April 2018

Leadership Message | Damara Gutnick, MD

This month we are presenting a special issue dedicated to this year’s state-sponsored All-PPS Learning Symposium. The content and messages presented during the event were so inspiring that we felt the symposium deserved its own newsletter. We were proud to have over 20 MHVC partner institutions attending and representing diverse stakeholder groups including hospitals, behavioral health, clinicians, and CBOs in attendance and learning alongside our MHVC staff. In fact, MHVC had the widest representation except for the Staten Island host PPS.

This special edition newsletter is organized as follows. The first section overview will get you started and includes links to symposium resources. The next section, “From Your Point of View,” has first-person accounts from partners and other participants who attended the symposium. We then highlight substance use disorder (SUD) innovations, and resources and tools that will, literally “change your view of change” and give you ways to implement those changes. The last section explores some of the posters, including MHVC’s own award-winner. As thrilling as it was to attend the symposium, it is even more exciting to share its learnings with you and to collaboratively begin to think about how to apply the lessons to our work going forward.

Personally, I felt this was an outstanding symposium, equivalent in caliber to the annual Institute of Healthcare Improvement (IHI) forums that health leaders from around the world attend each December. The speakers were ambassadors of best practices in health care transformation from around the world. The workshops were interactive and thought-provoking, and the keynotes were dynamic, relevant, and easily adaptable to our collaborative work. I was especially impressed with the number of sessions targeting CBOs.
You will read below about the most inspiring presentations, which came from speakers as far away as England and New Zealand. These are change agents who helped change happen in their organizations and their countries; hopefully we can take those lessons and apply them to our region, or state, or country too. From England’s National Health Service, Helen Bevan talked about creating a social movement around change in health care, and how important it is to identify change agents at every level of an organization. From New Zealand, Lynne Maher taught us about the Maori emphasis on “people, people, people,” and incorporating the patient voice in everything we do. Sounds familiar, right! At MHVC, we have been asking you to put your patients/clients/members first and ask what’s important to them -- “WMTY?” Maher reminded us to incorporate the patient’s voice into the design process, not just into the treatment plan and shared tangible tools to help guide us.

We hope that as you read this issue you will think of ways to incorporate some of the ideas, and will want to pass this newsletter along to staff or colleagues with whom you can initiate change and join the movement.

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**DSRIP News | PPS Learning Symposium overview**

**PPS Learning Symposium Caps DSRIP Year 3**

**MHVC well-represented, leading breakout sessions**

Over three days, February 6-8, 2018, staff and partners of all DSRIP Performing Provider Systems (PPSs) met on Staten Island to learn, to share, and to meet national and international experts who delivered inspirational and aspirational keynotes and workshops. Sponsored by the New York Department of Health and the Medicaid Redesign Team, the annual symposium offered breakout sessions, keynotes, workshops, a poster session, and networking opportunities. (The full symposium program PDF is available [here](#); the online overview with session summaries and presentation downloads can be found [here](#).)

The symposium was organized around the following themes:

- **Transform**: Transition to new care delivery models that deliver compassionate, high-quality, cost-effective care

- **Heal**: Enable compassionate care that reduces suffering and contributes to health

- **Partner**: Harness the power of community partners to collectively achieve outcomes

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- **Innovate**: Embrace new paradigms, tools or technologies
- **Learn**: Acquire new knowledge

Pre-symposium workshops were offered by national and international experts in change management, co-designing healthcare solutions, facilitation, improvement measurement, and organizational development tools. On Wednesday, February 7, Jason A. Helgerson, New York State Medicaid Director, gave the opening keynote. “This is a critical period for finalizing and beginning execution on plans to transition your organizations to their future state, a theme that will be carried through the events of our three days together in Staten Island,” Helgerson said, reminding attendees that they will soon begin DSRIP Year Four.

![Image of attendees](image)

**MHVC and Jason Helgerson’s Medicaid Reform Team (MRT) don their WMTY patient-focused lenses at the February All-PPS Learning Symposium.**

The morning breakout sessions included participation by many MHVC partners. Dr. Henry Chung, Senior Medical Director of Montefiore Care Management Organization, and Michelle Blackmore, PhD, Project Director, of Montefiore Medical Center, gave a presentation on “Advancing Behavioral Health Integration in Primary Care: Using Self-Assessment and Technology to Support Sustainability.” They shared the results from MHVC’s continuum-based framework and technology pilots that support sustainability and quality outcomes. Chung and Blackmore also led a lunchtime tabletop discussion on value-based payment and behavioral health later in the day.

MHVC partner, Caren Fairweather, Executive Director, Maternal-Infant Services Network, was a panelist in a late-morning Community-Based Organization (CBO) Consortium panel. The session, led by DSRIP Program Director, Peggy Chan, focused on better positioning CBOs for continuing engagement with PPSs, and ultimately, in future value-based payment and contracting arrangements. (Fairweather discusses the session in the section below.)

Another breakout, “If You Build it, They Will Screen’: Social Needs Screening,” featured Nicolette Guillou, Montefiore Senior Project Manager, Community & Population Health. The panel discussed how Montefiore Health System and others developed and implemented screening for social determinants of health (SDH). The organizations went through similar processes of reviewing literature and engaging interdisciplinary stakeholders in order to develop screening tools for a pilot integrating standardized SDH screening into workflows and Epic electronic health records. The organizations are continuing to work together on enhancing this SDH initiative by linking screening outcomes to Z-Codes and implementing NowPow to facilitate closed-loop community based organization referrals.
Several MHVC staff attended a concurrent session, "Practical Measurement for Improvement: Systems Level Measures and Project Level Measures," presented by Brandon Bennett of Improvement Science Consulting. Bennett talked about how to overcome the difficulty of building capability and designing improvement projects to achieve outcomes that matter for our communities. He also discussed the challenge of figuring out how to measure our systems and our progress toward those outcomes: To be successful, the system has to be seen as a whole instead of just different parts.

According to Manav Surti, MHVC Performance Improvement Specialist, "I can use this knowledge to design proxy measures that help partners track their performance in the absence of real-time performance data." Shauna Stephenson, MHVC Project Specialist, is going to look at the ways MHVC currently gathers data and identify where she can use the three processes to collect data she learned in the workshop: Driver Process, Mainstay Process, and Support Process. She said, "These can help the ED Care Triage partner hospitals point their focus on the whole system instead of only focusing on individual parts. Focusing on the whole system will help them see the big picture and guide them to where they need to be."

