Workforce Transition Roadmap Report

BRONX PARTNERS FOR HEALTHY COMMUNITIES

Delivery System Reform Incentive Payment Program

Workforce Strategy

Draft Issued: September 30, 2016

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Executive Summary

The overall goal of the Delivery System Reform Incentive Payment ("DSRIP") program is to reduce avoidable hospitalizations and ED visits by the Medicaid population in New York State ("NYS") by 25% through the transformation and redesign of the existing health care system.

As part of The Bronx Partners for Healthy Communities ("BPHC" or "the PPS") participation in the DSRIP program and completion of certain Workforce Strategy Milestones, The Bronx Partners for Healthy Communities ("BPHC") engaged BDO Consulting ("BDO"), as its workforce vendor, to assist in the development of a workforce transition roadmap that details the PPS's plans for achieving the target workforce state by the end of the five year program.

The BPHC workforce transition roadmap was developed in collaboration with key PPS stakeholders as well as Workforce Consortium members (OneCity Health PPS, Community Care of Brooklyn PPS, NYU Lutheran PPS, and Bronx Partners for Healthy Communities PPS) to ensure that workforce needs and impacts of the DSRIP projects were being evaluated consistently across the PPSs and were comprehensive of the PPS's specific service area. Collaboration took place through several in person working sessions and conference calls with representation from multiple PPS Leads. BPHC PPS stakeholders, including DSRIP Workforce lead, Project Managers and Clinical Workgroup Members providing significant input regarding project implementation strategies and timing of potential staffing impacts to inform the development of the PPS's transition roadmap.

The workforce transition roadmap aggregates findings from the PPS's current workforce state, target workforce state, and workforce gap analysis to detail the PPS's plans and timeline for achieving the target state by 2020.

The workforce transition roadmap will serve to guide the PPS in bridging identified workforce gaps and achieving its defined target workforce state by addressing the workforce implications of the DSRIP program. The transition roadmap provides an overview of the PPS's plans to recruit, train and redeploy the workforce over the five-year DSRIP program to better meet the needs of the population the PPS serves.

I. Workforce Transition Roadmap Overview

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

The workforce transition roadmap, as part of the DSRIP Workforce Strategy Milestones, is intended to define the Bronx's Partners for Healthy Communities plans for achieving the defined target workforce state by addressing workforce implications that the DSRIP program and other market forces will have on the PPS's current workforce as well as the need for new positions and skill sets. The workforce transition roadmap will be utilized to guide the PPS's overall workforce strategy throughout the five year program. In doing so, the workforce transition roadmap will detail work steps and target dates to effectively address projected timing of workforce impacts as a result of system transformation and implementation of clinically integrated programs including addressing the ongoing workforce recruitment, training, and redeployment needs of the PPS. The workforce transition roadmap considers any implications, issues and factors identified within the Gap Analysis Report and works to bridge the identified gaps to meet the needs of the PPS. The PPS's workforce transition roadmap was created in collaboration with the PPS's Workforce Governance Body.

The approach utilized to develop The BPHC workforce transition roadmap as well as the PPS's strategy and plans for bridging the identified workforce gaps have been detailed within the body of this report.

A. Workforce Transition Roadmap Approach

To support the development of a comprehensive workforce strategy, during the initial project planning and implementation planning phases, the BPHC PPS conducted an initial workforce survey to assess existing provider and staffing capacity. Building on this preliminary analysis in the early DSRIP program phases, the PPS conducted a current workforce state survey, as previously described and held discussions with key PPS stakeholders to further identify PPS Partners' current and anticipated staffing needs related to DSRIP program implementation. Findings from these discussions combined with the projected workforce staffing impacts as part of the PPS's target workforce state, were leveraged to determine potential workforce displacements, new staffing requirements, and new job functions and skill set requirements.

The Bronx Partners for Healthy Communities workforce transition roadmap was developed combining findings from the PPS's Current Workforce State Report, Target Workforce State Report, and Gap Analysis Report. Report details as well as the approach utilized to define the

PPS's current and target workforce states and workforce gaps are detailed in the following sections.

B. Current Workforce State Approach and Summary Findings

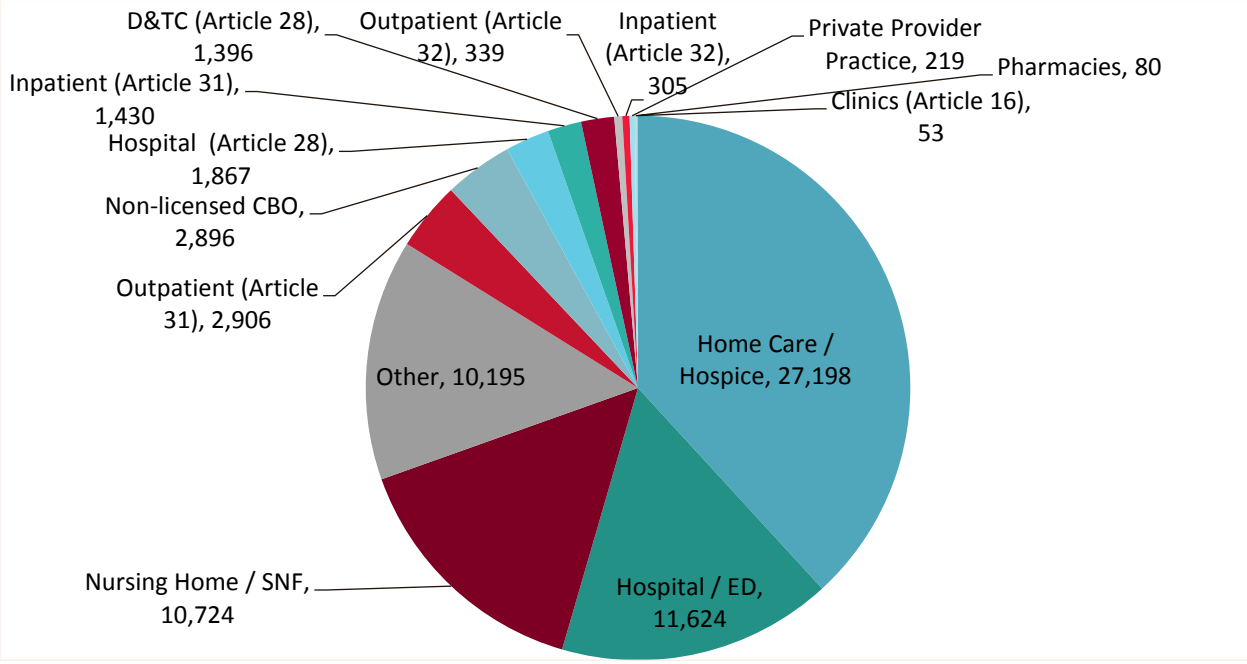
In order to assess the current workforce state, Bronx Partners for Healthy Communities engaged BDO and the Center for Health Workforce Studies ("CHWS") to collect and synthesize information pertaining to the current workforce including staffing, infrastructure, culture, strengths and challenges. The current state workforce assessment included the development and distribution of a survey to its PPS Partners to collect workforce data pertaining to the PPS's network, and additional data requests and stakeholder engagement sessions focused on obtaining additional pertinent data on the PPS workforce.

PPS Partners were requested to provide workforce data by job title pertaining to total headcount, full time equivalents ("FTEs"), number of vacancies, average hourly wages, fringe benefits (%), and collective bargaining agreements as well as data pertaining to temporary and agency staff including total headcount, hours, and FTEs. The survey also included sections for PPS Partners to indicate minimum requirements for certain job titles pertaining to degrees / education and years of experience. The partners surveyed were asked to only provide relevant workforce data for individuals working within the PPS's geographic region and thus serving the attributed Medicaid population. The purpose for collecting this level of workforce data is to establish a baseline or current state of the PPS's workforce and compare these findings to the projected target workforce state to identify workforce gaps between the two.

A total of 152 surveys were completed and submitted by 114 organizations within the BPHC PPS with an overall survey response rate of 56% by the PPS's Partners. Thus, the current workforce state data provides an approximate representation of the PPS's current workforce state detailing reported workforce data across facility types and job titles by headcount, FTEs, and FTE vacancies as well as agency and temporary staff by headcount, hours, and FTEs, but does not provide workforce data that is comprehensive of the entire workforce within the PPS. The following pie charts provide an overall summary of the BPHC PPS's reported workforce data which includes a total headcount of 71,232 individuals or 48,030 FTEs.

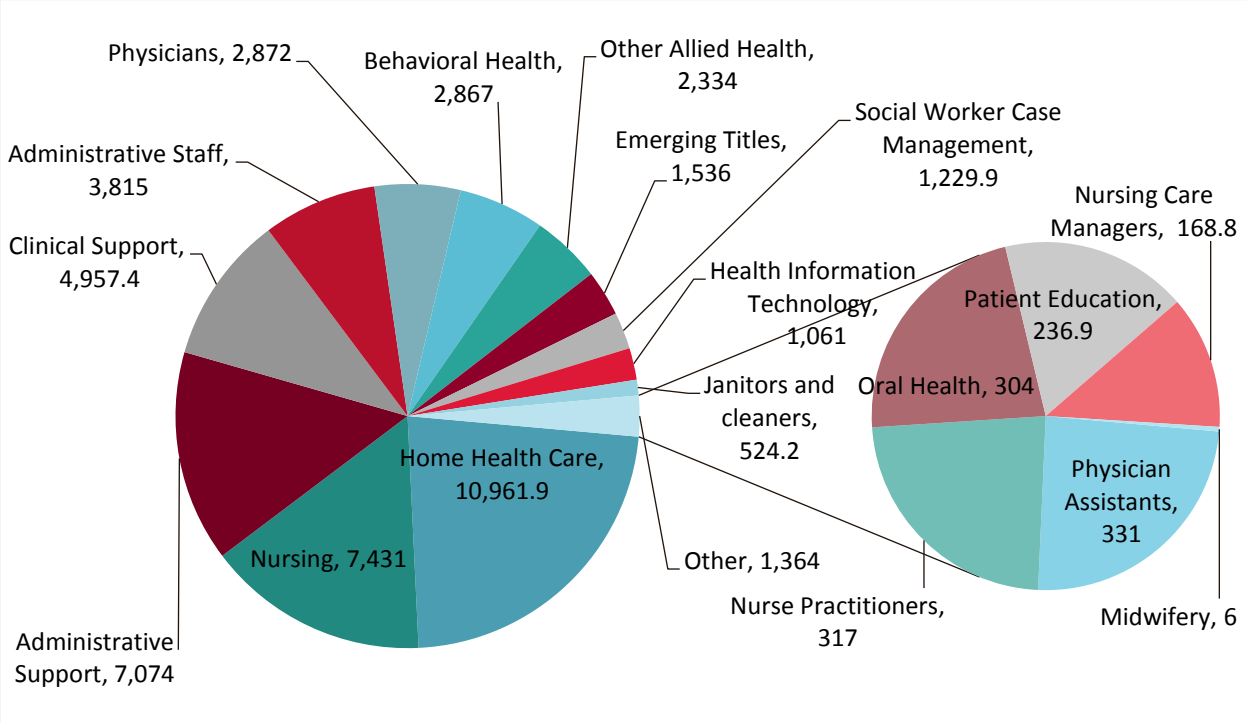
As detailed in *Exhibit 1*, which describes the total reported workforce across all Facility Types (by headcount), 38% of the PPS's workforce is represented by staff employed by Home Care Agencies / Hospices. The next largest numbers of workforce providing care in the PPS are at Hospital / ED, Nursing Home / Skilled Nursing Facilities ("SNFs"), "Other" Facility Types and Article 31 Outpatient Services for Mentally Disabled.

