CNYCC Training Strategy

Purpose:

The Central New York Care Collaborative (CNYCC) has completed the following Training Strategy in fulfilment of Milestone #8 ("Develop training strategy") of the DSRIP program's workforce initiative. The purpose of this document is to describe our PPS's approach to planning for the provision of training, either explicit in DSRIP program requirements or implicit in the development of an integrated delivery system, for both individual staff as well as new, multi-disciplinary teams. To this end, Health WorkForce New York (HWNY) and JSI, our contracted workforce vendors, collaborated with partner organization representatives and CNYCC staff to identify and prioritize the amount, type, and timing of training necessary for successful project implementation and system transformation. In developing this Training Strategy, CNYCC engaged with representatives of our partner organizations, organized labor, professional certification providers, and educational institutions to ensure that the full breadth and depth of locally available training resources were identified. The deployment of training will follow the five-step ADDIE instructional design model: Analyze, Design, Develop, Implement, and Evaluate.

Analysis	The projects were thoroughly reviewed to identify DSRIP project-specific, organizational, and occupational training requirements.
Design	For each element, learning objectives, target audiences, depth of content, and potential delivery modes (e.g., trainer-led, on-line, blended) were identified.
Development	As commercially-available content is identified, it will be vetted by subject matter experts for quality of content and ease of delivery. Local resources will be engaged when there is a training need for which currently options are insufficient.
Implementation	CNYCC has inventoried currently-available in-person and online training resources. Additionally, the Workforce Committee is vetting options to meet the PPS's training and reporting requirements from a central Learning Management System (LMS), market for vetted content, extending an LMS, or individual partner reporting.
Evaluation	Once the mode of delivery has been selected and training content has been acquired, CNYCC will monitor participation rates, pre- and post-test scores, patient satisfaction outcome measures, vacancy, and retention rates.

Phased Development of a Comprehensive PPS-wide Training Strategy

The development of a comprehensive PPS-wide training strategy is occurring in two phases - the first of which culminated in the submission of this approved Training Strategy, and the second which will continue with the creation of detailed a workplan to operationalize elements of this Training Strategy.

The first phase of development primarily addressed the "Analysis" and "Design" steps of the ADDIE model, designating the groups or individuals with decision-making authority or responsibility for carrying out this Training Strategy. The second phase will refine the "Analysis" and "Design" work described in this Training Strategy into a detailed workplan that will advance to the "Development," "Implementation," and "Evaluation" phases of the ADDIE model.

Training Strategy Decision-Making Structure & Resourcing

Our PPS is comprised of highly diverse partners in terms of size and complexity that are geographically dispersed, including rural and urban settings. CNYCC is the PPS lead entity and is a separately incorporated, independent organization governed by a Board of Directors drawn from our partner organizations. As a result of this structure, our PPS is less vertically integrated than others where the lead entity is a large hospital and subsequently lacks the direct authority over hiring practices and resources that other PPSs possess. Therefore, CNYCC's primary role is to support, facilitate, and coordinate efforts across the network while recognizing and differentiating partners' diverse needs.

This Training Strategy was approved by CNYCC's Workforce Committee, the PPS workforce governing body, after a series of meetings during which Committee members provided substantial input upon earlier drafts. The Training Strategy document was the work product of a series of CNYCC staff, both employed and loaned from a co-lead partner organization, and with guidance from HWNY.

To further vet course content and training delivery options, CNYCC has proposed the creation of two subcommittees comprised of subject matter experts and members of the Workforce Committees. Their findings and final recommendations will be advanced to the Workforce Committee and ultimately the Board of Directors for approval.

Workforce Committee recommendations requiring the expenditure of PPS financial resources must be reviewed by the CNYCC Executive Director to determine whether those costs will be included in the CNYCC annual operating budget. The implementation of the Training Strategy will be the responsibility

of the CNYCC Manager for Workforce Strategy, under the supervision of the CNYCC Director of Program Operations & Strategy, with consulting support from HWNY. Funding is currently available through the approved PHM Implementation Plan to hire four trainers as staff members of CNYCC. These trainers will play a part in delivering training to our partners in a variety of areas including PHM.

The CNYCC Manager for Workforce Strategy has collaborated with the CNYCC Director of Communications & Stakeholder Engagement on the development of a Workforce Communication & Engagement plan. When Workforce Committee recommendations require action on the part of partner organizations, the Workforce Communication & Engagement plan will be activated.

CNYCC has also licensed use of Health WorkForce Apps (HWApps) from HWNY to facilitate ongoing workforce strategy spend and staff impact reporting. HWApps also includes informal communication, training content identification, and Learning Management System (LMS) modules. CNYCC has the opportunity to expand its contract with HWNY to include access to additional, relevant modules of the application should this be required by the Workforce Committee's choice of mode of training delivery.

The CNYCC Finance Committee must approve requests for funding that result from Workforce Committee recommendations, and the CNYCC IT and Data Governance Committee must approve requests for the acquisition of new technology. The CNYCC Clinical Governance Committee must review required trainings that will be delivered to clinical staff. CNYCC's robust governance structure will ensure that decisions regarding PPS-wide training are fully vetted, have the support of the PPS provider network, and are adequately resourced in order to be implemented successfully.