Notable among the keynotes on this day was Dan Heath’s presentation on behavioral change. Heath, who is a Senior Fellow at Duke’s Fuqua School of Business, founded and directs the Change Academy, a program designed to boost the impact of social sector leaders. In his remarks, Heath used psychologist Jonathan Haidt’s widely-cited metaphor of the rider and the elephant: the mind is divided into parts, like a small rider (conscious reasoning) on a very large elephant (automatic and intuitive processes). (Link to a short video of the concept here.) The rider may want to go one way, but the elephant, which represents the emotional system, wants to go another. Heath asked, "Which would you bet on?” Another factor is the path: "This duo is more likely to complete a journey if you can shorten the distance and remove any obstacles in their way." The bottom line is, if you want to lead change, you have to give direction to the rider, motivate the elephant, and shape the path to allow for easy progress.

On Thursday, February 8, MHVC staff and partners were featured in three important breakout sessions. Dr. Damara Gutnick, MHVC Medical Director, and Kathy Pandekakes, CEO, Human Development Services of Westchester, gave a morning presentation on "What Matters to You? The Key to Patient Engagement, Improved Outcomes, and Joy in Work." This was an interactive session that gave examples of how MHVC's WMTY campaign has impacted patients and staff, and how participants might initiate, spread, and measure the effects of a similar campaign in their work. Christine Laplante, LMHC, Director of Care Management at Cornerstone Family Healthcare, joined in the presentation and shared the impact WMTY implementation has had on Cornerstone patients and staff. Videos capturing the WMTY implementation efforts of both Cornerstone and HDSW were shown, and are available here. Gutnick and Pandekakes also led a group in a lunchtime tabletop discussion on WMTY.

During the following breakout block, Joan Chaya, MHVC Director of Workforce Development and Management, and Maria Gerena, MHVC Workforce Development Manager, presented on "Mitigating Staff Resistance to Change Through Communication and Engagement." Chaya and Gerena discussed the
MHVC Workforce Communication Toolkit (an online support tool) and how it can be used to foster open communication with staff -- a key to developing a better-informed workforce, a greater sense of engagement, and a better understanding of our partners' work.

In an afternoon breakout, MHVC partner, Rockland Paramedics presented their Behavioral Health Response Team project. Timothy Egan, Chief Information Officer, described Rockland Paramedic's multi-tiered and innovative program in, "Success in Mobile Crisis Service Delivery: Building on the Efficiencies of the Emergency Response System."

MHVC was also well-represented in the poster presentations. MHVC's "Sustaining Cultural Competency and Health Literacy Beyond DSRIP" (Daniel Fontanez, Jasmine Cruz, and Joan Chaya, MHVC), won a gold medal for best poster in the "transform" category. Other MHVC posters included, "Blueprint for Health Equity -- Transforming How We Work" (Victoria Reid, Healthlink NY and Joan Chaya, MHVC), "Developing Talent For Responsive Sustainability" (Adyna Gamboa and Joan Chaya, MHVC), and "Incentivizing CBO Engagement in a Community of Care" (Marlene Ripa and Damara Gutnick, MHVC). (A link to all poster PDFs and authors is here.)

MHVC's Jasmine Cruz and Daniel Fontanez with their award-winning poster on "Sustaining Cultural Competency and Health Literacy Beyond DSRIP."

Fontanez, MHVC Project Associate, was very excited to present the award-winning MHVC "Sustaining Cultural Competency and Health Literacy Beyond DSRIP" poster. "It was extremely gratifying to be recognized for our work throughout the Hudson Valley, and to be able to highlight what we are doing with our partners. We look forward to continuing the progress we have made."

"Change management" was one of the key takeaways for MHVC staff as well as for participants. This was emphasized by the closing remarks of Jason Helgerson, who challenged participants to #StartTheMovement -- taking the lessons learned from DSRIP and applying them to future change. Summarizing the feelings of all MHVC staff attending the symposium, Fontanez said, "Change is never easy but when you have the passion and motivation, you can become the change agent throughout your organization. I will be incorporating what I learned into my work, and strive to become a change agent as we continue the implementation of DSRIP."
MHVC asked three partners, an MHVC CBO panelist, and a clinician who is part of many MHVC projects, to share their personal insights and takeaways.

Partner’s Perspective: An Interview with Eric D’Entrone

Eric D’Entrone, M. Ed., CRC, is Associate Director of Regional Services for Arms Acres and Conifer Park, providing inpatient and outpatient services for patients with chemical dependencies.

On “being in this together”...

Overall I was struck by how well thought-out and well-run the symposium was, and by the quality and variety of presentations. At every session I met colleagues who had something valuable to share -- we were all learning from each other. It was great to be with practitioners from across the state as a reminder that we are not working on these projects in a silo or just in our part of the world: We are all part of this transition. It was very helpful for me to see what others are doing to get ideas and to think about how it can be applied in my organization. It was also an invaluable opportunity to ask, “I am thinking about this -- can we do it? Did it work for you?”

On the theme of “managing change”...

A number of the sessions and keynotes addressed the major theme of managing change in our dynamic times. Personally, this theme was very eye-opening and one that was particularly applicable to my own organization.

I attended the pre-symposium intensive, “Championing Change in a Changing World,” by Dr. Helen Bevan, Chief Transformation Officer, NHS Horizons (English National Health Service). She presented clear, high-level thinking that focused us on the need for “change champions”: How do you get champions to emerge? How do you give them the skills they need to be champions in an organization? Bevan said that power needs to shift to have effective change: Instead of getting buy-in after the fact, we need “investors.” Investors in change start earlier and more upstream; plus, it’s important to get investors from various levels of the organization. Power then shifts from the top down to more collective change.

On learning from MHVC...

