Training Strategy Deliverable for
Montefiore Hudson Valley Collaborative (MHVC)

Yonkers, NY

06/30/2016

Document Purpose & Principles

- This document serves as the Workforce Training Strategy for the Montefiore Hudson Valley Collaborative (MHVC)

- The document addresses key questions on training the workforce such as:

  1. Who needs training?

  2. What training is required? (including whether this is individual or team based)

  3. How should MHVC operationalize for training?

  4. When should training be rolled out?

  5. What other general criteria should be addressed in training?

- This is intended to be a living document that informs the execution and implementation of training. By this we mean that this document will evolve over the remaining 4 years of DSRIP and continue to be adapted to the ground realities of implementation, funding, and other goings-on at MHVC

- This document was created by soliciting input from dozens of MHVC stakeholders and partners and was approved by the workforce committee

- The Director of Workforce and her team will be responsible for ongoing updates to this document and version control

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Executive Summary

A. Context for the MHVC Training Strategy

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

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

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

INCLUDED	EXCLUDED
1. All clinical staff training related to population health, care management from an organizational, process and technology perspective	1. Routine training that occurs today – e.g., fire safety, basic life support, etc.
2. All non-clinical staff training required for them to successfully work within this new care model and/or develop new skills needed to support the model	2. Training that only applies to Medicare or to Commercial payers
3. Training on adjacent topics such as value based contracting, performance monitoring etc.	3. Training that doesn't pertain to projects that MHVC has selected (even if it is applicable to Medicaid)
4. Training that focused on Medicaid and Uninsured – for e.g., cultural competency, health literacy etc.	4. Training of patients not included – just providers
5. Training on change management that is needed to ensure that the newly trained workforce is high-functioning	5. Vendor evaluations and selection RFPs for training vendors
6. Educational programs and tie-ups with local institutions of learning	

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

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

Data Request

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

Interviews & Discussion Forums

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

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

Training Survey

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

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C. Current State Findings

- The key current state findings most influential to development of the training strategy were as follows:

  - **Assets:** MHVC partners have some training in place internally and with vendors. About half of the partners indicated at least a part time trainer. MHVS has recently hired a full-time training specialist to support training across the network. The Montefiore CMO is a huge asset for MHVC given its extensive experience with managing the health of complex populations.

  - **Gaps:** The most significant gaps were found in the areas of behavior change, self-management support, patient centered communication skills training/ patient engagement.

  - **Positions:** New positions in the outpatient setting that focus on care navigation and coordination are in most need of robust training to function as a care team. Economies of scale may be achieved with training vendor relationships at the MHVC level vs. individual partner agreements.

  - **Constraints:** Time and backfill for staff training was expressed as a challenge; limited budget for vendor-provided training and for development of in-house training

- In conclusion, there exist a few training assets that could be leveraged if agreed to by network partners. However, given the new topic areas of care management, population health, and DSRIP program requirements, there is a clear need for a specialized vendor of training content to complement what exists in-house.

Executive Summary

D. Major Recommendations

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

Who needs to be trained?

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

What are the top training areas?

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

How should the training operating model look?

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

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E. Roadmap for Execution

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

When should training be rolled out?

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

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

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

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

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- Training Strategy

  1. Who" needs to be trained

  2. "What" training is needed

  3. "How" to operationalize the program

  4. "When" - Roadmap & Funding

  5. General Topics

- Appendix

Training Strategy Framework

The following organizational framework addresses key questions pertinent to training

Dimension	Questions Addressed

1

"Who"

Define targeted Partner employees and MHVC staff

- Which specific partner employee type will need to have training, retraining, or access to educational programs?
- What are the training implications for new roles that get created on account of DSRIP?
- What are the training implications for employees whose positions are put at risk due to DSRIP? Should these be priority employee types/areas of focus?
- How do we ensure that vendors who touch patients have the training they need?

2

"What"

General and Project Specific Training

- What are the generic training offerings needed for core topics for all network Partners and staff (e.g., DSRIP, population health, cultural competency, managing change)
- What training is project-specific, and for specific employees/staff, across the 10 DSRIP projects? What type of training will be needed for MHVC central staff members as compared to Partner employees?

For each role and project combination:

- What specific training topics are pertinent?
- What is the best medium for such training? (e.g., online, classroom)
- How frequently will it occur?
- Who could conduct this training?
- What does the current state assessment tell us? major gaps today?

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Training Strategy Framework
The following organizational framework addresses key questions pertinent to training

Dimension	Questions Addressed

3 — **"How"** — Organizing the Training Program
- What organization structure (e.g., shared service), processes, technology should be in place?
- What is the role of state programs, vendors and educational institutions?
- What 'train the trainer' capabilities are needed? What 'managerial' training capabilities are needed?
- How should training effectiveness be documented, measured, and evaluated?
- How can "lessons learned" about training implementation be shared?

4 — **"When"** — Roadmap & Funding
- What should the priority be for training? Over what timeline?
- What funding sources are anticipated for training?

5 — **General**
- What are the guiding principles that makes for effective and efficient training delivery?
- What are the elements of team based training?
- What specific training modifications are needed to account for (a) cultural differences? (b) hotspots?
- What change management practices should complement the training strategy?
- What are the top risks and mitigation anticipated?

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1 "Who" – Goals & Assumptions

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

Objectives for this Section	**Assumptions**

Objectives for this Section

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

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

Assumptions

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

▪ We add more granularity where necessary to certain partner/MHVC staff types (e.g., depression care manager, ED navigator, Psychiatrist consultant)

▪ We recognize that not all facilities in a "facility type" contribute equally (e.g., some SNFs are more critical that others because of volumes of Medicaid patients)

▪ We will use the training roadmap to adjust for higher or lower priority (tier 2, 3 …) partners/facilities and stagger them along the training timeline

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1 "Who" – Results

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

Examples (Full List in Spreadsheet)

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

YELLOW – Med. Training Need
- Executive Staff
- Financial Staff
- Human Resources
- Social/Human Assistants
- Medical Assistants
- Laboratory Technicians
- Health IT Hardware Maintenance
- Health IT Software Programmers
- Technical Support

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

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1

"Who" - Conclusion

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

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

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

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

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

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

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"What" – Categories of Training/Education

2

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

Training General

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

Training Project Specific

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

Educational Opportunities

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

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"What" – Lists of Training

2

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

General Training

A. DSRIP 101
B. MHVC Structure & Function
C. Compliance
D. Population Health Basics

E. Cultural Competence Basics
F. Career Counseling Program

Project Specific Training

Project

For each project #1 … #10
  A. Advanced Concepts
  B. Basic Concepts

Cross-Project

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

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

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

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

Value Based Payments
  i. VBP Plan
  ii. VBP Tools

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2   "What" – Medium, Setting, and Frequency

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

Medium

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

Not Mutually Exclusive

- **Reading Materials (Email, Letter):** Initial general set of reading materials (Frequently Asked Questions etc.)