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



As detailed in *Exhibit 2*, which reports the total reported workforce across all DOH Job Categories (by FTEs), nearly 23% (10,962 FTEs) of the PPS's reported FTEs are represented by the Home Health Care Job Category which contains titles such as Certified Home Health Aides, Personal Care Aides (Level I and Level II), and "Other" job titles. In addition to Home Health Care jobs, the aggregated survey data indicated that the PPS is also largely comprised of Nursing (7,431 FTEs), Administrative Support (7,074 FTEs), Clinical Support (4,957 FTEs), and Administrative staff (3,815 FTEs) jobs.

Exhibit 2: Total Reported PPS Workforce by Job Title (FTEs)



Based on the PPS's current workforce state data Home Health Care job titles were the most represented jobs within the PPS with nearly 11,000 FTEs reported followed by Nursing, Administrative Support, Clinical Support and Administrative Staff positions which combined account for over 70% of the reported job categories. In addition The PPS Partners also reported on FTE vacancies occurring within the PPS's workforce. Based on the data provided, approximately 25% of FTE vacancies are represented within the PPS's nursing positions with 773 FTE vacancies reported, followed by Administrative Support and Behavioral Health staffing vacancies.

The PPS also collected additional workforce data including minimum job requirements related to minimum years of experience and minimum degree requirements, CBA status, and Agency/ Temporary Staff for specific job titles to further inform the PPS's workforce planning efforts throughout the DSRIP program.

C. Target Workforce State Approach and Summary Findings

The target workforce state developed for the BPHC PPS identifies the PPS's projected workforce needs by the end of the DSRIP 5 year program in 2020. Project impacts from the target state report are summarized within this section and further detailed in the Target State Report.

The BPHC PPSs target workforce state was conducted in collaboration with key PPS stakeholders as well as Workforce Consortium members (OneCity Health PPS, Community Care

of Brooklyn PPS, NYU Lutheran PPS, and Bronx Partners for Healthy Communities PPS) to ensure that workforce needs and impacts of the DSRIP projects were being evaluated consistently across the PPSs in order to develop a comprehensive analysis of each PPS's target workforce state in its corresponding service area. BPHC PPS stakeholders, including DSRIP Workforce Lead, Project Managers and Clinical Workgroup Members, provided significant input into the DSRIP project impacts and assumptions made to inform the projection of the PPS's target workforce state.

As the DSRIP program progresses over five years, the demand for health care workforce within the BPHC PPS network will continue to evolve as DSRIP projects are implemented, impacts of those projects are realized, and as external factors, such as demographic and market changes, outside of the DSRIP program evolve.

Exhibit 3 below shows the PPS's estimated target workforce state staffing impacts by 2020, taking into account the anticipated results of the DSRIP program as well as anticipated demographic and health care coverage changes independent of DSRIP across the PPS's care settings and key job categories. The following summarizes the projected impacts to the PPS's workforce based on projected modeling outputs.

The estimated workforce demands, independent of the DSRIP program, are projected to grow by approximately 620.5 FTEs overall. The projected impact of DSRIP implementation is estimated to add another approximately 212 FTEs by 2020. This will result in a total estimated increase in demand of 832.5 FTEs overall that will create or increase gaps or shortages that already exist in the BPHC PPS workforce.

The greatest projected workforce impacts, taking into account both DSRIP and non-DSRIP related impacts, are estimated to take place among non-RN care coordinators/navigators, Primary Care Providers ("PCPs") and medical assistants that account for about 61% of the total impacted increased demand.

As previously noted, *Exhibit 3* details the projected workforce impacts of the PPS's future state in 2020, while *Exhibit 4* summarizes the reported current workforce state by reported FTEs by job titles for comparison purposes.

Exhibit 3: BPHC PPS Summary of Projected DSRIP Staffing Impacts

	Target State Analysis		
Setting and Job Category	**Non-DSRIP Impacts**	**DSRIP-related Impacts**	**Total Impacts**
Primary and Community-Based Settings			
Primary Care Providers	55.5	40.5	96
Cardiologists	8.5	4.5	13
Endocrinologists	2.5	2.5	5
Psychiatrists / Psychiatric Nurse Practitioners	8	4	12
Psychologists	37	-	37
Clinical Social Workers	-	42	42
Registered Nurses	28.5	-	28.5
Licensed Practical Nurses	9	24	33
Nurse Aides / Assistants	8.5	0	8.5
Medical Assistants	97	47.5	144.5
Administrative Support Staff	103	71	174
Emergency Department			
Emergency Physicians	2.5	-14.5	-12
Nurse Practitioners & Physician Assistants	1.5	-3	-1.5
Registered Nurses	20.5	-52.5	-32
Hospital Inpatient			
Hospitalists	3.5	-18	-14.5
Registered Nurses	160	-220	-60
Licensed Practical Nurses	21	-14.5	6.5
Nurse Aides / Assistants	36.5	-64	-27.5
Pharmacists	17.5	1	18.5
Care Managers / Coordinators / Navigators / Coaches			
Nurse Coordinator Leaders	-	46	46
RN Care Coordinators	-	13	13
Non-Nursing (Community Health Workers)	-	266	266
CVD Educators	-	15.5	15.5
Diabetes Educators	-	13	13
Asthma Educators	-	8	8
Total FTEs	**620.5**	**212**	**832.5**

Exhibit 4: BPHC PPS Current State Reported Workforce by Target State Corresponding Job Titles

Job Category	**Reported Workforce (FTEs)**
Primary and Community-Based Settings	
Primary Care Providers	331.8
Cardiologists	82.2
Endocrinologists	12
Psychiatrists / Psychiatric Nurses	250.2
Psychologists	125.4
Clinical Social Workers	1,339.5
Registered Nurses	4,352.3
Medical Assistants	10.3
Administrative Support Staff	1,627.8
Hospital Inpatient & Emergency Department	
Emergency Physicians	103.6
Primary Care Physicians	33.7
Specialists (except Psych)	846.6
Residents and Fellows	1,189
Physician Assistants	285.5
Registered Nurses	2,501.8
Licensed Practical Nurses	180.6
Nurse Aides	5
Nurse Practitioners	231.9
Care Managers / Coordinators / Navigators / Coaches	
Nurse Coordinator Leaders	48.1
RN Care Coordinators	120.6
Care Coordinators (non-RN)	929.3
Diabetes Educators	11
Asthma Educators	4.5
Total FTEs	**14,622.7**

D. Gap Analysis Approach and Summary Findings

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

Overall DSRIP project workforce impacts are projected to be the most significant for emerging title positions in the area of Care Management. Based on the current workforce state reported by the PPS Partners, the PPS's overall existing moderate vacancies amongst nursing will normalize some of the project workforce turnover. In specific instances where high workforce vacancies are reported, the impacts of DSRIP projects can work to either potentially minimize or further impact gaps that currently exist within the PPS's workforce.

Following a five year implementation of the DSRIP program, due to the combined impact of the program as well as non-DSRIP related impacts, the PPS's workforce is projected to experience potential impacts in demand for health care providers including Primary Care Providers ("PCPs"), nursing positions, Clinical Support, and Administrative Support positions.

Within the primary care / outpatient settings, the PPS's workforce gap is due to the anticipated increase in demand for PCPs as patients are redirected to seek care outside of the Emergency Department ("ED") through the combined impacts of the ED Triage project and increased referrals from the co-location of primary care and behavioral health services. Based on the PPS's reported current workforce state data, a vacancy rate of approximately 8% exists for PCPs across the PPS's network, which is above a rate that might be attributed to normal turnover. Further, the growth in overall demand for Physicians in NYS is forecasted to outpace growth in the current supply of Physicians. Given this workforce supply factor combined with the anticipated increase in demand for PCPs as well as current reported vacancy rates, the PCP gap in the PPS's workforce is likely to be further impacted over time as project goals are realized.

Within the ED / inpatient settings, the PPS is projected to experience a decrease in demand for ED Physicians as well as a decrease in demand for nursing positions including Nurse Practitioners ("NPs"), Physician Assistants ("PAs"), and Registered Nurses ("RNs") as patients seek care outside of the ED / inpatient settings as a result of the DSRIP program. However, the projected decrease in demand for ED / inpatient workforce is likely to be offset by factors unrelated to the DSRIP program such as population growth in the Bronx. For example, given ongoing changes within the Bronx's market, the PPS does not anticipate a decline in nursing positions but rather an increase in demand, particularly as some positions are redeployed to the outpatient setting or used to fill the current existing nursing vacancy rate in the PPS of over 10%.

As a result of anticipated project impacts for the co-location of primary care and behavioral health services, an increase in demand for Behavioral Health positions, specifically Licensed Clinical Social Workers, is projected. Additionally, based on the current workforce state data reported, there are significant vacancy rates for Behavioral Health positions currently within the PPS's network. As a result, gaps in the PPS's Behavioral Health workforce exist and are likely to be further increased as a result of project impacts.

Additionally, with the anticipated increase in community-based health care coordinators and navigators as a result of the care transition projects, demand for Community Health Workers, Care Managers and Coordinators is projected to increase. Based on the current workforce state data, the vacancy rate reported across the PPS's network for Patient or Care Navigators and Community Health Worker positions is rather minimal, but many such positions do not currently exist within the PPS network. Given the anticipated increase in utilization of patient navigation services and the overall increase in demand for care management services throughout NYS, these factors are likely to further expand the existing gap and potentially raise difficulties in recruitment for such positions.

II. Workforce Transition Plan

A. Central Services Organization and Workforce Governing Body

The BPHC Central Service Organization (CSO), based out of SBH Health System, oversees the PPS in implementing 10 DSRIP clinical projects and multiple work streams including workforce and cultural responsiveness. The CSO facilitates project planning and implementation along with multiple groups consisting of representatives from partner organizations. The CSO also manages the resources, performance and reporting to the State for BPHC. With the support of the Project Advisory Committee (PAC), consisting of the BPHC Executive Committee and four subcommittees including Workforce, the CSO ensures that the PPS initiatives create a sustainable and integrated delivery system that integrates social and health care services for Bronx residents.