The Bevan session set the tone for other presentations related to the theme of managing change, including sessions by MHVC. Maria Gerena, MHVC Workforce Development Manager, and Joan Chaya, Director, MHVC Workforce Development and Management, talked about how to be more strategic when implementing change. Their presentation, “Mitigating Staff Resistance to Change Through Communication and Engagement,” showcased the MHVC Workforce Communication Toolkit, which is an online support tool to help managers address communication gaps about changes in the workplace. It’s based on a simple but effective principle: Open communication with staff and keeping them abreast of the organization’s participation in healthcare transformation will foster a better informed workforce, a greater sense of
engagement, and a better understanding of how DSRIP works and where they fit in. In fact, how well an organization helps employees deal with change directly drives business outcomes.

It was clear that there are specific skills that can be learned and improved, and staff who reveal themselves as change agents can get training. I approached MHVC about bringing a workshop to our Arms Acres executive committee so they can get this training. We will pick one change that we can work on right away and use the three-hour training to jump-start the process as well as kick-off change management training within our organization. The presentation showed me that if we go about change management in a strategic way, it will be successful.

Another MHVC takeaway was from the presentation on “What Matters to You? The Key to Patient Engagement, Improved Outcomes and Joy in Work,” by Dr. Damara Gutnick, MHVC Medical Director, and Kathy Pandekakes, Chief Operating Officer, Human Development Services of Westchester. Reading about WMTY is one thing, but actually seeing examples of how it is used is very impactful. The simplicity of using the WMTY chart, taking the time to ask, “what matters to you,” and consciously integrating patient-centered care into treatment plans are all things we can do at Arms Acres. As another symposium takeaway, I have asked Dr. Gutnick to help us start a WMTY campaign -- and I left the symposium with a dozen WMTY buttons.

**On getting people to change...**

One of the most long-lasting images from the symposium came from a keynote speaker, Dan Heath, MBA, Senior Fellow at Duke’s Fuqua School of Business and founder/director of the Change Academy, a program designed to boost the impact of social sector leaders. Heath’s message included a visual Illustration of how to get people to change. He said you can’t get an organization to change unless you get individual people to change. But you can’t just negotiate with the rational brain -- it has to be an emotional experience that gets them to change. The image that Heath used is of a rider and an elephant. The rider -- representing the front of the brain, the frontal cortex -- controls the elephant. But the elephant is huge and powerful and will go where it wants to go. The elephant is the lower, experiential and emotional part of the brain.

Now, back at my organization, I am always thinking of that image. When I give a training at my organization, I start from a new place: How can I speak to the elephant? How can I connect to the people I am speaking to in a way that resonates -- and not just to the rider?

**On seeing poster evidence of “what works”...**

The posters were inspirational. The lesson from them was: “Just try it, measure it, and see if it works.” They got me thinking about great partnerships that we could form with other organizations and forging relationships that maybe didn’t exist before.

**On being inspired...**

And, finally, Jason Helgerson’s closing remarks tied everything together. His knowledge and passion were contagious, and I couldn’t wait to get back to my organization and start implementing what I learned. Although he challenged us to “start a movement,” I feel as if we are already part of one as MHVC partners.
Partner’s Perspective: An Interview with Dan Maughan
Daniel J. Maughan, RN, BSN, MBA, MSN, FNP-C, is Senior Vice President -- Transformation for St. Luke’s Cornwall Hospital (SLCH).

On “the power of one, the power of many”...
Thinking about how to manage change and what that means in my organization was the greatest challenge, as well as the greatest inspiration, of the symposium. The most impactful session I attended was Dr. Helen Bevan’s breakout session, “The Power of One, the Power of Many: Applying Social Movement Thinking to Health Care Improvement.” Dr. Bevan inspired us with a quote from Dr. Martin Luther King, Jr., “We must act with all due alacrity, yet also with the thoughtfulness and seriousness of purpose appropriate to meaningful action.” She used that as the basis for talking about how true power is really the “power of many.”

Dr. Bevan gave examples of how you begin a social movement with respect to improvement in health care, and focused on an area I had not thought of before: Which kind of activists are the most successful in change? She challenged us to learn to identify who was going to be most and least effective on our teams. She described lone wolves, mobilizers, and organizers: the lone wolves are the least effective, and a combination of mobilizers and organizers is the most effective. We use emotional intelligence tools here at the hospital to garner a better understanding of ourselves and value the insight it offers. So if we better understand who we are, and can identify what kind of activists are on our teams, and can better understand our “spectrum of allies” -- who are active allies and active opposition, and how to move people from opposition to ally -- we are better positioned to succeed.

On “upstream quality improvement”...
Another new concept for me was introduced in the keynote by Rishi Manchanda, MD, MPH, an author and founder of Health Begins. Dr. Manchanda spoke about the “upstreamist” movement, which says, “The question is no longer whether to address the upstream needs of patients and populations, but how.” He shared breakthrough solutions that primarily address SDHs at the source of illness. At SLCH and many of the Montefiore hospitals, we recognize the importance of identifying and acting to meet the SDHs if we are going to be successful in treating the physical and behavioral health issues our patients and families are facing. The focus was how health systems are building a wide variety of partnerships with non-medical partners to address SDHs in order to generate better outcomes and value for different populations. Through MHVC Innovation Funds, SLCH is working with our local Health Home Care Management agencies to address SDHs right from our ED, allowing for further reductions in avoidable ED use by connecting folks to vital services.

However, we recognize the importance of continuously assessing our readiness and capacity for addressing SDHs. Dr. Manchanda shared a link to his online Upstream Readiness Assessment tool: In fifteen minutes, professionals within healthcare organizations can self-assess their readiness to effectively address health-related social needs for specific patient populations. We will be definitely be doing this at St. Luke’s very soon.

On being inspired by two posters...
Many of the posters were helpful, but two very different ones made the greatest impression on me. The first was Statewide Performance: What
Happens in Brooklyn Matters in Buffalo, by the the NYS Department of Health Medicaid Redesign Team. Using SPARC’s data, the poster summarized the DSRIP journey -- What is DSRIP? Where were we? Where are we? Where are we going? The data are impressive, showing over 126,000 people who have avoided emergency department visits and received more appropriate care in the first three years of DSRIP. Our Involvement in the Medicaid Accelerated Exchange (MAX) Series program has allowed us to be part of this reduction, something we are very proud of.