Phase 1: Analysis & Design

To identify the training requirements the PPS-wide Training Strategy must support, the PPS's 11 DSRIP projects and organizational work streams were thoroughly reviewed for explicit references to the development, delivery, and tracking of training. CNYCC's interim workforce lead and workforce consultants then held a series of facilitated discussions with CNYCC project management staff, consultants, and project representatives from CNYCC partner organizations to identify implicit training requirements and the likely audiences for each required training. This information formed the basis of a holistic syllabus (Attachment 2) which will be updated over time with input from learning subject matter experts, the Workforce Committee, CNYCC staff, and PPS partner organizations.

Explicit and implicit training requirements, both for individuals and care teams, fell naturally into two categories: DSRIP project-specific training and organizational work steam-specific training, both of which are discussed in greater detail in the following pages. All such trainings will supplement and complement, rather than replace or make redundant, the trainings already being delivered by our partner organizations. A third category of training requirements, related to health sector occupations in acute shortage that have been identified as key to successful DSRIP implementation, is described later in this document.

DSRIP Project-Specific Training

To identify project-specific training requirements, the interim workforce lead and consultants analyzed each of the project implementation plans, and then summarized and organized the resulting information by project. To validate this information, it was presented and discussed during CNYCC's Project Implementation Collaborative meetings convened by CNYCC project managers/consultants and attended by representatives of participating CNYCC partner organizations. After incorporating their feedback, the results were then presented to CNYCC's Workforce Workgroup, which has subsequently been transitioned into a formal Committee. The resulting table of Training by Project, including overall Training by Project Summary, is attached herewith as Attachment 1. During this process the specific requirements including type of training, training audience, source document, partners involved, and timing of training were identified and verified.

Organizational Work Stream Specific Training

For the goals of DSRIP to be met, it is essential that the PPS prepare its health care workforce to perform core transformational functions that transect projects, facilities or partner types, and job titles. Cultural Competency and Health Literacy, Information Technology Change Management, and Performance and Outcome Measurement and Rapid-Cycle Improvement were identified as organizational work streams that carry additional training requirements. Like the project-specific trainings, the details of the training requirements drawn from their related implementation plans are shown in Attachment 2. These specific content areas were addressed early in the DSRIP cycle and the thorough inspection of those topics has set the pattern of needs review and content provision for the rest of the training strategy.

Occupational Training

The workforce Gap Analysis that resulted from comparison of the projected Future State of the PPS workforce with the Current State lead to the identification of workforce shortages in the following areas:

- Primary Care Physicians
- Psychiatrists
- Behavioral Health Professionals at all levels
- Nurse Practitioners, Psychiatric Nurse Practitioners and Physicians Assistants
- Care Coordinators
- Patient Navigators
- Patient Care Technicians and front line direct care givers

To ensure access to these professionals, CNYCC will partner with education, training, and content providers including but not limited to:

- 1199SEIU – Service Employees International Union
- 1199SEIU Training and Upgrading Fund
- NYSNA – New York State Nurses Association
- CSEA – Civil Service Employee Association
- PEF – New York State Public Employees Federation
- UUP – United University Professions
- NYHIMA – New York Health Information Management Association
- St. Elizabeth's College of Nursing
- Upstate Medical University
- St. Joseph's College of Nursing
- LeMoyne College
- Syracuse University
- Onondaga Community College
- Mohawk Valley Community College
- SUNY
- Area Health Education Centers (AHECs)
- Other PPSs

As a short term strategy to address these shortages, CNYCC will work with the above resources to identify options for certificate-based training modules to fill immediate workforce gaps, and to identify currently available content or programs from elsewhere in the State where local resources are lacking. The Workforce Committee will continue to vet longer term strategies to combat acute shortages in key

positions, which could include options such as working with local AHECs to ensure connections between local youth, educational institutions, and employers are fostered and maintained. The range of options under discussion are described in greater detail in CNYCC's Workforce Transitions Roadmap.

Training Delivery Options:

Key to effective implementation of the Training Strategy will be selection of an approach or combination of approaches to deliver and track required trainings across the PPS partner network. CNYCC has identified four potential approaches to meeting the functional requirements of content delivery and tracking: acquisition of a central Learning Management System (LMS) to deliver centrally licensed course content; the development of a central marketplace for vetted course content that partners could then license for their employee's use; the extension of one of our partner's LMSs to the rest of the network; or distribution of the training syllabus to partners who could then independently deliver or acquire needed training for their employees. A workgroup of the Workforce Committee has been charged with the evaluation of the advantages and disadvantages of these four approaches (Attachment 3).

In making its decision, the workgroup is taking into consideration the relatively low number of PPS partner organizations currently utilizing LMSs, the relative cost and administrative burden upon partners of each option, and the weight given to portability, continuity, and quality of training content. The learning workgroup of the Workforce Committee will vet the available options to provide access to online learning and course registration, attendance management, and content management for all partners. Additionally, CNYCC will work with other PPSs to ensure training programs and content at the project, organizational work stream, and occupational levels is identified and coordinated in a way that improves access and reduces redundant spending.

