



COMMUNITY CARE
OF
B R O O K L Y N

WORKFORCE TRAINING STRATEGY

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Chapter 1 EXECUTIVE SUMMARY

The Community Care of Brooklyn (CCB) Workforce Training Strategy is a comprehensive and detailed plan describing the delivery of training to address the needs of the CCB Performing Provider System (PPS). Workforce development is a key component of the New York State Delivery System Reform Incentive Payment (DSRIP) Program, which involves a reinvestment of more than six billion dollars to improve healthcare and to reduce avoidable hospital use by Medicaid beneficiaries by 25% over the next five years.

Each PPS is required to develop a workforce training strategy that includes the types of training needed for various titles, the modalities that will be used, and how training outcomes will be measured. CCB's workforce training strategy was developed collaboratively with the 1199SEIU Training and Employment Funds, key PPS stakeholders, the CCB Workforce Committee and staff of the CCB Central Services Organization.

This comprehensive strategy represents CCB's plan to create a well-trained workforce, use training to fill skill and knowledge gaps, create career pathways, implement and sustain change throughout the transition, and create stability to the existing workforce by providing new knowledge and skills. The Workforce Training Strategy was developed using a compilation of data collected from CCB's clinical operations plans, community needs assessment, training needs assessment, target state, gap analysis, and transition roadmap reports.

Using this data, CCB: (1) determined the knowledge and skills needed for its DSRIP projects, (2) identified gaps in training, (3) developed a menu of training offerings, and (4) researched training providers with capacity to meet CCB's training needs. This workforce training strategy identifies key titles impacted by DSRIP, describes their role within each project, lists the competencies needed to fulfill those roles, and describes how those competencies will be acquired through training.

CCB's plan is to retrain the existing workforce to provide staff with a knowledge of healthcare reform, population health, their role on interdisciplinary teams, integrated care models; and skills in care coordination, cultural competencies, and changing roles for expanded care management. CCB will offer a multimodal approach to deliver training to meet the demand of its workforce. Additionally, CCB will work with its stakeholders to mitigate job loss by offering training for staff to take on new roles in a variety of care settings. Finally, CCB has included in its workforce strategy, training scale and speed targets that support its current workforce needs and anticipated growth.

The workforce training strategy integrates CCB's cultural competency and health literacy training strategy, and aligns itself with key elements highlighted in CCB's community

engagement plan. This integrated approach is critical to achieving CCB's vision of a culturally competent workforce that meets the needs of patients and their communities. The workforce training strategy serves as a roadmap that will guide Community Care of Brooklyn and its partners in transforming the current state of the Brooklyn healthcare delivery system over the next five years.

Chapter 2 INTRODUCTION

The Community Care of Brooklyn, the Maimonides Medical Center led Performing Provider System (PPS), is participating in the New York State Department of Health (NYSDOH) Delivery System Reform Incentive Payment (DSRIP) program. CCB is comprised of over 800 participant organizations, more than 3,700 clinical providers (including 1,600 PCP's), and over 448,000 attributed Medicaid lives, making it one of the largest PPSs in New York State and the largest in Brooklyn. CCB includes organizations from across the social and clinical service continuum, including Interfaith Medical Center, Kingsbrook Jewish Medical Center, Maimonides Medical Center, New York Community Hospital, New York Methodist Hospital, and Wyckoff Heights Medical Center as Brooklyn hospital partners.

CCB's overall workforce strategy is focused on creating a well-trained, highly engaged, and patient-focused workforce. The workforce strategy encompasses the workforce development needs of employees across the CCB network. It includes five ways to address those needs and minimize negative effects on the workforce. These approaches strategically position CCB to achieve its workforce goals:

1. Retraining the existing workforce

Retraining is the provision of new skills and knowledge to existing employees of PPS partners who are at risk of lay-off or for the purpose of redeployment. Redeployed employees are people who are currently employed by any PPS partner in DSRIP Year 1 and who transition into another job title, including those who transition to another job with the same employer¹. Maintaining stability in the current workforce is a mitigation strategy within the CCB workforce vision, and retraining is crucial to the overall training strategy. The training strategy focuses on how newly-gained skills and knowledge necessary to support the goals of DSRIP projects are delivered. Skills development includes classroom instruction, whether provided by a college or another training provider².

2. Training newly hired staff needed to accomplish DSRIP goals in each of CCB's 10 projects

¹ *New York State Department of Health, Delivery System Payment Reform Program (DSRIP). Viewed September 15, 2016.* http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrp_project_toolkit.pdf

² *Ibid.*

New hires include all new employees who support DSRIP projects and PPS infrastructure, including, but not limited to executive and administrative staff, professional and para-professional clinical staff, and professional and para-professional care coordination staff³. Newly hired staff may be hired into existing titles or into emerging roles. Training newly hired staff members to learn new care models, interventions and workflows will help CCB to deliver on DSRIP project goals.

3. Training to support redeployment strategies

Staff members in jobs that are identified as most at-risk for elimination because of healthcare system transformation efforts will require training for similar jobs in the PPS network or for newly created positions. The workforce training strategy provides a plan for training redeployed staff, and for developing training programs needed to prepare staff for redeployment. In its transition roadmap, CCB has identified how trainings align with recognized career pathways and talent pipelines.

4. Training to support recruitment and retention strategies

CCB recognizes that recruitment and retention of highly qualified staff is critical to achieving project goals. The current state survey analysis includes information about needed credentials for various titles within the network. Additionally, initial workforce planning efforts have resulted in staffing models for each project and a delineation of the basic qualifications needed for those staff members who are providing care. This strategy identifies cross-cutting trainings needed to support staff retention, including training that is designed to best meet project goals.

5. Stakeholder and worker engagement

This document includes partner and workforce engagement in the planning process, including defining the PPS's approach to assessing training needs, modalities and measurement. Alignment with the Communications Strategy, the Community Engagement Workgroup, and the Cultural Competency and Health Literacy Training Strategy is also included in this training strategy.

Conclusion

CCB's workforce development training strategy is focused on delivering high-quality training that will mitigate the negative impact of healthcare transformation on the workforce and lead to a highly-motivated and patient-centered workforce across the PPS. By providing new knowledge and skills to newly hired, incumbent and

³ Ibid

redeployed workers, CCB will achieve workforce stability while improving clinical outcomes and patient engagement.

Chapter 3 TRAINING NEEDS ASSESSMENT

Section 3.1: Assessment: approach and method of assessing training needs

CCB assessed its workforce training needs in three phases. In an effort to meet its scale and speed targets, the first phase of the training needs assessment occurred in project workgroups. From February 6, 2015 to May 31, 2015, workgroups met to discuss the programmatic and clinical requirements for each project, including clinical workflows, staffing needs, and required competencies. These workgroups were charged with determining clinical milestones for Domain 2 (with exception of project 2.a.i) and Domain 3 projects, and related risks and mitigation strategies as part of implementation plan development. Workgroup members included experts from a wide array of network partners, including hospitals, Federally Qualified Health Centers (FQHCs), community providers, social service organizations, care management agencies, and workforce partners. Members discussed the roles and responsibilities of staff members needed for each project, how staff members worked on care teams and their role interdependencies. In addition, workgroups helped to develop clinical operation plans, which included immediate needs for trainings to improve patient engagement and clinical outcomes. Existing training resources and potential training partners were identified. The initial training needs assessment results were incorporated into later phases of the training plan.

