North Country Initiative

Workforce Transition Roadmap

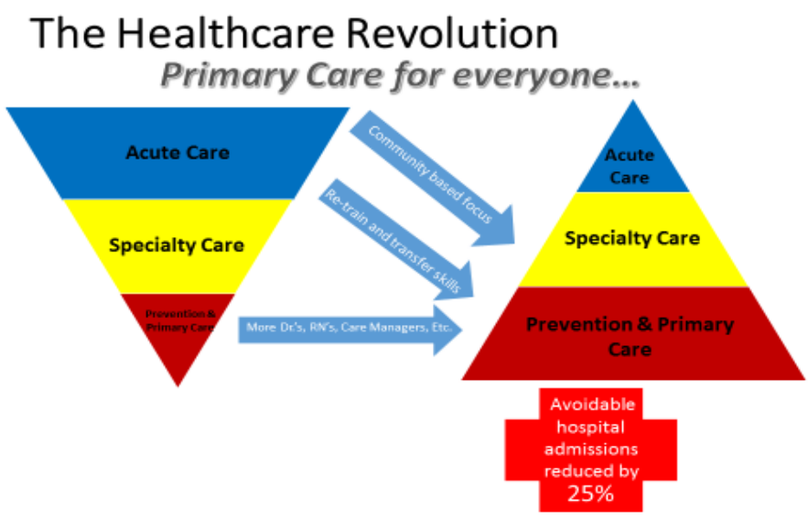
Milestone 2: Due DY2, Q2 (September 2016)

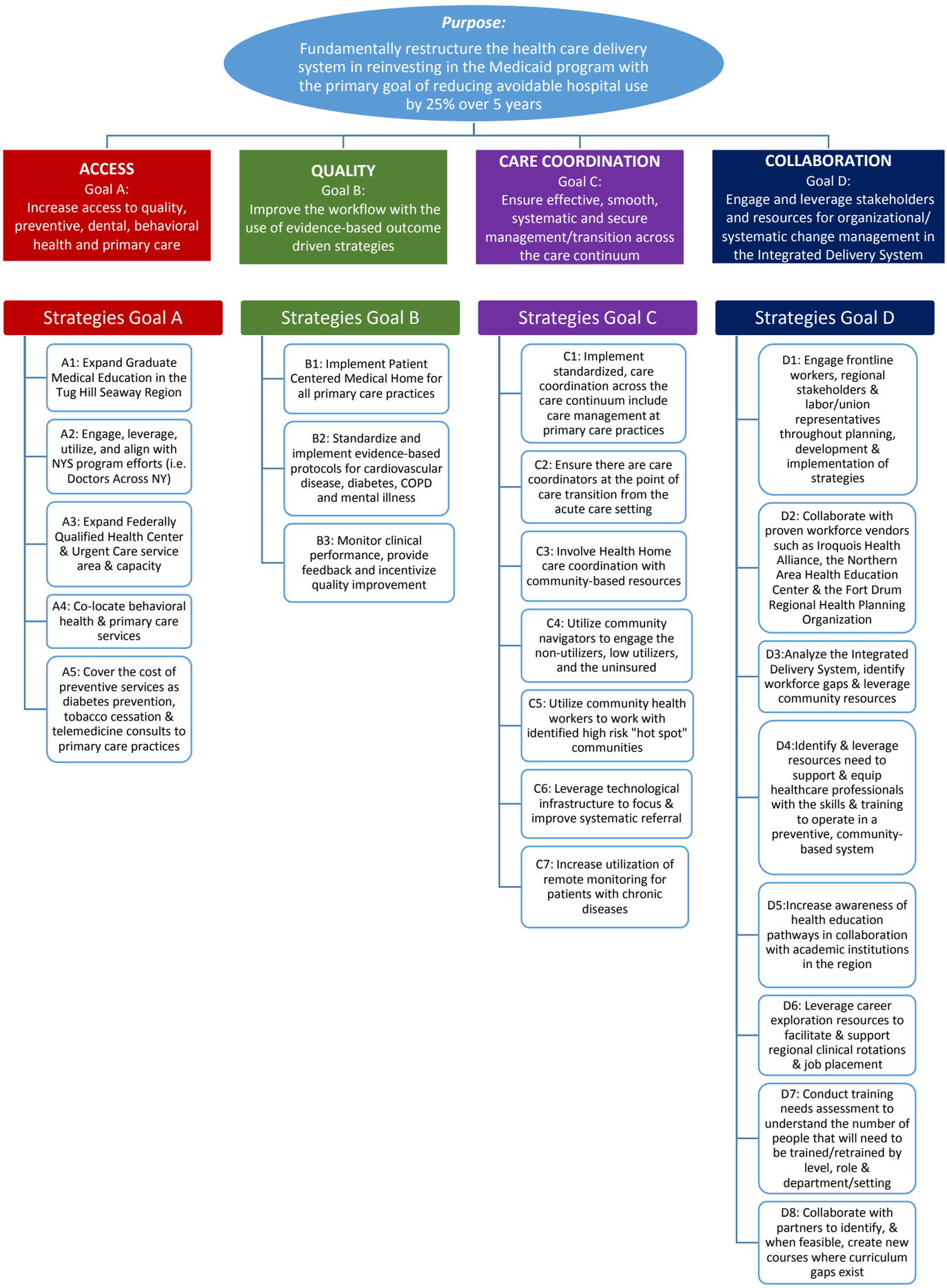
Successful Completion of Milestone:
The PPS must demonstrate it has defined the target workforce transition roadmap and received governance body approval. It must provide the IA:
• Evidence of the finalized PPS workforce transition roadmap that includes:
• Plans for recruitment, training and deployment needs of the PPS on an ongoing basis.
• Realistic target dates for all steps.
• Ways to close identified gaps so as to meet the needs of the PPS and its network partners.

