NewYork-Presbyterian
Queens

NewYork-Presbyterian/Queens PPS
PPS Workforce Training Strategy

PLAN OVERVIEW

Document Title:	NYP/Q PPS Workforce Training Strategy
Version	2.0
Purpose:	This document outlines the training strategy for the PPS including both the organizational and clinical components, curriculum examples, and mechanisms for testing competency.
Approving Committee:	Executive Committee
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NewYork-Presbyterian
Queens

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OVERVIEW

The NewYork-Presbyterian/Queens Performing Provider System (NYP/Q PPS) is comprised of partners in Queens County representing 33 of the 52 zip codes in the borough. The PPS is led by the NewYork-Presbyterian/Queens hospital and includes over 134 partner organizations. These partners represent the full healthcare spectrum, including homecare, post-acute care, hospice, pharmacies, behavioral health and substance abuse, primary care, and community based organizations. Through the DSRIP program, these organizations have come together to form a collaborative contracting entity and collaboratively transform the way in which healthcare is delivered in the community through the achievement of the DSRIP deliverables. Based on a robust community needs assessment, the PPS selected nine clinical projects to participate in along with the required organizational sections:

- Organizational Work Streams:
  - Governance
  - Financial Sustainability & Funds Flow
  - Cultural Competency & Health Literacy
  - IT Systems & Processes
  - Performance Reporting
  - Clinical Integration
  - Practitioner Engagement
  - Population Health
  - Workforce
- Clinical Projects:
  - 2.a.ii Increase certification of primary care practitioners with PCMH certification and/or Advance Primary Care Models
  - 2.b.v Care transitions intervention for skilled nursing facility residents
  - 2.b.vii Implementing the INTERACT project for SNF
  - 2.b.viii Hospital ï Home Care Collaboration Solutions
  - 3.a.i Integration of primary care and behavioral health services
  - 3.b.i Evidence-based strategies for disease management in high risk/affected populations (Cardiovascular Disease ï Adults Only)

- 3.d.ii Expansion of asthma home-based self-management program (Pediatric Only)
- 3.g.ii Integration of palliative care into nursing homes
- 4.c.ii Increase early access to, and retention in, HIV care

Each of these sections has numerous deliverables for completion by the PPS and by the PPS partners in order to achieve the goals of DSRIP and create sustainable healthcare transformation. One of the priority objectives of the PPS is to ensure that the partner organizations and their staff are ready to implement these requirements and are prepared for the paradigm shift that DSRIP is working towards. To that end, the NYP/Q PPS has developed a comprehensive strategy for training across both the organizational and clinical projects. This strategy, which will continue to evolve with the PPS, outlines the training needs for achieving these deliverables, sample curricula, and mechanisms for testing competency and effectiveness of training. The PPS aims to use this document to guide the training process across work streams and develop continued training based on the effectiveness of the plans included. This training strategy will serve to meet the following milestones for the PPS:

- Workforce
  - Milestone #4 ï Develop training strategy
- Practitioner Engagement
  - Milestone #2 ï Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda
- Clinical Integration
  - Milestone #2 ï Develop a Clinical Integration strategy

The NYP/Q PPS will also utilize the information from the compensation and benefit analysis, current state, and target state to create a gap analysis and transition roadmap for the PPS workforce. Through the development of these workforce deliverables, the PPS will continue to update the workforce-training plan and begun planning for the DY3 compensation and benefit analysis of the network. With guidance from the NYS DOH and engagement from the partners, the NYP/Q PPS will aide in supporting a well-trained and prepared workforce as healthcare in NYS moves from an inpatient and fee for service, to an outpatient value based system. The PPS

will update the plan annually based on feedback from the training sessions, needs identified by the workforce and/or project committees, and any changes to the DSRIP program.

The PPS will provide a significant amount of funding and attention to training the current workforce. Training for existing employees will include topics that are disease and/or clinical project specific, best practices, cultural competency, care coordination, PCMH physician champion training, and HIT tool training. These trainings will help the current workforce and new additions to the workforce ensure that they are meeting the growing needs of the patient population as the shift in healthcare moves from volume to value based care.

The PPS will continue to provide updates to the DOH and the Independent Assessor (IA) on the progress of the implementation and any changes to the training plan that are deemed necessary by the PPS to ensure competency and preparedness across the PPS workforce.

WORKFORCE TRAINING

DSRIP 101

Objectives & Target Audience

The NYP/Q PPS aims to train the PPS partnerôs workforce on DSRIP, including what DSRIP is, the goals of the program, the specifics of the NYP/Q PPS, how to participate, and the funds flow incentive model. The DSRIP 101 training sessions will ensure that the workforce impacted by the DSRIP initiatives are aware of the importance of the program and how this may impact their organization and their role in patient care.

Learning Objectives and Curricula

The goal of the DSRIP 101 trainings is to educate the workforce and partner organizations in three main areas; (1) DSRIP Program and Goals, (2) Projects specific to participation, and (3) funds flow and incentive payments. The PPS will be working towards these training goals through several mechanisms included in person meetings such as committee meetings, town hall meetings, and online trainings.