The second phase of the training needs assessment included an analysis of the PPS's current state survey and looked at specific job titles. This survey assessed the competencies and credentials of the existing workforce, which provided information on existing skill sets and where additional training would be needed. CCB's gap analysis provides a definitive composite of those needs and the transition roadmap describes how CCB will fill those gaps. In the interim, training is underway to address immediate needs.

Phase three of the training needs assessment included a survey of partners and the community-at-large of existing training resources available within the network and Brooklyn community. Additionally, partners were asked to identify training needs related to compliance, information technology (IT), cultural competency/health literacy (CC/HL), value-based payment models, and the development of an integrated delivery system.

Section 3.2: Results

The Training Needs Assessment identified three categories of trainings integral to support DSRIP goals and promote new knowledge and skills for the workforce. These categories are

cross-cutting training needs, project-specific training needs, and provider training needs. In addition to the education requirements summarized in CCB's Gap Analysis Report, core competencies in care management, care coordination, health information technology, healthcare reform, and cultural competency/health literacy were identified as fundamental to CCB's overall workforce training strategy. These competencies are included in the categories described below. Chapter 4 – Training Plan includes more information on the specific trainings that will be delivered to meet the training needs described in this section.

Cross-cutting training needs

Cross-cutting training needs are trainings that can benefit the entire PPS workforce. These are high-level, foundational or introductory trainings needed to provide fundamental information about DSRIP, healthcare policy, and CCB. These trainings will help to ensure that all workers understand the goals of DSRIP, patient-centered care and the promotion of health literacy and culturally competent care. Cross-cutting training needs are particularly applicable to 2.a.i – Creating an Integrated Delivery System. Project 2.a.i involves all partners in the PPS network.

Skills, Knowledge and Competency Needs

- Acclimation to DSRIP, CCB, Population Health, and Healthcare Reform
- Integrated Delivery System and PPS Protocols
- Cultural Competency/Health Literacy
- Competence in Care Coordination, Interdisciplinary Care Teams, and Health Information Technology

Project-specific training needs

Project-specific training needs are trainings that are necessary to support clinical outcomes for a specific DSRIP project. These trainings can be high-level, foundational courses with added skills enhancement. Some examples of project-specific trainings are: IMPACT collaborative care model, care model training (i.e. the Stanford Model for Chronic Disease Management); best-practices training such as transitional care and the American Lung Association Free from Smoking® (smoking cessation) program; and interdisciplinary team training.

CCB is also providing technical assistance to help primary care partners establish high-functioning patient-centered medical homes, achieve National Committee for Quality Assurance (NCQA) 2014 PCMH Level 3 recognition and meet DSRIP requirements simultaneously. As CCB's selected projects and interventions align with PCMH efforts, helping primary care practices become PCMHs will help CCB achieve DSRIP goals. Staff

working on these projects will improve care for patients by utilizing best practices in patient-centered care. CCB selected projects focused on improving health outcomes of people with multiple chronic conditions, including cardiovascular disease, asthma, diabetes, depression, palliative care needs and HIV/AIDS.

2.a.iii- Health Home at Risk (HHAR) Intervention Program

Project Objective

The HHAR project expands access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers from Health Homes) to meet the individual needs of patients who do not qualify for care management services from Health Homes under current NYS HH standards (i.e., patients with a single chronic condition but at risk for developing another), but who appear on a trajectory of decreasing wellness and increasing need that will likely make them HH eligible in the near future.

Skills, Knowledge and Competency Needs

- Chronic Disease Management
- Care Coordination
- Competence in patient navigation
- Patient Engagement skills

2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions

Project Objective

The project aims to provide a 30-day transitional care intervention to address the clinical and psychosocial drivers of readmission among a group of patients at high risk for avoidable utilization. This project will target patients with recent utilization as well as patient with cardiac, renal, endocrine, respiratory and/or behavioral health disorders that are at an increased risk for utilization. Key elements of the intervention will include the identification of all community-based providers (including medical providers and existing case managers; transmission of the discharge summary to the next-level provider; collaboration with community-based supports; linkage to long-term care management supports if needed.

Skills, Knowledge and Competency Needs

- Care planning
- Documentation
- Competence in best practices in care transitions and adopted models

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

Project Objective

Project goals of integrating primary care and behavioral health services include promoting access and ensuring coordination for members who receive care in these settings, which can be achieved by various approaches. CCB has chosen to implement the following models:

Model A: PCMH Service Site

This model involves integration of behavioral health specialists into primary care clinics using the collaborative care model and supporting the PCMH model. Behavioral health services will be co-located at primary care practice sites. Behavioral health specialists will conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT), and assessment and treatment services on site.

Model B: Behavioral Health Service Site

This model involves the co-location of primary care services at behavioral health sites. It requires collaborative evidence-based standards of care including medication management and care engagement process. Conduct physical health preventive care screenings, as well as behavioral health screenings (PHQ-9, SBIRT), as well as on-site ongoing primary care services.

Model C: IMPACT

Behavioral health specialists work with primary care providers on-site in this evidence-based model of collaborative care for depressive and anxiety disorders called IMPACT (Improving Mood - Providing Access to Collaborative Treatment). This model includes screening, assessment, and time-limited treatment for depression and anxiety.

Skills, Knowledge and Competency Needs

- Evidence-based practices for behavioral health
- Patient engagement skills
- Medication reconciliation

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

Project Objective

To ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of cardiovascular disease. These strategies are focused on improving practitioner population management, adherence to evidence based clinical treatment guidelines, and the adoption of activities that will increase patient self-efficacy and confidence in self-management. Strategies from the Million Hearts Campaign and the Stanford model are strongly recommended.

Skills, Knowledge and Competency Needs

- Evidence-based practices for Cardiovascular Disease prevention and management
- Care coordination
- Competence in care planning and patient goal setting

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

Project Objective

To ensure implementation of asthma self-management skills including home environmental trigger reduction, self-monitoring, medication use and medical follow-up to reduce avoidable ED and hospital care. Emergency department visits and hospitalizations for exacerbations should be considered avoidable events with good asthma management. Home-based services can address the factors that contribute to these exacerbations. Special focus will be on children where asthma is a major driver of avoidable hospital use.

Skills, Knowledge and Competency Needs

- Evidence-based practices for Asthma prevention and management
- Care coordination
- Competence in care planning and goal setting

Project 3.g.i: Integration of Palliative Care into the PCMH Model

Project Objective

The objective of this project is to increase access to palliative care programs. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of providers, nurses, and other specialists who work together with a patient's other providers to provide an extra layer of support.

Skills, Knowledge and Competency Needs

- Overview of Palliative Care
- Care planning
- Patient engagement

Project 4.a.iii: Strengthen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)

Project Objective

Support collaboration among leaders, professionals and community members working in Mental and Emotional Behavior health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery and strengthen infrastructure for MEB health promotion and MEB disorder prevention. MEB health promotion and disorders prevention is a relatively new field, requiring a paradigm shift in

approach and perspective. 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.

Skills, Knowledge and Competency Needs

- Evidence-based collaborative models for Mental Wellness
- Population Health Management
- Care Coordination

Project 4.c.ii: Increase early access to, and retention in, HIV care (Focus Area 1; Goal #2)

Project Objective

The goal of this project is to increase the percentage of HIV-infected persons with a known diagnosis who are in care and to increase the percentage of HIV-infected persons with known diagnoses who are virally suppressed.

