NCI Workforce Implementation Plan

***Milestone 1:* Define Target Workforce State**

Supporting Documentation Requirment:

Evidence of workforce needs associated with each approved DSRIP project being met, including consideration of skills and licensure requirements

Project Number	*Project Name*	*Workforce Impact/Skills*	*Licensure Requirements*
2ai	Create an Integrated Delivery System	Expand access to primary care providers and engage patients in the IDS through outreach and navigation activities, leveraging community health workers, peers and culturally competent community-based organizations as appropriate.	MD, DO, NP, PA Certification
2aii	Increase Certification of PCPs with PCMH	Ensure that all staff are trained on PCMH or APC models, including evidence-based preventive care and chronic disease management. Ensure staff are trained to implement behavioral health screenings (PHQ2/9 and SBIRT).	MD, DO, NP, PA Certification
2aiv	Create a Medical Village	Support workforce transformation related to service integration and providing a platform for primary care/behavioral health integration and ensuring safety net providers are actively sharing EHR systems and health information among clinical partners.	MD, DO, NP, PA Psychologist LMSW/LCSW MHC CASAC
2biv	Care Transitions Intervention to reduce 30 day readmits	Train staff on implementation of standardized protocols for the Care Transition Intervention Model.	MD, DO, NP, PA Psychologist LMSW/LCSW MHC CASAC CNA, LPN, RN
2di	Implementation of Patient Activation Activities	Ensure patient engagement, train and establish training teams, train providers on patient activation techniques, promote preventative care, develop & train a group of community navigators in patient activation techniques and education, and inform & educate community navigators about insurance options & healthcare resources.	Certificate CNA, LPN, RN LMSW/LCSW

3ai	Integration PC and BH	Ensure workforce is trained using the collaborative care and the PCMH models. Train staff to implement PHQ2/9 and SBIRT. Designate a Psychiatrist and Depression Care Manager to meet the requirements of the IMPACT model.	MD, DO, NP, PA Psychologist LMSW/LCSW MHC CASAC Certificate/Certification
3bi	Evidence Based Strategies for Disease Management in High Risk Populations	Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues and patient self-efficacy and confidence in self-management. Ensure all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	CNA, LPN, RN MD, DO, NP, PA Certificate/Certification
3ci	Implementation of Evidence Based Strategies in the Community to Address Chronic Disease	Develop care coordination teams including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers & health home care managers to improve health literacy, patient self-efficacy and patient self-management.	Certification CNA, LPN, RN Psychologist LMSW/LCSW MHC CASAC
3cii	Implementation of Evidence Based Strategies in the Community to Address Chronic Disease	Ensure community resources are equipped with staff and trained to assist patients with primary and secondary preventive strategies to reduce risk factors for diabetes and other chronic diseases.	Certification CNA, LPN, RN MD, DO, PA, NP
4aiii	Strengthen Mental Health and Substance Abuse Infrastructure	Provide cultural and linguistic training on MEB health promotion, prevention and treatment.	LMSW/LCSW Psychologist MD, DO, NP, PA CASAC MHC CNA, LPN, RN Certificate/Certification
4bii	Increase Access to High Quality Chronic Disease Preventive Care & Management	Ensure providers are trained to offer recommended clinical preventive services thus connecting patients to community-based preventive service resources.	MD, DO, PA, NP CNA, LPN, RN Psychologist LMSW/LCSW CASAC MHC Certificate/Certification