Who We Are

Montefiore, renowned for its long-standing commitment to community-based healthcare, is leading a group of nearly 250 healthcare providers, community-based organizations, local government officials and more, from across Westchester, Rockland, Orange, Sullivan, Dutchess, Ulster and Putnam counties, to form the Montefiore Hudson Valley Collaborative (MHVC). Working together, we are championing new models of providing over 200,000 Medicaid beneficiaries with higher quality care, while reducing expenditures through enhanced coordination, community-focused care and education.

Our Guiding Vision

- A more integrated delivery system, better able to take on risk and deliver value
- A more sustainable delivery system, care delivered locally and in the right care setting
- A more patient-centered delivery system, with expanded access to services tailored to the unique needs of our patients and communities
MHVC DSRIP 1.0 Project Impact

Patient Engagement, Supporting Care Transitions

• “What Matters to You” campaigns to target patient experience implemented at Wakefield, Nyack and St. Lukes - Cornwall Hospitals
  • Nyack saw an increase in 10/11 HCAPS PX scores (Q4’18 – Q4’19)

Lorraine’s WMTY Story
“What Matters to You?”

• Multi-stakeholder workflow redesign: upwards of 50% of ED referrals (St. Luke’s/Nyack) & 30% of community referrals enroll in Health Home

Reduce Readmissions (PPR, PPA, PPV)

• Community Paramedics (Nyack) – high risk patient cohort w/ 49% reduction in readmissions

Stopping the Revolving Door
“Stopping the Revolving Door”

• MAX high utilizer cohorts across 5 Hospital ED’s – reduce PPR by up to 52%

Community Partnerships Reduce ED-Utilization

• Addressing Food Insecurity through Information Outposts
  • “Healthy Food Distribution at Information Outposts”
• St. Luke’s/FQHC partnership to reduce PPR, PPV for high-risk patients. Estimated ROI = 3X project costs

Improved Access to Care

• Peer Recovery coaches improved 7/30 day follow-up for individuals w/ SUD discharges from 47% to 100%
  • Recovery Coaches Building Bridge for Care Transitions”

Primary care sites adopted EBG for patients with uncontrolled HTN, improving adherence by 38%
  • “Controlling Hypertension through Planned Interventions”

FQHC Mobile van promoted chronic disease mgmt at BH partner sites – improving adherence by 60%
  • Living Room program served 100+ patients at risk for BH Crisis ED/hospitalization

Open Access for substance abuse intakes across Hudson Valler improved from 28-166.5 hours per week (MTM Same Day Access Initiative)

MHVC DSRIP 1.0 Network Development

Strengthening Care Teams

• 44 practice sites achieved PCMH Level III certification
• Supported network adoption of PHQ 2/9, Brief Action Planning, Motivational Interviewing, Social Determinants of Health (SDH) screenings
• Regional BH networks (CBHS, CHN) aligned with HVIPA

Provider Engagement

• Provider Engagement
  • “Understanding the Role of Teamwork”
  • “Addressing Drivers of Burnout, Staff Resiliency & Joy in Work”
• Change Management Certification (100+), Executive/ Management Training across Network
• Joy In Work Learning Collaboratives
• Addressing Institutional Racism (various programs)

Building Network Interoperability

• 18 partners established HIE bidirectional connections

Emerging Roles – Successfully train/integrate

• Nurse Practitioner Residents (9)
• Community Health Worker (18)
• OASAS Certified Peer Recovery Coaches (24)

Research Roadmap w/ Einstein

• Launched Research Roadmap with Einstein College of Medicine researchers and Hudson Valley community partners to further innovation
  • “Understanding the Role of Teamwork”
  • “Evolution of the MHVC Research Roadmap”

Nida Opioids Grant (Collaboration with Columbia); 5 Hudson Valley Counties

Official news release from Columbia
HHS press conference-NIDA grant announcement
News 4 Feature
What Matters to You?: Building Relationships to Improve Patient Experience Metrics & Employee Engagement

Montefiore Nyack demonstrated an improvement in HCAHPS and Press Ganey key indicators, while receiving positive feedback from patients, families, and team members.

