Workforce Transition Roadmap for Nassau Queens Performing Provider System

Delivery System Reform Incentive Payment Program (DSRIP)

Workforce Strategy Deliverable

Report Issued: December 2016

Table of Contents

Executive Summary

The overall goal of the Delivery System Reform Incentive Payment ("DSRIP") program is to reduce avoidable hospitalizations and Emergency Department ("ED") visits by the New York State ("NYS") Medicaid population by 25%. The DSRIP program aims to transform and redesign the existing healthcare system through the creation of integrated delivery systems across the care continuum, support the transition to a value-based payment system, and facilitate workforce realignment and training to support system transformation.

As part of the Nassau Queens Performing Provider System's ("NQP", or "the PPS") participation in the DSRIP program and completion of certain Workforce Strategy Milestones, NQP engaged BDO Consulting ("BDO") as its workforce vendor to assist in the development of a workforce transition roadmap that details NQP's plans for achieving the target workforce state throughout the five year DSRIP program.

The NQP workforce transition roadmap was created in collaboration with key PPS stakeholders including DSRIP Hub Leads, Project Managers, and Workforce Committee Members, who provided significant input regarding project implementation strategies to inform workforce planning. The workforce transition roadmap aggregates findings from NQP's current workforce state, target workforce state, and workforce gap analysis to detail the PPS's plans and timeline for closing the projected workforce gaps as the DSRIP projects are implemented.

NQP 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, primary care providers ("PCPs") and related support staff, administrative support, behavioral health providers, and numerous emerging titles related to care management.

The workforce transition roadmap will serve to guide NQP in bringing identified workforce gaps by addressing the workforce implications of the DSRIP program. The transition roadmap outlines training and transition support that NQP 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 promotes collaboration across providers and community-level partners to increase access to care for the Medicaid population in the community and decrease dependence on hospitals and emergency departments. Achieving this goal will have implications on NQP's workforce needs.

NQP developed its workforce transition roadmap to align with the DSRIP program goals. The roadmap addresses the workforce recruitment, training, and deployment needs of the PPS, taking into consideration the implications, issues and factors identified in NQP's gap analysis.

This roadmap describes NQP's strategy and plans for bridging the identified workforce gaps as of DY2 Q3. As the project implementation progresses, it is likely that NQP's partners will identify additional gaps and, as needed, the PPS will update the transition plan.

A. Workforce Transition Roadmap Approach

This workforce transition roadmap is informed by work that NQP completed in DY1 and DY2, including:

1. Current State Workforce Survey
2. NQP Target State Workforce Report
3. Gap Analysis Report

To complete these deliverables, NQP engaged with key PPS stakeholders, identified PPS Partners' current and anticipated staffing needs related to DSRIP program implementation, and estimated potential workforce impacts and staffing resource requirements. The following sections describe these deliverables.

B. Current Workforce State Approach and Summary Findings

In early 2016, NQP designed and distributed a survey to its partners to collect information on their current workforce, including 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 included sections for participants to indicate minimum requirements for certain job titles pertaining to education and years of experience. The participants surveyed were asked to only provide relevant workforce data for individuals working within NQP's geographic region and serving the attributed Medicaid and uninsured population.

Along with the survey, NQP provided survey instructions, frequently asked questions ("FAQs") and DOH job title descriptions to facilitate completion of the current state survey. Organizations were requested to complete one survey per organization, per facility type for the facility types listed within *Exhibit 1*. In an effort to maximize survey response rates, BDO

provided multiple communication touch points including survey reminder emails and a survey support hotline and email address to support recipients with the completion of the survey.

The following exhibit provides detail into the number of survey responses that were received by the various facility types within NQP. The highest respondents to the survey were organizations identified as Private Provider Practices (20 responses), Nursing Home/SNF facility types (18 responses) and "Other" facility types and Inpatient Hospitals, (7 responses each). The "Other" facility types were generally identified as agencies providing residential/housing services or other community services within NQP's network.

Exhibit 1: Current State Workforce Survey Response by Facility Type

Facility Type	Number of Survey Responses
Private Provider Practice	20
Nursing Home/SNF	18
Other	7
Inpatient (Hospital/ED/ Inpatient Services Article 31 & Article 32)	7
Article 28 Diagnostic & Treatment Centers (FQHC)	6
Outpatient Behavioral Health (Article 31 & Article 32)	5
Hospital Article 28 Outpatient Clinics	4
Home Care Agency / Hospice	3
Non-licensed CBO	1
Total	**71**

NQP's partners employ more than 60,000 employees; in the survey, 40,649 employees – 33,504 FTEs – were reported under the 65 job codes included in the survey. There were an additional 1,175 reported FTE vacancies, bringing the total number of budgeted positions to 34,679 FTEs. NQP's partners reported a 5.2% average vacancy rate for reported positions. *Exhibit 2* presents the job titles with above average vacancy rates. By identifying and examining positions with above-average vacancy rates, NQP can address recruitment, training, retraining, and redeployment strategies for these positions.

Exhibit 2: Job Titles with Above-Average Vacancy Rates (>5.2%)

Job Category	Number of FTEs	Number of Vacancies	Vacancy Rate
Psychiatric Nurse Practitioners	15	5	33.2%
Midwives	5	1	21.8%
Health Coach	5	1	20.0%
Medical Interpreters	5	1	18.3%
Nurse Practitioners in Other Specialties (Except Psychiatric NPs)	343	45	13.1%
Physician Assistants in Primary Care	298	36	12.1%
Nurse Practitioners in Primary Care	323	38	11.8%
Psychologists	50	5	9.9%
Non-Licensed Care Manager/Coordinator	113	11	9.8%

Job Category	Number of FTEs	Number of Vacancies	Vacancy Rate
Licensed Clinical Social Workers	77	7	9.1%
Health Educators	12	1	8.6%
Speech Language Pathologists	62	5	8.0%
Physical Therapists	371	29	7.8%
Medical Assistants	965	70	7.3%
Clinical Laboratory Technologists and Technicians	704	47	6.7%
Nutritionists/Dieticians	151	10	6.6%
RN Care Coordinators/Case Managers/Care Transitions	236	15	6.4%
Physician Assistants in Other Specialties	507	28	5.5%

NQP also collected additional workforce data including collective bargaining agreements ("CBAs") status to further inform the workforce planning efforts throughout the DSRIP program.

C. Target Workforce State Approach and Summary Findings

The Target Workforce State report identifies NQP's projected workforce needs through 2020. Findings and project impacts from the report are summarized within this section and further detailed in the Target State Report.

The NQP target workforce state was developed in collaboration with NQP's Executive Committee ("Workforce Governance Body") and included input from multiple NQP partners and external data sources, including local, state and national surveys, medical claims databases, published literature and IHS's Health Care Demand Microsimulation Model (HDMM).

In modeling and projecting the estimated workforce impacts of the DSRIP projects on NQP's workforce, the following key points were considered:

- The number of patients that will be impacted by the intervention
- Current healthcare utilization patterns of impacted individuals, and how the intervention may change care utilization patterns
- Anticipated provider types and counts needed to implement the intervention and meet future patient demand for services
- The potential for DSRIP, as designed, to materially impact the region's healthcare delivery workforce

The demand for health care workforce within NQP will continue to evolve as DSRIP projects are implemented, impacts of those projects are realized, and demographic trends (unrelated to DSRIP) accelerate. Although the target workforce analysis was conducted using best efforts and project implementation assumptions to model workforce impacts over the DSRIP program, the target workforce state is a projection intended to inform NQP's workforce planning and

may need to be modified as the DSRIP program progresses. *Exhibit 4* summarizes NQP's estimated target workforce state staffing impacts expected by 2020, taking into account the anticipated impact of the DSRIP program as well as anticipated demographic and healthcare coverage changes across the NQP provider care settings and key job categories. In some cases, non-DSRIP impacts offset or moderate the effects of the DSRIP program, while in other cases they magnify DSRIP workforce impacts.

