Training Strategy Deliverable for SIPPS

Staten Island, NY

January 2015

Table of Contents

Executive Summary

A. Context for the DSRIP Training Strategy

- As part of DSRIP, the Dept. of Health wants each PPS to create a training strategy for the workforce. The DOH has not been prescriptive about the nature of this training strategy.
- In order to place some 'boundary conditions' around the training strategy, we proposed the following definition for 'training':

INCLUDED

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

EXCLUDED

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

Executive Summary

B. Key Input Sources – Data Requests supplemented by nine onsite interviews at provider sites

Data Request

- DOH Organizational Application
- Project Applications
- SIPPS Workforce Implementation Plan
- SIPPS Project Implementation Plans
- DOH Reporting Templates
- Domain 1 Metrics & Milestones

Interviews

- **SIPPS Leadership**
  - Joe Conte
  - Bill Myhre
  - Celina Ramsey
  - Sal Volpe
- **Training Committee**
  - R. Hall, S. Pitt (1199 SEIU TEF)
  - Margaret Dialto (NSLIJ)
  - Patricia Coleman (NSLIJ)
  - Christina Tavarez (CHC)
  - D. Faxio (Arch Care)
- **Workforce Committee**
  - Joe Conte
  - Bill Myhre
- **Skilled Nursing Facilities**
  - Carmel Richmond Nursing Home
  - Seaview Rehabilitation Center
  - Eger Lutheran
  - Verrazano Nursing Home
  - Clove Lakes Rehabilitation
- **BH Organizations**
  - Camelot of Staten island
- **Hospital RUMC**
  - Elizabeth Wolff
  - Ron Musselwhite
- **Hospital SIUH**
  - Margaret Dialto
  - Dina Wong
  - Dianne Gonzalez
- **PCP practices**
  - Victory Internal Medicine

Executive Summary

C. Current State Findings

- Key provider stakeholders across the PPS were interviewed to better understand the current state; major findings below:
    - **Assets:** No one provider system had training nailed down … but each provider had 1-2 robust training assets (content, trainers etc.). In principle, providers were willing to share these assets with the PPS partners, but would need to understand the economics of backfill/ remuneration better. Many used vendors, but others were skeptical of classroom/ webinars
    - **Gaps:** Basic DSRIP 101, Population Health & Value Based Contracting were listed as major gaps. Providers were concerned about how to meet their backfill needs. Process design precedes process training was a consistent message when cross-organizational collaboration was needed (e.g., hospital ER - SNF). High variation in the access to, use of and skill set in using computers.
    - **Positions:** An urgency to train newly created positions was expressed (e.g., care managers or equivalent); but general DSRIP 101 was a solid need across the board
    - **Constraints:** Providers their tips for effective training programs, for example: keep training local, adapt timings to accommodate shifts, refresher courses via medical record/ case audits, apprenticeship model is best way to train etc.
- In conclusion, there exist a few training ‘gems’ that could benefit the entire PPS if an arrangement is worked out with individual provider entities to license their training assets. However, given the new topic areas that DSRIP emphasizes, there is a clear need for a specialized vendor of such training content to complement what exists in-house. Affiliations with local educational institutes seemed low but can be explored further through DSRIP.

Executive Summary

D. Major Recommendations

Who needs to be trained?

- **New Positons**: Care Managers, Social Workers, Community Health Associates
- **Existing Provider 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** – Specific content areas like Care Management, PCMH, IT, etc. that are foundational

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 providers or vendors
- SIPPS focus should be on **air traffic control** and project management for training – not on creating training content

Executive Summary

E. Roadmap for Execution

1. In developing a roadmap, we have considered the following constraints in staging the training timetable
   - **Provider Rank Order:** Tier 1 providers that deliver 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 e.g., PAM for CBOs

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; Additionally, hiring of the training coordinator is another quick win.