Background
- Patient Experience Metrics and Employee Engagement data indicated a need for improvement, and became an organizational priority

Goal
- Demonstrate an improvement in HCAHPS and Press Ganey scores, specifically those questions related to relationship building

Strategy
- Introduced the “What Matters to You” initiative (WMTY), creating awareness and desire to change
- Provided education on a unit by unit basis
- Incorporated teachings into daily practice
- Data collection included patient survey results, patient comments, direct observations and Nurse Leader and Patient Experience Rounding
- Sustain focus on WMTY, participating in National WMTY Day Celebrations annually

Outcomes
- Attention to Special and Personal Needs
- Staff’s Effort to Reduce Anxiety
- Staff Worked Together to Care of You
- Staff Addressed Emotional Needs
- Response to Concerns & Complaints
- Communication with Nurses

- Successful outcomes have motivated spread through organizations, internationally and in collaboration with IHI

Lorraine’s WMTY Story
WMTY Wedding Anniversary

View Poster
More Than Books at the Yonkers Public Library: Innovative Partnerships to Address Social Determinants of Health in the Community

MHVC funded an innovation to improve access to critical services with the library, meeting people where they are. In just one year, a quarter of all consultations led to successful identification and connection to services.

Background

On any given day, librarians at the Yonkers Public Library (YPL) are asked a wide variety of questions, including:

“I just lost my job. Can you help me file for unemployment and find work?”

“I need to find a rehab center for a family member.”

“I don’t have medical insurance. How can I see a doctor?”

“My kids and I are sleeping on a friend’s couch, can you help us find housing?”

Goal

• Demonstrate how a successful cross-sector partnership among the YPL, CLUSTER, Inc. and Montefiore Hudson Valley Collaborative (MHVC) can effectively address Social Determinants of Health (SDH) needs in the community

Strategy

• Offer weekly case management services at the library with personalized one-on-one consultations and referrals to services

• Address attitudes of library staff toward Serious Mental Illness (SMI) and people experiencing homelessness through anti-stigma training

• Partner with MHVC and Einstein College of Medicine to conduct an ongoing community health survey collecting Patient Reported Outcomes (PRO) and SDH needs

Outcomes

January to October 2019 Outcomes

+25 housing units procured

+11 jobs found

+7 people insured
Stopping the Revolving Door: Advancing Community Paramedicine to Engage High Utilizers

Innovative program resulted in measurable cost savings for the hospital, as well as benefits to patients, providers, and paramedics.

Background

- In an effort to reduce unnecessary hospital and ED utilization, a unique partnership between Rockland Paramedic Services, Inc. and Montefiore Nyack Hospital yielded an innovative “Community Paramedicine Program” designed to provide “gap filling” services in patients’ homes.

Goal

- Reduce unnecessary readmissions and costs of care, and improve patient and provider experience (IHI Quadruple Aim) by providing “gap filling” services to individuals who are at high risk for hospital readmission

Strategy

- Case managers and ED care navigators Montefiore Nyack Hospital identified patients who meet ED “super utilizer”, or “High risk for readmission” criteria.
- Field based community paramedics visited patients at home and conducted home based assessments, which included SDH stressors and drivers of utilization.
- Focus group comprised of staff involved in program was conducted to understand program’s impact on provider experience.

Outcomes

Results Translate into Measurable Cost Savings

- 24% in ED utilization
- 52% overall # of ED visits
- 66% hospital admissions
- 61% multiple visits/day
Healthy Food Distribution at Information Outposts: A Patient Engagement Strategy

MHVC funded an innovation pilot project that integrated a case manager within library to link patrons to SDH resources and primary care. Program is a model to address social needs and provide linkage to medical services for high risk community member. Correlation between social needs and food access confirmed.