- **DSRIP 101 – Program Overview and Goals**
  - The PPS is providing education on the DSRIP program specific to why DSRIP is essentially to NYS and the impact it will make to both the Medicaid populations health as well as the cost for NYS. This education includes information on the overarching goals of the DSRIP program to reduce avoidable inpatient admissions and emergency department visits by 25% in 5 years. Additionally, the PPS is providing education on the structure of the NYP/Q PPS and the projects that were selected through the community needs assessment process. To date, the PPS has done this training at both clinical and organizational committee meetings, PAC committee meeting, and at town hall meetings. Additionally, the PPS distributed an introductory newsletter to partners, which is also available on the PPS website www.nyp.org/queens/dsrippps, which provides an overview of the PPS and the progress to date for all of the initiatives. The PPS will continue to provide these trainings to the PPS partners through an IT platform[1] specific to training. A DSRIP 101 module has been created by the HealthStream and will be updated and tailored to the NYP/Q PPS to ensure that the information is easily accessible to partners and provides a high-level overview on the program. This program will be rolled in coordination with the other IT platform based trainings.
- **Project Specific Training 101**
  - Similar to the DSRIP 101 training, the PPS has undertaken training specific to each of the projects for the partners participating in each. These project specific trainings are aimed at providing baseline knowledge of the goals and requirements of each project and provide a platform for in depth project specific training. These baseline trainings have taken place at committee meetings with participating providers/partners and at town hall meetings for the PPS. The PPS will continue to engage partners in these forums and through individual encounters to ensure any new participants to DSRIP have a thorough understanding of the projects that have been selected.
- **Funds Flow & Incentives 101**

[1] The NYP/Q PPS will provide sample-training curricula to the IA with the quarterly reports moving forward once the vendor contract has been executed by the PPS

- The PPS developed, in collaboration with the finance committee, a funds flow model to determine the methodology for providing partners with funding for their DSRIP activities. The funds flow model, in alignment with OMIG and DOH/IA requirements, details the principles of the PPS distribution plan as well as the activities that may trigger a payment for partners. The funds flow model has been approved by the executive committee and was communicated to partners through the committee meetings and budget development processes, town hall and PAC meetings, and the contracting process. In addition, the PPS develop an EOP (explanation of payment) which accompanies each payment that partners receive to detail the rationale for the activities that trigged payment during that period. The PPS will continue to use the contracting and onboarding process for partners to provide education regarding the funds flow methodology and eligibility for incentive payments.

PPS Milestones

The 101 trainings that are underway by the PPS lay the foundational groundwork for partners having a basic understand of DSRIP and the requirements that must be achieved for the PPS to succeed and the partners to receive incentive funding. These trainings, which have been and will be done in already existing settings such as partner meetings and town halls, enable the PPS to ensure that the workforce is ñspeaking the same DSRIP languageò. These trainings create the baseline for the following training specific milestones that are required:

- Practitioner Engagement
  - Milestone #2 ï Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.
- Workforce
  - Milestone #4 ï Develop training strategy

These trainings aim to enable the PPS to engage in more in depth training related to the specific deliverables of DSRIP to achieve the milestones, requirements and metrics of the program.

Cultural Competency & Health Literacy

The PPS cultural competency and health literacy (CC/HL) committee completed a robust strategy[2] to outline the needs of the PPS. This plan centers on embracing the principle of a óCulture of Oneô, which is a patient centric framework that respects that each individual patientôs culture is unique and a result of multiple social, cultural, and environmental factors. The framework avoids racial or ethnic stereotyping and focuses on the patient that is present for the interaction.

Objectives & Target Audience

The PPS aims to provide training specific to cultural competency and health literacy for the PPS partners and staff. The training aims to educate the workforce on what cultural competency and health literacy are and why they are important concepts for all patient interactions, not just for clinical providers. The trainings will help work towards the goal of having cultural competency and health literacy embedded into the foundation of the care provided at each of the PPS partner sites.

Learning Objectives and Curricula

NYP/Q PPS is in the process of engaging both vendors and PPS partners to complete a robust training curriculum for partners. The training will be broken into Cultural Competency and Health Literacy training plans.

- **Cultural Competency**

  The PPS has engaged HealthStream as the training vendor. The Healthstream e-learning system includes two modules specific to this topic:

  - Cultural Competency Background and Benefits ï module provides an introduction to cultural competency, compliance with all laws and regulations related to cultural competency, and how to use these skills to optimize patient care. In addition, the module will include four specific learning objectives:
    1. Distinguish the clinical outcomes associated with cultural competence vs. lack of cultural competence in the healthcare setting.

[2] PPS CC/HL strategy is available on the PPS website under the Resources tab

2. Identify laws and recommendations related to cultural competence.
3. Recognize key terms related to cultural competence.
4. List ñtypicalò characteristics of selected cultural groups.

- Providing Culturally Competent Care ï module focuses on best practices for delivering culturally competent care to patients and expands on how to optimize the patient interactions with these skills. Additionally, the module will include four specific learning objectives:
    1. Identify the assumptions you make about residents from culture groups other than your own.
    2. Recognize guidelines and best practices for improving the quality of your interactions with cross-cultural residents.
    3. Recall the components and overall goal of a trans-cultural resident assessment.
    4. Use the acronym *ADHERE* to improve resident compliance with treatment recommendations.
- PPS Developed Modules ï the PPS will develop content for Cultural Competency modules in HealthStream specific to the tools and techniques described in the Cultural Competency and Health Literacy Strategy. These include TeachBack, AskMe3, Behavioral Health Stigmas, CLAS Standards, and cultures specific to the NYP/Q PPS service area. This information will be sourced from available content within the HealthStream system, the NYP/Q PPS CNA, partner organization training content, and national best practices and standards.

The e-learning platform for these modules will allow for mass engagement as staff will able to complete these from their respective office spaces and can be incorporated into the existing annual training process. Additionally, the PPS is leveraging the in person training sessions offered by Greater New York Hospital Association (GNYHA) for partner organizations who are interested in having staff attend.