The poster that really resonated with me was JustTellOne.org: Starting the Conversation about Mental and Behavioral Health, about an initiative that is “empowering youth with tools and inspiration to start the conversation about mental and behavioral health issues before problems become crises.” In one year, the initiative has generated over 1.54 million social media views, 24.5 million Facebook impressions with 48,404 engaged users, and 43,888 website page views, with depression and suicide the most-visited sections. What started in Western New York has the potential to go worldwide, harnessing the power of social media and a well-crafted program.

It is very exciting, and although I don’t know how we will plug into this yet, we have some ideas: One of our Board members is the superintendent of schools for the Newburgh School District; we can put the link on our website and highlight it during Mental Health Awareness Month in May; and discuss it with our community partners as part of the “Community of Care” conversations.

On being inspired...

Overall, I felt privileged to be at the symposium. It gave us tangible evidence of what we are achieving together as a system through the MHVC network -- truly the sum of us is better than one of us. We are really impacting the health of those we reach, and recognize the importance of caring for our vulnerable populations. It is a privilege to be doing this work.

Partner’s Perspective: An Interview with Stephen Papas

Stephen M. Papas is Director of Development for Meals on Wheels Programs & Services of Rockland, Inc.

On the importance of CBOs to DSRIP...

One of the biggest takeaways for me was the acknowledgment that CBOs now have a large role to play in the future of DSRIP, leading to what Jason Helgerson called a “change in culture.” The change embraces a community-based approach to dealing with SDHs, which were more familiar to CBOs than hospital systems in the past. It could have been daunting to be a small CBO in a room with all of the major healthcare providers and agencies in the state, but Jason was speaking to us. One of the SDHs he cited often was food insecurity -- and that is our main focus. We felt welcomed, and that feeling continued throughout the entire symposium.

On CBOs gaining perspective on PPS needs...

Appreciation needs to go both ways: Although many sessions encouraged PPSs to work with CBOs, a really important message was that CBOs need to understand the challenges that PPSs face in a partnership with CBOs. Even if a CBO is willing to help a PPS, often there are limitations to the resources, outcomes, and research that the CBO can provide. That was an invaluable
insight. When a CBO is seeking a grant, sometimes it does not have the data needed because it doesn’t track it -- the CBO can’t “check all the boxes” on the grant application. As a grant applicant, I know the PPS has to check those boxes and have the data -- the CBOs have to bridge those two worlds and gain (or accommodate) that level of sophistication.

The symposium gave me the opportunity to hear about a lot of successful CBO relationships. One was as simple as opening a food pantry in a hospital, which gave patients a grocery bag of food upon discharge. I thought, yes, simple and interesting, but how do you get outcomes? And that’s when I realized, “I am thinking like a PPS now!” Even though I was a CBO participant in the audience, I was thinking like the funder, so maybe my next project proposal is more likely to be funded.

**On CBOs and PPSs speaking the same language...**
One PPS said it was hard to determine which CBOs can be of assistance to make their goals. Another said it was difficult to work with CBOs: “When we were in conversations with them we thought they understood. And then we actually did a site visit but they didn’t have the capacity to do what we needed to have done.” That was eye-opening for me, since we had been working with MHVC for a year and we haven’t asked them to visit. I immediately invited them to come, and the site visit was a huge success. The staff was thrilled -- MHVC and DSRIP was no longer an abstraction, or just an entity that required paperwork and numbers. The staff was able to interact with the people we are working with. And MHVC got to see our energized and passionate staff.

**On CBOs and SDHs...**
And finally, the keynote and breakout by Rishi Manchanda, MD, addressing SDHs and the “upstreamist” movement really resonated with me and summarized Jason’s themes. Dr. Manchanda emphasized the importance of being able to catch something upstream, saying that’s what addressing SDHs is all about. I came away feeling that the state understands that CBOs are uniquely qualified -- and uniquely positioned -- to work sooner, quicker, and better with SDHs, especially given the demographics and geographic challenges of our Hudson Valley region.

**Participant’s Perspective: An Interview with Caren Fairweather**

*Charting the Future of CBOs -- MHVC Partner on CBO Consortium Panel*

In 2017 the New York State Department of Health awarded funds for CBO planning grants to three regions: New York City’s five boroughs, the Hudson Valley and Long Island, and the rest of the state. The grant recognized the importance of supporting strategic planning for CBOs to facilitate engagement in DSRIP and post-DSRIP activities. The goal of the grants are to assist CBO Consortia to identify business requirements and formulate strategies for short-term needs, as well as longer term plans, envisioned for sustainability in health care system transformation.
MHVC’s Caren Fairweather, Executive Director, Maternal-Infant Services Network (MISN), located in Newburgh, NY, was a panelist on the “Community-Based Organization Consortium Panel” with moderator Peggy Chan, MPH, DSRIP Program Director, NYS Department of Health; Emily Rogan, Project Manager, CBO Planning Grant, Health and Welfare Council of Long Island, which is the fiscal agent for the joint Hudson Valley and Long Island grants; and other grant recipients. “Ensuring access to health care, maintenance, treatment, and long-term prevention is the war, and one that is more prevalent in our culture as the middle class has eroded,” said Fairweather. “CBOs are the front line of that war.”

“We signed our CBO grant contract a week before the panel at the PPS Symposium in Staten Island, so this was a great opportunity for us to learn from the NYC grantees, who have been working on their projects for eleven months,” said Fairweather. “We know that the biggest challenge for us, as small CBOs, is to figure out how we can position ourselves for a future as viable partners with PPSs, independent physicians associations (IPAs), managed care organizations (MCOs), and the transforming health care systems. How will we enter into value-based payment (VBP) contracting arrangements?”

Fairweather spoke to the needs of CBOs to have defined areas of participation, and the internal challenges that must be addressed to demonstrate the value of services as partners in the VBP environment. The Hudson Valley project is planned to help CBOs that meet the Tier 1 criteria eventually participate as compensated partners within the larger health care system. “It’s an ambitious undertaking for one year,” said Fairweather. “Our success depends on engaging about 50 Tier 1 CBO partners across the Hudson Valley that are willing to be immersed in learning together how to re-tool our data collection platforms, technology, and cost modeling, so we are thrilled that this symposium was the ‘kick-off’ for the effort.”