The Executive Director of the Bronx Partners for Healthy Communities CSO has provided leadership to a consortium of the four PPSs in the Bronx, whose goal it is to exchange information and develop synergies between the four organizations which frequently share members. Selecting and working together with one workforce vendor is such an initiative.

B. Care Protocol Development & Training

The development of care protocols and training of frontline staff will be a key component of DSRIP implementation and the workforce transition. The Central Services Organization will assist in the development of clinical protocols and training as needed and coordinate workforce planning. To support training development and implementation, BPHC will collaborate with 1199 Training and Employment Fund (TEF) and other contracted vendors that will serve as strategic advisors to the PPS around training and other workforce planning efforts. BPHC will also utilize Montefiore Medical Center's expertise and resources to train new and existing staff for emerging roles. In addition to the partners mentioned, BPHC also is contracting with community-based organizations to perform training and support program deployment. Such organizations include a.i.r. nyc, a home-based asthma self-management services provider and Health People, which will train peer educators in deploying the Stanford Chronic Disease Self-Management and LEAP amputation prevention patient engagement programs.

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

C. Expansion of Care Management

I. Project 2.a.iii: Health Home at Risk Intervention Program

The purpose of the Health Home at Risk (HHAR) project is to provide proactive care management to patients who are ineligible for services from Health Homes under the current New York State Department of Health (NYSDOH) Health Home functional requirements and standards. Through this project, BPHC and its partners will work to extend care management services to individuals who have a single chronic disease, who, based on their history of care plan adherence and/or social needs, are identified as at-risk. In particular, these include patients with cardiology and respiratory conditions, who alone accounted for 40% of readmissions to SBH Health System and Montefiore Medical Center (MMC) in 2012.

While the care coordination roles/functions of the HHAR care managers will be similar to those of the Health Home Care Managers, it is anticipated that the services may be at a lower intensity.

In addition, BPHC and its partners will facilitate communication and coordination between primary care providers and providers of HHAR services, and enhance the integration of social services into primary care; efforts which will help serve to drive down ED and hospital utilization.

Workforce Impacts

Using the IHS Health Care Demand Microsimulation Model (HDMM), preliminary estimates suggest that, in comparison to non-participants, participant's experience a decline of 3.7% in inpatient days, 4.2% decline in ED visits, 1.8% increase in primary care visits and a 2% increase in specialty outpatient visits.

Thus the distribution of staffing impacts by care settings and job titles most likely to be affected by 2020 include an infusion of 235 care coordinator FTEs and 46 nurse coordinator leader FTEs that may potentially be required to support the level of care management called for under this initiative to serve 57,600 patients. In addition within the In outpatient/office settings, a possible increase of 11,500 primary care visits and 5,800 specialist visits could increase demand for primary care providers by 8-9 FTEs, specialist providers, direct medical support by about 13 FTEs and direct administrative support by 6-7 FTEs.

In the ED setting, a potential decline of 5,800 visits could reduce demand for emergency physicians modestly and reduce demand for RNs by about 9-10 FTEs. Moreover, in the inpatient setting, a potential decline of 17,300 inpatient days could contribute to a large decrease in FTE RNs (-103), nurse aides (-34), LPNs (-8) and hospitalists (-8).

The analysis suggests that project 2.a.iii's greatest impact on the PPS workforce will be on the FTEs associated with care coordinators, along with increases in office-based primary care and specialty care providers and direct support. Workforce FTEs in the ED and inpatient

settings are anticipated to decline, with a greater impact on the inpatient setting and specifically on RNs, owing to this patient population achieving better control of their health.

Training

BHPC will be implementing at Health Home At-Risk Intervention Program with the objective of expanding access to high quality community primary care and support services, increasing referrals to existing Health Home care management services for eligible patients, proactively coordinating care for higher risk patients not currently eligible for Health Homes, and enhancing communication and coordination between medical and social services providers in an integrated delivery system.

The program will deliver targeted and integrated services for a patient population falling between the patient-centered medical home and the Health Home general population, i.e., patients with a single chronic condition, but at risk for developing another. The program will also intervene early to stabilize patient health status and reduce health risks /avoidable service utilization, embed care managers in primary care practices to provide care management services, increase connections to community-based services to address social determinants of health, and ensure closed-loop referral tracking.

By going beyond the traditional lecture-based learning, this program strengthens students' critical thinking skills by engaging them in rich discussion, individual exercises and group activities. Upon completion of this program, participants will be prepared to be strong, productive members of healthcare teams that provide coordinated, patient-centered care.

Over the course of The Care Coordinator 9-week Training Program, participants will be introduced to topics such as Health Literacy, Communication and Education, Cultural Competence and Cultural Humility, Strategies for Behavioral Change Motivational Interviewing, and Best Practices for Conducting Assessments and Care Planning.

The Primary Care Development Corporation will be the vendor for the Comprehensive Care Coordinator Training. The National Council for Behavioral Health is the vendor for the Motivational Interviewing training. The vendor for the Care Management for SMI/Substance Users has been identified by not yet confirmed. In addition, there will be a short training for Care Management Supervisors in which the vendor will also be the National Council for Behavioral Health. Two other vendors will also help conduct the training: New York Association of Psychiatric Rehabilitation Services) as well as Lehman College.

The trainings will focus on: Intro to New Models of Care; Working in Interdisciplinary Team; Person-Centeredness, Communication and Health Literacy; Chronic Disease and Social Determinants of Health; Assessment, Care Planning and Care Management; Transitions of Care and Closed Loop Referrals; Cultural Competence; Ethics and Professional Boundaries; Quality Improvement; Community Orientation; and Health IT, Documentation and Confidentiality.

There will be an alignment and referral among the Health Home at Risk program and the Asthma services. Asthma patients eligible for a.i.r Bronx services will almost certainly be

eligible for care management. Sites must coordinate with a.i.r. Bronx team; Care Coordinator is point of contact. To streamline, referrals to a.i.r. Bronx should go through PCMH Care Coordination team. Care Coordination teams will confirm eligibility and refer patients to a.i.r Bronx using closed loop referral tracking and (if possible) warm handoff. When a.i.r Bronx intervention ends, warm handoff to Care Coordinator.

In the transition, these are the activities that are taking place to work towards achieving DSRIP goals from a workforce prospective: Determine care management staffing needs, identify internal candidates, recruit to fill gaps (assistance from CSO provided) and training for individual roles and care teams provided.

II. Project 2.b.iii: ED Care Triage for At-Risk Populations

BHPC's implementation plan for Project 2.b.iii focuses on three phases, including linkage to primary care, linkage to care management, and ED transitions management. BPHC will target patients who visit the ED with non-emergent conditions that could be redirected to a more appropriate setting that also provides a continuum of care. The target patient population modeled is all attributed patients with two or more ED visits within the previous six months (or 4+ in the last rolling 12 months) potentially appropriate for diversion or usually treated and released from the ED. This includes patients with ambulatory sensitive chronic conditions and at-risk patients requiring more intensive ED care management services post discharge.

For patients without a primary care provider presenting with minor illnesses, patient navigators will assist the patient to secure an appointment with a primary care provider who is either Advanced Primary Care (APC) certified or has PCMH 2014 Level 3 recognition. For patients with a primary care provider, patient navigators will assist the member in receiving a timely appointment with their own provider.

Workforce Impacts

By 2020 the net projected PPS impact associated with achieving this model reduction in ED visits may be approximately 19,600 fewer ED visits and an additional 9,800 primary care visits (under our assumption that 50% of diverted ED visits will result in a visit to a PCP).

Examining the FTE effects by setting, changes in utilization suggest that by 2020, the PPS network in ED Settings may require approximately 9 fewer emergency physician FTEs, 32 fewer RN FTEs, as well as slight decreases in nurse practitioners and physician assistant FTEs. And in the office/outpatient settings, an estimated 4-5 additional primary care provider FTEs, 7 direct medical support FTEs, and several additional FTEs in direct administrative support may be required.

Primary Care Provider Workforce

The ED triage project is likely to increase the demand for PCPs by approximately 4-5 FTEs, as many patients will be redirected to a primary care provider, increasing the number of primary care visits by approximately 9,800 visits in the year 2020. As stated previously, the demand for PCPs due to non-DSRIP related impacts is also expected to increase, resulting in enhanced demand for PCPs as a result of this project. The current state workforce data reports a vacancy rate of 8% across the PPS. Thus, the PPS will need to address the increased demand for PCPs from project impacts adding to a shortage that already exists.

Nursing Workforce:

In support of an overarching goal of reducing avoidable ED admissions by 25%, project impacts are likely to result in a significant decrease in the demand for ED providers, particularly with the nursing workforce, as there is an expected decline of 32 RN FTEs. This reduction to the PPS's nursing positions is likely to occur most significantly in DY4, assuming full project implementation and a significant reduction in the number of potentially preventable ED visits by approximately 19,600 visits. However, the projected decrease in demand for nursing positions as a result of the ED Triage project is likely to be offset by market changes as well as by the number of reported nursing vacancies across the PPS.

Within the PPS's inpatient setting, there are 158 reported RN FTE vacancies. Further, the non-DSRIP impact on demand for ED RNs is estimated to be 20-21 FTEs. Thus, the anticipated decline in the demand for ED nurses as a result of DSRIP projects may be balanced by the combined opportunities of vacant positions and increased demand due to non DSRIP-related impacts such as population growth.

Training

BPHC has a contract with CMO, The Care Management Company, as the vendor for planning, training and program implementation consultant on ED Care Triage, as well as Care Transition Projects. Training will take place in phases. SBH Health System training will combine the Ed Care Triage (ED) training and Care Transitions Program (CTP) training so that all team members are cross trained. Montefiore staff will be trained separately for ED and CTP. Training will be staggered based on Go-Live dates and take place site by site for both programs. The transitional plan for the audience at SBH Health System and MMC will include training provided by CMO Care Management Learning and Innovation (CMO CLI) for two groups of new hires, training the trainer incorporated into one of the new hire training sessions, and ongoing training to transition to SBH Training Dept. upon completion of second training session

The ED training schedule will be broken up between a morning session and afternoon session over the course of three days.

III. Project 2.b.iv: Care Transitions to Reduce 30-day Readmissions

The Care Transition project provides for 30-day intensified care management during the transition period after a hospitalization for patients at high risk of readmission due to lack of effective patient adherence, engagement in follow-up care, and other risk factors. The objective of this project is to create as seamless a transition as possible from hospital to community settings in order to reduce the risk of readmission.