- GNYHA Cultural Competency Training ï training defies cultural competency and health disparities specific to race, ethnicity, gender identity, sexual orientation, language, disability, and end-of-life care. The training allows attendees to practice

cultural competency skills that are essential to guiding a patient through the healthcare system.

- **Health Literacy**

  The NYP/Q PPS is currently in the process of working with partner organizations on how best to leverage their internal training programs specific to health literacy. The goal of these training programs is to train both staff and the community on the importance of health literacy. The PPS will provide updates to the IA through the quarterly reporting process, as this training curriculum and frequency are determined.

- **Resource Center**

  NYP/Q PPS is collaborating with NYP PPS on the creation of a Cultural Competency and Health Literacy resource center. The center will be chaired by Dr. Emilio Carrillo, MD, MPH of New York Presbyterian.[3] The center will host webinars and trainings based on the DSRIP requirements and needs of the partner organizations.

PPS Milestones

The cultural competency and health literacy training is essential to the success of the NYP/Q PPS DSRIP program. This training impacts all of the clinical project and organizational work streams for the PPS and will ideally result in a paradigm shift in how cultural competency and health literacy is incorporated into the patient healthcare experience. Specifically, this training plan will meet the following milestone:

- Cultural Competency and Health Literacy
  - Milestone #2 ï Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).

Competency and Measurements

The PPS will include a pre- and post-competency test for the e-learning modules with HealthStream. Additionally, the PPS will monitor the decisions of NQF and OMG Think

[3] Dr. Carrilloôs Bio is available at: http://www.nyp.org/pdf/innovations_conf_carrillo.pdf

Cultural Health for progress towards determining standards/measures for the success of integrating these types of trainings into the organization. The PPS will provide updates to the IA as they become available.

IT Systems & Performance Reporting

Objectives & Target Audience

The NYP/Q PPS IT team is assisting partners with their internal IT strategies and interoperability to ensure that the PPS can meet the milestones required by DOH and the IA. The goal of the IT initiatives is to ensure that partners have access to electronic records and can both share and consume patient level data (ADT feeds) through the RHIO. The IT team has created two preliminary initiatives to begin this engagement process ï RHIO pilot and the SNF engagement. As DSRIP continues to move forward, the IT team will begin IT tool specific engagements to ensure partners are comfortable with the tools provided by the PPS for both clinical management and DSRIP reporting.

Training and Support

The PPS will offer training and/or support to staff for the IT tools that the PPS will be using.

- **IT Solutions**
  - RHIO Connectivity ï The PPS is engaging partners to join the Healthix RHIO to ensure interoperability of EHR systems. The PPS has aligned their EIP incentives with this initiative to help incentivize partners to participate with the program. Additionally, the IT team has partnered with IT staff from Silvercrest nursing home to do targeted SNF engagement. As SNFs are not eligible for Meaningful Use Incentives, not all of the facilities have technologies in place for interoperability. By partnering with the SNF IT team, the PPS will be able to provide tailored help and information for these organizations as they move through the transformation process.
  - Performance Logic ï Performance Logic is a project management tool that the PPS is utilizing. The PPS aims to roll out access to partners as a mechanism for data exchange and providing updates on the implementation progress. The PPS

will leverage the vendor training and provide PPS IT support as needed for the organizations as the roll out is phased in. The PPS aims to begin the roll out process in DY2, Q3.

- Allscripts Care Director (ACD) ï ACD is a population health management tool selected by the PPS for patient management and reporting of actively engaged patients. The PPS has completed the build of the tool with the vendor and created customized care plans based on the projects that the PPS is participating in and the actively engaged definitions. The PPS will complete a phased roll out of the tool beginning with the NYP/Q hospital during DY2, Q2.
- Cureatur Secure Messaging ï The PPS is in the process of securing a contract with the vendor to provide event notification through secure messaging for the PPS. The PPS aims to roll this tool out to primary care and home care providers in the PPS to ensure timely follow-up on any inpatient or ED admissions. The PPS will provide a detailed training plan once the vendor contracting process has been completed.
- eMOLST ï The PPS is encouraging partners to utilize the eMOLST tool for participation in the long-term care bundled projects. The PPS has engaged Dr. Patricia Bomba, MD, FACP with Excellus BlueCross BlueShield to provide training to PPS partners on how to utilize the tool most efficiently. This training will be provided based on demand by the PPS partners.

➢ **Compliance Training**

- Regulatory & HIPPA Compliance ï The PPS will utilize the HealthStream e-learning system to create a module on DSRIP regulatory and HIPPA compliance. This will be provided to partners on an annual basis and to ensure continued compliance with DSRIP.

➢ **DSRIP Metrics & Quality Improvement**

- Metrics Pay for Reporting & Pay for Performance ï The PPS has begun to introduce the DSRIP metrics into the project committee meetings and discuss the best quality improvement approach to addressing the low performers. Additionally, the PPS is hosting an in-service in late June for the PMO team, the IT team, and clinical leadership to discuss the metrics and complete a thorough

plan on how to ensure the PPS is successful on the P4P measures. The PPS will provide a more detailed update on this plan as it is developed.

PPS Milestones

The PPS training plan for the IT system and performance reporting will assist in completing four milestones:

- IT Systems and Processes
  - Milestone #2 ï Develop an IT Change Management Strategy
  - Milestone #3 ï Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network
  - Milestone #5 ï Develop a data security and confidentiality plan
- Performance Reporting
  - Milestone #2 ï Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting

CLINICALLY INTEGRATED NETWORK TRAINING

The PPS aims to offer trainings to partners based on their participation in specific projects with the PPS. These trainings will help to form the NYP/Q PPS as a clinically integrated network. In addition to the trainings for specific projects, the PPS is providing trainings on quality improvement initiatives for practitioners and staff.