Fairweather explained that the project includes Tier 2 and 3 CBOs, since the work needs to have synergy across the spectrum of health and human services providers. “We are in the partner-gathering phase,” she said. “We signed on about 30 CBOs when we were just applying for the grant; now we need to re-engage them as well as cast a wide net to recruit others who address SDHs in the region.”

The grantees have retained consultant Health Management Associates (HMA), which conducted a kick-off webinar for all three tiers. “Our focus is to have Tier 1 CBOs participate in assessments, training, and identifying best practices (BPs),” said Fairweather. “We are creating a technology platform to follow issues and BPs, and to archive trainings to ensure anytime, anywhere access to help overcome the geographic challenges of
our region. To that end we are approaching this region as two Hudson Valley Hubs: Mid-Hudson and Lower Hudson, with MISN and Lower Hudson Valley Perinatal Network collaboratively coordinating the project across the seven counties.”

Fairweather says they are approaching the project without conceptions of what will work. "We hear from large partners, 'We value our CBOs, but we can’t work with so many.' Maybe we need to ask how a cluster of CBOs that serve a certain high-needs community can come together? Or how can we coordinate what we do that involves cost sharing? Or maybe we need a different kind of cross-agency care management that shows collectively how we have improved health outcomes for a certain population? We need to identify the opportunities that are right in front of us.” These collaborative questions especially apply to technology:
Fairweather can envision having a technology platform that could be purchased collaboratively to collect and portray data uniformly.

"We are on the ground and work with people in a different way," said Fairweather. We are on the front line for SDHs and have been addressing them even before they were called SDHs. We connect people to the health care system, people who have been disconnected forever. We know how difficult it is to make health a priority when basic needs like food, housing, child care, employment, safety and transportation require immediate attention.”

Fairweather concluded, "Since we have a passion for what we do, we take for granted that our services are valued. But, ultimately, we have to change our business model so we are not so dependent on grants and small donors. To be sustainable we need to learn more concrete ways to demonstrate the value of our work so that we may continue to provide ongoing services to the people whose lives we touch and improve. This grant is a great first step in building a coalition to develop realistic plans and capacity for the long term.”

Caren Fairweather, Executive Director, Maternal-Infant Services Network (left) with MHVC’s Medical Director, Dr. Damara Gutnick.

Clinical Perspective: An Interview with Bruce Rapkin

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Bruce D. Rapkin, Ph.D., is Professor, Epidemiology & Population Health; Head, Division of Community Collaboration and Implementation Science; and Area Leader, Cancer Prevention and Control Research, Albert Einstein Cancer Center. He has been working with MHVC to support the implementation and evaluation of Innovation Fund projects, and to establish a "Research Roadmap" focused on quality improvement.

**On MHVC’s work...**

One of the nicest things about this meeting is that a number of our MHVC CBO partners -- especially Tier 1 CBOs -- were part of the program as well as active participants. It was also gratifying to see the range of the MHVC partners represented, from CBOs such as Meals on Wheels (Rockland), Maternal-Infant Services Network (Orange), TOUCH (Rockland) and Yonkers Public Library (Westchester); to our FQHCs (Hudson River Healthcare and Cornerstone Family Health Center); to our Behavioral Health and Substance Use providers; to our Innovation Grant recipients; and to well-known hospital innovators such as St. John’s Riverside, Nyack Hospital and St. Joseph’s.

I thought that the impact of MHVC’s work (especially with CBOs) was showcased really well in its poster presentations. A lot of the projects were related to crisis, and the posters clearly showed that bridge: How projects connected CBOs and providers, and how all of the entities and results are folded into that research. This is a testament to the success of the work being done to better integrate the CBOs into DSRIP.

**On new learning...**

One of the most helpful presentations was on accelerating the movement toward a learning-based health system, entitled, "Why Now? Accelerating Learning and Spread in Health Care Today," by Lisa Shilling, RN, National Vice President Quality and Care Delivery Effectiveness for Kaiser Permanente. She asked the questions all of us in health care have as the industry goes through dramatic changes and is under intense pressure to adapt to a model that focuses on value over activity: “What will it take for us to succeed? How might we learn from other industries and find ways to collaborate and solve intractable issues?”

Ms. Shilling challenged us to think about the change process, and the set of deliverables and goals that are needed at each step. She suggested that we start a project with a “bite-sized proof of concept” that doesn’t take a lot of resources, but then sets the stage for asking resources for each subsequent phase. The most important takeaway was to think about what stakeholders are needed at each phase. This process is used throughout the Kaiser system to deliberately manage the process of change.

I am interested in how we can apply this to thinking about our CBO partnerships. MHVC is usually not dealing with one CBO on a project, so it is often necessary to facilitate the work of different people across different organizations who need to work collaboratively. The idea of viewing our work as a multi-organizational process is something that I would like to bring to our work with CBOs to describe their coalitions. Although partners’ prior relationships and willingness to collaborate is important, it is even more important for applicants to explicitly articulate the coordination of organizational roles and resources, and how these align with their vision, goals and deliverables.
On “break through the noise”...

The symposium also challenged us to apply lessons from other industries. The final keynote was from Bisi Williams, who is Chief Insights Officer for Massive Change Network (MCN), the design consultancy she co-founded with Bruce Mau. MCN’s premise is that design is leadership. Ms. Williams introduced their 24 principles of design, and showed how they could be applied to impact your organization, solve problems, and inspire leadership. Here they are:

![24 Design Principles](image)

The one that stood out for me: “Break through the Noise.” Williams sounded a cautionary note: “Don’t do a lot of little things that don’t break through the noise.” In other words, do some things that have a high enough profile to get attention and have a noticeable impact. We have done a lot of important projects through DSRIP but we have to ask, how can we expand and build on the track record to create excitement and mobilize widespread participation and support? I think this could be the start of a larger discussion with MHVC and our partners about how to “break through the noise.”

On “starting a movement”...

Jason A. Helgerson, New York State Medicaid Director, closed the symposium with the most impactful presentation of all. He characterized DSRIP as a social movement, even starting a social media discussion at #StartTheMovementNY.

