Workforce Transition Roadmap Report for OneCity Health Services PPS

OneCityHealth

Partners for a Healthy NYC

Delivery System Reform Incentive Payment Program

Workforce Strategy Deliverable

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Executive Summary

The overall goal of the Delivery System Reform Incentive Payment ("DSRIP") program is to reduce avoidable hospitalizations and ED visits by the Medicaid population in New York State ("NYS") by 25% through the transformation and redesign of the existing healthcare system. As part of OneCity Health Service's ("OneCity Health" or "PPS") participation in the DSRIP program and completion of certain Workforce Strategy Milestones, OneCity engaged BDO Consulting ("BDO") as its workforce vendor to develop a Workforce Transition Roadmap that details the PPS's plans for achieving the target workforce state throughout the five year DSRIP program.

The development of the PPS's Workforce Transition Roadmap Report was completed in collaboration with key OneCity Health stakeholders and Workforce Consortium members (Community Care of Brooklyn PPS, NYU Lutheran PPS, and Bronx Partners for Healthy Communities PPS). The PPS workforce leads, in conjunction with its workforce vendors, engaged key stakeholders including internal PPS staff and clinical leadership in the development of the Current Workforce State Report assessment, target workforce state assessment, workforce gap analysis, compensation and benefits analysis, and transition roadmap. The Workforce Consortium was developed with other downstate PPSs to support collaboration across networks in data gathering, analysis, and strategy development, when appropriate. Collaboration took place through a series of in-person working sessions and conference calls with representation from multiple PPSs.

The Workforce Transition Roadmap Report aggregates findings from the PPS's Current Workforce State Report, Target Workforce State Report, and Workforce Gap Analysis Report to detail the PPS's plans and timeline for achieving the target state goals by 2020. It will guide the PPS in bridging identified workforce gaps and achieving its defined target workforce state by addressing the workforce implications of the DSRIP program. The transition roadmap provides an overview of the PPS's plans to recruit, train and redeploy the workforce over the five-year DSRIP program to better meet the needs of the population the PPS serves.

I. Workforce Transition Roadmap Overview

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

The Workforce Transition Roadmap Report, as part of the DSRIP Workforce Strategy Milestones, is intended to define the PPS's plans for achieving the defined target workforce state by addressing workforce impacts that the program will have on the PPS's current workforce as well as the need for new positions and skill sets. Further, the Workforce Transition Roadmap will be utilized to guide the PPS's overall workforce strategy throughout the five year program.

OneCity Health engaged BDO as their workforce vendor to assist in the development of the Workforce Transition Roadmap, which leverages findings from the Current Workforce State, the Target Workforce State, and the Workforce Gap Analysis.

The purpose of the Workforce Transition Roadmap is to provide the PPS with detailed plans and target dates to effectively address workforce impacts as a result of system transformation and implementation of clinically integrated programs, and to guide the PPS to achieve its target workforce state by the end of the DSRIP program in 2020. The PPS's Workforce Transition Roadmap was created in collaboration with the PPS's Workforce Governance Committee.

OneCity Health's Workforce Transition Roadmap has been developed to align with DSRIP program goals and details plans as well as timelines for addressing the PPS's ongoing workforce recruitment, training, and deployment needs. The Workforce Transition Roadmap takes into consideration any implications, issues and factors identified within the gap analysis and works to bridge identified gaps to meet the PPS's needs.

The approach utilized to define OneCity Health's Workforce Transition Roadmap, as well as the PPS's strategy and plans for bridging the identified workforce gaps, has been detailed within the body of this report.

A. Workforce Transition Roadmap Approach

OneCity Health developed numerous workforce deliverables to inform creation of the Workforce Transition Roadmap. In early 2016, OneCity Health's PPS conducted a current workforce state survey and engaged key PPS stakeholders to identify PPS partners' current and anticipated staffing needs related to DSRIP program implementation. Findings from these discussions, along with the projected workforce staffing impacts as part of the PPS's target workforce state, were leveraged to determine potential workforce displacements, new staffing requirements, and new job functions and skill needs and to identify workforce gaps.

OneCity Health's PPS workforce transition roadmap was developed utilizing findings from the PPS's Current Workforce State Report, Target Workforce State Report, and Gap Analysis

Report. An overview of the approach used to define the PPS's current and target workforce states and workforce gaps and the report findings are detailed in the following sections.

B. Current Workforce State Approach and Summary Findings

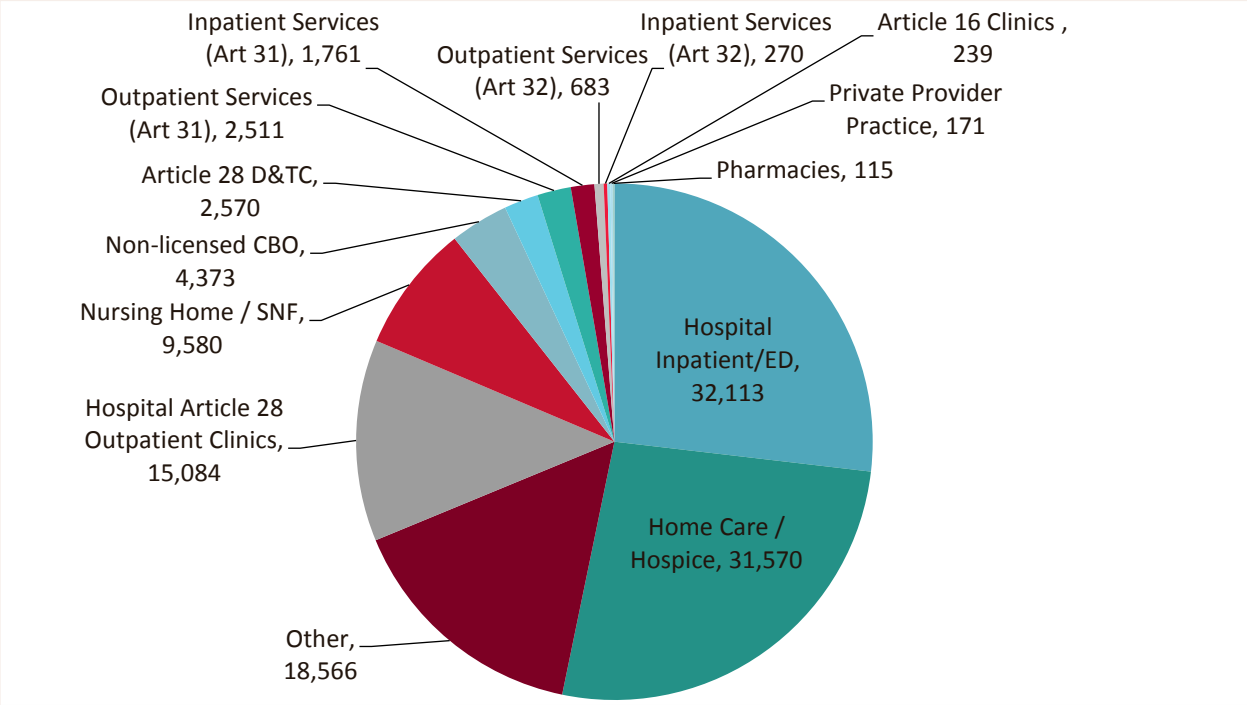
In assessing the PPS's current workforce state, OneCity Health engaged BDO and the Center for Health Workforce Studies ("CHWS") to collect and synthesize information pertaining to the PPS's current workforce including staffing, infrastructure, culture, strengths, and challenges. The current state workforce assessment included the development and distribution of a survey to PPS partners to collect workforce data pertaining to the PPS's network. Additionally, data requests and stakeholder engagement sessions were held to obtain supplemental data related to the PPS's workforce.

PPS partners were requested to provide workforce data by job title pertaining to total headcount, full time equivalents ("FTEs"), number of vacancies, average hourly wages, fringe benefits (%), and collective bargaining agreements as well as data pertaining to temporary and agency staff including total headcount, hours, and FTEs. The survey also included sections for PPS partners to indicate minimum requirements for certain job titles pertaining to degrees/education and years of experience. The purpose for collecting this level of workforce data was to establish a baseline or current state of the PPS's workforce and compare these findings to the projected target workforce state to identify workforce gaps, and to use these findings for other workforce planning efforts.

A total of 400 surveys was completed and submitted by 155 organizations, with an overall survey response rate of 76% by OneCity Health's PPS partners. As 76% of the PPS's partners responded, the current workforce state data reported provides an approximate representation of the PPS, but does not provide workforce data that is comprehensive of the entire workforce within the PPS. The current workforce state details reported workforce data across facility types and job titles by headcount, FTEs, and FTE vacancies, as well as agency and temporary staff by headcount, hours, and FTEs. The following pie charts provide an overall summary of the OneCity Health PPS's reported workforce data which includes a total headcount of 119,606 individuals and 101,507 FTEs.

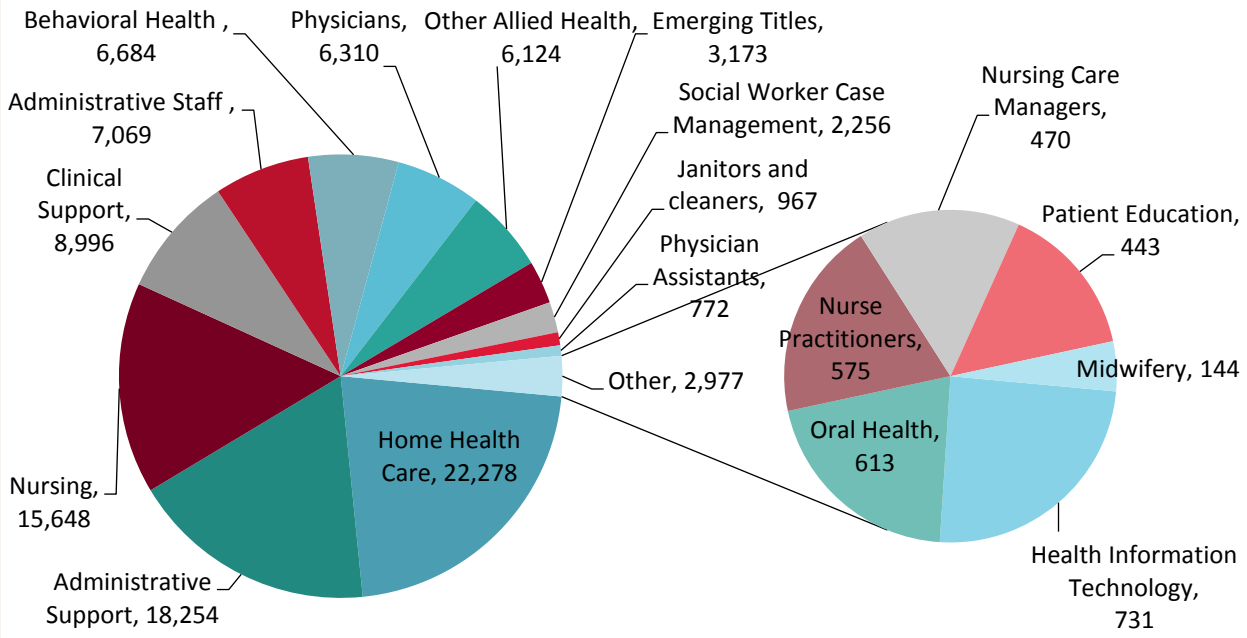
Exhibit 1 describes the total reported current workforce across all facility types by headcount. The largest headcount, 27% of the PPS's workforce, was reported by the 11 New York City Health + Hospitals (NYC H+H) hospitals, SUNY Downstate and several acute LTC Hospitals within the Hospital Inpatient/ED facility category. Next, 26% of the PPS's workforce was reported by Home Care/Hospices which contains titles such as Certified Home Health Aides and Personal Care Aides (Level I and Level II). Other major workforce employers include Hospital Outpatient (Article 28) facilities (13%), Nursing Homes/SNFs (8%) and Non-licensed Community Based Organizations (CBOs) (4%).