2.a.ii – Patient Centered Medical Home

The NYP/Q PPS is working with partners to complete the certification process for Patient Centered Medical Home (PCMH) 2014 Level 3 standards. The PPS has engaged a vendor, HANYS Solutions, to assist partners with the transformation process.

Objectives & Target Audience

The PPS is working with PCP partners and their office staff on the PCMH transformation process. The PPS committed to having 36 providers obtain the certification and is on track to meet the project requirement by the end of DY3. The goal of the trainings for PCMH is to

ensure that the providers and care coordinators have the skills and tools they need to be successful in the PCMH model.

Speed & Scale Project Commitment Project 2.a.ii	
Project Scale	**Commitment**
Primary Care Physicians	36

Learning Objectives and Curricula

The PPS is offering two training opportunities specific to the PCMH project. These trainings, in addition to the support provided by HANYS Solutions, will help partners to complete the certification process for PCMH Level 3 2014 standards and fully embrace the shift from a primary care site to a patient centered medical home.

- **Physician Champion Training**

  The PPS hosted a physician champion training for the practices undergoing the PCMH transformation and for those that have completed the transformation but had not yet had champion training. The training focused on:

  - NCQAôs 2014 PCMH Standards
  - True Practice Transformation
  - Role of Change Management
  - Role of HIT
  - Lessons learned

  The training session was recorded so that it can be used by practices that were not able to attend or will be undergoing the PCMH transformation process in the future.

- **Care Coordination Training**

In collaboration with GNYHA, the NYP/Q PPS is hosting an all-day training session for care coordinators in the PPS. Care coordinators and those who will play a coordination role, are invited to participate in the training. The goals of the training are to:

- Learn the fundamental, evidence-based concepts for building an effective care coordination process to achieve improved outcomes.
- Discuss their roles in the medical home and the medical neighborhood, focusing on coordination opportunities within the primary care practice, as well as across the continuum of care.
- Review strategies for implementing care coordination processes within each of the members roles, and develop recommendations for implementing specific elements of team-based care coordination.
- Share roles, responsibilities, and best practices within their individual sites.

PPS Milestones

The trainings provided by the PPS will help partners to achieve PCMH certification. This will directly impact the PPSs ability to achieve the following milestones:

- Project 2.a.ii ï PCMH
  - Milestone #1 ï Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.
  - Milestone #3 ï Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.
  - Milestone #7 ï Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.
- Project 3.a.i ï Co-location of Primary Care & Behavioral Health
  - Milestone #1 ï Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.

- Project 3.b.i ï Cardiovascular
  - Milestone #3 ï Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.
- Financial Sustainability
  - Milestone #6 ï Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation

Competency and Measurements

The PPS will use the success of PCMH certification as the measurement for success with these practices.

2.b.vii – INTERACT & 2.b.viii – Home Care Collaboration

Objectives & Target Audience

The PPS will provide training to the long-term care providers participating in the INTERACT and home care project. The PPS aims to implement a train-the-trainer model by having the facility champions trained and then having the champions act as the trainers and experts at their own facilities.

Speed & Scale Project Commitment Projects 2.b.v & 2.b.vii	
Project Scale	**Commitment**
Primary Care Physicians	97
Non-PCP Practitioners	72
Hospitals	1
Skilled Nursing Facilities	27
All Other	102
SNFs participating in the INTERACT program	27

Learning Objectives and Curricula

The PPS will provide training for staff on the INTERACT and INTERACT-like tools that are required for the projects. The PPS will provide an in-person champion training to achieve the goals of a train-the-trainer, or coaching, model for the PPS. Additionally, the PPS will work with partners to ensure that patients, families, and caregivers are educated and engaged in the care planning process.

- **INTERACT & INTERACT-like Tools**

  The PPS will engage a certified INTERACT trainer to provide in person training for the SNF and Home Care INTERACT principles and tools. The learning objectives of the trainings are:

  1. Describe the current landscape of health care reform and funding that make the INTERACTÊ an essential QI initiative for post-acute and long-term care organizations
  2. Articulate the key strategies that form the foundation of the INTERACTÊ QIP
  3. Understand how to optimally utilize INTERACTÊ QIP tools and resources
  4. Define key strategies for successful INTERACTÊ QIP implementation, including how INTERACTÊ can help meet QAPI requirements
  5. Define key strategies for successfully sustaining the INTERACTÊ QIP implementation processes
  6. Measure and track organization specific INTERACTÊ QIP implementation processes
  7. Measure and track organization specific INTERACTÊ QIP hospitalization and other related outcomes
  8. Report and interpret feedback on INTERACTÊ QIP implementation and outcomes to the facility team and leadership
  9. Demonstrate an ability to effectively educate facility staff on the INTERACTÊ QIP
  10. Understand how to complete the CIC training certification process

  The PPS will train 2 champions from each partner site; (1) nursing manager and (1) staff manager.

- **Patient, Family, and Caregiver Training**

  To be successful in reducing potentially preventable readmissions, the PPS must engage the community to educate them about the care planning process. The PPS will work with long term care partners to ensure that education for the patient, family, and caregiver is incorporated into the care planning and meetings with the clinicians. The PPS will help partners develop or access educational materials as needed.

PPS Milestones

INTERACT champion training for the SNF and home care partners will enable the PPS to achieve numerous project milestones.