Skills, Knowledge and Competency Needs

- Knowledge of retention strategies in care interventional training to promote viral load suppression
- Patient engagement skills
- Medication reconciliation
- Care coordination and navigation skills

Provider training needs

According to CCB's transition roadmap and gap analysis reports, the PPS has over 1,600 Primary Care Providers in its network with anticipated DSRIP impact growth of an additional 97 by 2020. Medical specialists such as cardiologists, emergency physicians, and psychiatrists are also included in the network. CCB's focus on NCQA standards, population health management and improved health outcomes requires a robust provider engagement and training plan. The following provider training needs were identified in addition to those listed as cross-cutting training needs.

- Psychopharmacology
- Evidence-based best practices for Chronic Disease Management
- Evidence-based best practices for Patient Engagement
- Use of Registries
- PCMH Technical Assistance

Chapter 4 TRAINING STRATEGY AND PLAN

Section 4.1: Approach

In an effort to align the workforce with CCB's DSRIP projects and goals, this strategy seeks to use the training needs assessment, project selection, DSRIP goals, and CCB's community needs assessment to identify the training needed to drive change, increase knowledge, enhance skills, and improve the workers' ability to provide patient-centered care. This strategy also outlines trainings to address workforce gaps.

The training programs will provide a comprehensive understanding of the practical skills essential to working in a diverse work environment that increasingly demands efficiency. The diversity of patients and healthcare-related reforms require the workforce to be trained to function in ever changing work environments, to think critically and to provide effective solutions to problems. Therefore, critical thinking skills, care coordination and care management are at the core of this training strategy. Embedded in CCB's training programs are evidence-based best practices, such as the Stanford Model for Chronic Diseases management. Trainings will demonstrate new ways to approach complicated situations and demonstrate how their actions influence health outcomes and improve patient engagement and patient self-management.

Recognizing that training is highly contextualized for systemic transformation, this strategy provides the following framework that meets the training requirements for DSRIP workforce spending.

The strategy includes:

1. Training related to population health, care management, interdisciplinary teams, and care coordination,
2. Training required for all non-clinical staff to successfully work within this new care delivery framework or to develop new skills needed to support new care models,
3. Training on adjacent topics such as value-based contracting, performance monitoring, and other compliance-related training,
4. Training that is focused on addressing social determinants of health-e.g. cultural competency and health literacy,
5. Training associated with managing change and process improvement,
6. Educational programs, continuing education and coursework leading to career pathways in collaboration with local institutions of learning,
7. Informational conferences, town hall meetings, seminars regarding population health, emerging models of care, and industry changes,
8. Technical training on regulatory compliance, IT platforms, health exchanges, etc.

The strategy excludes:

1. Training that does not pertain to the DSRIP projects that CCB has selected
2. Routine training that occurs already-e.g. fire safety, basic life support, etc.
3. Training that only applies to Medicare or to commercial payers
4. Training of patients and family members

CCB has identified the useful training approaches for its workforce training strategy, which are described below. CCB will ensure that its training partners incorporate these training approaches in all course offerings.

Adult Learning Theories

The training strategy includes a variety of approaches to allow people to use their preferred styles to learn and retain information. CCB will deploy the following adult learning theories: Constructive Learning Theory, Differentiated Instructional Theory, and Collaborative Learning Theory.

Constructive Theory uses the experience that people gain during their lifetime to help them learn. By relating life experiences to learning, healthcare teachers can help students understand healthcare related problems in a new way. This learning tool helps students relate concepts to their environment, and is constructive to the learning experience. The interactive role-plays included in the classroom trainings use constructive learning theory.

Differentiated Instructional Theory will provide a structural environment for learners. Understanding the importance of diversity in teaching and learning is very important, as not all students are alike. Therefore, differentiated instruction gives students multiple options for taking in information and making sense of ideas. Differentiated instruction is a teaching theory based on the premise that instructional approaches should vary and be adapted in relation to individual and diverse students in classrooms. The use of videos, tactile exercises, and graphically enhanced slide presentations are used throughout multiple modalities within the CCB training menu.

Collaborative Learning Theory is based on the view that knowledge is a social construct. Collaborative activities are based on four principles: (1) The learner or student is the primary focus of instruction; (2) interaction and "doing" are of primary importance; (3) working in groups is an important mode of learning; and (4) a structured approach to developing solutions to real-world problems should be incorporated into learning.

Collaborative learning can occur on a peer-to-peer basis or in larger groups. Peer learning, or peer instruction, is a form of collaborative learning that requires students to work in

pairs or small groups to discuss concepts and find solutions to problems. Large and small group discussions, group exercises, peer review and critique are examples of collaborative learning strategies that are included in classroom courses provided by CCB.

Use training to support change

DSRIP requires the workforce to think differently about how they deliver care. For example, the role of the Transitional Care Nurse (TCN) is to ensure that the patient remains connected to care and resources throughout the 30 days after discharge from the hospital in order to maintain stability throughout this critical period. The aim is for the TCN to understand his or her role as a care planner and connector to resources, as well ways to prevent an avoidable hospital re-admission. This requires a meta-cognitive shift in the way they see themselves as a caregiver, a care team member, and the decisions they make on behalf of their patients. The Interdisciplinary Care Team training and the TCN training are specifically designed with this strategy in mind.

Develop a core curriculum

Care coordination, care management, collaborative care, population health management, and patient-centered care are key healthcare reform principles. They are particularly critical to achieving CCB's DSRIP goals. The core curriculum meets the cross-cutting training needs and are those trainings associated with project 2.a.i. CCB's goal is that every staff person in its network have access to these trainings. These core trainings are listed in the training plan in Appendix I and are described in more detail in Appendix II.

Incorporate Best-practices into the Training

The CCB approach has identified several best-practices for its DSRIP project care models. Some of these practices include: The Stanford Model for Chronic Disease Management, the Million Hearts® Campaign, Motivational Interviewing, Critical Time Intervention, and IMPACT. Some of the trainings offered by the CCB PPS have incorporated best-practices in several ways. The courses on chronic disease management include practices from the Stanford Model and Million Heart Campaign (Cardiovascular Disease, or CVD).

Based on the training needs assessment and results, CCB inventoried existing training programs/resources, identified training curriculum/provider gaps and catalogued a menu of trainings that would meet the identified training needs. These needs were incorporated into a training strategy.

Section 4.2: Training Strategies for Meeting the Needs of CCB's Workforce

CCB has identified five strategies for training that are essential to workforce transformation in DSRIP. These strategies are: (1) retraining the existing workforce, (2)

training newly hired staff needed to accomplish DSRIP goals in each of CCB's 10 projects, (3) training to support redeployment (reassignment) strategies that will mitigate job loss resulting from system transformation, (4) training to support recruitment and retention strategies, and (5) actively engaging its stakeholders and its workforce.

Strategy 1: Retraining the existing workforce

DSRIP will create new demands for CCB's current workforce. Primary Care Providers will be required to connect care to new clinical measures, nurses will be required to maintain continuity of care for patients during transitions across care settings, behavioral health providers will be required to be members of the core care team. All of CCB's current workforce will be required to understand population health and social determinants that impact health outcomes. CCB has identified the following titles that may require retraining.