• Copies of meeting schedule of the Workforce Governance Body regarding the development of the PPS workforce transition roadmap.
• A template, “Meeting Schedule Template” has been developed to capture meetings, which have occurred in the past quarter. This template is mandatory and must be utilized to facilitate IA review. In completing the template, the IA is only looking for a list of meetings, dates conducted, and whether there are meeting minutes or an attendees list available. As part of random sampling the IA MAY request a list of attendees or minutes after review of the meeting template.

Ongoing Quarterly Reporting:
After the successful completion of the initial milestone, the PPS must provide the following information to the IA each quarter.
• Updates on the implementation of your workforce transition roadmap.
• Copies of meeting schedule regarding workforce transition roadmap during the quarter.

TODAY	TOMORROW
Operationally lean provider network (Health Professional Shortage Area) for dental, primary and behavioral health	Provider recruitment, retention & education incentive program, expand regional Graduate Medical Education & expanded local education/training opportunities
Limited capacity	Excess capacity, including utilization of telemedicine consults
Long wait times	Reduced/no wait times
Lack of an assigned provider	Primary care for all
Substantial need to increase and expand access to quality, preventive care	Access to quality, preventive care
Healthcare provided in separate silos across the care continuum	Integration of behavioral health and primary care
High burden of chronic disease	Chronic disease self-management programs
Patients with chronic and complex conditions often have multiple and contradictory care plans	Healthcare provided as an Integrated Delivery System with interdisciplinary teams
Volume based payments	Value based payments
Need for Patient Centered Medical Homes	Patient Centered Medical Home 2014, Level 3 Certification for all Primary Care Practices
No agreed upon protocols for care transitions	Regional, standardized protocols
Lacking standardized and systematic record transfer	Standardized, systematic record transfer
Limited ability to share records or care plans	Ability to share records or care plans (Population Health Management Tools, Electronic Health Records & Health Information Exchange)
Limited Federally Qualified Health Center access in Lowville and Ogdensburg	Growth of Federally Qualified Health Centers
No Urgent Care in Ogdensburg	Accessibility and growth of Urgent Care
Community-based organizations have little to no interaction with inpatient settings (lacking a systematic way to engage these resources)	Cross continuum collaboration between acute and post-acute providers (early notifications of discharge and warm transfer)
Limited coordination across the care continuum	Care management capabilities at primary care, in the hospitals and in the community
Need to more meaningfully use Health Information Technology	Meaningful use attestation among providers
Poor performance in the region compared to NYS on every single Prevention Quality Indicator	Incentive and evidence-based strategies