Phase 2: Workplan Refinement, Development, Implementation, and Evaluation

Once the mode of delivery has been determined, content aligning with the approved syllabus will be identified and vetted by the Learning subcommittee and sourced from commercially available resources, shared from partners that exhibit best practices, or developed by contracted instructional designers, as needed. Based on the result of this process, the CNYCC Manager for Workforce Strategy will be responsible for developing a detailed, actionable workplan that specifies the exact course content to be delivered, the content delivery mechanism(s), the intended recipients, and the timing of content delivery. Having completed the "Analysis," "Design," and "Development" steps, Phase 2 will advance to

"Implementation" of the holistic program across the PPS partnership and "Evaluation" of the resulting outcomes. The results of the "Evaluation" process will lead to iterative revisions of training content, the workplan, and the overall Training Strategy to ensure that our approach is adequate to meet our goal.

Conclusion

The system transformation that the DSRIP program advances will require changes to the typical workflows of thousands of workers across the six-county area served by the Central New York Care Collaborative. The approach that this PPS will take to provide training to support the current workforce in acquiring the new skills necessary to rise to this challenge is the purpose of this Training Strategy, and the planned future phases of its development and implementation. The broad scale and rapid speed of this change poses a significant challenge, one that must be met in order for providers in this region to successfully transition from a fee-for-service reimbursement model to value-based payment.

Training Strategy Attachment 1:

Training Needs Identified	2.a.i	2.a.iii	2.b.iii	2.b.iv	2.d.i	3.a.i	3.a.ii	3.b.i	3.g.i	4.a.iii	4.d.i	Totals
Standardized protocol to manage overall population health				X								1
Standardized protocol to perform as an integrated clinical team (hospitals and post-acute care providers) Cross continuum protocols?				X								1
Policies and procedures for early notification of planned discharges				X								1
Policies and procedures for including care transition plans in EHR and updating in interoperable EHR / primary care provider record				X								1
Establish Patient Activation Measure (PAM) training team					X							1
Policies and procedures for timely intake of Community Navigator referrals					X							1
Integration of flexible/open scheduling					X							1
Sensitivity to power dynamics which occur in engagement processes; provider as authority figure and controlling access					X							1
Knowledge of community/ neighborhoods					X							1

Training Strategy Attachment 1:

Training Needs Identified	2.a.i	2.a.iii	2.b.iii	2.b.iv	2.d.i	3.a.i	3.a.ii	3.b.i	3.g.i	4.a.iii	4.d.i	Totals
Training in PC culture (BH practitioners); Training in BH culture and practice (PC practitioners)						X						1
Provider orientation to practice site						X						1
Provider training (e.g. PHQ-9 and/or SBIRT)						X						1
Patient coaching (behavioral activation), offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan (Model 3)						X						1
Use of EHR to document screening and "warm transfer" activities (Models 1 and 2), or demonstrating relapse prevention plans, patient coaching, and other IMPACT interventions (Model 3)						X						1
Technical assistance for navigating regulatory processes and procedures						X						1
Distinction between co-location and integration						X						1
Coordinated treatment care protocols							X					1
Central triage service/protocol							X					1
Diversion protocols							X					1

Training Strategy Attachment 1:

Training Needs Identified	2.a.i	2.a.iii	2.b.iii	2.b.iv	2.d.i	3.a.i	3.a.ii	3.b.i	3.g.i	4.a.iii	4.d.i	Totals
Training to incorporate the use of EHR to prompt the use of 5 A's of tobacco control; (for example tobacco use diagnosis, billing codes and patient referral response).								X				1
Standardized treatment protocols for hypertension and elevated cholesterol.								X				1
Care coordination processes to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.								X				1
Protocols for blood pressure measurements								X				1
Effective patient identification (at-risk of hypertension)								X				1
Person-centered methods for self-management (documentation in EHR)								X				1
Warm referral and follow-up processes (CBOs); follow-up on home blood pressure monitoring (patient).								X				1
Policies and procedures which reflect principles and initiatives of Million Lives Campaign.								X				1

Training Strategy Attachment 1:

Training Needs Identified	2.a.i	2.a.iii	2.b.iii	2.b.iv	2.d.i	3.a.i	3.a.ii	3.b.i	3.g.i	4.a.iii	4.d.i	Totals
Clinical guidelines agreed to by all partners, includes services/eligibility									X			1
DOH-5503 Medical Orders for Life Sustaining Treatment (MOLST) form									X			1
Role appropriate competence in palliative care skills.									X			1
What is Primary Palliative Care?									X			1
Care giver needs & preferences									X			1
Training on integrating tobacco screening and referral processes (per the 5As—Ask, Advise, Assess, Assist, and Arrange) into their scope of care/services targeting pregnant women who smoke											X	1
Train entities to become qualified entities/providers for Medicaid presumptive eligibility, specifically targeting pregnant women											X	1
Provide/coordinate trainings to enhance knowledge and competencies to work with pregnant women (e.g., deliver basic health education, promote health care service use, & provide social support)											X	1