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



As detailed in *Exhibit* 2, which provides the total reported workforce across all DOH Job Categories (by FTEs), nearly 22% (22,278 FTEs) of the PPS's reported FTEs are represented by the Home Health Care DOH Job Category and another 18% are represented by Administrative Support (18,254 FTEs). The survey data indicates the PPS is also largely comprised of Nursing (15,648 FTEs), Clinical Support (8,996 FTEs), Administrative Staff (7,069 FTEs), Behavioral Health staff (6,684 FTEs) and Physicians (6,310 FTEs).

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



The PPS partners also reported on FTE vacancies occurring within the PPS's workforce. Based on the data provided, approximately 22% of FTE vacancies are represented within the PPS's nursing positions with 1,044 FTE vacancies reported, followed by Administrative Support and Clinical Support staffing vacancies. While Behavioral Health reported 6.6% of the total workforce by job title FTE, they represented about 11.8% of total workforce vacancies across the PPS.

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

C. Target Workforce State Approach and Summary Findings

OneCity Health's Target Workforce State Report identifies the projected workforce needs by the end of the DSRIP program in 2020. Project impacts from the Target State Report are summarized within this section and further detailed in the Target State Report.

OneCity Health PPS's Target Workforce State Report was completed in collaboration with key PPS stakeholders as well as Workforce Consortium members (Community Care of Brooklyn PPS, NYU Lutheran PPS, and Bronx Partners for Healthy Communities PPS) to ensure that workforce needs and impacts of the DSRIP projects were being evaluated consistently across the PPSs in order to develop a comprehensive analysis of each PPS's target workforce state in its corresponding service area. OneCity Health PPS stakeholders, including DSRIP Project Leadership and Clinical Workgroup Members, provided significant input into the DSRIP project impacts and assumptions made to inform the projection of the PPS's target workforce state.

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

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

The estimated workforce demands, independent of the DSRIP program, are projected to grow by approximately 1,167 FTEs overall. The projected impact of DSRIP implementation is estimated to add another approximately 1,024 FTEs by 2020. This will result in a total estimated increase in demand of 2,190 – 2,191 FTEs overall that will create or worsen gaps or shortages that already exist in the PPS's healthcare workforce.

The greatest projected workforce impacts, taking into account both DSRIP and non-DSRIP related impacts, are estimated to take place among non-registered nurse and registered nurse care coordinators/navigators, primary care providers ("PCPs") and support staff in outpatient and community-based settings, as well as behavioral health staff including licensed clinical social workers.

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

Exhibit 3: OneCity Health PPS Summary of Projected DSRIP Staffing Impacts (FTEs)

Setting and Job Category	Non-DSRIP Impact	DSRIP-related Impact	Total Impact
Primary and Community-Based Settings			
Primary Care Providers	107.5	88	195.5
Cardiologists	17.5	9	26.5
Endocrinologists	5	0	5
Psychiatrists/Psychiatric Nurse Practitioners	15.5	14	29.5
Psychologists	57	0	57
Licensed Mental and Substance Abuse Providers (e.g., Clinical Social Workers, Mental Health Counselors, Psychologists, Addiction Counselors)	0	139.5	139.5
Registered Nurses	57	43.5	100.5
Licensed Practical Nurses	18	0	18
Nurse Aides/Assistants	17.5	0	17.5
Medical Assistants	188.5	154.5	343

Administrative Support Staff	189	168.5	357.5
Emergency Department			
Emergency Physicians	3.5	-30.5	-27
Nurse Practitioners & Physician Assistants	2	-5	-3
Registered Nurses	29	-109	-80
Hospital Inpatient			
Hospitalists	7	-22.5	-15.5
Registered Nurses	367.5	-263	104.5
Licensed Practical Nurses	48.5	-15	33.5
Nurse Aides/Assistants	36.5	-66.5	-30
Care Managers/Coordinators/Navigators/Coaches			
Registered Nurse Care Coordinators and Managers	0	112.5	112.5
Non-Registered Nurses Care Coordinators	0	625.5	625.5
Community Liaisons	0	6.5	6.5
Community Health Workers (Asthma)	0	117	117
Asthma Educators	0	23.5	23.5
Cardiovascular Disease Educators	0	23.5	23.5
Palliative Care Educators	0	10	10
Registered Nurse Total	453.5	-216	237.5
Total FTEs	1,166.5	1,024	2190.5

As detailed within *Exhibit 4*, the current state workforce findings are aggregated across various reported job titles and facility types to align with the care settings and job categories indicated within *Exhibit 3* and throughout the projected workforce findings for each DSRIP project[1]. However, the numbers being reported do not include the PPS's total reported workforce for all job titles.

[1] Care Settings Reported:
The Primary Care and Community-based Setting section includes current workforce state findings for Article 31 Outpatient, Article 32 Outpatient, Article 28 D&TCs, Home Care/Hospice, Article 28 Hospital, Non-licensed CBOs, Private Provider Practices, Pharmacies, Retail Clinics, and "Other" Facility Types.
The Emergency Department ("ED") and Hospital Inpatient sections of the table are inclusive of reported current workforce state findings for Article 31 Inpatient, Article 32 Inpatient, and Hospital Inpatient/ED facility types.
The Nursing Home/SNF section is inclusive of reported current workforce for the PPS's Nursing Homes and SNFs.
The Care Managers/Coordinators/Navigators/Coaches section of the table is inclusive of all facility types.

Job Titles Reported:
Certain job categories in the table include aggregates of similar job titles:
The Psychiatrists/Psych Nurses category includes reported FTEs for Psychiatrists, Psychiatric Nurse Practitioners, and Psychiatric Tech Aides.
The Clinical Social Workers job category is inclusive of reported FTEs for Licensed Clinical Social Workers, Bachelors Social Workers, Licensed Masters Social Workers, Licensed Clinical Social Workers, and Social Worker Care Coordination/Case Managers/Care Transition job titles.
The Registered Nurses job category includes Nurse Managers/Supervisors, Staff Registered Nurses, Other Registered Nurses, and Per Diem Staff Registered Nurses.
The Administrative Support Staff category includes Office Clerks, Secretaries and Administrative Assistants, Coders/Billers, Dietary/Food Services, Financial Service Representatives, Housekeeping, Medical Interpreters, Patient Service Representatives, and Transportation positions.

Exhibit 4: OneCity Health PPS Current State Reported Workforce

Job Category	Reported Workforce (FTEs)	Vacancy Rates
Primary and Community-Based Settings		
Primary Care Providers	465	8.6%
Cardiologists	28	8%
Endocrinologists	12	34.2%
Psychiatrists/Psychiatric Nurses	347	14.7%
Psychologists	178	5.8%
Clinical Social Workers	1,900	7.5%
Registered Nurses	3,393	11.5%
Licensed Practical Nurses	492	7.5%
Nurse Aides/Assistants	405	8.4%
Medical Assistants	998	5.7%
Administrative Support Staff	7,549	4.4%
Hospital Inpatient & ED		
Emergency Physicians	241	8.6%
Primary Care Physicians	220	9.1%
Specialists (except Psych)	1,176	6.2%
Residents and Fellows	2,214	-
Physician Assistants	486	5.3%
Registered Nurses	7,699	3.8%
Licensed Practical Nurses	773	5.2%
Nurse Aides	1,442	4.6%
Nurse Practitioners	152	4.5%
Care Managers/Coordinators/Navigators/Coaches		
Nurse Coordinator Leaders	88	61%
RN Care Coordinators	382	3.8%
Care Coordinators (non-RN)	1,481	6.5%
Asthma Educators	8	30%
Cardiovascular Disease Educators	-	-
Peer Support Workers	173	20.4%
Nursing Home/SNFs		

The Specialist category includes Cardiologists, Endocrinologists, Obstetricians/Gynecologists, and Pediatricians. The Nurse n Leaders job category includes Licensed Practical Nurse Care Coordinator/Case Managers and "Other" related job titles.

Primary Care Physicians	120	10.8%
Specialists (except Psych)	39	2.5%
Physician Assistants	16	0%
Registered Nurses	851	6.7%
Licensed Practical Nurses	859	6.6%
Nurse Aides	3,036	3.3%
Nurse Practitioners	18	5.5%
Total FTEs	**37,061**	

D. Gap Analysis Approach and Summary Findings

The Gap Analysis incorporates findings from OneCity Health's Current Workforce State Report and Target Workforce State Report to identify existing workforce gaps that may be further impacted as a result of the DSRIP program, or new gaps in required job titles, skill sets, and training that will be created through DSRIP implementation. Findings from the PPS's Gap Analysis Report were used to inform the development of this Workforce Transition Roadmap, detailed in the following sections.