At-risk patients will be identified using a standardized risk assessment tool, which will look at frequent admissions and re-admissions in the past year, and patients will be provided with more intensive care management through a two-pronged approach. First, evidence-based care transition models including Project RED, BOOST and others will be enhanced and extended to all PPS hospitals. RED interventions provide comprehensive discharge planning, patient education, and post-discharge patient follow-up using designated discharge advocates who help patients reconcile their medicines and schedule follow-up appointments with their physicians. Second, PCPs and post-acute providers will be used to strengthen the coordination of medical and social services outside of hospitals. Health Homes and CBOs that provide health home –related services will build their relationships with physicians and play an important role in project implementation.

Workforce Impacts

To support the project the PPS will hire, retrain and redeploy clinical (RN, SW and LPN) and non-clinical (unit clerks and/or medical assistants) staff as care managers, navigators, and care coordinators. Care managers will assist with arranging follow-up appointments with primary care providers through expanded and enhanced centralized scheduling systems.

For the Care Transition project, BPHC is collaborating with OneCity Health Services (OneCity) and Community Care of Brooklyn (CCB) to focus on ensuring alignment and coordination of standardized protocols and the development of common risk assessment methodologies and workforce strategies. This includes common job descriptions and functional capabilities, workforce training efforts, data sharing, and selection of culturally competence patient education resources to support this project.

The potential impacts of this program upon completion in 2020 include readmissions decreasing by approximately 1,200, inpatient days may decline by approximately 6,400 days, and ED visits may be reduced by 600 visits.

Examining the FTE effect by setting, changes in utilization suggest approximately 16 care coordinator FTEs (with some care coordinators also assisting with ED triage). There might be small decreases in workforce FTE in the ED setting and in the inpatient setting, FTE workload is projected to decline by about 39 RNs, 10 nurse aides, as well as several hospitalists and LPNs.

According to the analysis, project 2.b.iv's greatest impact on workforce FTEs will be on the inpatient setting, and particularly on RNs and nurse aides, reflective of decreasing readmissions, which leads to a reduction in inpatient days. The impact on the ED is expected to be minimal, while care coordination efforts will require a combined 16 FTEs associated with care coordinators, nurse coordinators and social workers. Current shortfalls in staffing that may already be in the PPS network have not been taken into account.

ED/Inpatient Workforce

The PPS's current workforce state reported a need for nursing positions, with an overall vacancy rate of 10.6% for RNs, which is higher than the New York City vacancy rate of approximately 8%. Within the inpatient setting, there are 158 reported RN FTE vacancies, although there are no reported nurse aide vacancies.

In addition to the reported staffing needs for RN positions, the PPS is likely to experience an increased demand for these positions due to population growth, expanded insurance coverage, and an aging population. None-DSRIP related impacts are expected to increase the demand for inpatient RNs by 160 FTEs, inpatient LPNs by 21 FTEs, and inpatient nurse aides/assistants by 36-37 FTEs by the year 2020. Thus, even with the projected decline in the number of inpatient RNs, LPNs, and nurse aides due to project impacts, a gap still exists for these positions within the PPS's workforce.

Care Management Workforce

In contrast to the inpatient setting, project 2.b.iv requires increased staffing for RNs and LPNs in the care management setting, along with slight increases in non-nursing coordinator positions. Based on the current workforce state data, vacancy rates for both nursing and non-nursing coordinators is relatively low, at 5% and 4% respectively. However, with an emerging need for providers trained in care coordination, the PPS is likely to experience a gap in staffing needs when the project becomes fully implemented between DY3 and DY4.

Training

Bronx Partners for Healthy Communities (BPHC), the Performing Provider System (PPS) led by SBH Health System, plans to implement the Critical Time Intervention (CTI) as part of its DSRIP 30-day Care Transitions Intervention Program. CTI is a nine-month, evidence-based, intensive care transitions model designed to prevent homelessness and other adverse outcomes in people with Serious Mental Illness (SMI) following discharge from hospitals and shelters. This population is frequently excluded from care transitions programs based on Go-Live dates and take place site by site for both programs.

Care Transition Projects are to reduce potentially preventable visits to the ED (PPV) and Potentially Readmissions to the Hospital (PPR) within 30 days from discharge. The method to be successful in this will be to embed care management professionals (RN and non-RN) within inpatient units, EDs and in a post discharge unit/call center in order facilitate care transitions back to primary care, specialty appointments and community based organizations that will

address social determinants of health as well as reduce preventable utilization that could be addressed with community support. Also, there will be a method of engaging and making more effective warm hand offs to community resources such as housing, respite for behavioral conditions and Health Home. Training will take place in phases. SBH Health System training will combine the Ed Care Triage (ED) training and Care Transitions Program (CTP) training so that all team members is cross trained. Montefiore staff will be trained separately for ED and CTP.

BPHC has identified two existing CTI programs within the PPS: The "Pathway Home" program through Coordinated Behavioral Care (CBC), a HH operating in the Bronx (and other boroughs) and "Home to Stay" through BronxWorks, a member of the Bronx Accountable Healthcare Network (BAHN), a HH operated by Montefiore Medical Center. BPHC has approached these two HHs and both have expressed interest in increasing capacity of these programs to meet BPHC's needs.

The normal caseload of a HH CM is about 40 participants (a mix of low, medium and high acuity). Best practices for operating a CTI program within HHs indicate that the maximum caseload for a CM operating a CTI program within a HH is 20 participants. A CM with a lower caseload is able to spend more time with each participant. This increased time availability is especially needed for participants enrolled in CTI Phase 1, where the CM may need to meet with the participant up to five times a week. As the participant enters Phase 2, care management is gradually withdrawn and the amount of time needed from a CM is reduced. However, a participant enrolled in Phase 2 still requires more hands-on service than a regular HH participant would. Phase 3 is identical to the usual care a HH patient receives. In order to enable HH CMs to carry a reduced caseload with CTI patients, BPHC will provide supplemental financial support.

At program initiation, the first three-months of the program would have a slightly different funding model to offset startup costs with no participants yet enrolled in Phase 2 and fewer than 20 patients enrolled in CTI. To account for this, BPHC would fund twice the high acuity rate ($479 per member per month, or PMPM for HARP-eligible participants) for Phase 1 participants, totaling to $958 PMPM, in the first 3 months of the program only. After the first three months of the program, we expect HH CMs will have a mixed caseload of Phase 1 and Phase 2 patients, so BPHC will pay one and a half times the regular high acuity HH rate currently paid by NYS for Phase 1 participants, and one time the regular high acuity rate for Phase 2 participants. Phase 3 participants will require the same attention as regular HH participants and can be supported through the payment stream the HH already receives from NYSDOH HH funding for SMI participants.

BPHC expects CTI vendors to provide services for 40 to 80 new patients to be enrolled per year, to interface with hospital inpatient psychiatry and social work departments to garner referrals, to keep track of all visit data for every visit including visit documentation and any relevant information such as hospitalizations and/or ED visits to any hospital or ED, and agree to be trained by PPS selected training vendor and follow evidence-based protocols.

D. Primary Care & Behavioral Health

BPHC is committed, as part of its overall goal, to strengthen primary care and behavioral health services across the PPS network. This goal cuts across various projects as articulated in the sections below.

As presented in the Target State Report and Gap Analysis, it is anticipated that as DSRIP projects are implemented and more patients are connected to primary, preventive, and behavioral healthcare, there will be an increase in demand for primary care services. The target state analysis projected an additional demand for primary care services. The target state analysis projected an additional 41 PCPs across the PPS network resulting from project implementation. Additionally, general population growth and trends primarily associated with the growth in the Medicare population and expanded medical insurance coverage under the ACA may increase demand by an additional 56 PCPs, totaling close to 100 FTEs. This anticipated workforce gap may be further impacted by an identified statewide shortage of physicians. Furthermore, demand is also projected to increase for administrative support and clinical support upwards of 300 FTEs, which will be required in primary care and other outpatient settings to support primary care and behavioral health expansion.

IV. Project 3.a.1: Integration of Primary Care & Behavioral Health Services

The PPS is planning to implement all three integrated care models for Project 3.a.i: 1) increasing the physical co-location of behavioral health providers into primary care sites, 2) co-locating primary care services at behavioral health sites, and 3) implementing and improving mood-providing access to collaborative treatment (IMPACT) model for depression across the BPHC service area. The target population for the two models is Medicaid beneficiaries age 12 and older who receive primary care and/or behavioral health at committed partner sites. Achieving project goals will place additional demands on the behavioral health workforce by increasing access to behavioral health services. Modeling results detailed in the Target State report suggest a corresponding rise in behavioral health care providers and associated support staff FTEs.

Workforce Impacts

This intervention will be phased-in over two years beginning in DY2 and aims to have 100% of patients actively engaged by DY3Q4. Projected changes in utilization by 2020 as a result of program implementation include BH-related ED visits may decrease by about 500 and BH-related inpatient days may fall by about 800 days.

By 2020 the net projected PPS-wide workforce impact associated with this DSRIP initiative will likely include approximately 42 FTE increase in licensed clinical social workers as well as a 35 FTE increase in direct administrative support FTEs in the outpatient/office setting. There

is a projected minimal anticipated impact on the providers in the ED Setting and in the inpatient setting, a projected 5 FTEs reduction in RNs, with modest projected FTE reductions in hospitalists, lice practical nurses and nurse aides/assistants

The project goals will increase access to behavioral health services and the results indicate a corresponding rise in demand for BH care providers and associated support staff FTEs. While a reduction in workforce FTEs in the ED and inpatient settings is also anticipated, the projected impact in these settings is small, as is the overall impact of the project, due primarily to the modest increases in numbers who receive BH counseling even after full project implementation. Additionally, the current shortfalls in BH providers have not been taken into account.

Behavioral Workforce

Based on the projected workforce impacts, the PPS is likely to experience an increased demand in Licensed Clinical Social Workers and Administrative Support to facilitate the shift to community-based care. The increase in demand is projected to start in DY2 with the greatest impacts anticipated during DY4, as 26.6% of the PPS are expected to be actively engaged in this project. The current vacancy rate for Administrative Support workforce within the PPS is 6%, but increased demand for these positions as a result of DSRIP project impacts will likely widen this gap.

Based on the current workforce state data reported by Article 31 and Article 32 Behavioral Outpatient facilities, a vacancy rate of 6% exists among all Behavioral Health positions. However, a high vacancy rate exists particularly among Licensed Clinical Social Workers, which has a reported 11% FTE vacancy rate. Overall, the PPS reported a vacancy rate of approximately 11% for Behavioral Health positions. In addition to the reported vacancy rates for these positions across the PPS, the supply of Psychiatrists in NYS is forecasted to decline between 11.6% - 17.5%, while state-wide demand is projected to increase between 4.1% - 28.0% by 2030.[1] These external factors both impacting the supply and demand for Psychiatrists are likely to further increase the PPS's workforce gaps and create more difficulties in recruiting the necessary workforce to address project impacts. Recruitment difficulties are likely to primarily impact Article 31 Outpatient and Article 32 Outpatient facilities' Behavioral Health workforce during DY4 as a result of the projected workforce impacts for this project.

