NEW YORK STATE | Department of Health

MAX Series: Improving Care for High Utilizers and Sustaining Change (January 2017– July 2017)

MAX Series: Improving Care for High Utilizers and Sustaining Change

Final Report

New York State Department of Health, 2017


Goal: "Come together as providers, staff, and community agencies to support High Utilizers in the selection
will attain"
Identification
Planning
1
Standardized Care Plan
2
Cracker Jack Care Planner
3
Community Measure
in Care
Create, train, and pilot new care plan. Implement HU-specific alert
Create and hire for new care "Transition Care Manager". Determine role outside of hospital.
Identify common
patient-community
develop stronger re
with CBO
3-in house on March 1st
We celebrate because: After gap analysis of community organization linkages, team learned a lot of new
High Utilizer population. Of 98, 53% are enrolled in
, or local Health Homes. 63% are discharged with
on average, are older than previously believed. Have since included team's first CBO member on the
Ground Rules

Contents

1. Foreword from the New York State Department of Health

As we enter the third year of our Delivery System Reform Incentive Payment (DSRIP) Program efforts, we continue to work diligently toward our goal of better health, better care, and lower costs for New York State's Medicaid enrollees. Together, we have made important strides towards improving the lives of over seven million Medicaid members.

The Department of Health (DOH) has been proud to offer Performing Provider Systems (PPSs) the opportunity to participate in the Medicaid Accelerated eXchange (MAX) Series. The MAX Series has put front- line clinicians in a position to lead change. By enabling change at a grass-roots level, PPSs have been able to generate impressive results including:

1. Measurable decreases in hospital utilization and 30-day readmissions rates;
2. Development of meaningful collaborations among partners, both inside and outside of provider sites; and
3. Capacity building in process improvement.

The fourth and fifth cycles of the MAX Series focused on the relatively small proportion of patients who account for a disproportionate amount of utilization and cost ('High Utilizers"). The focus on High Utilizers brings a tremendous opportunity to move the dial on DSRIP measures and provide better care for those who need it most. This is aligned with the DSRIP goals of transforming the health care system and reducing avoidable hospital use by 25% in five years.

This report highlights the work of 22 Action Teams who participated in the fourth and fifth cycles of the MAX Series focused on improving care for inpatient High Utilizers. Collectively, these 22 teams were comprised of over 200 clinicians, administrators, and community providers. These individuals dedicated their time over an intensive eight-month period to identify their highest need patients, develop innovative solutions to providing better care for these individuals and rapidly implement, test, and measure these improvements.

It is my hope that these examples of innovative Rapid-Cycle Continuous Improvement (RCCI) programs, and the lessons learned from the front lines of DSRIP, inspire you to accelerate change towards improving care for your highest utilizers.

To the 22 Action Teams who participated in the MAX Series, **thank you for your dedication to this important work**. Your work is meaningful and has a profound impact on changing the trajectory of human lives.

Sincerely,

Jason Helgerson, Medicaid Director, New York

2. Acknowledgments

The success of the Medicaid Accelerated eXchange (MAX) Series would not have been possible without the leadership and dedication of the 22 Action Teams and 45 Train-the-Trainer (TTT) participants who shared in this intensive effort. The good will, teamwork, perseverance, optimism, and creativity demonstrated by each one of the Action Teams and TTT participants are what brought this work to life – in theory and in practice.

Although this report primarily focuses on the key steps necessary to build an effective High Utilizer care pathway, we would be remiss if we did not acknowledge the improvements that occurred by bringing interdisciplinary, cross-departmental, and cross-continuum clinical, behavioral, and social service providers together – often for the first time – to work collaboratively. The diversity of perspectives and expertise, coupled with dedicated time to work on a specific challenge in a structured format, allowed locally relevant solutions to emerge, be tested, and implemented in an incredibly compressed period of time.

To that end, we congratulate and thank the Action Teams and TTT participants for their hard work and dedication. A full listing of participants can be found in the Appendix.

3. Executive Summary

Background

Since its introduction in October 2015, the New York State Department of Health has run the Medicaid Accelerated eXchange (MAX) Series five times, engaging 45 Action Teams, including over 450 frontline care and social service providers. The key objective of the MAX Series is to support PPSs in their efforts to redesign the way healthcare is delivered to a specific patient population.

Starting in early 2017, 22 Action Teams from across New York State participated in the fourth and fifth cycles of the MAX Series, focused on improving care for the inpatient High Utilizer patient population – the small percentage of the patients who account for a disproportionate amount of hospital use and cost. Most Action Teams defined their inpatient High Utilizers as those patients with four or more admissions within a rolling 12-month time frame, excluding patients with planned obstetrical admissions and all pediatric admissions. The primary objective of the MAX Series was to reduce hospital utilization and/or 30-day readmissions by 10% in six months for inpatient High Utilizers.

Process Improvement and Results

With support from their PPSs, Action Teams were able to test and develop meaningful new practices and processes to generate measurable improvements in the way they provided care to High Utilizers in under six months. Through the development of interdisciplinary, cross-setting Action Teams, all teams learned about the inpatient High Utilizer population and how to better understand and meet their needs. The Action Teams rapidly developed key infrastructure (such as identification and notification systems) and concrete Action Plans to develop new care processes and pathways.

MAX Action Teams accomplished all of this work by participating fully in the structure provided by the MAX Series, as described later in this report. As a testament to the effectiveness of the MAX Series structure and the commitment of the 22 teams to improve care for High Utilizers, the following outcomes were achieved:

- **22 of 22 Action Teams** defined a specific, measurable **High Utilizer target population;**
- **22 of 22 Action Teams** meaningfully **assembled an interdisciplinary, cross-setting Action Team;**
- **21 of 22 Action Teams implemented systems (manual and/or electronic) to identify High Utilizers** when they **presented to the acute care setting;**
- **22 of 22 Action Teams engaged High Utilizers** in the acute care setting and **assessed the "drivers of utilization"** to understand the non-medical, human reason as to why the High Utilizer was frequently admitted;
- **19 of 22 Action Teams developed High Utilizer-specific care pathways** that integrated care for High Utilizers across care settings by developing effective linkages to key social services and support; and
- **21 of 22 Action Teams implemented interdisciplinary case conferences** to discuss High Utilizer patients and assess on-going care needs.

Prior to their involvement in the MAX Series, the Action Teams had little to no infrastructure or practices in place to specifically manage care for High Utilizers. The significant changes to care processes that the 22 Action Teams were able to implement in just six months are a remarkable achievement, and mark the most progress seen in the three years the MAX Series has been running.

Report Purpose

The purpose of this report is to outline the key process steps developed by the Action Teams through the MAX Series to improve care for inpatient High Utilizers. In addition, this report documents the solutions implemented by the Action Teams, including leading practice case studies. This report should be distinguished from the MAX Series Final Report published by the New York State Department of Health in January 2017, which specifically focused on key insights about High Utilizers and how to effectively provide care for the population.

As such, this report is divided into the following sections:

- **MAX Methodology** – Discusses principles and key components of the MAX Series methodology;
- **MAX Train-the-Trainer Program** – Provides an overview of the Train-the-Trainer Program;
- **Development of a High Utilizer Care Pathway** – Outlines the specific, critical steps in a High Utilizer care pathway and highlights processes implemented by Action Teams;
- **Conclusion** – Provides a high level summary of the results and impact achieved by the Action Teams; and
- **Appendix** – Includes a listing of MAX Series Action Team and Train-the-Trainer participants.

4. Medicaid Accelerated eXchange (MAX) Methodology

The MAX Series consists of three phases: assessment and preparation (phase I), workshops and Action Periods (phase II), and reporting (phase III), designed around the MAX Series' Rapid-Cycle Continuous Improvement (RCCI) methodology. The following section outlines key considerations for each of the three phases.

Phase I – People: The Importance of Preparation

To prepare for the MAX Series, sites are identified and recruited for participation. During this process, on-location site visits are conducted to understand local challenges and current-state processes. Historical data is also collected for prior High Utilizer admissions over a 24-month period. Recruited sites select a key champion—or Executive Sponsor—to lead the development of the Action Team and champion program improvement approaches. As **people are the true success factors behind the team's success in the MAX Series**, the main roles represented are described below.

The Executive Sponsor

Executive Sponsors are crucial to the success and sustainability of the teams' efforts. Their role serves to provide overall accountability, sponsorship, and championing of the program. They have the vision of what an improved process should look like, and can remove barriers that may prevent the team from being successful.

The Action Team

The Action Team is a multidisciplinary group of 8 – 10 individuals who represent different areas of expertise (e.g., clinical, administrative, and information technology), and who work collaboratively to address the needs of inpatient High Utilizers.

Subject Matter Professional

The Subject Matter Professional (SMP) helps to tailor program content to the series topic, shares leading practices and industry resources, assists with monitoring progress and outcomes, and provides ongoing program support. In the current MAX Series, Dr. Amy Boutwell serves as the SMP. Since 2008, Dr. Boutwell has been deeply immersed in the clinical, operational, and policy aspects of payment approaches to reduce avoidable hospitalizations and improve care transitions for High Utilizer patients.

Phase II – Process: Highly structured and Dynamic Workshop Series to Drive Results

Action Teams are challenged to drive change and accelerate results throughout three workshops and "Action periods," which are made up of Plan-Do-Study-Act (PDSA) cycles. Action Teams are supported through weekly coaching calls, continuous access to subject matter expertise, performance measurement, and additional touch points to assist in driving change. These educational opportunities include periodic virtual meetings, shared learning via online collaborative platforms or webinars, and on-location site visits and meetings.