OneCity Health's PPS Gap Analysis Report shows varying DSRIP project workforce impacts between the Hospital Inpatient/ED and outpatient and community based settings. DSRIP impacts in the Hospital Inpatient/ED setting will generate a decrease in utilization and thus decline in workforce through 2020, mostly in registered nurses, nurses aides, and emergency physicians. Conversely, the primary care and community-based settings will see an increase of over 600 FTEs over the course of the DSRIP program. The specific job category of care managers/coordinators/navigators/coaches is estimated to see an additional increase of about 918-919 FTEs across all settings creating the largest anticipated gap in the workforce resulting from DSRIP implementation.

It is anticipated that the net decrease in workforce demand in the Hospital Inpatient/ED setting may be off-set by FTE increases estimated from non-DSRIP impacts such as changing demographics and expanded medical insurance coverage under the Affordable Care Act. Specifically, independent of DSRIP implementation, workforce demand is projected to grow by about 1,166 – 1,167 FTEs through 2020 (in both inpatient and primary care and community-based settings).

Further, some OneCity Health PPS partners reported high workforce vacancies already impacting the PPS's provider community. The impacts of certain DSRIP projects may minimize or increase gaps that currently exist within the PPS's workforce.

Due to the combined impact of the program as well as non-DSRIP related impacts, the PPS's workforce is projected to experience a potential increase in demand for health care providers including PCPs and clinical support staff in the outpatient setting, nursing positions,

behavioral health staff, and care managers/coordinators. OneCity Health's PPS is likely to experience the greatest workforce impacts during DSRIP Demonstration Year 4 (2019).

Because of the combined impacts among the ED Triage project, the Home Health at-Risk project and increased referrals through the co-location of primary care and behavioral health services, the PPS's workforce should experience an increase in demand for PCPs as patients are redirected to providers outside of the ED setting and connected to a PCP. Given current workforce shortages for PCPs, DSRIP implementation is expected to only exacerbate this existing workforce gap. In addition to increasing the demand for PCPs, project impacts are estimated to increase demand for clinical and administrative support positions to support the projected increase in utilization of primary care and outpatient services.

Demand for behavioral health positions is projected to increase through the implementation of behavioral health and primary care integration, along with general population growth. As a result of the behavioral health workforce gaps that already exist within the PPS, the projected impacts of this project are likely to further enhance these identified gaps, particularly for job titles such as licensed clinical social workers, psychiatrists and psychiatric nurses.

OneCity Health anticipates experiencing a significant increased demand for community health workers, community liaisons, care managers and care coordinators. Given the expected increase in utilization of care coordination services and the high vacancy rate reported for these positions, the current gap for care managers will continue to grow.

II. Workforce Transition Roadmap

OneCity Health's Transition Roadmap Report identifies an approach to bridging workforce gaps that are expected to occur at the individual project level and combines those impacts to propose measures to address overall workforce gaps at the PPS level.

OneCity Health is developing an Integrated Delivery System ("IDS") through an expansion of interventions and resources including care management, the expansion of primary care and behavioral health capacity, and clinical improvement efforts, all of which will create new demands on the PPS workforce to support anticipated changes in health care service utilization. Additionally, as some DSRIP projects begin to reduce the use of inpatient and emergency department services and redirect patients to outpatient settings and care management services, staffing needs to support an increased demand for community-based services and potential reductions in inpatient workforce demand will need to be managed.

As part of the overall implementation approach, the PPS will take measures to minimize overall staffing reductions. OneCity Health anticipates that reductions will largely be absorbed by employee attrition and existing vacancies within the PPS's workforce. The PPS plans to help displaced staff redeploy into new positions within the existing human resources systems. All labor partners, including DC37, 1199SEIU, New York State Nurses Association and The Doctor's Council will continue to be engaged to ensure DSRIP impacts for unionized workers and the unions' other potential concerns are addressed. To support these efforts, the PPS has key union representatives as members of its Stakeholders and Workforce Committees.

The following sections address identified OneCity Health workforce gaps and documents the PPS's plans to address these gaps and transition the workforce by the completion of the DSRIP program in 2020. The PPS aims to support the development of an integrated delivery system and will emphasize the need to focus on coordination and collaboration amongst PPS partners through training, partnerships, and workforce development efforts.

A detailed work plan of key work steps and target dates for the workforce transition is included in the Appendix.

A. Central Services Organization and Workforce Governing Body

OneCity Health has identified 121 new positions in the Central Services Organization that have either been hired or are in the process of being hired. These positions will support, among many other things, the PPS's PMO around workforce planning needs as well as the PPS's care management and care coordination services.

The Workforce Committee, a subcommittee of the Stakeholder Engagement Committee, is made up of PPS partner representatives and labor representatives from across the PPS. The Workforce Committee will be key to supporting the transition of the workforce by providing input and recommendations around various workforce planning and implementation efforts. The Committee operated under the following guiding principles:

- Shared vision of healthier communities
- Improved access to quality healthcare
- Addressing the social determinants of health and well-being
- Creation of a patient-centered, community-focused delivery system
- Empowerment of patients, families, and communities
- Focus on outcomes
- Reduction of health disparities
- Meaningful collaboration
- Build and foster long-term partnerships
- Shared accountability and responsibility in this journey
- Assess the needs of workers through training and education
- A pledge in our transformation journey
- Provide honest, timely feedback to each other based on expertise and available data
- Respect everyone's perspectives and input
- Prioritize the patient experience and the success of the PPS
- Include patients, both Medicaid and uninsured, in our planning
- Acknowledge the diversity of the communities we serve

B. Care Protocol Development & Training

OneCity Health aims to implement an Integrated Delivery System (IDS) to transform healthcare delivery through an organized and collaborative network of primary, behavioral, specialty, long-term and post-acute care providers as well as through social service and

community-based providers. Additionally, the network will support seamless care transitions, care management for super-utilizers and enhanced PCMH care management staff, and enhance primary and behavioral health care across the network. The IDS goals include increasing PC/PCMH capacity through additional staffing, expanded hours of operation and increased scope of onsite services. The development of care protocols and training of frontline staff will be a key component of DSRIP implementation and the workforce transition. The Central Services Organization will assist in the development of clinical protocols and training as needed and coordinate workforce planning.

To support training development and implementation, OneCity Health executed an agreement with 1199 Training and Education Fund (TEF), which will serve as a strategic advisor to the PPS around training and other workforce planning efforts. OneCity Health will utilize 1199 TEF resources and expertise and leverage the existing training resources of its partners in the development of its training programs. The unions within the PPS currently provide a broad range of ongoing educational programs to the PPS partners including customized training materials pertaining to all allied health job titles as well as to Physicians around new models of care including PCMH and Accountable Care Organizations. OneCity Health will also procure a Learning Management system to support administration, documentation, tracking, reporting delivery and evaluation of e-learning courses and other training programs. In order to maximize quality effectiveness, OneCity Health will evaluate trainings pre-implementation through vetting processes and post-implementation through direct oversight processes with support from 1199 TEF.

The following two sections present OneCity Health's overall goals related to DSRIP workforce transformation: expanding robust, targeted care management and strengthening primary care and behavioral health services. The development and transition of the workforce in these key areas cuts across projects, as detailed below.

C. Expansion of Robust, Targeted Care Management

OneCity Health partners have been progressive in utilizing care navigators, community health workers and health coaches to meet current "non-DSRIP" needs. However OneCity Health anticipates that DSRIP will provide the opportunity to expand and enhance these roles to have meaningful impacts on their patients. As reported in the Target Workforce Report Summary and Gap Analysis Summary, DSRIP program implementation will significantly increase the demand for Care Management roles across the PPS network. The specific job titles associated with these roles may differ across care setting and organization; however the PPS has identified the need to expand its care management resources in the following areas: RN care coordinators and managers, non-registered nurse care coordinators, and community health workers, among others. To meet the demand for services, OneCity Health anticipates hiring approximately 90 additional care coordination staff, including 53 community health workers, 10 case workers (bachelor's social workers), 24 care managers and 3 licensed clinical social workers. The PPS anticipates much of this hiring will occur during DY 2. The PPS current state survey found that a majority of the existing care management workforce currently exists at partner community based partners. The PPS will leverage this workforce and community expertise to develop and expand its care management workforce as detailed in the sections below.

Across care management projects, training will be provided to ensure a core curriculum of care management skills. Trainings will focus on patient engagement, standard processes and documentation, care plan development, goal setting, chronic disease conditions, medication management, behavior change, and self-management, among other areas.

i. Project 2.a.iii: Health Home at Risk (HHAR) Intervention Program

The purpose of the Health Home-At Risk (HHAR) project is to expand access to care management services for patients who do not qualify for services from Health Homes under the current New York State Department of Health (NYSDOH) Health Home functional requirements and standards. Through this project, OneCity Health and its partners will work to extend care management services to individuals who have one chronic disease and are at risk of worsening health and who are likely to benefit from care management due to characteristics such as social risk factors.

While the care coordination roles/functions of the HHAR care managers will be the same as the Health Home care managers, it is anticipated that the services may be at a lower intensity.

In addition, the PPS and its partners will facilitate communication and coordination between primary care providers and providers of HHAR services; and enhance the integration of social services into primary care, drawing on Health Home capabilities and the OneCity Health network.

Workforce Impacts

To enhance and expand care management services and the care management workforce throughout the PPS and support the goals of Project 2.a.iii: Health Home at Risk, the PPS will partner with four NYSDOH designated Health Home lead agencies that are members of the OneCity Health PPS network. The PPS will rely on the existing Health Home infrastructure to engage additional patients through care management, leveraging the workforce that currently exists in the PPS as well as their expertise. Health Home leads may provide the service themselves or subcontract to their Care Management Agencies (CMAs) to provide services, and have been encouraged to work with those CMAs that are members of the OneCity Health Network. HHAR care managers may be centrally based at a Health Home lead agency or at a subcontracted CMA, or co-located at a primary care site. The Health Homes or CMAs may utilize existing staff, or hire and train new employees to fill these roles at their discretion. Before full implementation, the program will be piloted at three NYC H+H sites.

