Montefiore Hudson Valley Collaborative

Primary Care Plan

Current State Assessment and Strategy

November 3, 2016

Montefiore HUDSON VALLEY COLLABORATIVE

Montefiore Hudson Valley Collaborative
Primary Care Plan, November 3, 2016

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Fundamental #1: Primary Care Assessment and Strategy

Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs.

Expanding Primary Care Capacity: Assessment and Strategy

Montefiore Hudson Valley Collaborative (MHVC) has evaluated recent data provided by NYS and Salient to assess the adequacy of our primary care network. Within this section, we have framed key findings and outlined the strategies in place to address these gaps in primary care capacity within the MHVC network.

In response to the questions directly outlined by the DOH for fundamental one, we have organized our findings into the three categories below:

A. NYSDOH Primary Care Network Assessment – Key Findings
B. Overall Approach for Expanding Primary Care Capacity
C. Working with Community and Institution Based PCPs

A. NYSDOH Primary Care Network Assessment – Key Findings

Below we have listed key findings from the primary care network assessment which was performed by NYSDOH.

Understanding the MHVC Network

The Montefiore PCP Network Analysis provided by the NYSDOH indicated that MHVC has 1,260 PCPs, an attributed population of 213,505 and an average of 169 members per PCP. These numbers are not only reflective of our Hudson Valley network but they also include our Bronx network population.

Our Bronx network is comprised of PCPs that do not have our members assigned to them by the state. In order to comprehend and identify the needs of our patient population, which spans the Hudson Valley, we needed to acquire greater insight on the PCPs that actually serve our members. This analysis will also help us to better align with our PPS peers in the Hudson Valley. Our findings determined that:

- 48% of the PCPs in the MHVC network are in the Bronx; however based on the recently released state data, none of our MHVC attributed members are assigned to these PCP's.
- To more clearly understand the number of MHVC members per PCP, MHVC recalculated the members per PCP, excluding the Bronx PCPs. This increased the number of MHVC members per PCP to 393.
    - As shown in table 1below:
        - Compared to other PPSs in the Hudson Valley region, MHVC's number of members per PCP excluding Bronx PCPs is higher than that of WMC (180 members per PCP) or Refuah (286 members per PCP).
        - MHVC's 393 members per PCP, is close to that of other similar sized downstate PPSs and slightly higher than our peers upstate (excluding MHVC).

This data assisted us in understanding the amount of PCPs serving our members. We further analyzed the data to define our network overlaps, access and availability, as well as our engagement strategy for the practices in our network.

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Table 1: *Metric calculation for MHVC, other similar Sized PPSs and other PPSs in the region*

	Similar Sized PPSs				Other PPSs in the HV Region		
Metric	MHVC	MHVC (Exc Bronx PCPs)	Downstate	Upstate (Exc MHVC)	WMC	Refuah	BPHC
# of Members per PCP	169	**393**	391	304	180	286	362
% PCPs Participating in Multiple PPSs	79%	**51%**	51%	13%	62%	59%	89%
% of PCP offering extended hours	21%	**29%**	31%	25%	32%	36%	38%
Average Total Care Hours (Per PCP Per week)	30 hrs per week	**31 hrs per week**	31 hrs per week	46 hrs per week	35 hrs per week	33 hrs per week	32 hrs per week

Data Source: Montefiore PCP Network Analysis from NYSDOH – June 2016

PCP Network Overlap with other PPSs

The NYSDOH Network Assessment revealed that 79% of the PCPs in MHVC's network participate in multiple PPSs. This overlap is inflated because it includes our PCPs in the Bronx. This overlap is attributed to the location of Montefiore Medical Center (MMC), our largest partner network of PCPs, and the entire Montefiore IPA, which includes all physicians directly employed by MMC. Both organizations are included in both the MHVC and the BPHC PPS networks.

- The Network Assessment data indicated that in the Bronx only, the percentage of PCPs who are participating in multiple PPSs is 99%. If we look at the percentage of PCPs participating in multiple PPSs just for Hudson Valley counties, it is 51%. (See Table 1)
- For Hudson Valley PCPs only, MHVC has more PCPs participating in multiple PPSs than when compared to other upstate PPSs. However, compared to other similar sized downstate PPSs the percentage of PCPs participating in multiple PPSs is the same.
- Compared to our PPS peers in the Hudson Valley region, MHVC (excluding the Bronx) has less PCPs participating in multiple PPSs.

PCP Access and Availabilities

The data provided by the State, shown in table 1, also informed us of the amount of extended hours and the total care hours being offered per week by our PCPs across the network.

- We found that 21% of MHVC's PCPs offer extended hours of care to patients. Excluding Bronx PCPs, 29% of PCPs in the MHVC network provide extended hours.
  - There are fewer PCPs who offer extended hours in MHVC than in the downstate PPSs.
  - When compared to other PPSs in the Hudson Valley regions, MHVC has slightly fewer PCPs who offer extended hours to patients, 29%, versus 32% within the WMC PPS and 36% in the Refuah PPS.
- It was also determined that on average, a PCP in the MHVC network provides 30 hours of care per week and 31 hours of care per week if we exclude PCPs in the Bronx.
  - MHVC PCPs provide fewer hours of care per week when compared to other upstate PPSs of similar size.
  - Overall, PCPs who are in PPSs in the Hudson Valley region, serve fewer hours than PCPs in upstate PPSs.
- We wanted to further understand why our PCPs may have been providing fewer hours or care when compared to other PPS in the Hudson Valley region. We therefore did a deeper analysis of the PCPs that work in academic medical centers. We found that:

- 25% of the PCPs at MMC work in academic medical centers and they serve fewer hours on average than a PCP in a private practice setting. This may be attributed to teaching requirements and might contribute to lower average total care hours for MHVC PCPs when compared to other PPSs.

PCP Attribution and Panel Size

The state assessment data provided the panel size amounts by PCP within the MHVC network. Table 2 shows that:

- 42% of MHVC's PCPs have a panel size greater than 100 and 15% of the MHVC PCPs have a Medicaid panel size of zero.
- 55% of MHVC's total number of Medicaid lives are being served by physicians with a panel size of over 500.

Table 2: *Medicaid Panel Size Buckets per PCP*

Medicaid Panel Size Bucket	#of PCPs	% of Total PCPs	Sum of Panel Size	% of Total Panel Size
>1000	31	2%	42,229	17%
500 to 999	136	11%	92,391	38%
100 to 499	367	29%	92,249	38%
76 to 100	56	4%	4,884	2%
51 to 75	65	5%	4,023	2%
26 to 50	105	8%	3,850	2%
11 to 25	109	9%	1,914	1%
1 to 10	203	16%	803	0%
Zero	188	15%	-	0%
Total	**1,260**	**100%**	**242,343**	**100%**

Data Source: Montefiore PCP Network Analysis from NYSDOH – June 2016

This data helps to inform the MHVC provider engagement strategies. MHVC has been thoughtfully engaging partners through one-on-one site visits to assess practice readiness for PCMH and VBP. This work dovetails with our partner contracting model which focuses on engaging partners within the MHVC network and beginning the alignment toward a shared network vision for the integrated delivery system. Each contract period reflects the most current data available from the DOH related to member attribution and a partner's claims history. (See fundamental 5 for a comprehensive review of our funds flow approach.) As we implement our network assessments, MHVC strives to better understand the number of Medicaid patients that our PCPs serve, and consider practice size as one of the elements that drive our engagement strategies. In our most recent round of provider contracting, MHVC is contracting with 69 key partner organizations that include 984 PCPs (78% of total amount of PCPs in the MHVC network). Collectively these organizations serve ~90% of our attributed lives, based on the most recently released CPA data.

As we mature our integrated delivery system, the need for primary care services will increase. Our findings from the state provided data, substantiated by our Community Health Needs Assessment (CHNA), will augment our ongoing PCP practice assessments and our strategies going forward. Our strategies for developing increased capacity include: the wide spread adoption of the PCMH certification, which increases access and PCP availability, the deployment of medical villages, development of an urgent care strategy, and the utilization of state resources throughout the network as we move towards Valued Based Payment arrangements.

B. Overall Approach for Expanding Primary Care Capacity

MHVC has identified 5 key strategies for expanding primary care. They include:

1. **Implementing PCMH Standards across the Network**
2. **Utilizing CRFP Funding to Expand Primary Care and Behavioral Health Services**
3. **Deploying Medical Village Projects at 7 Hospital Sites**
4. **Incentivizing access through Reimbursement Models**
5. **Integrating Urgent Care in the IDS Continuum**

A detailed description for each strategy is presented below.

1. Implementing PCMH Standards across the Network

Strategy to increase Average Total Care hours per PCP per week

National Committee for Quality Assurance (NCQA) requirements for a 2014 PCMH Level 3 certification include practices having written processes and defined standards for providing timely access for patient appointments. Specifically, a practice is required to regularly assess its performance on:

1. Providing routine and urgent same-day appointments (Critical Factor)
2. Providing routine and urgent-care appointments outside regular business hours
3. Providing alternative types of clinical encounters
4. Availability of appointments
5. Monitoring no-show rates
6. Acting on identified opportunities to improve access

Successful achievement of 2014 PCMH level 3 certification will ensure that our network practices have increased access to care and help us increase our Average Total Care Hours (per PCP per week). MHVC is committed to supporting PCMH transformation across our network and has a robust strategy in place to assist our network partners in their transformation journey. (See fundamental #2)

2. Utilizing CRFP Funding to Expand Primary Care and Behavioral Health Services

Capital Restructuring Financing Program (CRFP) funding is a commitment made by New York State to help health care providers statewide fund critical capital and infrastructure improvements, as well as integrate and further develop health systems. These awards were created to support DSRIP goals.

The below chart outlines the CRFP funds awarded to members of the MHVC network as well as a brief description of the work that will be completed by each partner. The “estimated project size” includes the matching funds provided by each partner for their specific project. MHVC partner projects funded in the Hudson Valley align closely with two known MHVC “hotspots” of need, lower Westchester county and Newburgh (within Orange County). These areas contain high concentrations of MHVC members. CRFP funds will be critical to the success of an integrated delivery system in these areas.

Table 3: *CRFP Awards Granted to MHVC Partners*

Partner Name	Project Summary	Grant Award	Estimated Project Size and Total CRFP
St. Joseph's Hospital Yonkers: Medical Village	ED renovation, triage, expanded primary care with behavioral health, patient navigation, shuttle services. *More implementation details for this project are provided in table 4 below.*	$8,902,374	$17,804,747
St. John's Riverside Hospital, St. John's Division: Medical Village	Restructure outpatient system – ED triage, primary care, clinical care management, patient navigation, transportation, wellness center, tele-health, observation, imaging, pharmacy, IT. *More implementation details for this project are provided in table 4 below.*	$15,342,150	$31,326,970
The Greater Hudson Valley Family Health Center, Inc.: Expansion of Urgent Care	Create urgent care center at the main GHVFHC site	$247,500	$495,000
Montefiore New Rochelle Hospital: Medical Village	Renovation of ED; Partner with FQHC for primary care, behavioral health; Health Education and Training Institute. *More implementation details for this project are provided in table 4 below.*	$44,168,000	$44,545,527
Nyack Hospital: Medical Village	Renovation of ED space, purchase 3 vans for non-emergent transportation program *More implementation details for this project are provided in table 4 below.*	$17,754,586	$22,254,000
St. Joseph's Hospital : St. Vincent's Intensive Crisis Respite	Renovate existing structures to establish intensive crisis respite residential program as alternative to inpatient hospitalization	$375,000	$750,000
St. John's Riverside Hospital, St. John's Division: Integration of Primary Care and Behavioral Health Services	Expand behavioral health and substance abuse services at Park Care Pavilion	$661,254	$2,120,523
St. John's Riverside Hospital, St. John's Division: Behavioral Health Crisis Stabilization and Respite Program	Create a Crisis Stabilization Center for mental health and substance abuse	474,963	$1,724,713

3. Deploying Medical Village Projects at 7 Hospital Sites

MHVC is one of four PPS's in the state that selected the Medical Village Project and has committed to transforming 7 of our hospitals into Medical Villages over the course of the DSRIP 5 year plan.

Identified Gaps and Mitigations

We aim to meet two identified gaps in care with our medical village projects:

1. Address excess capacity leading to inefficient health care resource usage
2. Meet unmet community needs, including: improving access, providing integrated primary and behavioral health care, ensuring an even distribution of urgent care access points, providing care management and coordination, and addressing shortages in community-based resources such as crisis beds.

To meet these gaps, we are designing our medical villages using an iterative three-pronged approach:

1. Engagement of partner hospitals to co-create a future-state vision for facilities providing an integrated care experience tailored to the need of the local communities;
2. Conducting facility surveys to assess suitability of space for potential uses and estimate required capital; and
3. Ensuring financial sustainability by providing services capable of generating alternative revenue streams while maximizing additional sources of capital, including philanthropy.

MHVC is uniquely positioned to carry out this strategy given the breadth of our network, with more than 15 hospital campuses that serve patients from all 7 counties. This scale will allow our partners to work together to strategically adapt care delivery, taking into consideration both demand as well as quality of care, so as to achieve the maximal savings from the removal of unnecessary capacity. Similarly, creation of multiple villages at our partner facilities will allow us to coordinate the services to best meet community needs.

Implementation Approach

MHVC has taken a phased approach to Medical Village implementation. By rolling out site implementation in waves each facility can receive the focus of MHVC and Montefiore Health System as they progress through each milestone. Below is a summary of sites and planning for implementation:

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Table 4: *MHVC Partners – Medical Village Implementation Details*

Medical Village Site	Implementation Details
Montefiore New Rochelle (MNR)	Montefiore New Rochelle's (MNR) strategic plan will expand primary care capacity in the Hospital's service area, reduce avoidable hospital use and benefit the large number of Medicaid and uninsured community members. In the future state, MNR will be a high-quality, 232-bed community hospital with integrated outpatient care designed to provide access to the hospital's underserved community and eliminate inappropriate inpatient and ED utilization. MNR will have a reimagined and expanded ED, including a pediatric ED, emergency behavioral health services, radiology and an extended-hours urgent care center. The ED expansion which includes pediatrics, behavioral health, emergency acute care is a 24/7 operation. Although not finalized, we envision urgent care operational 8am to 8pm, Monday through Friday and 8am to 5pm, Saturday and Sunday. Radiology services would expand their hours of operation to 8am to 6pm Monday thru Friday and Saturdays from 8am to 4pm. Radiology services supporting the Emergency Department are available 24/7. MNR will transition the management of existing primary and specialty care services to another MHVC partner, Hudson River Healthcare, an FQHC, which will provide comprehensive care in the team-based, Patient Centered Medical Home model. The Community Health Center, located on three floors of a newly renovated, 33,000 square-foot, four-story building on campus, will provide a full range of services, including internal medicine, women's health, pediatrics, integrated behavioral health, oral healthcare, WIC nutrition services and care coordination and management. In addition, there will be meeting rooms for counseling, group sessions and community health education. This renovation is made possible via CRFP funding.
Montefiore Mount Vernon (MMV)	Montefiore Mount Vernon (MMV) will undertake a significant capital renovation to expand and enhance primary and specialty care (via increased providers, expanded hours and more patient-friendly operations); develop a new outpatient behavioral health care program integrated with primary care; and develop a new chronic disease management program that will serve as a learning lab across the MHVC network. The chronic disease management program will also offer community wellness programming and access to critical social services through partnerships with local community-based organizations, and additional support by a team of non-clinical community health workers trained in culturally competent care.
St. Luke's Cornwall Hospital – Newburgh **St. Luke's Cornwall Hospital – Cornwall**	We have determined service line priorities for the St. Luke's Cornwall Hospital campuses in order to stabilize these two institutions. In the second half of this year, we will develop business plans for the services to be provided in the medical villages. We expect the strategic plan for these two institutions to be completed by 12/31/16.
Nyack Hospital	Nyack Hospital will expand and modernize its ED, resulting in a streamlined process between the ED, an expanded fast-track center and Nyack's co-located primary care and behavioral health service partners. The new system will be able to quickly assess and route patients to the appropriate level of outpatient care and significantly decrease avoidable hospital use for ambulatory care sensitive conditions. As part of this process, Nyack will use patient navigation and transition coach services to: provide evidence-based care coordination to link patients with primary, specialty, and behavioral health care providers based on the patient's needs, support patients in understanding and self-managing health conditions, and provide support in transitioning patients to services. This renovation is made possible via CRFP funding.
St. John's Riverside Hospital **St. Joseph's Medical Center**	Beginning in 2017, we will turn our attention to the final two medical villages at St. John's Riverside Hospital and St. Joseph's Medical Center. We expect the strategic plan for these two institutions to be completed by 12/31/17. These strategic plans will included the CRFP funded projects described

	above including creation of a Crisis Stabilization Center for mental health and substance abuse at St. John's, expansion of behavioral health and substance abuse services at Park Care Pavilion, and the establishments of intensive crisis respite residential program as an alternative to inpatient hospitalization at St. Joseph's.

4. Incentivizing Access through Reimbursement Models

MHVC is committed to increasing primary care in regions in the Hudson Valley where primary care demand outstrips the supply of primary care providers. Through MHVC, Montefiore will improve access to primary care in the regions most in need. This may include attracting new physicians to the area through incentives or shifting provider hours that primarily practice in contiguous counties with greater supply.

MHVC will explore creating interim reimbursement models to compensate Primary Care providers for expanding hours, in advance of moving into Value Based Payment arrangements.

By way of the MHVC partner contracting model, MHVC has the opportunity to develop process metrics rewarding partners who expand the number and availability of ambulatory care services where data identifies a need. These metrics would be geared towards increasing the hours of availability of PCPs, and expanding primary care capacity, particularly in regions of shortages. Partners would be able to complete these metrics by increasing hours, recruiting primary care providers and using tele-health capabilities where feasible.

MHVC understands that current reimbursement models do not incentivize expanded access hours. To this end our funds flow model would incorporate metrics geared towards Primary Care Providers based on their capability to provide non-traditional expanded access hours to their patients. Additionally we would work with regional Managed Care Organizations to advocate for accelerated reimbursement for services provided after business hours.

5. Integrating Urgent Care in the IDS Continuum

The availability and popularity of urgent care throughout the Hudson Valley has grown in recent years. Integrating urgent care services into the MHVC integrated delivery system will ensure an MHVC member's urgent care needs are shared with their PCP. In our initial application, we identified 13 urgent care centers in the region: 2 each in Putnam and Ulster, 3 in Orange, 5 in Sullivan and 6 in Westchester. Since the filing of our application in 2014, there has been considerable expansion throughout the region. We see an opportunity for urgent care centers to be used in conjunction with extended PCP hours to direct care to an outpatient setting and away from the Emergency Department.

Through Montefiore Health System, MHVC is currently considering partnership opportunities with urgent care and retail clinics that are expanding throughout the Hudson Valley. This includes elements such as:

- Referrals back to PCPs
- Sharing Evidence Based Guidelines
- Data sharing, including EMR and connectivity to the RHIO
- Inclusion in VBP

By including urgent care in our integrated delivery system, MHVC will utilize an additional access point for our members. Urgent care facilities provide access to extended hours of care and an additional opportunity for patients to be redirected away from avoidable and potentially costly ambulatory sensitive ED visits.

In summary, the results of the community needs assessment conducted by MHVC and the recently released state data on primary care capacity, highlight areas of opportunity to expand primary care and ambulatory care services within our network. Currently the five areas of focus for MHVC are:

- Increasing ***access*** to primary care by supporting the patient centered medical home model,
- Optimizing the ***CRFP awards*** to expand primary care capacity in the Hospital's service area,
- The deployment of ***the medical village*** to address inefficient healthcare resource usage and improve access,
- Assisting our providers to transition to the ***VBP model***, through training and programmatic enhancements to infrastructure that will support value based payments.
- Exploring the opportunity to partner with the ***urgent care*** and retail clinics in the Hudson Valley.

At MHVC primary care is essential to building a higher-performing health care system. These strategies will assist to create a more patient centered system with access to services tailored to meet our community needs.

C. Working with Community and Institution Based PCPs

In accordance with the mission of DSRIP, MHVC has a goal of preparing its network and the Hudson Valley in general for a market shift towards value based purchasing. As policy and payers shift to reimbursement that has a growing focus on outcome and quality metrics based with the primary care practice as the lynchpin in this shift, MHVC will take a leadership role in the education and assimilation of the PCP network to this new environment.

MHVC is aware that PCPs across the continuum have varying levels of readiness for transformation and infrastructure required to be successful in value based purchasing. To ensure that MHVC provides a value add to providers in different settings, MHVC is leveraging data collected in the field, and the input received from our partners through our PPS Governance Committees and Project Specific Workgroups to frame our approach to practice level support.

Through these interactions we identified that many Community Based PCPs lack project management support and experience navigating the implementation of various simultaneous initiatives, with timeframes, as ambitious as DSRIP. To support practices with the tools needed to be successful, MHVC Project Workgroups created project specific toolkits. These interactive toolkits provide step-by-step guidance on what a practice needs to do in order to maintain a trajectory towards milestone achievement. In recognition of the fact that other Community Based PCPs and institutional PCPs have mature processes, policies and procedures and workflows in place, our Toolkits and Project Implementation Milestones allow for flexibility in approach. This strategy recognizes the innovation and sophistication of partners and reduces administrative "noise" that could prohibit them from being successful in their efforts. These practices are being leveraged as subject matter experts within our PPS, to share best practices and lessons learned.

Data collected in our Workforce Survey, Network Assessments and other structured surveys has been leveraged to frame the level of support needed. Our Provider Relations team has been allocated across the PPS Network, and is well prepared to support PCPs of varying infrastructure. Examples of variation in our support model include deploying performance improvement specialists to provide training around PDSAs and rapid cycle evaluation for practices with little

or no quality infrastructure and leveraging relationships with Quality Improvement Director/Lead within organizations that have more mature infrastructure in place. In addition, as articulated in Fundamental #3 below, MHVC is ensuring that our PCMH support model offers different tiers of support based on partner readiness.

Fundamental #2: Primary Care Expansion and Practice and Workforce Transformation

How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?

Primary care is fundamental to building a stronger and more viable health care system. The need for expanding primary care is essential. To that end, below are the three approaches MHVC has developed to support the training and technical assistance needs of our partners in the Hudson Valley region.

A. PCMH Strategy
B. Workforce Training Strategy
C. Leveraging State Resources

Employing our PCMH strategy, workforce training strategy and the leveraging of State resources will assist our partners in the transformation of their practices. Each strategy is explained in detail below.

A. PCMH Strategy

MHVC recognizes that community based PCP's may not have the resources or capacity to achieve PCMH 2014 recognition, nor existing staff to support operationalizing many of our MHVC DSRIP projects. In addition, we also recognize that many small practices may lack knowledge about the value and importance of PCMH transformation. To address these challenges, MHVC is committed to a "boots on the ground" approach to working with our community based PCPs. In collaboration with our vendor, the Primary Care Development Corporation (PCDC) we are guiding our network PCP practices through the PCMH transformation process, helping them achieve PCMH 2014 Level 3 certification and supporting them in our MHVC project work by aligning PCMH requirements with our project design whenever possible.