- Project 2.b.vii ï INTERACT
  - Milestone #4 ï Educate all staff on care pathways and INTERACT principles
  - Milestone #6 ï Create coaching program to facilitate and support implementation
  - Milestone #7 ï Educate patient and family/caretakers, to facilitate participation in planning of care
- Project 2.b.viii ï Home Care Collaboration
  - Milestone #2 ï Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.
  - Milestone #4 ï Educate all staff on care pathways and INTERACT-like principles
  - Milestone #6 ï Create coaching program to facilitate and support implementation
  - Milestone #7 ï Educate patient and family/caretakers, to facilitate participation in planning of care

Competency and Measurements

The PPS will use the DSRIP project metrics and the potentially preventable visit and readmission (PPV and PPR) rates as proxy measures for success with the training and implementation of these milestones.

3.b.i – Cardiovascular

Objectives & Target Audience

The PPS will target partners in the cardiovascular project for training related to the specific 3.b.i milestones. The PPS aims to ensure that the workforce is prepared for the new process of open access blood pressure readings and the utilization of the Million Hearts Campaign.

Speed & Scale Project Commitment Project 3.b.i	
Project Scale	**Commitment**
Primary Care Physicians	131

Non-PCP Practitioners	50
Clinics	1
Behavioral Health	1

Pharmacy	2
All Other	100

Learning Objectives and Curricula

The PPS is providing materials related to the Million Hearts Campaign, hypertension diagnosis and medication management, blood pressure check, and tobacco cessation referrals for partners.

- **Million Hearts Campaign**

  The Million Hearts Campaign, http://millionhearts.hhs.gov/, provides resources and protocols on hypertension and tobacco-smoking cessation. These protocols have been provided to participating sites for implementation by the clinical director. The PPS will offer an in service, as needed, with partners and participating sites on how to use the tools and protocols for improving patient care.

- **Blood Pressure Competency**

  The PPS has approved the competency checklist for both the manual and automatic blood pressure check. Partners will ensure that the BP competency is incorportated into their annual competency check process and provide copies of the completed certification of competency to the PPS.

PPS Milestones

The Cardiovascular training on blood pressure competency and the million hearts campaign will help the PPS to accomplish the following milestones:

- Milestone #9

  Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.

- Milestone #18

  Adopt strategies from the Million Hearts Campaign

Competency and Measurements

The PPS will request random audits and documentation of the partner blood pressure competency and utilization of the million hearts campaign. The PPS will use these samples as part of the documentation submission process for the IA quarterly reports.

3.d.ii – Asthma

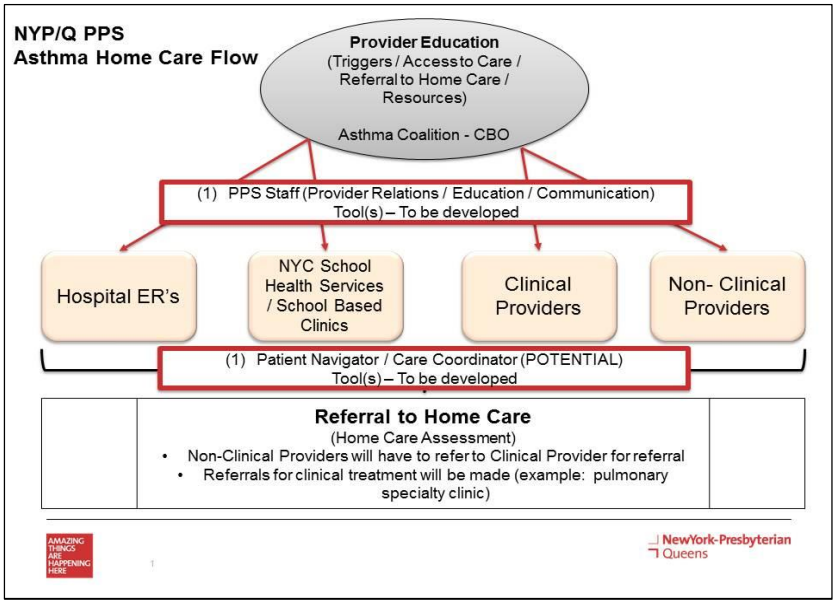
Objectives & Target Audience

The PPS has engaged a CBO partner with expertise in pediatric asthma to create an educational plan for PCPs participating in the project. Additionally, the PPS project has engaged a mental health partner with school based clinics to aide in addressing the pediatric asthma population while at school.

Speed & Scale Project Commitment Project 3.d.ii	
Project Scale	**Commitment**
Primary Care Physicians	13
Non-PCP Practitioners	14
Pharmacy	2
Community Based Organizations	1
All Other	6

Learning Objectives and Curricula

The PPS has created a home care flow to identify the entry points into the system for the target patient population and identify the high need areas for provider education.



- **Asthma Education**

  The Asthma Coalition Queens, a CBO partner, is currently in the process of creating an educational program for pediatricians and behavioral health partners to address the

pediatric asthma population. This education will include identification of asthma, common prescriptions that can be prescribed at ED presentation, how to use an asthma action plan, and the referral process for home care.

PPS Milestones

The PPS will achieve the following milestone through the proposed training plan:

- Milestone #4

  Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.

3.g.ii – Palliative Care

Objectives & Target Audience

The NYP/Q PPS has implemented a robust training program for partners who currently provide or will be providing this care to patients. The PPS has engaged clinical leadership, social workers, administrators, and providers for the training program.