Notable projected impacts for NQP include:

- By 2020, the combined impacts of a growing and aging population, expanded medical insurance coverage under ACA, and DSRIP implementation will increase the modeled demand for health providers by approximately 1,560.5 FTEs – **10%** of which is related to DSRIP.
    - **Non-DSRIP impacts:** Independent of DSRIP, demand in the workforce is projected to grow by approximately 1,400 FTEs.
    - **DSRIP impacts:** The projected impact of DSRIP implementation is estimated to increase demand for health providers modeled by approximately 160.5 FTEs.
- The greatest impact will be felt by registered nurses (RN) in the inpatient setting, and primary care providers and support staff in outpatient and community-based settings.
    - Net demand for registered nurses is estimated to increase by approximately 235 FTEs. The decrease in demand for RNs in inpatient settings as a result of DSRIP implementation will be more than offset by increased demand for RNs in the ambulatory setting.
- An estimated 338 FTE administrative support staff and 438 FTE medical assistants will be needed to support primary care practices.
- The need for primary care providers (physicians and mid-level practitioners) is estimated to increase by approximately 246 FTEs by 2020.
- Approximately 42 FTE licensed clinical social workers are needed.

Exhibit 4: NQP Summary of Projected Staffing Impacts (DY2 to DY5)

Setting and Job Category	DSRIP-related Impacts	Total Impacts
Primary and Community-Based Settings		
Primary Care Providers (MD, DO, NP, PA)	59	246
Nurse Practitioners (OBGYN)	5.5	5.5
Cardiologists	0	17.5
Endocrinologists	4	9
Psychiatrists / Psychiatric NPs	6.5	14.5
Psychologists	2	7.5
Licensed clinical Social Workers	41.5	41.5
Addiction counselors	7.5	7.5
Registered Nurses	44.5	101.5
Licensed Practical Nurses	1	19
Nurse Aides / Assistants	0	18
Medical Assistants	110.5	438
Administrative Support Staff	93.5	337.5
Emergency Department		
Emergency Physicians	-23	-20.5
Nurse Practitioners & Physician Assistants	-1.5	3
Registered Nurses	-91	-68
Hospital Inpatient		
Hospitalists	-14	-6.5
Registered Nurses	-163	126.5
Licensed Practical Nurses	-7.5	30.5
Nurse Aides / Assistants	-41.5	68
Care Managers/Coordinators/Navigators/Health Coaches/CHWs		
RN care coordinators and managers	42.5	42.5
Care coordinators (non-RN)	10.5	10.5
Community liaisons	6	6
Peer support	5	5
Cardiovascular disease health coaches	12	12
Diabetes health coaches	23.5	23.5
Patient activation health coaches	21.5	21.5
Patient activation program director	3	3
Other		
Security guards	2.5	2.5
Pharmacists	0	6
Registered Nurse Total	**-167**	**234.5**
Total FTEs	**160.5**	**1,560.50**

D. Gap Analysis Approach and Summary Findings

NQP's gap analysis incorporates findings from the NQP current workforce state and target state to identify existing and new workforce gaps that may be further impacted or created through DSRIP project implementation, and informs the workforce transition roadmap.

The primary project workforce impacts are projected to occur mainly for primary care practices (including clinical and non-clinical staff), medical assistants, registered nurses, behavioral health providers and the care management workforce. Assuming NQP meets its provider engagement targets, NQP is likely to experience the greatest workforce impacts during DY4.

NQP is anticipated to experience an increase in demand for primary care services as patients are redirected to seek care from providers outside of the ED setting. Similarly, the hospitals are anticipated to experience a slight decrease in demand for emergency medicine physicians and nurses. Additionally, as a result of the two behavioral health projects (Co-location of primary care and behavioral health services and Community-based crisis stabilization), an increase in demand for behavioral health positions is projected, specifically for LCSWs. This will address an existing identified gap in the behavioral health workforce in NQP.

Additionally, NQP anticipates a significant increase in care coordination services for inpatient and ambulatory settings and an increased demand for care managers, care coordinators and health coaches/educators. Given the current vacancy rates reported for these positions, the existing gap for care management and care coordination staff is likely to increase.

II. Workforce Transition Plan

NQP'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 the PPS.

NQP is developing an Integrated Delivery System ("IDS") that includes all providers – medical, behavioral, post-acute, and community-based service providers - and that will create new demands on the workforce to implement and support new care models. In keeping with the goals of the DSRIP program, the IDS will support increased utilization of primary care instead of the emergency department. Through trainings, partnerships and workforce development efforts, NQP will support clinical integration, coordination and collaboration among its partners.

The most significant impacts to the workforce will be to (a) care management programs and (b) primary care practices. Several project initiatives include proactive management of patients through access to high quality primary care and support services, which will accelerate the need for care management analytics and programs. Similarly, several projects have a goal of strengthening primary care services to reflect the Patient Centered Medical Home (PCMH) standards and include behavioral health and evidence-based chronic disease management. As presented in the Target State Report and Gap Analysis Report, it is anticipated that as DSRIP projects are implemented and more patients are connected to primary care for routine, preventive, acute and behavioral care, there will be an increase in demand for primary care positions, including physician, NP, RN, SW, and care manager. The aging population, and growth of Medicare beneficiaries, will also increase the demand for these positions.

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

A. Transition Roadmap – PMO Roles

The NQP Project Management Office ("PMO") is responsible for the development of the transition roadmap and will facilitate its adoption by each of the NQP Hubs: NuHealth, Catholic Health Services of Long Island (CSHLI) and LIJ Medical Center (LIJ). The Hubs are responsible for the recruitment of new hires, and training, retraining and redeployment of existing members of the workforce. The PMO will provide the Hubs with information about gaps in the current workforce and coordinate PPS-wide trainings, as needed. Dissemination of training and collection of information for performance reporting will be carried out by the PPS hubs.

NQP will contract with training vendors to support curriculum development and training opportunities on topics identified by the Hubs and NQP partners. Hubs may also develop and

offer their own training programs to their attested partners. NQP and the Hubs are committed to working with regional educational institutions, CBOs and other local health agencies to maximize the efficiency, efficacy and sustainability of workforce training efforts. The PPS will coordinate workforce planning and training as needed.

To support training development and implementation, NQP will collaborate with several contracted vendors and leverage the Hubs' expertise and resources. The following sections provide an overview of how NQP will support workforce initiatives in key areas and across key projects.

B. Training Development Support

To support training development and implementation, NQP will partner with 1199 Training and Education Fund (TEF) to serve as a strategic advisor to the PPS around training and other workforce planning efforts. NQP will utilize 1199 TEF resources and expertise in key areas of research, development, coordination, and delivery of training and educational programs. TEF will provide recommendations to NQP on programs that best meet their training objectives and evaluate such programs for quality and value through a vetting process. The results of training and education research will be used to identify resources available in New York and best practice instruction models. NQP will implement an HWP APPS web portal to serve as a tracking platform for supporting administration, documentation, tracking, reporting delivery and evaluation of training and educational programs. TEF will also assist in the development of training strategies for existing workforce, redeployment and new hires, and work with the workforce committee and hubs to identify/develop core competencies, staffing plans, and design and conduct workshops to achieve smooth workforce transitions that are sustainable across the PPS.

C. Project Workforce Impacts

i. Project 2.b.ii: Develop Co-located Primary Care Services in the Emergency Department

Many patients who seek care at the emergency department have non-urgent conditions that could have been treated in an ambulatory setting. Further, too many of these patients do not follow-up with a primary care provider after their ED visit to receive appropriate follow-up. In NQP, seven hospitals are participating in Project 2.b.ii and co-locating Primary Care practices with the Emergency Department to improve access and establish a relationship for improved care continuity. The goal is to interrupt current patterns of inappropriate utilization and reliance on the ED.