We have organized our PCMH Strategy into five categories:

1. **Network Assessment and Practice Readiness Assessments**
2. **Cross PPS Participation**
3. **Readiness Levels and Engagement Strategies**
4. **PCMH Technical Support Models**
5. **PCMH Transformation and DSRIP Project Alignment**

A detailed description for each category is presented below.

1. Network Assessment and Practice Readiness Assessments

A formal assessment of PCP practices conducted by our vendor, (The Primary Care Corporation (PCDC)), is in progress for PCP practices within our network. The network assessment is structured to provide MHVC with an understanding of each partner's eligibility and readiness to achieve NCQA Patient-Centered Medical Home 2014 recognition and their capability to deploy DSRIP initiatives.

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The network assessment of MHVC's primary care providers will establish:

- The number of primary care provider organizations, providers, and sites.
- The types of providers at each site within our network (e.g., MD, DO, NP, PA)
- Practice eligibility for NCQA PCMH 2014 recognition
- Provider's CMS EHR Incentive Program ("Meaningful Use") – If providers meet Meaningful Use Stage 2 requirements
- Provider's readiness for PCMH transformation (capability and capacity)
- Organizational appropriateness for a "multi-site" application for NCQA PCMH 2014 certification

Network Findings

MHVC has 205 organizations in our network that have a minimum of 1 Primary Care Provider. Within those 205 organizations 10 organizations have obtained PCMH 2014 Level 3 certification. The 10 organizations represent 456 Primary Care Providers. MHVC also has 2 organizations that are currently PCMH 2011 certified. This represents 10 Primary Care Providers.

Those practices identified as PCMH eligible, receive an in-depth PCMH readiness assessment that considers key elements of primary care functioning: including the use of registries, EMR based templates, and risk stratification of patients as a part of a population management strategy. It also assesses the tracking and follow-up of patient care transitions. The level of technical assistance that is provided to practices is based on analysis of the readiness assessments.

2. Cross PPS Participation

Our network analysis identified that some of our partners were participating in multiple PPSs. The PPSs collaboratively developed and agreed upon a methodology for deciding which PPS is responsible for lifting these types of practices. It was decided that member attribution would drive the decision of which PPS would lift each practice to meet the NCQA PCMH 2014 Level 3 certification requirements. The following table displays how we used the attribution data to carry out this methodology. Within this example, the gray boxes indicate which PPS would be responsible for each of the overlapping organizations. This approach will ensure that there isn't duplication of resources between the PPS's. As noted in the table below, while there may be PCP practices that have significant overlap between 2 PPS's, it is the actual member attribution that drives the decision of which PPS will support the PCMH transformation.

Table 5: *Attribution Percentage in PPSs per Organization*

	Weighted Averages			
Organization	%WMC PCP	%MHVC PCP	%WMC Attribution based on Valuation	%MHVC Attribution based on Valuation
Organization A	100%	10%	59%	41%
Organization B	100%	100%	16%	84%
Organization C	83%	100%	14%	86%
Organization D	100%	88%	61%	39%
Organization E	100%	93%	62%	38%
Organization F	100%	90%	56%	44%
Organization G	100%	85%	7%	93%
Organization H	26%	100%	24%	76%

3. Readiness Levels and Engagement Strategies

Readiness Level Classifications

Practices are classified into one of four readiness levels that determine site specific time frames for PCMH application submission, resource needs, and the intensity level of technical assistance that is required to support the practice in achieving NCQA PCMH 2014 recognition and their MHVC project goals. The chart below summarizes the four levels of readiness:

Network Assessment – Readiness Results	
Readiness Level 3:	Practices that have existing PCMH recognition; are fully EHR-enabled; conduct ongoing activities in care coordination, population health and quality improvement; and are highly motivated.
Readiness Level 2:	Practices that may not have previous PCMH recognition but are fully EHR-enabled, engage in regular QI and care management activities, and have dedicated staff for the PCMH recognition work.
Readiness Level 1:	Practices with a successfully implemented (EHR) but no prior PCMH experience, limited Quality Improvement (QI) procedures in place, and limited time and staff to dedicate to.
Readiness Level 0:	Practices that have no "Meaningful Use"-certified Electronic Health Record (EHR) or are ineligible for NCQAPCMH recognition. Vendor wouldn't engage these past the assessment.

Engagement Strategy by Readiness Level

Readiness Level 3

Highly motivated practices that are fully EHR-enabled, may have existing PCMH recognition, and conduct ongoing activities in care coordination, population health and quality improvement, fall into this level of readiness. MHVC's approach is to engage these practices by providing guidance on how MHVC projects can be aligned with the work they are already doing.

Practices that have already achieved PCMH Level 3 certification also fall into this readiness level and are engaged through MHVC project alignment activities.

Readiness Level 2

Practices that fall into this level may not have had prior PCMH recognition but have a Meaningful Use EHR and are able to engage in regular quality initiatives. There is dedicated staff available to help in the transformation process. These practices also have a defined process for care management.

Readiness Level 1

Practices that fall into this level are ready for the transformation process but have limited staffing resources dedicated to the implementation process. They have an EHR but limited experience with quality initiatives. These practices have no prior PCMH experience.

Readiness Level 0

At MHVC we realize that not every PCP practice may be ready for PCMH certification by the state-defined DSRIP deadline. Some practices lack a Meaningful Use eligible EHR and other providers are not motivated, are too scared to change, or do not feel the pressing need to transform. MHVC is committed to designing creative strategies to support these practices, and provide them with tools and education needed to help them to move toward a higher readiness level. MHVC incorporates successful provider engagement strategies employed by the Montefiore ACO as a foundation for engaging practices classified as readiness level zero. These strategies include:

- EHR optimization – Montefiore's Care Management Organization has facilitated discounted rates for a Web based EHR provided by Med-Gen.
- Providing education on quality HEDIS measures
- Providing practices with guidance on building patient registries and dashboards
- Sharing strategies for workflow optimization
- Sharing processes for patient flagging and attribution
- Sharing patient engagement and risk stratification tools

In addition, as described in the *"Leveraging State Resources"* section below (Section C), MHVC is committed to educating and linking these practices to alternative state supported programs including, Advance Primary Care (APC) and Transforming Clinical Practice Initiative (TCPI), which are designed to provide technical assistance for transformation.

4. PCMH Technical Support Models

Two models of MHVC PCMH technical support are graphically illustrated and described below. Practice readiness level will drive assignment of the appropriate technical support models to each PCP practice.

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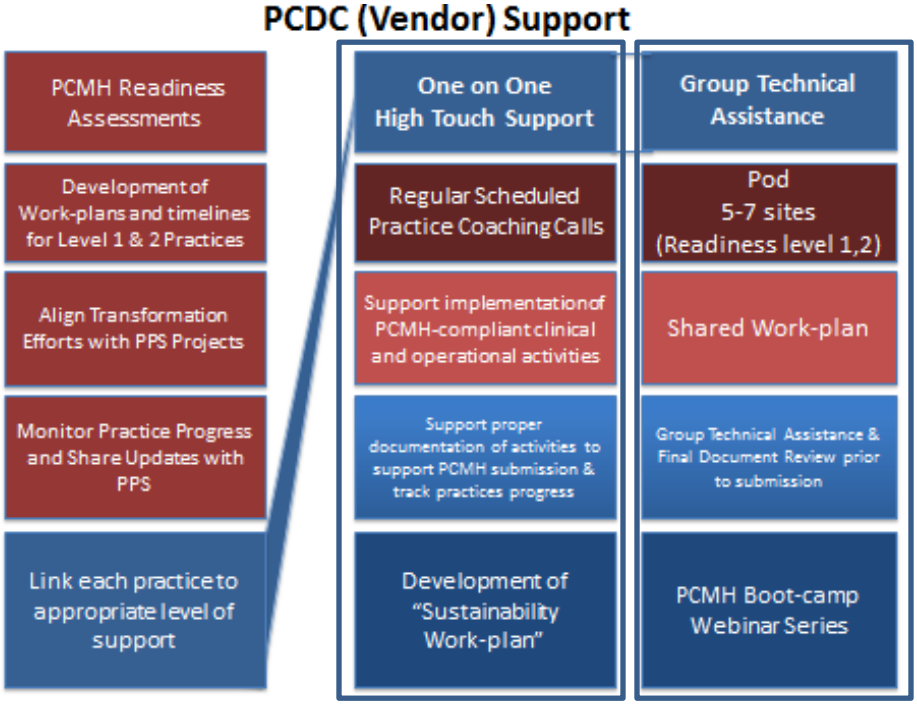


One-on-One PCMH Coaching Model

Practices designated to receive direct one-on-one technical assistance are assigned a "Practice Facilitator." The Practice Facilitator:

1. Conducts an in-depth, factor-by-factor assessment of the practice against the requirements of NCQA's PCMH 2014 Standards and Guidelines.
2. Develops an individualized work plan based on the practice's readiness level; outlining tasks to be completed and necessary resources, including people and technology.
3. Engages the practice in regular coaching calls according to the intensity of the phase of work. The practices readiness level will determine the length of engagement (3 - 9 months).

Group Technical Assistance Model

Primary care practices classified as readiness levels 1 and 2 may be assigned to participate in a group-based technical assistance model where pods of 4-6 practices with similar characteristics, are grouped together for telephonic technical assistance coaching sessions. Practices assigned to this model will:

1. Participate in a 16 hour "PCMH Boot Camp" delivered through webinars
2. Participate in weekly or biweekly telephonic coaching sessions (up to 30 sessions) focused on specific PCMH elements including review of practices documentation and materials for NCQA submission.

5. PCMH Transformation and DSRIP Project Alignment

Recognizing the burden on PCP practices of operationalizing MHVC DSRIP projects while simultaneously undergoing PCMH transformation, MHVC is working closely with our PCMH vendor, PCDC, to meaningfully align PCMH requirements with our MHVC DSRIP project design. Specifically we will:

- Create a crosswalk between MHVC DSRIP Projects and NCQA PCMH 2014 elements and factors.
- Develop a plan for implementing PCMH while incorporating DSRIP project requirements for PCMH-eligible practices across the MHVC network.
- Host webinars focused on identifying alignment of project specific deliverables with the practices' PCMH efforts.
- Structure and deliver PCMH implementation technical assistance, thereby supporting the practices in making progress toward PCMH recognition and DSRIP project goals.

B. Workforce Training Strategy

For many practices pursuing PCMH transformation, we recognize that additional staff will need to be hired for the care management and care coordination roles. MHVC's Workforce Management and Development team conducted a current state assessment and gap analysis to understand the number of staff that will need to be hired and developed a training strategy and plan to ensure that staff are able to develop the care management and care coordination skills foundational to PCMH.

Workforce Gap Analysis

Table 6: *MHVC Workforce Gap Analysis (All Projects) by FTE*

Job Categories	Position Type(s)	DY2Q1	DY2Q2	DY2Q3	DY2Q4	DY3Q1	DY3Q2	DY3Q3	DY3Q4	DY4Q1
Non-licensed Care Coordination	Referral Coordinator	0.9	4.0	13.0	30.3	30.3	30.3	44.2	74.0	74.0
Nursing Care Managers/ Coordinators	RN Care Manager / Case Manager	0.0	0.0	18.8	49.5	49.5	49.5	53.4	62.2	62.2
Physicians	Primary Care (MD)	6.7	6.7	6.7	14.0	14.0	14.0	26.6	53.0	53.0
Non-licensed Care Coordination	Peer Support Specialist / Peer Educator	15.8	15.9	25.6	40.8	40.8	40.8	43.4	48.9	48.9
Health Information Technology	Reporting / Data Analyst	0.7	3.2	10.4	19.2	19.2	19.2	22.8	30.5	30.5
Behavioral Health	Licensed Social Worker	0.0	0.0	0.0	0.0	0.0	0.0	5.8	27.6	27.6
Behavioral Health	Peer Support Specialist (BH)	0.0	0.0	12.4	27.1	27.1	27.1	27.1	27.1	27.1
Non-licensed Care Coordination	Community Health/Outreach Worker	9.2	9.2	12.2	22.6	22.6	22.6	23.8	25.4	25.4
Administrative Support	Front Desk Clerk / Office Clerk	2.9	2.9	4.8	9.4	9.4	9.4	14.6	24.5	24.5
Nursing	Cardiac Care (RN)	2.4	2.4	6.7	12.4	12.4	12.4	15.2	22.4	22.4
Non-licensed Care Coordination	Care / Patient Navigator	1.8	1.8	3.8	7.5	7.5	7.5	11.0	18.8	18.8
Behavioral Health	Mental Health Therapist / Behavioral Health Specialist	13.5	13.5	13.5	13.6	13.6	13.6	14.8	18.1	18.1
Physicians	Emergency Medicine (MD)	0.0	1.6	4.6	7.6	7.6	7.6	10.4	16.6	16.6
Social Worker Case Management / Care Management	Licensed Social Worker	3.4	3.4	3.4	10.7	10.7	10.7	12.1	16.3	16.3
Nurse Practitioners	Primary Care (NP)	3.0	3.3	4.1	5.1	5.1	5.1	7.8	13.8	13.8
Patient Education	Health Coach (Call Center)	0.4	0.4	2.5	5.4	5.4	5.4	6.8	10.4	10.4

Workforce Strategy and Training Plan

The Workforce Training Strategy includes:

- Clinical staff training related to population and care management
- Non-clinical staff training in support skills needed to reinforce the new care model

- Leveraging existing learning institutions/educational programs and partner trainings
- Developing training programs based on partners self-identified needs, including in areas of behavioral change, self-management support, and patient-centered communication skills training/engagement.
    - Including a robust program to develop trainers of self-management skills (Brief Action Planning (BAP) and Motivational Interviewing (MI)) within partner organizations.
- Developing a robust training for new positions in the outpatient setting that focus on care navigation and coordination.

The Workforce Training Strategy is attached to this plan as an appendix.

Creation of Workforce Training Workgroup

Various network partners and practices are represented in the MHVC Workforce Training Workgroup. This workgroup was created to ensure that our partners' voice and knowledge of training gaps and needs were incorporated into our workforce training strategy to support primary care expansion.

C. Leveraging State Resources

Recognizing that not every PCP practice will be ready to transform within the state defined DSRIP timeline, MHVC is committed to educating PCPs about the availability of additional state funded resources available to guide and support primary care transformation. For some practices, work plans may include guidance to pursue one of the alternative transformation funding streams listed below. One of the state funded resources noted below, The Care Transitions Network, was procured through a competitive grant application process in which Montefiore participated prior to the creation of the DSRIP initiative; however, it's goals align closely with MHVC. Additional detail on the scope of this program is provided at the end of this section.

State funded resources:

- The State Innovation Models (SIM) Program (i.e. Advanced Primary Care)
- The Transforming Clinical Practice Initiative (TCPI) Program
    - New York State Practice Transformation Network
    - Greater NYC Practice Transformation Network, and the
    - Behavioral Health Practice Transformation Network (Care Transitions Network- see detail below)
- Data Exchange Incentive Program (DEIP)

Educating MHVC Partners

MHVC is committed to ensuring our partners have knowledge and tools to navigate the existing alternative funding streams described above, as well as understanding the value of transformation as a foundation for participation in future value-based payment models. To this end, we have developed a communication and education strategy focused on the core "cross cutting" infrastructure requirements inherent in most DSRIP Projects; achievement of PCMH recognition, EHR adoption, and RHIO Connectivity.

- *Achievement of PCMH Recognition:* See Section A above.

- *EHR Adaption:* MHVC is working with provider groups that don't have an EHR, to promote EHR adoption through the use of a vetted EMR solution. Med-Gen is a web-based certified MU Stage 2 EHR that is currently in place for Montefiore's community physician groups that are members of the Montefiore ACO. The Montefiore Care Management Organization has facilitated discounted rates for this product.

- *RHIO Connectivity:* MHVC is collaborating with our local QE to provide partner education and stakeholder specific engagements to support QE connectivity, and ensure that existing temporary funding streams are utilized to offset the costs of connecting to the RHIO. We will continue to provide provider education and outreach around connecting to the QE.

MHVC's Partner Relations team has been using the following communication strategies to keep our PCP partners updated on these resource opportunities: postings within the MHVC partner portal, webinars, monthly newsletters, learning collaboratives, vendor and internal MHVC communications, one-on-one partner site visits, and dedicated partner relations support.

Care Transitions Network for People with Serious Mental Illness (SMI): Behavioral Health PTN

Montefiore in collaboration with the National Council of Behavioral Health and North Shore-LIJ was granted a competitive Practice Transformation Network award to improve primary care and behavioral health outcomes for adults with Serious Mental Illness. The Care Transitions Network is a 4-year initiative funded by CMS to move providers into value-based arrangements with an ultimate goal of reducing all-cause re-hospitalization rates for people with serious mental illness (SMI). It consists of three components:

- *Centralized Care Management for Short-Term Care Transitions Support*
  - Support is provided by a transitions care management team at Montefiore's University Behavioral Associates (UBA's team currently serves Montefiore's ACO and capitated arrangements covering 400,000 lives).
  - Support is focused on the 30-day period after discharge from mental health inpatient care and includes:
    - Linking inpatient (MH) and outpatient (MH and PCP) providers
    - Providing real-time data to inpatient and outpatient providers
    - Bridging to Health Homes for enrolled and eligible patients

- *Data Driven Learning Collaboratives -QI Support*
  - Analysis of Medicaid claims data to understand utilization and cost patterns for SMI patients at participating clinics (for HARP and non-HARP patients)
  - Providers know how much service they provide, but not services provided by other providers
  - OMH/PSYCKES Quality Collaborative to reduce readmissions
  - Increase use of LAIs and Clozapine
    - Technical assistance and consultation provided by Northwell experts
  - Clinicians will participate in tracing and care management

- *Robust Technology Platform*
  - Providers participating in the CTN will receive access to the Netsmarts CareManager Platform. The platform is integrated with the Health Information Exchange and designed to communicate and connect to various systems. It will enable PTN to use a provider registry to locate an optimal provider and to initiate referrals within care planning.

We have received clear guidance from CMS that practices enrolled in a the Care Transitions Network (Behavioral Health PTN) are also eligible for PCMH support as long as they are not receiving federally-financed support for the *same activities*. Since the technical assistance our PTN offers relates to the care for severely mentally ill patients, especially regarding care transitions after mental health hospitalization, there is little risk of duplication, however a process is in place to explicitly monitor for this.

Fundamental #3: Primary Care in the Integrated Delivery System

What is the PPS's strategy for how primary care will play a central role in an integrated delivery system?

MHVC's Vision

MHVC's guiding vision is to create an integrated delivery system focused on patients, partners and communities of care, where information flows empowering the right level of care to be delivered at the right place at the right time.

Our approach is to develop a system where primary care practices are not just aware of and connected to the many supportive Network resources, but they become the center of the delivery system. This shift in role for the PCP requires key health care transformation changes including:

1. Connection to broader networks of care including community based organizations, mental health providers and others,
2. Involvement in value based purchasing arrangements, which is in accordance with the state roadmap.
3. PCP education and resources such as IT for data analytics and
4. Care management support for PCP success in a value based reimbursement environment.

Defining Provider-Specific Project Requirements

A large number of DSRIP project milestones live within the Primary Care practice. This includes the adoption of standardized evidence based protocols, adoption of systems and processes to risk stratify patients, integration of behavioral health services, and patient assessments to identify social needs and arrange appropriate linkages. The number of requirements can easily overwhelm Primary Care Providers.

Through a collaborative process MHVC engaged diverse stakeholder groups, in a facilitated activity that led to the creation of a series of process maps illustrating the patient journey through the care continuum for each project. Swim lane diagrams highlighted the roles and responsibilities attributed to each provider type involved. The process maps note linkages between different provider types and points of intersection with other clinical projects.

After validating these process maps with diverse stakeholders in the field, they were used to inform the development of project specific roles and responsibilities as well as project work plans. In turn these materials guided the development of foundational process metrics that will help move our projects forward. These process metrics ("Project Implementation

Milestones") are project and provider type specific and form the foundation of MHVC's dynamic contracting strategy. We will continue to use this model, creating project implementation milestones in six-month cycles, to ensure active feedback on project success and provide opportunities to realign our approach as necessary.

Role in PPS Governance – Committees & Workgroups

MHVC's governance structure was designed to ensure that comprehensive governance and management of the DSRIP program aligned on a set of guiding principles to inform the overall strategy and decision-making. We committed to:

- Ground decisions in data, robust analytics, and evidence-based practices
- Approach decisions collaboratively, transparently and with input from multiple perspectives (including stakeholders beyond MHVC)
- Adopt approaches that are centered around the voice and needs of our patients
- Have a shared MHVC vision
- Promote local ownership of regional transformation
- Focus on DSRIP requirements and long-term financial sustainability of integrated systems of care

In order to ensure adequate representation of partners within MHVC's governance Committees, Sub-Committees and Workgroups, MHVC leadership developed an organizing matrix, broken out by provider type and geography. This matrix allowed MHVC to carefully monitor the creation of subcommittees and workgroups to ensure the participation of a diverse set of partners. This model also allowed MHVC to easily present the rosters to interested partners and governing bodies for approval. The model showed that membership was based on the need of the subcommittee and represented the diversity and breadth of the network. For primary care stakeholders, the matrix included a category for both community and institutional PCPs. Inclusion of PCPs with varying levels of infrastructure within our governance structure was imperative to the design of our IDS, development of shared service models and in creating standards for our various clinical projects. These partners provide different perspectives on the operational challenges associated with project deployment, workforce transformation and technology.

Many partners have taken the opportunity to speak publicly among their colleagues about the success of the governance structure and all it has accomplished in a short time. MHVC has also carefully monitored the structure; adapting and evolving when appropriate, to ensure responsibilities of the network are being met.

Field Work: Findings

We have learned a tremendous amount in the field through interactions with our partners and are confident that existing programs and funding streams for Medicaid billable services are not being utilized to their fullest potential, not because the programs are not well founded and designed but because providers have difficulty navigating what programs exist. One example is the Health Home program. Within our field work, we have identified that many PCPs and Hospitals offer episodic care management programs to support chronically ill patients. These programs and staffing are causing financial strain on the organization and primary care providers. Many of these organizations articulated a lack of knowledge as to what the Health Home program was, eligibility requirements and how to refer. Our continued work with the regional Health Home networks to facilitate educational webinars and trainings and our commitment to the development of a MHVC Heath Home referral policy are a few examples of how we are addressing this particular finding.

In summary, Primary Care practices will play an integral role in the delivery system through direct care and the identification and referral of patients to MHVC Network partners, to ensure that care is delivered in a patient centered comprehensive manner, and that resources are utilized appropriately. MHVC's role, as a facilitator, is to identify gaps and explore opportunities to provide shared services but also to connect the pieces of the puzzle, so that primary care providers are not over-burdened, but supported by the MHVC Network, so that patients, partners and communities of care are connected.

Fundamental #4: Primary Care's Participation in Value Based Payments

What is the PPS's strategy to enable primary care to participate effectively in value-based payments?

A. Strategy to Enable PCP Participation in VBP

Providing a Consistent and Pertinent Message

With the transition to VBP across the state, one of the overarching questions that primary care providers have is "what does VBP mean for me." Being able to succinctly respond to the needs and questions of primary care providers will be paramount to effective recruitment. We can help primary care providers eligible for DSRIP to understand the unique benefits of being in both MHVC (co-creating a new integrated delivery system) and the newly formed Hudson Valley IPA (participating in value based contracting).