Unlike prior movements, this one has a business case behind a shared vision of what health care should look like. Why would you think of going to the doctor and ask about housing? Why would the police connect you with a doctor? Because we are building a system that seamlessly addresses all of these issues. Helgerson feels that DSRIP finally breaks down the barriers.

The discussion got me thinking differently. I really like the idea of CBOs having a natural role in that social movement, like having no wrong door: When you go to Meals on Wheels, whether you have a problem with mobility or an infection, they can direct you to a clinic or provider. If you are homebound or have food insecurity, the emergency department can help. The idea is not radical -- the radical part is how can we make this part of our dialogue and share the enthusiasm and importance of this idea.

I think this represents the most important change in health care since Medicare and Medicaid. It is so logical, and it is driven by the community and accountability. So let’s “start a movement” and “break through the noise” together.
Bi-Directional Crisis Models: Law Enforcement and Health Care at the Same Table
Creating deliberate opportunities for sharing responsibility and investment in solutions

Throughout DSRIP, MHVC has been working closely with counties, partners, and CBOs on creative ways to approach the opioid crisis in the region. Crisis stabilization projects and county-wide mapping initiatives have brought diverse perspectives to the table, fostering better understanding and new, cost-effective, and results-driven ideas.

“Although MHVC is very proud of the crisis collaborations we have helped foster, this issue is so critical, and the opportunities for improvement so potentially transformative, that we were eager to learn about innovations at other PPSs,” said Dr. Damara Gutnick, MHVC Medical Director. Two sessions at the PPS symposium highlighted similar efforts on Staten Island, “Innovative Strategies to Impact the Substance Use Disorder Epidemic” and “Building Cross-Sector Partnerships for ER Diversion,” but with a distinct focus: Law enforcement and the judicial system were leading the conversations from their seats at the table.

Addressing the SUD issue requires cross-sector partnerships to identify practical solutions, investment in new programs and resources, and community-wide education. Aliza Travis, MHVC Provider Relations Specialist, was struck by the commitment and depth of the involvement, “Law enforcement was very vocal about knowing they have to be at the table regarding the health of the population; they were equally vocal about the opportunity for health care to have a seat at the table to address public safety.”

“While we expected to hear about efforts to impact measurable outcomes including the reduction in preventable ED utilization and engagement in SUD treatment, the HOPE (Heroin Overdose Prevention and Education) model of criminal justice system diversion and the embedded peer program were two innovations that showcased the partnership between law enforcement and health care,” said Gutnick.

The HOPE model was presented by Michael McMahon, District Attorney, Richmond County DA’s Office. “Too many lives were being lost between arrest and disposition, and many users simply accepted short prison stints instead of Drug Treatment Court. Our criminal justice system was missing a key opportunity to break the cycle of addiction by linking these people to treatment and supportive services.” The HOPE process applies to the whole borough. He continued, “We are saying: ‘We are not going to process these individuals; you can either serve time or go to rehab.’”

When an individual is determined eligible for HOPE, they are given a court date 7 days from the date they were arrested, and a trained “peer recovery coach/mentor” is dispatched to the precinct to meet with the potential participant. They escort individuals directly to resource or recovery centers.
and/or schedule appointments to visit centers. Attorneys from Legal Aid provide advice about HOPE before the 7-day hearing date. If the individual completes the program and meaningfully engages in services for the 30 days after their date of assessment, the DA will not prosecute, the arrest record will be sealed, and the participant will not have a criminal record.

There is HOPE: To date, 261 participants (94%) have meaningfully engaged and their cases have been withdrawn.

"This program has had stunning results, and even though the geography of our region presents challenges, our partners can apply the principles of the program in their communities," said Travis. "The program’s success is built upon extensive strategic and collaborative partnerships, including the PPS as the public health partner. Health care CBOs and partners are very involved -- this is not just a criminal justice initiative."

Building upon the HOPE partnerships, Richmond University Medical Center on Staten Island spearheaded the use of peer advocates in their ED to connect SUD clients to treatment and support services. These certified recovery peer advocates, recognizable by their purple jackets, are embedded in the ED, 24-hours a day. "If law enforcement brings someone to the precinct, a peer comes to the precinct to pick them up," said Travis. "The peers are employed by a CBO and certified so they can bill for services. Even though the distances would be a challenge in parts of our region, this may work for others." The PPS played a significant role in organizing and facilitating these conversations and providing data.

Project ECHO: Hub-and-Spoke Technology Brings MAT Where/When Needed
Overcoming geography and specialty bias to help PCPs

The opioid epidemic is real and people are dying across our country at alarming rates. In Orange County alone, the number of deaths due to opioid overdose nearly doubled between 2013 and 2017, from 55 to 99, despite intensive public health efforts. We also know there is a shortage of Hudson Valley clinicians trained to treat opioid addiction. While our primary care physicians (PCPs) are the front-line for our region’s health care, when it comes to medically-assisted treatment (MAT) for the opioid epidemic, there is often reluctance to engage in what has been traditionally a specialty area.

Project ECHO (Extension of Community Healthcare Outcomes) may be one answer to address this service gap. According to Daniel J. Maughan, Senior Vice President, Transformation, for St. Luke’s Cornwall Hospital. Project ECHO uses videoconferencing to enable board-certified specialists in a central location -- “a hub” -- to mentor other community clinicians who are not specially trained so their expertise can extend to “spokes” in the community. “Project ECHO allows hospitals like ours in a community health setting to direct medical education and care delivery in ways that were not possible in the past,” said Maughan. “It allows us to have access to specialty care and bring treatment where it is needed, especially in communities where SDHs limit a patient’s access.”

According to Dr. Damara Gutnick, MHVC’s Medical Director, “Project ECHO is
different from telemedicine in that Project ECHO builds capacity for learners at the spoke sites to develop expertise in managing a new condition themselves thereby impacting a larger patient base, unlike traditional telemedicine where the specialist directly manages the patient remotely.” A short video summary of Project ECHO can be seen here.

“Project ECHO would help us achieve the quadruple aim,” said Maughan. “The patient receives the right treatment in the right place at the right time with the right provider at a lower cost, and providers have the satisfaction of being able to deliver the care, increasing their expertise. It’s an elegant model.”