- **Online (Web-based) Course:** Content delivered online with test questions embedded to check for understanding

- **Webinars:** Content delivered online that is intended for information only – not a check for understanding at the end. Can embed questions (including polling) and interactive sections

- **Classroom (Academic):** Educational programs delivered by certified educational organization (leads to certification or degree)

- **Classroom (Provider Site):** Content that involves many folks at a site; Content that requires site-specific context (e.g., PCMH, "hot spot")

- **Shadowing (on site) & Mentoring (telephone):** Real-world experiences and coaching, visiting other sites to see CM in action (IMPACT)

- **Conferences (DOH, Learning Collaboratives, MAX series):** Messages that need to be disseminated to large groups

Setting

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

- **Individual:** Self paced training typically delivered via reading assignments or online (web-based)

- **Multi-disciplinary Team:** Training conducted by an onsite instructor and onsite participants across a variety of different roles - typically roles that require coordination (see general section for additional considerations)

- **Facility/practice team Meetings:** Classroom style training usually requiring site-specific context (e.g. primary care office setting)

Frequency

- **One-time:** Default is one-time, particularly for general training

- **Periodic (Quarterly, Annual):** When training is staged across time a progressively advancing scale OR if training needs to be updated periodically

- **Ad-hoc:** As needed e.g., if results are not promising

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2 General – DSRIP 101

'Introduction to DSRIP' course applies to almost all participants

Content Topics	Delivery

Content Topics

1. **Basics:** Origin of DSRIP, Objectives & Goals, focus on VBP and sustainability

2. **Timeline:** April 2015 … through 2020; concept of DSRIP years; quarterly reports, payment schedules

3. **MHVC:** Composition, functions, measures of success, board of directors, committee and regional meetings

4. **Projects:** List of projects, High level activities in each, Measures of success (active engagement & clinical)

5. **Resources:** Links to application, implementation plan, MHVC website, DOH DSRIP pages, Mailing lists, IT support, etc.

Delivery

- **Material:** DSRIP FAQ, DOH Whiteboard videos

- **Medium:** Reading of FAQ; Online coursework, webinars, large in-person sessions

- **Frequency:** Once; with ability for student to go back and refresh

- **Trainer:** MHVC Training Coordinator, MHVC exec leadership, or Training vendor for web-based program

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

- **Effectiveness:** (1) Percent of the network that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project, committee, and network partner meetings

- **Setting:** Individual, existing facility/practice team meetings

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General – MHVC Structure & Function

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

2

Content Topics

1. **Purpose:** Articulate the vision, goals, objectives, targets of the MHVC; List short and long term vision;

2. **Organization:** Clarify governance (board, committees, workgroups and project teams); relationship between partners and the MHVC executive structure; MHVC org. structure & responsibilities. What contracting requirements are there within MHVC?

3. **Services:** What services such as IT, personnel and training assistance can the network partners expect? How does the flow of funds work from the DOH, to MHVC, to the partners? How does that differ between a safety net and non-safety net provider? Availability of shared services to help efficiently drive care improvement

4. **Resources:** Website, Newsletter, Location other resources; Meeting minutes; Funds Flow logic etc.

5. **Contact:** How and when to get in touch; Partner portal, Compliance hotline, MHVC committee and regional meetings

Delivery

▪ **Material:** Power point presentation; Practitioner Communication and Engagement Plan, DSRIP FAQ section

▪ **Medium:** Recorded webinar, online coursework, Partner portal, large in-person sessions

▪ **Frequency:** Once; with ability for student to go back and refresh

▪ **Trainer:** MHVC Training Coordinator, MHVC exec leadership, or Training vendor for web-based program. Director, HR & Workforce

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

▪ **Effectiveness:** (1) Percent of the network that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project, committee, and network partner meetings

▪ **Setting:** Individual, existing facility/practice team meetings

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2 General – Compliance

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

Content Topics

1. **Basics:** What is Medicaid waste, fraud & abuse? What are the goals of the compliance program?

2. **Contact:** Who is the compliance officer? How to contact them? Is there a hotline? Can it be anonymous?

3. **OMIG Guidance:** What are the 8 basic elements of compliance that OMIG requires? What online resources are available?

4. **Frequency:** How often for MHVC staff? Other provider partner staff? How will new guidance be disseminated?

5. **Policies & Procedures:** Code of conduct, disciplinary action, risk assessment process, system for responses, non-intimidation and non-retaliation policy, compliance champions

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP FAQ Compliance; OMIG guidance documents

- **Medium:** Recorded webinar

- **Frequency:** Once; with ability for student to go back and refresh; Ad-hoc notifications when new guidance is issued

- **Trainer:** Compliance Officer of MHVC

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

- **Effectiveness:** (1) Percent of the network that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project, committee, and network partner meetings

- **Setting:** Individual

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2 General – Population Health Basics

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

Content Topics

1. **Basics:** Impetus for healthcare reform, origin of DSRIP, chronic condition management

2. **Patient-Centered:** Consumer education, cultural competency, medical, behavioral, psychosocial needs of patient

3. **"Volume-to-Value":** Traditional Fee-for-Service financing, P4P, bundled payments, global capitation, clinical redesign

4. **Success Drivers:** Care management infrastructure, well-trained workforce, payment reform, information technology, effective registry management and gap closure processes

5. **Resources:** Community health needs assessment, list of community-based organizations, PCP offices, etc.

Delivery

- **Material:** Power Point presentation, Population Health Management Roadmap, Clinical Integration Strategy, DSRIP FAQs

- **Medium:** NYS DOH whiteboard sessions on YouTube, DSRIP webinars

- **Frequency:** Once; with ability for student to go back and refresh

- **Trainer:** MHVC Training Coordinator, MHVC exec leadership , MHVC CMO, MHVC Care Management Director, Montefiore CMO

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

- **Effectiveness: Effectiveness:** (1) Percent of the network that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project, committee, and network partner meetings (4) Increased collaboration with community-based organizations

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

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2   General – Cultural Competence Basics

'Cultural Competence' course applies to all participants in the MHVC

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

2

General – Career Counseling Basics

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

Content Topics

1. **Basics:** Purpose of DSRIP, impact on current and future positions, high-level workforce strategy

2. **Job Types:** Emphasis on care coordination, social work, and community health worker positions

3. **Beyond Positions:** Expectations for compensation and benefits, DSRIP timeline

4. **Content:** New skills or competencies required, where to access training, how to access resources. Network-wide Job posting board. Redeployment pool function. How to access Rapid response case management which includes: career counseling, job search assistance for non-union workers, employment workshops and support to help employees cope

5. **Educational Resources:** Montefiore School of Nursing, St. John's Riverside Hospital's Cochrane School of Nursing, Mercy College and other private colleges, high schools, City University of New York, State University of New York, the 1199 Training and Education Fund

6. **Additional Resources:** SEIU 1199 training and employment fund (TEF) team, MHVC training fund, Phipps Neighborhood Career Network

Delivery

- **Material:** [Pre-read] DSRIP FAQ's, NY DSRIP workforce strategy webinar,

- **Medium:** Webinar, classroom training (provider), workshops

- **Frequency:** One-time with periodic updates to general information, ongoing access to targeted counseling available as needed

- **Trainer:** Director, HR & Workforce

- **Reporting:** MAPP tool, online logs, paper-based method to show attendance in training sessions

- **Effectiveness:** (1) Percent of network that took the course (2) Results of participant survey, (3) Number of retained employees, number of employees redeployed across MHVC, new hires made

- **Setting:** Individual

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2

Specific – Project 2.a.i
Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management

Content - Advanced	Content - Basic

Content - Advanced

- **Advanced Concepts:**

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

Content - Basic

- **Basic Concepts:**

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

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

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

2

Specific – Project 2.a.i (continued)

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

Delivery

Priority partners:

- Inpatient hospitals, focusing on safety net partners

- PCP sites , focusing on safety net partners and FQHCs

- BH inpatient and outpatient offices/ facilities

Locations - these partner types located in:

- Hot spot geographies for high volume patient population, high prevalence of clinical conditions, and high Inpatient and ED utilization