Workshops

The MAX Series consists of three intensive, in-person workshops designed to bring the Action Teams together to rapidly generate process improvement ideas and plans to achieve results. Workshops are fast-paced and planned to the minute, alternating between plenary and breakout settings. In the plenary sessions, RCCI theories such as business process design/LEAN, PDSA, theory of constraints, and change management, are presented and tailored to the topic. Immediately following a plenary session, Action Teams move to breakout groups, led by a trained group facilitator, for activities aimed at generating improvement ideas to address gaps and challenges in the local current state. Governing the workshops are "ground rules" outlined at the beginning of each session that encourage Action Team members to actively participate and "do something different." The ground rules culminate in the overarching theme for the MAX Series – **you must make a change!**

By the end of the workshop, each Action Team generates three concrete and measurable Action Plans to be implemented within a 30- or 60-day Action Period following the workshop. A workshop summary report created by the facilitator and shared with the Action Team following the workshop, captures key takeaways, including the three Action Plans, as a demonstration of the work committed, and a reminder for Action Team accountability.

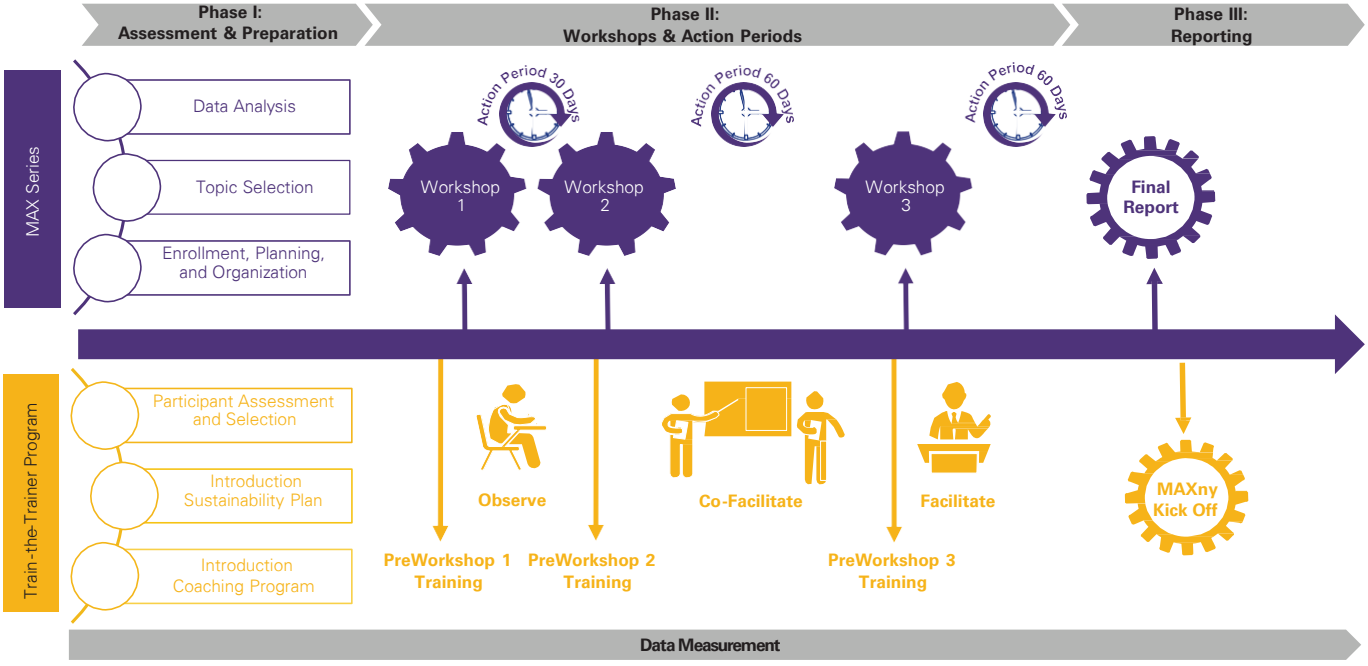
Action Periods

While the Action Teams and intensive workshops are designed to build consensus and momentum around a solution, **the Action Periods are where policy truly turns into practice.** Each of the three workshops in Phase II are followed by a PDSA cycle or Action Period. During this time, Action Plans generated during the workshops are implemented by the Action Team, and progress is monitored and measured. Changes to local processes are made, tested, and adjusted over compressed time periods, where the first Action Period covers 30 days, and the second and third Action Periods cover 60 days (the length may vary based on the selected topic). The first Action Period is focused on achieving quick wins. During this time, the expectation is that Action Team builds confidence in their process improvement capabilities. Action Plans developed and implemented in the second Action Period are typically focused on detailed process redesign. The third and final Action Period is designed to build concrete plans for reliable and sustainable process improvement.

Train-the-Trainer Program

The Train-the-Trainer (TTT) Program complements and directly aligns with the three phases of the MAX Series. This program was designed to scale and sustain process improvement work by training senior-level clinicians and administrators in the same RCCI methodology used in the MAX Series, while also equipping participants with the tools and frameworks to run their own independent RCCI workshops. Participants are identified and selected by PPS leadership as individuals with the skills and determination to drive local and sustainable change across their networks. Over the course of the program, participants follow a "See one, Do one, Lead one" approach to facilitating by observing, co-facilitating, and eventually leading MAX workshops (see Figure 1). In parallel, participants are supported in building a Sustainability Plan which outlines their site, target population, and Action Team for their independently run RCCI workshop series, coined the MAX New York (MAXny) Series.

***Figure 1**: MAX Series and Train-the-Trainer Process with 30–60–60 day PDSA cycles*



Phase III – Outcomes: Data, Measurability, and Accountability

Analytics play a pivotal role in the MAX Series, as teams use data to inform change and decision-making, as well as guide process improvement outcomes. Action Teams measure a baseline prior to implementation of process improvement approaches, and over the course of the MAX Series, drive, measure, analyze, and report on informed process improvement initiatives.

Measures are categorized as follows:

- **Structure:** Action Plans are aimed to create capabilities that successively build out process improvement initiatives. These measures can be simply answered with a "yes" or "no" (is it in place?), and are rapidly followed by process and, eventually, outcome measures to drive results;
- **Process:** Measurement of particular volumes (such as the weekly number of High Utilizer admissions or the number of High Utilizers served prior to and following discharge from the hospital); and
- **Outcomes:** These measures ultimately demonstrate impact of the collective efforts of the Action Team and care continuum. These measures are quantitative (comparison of baseline when program started vs. after new process was implemented, e.g. pre/post–utilization), as well as qualitative (High Utilizer success stories).

Participants at the final Series 4 MAX workshop

Participants at the final Series 5 MAX workshop

5. MAX Train-the-Trainer Program

MAX Train-the-Trainer Program

The New York State Department of Health launched the MAX Train-the-Trainer (TTT) Program in an effort to scale process improvement work across the State by training senior-level clinicians and administrators in the MAX Series' Rapid-Cycle Continuous Improvement (RCCI) methodology. The TTT program complements and directly aligns with the three phases of the MAX Series: assessment and preparation (phase I), workshops and Action Periods (phase II), and reporting (phase III). The primary objectives of the TTT program are to:

1. Teach participants facilitation skills and the MAX Series' RCCI methodology; and
2. Support participants in setting up their independent MAX Series (coined MAX New York (MAXny) Series) to be run upon completion of the training program.

Learning Facilitation Techniques and RCCI Methodology

Over the course of the TTT Program, each participant is trained in the MAX Series' RCCI methodology by:

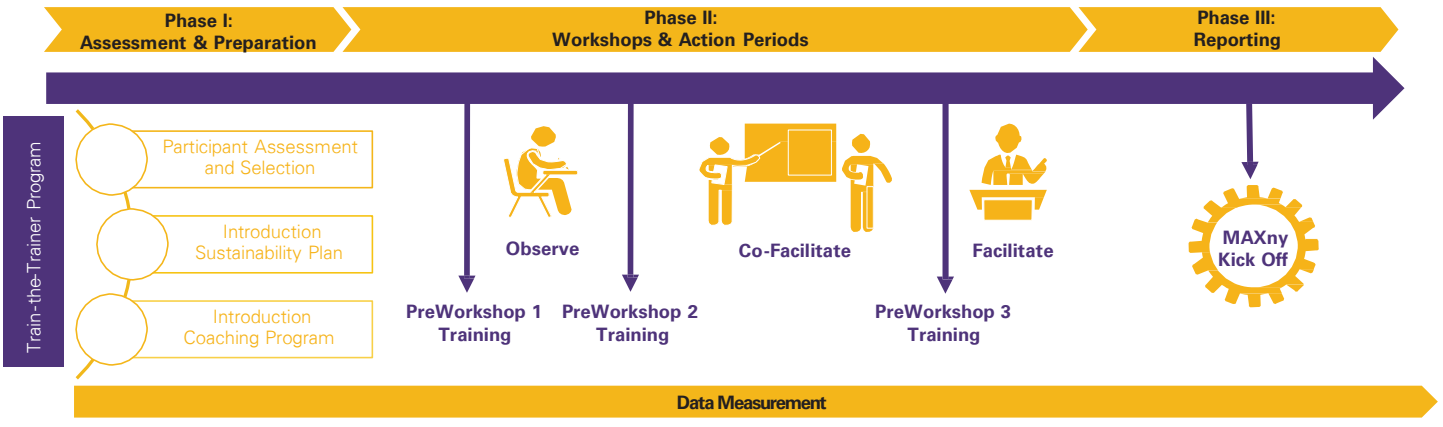
1. Attending PreWorkshop trainings focused on facilitation skills and techniques, High Utilizer content, and workshop-specific MAX modules; and
2. Being paired directly with a MAX Action Team for the duration of the program, during which time TTT participants observe, co-facilitate, and then independently facilitate workshops and status calls across the three Action periods.