Purpose:
Fundamentally restructure the health care delivery system in reinvesting in the Medicaid program with the primary goal of reducing avoidable hospital use by 25% over 5 years
ACCESS
Goal A:
Increase access to quality, preventive, dental, behavioral health and primary care
QUALITY
Goal B:
Improve the workflow with the use of evidence-based outcome driven strategies
CARE COORDINATION
Goal C:
Ensure effective, smooth, systematic and secure management/transition across the care continuum
COLLABORATION
Goal D:
Engage and leverage stakeholders and resources for organizational/ systematic change management in the Integrated Delivery System
Strategies Goal A
A1: Expand Graduate Medical Education in the Tug Hill Seaway Region
A2: Engage, leverage, utilize, and align with NYS program efforts (i.e. Doctors Across NY)
A3: Expand Federally Qualified Health Center & Urgent Care service area & capacity
A4: Co-locate behavioral health & primary care services
A5: Cover the cost of preventive services as diabetes prevention, tobacco cessation & telemedicine consults to primary care practices
Strategies Goal B
B1: Implement Patient Centered Medical Home for all primary care practices
B2: Standardize and implement evidence-based protocols for cardiovascular disease, diabetes, COPD and mental illness
B3: Monitor clinical performance, provide feedback and incentivize quality improvement
Strategies Goal C
C1: Implement standardized, care coordination across the care continuum include care management at primary care practices
C2: Ensure there are care coordinators at the point of care transition from the acute care setting
C3: Involve Health Home care coordination with community-based resources
C4: Utilize community navigators to engage the non-utilizers, low utilizers, and the uninsured
C5: Utilize community health workers to work with identified high risk "hot spot" communities
C6: Leverage technological infrastructure to focus & improve systematic referral
C7: Increase utilization of remote monitoring for patients with chronic diseases
Strategies Goal D
D1: Engage frontline workers, regional stakeholders & labor/union representatives throughout planning, development & implementation of strategies
D2: Collaborate with proven workforce vendors such as Iroquois Health Alliance, the Northern Area Health Education Center & the Fort Drum Regional Health Planning Organization
D3:Analyze the Integrated Delivery System, identify workforce gaps & leverage community resources
D4:Identify & leverage resources need to support & equip healthcare professionals with the skills & training to operate in a preventive, community-based system
D5:Increase awareness of health education pathways in collaboration with academic institutions in the region
D6: Leverage career exploration resources to facilitate & support regional clinical rotations & job placement
D7: Conduct training needs assessment to understand the number of people that will need to be trained/retrained by level, role & department/setting
D8: Collaborate with partners to identify, & when feasible, create new courses where curriculum gaps exist
Cross-Cutting Strategies
Leverage efforts across multiple stakeholders and across the care continuum
Ensure consistent, collaborative & transparent communication
Advance system for measurement, evaluation & continuous improvement
Promote sustainable financing & effective policies/procedures to support workforce development for system transformation

