NCI Workforce Transition Roadmap
Quarterly Updates: DY2, Q1

GOAL A: INCREASE ACCESS TO QUALITY, PREVENTIVE, DENTAL, BEHAVIORAL **Goal A focuses on ensuring Medicaid beneficiaries within the Integrated Delivery System have access to care, an assigned provider, and the ability to receive**				
Strategy # and Target Date	**Strategy Name**	**Strategy Descriptor**	**DY2, Q1 Update**	**DY2,Q2 Update**
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.	In Progress Draft proposal shared with workforce governing body. Timeline created based on DSRIP funding, deliverables & Match Day. Summer intern (Medical Student) drafting agreements, budget, promotional materials & informational resources associated with the proposal. Working with Chair of workforce governing body & Director of local GME to identify gaps in rotations and regional capacity to support program expansion. Anticipated GoLive - July 2017.	In Progress Work from DY2,Q1 continues. Samaritan Medical Center submitted a grant application for the Rural Residency Program. This would allow us to not only grow the existing GME Program through the use of DSRIP funds, but also to leverage these other grant dollars to build a rural tract into the program, obtain full time staff to assist with the project and move towards a more sustainable GME model for the future (with increased residency cap as an urban program with a rural tract). While work continues under the DSRIP initiatives, further work regarding matching and residency placements has been delayed as we'd like to align these initiatives if awarded. Award announcements are expected in DY2Q3.
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.	Ongoing NCI continues to share state program efforts with partners, students & healthcare professionals exploring employment in our region. Additionally, NCI worked to ensure the NCI Provider Incentive Program did not interfere with eligibility for these statewide programs.	Ongoing Organized by the Iroquois Healthcare Association (IHA) and made possible through $100,000 in state budget funding, Senator Ritchie successfully advocated for, the "Take a Look" tours which are designed to help address the critical physician shortage in rural areas. As a result of funding, IHA and the NY Chapter of American College of Physicians was able to continue the tours, enhance their outreach to medical schools, and expand into Central and Northern New York. At the end of this quarter, the FDRHPO and the NCI assisted with the facilitation and coordination of the visits and tours with NCI partners in the Tug Hill Seaway region. The NCI workforce lead, the board chairman and one of the medical directors presented on the FDRHPO and NCI healthcare transformation efforts. More information can be found here: http://www.wwnytv.com/news/local/Program-Looks-To-Attract-Doctors-To-North-Country-395329071.html www.nysenate.gov/newsroom/press-releases/patty-ritchie/ritchie-future-physicians-take-look careers-central-and
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.	In Progress The NCI has supported the recruitment, training & retention of healthcare professionals at the two FQHCs. With awarded funds from the NCI Provider Incentive Program, the North Country Family Health Center (NCFHC) has recruited a psychologist and 2 dentists. Similarly the Community Health Center of the North Country (CHCNC) is in the process of recruiting a Primary Care Provider with these funds. Approximately 150 employees from both the NCFHC & CHCNC have completed trainings in the following: Bridges Out of Poverty, Chronic Care Professional, DSRIP 101, Performance Reporting, Clinically Integrated Network, SBIRT, PAM, IMPACT, Care Coordination Certificate Program, Community Health Worker, HealtheConnections, etc.	In Progress Both FQHCs have submitted and have been certified as 2014, Level 3 PCMH clinics. Ongoing support is being provided to these clinics during their transformation effors. Staff at the two facilities continue to participate in ongoing training initiatives to include completion of the NCI customized videos (Introduction to the Medicaid Health Home, Standardized Care Transition Protocols, and Health Literacy, Cultural Competency & MEB promotion, prevention & treatment). Additionally, both FQHCs hosted physician residents for visits during the IHA Take a Look Tour which was noted above. The Community Health Center of the North Country has purchased a building location in Ogdensburg and is currently under renovation to prepare for the opening of the Ogdensburg FQHC site. Additionally, the North Country Family Health Center will be renovating their main building to ensure a more coordinated, systematic and patient-centered work flow.

