Workforce Transition Roadmap Report for

Issued: September 13, 2016

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Executive Summary

The overall goal of the Delivery System Reform Incentive Payment ("DSRIP") program is to reduce avoidable hospitalizations and ED visits by the Medicaid population in New York State ("NYS") by 25% through the transformation and redesign of the existing healthcare system. As part of the Community Care of Brooklyn Performing Provider System's ("CCB" or the "PPS") participation in the DSRIP program and completion of certain Workforce Strategy Milestones, Maimonides Medical Center ("MMC"), in its role as fiduciary and lead for CCB, engaged BDO Consulting ("BDO") as its workforce vendor to develop a workforce transition roadmap that details CCB's plans for achieving the target workforce state throughout the five year DSRIP program.

The development of CCB's workforce transition roadmap was created in collaboration with key CCB stakeholders and Workforce Consortium members (OneCity Health PPS, NYU Lutheran PPS, and Bronx Partners for Healthy Communities PPS). The workforce transition roadmap aggregates findings from CCB's current workforce state, target workforce state, and workforce gap analysis to detail CCB's plans and timeline for closing the projected workforce gaps as the DSRIP projects are implemented. CCB anticipates that currently unforeseeable gaps may be highlighted as the projects are implemented over the life of DSRIP.

CCB anticipates that the transition from inpatient care to community-based services, as impacted through the implementation of various DSRIP projects, will result in workforce impacts most notably for nursing, PCPs, clinical support, and numerous emerging titles related to care management.

The workforce transition roadmap will serve to guide CCB in bridging identified workforce gaps by addressing the workforce implications of the DSRIP program. The transition roadmap outlines training and transition support that CCB will provide to its network to successfully implement the DSRIP programs and better serve the PPS population.

I. Workforce Transition Roadmap Overview

The DSRIP program encourages healthcare system redesign and promotes collaboration across providers and community-level partners to reduce avoidable inpatient admissions and emergency room visits by 25% over the next five years for the Medicaid population in New York State. In line with this goal, the transformation of the existing healthcare system and implementation of the chosen DSRIP projects will have implications on CCB's workforce needs.

CCB's workforce transition roadmap, as part of the DSRIP Workforce Strategy Milestones, has been developed to align with DSRIP program goals, and details plans as well as timelines for addressing the ongoing workforce recruitment, training, and redeployment needs of the CCB PPS. The workforce transition roadmap takes into consideration any implications, issues and factors identified within the gap analysis and works to bridge the identified gaps to meet the needs of the PPS.

The approach utilized to define CCB's workforce transition roadmap, as well as CCB's strategy and plans for bridging the identified workforce gaps, has been detailed within the body of this report.

A. Workforce Transition Roadmap Approach

To support the development of a comprehensive workforce strategy, CCB has developed numerous workforce deliverables to inform the development of the workforce transition roadmap. In early 2016, CCB conducted a current workforce state survey, and engaged with key PPS stakeholders in order to identify PPS Partners' current and anticipated staffing needs related to DSRIP program implementation. Findings from these discussions, along with CCB's target workforce state were leveraged to determine potential workforce impacts and staffing resource requirements including emerging titles.

CCB's Current Workforce State Report, Target Workforce State Report, and Gap Analysis Report assisted in creating the Transition Roadmap deliverable. An overview of the deliverables is outlined below.

B. Current Workforce State Approach and Summary Findings

In assessing CCB's current workforce state, CCB engaged BDO and the Center for Health Workforce Studies ("CHWS") to collect and synthesize information pertaining to CCB's current workforce. The current state workforce assessment included the development and distribution of a survey to CCB's Participants to collect workforce data pertaining to CCB's network. Additionally, data requests and stakeholder engagement sessions were held to obtain supplemental data related to CCB's workforce.

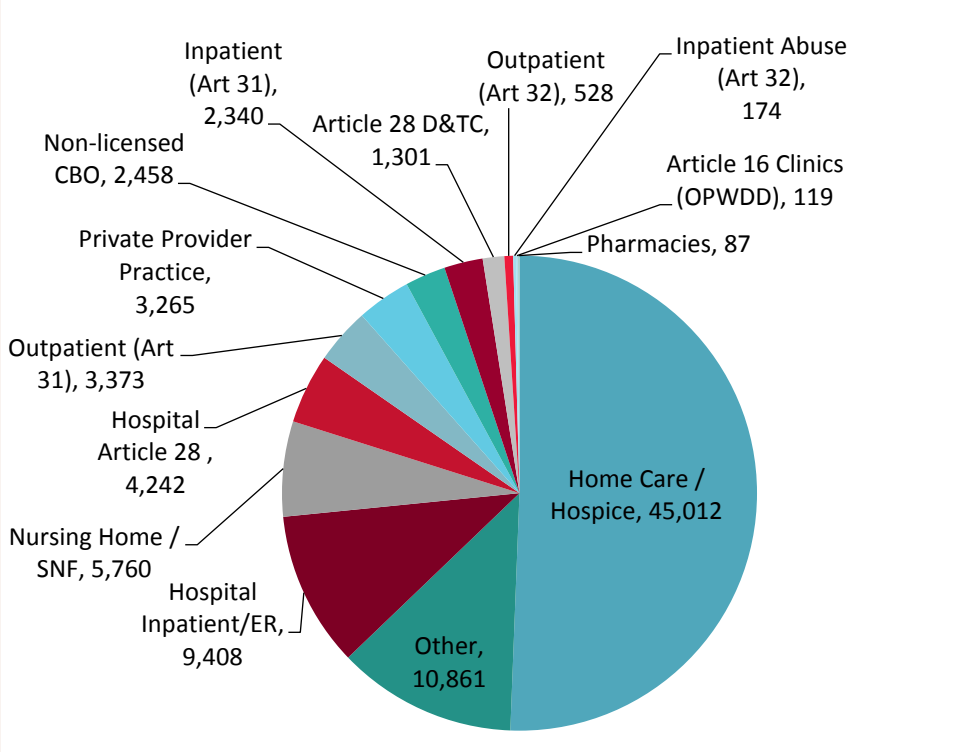
CCB Participants were requested to provide workforce data by job title pertaining to total headcount, full time equivalents ("FTEs"), number of vacancies, average hourly wages, fringe benefits (%), and collective bargaining agreements as well as data pertaining to temporary and agency staff including total headcount, hours, and FTEs. The survey also included sections for PPS Partners to indicate minimum requirements for certain job titles pertaining to degrees / education and years of experience. The purpose for collecting this level of workforce data was to establish a baseline or current state of CCB's workforce and compare these findings to the projected target workforce state to identify workforce gaps, and to use these findings for other workforce planning efforts.