- Predominant focus on Westchester and Orange counties

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

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

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

- **Trainer:** MHVC exec staff, MHVC Board members, MHVC Partner key leaders, MHVC project managers, Care Management Learning and Innovation Center, CM training resource or vendor

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

- **Effectiveness:** (1) Percent of partner/job types that took the course compared to expected (2) Improvement in DSRIP metrics

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

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

Specific – Project 2.a.iii

2

Health Home at-risk intervention program: proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services

Content

Advanced Concepts:

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

Basic Concepts:

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

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

  - PCMH, EHR/Technology, Care Management

Delivery

- **Priority partners/ locations**: Assume that "care management hubs" will be located in high volume hot spots first. Start with PCP and FQHC partners in those locations. Most likely focused on Westchester and Orange counties, but also several key rural counties

- **Material:** Power point presentation; standard patient identification and referral protocol, standard care management workflow. DSRIP Project Toolkit description for project 2.a.iii

- **Medium:** Recorded webinar, web-based training, Learning Collaborative, in-person training, mentoring/shadowing for CMs

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

- **Trainer:** MHVC Director of Care Management, MHVC CMO, Leadership of the 2 aligned Health Homes, Montefiore CMO's project toolkit, CM training resource or vendor

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

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

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

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2

Specific – Project 2.a.iv
Create a Medical Village Using Existing Hospital Infrastructure

Content

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

Basic Concepts:

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

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

- PCMH
- EHR/Technology

Delivery

- **Priority partners/locations**: Inpatient and outpatient facilities, PCP partners, and CBOs in primary and mental health HPSAs. counties with limited crisis bed capacity, transportation resources, lab and radiology access and urgent care access – primarily Rockland, Sullivan and Orange counties

- **Material:** Power point presentation; written standards to determine type and location of services to be provided that meet the patient population definitions laid out in the DSRIP application. DSRIP Project Toolkit description for project 2.a.iv

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

- **Frequency:** Initial advanced training for key partners in priority counties. Follow-up sessions quarterly may be needed for updates on Medical Village progress and DOH reporting needs.

- **Trainer:** MHVC exec staff, MHVC CMO, Network Partner key leaders (St Johns Riverside hospital who has done this work)

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

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

- **Setting:** Individual, participating facility leadership team

2 Specific – Project 2.b.iii
ED Care Triage for At-Risk Populations

Content

Advanced Concepts:

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

Basic Concepts:

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

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

Delivery

- **Priority partners/locations:** Clinical patient navigator training also a first priority. Then high volume inpatient/ED partners *"four hospitals in our network account for 38% of ER visits (St Josephs, St Lukes Cornwall, Nyack, and St Johns Riverside)"*. High volume PCP and FQHC partners affiliated with these EDs.

- **Material:** Power point presentation; standard ED navigation protocol, DSRIP Project Toolkit description for project 2.b.iii

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

- **Frequency:** Dependent on volume of material that needs to be trained on and the number of ED sites implemented. At least one follow-up session to share info on learnings/best practices.

- **Trainer:** MHVC Director of Care Management, MHVC CMO, the 2 aligned Health Homes, Montefiore CMO's project toolkit, CM training vendor, 4 partner organizations participating in the MAX Series, St. Luke's Cornwall Hospital and the Cornerstone Family Healthcare who have already done this work

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

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

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

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2 Specific – Project 3.a.i
Integration of primary care and behavioral health services

Content

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

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

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

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

- **Basic Concepts:**

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

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

Delivery

- **Priority partners/ locations**: PCP partners with embedded BH – first in high volume and hot spot locations (*behavioral health, mental health, and substance abuse hotspots were noted in Ulster, Rockland and southern Westchester counties*).   Training of Depression care managers, peer educators/bridgers/service providers

- **Material:** Power point presentation; BH and physical health standard care protocols, DSRIP Project Toolkit for project 3.a.i

- **Medium:** Learning Collaborative (managed by CMO) for models 1 and 3, separate one for Model 2. In-person training ,telephonic or web-based sessions, mentoring/shadowing for CMs

- **Frequency:** Initial session with PCP and BH sites and as much as monthly for 2 to 4 months

- **Trainer:** MHVC Director of Care Management, Key MHVC BH clinical leadership, MHCV CMO, CM training resource or vendor. Organizations currently piloting this work – CBHS and HRH

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

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

- **Setting:** Individual and Multi-Disciplinary Team (PCP and BH site teams)

2

Specific – Project 3.a.ii

Behavioral Health Community Crisis Stabilization Services

Content

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

- **Basic Concepts:**

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

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

Delivery

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

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

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

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

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

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

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

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

2 Specific – Project 3.b.i

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

Content

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

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

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

Delivery

- **Priority partner locations**: Inpatient and PCP partners in hot spot locations for CV-related Inpatient and ED utilization – Westchester and Orange counties

- **Material:** Power point presentation; standard Million Hearts campaign materials, standard self-management plan. DSRIP Project Toolkit description for project 3.b.i

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

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

- **Trainer:** Local Cardiologists, MHVC CMO, MHVC Care Management Director, Stanford Model certified trainers, MHVC Partners who have already participated in Million Hearts campaign (Hudson River Health), 1199 TEF, Care Management Learning and Innovation Center, CM training resource or vendor. Include use of peer leaders when relevant.

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

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

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

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2

Specific – Project 3.d.iii

Implementation of Evidence-Based Guidelines for Asthma Management

Content	Delivery

Content

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

- **Basic Concepts:**

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

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

Delivery

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

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

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

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

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

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

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

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

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2

Specific – Project 4.b.i

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

Content

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

- **Basic Concepts:**
What are the basic components of the program? How can a provider access information on the various support mechanisms available?

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

Delivery

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

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

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

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

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

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

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

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

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

2

Specific – Project 4.b.ii

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

Content

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

- **Basic Concepts:**

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

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

   - EHR/Technology

Delivery

- **Priority partners/locations** - cancer inpatient admission volume hotspots in northern Ulster (including Kingston), a large cluster spanning much of Rockland (from Nyack to Stony Point), and a cluster in lower Westchester. Identified Westchester and Rockland as having the highest number of cancer diagnoses.

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

- **Material:** Power point presentation; standard cancer screening guidelines, DSRIP Project Toolkit description for project 4.b.ii

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

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

- **Trainer:** MHVC Director of Care Management, MHVC CMO, MHVC CBO representatives, Human Development Services of Westchester. Montefiore CMO and 1199 Training Fund – for training modules

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

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

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

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2

Cross Project – Patient Centered Medical Home

Content Topics

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

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

Delivery

- **Priority partners/locations –** PCPs already with 2011 PCMH experience (quick wins), High volume Medicaid attribution PCP/FQHC sites

- **Material:** Power point presentation; 2014 PCMH requirements, Practice self-assessment tool, DSRIP FAQs

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

- **Frequency:** Initial intro for all PCP practices, then standard frequency (probably monthly) based on usual approach(PCMH vendor) Ad-hoc notifications when new guidance is issued

- **Trainer:** Internal MHVC PCMH training resource or PCMH training vendor, MHVC quality staff, MHVC CMO, Primary Care Development Corporation

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

- **Effectiveness: (**1) Percent of PCPs engaged in the training over time, (2) Results of participant survey

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

Cross Project – EHR/Technology

Content Topics

- **Training for data sharing (i)**
  - Consent, Privacy and Security
  - HIPAA compliance
  - Processes related to HealthlinkNY including secure direct messaging
  - Contractual obligations (e.g., participation agreement, business associate agreement, data use agreement, etc.)