With each Action Period, participants assume a greater role in facilitating and guiding their respective Action Teams, and delving into their care pathway, all in preparation for leading their own, independent RCCI workshop series once the training program is completed.

Independent RCCI Workshop Series

In parallel to Action Team-specific activities, TTT participants are enrolled in a coaching program to support the development of their MAXny Series (the independent and PPS-led MAX Series run by a trained and qualified TTT participant). The focus of the coaching program is primarily on the assessment and preparation phase (phase I) of the MAX Series, as well as to further enhance facilitation skills and techniques. Participants are supported in selecting the problem they are trying to solve (topic, such as improving care for inpatient High Utilizers), quantifying their target patient population, and identifying their site, Action Team members, workshop dates, and leadership. By combining these efforts, the program equips each participant with the tools, skills, and experience needed to continue transformation efforts independently, and to maximize the legacy benefits of the MAX Series.

MAX Train-the-Trainer Program Structure



6. Development of a High Utilizer Care Pathway

Assessment and Preparation Phase

The assessment and preparation phase of the MAX Series underpins the success of the program by establishing the foundation for the Action Team and subsequent process improvement efforts. Setting a MAX Action Team up for success begins by ***ensuring leadership commitment and buy-in*** at the designated hospital site, ***assembling an interdisciplinary Action Team,*** and ***developing a robust data infrastructure***. The key considerations in the assessment and preparation phase of the MAX Series are outlined below.

Ensure Leadership Commitment and Buy-in

One of the most critical factors to ensuring a successful MAX Series is leadership commitment and buy-in at the hospital, both at the time of enrollment and throughout the implementation of process changes. It is the responsibility of the hospital's leadership to not only ensure that the MAX Series aligns with the hospital's priorities and goals, but also that the hospital is ready, willing, and able to drive and sustain change. Upon enrolling into the program, the hospital must identify an Executive Sponsor to provide ongoing leadership support, hold the Action Team accountable, and champion efforts related to the MAX Series. A firmly committed Executive Sponsor will keep the Action Team motivated and committed to driving results throughout the program.

Assemble an Interdisciplinary Action Team

As High Utilizers often have a diverse set of medical, social, and behavioral needs, assembling an interdisciplinary Action Team that includes representation from across the care continuum is of critical importance. As a result, the Action Team should include individuals who can directly enact or facilitate change within and across their respective organizations. Action Teams are often comprised of the following organizational roles and departments:

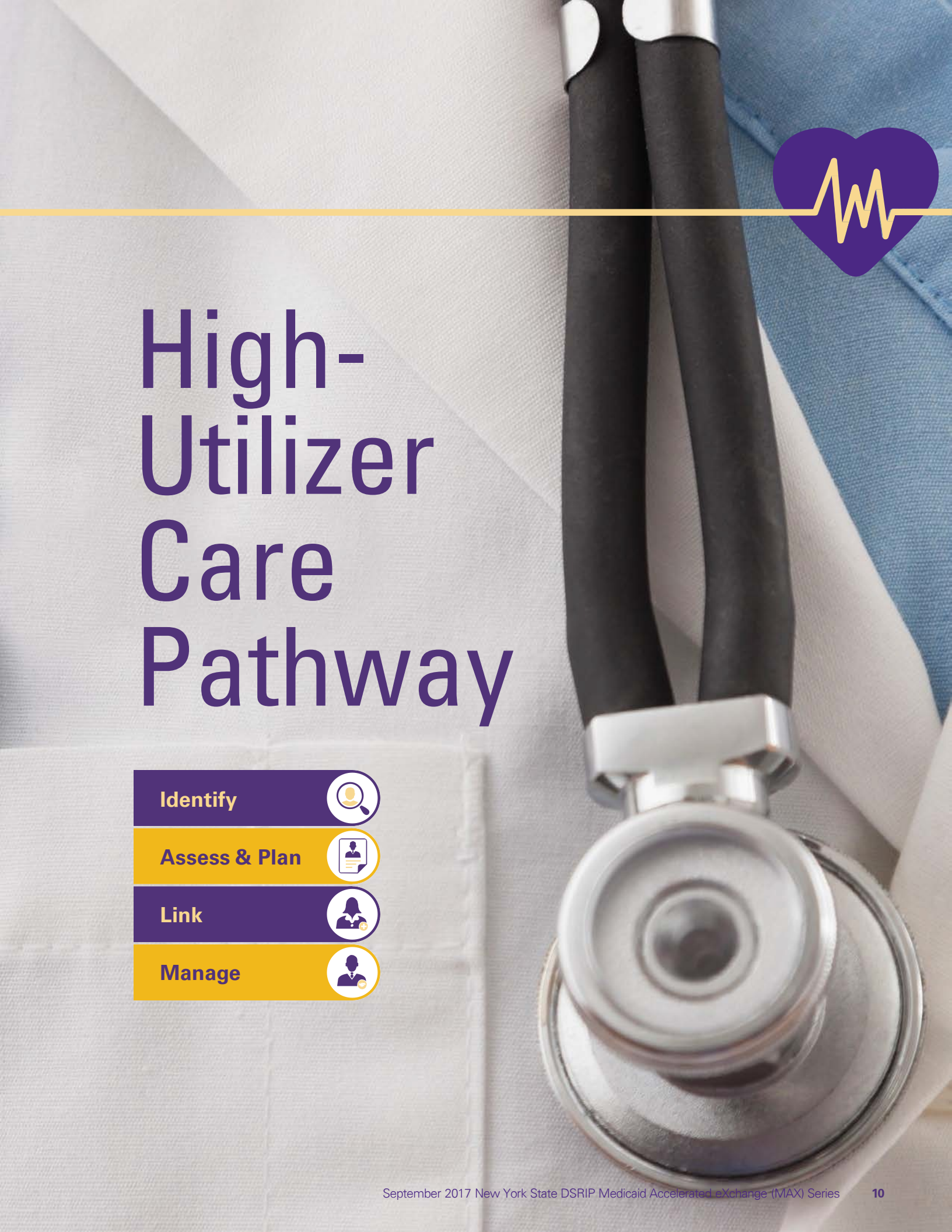
- Executive Sponsor;
- Administrative champion (VP, SVP or Chief);
- Clinical champion (Hospital Medicine, ED physician, Nursing Director, etc.);
- Director and/or staff from case management;
- Director and/or staff from social work;
- Director and/or staff from care transitions;
- Director and/or staff from health home;
- Practice manager or care manager from primary care;
- Practice manager or care manager from behavioral health clinic;
- Information Technology (IT);
- Data analyst;
- Community-based organizations;
- Skilled nursing facilities; and/or
- Palliative care services.

Develop a Robust Data Infrastructure

Data analysis and measurement are at the core of any successful RCCI program focused on implementing, testing, and analyzing change. As a requirement for enrollment into the MAX Series, Action Teams must clearly define their target patient population and commit to measuring and reporting on the impact of their work through specific metrics. In order to ensure successful data collection over the course of the MAX Series, ongoing involvement of IT and data analysts are critical.

Program Measurement can be divided into the following three components:

1. **Process Metrics –** metrics that examine the week to week activities of the team's impact on processes implemented such as "Number of High Utilizers served prior to discharge" or "Number of High Utilizers served after discharge;"
2. **Outcome Metrics –** metrics that provide an analysis of the comprehensive impact of the program, such as the 30-day readmission rate and pre- vs. post-hospital utilization; and
3. **Qualitative Metrics –** non-numerical indicators of the impact of the program such as patient success stories and descriptions of meaningful partnerships formed.



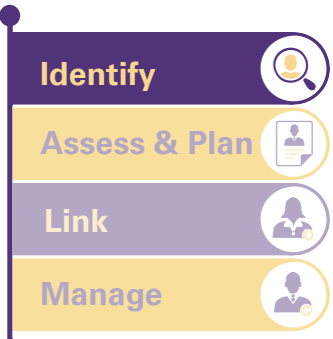
High-Utilizer Care Pathway

- Identify
- Assess & Plan
- Link
- Manage

Identify

Identify High Utilizers when they are admitted to the hospital

The first step in establishing an inpatient High Utilizer care pathway is knowing that a patient is a High Utilizer and has been admitted to the hospital. In order to set the High Utilizer care pathway into motion, it is important that key personnel are notified so they can engage the patient.



Key Actions

1. **Identify High Utilizers** by establishing an identification and/ or alert system that signals that a High Utilizer has been admitted to the inpatient unit.
2. **Notify key personnel** who are responsible for responding to the alert and engaging with the High Utilizer while the patient is still "in-house."

Lessons Learned

- Establish a system to identify patients who meet utilization criteria based on a rolling 12-month timeframe. It is very important that teams do not work off of a static list of High Utilizers, as a significant percentage of "last year's" High Utilizers will not remain "this year's" High Utilizers.

Preliminary Results

Key Stats

- 21 of 22 Action Teams implemented systems (manual and/or electronic) to identify High Utilizers when they presented to the acute care setting.
- 20 of 22 of Action Teams notified key personnel responsible for engaging with High Utilizers upon the patient's admission to the inpatient unit.

Solutions Implemented

- **Visual "flag"** placed in the patient's chart.
- **Developed a flag on the** emergency department **"tracker board"** when a High Utilizer presents.
- **Automated, daily list of admitted High Utilizers** sent to the MAX Action Team via email or text message.
- **Manual list of admitted High Utilizers** produced daily by hospital staff, who identify High Utilizers based on daily admission census and email key personnel of the admission.