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.	In Progress All primary care practices will receive technical support from the NCI/FDRHPO project team. 2 practices in the region have already received PCMH Level 3, 2014 standards. Many others are in the process. Approximately 180 individuals have completed SBIRT training. 5 individuals have completed the Depression Care Manager training and another 3 are in the process. 50 individuals completed an IMPACT Model/Collaborative Care webinar with the University of Washington AIMS Center and 4 primary care practices including physicians, nurse practitioners, care managers and a psychiatrist (approximately 25 total) will complete a full day, onsite training with the University of Washington AIMS Center on July 8th. Subject Matter Experts for each of the three models of integration have been identified and the IMPACT Model SME is also practicing in a NYS Learning Collaborative for this model. Regulatory waivers have been submitted and plans are underway for the integration of BH and PC (model 1 and 2).	In Progress Primary care practices continue to receive technical support from the NCI/FDRHPO project team. 3 practices in region have received PCMH Level 3, 2014 standards and others are in the moving in this same direction. Over 200 individuals have received SBIRT training and the NCI is currently exploring a 4 hour SBIRT training specifically targeted for the primary care practices. 3 additional individuals are expected to complete Depression Care Management training in December and another 5 will commence the training on Oct. 12th. 25 individuals completed IMPACT Model/Collaborative Care training with the University of Washington AIMS Center on July 8th including primary care physicians, NPs, care managers, a psychiatrist and office managers. Our subject matter expert for Model 3 (IMPACT) is completing Problem Solving Treatment training through the AIMS Center. Additionally, this practice enrolled their first few patients in the IMPACT Model this quarter and they conducted their first consults with the psychiatrist. Carthage Family Health Center has now committed to the IMPACT Model too. All NCI IMPACT Model sites were invited to participate in the OMH Learning Collaborative for IMPACT. Applications will be submitted next quarter. Policies, procedures and guidelines for care engagement, consulting with the psychiatrist and medication management for 3ai were approved by the Med Management Committee this quarter. Also, technological infrastructure has been put in place to ensure private, secure and HIPAA compliant communications for behavioral health and primary care integration. Project plans for Model 1 and 2 were also completed this quarter.
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.	In Progress A consulting psychiatrist was hired on June 10th. The NCI has identified at least 4 CDEs in the region. We will continue to explore a CDE consult agreement. The NCI is working with a representative from St. Joes to develop training resources and EMR templates for the 5 A's of tobacco control.	In progress The consulting psychiatrist continues to serve the IMPACT Model sites. The NCI launched a CDE Incentive Program on 9/30 to assist partners with the growth or recruitment of CDEs. We will also be developing an RFP for partners in efforts to ensure a CDE is included on PCP interdisciplinary teams for project 3ci. We continue to work with St. Joes on patient engagement, training resources and EHR templates for the 5 A's of Tobacco control and we have distributed resources/information for chronic disease self management and the NDPP. We will continue to explore ways to incentivze patients to complete programs such as the NDPP.
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**	**DY2, Q1 Update**	
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).	In Progress 13 have completed the PCMH content expert training. 50 partners completed the IMPACT Model webinar with the University of Washington AIMS Center. 5 individuals have been trained as Depression Care Managers and 3 are in the process of completing the training. 4 primary care practices including physicians, nurse practitioners, care managers and a psychiatrist (approximately 25 total) will complete a full day, onsite training with the University of Washington AIMS Center on July 8th.	In progress Approximately 40 people from the PCPs attended a HANYS PCMH training/conference at the Edgewood Resort on 9/30. IMPACT Model work is noted above. Additionally, 10 individuals are expected to complete the chronic care professional training program in December with an additional 25 individuals to commence on Oct. 12th.

B2 DY3	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.	In Progress The Medical Management Committee agreed upon and approved standardized, evidence-based protocols for blood pressure screenings. A webinar and training materials are being developed and will be launched within the next month.	In progress The Medical Management committee approved protcols this quarter for medication management for project 3ai and for care transition protocols across the region for project 2biv. Over 230 individuals have completed the Blood Pressure Measurement training in this quarter.
