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Performing Provider System

Milestone #1:
Target Workforce State

Target Workforce State

Bronx Health Access PPS
1276 Fulton Ave
Bronx, New York 10456

(June 30, 2016)

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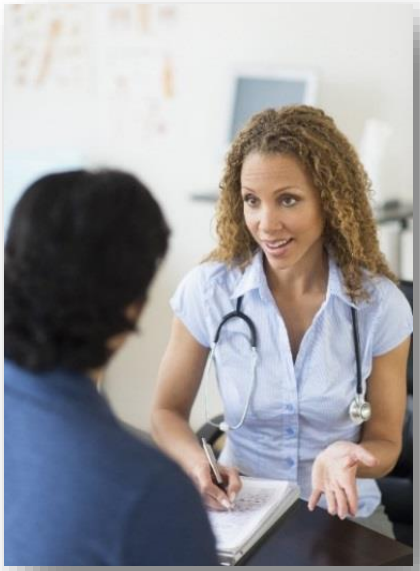

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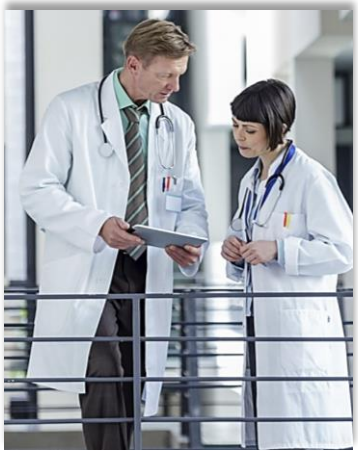
Executive Summary

The New York State Department of Health (NYSDOH) requires all Performing Provider Systems (PPS) to submit a Target Workforce State Projection Model for each DSRIP project. The Bronx Health Access (BHA) PPS has focused on defining a future workforce state that comprises having the right people in the right places with the right skills at the right times. Planning for the target state of our workforce involved analyzing the human capital resource needs of our partner organizations and our PPS office with the DSRIP business goals.

We commenced a methodical process of evaluating the project requirements, determining workforce functional needs, and identifying the job types essential for success. This process involved focus group meetings with each project team to analyze workforce variables, such as service delivery models, technological changes, expected patient engagement targets, population demographics and disease states, and skill requirements within different job families.



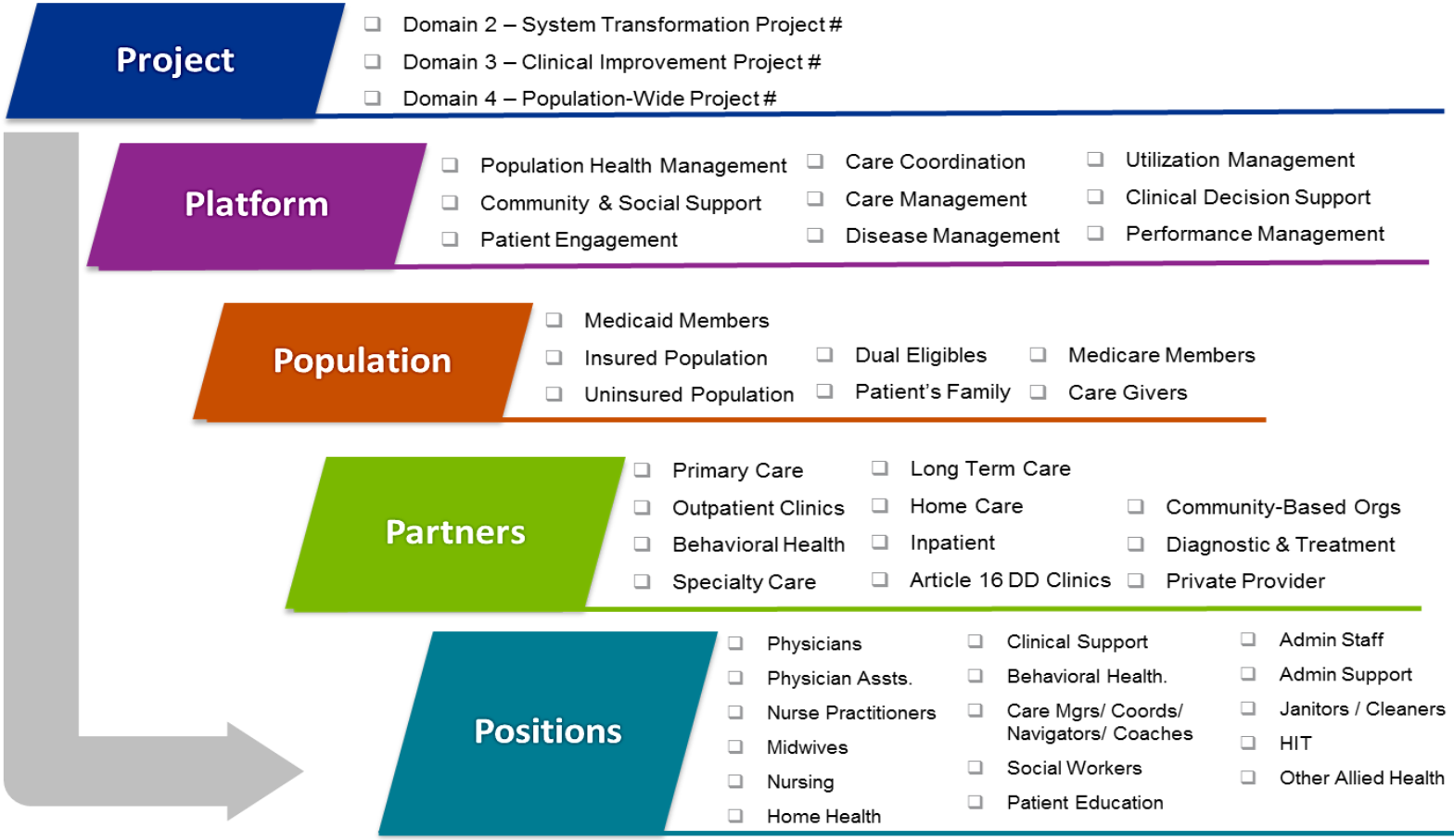
This document provides a baseline evaluation of the Target Workforce State needs for BHA. Due to the inevitable uncertainties in forecasting future demand, we plan to refine our target state workforce projections with scenario planning. The objective of our ongoing planning efforts will be to understand the plausible future business scenarios that may impact our workforce demands and adjust our projections, if necessary.