Emerging care coordination titles

CCB plans to leverage the workforce of its 35 partner community-based organizations. According to CCB's current state report findings, there are more than 1,117 staff in emerging care coordination titles currently in its network. Specific job titles within these partner organizations may vary. However, the roles are the same. Some commonly used titles are care manager (non-RN, health home care manager, transitional care manager), care coordinator, patient/care navigator, community health worker, health coach. The following projects directly impact these titles: 2.a.iii, 2.b.iv, 3.b.i, and 3.d.ii. In addition to the cross-cuttings under project 2.a.i, these titles will receive the following training courses to fulfill CCB retraining strategy:

- Health coaching
- Care Planning
- Communication and Documentation
- Care Management for Chronic Diseases
- Care Coordination
- Care Transitions
- Critical Time Intervention

Strategy 2: Training newly hired staff needed to accomplish DSRIP goals

According to CCB's Target State Report, CCB is anticipating a net growth of approximately 773 FTEs in varying titles across the DSRIP facility types. CCB will offer its newly hired staff the cross-cutting trainings that support creating an Integrated Delivery System. Additionally, new hired staff will receive the trainings listed in section 4.3 based on their title. To meet the growing demand, CCB will offer several of these trainings in multiple modalities to relieve training fatigue and increase accessibility of these trainings across its network.

Strategy 3: Training to support redeployment (reassignment) strategies that will mitigate job loss resulting from system transformation

CCB anticipates a decrease in demand for RNs in acute-care settings. Despite the reported vacancies in the current state analysis and increased demand in ambulatory settings, the network anticipates a decreased demand in this area equivalent to approximately 182.5 FTEs. CCB's strategy is to create job opportunities in expanded roles in ambulatory settings such as transitional care nurses, nurse supervisors, and nurse care managers. CCB will re-train existing nurses to fill these roles.

Strategy 4: Training to support recruitment and retention strategies

CCB will not actively take part in recruiting staff for its network partners. However, CCB is committed to creating career pathways for its workforce. CCB has identified and committed to a career path for medical assistants. It has already trained over 40 medical assistants as health coaches through partnerships with the New York Alliance for Careers in Health Care (NYACH), City University of New York (CUNY) and Kingsborough Community College. CCB is considering other care pathways for community health workers, care managers, and behavioral health specialists.

Strategy 5: Actively engaging its stakeholders and its workforce

CCB has developed an aggressive training strategy with a robust selection of trainings. In order to actively engage its stakeholders and its workforce, CCB plans to integrate its technology platforms to increase use, accessibility to training and training participation.

Section 4.3: Training Plan for CCB's DSRIP projects

Creating an Integrated Delivery System

CCB has a goal to provide training to the PPS workforce regarding healthcare reform, IDS protocols, population health, and care coordination to meet DSRIP goals. The outcome is that staff is adequately acclimated to DOH's overall transformation initiatives including DSRIP, CCB's vision for the PPS, and expectations for its partners.

Key staff

All

Trainings Selected

CCB 101

Dashboard training

DSRIP 101

IDS Training

Team Training
Introduction to CC/HL Training
Introduction to Motivational Interviewing
Introduction to Patient Self-Management

ED Care Triage Program

The key staff identified for this project work with patients in the ED who frequently utilize the ED (defined as more than three times a year), particularly s those presenting with low severity needs, eligible for palliative care services, presenting with asthma symptoms or diagnosed with asthma or asthma exacerbation, and anyone else who may benefit from the program.

Key Staff

Patient Navigators

Trainings Selected for key staff in this project

In addition to the trainings listed under project 2.a.i, key staff in this project will receive the following trainings.

- Care Coordination Training
- Communication and Documentation Training
- ED Triage training

Care Transitions to Reduce 30-Day Readmissions Program

This project aims to reduce avoidable readmissions by providing a 30-day supported transition period after hospitalization to ensure compliance with a 30 Day Care Plan, specifically for patients at high risk for readmission. The project has three main components: 1. Pre-discharge patient education, 2. Care record transition and connection to receiving practitioner, and 3. Community-based support. The key staff identified for this project work with Medicaid patients who are at high-risk for readmissions; patients who frequently utilize the Emergency Department, patients admitted to a Skilled Nursing Facility; and Health Home members.

Key Staff

Transitional Care Nurse
Transitional Care Manager
Primary Care Provider

Trainings Selected for key staff in this project

In addition to the trainings listed under project 2.a.i, key staff in this project will receive the following trainings.

- Care Planning
- Communication and Documentation
- Care Management for Chronic Diseases
- Care Transitions
- Critical Time Intervention
- Health Coaching
- Patient Self-management

The Patient-Centered Medical Home Projects

Patient-Centered Medical Homes (PCMH) is key to system transformation. For patients with complex needs, integrated care management services will connect them with care at PCMHs, behavioral health and substance use treatment, and social services. Focused outreach and engagement will occur during care transitions, such as at discharge from a hospital or emergency room, to prevent lapses in treatment.

PCMH+ Initiative

The key staff identified for this project work with Medicaid patients with one or more chronic condition, with a special focus on patients at risk for or living with depression, cardiovascular disease (CVD), asthma, diabetes, palliative care needs, and HIV/AIDS.

The major PCMH+ objectives are to:

- Encourage collaboration between CBOs and health providers
- Improve the healthcare system by transforming primary care practices to PCMHs
- Reduce avoidable hospital use by 25 percent over the next five years

Key Staff

Primary Care Provider

Behavioral Health Provider

Registered Nurses

Medical Assistant

Care manager

Depression Care Manager

Trainings Selected for key staff in this project

In addition to the trainings listed under project 2.a.i, key staff in this project will receive various options from the following trainings.

- MA to health coach training
- PCMH training
- Care Coordination Training
- IMPACT Model Training
- Psychopharmacology
- Evidence-based best practices for Chronic Diseases

Section 4.4: Mechanisms for measuring effectiveness

CCB is committed to ensuring that all training programs are pertinent to the workers' educational needs, DSRIP goals and the promotion of patient-centered care. To this end, CCB will be measuring training effectiveness.

CCB will measure the effectiveness of trainings in two ways. First, participants will be asked to complete a survey upon completion of their training. This survey, included as Appendix III, will measure participant experience, the usefulness of the training, and capture both quantitative data and qualitative data. Survey results will be continuously monitored so that program improvements can be made.

Secondly, surveys will be conducted with a random sample of the participants' supervisors three months after completion of identified trainings to assess the impact of the trainings on care delivery.

Section 4.5: Training Scale and Speed Timeline

The following are training scale and speed targets. CCB recognizes the challenge of accurately forecasting workforce staffing impact data. Therefore, these training scale and speed targets outlined below are goals, not commitments. Trainings will be offered in multiple formats and may vary across settings to meet these training goals.

Exhibit 1: Scale and Speed Cross-cutting Trainings by type for Project 2.a.i

All of CCB's workforce will be required to understand population health and social determinants that affect health outcomes. In order to meet DSRIP goals and create an effective IDS, cross-cutting trainings will be offered across CCB. Due to the size of the PPS, CCB will offer trainings through E-learning and web-based courses to increase availability and access to these core trainings. In addition, the IDS Champions training is a "train the trainer" course, designed to increase training capacity and enhance training opportunities throughout CCB participant organizations.

Staff Type	DY2	DY3	DY4	DY5	Total DY2-5
CCB 101	500	1500	100	112	2212
DSRIP 101	500	1500	100	112	2212
DSRIP 101 for Providers	500	750	37	10	1297
Dashboard Training	700	1,850	740	112	3402
IDS Champions Training	75	100	25	25	225
Interdisciplinary Team Training	140	1453	400	112	2105
CC/HL Training	1500	1535	255	112	3402
Motivational Interviewing	1500	1535	255	112	3402
Patient Self- Management	1500	1535	255	112	3402

Exhibit 2: Scale and Speed Targets for Retraining key titles in the current workforce, based on new roles and responsibilities.