- **Training for Meaningful Use best practices (ii)**
  - Meaningful Use basics
  - Accessing the health information exchange (HIE)
  - Standardized formats for clinical reporting
  - Access to self-management tools
  - Electronic submission of patient care summaries
  - Patient-controlled data

- **Training for partners on Clinical Integration (iii)**
  - Tools
  - Leveraging EHR in clinical redesign
  - Communication methods for coordination
  - Real time alerts from the RHIP when patients admitted or discharged

Delivery

- **Priority partners/locations –** All hospitals, high volume PCPs/FQHCs

- **Material:** Power point presentation; MHVC IT change management strategy and Roadmap document, Clinical Integration strategy document, EHR support strategy, RHIO connectivity strategy DSRIP FAQs

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

- **Frequency:** Dependent on volume of material that needs to be addressed in training for that partner type. May be as much as monthly for 2 to 4 months for PCP sites, or only once for other partner types.

- **Trainer:** Director - Health Information Technology, IT Vendors, HealthlinkNY

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

- **Effectiveness: (**1) Percent of network partners that took the course, (2) Percent of partners that meet Meaningful Use, (3) Results of participant survey, (4) Fewer basic questions being posed at project and large group meetings

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

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Cross Project – Care Management

2

Content Topics

- **Training for Care Management Advanced Concepts (i)**
  - Complex case management
  - Motivational interviewing, teach back, Ask-Tell-Ask
  - Medication reconciliation best practices
  - Closing care gaps
  - Self-management action plans, Brief Action Planning (BAP) and support strategies
  - Linkage to community support services
  - Exacerbation management

- **Training for Care Management Embedded Concepts: (ii)**
  - Risk stratification
  - Chronic condition management
  - Transitions of care (TOC)
  - Quality Support
  - Interdisciplinary care teams
  - Care planning

- **Care Management Tools (iii)**
  - Basic care coordination and care team communication tools (for CM and office staff)
  - Predictive modeling
  - Provider profiling
  - Telemonitoring
  - Patient portals

Delivery

- **Priority partners/locations** – Transition of care CMs first, including ED navigators (2.b.iii). CMs embedded in high volume PCP sites/FQHCs, nurses providing CM services in smaller practices

- **Material:** Power point presentation; MHVC care management structure document and standard policies/workflows, DSRIP FAQs

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

- **Frequency:** Standard CM training curriculum – over 6 to 8 weeks Higher frequency and intensity of training for CMs embedded in PCP practice sites, and for depression care manager (3.a.i).

- **Trainer:** MHVC Care Management Director, Montefiore CMO, Care Management Learning and Innovation Center, Care Management training vendor

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

- **Effectiveness:** 1) Percent of CMs that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project and large group meetings

- **Setting:** Individual and Multi-Disciplinary Team (RN, SW, Lay worker)

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Cross Project – Value Based Payments

2

Content Topics

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

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

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

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

Delivery

- **Priority partners/locations** – All participating hospitals, high volume PCP groups

- **Material:** Power point presentation; DSRIP FAQs, VBP roadmap

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

- **Frequency:** Monthly for first three months; with ability for student to go back and refresh; Ad-hoc notifications when new guidance is issued

- **Trainer:** MHVC Director, MHVC Finance lead. Facilities with experience in VBP – Montefiore

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

- **Effectiveness:** 1) Percent of network that took the course (2) Results of participant survey, (3) Percent of contracts that are based on VBP

- **Setting:** Individual and Facility/practice leadership team

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2 Cross Project – MHVC Performance Reporting

Content Topics

- **Department of Health (DOH) Concepts (i)**

  - Achievement Values
  - Quarterly Reporting
  - Domain 1 project requirements
  - Domain 2 and 3 clinical metrics
  - Actively engaged definitions

- **Medicaid Analytics Performance Portal (MAPP) Reporting Concepts (ii)**

  - Purpose of MAPP
  - Member tracking
  - Billing support
  - Provider management
  - Interoperability
  - Medicaid claims data management

- **Project Management Office Concepts (iii)**

  - DSRIP projects
  - Quarterly reporting
  - Functional committees/workgroups

- **MHVC Strategies (iv)**
  - Key concepts related to Partner network alignment, incentives, funds flow
  - Value-based payment
  - Plans to create sustainability

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP FAQs

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

- **Frequency:** Monthly for first six months; with ability for student to go back and refresh; Ad-hoc notifications when new guidance is issued

- **Trainer:** MHVC Leadership - Project Management Office, Performance Management

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

- **Effectiveness: (**1) Ability of MHVC to meet DOH quarterly reporting requirements, (2) Ability of projects to meet their expected speed and scale targets.

- **Setting:** Individual

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- Training Strategy

  1. Who" needs to be trained

  2. "What" training is needed

  3. **"How" to operationalize the program**

  4. "When" - Roadmap & Funding

  5. General Topics

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3 "How" – Training Program Operating Model
Four Key Questions

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

? *"How should the* **organization structure** *support training?"*

? *"What are the top* **processes** *that should be in place?"*

? *"What* **technology** *considerations should be addressed?"*

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

3 ❓ "How" – Training Program Organization Structure

How should the organization structure support training?

Centralized Training Organization

- MHVC will use a centralized training specialist (FTE) to organize and administer training

- Direct Report to Director of HR/ Workforce … with dotted line to MHVC Medical Director

- **Assumptions:**

1. MHVC shouldn't reinvent the training wheel – rather leverage partners and vendors to source key training content

2. MHVC shouldn't spend resources on creating a vast training bureaucracy; goal is to be lean but with some oversight

Key Functions of Centralized Organization

Included:

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

Excluded (since partners or vendors will deliver):

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

Training Content & Delivery Options

- Collaborate with Partners to deliver "gold-standard" training by reviewing existing training content and recommending minor revisions to enhance/meet requirements

- Encourage willing partner organization to open training slots for other network partners

- Negotiate with vendors on behalf of the network of partners – may increase negotiation leverage for high volume courses

- Use a "train the trainer" model to expand reach across the partner network – repeat sessions periodically to ensure sustainability of the model

- Record live sessions for replay and consider supporting with live collaboration sessions focused on key concepts and Q&A – may be most appropriate for courses that need to reach high volumes of staff

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3 ❓ "How" – Training Program Processes

What are the top processes that should be in place?

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

Considerations

1) **Keep processes lean** … minimize any non value-added overhead that creates more work than needed

2) **Ensure transparency** … e.g., partners may want to know why their employees are scheduled later in the cycle; having transparent criteria and open communication lines essential

3) **Make it easy to do the right thing** … e.g., ensure that partner trainings are conducted early mornings, late evening outside of patient hours

4) **Payments to MHVC partners** … e.g., MHVC can explore if it can link payment releases to network partners with completion of their training obligations

5) **DOH Documentation Template:** Special attention must be paid to keeping up-to-date the **training schedule** and the **training materials** templates

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3 **"How" – Training Program Technology Needs**

? What technology considerations should be addressed?

Technology plays two important roles within the 'Training Strategy'

Tracking

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

Delivery

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

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

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3 ❓ "How" – Training Program (Vendors/Network Partners)
*What is the role of **vendors** or **Network Partners**?*

Vendors

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

Network Partners

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

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3 ❓ "How" – Training Program (Academia)

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

Academia

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

NY State Programs

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

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Table of Contents

4

Roadmap & Funding
List of Pertinent Questions

Roadmap Questions

? <u>Guidelines</u>: Should providers within a 'partner type' be tiered? i.e., are all PCP sites built equal?