This document also details how we performed a staffing-by-project needs analysis with the involvement of our PPS partners. It outlines our approach to the future workforce state design, development of the project-level staffing models, and the identification of quantitative and qualitative workforce needs to meet the DSRIP goals both now and in the future.

Scope and Approach

THE TARGET STATE FORECASTING PROCESS

To determine our future workforce needs, we used an assessment framework provided by our workforce vendor. This framework enabled us to identify the capabilities and processes applicable to each project, outline the population service needs, pinpoint the key partners to engage in each project, and classify the specific job categories and positions needed to support each project.



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Scope and Approach

THE APPROACH

The BHA PPS Workforce Committee members, Project Leads, and representatives from our network partner organizations worked collaboratively through a series of meetings to identify the types of positions, qualifications, and skills and competencies needed to meet the DSRIP goals for each project.

The model below demonstrates the approach we followed to achieve the most efficient Target Workforce State.

Research

- Conduct a literature review of optimal staffing models and position ratios related to each DSRIP project
- Identify the skills, licensures, and certification requirements by job category and/or job type based on the platform (i.e. model of care, delivery process, capabilities)

Construct

- Develop a position-by-project staffing model based on the DOH job categories
- Use the target population number for each project as the denominator
- Apply current and national ratios or benchmarks to calculate the estimated number of positions needed by job type

Review

- Present the position-by-project staffing models to BHA Project Leads and representatives from our network partner organizations to review
- Adjust the estimated number of positions (if needed) based on feedback from BHA Project Leads and representatives from our network partners organizations

Validate

- Present the updated Target State model to BHA PPS Core Team members, Project Leads, and key Partners to validate
- Adjust the number of positions (if needed) based on feedback from the BHA PPS Core Team members, Project Leads, and key Partners
- Finalize the target state model

While we believe the Target Workforce State that resulted from our collaboration will allow successful implementation of the DSRIP projects which we are participating in, we understand that changes may arise in the workforce needs once our projects are fully implemented.

Advancing Care Coordination

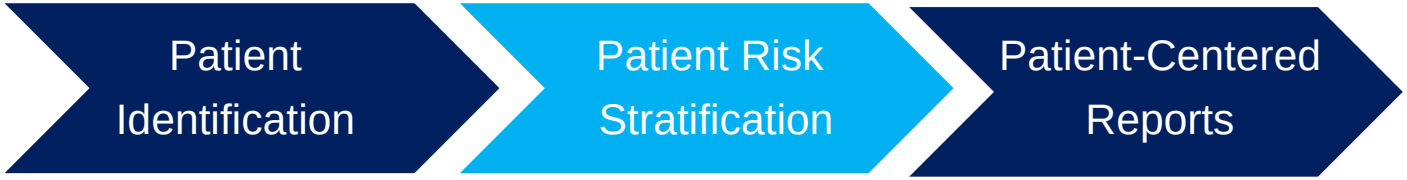
CARE COORDINATION CLEARINGHOUSE:

Care Coordination is an key element of the NYS DSRIP initiative and has been a central focus of the BHA workforce planning efforts. Our PPS is establishing a Care Coordination Clearinghouse to enable our licensed and non-licensed care coordinators to proactively partner with providers and other members of the care team to support continued PCMH transformation, such as using point-of-care reports to review missing preventive screenings or needed lab work at each patient visit.