Leading Practice Case Study – Identify

Action Team: Finger Lakes Performing Provider System – Arnot Ogden Medical Center

Objective: Identify all High Utilizers upon admission and notify the on-site care team

Solution:

- The Action Team developed a real-time alert system within their electronic medical record (EMR) that identified any patient with four or more admissions within a rolling 12-month timeframe once that patient was admitted.
- The alert informs care teams in the inpatient unit and initiates the High Utilizer care pathway.
- Upon receiving the alert that a High Utilizer has been admitted, a care manager or social worker meets the patient at the bedside and performs a "driver of utilization" interview.
- Once the drivers of utilization are identified, an interdisciplinary care team begins developing a care plan that addresses the identified needs.
- 98% (61 of 62) of identified High Utilizers were engaged and received an assessment to identify their drivers of utilization.

Assess & Plan

Assess patient needs and develop a plan to address those needs

The critical, unique competency developed by successful High Utilizer programs is to view high utilization as a symptom of an unmet, unidentified, or inadequately addressed need. As such, Action Teams learn how to identify the driver of utilization, which is the underlying reason that the person returns to the acute care setting so frequently. The driver of utilization is typically not the primary diagnosis or the chief complaint, but rather it is the human, individual reason that this person, with his/her complexities and social needs, comes to the hospital so frequently. Once the driver of utilization is identified, it is important for key personnel to develop a plan to address this identified, unmet need.

Key Actions

1. **Identify the driver of utilization** by engaging with the patient at the bedside and getting the "story behind the story" to understand the social, behavioral, or logistical reasons that lead to this patient being frequently admitted.
2. **Develop a plan of care** with an interdisciplinary team of providers and social services that can address the drivers of utilization through connection to key services.

Lessons Learned

- View recurrent utilization as a symptom of an unmet need or previously ineffective approaches that have failed to meet the patient's needs.
- The driver of utilization cannot be identified through chart review, rather it is necessary to engage with the patient, the family/caregivers, and/or community clinical or service providers. The encounter in the acute care setting should be used as an opportunity to build a helpful, trusting relationship with the patient.
- Listen for and identify all of the drivers of utilization as there is often more than one reason for why the patient is frequently admitted.
- Do not over-medicalize the drivers of utilization as most "drivers" are non-medical, even if the individual has numerous medical conditions.
- A person trained in motivational interviewing or patient engagement is very helpful in identifying the driver of utilization (e.g. a social worker, care transition nurse, or care manager).
- Interdisciplinary daily "huddles" are a useful strategy for real-time problem-solving on how best to address the identified drivers of utilization.

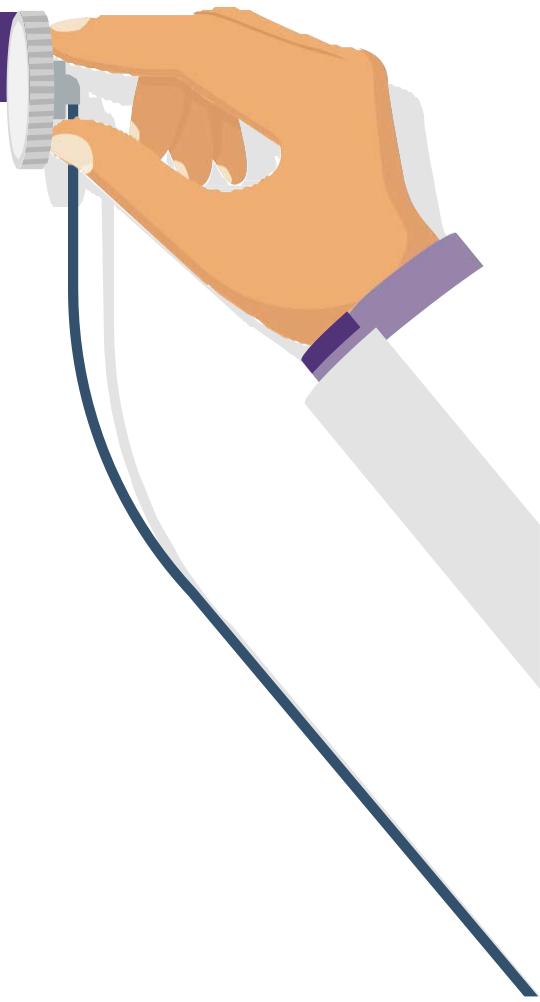
Preliminary Results Key Stats

- 21 of 22 Action Teams assigned a dedicated individual to perform a driver of utilization assessment on admitted High Utilizers.

Solutions Implemented

- **Driver of Utilization Assessment**
  - **A driver of utilization screening tool/assessment (digital or paper-based)** administered by hospital staff (licensed or non-licensed) to identify High Utilizers' medical, social, and behavioral needs.
  - **An EMR-based automated "order"** used to prompt hospital staff to conduct a driver of utilization assessment.
  - **A database used to document the identified drivers of utilization** among the High Utilizer patient population. The database was shared with Action Team members, including external community-based partners. The database can be analyzed for trends that will inform development of future solutions.
- **Interview Techniques**
  - **Motivational interviewing** to determine the social determinants of health that promote high utilization, looking at social, behavioral, and medical reasons.
  - **Asking "why" at least 5 times** to get to the root cause of readmission.
- **Care Plans**
  - **Care plans** used to summarize the High Utilizer's medical history and identified drivers of utilization. The care plan is typically one page or less and was used to create a longitudinal history of the patient's identified needs.
- **Meetings**
  - **Bedside huddles** used to meet with the High Utilizer and discuss the patient's drivers of utilization, care plan, and next steps.
  - **Family and caregiver meetings** with key hospital staff to engage individuals close to the patient and gain more insight into the High Utilizer's needs.
  - **Interdisciplinary huddles** with the care team (hospital and community-based organizations) to discuss care planning in a collaborative environment, including addressing the identified drivers of utilization.

Leading Practice Case Study – Assess & Plan



Action Team: Montefiore Hudson Valley Collaborative – Vassar Brothers Medical Center

Objective: Assess each High Utilizer to identify the key driver of utilization and develop a collaborative plan of action with the hospital team and community-based partners to meet the patient's needs and to ultimately reduce hospital use.

Solution:

- A case manager meets with the patient at the bedside and uses motivational interviewing to better understand the patient's history and to identify the patient's primary drivers of utilization.
- The case manager then informs the care team of the identified drivers of utilization, and incorporates solution-based approaches into the patient's care plan.
- The care plan includes questions covering the following key areas:
  - Driver of utilization
  - Independence/assistance needs
  - Housing
  - Services in the community
  - Follow-up appointments

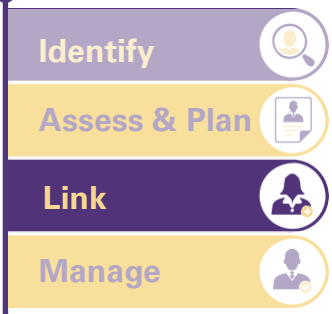
Results:

- 88% of identified High Utilizers were engaged by a case manager and assessed for their drivers of utilization.
- Care plans were created for 100% of assessed High Utilizers.
- The implementation of this process has increased awareness among hospital staff of the true drivers of utilization and has improved care coordination between the hospital and community-based providers.

Link

Link patients to care in the community in a definitive, timely manner

Once the driver of utilization has been identified and care plan has been developed, it is critical that High Utilizers are "linked" with necessary services in a definitive and timely manner post-discharge from the hospital. This is distinctly and necessarily different from advising or referring the patient to follow up with services or providers. In order to establish a definitive, timely linkage, the hospital should develop strong relationships and referral pathways and communicate with key community partners.



Key Actions

1. **Develop an understanding** of key services required to effectively address the drivers of utilization.
2. **Identify community-based partners** who deliver those services.
3. **Quantify the number of High Utilizers** per week who would need to be linked to a given provider or agency.
4. **Meet with the provider/agency** to explore what percentage of that demand for timely linkage to services could be accommodated given their capacity.
5. **Test the process** to definitively link High Utilizers to their services.
6. **Establish a real-time feedback loop** to ensure that High Utilizers received services from the provider/agency in a timely manner; if not, identify the causes for process failure and iteratively problem-solve to increase reliability.

Lessons Learned

- Establishing a "warm" (person-to-person) hand-off for the High Utilizers to the next person supporting the care post-discharge is helpful in ensuring that the "link" happens between the hospital care and community-based support.
- An interagency feedback loop works best when there are direct points of contact at partnering organizations. More specifically this refers to having designated, named individuals in each partnering organization who have a direct access (through email or phone, for example) to each other to coordinate care.
- Linking a member of a patient's family, or immediate circle of support, to key services can be just as critical to reducing the patient's utilization as supporting the patient him/herself.
- Excess hand-offs between care providers can be disruptive to the High Utilizer's stability and continuity of care.

Preliminary Results

Key Stats

- 19 of 22 Action Teams established new referral pathways and partnerships with community-based organizations.
- 18 of 22 Action Teams developed a list of new community-based resources that could provide key social services and support to High Utilizers in the community.

Solutions Implemented

- **Community Resource Guides** developed and used by hospital discharge staff to identify available community resources and link patients post-discharge; information included summary of services, hours, and key point of contact. Some Action Teams leveraged software solutions, such as Healthify, to develop a list of resources and assist in care coordination.
- **Single points of contact** at key community partners to facilitate improved care coordination.
- **Care Managers/Navigators** assigned to High Utilizers to provide transitional care.
- **Community partners embedded in the hospital** to provide direct linkages to care through warm hand-offs.