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.	In Progress Protocol development is underway. Once adopted, appropriate partners will be trained. The NCI Board approved moving forward with a contract for a Population Health Management Tool (Light Beam). We hope to sign a contract this month and then move forward with building interfaces.	In progress The LightBeam contract was signed. Implementation is on track with 80% of the interfaces going live and valid within 120 days of signed contract. The care management functionality of the system will be discussed in the future. Lightbeam will aggregate data from multiple sources: CMS Medicare claims file (currently loaded into the system - working out attribution with the patient roseter- financial and clinical data that was billed), clinical interfaces with primary care offices (clinical data) and hospitals (inpatient admissions, discharges and ED visits), and Medicaid Claims (in the future). PMO office staff are being
GOAL C: ENSURE EFFECTIVE, SMOOTH, SYSTEMATIC AND SECURE CARE MANAGEMENT/TRANSITION **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**	**DY2, Q1 Update**	
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.	In Progress Protocol development is underway. The Care Connections Committee has identified key components of the protocol and have just completed an IT feasibility assessment related to the draft protocol. Once adopted, the appropriate staff will be trained. Subject Matter Experts have been identified for the following care settings: primary care, hospital, community-based and nursing home. These experts have been instrumental in the development of protocols.	In Progress Standardized, regional care transition protocols were reviewed and approved by the following governance bodies within NCI: Care Transition Committee, HIT Committee, Medical Management Committee and Board. Meetings to review the protocols and key timelines were held with each primary care practice, each hospital and then two group meetings (one in Jefferson County & one in St. Lawerence County) with receiving entities (clinics, behavioral health, health home, home care, nursing homes and CBOs). Also the NC launched an Intro to the Medicaid Health Home training video and a Protocol training video via SurveyMonkey. Hospitals reviewed, approved and adopted the protocols this quarter. Protocol training for staff also took place this quarter. Policies and procedure development is underway with implementation timeline on track in alignment with 2biv plan.
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.	Ongoing The Care Connections Committee, Finance Committee and NCI Board have approved a budget to resource hospitals and primary care clinics with care management dollars. The NCI is currently developing MOUs for identified entities who are eligible for care coordination dollars. Additionally, the NCI is working to develop a plan to resource community health workers, patient navigators and peer supports. The NCI developed a Care Coordination Certificate Program in partnership with SUNY Jefferson and SUNY Canton. 39 students completed the program in cohort 1 and 40 students are enrolled in cohort 2. Additionally, 13 individuals completed the Chronic Care Professional Training and 10 more are in the process of completing the training.	Ongoing MOUs were developed, distributed and duly executed with the purpose of resourcing hospitals and primary care offices for care management. These funds are deliverable based and the timeline is in alignment with task deadlines associated with DSRIP projects. First payments went out to eligible partners. The NCI Care Coordination Certificate Program continues, with administrative responsibilities being transferred to SUNY Canton and SUNY Jefferson this quarter. 40 students completed cohort 2. Cohort 3 begins in Oct. at JCC and in Nov. at Canton. Marketing and recruitment is underway. 10 individuals are scheduled to complete the Chronic Care Professional training in Dec, with another 25 scheduled to begin on Oct. 12th.

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.	Ongoing Protocol development is underway. Each partner entity participating in project 2biv received an implementation plan indicating that they must identify and refer health home eligible patients. This will be incorporated into the standardized protocols as well. The number of health home downstream providers has increased based on the increase of referrals and utilization of the health home. Downstream providers in Jefferson County include: ACR Health, Cerebral Palsy Association of the North Country, Children's Home of Jefferson County, Credo Community Center, HCR Care Management, and Transitional Living. Downstream providers in St. Lawrence County include: ACR Health, Cerebral Palsy of the North Country, HCR Care Management, St. Lawrence County Community Services, Transitional Living Services and United Helpers. Finally, Downstream Providers in Lewis County include ACR Health, Cerebral Palsy Association of the North Country, HCR Care Management and Transitional Living Services. Embedded care managers are also placed at Samaritan Medical Center, Dr. Meny's practice, the North Country Family Health Center, Watertown Urban Mission and Jeff. County Public Health. Claxton Hepburn Medical Center and Carthage Area Hospital are also exploring the embedded care manager opportunity.	Complete Standardized, regional care transition protocols were reviewed and approved by the following governance bodies within NCI: Care Transition Committee, HIT Committee, Medical Management Committee and Board. Meetings to review the protocols and key timelines were held with each primary care practice, each hospital and then two group meetings (one in Jefferson County & one in St. Lawerence County) with receiving entities (clinics, behavioral health, health home, home care, nursing homes and CBOs). Also the NC launched an Intro to the Medicaid Health Home training video and a Protocol training video via SurveyMonkey. Hospitals reviewed, approved and adopted the protocols this quarter. Protocol training for staff also took place this quarter. Policies and procedure development is underway with implementation timeline on track in alignment with 2biv plan. The North Country Health Home has signed agreements with all the hospitals which allows the care managers access to the patients prior to discharge. Finally, the health home has embedded care managers in public health, primary care offices and 3 of the 6 hospitals thus far. NCI continues to assist with the training of these care managers through the North Country Care Coordination Certificate Program.