We recognize the vital role that Care Coordination plays in achieving the quality and cost metrics required by insurers, and capitalizing on other emerging value-based payment models. We are committed to providing our workforce with the tools and resources required to institute a team-based care model that includes coordination across the continuum of care.

The chief purpose of the BHA clearinghouse is to align patients throughout the PPS with Care Coordination services. The clearinghouse will serve as a centralized point of contact for PPS providers to determine if a patient already has a care coordinator, if they are in a health home, etc. Additionally, the clearinghouse will deploy staff to funnel patients from the Inpatient, Emergency Department, and Psychiatric Emergency Department back to the PPS' care coordinators by using the same clearinghouse process.

The model below outlines the three key components of our Care Coordination Clearinghouse:



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Overview of DSRIP Project Workforce Needs

2.a.i Create an Integrated Delivery System

- **Core Functions**:
  - Establish connectivity to support reporting, EHR, HIE/DIRECT, claims-based analytics, care plan sharing, and consumer technology
  - Create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services
  - Evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes
- **Core Job Categories Required:**
  - Administrative Staff
  - Health Information Technology
  - Clinical Support

2.a.iii Health Home At-Risk Intervention Program

- **Core Functions**:
  - Expand access to community primary care services
  - Develop integrated care teams to meet individual needs of higher risk patients
  - Build care management resources and establish a care management pathway
- **Core Job Categories Required:**
  - Non-licensed Care Coordination / Case Mgmt / Care Mgmt / Patient Navigators / Community Health Workers
  - Administrative Staff
  - Administrative Support

Overview of DSRIP Project Workforce Needs

2.b.i Ambulatory ICUs

- **Core Functions**:
  - Create a multi-provider team for patients with complex medical, behavioral conditions, and social complexities
  - Include community-based non-physician care, complex specialty care, for stable patients in need of additional social services
- **Core Job Categories Required:**
  - Non-licensed Care Coordination / Case Mgmt / Care Mgmt / Patient Navigators / Community Health Workers
  - Administrative Staff
  - Social Worker Case Managers
  - Behavioral Health
  - Physicians
  - Nurse Practitioners
  - Other Allied Health

2.b.iv Care Transitions Intervention Model

- **Core Functions**:
  - Provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented
  - Develop a model to encapsulate pre-discharge patient education, care record transition to receiving practitioner, and community-based support for the patient for a 30-day transition period post-hospitalization
- **Core Job Categories Required:**
  - Non-licensed Care Coordination / Case Mgmt / Care Mgmt / Patient Navigators / Community Health Workers
  - Administrative Staff
  - Administrative Support
  - Nurse Practitioners
  - Nursing

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Overview of DSRIP Project Workforce Needs

3.a.i Integration of Primary Care and Behavioral Health

- **Core Functions**:
  - Integrate metal health and substance abuse with primary care services to ensure coordination of care for both services
  - Identify behavioral health diagnoses earlier, allowing rapid treatment
  - Ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects
  - De-stigmatize treatment for behavioral health diagnoses
- **Core Job Categories Required:**
  - Behavioral Health
  - Clinical Support
  - Administrative Staff
  - Administrative Support

3.c.i Evidence-based Strategies for Disease Management

- **Core Functions:**
  - Ensure clinical practices in the community and ambulatory care setting use strategies to improve management of diabetes
  - Improve practitioner population management, increase patient self-efficacy and confidence in self-management, and implement diabetes management evidence-based guidelines
- **Core Job Categories Required:**
  - Non-licensed Care Coordination / Case Mgmt / Care Mgmt / Patient Navigators / Community Health Workers
  - Nursing Care Managers
  - Administrative Staff
  - Administrative Support
  - Behavioral Health
  - Physicians, Physician Assistants, and Nurse Practitioners
  - Other Allied Health

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Overview of DSRIP Project Workforce Needs