Collaboration on Project Implementation

Through a collaborative process, MHVC engaged diverse stakeholder groups in a facilitated activity that led to the creation of a series of process maps illustrating the patient journey through the care continuum for each project. Swim lane diagrams highlighted the roles and responsibilities attributed to each provider type involved. The process maps note linkages between different provider types and points of intersection with other clinical projects.

After validating these process maps by diverse stakeholders in the field, they were used to inform the development of project specific roles and responsibilities as well as a project work plan. In turn these materials guided the development of foundational process metrics that will help move our projects forward. These process metrics ("Project Implementation Milestones") are project and provider type specific and form the foundation of MHVC's dynamic contracting strategy. We will continue to use this model, creating project implementation milestones in six-month cycles, to ensure active feedback on project success and provide opportunities to realign our approach as necessary.

Utilization of Existing Resources

MHVC will be leveraging Montefiore's existing experience with risk-based contracting and care management activities to educate providers on value based arrangements and the benefits of IPA membership to encourage long-term sustainability of the improvements made through the DSRIP program.

B. VBP Transition: Risks and Mitigations

The following are believed to be key risks associated with meeting the needs of the most important stakeholders in the region and corresponding plans to move primary care providers closer to VBP contracting readiness.

Table 7: *Key risks for meeting regional stakeholder needs and corresponding VBP readiness improvement plans*

Risk	Mitigation
Building alignment across the new partner network	1. Process mapping and the collaborative development of toolkits 2. Population Health workgroup, drawn from diverse stakeholders to develop standards for practice services centralized or delegated. 3. Build IT systems robust enough to facilitate tracking against all DSRIP milestones while capturing the data elements needed to achieve the milestones. 4. Build partner relations management tool which will also include the functionality to facilitate communication on multiple levels across the Network. This includes ongoing communication, job boards, posting of committee documents, as well as incoming issues and/or community concerns. The tool must be aligned with the final governance structure and needs to be flexible enough to adapt to changes in this structure as needed.
Lack of financial and/or cultural readiness of partners for the shift to value-based payment models and risk-based arrangements	1. Leverage the experience of Montefiore Care Management Organization (CMO) and other partners with value based payment models and practice transformation. 2. Engage in regular outreach and communication with partners, focused on educating partners on shifting payment models. 3. Coordinate communications and readiness work with the Montefiore Hudson Valley IPA team.
Lack of timely claims data provided by the state (i.e., sharing mediums, protocols and processes)	1. Encourage the DOH to more expediently deliver data, including cost data, and consider other potential data sources to use in lieu of claims data. 2. Design informative and actionable reports for primary care providers using their own claims data and sharing information that is under the regulations of the BAA. This is critical in conveying appropriate information for primary care providers to understand the needs of their attributed population.
Workforce	1. There is the risk that unanticipated lay-offs within the network could make it difficult to achieve our target workforce state. In the event that this happens, we will work with union leadership and internal and external stakeholders to minimize the impact of unanticipated lay-offs. 2. There is a risk that partner organizations may not be able to mitigate regional wage disparities. To address this we will work closely with our partners to understand their compensation structures and capability to mitigate wage disparities. 3. There is a risk that labor strikes will impact our ability to conduct trainings according to planned timelines. In this case we will need to increase the number of trainings delivered once labor issues are resolved. 4. There may be resistance to change among staff, which we will address with a robust change management and engagement strategy. 5. We will address potential workforce shortages by exploring possible incentives to work in underserved areas.

Insufficient PCP offices with extended hours	1. By way of DSRIP funds flow, develop process metrics rewarding partners who expand the number and availability of outpatient care services where data identifies a need. The metrics will be geared towards increasing the hours of availability of PCPs, and expanding primary care capacity, particularly in regions of shortages. Partners can complete these metrics by increasing hours, recruiting primary care providers and using tele-health capabilities where feasible.
Insufficient care management for high risk lives (those that are health home eligible) and those that are at risk for chronic conditions	1. Leverage Montefiore CMO care management model and population health strategy. 2. Customize to Health Homes via population health workgroup. 3. Engage Health Homes in planning. 4. Standardize model to be deployed centrally or by delegation to qualified partners.
Improved collaboration between Behavioral Health (BH) and Primary Care	1. MHVC will facilitate the development of BH crisis hubs by collaborating with neighboring PPSs and existing crisis programs to ensure we are leveraging the strengths of the community. 2. Additionally, using the MHVC funds flow model as a vehicle of change and aligning with IPA VBP contracts, reward integration of BH and primary care services by first assessing capabilities of existing services and building on regional capacity and investing in areas of greatest need.

Fundamental #5: Supporting Primary Care Strategies – Funds Flow

How does your PPS's funds flow support your Primary Care strategies?

A. Funds Flow Strategy

Over the course of DY1, MHVC worked closely with partners (including the MHVC Finance and Sustainability Subcommittee and ad hoc MHVC partner workgroups) to develop a funds flow methodology that supports DSRIP success.

MHVC is committed to a funds flow model that is a careful steward of state and federal dollars and distributes funds in a thoughtful, fair, and equitable manner. At the same time, this model recognizes critical MHVC partners and supports the development of an Integrated Delivery System infrastructure to ensure a financially stable future for MHVC partners in the Hudson Valley. As such, one innovation that the MHVC network has adopted is that of a "reliable budget" based on projected earnings in each DSRIP funding category and associated cash flow. This principle, which was reviewed and approved through the MHVC formal governance structure, allows MHVC to make careful assumptions about the way we will draw down funds and then budget accordingly. It puts our network in a position to safely plan without overextending or overpromising DSRIP dollars. Plans for dollars earned above the reliable budget will be crafted and vetted with the MHVC Finance and Sustainability Subcommittee and Steering Committee. Further detail on budget allocations can be found below.

Considerations for funds flow to partners

We have designed the MHVC funds flow methodology to closely mirror the DOH methodology. Funding is tied directly to stakeholders' role in projects and outcomes and is distributed to partners by assessing the patient population impacted by the projects. As the needs of each partner may be slightly different, partners have autonomy and will maintain control

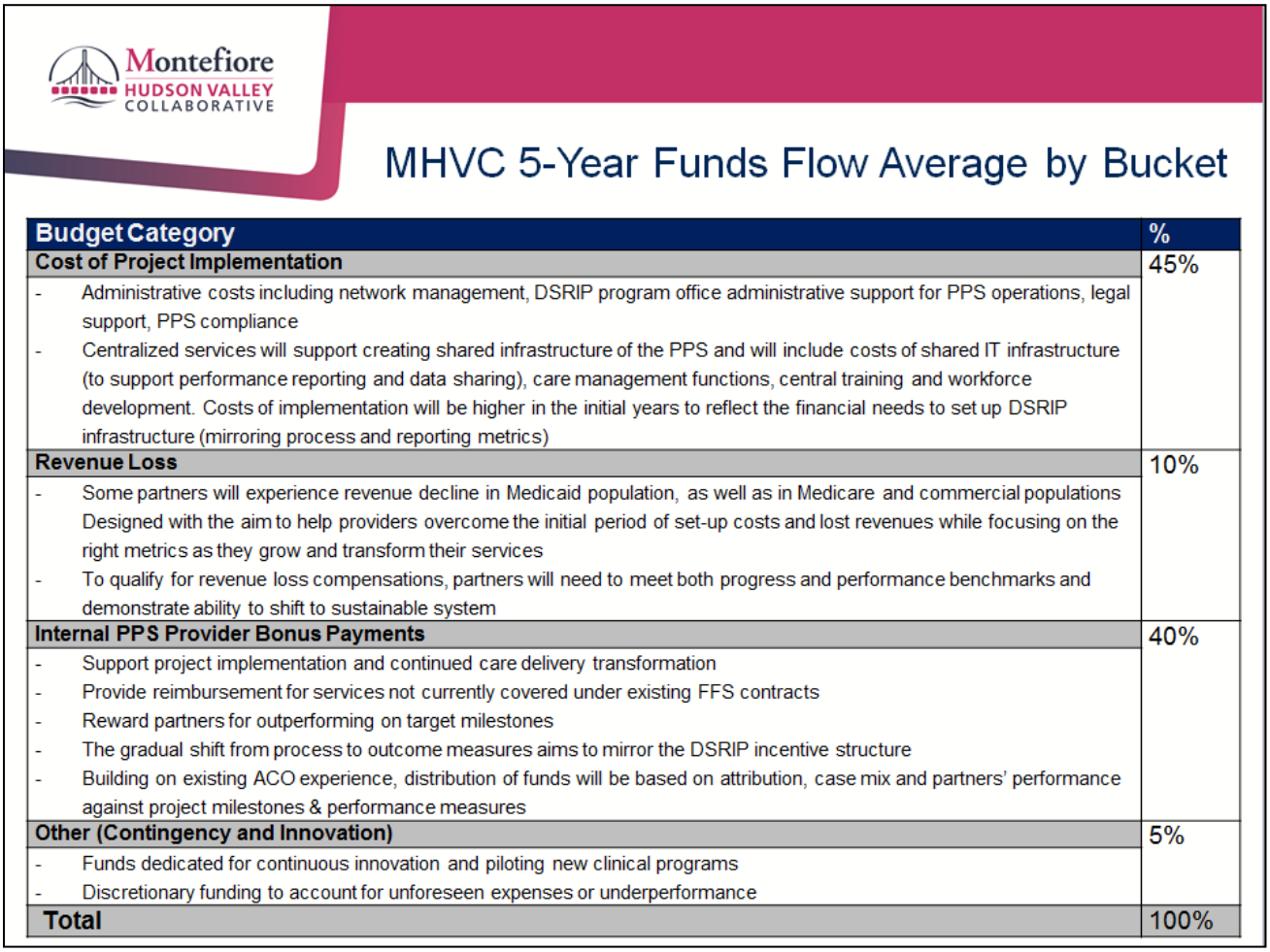
over individual budgets and implementation plans (in close collaboration with the MHVC office). We expect partners to provide regular status updates to ensure DOH milestones and requirements are met. Reflecting how MHVC will earn incentive payments from the DOH, partner funds will be increasingly tied to performance over the course of DSRIP.

MHVC's Phase I of funding (October – December 2015) was allocated to partners based on provider type, network development needs and member attribution. MHVC's Phase II of partner contracting covers the 18 month period July 2016 – December 2017 and is organized in three 6-month contract periods. Each contract period will reflect the most current data available from DOH related to member attribution and a partner's claims history as well as a partners role in Project Milestones, their use of shared services, and regional needs. Additionally funds flow will continue to adhere strictly to the "95/5" safety net rule that ensures that 95% of partner payments are distributed to safety net entities.

MHVC will ensure that the roles of CBOs are valued in the funds flow methodology by understanding and documenting their critical role in regional communities of care and a value based future. To that end, MHVC has kicked off a regional assessment of CBO readiness for VBP, working closely with NYAPRS, a strategic ally of CBOs regionally. This work will set the stage for future discussions regarding the role of CBOs in VBP arrangements.

B. MHVC Resource Distribution

As MHVC continues to advance its funds flow methodology, budget categories have been established and will be further evolved to ensure the alignment between the policies and guidelines for partner access and the funds flow key principles. The MHVC budget and funds flow methodology aligns with definitions set forth in the MHVC Implementation Plan and are aligned with the budget projections reported in the December 2014 MHVC Lead Agency DSRIP application. Funds are allocated to the following budget categories:



Budget Category	%
Cost of Project Implementation - Administrative costs including network management, DSRIP program office administrative support for PPS operations, legal support, PPS compliance - Centralized services will support creating shared infrastructure of the PPS and will include costs of shared IT infrastructure (to support performance reporting and data sharing), care management functions, central training and workforce development. Costs of implementation will be higher in the initial years to reflect the financial needs to set up DSRIP infrastructure (mirroring process and reporting metrics)	45%
Revenue Loss - Some partners will experience revenue decline in Medicaid population, as well as in Medicare and commercial populations Designed with the aim to help providers overcome the initial period of set-up costs and lost revenues while focusing on the right metrics as they grow and transform their services - To qualify for revenue loss compensations, partners will need to meet both progress and performance benchmarks and demonstrate ability to shift to sustainable system	10%
Internal PPS Provider Bonus Payments - Support project implementation and continued care delivery transformation - Provide reimbursement for services not currently covered under existing FFS contracts - Reward partners for outperforming on target milestones - The gradual shift from process to outcome measures aims to mirror the DSRIP incentive structure - Building on existing ACO experience, distribution of funds will be based on attribution, case mix and partners' performance against project milestones & performance measures	40%
Other (Contingency and Innovation) - Funds dedicated for continuous innovation and piloting new clinical programs - Discretionary funding to account for unforeseen expenses or underperformance	5%
Total	100%

The following table further outlines budget categories accessible to partners and PCP support from each MHVC budget.

Table 8: *Partner accessible budget categories and corresponding PCP support*

Cost of project implementation and administration	PCP support
▪ Centralized services will support creating shared infrastructure of the PPS and will include costs of shared IT infrastructure (to support performance reporting and data sharing), care management functions, central training and workforce development. Costs of implementation will be higher in the initial years to reflect the financial needs to set up DSRIP infrastructure (mirroring process and reporting metrics).	▪ Centralized and shared services are key for small PCP practices to enhance their services and move further along on the population health management continuum. Examples of services to support PCPs include care management, PCMH implementation guidance, call center resources and centralized evidence based practice guidance. PCPs can take advantage of these services to reduce costs and improve quality of care for their patients. These services will continue to be available through and incentivized by IPA VBP contracts.

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Internal PPS Provider Bonus Payments	PCP support
▪ Support project implementation and continued care delivery transformation. ▪ Provide reimbursement for services not currently covered under existing FFS contracts. ▪ Reward partners for outperforming on target milestones. ▪ Mirror the DSRIP incentive structure by gradually shifting dollars from process to outcome measures. ▪ Building on existing ACO experience, distribution of funds will be based on attribution, case mix and partners' performance against project milestones and performance measures.	▪ This is the main budget category supporting incentive payments for partners for meeting implementation milestones. ▪ Attribution based, fostering alignment with PCPs. ▪ Contracting deliverables emphasize role of PCP as a primary point of contact for members.
Other (Contingency and Innovation)	**PCP support**
▪ Funds dedicated for continuous innovation and piloting new clinical programs.	▪ Various groups will have access to these funds based on the projects the PPS deems is most appropriate for investment based on the needs of the region. ▪ Management reserves will be maintained for future needs that are not yet known.

The funds flow process is highly iterative and will continue to be revised as DSRIP and the MHVC network matures. In late 2015, MHVC contracted with partners via a Phase I funds flow focused on network development. In Phase I of contracting, MHVC focused on the MHVC partners that represented more than 90% of our network attribution based on the data that was available at the time. This data identified that 50 MHVC partners were the primary provider of services to 90% of the MHVC member attribution. Using attribution ensures that primary care providers are highly valued within our funds flow model.

In Phase II contracting, engagement of partners making up 90% of the attribution was still a key driver of network partner selection. Newly released state data brought the threshold of partners that contributed to reaching 90% of our MHVC members up to 69. These 69 partners are the focus of our Phase II Funds Flow model. Additionally, in the Phase II funds flow framework, partner dollar eligibility was driven in part by a stakeholder group's role in impacting key clinical outcomes. This focus, which was recommended by the MHVC Clinical Quality Committee resulted in PCPs being weighted the highest of all other stakeholder types.

To date MHVC has issued partner contracts for over $11M for partner activities through January 2017. To date, approximately $4.8M of these funds have been distributed to partners. Forty-three percent (43%) of those funds were distributed to PCP's/Clinics ($2M of the $4.8M). However this is just one of the forms of financial support provided to PCPs to further their DSRIP success and transformation efforts. MHVC has budgeted $1.7 million in resources for the aforementioned PCDC contract which will provide PCPs with hands on assessment and guidance through the PCMH

process. Additionally, MHVC has allocated $0.5 million annually, of its personnel budget towards support of the PCMH effort.

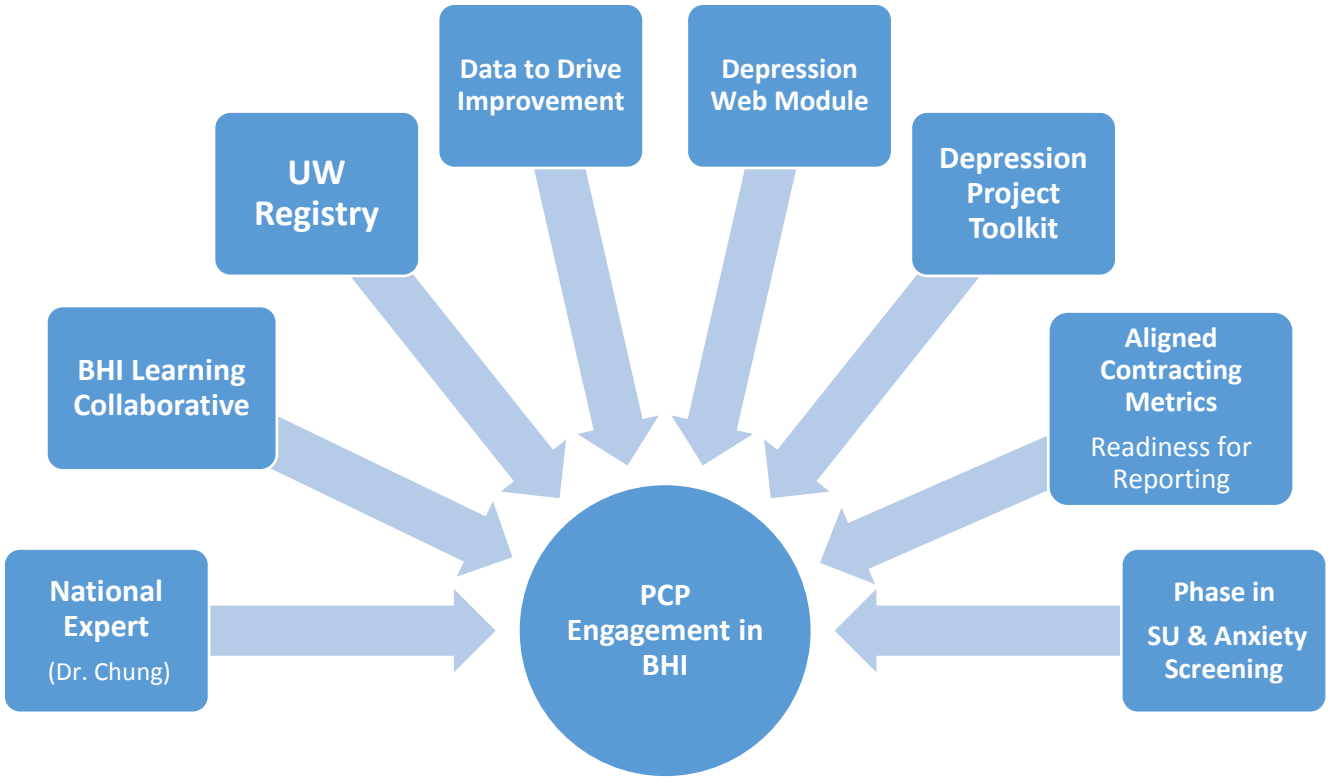
Fundamental #6: Primary Care and Behavioral Health Integration

How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?

Integration of Services: Collaborative Care and Development of Community Based Providers

Behavioral Health Integration (BHI)

MHVC has a multifaceted approach to engaging PCPs in BHI.



1. **First, we have engaged a national expert (Dr. Henry Chung) in BHI to help guide our implementation efforts.**

    a. Dr. Henry Chung is the Chief Medical Officer of the Montefiore Care Management Organization. He is the PI on a CCMI grant studying the feasibility of payment models for collaborative care and the effectiveness of collaborative care vs. co-located BHI. At MMG there are:
        i. 7 sites Collaborative Care
        ii. 12 sites co-location of BHI

    b. We are piloting Dr. Chung's UHF BHI Framework as a readiness assessment survey for practices and will using survey results to guide the development of training programming for our learning collaborative. The surveys will be repeated over time to follow movement toward BHI at the site level.

2. **Second, we are excited to launch an 18 month BHI learning collaborative that will commence on November 1st, 2016**

    a. The learning collaborative will include three full day learning sessions separated by action periods, webinars, skills based training programs for care team members (care managers) and telephonic and on site coaching.
    b. Learning Collaborative faculty will include partners with experience guiding BHI

3. **Third, we are contracting with the University of Washington so that our provider partners will have access to the UW registry to guide efficient case reviews**

    a. Data will be used to drive improvement strategies from the onset of the learning collaborative.

    b. We have aligned our contracting metrics (PIMS) in order to prepare our partners for data reporting including depression screening rates and screening yields, which can guide improvement efforts. Reports will enable us to target improvement efforts through coaching

    c. Use of the UW registry will also enable ease of calculating improvement rates (50% reduction in PHQ9 scores) since the registry is already being used by the state for reporting

4. **Forth, we are developing a web based teaching module to educate primary care providers and their care teams on Collaborative Care principles**

5. **Fifth, our BHI project tool-kit will over time become a robust repository of best practices and educational materials to support BH implementation.**

6. **Recognizing the importance of substance abuse screening, all MMG sites are currently screening for SU as part of the initial 5 item BH screen administered to all patients (PHQ2, GAD2 and 1 item substance abuse screener**).

    a. Substance abuse screening will be phased in at other BHI sites over time after they develop standard workflows.

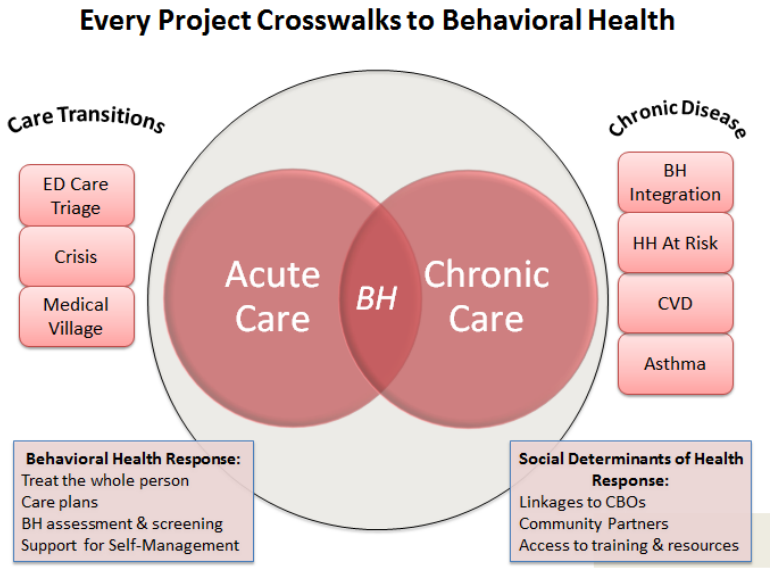
7. **Multiple MHVC partner sites were selected to participate in the state collaborative care funding pilot. We are encouraging other sites pursuing BHI to consider the impact model because of this potential funding source aligned with VBP.**

In summary, to date, we have:

- 19 organizations (13 - Model 1; 2 -Model 2; 6 -Model 3)
- More than 40 unique sites, and
- >300 PCPs participating BHI activities.