The Primary Care practices that are co-located with the ED will require staff, including care coordinators who can address the psychosocial needs of individuals with complex conditions and can educate patients on self-management, including how to respond to symptoms.

Workforce Impacts

There are seven sites that are participating in this project, and the workforce impact will be on both the Emergency Department and the newly established PCMH practice. The impact includes potential decreases in emergency physicians (11-12 FTEs across the seven sites), NPs, physician assistants, and RNs (44-45 combined FTEs across the seven sites).

To staff the seven PCMH practices, NQP estimates an increase of 55 total FTEs comprised of primary care providers, direct medical and administrative support, mid-level practitioners, RNs, LPNs, and clinical social workers.

Recruitment & Training

NQP and its partners understand the importance of recruiting new hires and redeploying current staff to primary care settings. As a general recruitment strategy, NQP will explore leveraging partner agreements with schools and universities to transition qualified graduating students to primary care positions. For example, NUMC retains a percentage of their graduates to enter primary care services and has also established Fellowship programs successful in training, recruitment and retention of RNs, some of which may be redirected to primary care.

To address Project 2.b.ii, NQP's Hubs will support the Patient Centered Medical Home (PCMH) transformation and have contracted with vendors who can support the PCMH process as needed to the co-located primary care practices to achieve 2014 Level 3 recognition.

i. Project 2.b.iv: Care Transitions to Reduce 30 Day Readmissions

The Care Transitions project establishes a 30-day supported transition period after a hospitalization for patients at high risk of readmission Transition care managers will follow-up with patients and their families for 30 days post-discharge to ensure that patients have a follow-up appointment with their PCP, discuss medications and improve self-management, as needed.

Workforce Impacts

The primary impact of the project will be an increase in transitional care managers, who could be RNs, NPs, SWs, health coaches, or care coordinators. These staff will be hired and trained by the Hubs.

As readmissions are reduced, the impact to the workforce could be a reduction in inpatient staff, including an estimated reduction of 46 RN FTEs total across the 12 participating hospitals (an estimated 4 RNs per hospital) and 11-12 nurse aide FTEs (an estimated 1 nurse

aide per hospital). These staff could be redeployed to the outpatient setting, where an increase in RNs and MOAs is expected. Hubs will support retraining and redeployment efforts for their sites.

To support this project, the PPS partners including the Hubs will hire, retrain, and redeploy clinical (RN, SW and LPN) and non-clinical (medical assistant) staff as care managers, care coordinators, and health coaches. Care managers will assist with arranging follow-up appointments with primary care providers through expanded and enhanced centralized scheduling systems.

Recruitment & Training

As a general recruitment strategy, NQP will explore leveraging partner agreements with schools and universities to transition qualified graduating students to positions newly created under DSRIP initiatives, several of which revolve around care management. For example, Northwell Health has hired Nurse Practitioners in its transitional care programs, and can discuss strategies with regional NP programs.

For training, individual PPS partners are discussing and contracting with the following partners to support workforce training efforts:

- Cipherhealth for transitions of care and care coordination
- xG for care coordination
- Athena Platform Institute for providing modules to support care management education, including orientation and annual competencies
- 1Unit for training inpatient teams on Standardized Interdisciplinary Bedside Rounds (SIBR)

Additionally, Northwell Health's Center for Learning & Innovation (CLI) operates the Patient Safety Institute (PSI), one of the largest simulation centers in the country. PSI is accredited in the areas of assessment, education, teaching and systems integration, and features 14 standardized patient rooms in which actors portray patients presented with various illnesses to test the diagnostic and clinical management skills of physicians, nurses, and behavioral health staff. These rooms are well-designed for patient engagement and care management simulations and can therefore be utilized to train providers in care coordination efforts without risk to actual patients.

ii. Project 2.b.vii: Implementing the INTERACT Project

The INTERACT project is one of several evidence-based models aimed at improving care and care transitions for older residents of Skilled Nursing Facilities ("SNFs"). In NQP, more than 60 SNFs in the region have agreed to participate in Project 2bvii and train their staff on the INTERACT tools.

Workforce Impacts

The primary workforce impact will be the training provided to all staff in SNFs – including clinical staff, patient care aides, and housekeepers.

As SNFs reduce transfers to acute care settings (including an estimated 350 fewer readmissions and 1,820 fewer inpatient days by 2020), the net projected PPS-wide impact is a reduction of an estimated 11 RN FTEs (total) across NQP's 12 participating hospitals (an impact of 1 RN FTE per hospital). The analysis suggests that Project 2.b.vii's impact on the workforce may be minimal, with no estimated effects seen in the ED setting.

Recruitment & Training

NQP's Hubs will provide its SNF partners a combination of internally and externally-led trainings on the INTERACT tools, such as SBAR, care pathways and other clinical tools for monitoring chronically ill patients. The Intro to INTERACT Version 4.0 toolkit, developed by Dr. Joseph Ouslander and his team, will be used to implement INTERACT at each participating SNF. Workforce training partners that will be utilized for trainings include:

- Evicore for INTERACT (Interventions to Reduce Acute Care Transfers) and utilization training
- Medline University to provide online INTERACT training modules for all SNF staff

iii. Project 2.d.i: Implementation of Patient Activation Activities for Uninsured and Low/Non-Utilizing Medicaid Populations

Project 2.d.i focuses on uninsured and Medicaid patients who are not currently utilizing or underutilizing the health care system, and works to engage and activate those individuals to utilize primary and preventive care services.

Using Patient Activation Measurement (PAM) surveys, individuals are assessed to determine their level of engagement, with a goal of increasing patient self-management skills to the highest level possible. Staff who conduct the PAM assessments will either provide counseling to the patient or refer them to their PCP for this purpose.

Workforce Impacts

The primary impact of this project will be hiring staff to survey individuals using the PAM® and providing Coaching for Activation for patients who are low-activated. NQP estimates its partners will hire 19 health coach FTEs and 4 community outreach worker FTEs to implement the intervention.

As more individuals are successfully linked to a primary care provider, NQP estimates 43,620 additional urgent (unscheduled) primary care visits. As a result, there is an anticipated need

for additional staffing at primary care practices, including a potential increase of 18-19 PCP FTEs and 9-10 staff RN FTEs across the total number of participating practices.

In addition, by connecting individuals to a usual source of care, the project could help reduce avoidable emergency visits. The modeled impact of this project on the ED and inpatient settings is 1,220 fewer ED visits and 1,310 fewer inpatient days through 2020, resulting in small decreases in demand for hospital ED and inpatient staff, including 7-8 fewer RN FTEs (total) across the 12 participating sites.

Recruitment & Training

NQP has a contract with Insignia Health that includes training for health coaches or care coordinators on the PAM® and Coaching for Activation. Insignia Health trained staff in the NQP network in October 2015 and trained identified "super users" in the NQP network 2016. These super users comprise the PPS training team, and include staff with clinical and administrative roles in Hubs and CBOs. The Super Users use a train-the-trainer model to train their colleagues and other staff in the NQP network. NQP is on track to meet its goal of training 250 individuals on the PAM. Trainings have taken place with CBOs, Emergency Department staff, Inpatient staff, and staff at the Financial Assistance Unit.

NQP's Cultural Competency and Health Literacy workgroup created a training for providers located within "hot spots" on techniques such as shared decision-making, measurements of health literacy, and cultural competency.

iv. Project 3.a.i: Integration of Primary Care and Behavioral Health Services

NQP's partners have committed to successfully integrating behavioral health and primary care services. To support the achievement of this goal, the PPS is implementing Model 1: Integration of behavioral health specialists into primary care clinics using the collaborative care model and supporting the PCMH model; and Model 2: Integration of primary care services into established behavioral health sites such as clinics and Crisis Centers.