Roadmap Descriptors

GOAL A: INCREASE ACCESS TO QUALITY, PREVENTIVE, DENTAL, BEHAVIORAL HEALTH AND PRIMARY CARE. Goal A focuses on ensuring Medicaid beneficiaries within the Integrated Delivery System have access to care, an assigned provider, and the ability to receive timely appointments.		
Strategy # and target date	**Strategy Name**	**Strategy Descriptor**
A1 DY3	Expand Graduate Medical Education in the Tug Hill Seaway Region	Samaritan Medical Center currently offers an American Osteopathic Association (AOA) Accredited Osteopathic Internship Training Program and an Osteopathic Residency Program in both Family Medicine and Internal Medicine. The NCI hopes to expand residency experiences to other facilities within the region, utilizing Samaritan's successes as a cornerstone. It is likely that residents who train here will stay here to practice medicine.
A2 DY1	Engage, leverage, utilize, and align with NYS program efforts (i.e. Doctors Across NY)	While care coordination and connectivity with community-based services is critical, the most significant immediate modification to meet the needs of the community is to increase the number of primary care, psychiatry and dental providers in the region. We cannot connect people to primary and preventive care that does not exist. The region has fewer than 74 primary care providers per 100,000 population compared to the NYS rate of 120 and the entire region is a Medicaid Primary Care and Mental Health Provider Shortage Area (HPSA). The NCI will align and intersect with existing State program efforts such as Doctors Across NY, Physician Loan Repayment, and Healthcare Workforce Retraining Initiatives to recruit, retrain and retain professionals in our rural communities.
A3 DY3	Expand Federally Qualified Health Center (FQHC) & Urgent Care service area & capacity	Urgent Care facilities and Federally Qualified Health Centers interface with the target population and have the insight, reach and experience to assist the PPS to engage and activate low-income beneficiaries within the region. They are critical partners of the care delivery system, also offering prevention services and playing a vital role in the coordination of care. FQHC expansion is needed in Lewis County and in the City of Ogdensburg. In addition, there is no urgent care center to serve Ogdensburg. New infrastructure growth correlates with the need for additional healthcare professionals. NCI will assist with the recruitment, training and retention of these professionals as necessary.
A4 DY3	Co-locate behavioral health & primary care services	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit. In addition, it is clear that there is a disconnect between behavioral health services and primary care services. Primary care providers report being unable to get their referred patients appointments for behavioral health care and behavioral health providers report being unable to get access to primary care for their behavioral health patients. Behavioral Health patients have high rates of co-occurring diabetes, cardiac and respiratory diseases. The suicide rate for the region is nearly twice the state rate and Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. There is clear and compelling evidence that integrating primary care and behavioral health at the primary site of care for the patient is needed. Training for staff on collaborative care (IMPACT Model), Patient Centered Medical Home, Systematic Brief Intervention and Treatment (SBIRT) and Depression Screenings will be necessary.
A5 DY2	Cover the cost of preventive services such as diabetes prevention, tobacco cessation & telemedicine consults to primary care practices	Throughout the needs assessment, it was clear that respiratory disease and in particular, COPD needed a concentrated prevention strategy as did colorectal cancer. COPD is the third leading cause of hospitalizations and emergency room visits for the target population. More than 20% of the region's population smokes and prevention efforts need to be improved. Colorectal cancer

		mortality rates exceed NYS rates and colorectal cancer screening rates are significantly lower than NYS. A concerted effort to advance respiratory disease prevention and incorporate smoking prevention and cessation is needed. A concentrated effort to engage the region in cancer prevention screenings is also needed. Both of these activities will impact total health as the region moves from a healthcare system to a system for health. A consulting tele-psychiatrist will need to be secured, as will a consulting certified diabetes educator. Providers will also need to be trained on the 5 A's of tobacco control.
GOAL B: IMPROVE WORKFLOW WITH THE USE OF EVIDENCE-BASED, QUALITY AND OUTCOME DRIVEN STRATEGIES. Goal B focuses on the data collected during the Community Needs Assessment and how it will be used to help us understand the community we seek to serve, how the health care delivery system functions and key populations to be served.		
Strategy # and target date	**Strategy Name**	**Strategy Descriptor**
B1 DY3	Implement Patient Centered Medical Home for all primary care practices	Patient Centered Medical Home Certification 2014 and Advanced Primary Care requires that primary care be team oriented, meet quality standards, be meaningfully utilizing health information technology (to coordinate care and improve quality of care), and adhere to best-practices for prevention screenings and follow-up. In addition, specific patient engagement activities are required. The combination of requirements for PCMH will ensure that prevention and best practices will be standardized and universally applied resulting in fewer Potentially Preventable Visits (PPVs) and Potentially Preventable Admissions (PPAs). The NCI is supporting PCMH content expert training for our DSRIP support staff as well as for our hospitals and Federally Qualified Health Centers. This PCMH staff, along with primary care practices, are also receiving training on collaborative care in collaboration with the University of Washington AIMS Center (IMPACT Model).
B2 DY2	Standardize and implement evidence-based protocols for cardiovascular disease, diabetes, COPD and mental illness	Cardiovascular disease, diabetes, COPD and mental illness can be effectively treated in the outpatient setting. Cardiovascular disease is the second highest driver of inpatient hospitalizations and emergency department use for the target population. COPD is the third highest and diabetes is the fourth highest. In addition, the region's rate of hospitalizations and emergency department use for mental illness and substance abuse are very high and of deep concern. The region performs below the NYS average on all 4 of these chronic diseases. Primary Care implementation of evidence-based strategies in the treatment of cardiovascular disease will result in less Emergency Department and inpatient utilization, and improved quality of life for beneficiaries. PPS partners will need to be trained on the standardized and evidence-based protocols that are selected in partnership with the Medical Management Committee.
B3 DY2	Monitor clinical performance, provide feedback and incentivize quality improvement	By performing population health management by actively using electronic health records and other IT platforms, including targeted patient registries for all participating providers, the NCI can monitor clinical performance, provide feedback and incentivize providers for quality improvement. Training and support for workflow changes will be supported by the NCI.
GOAL C: ENSURE EFFECTIVE, SMOOTH, SYSTEMATIC AND SECURE CARE MANAGEMENT/TRANSITION ACROSS THE CARE CONTINUUM. **Goal C focuses on standardized protocols and capacity needs to grow care management/coordination to ensure patients receive care at the right time, in the right place, and in the most cost-effective way.**		
Strategy # and target date	**Strategy Name**	**Strategy Descriptor**