Training Strategy Attachment 1:

Training Needs Identified	2.a.i	2.a.iii	2.b.iii	2.b.iv	2.d.i	3.a.i	3.a.ii	3.b.i	3.g.i	4.a.iii	4.d.i	Totals
Conduct an information seminar for prospective CenteringPregnancy® sites											X	1
Training on use of standard intake, enrollment, referral and follow-up forms & protocols											X	1

Training Strategy Attachment 2:

Project 2ai

Create an Integrated Delivery System Focused on Evidence-Based Medicine and Population Health Management

Training Needs Identified	Audience	Partners	Timing
PPS trains staff on IDS protocols and processes.	All PPS partners		DY2
EHR training	Safety net providers	EHR vendors; Practice Facilitators	DY3
Staff training on alerts and secure messaging functionality	Safety net providers	HealtheConnections, EHR vendors	DY3
Patient Centered / Whole Person Care o Development of effective, caring relationships with patients o Assessment of bio psychosocial needs across the life span o Patient-centered care planning, including collaborative decision-making and patient self-management o Cultural sensitivity and competence in culturally appropriate practice	PCMH eligible primary care practices	NCQA, HANYS; Practice Facilitators; CNYCC Cultural Competency/Health Literacy Workgroup	DY3
System-Based Care o Advocacy for patient-centered integrated care o Business models for patient–centered integrated care o Care coordination for comprehensive care of patient and family in the community o Promotion of appropriate access to care (e.g., group appointments, open scheduling)	PCMH eligible primary care practices	HANYS; EHR vendors; Practice Facilitators	DY3
Practice-Based Learning	PCMH eligible primary care practices	HANYS; EHR vendors; Practice Facilitators	DY3
Teamwork & Interprofessional Training o Communication & Professionalism o Team leadership o Interprofessionalism and interdisciplinary team collaboration	PCMH eligible primary care practices	HANYS; Practice Facilitators	DY3
Chronic Disease, Practice & Population Management o Population-based approaches to health care delivery o Risk identification	PCMH eligible primary care practices	HANYS; EHR vendors; Practice Facilitators	DY3

Training Strategy Attachment 2:

Project 2aiii

Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for health homes through access to high quality primary care and support services

Training Needs Identified	Audience	Partners	Timing
Staff training on alerts and secure messaging functionality	Safety net providers	HealtheConnections, EHR vendors	*See CNYCC Speed and Scale Commitments*
Create curriculum for training staff and providers on care plan process, and 'tip sheets' with screen shots to support learning. (5) Roll out training throughout clinic. (6)	PCMH Primary Care Practices and Health Homes	Health Home staff	*See CNYCC Speed and Scale Commitments*
Train providers and Health Home staff on using the evidence-based guidelines selected and share best practices. (8) Provide additional training and answer questions as needed. (11)	PCMH Primary Care Practices and Health Homes	NCQA	DY1 and DY2
Outreach and educate partner organizations on HHRIP and referral process, begin engaging patients	Safety net providers, others?	Health Home staff	DY1
Conduct meetings and trainings regularly. The purpose of the meetings is to discuss how to improve the functionality of the tools (for sharing care/patient info)	Safety net providers, others?	HealtheConnections, EHR vendors? Health Home staff?	
Motivational Interviewing	PCMH Primary Care Practices and Health Homes		

Training Strategy Attachment 2:

Project 2biii

ED Care Triage for At-Risk Populations

Training Needs Identified	Audience	Partners	Timing
Triage protocols with ED dedicated – Patient Navigators and ED medical providers (especially if planning to divert patients from ED). (7)	ED providers, Patient Navigators, Current staff - TBN (e.g. Social work)		DY1 and DY2
Identify/develop and implement procedures and protocols that connect the ED with community PCPs and track the transition of the patient from the ED to the PCP. (6) Protocols must also establish connectivity between ED and PCP's/CBO's. (10)	Patient Navigators, Primary Care Practices (PCPs), Current staff - TBN (e.g. Social work)		DY1 and DY2
Use EHRs and other technical platforms to track actively engaged patients for project milestone reporting.	Patient Navigators, Current staff - TBN (e.g. Social work)	EHR vendors, HealtheConnections	DY1 -
Develop and implement protocol for determining additional care management/community based (social) needs of triaged patients. (10)	Patient Navigators, Current staff - TBN (e.g. Social work)	Local Government Units (LGUs?), 211?	DY1 and DY2
Health Home (HH) scope of services, eligibility criteria and referrals process	Patient Navigators, Current staff - TBN (e.g. Social work)	Health Homes	DY1 and DY2
Patient Navigator Competencies *Cultural competency, Customer service, Patient Advocacy*	Patient Navigators, Current staff - TBN (e.g. Social work)		

Training Strategy Attachment 2:

Project 2biv
Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

Training Needs Identified	Audience	Partners	Timing
Standardized protocol to manage overall population health	Intensive Care Transitions Teams	Home care, County LGUs, Hospice, MLTC, Health Homes, Pharmacies, or other CBOs	DY1 and DY2
Standardized protocol to perform as an integrated clinical team	Intensive Care Transitions Teams	Home care, Hospice, Health Homes, MTLC, Pharmacies, or other CBOs	DY1 and DY2
PPS protocol to identify Health Home eligible patients and link them to services as required under ACA	Intensive Care Transitions Teams	Medicaid Managed Care Orgs, Health Homes	*See CNYCC Speed and Scale Commitments*
Policies and procedures for early notification of planned discharges	Primary Care Practices, Non Primary Care Practices, Hospitals, Long term care, Nursing homes, Rehab, HH, MLTC, Hospice, Behavioral Health providers		DY1 and DY2
Policies and procedures for including care transition plans in EHR and updating in interoperable EHR / primary care provider record	Non Primary Care Practices, Hospitals, Health Homes, Long term care, Nursing homes, Rehab, MLTC, Hospice, Pharmacies	HealtheConnections, EHR Vendors, PCPs	DY1 and DY2
Develop Protocol Implementation Training, include cultural sensitivity training in the curriculum (13)	Intensive Transition Team members, Transition Coaches, Peer Coaches and Health Home Care Managers	***Onondaga Co:*** *Interfaith works?* ***Oneida Co.:*** *MV Resource Center for Refugees.* ***FQHCs*** *have well-established cultural competency programs for care coordination*	DY1 and DY2
Motivational interviewing	Intensive Care Transitions Teams	*Health Homes*	DY1 and DY2
Stages of Change Framework for patient activation	Intensive Care Transitions Teams		DY1 and DY2
Use of telehealth for post-discharge monitoring?	Intensive Care Transitions Teams, Home Health Care, Skilled Nursing Facilities, PCPs, Specialty Care?	*SJHHC telehealth*	DY1 and DY2

Training Strategy Attachment 2:

Project 3ai
Integration of Primary Care and Behavioral Health Services

Training Needs Identified	Audience	Partners	Timing
Training in PC culture (BH practitioners); Training in BH culture and practice (PC practitioners)	PC and BH professionals	PC and BH professionals, Others?	DY1 -
Provider orientation to practice site	PC and/or BH professionals new to a practice	Practitioners, staff	DY2 -
Provider training (PHQ-9 and/or SBIRT)	PC and BH professionals (Models 1 & 2)	OMH, SBIRT trainers, Syracuse Behavioral Healthcare Training Institute	DY1 -
Patient coaching (behavioral activation), offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan (Model 3)	Depression Care Manager (Model 3)		DY1 -
Use of EHR to document screening and "warm transfer" activities (Models 1 and 2), or demonstrating relapse prevention plans, patient coaching, and other IMPACT interventions (Model 3)	PC and BH professionals (Models 1 & 2), Depression Care Manager (Model 3)	HealtheConnections, EHR vendors	DY1 -
Use of telehealth (telepsychiatry) for consultation?	Depression Care Manager (Model 3)		
Technical assistance for navigating regulatory processes and procedures	PC and BH professionals (Models 1 & 2)		
Distinction between co-location and integration	PC and BH professionals (Models 1 & 2)		DY2 -

Training Strategy Attachment 2:

Project 3aii
Behavioral Health Community Crisis Stabilization Services

Training Needs Identified	Audience	Partners	Timing
Coordinated treatment care protocols	CPEP at SJHHC, outreach, mobile crisis, and intensive crisis service providers, Health Homes, EDs, substance abuse		DY1 and DY2
Coordinated evidenced-based care protocols for mobile crisis	Mobile crisis teams	Medical staff from partner organizations (outreach, mobile crisis, and intensive crisis, substance abuse)	*See CNYCC Speed and Scale Commitments*
Staff training on alerts and secure messaging functionality	Safety net providers (PCP, non-PCP, Hospital, Behavioral Health)	HealtheConnections, EHR vendors	DY3
Central triage service/protocol	Psychiatrists and behavioral health providers	Psychiatrists, behavioral health, and substance abuse providers	*See CNYCC Speed and Scale Commitments*
Use EHRs or other technical platforms to track all actively patients.	Mobile crisis teams	EHR vendors, HealtheConnections	
Diversion protocols	First responders (schools, police, fire, EMS)	CPEP at SJHHC, outreach, mobile crisis, and intensive crisis service providers, Health Homes, EDs, substance abuse providers, *peer respite*	DY2-DY4
Cultural competency		*Peer supports*	

Training Strategy Attachment 2:

Project 3bi

Evidence-Based Strategies for Disease Management in High Risk/Affected Population (Adults Only) Cardiovascular Care