Workforce Impacts

The primary workforce impact will be an increase in behavioral health care managers (typically LCSW or Psychologists) who will be integrated with primary care practices, and physicians/mid-level practitioners who are integrated in behavioral health ambulatory practices.

As a result of this project, NQP estimates there will be a decrease in behavioral health-related ED visits by approximately 830 visits and a decrease in BH-related inpatient days by approximately 1,350 days. NQP projects minimal impact to the ED staff FTEs, and a small decline in demand for RNs and nurse aides/assistants in the inpatient setting (8 FTEs and 2-3 FTEs, respectively, across 12 hospitals).

Recruitment & Training

For the integration of behavioral health and primary care to be successful, all staff in primary care practices need to receive training on:

- Behavioral health screenings, including how to administer, how to score, and protocols for clinical escalation
- The integrated care model and the role of the behavioral health care manager

Primary care physicians and mid-level practitioners need to confirm understanding of:

- Evidence-based protocols, including medication management and care engagement

Additional behavioral health trainings can be offered to primary care practices as needed.

There are several approaches underway to recruit qualified behavioral health specialists to integrate with NQP's primary care physicians:

1) NQP's Hubs are recruiting and hiring new behavioral health care managers
2) Several primary care practices in Queens were selected to participate in New York City's new Mental Health Service Corps program, which places and supervises recent social work graduates in primary care practices
3) NQP's Hubs are exploring relationships with mental health providers in the community who could hire and train the clinicians for the integrated care model.

For Model 2, NQP's hubs are recruiting physicians and mid-level practitioners at an eligible behavioral health practice. Currently, there is a high demand for bilingual (Spanish, Korean) mid-level practitioners.

v. Project 3.a.ii: Behavioral Health Community Crisis Stabilization Services

NQP is implementing a crisis intervention program that will integrate and develop outreach, mobile crisis teams, and community-based intensive crisis services, following successful models that have been demonstrated in other areas of the state. The objective is to serve patients with behavioral health diagnoses who need crisis stabilization services that could be delivered in community settings and reduce reliance on the ED or inpatient settings.

Workforce Impacts

The primary impact will be an increase in behavioral health providers hired to support the new crisis programs. The most significant demand will be for LCSWs, psychiatrists/psychiatric NPs, and peer counselors. At the current time, an additional eight LCSWs are expected to staff the new crisis stabilization centers and mobile units. Once services begin, the staffing projections could change, and demand for nursing, including psychiatric nurses, will also grow as mental and behavioral health services shift from the ED to outpatient settings.

The expansion of behavioral health crisis stabilization services is expected to reduce the number of ED visits by approximately 19,420 visits by 2020 and to reduce the number of

hospitalizations by approximately 400 hospitalizations by 2020, which is equivalent to an estimated 2,920 fewer inpatient days. As a result, NQP projects for a decrease of emergency medicine physicians (9 FTEs across 12 participating hospitals) and ED nurses (31-32 FTEs across 12 participating hospitals). In the 12 inpatient settings, there is an estimated decrease in demand of about 17-18 RN FTEs and 4-5 nurse aides, along with FTE decreases of 1-2 hospitalists and 1 LPN.

Recruitment & Training

Staff participating in the crisis stabilization programs will receive training appropriate to their program and position, such as de-escalation techniques, protocols for the treatment of suicidal individuals, and safety.

NQP and the Hubs will provide participating staff with trainings such as:

- Cultural competency & health literacy
- DSRIP 101
- Health Homes and RHIOs
- Community resources

NQP will similarly ensure appropriate providers and community organizations are educated and informed about crisis programs so that patients are appropriately and expediently referred.

vi. Project 3.b.i: Evidence-based Strategies to Improve Management of CVD

NQP will implement evidence-based strategies to address cardiovascular disease, which is the primary cause of hospital admissions for Medicaid beneficiaries in Nassau County. Disease educators, health coaches, and/or care managers will work with primary care practices to identify high risk patients with cardiovascular disease and support these patients in the management of their illness.

Workforce Impacts

NQP anticipates that the primary workforce impacts will be an additional 12 disease care managers, disease educators, and health coaches.

As primary care teams improve the health of patients with cardiovascular disease, fewer of these individuals will be seen in acute care settings. By 2020, the net projected annual utilization impact is an estimated fewer 610 Emergency Department visits and an estimated 1,570 fewer inpatient days. In the primary care setting, an estimated increase of 24,300 urgent (unscheduled) visits to PCPs is also estimated as well as 12,160 more visits to cardiologists. As a result, there is a projected increase of 11-12 PCPs and 8-9 RNs, supported by approximately 33 direct medical support staff and administrative support staff in outpatient/office settings. Minimal impact is expected to occur in the ED setting, and modest impact is expected to occur for hospital inpatient staff with a reduction of 9 RN FTEs.

Recruitment & Training

NQP's PCMH/3bi/3ci Workgroup recommends policies and clinical protocols for approval by the Clinical Oversight and Quality Committee. These policies, procedures, and clinical protocols pertain to primary care practices and include:

- Use of 5 A's of Tobacco Control
- Standardized treatment protocols for hypertension and elevated cholesterol aligned with national guidelines, such as the National Cholesterol Education Program
- Clinical protocols involving care coordination teams
- Blood pressure measurement
- Identification of patients with hypertension, including using a registry to identify patients with elevated blood pressure readings who do not have a diagnosis of hypertension
- Development and documentation of self-management goals
- Warm referral to community-based programs and Health Homes
- Home blood pressure monitoring procedure
- NYS Smoker's Quitline
- Million Hearts Campaign

NQP's PCMH Workgroup has started a toolkit that includes training resources and links to existing resources (e.g. Million Hearts Campaign). NQP's Hubs plan to provide these trainings to their primary care practices and have not yet identified a need for external vendors. Several Hubs have already increased their staff to support this education.

vii. Project 3.c.i: Evidence-based Strategies to Improve Management of Diabetes

The goal of project 3.c.i is to improve the management of diabetes and reduce the progression of disease. NQP partners will provide care to patients with diabetes through the consistent use of evidence-based care. NQP will develop protocols with guidelines on the diagnosis and management of diabetes, and will develop educational programs to improve the community's knowledge of diabetic risk factors and self-management per evidence-based clinical guidelines.

Workforce Impacts

The primary impact of this project is the increased use of primary care services. By 2020, the projected annual impact is an estimated 6,220 fewer emergency department visits, 10,710 fewer inpatient days, and 46,930 additional primary care visits.

The workforce impact by 2020 includes approximately 23-24 additional diabetes health coaches. In primary care settings, there is a projected increase of 20-21 PCPs, 35 additional direct medical support staff, and 25-26 direct administrative staff. There is a projected slight decrease in emergency department staff in the ED setting, and in inpatient settings, there is

a projected decrease in demand for hospital inpatient staff – including approximately 64 fewer RN FTEs and 16 fewer nurse aide FTEs across the 12 participation hospitals.

Recruitment & Training

NQP's PCMH Workgroup has started a toolkit that includes training resources and links to existing resources. NQP's Hubs plan to provide these trainings to their primary care practices and have not yet identified a need for external vendors. Several Hubs have already increased their staff to support this education. For example, NUMC is certified as a Center of Excellence on Diabetes, and has recently hired a new Director of Chronic Disease Management.

NQP's partners will recruit RNs and other clinical staff with certified knowledge in diabetic care and self-management who can serve as health educators/coaches.

In addition to implementing these practices, health educators/coaches will facilitate the Stanford Chronic Disease Self-Management Program, a 6-week workshop where patients learn how to take control of their disease. Peer-led workshops develop tools to learn about the disease and self-monitoring, understand and deal with emotions, manage medications, work with health care providers, and make action plans for exercise and eating healthy. The workshop will be conducted using the Train the Trainer model, and will have a long term focus on improvements in stress management, self-reporting health, aerobic exercise, health distress, self-efficacy, communication with physicians, and fewer hospital days/more PCP visits.