Training

As part of BPHC's project implementation plans, workforce needs with regards to recruitment and training have been identified for Behavioral Health providers including Licensed Clinical Social Workers and Administrative Support to support increased patient visits, psychiatrists, and depression care managers.

[1] Center for Health Workforce Studies, The Health Care Workforce in New York
See: http://chws.albany.edu/archive/uploads/2014/08/nytracking2014.pdf

Trainings are in progress as staff is participating in various trainings on collaborative care, the IMPACT model, screenings, and treatment methods.

The Institute for Family Health (The Institute) continues to work with Bronx Partners for Healthy Communities (BPHC) to produce trainings and technical assistance for the Primary Care/Behavioral Health Integration DSRIP project. The Institute has provided a number of additional, related webinars; these webinars will continue on a routine basis. Participating BPHC organizations are eligible for on-site trainings with The Institute including, but not limited to: Screening Tools, Psychopharmacology for Prescribers and/or Non-Prescribers, Workflow Development, Motivational Interviewing, and Problem Solving Treatment.

While similar to the Collaborative Care Model, the Co-Location Model is not full integration, there are two practices operating independently in the same physical space. Integration can serve to: 1) identity diagnoses early, allowing rapid treatment 2) ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects 3) de-stigmatize treatment for behavioral health diagnoses. Co-location occurs when a behavioral health care provider is embedded within the primary care setting OR when a primary care provider is embedded within the behavioral health care setting to ensure coordination of care

There are upcoming plans for assessing implementation, site visits and continued ongoing technical assistance and trainings. There will also be a Cross-PPS Collaborative working towards an analysis of behavioral health package for impending value-based payment models.

V. Project 3.b.i: Evidence-based Strategies to Improve Management of Cardiovascular Disease

BPHC will pursue a multi-pronged approach to address major cardiovascular disease (CVD) risk factors. This includes improving prescription and adherence to aspirin prophylaxis among eligible patients, improving blood pressure control by updating and strengthening implementation of hypertension (HTN) guidelines, improving cholesterol control by updating current cholesterol management and treatment guidelines, and increasing smoking cessation by enabling PCPs to distribute nicotine replacement therapy at the point-of-care. The targeted patient population will include all uniquely attributed adult patients (ages 18+ years) with cardiovascular conditions based on a defined set of ICD-9 diagnosis codes.

Workforce Impacts

The PPS anticipates that primary workforce impacts will be related to the need to hire or train additional Certified CVD Health Coaches.

By 2020, the net projected annual utilization impact associated with this DSRIP clinical initiative includes emergency visits may decline by about 900 and Inpatient days may

potentially decrease by about 5,100. Also, 30,800 additional urgent (unscheduled) visits to primary care providers is estimated and 15,400 more visits to cardiologists may occur

The projected workforce impact includes approximately 15-16 additional CVD health coaches to provide counseling services to 30,800 patients. There is also projected to be an increase of 15-16 additional primary care providers and 4-5 additional cardiologists, supported by approximately 30 direct medical support staff and 15 direct administrative support staff in outpatient/office settings. In the ED setting, the projected impact is a slight decrease in emergency department staff and in inpatient settings, the impact is a decrease in demand for hospital inpatient staff—including approximately 30 fewer RN FTEs

In terms of workforce implications, the analysis suggests that the greatest impact of this project on workforce will be in outpatient settings where most care management activities associated with this project will occur. The project also has impact on nursing staff in the inpatient setting. There is minimal workforce impact in the ED setting.

Primary Care/Outpatient Workforce

The most significant impacts to occur from the CVD Management initiative are within the outpatient setting. Current shortages already exist among PCPs in the PPS, where there are 27 reported FTE vacancies, a rate of approximately 8.0%. Medical assistants also have a reported vacancy rate of 8.0%, and LPN's have a reported vacancy rate of 9.6%. Cardiologists have a vacancy rate of 10.7%.

Additionally, by 2020, the anticipated growth in demand for PCPs due to non-DSRIP related impacts is 55-56 FTEs based on the PPS's current market share; the growth in demand for medical assistants is 97 FTEs, for LPNs is 30 FTEs, and for cardiologists is 8-9 FTEs. The combination of both DSRIP and non-DSRIP related impacts is expected to create a gap in staffing needs for many of these primary care / outpatient positions.

ED/Inpatient Workforce

Within the inpatient setting, the largest workforce impacts are predicted to occur among the nursing staff. An anticipated decline in ED visits and inpatient days will likely decrease the demand for RNs by about 30 FTEs, and nurse aides/assistants by 7-8 FTEs. However, workforce gaps reported in the Current Workforce State include high reported vacancy rates for the PPS's nursing workforce with RNs experiencing a vacancy rate of approximately 10.6%, including 6.5% in inpatient settings. Additionally, non-DSRIP impacts such as population growth and an aging population are expected to increase the need for inpatient RNs by 160 FTEs and inpatient nurse aides/assistants by 45 FTEs. Therefore, while this project's goals aim to reduce ED and inpatient utilization through CVD self-management, the projected decrease in demand for nursing positions is likely to be offset by the PPS's identified existing workforce needs as well as a change in population dynamics.

Other workforce impacts expected to occur in the inpatient setting are for care management positions such as CVD health coaches and care coordinators. Both of these positions are

expected to see an increase in demand by 15-16 FTEs and 10 FTEs, respectively. The current reported vacancy rate for health educators is 21.6%. As a result, project implementation will likely widen this gap.

Training

Self-Management Goals is one of the main programs that fall under Improving Cardiovascular Disease. The program will look to document patient driven self-management goals in the medical record and review with patients at each visit. Just as patients require ongoing support for changing health behaviors, practice teams need repeated opportunities to learn new skills and change their communication and practice patterns in support of patient self-management. Many practices find that designating a self-management support coach who provides ongoing training to all care team members is the best way to establish skills over time. The coach should be a staff member with talent and inclination to work with health behavior change—or, at minimum, be "a people person" who receives the appropriate training to support him or her in such a role, including in-depth training in behavior change.

Often, the coach can do focused trainings as brief as 15 minutes during a regular care team meeting to demonstrate a particular skill or introduce a new tool. A series of these shorter trainings over time may be more effective than a one-time only training of several hours. The trainings can be tailored to specific staff roles and tasks, giving participants an opportunity to try a technique, get feedback, and develop skills over time.

Another training focus will be to perform population health management follow-ups for patients with (a) repeated elevated blood pressure readings and no hypertension diagnosis; (b) a hypertension diagnosis and no recent visits; and (c) A diabetes diagnosis missing one or more of the following: HbA1c test, diabetes eye exam, and medical attention for nephropathy.

There will be a BP Training program to provide training to all staff involved in measuring and recording blood pressure on correct measurement techniques and equipment. There will also be an At-Home Blood Pressure Monitoring training to implement workflow for at-home blood pressure monitoring, including process for addressing BP values that are out of range.

In the hopes to provide opportunities for follow-up blood pressure checks without a copayment or advanced payment, there will be a No-Copay, Drop-in Blood Pressure Checks program.

And with focus on Tobacco and Smoking, there will be Tobacco Cessation Prompts which will use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange) and a NYS Smoker's Quitline Referrals to facilitate referrals to NYS Smoker's Quitline.

VI. Evidence-based Strategies to Improve Management of Diabetes

The goal of project 3.c.i is to reduce the progression of disease and lower hospital utilization rates. Under this program, BPHC will implement evidence-based 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 diabetes management with focus on lifestyle modification, and self-management per evidence-based clinical guidelines. To achieve reduction in hospitalizations, BPHC will develop multidisciplinary care teams including PCPs, endocrinologists, cardiologists, nurses, social workers, pharmacists, diabetic educators, and others to fill current gaps in patient care and compliance.

Workforce Impacts

By 2020 the projected annual health care use impacts associated with this initiative include approximately 3,500 fewer emergency visits (relative to no change in care use patterns), 6,400 fewer inpatient days, 25,800 additional primary care visits, and 6,500 additional visits to an endocrinologist.

The workforce impact by 2020 includes approximately 13 additional diabetes health coaches to provide services to an estimated 25,800 patients. In primary care settings, there is a projected increase of 12-13 primary care providers, 22-23 additional direct medical support staff, and 11-12 direct administrative staff. There is a projected slight decrease in emergency department staff (e.g., 5-6 RNs) in the ED setting. And in inpatient settings, there is a projected decrease in demand for hospital inpatient staff—including approximately 38 fewer RN FTEs, and 9-10 fewer nurse aides FTEs.

In terms of workforce implications, the analysis suggests that the overall estimated impact of this DSRIP project is not significant. Primary care and inpatient settings will likely experience some change, while the emergency department will experience modest impacts. The primary Inpatient impacts include decreases in FTEs associated with staff RNs and other nursing staff. The results indicate that successful participation in the care management program also will impact primary care settings in the short-to-midterm, but current possible staffing shortfalls have not been taken into account.

Primary Care Workforce

At the primary care / outpatient settings, the PPS will experience increases from DY2 to DY4 for the demand of PCPs as well as Medical and Administrative Support as a result of project impacts due to an anticipated increase in the number of PCP visits, assuming full project implementation. Similarly and as described for Project 2.c.i, workforce gaps within the primary care / outpatient setting currently exist due to a reported vacancy rate of approximately 8.0% reported for PCPs across the PPS. As a result of project impacts, an increased demand for PCPs and a projected shortage of PCPs in NYS, this gap is likely to further increase throughout the DSRIP program's term. Similar vacancy rates are also

reported for Medical and Administrative Support, and these positions may also experience a gap in staffing.

As a result of project implementation and the provision of increased diabetes self-management services, an increase in the demand for Certified Diabetes Educators is anticipated. This increase in demand may occur initially in DY2 but will increase in DY4 and DY5 as approximately 7.5% of the PPS's Medicaid attributed lives become actively engaged in diabetes self-management services. Based on the current state data reported, the PPS's network includes approximately 11 Certified Diabetes Educator FTEs with 1 vacancy reported for this position. Thus, based on the PPS Partners' reported data, workforce gaps for this position do not currently exists but as demand increases throughout the project's implementation, this is likely to change.

ED/Inpatient Workforce

Although workforce impacts in the ED are projected to be minimal, there are anticipated project impacts occurring within the inpatient setting, particularly with a decreased demand for RNs during DY4 due to an estimated reduction in approximately 3,500 ED visits. Further, workforce gaps reported in the ED and inpatient settings include a vacancy rates for the PPS's nursing workforce of approximately 9.0%. As a result of the high number of reported vacancies, the projected decrease in demand for these positions is likely to be offset by the PPS's identified existing workforce needs.