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. **Core group of CMs:** Ultimately, only well staffed and trained care managers (RN, SW, CHWs etc.) will make a difference in the end goals of DSRIP – reduced ED, Readmissions. Ensure this group is trained in a robust manner earlier in the DSRIP timeline … and ensure that they get periodic follow-up refresher training

5. 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 with targets that SIPPS has committed to in the DSRIP implementation

Executive Summary

G. Key Risks & Mitigation

	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. Assign a senior/executive champion for training in each provider setting 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**	The PPS has a limited set of resources to establish workforce training	1. Leverage existing training that already exists within the PPS partners 2. Assess if PPS 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

Table of Contents

Deliverable Organization

The DOH has not prescribed a format for the training strategy deliverable … hence, we have proposed the following organizational framework for addressing key questions pertinent to training

	Dimension	Questions Addressed
1	**"Who"** Define targeted Provider employees and PPS staff	▪ Which specific PPS provider 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 PPS 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 PPS Providers and staff (e.g., DSRIP, population health, cultural competency, managing change) ▪ What training is project-specific, and for specific employees/staff, across the 11 DSRIP projects? What type of training will be needed for PPS central staff members as compared to Provider 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 should conduct this training? ▪ What does the current state assessment tell us? major gaps today?

Deliverable Organization

The DOH has not prescribed a format for the training strategy deliverable … hence, we have proposed the following organizational framework for addressing key questions pertinent to training

	Dimension	Questions Addressed
3	**"How"** Organizing the Training Program	▪ How should training effectiveness be documented, measured, and evaluated? ▪ 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?
4	**"When"** Roadmap & Funding	▪ What should the priority be for training? Over what timeline? ▪ What funding sources are anticipated for training (besides the PPS)?
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?

Table of Contents

Current State - Training Assets

Current assets and capabilities of partners can be leveraged for DSRIP training across the PPS

Interview Site	Key Training Asset(s)
Richmond University Medical Center	▪ Nurse “teach back” method and best practices for nursing staff
archcare Carmel Richmond Nursing Home	▪ Access to palliative care training and best practices from the Avila Institute of Gerontology
Seaview Hospital Rehabilitation Center	▪ Four (4) INTERACT “train the trainer” resources could be made available ▪ Monthly in-service palliative care program
Camelot Treatment Works	▪ Access to best practices to combat substance use disorder (i.e., rational emotive therapy training, etc.) ▪ Ability to leverage Logan Lewis as a trainer (former Adjunct Professor at Stony Brook University)
	▪ Connection with Optum training program for NP’s which is part of the I-SNP (Institutional Special Needs Plan); training addresses family communication, patient preparedness and care
1199SEIU Training and Upgrading Fund	▪ See brochure; Inter-disciplinary team training for doctors has had very good reviews
Staten Island University Hospital	▪ Training for Medical Assistant and Nursing intern from St. Paul (Associate Degree program) ▪ Access to patient safety training through the Patient Safety Institute ▪ Existing programs for crisis prevention, diabetes management, leadership, and palliative care
Victory Internal Medicine	▪ Training in place to utilize advanced communication tools to share data between Hospitalists and Primary Care Physicians
Clove Lakes Healthcare	▪ Four to six week training program in place for all newly hired nurses ▪ Monthly team-based training sessions

Current State - Training Gaps

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

Content Category	Training Gaps
DSRIP 101	▪ Basic understanding of the DSRIP program can be expanded across PPS ▪ History of Medicaid reform, DSRIP background, timeline, goals, explanation of acronyms, etc. must be delivered periodically
Care Transitions	▪ There is a need to design a Transition of Care (TOC) process that involves Outpatient and Inpatient resources ▪ 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	▪ Wide variation exists in regard to practitioner access to computers or internet in their workspace. Some provider locations do not have an EMR system in place.
Behavioral Health	▪ Need training for Cognitive Behavioral Therapy, Motivational Interviewing, Rational Emotive Behavioral Therapy best practices ▪ Social Worker training for ED placement needs to be developed
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 an extended team; recognition of virtual team and cross-organizational constraints; recognition of shared decision making on the team