D. Domain 4 Projects – Strengthen Mental Health and Substance Abuse Infrastructure and Promote Tobacco Use Cessation

The Gap Analysis does not separately address the workforce gaps that may be created by the two population-wide prevention projects which pertain to strengthening mental health and substance abuse infrastructure and promoting tobacco use cessation. The goals and impacts of these projects are closely aligned with other clinical improvement projects already discussed and the workforce impacts are assumed to have been captured in the projects detailed above.

Project 4.a.iii will help to strengthen mental health and substance abuse infrastructure across systems and support collaboration among leaders, professionals, and community members in mental, emotional, and behavioral (MEB) health promotion to address substance abuse and other MEB disorders. NQP will provide trainings on MEB, Screening, Brief Intervention, and Referral to Treatment (SBIRT), and Patient Health Questionnaires to screen for depression and anhedonia (PHQ-2 and PHQ-9).

Project 4.b.i requires the implementation of strategies to promote tobacco cessation using evidence-based practices. As with other DSRIP initiatives that address smoking and chronic disease, NQP will provide training on the 5A's of Tobacco Cessation, and a process for

facilitating referrals to NYS Smokers' Quitline. NQP is emphasizing tobacco cessation training for mental health providers.

III. Other Workforce Development & Transition Strategies

A. Cultural Competency and Health Literacy

In an effort to ensure a systematic and sustainable implementation of cultural competency and health literacy strategies, NQP plans to deploy strategic interventions as part of its core programs. NQP has formed a Cultural Competency and Health Literacy (CCHL) workgroup that has developed a DSRIP 101 webinar and a Train the Trainer workshop for interpretation services. The Workgroup will collect data on the training practices and resources for clinicians and non-clinician segments to identify gaps in existing clinical and non-clinical segments and support development of training resources and plans. The CCHL Workgroup will also partner with the Clinical Oversight & Quality Sub-Committee, Practitioner Engagement, and project workgroups to identify overlapping training needs and will collaborate, as needed, to schedule and execute training sessions across the PPS.

Additionally, NQP is partnering with the Long Island Health Collaborative and Suffolk Care Collaborate to provide a full day Train-the-Trainer session. The objectives of the course are as follows:

- Define and identify cultural barriers
- Understand unconscious bias
- Explain how social determinants affect health in communities on Long Island
- Apply the concepts of cultural humility in community-based organizations
- Identify tools to create an environment that is welcoming to people from all cultures
- Describe the components of health literacy
- Understand how to use the "teach back" method

B. Redeployment and Retraining

For certain positions where workforce impacts may occur, NQP and its Hubs are preparing to support successful redeployment programs. Employees who would be candidates for potential redeployment will be identified early and offered opportunities to receive training to transition to an appropriate job setting.

NQP is also evaluating potential training or retraining needs to prepare the healthcare workforce for value-based payment. The training will include a description of value based payment models and the essential tenets of population health models, including risk, care

management and analytics. Employees who require additional skills will have access to trainings and resources to function in their current positions.

IV. Appendix - Workforce Transition Roadmap (Timeline)

Workforce Strategy	Target Completion Date	Target Completion Status
Milestone #1: Define Target Workforce State (in line with DSRIP goals)	**03/31/2016**	**Completed**
Establish a Workforce Project Team to include the workforce committee, project leads, union representation and other appropriate subject matter experts/key stakeholders. This team will be tasked with implementing and executing workforce-related activities.	10/31/2015	Completed
The Workforce Project Team will document and characterize the current workforce state.	01/31/2016	Completed
The Workforce Project Team will work with DSRIP Project Teams to identify and define specific requirements of each DSRIP project and the new services each of the projects will require to deliver (based on interviews and surveys of key stakeholders).	03/31/2016	Completed
The Workforce Project Team will perform an impact analysis to determine on a project-by-project basis, how the PPS workforce needs will change over the course of DSRIP implementation (magnitude of impact by role/provider organization, key roles and responsibilities changes, skills competency changes, impact on staffing and caseloads). This analysis will result in a plan for the future state of the workforce.	03/31/2016	Completed
Obtain sign off from the Workforce Key Stakeholders on workforce state analysis. The Workforce Strategy will include a finalized plan, budget, and hiring / redeployment plan. The Executive Committee will be the final approval authority.	03/31/2016	Completed
Milestone #2: Create a workforce transition roadmap for achieving defined target workforce state.	**12/31/2016**	**Completed**
The Workforce Project Team, in collaboration with key stakeholders (including union), will identify issues and concerns that will shape the workforce transition roadmap.	12/15/2016	Completed
Based on the identified future state workforce, the Workforce Project Team will map out all of the specific workforce changes that will be required. This will include detail re: when these changes will need to be implemented and what else will need to be done to accomplish the changes (training, redeployment, hiring, etc.)	12/15/2016	Completed
The Workforce Project Team will identify issues regarding training (e.g. scheduling) and backfills on positions to maintain operations during DSRIP implementation.	12/15/2016	Completed
The Workforce Project Team will formally document a complete workforce transition roadmap. This will be	12/31/2016	Completed

reviewed with key stakeholders. The Executive Committee will be the final approval authority.		
Milestone #3: Perform a detailed gap analysis between current state assessment of workforce and projected future state.	**12/31/2016**	**Completed**
Perform a current state assessment of staffing and capabilities across the PPS and member organizations to identify staff who can fill future state roles.	12/15/2016	Completed
Compare current state workforce with future workforce needs to determine the requisite number and type of new hires. This is the gap analysis.	12/15/2016	Completed
Based on the results of the workforce needs, establish a workforce budget for the projects over the duration of the DSRIP project.	12/15/2016	Completed
Milestone #5: Develop training strategy.	**03/31/2017**	**In Progress**
Identify training needs based on workforce changes, as planned in the transition roadmap and across all workstreams.	03/15/2017	In Progress
Finalize training strategy, including goals, objectives and guiding principles for the detailed training plan.	03/15/2017	Not Started
Project training needs over time and identify a training schedule.	03/15/2017	Not Started
Finalize the training plan. Include methods, channels and key messages required for training based on project needs. Include consideration of geography, languages spoken, levels of education, training tools and methods of delivery.	03/15/2017	Not Started
This will be reviewed with key stakeholders. The Executive Committee will be the final approval authority.	03/31/2017	Not Started
Cultural Competency and Health Literacy	**Target Completion Date**	**Target Completion Status**
Milestone #2: Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	**6/30/16**	**Completed**
This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: *-- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy* *-- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches*	06/30/2016	Completed
Identify patient-facing staff and CBO staff who would benefit from training on cultural competency and health literacy issues.	12/31/2015	Completed
Create training schedule and materials to execute training. The focus of the training will be on strategies to improve effective patient engagement; and the use of data oriented approaches to identify those likely to suffer from health disparities.	06/30/2016	Completed