Montefiore Hudson Valley Collaborative
Primary Care Plan, November 3, 2016

Behavioral Health is a foundational component of a redesigned Health System. MHVC believes that every DSRIP project must consider the behavioral health needs of all members.



Below we have provided additional detail on several of our active projects and how they interface with our Behavioral Health integration strategy.

Health Home at Risk

- The HH at Risk project guides participating primary care providers to target specific chronic conditions, including depression when identifying their "at risk" population. We advocate for the integration of the PHQ 2 and PHQ 9 to begin identifying patients with depression and the presence of social risk factors that may increase their risk for more severe depression.
- We are also guiding participating providers to build or enhance relationships with CBOs that can provide supportive and complementary services to the patients they are targeting through this project, and can address the social determinants of health.

BH Crisis Stabilization

- Through the BH Community Crisis Stabilization project, we are developing shared assessment and treatment protocols, which will allow providers to determine the most appropriate and least restrictive level of care for patients experiencing a BH crisis. We have invited primary care providers and CBOs to participate in the development of these protocols, and once developed and piloted, they will be shared with medical providers in the region as a resource for helping them recognize and manage BH crises among their patient population.

ED Care Triage

- The primary goal of the ED Care Triage project is to link high utilizing patients to PCMH or HH Care Managers. We recognize that the underlying drivers of ED utilization for some patients may be related to behavioral health and are advocating that these patients be referred to PCPs who are participating in the Integrated BH project (3.a.i) and other BH providers if appropriate.

- Additionally, ED staff will be screening high utilizing patients for social risk factors and the social determinants of health that may be impacting their decision making around where they access care. We are providing guidance to use patient centered approaches, such as Motivational Interviewing, that are designed to engage and collaborate with patients, and lay the groundwork for future BH interventions. We are also guiding hospitals to develop meaningful resource directories that correspond to the emerging patient needs, for the purpose of establishing relationships and improving linkages to CBOs that can support patient needs.

Self-Management Support "Train the Trainer" Program

- The ability of staff to support patient self-management is foundational to all of our DSRIP projects and achievement of Performance Metrics. For example:
  - Development of Self-Management Goals and medication adherence (Cardiovascular Project)
  - Asthma Self-Management using Asthma Action Plans (Asthma project)
  - Medication Adherence (cross cutting)
  - Keeping Follow-up Appointments (ED care triage, High Performance BH measures)
  - Behavioral Activation and Patient Centered Goal Setting (Behavioral Health Integration)
  - Motivational Interviewing to support behavior change (tobacco, substance abuse, chronic disease self-management)
- In an effort to help organizations build sustainable capacity for ongoing staff training in patient-centered self-management support skills MHVC partnered with the Centre for Collaboration, Motivation & Innovation (CCMI) to provide an opportunity for select staff at our network partner sites, to become trainers in Brief Action Planning (BAP) and Motivational Interviewing (MI).
- This is a robust Train-the-Trainer program that includes four separate and progressive learning opportunities as illustrated in the graphic below.

Tele-Health

MHVC recognizes the impact co-location of primary care and behavioral health will have on patients with physical and mental health co-morbidities. MHVC is exploring the use of tele-health as a method for the delivery of healthcare via consultations and other collaboration when co-location is not a viable option. This will offer Primary Care Providers and care managers the added support needed to manage the complexity of this patient population.

Montefiore Hudson Valley Collaborative
Primary Care Plan, November 3, 2016

MHVC envisions a system that will have the ability to share treatment plans and assist the patient in managing their self-management goals. This can be accomplished through various methods:

- Text messaging (to facilitate alignment with their care plan)
- Asthma self- management tool (for pediatrics)
- Smartphone apps (allowing patients to connect on their own schedule in a way that they feel comfortable).
- Tele-Psychiatry
  - Skype, for business, is being used for tele-psych services at our Montefiore Medical Group and School Health program. The service is billable as long as the patient is in the office.
  - A MHVC partner, Access Supports for Living, has contracted with an independently contracted Psychiatrist to provide telephonic consults.

Several partners currently utilize some form of tele-health. MHVC is evaluating current options to assess the capability for scalability and expanding services, especially in rural areas and areas where referrals to specialists are not readily available.

MHVC understands that the pathway to improved patient outcomes, and the success and sustainability of all of our clinical projects, is dependent on providers understanding and addressing whole patient needs including the social determinants of health. To achieve this, we are working to expand access to services by the creation of a truly integrated delivery system and by ensuring that a strong behavioral health lens is applied to every project.

We are working with partners to foster the meaningful integration of care, where all members of the treatment team have a shared understanding of a patient's behavioral health issues, work to develop workflows that integrate screening for social risk factors that can greatly impact a patient's health and functioning, and have a clearly identified role in supporting the patient's whole recovery and wellness. In situations where co-location or integration of behavioral health is not a viable option tele-health services are being explored. We have encouraged our MHVC primary care and behavioral health providers to participate in the opportunity

Summary Statement:

In summary, MHVC is committed to supporting primary care transformation and increasing access to care in the Hudson Valley. Specific strategies to address each of the 6 state defined fundamentals are described in depth within this Primary Care Plan document. Our MHVC current state PCP analysis identified three important themes that will form the foundation of our work: expanding access and capacity, financial sustainability and ensuring quality care. Our strategic approach to each theme is highlighted below.

1. Expanding access
   - Analysis helped us understand baseline and gaps:
     - According to New York State data, primary care physicians in MHCV's network provide fewer hours of care per week when compared with other upstate PPS's of similar size. MHVC's Community Needs Assessment (CNA) indicated a need to provide more primary care services in locations and times that are more convenient and accessible to patient
   - Medical village
     - The medical village project addresses excess capacity leading to inefficient health care resource

usage and unmet community needs, by re-visioning the scope of programs and services offered on campus, emphasizing: improving access, providing integrated primary and behavior health care, ensuring an even distribution of urgent care access points, providing care management and coordination and shortages in community-based resources such as the availability of crisis beds.

- PCMH transformation requirement
  - Primary Care Physicians are critical to the success of the overall DSRIP goal. Assisting our network providers to obtain PCMH 2014 level 3 certification will ensure that our network practice sites have increased access to care and have increased average total care hours per PCP per week.
  - In collaboration with the Montefiore CMO, MHVC is utilizing several practice level supports as an alternative to engage community based PCP's that are not ready for PCMH transformation..

2. Financial sustainability
   - Bridging to VBP
     - A fundamental goal of MHVC's DSRIP work has been, and will continue to be, to drive towards a successful Value Based Payment (VBP) arrangement future for our partners.
   - Building partners capacity to support VBP
     - Close collaboration with our network ensures that the resources that lead to quality care and that drive VBP payments will be in reach for partners throughout the Hudson Valley.
   - Funds Flow
     - MHVC has developed a funds flow model that is a careful steward of state and federal dollars and distributes funds in a thoughtful, fair, and equitable manner. At the same time this model recognizes critical MHVC partners and supports the development of an Integrated Delivery System infrastructure to ensure a financially stable future for MHVC partners in the Hudson Valley.
     - To date, 43% of our partner contracting has been distributed to PCP's/Clinics.
   - Hudson Valley IPA
     - MHVC is committed to the long term financial sustainability of the Hudson Valley network and community of care. To this end, MHVC is a close partner in the creation and setup of the Hudson Valley IPA (HVIPA) which will be both the vehicle for the continuation of our DSRIP progress and the way in which our network will earn the value it creates over the life of the DSRIP program.
3. Quality of Care
   - The clinical innovations our partners already practice, and those they have committed to making, will be the foundation of that sustainable future. MHVC, building off of Montefiore Health System's decades of VBP experience, is uniquely positioned to turn high quality care into value based reimbursement for our partners.
   - MHVC is committed to bridging the gap between primary care and behavioral health through the behavioral health integration project. In collaboration with Dr. Henry Chung MHVC is incorporating substance abuse screening as part of primary care behavioral health integration. Currently an initial 5 item behavioral health screening is administered to all patients at 12 practice sites. Recognizing the importance of substance abuse screening, this approach will be phased in at other BHI sites over time as standard workflows are developed.

All of these efforts have put MHVC and its partners on a path to sustainability that is built on improved delivery of care by an integrated system of providers, better health for residents of the Hudson Valley and lower costs for providers, plans and the State.

Appendix

1. MHVC Workforce Training Strategy (See Next Page)

Training Strategy Deliverable for Montefiore Hudson Valley Collaborative (MHVC)

Yonkers, NY

07/20/2016

Document Purpose & Principles

- This document serves as the Workforce Training Strategy for the Montefiore Hudson Valley Collaborative (MHVC)
- The document addresses key questions on training the workforce such as:
  1. Who needs training?
  2. What training is required? (including whether this is individual or team based)
  3. How should MHVC operationalize for training?
  4. When should training be rolled out?
  5. What other general criteria should be addressed in training?
- This is intended to be a living document that informs the execution and implementation of training. By this we mean that this document will evolve over the remaining 4 years of DSRIP and continue to be adapted to the ground realities of implementation, funding, and other goings-on at MHVC
- This document was created by soliciting input from dozens of MHVC stakeholders and partners and was approved by the workforce committee
- The Director of Workforce and her team will be responsible for ongoing updates to this document and version control

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Montefiore HUDSON VALLEY COLLABORATIVE

Executive Summary

A. Context for the MHVC Training Strategy

The Montefiore Hudson Valley Collaborative (MHVC) and its network of partners prepares to embark on a workforce training effort to support the Medicaid and uninsured populations (within the context of the DSRIP program) and other future populations by development of this workforce training strategy. The overarching goal is to enhance the learning of the network in new concepts such as population health and value-based healthcare, train/retrain staff for new positions, and ultimately to provide better coordinated care, in an efficient, cost-effective manner while meeting or exceeding defined quality standards.

The MHVC Workforce Committee created this Workforce Training Strategy and related training strategy documents in collaboration with Health Literacy Partners, LLC and xG Health Solutions. The separate, but related supporting documents provide greater detail on specific training concepts such as cultural competency and health literacy; provider engagement; clinical integration; and performance reporting.

Agreed to 'boundary conditions' aligned the group on the definition of 'training' as follows:

INCLUDED

1. All clinical staff training related to population health, care management from an organizational, process and technology perspective
2. All non-clinical staff training required for them to successfully work within this new care model and/or develop new skills needed to support the model
3. Training on adjacent topics such as value based contracting, performance monitoring etc.
4. Training that focused on Medicaid and Uninsured – for e.g., cultural competency, health literacy etc.
5. Training on change management that is needed to ensure that the newly trained workforce is high-functioning
6. Educational programs and tie-ups with local institutions of learning

EXCLUDED

1. Routine training that occurs today – e.g., fire safety, basic life support, etc.
2. Training that only applies to Medicare or to Commercial payers
3. Training that doesn't pertain to projects that MHVC has selected (even if it is applicable to Medicaid)
4. Training of patients not included – just providers
5. Vendor evaluations and selection RFPs for training vendors

Executive Summary

B. Key Input Sources – Data Requests supplemented by onsite interviews and discussion forums

The development of the training strategy was a collaborative effort of network partners (represented via committees), consulting support (xG Health Solutions, and Health Literacy Partners) and MHVC leadership and PMO staff. Current state was evaluated via a workforce survey, the community needs assessment, interviews/discussion groups, among other sources. The future state understanding was collected from the project applications, project requirements, and implementation plans known to date.

Data Request

- MHVC Organizational Application
- MHVC Project Applications
- MHVC Implementation Plan – workforce, IT, cultural competency, CI, population health
- MHVC Implementation work plans by project
- Workforce Survey Preliminary Findings
- MHVC Community Needs Assessment (CNA)
- Domain 1 DSRIP Project Requirements Milestones & Metrics

Interviews & Discussion Forums

- MHVC Leadership
- Project Specialists (DSRIP Projects)
- Workforce Committee
- Cultural Competency/Health Literacy (CCHL) Committee

** Please refer to the appendix for resource names & organization/roles*

Training Survey

- **105** Respondents
- Spanned Hospitals, SNFs, Health Homes etc. across the network of partners

Executive Summary

C. Current State Findings

- The key current state findings most influential to development of the training strategy were as follows:
    - **Assets:** MHVC partners have some training in place internally and with vendors. About half of the partners indicated at least a part time trainer. MHVS has recently hired a full-time training specialist to support training across the network. The Montefiore CMO is a huge asset for MHVC given its extensive experience with managing the health of complex populations.
    - **Gaps:** The most significant gaps were found in the areas of behavior change, self-management support, patient centered communication skills training/ patient engagement.
    - **Positions:** New positions in the outpatient setting that focus on care navigation and coordination are in most need of robust training to function as a care team. Economies of scale may be achieved with training vendor relationships at the MHVC level vs. individual partner agreements.
    - **Constraints:** Time and backfill for staff training was expressed as a challenge; limited budget for vendor-provided training and for development of in-house training
- In conclusion, there exist a few training assets that could be leveraged if agreed to by network partners. However, given the new topic areas of care management, population health, and DSRIP program requirements, there is a clear need for a specialized vendor of training content to complement what exists in-house.

Executive Summary

D. Major Recommendations

A simple framework of “who”, “what”, “how”, and “when” helped organize the training strategy. Each section answers key questions (explained within the training strategy framework section of this document). Highlights are noted within this summary section, but the framework is supported by a separate, detailed section with this training strategy document.

Who needs to be trained?

- **New Positons**: Care Managers, Social Workers, ED navigators
- **Existing Partner Staff** (clinical and operational), esp. those directly involved with the delivery of the DSRIP projects
- **Broad-based** workforce training on basics (DSRIP 101, Population Health etc.)

What are the top training areas?

- **General** – DSRIP 101, Population Health, Value based Contracting, Cultural Competence etc.
- **Project Specific** – Basic and Advanced training for each project
- **Foundational/Cross-Project** – Specific content areas like Care Management, PCMH, IT, etc. that are foundational
- Considerations for the **training medium, setting (individual vs. multi-disciplinary team),** and **frequency** are suggested in addition to courses and course topics

How should the training operating model look?

- **Training coordinator** for oversight of programs (scheduling, reporting, vendor RFP, etc.)
- Don’t reinvent the wheel – **leverage training assets** that exist among participating network partners or vendors
- MHVC focus should be on **air traffic control** and project management for training – not on creating training content
- Training options for **content creation and delivery** are explored for implementation consideration

Executive Summary

E. Roadmap for Execution

The Roadmap lays the foundation for "when" training should occur and guides the MHVC training specialist, her team, and the network of partners in building the implementation plan – a next step beyond this training strategy.

When should training be rolled out?

1. **Constraints and timing for training**:
   - **Partner Rank Order:** Key partners that deliver a disproportionate share of outcomes, get trained first
   - **DSRIP Timing Deadlines:** e.g., NCQA Level 3 PCMH needs to be done by end of DY3
   - **Self Initiated Partners:** Some partners that have robust internal training already underway, can proceed concurrently
   - **Targeted Training:** Niche training to meet certain immediate goals

2. **Quick Wins:** DSRIP 101, Population Health basics, Cultural Competency basics etc. are topics that should be rolled out broadly to get quick training adoption

3. **Basic vs. Advanced:** Focus the training rollout (esp. for projects) on those individuals who have a high role/ stake in the end outcomes that emerge from that project. Other roles within the organization can get basic training at a later date if they aren't directly connected with the outcomes.

4. **Considerations**: While every item on the training plan may seem important, it is essential to go about it in a methodical manner to avoid training overload and coordinate training needs within MHVC committed DSRIP timelines.

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Training Strategy Framework

The following organizational framework addresses key questions pertinent to training

	Dimension	Questions Addressed
1	**"Who"** Define targeted Partner employees and MHVC staff	▪ Which specific partner employee type will need to have training, retraining, or access to educational programs? ▪ What are the training implications for new roles that get created on account of DSRIP? ▪ What are the training implications for employees whose positions are put at risk due to DSRIP? Should these be priority employee types/areas of focus? ▪ How do we ensure that vendors who touch patients have the training they need?
2	**"What"** General and Project Specific Training	▪ What are the generic training offerings needed for core topics for all network Partners and staff (e.g., DSRIP, population health, cultural competency, managing change) ▪ What training is project-specific, and for specific employees/staff, across the 10 DSRIP projects? What type of training will be needed for MHVC central staff members as compared to Partner employees? For each role and project combination: ▪ What specific training topics are pertinent? ▪ What is the best medium for such training? (e.g., online, classroom) ▪ How frequently will it occur? ▪ Who could conduct this training? ▪ What does the current state assessment tell us? major gaps today?

Training Strategy Framework

The following organizational framework addresses key questions pertinent to training

	Dimension	Questions Addressed
3	**"How"** Organizing the Training Program	▪ What organization structure (e.g., shared service), processes, technology should be in place? ▪ What is the role of state programs, vendors and educational institutions? ▪ What 'train the trainer' capabilities are needed? What 'managerial' training capabilities are needed? ▪ How should training effectiveness be documented, measured, and evaluated? ▪ How can "lessons learned" about training implementation be shared?
4	**"When"** Roadmap & Funding	▪ What should the priority be for training? Over what timeline? ▪ What funding sources are anticipated for training?
5	**General**	▪ What are the guiding principles that makes for effective and efficient training delivery? ▪ What are the elements of team based training? ▪ What specific training modifications are needed to account for (a) cultural differences? (b) hotspots? ▪ What change management practices should complement the training strategy? ▪ What are the top risks and mitigation anticipated?

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1 “Who” – Goals & Assumptions

Identifying the Partner/MHVC staff types that are in need of training is the first step

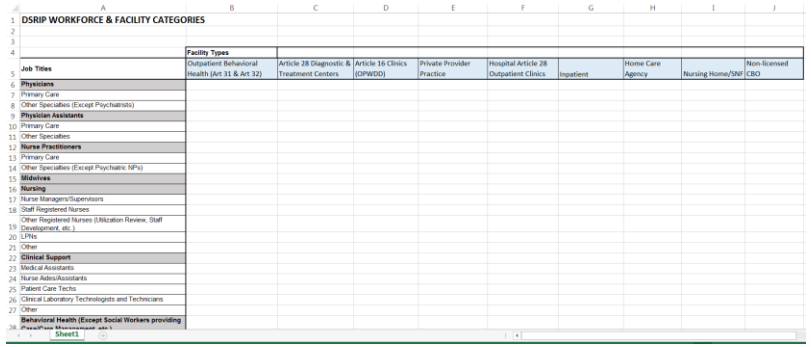
Objectives for this Section

a. **Identify partner and MHVC staff types** (from among the universe of job titles) that are impacted by DSRIP

b. **Prioritize categories of partner/MHVC staff types** which are instrumental to DSRIP success in an objective manner

Assumptions

- We use the DOH prescribed job title matrix as a starting point



DSRIP WORKFORCE & FACILITY CATEGORIES

Job Titles	Facility Types: Outpatient Behavioral Health (Art 31 & Art 32)	Article 28 Diagnostic & Treatment Centers	Article 16 Clinics (OPWDD)	Private Provider Practice	Hospital Article 28 Outpatient Clinics	Inpatient	Home Care Agency	Nursing Home/SNF	Non-licensed CBO
Physicians									
Primary Care									
Other Specialties (Except Psychiatrists)									
Physician Assistants									
Primary Care									
Other Specialties									
Nurse Practitioners									
Primary Care									
Other Specialties (Except Psychiatric NPs)									
Midwives									
Nursing									
Nurse Managers/Supervisors									
Staff Registered Nurses									
Other Registered Nurses (Utilization Review, Staff Development, etc.)									
LPNs									
Other									
Clinical Support									
Medical Assistants									
Nurse Aides/Assistants									
Patient Care Techs									
Clinical Laboratory Technologists and Technicians									
Other									
Behavioral Health (Except Social Workers providing									

Sheet1

- We add more granularity where necessary to certain partner/MHVC staff types (e.g., depression care manager, ED navigator, Psychiatrist consultant)
- We recognize that not all facilities in a “facility type” contribute equally (e.g., some SNFs are more critical that others because of volumes of Medicaid patients)
- We will use the training roadmap to adjust for higher or lower priority (tier 2, 3 …) partners/facilities and stagger them along the training timeline

1 “Who” – Results

Based on the analysis described previously, the following categorization of ‘provider role – types’ emerges

Examples (Full List in Spreadsheet)

RED – High Training Need

- Primary Care Physician/NP
- Nurse Manager
- Staff Registered Nurse/LPN
- RN Care Manager
- LPN Care Manager
- Care navigator
- Bachelor’s Social Work
- Licensed Masters Social Workers
- Social Worker Care Coordinator
- Peer Support Worker
- Community Health Worker
- Substance Use Disorder/ Behavioral Health Workers

YELLOW – Med. Training Need

- Executive Staff
- Financial Staff
- Human Resources
- Social/Human Assistants
- Medical Assistants
- Laboratory Technicians
- Health IT Hardware Maintenance
- Health IT Software Programmers
- Technical Support

GREEN – Low Training Need

- Office Clerks
- Nutritionists
- Occupational Therapists
- Pharmacists
- Pharmacy Technicians
- Physical Therapists
- Physical Therapy Aides
- Respiratory Aides
- Respiratory Therapists
- Housekeeping
- Medical Interpreters
- Patient Service Reps.

1

“Who” - Conclusion

All partners and staff across the Montefiore Hudson Valley Collaborative network will require a basic level of training on general content, but with a more concentrated training effort dedicated towards primary care, care management and social work providers

1) The focus of the integrated efforts will be on increasing the availability and effectiveness of patient care in the outpatient setting, but all inpatient employees across the network of partners, especially clinical staff, will still require basic training content. As all project efforts evolve, the network of partners will need to be prepared to redeploy and retrain these workforce members as needed.

2) As outpatient activity increases, many new roles will be created to achieve success. Nursing staff, care navigators and care managers should receive prioritized, specialized training given their significant involvement in the transformation.

3) Next in order of priority for specialized training are those roles that interact most closely with care managers and the patients themselves. Primary Care Physicians, Nurse Practitioners, Registered Nurses, Medical Assistants, etc. – all members of the workforce require a combination of basic and specialized training to create sustainable transformation within the network of partners.

4) Finally, there are roles that need training in specific skills to support the development of a high-functioning medical neighborhood. These roles include finance staff to assist with contracting and value-based payments in addition to health information technology roles to manage the variety of EHR systems across the network, as well as best practices in data integration and sharing.

5) In addition to the specialized training required for the above roles, there is a broad-based need to raise awareness for DSRIP, Population Health, Cultural Competency/Health Literacy and other topics across the entire workforce.