Current State – Suggested Guiding Principles

Interviewees proposed some guiding principles for framing the Training Strategy

- "Videotape the trainer so training can be reviewed offline"
- "Move staff education department to more visible location in the building, so education gains prominence"
- "Training should be hands-on similar to an apprenticeship model"
- "Key trainings should be located on Staten Island itself as much as possible"
- "Ensure that backfill exists so that nurses are focused on training and not worried about rushing back to patients"
- "Ensure that refresher training occurs, preferably in the form of audit of actual cases"
- "Free food tends to attract a crowd"
- "Peer training culture where the strong team members are paired with new hires"
- "Cross-organizational education about the range of SNF capabilities that exist"
- "Unions should get involved for stop-and-watch training for union staff"
- "Regarding BH, physicians think they know everything… but they don't know what is really effective"
- "Internet videos don't always work – ideally the apprenticeship model of learning by doing should occur"
- "Keep trainings to ~1 hour to hold attention of trainees" [Others questioned how much could be learnt in 1 hour training]
- "Ensure that training feedback is collected and acted upon"
- "Coordinate large volumes of training e.g., don't overwhelm PCP practices with too much at once"
- "Front loaded training may be needed, so workforce is equipped to tackle DSRIP metrics over course of program"
- Deploy adult learning principles in the training design e.g., make it interactive

Table of Contents

1

“Who” – Goals & Assumptions

Identifying the provider/PPS staff types that are in need of training is the first step

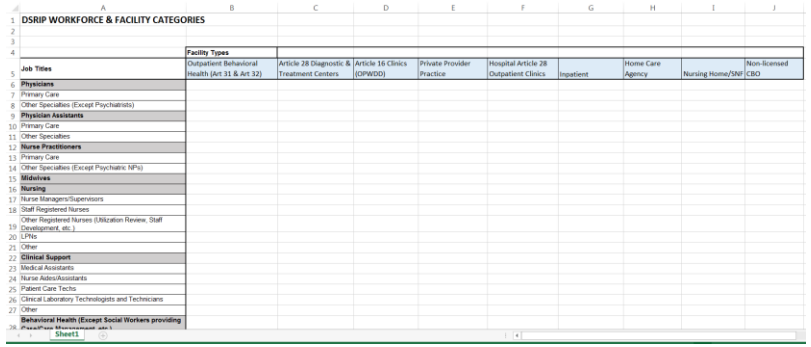
Objectives for this Section

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

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

Assumptions

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



DSRIP WORKFORCE & FACILITY CATEGORIES

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

- We add more granularity where necessary to certain provider/PPS staff types (e.g., embedded vs. non-embedded Care Management staff)

- 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 …) providers/facilities and stagger them along the training timeline

"Who" – Approach & Methodology

Each 'provider job title – facility type' intersection (e.g., RN in PCP clinic) is scored across multiple criteria; 'Threshold' scores are the defined that distinguish the importance and urgency of training

Approach to Evaluating Roles for Training

a. In the DOH matrix on 'provider job title and facility type ', we assess each job title and facility type individually as to the role they play across the following criteria if applicable

b. Assessment Criteria (scored 1 – 10)
   1. **No. of projects** where their participation is needed to meet project requirements
   2. Is care delivered **Outpatient or Primary Care** focused?
   3. Is there a **Material Gap** in Current State Training?
   4. Is the position key to the generation of **early engaged** numbers and clinical results?
   5. If the position is at **Risk for Redeployment** that is an automatic RED priority?

c. From this we develop a weighted average 'composite' score for that 'provider job title – facility type'

d. Composite scores result in the 'provider job title – facility type' falling in one of the following categories:
   1. RED – High need for training
   2. YELLOW – Medium training need
   3. GREEN – Low training need