In addition to cross-cutting trainings, the current workforce in key titles (as identified in the previous section) will receive specific job-related trainings to enhance care throughout the PPS. Examples of additional trainings for key titles will include: psychopharmacology training to raise awareness of the impact of psychotropic drugs on behavior, the use registries and its value in population health management for Primary Care Providers (PCPs) ; IMPACT and SBIRT training for behavioral health providers and social workers; and documentation in team settings for medical assistants. Current workforce staff who are training for new jobs such as Care Managers, Care coordinators/navigators, community health workers and community health coaches will receive training in Health Coaching, Patient self-management and Care Planning. A full listing of courses by targeted key titles is included in the Appendix I.

Staff Type	DY2	DY3	DY4	DY5	Total DY2-5
Primary Care Providers	150	400	375	275	1200
Behavioral Health Providers (Psychiatrists, Psychologists)	15	26	25	15	81
Licensed Clinical Social Workers	15	26	25	15	81

Registered Nurses (including Transitional Care Nurses)	25	75	25	52	177
Medical Assistants	80	160	80	80	400
Emerging care coordination staff (care coordinators/navigators, care managers, community health workers, health coaches)	240	500	240	137	1,117
Total Impacted staff trained	525	1187	770	574	3056

Exhibit 3: Training targets for key titles based on anticipated demand

According to CCB’s Target State Report, CCB is anticipating a net growth of approximately 773 FTEs in varying titles across the DSRIP facility types. CCB will offer its newly hired staff the cross-cutting trainings that support creating an IDS. In addition, newly hired staff in key titles will offered the same training opportunities as incumbent staff members (see descriptions above). A full listing of training courses by targeted key titles is included in the Appendix I.

Staff Type	DY2	DY3	DY4	DY5	Total DY2-5
Primary Care Providers	20	35	37	10	102
Behavioral Health Providers (Psychiatrists, Psychologists)	12	10	10	5	37
Licensed Clinical Social Workers	16	25	25	15	81
Registered Nurses (including Transitional Care Nurses)	15	25	25	15	80
Medical Assistants	80	50	25	15	170
Emerging care coordination staff (care coordinators/navigators, care managers, community health workers, health coaches)	100	200	94	15	409
Total Impacted staff trained	273	545	255	112	1185

Chapter 5 INTEGRATING CULTURAL COMPETENCY AND HEALTH LITERACY – The Integrated Strategy

Section 5.1: Cross-collaboration with the Cultural Competency and Health Literacy Training Strategy

According to the Brooklyn Community Needs Assessment (CNA)⁴, Brooklyn is one of the nation’s most diverse areas, with a significant portion of its population composed of minority groups, foreign born, and speaking a language other than English at home. It is well established that individuals in these groups experience significant health disparities. Additionally, there are other groups (the elderly, dual-eligible beneficiaries, those who identify as LGBTQ, persons living with disabilities, those who re-enter the community from prison, and the uninsured) who also experience pronounced health disparities.

CCB’s Community Engagement Committee (CEC) has developed a training plan specific to the integration of Cultural Competency/Health Literacy (CC/HL). The plan utilizes the standards of Culturally and Linguistically Appropriate Services (CLAS) in order to ensure all trainings promote culturally sensitive care and the alleviation of health disparities. It also addresses how clinicians should utilize interpretation services so that care is person-focused and patient confidentiality is maintained.

The trainings will aim to reduce the attitudes and behaviors that contribute to four key and interrelated problems: (1) the visible and invisible disabilities of under-represented populations, (2) the “silent” but salient cultural competency and health literacy stigmas, (3) patient confusion regarding what services are appropriate and available, and (4) structural and systemic impediments to transformative culture change⁵.

Working with the CEC and the Workforce Committee, the 1199SEIU/League Training and Upgrading Fund (TUF) is inventorying existing programs for alignment with CLAS Standards and will develop additional programs with such alignment. Additionally, TUF will ensure that CC/HL is integrated in all curricula. As an example, care managers will not only be taught how to conduct meal planning with diabetic clients, but how to conduct meal planning that takes into consideration clients’ cultural norms and food preferences. Finally, TUF will ensure that through the training, participants examine their own cultural lenses and biases that impact care and therefore contribute to health disparities.

⁴ New York Academy of Medicine. New York City Healthcare Provider Partnership Brooklyn Community Needs Assessment. (October 2014).

⁵ Community Care of Brooklyn. Cultural Competency and Health Literacy Training Plan. (2016).

CCB has identified three strategies for the implementation of the CC/HL plan:

Strategy 1

Identify Core Competencies

Similar to its approach for its workforce training strategy, the CC/HL training strategies targets those competencies in cultural competence and health literacy that are fundamental across the network and ensure that training in these foundational competencies are extended to everyone in the network. Developing a model core cultural competency curriculum is a recommended best practice by The National Health Law Program⁶.

Strategy 2

Learner-centered Approaches

Training needs of the professionals across the CCB network vary based on learning styles, roles and nature of their work, time-commitment, access to technology, and the benefits gained. CCB's commitment to cultural competency is demonstrated by its approach to providing learner-centered approaches and flexibility in the menu of trainings presented or required for its workforce. The strategy is to tailor the content and delivery of the core competencies to the specific learner needs.

Strategy 3

Sustainability

CCB's commitment to developing a culturally competent workforce is further demonstrated in its efforts to sustain this vision. In doing so, the sustainability strategy is to embed Cultural Competence and Health Literacy as a principle into trainings where applicable. The core competencies listed above in strategy 2 are integrated into several of the trainings listed in Appendix I: Training Menu.

Chapter 6 COMMUNICATION STRATEGY

Section 6.1: Cross-collaboration with the Community Engagement Plan

CCB's Central Services Organization, the Project Advisory Committee (PAC), the Workforce Workgroup and the 1199SEIU Training and Upgrading Fund will be responsible for communicating the training plan, purpose, goals and outcomes to stakeholders—including frontline workers and the community. CCB is committed to engaging workers in planning and implementing training.

⁶ Beamon, C.; Devisetty, V.; Hill, J.; Huang, W.; Shumate, J. (2006). A guide to incorporating cultural competency into health professionals' education and training. *The National Health Law Program*. <http://njms.rutgers.edu/culweb/medical/documents/CulturalCompetencyGuide.pdf>

CCB will hold a series of “Town Hall” meetings to educate staff at all levels about DSRIP, including the trainings available. Surveys and/or focus groups will provide feedback for planning, as appropriate. Workers will be encouraged to obtain further information on the CCB website and will be encouraged to raise concerns through CCB’s established governance structure.

CCB has identified three potential communication barriers in need of remediation:

1. Cross-PPS Coordination: How to recruit essential workers needs to be openly coordinated with other PPSs.
2. Robust communication with frontline workers: CCB must work to engage workers through focus groups and/or surveys. CCB’s Workforce Workgroup will need to identify new ways to improve communication with frontline staff.
3. Divergence of views within the Workgroup: CCB is committed to ensure that all voices are heard in planning and implementation of training. A consensus-based process—75% of members—will be used in decision-making processes. This will build buy-in for decisions.⁷

Chapter 7 ACKNOWLEDGMENTS

The Community Care of Brooklyn PPS would like to acknowledge the following for its contributions to the development of this training strategy:

BDO Consulting

The Care Delivery and Quality Committee

The Community Engagement Committee

The Workforce Committee

⁷ Maimonides PPS “Community Care of Brooklyn Workforce Committee Charter”, pg.3

Chapter 8 APPENDICES

Appendix I: Training Plan

The following chart outline all trainings that will be offered by CCB, the associated projects, titles to be trained, training partners, timelines, modalities and competencies that will be gained from each program.