? What are the "quick win" training items? "regulatory" training items?

? What does the 5 year timeline look like?

Funding Questions

? How will training dollars be split among Network Partners who want to do their own training?

? When will training dollars be distributed to partners?

? How is training affected if MHVC does not receive full funding throughout five years of DSRIP?

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4 Roadmap – Guidelines

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

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

DSRIP Timeline Mandates: DSRIP requires that certain requirements be achieved by a certain timeline; MHVC may also have made similar commitments for partner implementation speed. Training should synchronize with these commitments
- For e.g., safety-net primary care practices need to be at NCQA 2014 PCMH Level 3 (or APC) by end of DY3

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

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

4

Roadmap – Quick Wins, Regulatory and Cross Project

By December 2016, early wins can be achieved

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

1. Hiring of the "training specialist" for the MHVC - completed

2. "DSRIP 101" for the entire network should be conducted via online video sessions

3. "Basics of Population Health" – online videos and series of articles

4. "Basics of Cultural Competence" – online videos and series of articles

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

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

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

1. Patient-Centered Medical Homes – Initial workshop and practice site assessments

2. Care Management – Web-based modules and external vendor expertise

3. EHR/Technology – online videos/demos and onsite training sessions for partners

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Roadmap – Vendors & Educational Institutes

4

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

Vendors

Subject Areas to consider vendors:

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

Timing to select vendors:

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

Network Partners as vendors:

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

Educational Institutes

Subject Areas to consider educational institutes:

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

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

Timing to select educational institutes:

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

Roadmap – General and Project-Specific Timeline

4

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

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

Roadmap – Cross Project Timeline

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

Training Types	D2, Q2	D2, Q3	D2, Q4	D3, Q1	D3, Q2	D3, Q3	D3, Q4	D4, Q1	D4, Q2	D4, Q3	D4, Q4	D5, Q1	D5, Q2	D5, Q3	D5, Q4
Cross Project Training															
PCMH															
PCP Tier 1 Partners															
PCP Tier 2 Partners															
PCP Tier 3 Partners															
Care Management															
Tier 1 PCP, Hospital, ED															
Tier 1 Other Facilities															
Tier 2/3 Partners															
EHR/Technology															
Tier 1 Partners															
Tier 2 Partners															
Tier 3 Partners															
MHVC Performance Reporting															
All Applicable Partners															
Value Based Payment Training															
All Applicable Partners															
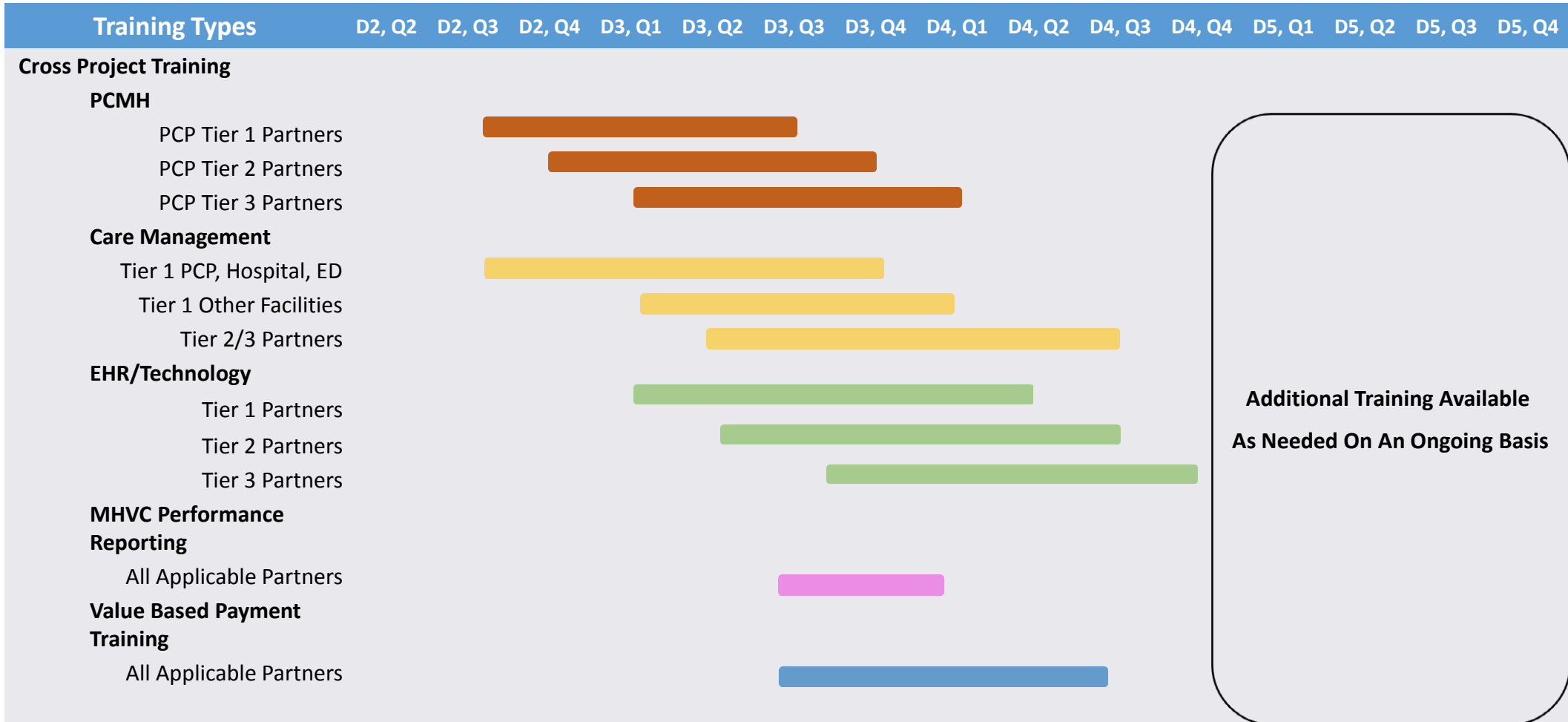
Additional Training Available

As Needed On An Ongoing Basis

Legend:
- PCMH Training
- EHR/Technology Training
- Value-based Payment Training
- Care Management Training
- MHVC Performance Reporting

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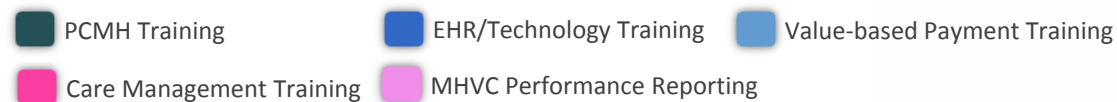
4 Roadmap – Inpatient Hospital

Tier 1 Partners

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

* Non-Safety-Net Provider
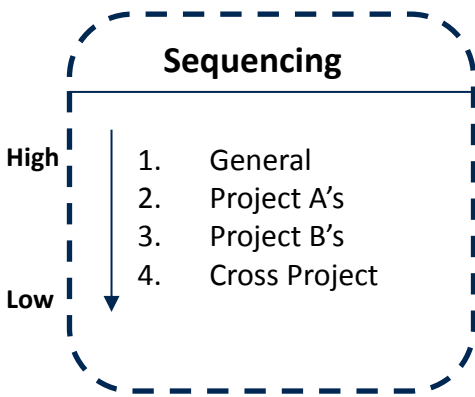
Sequencing

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

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

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

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

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

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

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

Value Based Payments
i. VBP Plan
ii. VBP Tools

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

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4 Roadmap – Emergency Department (ED)

Tier 1 Partners

1.
2.