Background
- Leveraging its relations with CBOs, including Feeding Westchester, the Montefiore Hudson Valley Collaborative (MHVC) is testing innovative models to address social and medical needs of the community

Goal
- To use “food” as an innovative strategy to engage “food insecure” patrons in Health Programming, and address “What Matters” most, while meeting our patients where they are at

Strategy
- Identification of “Impact Sites” within targeted census tracts to provide health programming and food distribution
- Construct model for partnership - Yonkers Public Library (YPL) pilot program – administer survey with patrons to identify association of food insecurity, and collect survey Patient Reported Outcomes (PROs) at “Impact Sites” during food distribution
- Based on survey analysis, targeted health programming implemented at library, and embedded care navigation at “Impact Sites”

Outcomes
Survey revealed 25% respondents unable to get adequate food when needed over past year making the odds:

- 10X as likely to have stress related to transportation
- 6X as likely to have stress related to housing
- 2X as likely to have stress related to access to medical care

Draft in Progress | 2/26/20
Recovery Coaches Building the Bridge for Care Transition: Keeping Patients Engaged in Outpatient Care

MHVC provided innovation funding for a novel pilot project that integrated Recovery Coaches into the care team of Arms Acres.

Background

- At Arms Acres, a New York State licensed provider of inpatient and outpatient substance use treatment services, only 47% of patients discharged from inpatient substance use treatment actually attended their first follow-up outpatient treatment visits. In many cases, this number was achieved due to staff driving patients to their first visit.

Goal

- To improve 7 and 30 day follow-up HEDIS metrics (follow-up care after discharge to improve transitions of care between inpatient and outpatient substance use treatment) by adding a Recovery Coach to the multidisciplinary team.

Strategy

- Paired Recovery Coaches (Peers) with consenting patients who clinicians identifies as having a high risk of recidivism.
- Recovery Coaches met with patients to collaboratively develop recovery goals and assist with necessary linkages to harm reduction, support groups, family support and education.
- Recovery Coaches were available to accompany patients to first outpatient appointment and self-help meetings.

Outcomes

Utilizing Recovery Coaches led to:

- Routine Discharge Rates
- Readmission Rates
- Patient Engagement in Care

Results provide clear implications for reduction in downstream costs:

Estimated prevention of 63 ED visits + 315 inpatient days =

ROI > $225,000
Understanding the Role of Teamwork Across Organizations and Job Roles

Surveyed providers cited teamwork as key dynamic for improved patient care. Responses suggest stronger team dynamics lead to increased joy in work and less burnout.

Background
- Burnout amongst providers has been shown to have a downstream impact on patient outcomes
- Team-based care is a recognized strategy in improving healthcare, but there is a lack of data-proven methods to improve or implement it

Goal
- Assess satisfaction with team dynamics and workflow across job roles and organizations

Strategy
- Utilize validated instruments and scales to survey and assess various domains of staff’s experience
- Conduct statistical analysis using a combination of Pearson correlation tests, one way analyses of variance (ANOVA), and chi square tests

Outcomes
- Stronger teamwork and team dynamics ranked as the second most important measure needed in order to better service patients.
- Significant positive correlations with joy in work, and negative correlations with burnout
- Stronger team dynamics could lead to positive effects on the healthcare system by decreasing staff turnover and medical errors
Combating the Opioid Epidemic: Using Real-time Data to Inform Coordinated Response

Addressing access from a supply and demand lens, combined with the use of real-time data, is a critical strategy in facilitating rapid response collaboration, preparation, and intervention.

Background

- Deaths related to opioid overdose continue to rise in New York State
- In Orange County alone, there were 68 opioid related deaths in 2016
- NY National Guard Counterdrug Task Force, Catholic Charities Community Services of Orange, Sullivan & Ulster, The 1Life Project and HealthLink NY joined forces to develop coordinated strategy

Goal

- Aim to address the opioid epidemic in the Hudson Valley region through streamlined data collection and coordinated stakeholder communication

Strategy

- Streaming analytics platform created to track timely information related to overdoses
- Pilot with St. Luke’s Cornwall Hospital in Orange County - multiple stakeholders including the prevention/treatment/recovery community, law enforcement, and county government

Outcomes

Collaboration between NY National Guard Counterdrug Taskforce, Catholic Charities, The 1Life Project and HealthLink NY

- Pilot results captured 319 total overdoses requiring multiple doses of Narcan, and enabled rapid coordinated responses, including ensuring regional availability of Narcan supply, linkage to peer supports and potential deployment of the clean needle van
- The pilot demonstrated how the use of real time data and Artificial Technology can facilitate rapid response collaboration, preparation, and intervention
Improvement in a Value-Based World: One Regional Hospital’s Approach to Reducing Behavioral Health ED Utilization

Hospital pilot highlights the benefits of diverse stakeholder engagement and a multifaceted team approach to identifying gaps in care and improving communication, efficiency, and workflows across systems.