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2

“What” – Categories of Training/Education

We break down training into three broad categories – General (applies to all) & Specific (applies to roles) and a category of available educational programs

Training - General

- Concepts that apply to almost everyone
- Generally conducted via online learning OR at large network gatherings – i.e., mass outreach
- Periodic refreshers needed; training content may need some updating from time to time
- Examples: DSRIP 101, Cultural Competence Basics, Population Health Basics, Change Management, Compliance

Training – Project Specific

- Concepts that apply to a more limited group of partners, facilities, job titles
- Generally conducted in person at the provider facility or in a regional location, to get the most effective result. May be supplemented via online learning

Educational Opportunities

- Locally available educational programs that staff can access to improve their skills or advance their career
- Ideally with easier access for any individual who is at risk of redeployment
- Examples: Medical Assistant training program, Nurse Practitioner training program, Business degree programs, Community Health Worker program

2

“What” – Lists of Training

We break down training into two broad categories – General (applies to all) & Specific (applies to projects/roles)

General Training

A. DSRIP 101
B. MHVC Structure & Function
C. Compliance
D. Population Health Basics
E. Cultural Competence Basics
F. Career Counseling Program

Project Specific Training

Project

For each project #1 … #10

A. Advanced Concepts
B. Basic Concepts

Cross-Project

Patient Centered Medical Home (PCMH)

i. PCMH Basics
ii. NCQA 2014 Level 3

EHR/Technology

i. Data Sharing
ii. Meaningful Use standards
iii. Clinical integration

Care Management

i. Care Management Advanced
ii. Care Management Embedded
iii. Care Management Tools

MHVC Performance Reporting

i. Department of Health (DOH) Reporting
ii. Medicaid Analytics Performance Portal (MAPP)
iii. Project Management Office (PMO) Concepts
iv. MHVC strategies

Value Based Payments

i. VBP Plan
ii. VBP Tools

Montefiore HUDSON VALLEY COLLABORATIVE

2 "What" – Medium, Setting, and Frequency

Multiple mediums can be used to disseminate the same training … typically some have advantages over others

Medium

Several options exist for the choice of medium – we have laid down some suggestions on which choice may be optimal in different circumstances:

Not Mutually Exclusive

- **Reading Materials (Email, Letter):** Initial general set of reading materials (Frequently Asked Questions etc.)
- **Online (Web-based) Course:** Content delivered online with test questions embedded to check for understanding
- **Webinars:** Content delivered online that is intended for information only – not a check for understanding at the end. Can embed questions (including polling) and interactive sections
- **Classroom (Academic):** Educational programs delivered by certified educational organization (leads to certification or degree)
- **Classroom (Provider Site):** Content that involves many folks at a site; Content that requires site-specific context (e.g., PCMH, "hot spot")
- **Shadowing (on site) & Mentoring (telephone):** Real-world experiences and coaching, visiting other sites to see CM in action (IMPACT)
- **Conferences (DOH, Learning Collaboratives, MAX series):** Messages that need to be disseminated to large groups

Setting

In addition to medium, the setting of training can vary based on the type of training required. Options included in this strategy are:

- **Individual:** Self paced training typically delivered via reading assignments or online (web-based)
- **Multi-disciplinary Team:** Training conducted by an onsite instructor and onsite participants across a variety of different roles - typically roles that require coordination (see general section for additional considerations)
- **Facility/practice team Meetings**: Classroom style training usually requiring site-specific context (e.g. primary care office setting)

Frequency

- **One-time:** Default is one-time, particularly for general training
- **Periodic (Quarterly, Annual):** When training is staged across time a progressively advancing scale OR if training needs to be updated periodically
- **Ad-hoc:** As needed e.g., if results are not promising

2 General – DSRIP 101

'Introduction to DSRIP' course applies to almost all participants

Content Topics

1. **Basics:** Origin of DSRIP, Objectives & Goals, focus on VBP and sustainability
2. **Timeline:** April 2015 … through 2020; concept of DSRIP years; quarterly reports, payment schedules
3. **MHVC:** Composition, functions, measures of success, board of directors, committee and regional meetings
4. **Projects:** List of projects, High level activities in each, Measures of success (active engagement & clinical)
5. **Resources:** Links to application, implementation plan, MHVC website, DOH DSRIP pages, Mailing lists, IT support, etc.

Delivery

- **Material:** DSRIP FAQ, DOH Whiteboard videos
- **Medium:** Reading of FAQ; Online coursework, webinars, large in-person sessions
- **Frequency:** Once; with ability for student to go back and refresh
- **Trainer:** MHVC Training Coordinator, MHVC exec leadership, or Training vendor for web-based program
- **Reporting:** Logs from online tool, or paper-based tracking system
- **Effectiveness:** (1) Percent of the network that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project, committee, and network partner meetings
- **Setting:** Individual, existing facility/practice team meetings

2 General – MHVC Structure & Function

'MHVC Structure & Function' esp. applies to MHVC staff, but also to partner participants in the projects

Content Topics

1. **Purpose:** Articulate the vision, goals, objectives, targets of the MHVC; List short and long term vision;
2. **Organization:** Clarify governance (board, committees, workgroups and project teams); relationship between partners and the MHVC executive structure; MHVC org. structure & responsibilities. What contracting requirements are there within MHVC?
3. **Services:** What services such as IT, personnel and training assistance can the network partners expect? How does the flow of funds work from the DOH, to MHVC, to the partners? How does that differ between a safety net and non-safety net provider? Availability of shared services to help efficiently drive care improvement
4. **Resources:** Website, Newsletter, Location other resources; Meeting minutes; Funds Flow logic etc.
5. **Contact:** How and when to get in touch; Partner portal, Compliance hotline, MHVC committee and regional meetings

Delivery

- **Material:** Power point presentation; Practitioner Communication and Engagement Plan, DSRIP FAQ section
- **Medium:** Recorded webinar, online coursework, Partner portal, large in-person sessions
- **Frequency:** Once; with ability for student to go back and refresh
- **Trainer:** MHVC Training Coordinator, MHVC exec leadership, or Training vendor for web-based program. Director, HR & Workforce
- **Reporting:** Logs from online tool, or paper-based tracking system
- **Effectiveness:** (1) Percent of the network that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project, committee, and network partner meetings
- **Setting:** Individual, existing facility/practice team meetings

2 General – Compliance

‘Compliance’ applies to individual MHVC staff, but also to partner participants in the projects

Content Topics

1. **Basics:** What is Medicaid waste, fraud & abuse? What are the goals of the compliance program?
2. **Contact:** Who is the compliance officer? How to contact them? Is there a hotline? Can it be anonymous?
3. **OMIG Guidance:** What are the 8 basic elements of compliance that OMIG requires? What online resources are available?
4. **Frequency:** How often for MHVC staff? Other provider partner staff? How will new guidance be disseminated?
5. **Policies & Procedures:** Code of conduct, disciplinary action, risk assessment process, system for responses, non-intimidation and non-retaliation policy, compliance champions

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP FAQ Compliance; OMIG guidance documents
- **Medium:** Recorded webinar
- **Frequency:** Once; with ability for student to go back and refresh; Ad-hoc notifications when new guidance is issued
- **Trainer:** Compliance Officer of MHVC
- **Reporting:** Logs from online tool, or paper-based tracking system
- **Effectiveness:** (1) Percent of the network that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project, committee, and network partner meetings
- **Setting:** Individual

2 General – Population Health Basics

'Population Health Basics' course applies to almost all participants in the MHVC

Content Topics

1. **Basics:** Impetus for healthcare reform, origin of DSRIP, chronic condition management
2. **Patient-Centered:** Consumer education, cultural competency, medical, behavioral, psychosocial needs of patient
3. **"Volume-to-Value":** Traditional Fee-for-Service financing, P4P, bundled payments, global capitation, clinical redesign
4. **Success Drivers:** Care management infrastructure, well-trained workforce, payment reform, information technology, effective registry management and gap closure processes
5. **Resources:** Community health needs assessment, list of community-based organizations, PCP offices, etc.

Delivery

- **Material:** Power Point presentation, Population Health Management Roadmap, Clinical Integration Strategy, DSRIP FAQs
- **Medium:** NYS DOH whiteboard sessions on YouTube, DSRIP webinars
- **Frequency:** Once; with ability for student to go back and refresh
- **Trainer:** MHVC Training Coordinator, MHVC exec leadership , MHVC CMO, MHVC Care Management Director, Montefiore CMO
- **Reporting:** Logs from online tool, or paper-based tracking system
- **Effectiveness: Effectiveness:** (1) Percent of the network that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project, committee, and network partner meetings (4) Increased collaboration with community-based organizations
- **Setting:** Individual and Multi-Disciplinary Team

2 General – Cultural Competence Basics

‘Cultural Competence’ course applies to all participants in the MHVC

- Refer to the MHVC Cultural Competency and Health Literacy Training Strategy Document

2

General – Career Counseling Basics

‘Career Counseling’ course applies to all participants in the MHVC with an emphasis on care management positions

Content Topics

1. **Basics:** Purpose of DSRIP, impact on current and future positions, high-level workforce strategy
2. **Job Types:** Emphasis on care coordination, social work, and community health worker positions
3. **Beyond Positions:** Expectations for compensation and benefits, DSRIP timeline
4. **Content:** New skills or competencies required, where to access training, how to access resources. Network-wide Job posting board. Redeployment pool function. How to access Rapid response case management which includes: career counseling, job search assistance for non-union workers, employment workshops and support to help employees cope
5. **Educational Resources:** Montefiore School of Nursing, St. John's Riverside Hospital's Cochrane School of Nursing, Mercy College and other private colleges, high schools, City University of New York, State University of New York, the 1199 Training and Education Fund
6. **Additional Resources:** SEIU 1199 training and employment fund (TEF) team, MHVC training fund, Phipps Neighborhood Career Network

Delivery

- **Material:** [Pre-read] DSRIP FAQ’s, NY DSRIP workforce strategy webinar,
- **Medium:** Webinar, classroom training (provider), workshops
- **Frequency:** One-time with periodic updates to general information, ongoing access to targeted counseling available as needed
- **Trainer:** Director, HR & Workforce
- **Reporting:** MAPP tool, online logs, paper-based method to show attendance in training sessions
- **Effectiveness:** (1) Percent of network that took the course (2) Results of participant survey, (3) Number of retained employees, number of employees redeployed across MHVC, new hires made
- **Setting:** Individual

2

Specific – Project 2.a.i

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

Content - Advanced

- **Advanced Concepts:**
  - In depth review of MHVC organizational structure, governance, and strategic plan for growth in support personnel. Also, core elements related to funds flow, provider performance reporting, clinical integration plans and cultural competency, health literacy
  - The structure, role and processes of the Care management organization – how existing staff are integrated with newly hired staff, minimum requirements for CM functions provided by partners – risk stratification, patient assessments, care plans and measurement of process results. The role of community health workers and peer support. How this organization provides coordination with Health Homes and MCO care management staff. Who will take the CM lead in the provision of the key patient interventions needed?
  - Review of the IT strategic plan and expected implementation timeline. Description of all data warehouse capabilities, decision-support tools (or output) that will be available for the Network Partners to use. Description of plans for interconnectivity between MHVC and Provider EHR systems, as well as connectivity with the RHIO
  - Use of registries and interoperable IT platforms for effective population health management of this population
  - Provider training on use of resources to access community-based support services
  - Educate and support the network of Partners on the transition towards value-based payment reform that includes alignment of provider compensation to patient outcomes
  - Leverage the use of local learning collaborative to provide training/information for all participating partners

Content - Basic

- **Basic Concepts:**

What are the basic concepts around the function of an integrated delivery system? What are the key components of the care management system within the IDS? What are the technologic components that will be offered to help support communication between Network Partners and their patient care processes? What might a provider be asked to do to support the program? How might a provider see communication related to program interventions? Key deadlines.

- **Cross Project Training - see "cross-project" training needs section:**
  - PCMH
  - EHR/Technology
  - Care Management
  - Value-Based Payments
  - MHVC Performance Reporting

Note: Cultural Competency, Language, Diversity and Health Literacy issues should be addressed appropriately in all training. For more details see Cultural Competence section for additional details

2

Specific – Project 2.a.i (continued)

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

Delivery

Priority partners:

- Inpatient hospitals, focusing on safety net partners
- PCP sites , focusing on safety net partners and FQHCs
- BH inpatient and outpatient offices/ facilities

Locations - these partner types located in:

- Hot spot geographies for high volume patient population, high prevalence of clinical conditions, and high Inpatient and ED utilization
- Predominant focus on Westchester and Orange counties

Material: Power point presentation; all key MHVC documentation (i.e. governance system, IT system, funds flow). DSRIP Project Toolkit description for project 2.a.i

Medium: In person by MHVC staff, MHVC Board members, MHVC Partner key leaders, MHVC project managers. Recorded webinar, web-based training, team-based training, mentoring/shadowing for CMs

Frequency: Dependent on volume of material that needs to be trained on within the advanced and basic categories. May be as much as monthly for 2 to 4 months, or only once

- **Trainer:** MHVC exec staff, MHVC Board members, MHVC Partner key leaders, MHVC project managers, Care Management Learning and Innovation Center, CM training resource or vendor
- **Reporting:** Attendance logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of partner/job types that took the course compared to expected (2) Improvement in DSRIP metrics
- **Setting:** Individual and Multi-Disciplinary Team

Note: Training for Project 2.a.i as outlined would be focused on key clinical and non-clinical partners directly involved in patient care. Other staff – housekeeping, clerks, maintenance, dietary, coders etc. would just get DSRIP 101 for non-clinical staff

2

Specific – Project 2.a.iii

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

Content

Advanced Concepts:

- The role of the Care management staff (accountable care manager) who will take the lead in the provision of the key patient interventions needed. Who will own the care plan and what does that mean?
- Train all participants on the Health Home At-Risk Intervention Program processes – primarily driven through the PCP - risk stratification, referral criteria, standard care management processes, sharing of care management plans, use of a resource repository, and linkages with CBOs who address the social determinants of health
- Use of registries and interoperable IT platforms for effective population health management of this population
- Use of a comprehensive care management plan template that is standardized across the partner network
- Provider training on use of resources to access community-based support services, link as needed to Health Homes, the use of evidence-based guidelines for chronic illness and prevention, and team-based care

Basic Concepts:

What are the basic components of the program? How can a provider refer a case to the program? Who will be "taking the lead on all care management activities (MHVC CMs, Office-based CMs, Health Home CMs etc.)? What might a provider be asked to do to support the program? How might a provider see communication related to program interventions?

- **Cross Project Training - see "cross-project" training needs section:**
  - PCMH, EHR/Technology, Care Management

Delivery

- **Priority partners/ locations**: Assume that "care management hubs" will be located in high volume hot spots first. Start with PCP and FQHC partners in those locations. Most likely focused on Westchester and Orange counties, but also several key rural counties
- **Material:** Power point presentation; standard patient identification and referral protocol, standard care management workflow. DSRIP Project Toolkit description for project 2.a.iii
- **Medium:** Recorded webinar, web-based training, Learning Collaborative, in-person training, mentoring/shadowing for CMs
- **Frequency:** Dependent on volume of material that needs to be trained on within the advanced and basic categories. May be as much as monthly for 2 to 4 months, or only once
- **Trainer:** MHVC Director of Care Management, MHVC CMO, Leadership of the 2 aligned Health Homes, Montefiore CMO's project toolkit, CM training resource or vendor
- **Reporting:** Attendance logs from online tool, or paper-based tracking system
- **Effectiveness:** (1) Percent of partners/job types that took the course compared to expected (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

2 Specific – Project 2.a.iv

Create a Medical Village Using Existing Hospital Infrastructure

Content

Advanced Concepts:

- Train all key participants on the Medical Village project requirements that need to be met –project plan for implementation of specific sites, services implemented supported by the CNA, and documentation of timeline for bed reduction
- Use of registries and interoperable IT platforms for effective tracking of the population engaged in this project and how that connects to other resources such as care management within projects 2.a.i., 2.a.iii, and Domain 3 projects
- Provider training on the availability of and the mechanism to access these medical village resources.

Basic Concepts:

What are the basic components of the program? How can a provider access support for patients from these medical village services? What communication will patients receive about the availability of these services? What might a provider be asked to do to support the program? How might a provider see communication related to program interventions?

Cross Project Training - see "cross-project" training needs section:

- PCMH
- EHR/Technology

Delivery

- **Priority partners/locations**: Inpatient and outpatient facilities, PCP partners, and CBOs in primary and mental health HPSAs. counties with limited crisis bed capacity, transportation resources, lab and radiology access and urgent care access – primarily Rockland, Sullivan and Orange counties
- **Material:** Power point presentation; written standards to determine type and location of services to be provided that meet the patient population definitions laid out in the DSRIP application. DSRIP Project Toolkit description for project 2.a.iv
- **Medium:** Recorded webinar, Web-based training sessions, in-person training
- **Frequency:** Initial advanced training for key partners in priority counties. Follow-up sessions quarterly may be needed for updates on Medical Village progress and DOH reporting needs.
- **Trainer:** MHVC exec staff, MHVC CMO, Network Partner key leaders (St Johns Riverside hospital who has done this work)
- **Reporting:** Attendance logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of partners/job types that took the course compared to expected (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual, participating facility leadership team

2 Specific – Project 2.b.iii

ED Care Triage for At-Risk Populations

Content

Advanced Concepts:

- Train all participants on the ED Care Triage program components – standard clinical or non-clinical job profiles that ensure the successful application of the "patient navigator" role in all locations. Includes tie-in to Project 2.a.iii
- Standard patient navigation protocols, work flows, tools, patient education materials, sharing of management plans with care manager or health home.
- Clinical patient navigators – training on medical and behavioral health care pathways, specific clinical diagnoses that drive ED visits, training in MI, urgent care availability, availability of community support resources and how to access social service directories, DSRIP model of care and transitional care
- Protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care
- Use of registries and interoperable IT platforms for effective tracking of the population engaged in this program.
- PCP Provider training on the need for open access scheduling and process for connectivity with the ED staff and the patient navigator.
- ED Triage work list acuity (ESI levels and documentation), ED triage program assessment
- Closed loop referral processes: health home, CBO, Behavioral health, Care Management programs

Basic Concepts:

Basic components of the program? Who will be "taking the lead on all care management activities (Navigator, CMs, Office-based CMs, Health Home CMs etc)? What might a provider be asked to do to support the program? How might a provider see communication related to program interventions?

- **Cross Project Training - see "cross-project" training needs section:**
  - PCMH, Care Management, EHR/Technology

Delivery

- **Priority partners/locations**: Clinical patient navigator training also a first priority. Then high volume inpatient/ED partners *"four hospitals in our network account for 38% of ER visits (St Josephs, St Lukes Cornwall, Nyack, and St Johns Riverside)".* High volume PCP and FQHC partners affiliated with these EDs.
- **Material:** Power point presentation; standard ED navigation protocol, DSRIP Project Toolkit description for project 2.b.iii
- **Medium:** Recorded webinar, Web-based training sessions, in-person training , mentoring/shadowing for patient navigators
- **Frequency:** Dependent on volume of material that needs to be trained on and the number of ED sites implemented. At least one follow-up session to share info on learnings/best practices.
- **Trainer:** MHVC Director of Care Management, MHVC CMO, the 2 aligned Health Homes, Montefiore CMO's project toolkit, CM training vendor, 4 partner organizations participating in the MAX Series, St. Luke's Cornwall Hospital and the Cornerstone Family Healthcare who have already done this work
- **Reporting:** Attendance logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of partners/job types that took the course compared to expected (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

2 Specific – Project 3.a.i

Integration of primary care and behavioral health services

Content

- **Advanced Concepts: (additional details of content by job type in appendix)**

  Full-project requirements for Intervention Type 1 – PCMH service site:
  - Team training for full care team in PCP office, specific roles and accountabilities. Use of screening - PHQ2/9, SBIRT
  - Training in best practices for depression management, patient hand-offs, referrals to Health Homes, etc.
  - Training on coordination with Health Homes and other stakeholders

  Full-project requirements for Intervention Type 2 – BH service site:
  - Team training for full care delivery team in BH office
  - Training for the physical health provider who will be supporting the BH practice site
  - Training in best practices for hand-offs, Health Home referrals
  - Training on coordinating with Health Homes and other stakeholders
  - LOCADTR3 training, CFR42
  - Use of peer navigation, family navigators, and recovery coaches

  Full-project requirements for Intervention Type 3 – IMPACT model at Primary Care sites:
  - Training on the IMPACT model
  - Use of collaborative care standards
  - Role of the "depression care manager", referral to Health Homes
  - Psychiatrist training to be a care consultant for the team

- **Basic Concepts:**

  Basic components of the program? What clinical documentation will be created? How will this be shared with other Providers?

- **Cross Project Training - see "cross-project" training needs section:**
  - PCMH, EHR/Technology, Care Management, MHVC Performance Reporting

Delivery

- **Priority partners/ locations**: PCP partners with embedded BH – first in high volume and hot spot locations (*behavioral health, mental health, and substance abuse hotspots were noted in Ulster, Rockland and southern Westchester counties).* Training of Depression care managers, peer educators/bridgers/service providers
- **Material:** Power point presentation; BH and physical health standard care protocols, DSRIP Project Toolkit for project 3.a.i
- **Medium:** Learning Collaborative (managed by CMO) for models 1 and 3, separate one for Model 2. In-person training ,telephonic or web-based sessions, mentoring/shadowing for CMs
- **Frequency:** Initial session with PCP and BH sites and as much as monthly for 2 to 4 months
- **Trainer:** MHVC Director of Care Management, Key MHVC BH clinical leadership, MHCV CMO, CM training resource or vendor. Organizations currently piloting this work – CBHS and HRH
- **Reporting:** Attendance logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of job types that took the course compared to expected (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team (PCP and BH site teams)

2 Specific – Project 3.a.ii

Behavioral Health Community Crisis Stabilization Services

Content

- **Advanced Concepts:**

- Train all participants on the BH Community Crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.
- Train on written protocols developed for diversion of patients from emergency room and inpatient services, with linkages/workflows/communication mechanisms established between Health Homes, MHVC care management staff, EDs, BH facilities and Inpatient facilities as needed. Approaches to engagement such as motivational interviewing, patient self-management strategies, crisis/sensitivity skills, use of SBIRT.
- Training for BH providers on new or enhanced office processes that will support the program (scheduling flexibility, urgent appointment availability) and education for providers about the benefits of utilizing peers and peer services
- Availability and make-up of mobile crisis teams, both existing resources as well as newly developed teams
- Availability and function of a central triage service developed in conjunction with existing public and private resources and participating psychiatrists, mental health, behavioral health, and substance abuse providers.
- Use of registries and interoperable IT platforms for effective tracking of the population engaged in this program

- **Basic Concepts:**

What are the basic components of the program? How can a provider access the triage service or the mobile crisis team? What might a provider be asked to do to support the program? How might a provider see communication related to program interventions?

- **Cross Project Training - see "cross-project" training needs section:**
    - EHR/Technology

Delivery

- **Priority partners/locations**: Inpatient partners (*four hospitals were responsible for billing 36% of ED visits for behavioral health primary diagnoses – all in Westchester and Orange Counties)* High volume PCP, FQHC, and BH partners in these counties

- **Material:** Power point presentation; compendium of standard resources available (24 hr. crisis hotline, mobile crisis teams, participating BH practices and urgent cares). DSRIP Project Toolkit description for project 3.a.ii

- **Medium:** Recorded webinar, Web-based training sessions, in-person training

- **Frequency:** Once support mechanisms are determined or built, should be able to train key Network Partners in one session. Follow-up session in 3 to 4 months

- **Trainer:** key MHVC BH provider leadership, MHVC CMO, Leverage the experience in mobile crisis of Orange County Department of Mental Health, CBHS/Occupations, Independent Living, and People Inc., St. Luke's Cornwall Hospital , St. Joseph's Hospital, Yonkers

- **Reporting:** Attendance logs from online tool, paper-based tracking system

- **Effectiveness:** (1) Percent of partners/job types that took the course compared to expected (2) Improvement in Actively Engaged and clinical metrics

- **Setting:** Individual and IP/OP facility leadership teams

2 Specific – Project 3.b.i

Evidence-based strategies for disease management in high risk/affected populations. (adult only)

Content

- **Advanced Concepts: (additional details of content by job type in appendix)**
- Train all key participants on the requirements for the cardiovascular care program and the Million Hearts campaign components
  - clinical – best practice treatment guidelines, care pathways, CME for PCPs and CEUs for Nurses/SW, processes and standard template for documentation of self-management goals in the medical record, integration with PCMH transformation, integration with BH 3.a.i. Provider Training on HTN treatment algorithms, team-based care, MI, behavioral action planning, teach-back trainings and use of self-management goals and plan
  - operational – best practice office processes. Leverage use of EHR for alerts, reminders, etc. Improving PCP access – recruiting, same-day access/open appointment slots, Medical Village locations (2.a.iv)
- Use of registries and interoperable IT platforms/RHIO for effective population health management of this population
- **Basic Concepts:**

What are the basic components of the program? How can a provider refer a case to the program? Who will be "taking the lead on all care management activities (CMs, Office-based CMs, Health Home CMs etc)? What might a provider be asked to do to support the program? How might a provider see communication related to program interventions?