Training Type	Project (s)	Title(s)	Partner(s)	Timeline	Modality	Competencies
Integrated Palliative Care Collaborative Model Training	3 g.i.	Primary Care Team	MJHS Institute for Innovation in Palliative Care	DY2-3	E-Learning Course or Instructor Led Course	Specific care model components, care coordination delivery and workflows
MA to Health Coach Training	2 a.iii.	MA , HC	Kingsborough Community College/TEF	DY2-4	Instructor Led Course	Health Coaching, Patient Education, Effective Communication
PCMH training	2 a.iii.	PCMH Staff	1199SEIU/League Training and Upgrading Fund	DY2-5	Multimodal: combination of E-Learning Course, and Instructor-led course	Specific care model components, Care Coordination delivery and workflows
Technical Assistance Training for PCMH Certification	2 a.iii., 3 a.i., 3 b.i.	PCMH Managers	TBD	DY2-3	Instructor Led Webinar or Instructor Led Course	Requirements for Designation
Care Planning	2 b.i.v., 2 a.iii.	TCN, TCM, CM	1199SEIU/League Training and Upgrading Fund	DY2-5	Instructor Led Course	Creating a robust care plan, Care Coordination
Communication and Documentation	2 b.i.v., 2 a.iii.	TCN, TCM, CM PN	1199SEIU/League Training and Upgrading Fund	DY2-5	Instructor Led Course	Effective Communication, Effective Documentation

Training Type	Project (s)	Title(s)	Partner(s)	Timeline	Modality	Competencies
Care Management for Chronic Diseases	2 b.i.v., 2 a.iii.	TCN, TCM, CM PN, HC	1199SEIU/League Training and Upgrading Fund	DY2-5	Instructor Led Course	Health Coaching, Patient Education, Crisis Intervention, Chronic Disease Management
Care Coordination	2 b.iii.	CM, PN, HC TCM, TCM	1199SEIU/League Training and Upgrading Fund	DY2-5	Multimodal: combination of E-Learning Course, and Instructor-led course	Health Coaching, Patient Education, Effective Communication, Accessing Resources
Care Transitions	2 b.iv	TCM, TCN, CM PN, HC	CCNC	DY2-5	Instructor Led Course	Health Coaching, Effective Communication, "Teach Back" Education Tool
Critical Time Intervention (CTI)	2 b.iv.	TCM, TCN, CM PN, HC	CUCS	DY2-4	Instructor Led Course	Resource networking, referral skills, care coordination
IMPACT Model	3 a.i.	RN, LPN, MA, CM LCSW, BHP PCP	1199SEIU/League Training and Upgrading Fund	DY2-4	Instructor Led Course	Specific care model components, Care Coordination delivery and workflows for Depression Care Management
Psychopharmacology	3 a.i.	RN, LPN DCM	CCNC	DY2-3	Instructor Led Webinar or Instructor Led Course	Impact of psychotropic medication on mood, Care coordination for integrated models

Training Type	Project (s)	Title(s)	Partner(s)	Timeline	Modality	Competencies
Evidence-based Model training - Million Hearts(R) Campaign	3 b.i.	RN, LPN, CM, HC, TBD	TBD	DY2-5	Integrated in Chronic Conditions, C/HL and MI trainings	Working knowledge of this best practice and its use in patient engagement for people with CVD
Evidence-based Model training Stanford Model	3 b.i.	RN, LPN, CM, HC, DCM TBD	TBD	DY2-5	Integrated in Chronic Conditions, C/HL and MI trainings	Working knowledge of the model and its use for patient self-management of chronic conditions
Primary Palliative Care Outcome Scale (POS)	3 g.i.	TBD	MJHS	DY2-3	Multimodal: combination of Instructor Led Course and e-courses	Overview of the measures and various inventories and their use in integrated care models
The Undetectables Project	4 c.ii.	Peers, TBD	Housing Works	DY2-4	Instructor Led Course	Overview of the project, Patient Engagement, Medication Adherence
CCB 101	All	All, beginning with patient-facing caregivers	1199SEIU/League Training and Upgrading Fund	DY2	Multimodal: combination of E-Learning Course, and Instructor-led course	CCB projects and DSRIP outcomes
Dashboard	All	All	GSI	DY2-5	Instructor Led Course	Proficiency with Web-based Care Coordination Platform
DSRIP 101	All	All, beginning with patient-facing caregivers	1199SEIU/League Training and Upgrading Fund	DY2	E-Learning Course	Introduction to healthcare reform
DSRIP 101 for Providers	All	Providers	1199SEIU/League Training and Upgrading Fund	DY2	E-Learning Course	Accelerated Introduction to healthcare reform with

Training Type	Project (s)	Title(s)	Partner(s)	Timeline	Modality	Competencies
Ethics	All	All, focus on patient-facing caregivers	1199SEIU/League Training and Upgrading Fund	DY2-5	Multimodal: combination of Instructor Led Course and e-courses	Proficiency with Ethical Decision Making Process
Health Coaching	All	TCN, TCM, CM, RN, MA, HC, DCM	1199SEIU/League Training and Upgrading Fund	DY2-5	Instructor Led Course	Health Coaching, Patient Education, Effective Communication
Integrated Delivery System Champions Training	All	All, beginning with PCMH, Behavioral Health and managerial staff	1199SEIU/League Training and Upgrading Fund	DY2	Multimodal: combination of Instructor Led Course and train-the-trainer	DSRIP policy & program initiatives; CCB's quality improvement agenda
Interdisciplinary Care Team Training	All	Care Teams	1199SEIU/League Training and Upgrading Fund	DY2-5	Multimodal: combination of Instructor Led Course and e-courses	Care Team Roles, Responsibilities ; Care Coordination for Care Management; Team Communication
Introduction to Cultural Competency (CC)	All	All, beginning with patient-facing caregivers	1199SEIU/League Training and Upgrading Fund	DY2-4	Multimodal: combination of Instructor Led Course and e-courses	Cultural Sensitivity and awareness; CLAS standards
Introduction to Health Literacy (HL)	All	Patient-facing caregivers	1199SEIU/League Training and Upgrading Fund	DY2-4	Multimodal: combination of Instructor Led Course and e-courses	Health Promotion, Health Education, Patient Advocacy
Motivational Interviewing	All	Patient-facing Caregivers	1199SEIU/League Training and Upgrading Fund	DY2-4	Multimodal: combination of Instructor Led Course and e-	Effective Communication, Active Listening, Patient

Training Type	Project (s)	Title(s)	Partner(s)	Timeline	Modality	Competencies
Patient Self-Management	All	All, focus on CM, TCM, TCN	1199SEIU/League Training and Upgrading Fund	DY2-5	Multimodal: combination of Instructor Led Course and e-courses	Coaching, Goal Setting, Patient Engagement
Performance Improvement	All	All, focus on managerial staff	1199SEIU/League Training and Upgrading Fund	DY2-5	Instructor Led Course	Creation, Implementation, Evaluation and Revision of a Performance Improvement Project
Use of Registries	All	PCP	1199SEIU/League Training and Upgrading Fund	DY2-3	E-Learning Course	Proficiency in the Use of Registries; Utilization Review for Population Health Management

Abbreviations

BHP	Behavior Health Provider
CM	Care Manager
DCM	Depression Care Manager
HC	Health Coach
LCSW	Licensed Clinical Social Workers
LPN	Licensed Practical Nurse
MA	Medical Assistant
PCMH	Patient Centered Medical Home

PCP	Primary Care Providers
PN	Patient Navigator
RN	Registered Nurse
TBD	To Be Determined
TCM	Transitional Care Manager
TCN	Transitional Care Nurse

Appendix II: Training Descriptions

DSRIP 101

The interactive, 30-minute e-learning course, DSRIP 101, is appropriate for both frontline workers and managerial staff. Designed for those who are unfamiliar with DSRIP, the course gives participants a basic understanding of the initiative and the rationale behind why DSRIP is being instituted in the state of New York. The course focuses on the Triple Aim (better care, better health and lower costs) and how DSRIP will meet it through reforming the healthcare system to a system in which well and preventative care become the standard for New York State. Participants will gain an understanding of care delivery and how their work will change due to this system transformation.