Background

- ED providers at Nyack Hospital perceived that patients presenting with schizophrenia and/or psychosis, combined with limited access to appropriate outpatient behavioral health (BH) services, were the primary drivers of ED-utilization.

Goal

- Aim to address the opioid epidemic in the Hudson Valley region through streamlined data collection and coordinated stakeholder communication.

Strategy

- MHVC engaged community stakeholders to assess 911-call data and identify presentation paths for targeted intervention.
- Visits to targeted group homes to both encourage development of individual crisis plans and conduct Mental Health First Aid training.
- Analysis of treat and release data from Nyack Hospital ED to determine ED utilization impact.

Outcomes

Rapid cycle improvement & staff training led to positive impacts for group homes.

- 52% decrease in 911 calls.
- Improved staff confidence due to Mental Health First Aid training.
Driving Member Outcomes: Community of Care Creates post discharge Care Transition Workflow for Behavioral Health Patients

Key lesson learned in this process: Multiple “helpers” reaching out with good intentions to engage the member who is hospitalized is overwhelming from the member’s perspective. Lack of a streamlined process, clear roles, and teamwork and accountability leads to an ineffective care transition process.

Background
- Community of Care (CoC) was created encompassing Montefiore Hudson Valley Collaborative (MHVC) contracted partners in Rockland County
- Guided by data highlighting performance gaps, the Rockland CoC committed to address access to mental health treatment and performance on the DSRIP/HEDIS follow-up after a mental health hospitalization measures.

Goal
- Focused improvement to performance on both HEDIS measure, Follow-up after Hospitalization for Mental Illness (30 Days) and (7 Days)

Strategy
- Rapid cycle improvement project team comprised of workflow stakeholders, including hospital staff, Health Home and Care Management Agency representatives
- Commit to targeted opportunities for streamlining post-discharge workflow to connect members to eligible services and ensure continuity of care
- Process measures identified for tracking progress and success post implementation

Outcomes
- Key lesson learned – multiple “helpers” reaching out with good intentions to engage the hospitalized member is overwhelming from the member’s perspective.
- Team developed and committed to an efficient and effective “community” workflow to streamline the post-discharge follow-up process to connect members to eligible services and ensure continuity of care
Designing Effective Substance Use Referrals: Building the Bridge from Both Sides

Outcomes can also be leveraged to streamline referrals from hospitals, primary care and behavioral health providers laying the groundwork for successful integrated care transitions.

Background

- In an effort to improve care transitions between inpatient and outpatient substance use providers, Montefiore Hudson Valley Collaborative (MHVC) brought both stakeholder groups to the table for a series of facilitated workshops.

Goal

- Improve care transitions and referral pathways between inpatient and outpatient substance use providers in the MHVC network.

Strategy

- Engage inpatient and outpatient substance use providers and build an awareness of the services and programming each offered.
- Leverage facilitated workshop series to assess the multiple barriers for resolution.
- Collaboratively develop standardized referral protocols and processes.

Outcomes

- Future state process maps, standard protocols, and referral templates that incorporated patient preference.
- Commitment from each stakeholders for continued collaboration; consider patient/client voice (WMTY) when making appointments.
- Processes and service access developed as a result, can also be leveraged to streamline referrals from hospitals, primary care and behavioral health providers laying the groundwork for successful integrated care transitions.

An Inpatient SU provider stated...

"When I discharge my patients, I have very low confidence that they are being discharged to the appropriate level of care."

An Outpatient SU provider shared...

"We are often not the right setting for the clients referred to us."

View Poster
Addressing Social Determinants of Health: Drivers of Burnout, Staff Resiliency & “Joy in Work”

Utilized staff survey data to identify actionable results that could inform the development of strategies to improve Cultural Competency and Health Literacy (CCHL), decrease staff burnout, improve staff “joy in work”.