Preliminary Results

Key Stats

- 21 of 22 Action Teams implemented regular, scheduled interdisciplinary case conferences to discuss High Utilizer cases.
- 16 of 22 of Action Teams established 24-48 hour post-discharge protocols including phone calls and home visits.

Solutions Implemented

- **Conduct 24 – 48 hour post discharge follow-up calls** to speak with the patient about the care plan, if medications were obtained, additional services needed, and appointment confirmation, including logistical feasibility.
- **Home visits** to check in on the High Utilizer and understand on-going needs.
- **Closed-loop text, email, or portal message** to patients in the community to remind them of appointments or to check in on how the patient is feeling.
- **Transitional care plans** to identify post-hospital needs and ensure effective communication with the patients and their providers within the community over a 30-day transitional period. Activities included: timely follow- up appointments, frequent contact with the High Utilizer, and/or face-to-face interactions.
- **Interdisciplinary case conferencing (in-person or teleconference)** to review the needs of High Utilizers and to develop a plan for when the patient re-presents to the hospital; the case conferences were often attended by physicians, care managers, social workers and community-based organizations, with the primary output of the meeting being a care plan and action items to manage the patient's care in the community.
- **ED care plans and alerts** provide the emergency department (ED) with a plan to improve the management of the High Utilizer the next time the patient presents to the hospital.

Leading Practice Case Study – Link

Action Team: OneCity Health PPS – Lincoln Hospital

Objective: Establish warm hand-offs between the hospital and key community partners to ensure definitive and timely linkage to critical services that can address the High Utilizer's needs post-discharge.

Solution: The Action Team has established four linkage pathways for High Utilizers to the following services based on the patients' needs:

- **Connection to Patient Centered Medical Home (PCMH) nurse care transition program**
  - After the High Utilizer has been admitted, the **assigned PCP is alerted** that his/her patient has been admitted and **seen by a PCMH nurse** to best determine how to connect the High Utilizer to the required services.
  - The PCMH nurse works in tandem with the Care Manager (CM) assigned to the High Utilizer to ensure the patient receives all required post-discharge services.
- **Health Home**
  - The Health Home Care Coordinator works closely with the patient to **create a plan of care that best meets all of his/her physical, mental health, and social service needs**. Then, he or she helps the patient find appropriate services and programs.
  - The Care Coordinator remains engaged with the patient throughout the healing/recovery process until able to self-manage.
- **Transitions of Care Team**
  - High Utilizers enrolled in the program are assigned a dedicated transition manager who works closely with inpatient staff and the patient/caretakers to organize, communicate, and follow up on a care transition plan that has input from an interdisciplinary care management team.
  - The patient is **visited in the community**, including at the patient's home, throughout program enrollment and receives **follow-up phone calls for a minimum of 30 days post-discharge.**
- **Care Management**
  - Patients are assigned an **Accountable Care Manager (ACM)** or **Community Liaison Worker (CLWs)** who meets the patient face-to-face at the bedside and works closely to coordinate care with services the patient is currently receiving or new services the patient requires.

Results:

- Greater than 51% of patients were connected to services post-discharge and received warm hand-offs to key services.
- As a result of the MAX Series, the Lincoln team established a number of new partnerships with community- based organizations to better serve the needs of their patients, with at least three new memorandums of understanding with partners being newly established and with others currently in process.

Manage

Manage care for High Utilizers in the Community

High Utilizers often require multiple efforts and sustained support over time before the cycle of utilization can be reduced. It is important to develop a persistent and dynamic approach in managing a High Utilizer's care in the community. Management should be a joint effort between the hospital and key community partners that provide necessary social services and support over time, until stability has been achieved.

Key Actions

1. **Directly manage the High Utilizer** in both the short and long term until stability is achieved.
2. **Establish a case conference** with key partners from across the care continuum to problem-solve the patient's needs.

Lessons Learned

- Flexible, iterative, high-frequency contact is effective.
- "Whole-person" care management is necessary to meet the clinical, behavioral health, and social needs of High Utilizers.

Leading Practice Case Study – Manage

Action Team: Advocate Community Providers PPS – Jamaica Hospital

Objective: Better manage and meet the needs of High Utilizers in the community by holding regularly scheduled case conferences that include departmental leadership.

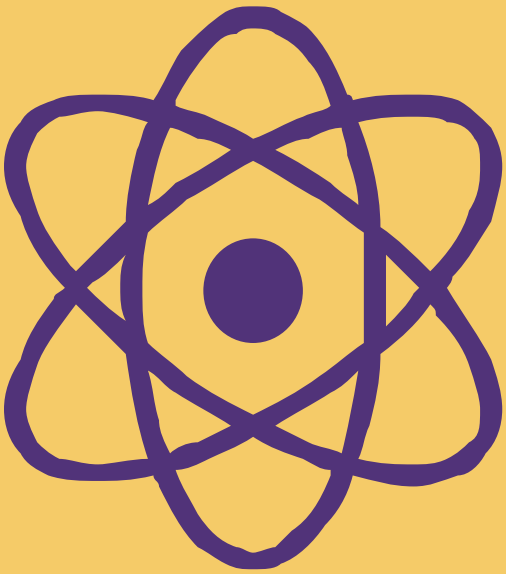
Solution:

- The Action Team established a Root Cause Analysis (RCA) Team that receives the High Utilizer list every weekday by 5:00 a.m. (on Mondays the team goes through the High Utilizers from the weekend).
- The RCA Team includes the Chairs of key departments, such as: Ambulatory Care, Family Medicine, Psychiatry, Emergency Department, the inpatient unit, Social Work, and Case Management.
- Prior to the case conference, all RCA members are asked to individually review the list and come up with a plan of action for each High Utilizer.
- The RCA Team then discusses the combined plan of action at 11:45 a.m. everyday, which is executed thereafter.

Results:

- The team has consistently conducted case conferences from Monday to Friday since February 2017.

Sustainability



Engaging frontline providers in designing and testing locally relevant solutions is critical to process improvement work. Factoring in a strong sustainability component focused on continuous improvement is equally critical to ensuring that changes made during the program are sustained, teams continue to focus on driving results, and additional high leverage opportunities for change are identified. Both the MAX Series andTTT Program have built in sustainability as a crucial component of the program. All 22 ActionTeams were required to schedule and plan Continuous ImprovementWorking Sessions. In these working sessions, the ActionTeams reconvened to report out on results, and generate new ideas on how to continuously improve care for High Utilizers. The recurrence of these working sessions are expected to lay the groundwork for ongoing improvements to care delivery and outcomes for current and future High Utilizers.

7. Conclusion

Over the course of the eight-month MAX Series, the 22 participating Action Teams developed robust care pathways for their High Utilizer patient populations that followed the four key process steps described in this report: Identify, Assess and Plan, Link, and Manage. These High Utilizer care pathways have had a positive impact on reducing inpatient admissions among the High Utilizer population. In addition, nearly all of the Action Teams achieved these results by leveraging existing workforce, infrastructure, and budget, demonstrating that improving care for High Utilizers can be achieved, not by doing more, but by doing something different for the patients who need it most.

MAX Series Results

MAX Series engaged **22 Action Teams** representing over **200 Providers and Administrators** from across the continuum of care, who each attended 3 Workshops for a total of **11 Workshops**, and committed to **198 Action Plans** focused on improving care for High Utilizers.

System Integration

100% of Action Teams meaningfully engaged an **interdisciplinary, cross-setting team.**
100% of Action Teams **implemented systems to identify High Utilizers** in the acute care setting.

100% of Action Teams **assessed the drivers of utilization** to understand the non-medical, human reason as to why the High Utilizer was frequently admitted.
100% of Action Teams **developed High Utilizer-specific care pathways** that integrated care for High Utilizers across care settings by developing effective linkages to key social services and support.

RCCI Capability

100% of Action Teams convened or **planned their own RCCI Workshops.**
Overall, Action Teams reported **increased confidence in their ability to make change in the following areas:** reduce utilization, improve outcomes, successfully implement and sustain improvements to HU care processes, and work with other organizations across the care continuum.

Patient Outcomes

In just six months, the Action Teams reported a **7% average decrease in inpatient admissions when comparing 90 days before and after program interventions[1].**

[1]The decrease in inpatient admissions is net of the historical baseline.