DSRIP 101 for Providers

This e-learning course covers how DSRIP came about, the goals of DSRIP, how it works and how it affects providers. Upon completion of this course, participants will understand the compelling circumstances that led to the creation of DSRIP, the goals created to support the program’s mission, and how the program infrastructure supports these goals. In addition, participants will be able to identify how CCB has initiated DSRIP in order to help transform the healthcare delivery system in Brooklyn. Finally, participants will recognize the role of providers in helping CCB align with and achieve DSRIP program goals. This is an accelerated version of DSRIP 101 targeted for physicians and other clinical providers.

CCB 101

This course details how Community Care of Brooklyn will reform the healthcare system in the borough. An overview of DSRIP will be given. Participants will gain knowledge about the Performing Provider System and the projects chosen by CCB will be reviewed in detail so that participants understand how and why their work will change. Participants will also

develop an understanding of how these projects and changes will positively impact the health of Brooklyn Medicaid beneficiaries.

Additionally, quality measures, IT infrastructure, the Health Home, and resources will be covered in this course.

Integrated Delivery System (IDS) Champions Training

The Integrated Delivery System Champions Training will bring together multidisciplinary teams to explore why healthcare systems have become integrated and what this mean in terms of quality and consistency for patients. Participants will be able to articulate why integration is crucial, how it affects patients, and why working in teams is pivotal to the success of the IDS.

Motivational Interviewing (MI)

MI is a best practice that allows healthcare workers to assist patients to make healthy behavior changes by using the patient's intrinsic reasons for change. The spirit of MI is collaborative, evocative and honors patient autonomy. MI is a very specific and effective skill that uses OARS (open-ended questions, affirmations, reflections and summaries) as a way to guide the interaction. While using OARS, workers also need to know how to handle resistance. This two-day training allows for intensive practice of this skill. It also incorporates the Stanford Model and the Million Hearts® Campaign.

Introduction to Cultural Competency

Cultural Competency is the capacity for individuals and organizations to work and communicate effectively in cross-cultural situations, which is increasingly important in the rapidly changing healthcare industry. It allows healthcare providers to accommodate diverse patient populations, improve the quality of care delivered and build awareness. These skills are key to providing patient-centered care and increasing patient engagement.

The Cultural Competency training explores various types of diversity that impact healthcare delivery, such as religion, gender, race, ethnicity, country of origin, etc.. It also provides information on both health disparities and the social determinants of health. Participants gain awareness, improve their sensitivity and learn practical ways to provide culturally competent care. They also explore their role in addressing health disparities.

Introduction to Health Literacy

Health Literacy is the wide range of competencies and skills that people develop to seek out, comprehend, evaluate, and use health information to make informed choices. While only 12% of Americans have a proficient level of health literacy, our health care system

often demands that patients have proficient health literacy to effectively manage their health care.⁸

This workshop is designed to supply front line workers with an extensive overview of Healthcare Literacy concepts and procedures in order to assist the care team to become more efficient when serving patients throughout the healthcare industry. Topics include factors that influence health literacy, overview of literacy, challenges of patients, responsibility of working as part of an interdisciplinary team, how to negotiate complex health systems, analytical skills and advocating for patients.

Dashboard Training

Seamless and meaningful communication by providers, including medical, social and community-based providers is critical. CCB's web-based easily accessible care coordination and population health management IT solution, the "Dashboard" enables care team members to store and share information and to collaborate on a single integrated care plan, regardless of location and organization.⁹

Dashboard training gives participants the skills to use the platform, including how to enter patient demographic information, encounters, progress notes and an integrated care plan. Upon completion of the training, participants can fully function using this platform.

Performance Improvement (PI)

Performance Improvement (PI) is a systematic way to improve healthcare services and the health of targeted patient groups. Areas that need improvement are identified and interdisciplinary teams work to implement solutions and measure success. The process is continuous and new ideas are implemented based on performance on predefined measures.

The PI training teaches interdisciplinary teams the Plan, Do, Study, Act (PDSA) Performance Improvement methodology. Upon completion of the training, teams are able to work together to create, implement, measure and revise a PI project.

Patient Self-management

Patient self-management requires patients to have skills and confidence to manage their health conditions. Healthcare workers are integral to increasing patient self-management by providing support in terms of education, regular assessment, goal setting and problems

⁸ America's Health Literacy: Why We Need Accessible Health Information. An Issue Brief from the U.S. Department of Health and Human Services. 2008.

⁹ Maimonides PPS "Community Care of Brooklyn Workforce Committee Charter", pg.3

solving support. Upon completion of this program, participants will be able to articulate why patient self-management is important and describe concrete ways in which healthcare workers can increase the self-management of patients they serve.

Use of Registries

“A registry is a collection of information about individuals, usually focused around a specific diagnosis or condition. Many registries collect information about people who have a specific disease or condition, while others seek participants of varying health status who may be willing to participate in research about a particular disease. Individuals provide information about themselves to these registries on a voluntary basis. Registries can be sponsored by a government agency, nonprofit organization, health care facility, or private company.”¹⁰

Upon completion of this training, Primary Care Providers will be able to articulate how and why to use registries and its value in population health management.

Ethics

Healthcare workers face ethical dilemmas frequently on the job. Knowing what the best course of action is for a patient is not always an easy task. Upon completion of this training, workers will be able to use an ethical decision-making process.

Interdisciplinary Care Team Training

Care has shifted from “multidisciplinary”, where disciplines work in silos, to that which is “interdisciplinary”, where the team works together seamlessly. This requires communication, coordination, documentation and the building of mutually respectful relationships. How can a care team make this challenging shift? The “Interdisciplinary Care Team Training” assists care teams in moving towards an interdisciplinary approach while promoting positive patient outcomes, person-centered care and clear communication.

This full-day training program is interactive with minimal lecture and includes role-plays, small group work, large group discussion and experiential activities to facilitate learning for those with varying learning styles.

Topics covered include the changes in healthcare, the benefits of care coordination, care planning and utilizing technology to communicate with the care team. CCB can expect increased teamwork including effective communication for care teams completing the program.

¹⁰ National Institutes of Health. (n.d.) List of Registries. Retrieved from <https://www.nih.gov/health-information/nih-clinical-research-trials-you/list-registries>

Care Management for Chronic Diseases

Care Managers and Transitional Care Managers will have to interface with the interdisciplinary team (which includes clinicians), provide health coaching and promote health literacy. In order to do this, they must have a strong understanding of common chronic illnesses and appropriate care management interventions for those living with such illnesses. These modules teach workers about common chronic conditions, and how to provide care management services to those with such conditions with a focus on patient self-management and the promotion of healthy lifestyle behaviors. The following common chronic conditions are covered in detail: cardiovascular disease, diabetes, asthma, substance use disorders, serious mental illnesses, HIV/AIDS, hepatitis, cancer, and sickle cell anemia.