Training

BPHC will partner with Health People in an innovative program to recruit, select & train individuals who will become Peer Leaders/Coaches. After Training, Peer Leaders/Coaches will facilitate the Stanford Diabetes Self-Management Program (DSMP) and Lower Extremity Amputation Prevention (LEAP) 7-session workshop for patients.

DSMP was developed at Stanford and is a program where patients learn to take control of their diabetes. Peer-led workshops develops tools to: learn about the disease and self-care and monitoring, understand and deal with emotions, manage medications, work with health care providers, and make action plans for exercise and healthy eating. Then one year after the 6-week workshop: Improvements in stress management, self-reporting health, aerobic exercise, health distress, self-efficacy, communication with physicians, and fewer hospital days; more PCP visits.

LEAP is a peer-delivered education for people with diabetes who have neuropathy or any condition that results in loss of protective sensation in the feet. It teaches annual foot screening, daily self-inspection of the feet, appropriate footwear selection and management of simple foot problems.

DSMP course implementation has already begun as recruiting for Peer Coaches are underway with training for English- and Spanish-speaking peer coaches to teach the DSMP. There are currently 18 participants; more than half of these participants were referred by the PPS's

CBO partners. There will be webinars for CBOs around the workflow for referrals of more students. Referrals have come from the following BPHC clinicians and partners: Dr. Morrow and Dr. Pino, SBH and BPHC staff, BPHC community partners, Recruitment from SBH and Montefiore clinics, Self-referrals (flyers), and Health People outreach.

VII. Project 3.d.ii: Expansion of Asthma Home-based Self-Management Program

The goal of the "Home Environmental Asthma Management Program" is to improve asthma control in order to help people with asthma live healthier lives and reduce avoidable emergency room use and hospitalizations related to asthma. The target population for this project will be attributed beneficiaries with an asthma diagnosis. The PPS will actively engage a proportion of patients who either have had three or more PCP visits or an ED visit or hospital discharge with asthma as the primary diagnosis in the past year.

Strategies to be employed include:

1. Instituting evidence-based asthma management protocols for primary care providers (PCPs) to help reduce asthma exacerbations;
2. Conducting outreach to PCPs to ensure they are aware of and can easily refer asthma patients to the home-based visiting program;
3. Establishing protocols to link asthma patients who visit the ED with PCPs and care coordination services via PCMHs or the Health Home;
4. Establishing IT systems to transmit data from the CHWs back to the PCP to integrate the asthma action plan and data collected during asthma home visits into a care planning tool and the patient's medical record; and
5. Implementing clinical guidelines across PCMH partners modeled on the National Asthma Education and Prevention Program's guidelines.

Workforce Impacts

By 2020, the net projected annual utilization impact associated with this DSRIP clinical initiative includes a reduction of 1,300 emergency visits, 900 fewer inpatient days, and 2,800 fewer urgent (unscheduled) primary care visits. The projected workforce impact includes approximately 8 asthma health coaches to provide services to 15,500 patients. In primary care settings, there projects to be very minimal change, with slight decreases in FTEs associated with providers in this setting. There also projects to be minimal changes in demand for emergency department staff FTEs in the ED setting. And in the inpatient settings, there is a projected small decline in demand for hospitalists and other hospital inpatient staff FTEs (including 5-6 fewer RNs)

BPHC anticipates the need to hire Health Coaches for the implementation of the Asthma Home-Based Self-Management program. Based on the PPS's target workforce analysis'

projected workforce impacts for this project, by DY5, this would require approximately 8 Asthma Health Coaches for the provision of asthma-self management services. This increase in demand for health coaches will likely be felt in DY2, assuming initial project implementation impacts, but will primarily increase starting in DY4 through to DY5 as the PPS engages increasingly more Medicaid attributed lives in asthma self-management services. Based on the current workforce state data, the PPS's network includes only 5 reported Certified Asthma Educators.

Training

There will be a plan to adopt BPHC evidence-based guidelines for asthma (GINA) and implement workflow for asthma patients that will include the use of Asthma Action Plan (AAP), Annual spirometry, and develop and provide patient education material. BPHC will also provide coordinated care to asthma patients under Care Team model (care navigation via Health Home at Risk or Health Home). BPHC will implement workflow to assess and refer patients to a.i.r. Bronx by referring eligible asthmatic patients to a.i.r. Bronx and employ Closed Loop Order Processing (bidirectional referrals). And the goal is to develop a system to track patient care and adherence to project requirements.

There will be an alignment and referral among the Health Home at Risk program and the Asthma services. Asthma patients eligible for a.i.r Bronx services will almost certainly be eligible for care management. Sites must coordinate with a.i.r. Bronx team; Care Coordinator is point of contact. To streamline, referrals to a.i.r. Bronx should go through PCMH Care Coordination team. Care Coordination teams will confirm eligibility and refer patients to a.i.r Bronx using closed loop referral tracking and (if possible) warm handoff. When a.i.r Bronx intervention ends a warm handoff to Care Coordinator is completed.

VIII. Project 4.a.iii: Strengthen Mental Health and Substance Abuse Infrastructure

This project will help to strengthen mental health and substance abuse infrastructure across systems. Support collaboration among leaders, professionals, and community members working in mental, emotional and behavioral (MEB) health promotion to address substance abuse and other MEB disorders. MEB health promotion and disorders prevention is a relatively new field, requiring a paradigm shift in approach and perspective. This project will address chronic disease prevention, treatment and recovery, and strengthen infrastructure for MEB health promotion and MEB disorder prevention. Meaningful data and information at the local level, training on quality improvement, evaluation and evidence-based approaches and cross-disciplinary collaborations need to be strengthened. Performing Providers Systems, schools, PCPs, CBOs, NYCDOHMH and NYC Department of Education (DOE) will work as partners to strengthen the infrastructure that screens, assesses, refers, treats, and manages the care of young people ages 12-25 with mild to moderate mental health and substance abuse (MHSA) needs, as well as those at risk of developing such needs. The Project aims to prevent and

reduce mental health conditions, risky substance use and inappropriate use of emergency departments (EDs) by expanding the skills of school-based staff.

This project will target youth ages 12-25 with mental, emotional, and behavioral (MEB) health diagnoses or substance use disorders, as well as those at high risk for developing mental health or substance abuse disorders and who have other health and social factors linked to risky substance use and MEB needs.

Training

To implement this project the PPS has contracted with The Jewish Board of Family & Children's Services, a PPS partner in collaboration with four New York City DSRIP Performing Provider Systems (PPSs). The Jewish Board will provide trainings on designated curricula and school-based approaches to subcontractors, who will work to enhance the ability of school communities to meet the behavioral health needs of students and families.

BPHC is one of four PPSs that has committed to investing in MHSA prevention-related activities in an estimated 100 middle and high schools across the Bronx, Brooklyn, Manhattan, and Queens. The MHSA Project activities will not include the delivery of selective or targeted interventions. The Project activities will also not include the assessment or treatment of mild to moderate MHSA clinical needs. Instead, the activities will focus on enhancing the capacity of school-based support staff to perform assessments and interventions for students.

A full-time School Behavioral Health Consultant (SBHC) such as a social worker will work directly with a group of schools, coaching, educating, and advising school administrators, teachers, and health support staff (nurses, counselors, etc.) on best practices. The SBHC will help better equip school-based staff and their partners to assess their needs and address issues related to mental health and substance use. The SBHC will be supervised by a psychologist with experience in prevention, intervention, and treatment of children, adolescents, and young adults.

The SBHC will implement three levels of activities:

1. Coach and support schools and their partners to provide proven universal, selective, and targeted interventions that are consistent with school needs and priorities.
    a. Train teachers, administrators, and other school staff on how to identify basic behavioral indicators of MHSA risks and early warning signs of incipient problems, including which students may benefit from selective or targeted interventions and/or linkages to community-based care.
    b. Train teachers, administrators, and other school staff to implement culturally- and linguistically-appropriate universal interventions.
        i. Universal interventions are aimed at all students and include trainings and workshops for all school staff or all students to impart knowledge, awareness, or skills that promote behavioral well-being for themselves and their interactions with others. These may also include efforts to reduce stigma by educating school staff and students on typical

behavioral health issues, mental health first aid, and general self-care strategies.
    ii. These programs aim to promote behavioral health and avoidance of risky substance use by highlighting the medical risks of risky use and other adverse consequences.
c. Train school staff to deliver selective and targeted interventions to groups of students, or individual students.
    i. Selective interventions are aimed at groups of students that may have symptoms or behaviors of concern that prompt early or preventive interventions, often delivered in a group-based setting. Examples include group sessions on cognitive behavioral management of stress and anger-violence.
    ii. Targeted interventions are aimed at students who are at high risk for MHSA issues and may have symptoms of behaviors of concern that prompt individualized clinical interventions. They typically involve individual motivational interviewing and counseling delivered by a Licensed Mental Health Counselor (LMHC) or a LCSW.
d. Consider working with community-based organizations to implement standardized, evidence-based interventions that teach adolescents and young adults about MHSA topics.
e. Given the diversity among NYC schools, the approach will vary on a school-by-school basis, and the SBHC will work with the DOE Office of School Health for technical assistance. However, a standard model consisting of an evidence-based intervention menu, along with methods for local assessment and planning, will be developed that can be adapted for individual schools.

2. Integrate adaptation of the "Collaborative Care" model into schools, equipping school support staff to perform clinical assessments and interventions for students with mild to moderate MHSA needs.
    a. Train school support staff to assess students with mild to moderate MHSA needs, emphasizing the use of evidence-based tools for assessment.
    b. Train school-based staff to address these mild to moderate MHSA needs by performing interventions that consist of standardized short-term training modules and aim to prevent more serious MHSA conditions. The interventions will address issues potentially including substance use/risky use, anxiety, depression, conduct disorders, and trauma.
    c. The SBHC, in conjunction with the supervising psychologist, will provide consultative support to school support staff on clinical assessments and interventions.
    d. The SBHC will work closely with the DOE Office of School Health for technical assistance in developing a standard model consisting of evidence-based assessment tools and interventions.

3. Strengthen school linkages and referral channels to community mental health and substance use clinics, other addiction and mental health services, Health Homes, and pediatric primary care practices using the Collaborative Care Model.
    a. Train school staff about MHSA health and community-based resources in their borough, including Health Homes and pediatric practices that use the integrated behavioral health care or the Collaborative Care model.
    b. Help develop and strengthen schools' referral networks and relationships with appropriate local providers by providing school support staff with referral criteria and protocols that assure appropriate and timely interventions for MHSA needs and assessment and treatment for higher acuity conditions, and by coaching staff on utilizing appropriate community alternatives to the emergency room.
    c. Use the SBHC to serve as a liaison between school support staff and providers/other identified MHSA resources.