- **Cross Project Training - see "cross-project" training needs section:**
  - EHR/Technology - include prompt for providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).
  - Care Management
  - MVVC Performance Reporting

Delivery

- **Priority partner locations**: Inpatient and PCP partners in hot spot locations for CV-related Inpatient and ED utilization – Westchester and Orange counties
- **Material:** Power point presentation; standard Million Hearts campaign materials, standard self-management plan. DSRIP Project Toolkit description for project 3.b.i
- **Medium:** Recorded webinar, Web-based training sessions, in-person training , mentoring/shadowing for CMs
- **Frequency:** Dependent on volume of material that needs to be trained on within the advanced and basic categories. At PCP office may be as much as monthly for 2 to 4 months
- **Trainer:** Local Cardiologists, MHVC CMO, MHVC Care Management Director, Stanford Model certified trainers, MHVC Partners who have already participated in Million Hearts campaign (Hudson River Health), 1199 TEF, Care Management Learning and Innovation Center, CM training resource or vendor. Include use of peer leaders when relevant.
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of partner job types that took the course versus expected (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

2 Specific – Project 3.d.iii

Implementation of Evidence-Based Guidelines for Asthma Management

Content

- **Advanced Concepts:**

- Train all participants on the Asthma Management program components – care guidelines, risk stratification, referral criteria, standard care management processes, sharing of care management plans.
  - 1) clinical – best practice treatment guidelines, care pathways, CME for PCPs, including use of the Asthma Action Plan
  - 2) operational – best practice office processes; alerts, reminders
- Train CM staff – on asthma management guidelines, how they should interact and align with patient care provided by the PCP and/or specialist, and process for linkage as needed to the Health Home. Training in MI and in assessment of social risk factors, linkage to required services, and resource/referral repository
- Training of asthma site champions at each project site (may be MD/DO, NP or RN)
- Use of registries and interoperable IT platforms/RHIO for effective population health management of this population
- Provider training/education on use of asthma management guidelines, use of the Asthma Action Plan and resources they can access in the community.
- Align with processes involved with projects 2.a.iii and 2.b.iii

- **Basic Concepts:**

What are the basic components of the program? How can a provider refer a case to the program? Who will be "taking the lead on all care management activities (CMs, Office-based CMs, Health Home CMs etc)? What might a provider be asked to do to support the program? How might a provider see communication related to program interventions?

- **Cross Project Training - see "cross-project" training needs section:**
  - EHR/Technology, Care Management

Delivery

- **Priority partner locations**: Inpatient and PCP partners in hot spot locations for asthma-related Inpatient and ED utilization – Westchester - St. Joseph's hospital and St. John's Riverside Orange counties - St. Luke's Cornwall hospital, high volume PCPs

- **Material:** Power point presentation; standard asthma guidelines and care management workflows. DSRIP Project Toolkit for project 3.d.iii

- **Medium:** Recorded webinar, Web-based training sessions, in-person training , mentoring/shadowing for CMs

- **Frequency:** Dependent on volume of material that needs to be trained on within the advanced and basic categories. For key PCP practices may be as much as monthly for 2 to 4 months

- **Trainer:** Local Pulmonologists, Allergy/Immunologists, Stanford Model certified trainers, Asthma Educator Institute - Hudson Valley Asthma Coalition (HVAC), Haverstraw Pediatrics, Montefiore CMO, care management vendor

- **Reporting:** Attendance logs from online tool, paper-based tracking system

- **Effectiveness:** (1) % of job types that took the course versus expected (2) Improvement in Engaged and clinical metrics

- **Setting:** Individual and Multi-Disciplinary Team

2 Specific – Project 4.b.i

Promote tobacco use cessation, especially among low SES populations and those with poor mental health

Content

- **Advanced Concepts:**

- The identification of various tobacco-free policies for organizational use and thorough information concerning the best practice implementation mechanisms for each.
- The US PHS guidelines for treating tobacco, with implementation recommendations for such. How to avoid implementation barriers. Potential interventions including , but not limited to:
    - Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).
    - Mechanisms available to increase the use of the NYS Quitline
    - Promote cessation counseling among all smokers, including people with disabilities.
    - Improve access to cessation services including prescription and OTC meds through work with local MCOs

- **Basic Concepts:**

What are the basic components of the program? How can a provider access information on the various support mechanisms available?

- **Cross Project Training - see "cross-project" training needs section:**
    - EHR/Technology - prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).

Delivery

- **Priority partners/locations**: Sullivan county, with the highest rates of smoking and the highest rates of poverty within the Hudson Valley . High volume BH facilities and practices – those with high volume of SMI and young patients

- **Timing:** Need to align roll-out of training with project milestones quoted in the application

- **Material:** Power point presentation; US PHS guidelines, MHVC Partner resource guide. DSRIP Project Toolkit for project 4.b.ii

- **Medium:** Recorded webinar, Web-based training sessions, in-person training

- **Frequency:** Dependent on volume of material that needs to be trained on within the advanced and basic categories.

- **Trainer:** MHVC Care Management Director, MHVC CMO**,** NY state smokers quit line , Center for a Tobacco Free Hudson Valley, The Council on Alcoholism & Drug Abuse of Sullivan County, American Lung Association of the Northeast , Human Development Services of Westchester. The 1199 Training Education Fund and Montefiore's Care Management Organization for training module development

- **Reporting:** Logs from online tool, paper-based tracking system

- **Effectiveness:** (1) Percent of the network partners that took the course (2) Improvement in clinical metrics

- **Setting:** Individual and Multi-Disciplinary Team

2

Specific – Project 4.b.ii

Increase access to high quality chronic disease preventive care and management in both clinical and community settings

Content

- **Advanced Concepts:**
- Create a foundational understanding across the network of recommended clinical preventive services that are in alignment with the New York State Prevention Agenda goals to improve preventive care. Where can a list of available community services be accessed?
- Train Network Partners on potential interventions, designed to improve access to preventive care services and to reduce other gaps that may be present in patient populations by SES status and lack of health literacy. Align with project 2.a.iii CM efforts
- Train hospital partners on the need to incorporate Prevention Agenda goals and objectives into hospital Community Service Plans
- Train key Network Partners on the use of reminders for preventive services, leveraging EHR systems where possible, as well as on medical home and team-based care models
- Develop and train providers on new incentive and reimbursement models for prevention services and on the performance data and standard dashboards that are provided to each participating PCP within MHVC
- **Basic Concepts:**

  What are the basic components of the program that Network Partners should be aware of? How can they find out information on various prevention events that may be held locally? How can a provider access information on the various resource for prevention that exist in the community?

- **Cross Project Training - see "cross-project" training needs section:**
  - EHR/Technology

Delivery

- **Priority partners/locations -** cancer inpatient admission volume hotspots in northern Ulster (including Kingston), a large cluster spanning much of Rockland (from Nyack to Stony Point), and a cluster in lower Westchester. Identified Westchester and Rockland as having the highest number of cancer diagnoses.
- **Timing:** Need to align roll-out of training with project milestones quoted in the application
- **Material:** Power point presentation; standard cancer screening guidelines, DSRIP Project Toolkit description for project 4.b.ii
- **Medium:** Recorded webinar, Web-based training sessions, in-person training
- **Frequency:** Dependent on volume of material that needs to be trained on within the advanced and basic categories. May be as much as monthly for 2 to 4 months, or only once
- **Trainer:** MHVC Director of Care Management, MHVC CMO, MHVC CBO representatives, Human Development Services of Westchester. Montefiore CMO and 1199 Training Fund – for training modules
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of job types that took the course (2) Improvement in clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

2 Cross Project – Patient Centered Medical Home

Content Topics

- **Patient Centered Medical Home (PCMH) Basics (i)**

  Training for core components of PCMH
  - Patient Centered Primary Care Design
  - Medical Neighborhood
  - Performance Management
  - Value-based Payment
  - Integration with Care Management services
  - Data sharing best practices

- **NCQA 2014 Level 3 Training (ii)**
  - Patient Centered Access
  - Long term patient and provider relationships
  - Shared decision-making
  - Patient engagement on health and healthcare
  - Team-Based Care
  - Better quality and experience of care
  - Lower cost from reduced ED and hospital use

Delivery

- **Priority partners/locations –** PCPs already with 2011 PCMH experience (quick wins), High volume Medicaid attribution PCP/FQHC sites
- **Material:** Power point presentation; 2014 PCMH requirements, Practice self-assessment tool, DSRIP FAQs
- **Medium:** Recorded webinar, Web-based training sessions, in-person training
- **Frequency:** Initial intro for all PCP practices, then standard frequency (probably monthly) based on usual approach(PCMH vendor) Ad-hoc notifications when new guidance is issued
- **Trainer:** Internal MHVC PCMH training resource or PCMH training vendor, MHVC quality staff, MHVC CMO, Primary Care Development Corporation
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness: (**1) Percent of PCPs engaged in the training over time, (2) Results of participant survey
- **Setting:** Individual and Multi-Disciplinary Team

2 Cross Project – EHR/Technology

Content Topics

- **Training for data sharing (i)**
  - Consent, Privacy and Security
  - HIPAA compliance
  - Processes related to HealthlinkNY including secure direct messaging
  - Contractual obligations (e.g., participation agreement, business associate agreement, data use agreement, etc.)
- **Training for Meaningful Use best practices (ii)**
  - Meaningful Use basics
  - Accessing the health information exchange (HIE)
  - Standardized formats for clinical reporting
  - Access to self-management tools
  - Electronic submission of patient care summaries
  - Patient-controlled data
- **Training for partners on Clinical Integration (iii)**
  - Tools
  - Leveraging EHR in clinical redesign
  - Communication methods for coordination
  - Real time alerts from the RHIP when patients admitted or discharged

Delivery

- **Priority partners/locations –** All hospitals, high volume PCPs/FQHCs
- **Material:** Power point presentation; MHVC IT change management strategy and Roadmap document, Clinical Integration strategy document, EHR support strategy, RHIO connectivity strategy DSRIP FAQs
- **Medium:** Recorded webinar, Web-based training sessions, in-person training
- **Frequency:** Dependent on volume of material that needs to be addressed in training for that partner type. May be as much as monthly for 2 to 4 months for PCP sites, or only once for other partner types.
- **Trainer:** Director - Health Information Technology, IT Vendors, HealthlinkNY
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness: (**1) Percent of network partners that took the course, (2) Percent of partners that meet Meaningful Use, (3) Results of participant survey, (4) Fewer basic questions being posed at project and large group meetings
- **Setting:** Individual and Multi-Disciplinary Team

2 Cross Project – Care Management

Content Topics

- **Training for Care Management Advanced Concepts (i)**
  - Complex case management
  - Motivational interviewing, teach back, Ask-Tell-Ask
  - Medication reconciliation best practices
  - Closing care gaps
  - Self-management action plans, Brief Action Planning (BAP) and support strategies
  - Linkage to community support services
  - Exacerbation management
- **Training for Care Management Embedded Concepts: (ii)**
  - Risk stratification
  - Chronic condition management
  - Transitions of care (TOC)
  - Quality Support
  - Interdisciplinary care teams
  - Care planning
- **Care Management Tools (iii)**
  - Basic care coordination and care team communication tools (for CM and office staff)
  - Predictive modeling
  - Provider profiling
  - Telemonitoring
  - Patient portals

Delivery

- **Priority partners/locations** – Transition of care CMs first, including ED navigators (2.b.iii). CMs embedded in high volume PCP sites/FQHCs, nurses providing CM services in smaller practices
- **Material:** Power point presentation; MHVC care management structure document and standard policies/workflows, DSRIP FAQs
- **Medium:** Recorded webinar, Web-based training sessions, in-person training , mentoring/job shadowing for CMs
- **Frequency:** Standard CM training curriculum – over 6 to 8 weeks Higher frequency and intensity of training for CMs embedded in PCP practice sites, and for depression care manager (3.a.i).
- **Trainer:** MHVC Care Management Director, Montefiore CMO, Care Management Learning and Innovation Center, Care Management training vendor
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** 1) Percent of CMs that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project and large group meetings
- **Setting:** Individual and Multi-Disciplinary Team (RN, SW, Lay worker)

2 Cross Project – Value Based Payments

Content Topics

- **Value Based Payments Plan (i)**

  Training for Value Based Payments (VBP):
  - Timeline of VBP plan
  - Key components of VBP Plan (for e.g., capitation, integrated primary care, bundled payments, etc.)
  - MCO contracting

- **Value Based Payment Tools (ii)**

  Training on new payment methodologies and tools:
  - Risk management
  - Risk adjustment
  - Patient attribution
  - Integrated Primary Care
  - Episodes of care and bundled payments
  - Capitation

Delivery

- **Priority partners/locations** – All participating hospitals, high volume PCP groups
- **Material:** Power point presentation; DSRIP FAQs, VBP roadmap
- **Medium:** Recorded webinar, Web-based training sessions, in-person training
- **Frequency:** Monthly for first three months; with ability for student to go back and refresh; Ad-hoc notifications when new guidance is issued
- **Trainer:** MHVC Director, MHVC Finance lead. Facilities with experience in VBP – Montefiore
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** 1) Percent of network that took the course (2) Results of participant survey, (3) Percent of contracts that are based on VBP
- **Setting:** Individual and Facility/practice leadership team

2 Cross Project – MHVC Performance Reporting

Content Topics

- **Department of Health (DOH) Concepts (i)**
  - Achievement Values
  - Quarterly Reporting
  - Domain 1 project requirements
  - Domain 2 and 3 clinical metrics
  - Actively engaged definitions
- **Medicaid Analytics Performance Portal (MAPP) Reporting Concepts (ii)**
  - Purpose of MAPP
  - Member tracking
  - Billing support
  - Provider management
  - Interoperability
  - Medicaid claims data management
- **Project Management Office Concepts (iii)**
  - DSRIP projects
  - Quarterly reporting
  - Functional committees/workgroups
- **MHVC Strategies (iv)**
  - Key concepts related to Partner network alignment, incentives, funds flow
  - Value-based payment
  - Plans to create sustainability

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP FAQs
- **Medium:** Recorded webinar, Web-based training sessions, in-person training
- **Frequency:** Monthly for first six months; with ability for student to go back and refresh; Ad-hoc notifications when new guidance is issued
- **Trainer:** MHVC Leadership - Project Management Office, Performance Management
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness: (**1) Ability of MHVC to meet DOH quarterly reporting requirements, (2) Ability of projects to meet their expected speed and scale targets.
- **Setting:** Individual

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- Training Strategy Framework
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    5. General Topics
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3 “How” – Training Program Operating Model

Four Key Questions

Operationalizing the training program requires a coherent implementation plan that integrates answers to the following operating model questions

- *“How should the **organization structure** support training?”*
- *“What are the top **processes** that should be in place?”*
- *“What **technology** considerations should be addressed?”*
- *“What is the role of **vendors** or **academic institutions** or **state training** programs?”*

3 “How” – Training Program Organization Structure

How should the organization structure support training?

Centralized Training Organization

- MHVC will use a centralized training specialist (FTE) to organize and administer training
- Direct Report to Director of HR/ Workforce … with dotted line to MHVC Medical Director
- **Assumptions:**
  1. MHVC shouldn’t reinvent the training wheel – rather leverage partners and vendors to source key training content
  2. MHVC shouldn’t spend resources on creating a vast training bureaucracy; goal is to be lean but with some oversight

Key Functions of Centralized Organization

Included:

1. Day to day Oversight of training program
2. Ensure training is occurring on schedule
3. Vendor RFP creation, selection
4. Partner and Vendor management
5. Liaison with central training teams
6. Troubleshoot issues with training
7. Ensure DOH-ready reporting is created
8. Create process to share lessons learned
9. Coordinate support (email or 800#)

Excluded (since partners or vendors will deliver):

1. Creation of actual training content will be selective and created on an exception basis
2. Conduct clinical training

Training Content & Delivery Options

- Collaborate with Partners to deliver “gold-standard” training by reviewing existing training content and recommending minor revisions to enhance/meet requirements
- Encourage willing partner organization to open training slots for other network partners
- Negotiate with vendors on behalf of the network of partners – may increase negotiation leverage for high volume courses
- Use a “train the trainer” model to expand reach across the partner network – repeat sessions periodically to ensure sustainability of the model
- Record live sessions for replay and consider supporting with live collaboration sessions focused on key concepts and Q&A – may be most appropriate for courses that need to reach high volumes of staff

3 “How” – Training Program Processes

What are the top processes that should be in place?

Process	Description
1. Directory	▪ Maintain a list of the network workforce and the list of trainings that are available throughout MHVC
2. Communications	▪ Develop an (automated) method for notifying network workforce about training alerts, deadlines, information etc. (e.g., salesforce)
3. Reporting & Documentation	▪ Creation of error-free reports in DOH ready format for upload into the MAPP tool each quarter
4. Vendor & Partner Management	▪ Selection, evaluation and ongoing relationship management with vendors (and network partners)
5. Logistics & Administrative	▪ Management of meeting rooms, travel, trainers, schedules, sign-ups, attendance, CMEs etc.
6. Future Orientation	▪ Scan market for new trends in training and explore how these may be beneficial for MHVC
7. Upward Management	▪ Share updates with Training and Workforce committees; ensure bi-directional communication with network partner stakeholders
8. Post-Assessment Training Evaluation	▪ Collect feedback on training effectiveness ▪ KPI management to link training to results

Considerations
1) **Keep processes lean** … minimize any non value-added overhead that creates more work than needed
2) **Ensure transparency** … e.g., partners may want to know why their employees are scheduled later in the cycle; having transparent criteria and open communication lines essential
3) **Make it easy to do the right thing** … e.g., ensure that partner trainings are conducted early mornings, late evening outside of patient hours
4) **Payments to MHVC partners** … e.g., MHVC can explore if it can link payment releases to network partners with completion of their training obligations
5) **DOH Documentation Template:** Special attention must be paid to keeping up-to-date the **training schedule** and the **training materials** templates

3 “How” – Training Program Technology Needs

What technology considerations should be addressed?

Technology plays two important roles within the ‘Training Strategy’

Tracking

- Tool needed for tracking training lists, sign-ups, completions etc. and creating DOH-ready reports for MAPP
- If vendors are used, they must conform with data feed formats on training completion so their input can be merged in
- While tracking can occur in an excel sheet, there exist a range of inexpensive ‘training tracker’ tools that can be explored
- A web-based solution that is available on the MHVC website or newsletter will enhance training transparency

Delivery

- Online coursework (typically vendor produced) should be accessible to all eligible MHVC partners
- Reports on coursework completion (or reminders about being stuck) should be generated by online course vendor
- MHVC may want to maintain a webinar account (e.g., Webex) for MHVC-initiated courses or training
- Leverage communication media (e.g., website, social media, newsletters) critical to communicating about training

In general, since the ‘Training Strategy’ is not advocating that MHVC create, maintain and deliver huge amounts of training content … there is a relatively moderate role for technology across the network of partners

3 ? "How" – Training Program (Vendors/Network Partners)

*What is the role of **vendors** or **Network Partners?***

Vendors

- Leveraging vendor relationships should be explored as an option to deliver training content. Survey results indicate the vendors are already providing content to network partners - examples of common vendors:
  - 1199 Training Fund
  - Relias Learning
  - Kathleen Sciacca; Dr. Gutnick
  - New York Association Psychiatric Rehabilitation Services (NYAPRS)
  - New York State Nurses Association (NYSNA)
  - Primary Care Development Corporation
  - Note: There are several other vendors that provide best-in-class content (e.g., xG for Care Mgmt.)

Network Partners

- Some network partners may have capacity or be open to sharing training content on select training topics
- According to the survey results, approximately 25% of the respondents have a full time trainer; another 25% with part-time trainer

3 “How” – Training Program (Academia)

What is the role of academic institutions or state training programs?

Academia

- Survey results indicate that existing training is being provided by some academic institutions – among those most noted were Hostos Community College, Lehman College, Binghamton University & College of New Rochelle
- Relationship with academia can take one or more of the following forms:
  1. **Clinical Placements & Non-clinical Internships** – Rotate interns from medical, nursing, social work schools through the network of partners
  2. **Courses** – Get customized DSRIP courses created for network partners
  3. **Career Counseling** – Leverage resources at local university career centers to facilitate placements
- MHVC can leverage **free educational content** at Khan Academy or Coursera and other online free courses
- MHVC can leverage **cross-network training collaborations** (student exchange program, bartering course content etc.)

NY State Programs

- NY DOH offers various training options for clinical and non-clinical providers
- Office of Mental Health (OMH) Bureau of Education provides training on policy and guidance and community resources

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4 Roadmap & Funding

List of Pertinent Questions

Roadmap Questions

- ? Guidelines: Should providers within a ‘partner type’ be tiered? i.e., are all PCP sites built equal?
- ? What are the “quick win” training items? “regulatory” training items?
- ? What does the 5 year timeline look like?

Funding Questions

- ? How will training dollars be split among Network Partners who want to do their own training?
- ? When will training dollars be distributed to partners?
- ? How is training affected if MHVC does not receive full funding throughout five years of DSRIP?