A total of 288 surveys was completed and submitted by 172 Participants, of which 37 organizations were private practitioners. The submissions equate to a response rate of approximately 10.0% for private practitioners and 31.0% for other organizations.

The current workforce state survey requested workforce data across Facility Types and Job Titles by headcount, FTEs, and FTE vacancies, as well as agency and temporary staff by headcount, hours, and FTEs. The following pie charts provide an overall summary of CCB's reported workforce data which includes a total headcount of 88,927 individuals.

Exhibit 1 below presents the total reported workforce across all Facility Types (by headcount).

Exhibit 1: PPS Workforce Reported by Survey Participants by Facility Type (Headcount)



The CCB survey Participants also reported on FTE vacancies across all DOH Job Categories in CCB's workforce. Based on the reported data, approximately 27% of the FTE vacancies within Participants' workforce are nursing positions, with 700 FTE vacancies reported. This equates to a vacancy rate of 9.5% based on the 7,376 nursing FTEs reported for CCB. Other DOH Job Categories which reported significant FTE vacancies include Administrative Support and Behavioral Health.

CCB also collected workforce data including minimum years of experience and minimum degree requirements for certain job titles, CBA status, and the utilization of Agency/Temporary staff to further inform CCB's workforce planning efforts throughout the DSRIP program.

C. Target Workforce State Approach and Summary Findings

The Target State report identified CCB's projected workforce needs by the end of the DSRIP program in 2020. Findings and project impacts from the report are summarized within this section and further detailed in the Target State Report.

Development of CCB's target workforce state was conducted in collaboration with CCB's Executive Committee ("Workforce Governance Body") and included input from multiple stakeholders within CCB's partner network as well as external data sources. External data sources included local, state, and national surveys, medical claims databases, published literature and IHS's Health Care Demand Microsimulation Model (HDMM).

As the DSRIP program progresses, the demand for healthcare workforce within CCB's network will continue to evolve as DSRIP projects are implemented, impacts of those projects are realized, and as external factors outside of the DSRIP program take shape. Although the target workforce state analysis was conducted using best efforts and project implementation assumptions to model workforce impacts over the DSRIP program, the target workforce state summarized within this section and further detailed in the Target State Report is a projection intended to inform CCB's workforce planning. Workforce needs will be reevaluated as project impacts are realized over time.

Exhibit 2 below summarizes CCB's estimated target workforce state staffing impacts by 2020, taking into account the anticipated impact of the DSRIP program as well as anticipated demographic and healthcare coverage changes, independent of DSRIP, across the PPS' care settings and key job categories. In some cases, non-DSRIP impacts offset or moderate the effects of DSRIP, while in other cases they magnify DSRIP workforce impacts. Notable projected impacts for CCB include:

- By 2020, the combined impact of a growing and aging population, expanded medical insurance coverage under ACA, and DSRIP implementation will increase the modeled demand for health care providers by approximately 773 FTEs:
    - Independent of DSRIP workforce, demand is projected to grow by approximately 525 FTEs.
    - The projected impact of DSRIP implementation alone is estimated to increase demand for health care providers modeled by approximately 249 FTEs.
- The largest DSRIP-related increase is seen in demand for care coordinators/navigators/coaches (combined), which is projected to rise by approximately 409 FTEs.
- Also significant both in terms of projected workforce impacts related to DSRIP, and changes independent of DSRIP, are changes in registered nurses ("RNs") in the inpatient setting, non-nursing care coordinators/navigators and primary care providers and support staff in outpatient and community-based settings:
    - Net demand for registered nurses is estimated to decrease by approximately 177 FTEs, as DSRIP-related declines of approximately 337 FTEs, primarily in inpatient settings, are partially offset by increased demand for registered nurses due to non-DSRIP environmental factors (approximately 160 FTEs).
    - However it should be noted that RN vacancies were reported by CCB Partner's that completed the Current State Workforce Survey.
- An estimated additional 209 FTE administrative support staff and 170 FTE medical assistants are projected to be required in primary care settings to support primary

care and other medical and behavioral health specialties to meet both DSRIP-related needs and those associated with population growth and aging.

- The need for Primary Care providers is estimated to increase by approximately 97 FTEs by 2020 due to both DSRIP and non-DSRIP factors.
- Approximately 81 FTE licensed clinical social workers are estimated to be required by 2020 to implement the DSRIP projects. This increase is driven by the integration of behavioral health into the primary care setting.

Exhibit 1: CCB's Summary of Projected DSRIP Staffing Impacts (DY2 to DY5)

Target State Analysis			
Setting and Job Category	**Non-DSRIP Impacts**	**DSRIP-related Impacts**	**Total Impacts**
Primary and Community-Based Settings			
Primary Care Providers	58.5	38	96.5
Cardiologists	10	6.5	16.5
Endocrinologists	3	0	3
Psychiatrists / Psychiatric Nurses	7.5	8	15.5
Psychologists	21.5	0	21.5
Licensed clinical Social Workers	0	80.5	80.5
Registered Nurses	27	25	52
Licensed Practical Nurses	8.5	0	8.5
Nurse Aides / Assistants	8.5	0	8.5
Medical Assistants	102	67.5	169.5
Administrative Support Staff	95	114	209
Emergency Department			
Emergency Physicians	1	-15	-14
Nurse Practitioners & Physician Assistants	0.5	-2.5	-2
Registered Nurses	6.5	-53	-46.5
Hospital Inpatient			
Hospitalists	3.5	-26	-22.5
Registered Nurses	126	-308.5	-182.5
Licensed Practical Nurses	16.5	-17	-0.5
Nurse Aides / Assistants	29	-78	-49
Care Managers / Coordinators / Navigators / Health Coaches/CHWs			
Transitional care nurses	0	21	21
Care coordinators, health coaches & transitional care managers (non-RN)	0	317	317
Palliative care health coach	0	10	10
Community health workers (asthma educators)	0	35.5	35.5
CVD Health coaches	0	17.5	17.5
Patient Navigator	0	8	8
Total FTEs	**524.5**	**248.5**	**773**

D. Gap Analysis Approach and Summary Findings

The gap analysis incorporates findings from CCB's current workforce state and target state to identify existing workforce gaps that may be further impacted as a result of the DSRIP program, or new gaps in required job titles, skill sets, and training that will be created through DSRIP implementation. Findings from CCB's gap analysis were used to inform the development of the workforce transition roadmap, which will assist CCB with workforce planning to reach its target workforce state by the end of the program.