IX. Project 4.c.ii: Increase Early Access to HIV Care

In collaboration with seven New York City PPSs, BPHC will implement a program focused on developing common approaches and resources, addressing identified gaps in HIV care spanning the New York City boroughs. The PPSs' HIV Collaborative include strengthening screening and linkage infrastructure, identification and treatment of patients eligible for pre-exposure prophylaxis treatment, and enhancement of peer support programs for HIV patients. In addition, the collaborative will seek to address care gaps in terms of promoting wide-spread screening, early intervention measures, patient engagement and education, and culturally competent care.

Training

BPHC will partner with NYLinks with the goal of bridging systemic gaps between HIV related services and achieve better outcomes for PLWHA through improving systems for monitoring, recording, accessing, and sharing information about linkage to care, retention in care, and viral load suppression in New York State. NYLinks will look to leverage existing activities in the Bronx around clinical improvement. Through the NYLinks/BPHC collaboration, participants will receive training and TA to enhance or establish Staffing and Peer Supports, Improving Linkages to Community Resources, Establish Retention to Care Units, Building Effective Adherence Plans, HIV Registry and Data Access, and Cross-PPS Coordination and Educational Campaigns.

E. Movement Across Settings

If successfully implemented, multiple DSRIP projects, as reported in the Target State Report and Gap Analysis, will decrease the number of inpatient days (avoidable admissions) and

avoidable ED visits, and increase primary care visits across the PPS network. Projected DSRIP-related staffing reductions for certain job titles, due to reduction in utilization of inpatient/ED services, may result in a decline in demand for nurses (including Registered Nurses, LPNs and Nursing Aids). This reduction in inpatient utilization and related increase in demand will likely be offset by non-DSRIP trends, including increased insurance coverage and a growing and aging population. Additionally, the DSRIP program will enhance demand in outpatient and community based settings as care is shifted. Shifting demand across settings may present the opportunity for a focus on the expansion of the workforce and training programs to support community-based care.

III. Other Workforce Development & Transition Strategies

A. Cultural Competency and Health Literacy

As described in the Current State Report, the BPHC PPS has a wealth of existing resources and infrastructure that can be further leveraged to support comprehensive cultural competency and health literacy throughout the PPS's provider network. As part of the PPS's ongoing cultural competency and health literacy strategy the PPS is in the process of developing a training strategy for its workforce. These training strategies will be deployed through the PPS's clinical projects as well as through the CSO.

The PPS recognizes that in order to achieve a sustainable reduction in avoidable hospitalizations and ED visits, improving on and integrating health education and literacy into all of the DSRIP projects is necessary including training for the workforce. The PPS plans to identify health literacy strategies based on industry best practices and will leverage many of the existing standards in place at its hospital partner and other member organizations with the PPS. For example the PPS has developed training for front line staff, BPHC organizations serving seniors, homecare professionals, leadership from BPHC partners, BPHC organizations with cross PPS collaboration, Primary Care staff, Behavior health specialists and CBO staff trained to target community members.

As part of the PPS's plans to promote cultural competency throughout its workforce, the PPS will focus on verity of training

B. Health Information Technology Training and Implementation

BPHC has pledged to support any technology that they develop or purchase. Right now, they are currently looking for a CCMS tool. They will also support a referral tracking tool if the CCMS that they select doesn't have one. For the Bronx RHIO, orientations are currently conducted for new staff at the sites. The Bronx RHIO is also conducting training for all staff that are collecting consents so that they fully understand what they are asking patients to sign. In addition, any new functions that are developed to support the Integrated Delivery

System will be supported by training for IT staff and users, including how to use the registry and the spectrum dashboard.

C. Minimizing Workforce Impacts

BPHC will look to minimize workforce impacts but to maximize utilization of exiting staff. There were three programs for DY2 which were selected by the Community Engagement Workgroup: (1) DSRIP 101 – Interactive 30 minute e-learning course designed for BPHC members who are less familiar with DSRIP. Provides a basic understanding of DSRIP and the triple aim; (2) Cultural Competency in the Bronx; and (3) Motivational Interviewing.

There is also training and re-training programs which will be open to new hires and existing care management staff. There is a Medical Office Assistant Refreshers and Certification Course (9 day program leading to CCMA certification). There is a Care Coordinator Training Program (9 day program) as well as a Care Nurse Management Supervisor (10 day program).

There is also a 2-day Essentials of Care Coordination program designed for DSRIP new hires and redeployed staff not participating in any programs above (excluding IT staff) which will launch in October of 2016.

IV. Appendix: Workforce Transition Roadmap (Timeline)

Workforce Strategy	
	Target Completion Date
Milestone #1 Define target workforce state (in line with DSRIP program's goals)	**6/30/2016**
Establish and convene Workforce Project Team (including Workforce Sub-Committee, Workforce Workgroups, workforce liaison and other supportive staff from the CSO, 1199 SEIU Training and Employment Funds (TEF), subject matter experts and stakeholders) responsible for implementing, executing and overseeing workforce activities.	7/1/15
Identify the requirements for each DSRIP project and the new services that will be delivered, in conjunction with the Quality and Care Innovation Sub-Committee.	6/30/16
Identify the types and numbers of workers needed for each DSRIP project.	6/30/16
Identify the competencies, skills, training and roles required for each DSRIP project, with particular attention to developing common standards and definitions for care management roles.	6/30/16
Consolidate project-by-project analysis to develop a comprehensive view of the workforce needs to support all DSRIP projects.	6/30/16
Finalize target workforce state and receive signoff from Workforce Sub-Committee and Executive Committee.	6/30/16
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state	**9/30/2016**
Convene Workforce Sub-Committee to provide input on the approach for developing the workforce transition roadmap.	9/9/2015
Working with the Center for Health Workforce Studies (CHWS), provide PPS member organizations with individualized survey data to determine their current workforce state.	9/30/2016
Based on current workforce state and future targeted workforce state (as defined in the milestone above and below), work with TEF to draft a workforce transition plan template that addresses workforce volume including hiring, training, deploying staff as well as the timeline for the changes and the related dependencies to assist PPS member organizations in developing individualized workforce transition roadmaps	9/30/2016

Obtain approval of transition plan template by Workforce Sub-Committee and Executive Committee to assist PPS member organizations in achieving future target workforce state.	9/30/2016
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state	9/30/2016
Work with BDO/CHWS to gather baseline information on current workforce state through member surveys and available workforce data. Baseline information will include an assessment of staff volume, staff titles/types, competencies and credentials related to implementing each DSRIP project	3/31/2016
Work with CHWS and TEF to identify overall change in numbers, FTEs, salary, and benefits, by organization and in the aggregate as well as identify if the potential workforce changes are a result of: retraining, redeployment, new hires, or attrition.	9/30/2016
Work with TEF to apply training costs and training strategies to the retraining of health workforce staff and identify any other training costs (i.e. CBOS w/o new staff, but may need training to understand DSRIP and the process).	9/30/2016
Work with TEF to link training strategies and training costs to PPS DSRIP projects	9/30/2016
Work with PPS partners, including unions, to identify staff who could be redeployed into future state roles to implement DSRIP projects. Workforce Advisory Work Group will be available to facilitate.	9/30/2016
Work with TEF and other members of the Workforce Sub-Committee to conduct a job analysis of at-risk positions and a skill transferability analysis to create job transition maps and career ladders within the PPS.	9/30/2016
Identify new hire needs to implement DSRIP projects	9/30/2016
Perform workforce budget analysis for each DSRIP project over the duration of the projects, taking into consideration overlap of training needs in projects	9/30/2016
Obtain sign-off on current state assessment report and gap analysis from Workforce Sub-Committee and Executive Committee.	9/30/2016
Milestone #4 **Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements**	6/30/2016
As part of gathering baseline information from CHWS in the milestone above through member surveys and available workforce data, work with partners and stakeholders (including unions) to identify compensation and benefits ranges for	6/30/2016

current staff critical to implementation of DSRIP projects, including care managers.	
Working with TEF, build on analysis of at risk positions to develop impact analysis on staff needing to be retrained and redeployed across PPS member organizations.	6/30/2016
Work with PPS members and targeted stakeholders to develop compensation and benefit range targets for staff positions, including new hires, critical to DSRIP implementation to inform PPS budgeting and workforce impact analysis.	6/30/2016
Convene the Workforce Advisory Work Group to determine impacts to partial placement staff and potential contingencies and develop and incorporate policies for staff who face partial placement and for staff who refuse retraining or redeployment, taking into consideration Collective Bargaining Agreements and HR policies at Partner organizations.	6/30/2016
Draft comprehensive compensation and benefit analysis report.	6/30/2016
Review and approval of compensation and benefit analysis report by Workforce Sub-Committee and Executive Committee.	6/30/2016
Milestone #5 **Develop Training Strategy**	**9/30/2016**
Contract with 1199 Training and Employment Fund to provide training, as well as case management, counseling, job search assistance, employment workshops and tracking systems for impacted workers.	9/30/2016
Contract with other organizations (CBOs) to provide specialized training for specific DSRIP projects, including training on cultural competency and health literacy strategies, as needed.	9/30/2016
In concert with the Workforce Sub-Committee, Quality and Care Innovation Sub-Committee and workforce vendors and through member surveys and stakeholder input, create an inventory of needed training to implement each DSRIP project, including specific skills, certifications and competencies	9/30/2016
As part of the inventory effort and the above milestones, work with TEF to identify existing staff and new hires that will need to be retrained, and the competencies and skills they will need in the future to implement DSRIP projects.	9/30/2016
Work with TEF to develop vision, goals and objectives for training strategy and draft detailed training strategy, including plans and process to develop training curricula in concert with training vendors and the associated timeline.	9/30/2016
Work with partner organization HR leads to develop a mechanism to measure effectiveness of training in relation to training goals to implement DSRIP projects	9/30/2016
Finalize, review and approve training strategy by Workforce Sub-Committee and Executive Committee.	9/30/2016