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.	Complete Approximately 85 individuals have been trained in the PAM.	Complete Another 75 individuals completed PAM training in this quarter.
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.	Complete Approximately 25 individuals completed the Community Health Worker training. The NCI ha identified "hot spots" within the community. The Seaway Valley Prevention Council and various CBOs conducted 12 focus groups in these hot spots. Medicaid beneficiaries, Medicaid eligible individuals and the uninsured population shared their thoughts and ideas related to health care. The Seaway Valley Prevention Council, the RFP awardee, provided a summary o the findings to the Health Literacy and Cultural Competency Committee. Common themes were incorporated into the Health Literacy and Cultural Competency strategic plan & training and education plan. We will continue to monitor and assess initiatives related to this, utilizing two-way communication strategies within these hot spot communities. Additionally, the NCI is developing a plan to resource care management dollars for community health workers, patient navigators and peer supports.	Complete The NCI launched a Health Literacy, Cultural Competency and MEB training video this quarter which incorporated many of the themes that surfaced as a result of the community forums. Patient Engagement materials such as Ask Me 3 are also being developed to enhance two-way communication between patients and providers.
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.	Ongoing All partners will complete compliance training by June 30th under the instruction of the NCI Compliance Officer. Training objectives include: why you need a compliance plan including the following components: 8 elements of compliance, fraud, waster and abuse, false claim act, code of conduct, reporting. Additionally, partners will receive HIPAA, Privacy & Security Training via a PPS provided webinar/HIPAA training slides or practice equivalent training (partners must provide training materials). Finally, partners will be trained on workflow as it relates to EHR screen shots, acquiring patient engagement numbers and/or adopted protocols.	Ongoing All partners are being signed up for direct messaging either through HealtheConnections or their vendor-specific EHR systems (care managers are a targeted focus area for this work). A PPS inventory will be created and distributed utilizing this information once everyone is set up. Direct messaging fact sheets and information has been shared with partners through meeting packets, training videos and in Fast Facts. HealtheConnections has conducted on site training for various partner facilities and the NCI is working to ensure RHIO Administrators at each site are aware of their role and responsibilities within their individual facilities. Additionally, the NCI has partnered with The Compliancy Group to provide a web-based HIPAA Compliant solution to partners free of charge. The Compliancy Group provides a compliance coach to walk through the entire process and provide assistance to the partners in regards to HIPAA. The NCI is currently working to get appropriate partners signed up for these services.

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.	In Progress The FDRHPO developed a Remote Monitoring User Collaborative and is hosting monthly meetings. The plan is to develop and increase process development with engaged hospitals, primary care providers and specialists. Two established partners include Jefferson County Public Health and St. Lawrence Valley Hospice. The internal team (through a rural health network grant) is currently working to secure a contract with our preferred vendor, Vivify. Upon contract execution, trainings will be conducted for healthcare professionals who chose to adopt and implement the telehealth devices.	In Progress A contract has been secured with Vivify. The implementation is ongoing with Jefferson County Public Health. The team has been identified and assigned roles (clinical champion, executive champion). The units have been ordered and should be arriving in DY2 Q3. Training will also take place in Q3.
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.	Ongoing The NCI Project Advisory Committee is advising the PPS on project plans and includes representation from PPS partners as well as workers and relevant unions to include the Civil Services Employees Association (CSEA), the NYS Nurses Association (NYSNA), and the Service Employees International Union (SEIU). As members of the PAC, these union representatives offer recommendations and feedback on PPS initiatives and are involved in various facets of the developing project plans (i.e. training initiatives that are designed to meet the needs of the transforming system) to include the integrated workforce strategy. They have been consulted and will continue to remain engaged in the implementation and oversight of th project plans.	Ongoing Continuation of efforts as outlined in DY2 Q1.