Background
- Inadequate cultural competence and low support for health literacy have been linked to poorer patient outcomes and identified as contributing to health disparities

Goal
- Use CCHL staff survey data to identify actionable results that could inform the development of strategy to improve CCHL, decrease staff burnout, and improve “joy in work”

Strategy
- Survey developed by Research team at the Einstein COM, utilized validated instruments and scales to assess staff comfort screening for SDH needs, as well as provider readiness to address SDH, burnout, and “joy in work”
- Multiple linear regressions then performed to analyze the survey data and identify key relationships between different measures

Outcomes
Survey data revealed:
- Front line staff had the highest rate of burnout, and lower levels on measure of engagement
- In contrast, senior leaders and peer roles were more likely to have “joy in work” and had more positive responses on employee engagement

Improvement strategy considerations
- Alignment of values, employee recognition, readiness for VBP, and resources for professional growth, found to be predictive of “joy in work”
- Be mindful of living and integrating their values, implement employee recognition programs, offer professional development opportunities/pathways for growth, and clarity around how the organization will transition to a value-based payment model
Controlling Hypertension Through Planned Interventions

MHVC incentivized its partners to design a Hypertension project, reducing rates of hypertension patients with uncontrolled blood pressure.

Background

- Uncontrolled hypertension rates are notoriously challenging to curb
- Lack of dedicated staff and financial resources make it difficult for provider to consistently monitor and educate hypertension patients as well as provide them with the tools to keep their blood pressure under control

Goal

- Build the foundation to reduce rates of hypertension patients with uncontrolled blood pressure

Strategy

- Standardize process for outreach to engage at risk patients; include interventions ensuring patients receive concentrated attention to help manage their BP, e.g. pre-visit planning, alerts, and chart audits
- Standardize patient visit workflow and outline steps that clinicians should follow during visit
- Educate patients to manage their BP - provide self-management tools, educational materials and referrals to health/nutrition educators

Outcomes

Cornerstone’s goal was to reduce the rate of uncontrolled patients by 30% over the course of the project, however the team achieved this goal by the end of month two – by the end of project, achieved a remarkable 57% reduction

![Hypertension Rate Reductions Achieved](image-url)
Sustaining Cultural Competency and Health Literacy Beyond DSRIP

Workgroup-developed Resource Repository organized by Competencies and included Training Resources, Information Resources, and CNAs

Background
- MHVC conducted an initial Community Needs Assessment to better understand the community needs
- MHVC conducts ongoing CCHL Staff Engagement Surveys to better understand where our partners are in regards to their Cultural Competency & Health Literacy (CCHL) strategies

Goal
- Work together cohesively to address the CCHL needs of our partners and their impacted client populations

Strategy
- Created a CCHL Workgroup with partners and collaboratively created a resource repository that houses articles and case studies that touch on CCHL best practices
- A CCHL Best Practices Forum was created with the workgroup, to identify issues impacting communities and determine how best to address them
- Plans for evolution of sustainability agreed on to ensure growth and adoption

Outcomes

Working Together

MHVC CCHL Workgroup

- Biannual meetings with Workgroup and CCC
- On-going communication
- Real-time Updates
- Webinars

Best Practices Forum every 2 years

MHVC CCHL Repository

- Resource Repository
- Real-time Information Updates

Provider Organizations

- Membership in County-level Cross-Setting Coalitions
- Real-time communication

County-level Cross Setting Coalitions (CCO)
Rapid Cycle Improvement in “Action”: Community Partnerships Addressing Social Determinants Reduces ED Utilization

Plan-Do-Study-Action (PDSA) strategy provided the tools and momentum needed to develop a system of care that better meets patient needs.