Cultural Competency & Health Literacy	
Milestone #2: Develop a training strategy focused on addressing the drivers of health disparities	
Develop 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	6/30/16
Convene Workforce Sub-Committee and QCIS to support development of health disparities training strategy	6/30/15
Perform inventory of existing training programs within the PPS and identify best practices to leverage	9/30/15
Based on inventory and research, identify key features of training plans, including scope of providers trained, mechanisms for delivering training services, and frequency of offerings	3/31/16
Vet training plan through Workforce Sub-Committee, QCIS and Executive Committee	6/30/16
Develop a plan for conducting ongoing quarterly reports on training program	6/30/16
Present the training strategy to PPS providers through the rapid deployment collaborative	6/30/16
Practitioner Engagement	
Milestone#2: Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	
Review PPS practitioner listing and organize the list into provider specific types for DSRIP project training purposes.	9/30/15
Contract with vendors and/or partners with curriculum development and/or training capabilities geared to DSRIP project and practitioner type. Include Subject Matter Experts from our PPS partners in MH/BH, I/DD, and SAS in the curriculum development process.	9/30/15
Develop training schedule and logistics to maximize participation by practitioners and arrange CME credit	12/31/15
Work with the Quality and Care Innovation Sub-Committee and the RDCs to establish a process for curriculum content reviews/updates for general and provider type-specific education programs to address issues of special relevance including culture change, BPHC's quality agenda and the impact of quality	6/30/16

improvement on practitioner incentive	
Clinical Integration	
Milestone #2 Develop a Clinical Integration strategy	
Develop strategy for dissemination of recommendations, training on guidelines/protocols/implementation strategies	12/31/15
Project Specific Workforce Transition	**END DATE**
2.a.i – Create an Integrated Delivery System focused on Evidence Based Medicine and Population Health Management	
Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	12/31/2016
Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	9/30/2016
Identify community based services relevant to the community, and identify organizations that provide them, to gain an understanding of their willingness in and capability to expand their services and to contractually engage with BPHC to engage patients in their care through outreach activities, performing patient screening and assessment, helping patients navigate service providers (including engagement and activation with primary care) and providing patient education and self-management assistance	9/30/2015
2.a.iii – Health Home At-Risk Intervention Program	
Identify qualified coordinated care management (CCMS) vendors	9/30/2015
Assess participating practices' care management staffing needs to meet care management service needs of HH at-risk population, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD.	12/31/2015
Develop, in conjunction with Workforce Subcommittee, training curriculum for PPS provider staff	4/1/2016
Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care. Training has been deployed on assessment for care coordination (part of care coordinator training) and on registry use with site-based DSRIP Program Directors/IT Staff/Quality Assurance staff. However, there have been delays in contracting with and deploying our PPS-wide CCMS tool—trainings are expected to go live in DY2 Q3.	6/30/16
2.b.iii – ED Care Triage for At-Risk Populations	
Establish ED care triage program for at-risk populations	3/31/2017

Draft job descriptions, staffing and recruitment plan, in consultation with the Workforce Subcommittee	3/31/2016
Develop training curriculum for Patient Navigators and ED staff using evidence-based care management principles and project specific procedures and tools	6/30/2016
Survey participating providers to identify gaps in services and identify additional potential community organization partners	3/31/2016
Conduct periodic meetings/learning collaborative with community organization partners to gather feedback and share best practices	3/31/2017
Recruit and hire Patient Navigators	3/31/2017
Train Patient Navigators, their supervisors, and ED staff using the curriculum developed including use of Community Resource Database, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD	3/31/2017
2.b.iv – Care Transitions Intervention Program	
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	3/31/2017
Define the population to be targeted by Critical Time Intervention strategies	3/31/2016
In conjunction with the Workforce subcommittee, define a Critical Time Intervention staffing model, to address the needs of the target population including staff qualifications, roles, functions, and panel size of team members	3/31/2016
Working with Workforce Subcommittee, design training and recruitment strategy for Critical Time Intervention staffing	3/31/2016
Complete assessment of Critical Time Intervention staffing needs across the PPS in conjunction with the Workforce Subcommittee	5/31/2016
Recruit and hire needed Care Transition staff	3/31/2017
Train Care Transition staff and their supervisors	3/31/2017
3.a.i – Integration of Primary Care and Behavioral Health Services	
Provide support, trainings, resources and education to participating providers as needed to ensure successful completion of co-located and integrated behavioral health services.	3/31/2018

Assess current state of PCPs engaged in project, including behavioral health service delivery capabilities, work flow, IT infrastructure, interoperability, staffing, etc.	6/30/2016
Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education	4/15/2016
In collaboration with BPHC Workforce Sub-committee, assign roles and responsibilities for practice specific implementation of evidence based guidelines and protocols and action plans to engage PCPs with behavioral health specialists	3/31/2016
Provide education/trainings needed to ensure success in conjunction with Workforce Sub-committee	3/31/2016
Develop training plan and curriculum to deploy risk assessment tool, registry and care coordination management solution (CCMS) tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care. Training has been deployed on assessment for care coordination (part of care coordinator training) and on registry use with site-based DSRIP Program Directors/IT Staff/Quality Assurance staff. However, there have been delays in contracting with and deploying our PPS-wide CCMS tool—trainings are expected to go live in DY2 Q3.	6/30/2016
In collaboration with BPHC Workforce Sub-committee, assign roles and responsibilities for practice specific implementation of evidence based guidelines and protocols and action plans to engage PCPs with behavioral health specialists	3/31/2016
Finalize the formal hiring and creation of DCM role with the Workforce Sub-committee.	12/31/2016
Create/provide training protocols and procedures for DCM role to ensure they are proficient in all required IMPACT interventions.	3/31/2017
Provide training of designated psychiatrist to ensure they are able to adequately perform the requirements of the position.	6/30/2016
Provide training for IMPACT collaborative care teams, including collaborative care case consultation.	6/30/2016
Provide training for care teams on IMPACT model and designated psychiatrist's role.	3/31/2017
3.b.i – Evidence-Based Strategies for Disease Management in High Risk/Affected Populations - Cardiovascular Disease (Adults Only)	
Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG	3/31/2016
Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care.	6/30/2016

Training has been deployed on assessment for care coordination (part of care coordinator training) and on registry use with site-based DSRIP Program Directors/IT Staff/Quality Assurance staff. However, there have been delays in contracting with and deploying our PPS-wide CCMS tool—trainings are expected to go live in DY2 Q3.	
Develops educational materials suitable to the needs, culture and language of the target populations in conjunction with select CBOs, PCPs, and SMEs	3/31/2016
Working with Workforce Subcommittee, design training and recruitment strategy for care managers and care teams	6/30/2016
In conjunction with Workforce Subcommittee, identify relevant training resources and nursing competencies to create protocols (standardized across PPS) for inclusion in the COP	3/31/2016
Establish the schedules and materials for periodic staff training on person-centered methods that include documentation of self-management goals	3/31/2017
Identify nursing competencies and training resources to support SBPM in conjunction with Workforce Subcommittee.	9/30/2016
Identify opportunities to coordinate processes, education and communication including incorporation of increased blood pressure identification for screening checks into PCMH workflow processes	3/31/2016
3.c.i - Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease - Diabetes (Adults Only)	
Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG	3/31/2017
Identify opportunities to coordinate processes, education and communication into PCMH workflow processes	3/31/2016
Collaborate with other BPHC project-specific workgroups and teams to ensure that diabetes management training is incorporated/included in other care coordination training sessions	3/31/2017
Working with Workforce Subcommittee, design training and recruitment strategy for care coordinators/managers and care teams with a training focus on improving health literacy, patient self-efficacy.	12/31/2015
Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations of how interventions will be logged, tracked and reported.	12/31/2015
Operationalize partner and workforce roles by providing gap analysis and appropriate training.	3/31/2016

Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care. Training has been deployed on assessment for care coordination (part of care coordinator training) and on registry use with site-based DSRIP Program Directors/IT Staff/Quality Assurance staff. However, there have been delays in contracting with and deploying our PPS-wide CCMS tool—trainings are expected to go live in DY2 Q3.	6/30/2016
Conduct training around close loop processing/referral and preventative service tracking	12/31/2016
3.d.ii – Expansion of Asthma Home-Based Self-Management Program	
Develop comprehensive provider/participant engagement, education and communication plan to engage community medical and social services providers in the project and establish productive collaborative relationships and linkages among them.	9/30/2015
In conjunction with the Workforce Subcommittee, develop training materials for Community Health Workers (CHWs) on 1) how to conduct home environmental assessments with establishment of asthma action plan for remediation; and 2) the protocols for engaging IPM vendors for trigger reduction interventions.	12/31/2015
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	3/31/2017
PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	3/31/2017
Conduct ongoing education/training to introduce/update/refresh care teams' knowledge of new patient education materials and evidence-based guidelines	3/31/2017
PPS has developed and conducted training of all providers, including social services and support.	9/30/2017
In conjunction with the Workforce Subcommittee, develop training that includes social services reports and develop training calendars.	3/31/2016
Conduct educational sessions/webinar and ongoing training as needed for providers on use of Asthma Project COP.	9/30/2017
Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how	12/31/2015

interventions will be logged, tracked and reported.	
Operationalize partner and workforce roles by providing gap analysis and appropriate training.	3/31/2016
In conjunction with Workforce Subcommittee, describe roles and responsibilities of care coordination team that includes clinical practice care team (e.g., PCPs, nurses, medical assistants), dietitians, pharmacists and community health workers.	12/31/2015
4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure across Systems (MHSA)	
Contract with selected Lead Agency to manage all aspects of the MHSA project including developing operational plan, selection of community mental/behavioral health agencies, selection of target schools, project staffing structure, and training curriculum	12/31/2015
Develop schedule for MHSA project activities, including activities preparatory to launch of CC adaptation in schools such as contracting, staff recruitment and deployment, training.	3/31/2017
Refine MHSA intervention to integrate programming to reach these young adult groups, including by developing culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation plan, and staffing and training plans	3/31/2018
4.c.ii – Increase early access to, and retention in, HIV care	
In conjunction with workforce subcommittee, evaluate staffing needs to design culturally competent training and recruitment strategy	3/31/2016
Collaborate with NYCDOHMH to develop and implement broad-based education campaigns	6/30/2016
In conjunction with Workforce Subcommittee, recruit, hire and train existing and new staff. Include cultural competence around LGBTQ community and SUD	12/31/2016
Identify peer leaders who have achieved VLS to co-facilitate support groups, assist with education and outreach, and act as escorts for appointments	3/31/2017
Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care. Training has been deployed on assessment for care coordination (part of care coordinator training) and on registry use with site-based DSRIP Program Directors/IT Staff/Quality Assurance staff. However, there have been delays in contracting with and deploying our PPS-wide CCMS tool—trainings are expected to go live in DY2 Q3.	6/30/2016

Develop and implement peer-based educational support and self-management programs	9/30/2017
Provide follow up support and materials to reinforce training objectives, including connecting clients with case managers/ retention to care unit and screening for barriers to adherence.	6/30/2017
Execute educational campaigns developed in collaboration with cross-PPS collaborative and NYCDOHMH	6/30/2017
In conjunction with BPHC Workforce Subcommittee, identify curricula for training providers, including care managers and peer support teams, on cultural competency, motivational interviewing, and other adherence support strategies. Include cultural competence around LGBTQ community and SUD.	6/30/2017