Overall the DSRIP related project workforce impacts are projected to be most significant for the following job categories; primary care providers ("PCPs"), Licensed Clinical Social Workers ("LCSW"), Medical Assistants ("MAs"), administrative support, Registered Nurses ("RNs"), nurse aids/assistants, and the emerging title positions in the area of Care Management. Based on the current workforce state reported by CCB's Participants, the PPS's overall existing vacancies amongst nursing and behavioral health positions may normalize some of the future workforce turnover. In specific instances where high workforce vacancies are reported (RNs), the estimated impacts of DSRIP Projects may minimize the gaps that currently exist within the CCB's workforce.

Within primary care / community based settings the anticipated increase in demand for PCPs as patients are redirected to seek care outside of the Emergency Department ("ED") through the ED Triage project and increased use of PCPs through the Health Home at Risk project and Cardiovascular Disease Management project may create a workforce gap within CCB. Based on the CCB's reported current workforce state data, a vacancy rate of over 10% exists for PCPs across CCB's network, which is well above a rate that might be attributed to normal turnover. Further, the growth in overall demand for Physicians in NYS is forecasted to outpace growth in the current supply of Physicians. Given this workforce supply factor combined with the anticipated increase in demand for PCPs as well as current reported vacancy rates, the existing PCP gap is likely to be further impacted over time as project goals are realized.

As a result of anticipated project impacts for the co-location of primary care and behavioral health services, an increase in demand for Behavioral Health positions, specifically LCSWs, is projected. Additionally, based on the current workforce state data reported, there are significant vacancy rates for Behavioral Health positions currently within CCB and are likely to be further increased as a result of project implementation. In addition to LCSWs, a significant number of administrative support staff is anticipated to be needed to support the integration of primary care and behavioral health services.

Within the ED / hospital inpatient settings, CCB may experience a decrease in demand for ED Physicians and hospitalists as well as a decrease in demand for nursing positions including Nurse Aids/Assistants and RNs as patients seek care outside of the ED / inpatient settings as a result of the DSRIP program. The projected decrease in demand for the ED / hospital inpatient workforce may be partially offset by factors unrelated to the DSRIP program such as population growth within Brooklyn. Given current RN vacancies, the forecasted population

growth in Brooklyn and the number of RNs nearing retirement age within CCB, the projected decline in the need for RNs due to DSRIP may be partially offset.

Through the implementation of the Care Transitions project and the Health Home at Risk Intervention program, demand for Care Coordinators, Health Coaches, Transitional Care Managers, Transitional Care Nurses, Community Health Workers, and Patient Navigators are projected to significantly increase.

II. Workforce Transition Plan

CCB's transition roadmap identifies an approach to bridging workforce gaps that are expected to occur at the individual project level and combines those impacts to propose measures to address overall workforce gaps across CCB.

CCB is developing an Integrated Delivery System ("IDS") through an expansion of interventions and resources including care management, the expansion of primary care and behavioral health capacity, and clinical improvement efforts, all of which will create new demands on CCB's workforce to support anticipated changes in health care service utilization. Additionally, as some DSRIP projects begin to reduce the use of inpatient and ED services and redirect patients to outpatient settings and care management services, staffing needs to support an increased demand for community-based services and potential reductions in inpatient workforce demand will need to be managed.

As part of the overall implementation approach, CCB will take measures to minimize overall staffing reductions, and anticipates that reductions will largely be absorbed by employee attrition and existing vacancies within CCB's workforce.

The following sections address identified CCB workforce gaps and documents CCB's plans to address these gaps and transition the workforce by the completion of the DSRIP program in 2020. CCB aims to support the development of an integrated delivery system and will emphasize through training, partnerships and workforce development efforts, the need to focus on coordination and collaboration amongst CCB's partners.

A detailed work plan of key work steps and target dates for the workforce transition is included in the Appendix.

A. Central Services Organization & Training

CCB aims to implement an Integrated Delivery System (IDS) to transform healthcare delivery through an organized and collaborative network of primary, behavioral, specialty, long-term and post-acute care providers as well as through social service and community-based providers.

CCB's Central Services Organization ("CSO") will identify the gaps in the healthcare workforce throughout the implementation of the DSRIP projects; however the CSO will not be actively involved in the recruitment of the workforce for the PPS partners.

Training will include instruction on care protocols as well as any competency gaps identified through project implementation. The development of care protocols and training of frontline staff will be a key component of DSRIP implementation and the workforce transition. The CSO will assist in the development of clinical protocols and training as needed and coordinate workforce planning.

To support training development and implementation, CCB is leveraging their workforce partner 1199SEIU Training and Upgrading Fund to develop the workforce training program. Workforce training will incorporate cultural competency and health literacy along with the social determinants of health and drivers of health disparities.

To enable successful implementation of the DSRIP programs, CCB is facilitating a number of training initiatives as listed below. These training offerings are discussed further throughout this report as well as in CCB's training strategy deliverable. Additional details related to CCB's training plans can be found in the PPS Workforce Training Strategy. CCB will continue to reevaluate training needs on an ongoing basis and make any required adjustments.

- DSRIP 101
- CCB 101
- Integrated Delivery System Training
- Motivational Interviewing
- Introduction to Cultural Competency ("CC")
- Introduction to Health Literacy ("HL")
- Dashboard Training
- Performance Improvement
- Patient Self-Management
- Use of Registries
- Ethics
- Care Management for Chronic Diseases
- Care Planning
- Communication and Documentation
- MA to Health Coach Training
- Health Home at Risk Project
- Health Coaching
- Care Coordination
- ED Care Triage Project
- Care Transitions Project
- Critical Time Intervention (CTI)
- Care Transitions
- Integration of Behavioral Health and Primary Services Project
- IMPACT Model
- Depression Care Management
- Psychopharmacology
- The Cardiovascular Disease Project

- Million Hearts Campaign
- Stanford Model
- Asthma Home Based Medication Self-Management Project
- The Integration of Palliative Care into PCMH Model
- Primary Palliative Care
- Primary Palliative Care Outcome Survey (POS)
- Palliative Care Collaborative Model Training
- Primary Palliative Care
- The Strengthening Mental Health and Substance Abuse Infrastructure Project
- The Increase Early Access to and Retention in HIV Care Project
- The Undetectables Project
- Technical Assistance Training for PCMH Certification
- Patient-Centered Medical Home

The following sections provide an overview of how CCB will work to transition the workforce based on DSRIP requirements in key areas, including additional details around workforce training.