C1 DY2	Implement standardized, care coordination across the care continuum including care management at primary care practices	There is substantial need to support smooth care transitions from inpatient to outpatient settings for at risk patients with chronic disease and mental illness within the PPS. Due to the rural geography and transience of many high-risk patients once they leave the “teaching/engaging” moment at the hospital, the health home care managers are unable to find them to engage them in outpatient services and active participation in their care plans that would prevent future hospitals and emergency department use. In addition, it is at this point that home situations (housing, food, heat, transportation, etc.) can be coordinated with community-based supports to ensure the patient has the means to actually comply with the care plan recommendations. Without this support at the point of transition, patients often leave the hospital with little capability to support their future health or to make/keep follow-up care appointments. Standardized protocols (to include patient education, the teach-back method, early notification of discharge, a warm hand off and systematic record transfer) will need to be developed to assist this process. The degree of care management will vary depending on the level of risk, however, at all levels, the NCI will focus on medication self-management, the use of patient-centered records to ensure the continuity of care plans across providers and settings, follow-up visits with primary care, and patient education so the patient is knowledgeable about indications that their condition is worsening and how to respond. Once protocols are adopted, staff ((senders (inpatient) and receivers (outpatient)) will need to be trained.
C2 DY1	Ensure there are care coordinators at the point of care transition from the acute care setting	The NCI will train, hire and resource care transition staff in the hospitals, primary care settings and in the community. These care coordinators will need to be trained on the standardized protocols adopted by the PPS. Additionally, the NCI will develop a North Country Care Coordination Certificate Program designed to prepare and train existing and/or new care coordination professionals who will play a critical role in support health transformation in the region. This program will help prepare professionals to work in interdisciplinary teams, help deliver services to improve outcomes for patients, providers and payers, and assist regional and statewide initiatives to reduce potentially preventable hospital admissions and emergency department use.
C3 DY2	Involve Health Home care coordination with community-based resources	The PPS will adopt standardized protocols to ensure that patients are identified in the acute care setting and referred to the North Country Health Home based on the presence of one or more chronic condition, or one single qualifying condition of either HIV/AIDS or Serious Mental Illness. By increasing awareness of, and leveraging the health home and home care agencies, we will focus on both clinical and social determinants of health that are highly correlated with admissions or readmissions. Hospital-based staff will need to be trained on these protocols and as the need for health home care management grows, the number of downstream providers may need to grow to meet the demand. As needed, the NCI will assist with the recruitment, training, resourcing, and retention of care managers to fill this gap.
C4 DY1	Utilize community navigators to engage the non-utilizers, low utilizers, and the uninsured	Currently and often, the only contact that the uninsured and Medicaid NU/LU have with the healthcare system is through the emergency department or an acute care hospitalization. Engaging this population in the healthcare system can prevent future Emergency Department and inpatient utilization, and prevent future onset of chronic disease. Community navigators and other agencies within the PPS will be trained to utilize Insignia Health’s Patient Activation Measure (PAM) tool as a way to engage and activate this population.

