30-35 group homes, and the portal is a valuable resource.

MHVC will be planning future and Recruitment Roundtables. For more information, contact Jasmine Cruz, Senior Human Resources Specialist, at jascruz@montefiorehvc.org.

Partner Highlights

**New and Old: With New Name and New Technology, CoveCare Center Focuses on Older New Yorkers**

*BH provider using $1 MM state grant to expand services*

Using a combination of technology and high-touch outreach, one Putnam County behavioral health (BH) provider is overcoming the limitations of its rural setting to reach its senior clients.

"This population is very vulnerable," explained Alison Carroll, LCSW-R, VP of Strategic Initiatives at CoveCare Center. "Age and isolation compound the problems with substance use and mental health conditions, jeopardizing how long they are able to live in our community. We needed to figure out how to get to them in their homes." Putnam has one of the largest senior populations in the state, and is one of the fastest growing: one in four residents is over the age of 55. In addition, the county is rural, so the elderly tend to be isolated and can't easily get to services.

In January 2017 CoveCare Center, which changed its name from Putnam Family & Community Services in July, was one of eight behavioral health providers that received $1 million grant, spread over five years, through the New York State Office of Mental Health (OMH). The goal of the grant was expansion of community-based programs for older adults facing mental health, substance use, and aging related issues.

CoveCare is the lead agency of a "Triple Partnership" with the Office for Senior Resources (OSR) and the Prevention Council of Putnam (formerly known as the National Council on Alcoholism and Other Drug Dependencies/Putnam). The three agencies are collaborating to identify, assess, and provide access to behavioral health and aging services to Putnam seniors aged 55 and older in need.

Leading the initiative is a licensed clinical social worker, care manager, and recovery coach, as well as nursing and psychiatric supports. The program identifies and offers services to individuals aged 55 and older whose
independence and involvement in the community may be compromised by behavioral health issues. "This is an exciting new model of care that not only involves mobile services for this population, but also employs telehealth monitoring units for our more fragile individuals," adds Carroll. The telehealth monitors will be used to communicate with seniors who are at risk and can benefit from daily monitoring of certain conditions.

According to OMH, the inclusion of telehealth monitors, which will be activated by the end of this year, was a big deciding factor in the awarding of the grant to CoveCare. The monitor boxes are attached to the phone system in the client's home and are pre-programmed with functions tailored for each client. "The telehealth monitors were a critical component for us," explained Carroll. "Many clients miss appointments or never engage in treatment because they can't get to the clinic site. The monitor will allow us to see client data in real time, regularly, and lets the client 'check in' to the clinic virtually."

"In addition to the Triple Partnership, we are working with police departments, emergency rooms, the Department of Social Services, and many others to identify at-risk individuals," said Carroll. "The emphasis is on identifying resources needed before someone goes into crisis." Carroll gave the example of repeat calls the police department receive on 911; instead of directing these callers to the emergency department (ED), they now refer these callers to the program for assessment.

Recovery coaches are another critical part of the program's success. "Our recovery coach is working hard to connect to clients and to connect clients to the resources they need," said Mariel Roth, LCSW, Director of Community-Based Services for CoveCare. "For example, they pick up clients and take them to Alcoholics Anonymous or Narcotics Anonymous meetings, or set up online meetings." The team is constantly looking for ways to improve the quality of life and services for their client population, especially ones that acknowledge access difficulties. "These clients have been isolated for so long that they often lack social connections," continued Roth. "Those connections are an important part of getting healthy."

"This is a team effort, between the Triple Partnership and all of our other collaborators in Putnam County," said Carroll. "Our aim is to identify how to get clients the services they need, where they need them -- whether at home through the monitors and services from the care team, AA or NA meetings, other county services, or our clinics. The ED is no longer the first stop, and remaining in the community is the expected outcome."

Puppet Troupe Takes on Tough Issues -- with Fun!
"Kids on the Block" educates in forgotten, unexpected places

If a picture is worth a thousand words, then a troupe with life-size puppets of kids in every shape and color would be worth a whole lot more.

Kids on the Block (KOB) is a community education program of Mental Health America of Dutchess County, Inc. (MHA Dutchess), that educates children using life-like, life-sized puppets on personal safety, bullying, gang prevention, learning disabilities, children's mental health, alcohol/tobacco/drug abuse prevention, childhood obesity, and multiculturalism. "In the mid-1990s, United Way came to us and asked for an idea for a special project," said Janet Caruso, Director of MHA Dutchess. "A staff person had seen KOB puppets and scripts,
but they were expensive so we started small, with a few puppets and scripts. Over the years we obtained more scripts and puppets with small grants from local funders."

Performances are free, and have been given to thousands of kids over the years. The troupe has performed in public schools, day camps, after-school programs, health fairs, day care centers, nursery schools, libraries, and reading programs in the summer. "We like to set up shows at unexpected, unusual, and forgotten places and populations, such as family shelters," said Marlene Taylor, Coordinator of Community Education. "We also strive for diversity in our puppet troupe. For example, we have a group of special-needs young adults practicing to be puppeteers."

Each puppet’s character, like real children, has likes and dislikes, hopes, fears, talents, and limitations; some have mental, physical, or emotional disabilities. Each performance includes a lively script that stimulates open communication between the audience and the puppets. The program currently has 14 puppets and 35 scripts, according to Taylor. "I have been doing this about ten years, and it is gratifying to see how creative our team and the kids are. The kids themselves are now generating scripts."

The post-performance discussion is a critical part of the process. Educators are given enrichment materials for follow-up, and the audience is engaged with scripted questions. "Once we do a script, we ask both the adults and kids, 'Why did we share this script with you?,' 'What does this mean to you?'” said Taylor.

If you are interested in learning more about KOB, volunteering, or scheduling a performance, contact Marlene Taylor at mtaylor@mhadutchess.org or 845-473-2500, ext. 1309.
Contact Us

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The Montefiore Hudson Valley Collaborative Team

Allison McGuire, MPH Executive Director, almguir@montefiore.org
Damara Gutnick, MD, Medical Director, dgutnick@montefiore.org
Joan Chaya, Director of Workforce Development and Management, jchaya@montefiore.org
Marlene Ripa, Director, Network Development, mripa@montefiore.org
Natalee Hill, Director, Quality & Innovation, nahill@montefiore.org
Adam Goldstein, Director, adgoldst@montefiore.org
Aliza Travis, Partner Relations, altravis@montefiore.org
Stephanie Nieto, Partner Relations, snieto@montefiore.org
Rachel Evans, Community Engagement, racevans@montefiore.org

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Our mailing address is:
3 Executive Boulevard, 3rd floor
Yonkers, New York 10701

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