B. Expansion of Care Management

CCB partners have been progressive in utilizing care managers to meet current "non-DSRIP" needs. However, CCB anticipates that DSRIP will provide the opportunity to expand and enhance these roles to have meaningful impacts on the PPS's population. As reported in the Target Workforce Report Summary and Gap Analysis Summary, the DSRIP program implementation will significantly increase the demand for Care Management roles across the PPS network. The specific job titles associated with these roles may differ across care setting and organization; however, CCB has identified the need to expand its care management resources in the following areas: transitional care nurses and care managers (non-RN), care coordinators, health coaches, community health workers, and patient navigators. Workforce impacts related to these care management roles will be largely driven by the following projects:

- Project 2.a.iii: Health Home at Risk Intervention Program
- Project 2.b.iv: Care Transitions to Reduce 30-Day Readmissions
- Project 3.b.i: Evidence-based Strategies to Improve Management of Cardiovascular Disease
- Project 3.d.ii: Expansion of Asthma Home-based Self-Management Program

CCB's Current State survey reported that a majority of the existing care management workforce currently exists at partner CBO organizations. CCB plans to leverage this workforce and community expertise to develop and expand its care management workforce as detailed in the sections below.

Transitional Care Nurses / Care Managers (non-RN)

For project 2.b.iv, CCB is collaborating with OneCity Health Services ("OneCity") and Bronx Partners for Healthy Communities ("BPHC") to focus on ensuring alignment and coordination of standardized protocols and the development of common risk assessment methodologies and workforce strategies. This includes using common job descriptions and functional capabilities, workforce training efforts, data sharing and selection of culturally competent patient education resources to support this project.

Transitional care nurses ("TCNs") are RNs who will work closely with case management/discharge planning staff at each hospital in order to identify appropriate discharge plans and follow up in the community. Responsibilities include developing *30 Day Care Plans* prior to patient discharge, communicating with PCPs and other providers and/or social organizations where patients have been discharged, following up with patients following discharge, and documenting all procedures in the GSI Health Dashboard. Transitional care managers ("TCMs") will support the TCN in implementing the above duties, and do not require an RN license.

As part of CCB's estimated workforce impacts, transitional care nurses will likely be nurses from existing positions within the CCB hospital network who will be retrained to provide services required of the DSRIP care transition initiative. Non-RN care managers may be redeployed within the PPS or hired by CCB Partners including Maimonides, Kingsbrook, Interfaith, Methodist, and New York Community. In conjunction with 1199 SEIU and Center for Urban and Community Services, the Brooklyn Health Home has innovative training programs in place to transform the existing workforce into a high functioning care management team. Maimonides, through its CMMI grant, developed an extensive training program for Brooklyn Health Home care managers on the basics of chronic illness and care management, cultural competency, patient activation tactics including behavioral activation, CBT, and problem solving therapy and on team-building among providers. CCB will utilize and adapt the program to build the required expanded workforce.

Care Coordinators

On-site Health Home Care Coordinators ("HHCC") will work closely with hospital staff to coordinate care for existing Health Home members and facilitate referrals for Health Home-eligible patients admitted to the hospital or ED. Care Coordinators will work closely with TCNs, TCMs, and Patient Navigators ("PNs") working in the hospital as part of the ED Care Triage and 30-Day Care Transitions initiatives. Responsibilities include working with hospital staff to determine Health Home ("HH") or Health Home at Risk ("HHAR") eligibility of patients, connecting hospital staff with patients' Care Managers to enable coordinated care, and utilizing the GSI Health Dashboard to participate in care coordination of Health Home patients and to document referral, outreach, and enrollment data for the CCB HHAR program.

The care coordinator roles/functions of the HHAR care managers will be similar to those of the HH care managers, though it is anticipated that the services may be at a lower intensity.

CCB's participating Health Homes work with over 35 care management agencies ("CMAs") that have developed a customized set of protocols to provide services to high risk, health home-eligible patients. The Health Homes or CMAs may utilize existing staff, or hire and train new employees to fill these roles at their discretion.

Care coordinators will be trained to educate primary care staff on acceptance and screening of referrals, and on coordination and navigation of medical, behavioral health, and social and family support services. Care coordination staff will also receive training through the 1199 SEIU TEF which encompasses Motivational Interviewing, Self-Management and Health Coaching: Ethics & Cultural Competencies, and Chronic Conditions. Instructor led training sessions will take place over a period of 10 weeks, with each session lasting 8 hours.

Health Coaches

Individuals designated by a CCB Participant organization to serve as a Health Coach will report to a licensed RN and have primary responsibility for implementing a collaborative process of assessment for the HHAR project and HH eligibility, care planning, facilitation of population health management, coordination of care for patients on caseload, patient education, patient advocacy, and regular evaluation of patients on caseload.

Health coaches will be required to educate patients on management of chronic diseases for specific projects including the Asthma Self-Management initiative and Management of CVD project. For CVD Management, CCB anticipates that primary workforce impacts will revolve around training existing staff in guidelines and new roles. For example, in an effort to facilitate better care coordination for CVD patients, coaches will be trained to track population outcomes through clinical registries to identify patients with newly diagnosed, undiagnosed, or poorly controlled chronic conditions. Health coaches will also be trained in measuring vital signs, the use of standardized assessments of basic medical and substance use history and symptoms, and Motivational Interviewing including goal-setting. CCB anticipates that many of these positions will be filled by existing Medical Assistants, LPNs, and other clinical support staff members who will undertake health coach training.

Additionally, CCB anticipates the need to hire health coaches for the integration of palliative care. This is a relatively new position and may require mostly new hires (with some potentially retrained staff) that are not currently employed by CCB. To fill this role CCB will work with partners to provide training/coaching to members of the primary care team including on-site training, coaching, development of decision support algorithms, case conference facilitation, and/or phone consultation.

Health coaches, whether experienced incumbents or new hires, will complete a 3 month training program (60 hours) through Kingsborough Community College. Included in the

curriculum are an Introduction to New Models of Care and Overview of Health Coaching; Patient Engagement and Health Coaching Techniques; Chronic Disease, Wellness, Prevention; and a Practicum with supervisor observation. Two groups of 20 people completed the health coach training course over the 2016 summer.