4 Roadmap – Guidelines

Some guiding principles should inform the staging and rollout of training to Network Partners

Partner Rank Order: Not all partners can contribute equally to MHVC success – so training emphasis should be on the 'tier 1' partners set. Tier 1 partners are those that see large volumes of Medicaid patients, those located in hotspot areas and those with Safety-Net designation

DSRIP Timeline Mandates: DSRIP requires that certain requirements be achieved by a certain timeline; MHVC may also have made similar commitments for partner implementation speed. Training should synchronize with these commitments

- For e.g., safety-net primary care practices need to be at NCQA 2014 PCMH Level 3 (or APC) by end of DY3

Self-Initiated Partners: DSRIP partners who have the capability and funding to initiate training amongst their own employee cohorts and thus contribute to the training goals of the overall network

Niche Training: Training that is very targeted and necessary for achieving certain goals can be conducted expeditiously on a small scale to meet that goal

4

Roadmap – Quick Wins, Regulatory and Cross Project

By December 2016, early wins can be achieved

Quick Win – Training activities that are easy to execute starting as early as October 2016

1. Hiring of the "training specialist" for the MHVC - completed
2. "DSRIP 101" for the entire network should be conducted via online video sessions
3. "Basics of Population Health" – online videos and series of articles
4. "Basics of Cultural Competence" – online videos and series of articles

Regulatory – Training activities that are a "must have" by December 2016 (and possibly ongoing)

1. Compliance training as mandated by DSRIP or other state/federal requirements

Cross Project – Training activities that should be started early and sustained through DSRIP life cycle to drive early results

1. Patient-Centered Medical Homes – Initial workshop and practice site assessments
2. Care Management – Web-based modules and external vendor expertise
3. EHR/Technology – online videos/demos and onsite training sessions for partners

4

Roadmap – Vendors & Educational Institutes

'Best in class' vendors should be considered for core skills; Educational Institutes should be approached based on their areas of specialty

Vendors

Subject Areas to consider vendors:

1) **Core Skills for DSRIP success** such as care management training and PCMH training for practices

Timing to select vendors:

Vendor selection should between now and the end of 2016 such that training can start in a staggered approach beginning in Fall 2016 thru Dec 2017

Network Partners as vendors:

Network partners can be vendors if they have a substantial training offering that is productized; the same bar should be set for internal or external vendors to ensure optimal value for training dollars

Educational Institutes

Subject Areas to consider educational institutes:

1) If the local / regional education institute is well-renowned for a particular training course, then explore a long term partnership to make that course work available to all partners

2) Explore free course work that may be available through premier educational institutions through websites like Coursera

Timing to select educational institutes:

Can be a lower priority to vendor selection but explored as an option to deliver general training

4

Roadmap – General and Project-Specific Timeline

All components of the training strategy will require an initial burst of content training… followed by a long tail of refresher courses

Note: The length of training depicted in the roadmap is representative of the expected average. Some partners/topics might require longer or shorter periods of training

Advanced Concepts Basic Concepts Initial Conceptual Training

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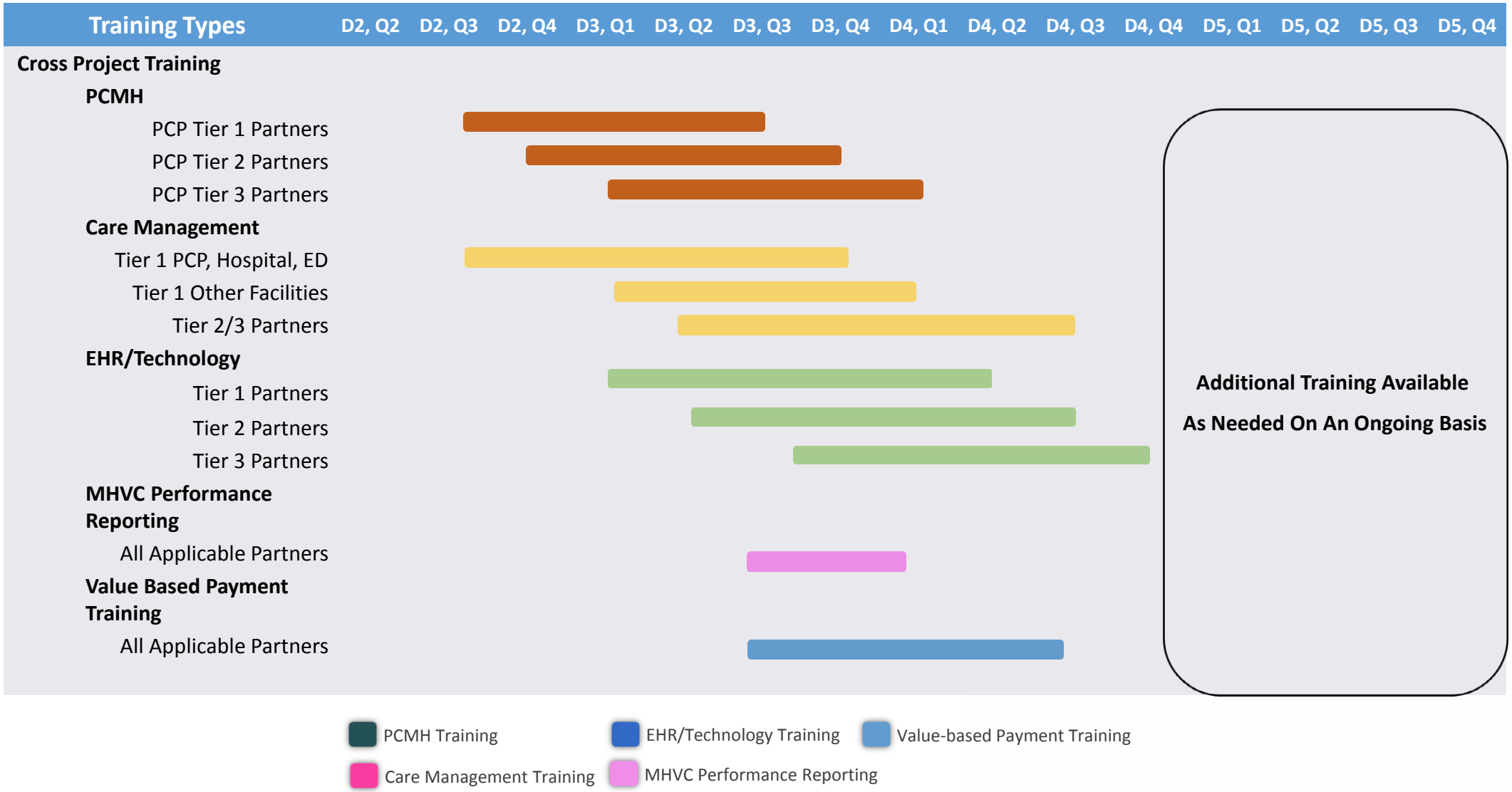
4

Roadmap – Cross Project Timeline

All components of the training strategy will require an initial burst of content training… followed by a long tail of refresher courses



4 Roadmap – Inpatient Hospital

Tier 1 Partners

1. St Joseph's – Yonkers
2. St John's Riverside Hospital
3. Montefiore New Rochelle
4. Nyack Hospital
5. St. Luke's Cornwall
6. White Plains Hospital*

* Non-Safety-Net Provider

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. IP Hospital Executive Leadership	A	B	A	B	B	B	B	B	A	B	-	i, iii	-	i, iv	Ii, iii
2. IP CM Leadership	A	B	-	B	B	B	B	B	A	B	-	i, iii	i	-	i
3. IP CM Staff (RN, SW)	A	B	-	A	B	B	B	B	A	B	-	i, iii	i	-	i
4. IP Nursing Leaders & Staff	B	-	B	-	-	-	-	-	A	-	-	i, iii	-	-	i
5. IP HIT leadership	A	-	A	-	-	-	-	-	-	-	-	i, ii, iii	-	-	i, ii
6. IP Enrollment Staff	B	-	-	-	-	-	-	-	-	-	-	-	-	-	-
7. IP Contracting Staff	B	-	-	-	-	-	-	-	-	-	-	-	-	-	i, ii, iii
8. Finance /HR	B	-	B	-	-	-	-	-	-	-	-	-	-	-	i, ii, iii

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

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4 Roadmap – Emergency Department (ED)

Tier 1 Partners

1. St Joseph's – Yonkers
2. St John's Riverside Hospital

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. ED Administrative Leadership	A	B	B	A	-	A	B	B	B	B	-	i, iii	-	i	i
2. ED Physician Leadership	A	B	B	A	-	A	B	B	B	B	-	i, iii	i	-	i
3. ED Nursing Leadership	A	B	B	A	-	-	B	B	B	B	-	i, iii	i	-	i
4. ED Nursing staff	A	-	B	-	-	-	B	B	B	B	-	i, iii	i	-	-
5. ED Clinical navigators (RN, SW)	-	-	-	B	-	B	-	-	-	B	-	i, iii	ii, iii	-	-
6. ED non-clinical navigators	-	-	-	B	-	B	-	-	-	B	-	i, iii	i, iii	-	-
7. ED Enrollment Staff	-	-	-	A	-	A	-	-	-	-	-	i	-	-	i

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

4 Roadmap – SNF, Nursing Homes

Tier 1 Partners

1. Regency Extended Care
2. St Joseph's Hospital
3. Centers for Specialty Care
4. Sutton Park*
5. Elizabeth Seton*
6. Wingate*

* Non-Safety-Net Provider

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. SNF Clinical Lead/Facility Champion	A	-	B	-	-	-	-	-	A	B	-	i, iii	-	i	i, ii
2. SNF Exec. Leadership	A	-	B	-	-	-	-	-	A	B	-	i, iii	-	i	I, ii
3. SNF nurse staff (RN, LPN)	B	-	B	-	-	-	-	-	B	B	-	i, iii	-	-	i
4. SNF nurse aide	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5. SNF HIT leadership	A	-	-	-	-	-	-	-	-	-	-	i, iii	-	-	-

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

4 Roadmap – Behavioral Health Acute Care Hospital

Tier 1 Partners

1. St Joseph's – Yonkers
2. St John's Riverside Hospital

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. IP Hospital Executive Leadership	A	-	B	B	B	B	-	-	A	B	-	i, iii	-	i	i, ii
2. IP CM Leadership	A	-	-	B	B	A	-	-	A	B	-	i, iii	i	-	i
3. IP CM Staff (RN, SW)	A	-	-	B	-	A	-	-	B	B	-	i, iii	i	-	i
4. IP Nursing Leaders & Staff	B	-	-	-	-	B	-	-	B	B	-	i, iii	-	-	-
5. IP HIT leadership	A	-	-	-	-	-	-	-	-	-	-	i, iii	-	-	i, ii
6. IP Enrollment Staff	B	-	-	-	-	-	-	-	-	-	-	-	-	-	-
7. IP Contracting Staff	B	-	-	-	-	-	-	-	-	-	-	-	-	-	i,ii, iii

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

4 Roadmap – Outpatient BH (Article 31, 32)

Tier 1 Partners

1. Hudson River Healthcare
2. Access: Supports for Living
3. Mental Health Association Westchester
4. Westchester Jewish Community Services
5. Hudson Valley Mental Health
6. St Josephs Hospital

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. Exec. Leadership	A	B	B	B	A	A	B	-	A	B	-	i, iii, iii	-	i	i, ii
2. Psychiatrists, Psychologists, Substance Abuse counselors	A	B	B	B	A	A	B	-	A	B	-	i, ii, iii	-	-	i, ii
3. Nursing leadership	A	B	B	B	A	A	B	-	A	B	-	i, ii, iii	i	-	i
4. BH clinical staff (RN, LPN, SW)	B	B	-	B	-	A	-	-	B	B	-	i	-	-	i
5. BH Care Management staff	A	A	B	B	A	A	-	-	-	-	-	i	ii, iii	-	i
6. Administrative support staff	-	-	-	-	-	B	-	-	-	B	-	i	-	-	-
7. Peer support staff	-	B	-	-	A	A	-	-	-	-	-	i	-	-	-
8. HIT support leader	A	-	-	-	-	-	-	-	-	-	-	i, ii, iii	-	-	i,ii

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

Montefiore HUDSON VALLEY COLLABORATIVE

4

Roadmap – Diagnostic Treatment Centers (Article 28)

Tier 1 Partners

1. Cornerstone Family Healthcare
2. Hudson River Healthcare
3. St. John's Riverside
4. Nyack Hospital
5. St. Luke's Cornwall

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. Exec. Leadership	A	B	B	B	A	A	B	-	A	B	-	i, iii, iii	-	i	i, ii
2. Psychiatrists, Psychologists, Substance Abuse counselors	A	B	B	B	A	A	B	-	A	B	-	i, ii, iii	-	-	i, ii
3. Nursing leadership	A	B	B	B	A	A	B	-	A	B	-	i, ii, iii	i	-	i
4. BH clinical staff (RN, LPN, SW)	B	B	-	B	-	A	-	-	B	B	-	i	-	-	i
5. BH Care Management staff	A	A	B	B	A	A	-	-	-	-	-	i	Ii, iii	-	i
6. Administrative support staff	-	-	-	-	-	B	-	-	-	B	-	i	-	-	-
7. Peer support staff, recovery coaches	-	B	-	-	A	A	-	-	-	-	-	i	-	-	-
8. HIT support leader	A	-	-	-	-	-	-	-	-	-	-	i, ii, iii	-	-	i,ii

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

Montefiore HUDSON VALLEY COLLABORATIVE

4 Roadmap – Hospital OP Clinics (Article 28)

Tier 1 Partners

1. St. Joseph's Hospital
2. St. John's Riverside
3. Montefiore New Rochelle
4. St Luke's Cornwall Hospital

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. Exec. Leadership	A	B	A	B	A	A	B	-	A	B	-	i, iii, iii	-	i	i, ii
2. Psychiatrists, Psychologists, Substance Abuse counselors	A	B	B	B	A	A	B	-	A	B	-	i, ii, iii	-	-	i, ii
3. Nursing leadership	B	B	B	B	A	A	B	-	A	B	-	i, ii, iii	i	-	i
4. BH clinical staff (RN, LPN, SW)	B	B	-	A	-	A	-	-	A	B	-	i	-	-	i
5. BH Care Management staff	A	A	B	B	A	A	-	-	-	-	-	i	ii, iii	-	i
6. Administrative support staff	-	-	-	-	-	B	-	-	-	B	-	i	-	-	-
7. Peer support staff	-	B	-	-	B	A	-	-	-	-	-	i	-	-	-
8. HIT support leader	A	-	-	-	-	-	-	-	-	-	-	i, ii, iii	-	-	i,ii

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

Montefiore HUDSON VALLEY COLLABORATIVE

4 Roadmap – OPWDD Clinics (Article 16)

Tier 1 Partners

1. Jawonio Inc.
2. Access

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. Executive leadership	A	-	-	-	-	-	-	-	A	B	-	i, ii	-	i	I, ii
2. Rehab staff (physical therapists, occupational therapists, etc.)	B	-	-	-	-	-	-	-	-	-	-	i, ii, iii	-	-	i
3. Dental staff	B	-	-	-	-	-	-	-	-	-	-	i, ii, iii	-	-	i
4. Medical staff	B	-	-	-	-	-	-	-	B	B	-	i, ii, iii	-	-	i
5. Ancillary services staff (dieticians, nutritionists, podiatrists, etc.)	B	-	-	-	-	-	A	-	-	-	-	i, ii	-	-	-
6. HIT support leader	A	-	-	-	-	-	-	-	-	-	-	i, ii	-	-	i

B Basic Concepts

A Advanced Concepts (includes Basic materials)

\- Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

Montefiore HUDSON VALLEY COLLABORATIVE

4 Roadmap – Primary Care Practice

Tier 1 Partners

1. Hudson River Healthcare
2. Westmed Medical Group
3. The Children's Medical Group
4. Eckerson Pediatrics
5. Haverstraw Pediatrics

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. PCP Exec. Leadership	A	A	B	A	A	B	A	A	A	A	i, ii	i, ii	i	i	i, ii, iii
2. Primary Care clinical staff (MDs, DOs, NP)	A	A	B	A	A	B	A	A	A	A	i, ii	i, ii, iii	i	-	i, ii
3. Nursing Leadership	A	A	B	A	A	B	A	A	A	A	i, ii	i, ii, iii	i, iii	-	i, ii
4. Nursing staff (RN, LPN, MA)	A	A	-	A	A	B	A	A	B	B	i, ii	i, iii	i, iii	-	i
5. CM staff (clinical and non-clinical)	A	A	B	A	A	A	A	A	B	A	-	i, iii	ii, iii		i
6. Office Administrative Staff	-	B	-	A	-	-	-	B	-	-	-	i, ii	i	-	-
7. HIT support leader	A	B	-	B	-	-	-	-	-	-	i, ii	i, ii, iii	iii	i	ii
8. PCP Referral Coordinators	-	A	-	A	-	-	-	B	-	-	i, ii	i, ii	i, iii	-	-

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

Montefiore Hudson Valley Collaborative

4 Roadmap – Non-PCP Physician Practice (Specialist)

Tier 1 Partners

1. Planned Parenthood Hudson
2. Community Medical and Dental

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. Non-PCP Exec. Leadership	A	B	B	B	-	-	A[1]/B	A[2]/B	A	B	-	i, ii	i	i	i, ii
2. Clinical staff (MDs. NP, etc.)	A	B	B	B	-	-	A[1]/B	A[2]/B	A	B	-	i, ii, iii	i	-	i
3. Nursing Leadership	A	B	B	B	-	-	A[1]/B	A[2]/B	A	B	-	i, ii, iii	i	-	i
4. Nursing staff (RN, LPN, MA)	B	B	B	B	-	-	A[1]/B	A[2]/B	B	B	-	i, ii	-	-	i
5. Office Administrative Staff	-	-	-	-	-	-	-	-	-	-	-	i, ii	-	-	-
6. HIT Support Leader	A	-	-	-	-	-	-	-	-	-	-	i, ii	-	-	i, ii

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

[1] **Cardiology offices**

[2] **Pulmonology, Allergy/Immunology offices**

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

4 Roadmap – Health Homes

Tier 1 Partners

1. Hudson Valley Care Collation
2. Hudson River Health Care

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. Health Home Executive Leadership	A	A	A	A	B	B	A	A	A	A	-	i, iii	-	i	i
2. Health Home Clinical Leadership	A	A	A	A	B	B	A	A	A	A	-	i, iii	-	-	i
3 . Health Home Care Management Clinical and non-clinical Staff (RN, LPN, SW, CHW, peer support)	A	A	A	A	B	B	A	A	B	A	-	i, iii	ii, iii	-	i
4. HIT support leader	A	-	-	-	-	-	-	-	-	-	-	i, iii	-	-	i

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

Montefiore HUDSON VALLEY COLLABORATIVE

4 Roadmap – Home Care

Tier 1 Partners

1. St Joseph's Hospital
2. Elant
3. Cabrini of Westchester*

* Non-Safety-Net Provider

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. Home Care Exec. Leadership	A	A	B	B	B	A	A	A	A	B	-	i	-	i	i, ii
2. Home Care Nursing Leadership	A	A	B	B	B	A	A	A	A	B	-	i, iii	-	-	i
3. Home Health clinical staff (RN, LPN, SW)	-	A	B	B	B	A	A	A	A	B	-	i, iii	-	-	i
4. Home Health Aides / Ancillary Staff	-	A	B	B	B	A	A	A	b	B	-	-	-	-	-
5. HIT support leader	A	-	-	-	-	-	-	-	-	-	-	i, iii	-	-	i

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

4 Roadmap – Clinical Educators, Trainers

Tier 1 Partners

1. Hudson River Healthcare
2. St. Joseph's Hospital
3. St. John's Riverside
4. Cornerstone Family Healthcare
5. Montefiore Medical Center

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. Asthma educators	A	A	-	A	-	-	-	A	B	B	-	iii	i	-	i
2. CDEs	A	-	-	-	-	-	-	-	B	B	-	iii	i	-	i
3 . Health Coaches	A	-	-	-	-	-	A	-	B	B	-	iii	-	-	i
4. Self-management trainers	-	-	-	-	-	-	A	-	B	B	-	iii	-	-	i

B Basic Concepts

A Advanced Concepts (includes Basic materials)

\- Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

4 Roadmap – CBO (Non-licensed)

Tier 1 Partners

1. Access
2. Mental Health Association Westchester
3. Hudson Valley Community Services
4. Human Development Services of Westchester
5. Jawanio Inc.
6. Independent Living

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. CBO Executive Leadership	A	B	B	A	A	B	-	-	A	A	-	-	-	i	i
2. CBO Clinical Leadership	A	B	B	A	A	B	-	-	A	A	-	-	-	-	i
3. Clinical Staff (RN, LPN, SW)	B	B	B	A	A	B		-	B	B	-	-	-	-	-
4. Self-management trainers	B	-	-	A	A	-	-	-	A	-	-	-	-	-	-
5. HIT support leader	A	-	-	-	-	-	-	-	-	-	-	-	-	-	i
6. Ambulance service, paramedics, first responders	-	-	-	A	-	-	-	-	-	-	-	-	-	-	-
7. Community event leaders, business leaders, educational institutions, faith-based orgs, etc.	-	-	-	-	-	-	-	-	-	A	-	-	-	-	-

B Basic Concepts

A Advanced Concepts (includes Basic materials)

\- Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

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4 Roadmap – MHVC Staff

Tier 1 Partners

Not applicable

Sequencing

High

1. General
2. Project A's
3. Project B's
4. Cross Project

Low

	Project-Specific										Cross Project				
Employee Group	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
1. MHVC Executive Leadership	A	B	B	B	B	B	B	B	B	B	-	-	-	i, iv	i, ii
2. MHVC Clinical Leadership (CMO & RNs)	A	B	B	B	B	B	B	B	B	B	-	-	-	i, iv	i, ii
3 . MHVC HR and Finance director	A	-	-	-	-	-	-	-	-	-	-	-	-	iv	i, ii
4. Care management Staff - clinical and non-clinical (RNs, SWs, navigators)	A	A	B	A	A	A	A	A	B	B	-	i, iii	ii, iii	-	i
5. HIT Leadership/Mgr	A	B	B	B	B	B	B	B	B	B	-	i, ii, iii	-	-	i
6. Project coordinator	A	A	A	A	A	A	A	A	A	A	-	i, iii	-	ii, iii	i
7. Data analyst	A	A	A	A	A	A	A	A	A	A	-	-	-	i, ii	-

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

Patient Centered Medical Home (PCMH)
- i. PCMH Basics
- ii. NCQA 2014 Level 3

EHR/Technology
- i. Data Sharing
- ii. Meaningful Use standards
- iii. Clinical integration

Care Management
- i. Care Management Advanced
- ii. Care Management Embedded
- iii. Care Management Tools

MHVC Performance Reporting
- i. Department of Health (DOH) Reporting
- ii. Medicaid Analytics Performance Portal (MAPP)
- iii. Project Management Office (PMO) Concepts
- iv. MHVC strategies

Value Based Payments
- i. VBP Plan
- ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

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4

Cultural Competency/Health Literacy Embedded Topics

In addition to general cultural competency and health literacy training, topics should be reinforced in project/cross project specific training

	Project-Specific										Cross Project				
Cultural Competency/ Health Literacy Training	**2a1**	**2a3**	**2a4**	**2b3**	**3a1**	**3a2**	**3b1**	**3d3**	**4b1**	**4b2**	**PCMH**	**EHR**	**CM**	**MHVC**	**VBP**
• High risk clinical conditions with specific CC gaps and remediation (i.e.- in low SES or specific REAL populations (racial/ethnic minorities, older adults, chronic disease, DD)	-	-	-	-	X	-	X	X	X	X	-	-	-	-	-
• CC gaps that should be addressed in patient communication mechanisms, style, content, etc.	X	X	X	X	-	X	-	-	-	-	X	-	X	-	-
• High risk clinical condition with specific HL gaps that should be addressed (i.e. chronic disease, medication management, care transitions)	-	-	-	-	X	-	X	X	X	X	-	-	-	-	-
• HL gaps that may impact effective patient verbal/written language and communication barriers	X	X	X	X	_	X	-	-	-	-	X	-	X	-	-

X **I**ndicates training topic should be included as part of project-specific or cross-project training

\- Indicates some element of training should be incorporated but lesser priority than the X

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4

Funding Considerations

MHVC Workforce Strategy Budget

Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	1,198,457	1,492,682	2,116,682	1,454,950	1,701,207	7,963,978
Redeployment	224,908	221,883	221,883	56,450	193,658	918,782
Recruiting	59,475	56,450	56,450	56,450	28,225	257,050
Other	126,750	253,500	253,500	253,500	125,750	1,013,000

- Total training budget for **Retraining** across 5 years estimated at $8M, which is about 3% of the MHVC total valuation and 78% of the total workforce budget
- Vendor support for training and development of training can be costly making it advantageous to consider sharing “gold-standard” content and training resources across the partner network
- The MHVC training specialist or designee should negotiate vendor contracts on behalf of the network partners to receive the best pricing
- Training resources across the network should collaborate on training content to share the effort and cost of content creation
- Retraining dollars may be shared with partners contributing training content and/or training delivery
- Year to year retraining budget may be impact by MHVC performance and overall DSRIP funding

Table of Contents

- Executive Summary
- Training Strategy Framework
- Training Strategy
    1. Who" needs to be trained
    2. "What" training is needed
    3. "How" to operationalize the program
    4. "When" - Roadmap & Funding
    5. **General Topics**
- Appendix

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5

General – Guiding Principles

1. Training strategy should be **supported by Sr. Leadership** of key network partners – ideally a training champion from the C-Suite should be nominated

2. Focus on keeping training **short and effective** … the best way to do this is to have real world examples, case studies etc. delivered through multiple mediums

3. 'Training Content' is just one part of **organizational capability development** – arranging it and delivering it with a focus on continuous capability development is essential to effectiveness[1]

4. **Feedback** from each session needs to be collected and analyzed – nuances about local region, trainer capabilities, content richness etc. should be acted upon

5. The trio of 'health literacy', 'cultural competence' and ' language' should be jointly considered when developing training content (e.g., video vignettes, teach backs are crucial) … to handle unconscious bias

Source: 1) Bershin

5 General – Multi-Disciplinary Team Based Training

Certain training needs to occur in a team based environment for maximal effectiveness

When is multi-disciplinary team based training necessary?