C5 DY1	Utilize community health workers to work with identified high risk "hot spot" communities	Community Health Workers serve as liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. They also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy (American Public Health Association, 2008). The PPS, in collaboration with the Community Health Worker Network of NYC, will provide training to PPS partners. This training is designed to provide Community Health Workers with the specific skills they need to accomplish tasks in this role. The NCI Community Health Workers will be deployed within identified high risk “hot spots”. Additionally, in collaboration with the health literacy and cultural competency committee and various community-based organizations, the NCI will host twelve focus groups (with Medicaid beneficiaries, Medicaid eligible and uninsured populations) conducted across the tri-county region. Participants will be directed to share their experiences of care in an open communication format.
C6 DY3	Leverage technological infrastructure to focus & improve systematic referral	The PPS will ensure that all safety net providers are actively sharing electronic health record systems with our local health information exchange (HealtheConnections) and through the Health Information Exchange, the appropriate data will be securely shared throughout NYS via the SHIN-NY. HealtheConnections will be the standardized method for sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, and all participating providers will be connected by the end of DY3. Partners within the PPS will need to be trained on workflow, security, privacy and compliance associated with this technological infrastructure.
C7 DY2	Increase utilization of remote monitoring for patients with chronic diseases	Telehealth remote monitoring gives clinicians the ability to monitor and measure patient’s health data and information. It increases access to health services, improves disease management and assists with early intervention. It is self-directed and cost-effective, aligning with the overall goal of preventing potentially preventable admissions/readmissions or emergency department visits. The NCI will work with PPS partners to select a remote monitoring vendor as well as engage partners and patients on the adoption and implementation of the devices. This will require training for healthcare professionals who use this strategy.
GOAL D: ENGAGE AND LEVERAGE STAKEHOLDERS AND RESOURCES FOR ORGANIZATIONAL/SYSTEMATIC CHANGE MANAGEMENT IN THE INTEGRATED DELIVERY SYSTEM **Goal D focuses on engaging stakeholders in the planning and implementation of system change.**		
Strategy # and target date	**Strategy Name**	**Strategy Descriptor**
D1 DY1	Engage frontline workers, regional stakeholders & labor/union representatives throughout planning, development & implementation of strategies	The redesign of the care delivery system hinges on workforce modifications – hiring, retraining and redeployment. To effectively engage the healthcare workforce and ensure smooth transitions during system reconfiguration, labor unions service healthcare workers need to be involved in the development of PPS strategies.
D2 DY1	Collaborate with proven workforce vendors such as Iroquois Health Alliance, the Northern Area Health Education Center & the Fort Drum Regional Health Planning Organization	NCI will leverage existing partnerships with the Fort Drum Regional Health Planning Organization and the Northern Area Health Education Center to increase awareness of health education pathways, job placement and career exploration resources, and clinical rotations. We will also work with these vendors to conduct training-needs assessments and select training or academic partners to create and deliver training modules or curriculum. IHA has successfully demonstrated the ability to identify eligible