Speed & Scale Project Commitment Project 3.g.ii	
Project Scale	**Commitment**
Primary Care Physicians	98
Non-PCP Practitioners	70
Skilled Nursing Facilities	27
Hospice	6
All Other	99

Learning Objectives and Curricula

The PPS has engaged a certified trainer, Dr. Cynthia Pan from NYP/Q, to provide palliative care training.

- **Education in Palliative and End-of-Life Care (EPEC)**

  The EPEC training is held bimonthly[4] at different SNF partner sites. Dr. Pan reviews two modules per session, which include the following topics:

  - Gaps in End-of-Life Care
  - Physician Assisted Suicide

[4] EPEC Schedule provided in Appendix

- Legal Issues
- Next Steps
- Advance Care Planning
- Communicating Bad News
- Whole Patient Assessment
- Pain Management
- Elements & Modules in End-of-Life Care
- Depression, Anxiety, Delirium
- Goals of Care
- Sudden Illness
- Medical Futility
- Common Physical Symptoms
- Withholding, Withdrawing Therapy
- Last Hours of Living

The training incorporates videos, slides, and discussion to create an engaging environment for participants. Providers who attend all 8 sessions (16 modules) will receive EPEC certification in addition to receiving CME credits.

- **Center to Advance Palliative Care (CAPC)**

  The PPS has provided partners with information on joining CAPC for a reduced fee as part of the DSRIP initiatives. CAPC provides educational opportunities and resources specific to palliative care to members.
- **Palliative Care Outcome Score (PCOS) Tool**

  The DOH has implemented a new tool as a mechanism of measuring quality for palliative care for the project. The PPS has begun the process of piloting the tool at a partner site. The pilot will kick-off in July 2016 and based on the lessons learned and needs of the partner, the PPS will determine the appropriate next steps for whether a training program is needed for partners.

PPS Milestones

The PPSs EPEC, CAPC and PCOS tool trainings will be used to complete the following project milestone:

- Milestone #4

  Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.

Competency and Measurements

The EPEC program required pre- and post-competency exams as part of the training program. These competencies will be used, along with the implementation of all f the project requirements, to determine the success of the training program. Education opportunities from CAPC will include competencies as required by CAPC based on the specific topic and curriculum. The PPS will use the metric for PCOS as a determination on the success of training in addition to feedback from the pilot site.

NEXT STEPS

The NYP/Q PPS is committed to providing training to the PPS workforce and partner organizations. This document outlines the goal and strategies for creating a clinically integrated network through connectivity and training programs and will continue to be updated by the PPS as vendors are appropriately engaged and lessons learning are leveraged based on the implementation of the projects. As training curricula, competencies, and workforce needs are both identified and created, the PPS will provide the appropriate documentation to the IA for review.

APPENDIX

Training / Milestone Matrix

The following list of NYP/Q PPS milestones and project requirements related to training provides a high-level overview of the training that will be provided to meet the requirements for each.

Org. / Project	Name	Training Name	PPS / Vendor?	Frequency
Cultural Competency & Health Literacy	Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Cultural Competency Background & Benefits Providing Culturally Competent Care	HealthStream	Annual
		Cultural Competency	GNYHA	Bi-Monthly
		Health Literacy	PPS Partner	As Needed
		PPS Resource Center	NYP PPS	As Needed
IT Systems & Processes	Milestone #2 Develop an IT Change Management Strategy	IT Solutions: ▪ ACD ▪ Cureatur ▪ Performance Logic ▪ RHIO ▪ eMOLST	PPS & Vendors	Once
	Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network			
	Milestone #5 Develop a data security and confidentiality plan	Compliance Training	PPS via HealthStream	Annual
Performance Reporting	Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting	Metrics & Quality Improvement	PPS	Ongoing

Org. / Project	Name	Training Name	PPS / Vendor?	Frequency
2.a.ii – PCMH	Milestone #7 Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.	Physician Champion https://hanys.adobeconnect.com/twy87da.psev5f/	HANYS Solutions	Once *Recorded for future use
		Care Coordination	GNYHA	Once
		PCMH Training Curriculum	HANYS Solutions	3 Waves
2.b.vii – INTERACT	Milestone #4 Educate all staff on care pathways and INTERACT principles.	INTERACT Champion Training	INTERACT Certified Vendor	Once
	Milestone #6 Create coaching program to facilitate and support implementation.			
	Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Partner Engagement of Patient/Family/Caregiver	PPS & PPS Partner	Ongoing
2.b.viii – Home Care	Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	INTERACT-like Tool Champion Training	INTERACT Certified Vendor	Once
	Milestone #4 Educate all staff on care pathways and INTERACT-like principles.			
	Milestone #6 Create coaching program to facilitate and support implementation.			

Org. / Project	Name	Training Name	PPS / Vendor?	Frequency
	Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Partner Engagement of Patient/Family/Caregiver	PPS & PPS Partner	Ongoing
3.b.i – Cardio	Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of DY 3.	Physician Champion https://hanys.adobeconnect.com/twy87da.psev5f/	HANYS Solutions	Once *Recorded for future use
		Care Coordination	GNYHA	Once
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	BP Competency	PPS & Partner Organization	Annual
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Million Hearts Campaign	PPS	As Needed
3.d.ii – Asthma	Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Asthma Education Program	PPS & CBO Partner	Ongoing
3.g.ii – Palliative Care	Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Education in Palliative and End-of-Life Care (EPEC)	PPS	Bi-Monthly