Community Health Workers

Through Project 3.d.ii, CCB plans to expand staffing for community health worker ("CHWs") and certified asthma educators. CHWs are recognized as trained personnel with an understanding of local communities who will provide home visits in support of existing clinical, care management, and social services. CHW services for patients with asthma will be conducted via physical outreach (e.g. home visits) and telephonic outreach, and will include reinforcement of education on self-monitoring, medication use, and trigger reduction; home environmental assessment; and coordination with other services such as primary care, specialty care, social services, home remediation services, and care management.

CHWs will be trained in care management and care coordination.

Patient Navigators

Patient navigators will work with ED staff, as part of the ED Care Triage project, to redirect patients who visit the ED with non-emergent conditions to a more appropriate setting that also provides a continuum of care. Patients with a PCP will be assisted to schedule a timely appointment, while those who do not have a PCP will be linked to existing resources in primary care, health homes (for health home eligible patients), HHAR, and care transition teams (TCNs and TCMs). Patient navigators will also follow up telephonically with providers to ensure patients have attended their scheduled appointments, follow up with patients within two business days to ensure patients have picked up prescribed medications, and document the PCP appointment and other follow-up in the GSI Health Dashboard.

New and redeployed staff will be required to receive training in CCB's developed ED triage protocols. Additionally, patient navigators will receive care coordination training through the 1199SEIU TEF which encompasses Motivational Interviewing, Self-Management and Health Coaching: Ethics & Cultural Competencies, and Chronic Conditions. Training sessions take place over a period of 10 weeks, with each session lasting 8 hours.

C. Strengthen Primary Care & Behavioral Health

CCB is committed to strengthening primary care and behavioral health services across the PPS network. As presented in the Target State Report and Gap Analysis, it is anticipated that as DSRIP projects are implemented and more patients are connected to primary, preventive, and behavioral healthcare services, there will be an increase in demand for workforce within the primary care/outpatient settings, with notable impacts on PCPs and Clinical and

Administrative Support for primary care, and Licensed Clinical Social Workers ("LCSWs"). Workforce impacts related to primary care and behavioral health will be primarily driven by the following projects:

- Project 2.a.iii: Health Home at Risk Intervention Program
- Project 3.a.i: Integration of Primary Care and Behavioral Health Services
- Project 3.b.i: Evidence-based Strategies to Improve Management of Cardiovascular Disease

Additionally, general population trends associated with the growth in the Medicare population and expanded medical insurance coverage under the ACA may increase workforce demand for primary care providers.

Primary Care Providers

The primary care provider workforce will be impacted by additional PCP visits as a result of redirecting of care from the ED to more appropriate settings for non-emergent conditions, as well as proactive management of chronic diseases. The CSO will offer Primary Care Palliative Care training to PCPs. PCPs that are part of Care Teams will also receive IMPACT training through the Institute for Family Health. PCPs will be offered two introductory courses on cultural competency and health literacy that will be delivered through a combination of e-courses and instructor led training. The CSO will continually engage with PCP Partners to evaluate the requirement for additional training and assistance to successfully implement the DSRIP programs.

Medical Assistants

In addition to PCPs, there will likely be an increased need for direct medical and administrative support to support the projected increase in PCP visits. Several existing MAs within the network may be redirected into emerging roles (e.g. health coaches), which will also create a need to backfill the MA position.

Licensed Clinical Social Workers

To support the integration of primary care and behavioral health services, workforce needs with regards to recruitment and training have been identified for Behavioral Health providers including LCSWs. In order to increase Behavioral Health capacity, CCB plans to expand the Behavioral Health clinical workforce as well as maximize utilization of current Behavioral Health resources by identifying potentially underutilized resources. Strong recruitment efforts will be pertinent to staffing positions related to behavioral health services, particularly because of the strong need for social workers who have received clinical licensure. Licensed Masters Social Workers may be utilized if PPS Partners experience recruitment difficulties in recruiting or retaining LCSWs.

To support project 3.a.i, LCSWs and LMSWs may undertake Depression Care Management training which will be an instructor led course, conducted in partnership with the Institute for Family Health.

D. Movement across Settings

If successfully implemented, multiple DSRIP projects, as reported in the Target State Report and Gap Analysis, will decrease the number of inpatient days (avoidable admissions) and avoidable ED visits, and increase primary care visits across the PPS network. Projected DSRIP-related staffing reductions for certain job titles, due to reduction in utilization of inpatient/ED services, may result in a decline in demand for nurses (including Registered Nurses, LPNs and Nursing Aids). This reduction in inpatient utilization and related increase in demand will likely be offset by non-DSRIP trends, including increased insurance coverage and a growing and aging population. Additionally, the DSRIP program will enhance demand in outpatient and community based settings as care is shifted. Shifting demand across settings may present the opportunity for a focus on the expansion of the workforce and training programs to support community-based care. The Health Workforce Retraining Initiative will continue to be a key resource for CCB Participants in training redeployed workers, including training new care managers within the Health Home and PCMH settings.

Nursing

Several members of the nursing workforce may be retrained and/or redirected within the network to support the transition from inpatient care to community-based services. Opportunities will exist for current RNs to transition from inpatient to care management roles, including depression care manager, transitional care nurse, and health coach supervisor. CCB is committed to providing the necessary training and education for current staff members to fill in workforce gaps impacted by DSRIP implementation so as to eliminate the need for staff reductions.

Medical Assistants

CCB anticipates that many of the emerging titles (e.g. health coach, care coordinator) may be filled by existing MAs within the network. MAs who move into the emerging title roles will receive training and education to complete qualifications for these roles.

E. Cultural Competency and Health Literacy

Brooklyn has a diverse population with a significant immigrant population speaking over 35 languages, with two-thirds of residents speaking a language other than English at home. CCB recognizes that in order to achieve a sustainable reduction in avoidable hospitalizations and ED visits, improvement and integration of cultural competency and health literacy into all of the DSRIP projects is required. CCB's organizing framework is the federal guidance to provide Culturally and Linguistically Appropriate Services ("CLAS"). In alignment with CCB's goals, the CLAS guidelines address three broad focus areas: 1) Governance, Leadership and Workforce;

2) Communication and Language Assistance; and 3) Engagement, Continuous Improvement, and Accountability.

CCB's goals will focus on achieving CLAS within CCB's existing structures, services, activities, and projects delivered by providers throughout the network. In addition, CCB aims to coordinate with other PPSs to share resources, trainings, and best practices wherever possible. Planned activities are intended to change leadership dynamics resulting in adoption of the CLAS standards, including promotion of diverse and inclusive hiring, CLAS orientation and training for staff and consumers, and coordinated interventions to improve community outreach, education, and accommodations. CCB's CC/HL strategy involves making the implementation of culturally and linguistically patient-centered care as streamlined as possible through extensive training and via immediately accessible, user-friendly resources. Resources and technical assistance to support CLAS adherence will be provided to support policy and practice refinements, especially related to hiring, consumer input, and ongoing quality improvement to address disparities and remediate barriers to care related to issues of culture and language.