Develop training plans for clinicians, CBOs and other workforce segments based on best practice research that addresses the needs of ethnic and racial minority groups served by the PPS who suffer from health disparities.	06/30/2016	Completed
Obtain NQP Executive Committee sign-off on training plans.	06/30/2016	Completed
Execute trainings for all organizations and individuals identified in Step 1 based on training plans.	06/30/2016	Completed
Evaluate training sessions regarding specific engagement strategies and patient engagement approaches.	06/30/2016	Completed
Practitioner Engagement	**Target Completion Date**	**Target Completion Status**
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	**03/31/2017**	**In Progress**
Identify training needs among providers for DSRIP projects, utilizing both provider surveys and gap assessments derived from the project plans. Identify available professional groups and subject matter experts to assist in training efforts.	12/31/2015	Completed
Develop training and education plans overall and for individual DSRIP projects. The scope of training should address identified training gaps and cover all practitioners touched by the DSRIP project.	03/31/2017	In Progress
From the gap assessment in prior task steps, create a directory of topics, trainer types and skills needed. Reach out to professional groups and subject matter experts to identify appropriate trainers.	03/31/2016	Completed
Schedule and execute training for DSRIP projects	03/31/2017	In Progress
Evaluate initial training, and report out as appropriate	03/31/2017	In Progress
Determine content for onboarding, semi-annual, and annual refresher training.	03/31/2017	In Progress
Develop a PPS-wide provider communications strategy that supports all provider engagement activities by provider type and geographic location.	03/31/2016	Completed
Identify provider champions to act as DSRIP ambassadors and as representatives for relevant governing bodies such as the Clinical Oversight Committee who can also support educational efforts across the network.	03/31/2016	Completed
Develop standard performance reporting templates for professional groups by provider type.	06/30/2016	Completed
Create a provider data base identifying all provider types and key identifiers; by hub and by geographic area.	09/30/2015	Completed
Create a PPS-wide structure to conduct provider engagement activities.	09/30/2015	Completed
Clinical Integration	**Target Completion Date**	**Target Completion Status**
Milestone #2: Develop a Clinical Integration strategy	**09/30/16**	**Completed**
Clinical Integration Strategy, signed off by Clinical Quality Committee, including:	09/30/2016	Completed

-- Training for providers across settings (including ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination *-- Training for operations staff on care coordination and communication tools*		
Training for all provider types will be developed and executed. Training will cover new work flows, new tools, and the underlying concepts of care coordination.	09/30/2016	Completed
Project Specific Workforce Transition	**Target Completion Date**	**Target Completion Status**
Project 2.a.i - IDS Implementation		
Train staff on IDS protocols and processes	03/31/2017	In Progress
Develop a strategy, by recognition status category to achieve PCMH Level 3 / APCM recognition by the end of DY 3	09/30/2016	In Progress
Identify resources to assist providers in achieving PCMH / APCM recognition status based on current state.	12/31/2016	Completed
Identify patient needs and preferences for patient navigation activities based on patient input, stakeholder input in the community (e.g. health workers, peers, culturally competent CBOs, etc.) and data analysis. Create subgroups (e.g. behavioral health) based on population need.	06/30/2016	Completed
Collaborate with culturally-competent community-based organizations and stakeholders to develop an understanding of specific cultural, linguistic and ethnic needs across the PPS service area as hubs. Create subgroups to focus on outreach and engagement within these populations.	06/30/2016	Completed
Develop an engagement strategy, based on community needs, PAC involvement, other stakeholder input and review of best practices to outreach patients as appropriate. Ensure engagement strategy reflects the needs of individuals with behavioral health disorders.	09/30/2016	In Progress
Develop a workforce and training plan to train/retrain/redeploy community health workers, peers, care managers and other PPS staff in outreach and navigation. The training program will include modules on cultural competency and behavioral health to help PPS achieve high levels of patient engagement in all communities	12/31/2016	In Progress
Project 2.b.ii – Development of Co-Located Primary Care Services in the ED		
Support implementation and provide technical assistance and training as needed to each co-located primary care practice on meeting the NCQA requirements.	03/31/2018	Not Started
At the PPS level, develop Care management protocols and procedures, consistent with EMTALA standards, for medical screening exam.	06/30/2016	Completed
Convene team at hub-level to implement and tailor the PPS protocols and procedures. Local team members may include, but not limited to, clinical staff, and administrative staff, CBOs and navigators.	03/31/2017	In Progress

Implement strategy at the hub-level via the multi-disciplinary hub-level teams.	03/31/2020	On Hold
Ensure utilization of EHR that supports secure notification/messaging and sharing of medical records between participating local health providers, and meets Meaningful Use Stage 2 CMS requirements	03/31/2018	In Progress
Establish protocols and training for care coordinators to assist patients in understanding use of the health system, and to promote self-management and knowledge on appropriate care.	03/31/2017	In Progress
Identify best practices in patient education by care coordinators on self-management and knowledge of appropriate care that are culturally and linguistically competent at the PPS level.	03/31/2016	Completed
Develop guidance on care coordination requirements between the EDs and PCP practices with input across EDs and primary care practices at the PPS level.	06/30/2016	Completed
Tailor approach at the hub level to employ care coordination teams to educate patients on the use of the health system, including self-management and knowledge of appropriate care.	03/31/2017	In Progress
Review ongoing progress on care coordination efforts in project work group meetings across health systems at the PPS level. Monitor opportunities to improve the delivery of services	03/31/2017	In Progress
Develop protocols for connectivity to the assigned health plan PCP and real-time notification to the Health Home care manager as applicable.	03/31/2017	In Progress
Convene hub-level Workgroup to tailor protocols to hospital EDs. Workgroup may include members such as clinical staff, administrative staff, and CBOs.	03/31/2017	In Progress
Review ongoing progress on connectivity efforts in project work group meetings across health systems at the PPS level. Act on and monitor opportunities to improve the delivery of services.	03/31/2017	In Progress
Utilize culturally competent community based organizations to raise community awareness of alternatives to the emergency room.	03/31/2018	In Progress
Work with CBO workgroup at the PPS level with attention to cultural competency and health literacy requirements to develop a process to educate patients on alternatives to the emergency room, including the development of culturally competent education materials.	06/30/2016	Completed
At the Hub level, engage providers to report patient engagement. Each Hub will analyze provider attribution and EHR use to prioritize providers, with the goal of receiving automated reports from all providers.	03/31/2016	Completed
Project 2.b.iv – Care Transitions to Reduce 30 Day Readmissions		
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	03/31/2017	In Progress
Develop PPS-wide Workgroup with participation from groups such as the Health Homes, hospitals, care	07/20/2015	Completed

management agencies, home health care agencies, nursing homes and SNFs, behavioral health and substance abuse services providers, and other related stakeholders		
Convene hub-level Workgroup to implement care transitions protocols and tailor the PPS approach. Team members may include clinical staff, administrative staff, Health Homes and CBOs	03/31/2017	In Progress
Develop a strategy at the PPS-level to document care transition planning efforts in the EHR and, to ensure that records are interoperable across NQP in collaboration with the IT workgroup.	06/30/2016	Completed
Develop a PPS-level strategy to implement a system that shares information across provider types and EHRs about care transition plans.	06/30/2016	Completed
Implement protocol at the hub level via the identified responsible parties across care providers within each hub and report back to the PPS-wide Workgroup about progress.	03/31/2017	In Progress
At the PPS level, develop a protocol and workflow for the 30 day transition of care period.	12/31/2015	Completed
At the hub level, develop and implement a strategy to monitor compliance with the care transitions protocol including strategies to improve compliance and further decrease- re-admissions within 30 days.	03/31/2017	In Progress
At the hub level, develop and implement a mechanism to monitor discharges during the 30-day transition of care period. Report back to PPS workgroup.	03/31/2017	In Progress
At the Hub level, engage providers to report patient engagement. Each Hub will analyze provider attribution and EHR use to prioritize providers, with the goal of receiving automated reports from all providers.	03/31/2016	Completed
Project 2.b.vii – Implementing the INTERACT Project		
Develop a strategy to train and organize SNFs across the PPS, including the use of INTERACT champions.	06/30/2016	Completed
Conduct meeting with Directors of Nursing and Medical Directors to help advise and modify implementation strategy and confirm INTERACT tool selection.	03/31/2017	In Progress
Conduct trainings based on agreed upon infrastructure and the results of the INTERACT selected trainers. Trainer will be responsible for (a) teaching on-site staff trainers; ensuring each SNF has identified a facility champion and (c) coordination of INTERACT Version 4.0 tools implementation across SNFs. Tools must include care paths and advance care planning tool.	03/31/2018	In Progress
Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	03/31/2017	In Progress
Train INTERACT champions to facilitate implementation efforts at all NQP facilities.	03/31/2020	On Hold
Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	03/31/2017	In Progress