3.d.ii Expansion of Asthma Home-based Self-management Programs

- **Core Functions**:
  - Implement an asthma self-management program, including home environmental trigger reduction, self-monitoring, medication use, and medical follow-up
  - Reduce avoidable ED and hospital care
- **Core Job Categories Required:**
  - Non-licensed Care Coordination / Case Mgmt / Care Mgmt / Patient Navigators / Community Health Workers
  - Administrative Staff
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Nursing

3.f.i Increase Support for Maternal and Child Health

- **Core Functions**:
  - Reduce avoidable poor pregnancy outcomes and subsequent hospitalization
  - Improve maternal and child health through the first two years of the child's life
  - Create an evidence-based home visitation model for pregnant high-risk mothers
  - Implement a Community Health Worker program on the model of the Maternal and Infant Community Health Collaborative program
- **Core Job Categories Required:**
  - Social Worker Case Managers
  - Nursing Care Managers
  - Non-licensed Care Coordination / Case Mgmt / Care Mgmt / Patient Navigators / Community Health Workers
  - Physicians
  - Nursing

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Overview of DSRIP Project Workforce Needs

4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure

- **Core Functions**:
  - Strengthen mental health and substance abuse infrastructure across systems
- **Core Job Categories Required:**
  - Behavioral Health
  - Administrative Staff
  - Health Information Technology

4.c.ii Increase Early Access To, and Retention In, HIV Care

- **Core Functions**:
  - Increase early access to and retention in HIV care
- **Core Job Categories Required:**
  - Non-licensed Care Coordination / Case Mgmt / Care Mgmt / Patient Navigators / Community Health Workers
  - Social Worker Case Managers
  - Administrative Staff
  - Administrative Support

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Skills and Competencies

An assessment of our workforce skills and competencies was conducted as part of our Target Workforce State Projection Modeling. The results of that assessment were factored into our determination of the workforce needs, as well as gaps and training opportunities.

2.a.i Create an Integrated Delivery System

- IDS Care Planning & Management Processes
- IDS Processes & Protocols / Systems Thinking
- Technology Skills (EHR; HIE; Alerts; Direct Messaging; RHIO)
- Meaningful Use Stage 2 Standards

2.b.i Ambulatory ICUs

- Ambulatory Care Protocols

2.a.iii Health Home At-Risk Intervention Program

- Care Coordination / Transitions Process

2.b.iv Care Transitions Intervention Model

- Care Transitions Intervention Model
- Transitions of Care Protocols

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Skills and Competencies

3.a.i Integration of Primary Care and Behavioral Health

- Collaborative Care Evidence-based Standards
- Crisis / Sensitivity Skills
- Integrated Care Reporting
- IMPACT Model

3.f.i Increase Support for Maternal and Child Health

- Evidence-based Guidelines for Pregnant High-risk Mothers
- Cultural Competency / Health Literacy
- Documentation and Outreach Skills for Community Health Workers

3.c.i Evidence-based Strategies for Disease Management

- Stanford Model
- Diabetes Evidence-based Strategies and Protocols

4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure

- Supervisory Experience
- Cultural Competency
- Administrative Management Experience

3.d.ii Expansion of Asthma Home-based Self-management Programs

- Techniques for Promoting Asthma Self-management

4.c.ii Increase Early Access To, and Retention In, HIV Care

- HIV Health Care Maintenance and Disease Prevention
- Understanding Comorbidities, Coinfections, and Complications

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Workforce Projections

DOH Job Category	Position Type(s)	Project(s)	New (N) or Current (C) Role	Is Training Required? (Y or N)	Is there a Skills / Competency Gap to be filled? (Y or N)	Total Target State Number (in FTE)
Administrative Staff	Care Coordination Liaison (Clearing House)	2ai	N	Y	Y	4
	Care Coordination Liaison Supervisor (Clearing House)	2ai	N	Y	Y	1
	Data Analyst	2ai	N	Y	Y	1
	Financial Analyst	2ai	N	Y	Y	1
	Fiscal / Billing Coordinator	4aiii	N	Y	Y	1
	Governance Committee Participants	4aiii	C	Y	Y	0.1
	MHSA Senior Director	4aiii	N	Y	Y	1
	Master Trainer	4aiii	N	Y	Y	0.4
	Nurse Manager	3fi m1	C	Y	Y	0.5
	PMO Staff	2ai	C	Y	Y	5
	Program Director / Manager / CHW Supervisor / Medical Director	2aiii, 2bi, 2biv, 3ci, 3dii, 3fi m1, 3fi m3, 4aiii, 4ci	C/N	Y	Y	7.9
	Project Lead	2bi, 3ai, 3ci, 4ci	C/N	Y	Y	3.25
	Quality Improvement / Quality Assurance Coordinator	4aiii	N	Y	Y	1
	Stakeholder Engagement Staff	2ai	C	Y	Y	5
	Training Specialist	2ai	N	Y	Y	2
	VP of Human Resources	2ai	C	Y	Y	0.5