Sequencing

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

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

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

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

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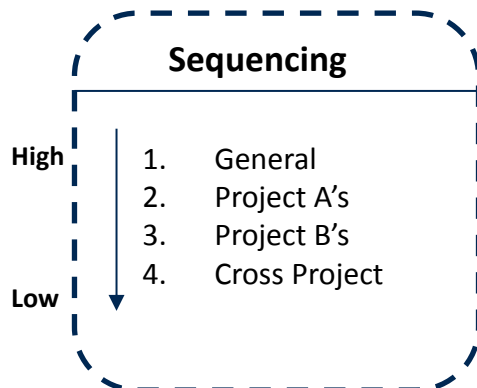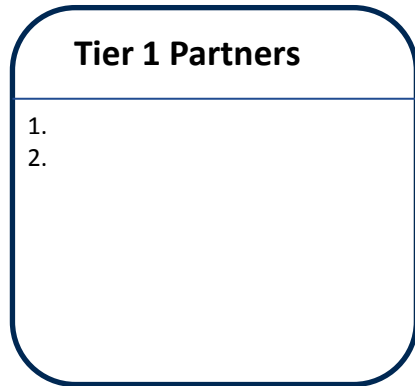iii. Clinical integration

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

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

Value Based Payments
i. VBP Plan
ii. VBP Tools

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Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

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4 Roadmap – SNF, Nursing Homes

Tier 1 Partners

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

* Non-Safety-Net Provider
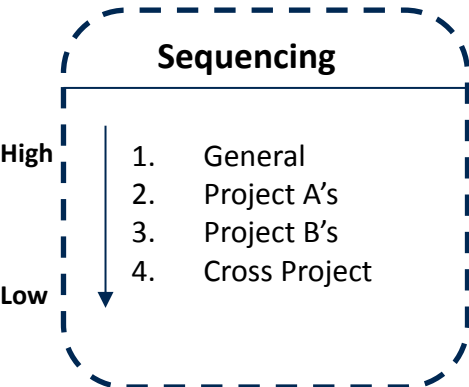
Sequencing

High

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

Low

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

B Basic Concepts

A Advanced Concepts (includes Basic materials)

- Not applicable to employee group and project

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

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

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

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

Value Based Payments
 i. VBP Plan
 ii. VBP Tools

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
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Roadmap – Behavioral Health Acute Care Hospital[59]

4

Tier 1 Partners

1.
2.

Sequencing

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

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

B Basic Concepts

A Advanced Concepts (includes Basic materials)

- Not applicable to employee group and project

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

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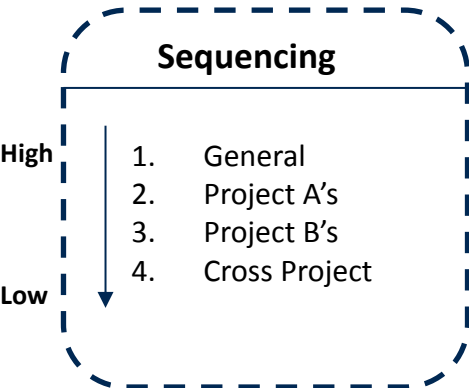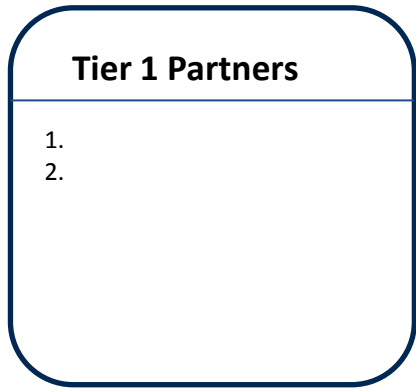iii. Clinical integration

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

MHVC Performance Reporting
i. Department of Health (DOH) Reporting
ii. Medicaid Analytics Performance Portal (MAPP)
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iv. MHVC strategies

Value Based Payments
i. VBP Plan
ii. VBP Tools

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

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4 Roadmap – Outpatient BH (Article 31, 32)

Tier 1 Partners

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

Sequencing

High

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

Low

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

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

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

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

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

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

Value Based Payments
  i. VBP Plan
  ii. VBP Tools

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

Roadmap – Diagnostic Treatment Centers (Article 28)

4

Tier 1 Partners

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

Sequencing

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

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

B Basic Concepts
A Advanced Concepts (includes Basic materials)
– Not applicable to employee group and project

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

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

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

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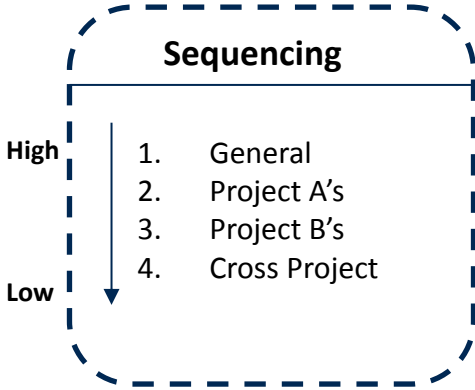iv. MHVC strategies

Value Based Payments
i. VBP Plan
ii. VBP Tools

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

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4 Roadmap – Hospital OP Clinics (Article 28)

Tier 1 Partners

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

Sequencing

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

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

B Basic Concepts
A Advanced Concepts (includes Basic materials)
– Not applicable to employee group and project

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

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

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

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

Value Based Payments
i. VBP Plan
ii. VBP Tools

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

Montefiore HUDSON VALLEY COLLABORATIVE

4 Roadmap – OPWDD Clinics (Article 16)

Tier 1 Partners

1. Jawonio Inc.
2. Access

Sequencing

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

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

B Basic Concepts
A Advanced Concepts (includes Basic materials)
– Not applicable to employee group and project

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

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

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

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

Value Based Payments
i. VBP Plan
ii. VBP Tools

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

Montefiore HUDSON VALLEY COLLABORATIVE

4 Roadmap – Primary Care Practice

Tier 1 Partners

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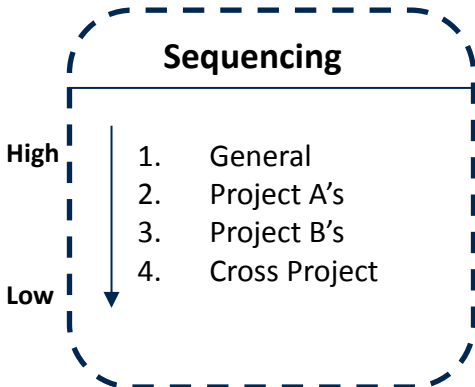
Sequencing

High

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

Low

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

B Basic Concepts

A Advanced Concepts (includes Basic materials)

- Not applicable to employee group and project

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

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

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

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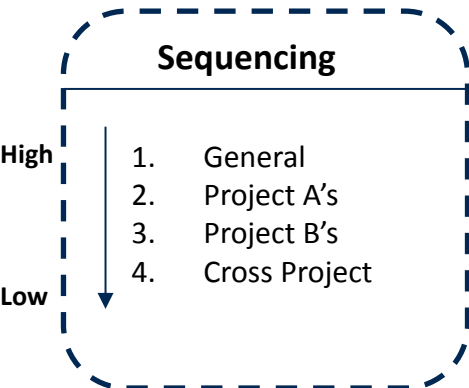 iii. Project Management Office (PMO) Concepts
  iv. MHVC strategies

Value Based Payments
  i. VBP Plan
  ii. VBP Tools

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

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4 Roadmap – Non-PCP Physician Practice (Specialist)

Tier 1 Partners

1.
2.