CCB will implement the following strategies to achieve a culturally competent workforce:

- **Identification of Resources, Tools, and Interventions** – CCB has prepared an initial inventory of tools and resources for adopting person-centered, culturally competent care that providers can consider as they work towards CLAS adherence. CCB will continuously add to this initially inventory of tools and resources via an online Resource Library.
- **System-wide Workforce Training and Staff Development** – CCB is currently working with 1199 SEIU Training and Upgrading Fund to develop the workforce training program, which will incorporate cultural competency and health literacy along with the social determinants of health and the drivers of health disparities. Based on identified gaps, the Community Engagement Advisory Committee will host interactive workshops, lectures, and discussions; host live and recorded webinars; and promote opportunities to join learning collaboratives and receive technical assistance.
- **Staff Recruitment and Hiring** – The CC/HL strategy will explore recruitment strategies to promote diverse hiring and opportunities to support the integration of culturally diverse staff into targeted health care operations (e.g., tuition reimbursement), as well as assess linguistic and communication competencies of staff, including their ability to utilize interpreters (verbal)/translation (written) services effectively where necessary and to actively match employees to patients based on linguistic and cultural needs.
- **Community Engagement and Outreach** – CCB intends to address community engagement and outreach as it relates to cultural competency and health literacy via: 1) all partner meetings, 2) other community-based forums or conferences, 3) consumer education initiatives and help lines, and 4) consumer involvement in CCB Governance.

Please reference the CCB's Cultural Competency and Health Literacy Strategy for additional details regarding strategy training phases and target workforce roles.

III. Appendix- Workforce Transition Roadmap (Timeline)

Workforce Strategy	Target Completion Date	Target Completion Status
Milestone #1: Define Target Workforce State (in line with DSRIP goals)	**6/30/16**	**Completed**
Form dedicated workforce team comprised of the Workforce Committee, CSO staff, and others (e.g., consultants, vendors) with workforce responsibility	03/31/2016	Completed
Initiate work on creation of workforce terminology definitions guide to map specific job titles to the various workforce categories of relevance under DSRIP	06/30/2016	Completed
Define target workforce state based on DSRIP projects/goals	06/30/2016	Completed
Identify consultants/experts to help develop target workforce state	12/31/2015	Completed
Collaborate with selected consultants/experts to ensure baseline workforce survey (see milestone 3) captures information relevant to target workforce state	03/31/2016	Completed
Review and analyze CCB baseline workforce survey data to validate/refine target workforce model	06/30/2016	Completed
Review and finalize target workforce state with Workforce and Executive Committees and obtain approval	06/30/2016	Completed
Milestone #2: Create a workforce transition roadmap for achieving defined target workforce state.	**9/30/16**	**In Progress**
Convene stakeholders, participants and workforce development experts to collaborate on workforce transition planning and transition map development	09/30/2016	In Progress
Identify training and retraining needs as programs develop	09/30/2016	In Progress
Identify existing training curriculum/programs to meet competency gaps	09/30/2016	In Progress
Develop training curricula	09/30/2016	In Progress
Review CCB's workforce survey data and analysis, including gap analysis	09/30/2016	In Progress
Based on workforce survey data, identify and review competency gaps	09/30/2016	In Progress
Develop evaluation mechanism for the workforce transition plan and include regular review of this evaluation mechanism in the transition timeline	09/30/2016	In Progress
Develop a draft workforce transition roadmap leveraging gap assessment (detailed in milestone below), target workforce state, and stakeholder input	09/30/2016	In Progress

Review workforce transition roadmap with Workforce Committee and other stakeholders and edit based on feedback	09/30/2016	Not Started
Review final version of workforce transition roadmap with Workforce Committee and Executive Committee for approval	09/30/2016	Not Started
Milestone #3: Perform a detailed gap analysis between the PPS's current state assessment of workforce the PPS's projected future workforce state	**09/30/2016**	**In Progress**
Identify consultants/vendors to help develop a workforce survey, including current and future state targets that align with CCB selected projects	12/31/2015	Completed
Develop the workforce survey	03/31/2016	Completed
Promote and distribute the workforce survey to CCB Participants	03/31/2016	Completed
Collect information and conduct baseline assessment of current staffing/ workforce within CCB Participants	06/30/2016	Completed
Using baseline assessments, conduct gap analysis between current workforce and target workforce state, including a headcount and competency gap for new and incumbent workers	09/30/2016	In Progress
Draft report summarizing findings of current state and gap assessments; Review current state and gap assessment report with Workforce Committee and Executive Committee	09/30/2016	In Progress
Identify training resources and workforce pipelines to meet identified needs in the gap analysis	03/31/2020	On Hold
Deliver training/retraining curricula to Participants to close headcount and competency gaps	03/31/2020	On Hold
Develop mitigation strategies around risks associated with transition issues	03/31/2020	On Hold
Forecast anticipated number of trained and retrained workers and compare with baseline assessments	03/31/2020	On Hold
Update all workforce tables (e.g. workers redeployed, retrained, new hires, placement impacts, training budget, new hires by category, etc.) according to defined categories	03/31/2020	On Hold
Finalize report and receive approval from Workforce Committee	03/31/2020	On Hold
Refine and update the workforce budget analysis based on the gap analysis	03/31/2020	On Hold
Milestone #4: Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	**06/30/2016**	**Completed**