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Workforce Projections

DOH Job Category	Position Type(s)	Project(s)	New (N) or Current (C) Role	Is Training Required? (Y or N)	Is there a Skills / Competency Gap to be filled? (Y or N)	Total Target State Number (in FTE)
Administrative Support	Administrative Assistant / Data Entry Clerk / Office Clerk	2aiii, 2biv, 3ai, 3ci, 3fi m1	C/N	Y	Y	7.95
	Intake Coordinator	2aiii	C	Y	Y	0.5
	Social Media Specialist	4ci	N	Y	Y	0.25
Behavioral Health	Depression Care Manager	3ai	N	Y	Y	15
	Psychiatrist / Psychiatrist (Consultant)	2bi, 3ai, 3ci	C/N	Y	Y	7.25
	Psychologist	3ci	C	Y	Y	0.25
	School Behavioral Health Consultant	4aiii	N	Y	Y	6
	Supervising Psychologist	4aiii	N	Y	Y	0.8
Clinical Support	CMO/Clinical Lead	2ai	C	Y	Y	0.25
	Medical Assistant	3ai	C	Y	Y	15
Health Information Technology	Data Analyst / Administrator	4aiii	N	Y	Y	1
	Reporting / Data Analyst	2ai, 3fi m1	C/N	Y	Y	3.2

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Workforce Projections

DOH Job Category	Position Type(s)	Project(s)	New (N) or Current (C) Role	Is Training Required? (Y or N)	Is there a Skills / Competency Gap to be filled? (Y or N)	Total Target State Number (in FTE)
Non-licensed Care Coordination	Care Coordinator	**2.a.iii, 2.b.i, 2.b.iv, 3.c.i**	C/N	Y	Y	193
	Care Manager	**2.a.iii**	C/N	Y	Y	
	Community Health Worker / Community Outreach Worker	**2.a.iii, 3.c.i, 3.d.ii**	C/N	Y	Y	
	Community Health Worker (Hospital)	**3.f.i m3**	C/N	Y	Y	
	Community Health Worker (Clinics)	**3.f.i m3**	C/N	Y	Y	
	Care / Patient Navigator	**2.a.iii, 2.b.iv, 3.c.i**	C/N	Y	Y	
	Peer Support Specialist	**2.a.iii, 4.c.ii**	C/N	Y	Y	
	Care Coordinator Supervisor	2aiii	C	Y	Y	2
Nurse Practitioners	Primary Care (NP)	2bi, 2biv, 3ci, 3dii	C/N	Y	Y	5
Nursing	OB/GYN Registered Nurse	3fi m3	C	Y	Y	0.8
	Other Registered Nurse (Specialists)	3dii	C	Y	Y	1
	Registered Nurse/Care Transitions	2biv	C	Y	Y	15
Nursing Care Managers / Coordinators / Navigators / Coaches	Registered Nurse Care Coordinator / Nurse Care Manager	3ci, 3fi m1	C	Y	Y	29
Other Allied Health	Clinical Pharmacist	3ci	C	Y	Y	1
	Dentist	3ci	C	Y	Y	1
	Nutritionist/Dietician	2bi, 3ci	C/N	Y	Y	3
	Podiatrist	3ci	C	Y	Y	1

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Workforce Projections

DOH Job Category	Position Type(s)	Project(s)	New (N) or Current (C) Role	Is Training Required? (Y or N)	Is there a Skills / Competency Gap to be filled? (Y or N)	Total Target State Number (in FTE)
Patient Education	Diabetes Educator	3ci	C	Y	Y	5
	Peer Educator	3ci	C	Y	Y	5
Physician Assistants	Primary Care (PA)	3ci, 3dii	C	Y	Y	2
Physicians	Endocrinologist	3ci	C	Y	Y	1
	Ophthalmologist	3ci	C	Y	Y	1
	Other Specialists (Except Psychiatrists)	3dii, 3fi m3	C	Y	Y	6
	Primary Care (MD) / Consultant	2bi, 2bi, 3ci, 3dii, 3fi m3	C/N	Y	Y	37
	Vascular Surgeon	3ci	C	Y	Y	1
Social Worker Case Management / Care Management	Licensed Social Worker	2bi, 3fi m1	C/N	Y	Y	3.5
	Peer Support Supervisor	4ci	C	Y	Y	2
						407.4

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Sources

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