Develop training strategy that will be reflected in the INTERACT training procurement across the PPS in collaboration with SNFs and champions.	06/30/2016	Completed
Educate all staff on care pathways and INTERACT principles.	03/31/2018	In Progress
Develop a broad-based training strategy. Identify all staff that require training. Develop curriculum with training vendor	06/30/2016	Completed
Meet with DONs and Medical Directors to help advise and modify implementation strategy and schedule trainings	03/31/2017	In Progress
Develop a methodology to evaluate training efforts.	09/30/2017	Not Started
Execute Care Pathways and INTERACT training, as well as training evaluation.	03/31/2018	In Progress
Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	03/31/2017	In Progress
Develop ACP training strategy that will be reflected in the INTERACT training procurement across the PPS in collaboration with SNFs & champions.	06/30/2016	Completed
Conduct meeting with Directors of Nursing & Medical Directors to help advise & modify implementation strategy; confirm INTERACT ACP tool selection.	03/31/2017	In Progress
Create coaching program to facilitate and support implementation.	03/31/2017	In Progress
Develop coaching program based on current state assessment of participating SNFs, incl. staff needs; population needs; current programs; best practices and other data. (NOTE: The training of coaches will be incorporated into the procurement of INTERACT training).	06/30/2016	Completed
Select "coaches" to be trained.	03/31/2017	In Progress
Conduct, evaluate, modify/enhance training	03/31/2017	In Progress
Project 2.d.i - Implementation of Patient Activation Activities		
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	03/31/2017	In Progress
Identify individuals for the PPS-wide training team, including people familiar with patient engagement and activation.	12/31/2015	Completed
Coordinate PAM® training session with Insignia Health for PPS-wide training team.	12/31/2015	Completed
Coordinate additional training sessions on periodic basis or as necessary.	03/31/2017	In Progress
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	03/31/2018	In Progress
Identify baseline knowledge among providers in hot spots regarding shared decision-making, measurement of health literacy and cultural competence among other topics. Also assess baseline knowledge re: cultural and linguistic competence as well as health literacy.	06/30/2016	Completed
Develop a curriculum on patient activation techniques for providers.	12/31/2016	Completed

Train providers located within "hot spots" on patient activation strategies including decision-making, measurement of health literacy and cultural competence. As necessary, offer additional training sessions.	03/31/2018	In Progress
Hire and train patient navigators to perform outreach in the community. Hubs will make best efforts to engage consumers who represent the population served.	03/31/2017	In Progress
Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	03/31/2018	In Progress
Train community navigators in use of identified community resources and linkages to care.	03/31/2018	In Progress
Deploy community navigators to hot spot areas.	03/31/2018	In Progress
Provide additional trainings as necessary.	03/31/2018	In Progress
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	03/31/2017	In Progress
Coordinate PAM training sessions with Insignia Health for community navigators and other personnel, with participation from PAM training team	12/31/2015	Completed
Offer additional trainings, utilizing PAM training team, as needed.	03/31/2017	In Progress
Develop a curriculum to train community navigators to educate persons on insurance coverage, primary and preventive services and resources.	06/30/2016	Completed
Provide training for community navigators using the above curriculum. Offer additional trainings as needed.	03/31/2018	In Progress
Develop a curriculum to train community navigators to educate persons about insurance options and healthcare resources available to UI, NU, and LU populations.	03/31/2018	In Progress
Engage and educate PCPs on community navigator role	03/31/2018	In Progress
Project 3.a.i - Integration of Primary Care and Behavioral Health Services		
At the PPS level, develop current state and future state workflows to co-locate behavioral health at primary care practice sites within the PCMH / APCM	03/31/2017	In Progress
Develop current and future state workflows to deliver preventive care screenings for mental health and substance abuse including but not limited to a warm transfer to behavioral health providers as measured by EHR documentation.	03/31/2016	Completed
At the Hub level, engage providers to report patient engagement. Each Hub will analyze provider attribution and EHR use to prioritize providers, with the goal of receiving automated reports from all providers.	03/31/2016	Completed
Collaborating with PPS workgroup and selected subject matter experts, develop future state and program design that reflects co-located PCMH in Behavioral Health practice sites (consistent with NCQA requirements) including work flows and processes, documentation requirements, criteria for transfer to the behavioral health setting and vice versa, and approach to offering community-based supports.	09/30/2016	Completed

Project 3.a.ii - Behavioral Health Community Crisis Stabilization Services		
Develop PPS-wide Workgroup to address project deliverables, including the Department of Social Services, behavioral health providers, mobile crisis, and other related stakeholders.	07/20/2015	Completed
Develop and agree on a crisis intervention strategy based on current state workflow, DSRIP requirements and capacity with input from project workgroup that includes centralized triage, outreach, mobile crisis, and intensive crisis services.	09/30/2016	Completed
Implement crisis intervention strategy at participating organizations.	3/31/2018	In Progress
Implement continuous improvement activities, including convening meetings to discuss challenges and lessons learned, with involvement from the PPS as appropriate based on data and comparisons across all participating organizations in NQP.	03/31/2018	Not Started
Develop a collaborative workgroup including Health Homes, ER & hospital staff to cultivate linkages across the continuity of care.	03/31/2016	Completed
As part of developing guidelines and building upon existing services (and potentially creating new services), provide training and other resources on diversion techniques and alternatives to hospital-based services (e.g., mobile crisis).	03/31/2018	In Progress
Develop a proposed strategy to leverage and expand MCO crisis stabilization practices coverage of services at the PPS level.	03/31/2017	In Progress
Develop specialty psychiatric services and specialty program design in collaboration with the PPS-wide workgroup.	06/30/2016	Completed
Engage representatives on PPS-wide Workgroup and solicit feedback on project design, as well as information with regards to guideline development and availability of specialty psychiatric services.	03/31/2016	Completed
Implement crisis stabilization guidelines and workflows at the local level, tailoring guidelines to the specific organization as necessary.	03/31/2017	In Progress
Expand mobile crisis capacity and train additional teams with resources available at participating organizations.	03/31/2018	In Progress
Incorporate mobile crisis team processes into crisis stabilization guidelines and workflows and customize, to the degree necessary and appropriate, by hub.	03/31/2018	In Progress
Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration	03/31/2018	In Progress
Develop a PPS-level strategy and timeline for implementing a centralized triage system design under DSRIP. Develop guidelines for directing patients to services with input from PPS-wide Workgroup.	06/30/2016	Completed

Implement central triage service with guidelines in place for connecting patients to appropriate crisis stabilization resources and services.	03/31/2018	In Progress
Develop strategy for oversight and assurance on engagement at the PPS level, including recurring reviews of quarterly reports, on-site visits, and other assessment mechanisms. Continuously improve crisis services to meet DSRIP metrics as needed.	03/31/2018	In Progress
Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	03/31/2017	In Progress
In collaboration with the PPS Performance Reporting committee, develop a PPS-level strategy to identify and track patients who are actively engaged.	12/31/2015	Completed
At the Hub level, engage providers to report patient engagement. Each Hub will analyze provider attribution and EHR use to prioritize providers, with the goal of receiving automated reports from all providers.	03/31/2016	Completed
Project 3.b.i - Evidence-based Strategies for Disease Management		
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	03/31/2018	In Progress
Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	03/31/2018	In Progress
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	03/31/2018	In Progress
For safety net providers using a non-certified EMR, work with REC and other resources to create an EMR upgrade plan for these providers.	03/31/2017	In Progress
Support certified EHR implementation to participating safety net providers at the hub level.	03/31/2018	In Progress
At the Hub level, engage providers to report patient engagement. Each Hub will analyze provider attribution and EHR use to prioritize providers, with the goal of receiving automated reports from all providers.	03/31/2016	Completed
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange)	03/31/2017	In Progress
PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	03/31/2017	In Progress
Develop and implement a performance improvement program to optimize 5 A use in practices.	03/31/2017	In Progress
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	03/31/2017	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.	03/31/2017	In Progress