During the learning symposium session “Using Project ECHO to Spread Office-Based Medication Assisted Treatment: Life-Saving System Transformation,” James Anderson, PhD, Medical Director, Behavioral Health and Integrated Services for the Leatherstocking Collaborative, demonstrated how that PPS utilized Project ECHO’s hub-and-spoke model to dramatically increase capacity for MAT treatment across five rural counties. Through a three-way partnership between Bassett Healthcare Network, University of Massachusetts Medical School, and the PPS, 31 clinicians were trained and mentored in MAT during 2017 resulting in a 150% increase in the number of patients with opioid addiction being treated with Buprenorphine.

Paul Meissner, Director of Research Program Development for Montefiore Medical Center (MMC), knows the potential of Project ECHO for MHVC first-hand. Meissner received a two-year, $175,000 grant from the state to support Project ECHO in the Bronx and the Hudson Valley. “Three of us went to New Mexico for the immersion trainings,” said Meissner, and then planning began in January 2018 through a partnership with the Montefiore Learning Network (MLN). For the first phase, three partnerships and topical areas of focus were identified: With MHVC and Orange County for MAT; with the Center for Excellence in Alzheimer’s Disease in the Hudson Valley; and a primary care project in the Bronx with the Montefiore Medical Group.

“We are just beginning project development,” said Meissner. “We will be using Zoom as our video conference vendor. Each of the different projects will develop its own hub and spokes with support from MLN. After we get our hub teams together, we will start advertising to recruit the spokes. Our aim is to launch Project ECHO for MAT in September 2018.” Meissner is already responding to requests for other collaboration. For more information, contact Erka Amursi at the MLN, eamursi@montefiore.org.
School for Change Agents and Certified Change Practitioners: MHVC Develops “Change Management Fundamentals”
MHVC is offering training based on prominent tools

Helen Bevan, Chief Transformation Officer for NHS Horizons, introduced the launch of the “School for Change Agents” at the symposium. “MHVC is participating as change agents ourselves, and we wanted to share this opportunity with our partners since it is so beneficial,” said Joan Chaya, MHVC Director of Workforce Development and Management. “We realized that when we combined the principles of School for Change Agents with our three-day change management certification program, we had an offering that would really resonate with our partners: ‘Change Management: Help Your Team Embrace Change.’”

The School for Change Agents is a global online learning community of change management practitioners and subject matter experts (link here). The school is led by the Horizons Group-National Health System (NHS) England, a national improvement cohort that aims to support colleagues in health care to think differently about how effective change practice can lead to better outcomes for patients. The school provides one-hour webinars on change management, and “Edge Talks” that are live and interactive video calls that focus on specific topics followed by group discussion. Webinars are recorded and may be viewed individually, in a group setting, or accessed on the school’s homepage or YouTube channel. The website includes a repository of articles, videos, books, and tools on change management that are accessible to everyone.

Bevan’s presentations were highlights of the symposium and reinforced the themes of transformation and change management. According to Maria Gerena, MHVC Workforce Development Manager, “Building our competency to lead and implement change successfully is a top priority in health care transformation. We must be able to effectively manage the people-side of change to realize the full potential of our strategic initiatives. When we hear presentations such as the School for Change Agents, we immediately think about how it fits into what we have already begun at MHVC.”

“Bevan inspired us to value the ‘boat rockers’ in our organizations who are asking for change, since they are mission-focused, passionate, see the possibilities of change, and are energized. She also explained that these same boat rockers will lead to complainers and energy-sapping staff if their voice is not acknowledged. That is why we are focusing on the people side of change,” said Chaya.

Bevan talks about change theory, studies, and data. Her curriculum uses data
to explain the phases of change management; what has worked and not worked; and how to create that social movement of change. "She paints a high-level picture of the movement and how to create platforms that value diversity of thought," said Gerena. "That level of change applies not just to a social movement, but to business and your life. Everyone can get inspired: You walk away and say, 'How do I implement this movement in my organization? What are the competencies we need, and who do you designate to implement this change?"

"Our partners can say, 'I have been inspired by Helen Bevan to be part of a social movement and certified as a change practitioner with skills to help build my organization.' We will have over 40 certified change management practitioners in the Hudson Valley alone by May," said Gerena, "MHVC plans to stay connected to these change practitioners and build a learning cohort for sharing of best practices." The team is just starting to build the cohort, with activities such as check-in calls, asking practitioners what they need, what kind of programming would be useful, webinars, speakers, and a best-practices forum. "We will be including all certified practitioners in building that support platform," emphasized Gerena.

MHVC’s three-day change management training program supports partners in building and enhancing change management capabilities and helps set a new standard of competency around change leadership. (See MHVC January newsletter article, here.) Bringing change management into the region, MHVC has developed an onsite change management workshop that it will initiate with the Arms Acres senior leadership team. This workshop “Change Management: Help Your Team Embrace Change," is a customized presentation by MHVC that focuses on the value of change management and the role sponsors play in developing themselves and others as change management investors. “We will give them basics of how they can apply change management in their organization, and concrete suggestions of how they can implement change and build momentum," said Gerena. “This is an MHVC offering tailored to meet the needs of our partners who recognize the importance of change management. Most importantly, this is one of the critical tools that our partner organizations can have in their toolkit post-DSRIP for sustainability.”

For more information on "Change Management: Help Your Team Embrace Change," contact Maria Gerena, mageren@montefiore.org. For more information on the School for Change Agents and to access its resources, visit the School’s home page here and sign up for the School’s newsletter.

Go to MHVC Website

“Co-design” Reflects a Fundamental Change to Finding Solutions

Experience questionnaire uses emotions, not metrics, as basic tool

MHVC has been encouraging conversations that highlight the importance of incorporating the patient voice into treatment plans, program design, and care delivery. The WMTY campaign has been adopted throughout our network and partners have reported great results. But how can your organization do this in a
time-efficient manner and on a larger, systemic scale?

One answer was provided by Dr. Lynne Maher, Director of Innovation, Ko Awatea, Health System Innovation and Improvement, Counties Manukau Health, New Zealand, at her pre-symposium intensive entitled, “Understanding Experience and Co-Designing Solutions.” Dr. Maher described the “new normal” in health and care improvement and innovation: Ways to effectively capture patient voices and experiences during the care journey, and to utilize co-design principles to redesign the patient experience based on what you learn.