Training

The PPS will also work with the four Health Home lead agencies to ensure that consistent care coordination training protocols are utilized throughout the PPS. OneCity Health will implement standardized HHAR training in consultation with designated HHs. Trainings will target building competencies in: identification of patients for referral to community-based care management and effectively partnering with care coordinators. The HHAR providers will be trained to educate primary care staff on acceptance and screening of referrals, and on

coordination and navigation of medical, behavioral health and social and family support services. Partners will be trained on the GSI Health Care Management platform to document referral, outreach and enrollment data for the OneCity Health HHAR program.

ii. Project 2.b.iv: Care Transitions to Reduce 30 Day Readmissions

The Care Transitions project provides for 30-day intensified care management during the transition period after a hospitalization, for patients at high risk of readmission, with the goals of reducing hospital readmission and creating as seamless a transition as possible from hospital to community settings. OneCity Health will implement the project through the development of Transition Management Teams (TMTs). The TMTs will work closely with hospital staff and psychiatric and substance abuse peers to create a comprehensive plan for patients who are at a high risk of returning to the hospital within weeks of being discharged. OneCity Health will utilize a pilot program to implement, test, improve and expand the program throughout the PPS network. The pilot teams will be located within the inpatient setting of four OneCity Health partner hospitals and work collaboratively with the clinical teams on the in-patient units as well as the hospital care management staff. During the 30 day post-discharge, the TMTs will coordinate services with Primary Care to ensure patients have a PCP as part of their care team. In addition, TMTs will refer patients to Health Homes if criteria is met, work with the patient's MCO in order to identify additional resources and ensure that all identified goals are addressed including all social determinants of health.

The TMTs will leverage and coordinate services with the many resources that exist within the PPS network both inside and outside of the hospitals such as PCMH sites, home care, Health Homes, community based partners, physician practices and others.

Workforce Impacts

The primary immediate workforce impact relates to the need to develop Transition Teams. Transition Teams will collaborate with clinical teams and discharge planning/case management staff in order to identify appropriate discharge plans and follow up in the community. The teams, which will be provided by H+H Health and Home Care Division as well as by OneCity Health community partners, will be made up of a registered nurse, social worker, and community liaison. OneCity Health will contract with community partners to provide transition teams, where the community partner will be responsible for hiring and retaining the staff. OneCity Health also anticipates an increase in use of peer counselors within psychiatric inpatient and psychiatric emergency department settings, as part of this project.

The PPS has existing experience with care transitions models through its Project RED efforts at NYC H+H hospitals, and will build on this existing infrastructure as care transitions work expands. Care management teams will be located at all acute hospitals and will focus on working with existing Health Homes and community providers. As part of the project's estimated workforce impacts, the registered nurse care coordinators or transitional care nurses will likely be redeployed from existing jobs within the OneCity Health Hospital network.

For the Care Transition project, OneCity Health is collaborating with Bronx Partners for Communities (BPHC) and Community Care of Brooklyn (CCB) to focus on ensuring alignment

and coordination of standardized protocols and the development of common risk assessment methodologies and workforce strategies. This includes using common job descriptions and functional capabilities, workforce training efforts, data sharing and selection of culturally competent patient education resources to support this project.

Training

OneCity Health conducted GSI training for its first group of TMTs, which included program overview, identification of assessment tools to be utilized during the initial patient engagement process, and development of care plans and mandatory domains. In addition, several refresher trainings will be made available to the TMTs. All partners participating in this project will be trained on the GSI Health Care Management platform to document referral, outreach and enrollment data for the OneCity Health HHAR program since they are required to use this PPS sponsored IT platform. They will also be trained in topics such as motivational interviewing, chronic disease conditions, serious mental illness diagnosis, and health advocacy. Hospital and peer staff will receive similar and complimentary training around integrated team roles and referral processes for targeted patients.

iii. Project 2.b.iii: Emergency Department (ED) Care Triage for At-Risk Populations

The ED Triage Care project is targeted at developing an evidence-based care coordination and transitional-care program. The PPS's implementation plan for Project 2.b.iii: ED Care Triage for At Risk Populations focuses on three components for patients and providers: linkage to primary care for patients presenting at the ED for non-urgent care; provision of patient support for understanding and engaging in health condition self-management; and, improving provider communication with patients and care management transition teams. The PPS will begin project implementation at four NYC H+H facilities, targeting patients who can be redirected to primary care (with more minor illnesses) as well as those who have more complex issues and require additional follow-up, such as linkages to care management services. Patients will be linked to existing resources including Health Homes (for Health Home eligible patients), HHAR, and care transitions as previously described. Linkages to insurance are also being considered.

Workforce Impacts

To meet staffing needs associated with this project and other care management requirements, OneCity Health plans to retrain current staff and/or hire new staff as care managers, social workers, navigators, triage nurses and physician advisors. Peer care managers will be used to engage and redirect non-emergent patients who present in the ED. The PPS will leverage and expand on its current experience with ED care management, including experience from a model funded by the Centers for Medicare and Medicaid Innovation, which is currently active at five of the PPS's 12 ED sites.

Training

New and redeployed staff will be required to receive training to support implementation of PPS's developed ED triage protocols. Training will be targeted at both ED transition teams and ED staff. For ED transition teams sample training content includes: team roles in transition management, effective interaction with hospital clinical staff and care management for common causes of ED revisit or hospitalization. Sample training content for ED staff includes: effective identification of patients at high risk of potentially preventable readmission, referral processes for transition management and role definition and effective collaboration with transition management teams.

iv. Project 2.d.i: Patient Activation

The Patient Activation project focuses on uninsured and Medicaid beneficiaries who are not utilizing or underutilizing the health care system, and works to engage these individuals to utilize primary and preventive care services. OneCity Health will initially focus on patients with chronic illness, immigrants, and the undocumented. Project goals include closing gaps in care identified by the PPS Community Needs Assessment, and improving outcomes of uninsured and low and non-utilizing Medicaid beneficiaries in the PPS service area. OneCity Health will focus on outreach and patient identification, eligibility determination, and enrollment in healthcare coverage, with the overall goal of maximizing patient activation and education, and enhancing community and provider linkages to care for all patients.

Workforce Impacts

The PPS will leverage existing provider and community-based staff to improve patient engagement, strengthen existing partnerships and develop new partnerships with primary care and preventive services. The PPS has identified partners capable of conducting outreach and engagement to administer the Insignia PAM-10 survey as well as to connect them to primary care and other outreach efforts. The PPS anticipates that a large portion of new hires or redeployed staff will be non-registered nurse care coordinators hired by community partner organizations participating in the Patient Activation Project.

Training

The PPS will leverage existing OneCity Health partners interested in and capable of delivering training on the Insignia Patient Activation Measure 10-question survey (PAM-10), a product of Insignia Health; and/or conducting outreach and engagement to administer the Insignia PAM-10 survey to uninsured individuals and low utilizing or non-utilizing Medicaid members.

D. Strengthen Primary Care & Behavioral Health

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

As presented in the Target State Report and Gap Analysis Report, it is anticipated that as DSRIP projects are implemented and more patients are connected to

primary/preventive/behavioral health care, there will be an increase in demand for primary care services. The target state analysis projected an additional demand for 88 PCPs across the PPS network resulting from project implementation. Additionally, general population growth and trends primarily associated with the growth in the Medicare population and expanded medical insurance coverage under the ACA may increase demand by an additional 108 PCPs, totaling approximately 200 FTEs. This will also increase demand for administrative support (360) and clinical support staff (including medical assistants), 343 FTEs, which will be required in primary care and other outpatient settings to support primary care and behavioral health expansion.

Project 2.d.i: Patient Activation will likely contribute to this increased workforce demand as an estimated 55,000 uninsured and Medicaid recipients previously not utilizing, underutilizing or inappropriately using the healthcare system are engaged. New access will likely increase service demand for primary care, behavioral health and some specialty care, and reduce inappropriate ED use and hospitalizations.

Further exacerbating this gap is the high vacancy rate identified by PPS partners for primary care physicians as well as a state-wide shortage.

For example, the ED Triage project will likely increase primary care utilization and the demand for PCPs and support staff. Specifically, the project will establish a 24/7 central telephone triage program that will employ telephone nurses and physician advisors and include the potential extension of hours of operation at some primary care providers, further stressing demand in the network.

Through the ED Care triage project, the PPS will work to increase PCP and PCMH capacity through increasing hours of operation and providing on-site services and convenient access points for patients in lower-cost care settings.

NYC H+H, OneCity Health's largest partner, has been continually identifying site-specific staffing needs across the network and actively recruiting for these positions. Further, the implementation of care teams that can be leveraged to support PCP providers will be utilized to allow PCPs to operate at the top of their license to support primary care expansion requirements across relevant projects.

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

The project to integrate primary care services with mental health and substance abuse services is targeted at optimizing care coordination for patients who require behavioral services. The PPS will use the following implementation strategies in achieving this: 1) increasing the physical co-location of behavioral health providers into primary care sites, 2) co-locating primary care services at behavioral health sites and 3) improving access to collaborative treatment (IMPACT) model for depression across the PPS service area. Achieving project goals will place additional demands on the already stressed behavioral health workforce by increasing access to behavioral health services. Modeling results detailed in the Target State Report suggest a corresponding rise in BH care providers and associated support staff FTEs.

To support PPS partners with the two models for co-location, the PPS will engage a vendor with specific expertise in behavioral health/primary care integration to provide participating primary care and behavioral health sites (Article 28, Article 31, and Article 32) with expertise in local design and implementation planning. This vendor will provide support to partners around staffing planning and workflow including: reviewing current staffing models, considering options for new staffing models that meet integration goals, changing the mix of position types, changing the roles/job descriptions for various positions, and implementing telemedicine services.

Workforce Impacts

The PPS' primary care sites, Diagnostic and Treatment Centers and Federally Qualified Health Centers look-alikes, will work to integrate behavioral health services to improve the delivery of care to underserved communities. As part of the PPS's project implementation plans, workforce needs with regards to recruitment and training have been identified for Behavioral Health providers including licensed clinical social workers and administrative support to support increased patient visits, counselors, therapists, psychiatrists, and peer counselors. Implementation of the IMPACT model requires that primary care teams provide dedicated staffing for the role of the depression care manager, as well as identify a consulting psychiatrist.

In order to increase behavioral health capacity, the PPS plans to expand the behavioral health clinical workforce as well as maximize utilization of current behavioral health resources by identifying potentially underutilized resources. The PPS's projected increase in staffing requirements is estimated to start in DY2 with the greatest impacts anticipated during DY4.