Background
• Two safety-net hospitals participated in a NYS DSRIP 8-month rapid-cycle improvement collaborative

Goal
• Reduce hospital and ED-utilization through intensive care management and community based linkages

Strategy
• Use rapid cycle change processes to design, test and guide implementation of targeted interventions for an identified cohort of super-utilizer patients
• Team successfully modified workflows to be more patient-centric and attuned to SDH driving patient ED utilization and hospital admissions
• Partnered with community stakeholders that impact key SDH needs identified among the SU population

Outcomes
Unmet needs identified and addressed
• St. Joseph’s partnered with local provider to provide flexible scheduling for urgent dialysis
• St. Luke’s found many coming to ED for food – partnered with local food banks to provide meals outside ED

St. Joseph’s Hospital

- 20% ED utilization
- 88% ED Admissions
- 280% Engagement with Care Coordination Team

St. Luke’s Cornwall

- 33% ED utilization 2015-2016
The Evolution of the Montefiore Hudson Valley Collaborative Research Roadmap

Collaborative journey brings “Research Roadmap” to life.

**Background**
- In June, 2017, researchers from Montefiore Medical Center and Albert Einstein College of Medicine were convened by the Montefiore Hudson Valley Collaborative (MHVC) leadership to initiate a research strategy for MHVC

**Goal**
- Collaboratively develop research strategies and capacity for the Hudson Valley, leveraging extensive research experience, and strong partnerships

**Strategy**
- Create a forum for collaboration between key Montefiore stakeholders to maximize research opportunities and community engagement aligned with Montefiore Health System’s priorities
- Focus on stakeholder engagement, strategy development, planning and project implementation

**Outcomes**

**Resulting Research Roadmap Projects**

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<th>Innovative Fund Pilot Projects</th>
<th>Community Health Surveys</th>
<th>Information Outpost Strategy</th>
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<td>TA provided by Einstein Researchers on a project evaluation strategy</td>
<td>Administered at Yonkers Public Library</td>
<td>Collaboration with Feeling Westchester, YPL, other CBO’s and St. Johns</td>
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<th>Community Needs Assessment</th>
<th>“What Matters to You?”</th>
<th>Cultural Competency &amp; Health Literacy</th>
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<tr>
<td>Collaboration with HealthlinkNY Siena College, LGUs and MHVC Partner Hospitals</td>
<td>Impact on patient experience &amp; HEDIS measures</td>
<td>Provider &amp; staff capacity survey &amp; reports</td>
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<th>“Joy in Work &amp; Burnout”</th>
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<tr>
<td>Collaboration with local colleges &amp; universities (Sarah Lawrence, NYMC)</td>
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<th>Albert Einstein NCI Cancer Center</th>
<th>PGY4 Public Health Research Fellowship (Collaboration with Department of Family Medicine)</th>
<th>NIDA Opioids Grant (Collaboration with Columbia)</th>
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<td>Community outreach &amp; engagement initiative</td>
<td>(Collaboration with Department of Family Medicine)</td>
<td>5 Hudson Valley Counties MHVC Partners LOS</td>
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Wolinsky T, McAuliff K, Gutnick DN, Rapkin B. Understanding the Role of Teamwork Across Organizations and Job Roles, Institute for Healthcare Improvement International Forum. Orlando. FL December 2019


Woodlock K RN, Hill N, MPA, Surti M, MBA. Driving Member Outcomes: Community of Care Creates post discharge Care Transition Workflow for Behavioral Health Patients. Take the Pressure Off, NYC! 3rd Annual Summit @ NYU Kimmel 60 Washington Square S, New York, NY 10012; October 29, 2019

Hill N, MPA, Delos Santos-Little R, RN. Controlling Hypertension Through Planned Interventions, NYS All PPS Learning Symposium, Saratoga Springs, NY; February 12, 2019

Chaya J, Cruz J, Fontanez D. Sustaining Cultural Competency and Health Literacy Beyond DSRIP; 2018 DSRIP Learning Symposium Poster Award, Staten Island, NY; 2018


Addiction Treatment Process Improvement

- OC Value Stream Sizzle Reel - a sizzle reel highlighting Orange County’s Process Improvement Implementation plan.
- Corey Waller Value Stream Map - Corey Waller speaks on changing the local environment for addiction treatment.