Org. / Project	Name	Training Name	PPS / Vendor?	Frequency
4.c.ii – HIV	Milestone #3 Launch educational campaigns to improve health literacy and patient participation in healthcare, especially among high-need populations, including: Hispanics, lesbian, gay, bisexual, and transgender (LGBT) groups.	Cultural Competency Background & Benefits Providing Culturally Competent Care	HealthStream	Annual
		Cultural Competency	GNYHA	Bi-Monthly
		Health Literacy	PPS Partner	As Needed
		PPS Resource Center	NYP PPS	As Needed

2.a.ii – PCMH

HANYS Solutions
PCMH Advisory Services

NYPQ – Cohort 1
Learning Platform Curriculum Schedule
Pre-EMR Implementation Work

Milestone	Timeline	Modules
1: Policy and Initial Planning Phase	2/4 - 2/18	**Referral Management** In this module, we discuss the importance of having detailed referral orders and clinical questions in addition to a solid and proactive process in place to close the order loop and ensure that patients are seen in a timely manner. Efficient referral management, beyond closing the order loop is also discussed. This includes sharing electronic summary of care documents (CCD) with the specialists, establishing co-management agreements and ensuring that we seek to obtain self-referral information from patients at each visit. As a result of this module, the practice develops and/or updates a Referral Management policy that includes: who, what, when, how, where and how often of referral management within the practice. **Behavioral Health Integration Models** This module will give an overview of the three (3) main behavioral health integration models that practices use: Consultative, Co-located and Collaborative. There is not a one size fits all solution to Behavioral Health Integration, and the intent of this module is to give a high level overview of the options available. As a result of this module, practices will consider current resources and relationships in order to develop a behavioral health integration plan that best fits their needs.
2: QI/Care Teams/Care Management	2/19 - 3/3	**Gaps in Care** In this module, we discuss Element 3D: population health management which is a must pass element within the NCQA 2014 Standards. A population health management program requires data, a proactive process and documentation of outreach efforts. This element specifically addresses nine (9) targets, with immunization having been separated from preventive services into a separate factor for 2014. As a result of this module, practices will understand what is required to meet the criteria for Element 3D, which includes lists of patients identified and documentation of reminders given to patients.

		Motivational Interviewing and Patient Coaching This module is intended to assist practices with care planning and self-care support skills. Motivational interviewing is a patient coaching technique that seeks to engage the patient in the behavior change process and as a result, improve patient compliance. The module outlines how to identify barriers and personal motivations to attain healthcare goals; explain the differences between directive and collaborative care; and emphasize the importance of the entire care team participating in the patients' care. As a result of this module, practices should be able to identify how each care team member can use motivational interviewing at each patient touch point. **PVP and Huddles** This module highlights care team communication. In particular, Element 2D, Factor 3, which is a critical factor in a must pass element. Pre-visit planning (PVP) is necessary to prepare for and have meaningful patient encounters. This process is necessary for patients who meet the care management criteria. Huddles are daily, brief (5-10 minutes) structured meetings that focus on individual patient care. This communication process is an essential part of a patient-centered medical home. As a result of this module, practices will develop their written communication plan and outline which care team member(s) will be responsible for performing PVP and huddles.
	3/4 - 3/17	**Care Team Involvement in Care Management** This module builds upon previous modules related to care teams and care management. The care management program in NCQA's 2014 Standards is focused on the top 5-10% high risk patients. It is critical that practices have care team roles designated as they relate to this process. Practices need to ensure that all care team members are working to the top of their license and/or skills. This fosters responsibility, accountability and teamwork.

		As a result of this module, practices will assess their care teams' level of understanding and involvement in care management activities and develop an action plan on how their team will provide necessary education and training to meet the expectations of care management in a PCMH. **Care Planning** This module gives an overview of Element 4B in the 2014 Standards, which is a must pass element. This module ensures that practices understand what components must be included in a care plan and that the care plan is created in collaboration with the patient. The foundation for care planning is developing a goal oriented road map for high risk patients identified for care management. As a result of this module, practices will need to assess the EMR capabilities in documenting the factors from Element 4B. These factors will have to be reported on or audited during the Record Review Workbook process. **Self-Support Management** This module gives an overview of Element 4E within the 2014 Standards. Practices have to demonstrate the use of materials to support patients' in self-management and shared decision making. The module will define shared decision making, explain how to assess a patient's level of activation, and outline the multiple tools and resources that are available. As a result of this module, practices will assess how they document patient's self-management, lifestyle goals and preferences in their EMR.
	3/18 - 3/31	**Patient Experience of Care** In this module, we discuss Element 6C, measuring patient and family experience. Survey administration is the most popular way to accomplish this. However, practices need to decide the best route for administration by assessing their resources not only for administration, but also for analysis. A survey needs to include 3 of the 4 required areas, and the practice needs to address vulnerable populations. Additionally, practices need to have a method other than surveys to collect qualitative data.

		As a result of this module, practices assess their current approach to measuring patient experience of care, identify current tools and describe the reporting processes. **Evidence-Based Decision Support** In this module, we cover Element 3E and discuss what evidence-based decision support is. We give examples for each factor of what is needed within the practice's EMR to meet the criteria. It is important to note the intent of this element is not only to use evidence-based tools, but to use the guidelines in order to treat the designated conditions. As a result of this module, practices will define what evidence-based guidelines are going to be used for each condition selected, what clinical decision supports (CDSS) are available to them, and how they will incorporate both the EBM guidelines and alerts into their EMR workflow.