- Situations where 'change' occurs in multiple roles simultaneously
- Situations where management support is needed for changes … even if it affects a subset of employees
- Situations where the success of the effort is dependent on multiple roles synchronizing their efforts
- Situations where we are changing the paradigm of how healthcare is to be delivered in the future

What are the characteristics of good multi-disciplinary team based training?

- Generally onsite at the team location (e.g., PCP practice)
- At a time that allows all team members a reasonable chance of participating (e.g., over lunch)
- In person trainer present at the location

Example:

- PCMH Training which involves changing the workflows of the patient and every one from front office to rooming nurse to physician is involved

5 General – Language

English and Spanish are a must … and an infrastructure to support multiple languages should exist

- **Key Languages:** English & Spanish
- **Language Translation Services:** Establishment of language lines in the MHVC service area for telephonic translations; training on how to access these resources should be provided
- **Training Material Translation Considerations:**
  1. Critical that when 'peer' workers from the community are hired, that essential training materials also be available in Spanish
  2. For select courses, alternate "short versions" should be created in Spanish
  3. Whether English or Spanish, the training documents should be in 5th grade reading level to accommodate literacy issues

5 General – Change Management

Change Management is an essential process to ensure sustainability of the program

1 Top Risks

- Top 3 risks are:
  1. Obtaining individual buy-in management willingness
  2. Assessing and reinforcing to lead change
  3. Lack of resources to drive change

2 Key Actors

- Top 3 actors are:
  1. Organizational leadership (e.g., C-suite executives, departmental leadership, etc.)
  2. Operational leadership (e.g., project managers for specific projects, provider staff directly involved)
  3. External education team to provide unbiased guidance and direction

3 Sustaining Change

- Creating sustainable change involves reinforcement through numerous channels including:
  - Nomination of change mgmt. champion to monitor issues, troubleshoot unique situations and explain reason for change to per group and new hires
  - Produce periodic reports for executive leadership team

4 Success Factors

- Successful change management is an ongoing process. In the short-term, success is can be measured by proxy through surveys and other tools that are linked to specific interventions
- These surveys help to build momentum and create buy-in from stakeholders participating in creating change

5 General – Risk & Mitigation

Participation risk, Resource risk and Effectiveness risk need to be monitored and mitigated

	Risk	Mitigation
 **Participation**	We're short-staffed … can't afford to let people off for training We've already trained them on these topics – no refresher needed	1. Have a senior executive champion for training in each provider 2. Make it easy to do the right thing (e.g., online from desk etc.) 3. Ensure training is succinct and relevant … and fun!
 **Resource Allocation**	MHVC has a limited set of resources to establish workforce training	1. Leverage existing training that already exists within the network partners 2. Assess if network partners are willing to volunteer time and trainers 3. Prioritize the highest impact training and participants
 **Effectiveness**	Didn't get much out of that training It was too: • Basic • Academic • High level • Not actionable • …	1. Invest in best practice content esp. content that uses real world experiences as training material 2. Set expectations upfront … esp. if a wide range of learners is participating in the same course

appendix

Information Sources

Data and Key Sources

Supplemented by onsite discussion groups with identified key stakeholders

Data Reviewed

- MHVC Organizational Application
- MHVC Project Applications
- MHVC Implementation Plan – workforce, IT, cultural competency, CI, population health
- MHVC Implementation work plans by project
- Workforce Survey Preliminary Findings
- MHVC CNA
- Domain 1 DSRIP Project Requirements Milestones & Metrics

Discussion Groups

- **MHVC Leadership & Project Support**
  - J. Chaya (Dir., Workforce Dev & Management)
  - T. Howard-Eddings (Dir., Practice Transformation)
  - N. Hill (Dir., Quality & Innovation)
  - M. Ripa (Dir. System Transformation)
  - S. Seltzer-Green (Assoc. Dir, Transformation)
  - M. Gerena (Mgr, Workforce Dev & Management)
  - D. Gutnick (Medical Director)
  - A. Gamboa (Training Specialist)
  - A. Barba (Project Specialist)
  - M. Wolff-Diamond (Project Specialist)

- **CCHL Workgroup**
  - K. Pandekakes (Human Dev. Services of Westchester)
  - N. Allen (MHA Orange County)
  - N. Climes (Rehabilitation Support Services)
  - D. Strock (The Arc of Orange County)
  - R. Rodriquez (Independent Living)
  - A. Barba (MHVC)
  - E. Wiggins (Arms Acres)
  - K. Brieger (Hudson River Healthcare)
  - S. Wright (MHA of Rockland County)
  - N. Hollingsworth (Montefiore Medical Center)
  - N. Sanchez-Bahr (Putnam Family& Community Services)
  - A. Reyes (Cornerstone Family Healthcare)
  - Lt. R. Carrion (City of Newburgh Police)

- **Workforce Committee**
  - P. Forde (1199 SEIU)
  - P. Wallace-Moore (Arms Acres)
  - I. Rabinowitz (BestCare Inc.)
  - J. Todora (County of Sullivan, Dept. of Community Srvcs)
  - N. Sander (Hudson Valley Care Coalition)
  - K. Pandekakes (Human Development Services of Westchester)
  - J. Kasoff (Montefiore Health System)
  - M. Singh (Montefiore New Rochelle)
  - M. Guillaume (New York State Nurses Association)
  - D. Bengyak (St. Luke's Cornwall Hospital)
  - N. Climes (Rehabilitation Support Services)
  - M. Buck (Cornerstone Family Healthcare)
  - M. Leff (St. John's Riverside)

Data and Key Sources

Supplemented by onsite discussion groups with identified key stakeholders

Discussion Groups

Behavioral Health (3.a.ii) Integration Workgroup

- Marilyn Morales, Cornerstone
- Amy Anderson-Winchell, Access: Supports for Living
- Amelia Gallo, Arms Acres
- Andrea Kocsis, Human Development Services of Westchester
- Nancy Magliocca, Nyack Hospital
- Kay Scott, St. John's Riverside Hospital
- Andrew O'Grady, Mental Health America of Dutchess
- Shelley Carolan, Haverstraw Pediatrics
- Daniel Miller, Hudson River Healthcare
- Ann-Marie Bentsi-Addison, Planned Parenthood Hudson Peconic
- Craig Orvieto, St. Joseph's Hospital, Yonkers
- Laurie Orfe, Montefiore Mount Vernon
- Alissa Mallow, Montefiore Medical Center
- Stephanie Turco, Gateway Community Industries, Inc.
- Natalee Hill, Montefiore Hudson Valley Collaborative
- Marilyn Wolff Diamond, Montefiore Hudson Valley Collaborative
- Damara Gutnick, Montefiore Hudson Valley Collaborative
- Pam Tripodi, St. Joseph's Hospital, Yonkers

Cardiovascular (3.b.i) Workgroup

- Ashley Brody, Search for Change
- Cornelia Schimert, VNA – Hudson Valley
- Damara Gutnick, MHVC
- Darcy Shepard, Middletown Medical
- Janeen Pendergast, Community Medical and Dental
- John Ohnmacht, St. Joseph’s Hospital
- Kay Scott. St. John’s Riverside
- Lisa Aaronberg, Westmed
- Marilyn Wolff Diamond, MHVC
- Mary Lackey, Planned Parenthood – Mid Hudson
- Mary Ortiz-Collazo, Nyack Hospital
- Nasir Mahmood, Pine Plains Pharmacy
- Natalee Hill, MHVC
- Richard Morel, Westmed
- Sneha Shrivastava, Cornerstone
- Sophia McIntyre, Hudson River Healthcare
- Vanessa Pratomo, Montefiore Medical Center
- Vivian Volterre, White Plains Hospital

Health Home at Risk (2.a.iii) Workgroup

- Alissa Mallow, Montefiore Medical Center
- Amie Parikh, Hudson Valley Care Coalition
- Andrew O’Grady, Mental Health America of Dutchess
- Antonia Barba, MHVC
- Avi Silber, Cornerstone
- Damara Gutnick, MHVC
- Elizabeth Hurley, Hudson Valley Community Services
- Hope Glassberg, Hudson River Healthcare
- Jackie Metakes, Orange County Department of Mental Health
- Jesse C. Sarubbi, Cornerstone
- Jillian Annunziata, Hudson River Healthcare
- John Williford, Montefiore Medical Center
- Karen Hanney, White Plains Hospital
- Katharine Burnett, Planned Parenthood – Mid Hudson Valley
- Kathleen Clay, Hudson River Healthcare
- Noel Sander, Hudson Valley Care Coalition
- Pam Tripodi, St. Joseph’s Hospital
- Patricia Hewston, Middletown Medical
- Patricia Lemp, Westchester Jewish Community Services
- Rosemary A. Martino, Montefiore New Rochelle
- Saqib Altaf, Hudson Valley Community Services
- Tawana Howard-Eddings, MHVC

appendix

Detailed training content by job type

2 Specific – Project 3.a.i

Integration of primary care and behavioral health services

Detailed Content by Job Type

Depression Care Manager

- Behavioral Health Screenings -PHQ2/9, GAD 7, Anxiety screening etc.
- Substance Abuse screening and Brief Intervention
- EBG
- Antidepressant medication side effects and management
- Shared Decision Making
- Adherence counseling
- Problem Solving Treatment
- Behavioral Activation
- Motivational Interviewing
- Brief Action Planning
- ASK-TELL-ASK for giving information and advise
- Using registry to manage a population of patients
- Case reviews
- Team Work
- Stigma (CCHL Overlay)
- Suicide Assessment
- PDSA Rapid Cycle Improvement

Supervising Psychiatrist

- Problem Solving Treatment
- Behavioral Activation
- Motivational Interviewing
- Brief Action Planning
- ASK-TELL-ASK for giving information and advise
- Using registry to manage a population of patients
- Efficient Case review process
- Team Based Care/ TEAM Work
- Suicide Assessment Documentation
- PDSA Rapid Cycle Improvement

Primary Care Provider

- Behavioral Health Screenings -PHQ2/9, GAD 7, Anxiety screening etc.
- EBG
- Initiating Antidepressant medications, side effect management
- Team Work
- Documentation
- Stigma (CCHL Overlay)
- Suicide Assessment and documentation
- Self Management Support
- Behavioral Activation
- PDSA Rapid Cycle Improvement

Medical Assistants – see materials created for HHC coaching

- Administering Behavioral Health Screenings -PHQ2/9 screening, etc
- Stigma (CCHL Overlay)
- suicide prevalence and make it personal – How many of you have a friend, loved one, someone you know who attempted or succeeded in suicide?
- Workflows
- PDSA Rapid Cycle Improvement

2 Specific – Project 3.b.i

Evidence-based strategies for disease management in high risk/affected populations. (adult only)

Detailed Content by Job Type

Primary Care Practices (FQHCs, hospital clinics, etc)

Nurses and Nursing Assistants (RN, LPN)

- Training on correct blood pressure measurement technique and home BP monitors. (Nurses will need to train patients)
- HTN treat to target- using EBG and algorithms to adjust BP meds.
- Team Work – work at the top of license and collaborate with healthcare team
- Self Management Support including patient centered goal setting (BAP), ask-tell-ask for giving information and advise, teach back, spirit of Motivational Interviewing,
- BP and diet –CCHL training overlay (different education needed for different cultural groups – adobe, accent, sason (Latino diet), soy, rice (Asian diet etc.)
- Adherence Counseling
- Population Health - Managing Patient Registries
- PDSA Rapid Cycle Improvement

Primary Care Physicians (MD, NP, PA)

- For physicians who are not currently working in a collaborative team, need to learn how to work as a member of a care team so that all team members can assist the patient in creating and adhering to Self-Management Goals.
    - Team Work – working with nurses for HTN treat to target
- EBG for HTN treatment - algorithms
- Use of combination medications
- Adherence Counseling
- Population Health – using registries to manage populations and panels
- PDSA Rapid Cycle Improvement

PCP Office Staff

- Population Health – using registries to manage populations
    - Identifying patients with 2 high BP results without a dx of HTN
    - Add patients with poor BP control to HTN registry. (MHVC will provide the criteria to ID the patients.)
- Staff will need to be trained in using the registries, and to call patients and invite them to schedule an appointment. Training will need to be performed but may be completed internally based on scripts, etc provided by MHVC.
- Self Management Support (BAP, Goal setting, ASK_TELL_ASK)
- PDSA Rapid Cycle Improvement

Cardiologists

- Training on Self-Management Goals documentation.
- Close loop referrals
- PDSA Rapid Cycle Improvement

IT

- Population Health – using registries to manage populations and panels
    - Identifying patients with 2 high BP results without a dx of HTN
    - Add patients with poor BP control to HTN registry. (MHVC will provide the criteria to identify the patients.)
- PDSA Rapid Cycle Improvement

appendix

Current State Findings

Workforce Survey Questions

- For each training topic[1], please select all applicable statements listed below that apply to your site:
  - Training is required for all staff
  - Training is provided internally
  - Training is provided by an external vendor
  - Training is not available, but we would like to have (Training Gap)
  - Our site is able to share training materials with other Partner Sites/Organizations
  - Our site is able to train other trainers at Partner Sites/Organizations
  - Sites/Organizations can attend our trainings
  - Our site is unable to provide training materials nor include others in our trainings
  - Training is not applicable to our site
- How does your site or organization track staff training and certification?
- Is your site interested in assistance in implementing a system to track employee training?
- Select the response that best describes your organization/sites capacity to support DSRIP training efforts?
- Staff Training Contact. Please provide contact information on your site's primary staff training contact.
- If your site or organization uses an external source for training, who provides the external training? Select all that apply.
- If your site or organization uses an external source for training, please provide the name of the preferred training vendors and the training that they provide to your site.
- Does your site offer Continuing Education for Credits (e.g. CEU, CME, CE, etc.)?
- What types of Continuing Education do you offer? Select all that apply.

[1]**Training Topic Categories**: Behavior Change and Self-Management Support, Trauma Treatment, Cultural Competency and Health Literacy, Patient Centered Communication Skills Training/ Patient Engagement, Quality Improvement Skills

Current State - Existing Assets

Some training assets and best practices exist in the partner network. Partners may be willing to share assets and expertise.

Care Management & Population Health Training & Best Practices

- *Visiting Nurse Service of New York – a grant that provides funding to train nurses as Population Care Coordinators (PCCs)*
- *Montefiore Bronx hospitals – best practice experience with ER care triage patient navigator who is clinically trained (RN, LPN, MSW) and works closely with the ER physicians to transition members to an outpatient setting*

Blood Pressure Training

- *1199 Training Employment Fund to train partners and staff to measure blood pressures and to counsel and educate patients*

Patient Education Training

- *1199 Training Education Fund and Montefiore's Care Management Organization - training modules for partners regarding tobacco cessation*
- *People, Inc. - provides emergency department peer advocacy services to a local hospital ER where peers work with hospital staff and patients to advise on community resources and empower patients to take a role in treatment*

Asthma Training

- *Hudson Valley Asthma Coalition (HVAC), Human Development Services of Westchester, Haverstraw Pediatrics – Asthma care standards, guidelines and best practices*

Behavioral Health Best Practices

- *Mental Health America Dutchess – uses CBHCare as a member of CBHS to develop integrated primary care and behavioral health services for the clients receiving care from HRHCare article 28 sites*

Trauma Best Practices

- *Westchester County – using a team trained in evidence-based Trauma Systems Therapy (TST) which is a mental health treatment model) targeted for children*

Current State - Training Assets

Existing vendor relationships can be leveraged for DSRIP training across the network

Vendor Name	Key Training Asset(s)
New York University	▪ Trauma Systems Therapy (TST) a model of care for traumatized children
1199SEIU Training & Upgrading Fund	▪ Accurate blood pressure training, provider education for smoking cessation
Fordham University	▪ Trauma Systems Therapy (TST) and evidence based trauma treatment
Office of Mental Health (OMH) Bureau of ED	▪ Motivational Interviewing
Kathleen Sciacca	▪ Motivational Interviewing (Note: Dr. Gutnick at MHVC is also an expert in this field)
New York Association Psychiatric Rehabilitation Services (NYAPRS)	▪ Peer Bridger model and transforming to recovery , PROS (Pathway to Integration, Innovation and Outcomes)
New York State Nurses Association (NYSNA)	▪ Patient Centered Medical Home (PCMH) training, infection control, NYSNA's online learning system
National Council BH, MTM Services Consulting	▪ Clinical best practices such as same day access ▪ Business best practices including strategic and performance improvement
Primary Care Development Corporation	▪ Patient Centered Medical Home (PCMH) training

Current State - Workforce Training Survey Results

89

n = 105 site participants

Survey Topic	Response
Capacity to support training	• 50% of the sites have at least a part time trainer • 40% of the sites do not have a dedicated trainer and have no plans to hire one • Remaining plan to hire a dedicated trainer
Continuing education credits	• 25% of the sites offer credits
System to track employee training	• Half of the sites decline assistance in implementation of a tracking system because most have a database and/or paper tracking system in place
External training providers	• 70% of sites use an outside source (vendor, academic, government agency, etc.) to provide training
EHR system	• 16 sites (15%) do not have an EHR in place yet but is planned or in progress
Behavior Change and Self-Management Support	• 75% of the sites indicated there is a training gap in topics such as motivational interviewing, problem solving treatment, support intervention, smoking cessation, substance abuse counseling, motivational enhancement therapy
Trauma Treatment	• 20% of the sites indicated a training gap in adult and child related trauma treatments
Patient Centered Communication Skills Training/ Patient Engagement	• Average of 35% of the sites indicated training gaps in this area • Lowest gap (12%) was in suicide prevention • Most significant gap was 40% for teach back and shared decision making
Clinical Skills and Patient Education	• Correct blood pressure training had the lowest gap (13%) • Asthma teaching had most significant gap reported by 22% of the sites
Quality Improvement Skills	• Approx. 70% of sites indicated training is in place for a process improvement methodology – LEAN, Six Sigma, etc. • 80% of the sites indicated they have training for case management basics in place

Current State - Training Gaps

While training is being conducted, some gaps exist specific to DSRIP

Content Category	Training Gaps
DSRIP 101	▪ Basic understanding of the DSRIP program can be expanded across the network ▪ History of Medicaid reform, DSRIP background, timeline, goals, explanation of acronyms, etc. must be delivered periodically
Care Transitions	▪ Need training focused on Transition of Care (TOC) handoffs in addition to other care management embedded or advanced topics ▪ Once aligned on process, a robust training program must be put in place that will allow for change management to sustain the process
Shifts & Backfill	▪ Need to optimize training sessions to align with workday shifts covered by certain employees ▪ Additional resources must be made available to backfill these positions when the employees are receiving training
Computer Access	▪ Likely wide variation in practitioner access to computers or internet in their workspace. Some sites to not yet have an EHR system in place
Behavioral Health	▪ Need training for Motivational Interviewing, Rational Emotive Behavioral Therapy best practices to address significant training gap across sites
Team-based Training	▪ In some instances, cross-organizational training needs to occur (e.g., SNF, Emergency Department, and “on the ground” practitioners) ▪ For palliative care, ensure the nursing aides, housekeeping, nurses and physicians are all trained in best practices
Palliative Care	▪ Ability to educate family on advanced directives, DNR, advanced care plan, living will, etc.
Training Unit	▪ Clarity on the definition of the core and extended team; recognition of virtual team and cross-organizational constraints; recognition of shared decision making on the team

appendix

Training Course Listing

List of Training Courses

General

- DSRIP 101
- Population Health Basics
- MHVC Structure and Function
- Compliance
- Career Counseling
- Cultural Competency - Advanced
- Cultural Competency - Basic

Project Specific

- 2.a.i Integrated Delivery System – Advanced
- 2.a.i Integrated Delivery System – Basic
- 2.a.iii Health Home at-risk – Advanced
- 2.a.iii Health Home at-risk – Basic
- 2.a.iv Create a Medical Village – Advanced
- 2.a.iv Create a Medical Village – Basic
- 2.b.iii ED Care Triage for At-Risk Populations – Advanced
- 2.b.iii ED Care Triage for At-Risk Populations – Basic
- 3.a.i Integration of PC and BH services – Advanced
- 3.a.i Integration of PC and BH services – Basic
- 3.a.ii BH community crisis stabilization services – Advanced
- 3.a.ii BH community crisis stabilization services – Basic
- 3.b.i Evidence-based strategies for disease management – Advanced
- 3.b.i Evidence-based strategies for disease management – Basic
- 3.d.iii Evidence-Based Guidelines for Asthma management – Advanced
- 3.d.iii Evidence-Based Guidelines for Asthma management – Basic
- 4.b.i Promote tobacco use cessation – Advanced
- 4.b.i Promote tobacco use cessation - Basic
- 4.b.ii Increase access to high quality chronic disease preventive care - Advanced
- 4.b.ii Increase access to high quality chronic disease preventive care - Basic

Cross-Project

- PCMH Basics
- NCQA 2014 Level 3
- EHR/Technology – Data Sharing
- EHR/Technology – Meaningful Use
- EHR/Technology – Clinical Integration
- Care Management Embedded
- Care Management Advanced
- Care Management Tools
- Department of Health (DOH) Reporting
- Medicaid Analytics Performance Portal (MAPP)
- Project Management Office (PMO) Concepts
- MHVC Strategies
- Value Based Purchasing (VBP) Plan
- Value Based Purchasing (VBP) Tools