Training Plans

Training will support the integration of mental health and substance abuse services and primary care. Trainings will be developed and provided for the PPS's behavioral health workforce including primary care providers, depression care managers, psychiatrists, and other PPS care team partners implementing the IMPACT (Improving Mood – Promoting Access to Collaborative Treatment) model. In addition, the PPS will develop a consistent training and communication strategy, including training materials that pertain to project goals as well as the adoption and use of EHR systems, to ensure screenings are being captured consistently and electronically.

i. Project 3.b.i: Cardiovascular Disease (CVD) Management for Adults Activities

The cardiovascular disease management project will support primary care teams in the implementation of best practices for cardiovascular disease management. This project will address major cardiovascular disease (CVD) risk factors in New York City. The PPS will disseminate and provide training support to leverage a variety of evidenced-based best practices for primary care teams to implement. These include: clinical guidelines around hypertension, smoking cessation, aspirin use and cholesterol management; blood pressure

measurement techniques; registry management; support for patient self-management and medication adherence; documentation of self-management plans; and, management of home-based blood pressure monitoring.

Workforce Impacts

The PPS anticipates that primary workforce impacts will be related to the need to hire or train additional certified CVD educators (or other staff support to meet this need). OneCity Health is using collaborative care nurses (non-care management) to complete the blood pressure monitoring part of the CVD management program, and plans to train existing nurses for monitoring. This increase in demand may occur initially in DY2 but will become amplified in DY4 and DY5.

Training

Training is targeted at primary care teams among our PPS partners. Much of this project's impact on workforce will revolve around the training/re-training of existing PCMH staff on relevant clinical workflows and standards. Many OneCity Health partners have educators in place at their facilities who train on evidence-based clinical guidelines. OneCity Health will leverage and integrate that whenever possible. The PPS will train existing staff in guidelines and, where appropriate, how to support development and/or expansion of roles and duties on CVD teams. In an effort to facilitate better care coordination for the CVD patients, OneCity Health Services will train workforce to track population outcomes through clinical registries and to identify and effectively coach patients to achieve adherence and self-management for their blood pressure or cholesterol management.

ii. Project 3.d.ii: Asthma Home-Based Self-Management

Project 3.d.ii: Asthma Home-Based Self-Management targets improving asthma control in order to help people with asthma live healthier lives and reduce avoidable emergency room use and hospitalizations related to asthma. To achieve this, the PPS will implement an integrated asthma management program that includes home-based services. Key strategies and components include: reduction of home environmental triggers; use of patient self-management and self-monitoring; targeting and tracking of medication use; effective medical follow-up of patients to reduce avoidable ED and hospital care. OneCity Health's asthma self-management program will initially focus on the pediatric and adolescent populations. Additionally, The PPS plans to implement evidence-based clinical guidelines for asthma management at each PCMH site, increase PCP capacity, and reinforce asthma management capabilities within primary care teams at PPS Partner sites, including certified asthma educators. Community health workers will be deployed to assist patients and their families with asthma management, including through the provision of home visits. Home remediation services will be contracted for separately for patients and their families who require these services in order to mitigate allergens and irritants in the home that are worsening asthma control.

OneCity Health recognizes the importance of extending environmental assessments beyond individuals' homes to the other environments in which they spend a high percentage of their time, such as the home, workplace, and correctional settings. As part of broader workforce

and public health transformations, increased focused should be paid to these non-home environments.

Workforce Impacts

Through Project 3.d.ii: Asthma Home-Based Self-Management, the PPS plans to expand community health worker (CHW) programs for children with asthma. CHW services for children with asthma will be conducted via physical outreach (e.g. home visits) and telephonic outreach, and will include reinforcement of education on self-monitoring, medication use, and trigger reduction; home environmental assessment; coordination with other services such as primary care, specialty care, social work, social services, and care management; and tracking and reporting of metrics requested by OneCity Health. OneCity Health recognizes community health workers as trained personnel with understanding of local communities who will provide home visits in support of existing clinical, care management, and social services. OneCity Health anticipates funding the expansion of CHW programs within the partner network through the identification of partners with relevant expertise, through existing workforce, or through the use of DSRIP funds.

Additionally, OneCity Health anticipates the need to hire patient educators within the clinical environment for the implementation of the Asthma Home-Based Self-Management program. Based on the PPS's target workforce analysis' projected workforce impacts for this project, by DY5, this would require approximately 24 certified asthma educators for the provision of asthma-self management services. This increase in demand for certified asthma educators will likely be felt in DY2, assuming initial project implementation impacts, but will primarily increase starting in DY4 through to DY5 as the PPS engages increasingly more Medicaid attributed lives in asthma self-management services. Based on the current workforce state data, the PPS's network includes only 8 reported certified asthma educators.

OneCity Health expects to contract for home remediation services based on projected demand increases. These services will likely include Integrated Pest Management.

Training

OneCity Health will implement evidence-based clinical guidelines for asthma self-management practice across provider sites, including EDs, primary care and PCMH sites. The trainings are projected to be ongoing throughout DY3 and will include the development of materials as well as a communication strategy that will be issued to providers throughout the PPS's network.

The PPS is working to ensure that PPS partners engaged in providing community health workers to support project implementation demonstrate that each community health worker has received or will receive training in the following three curricula. Alternatively, the partner can demonstrate that the community health worker has received equivalent training covering the same core competencies.

- General community health worker training developed by the Community Health Network of NYC or other comparable, validated vendor. Core competencies include: Communication skills, interpersonal skills, knowledge of community services, service coordination skills, capacity-building skills, teaching skills and organizational skills.

- CHW Home Environmental Assessment Training developed by the National Healthy Home Program, which provides knowledge and skills about how to identify health hazards in the home environment.
- Asthma Management training for community health worker by the National Institute of Health or other validated asthma training curriculum for community health workers.

Community health workers, asthma educators, and other personnel will use an asthma registry to track asthma patients to document care and/or conduct disease management.

According to projections, the role of the CHW will likely expand and strengthen over the course of the 5-year DSRIP program. PPS partners already have a substantial existing CHW workforce, primarily located at community based partners throughout the network. Although the CHW role varies across PPS partners, and titles and responsibilities often depend on the organization in which the CHWs are employed, the PPS is working to provide additional clarity and consistency around CHW role definition.

As part of broader workforce shifts from inpatient to outpatient services, partners will likely see greater focus on the importance of supervision, parent/provider education, and reliance on untraditional workforce assets. Home health aides, for example, may be utilized as community health workers given their skills and assets related to cultural competency, health literacy, language as well as their already embedded role in the community.

i. Project 3.g.i: Integration of Palliative Care

Palliative care is a specialized form of medical care for individuals with serious illnesses. Its goal is to provide relief from the symptoms and stress of their condition to developing improved quality of life for both patients and their families. Focusing on pain and symptom control, communication and coordination, and family/caregiver and emotional support, palliative care allows patients and their families to understand their treatment options and develop end-of-life plans as necessary. The Palliative Care in Primary Care model will integrate palliative care skills and services into PPS primary care practices.

Workforce Impacts

It is anticipated that primary care sites will need additional staffing in order to manage the needs of patients with advanced illness and palliative care needs. This need is anticipated to be filled by mostly new hires (with some potentially retrained staff) that are not currently employed by OneCity Health. To fill this role the PPS will work with partners to provide training/coaching to members of the primary care team including on-site training, coaching, development of decision support algorithms, case conference facilitation, and/or phone consultation.

Training

The PPS will focus on providing training and education related to strengthening and enhancing primary care teams' skills and abilities in advanced illness management in primary care delivery settings. Primary care team members, including physicians, nurse practitioners, physician assistants, nurses, social workers, care coordinators, registration staff, medical

records staff and others with relevant patient-related contact, will be trained on implementation and administration of health care proxies (simple advance planning) and how to identify, manage and refer patients (and caregivers) to necessary supports and services in a holistic and culturally sensitive context.

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

For this project, OneCity Health will train school employees to screen children in middle schools for behavioral health issues. In developing educational models for adolescents and adults (e.g., parents, teachers) on Mental Health and Substance Abuse needs, OneCity Health will develop and support partnerships among health professionals, community based partners, and/or middle and high schools that have strong experience in this arena.

Workforce Impacts/Training

To implement this project the PPS has contracted with The Jewish Board of Family & Children's Services, a PPS partner in collaboration with four New York City DSRIP Performing Provider Systems (PPSs) - Bronx Health Access, Bronx Partners for Healthy Communities, Community Care of Brooklyn and OneCity Health. To support this effort, the PPS will utilize other community partners to (1) Provide trainings for staff at NYC public schools on understanding mental health and substance use and effective prevention strategies; (2) Assist staff to teach students skills for reducing high risk behaviors and to lower the stigma of mental health treatment; (3) Provide staff professional development, support, self-care and resource sharing; (4) Establish and make community referrals and linkages for students in need of treatment by providing clear and easy to use "warm hand offs" to mental health and substance use treatment; (5) Train, coach, and support school staff on effective crisis response and, when needed, assist in de-escalation of crises; and (6) Assist school staff in early identification of behavioral health issues, and/or identification of gaps in services in the school and community-based behavioral health services. The Jewish Board will provide trainings on designated curricula and school-based approaches to subcontractors, who will work to enhance the ability of school communities to meet the behavioral health needs of students and families.

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

The objective of this project is to improve HIV prevention and treatment by screening and referral of for pre-exposure prophylaxis (PrEP) eligible patients in the primary care setting. In collaboration with seven New York City PPSs, OneCity Health will implement a program focused on developing common approaches and resources to address identified gaps in HIV care spanning the New York City boroughs (Project 4.c.ii). The PPSs' HIV Collaborative include strengthening screening and linkage infrastructure, identification and treatment of PrEP-eligible patients for treatment, and enhancement of peer support programs for HIV patients. In addition, the collaborative will seek to address care gaps in terms of promoting wide-

spread screening, early intervention measures, patient engagement and education, and culturally competent care.

Workforce Impacts/Training Plans

As part of the program, the PPSs will leverage community based partners' resources to deliver effective HIV prevention programs, including community based partners' expertise in training and deploying peers to support patient efficacy and self-management. Primary care staff (including clinical providers as well as non-clinical providers who have direct contact with these patients) will be trained to identify and refer or treat patients who may benefit from pre-exposure prophylaxis. New cultural competency training will be important to improve the access and utilization of services to ensure that key issues, such as conducting effective and respectful sexual histories, are addressed.

E. Movement across Settings

If successfully implemented, multiple DSRIP projects will decrease the number of inpatient days (avoidable admissions) and avoidable emergency department visits, and increase primary care visits across the PPS network. Projected DSRIP-related staffing reductions for certain job titles, due to reduction in utilization of inpatient/ED services, may result in a decline in demand for nurses (including registered nurses, licensed practical nurses and nursing aids). This reduction in inpatient utilization and related increase in demand will likely be offset by non-DSRIP trends, including increased insurance coverage and a growing and aging population. Additionally, the DSRIP program will enhance demand in outpatient and community based settings as care is shifted. Shifting demand across settings may present the opportunity for a focus on the expansion of the workforce and training programs to support community-based care.