As part of a workforce survey, identify the number of employees, vacancies, range of compensation levels, including salaries/benefits, for key positions in current marketplace for State-required workforce categories (e.g., redeploy, retrain, new hire) impacted by DSRIP projects	06/30/16	Completed
Develop methodology to measure workforce impacts, including number of retrained and redeployed, and new hires along with compensation impacts, including full placement and partial placement	06/30/16	Completed
Using baseline assessment, conduct gap analysis of current compensation/benefits versus anticipated compensation/benefits for workforce categories	06/30/16	Completed
Assess difference in benefit levels for workforce categories and develop draft report	06/30/16	Completed
Share compensation and benefit analysis report with Workforce Committee and Executive Committee for review/approval	06/30/16	Completed
Milestone #5: Develop a training strategy	**09/30/2016**	**In Progress**
Convene workforce committee to develop a training strategy, including types of training needed by different types of staff, curriculum, frequency of training, method of training, how training outcomes will be measured, etc.	09/30/2016	In Progress
Work with the 1199SEIU Training and Education Fund, the City University of New York, workforce development experts and CCB partners to inventory existing training programs/resources, including their capacity to expand to address CCB workforce training needs, and conduct a training needs assessment	06/30/2016	Completed
Identify training curriculum/provider gaps	06/30/2016	Completed
In collaboration with training providers, update existing training curricula, if needed, and/or develop new curriculum to meet competency gaps	09/30/2016	In Progress
Review preliminary training budget and revise/update as necessary	09/30/2016	In Progress
Identify training needs using information from CCB's workforce survey results and analysis, which includes competency gaps	06/30/2016	Completed
Identify training providers with capacity to develop and deliver needed training and contract with them	09/30/2016	In Progress
Review/finalize training strategy plan and budget with Workforce Committee and Executive Committees	09/30/2016	In progress
Cultural Competency and Health Literacy		
Milestone #2: Develop a training strategy focused on addressing the drivers of health disparities	**6/30/16**	**In Progress**
Identify and inventory existing training programs for clinicians and other members of the workforce that serve	6/30/2016	In Progress

CCB beneficiaries and address health disparities among racial ethnic groups.		
Review CNA and other available data to identify critical areas of health and social disparities for training support.	12/31/2015	Completed
Identify gaps in training programs based on inventory of existing programs and review of CNA and other available data, and begin to develop training strategies that address identified gaps by augmenting current training programs, and identifying the need for development of new training programs.	06/30/2016	In Progress
Working with the Workforce and Care Delivery and Quality Committees, develop draft training plan to address gaps and leverage/augment existing training programs, identifying distinct needs by sub-population, type of provider or other workforce members and present to the Executive Committee for review and approval.	06/30/2016	In Progress
Identify, in collaboration with the Workforce and Care Delivery and Quality Committees, provider champions to deploy the training plan and ongoing evaluation and enhancement.	06/30/2016	In Progress
Implement training plan using a system/methodology to monitor and report on adoption and delivery.	06/30/2016	In Progress
Initiate ongoing evaluation of training effectiveness through such methods as surveys and focus groups.	06/30/2016	Not Started
Practitioner Engagement		
Milestone #2: Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	**6/30/2016**	**In Progress**
Review CCB practitioner listing and organize into provider-specific types (such as medical, behavioral health and substance abuse, etc.) for DSRIP project training and education purposes	12/31/2015	Completed
Working with the Workforce Committee and key training partners, research vendors or Participants with curriculum development and/or training capabilities, including higher educational entities	06/30/2016	In Progress
Leverage early PAC meetings to present CCB specific DSRIP projects and the CCB quality improvement agenda to give practitioners context of the CCB DSRIP program goals	06/30/2016	In Progress
Draft the practitioner training/education plan, to include 1) modalities and metrics to measure the success of trainings, such as focus groups, surveys, completion of CCB deliverables, and 2) supports necessary to provide to	06/30/2016	In Progress

practitioners on a continual basis to ensure compliance with CCB requirements		
Identify longer term professional education and training needs to be discussed with area colleges, medical schools and other degree granting entities as appropriate for consideration in the review of strategies to address the future supply of qualified providers of medical and other professional services	06/30/2016	In Progress
Present practitioner training/education plan to Care Delivery and Quality Committee for review/approval	06/30/2016	In Progress
Clinical Integration		
Milestone #2: Develop a Clinical Integration strategy	**9/30/16**	**In Progress**
Identify implications for workforce development and training.	6/30/2016	In Progress
Project Specific Workforce Transition		
Project 2.a.i: IDS implementation		
Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	03/31/2018	In Progress
Project 2.a.iii Health Home at Risk Intervention Program		
Assess workforce requirements and training needs to implement program	03/31/16	Completed
Develop training and recruitment strategy to meet project requirements.	06/30/16	In Progress
Recruit and train new staff and/or retrain existing staff.	03/31/17	In Progress
Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	03/31/18	In Progress
Develop and initiate training for Participants on PHM initiatives, including use of interim data collection and reporting solutions, use of EHRs and other available IT solutions.	09/30/16	Not Started
Train staff on developing and updating comprehensive care management plans for patients.	06/30/16	In Progress
Provide training to participating PCPs, HHs, and CMAs on the standards, roles, and information sharing procedures.	03/31/17	In Progress
Working with CBOs, develop and identify educational and training materials suitable to the needs, culture, and language of the target populations.	06/30/16	In Progress

Project 2.b.iii: ED Triage Program		
Assess workforce requirements to implement program	12/31/2015	Completed
Develop training and recruitment strategy to meet project requirements.	3/31/2017	In Progress
Recruit and train new staff and/or retrain staff where applicable.	3/31/2017	In Progress
Train staff on technology used to establish connectivity between EDs and PCPs and real time encounter notification to HH care managers.	3/31/2017	In Progress
Identify process changes and staffing requirements to achieve project goals	3/31/2016	Completed
Develop patient navigator job responsibilities, including any applicable policies & procedures and assessment tools needed to meet project requirements.	3/31/2016	Completed
Develop an outreach strategy to hire patient navigators; refer to Health Homes and PCMHs.	3/31/2016	Completed
Recruit and hire patient navigators according to workforce needs.	6/30/2016	Completed
Provide training to patient navigators on processes and procedures, and revise training over time as needed.	3/31/2017	In Progress
Project 2.b.iv: 30 Day Readmission		
Develop training and recruitment strategy to meet project requirements.	3/31/2017	In Progress
Deploy trainings and disseminate training materials to providers.	6/30/2016	Completed
Train transition care managers on transition of care protocols and discharge processes.	3/31/2017	In Progress
In line with COP, recruit new hires and/or retrain current workforce to occupy role of transition care manager	3/31/2017	In Progress
Train providers to use technology to enable care transition team to communicate with assigned PCPs and care management agencies regarding the recorded care transitions plan.	3/31/2017	In Progress
Project 3.a.i: Integration of PC/BH-Model 1		
Develop training for participants in behavioral health co-location, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices.	6/30/2016	Completed
Deliver training to participants in behavioral health co-location and develop a process for assessing the effectiveness of training.	3/31/2018	In Progress
Provide training and technical assistance to participating practices on evidence-based care protocols, including	12/31/2016	In Progress