8. Appendix


13
PATHWAYS
groups and using the referral
Non-Definitive, Linkage to Services
Definitive, Timely Linkage to Services
Current State
Referral Pathways Activity
Non-Definitive, Linkage to Services
Definitive, Timely Linkage to Services
Current State

Series 1 Action Teams

Performing Provider System: Advocate Community Providers Team Name: MAXimizers	Site: Jamaica Hospital	
Angel Canedo, PhD	Network Vice President	**acanedo@jhmc.org**
Shi-Wen Lee, MD	Associate Director for Emergency Medicine	**slee@jhmc.org**
Alan Roth, DO	Chair Family Medicine and Ambulatory Care	**aroth@jhmc.org**
Anthony Maffia, LCSW	Vice President, Behavioral Health Services	**tmaffia@jhmc.org**
Sudheer Chauhan, MD	Internist	**schauhan@jhmc.org**
Michael Callaghan	IT Director	**mcallagh@jhmc.org**
Zoe Vanderweide	DSRIP Program Director	**zvanderw@jhmc.org**
Nancy Tartakoff	Director, Network Development, Quality Assurance and Regulatory Compliance	**nancytartakoff@aol.com**
Charles Madry	Vice President, Health Services and Community Based Programs	**charles.madray@samaritanvillage.org**
Cindy Klein, MPH	Project Management Director	**cklein@acppps.org**
Martine Baron, L-CSW-R	Social Worker	**mbaron@acppps.org**

Performing Provider System: Community Care of Brooklyn Team Name: Improving Transitional Care for High Utilizers We Engage (ITCHE)	Site: Maimonides Medical Center	
Karen Nelson, MD	Senior Vice President	**knelson@maimonidesmed.org**
Kishor Malavade	Associate Medical Director, Central Services Organization	**kmalavade@maimonidesmed.org**
Shari Suchoff	Vice President, Population Health Policy and Strategy	**ssuchoff@maimonidesmed.org**
Zachary Lockerman, MD	Associate Chief Medical Officer	**zlockerman@maimonidesmed.org**
Aviva Berman	DSRIP Project Manager	**aberman@maimonidesmed.org**
Lloyd Conliffe	Transitional Care Manager	**lconliffe@maimonidesmed.org**
Patricia Ursomanno, PhD	Director, Program Development and Performance Improvement, Cardiac Cath Lab	**pursomanno@maimonidesmed.org**
Christie Blickle	Transitional Care Member	**cblickle@maimonidesmed.org**
Kathryn Burndrett	Care Manager	**k.burndrett@housingworks.org**
Megan Grillo	Clinical Nurse Liaison	**mgrillo@centershealthcare.org**

Series 1 Action Teams *(continued)*

Mount Sinai PPS Team Name: BK Bridges	Site: The Brooklyn Hospital Center	
John Gupta	Executive Vice President Growth and Innovation	**jgupta@tbh.org**
Edwidge J. Thomas, DNP	Medical Director	**edwidge.thomas@mountsinai.org**
Sam Amirfar, MD	Chief Information Office	**samirfar@tbh.org**
Sheila Anane	Director, Innovation	**sanane@tbh.org**
Cynthia Fox	Director of Care Coordination Development	**cfox@nadap.org**
Yolanda Andres Deguzman	ED Case Manager	**yandresdeguzman@tbh.org**
Yoany Cordones	Hospitalist Coordinator	**ycordones@tbh.org**
Sheryl Abraham, MD	Chair, Family Medicine	**sabraham@tbh.org**
Prabhjot Manes, MD	Hospitalist	**pmanes@tbh.org**
Heidi Waite	Health Home Representative	**heidiw@villagecare.org**
Elvin Cruz	Security Guard	**ecruz@tbh.org**

Performing Provider System: Nassau Queens (NQP) Team Name: Nassau University High Utilizer Treatment Team (NU H.U.T.T.)	Site: Nassau University Medical Center (NUMC)	
James Karkenny	NUMC Executive Director DSRIP Delivery System Transformation and Healthcare Innovation	**jkarkenn@numc.edu**
Samia Qazi, MD	Clinical Director of Primary Care	**sqazi1@numc.edu**
Lisa McLaughlin	Director of Social Work	**lmclaugh@numc.edu**
Laurie Ward, MD	Vice President of Ambulatory Care	**lward1@numc.edu**
Valerie Tanis	DSRIP and IT Manager	**vtanis@numc.edu**
Manasa Muthu	Account Director of Strategic Alliances	**mmuthusubramanian@healthfirst.org**
Umer Farooq, MD	Psychiatrist for Substance Abuse Rehabilitation	**ufarooq@numc.edu**
Estrella Perez, RN	Transitions of Care	**eperez3@numc.edu**
Gregory Schroeder	Clinical Systems Analyst	**gschroed@numc.edu**

Series 1 Action Teams *(continued)*

Performing Provider System: New York Presbyterian (NYP) **Team Name: We Won't Be Seeing You In A Weill (Cornell)**		**Site: Weill Cornell Medical Center**
Julie Mirkin	Vice President for Care Coordination	**jlm9015@nyp.org**
Claudia A. Beck	Director, Ambulatory Care Management	**cbb9003@nyp.org**
Isaac Kastenbaum	Director, DSRIP Programs	**ink9012@nyp.org**
Tim McGarvey	Director of Care Coordination	**tim9004@nyp.org**
Alissa Wassung	Director	**alissawassung@glwd.org**
Jennifer Lee, MD	Director, Hospitalist Service	**Jel9026@med.cornell.edu**
Ilya Goldstein	Manager, Analytics	**ilg9007@nyp.org**
Nelson Mesa	Director, DSRIP IS	**nem7005@nyp.org**
Tiffany Sturdivant-Morrison	Program Administrator, Health Home	**tis9034@nyp.org**
Evelyn Espana	Manager, CHW Program	**eve9001@nyp.org**
Deena Schmitz	Transitional Care Manager	**des9075@nyp.org**
Ruble Ryan Hatsu	Transitional Care Manager	**ruh9006@nyp.org**
Sheryl Silver	SVP, Community Support Programs	**ssilver@thebridgeny.org**
Patricia Hernandez	Manager, Team Based Care	**pah9051@nyp.org**

Performing Provider System: New York Presbyterian Queens (NYPQ) **Team Name: The Mighty Queens**		**Site: New York Presbyterian Queens (NYPQ)**
Maureen Buglino	Vice President for Ambulatory Care and Population Health and Executive Lead NYPQ DSRP PPS	**mabuglin@nyp.org**
Maria D'urso	Administrative Director, Community Medicine and Co-Executive lead NYPQ DSRIP PPS	**mda9005@nyp.org**
Caroline Keane	Vice President for Care Coordination, Social Work and Transitions of Care	**cakeane@nyp.org**
Adam Dorfman, RN	Case Manager	**add9011@nyp.org**
Robert S.Crupi, M.D.	Medical Director Ambulatory Care and Population Health	**rcrupi.flushing@jhmc.org**
Denise Lawson	PI Director	**dlawson@silvercrest.org**
Althea Baily	Clinical Nurse Director	**alb9156@nyp.org**
Janice Hlenski	Social Worker	**jah9069@nyp.org**

Series 1 Action Teams *(continued)*

Performing Provider System: New York Presbyterian Queens (NYPQ) **Team Name: The Mighty Queens**		**Site: New York Presbyterian Queens (NYPQ)**
Johnathan LeBaron, DO	Attending ED Physician	**jol9144@nyp.org**
Enrique Carmona	PI Health Informatics Analyst	**ecarmona@silvercrest.org**
Joseph Cooke, MD	Chairman of Medicine	**jcooke@med.cornell.edu**
Juliet Chang	Director of Nursing	**julietc@franklinnh.net**

Performing Provider System: NYU Lutheran **Team Name: The Brooklyn Intervention Specialists (BIZ)**		**Site: NYU Lutheran Hospital**
Isaac Dapkins, MD	Chief Medical Officer of Lutheran Family Health Centers (LFHC) and DSRIP Medical Director	**isaac.dapkins@nyumc.org**
Alessandra Taverna-Trani	Director of DSRIP	**alessandra.taverna-trani@nyumc.org**
Tim Stroupe, MD	Deputy Chief Director, Psychiatric Emergency Service & Psychiatry Consultation/Liaison Service	**samuel.stroupe@nyumc.org**
Jeffrey Bouchard-Burns, MD	Medical Director of Behavioral Health Community Medicine Program	**jeffrey.bouchard-burns@nyumc.org**
Jason Hyde	Assistant Vice President of Community Case Management	**jason.hyde@nyumc.org**
Neil Pasco, MD	Internal Medicine Residency Program Director & Associate Medical Director of Quality	**neil.pasco@nyumc.org**
AmarpreetSing Bains, MD	Hospitalist/Clinical Assistant Professor of Medicine	**amarpreetsingh.bains@nyumc.org**
Demetria Comer	Data Analyst	**demetria.comer@nyumc.org**
Nana Twumasi	Senior Project Coordinator, Clinical Partnerships	**ntwumasi@healthfirst.org**
Semhar Fisseha	Assistant Program Director	**semharf@camba.org**
Dina Budman	Project Manager, DSRIP	**diana.budman@nyumc.org**
Sonia Hudson	Nurse Practitioner	**sonia.hudson@nyumc.org**
Ellen Mitchell	Director, Case Management	**ellen.mitchell@nyumc.org**

Series 1 Action Teams *(continued)*

Performing Provider System: OneCity Health **Team Name: Cut Admissions Through Teamwork (CATT)**	**Site: Bellevue Hospital**	
William Hicks	CEO	**william.hicks@nychhc.org**
Christina Jenkins, MD	President and CEO	**christina.jenkins@nychhc.org**
Hillary Jalon	Senior Director, Quality Improvement	**jalonh1@nychhc.org**
Marcy Pressman	Deputy Executive Director	**marcy.pressman@bellevue.nychhc.org**
Elvis Durazzo	DSRIP Program Director	**elvis.durazzo@nychhc.org**
Susanne Greenblatt	Acting Executive Director, Case Management	**susanne.greenblatt@bellevue.nychhc.org**
Courtney Nelson	Project Manager	**cnelson@dhs.nyc.gov**
Dina Goldemberg	Assistant Director, Social Work	**dina.goldemberg@bellevue.nychhc.org**
Todd Hixson	Senior AED, Psychiatry Administration	**todd.hixson@nychhc.org**
Hope Iliceto	Deputy Executive Director, Health and Home Care	**iliceto@nychhc.org**
Reina Smith	Sr. Associate Executive Director of Ambulatory Care	**reina.smith@bellevue.nychhc.org**
Natalie Kramer	Associate Director, BH Social Work	**natalie.kramer@bellevue.nychhc.org**
Dr. Ian Fagan	Attending Internal Medicine	**ian.fagan@bellevue.nychhc.org**
Dr. Omar Fattal	Attending Behavioral Health	**omar.fattal@bellevue.nychhc.org**