Sequencing

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

Employee Group	Project-Specific										Cross Project				
	2a1	2a3	2a4	2b3	3a1	3a2	3b1	3d3	4b1	4b2	PCMH	EHR	CM	MHVC	VBP
1. Non-PCP Exec. Leadership	A	B	B	B	-	-	A¹/B	A²/B	A	B	-	i, ii	i	i	i, ii
2. Clinical staff (MDs. NP, etc.)	A	B	B	B	-	-	A¹/B	A²/B	A	B	-	i, ii, iii	i	-	i
3. Nursing Leadership	A	B	B	B	-	-	A¹/B	A²/B	A	B	-	i, ii, iii	i	-	i
4. Nursing staff (RN, LPN, MA)	B	B	B	B	-	-	A¹/B	A²/B	B	B	-	i, ii	-	-	i
5. Office Administrative Staff	-	-	-	-	-	-	-	-	-	-	-	i, ii	-	-	-
6. HIT Support Leader	A	-	-	-	-	-	-	-	-	-	-	i, ii	-	-	i, ii

B Basic Concepts
A Advanced Concepts (includes Basic materials)
- Not applicable to employee group and project
¹ **Cardiology offices**
² **Pulmonology, Allergy/Immunology offices**

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

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

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

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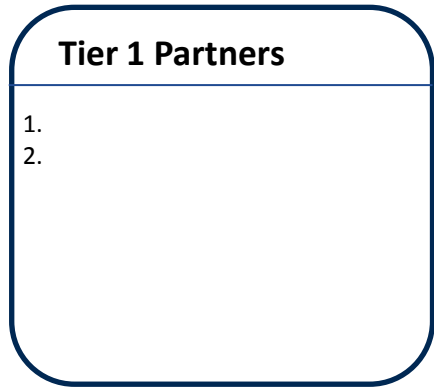iii. Project Management Office (PMO) Concepts
iv. MHVC strategies

Value Based Payments
i. VBP Plan
ii. VBP Tools

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

4 Roadmap – Health Homes

Tier 1 Partners

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

Sequencing

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

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

B Basic Concepts
A Advanced Concepts (includes Basic materials)
– Not applicable to employee group and project

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

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

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

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

Value Based Payments
i. VBP Plan
ii. VBP Tools

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

4 Roadmap – Home Care

Tier 1 Partners

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

* Non-Safety-Net Provider

Sequencing

High

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

Low

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

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

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

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

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

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

Value Based Payments
  i. VBP Plan
  ii. VBP Tools

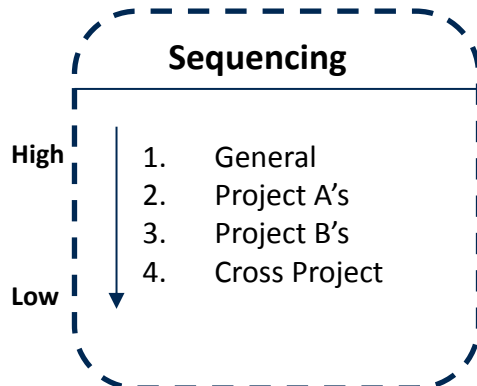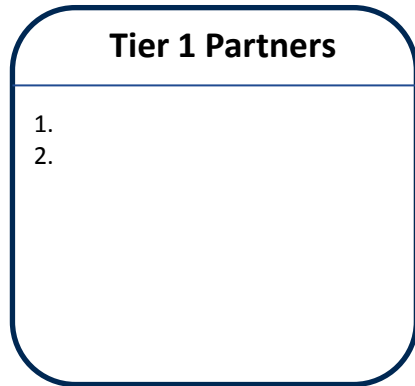Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)
Project specific training details can be found in the project specific "what" section
Cross project specific training details can be found in the cross project "what" section

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4 Roadmap – Clinical Educators, Trainers

Tier 1 Partners

1.
2.

Sequencing

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

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

B Basic Concepts

A Advanced Concepts (includes Basic materials)

- Not applicable to employee group and project

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

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

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

MHVC Performance Reporting
  i. Department of Health (DOH) Reporting
  ii. Medicaid Analytics Performance Portal (MAPP)
 iii. Project Management Office (PMO) Concepts
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Value Based Payments
  i. VBP Plan
  ii. VBP Tools

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

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4 Roadmap – CBO (Non-licensed)

Tier 1 Partners

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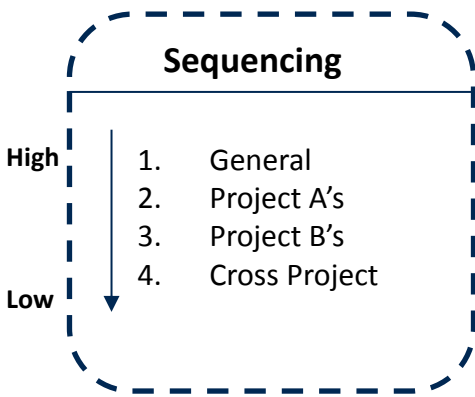
Sequencing

High

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

Low

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

B Basic Concepts

A Advanced Concepts (includes Basic materials)

– Not applicable to employee group and project

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

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

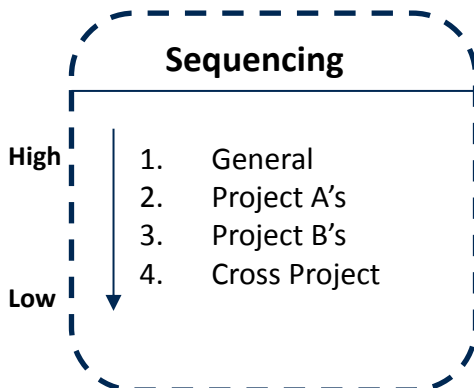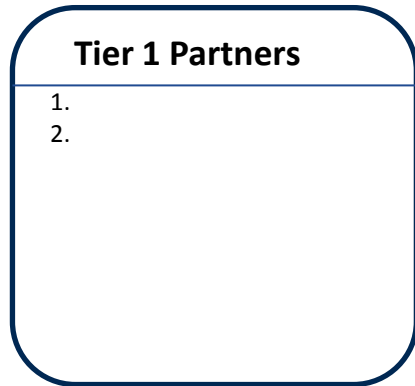**Care Management**
  i.   Care Management Advanced
  ii. Care Management Embedded
  iii. Care Management Tools

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

Value Based Payments
  i.   VBP Plan
  ii. VBP Tools

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

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4 Roadmap – MHVC Staff

Tier 1 Partners
1.
2.

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

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

Project-Specific | **Cross Project**

B Basic Concepts
A Advanced Concepts (includes Basic materials)
- Not applicable to employee group and project

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

Cultural Competency/Health Literacy Embedded Topics

4

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

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

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

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

4 # Funding Considerations

MHVC Workforce Strategy Budget

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

- Total training budget for **Retraining** across 5 years estimated at $8M, which is about 3% of the MHVC total valuation and 78% of the total workforce budget

- Vendor support for training and development of training can be costly making it advantageous to consider sharing "gold-standard" content and training resources across the partner network

- The MHVC training specialist or designee should negotiate vendor contracts on behalf of the network partners to receive the best pricing

- Training resources across the network should collaborate on training content to share the effort and cost of content creation

- Retraining dollars may be shared with partners contributing training content and/or training delivery

- Year to year retraining budget may be impact by MHVC performance and overall DSRIP funding

Table of Contents

- Executive Summary

- Training Strategy Framework

- Training Strategy

  1. Who" needs to be trained

  2. "What" training is needed

  3. "How" to operationalize the program

  4. "When" - Roadmap & Funding

  5. **General Topics**

- Appendix

5

General – Guiding Principles

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

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

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

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

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

Source: 1) Bershin

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General – Multi-Disciplinary Team Based Training

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

5

When is multi-disciplinary team based training necessary?