Reflecting her origins, Dr. Maher set the tone by sharing an important Maori proverb, translated as: “What is the most important thing in the world? It is the people, it is the people, it is the people.” Co-design reflects a fundamental change in the traditional health professional-patient relationship. The approach is based on partnership, values, and expertise of those delivering and those receiving care. This approach enables a wide range of people to contribute to solutions which will lead to improvements. While relatively new to many health services, co-design is the “go to” method for leading service organizations such as Starbucks, Ritz Carlton, and many airlines.

Dr. Maher gave an overview of the co-design process and shared key insights and tools. The co-design approach includes the following stages:

- **Project start up**: scope, plan, aim
- **Engage**: consumers, families, and staff
- **Capture**: consumer, family, and staff experiences using a range of methods
- **Understand**: emotions and “touch points” along the journey of care
- **Improve**: work together to identify and prioritize what to improve
- **Measure**: check to see if experience is improving

According to Christina Hamilton, MHVC Reporting Specialist, “Dr. Maher focused on working with a client or patient to figure out what matters to them, and then designing solutions together. She showed us how we could quickly collect more meaningful patient experience data by capturing the emotions associated with each process a patient goes through during an episode of care.”

Although some of the individual tools -- such as Plan-Do-Study-Act (PDSA) -- were familiar to participants, Dr. Maher’s “experience questionnaire” that led to an “experience map” provided a method that was accessible, effective, and meaningful. The experience questionnaire uses words, such as “happy, supported, safe, good, comfortable, in pain, worried, lonely, sad” and “smiley faces” such as those used for a pain scale, from a smile to frown to tears.
Hamilton explained, “Instead of asking the patient to rate their experience on a 1-5 numerical scale, you are asking them to rate their experience as feelings. The assessment can be utilized during care, while the patient is going through each phase of the care journey, or after care. It allows for a more precise discovery of possible process improvement areas.” This tool can be used for any kind of process, such as registration intake, discharge, etc.

“What really brought the experience home was one of the breakout activities,” said Hamilton. “We were asked to rate a recent restaurant visit on a scale of 1-5. Initially I rated my visit as a ‘3’ -- kind of good, but not all great. Then we paired up and had to describe the emotion of the visit to our partner. This brought up a lot of emotions, and I realized that I actually should have given the restaurant a lower rating since I had more negative emotions than positive. It made all of us realize that emotions were a much better evaluation scale than just numbers.”

This technique works hand-in-hand with MHVC’s WMTY initiative, which emphasizes the importance of providers designing treatment plans directly with patients. “The experience questionnaire resonated with me,” continued Hamilton, “since the patient is the expert on themselves, and you need to work with them in order to meet their needs.”

The experience questionnaire can be implemented immediately in any organization to revise or implement processes. Decomposing the information collected from the questionnaire and using it as an input to process improvement is a technique known as “experience mapping.” Dr. Maher mapped the patient journey and was able to identify separate component steps, who is involved at what stages, what went well and what needed improvements. This deliberate process, based on co-design principles and the results of the experience questionnaires, led to more successful and immediate implementation.

Katie McAuliff, PhD, a Project Director within the Einstein College of Medicine, was in one of the patient-journey mapping breakout groups. Dr. Maher gave each group the same scenario, but they had to look at what happens to a patient between different points in time. McAuliff said, ‘It was helpful to think how each interaction a patient has with the healthcare system can be an emotional experience. The exercise taught us to identify opportunities for improvement more frequently and in a more comprehensive way, especially since we all have a different understanding of how the health care system
works.”

Hamilton observed, “Dr. Maher showed how this process is well-suited to situations where there are a lot of cultural differences. It also can be used to implement change on a large scale. This is another interesting and effective application for our diverse region!”

Poster Highlights

What’s Happening? Posters Summarize Projects and Innovations

Posters make it easy to see results, inspiring attendees

At any conference it’s impossible to attend all of the sessions, so how does one find out what’s happening around the state? Who is doing the most innovative work in an area important you?

Posters, posters, posters. The symposium had 53 posters representing a wide array of improvement efforts from all of the PPSs (a link to all poster PDFs and authors is [here]). Attendees could visit the posters area at any time; in addition, there were poster receptions at the end of each day when the presenters were at their posters to discuss their work and answer questions.

Participants were asked to vote for their favorite posters following voting instructions that were handed out at registration and at the poster receptions. Awards were presented to the posters that demonstrated significant achievement, with attention to measurable results, in each of the symposium theme categories. Jason Helgerson presented the awards during his closing remarks to the following winners:

-- **Heal**: Optimizing the Quality of Life for Patients with Chronic Illness Through Palliative Care. Mary Han, Paula McAvoy, Frank Forte, Maura Ellis, Bonnie Lauder, Carmel Festa (Staten Island PPS)

-- **Innovate**: Transforming the Delivery System for a Seriously Mentally Ill Population: Innovations in Care Coordination, Network Building, and Health Information Technology. Sara Kaplan-Levenson (Community Care of Brooklyn PPS)

-- **Learn**: Developing and Implementing a Cultural Competence/Health Literacy Training Program. Wendy Weil, Duane Granston (Bronx Health Access PPS)

-- **Learn**: Supporting Value-Based Healthcare in the UK. Catherine Mitchell (NHS)

-- **Partner**: Transition of Care Event Model (Demonstration Pilot). Maureen Doran, Hal Smith, Aby Diop (WMC Health PPS)

-- **Transform**: Sustaining Cultural Competency and Health Literacy Beyond DSRIP. Daniel Fontanez, Jasmine Cruz, Joan Chaya (MHVC PPS)

In addition to the winning poster in the "Transform" category (above), MHVC is especially proud to have had three other posters accepted: “Blueprint for
Health Equity -- Transforming How We Work” (Victoria Reid, Healthlink NY and Joan Chaya, MHVC), “Developing Talent For Responsive Sustainability” (Adyna Gamboa and Joan Chaya, MHVC), and “Incentivizing CBO Engagement in a Community of Care” (Marlene Ripa and Damara Gutnick, MHVC).

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