Training Needs Identified	Audience	Partners	Timing
Staff training on alerts and secure messaging functionality	Safety net providers (PCP, non-PCP, BH)	HealtheConnections, EHR vendors	DY1 - DY3
Use EHRs or other technical platforms to track all patients engaged in this project.	PCP providers and staff	HealtheConnections, EHR vendors	DY1 and DY2
Training to incorporate the use of EHR to prompt the use of 5 A's of tobacco control; (for example tobacco use diagnosis, billing codes and patient referral response).	PCP providers	EHR vendors	DY1 and DY2
Standardized treatment protocols for hypertension and elevated cholesterol.	PCP providers	Guideline sources: National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF)	DY1 and DY2
Care coordination processes to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	PCP care coordination team (may include nurses, pharmacists, dieticians, community health workers and HH care managers where applicable)	Public health organizations, NYS Smokers' Quitline website	DY1 and DY2
Protocols for blood pressure measurements	PCP staff		DY1 and DY2
Effective patient identification (at-risk of hypertension)	PCP care coordination team, clerical staff	EHR vendors	*See CNYCC Speed and Scale Commitments*
Person-centered methods for self-management (documentation in EHR)	PCP care coordination team	EHR vendors	*See CNYCC Speed and Scale Commitments*
Warm referral and follow-up processes (CBOs); follow-up on home blood pressure monitoring (patient).	PCP care coordination team	HealtheConnections, EHR vendors, CBOs	DY1 and DY2
If applicable… *1) Utilize race, ethnicity, and language (REAL) data to target high-risk populations; 2) established linkages to health homes for targeted patient populations; 3) implement Stanford Model through partnerships with CBOs.*	PCP care coordination team, CNYCC staff, CBOs	HealtheConnections, Health Homes, OASIS Chronic Disease Self-Management Program (Onondaga Co)	*See CNYCC Speed and Scale Commitments*
Policies and procedures which reflect principles and initiatives of Million Lives Campaign.	PCP care coordination team		*See CNYCC Speed and Scale Commitments*

Training Strategy Attachment 2:

Project 3gi
Integration of Palliative Care into PCMH Model

Training Needs Identified	Audience(s)	Partners	Timing
Clinical guidelines agreed to by all partners, includes services/eligibility	PCPs, Palliative care services	Hospice, *other community resources (?)*	DY1-DY2
DOH-5503 Medical Orders for Life Sustaining Treatment (MOLST) form	PCPs, Palliative care services	Hospice, *other community resources (?)*	DY1-DY2
Role appropriate competence in palliative care skills.	PCPs, Palliative care services	Hospice, *other community resources (?)*	DY1-DY2
Staff training in appropriate palliative care skills training, including training on PPS care protocols. *Cultural competency cited in Project Implementation Plan.*	PCP staff	Hospice, *other community resources (?)*	DY2
Use of EHR to track all patients engaged in the project	PCP	EHR vendor, HealtheConnections (RHIO)	DY1-DY2
What is Primary Palliative Care?	Primary care physicians and extenders; specialists? (Sometimes the patient is no longer seeing their primary care MD.)	Hospice, other community resources (?)	DY1-DY2
Care giver needs & preferences	Primary care physicians and extenders; front line staff.	Hospice, other community resources (?)	DY1-DY2
Available Community Resources	Primary care practices	?	DY1-DY2

Training Strategy Attachment 2:

Project 4di
Reduce Pre-term Births

Training Needs Identified	Audience(s)	Partners	Timing
Training on integrating tobacco screening and referral processes (per the 5As—Ask, Advise, Assess, Assist, and Arrange) into their scope of care/services targeting pregnant women who smoke	• Clinical providers (FQHCs, private practices) • Health Homes • Home visiting services • Community health workers • WIC	Tobacco-Free Coalition(s) and NYS Tobacco Control Program	By DY2 Q2
Train entities to become qualified entities/providers for Medicaid presumptive eligibility, specifically targeting pregnant women	• WIC • FQHCs • Hospitals • Homeless shelters	Free NYS online training for enrollment staff (only available to Article 28 facilities)	By DY2 Q2
Provide/coordinate trainings to enhance knowledge and competencies to work with pregnant women (e.g., deliver basic health education, promote health care service use, & provide social support)	Paraprofessionals (Community health workers)	U of R Center of Excellence? Healthy Families?	By DY1 Q4
Conduct an information seminar for prospective CenteringPregnancy® sites	• Clinical providers (FQHCs, private practices) • Community organizations	Centering Healthcare Institute	By DY2 Q2
Training on use of standard intake, enrollment, referral and follow-up forms & protocols	• Clinical providers (FQHCs, private practices) • Health Homes • Home visitation • Community health workers • WIC • Home Care • MCOs outreach staff		By DY3 Q4

Training Strategy Attachment 2:

Titles involved on Projects	2.a.i	2.a.ii	2.b.ii	2.b.i	2.d.i	3.a.i	3.a.ii	3.b.i	3.g	4.a.ii	4.d.i
Staff Type											
Physicians											
Primary Care Physicians	x			x	x	x		x	x		x
Other Specialties (Except Psychiatrists)	x				x	x		x			x
Mid-levels											
Physician Assistants	x					x		x			
Primary Care Physician Assistants	x			x		x		x	x		
Behavioral Health Physician Assistants	x							x			
Nurse Practitioners	x					x		x			x
Primary Care Nurse Practitioners	x			x		x		x	x		x
Other Specialties (Except Psychiatric NPs)	x							x			
Nursing											
Nurse Managers/Supervisors	x			x	x	x		x	x		x
Staff Registered Nurses	x				x	x		x			x
Other Registered Nurses (Utilization	x				x	x		x			x
LPNs	x				x			x			x
Clinical Support											
Medical Assistants	x				x			x	x		
Behavioral Health (Except Social Workers											
Psychiatrists				x		x	x		x		
Psychologists	x					x	x	x			
Psychiatric Nurse Practitioners	x				x	x	x	x			x
Licensed Clinical Social Workers	x				x	x	x	x			x
Substance Abuse and Behavioral Disorder	x			x		x	x	x			
Other Mental Health/Substance Abuse						x	x				
Social and Human Service Assistants					x	x	x				x
Psychiatric Aides/Techs						x	x				
Nursing Care	x	x		x	x			x	x		
RN Care Coordinators/Case	x	x		x	x	x		x	x		
LPN Care Coordinators/Case Managers	x	x		x	x	x		x	x		
Social Worker Case Management/Care	x	x		x	x	x	x	x	x		x
Bachelor's Social Work	x				x	x	x	x			
Licensed Masters Social Workers					x	x	x				x
Population Health											
Social Worker Care Coordinators/Case				x		x	x		x		
Non-licensed Care Coordination/Case	x	x	x		x		x	x			
Care Manager/Coordinator (Bachelor's	x	x		x	x	x		x			
Care or Patient Navigator		x	x		x						
Community Health Worker (All education	x	x	x					x			x
Peer Support Worker (All education levels)	x			x			x	x			
Patient Education	x			x				x			
Health Coach	x			x	x			x			
Health Educators	x			x	x			x			
Administration and Non-clinical support											
Administrative Assistant	x					x		x			
Executive Staff	x				x			x			x
Medical Secretaries	x				x			x			
Coders/Billers	x							x			
Financial Service Representatives											

Training Strategy Attachment 2:

Titles involved on Projects	2.a.i	2.a.iii	2.b.iii	2.b.iv	2.d.i	3.a.i	3.a.ii	3.b.i	3.g.i	4.a.ii	4.d.i
Staff Type											
Housekeeping											
Medical Interpreters	x			x				x			
Patient Service Representatives											
Patient Transport											
Health Information Technology	x	x		x			x	x	x		
Health Information Technology Managers				x							
Home Health Care											
Certified Home Health Aides Personal Care Aides				x	x						
Other Allied Health											
Nutritionists/Dieticians Occupational Therapists	x							x			x
Occupational Therapy Assistants/Aides Pharmacists						x	x				
Pharmacy Technicians	x			x			x				
Physical Therapists											
Physical Therapy Assistants/Aides											
Respiratory Therapists											
Speech Language Pathologists											

Training Strategy Attachment 2:

Training Course Catalogue

Required for Project Payment:

5 A's-Ask, Advise, Assess, Assist, and Arrange
Becoming a qualified entity/ Provider for Medicaid presumptive eligibility
Brief Action Planning
Care Coordination Fundamentals
Clinical Educational protocols
Coaching For Activation
Collaborative Care (interdisciplinary and interprofession)
C o ordinated treatment care protocols
Empanelment
Evidence Based guidelines, standards, or protocols
Health Home scope of services, eligibility, referral, and handoff
Intake Community Navigator referrals
Integrated tobacco screening
MOLST form Training
Motivational Interviewing
Palliative Care Integration
Patient Activation Measure (PAM)
Patient Activation Techniques
Patient Centered Care
Patient Navigation (Care Navigator)
Patient-Centered Medical Home
Population Health Management and Chronic Disease
Presumptive Eligibility
Primary Care and Behavioral Care Integration
Self-Management Support
Shared Decision Making
Social determinant health
Standard intake, enrollment, referral
Standardized Protocols for an integrated clinical care team
Standardized Talking Points for Health Care Connectivity
Standards of care for blood pressure (and home blood pressure) measurement standards
Standards of care for Combination hypertension medications
Standards of care for Hypertension and Elevated Cholesterol Evidence-Based guidelines
Standards of care for Integration of Primary Care and Behavioral Health Services
Standards of care for Tobacco use cessation strategies
Transitional Care
Triage protocols and Diversion

Training Strategy Attachment 2:

DSRIP Essential, Unmapped for Payment:

Actively Engaged Patients Standards and Measurement

Cultural Competency

DSRIP 101

Health Literacy Performance and Outcomes Measures based on Clinical Quality Standards

Rapid Cycle Improvement and Evaluation Methods

Needed for High Performance in the PPS:

Leadership Development
Learning to Work as a Team
Communications and Leadership (Professionalism)

Training Strategy Attachment 2:

CHANGE PROCESS ROLES AND RESPONSIBILITIES

The change process governance structure draws upon CNYCC's existing governance and organizational structures, but supports the need for rapid and direct decision making through the creation of a Change Advisory Panel (CAP). Roles and responsibilities for each of the governing participants are outlined below (Table 1).