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

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

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

Example:

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

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5 General – Language

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

- **Key Languages:** English & Spanish

- **Language Translation Services:** Establishment of language lines in the MHVC service area for telephonic translations; training on how to access these resources should be provided

- **Training Material Translation Considerations:**

  1. Critical that when 'peer' workers from the community are hired, that essential training materials also be available in Spanish

  2. For select courses, alternate "short versions" should be created in Spanish

  3. Whether English or Spanish, the training documents should be in 5th grade reading level to accommodate literacy issues

5   General – Change Management

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

1   **Top Risks**

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

2   **Key Actors**

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

3   **Sustaining Change**

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

4   **Success Factors**

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

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5 General – Risk & Mitigation

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

Risk	**Mitigation**

Participation

We're short-staffed … can't afford to let people off for training

We've already trained them on these topics – no refresher needed

1. Have a senior executive champion for training in each provider
2. Make it easy to do the right thing (e.g., online from desk etc.)
3. Ensure training is succinct and relevant … and fun!

Resource Allocation

MHVC has a limited set of resources to establish workforce training

1. Leverage existing training that already exists within the network partners
2. Assess if network partners are willing to volunteer time and trainers
3. Prioritize the highest impact training and participants

Effectiveness

Didn't get much out of that training

It was too:
- Basic
- Academic
- High level
- Not actionable
- …

1. Invest in best practice content esp. content that uses real world experiences as training material
2. Set expectations upfront … esp. if a wide range of learners is participating in the same course

appendix

Information Sources

Data and Key Sources

Supplemented by onsite discussion groups with identified key stakeholders

Data Reviewed

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

Discussion Groups

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

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

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

Data and Key Sources
Supplemented by onsite discussion groups with identified key stakeholders

Discussion Groups

Behavioral Health (3.a.ii) Integration Workgroup
- Marilyn Morales, Cornerstone
- Amy Anderson-Winchell, Access: Supports for Living
- Amelia Gallo, Arms Acres
- Andrea Kocsis, Human Development Services of Westchester
- Nancy Magliocca, Nyack Hospital
- Kay Scott, St. John's Riverside Hospital
- Andrew O'Grady, Mental Health America of Dutchess
- Shelley Carolan, Haverstraw Pediatrics
- Daniel Miller, Hudson River Healthcare
- Ann-Marie Bentsi-Addison, Planned Parenthood Hudson Peconic
- Craig Orvieto, St. Joseph's Hospital, Yonkers
- Laurie Orfe, Montefiore Mount Vernon
- Alissa Mallow, Montefiore Medical Center
- Stephanie Turco, Gateway Community Industries, Inc.
- Natalee Hill, Montefiore Hudson Valley Collaborative
- Marilyn Wolff Diamond, Montefiore Hudson Valley Collaborative
- Damara Gutnick, Montefiore Hudson Valley Collaborative
- Pam Tripodi, St. Joseph's Hospital, Yonkers

Cardiovascular (3.b.i) Workgroup
- Ashley Brody, Search for Change
- Cornelia Schimert, VNA – Hudson Valley
- Damara Gutnick, MHVC
- Darcy Shepard, Middletown Medical
- Janeen Pendergast, Community Medical and Dental
- John Ohnmacht, St. Joseph's Hospital
- Kay Scott. St. John's Riverside
- Lisa Aaronberg, Westmed
- Marilyn Wolff Diamond, MHVC
- Mary Lackey, Planned Parenthood – Mid Hudson
- Mary Ortiz-Collazo, Nyack Hospital
- Nasir Mahmood, Pine Plains Pharmacy
- Natalee Hill, MHVC
- Richard Morel, Westmed
- Sneha Shrivastava, Cornerstone
- Sophia McIntyre, Hudson River Healthcare
- Vanessa Pratomo, Montefiore Medical Center
- Vivian Volterre, White Plains Hospital

Health Home at Risk (2.a.iii) Workgroup
- Alissa Mallow, Montefiore Medical Center
- Amie Parikh, Hudson Valley Care Coalition
- Andrew O'Grady, Mental Health America of Dutchess
- Antonia Barba, MHVC
- Avi Silber, Cornerstone
- Damara Gutnick, MHVC
- Elizabeth Hurley, Hudson Valley Community Services
- Hope Glassberg, Hudson River Healthcare
- Jackie Metakes, Orange County Department of Mental Health
- Jesse C. Sarubbi, Cornerstone
- Jillian Annunziata, Hudson River Healthcare
- John Williford, Montefiore Medical Center
- Karen Hanney, White Plains Hospital
- Katharine Burnett, Planned Parenthood – Mid Hudson Valley
- Kathleen Clay, Hudson River Healthcare
- Noel Sander, Hudson Valley Care Coalition
- Pam Tripodi, St. Joseph's Hospital
- Patricia Hewston, Middletown Medical
- Patricia Lemp, Westchester Jewish Community Services
- Rosemary A. Martino, Montefiore New Rochelle
- Saqib Altaf, Hudson Valley Community Services
- Tawana Howard-Eddings, MHVC

appendix

Detailed training content by job type

2

Specific – Project 3.a.i
Integration of primary care and behavioral health services

Detailed Content by Job Type

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

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

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

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

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2 Specific – Project 3.b.i

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

Detailed Content by Job Type

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

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

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

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

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

appendix

Current State Findings

Workforce Survey Questions

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

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

Current State - Existing Assets

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

Care Management & Population Health Training & Best Practices

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

Blood Pressure Training

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

Patient Education Training

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

Asthma Training

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

Behavioral Health Best Practices

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

Trauma Best Practices

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

Current State - Training Assets

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

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

Current State - Workforce Training Survey Results

n = 105 site participants

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

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Current State - Training Gaps

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

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

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appendix

Training Course Listing

List of Training Courses

General

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

Project Specific

- 2.a.i   Integrated Delivery System – Advanced
- 2.a.i   Integrated Delivery System – Basic

- 2.a.iii   Health Home at-risk – Advanced
- 2.a.iii   Health Home at-risk – Basic

- 2.a.iv   Create a Medical Village – Advanced
- 2.a.iv   Create a Medical Village – Basic

- 2.b.iii   ED Care Triage for At-Risk Populations – Advanced
- 2.b.iii   ED Care Triage for At-Risk Populations – Basic

- 3.a.i   Integration of PC and BH services – Advanced
- 3.a.i   Integration of PC and BH services – Basic

- 3.a.ii   BH community crisis stabilization services – Advanced
- 3.a.ii   BH community crisis stabilization services – Basic

- 3.b.i   Evidence-based strategies for disease management – Advanced
- 3.b.i   Evidence-based strategies for disease management – Basic

- 3.d.iii Evidence-Based Guidelines for Asthma management – Advanced
- 3.d.iii Evidence-Based Guidelines for Asthma management – Basic

- 4.b.i   Promote tobacco use cessation – Advanced
- 4.b.i   Promote tobacco use cessation - Basic

- 4.b.ii   Increase access to high quality chronic disease preventive care - Advanced
- 4.b.ii   Increase access to high quality chronic disease preventive care - Basic

Cross-Project

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

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