Performing Provider System: OneCity Health **Team Name: Lincoln Cares**	**Site: Lincoln Hospital**	
Akinola Fisher, MD	Chief Ambulatory Care	**akinola.fisher@nychhc.org**
Christina Jenkins, MD	President and CEO	**christina.jenkins@nychhc.org**
Hillary Jalon	Senior Director, Quality Improvement	**jalonh1@nychhc.org**
Ammar Nassereddin, MD	Attending Physician	**ammar.nassereddin@nychhc.org**
Cristina Ho, MD	Attending Physician	**cristina.ho@nychhc.org**
Pawan Suri	Research Assistant, Graduate Medical Education	**pawans@nychhc.org**
Milly Toro, LCSW	Associate Director, Social Work	**milly.toro@nychhc.org**
Elizabeth A. Stone, PharmD	Transitional Care Pharmacist	**elizabeth.stone@nychhc.org**
Michelle Colon, MA	Bronx Borough Director	**michelle.colon@nychhc.org**

Series 1 Action Teams *(continued)*

Performing Provider System: OneCity Health **Team Name: Lincoln Cares**		**Site: Lincoln Hospital**
Corazon Beltran, RN, MSN	Inpatient Care Manager	**corazon.beltran@nychhc.org**
Quennie-Joy Papa, RN, MS	Care manager	**queeniejoy.papa@nychhc.org**
Colette M. Barrow, MPA, PhD	Senior Associate Director, DSRIP and Grants Management Director	**colette.barrow@nychhc.org**
Ma Carla Angela Evangelista, MD	Physician Lead for High Risk Utilizer PI ACO, Medicine Clinic	**evangelmh@nychhc.org**
Wanda Gonzalez, RN	High Risk Utilizer PI ACO Project, Medicine Clinic	**jay.itzkowitz@chsli.org**
Delmy Herz, RN	Care Manager, Care Transitions Team	**gonzalew1@nychhc.org**
Belinda Egyir, RN	Assistant Director Nursing, Care Transitions Team	**hertzd@nychhc.org**
Tonya Mitchell, CLWII	Community Health Worker, DSRIP	**belinda.egyir@nychhc.org**

Performing Provider System: Suffolk Care Collaborative (SCC) **Team Name: SAM-I-AM**		**Site: Good Samaritan Medical Center**
Donald Teplitz, MD	Chief Medical Officer	**donald.teplitz@chsli.org**
Joel Shu, MD	Vice President Population Health	**joel.shu@chsli.org**
Karen Eckert	Vice President Operations	**karen.eckert@chsli.org**
Linda Efferen, MD	Medical Director	**linda.efferen@stonybrookmedicine.edu**
Jay Itzkowitz, MD	Assistant Chief Medical Officer	**jay.itzkowitz@chsli.org**
Gloria Mooney	DSRIP Project Manager	**gloria.mooney@chsli.org**
Jiwanjot Narula, MD	Chief Hospitalist	**jiwanjotk.narula@chsli.org**
Jennie Lewis	RN TOC Coordinator	**jennie.lewis@chsli.org**
Jing Wen	Performance Improvement Coordinator	**jing.wen@chsli.org**
Christine Nevitt	Educator/Auditor	**christine.nevit@chsli.org**
Jessica Wyman	DSRIP Associate Director	**jessica.wyman@chsli.org**
Laquetta Soloman	Social Worker	**laquetta.solomon@chsli.org**
Barbara Rowe	Director, Specialty Services	**barbara.rowe@chsli.org**
Joan Geagan	Care Manager	**joan.geagan@chsli.org**
Roshni Samuel, MD	Hospitalist	**roshnis.samuel@chsli.org**

Series 1 Action Teams *(continued)*

Performing Provider System: Westchester Medical Center Team Name: Care Accelerated Redesign Team (CART)		Site: Bon Secours Community Hospital
Peter Kenniff	Chief Financial Officer	**peter_kenniff@bshsi.org**
Sophie Crawford Rosso	Vice President Patient Care/Chief Nurse Executive	**sophie_crawford-rosso@bshsi.org**
Naim Korca	Administrator, Behavioral Health	**naim_korca@bshsi.org**
Janet Baily	Director, Emergency Department	**janet_bailey@bshsi.org**
Maureen Doran	VP Integrated Care Network	**maureen.doran@wmchealth.org**
Lyn Wessels	Case Manager	**lyn_wessels@bshsi.org**
Anita Lindstrom	Sr. Financial Clinical Analyst	**anita_lindstrom@bshsi.org**
Sapna Shah	Admin-Legal	**sapna_shah@bshsi.org**
Tera Colavito	Director of Social Work	**tera_colavito@bshsi.org**
Beverly Robinson	Behavioral Health Screener	**beverly_robinson@bshsi.org**
Faynette Sherlock	Registered Nurse	**faynette_sherlock@bshsi.org**
Tammy Rhein	Director of Mental Health Services	**trhein@orangecountygov.com**

Performing Provider System: Westchester Medical Center Team Name: Good Health Gladiators		Site: Health Alliance of the Hudson Valley
David Scarpino	President and CEO	**david.scarpino@hahv.org**
Sandy Horan	Chief Nursing Officer	**shoran@hahv.org**
Maureen Doran	Vice President Integrated Care Network	**maureen.doran@wmchealth.org**
Kathy Dellaripa	Strategic Planning	**kathleen.dellaripa@hahv.org**
Maddie Smith	Registered Nurse – Medical Surgical	**madelyn.smith@hahv.org**
Courtney Beaupre	Director of Care Management	**cbeaupre@institute.org**
Sharon Miller	Manager – Psychiatric ED	**scmiller@hahv.org**
Carole Hilbrandt	Manager – Care Management	**carole.hilbrandt@hahv.org**
Arnell Tuttle	Director – Partial Hospitalization Program	**arnell.tuttle@hahv.org**
Allen Nace	Director – Substance Abuse	**allen.nace@hahv.org**
Amy McCracken	Deputy Commissioner	**amcc@co.ulster.ny.us**

Series 2 Action Teams

Performing Provider System: Adirondack Health Institute Team Name: High Peaks Care Collaborative		Site: Adirondack Medical Center at Saranac Lake
Dave Mader	VP of Patient Care	**dmader@adirondackhealth.org**
Andre Cappiello	Data Analyst	**acappiello@adirondackhealth.org**
Sara Crystal	NP	**scrystal@adirondackhealth.org**
Marc Johnson	Social Worker	**mjohnson@adirondackhealth.org**
Robin Gay	Director Comm. Svcs.	**robingay@stjoestreatment.org**
Deceil Moore	Director of Behavioral Health	**deceilmoore@citizenadvocates.net**
Becky Preve	Care Manager	**bpreve@co.franklin.ny.us**
AnnMarie Tripp	Care Manager	**atripp@adirondackhealth.org**

Performing Provider System: Adirondack Health Institute Team Name: Fulton County		Site: Nathan Littauer Hospital
Geoffrey Peck	VP/Executive Director	**gpeck@nlh.org**
Dr. Nosa Aigbe-Lebarty	Director of Hospitalist Program	**naigbelebarty@nlh.org**
Dr. Irina Gelman	Director	**igelman@co.fulton.ny.us**
Rene Norris	Clinical Data Analyst	**rnorris@nlh.org**
Karen Clark	Executive Director	**kclark@newyorkhomehealthcare.com**
Janine Dykeman	President	**jdykeman@mhafm.org**
Jennifer Elmendorf	Former nurse manager	**jelmendorf@nlh.org**
Susan Frasier	CEO	**susan.frasier@mvhcares.org**
Margaret Rowley	Care Coordination Manager	**mrowley@nlh.org**

Performing Provider System: Alliance for Better Health Care Team Name: Uncle Sam's Angels		Site: Samaritan Hospital
Meg Wallingford	SVP of Transformation	**meg.wallingford@allianceforbetterhealthcare.com**
Dr. John Krisa	Hospitalist	**john.krisa@sphp.com**
Rachael Handler	Director of Rehabilitation Services	**rachel.handler@sphp.com**
Laurie Lanphear	Director of Health Homes and DSRIP	**llanphear@alliancefph.org**
Dr. John Janikas	CMO	**jjanikas@usacs.com**
Christina Yerdon	Director of Care Coordination	**christina.yerdon@sphp.com**
Michelle Horan	Director, SPHP Medical Associates	**michele.horan@sphp.com**
Kelly Piotrowski	Manager of Data Analytics	**kelly.piotrowski@ihany.org**

Series 2 Action Teams *(continued)*

Performing Provider System: Care Compass Network Team Name: MAD MAX		Site: Cortland Regional Medical Center
Sue Ryan	Director of Case Management	**sryan@cortlandregional.org**
Tara Wetherell	Clinical Coordinator	**twetherell@cortlandregional.org**
Ken Ippolito	Data Scientist	**kippolito@cortlandregional.org**
Patti Lord	Nurse	**plord@cortlandregional.org**
Millissa Ross	Director	**mross@cortlandregional.org**
Tarry Gay	ED Case Manager	**tgay@cortlandregional.org**
Tim Lockwood	Director of Compliance	**tlockwood@ccocc.org**