F. Human Resource Policies for PPS Partners

Although NYC Health + Hospitals is the lead fiduciary organization for the PPS partners, OneCity Health PPS will not be implementing any PPS-specific human resource policies or staffing requirements for its PPS partners. The PPS partners will continue human resource and workforce staffing operations based on their own existing policies and hire staff based on care needs independent of the DSRIP program. PPS partners are able to leverage the resources and expertise of the PPS network as well as workforce planning documents to support their efforts.

Additionally, the PPS will not mandate that organizations across the PPS standardize titles or consolidate roles; however to the extent it supports the goals of the DSRIP program and workforce planning, the PPS may make efforts to work within the PPS and across PPSs as well as with workforce partners to standardize job roles and responsibilities for emerging titles.

G. Cultural Competency and Health Literacy

The PPS recognizes that in order to achieve a sustainable reduction in avoidable hospitalizations and ED visits, improvement and integration of cultural competency and health literacy into all of the DSRIP projects is required. The PPS plans to develop and implement cultural competency, health literacy and health equity performance frameworks or dashboards to measure progress across the PPS network. OneCity Health has contracted with a vendor to complete a comprehensive organizational assessment to refine its health equity agenda. OneCity Health will build on the capacity of all PPS partners to deliver equitable health care services through workforce training, education, and recruitment initiatives that provide the tools needed to deliver high-quality, culturally responsive, patient-centered care to diverse populations. The PPS is in the midst of developing a detailed training strategy and execution plan, and received proper governance approval in summer 2016. The PPS will implement a three-phased approach to achieving a culturally competent workforce:

- Phase I: Assessment – Identification of key groups experiencing disparities; key factors to improve access and utilization of primary, behavioral and preventive care
    - Community Needs Assessment Refresh
    - CCHL Assessment Findings at individual, family, and provider level across the PPS
- Phase II: Intervention Design – Identification of Community-based interventions to reduce disparities, and improve healthcare access and utilization; assessments and tools to assist patients with self-management
    - Culturally relevant healthcare resource repository
    - CCHL Training Plan
    - Community-level intervention development
- Phase III: Implementation, Measurement, & Evaluation
    - Continuous Improvement cycles

Key work steps and target dates for transitioning the workforce in line with DSRIP goals are included in the Appendix.

III. Appendix: Workforce Transition Roadmap (Timeline)

Milestones and Steps	Target Completion Date	Target Completion Status
Milestone #1: Define target workforce state (in line with DSRIP program's goals	09/30/16	In Progress
Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	12/31/2015	Completed
Collaborate with cross-PPS vendor and PPS Workforce Consortium to conduct current state survey of workforce impacted by DSRIP program.	03/31/2016	Completed
Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify drivers of change to consider in target workforce analysis.	03/31/2016	Completed
Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify relevant populations and build target workforce state staffing scenarios.	03/31/2016	Completed
Convene internal and external stakeholders for discussion and input on target state scenarios.	09/30/2016	In progress
Present target-state workforce scenarios to PPS Workforce Committee for review and approval.	09/30/2016	In progress
Milestone #2: Create a workforce transition roadmap for achieving defined target workforce state	**09/30/2016**	**In Progress**
Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	12/31/2015	Completed
Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment.	03/31/2016	Completed
Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify key milestones that PPS will need to achieve workforce transition.	06/30/2016	Completed
Collaborate with cross-PPS vendor and PPS Workforce Consortium to prioritize workforce transition steps.	06/30/2016	Completed
Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify short and long term strategies to address workforce gaps; identify ability to address workforce gaps through training of existing staff or through long term strategies in partnerships with academic institutions.	06/30/2016	Completed
Collaborate with cross-PPS vendor and PPS Workforce Consortium to develop steps and corresponding timelines in order for the PPS to meet the established milestones in alignment with the DSRIP program expectations; finalize draft workforce transition roadmap.	09/30/2016	In progress
Convene internal and external stakeholders for discussion and input.	09/30/2016	In progress
Present workforce transition roadmap document to PPS Workforce Committee for review and approval.	09/30/2016	Not Started
Milestone #3: Perform detailed gap analysis between current state assessment of workforce and projected future state	**09/30/2016**	**In Progress**

Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	12/31/2015	Completed
Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment; identify key findings, patterns and themes.	03/31/2016	Completed
Collaborate with cross-PPS vendor and PPS Workforce Consortium to perform gap analysis to compare and contrast current workforce state to future workforce state.	09/30/2016	In progress
Convene internal and external stakeholders for discussion and input.	09/30/2016	In progress
Present current state assessment report and gap analysis to PPS Workforce Committee for review and approval.	09/30/2016	In progress
Milestone #5: Develop training strategy.	3/31/2017	In Progress
Based on current state assessment report and gap analysis, identify training and pipeline development needs across the PPS, by Hub.	09/30/2016	In Progress
Based on anticipated roll-out and ramp up schedule of projects by Hub, map timing of anticipated training needs within each Hub by role and by project, specific to care setting.	09/30/2016	In Progress
Conduct gap analysis of key skills required to implement new delivery models by Hub.	09/30/2016	In Progress
Identify partners within each Hub who have existing training capacity and resources to leverage.	12/31/2016	In Progress
For remaining training needs, contract with appropriate training vendors to meet identified needs.	12/31/2016	In Progress
Develop draft training and pipeline development strategy document and convene internal and external stakeholders for discussion and input, including SUNY Downstate and other partners; document may include guiding principles, timing projections, and tactics to pursue—by Hub, by care setting, and by job classification.	03/31/2017	In Progress
Present training and pipeline development strategy document to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	03/31/2017	Not Started
Present training and pipeline development strategy document to PPS Executive Committee for review and approval.	03/31/2017	Not Started
Cultural Competency & Health Literacy		
Milestone #2: Develop a training strategy focused on addressing the drivers of health disparities	**06/30/2016**	**In Progress**
Determine approach to developing PPS wide training strategy, including identifying contractors (as relevant) and developing high level requirements for training needs, taking into account unique local training needs within each of OneCity Health's hubs.	12/31/2015	Completed
In the context of overall DSRIP-related training, develop specific requirements for training plan for clinicians, focused on available evidence-based research addressing health disparities for groups identified in the OneCity Health cultural competency strategy.	03/31/2016	Completed
In the context of overall DSRIP-related training, develop specific requirements for training plans for other segments of the workforce regarding specific population needs and effective patient engagement approaches.	03/31/2016	Completed

Finalize approach to implementing cultural competency training, including contracting (as applicable).	06/30/2016	Completed
OneCity Health Executive Committee reviews and approves cultural competency training strategy document.	06/30/2016	Completed
Practitioner Engagement		
Milestone#2: Develop training/education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	06/30/2016	In Progress
Develop draft training/education plan targeting practitioners and other professional groups, designed to educate them about DSRIP and the OneCity Health quality improvement agenda.	06/30/2016	Completed
Solicit input from key partners and existing professional groups, and revise plan.	06/30/2016	Completed
Review and consensus-driven recommendation of plan by Care Models Subcommittee and Stakeholder & Patient Engagement Subcommittee.	06/30/2016	Completed
Clinical Integration		
Milestone #2: Develop a Clinical Integration strategy	03/31/2017	In Progress
Identify key training needs related to care coordination and communication tools as part of care management program planning process and in collaboration with the Stakeholder & Patient Engagement Committee.	12/31/2016	In progress
Project Specific Workforce Transition		
Project 2.a.i: IDS implementation		
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	3/31/2017	In progress
Develop objectives and components of the community outreach plan to achieve patient engagement with the PPS, taking into account the unique community needs and network capacity within each HUB.	9/30/2016	In progress
Conduct assessment of current resources in the community, by Hub.	12/31/2016	In progress
Identify the timing, resource requirements and culturally competent expertise to launch the community outreach plan.	12/31/2016	In progress
Implement the community outreach plan, within the context of the PPS care management and patient engagement strategies.	03/31/2017	In progress
Develop and implement tools to track, on an on-going basis, levels of community engagement and identify priority areas for further engagement efforts by the PPS.	03/31/2017	In progress
Project 2.a.iii: Health Home at Risk Intervention		
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	03/31/2017	Complete
Convene Clinical Leadership Team to define PPS-wide guidelines for addressing risk factor reduction and ensuring appropriate management of chronic diseases and BH/SUD comorbidities.	06/30/2016	Complete

Synthesize PPS-wide guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	06/30/2016	Complete
Review and consensus-driven recommendation of PPS- wide guidelines by Care Models Subcommittee.	06/30/2016	Complete
Refine care management plan guidelines through Hub- based planning process.	06/30/2016	Complete
Monitor use of care management plans and refine guidelines as necessary.	03/31/2017	In Progress
Define training needs around risk factor reduction and chronic disease management.	06/30/2016	Complete
Develop educational materials that are culturally and linguistically appropriate.	03/31/2017	In Progress
Identify training resources available and create a culturally and linguistically sensitive training plan around risk factor reduction and chronic disease management.	06/30/2016	Complete
Launch and roll out training program.	03/31/2017	In Progress
Project 2.b.iii: ED Triage Program		
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non- emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	09/30/2018	In Progress
Convene Clinical Leadership Team to define PPS-wide protocols for connecting patients to non-emergency PCP and needed community support resources. Synthesize guidelines.	06/30/2016	Complete
Obtain input from PAC on protocols for connecting patients to non-emergency PCP & community support resources. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	06/30/2016	Complete
Care Models Committee reviews and makes consensus- driven recommendation on protocols for connecting patients to non-emergency PCP & community support resources.	06/30/2016	Complete
Through Hub-based planning process, refine protocols for connecting patients to non-emergency PCP & community support.	06/30/2016	Complete
Define PPS training needs on protocols for connecting patients to non-emergency PCP & community support.	09/30/2016	In Progress
Develop curriculum for training on connecting patients to non-emergency PCP & community support; identify training resources and create training plan.	09/30/2016	In Progress
Launch and roll out training program.	03/31/2017	In Progress
Monitor roll out of protocols and refine as needed.	09/30/2018	In Progress
Project 2.b.iv: Care Transitions to Reduce 30 Day Readmissions		

Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	03/31/2017	In Progress
Convene Clinical Leadership Team to define PPS-wide protocols for Care Transitions Intervention Model, including partnerships with home care services and other appropriate community agencies. Synthesize guidelines.	06/30/2016	Complete
Obtain input from PAC on protocols for Care Transitions Intervention Model. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	06/30/2016	Complete
Coordinate with other PPSs in overlapping service areas to ensure consistency in transition protocols, as appropriate.	06/30/2016	Complete
Care Models Committee reviews and makes consensus- driven recommendation on protocols for Care Transitions Intervention Model.	06/30/2016	Complete
Through Hub-based planning process, refine protocols for Care Transitions Intervention Model.	06/30/2016	Complete
Define PPS training needs on protocols for Care Transitions Intervention Model.	09/30/2016	In Progress
Develop curriculum for training on Care Transitions Intervention Model; identify training resources and create training plan	09/30/2016	In Progress
Launch and roll out training program	03/31/2017	In Progress
Milestone 4: Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	03/31/2017	In Progress
Convene Clinical Leadership Team to define PPS-wide transition of care protocols that include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital. Synthesize protocols.	06/30/2016	Complete
Obtain input from PAC on protocols for early notification, transition care manager visits to patient in hospital. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	06/30/2016	Complete
Care Models Committee reviews and makes consensus- driven recommendation on protocols for early notification, transition care manager visits to patient in hospital.	06/30/2016	Complete
Through Hub-based planning process, refine guidelines protocols for early notification, transition care manager visits to patient in hospital.	06/30/2016	Complete
Define PPS training needs on guidelines for protocols for early notification, transition care manager visits to patient in hospital.	09/30/2016	In Progress
Develop curriculum for training on protocols for early notification, transition care manager visits to patient in hospital; identify training resources and create training plan.	09/30/2016	In Progress
Launch and roll out training program.	03/31/2017	In Progress
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	03/31/2017	In Progress

Convene Clinical Leadership Team to define PPS-wide policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans (updated in interoperable EHR or updated in primary care provider record). Synthesize policies and procedures.	06/30/2016	Complete
Obtain input from PAC on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders	06/30/2016	Complete
Care Models Committee reviews and makes consensus- driven recommendation on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.	06/30/2016	Complete
Through Hub-based planning process, refine policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.	06/30/2016	Complete
Define PPS training needs on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.	09/30/2016	In Progress
Develop curriculum for training on including care transition plans in the patient medical record and ensuring PCP access to care transition plans; identify training resources and create training plan.	09/30/2016	In Progress
Launch and roll out training program.	09/30/2016	In Progress
Milestone 6 Ensure that a 30-day transition of care period is established.	3/30/2017	In Progress
Convene Clinical Leadership Team to define PPS-wide policies and procedures to establish a 30 day transition of care period.	06/30/2016	Complete
Obtain input from PAC on policies and procedures to establish a 30 day transition of care period. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	06/30/2016	Complete
Care Models Committee reviews and makes consensus- driven recommendation on policies and procedures to establish a 30 day transition of care period.	06/30/2016	Complete
Through Hub-based planning process, refine policies and procedures to establish a 30 day transition of care period.	06/30/2016	Complete
Monitor roll out of policies and procedures and refine as needed.	03/31/2017	In Progress
Project 2.d.i: Implementation of Patient Activation Activities		In Progress
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	03/31/2017	In Progress
Refine approach to defining current-state coaching and patient activation activities across the PPS.	03/31/2016	Completed
Develop curriculum and training for PAM administration and coaching/activation to augment the training offered under the Insignia contract.	03/31/2016	Completed

Launch and roll-out training program for core teams of PAM administrators and PAM coaching/activation experts, with realization these groups may in some cases differ in composition.	03/31/2017	In Progress
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	09/30/2017	In Progress
Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross- partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.	03/31/2016	Completed
Develop curriculum and training for providers in "hot spot" areas on PAM administration and coaching/activation techniques such as shared decision-making, measurements of health literacy, and cultural competency to augment the training offered under the Insignia contract.	03/31/2016	Completed
Launch and roll-out training program for providers.	09/30/2017	In Progress
Project 3.a.i: Integration of Primary Care and Behavioral Health Services		
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	03/31/2017	In Progress
Convene Clinical Leadership Team to define evidence-based standards of care, including medication management and care engagement process.	09/30/2016	In Progress
Synthesize standards of care and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Work with collaborating PPSs to identify opportunities to co- develop or coordinate standards of care, as appropriate.	12/31/2016	In Progress
Review and consensus-driven recommendation of standards of care by Care Models Subcommittee.	12/31/2016	In Progress
Define PPS training needs on evidence-based standards of care.	12/31/2016	In Progress
Develop curriculum for training on evidence- based standards of care.	12/31/2016	In Progress
Launch and roll out training program.	03/31/2017	In Progress
Monitor roll out of protocols and refine as needed through Care Models Subcommittee.	03/31/2017	In Progress
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	03/31/2019	In Progress
Assess existing provider capabilities to document preventive care screening and warm hand- off in EHR. Provide guidance to partners on EHR documentation.	03/31/2017	In Progress
Define process to complete and document preventive care screening and warm hand-off in co- located sites.	03/31/2017	In Progress
Define PPS training needs on process to complete and document preventive care screening and warm hand-off in co-located sites.	06/30/2017	In Progress

Develop curriculum for training on process to complete and document preventive care screening and warm hand-off in co-located sites.	06/30/2017	In Progress
Launch and roll-out training program.	03/31/2019	In Progress
Monitor roll out and refine process as needed.	03/31/2019	In Progress
Milestone #5 Co-locate primary care services at behavioral health sites.	03/31/2019	In Progress
Define process by which to prioritize behavioral health sites for co-located primary care services (e.g., based on patient need, site readiness, need for modifications to physical plant /site).	03/31/2016	Complete
Identify behavioral health sites that will provide co-located services.	06/30/2016	Complete
As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.	12/31/2015	Complete
Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.	12/31/2016	
Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.	12/31/2016	
Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.	03/31/2017	
Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.	03/31/2017	
Identify potential regulatory issues associated with co-location of Primary Care and Behavioral Health services. Create mitigation plan for regulatory issues including applying for existing DSRIP regulatory waivers, as appropriate. Escalate regulatory concerns to State Agencies and other stakeholders, as needed.	06/30/2016	
Convene Clinical Leadership Team to define PPS-wide protocols for co-located primary care services at behavioral health sites, including staffing model and processes for interdisciplinary team communication. Synthesize guidelines.	06/30/2016	Complete
Obtain input from PAC on protocols for co- located primary care services at behavioral health sites. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	06/30/2016	Complete
Care Models Committee reviews and makes consensus-driven recommendation on protocols for co-located primary care services at behavioral health sites.	06/30/2016	Complete
Through Hub-based planning process, refine protocols for co-located primary care services at behavioral health sites.	09/30/2016	In Progress
Identify hiring needs to support co-located primary care services at behavioral health sites.	09/30/2017	In Progress
Define PPS training and onboarding needs on protocols for co-located primary care services at behavioral health sites.	09/30/2017	In Progress
Develop curriculum for training and onboarding on protocols for co-located primary care services at behavioral health sites; identify training resources and create training plan.	09/30/2017	In Progress

Launch and roll out training and onboarding program.	03/31/2019	In Progress
Pilot and roll-out co-location of primary care services at participating behavioral health sites. Monitor roll-out and refine, as needed.	03/31/2019	In Progress
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	03/31/2017	In Progress
Convene Clinical Leadership Team to define evidence-based standards of care, including medication management and care engagement process.	09/30/2016	In Progress
Synthesize standards of care and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Work with collaborating PPSs to identify opportunities to co- develop or coordinate standards of care, as appropriate.	12/31/2016	In Progress
Review and consensus-driven recommendation of standards of care by Care Models Subcommittee.	12/31/2016	In Progress
Define PPS training needs on evidence-based standards of care.	12/31/2016	In Progress
Develop curriculum for training on evidence- based standards of care.	12/31/2016	In Progress
Launch and roll out training program.	03/31/2017	In Progress
Monitor roll out of protocols and refine as needed through Care Models Subcommittee.	03/31/2017	In Progress
Milestone #9 Implement IMPACT Model at Primary Care Sites.	03/31/2019	In Progress
Define process by which to prioritize primary care sites for implementation of IMPACT model (e.g., based on patient need, site readiness including readiness for 2014 NCQA Level 3 PCMH/Advanced Primary Care Model standards).	03/31/2017	In Progress
Work with partners to document behavioral health screening and services already provided at PPS primary care sites, including primary care sites that have already implemented IMPACT model.	06/30/2017	In Progress
Identify primary care sites that will implement IMPACT model.	06/30/2017	In Progress
Define PPS training needs on IMPACT model and collaborative care standards.	03/31/2017	In Progress
Develop curriculum for training program.	03/31/2017	In Progress
Launch and roll out training program.	03/31/2017	In Progress
Launch and roll-out IMPACT model – including collaborative care standards - at participating primary	03/31/2019	In Progress
Monitor roll out of IMPACT model and collaborative care standards, ensuring compliance with program standards. Make refinements to standards as needed.	03/31/2019	In Progress
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	03/31/2017	In Progress
Convene Clinical Leadership Team to define PPS-wide guidelines.	09/30/2016	In Progress

Synthesize guidelines and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Coordinate with other PPSs to adapt/develop training materials and curricula, as appropriate.	12/31/2016	In Progress
Review and consensus-driven recommendation by Care Models Subcommittee.	12/31/2016	In Progress
Monitor and refine as needed.	03/31/2017	In Progress
Project 3.b.i: Evidenced-based Strategies to Improve Management of Cardiovascular Disease.		
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	03/31/2018	In Progress
Convene Clinical Leadership Team to define PPS-wide programs for improving management of cardiovascular disease (CVD) using evidence-based strategies in ambulatory and community care settings.	06/30/2016	Complete
Synthesize programs for improving management of CVD and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.	06/30/2016	Complete
Care Models Committee reviews and makes consensus- driven recommendation on programs for improving management of CVD.	06/30/2016	Complete
Refine programs for improving management of CVD through Hub-based planning process.	06/30/2016	Complete
Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational and staffing capacity and capabilities. Use PRAT to understand PPS capacity for implementing evidence-based strategies for improved care of CVD. Educate partners on PRAT and roll out PRAT.	12/31/2015	Complete
Analyze current state baseline data to assess existing provider capabilities for implementing evidence-based strategies for improved care of CVD. Segment providers.	03/31/2016	Complete
Identify staff needed (e.g. registry coordinator, outreach manager, data manager, pharmacist, care manager, collaborative care nurses) and location (on-site vs. centralized support), roles/responsibilities, local practitioner champions and processes for implementing evidence-based strategies for improving management of CVD. As implementation progresses, modify as needed.	09/30/2016	In Progress
Roll out, monitor, and refine rollout of evidence-based strategies for improving management of CVD, as needed.	03/31/2018	In Progress
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	03/31/2017	In Progress
Convene Clinical Leadership Team to define PPS-wide guidelines for adopting standardized treatment protocols for hypertension and elevated cholesterol that align with national guidelines.	06/30/2016	Complete
Synthesize adoption guidelines and treatment protocols, and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.	06/30/2016	Complete