Behavioral Health Collaborative

- State of the Collaborative - Dr. Henry Chung and Dr. Damara Gutnick discuss the current state of the Behavioral Health Integration projects.
- Dr. Chinazo Cunningham - Dr. Chinazo Cunningham discussing innovations in the management of alcohol and substance use disorder in primary care.
- MHVC Behavioral Health Roadmap - Dr. Damara Gutnick discussing the Behavioral Health Integration Roadmap

Change Management

- Change Management Sizzle Reel - a sizzle reel highlight Prosci’s Change Management practices and how to implement throughout your organization.
- Change Management - Dr. Damara Gutnick and Joan Chaya discuss managing the people side of change.
- Championing Change in a Changing World - Dr. Helen Bevan, Chief Transformation Officer at N.H.S. Horizons discusses Championing Change in a Changing World at the 2018 NYCRING event.
- Change Management BHI Learning Collaborative - MHVC highlighting Prosci’s Change Management process during our Behavioral Health Learning Collaborative.

Cultural Competency & Health Literacy

- CCHL Best Practices Forum - a sizzle reel highlighting MHVC’s Cultural Competency and Health Literacy forum.
- CCHL Best Practices Panelists - Panelist from MHVC's Cultural Competency and Health Literacy Best Practices forum discuss the social determinants of health that are inflicting their specific populations.
- Dr. Michele Galietta on Implicit Bias - the full presentation of Dr. Michele Galietta's keynote speech on implicit biases.
- HealthLinkNY Poverty Simulation - HealthLinkNY Poverty Simulation lets the participant live a day in the life of a variety of people, with complex problems.
- Poverty Simulation: Netter Family - Take a first-hand glimpse of the Netter family and witness the complexities of their day to day life.
- Poverty Simulation: Chen Family - Take a first-hand glimpse of the Chen family and witness the complexities of their day to day life.

ED Care Triage

- Doug Hovey - speaking on his life experiences and how to better relate to patients with disabilities.
- ED Care Triage Workshop - a sizzle reel highlighting the Montefiore Hudson Valley Collaborative ED Care Triage Workshop: Referrals.
- Amie Parikh and Katie Clay - watch full presentation of Amie Parikh and Katie Clay discuss the process of referrals to health homes.
**Integrated Delivery System**

- Creating Integrated Delivery Systems - a sizzle reel highlighting how Montefiore Hudson Valley Collaborative is driving the change in order to create an Integrated Delivery System.

- Stopping the Revolving Door - A sizzle reel highlighting Montefiore Nyack's Community Paramedicine program and its impact on the community.

**Nurse Practitioner Residency Program**

- NP Residency Program - a sizzle reel highlighting Hudson River Healthcare's nurse practitioner program.

**What Matters to You**

- Implementing WMTY - a sizzle reel on implementing “What Matters to You?” throughout their organization.

- LGBTQ ally WMTY Event - sponsored by Montefiore Learning Network

- Nursing student speaks about the impact of WMTY - Nursing student, Cody Hepworth discusses the impact of the “What Matters to You?” movement is helping him do his job.

- Damara Gutnick MD - MHVC's Medical Director, Dr. Damara Gutnick discusses the importance of implementing “What Matters to You?” throughout their organization.

- WMTY Behavioral Health Organizations - a sizzle reel highlighting the effects of implementing the “What Matters to You?” throughout their organization.

- WMTY Health Care Providers - healthcare providers implementing “What Matters to You” in their daily routines.

- Patient Experience - Montefiore’s leadership discusses the importance of implementing “What Matters to You”

- WMTY Webinar - Find out all the ways you can participate for WMTY day on June 6th!

- YPL Cluster More than Books - MHVC, CLUSTER and Yonkers Public Library (YPL) turns issues into answers by integrating case managers in YPL.

- Lorraine’s WMTY Story - Lorraine discusses the powerful impact WMTY made in her father’s life.

- WMTY Wedding Anniversary - patient’s family member discusses how Cabrini of Westchester staff accommodated their wedding anniversary.

- CLUSTER Case Manager WMTY - CLUSTER Community Services Case Manager Jon Shenk talks about the how he implements the WMTY strategy in his line of work.

- CLUSTER Patron WMTY - Anel Eusebio, Yonkers Public Library patron describes the services CLUSTER Community Services is providing