Performing Provider System: Central New York Care Collaborative Team Name: CNY-CAP		Site: SUNY Upstate University Hospital
Kari Burke	DSRIP Program Coordinator	**burkeka@upstate.edu**
Dr. Brian Changlai	Hospitalist/Assistant Professor of Medicine	**changlbr@upstate.edu**
Samadhi Moreno	Program Coordinator Transitional Ca Services	**remorenos@upstate.edu**
Diane Nanno	Director of Transitional Care	**nannod@upstate.edu**
Dr. Ross Sullivan	Director of Med Toxicology/ED	**sullivar@upstate.edu**
Mark Buttiglleri	Director of Social Work	**buttiglm@upstate.edu**
Deborah Donahue	Director of Community Based Servi	**cesddonahue@circare.com**
Kim Rodgers	Clinical Staff Supervisor	**krogers@hcrhealth.com**
Scott Elia	Manager Decision Support	**elias@upstate.edu**

Performing Provider System: Finger Lakes Performing Provider System Team Name: Chemung County Choppers		Site: Arnot Ogden Medical Center
Lori Lawrence	ED Case Management	**llawrence@ah.arnothealth.org**
Diana Durfey	Director of Emergency Department	**ddurfey@ah.arnothealth.org**
Hannah Smith	PPS Co-Lead	**hasmith@arnothealth.org**
Ellen Topping	Housing	**etopping@dor.org**
Rose Barnes	Primary care case management	**rbarnes@ah.arnothealth.org**
Marilyn Cristafaro	Behavioral Health/Substance abuse	**mcristofaro@familyservices.cc**
Pallavi Kamjula	Medical Director of Care Coordination	**pkamjula@ah.arnothealth.org**

Series 2 Action Teams *(continued)*

Performing Provider System: Leatherstocking Collaborative Health Partners **Team Name: AO Fox Community Partnership**		**Site: AO Fox Memorial Hospital**
Jennie Gliha	VP Patient & Employee Experience	**jgliha@aofmh.org**
Dr. Reginald Knight	VP Medical Affairs	**reginald.knight@aofmh.org**
Dan Quemada	Patient Engagement Coordinator	**dan.quemada@aofmh.org**
Lynne Bolstad	Hospitalist PA	**lynne.bolstad@aofmh.org**
Erica Holoquist	ED Nursing Director	**erica.holoquist@aofmh.org**
Renata Talbot	Interim VP Nursing/Education	**rtalbot@aofmh.org**
Carolyn O'Reilly	Ambulatory Nurse Manager	**carolyn.oreilly@aofmh.org**
Tina Snyder, RN, MSN	Vice President of Clinical Services	**tina.snyder@cahpc.org**
Maria DeMott	Senior Director of Clinical Operations	**mdemott@ahcnys.org**

Performing Provider System: Millennium Collaborative Care **Team Name: C2 Niagara**		**Site: Niagara Falls Me**
Sheila Kee	Vice President and Chief Operating Officer	**sheila.kee@nfmmc.org**
Thomas Myrter	Physician	**thomas.myrter@nfmmc.org**
Vicki Landes	Director of Health Home	**vicki.landes@nfmmc.org**
Kevin Burgess	Clinical Supervisor of Adult Mental Health	**kevin.burgess@nfmmc.org**
Patty LeGasse	Quality Assurance Coordinator	**patricia.legasse@nfmmc.org**
Samantha Sessamen	Director of Practice Facilitation	**samantha.sessamen@nfmmc.org**
Diane Martin Pratt	Applications Manager	**diane.martin-pratt@nfmmc.org**
Judy Krupa	ED Transitions Manager	**judy.krupa@nfmmc.org**

Series 2 Action Teams *(continued)*

Performing Provider System: Montefiore Hudson Valley Collaborative Team Name: Readmission Warriors		Site: Vassar Brothers Medical Center
Diane Leach	Director of Clinical Quality	**dleach@health-quest.org**
Albert Belaro	Assistant Chief Nursing Officer	**abelaro@health-quest.org**
Martha Haag	Assistant Nurse Manager and Outcomes Coordinator, ED	**mhaag@health-quest.org**
William Eckert	Director of Clinical Services	**weckert@dutchessny.gov**
Alison Gilmore	MSW	**agilmore@nathealthcare.com**
Edna Muhammad	Manager of Case Management	**emuhamma@health-quest.org**
Chanel Artist	Community Case Manager	**cartist@health-quest.org**
Aly Dubois	COO	**adubois@hrhcare.org**
Beth Falder	Manager of Corporate Clinical Data	**bfalder@health-quest.org**
Dr. Imtiaz Mallick	Associate VP of Medical Affairs	**imallick@health-quest.org**
Dr. Michael Doyle	VP of Medical Affairs	**mdoyle2@health-quest.org**

Performing Provider System: North Country Initiative Team Name: E3 A-Team		Site: Samaritan Medical Center
Dr. Aaron Campbell, MD	Director – Hospitalist Program	**acampbell1@shsny.com**
Sarah Delaney-Rowland, MD	Emergencey Department Physician	**sdelaney@shsny.com**
Jilayne Salisbury, RN	Clinical Director of Physician Practices	**jsalisbury@shsny.com**
Kathy Hunter, RN	Manager of Case Management & Discharge Planning	**khunter@shsny.com**
Kim Thibert	VP Patient Care Services/CNO	**kthibert@shsny.com**
Tim Ruetten	Executive Director	**truetten@co.jefferson.ny.us**
Jeri Gray	Medical Social Worker	**jgray@co.jefferson.ny.us**
Mary Whalen	COO	**mwhalen@shsny.com**

Train-the-Trainer Participants

The individuals listed below successfully completed training under the TTT Program.

Trainer Name	(PPS) ActionTeam Site	Email Address
Diego Ponieman	(ACP) Jamaica Hospital	dponieman@acppps.org
Soraya Sussman	(ACP) Jamaica Hospital	ssussman@acppps.org
Deborah LaRose	(AHI) Saranac Lake	dlarose@ahihealth.org
Jessica Chanese	(AHI) Saranac Lake	jchanese@ahihealth.org
Kelly Owens	(AHI) Nathan Littauer Hospital	kowens@ahihealth.org
Brittany Trybendis	(AHI) Nathan Littauer Hospital	flem6282@plattsburgh.edu
Juliette Price	(FLPPS) Arnot Ogden Medical Center	jcprice@albany.edu
Rebecca Stahl	(Bassett) AO Fox Hospital	rstahl@albanmy.edu
Carol Ann Tiberia	(Alliance) Samaritan Hospital	carolann.tiberia@abhealth.us
Millie Ferriter	(Alliance) Samaritan Hospital	mferriter@chchomecare.org
Stephanie Woolever	(CCN) Cortland Regional Medical Center	swoolever@carecompassnetwork.org
Jennifer Coughlin	(CNYCC) SUNY Upstate University Hospital	jcoughlin@cir.care
Karen Joncas	(CNYCC) SUNY Upstate University Hospital	karen.joncas@cnycares.org
Janet King	(FLPPS) Arnot Ogden Medical Center	janet_king@flpps.org
Dupe Ajayi	(Maimonides) Maimonides Medical Center	dajayi@maimonidesmed.org
Joyce Leiz	(Maimonides) Maimonides Medical Center	jleiz@kingsbrook.org
Saralin Tiedeman	(MCC) Niagara Falls	stiedeman@millenniumcc.org
Tammy Fox	(MCC) Niagara Falls	tfox@millenniumcc.org
Alana Murphy	(Bassett) AO Fox Hospital	almurphy@montefiore.org
Donovan Lightbourne	(Montefiore) Vassar Brothers Medical Center	dlightbo@montefiore.org
Manav Surti	(Montefiore) Vassar Brothers Medical Center	msurti@montefiore.org
Valerie Capalbo	(Montefiore) Vassar Brothers Medical Center	vcapalbo@asfl.org
Charles McArthur	(NCI) Samaritan Medical Center	cmcarthur@fdrhpo.org
Erin Shustack	(NCI) Samaritan Medical Center	eshustack@northcountryinitiative.org
Nicole Beltrez	(NQP) Nassau University Medical Center	nbeltrez@numc.edu
Brian Youngblood	(NYP) Weill Cornell Medical Center	bjy9001@nyp.org
Leslie Chiu	(NYP) Weill Cornell Medical Center	lma9008@nyp.org
Patricia Hernandez	(CCB) Maimonides Medical Center	pah9051@nyp.org
Coleen Dunkley	(NYP/Q) NYP-Queens Hospital	cod9034@nyp.org
Marlon Hay	(NYP/Q) NYP-Queens Hospital	mah9214@nyp.org

Trainer Name	(PPS) ActionTeam Site	Email Address
Dena Rakower	(OCH) Bellevue Hospital	**dena.rakower@bellevue.nychhc.org**
Jeanne Dzurenko	(OCH) Bellevue Hospital	**dzurenkj@nychhc.org**
Marcia Parker	(OCH) Lincoln Hospital	**marciam@xinconcare.com**
Vipul Shah	(OCH) Lincoln Hospital	**vipul.shah@nychhc.org**
Michelle Sentell	(WMC Health) Bon Secours Community Hospital	**msentell@rhcnys.org**
Tamy Skaist	(WMC Health) Bon Secours Community Hospital	**tskaist@echckj.org**
Caitlin Verrilli	(NYU Lutheran) NYU Lutheran Medical Center	**cverrilli@sbhny.org**
Meredith Stanford	(WMC Health) Kingston Health Alliance	**mstanford@sbhny.org**
Rebekah Epstein	(NYU Lutheran) NYU Lutheran Medical Center	**repstein@sbhny.org**
Jennifer Kennedy	(SCC) Good Samaritan Hospital	**jkennedy@gurwin.org**
Susan Jayson	(SCC) Good Samaritan Hospital	**susan.jayson@stonybrookmedicine.edu**
Kathleen Craig	(WMC Health) Kingston Health Alliance	**kathleen.craig@wmchealth.org**

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Contact for more information:
MRTUpdates@health.ny.gov