Care Models Committee reviews and makes consensus- driven recommendation on adoption guidelines and treatment protocols.	06/30/2016	Complete
Refine adoption guidelines and treatment protocols through Hub-based planning process.	06/30/2016	Complete
Identify roles, responsibilities, and processes for providing standardized treatment protocols for hypertension and elevated cholesterol.	12/31/2016	In Progress
Establish contracts with partners to follow standardized treatment protocols for hypertension and elevated cholesterol.	03/31/2017	In Progress
Create training curriculum and training plan, and roll out training program.	12/31/2016	In Progress
Monitor roll out of treatment protocols and refine as needed.	03/31/2017	In Progress
Milestone #7 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.	03/31/2017	In Progress
Convene Clinical Leadership Team to define PPS-wide protocols, procedures and workflows for care coordination teams to address lifestyle changes, medication adherence, health literacy issues, and patient self-management.	06/30/2016	Complete
Synthesize care coordination clinical protocols and workflows and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	06/30/2016	Complete
Care Models Committee reviews and makes consensus- driven recommendation on care coordination protocols and workflows.	03/31/2020	Complete
Refine care coordination guidelines through Hub-based planning process.	06/30/2016	Complete
Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational and staffing capacity and capabilities. Use PRAT to understand partner capacity for coordinating care with other PPS partners to help patients manage lifestyle changes, adhere to medication as prescribed, and self-manage their care. Educate partners on PRAT and roll out PRAT.	12/31/2015	Complete
Analyze current state baseline data to assess existing provider capabilities to coordinate care with other providers. Segment providers.	03/31/2016	Complete
Identify staffing needs, roles, responsibilities, and processes of delivering coordinated care.	12/31/2016	In Progress
Contract with partners as needed.	03/31/2017	In Progress
Create training curriculum and training plan, and roll out training program.	12/31/2016	In Progress
Roll out care coordination teams, monitor performance, and refine as needed.	03/31/2017	In Progress
Care Models Committee reviews and makes consensus- driven recommendation on care coordination protocols.	06/30/2016	In Progress

Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment	03/31/2018	In Progress
Assess existing provider capabilities to provide follow-up blood pressure checks without a copayment or advanced appointment.	06/30/2017	In Progress
Define process to provide follow-up blood pressure checks without a copayment or advanced appointment.	06/30/2017	In Progress
Define PPS training needs on process to provide follow- up blood pressure checks without a copayment or advanced appointment.	06/30/2017	In Progress
Develop curriculum for training on process to provide follow-up blood pressure checks without a copayment or advanced appointment.	06/30/2017	In Progress
Launch and roll-out training program.	03/31/2018	In Progress
Monitor roll out and refine process as needed.	03/31/2018	In Progress
Milestone 10: Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	03/31/2018	In Progress
Determine IT infrastructure needed to identify patients seen routinely with repeated elevated blood pressures in the medical record but no diagnosis.	09/30/2016	In Progress
Determine clinical review process and care team roles in identifying patients needing outreach and scheduling follow up BP visit.	09/30/2016	In Progress
Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification, tracking, and automated scheduling of follow-up visits. Plan should include training requirements.	09/30/2016	In Progress
Develop a training program, roll out training program, and track those trained on identification of patients with undiagnosed hypertension.	09/30/2016	In Progress
Complete deployment of CCMS and related registries to support patient identification, tracking, and automated scheduling of follow-up visits.	03/31/2017	In Progress
Roll out, monitor and refine protocol for identifying those at-risk of HTN and use of CCMS as needed.	03/31/2018	In Progress
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	03/31/2018	Complete
Convene Clinical Leadership Team to define PPS-wide guidelines for documenting self-management goals in medical records.	06/30/2016	Complete
Synthesize guidelines and IT requirements for documenting self-management goals in medical records and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	06/30/2016	Complete
Care Models Committee reviews and makes consensus- driven recommendation on guidelines for documenting self- management goals in medical records.	06/30/2016	Complete

Refine guidelines for documenting self-management goals in medical records through Hub-based planning process.	06/30/2016	Complete
Define PPS training needs, for documenting self- management goals through person-centered methods.	06/30/2016	Complete
Develop curriculum for training on person-centered methods that include documenting self-management goals; identify training resources and create training plan.	06/30/2016	Complete
Launch and roll out training program.	03/31/2018	
Monitor referrals, follow-ups, documentation, and feedback, and refine process as needed.	03/31/2018	
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	03/31/2017	In progress
Convene Clinical Leadership Team to define PPS-wide clinical protocol and workflow for home blood pressure monitoring and follow-up support.	06/30/2016	Complete
Synthesize clinical protocol and workflow for home blood pressure monitoring and follow-up support, and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	06/30/2016	Complete
Care Models Committee reviews and makes consensus- driven recommendation on clinical protocols and workflow for home blood pressure monitoring and follow-up support.	06/30/2016	Complete
Through Hub-based planning process, refine guidelines for home blood pressure monitoring and follow-up support.	06/30/2016	Complete
Identify team capacity and roles, identify equipment vendor, create plan for equipment supply distribution and tracking, and determine IT needs for patient tracking.	03/31/20	On Hold
Define PPS training needs for making warm referrals and	03/31/20	On Hold
Develop curriculum for training on making warm referrals and the follow-up process.	03/31/20	On Hold
Identify training resources, create training plan, launch training program.	06/30/2016	Complete
Monitor referrals, follow-ups, and documentation; refine protocol as needed.	03/31/2017	
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	03/31/2017	In Progress
Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational and staffing capacity and capabilities. Use PRAT to understand partner capacity to delivery primary care to affected populations. Educate partners on PRAT and roll out PRAT.	12/31/2015	Complete
Analyze current state baseline data to assess the number of primary care providers within a PPS. Segment providers.	12/31/2015	Complete
Identify roles, responsibilities, and processes for engaging primary care providers.	12/31/2016	In Progress
Contract with primary care providers as needed.	03/31/2017	In Progress
Roll out campaign to engage primary care providers. Monitor number of PCPs in the PPS and revise campaign as needed.	03/31/2017	In Progress
Project 3.d.ii: Asthma Self-Management		

Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	03/31/2018	In Progress
Develop Asthma Baseline/Readiness Assessment Survey to identify available community medical and social service providers within the geographic areas, and understand PPS capacity for assessing patients' homes and educating patients on self-management of asthma. Educate partners and roll out survey.	12/31/2015	Completed
Use Community Needs Assessment (CNA) data and other data sources to target areas of highest need for asthma home-based self-management program.	12/31/2015	Completed
Develop an Asthma Task Force in collaboration and partnership with community's medical, social and other services providers. The Task Force will develop and update strategies for implementation, monitoring and evaluation on an ongoing basis/as needed.	12/31/2016	In Progress
Identify/develop evidence-based best practice protocols/standards for patient's home environmental assessment and home-based patient asthma self-management.	12/31/2016	In Progress
Develop/update contracts with partners to provide patient home environmental interventions, to remediate those environmental triggers.	12/31/2016	In Progress
Define PPS training needs for protocols on patient self- management and protocols for clinical providers and health educators/CHW/Care Managers. Develop curriculum for training. Identify training resources, create training plan, and launch training plan. Coordinate with collaborating PPSs, as appropriate.	In Progress	12/31/2016
Pilot home visits and follow-ups. Monitor performance, including rosters of patients who have received home-based interventions. Refine and roll out program across PPS.	In Progress	03/31/2018
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	03/31/2017	In Progress
The Asthma Task Force will convene a Clinical Leadership Team to define PPS-wide guidelines for evidence- based trigger reduction interventions. These interventions would target specifically indoor environmental management of asthma. The team will be represented with participants from multidisciplinary areas of expertise (e.g., physicians, nurses, health educators, community health workers, healthy homes, pest management, smoking counselors, social workers, legal services, NYC-DOHMH, NYCHA).	06/30/2015	Complete
Synthesize intervention guidelines and obtain input from the baseline/readiness survey.	09/30/2015	Complete
Care Models Committee reviews and makes consensus- driven recommendation on intervention guidelines, including process and workflow, to monitor proper implementation and compliance with the guidelines for connecting clients to resources for trigger reduction interventions.	12/31/2015	Complete

Refine intervention guidelines through Hub-based planning process and Asthma Task Force committee meetings.	03/31/2016	Complete
Define and monitor PPS-wide and hub-based training needs for intervention program, including providers and CBOs.	06/30/2016	Complete
Identify/Develop evidence-based, best practice education and training materials for intervention protocols for indoor trigger reductions.	09/30/2016	
Launch and roll out training program.	03/31/2017	
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	03/31/2017	In Progress
Define PPS patients' training needs for self-management including environmental assessment and self-monitoring.	09/30/2016	In Progress
Identify/Develop curriculum for training and education in asthma self-management.	09/30/2016	In Progress
Identify/Develop training resources (including online-web based) and create training plans that include patient outreach incentives, patient education materials, and patient self- monitoring tools.	12/31/2016	In Progress
Incorporate plan and materials into a pilot project before broader rollout.	12/31/2016	In Progress
Monitor training program, including the number of patients trained in both one-on-one sessions and in group sessions.	03/31/2017	In Progress
Project 3.g.i: Integration of Palliative Care into the PCMH Model		
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	03/31/2017	In Progress
Define PPS provider training needs for enhancing competence in palliative care skills and protocols.	03/31/2016	Completed
Develop curriculum for training and education in palliative care protocols tailored to the primary care setting.	03/31/2016	In Progress
Identify training resources and create training plan.	03/31/2016	In Progress
Launch and roll-out palliative care training plan	03/31/2017	In Progress
Monitor training program, including the number of providers trained.	03/31/2017	In Progress