medication management and care engagement processes.		
Provide training and technical assistance to participating practices to implement screening protocols and document warm transfer, as outlined in COP.	3/31/2018	In Progress
Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.	3/31/2017	In Progress
Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.	3/31/2017	In Progress
Develop training strategy for participants in primary care co-location, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.	6/30/2016	Completed
Implement and train interested participants in primary care co-location based on the COP, and revise as needed.	3/31/2018	In Progress
Provide training and technical assistance to participating practices on evidence-based care protocols, including medication management and care engagement processes.	12/31/2016	In Progress
Provide training and technical assistance to participating practices to implement screening protocols and document warm transfer, as outlined in COP	03/31/2018	In Progress
Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.	03/31/2017	In Progress
Create a clinical operations plan (COP) for implementing IMPACT Model as developed in the workgroup, including plans and resources for staffing.	12/31/2015	Completed
Develop training strategy for participants in IMPACT Model, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.	06/30/2016	Completed
Implement and train interested participants in IMPACT Model based on the COP, including how to provide "stepped care", and revise as needed.	03/31/2018	In Progress
Provide training and technical assistance to participating practices on the IMPACT model standards and guidelines, including medication management and care engagement processes.	12/31/2016	In Progress
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	03/31/2017	In Progress

Identify or develop as necessary Depression Care Manager training in IMPACT Model, including coaching patients in behavioral activation, relapse, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan, and share with care management partners.	03/31/2016	Completed
Work with participating care management agencies as needed to provide IMPACT Model training.	03/31/2017	In Progress
Implement and train interested participants as needed in stepped care, including regular assessment at intervals and appropriate steps for treatment adjustment as outlined in the COP.	03/31/2018	In Progress
Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.	03/31/2017	In Progress
Project 3.b.i – Evidence-based strategies for disease management - CVD		
Develop training strategy for participants based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.	9/30/2016	In Progress
Implement and train interested participants in evidence-based, comprehensive cardiovascular disease management based on the COP, and revise as needed.	3/31/2018	Not Started
Recruit or contract for EHR implementation resources as needed	9/30/2016	Not Started
Develop and provide training to staff on the 5 A's of tobacco control.	3/31/2017	In Progress
Develop tools and/or training materials, as needed, to help practices implement standardized treatment protocols for hypertension and elevated cholesterol as outlined in COP.	9/30/2016	In Progress
As described earlier, provide technical assistance and/or training to participating practices as needed to implement protocols as outlined in COP.	3/31/2017	In Progress
Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	3/31/2017	In Progress
Incorporate plan for training staff on correct blood pressure measurement techniques in the COP.	12/31/2015	Complete
Develop tools, e.g., training materials, as needed, to help practices implement care coordination teams as outlined in COP.	12/31/2015	Complete

Disseminate training materials to participating practices to ensure blood pressure measurements are taken correctly with the correct equipment, and track training of targeted personnel as applicable.	3/31/2017	In Progress
Develop tools, e.g., training materials, as needed, to help practices implement patient identification, stratification and tracking guidelines.	9/30/2016	In Progress
Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying and tracking patients with repeated elevated blood pressure readings and no hypertension diagnosis as outlined in COP.	3/31/2018	In Progress
Develop tools, e.g., training materials, as needed, to help practices implement protocols for home blood pressure monitoring with follow-up support.	9/30/2016	In Progress
Provide technical assistance, e.g., training, as needed, to implement home blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.	3/31/2017	In Progress
Develop tools, e.g., training materials, as needed, to help practices implement patient identification, stratification and tracking guidelines, and automated scheduling for targeted patients as outlined in the COP.	9/30/2016	In Progress
Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying, tracking and scheduling patients with hypertension as outlined in COP.	3/31/2017	In Progress
Develop tools, e.g., linkages to health homes or training materials, as needed, to help practices implement guidelines for identification of high-risk patients and the Stanford Model for chronic disease management as outlined in the COP.	3/31/2017	In Progress
Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying high risk patients and the Stanford Model for chronic diseases as outlined in COP.	3/31/2018	In Progress
Develop tools, e.g., training materials, as needed to help practices adopt strategies from the Million Hearts Campaign as outlined in COP.	9/30/2016	In Progress
Provide technical assistance, e.g., training, as needed, to help practices implement policies and procedures that include strategies from the Million Hearts Campaign.	3/31/2017	In Progress
Project 3.d.ii: Asthma Self-Management		

Develop training strategy for participants based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.	9/30/2016	Not Started
Implement and train participants in identification and referral of patients with asthma to home-based self-management programs based on the COP, and revise as needed.	3/31/2017	Not Started
Provide assistance to participating practices as needed to implement program as outlined in COP. Assistance may include providing training on self-management education and population health management protocols for asthma or helping establish agreements with community-based asthma self-management programs	3/31/2017	In Progress
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	3/31/2017	In Progress
Develop and conduct training of relevant providers on coordination of care standards.	9/30/2016	In Progress
Work with partners, including social services providers and schools, as needed to develop staffing needs for care coordination teams as outlined in COP, including nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	3/31/2017	In Progress
Work with participating partners as needed to develop staffing needs, including referral agreements with asthma self-management programs and training, to ensure post-discharge follow-up services, such as root cause analysis to avoid future events.	3/31/2017	In Progress
Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.	3/31/2017	In Progress
Project 3.g.i: Integration of Palliative Care into the PCMH Model		
Develop training strategy for participants in palliative care integration, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources	6/30/2016	Complete

for evaluation, ongoing training, and onboarding of new staff.		
Implement and train participants in palliative care integration in the PCMH based on the COP and feedback from Participants.	3/31/2018	Not Started
Develop and implement training that incorporates clinical guidelines and role-appropriate competence in palliative care skills.	3/31/2017	In Progress
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	3/31/2017	In Progress
Develop and implement training that incorporates palliative care skills and protocols (consistent with the COP).	3/31/2017	In Progress
Project 4.a.iii: Strengthen Mental Health and Substance Abuse Infrastructure across Systems		
Contract with selected Lead Agency to manage all aspects of the MHSA project including developing operational plan, selection of community mental/behavioral health agencies, selection of target schools, project staffing structure, and training curriculum	12/31/2015	Complete
Develop draft operational plan for MHSA Workgroup review that incorporates development of culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation, staffing, training, and referral planning, as needed	3/31/2016	Complete
Project 4.c.ii: Increased Early Access to HIV Care		
Convening a PPS HIV Learning Collaborative	3/31/2020	In Progress
Develop agenda for Learning Collaborative meetings and hold meetings	3/31/2020	In Progress