At PPS level, develop recommended work flow to accommodate walk-in patients for blood pressure checks	03/31/2016	Completed
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	03/31/2017	In Progress
PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	03/31/2018	In Progress
Coordinate periodic training at the hub level around patient identification and hypertension visit scheduling.	03/31/2018	In Progress
At the PPS level, identify best practice and evidence-based guidelines on when to use preferential drug regimens that provides increased chance of medication adherence, considering Million Hearts Campaign strategies.	12/31/2015	Completed
Develop a PPS-wide strategy to support adoption of the guidelines across the hub level.	03/31/2016	Completed
PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	09/30/2018	In Progress
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	03/31/2018	In Progress
PPS provides periodic training to staff on warm referral and follow-up process.	03/31/2018	In Progress
Develop and implement protocols for home blood pressure monitoring with follow up support.	03/31/2017	In Progress
PPS provides periodic training to staff on warm referral and follow-up process.	03/31/2017	In Progress
Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	03/31/2018	In Progress
Adopt strategies from the Million Hearts Campaign.	03/31/2017	In Progress
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	03/31/2018	In Progress
Engage a majority (at least 80%) of primary care providers in this project.	03/31/2017	In Progress
At the PPS level, develop a provider engagement strategy, which may include incentives, to identify and manage patients with cardiovascular disease.	3/31/2017	In Progress
Project 3.c.i - Evidence-based Strategies for Disease Management		
Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	03/31/2018	In Progress
Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	03/31/2017	In Progress
At the PPS level, develop a provider engagement strategy, which may include incentives, to identify and manage patients with diabetes disease.	03/31/2016	Completed

Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	03/31/2017	In Progress
Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	03/31/2017	In Progress
Ensure coordination with the Medicaid Managed Care organizations serving the target population.	03/31/2018	In Progress
Develop a PPS-level strategy to engage MCOs, with a focus on resources associated with smoking cessation, hypertension screening, cholesterol screening & other preventative services relevant to this project.	03/31/2020	On Hold
In collaboration with the PPS Performance Reporting committee, develop a PPS-level strategy to identify and track patients who are actively engaged.	12/31/2015	Completed
At the Hub level, engage providers to report patient engagement. Each Hub will analyze provider attribution and EHR use to prioritize providers, with the goal of receiving automated reports from all providers.	03/31/2016	Completed
Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	03/31/2018	In Progress
Determine which safety net providers are not using EMR. Work with REC and other resources to create an EMR implementation plan for these providers, including incentive structure.	09/30/2016	In Progress
For safety net providers using a non-certified EMR, work with REC and other resources to create an EMR upgrade plan for these providers.	03/31/2017	In Progress
Project 4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure		
Organize a PPS-wide multi-disciplinary committee, meeting regularly, of individuals dedicated to developing strategies to promote mental, emotional and behavioral health and well-being, including clinicians and public health practitioners focused on behavioral health conditions. Relevant stakeholders to include in the Behavioral Health committee are members such as clinicians, public health practitioners, local and state government agencies, and navigators. NOTE: A second workgroup of CBOs will be developed as well, and the PPS-wide Behavioral Health Workgroup and the CBO Workgroup will work together as appropriate. The CBO Workgroup (Non-BH) will include faith-based organizations, community-based organizations, organizations that offer supports for food, shelter and other social determinants of health.	12/31/2015	Completed
In collaboration with Health Homes and CBOs, develop, implement and manage "Collaborative Care" in primary care teams including all relevant team members.	03/31/2018	In Progress
Conduct outreach to Health Homes to participate in a workgroup dedicated to implementing "Collaborative Care" in primary care, in alignment with relevant DSRIP projects.	06/30/2016	Completed

Identify primary care providers with patients served by health homes and engage those practices in Collaborative Care efforts.	03/31/2017	In Progress
In collaboration with the PPS-wide Workforce and Clinical Integration committee, develop training on collaborative care models for promoting mental, emotional, and behavioral health at the PPS level. This task includes training material development, initial training scheduled and execution, and incorporation by all primary care practices in their new hire training packages.	03/31/2017	In Progress
Conduct collaborative training for PCPs, MCOs, and Health Homes with shared patients.	03/31/2017	Not Started
Develop strategies to deliver culturally and linguistically appropriate behavioral health services in collaboration with community-based organizations through staff training, based on patient needs as defined by patients and families.	03/31/2018	In Progress
Conduct training broadly for all relevant NQP employees, network providers, CBOs and others with regard to Collaborative Care Model efforts.	03/31/2017	In Progress
Develop and produce PPS-wide culturally and linguistically appropriate health education materials on mental, emotional and behavioral health promotion for use across health systems in appropriate languages based on cultural and linguistic needs. Distribute materials across NQP.	03/31/2017	In Progress
Engage the PPS-wide Cultural Competency and Health Literacy committee and the PPS-wide CBO workgroup for feedback on proposed Collaborative Care models and MEB partnerships as well as input on MEB training at the PPS level.	03/31/2018	Not Started
Project 4.b.i – Promote Tobacco Cessation		
Organize a multi-disciplinary PPS-wide Workgroup dedicated to developing strategies to promote tobacco dependence treatment including clinicians, public health specialists focused on cardiovascular health, behavioral health conditions and other chronic conditions.	03/31/2018	In Progress
Develop a PPS-wide strategy, in collaboration with NYC DOHMH, based on evidence-based strategies and other relevant information to develop, implement, measure and improve tobacco dependence treatments across the local hub levels.	03/31/2018	In Progress
Convene hub-level workgroup to implement the project and tailor the PPS approach proposed by the PPS-wide workgroup. Workgroups may include members such as clinical staff, administrative staff, and CBOs.	03/31/2018	In Progress
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	03/31/2017	In Progress
Adopt and follow standardized treatment protocols for tobacco cessation, including people with disabilities.	03/31/2018	In Progress
Adopt tobacco-free outdoor policies. *-- At the PPS level, develop strategies to implement outdoor tobacco- free policies across the local hubs.* *-- Convene hub-level Workgroup to implement the project and tailor the PPS strategy proposed by the PPS-wide Workgroup, including identifying hot spots. Workgroup*	03/31/2018	In Progress

members may include clinical staff, administrative staff, and CBOs.		
Facilitate referrals to NYS Smokers' Quitline, *-- At the PPS level, develop best practice workflow (based on evidence-based practices elsewhere in the country) to promote use of the NYS Smokers' Quit line at the local hub level.* *-- At the PPS-level, develop a protocol/process to document patient utilization of the NYS Smokers' Quitline and related health status changes to be implemented in primary care practices at the local hub level.*	03/31/2017	In Progress
Perform additional actions including "hot spotting" strategies in high-risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	03/31/2018	In Progress
Adopt smoking cessation strategies from the Million Hearts Campaign	03/31/2017	In Progress
Develop a PPS-wide strategy to support adoption of the protocols across the hub level.	03/31/2017	In Progress
Convene hub-level Workgroup to implement the project and tailor the PPS strategy proposed by the PPS-wide Workgroup. Workgroup members may include clinical staff, administrative staff, and CBOs.	03/31/2017	In Progress
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate health benefits for smoking cessation.	03/31/2018	In Progress
Collaborate with MCOs, Health Homes and CBOs to ensure high risk populations are educated on the availability of tobacco cessation coverage benefits, as mandated under the Affordable Care Act.	03/31/2018	In Progress