Table 1. Change Process Roles and Responsibilities

Role	Change Process Responsibilities
Change Requestor(s)	• Person(s), PPS partner organization, PPS governing body, or CNYCC staff member that has identified and initiated a Change Request • Work with Change Owner to complete Change Request Submission • Define functional requirements and specifications • Participate in User Acceptance Testing (UAT) as applicable
Change Owner(s)	• Member(s) of CNYCC staff responsible for coordinating overall Change Request • Responsible for working with the Change Requestor to facilitate Change Request submission • Responsible for identifying business requirements, driving the proper business justification, and final signoff of a change at post-implementation review • Obtain input from CNYCC Learning Collaboratives, governing bodies, workgroups, or partner organizations as appropriate to generate, validate, test, or obtain advisement on, requested changes • Develop Testing, Implementation and Back-out Plans • Facilitate Testing Plan Execution and/or validation as applicable
Change Advisory Panel (CAP)	• Responsible for review and approval of Change Requests with Level 3 and Higher Risk Scores • Responsible for evaluating training, communications, testing, cost and timeline requirements for given changes • Responsible for assuring that all required approvals and inputs have been obtained for a Change Management Request • Review Risk Assessment and Partner Risk Assessment Outcomes
CNYCC IT Department & Change Control Manager	• Work with Change Requestor and Change Owner to determine if change requests should be processed as Urgent or Standard • Complete Partner Impact Assessment • Complete Risk Assessment • Coordinate changes with 3rd Party IT solution vendors, as applicable

	• Support development of Testing, Implementation and Back-out Plans, as applicable • Support Testing Plan Execution • Manage Communication Plan for IT level Change Requests
CNYCC PMO	• Validate that requested changes are aligned with DSRIP goals, objectives, projects, or program requirements • Identify stakeholder groups to provide input on Change Requests, as applicable • Assigns Change Owner
CNYCC Communications Department	• Manage Communication Plan for Enterprise level Change Requests
CNYCC Training Department	• Manage Training Plan for all applicable Change Requests
CNYCC Compliance Officer	• Advise Change Owner and CNYCC's IT Department on compliance considerations associated with all applicable change requests
IT and Data Governance Committee	• Review and approve standards for data definitions, data elements, and data exchange • Establish priorities for IT expenditures • Monitor progress in achieving IT goal
Clinical Governance Committee	• Oversee development of and approve related clinical protocols, standardized care management processes, clinical workflows and evidence-based standards • Oversee Change Implementation related to care delivery, care coordination, quality standards, and quality performance • Review plan for changes to carry out clinical quality improvement and care coordination
Board of Directors	• Review and approval of applicable budgetary considerations associated with Change Requests

The CNYCC Change Advisory Panel (CAP):

The CAP was established to oversee changes and ensure integrity for all systems in the IT Production environment. The CAP is a cross-functional team (Table 2) containing representatives responsible for the oversight and operation of CNYCC's IT infrastructure, security, and applications and that meets weekly (or as needed) to evaluate change requests for business needs, priorities, costs/benefits, and potential affects to other systems or processes. They also identify if further analysis is required and if additional approvals must be obtained. Barring no further input, or approvals are required, the CAP makes a decision for approval or denial of the Change Request.

Training Strategy Attachment 3:

LMS Options	CNYCC Hosted LMS	CNYCC Hosted Learning Market
Pro's	• All PPS partners have access to all training needed to meet DSRIP needs, expand collaboration, and improve employee performance • Reporting pressure removed • Messaging is consistent across the region • Current best practices will be available to all partners as they emerge through the training deck • Mandatory training is provided by the PPS • Optional training will be considered for coverage on an individual basis	• All PPS partners have access to all training needed to meet DSRIP needs, expand collaboration, and improve employee performance • Reporting pressure removed • Messaging is consistent across the region • Current best practices will be available to all partners as they emerge through the training deck • Courses will reside on and purchased via the central Learning Market for the PPS • Messaging is consistent across the region • CNYCC will coordinate delivery with the vendors for "live" trainer-led classes and webinars • Validation testing may be made available PPS-wide
Con's	• Cost to the PPS to pilot is $10,000 for 6 months with extended use to be negotiated • Agreement on selection or development of best-in-class content will take time and resources from partners SME's • Time to implement the LMS • Potential redundancy in training	• Cost to the partners may vary depending on the vendors licensing or delivery model • Agreement on selection or development of best-in-class content will take time and resources from partners SME's • Time to implement the LMS • Potential redundancy in training
	PPS Accesses Partner LMS	**CNYCC Collects Partner Training Reports**
Pro's	• Infrastructure and content has been vetted and is functional • All PPS partners have access to all training needed to meet DSRIP needs, expand collaboration, and improve employee performance • Messaging is consistent across the region • Current best practices will be available to all partners as they emerge through the training deck • Validation testing may be made available PPS-wide	• PM will alert DSRIP Coordinators when a payment will be effected by training reporting • When known PM's will share reporting templates asap with partners • Partners are free to build best in class content and innovate • Validation testing may be made available PPS-wide
Con's	• Cost to the partners may vary depending on the vendors licensing or delivery model • Agreement on selection or development of best-in-class content will take time and resources from partners SME's • Time to implement access or migration • Reporting may be available but would reside with the partner • Potential integrity risk to network	• All responsibility to develop and deliver content, track and report on participation and corresponding auditing will reside with the partner • Messaging, continuity, and efficacy will vary and may impact performance reporting • The financial burden will reside with each partner separately