Care Planning

The care plan is the tool in which a patient's health and social goals are documented. It provides information about the patient's status and challenges to the interdisciplinary care team. Care Managers, Transitional Care Managers and Transitional Care Nurses will have to create care plans as a key tool in planning patient care and communicating patient goals to the care team. This training teaches participants how to create patient-centered care plans using S.M.A.R.T (specific, measurable, attainable, realistic and time-bound) goals. It also teaches participants how to include the patient in the care planning process.

Communication and Documentation

Transitional Care Nurses, Transitional Care Managers, Care Managers and Health Coaches must communicate with the interdisciplinary care team in an effective manner. Interdisciplinary communication is vital for the achievement of DSRIP goals. Best practices in communication are taught and practiced. The training covers best practices in documentation, as Transitional Care Nurses, Transitional Care Managers, Care Managers and health Coaches must document patient encounters and progress notes in order to effectively communicate with the care team. The training will assist participants in the development of documentation skills and promotes documentation that is accurate, succinct, patient-centered and pertinent and is in accordance with their organization's policies and procedures.

Medical Assistant to Health Coach Training

This credit-bearing course teaches existing Medical Assistants or newly hired Health Coaches how to function as a Health Coach in a medical practice/Patient-Centered Medical Home. Participants learn about new models of care, patient engagement and health coaching techniques, chronic disease, wellness and prevention. Additionally, there is a practicum component as supervisors visit the classroom setting and observe and critique a

role-play activity. Upon completion of the training, participants will be able to provide health coaching to patients in a primary care setting.

Care Coordination

This program prepares front-line healthcare workers for seismic shift in the healthcare delivery system, emphasizing the triple aim of improved health outcomes, improved care and lower healthcare costs. The course enables participants to develop practical skills, to serve as a bridge between patients and providers, and to become effective members of interdisciplinary teams that provide coordinated and patient-centered care.

Course topics include: orientation to care coordination, basics of chronic physical and mental diseases, cultural diversity, accessing patient resources, communication skills, home visits, navigating the insurance system, motivational interviewing, health coaching, care transitions, electronic health records, quality improvement, and professional boundaries.

Critical Time Intervention (CTI)

“Critical Time Intervention (CTI) is a care coordination model designed to prevent recurrent homelessness among persons with severe mental illness by enhancing continuity of care during the transition from institutional to community living. CTI is based on the assumption that during any transition—in this case going from the hospital back into the community after a psychiatric breakdown—the patient may feel overwhelmed, anxious, depressed, embarrassed, confused and/or just lack the necessary connections to make the transition successful. CTI assists the patient in the development of necessary skills and provides connections to providers and other supports so that he or she does not recidivate back to the hospital or have other negative outcomes such as jail, homelessness, loss of housing, etc”.¹¹

The training teaches participants the mechanics of CTI, how CTI is an evidence-based practice, the six areas of focus of CTI, the three phases of this nine-month program and how to successfully implement CTI.

IMPACT Model for Depression Care Management

The IMPACT (Improving Mood—Providing Access to Collaborative Treatment) Model is an evidence-based program designed to provide collaborative care for those with a diagnosis of depression. In a large clinical trial, about half of those receiving the treatment showed a 50 percent decrease in depressive symptoms.¹² This program trains the care team in the

¹¹ CUCS. Critical Time Intervention PowerPoint. (2013).

¹² Unützer J. et al. (2002). Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *The Journal of the American Medical Association*. Vol 288, No. 22.

model. Additionally, PCPs are trained in psychopharmacology and Depression Care Managers are trained in cognitive behavioral therapy and patient activation.

Psychopharmacology

The psychopharmacology training raises awareness of the impact that psychotropic drugs have on mood, sensation, thinking and behavior. This training focuses on how these factors impact a persons' daily life. The goal of this training is to make providers aware of the interactions, encourage medication reconciliation, and support care coordination around medication prescribing to increase adherence.

Million Hearts® Campaign

“Heart disease and stroke are the first and fifth leading causes of death in the United States. Every 43 seconds, someone in the United States has a heart attack, many of them fatal. On average, one American dies from stroke every 4 minutes.

Million Hearts® is a national initiative with an ambitious goal to prevent 1 million heart attacks and strokes by 2017. The Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services co-lead the initiative on behalf of the U.S. Department of Health and Human Services.”¹³

Upon completion of this training, participants will be able to counsel patients about methods for preventing cardiovascular disease and stroke.

Stanford Model for Chronic Disease Management Model Training

The Stanford Model, a community-based intervention emphasizing social supports and personal empowerment, was developed by Stanford University's patient education program. Patients participate in a six-week course and explore the following topics: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, 6) decision making, and, 7) how to evaluate new treatments.¹⁴

Participants in this training are acclimated with the model, its goals and principles. Upon completion of this training, participants will be able to explain the Stanford Model and support self-management with patients.

¹³ Million Hearts®. (2016.) About Million Hearts. Retrieved from <http://millionhearts.hhs.gov/about-million-hearts/index.html>

¹⁴ Stanford Medicine. Patient Education in the Department of Medicine. (2016.) Chronic Disease Self-Management Program. Retrieved from <http://patienteducation.stanford.edu/programs/cdsmp.html>

The Integration of Palliative Care into PCMH Model

This training is provided by the MJHS Institute for Innovation in Palliative Care. The course focuses on delivering the needs of palliative care patients in primary care settings. The training is based on an integrated model, supports integration transition, and improving outcomes for patients in end of life care.

The Undetectables Project

The Undetectables Project is a campaign initiated by Housing Works that aims to assist the HIV+ community in achieving and maintaining viral suppression. The project consists of a comic book narrative and medical and social supports in the form of case management.¹⁵

Peers and other staff will be trained in this project. Topics include adherence to medications, stigma, disclosure, substance use, mental health issues. Additionally, participants will learn about support groups, behavioral health assessment and pill boxing. Upon completion of this training, peers and other staff will be able to market the program to patients.

¹⁵ Housing Works. (2016). The Undetectables Project. Retrieved from <http://www.housingworks.org/health/medical-and-dental-care/the-undetectables/>

Appendix III: Sample Training Evaluation



NAME OF YOUR ORGANIZATION:

NAME OF TRAINING:

DATE:

TRAINER:

2016 Training Evaluation

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The facilitator helped me learn about creating a safer and healthier environment for patients and staff.					
I have a better understanding of assessing the patient's/client's needs and how it affects hospital readmissions.					
2. I will be able to better assist the patient/client in navigating the system.					
3. I have a better understanding of care transitions and why clients are vulnerable during these transitions.					
4. I understand why it is important to ensure the Care Plan captures concerns indicated in the Progress Notes.					

Your comments and/or opinions about this training are valuable to us. Please provide us with feedback to improve future trainings.

Question	Response
1. What did you like the most about this training?	
2. How do you think you will change your daily work practices as a result of this training?	
3. Additional comments	

Appendix IV: List of Training Partners

1199SEIU/League Training and Upgrading Fund
AirNYC
Center for Urban and Community Services
City University of New York
GSI Health
Housing Works
The Institute for Family Health
Kingsborough Community College
New York Alliance for Careers in Health Care
MJHS Institute for Innovation in Palliative Care
Wyckoff Heights Medical Center