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.	Ongoing NCI continues to leverage existing partnership with the FDRHPO and NAHEC to increase awareness of health education pathways, job placement and career exploration resources, and clinical rotations. IHA has conducted our compensation and benefits analysis and continues to serve as a daily resource as it relates to DSRIP workforce related activities. The NCI has chosen not to pursue a contractual agreement with HealthStream, but rather to develop other internal strategies to deliver key training programs for DSRIP (i.e. development of DSRIP 101 using SurveyMonkey or using Vimeo to create and launch a Cultural Competency video). The NCI also worked with SUNY Jefferson & SUNY Canton to develop the North Country Care Coordination Certificate Program. NCI will continue to work with partners to identify, and when feasible, create new programs to meet the needs of the transforming system.	Ongoing Continuation of efforts as outlined in DY2 Q1. To date, the following NCI customized training videos have been launched via SurveyMonkey: DSRIP 101; Intro to Medicaid Health Home; Blood Pressure Measurement; Health Literacy, Cultural Competency & MEB; Performance Reporting (Task reporting for DSRIP POC); and Standardized Protocols for Care Coordination. The NCI continues to leverage partnerships with the Community Colleges in the area to offer appropriate, DSRIP related training opportunities such as the Bachelors of Social Work, the Masters of Social Work, NP, HIT, Care Coordination, etc.
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.	Complete In consultation with workforce partners, the NCI outlined the current state of the workforce against the future needs to identify new hire or new training requirements. The transition roadmap, the compensation and benefits report and a detailed assessment of the job titles by licensure requirement were used to inform this process.	Complete See DY2 Q1
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.	Ongoing The NCI continues to monitor and assess the needs of the workforce. Various training opportunities have and will continue to take place including: PAM, Community Health Worker, Health Literacy, Depression Care Manager, Chronic Care Professional, Care Coordination Certificate, HIT, PCMH, Cultural Competency, MEB health promotion, prevention and treatment, etc. The NCI will work with partners such as NAHEC and FDRHPO to develop new programs as identified/needed.	Ongoing Continuation of efforts as outlined in DY2 Q1.

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.	Ongoing In consultation with workforce partners, the NCI continues to monitor the workforce, identify gaps and leverage resources based on community need. To date, existing program offerings meet the needs of the region as it relates to DSRIP. Some trainings are still under development but will depend on the adoption of protocols by the committees and boards.	Ongoing Continuation of efforts as outlined in DY2 Q1.
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.	Ongoing The FDRHPO and NAHEC continue to identify, support and monitor local students who are engaged in the pipeline. While this is a long-term strategy, we are beginning to see successes from years past. For example, one of the students we worked with while she was in high school has recently come back to the area as a PCP via the NCI Provider Incentive Provider Program.	Ongoing 64 students completed MASH Camp this summer. 3 students completed the Job Shadow Program and 4 additional students are scheduled to begin the Job Shadow Program next quarter. Classroom presentations have been scheduled for next quarter in 10 high schools in the region. Additionally, during the next quarter, FDRHPO's Outreach Coordinator will participate in Higher Ed Day at JCC and Workforce 2020.
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.	Ongoing The compensation and benefits analysis for year 1 is complete. Findings are consistent with strategies noted throughout this roadmap. NCI will continue to monitor changes over the course of DSRIP.	Ongoing The NCI has utilized the compensation and benefits data to help inform partners of average salary ranges specific to newly defined roles at facilities such as care coordinators. Community-based care managers, community health workers, peer supports and patient navigators surfaced as areas of need. The NCI is resourcing partners with deliverable based funds to assist with the training, education and tools needed to successfully prepare and utilize these roles for project related tasks. Other areas include CDEs, Home Health Aids, CNAs, LCSWs, NPS and PCPs. This quarter, the NCI launched a CDE and LCSW incentive program for the growth and/or recruitment of these professionals. NCI/FDRHPO is partnering with BOCES, local hospitals and the community colleges to address the Home Health and CNA needs of the region. JCC offers a NP program through Upstate and the Provider Incentive Program continues to resource dollars to NCI Partners for the recruitment of PCPs, NPs, PAs, Psychologists, Psychiatrists and Dentists. 10 additional awards were announced in DY2 totaling approximately $1.5M for 7 PCPs, 1 PA, 1 Psychologist and 1 Psychiatrist (in addition to DY1 awards totaling $1.2M for 2 NPs, 4 PCPs, 2 PAs, 1 Psychologist, 1 Psychiatrist and 2 Dentists).
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.	Ongoing The NCI will continue to monitor the status of the workforce and develop new programs where gaps exist. This roadmap will be used as a guide for the process.	Ongoing Continuation of efforts outlined in DY2 Q1 and noted above through other strategies.