Post-EMR Implementation Work

Milestone	Timeline	Modules
3: Audit Phase		**QI worksheet** In this module, we utilized previously recorded training sessions from NCQA. This module gives a step by step overview of how to obtain and complete the QI worksheet. It is important to clearly separate the baseline, performance and re-measurement periods. Additionally, practices need to ensure that the baseline and re-measurement periods are within the NCQA allowable range. As a result of this module practices will locate, save, and begin completing their QI worksheet based on the QI activities they have been performing throughout the transformation process.
		RRWB This module uses previously recorded training sessions from NCQA. The module gives a step by step overview of how to obtain and complete the RRWB. Practices need to decide which factors, if any they will be using reports for in lieu of the RRWB. It is also important to note that practices need to show examples for each factor within the RRWB that they select yes for. Practices also need to maintain patient-specific information in the event of an audit. As a result of this module practices will locate, save, and begin completing their audit of 30 Care Management patients for the RRWB.

Milestone	Timeline	Modules
4: Submission Preparation Phase		Complete submission preparation work associated with Milestone 4

NYPQ – Cohort 1
Learning Platform Curriculum Schedule

Milestone	Timeline	Modules
5: Submission		Submit ISS tool and document library to NCQA. ISS Tool: • Internet browsers that work best with the ISS tool • Use the ISS tool for submission AND evaluation of current state • Loading/linking files when they are final • Merge documents into single pdf files • Save responses regularly

- Extend audit phase significantly, for implementation with new EMR. Timeline dependent on EMR dates. All reports and data will need to be developed during this time, as well as tweaking of processes/written policy to marry any currently developed process and the new EMR.

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NYPQ – Cohort 1
Learning Platform Curriculum Schedule

Completed Modules

Milestone	Milestone Period	Week	Week of	Modules to be Introduced- Assignments due following Tuesday
0: Pre-project Activities	November 2-20, 2015	1	November 2, 2015	Welcome Video and How to Use this Portal
				DSRIP
				Creating Policies & Procedures
		2	November 9, 2015	Culture and Change Introduction
				Creating Care Teams
		3	November 16, 2015	Document Organization
				Document Submission and Attestation
				Data and Reporting Needs

Milestone	Milestone Period	Week	Week of	Modules to be Introduced- Assignments due following Tuesday
1: Policy and Initial Planning Phase	November 23, 2015 - January 29, 2016	4	November 23, 2015	Change Management Strategies #1
				Access and Continuity
		5	November 30, 2015	Change Management Strategies #2
				Clinical Advice
		6	December 7, 2015	Measure Selection
				Understanding your Patient Population
		7	December 14, 2015	Welcome Letter/Brochure
				Website, Portal and Orientation Process
		8	December 14, 2015	Identifying Patients for Care Management
		9	December 28, 2015	Referral Source and Agreements
				Test Tracking and Follow-up
		10	January 7, 2016	Care Transitions
				Introduction to Behavioral Health Integration

3.d.ii – Asthma

Pending -- Claudia

3.g.ii – Palliative Care EPEC Training Overview

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NYP/Q PPS EPEC Training Schedule
Project 3.g.ii Palliative Care in Skilled Nursing Facilities

Tentative Date / Time (2nd Wednesday of Every Other Month)	#	Plenary / Module	Title of Session	Location
Wednesday, February 10, 2016				
6:00 PM – 7:00 PM	A	Plenary 1	Gaps in End-of-life Care	**Cliffside Rehabilitation and Residential Health Care Center** 11919 Graham Ct, Flushing, NY 11354
7:00 PM – 8:00 PM	B	Plenary 2	Legal Issues	
Wednesday, April 13, 2016				
6:00 PM – 7:00 PM	C	Plenary 3	Elements & Models of End-of-life care	**Woodcrest Rehabilitation** 11909 26th Ave, Flushing, NY 11354
7:00 PM – 8:00 PM	D	Plenary 4	Next Steps	
Wednesday, June 08, 2016				
6:00 PM – 7:00 PM	1	Module 1	Advanced Care Planning	**Silvercrest Center for Nursing & Rehabilitation** 144-45 87th Ave, Briarwood, NY 11435
7:00 PM – 8:00 PM	2	Module 2	Communicating Bad News	
Wednesday, August 10, 2016				
6:00 PM – 7:00 PM	3	Module 3	Whole Patient Assessment	**Dry Harbor Nursing Home & Rehabilitation Center** 6135 Dry Harbor Rd, Middle Village, NY 11379
7:00 PM – 8:00 PM	4	Module 4	Pain Management	
Thursday, October 13, 2016				
6:00 PM – 7:00 PM	5	Module 5	Physician Assisted Suicide	**Margaret Tietz Nursing and Rehabilitation Center** 164-11 Chapin Pkwy, Jamaica, NY 11432
7:00 PM – 8:00 PM	6	Module 6	Depression, Anxiety, Delirium	
Wednesday, December 14, 2016				
6:00 PM – 7:00 PM	7	Module 7	Goals of Care	**St. Mary's Hospital for Children** 29-01 216th St. Music Room – Ground Floor Bayside, NY 11360
7:00 PM – 8:00 PM	8	Module 8	Sudden Illness	
Wednesday, February 08, 2017				
6:00 PM – 7:00 PM	9	Module 9	Medical Futility	**Parker Jewish Institute for Health Care and Rehabilitation** 271-11 76th Ave, New Hyde Park, NY 11040
7:00 PM – 8:00 PM	10	Module 10	Common Physical Symptoms	
Wednesday, April 12, 2017				
6:00 PM – 7:00 PM	11	Module 11	Withholding, Withdrawing Therapy	**TBD**
7:00 PM – 8:00 PM	12	Module 12	Last Hours of Living	