		candidates for training programs, organize appropriate trainings, and assist with retention and employment for training individuals in the health care sector. The IHA also has an existing partnership with HealthStream to deliver online training to PPS employees, specifically as it relates to engaging and training frontline workers to improve outcomes due to cultural competency challenges, population health, transitional care, process improvement, and care coordination.
D3 DY1	Analyze the Integrated Delivery System, identify workforce gaps & leverage community resources	The NCI will perform a future state staffing strategy analysis across the PPS by reviewing and assessing workforce commitments made in the PPS Organizational and Project applications in relation to defining the target workforce state.
D4 DY1	Identify & leverage resources needed to support & equip healthcare professionals with the skills & training to operate in a preventive, community-based system	The NCI strategy will aim to leverage existing resources and enhance active interventions to prevent work overloads and reduce stress related to attrition. Retraining and retaining professionals through strategic, effective methods such as human resource planning, incentivizing providers, providing education, training and career advancement, as well as workforce projections will improve the practice environment within the Tug Hill Seaway region.
D5 DY1	Increase awareness of health education pathways in collaboration with academic institutions in the region	The NCI will work with Jefferson Community College, SUNY Canton, the State University of New York and the Iroquois Health Alliance to conduct training needs assessments and select training or academic partners to create and deliver training modules or curriculum.
D6 DY1	Leverage career exploration resources to facilitate & support regional clinical rotations & job placement	In collaboration with the workforce committee and proven workforce vendors, the NCI will seek to recruit and retain local students and professionals, for individuals who are from this region are more likely to stay and practice in this region. We will work with employers and academic institutions to identify training and education gaps and then leverage academic partnerships to bring exploration or curriculum programs to the region.
D7 DY2	Conduct training needs assessment to understand the number of people that will need to be trained/retrained by level, role & department/setting	Utilizing the compensation and benefits analysis, the workforce committee will reconcile this data between current and future state positions, taking into account job roles, functions and location. Where there are vacancies related to the chosen project deliverables/commitments, the NCI will identify local resources to provide necessary training or education to ensure we fill this gap.
D8 DY2	Collaborate with partners to identify, & when feasible, create new courses where curriculum gaps exist	Utilizing the defined target workforce state, the training needs assessment, the compensation and benefits analysis and other key data, the NCI will work with community partners to develop, implement, track, monitor and evaluate education or training programs in the region to ensure our regional healthcare professionals are prepared, supported and equipped to operate in the Integrated Delivery System.

DY1

- A2: Engage, leverage, utilize and align with NYS Program Efforts
- C2: Ensure there are care coordinators at the point of care transition from the acute care setting
- C4: Utilize community navigators to engage the non-utilizers, low utilizers and the uninsured
- C5: Utilize community health workers to work with identified high risk "hot spot" communities
- D1: Engage frontline workers, regional stakeholders & labor/union representatives throughout planning, development & implementation of strategies
- D2: Collaborate with proven workforce vendors such as the Iroquois Health Alliance, the Northern Area Health Education Center & the Fort Drum Regional Health Planning Organization
- D3: Analyze the Integrated Delivery System, identify workforce gaps and leverage community resources
- D4: Identify & leverage resources needed to support & equip healthcare professionals with the skills & training to operate in a preventive, community-based system
- D5: Increase awareness of health education pathways in collaboration with academic insitutions in the region
- D6: Leverage career exploration resources to facilitate & support regional clinical rotations & job placement

DY2

- A5: Cover the cost of preventive services such as diabetes prevention, tobacco cessation & telemedicine consults to primary care practices
- B2: Standardize and implement evidence-based protocols for cardiovascular disease, diabetes, COPD and mental illness
- B3: Monitor clinical performance, provide feedback & incentivize quality improvement
- C1: Implement standardized, care coordination across the care continuum including care management at primary care practices
- C3: Involve Health Home care coordination with community-based resources
- C7: Increase utilization of remote monitoring for patients with chronic diseases
- D7: Conduct training needs assessment to understand the number of people that will need to be trained/retrained by level, role and & department/setting
- D8: Collaborate with partners to identify, & where feasible, create new courses where curriculum gaps exist

DY3

- A1: Expand Graduate Medical Education in the Tug Hill Seaway Region
- A3: Expand Federally Qualified Health Center (FQHC) and Urgent Care service area & capacity
- A4: Co-locate behavioral health and primary care services
- B1: Implement Patient Centered Medical Home for all primary care practices
- C6: Leverage technological infrastructure to focus and improve systematic referral

DY4 & DY5

- Ongoing efforts to sustain workforce strategies across years

- **Note: Demonstration Year (DY) is based on anticipated completion date of strategy/task; however, many of these initiatives will be ongoing throughout and beyond DY5**