Scoring Methodology

- **Definitions & Weights:**
  - **No. of projects impacted (20%):** This is a number between 0 and 11, depending on how many projects this *role-type* is expected to influence
  - **Outpatient or Primary Care focus (25%):** This is a number between 0 - 10 and represents a continuum (10 implies high primary care focus of *role – type*)
  - **Material Gap in Current State Training (25%):** This is a number between 0 – 10 and represents training gap magnitude (10 implies large gap)
  - **Key to early engaged and clinical results (30%):** This is a number between 0 – 10 and represents magnitude of impact on early results (10 implies large impact)

- All four criteria have been weighted similarly but not equally -- **so the average is the weighted average;**
  - **Position at Risk for Redeployment** - Automatic RED category

"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	▪ Nurse Manager ▪ Staff Registered Nurse ▪ Licensed Practical Nurse	▪ RN Care Coordinator ▪ Care Manager ▪ LPN Care Manager	▪ Bachelor's Social Work ▪ Licensed Masters Social Workers ▪ Social Worker Care Coordinator	▪ Peer Support Worker ▪ Community Health Worker ▪ SUD/Behavioral Health Workers
YELLOW – Med. Training Need	▪ Executive Staff ▪ Financial Staff ▪ Human Resources	▪ Social/Human Assistants ▪ Medical Assistants ▪ Laboratory Technicians	▪ Health IT Hardware Maintenance ▪ Health IT Software Programmers ▪ Technical Support	
GREEN – Low Training Need	▪ Office Clerks ▪ Nutritionists ▪ Occupational Therapists	▪ Pharmacists ▪ Pharmacy Technicians ▪ Physical Therapists	▪ Physical Therapy Aides ▪ Respiratory Aides ▪ Respiratory Therapists	▪ Housekeeping ▪ Medical Interpreters ▪ Patient Service Reps.

1

“Who” – Conclusion

All providers and staff across the PPS network will require a basic level of DSRIP training with a more concentrated training effort dedicated towards primary care, care management and social work providers

1) DSRIP is focused on increasing outpatient activity but all inpatient employees across the PPS, especially clinical staff, will still require basic DSRIP training. As DSRIP evolves, the PPS will need to be prepared to redeploy and retrain these workforce members as needed.

2) As outpatient activity increases across the PPS, many new roles will be created to achieve DSRIP success measures. Nursing staff, care coordinators and care managers should receive prioritized, specialized training given their involvement in the highest volume of PPS projects.

3) Next in order of priority for specialized training are those roles that interact most closely with care managers. From Primary Care Physicians and Registered Nurses down to housekeeping staff – all members of the PPS workforce require a combination of basic and specialized DSRIP training to create sustainable transformation.

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 EMR systems across the PPS, 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 less intense, broad-based need to raise awareness for DSRIP, Population Health, Cultural Competency/Health Literacy and other topics across the entire PPS workforce.

Table of Contents

"What" – Categories of Training/Education

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

Training - General

- Concepts that apply to almost everyone in the PPS
- Generally conducted via online learning OR at large PPS gatherings (e.g., PAC) – 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, VBR Basics

Training - Specific

- Concepts that apply to a more limited group of providers, facilities, job titles in the PPS
- 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
- Examples: PCMH training for PCP offices, INTERACT training for SNFs, Million Hearts Campaign training for CV project

Educational Opportunities

- Locally available educational programs that PPS Provider staff or PPS 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

"What" – Lists of Training

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

General Training

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

Specific Training

Project

For each project #1 … #11

A. Advanced Concepts
B. Basic Concepts

Cross-Project

PCMH

i. PCMH Basics
ii. NCQA 2014 Level 3

EHR/Technology

i. Data Sharing
ii. Meaningful Use standards

Care Management

i. Care Manager Advanced
ii. Care Manager Embedded
iii. Care Mgmt. Tools

PPS Staff

i. DOH Reporting
ii. MAPP
iii. PMO Tool

Value Based Payments

i. VBP Plan
ii. VBP Tools

2

"What" – Medium & 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 (FAQs etc.)
- **Online 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
- **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, North Shore "hot spot")
- **Shadowing (on site) & Mentoring (telephone):** Topics that need hands-on real world experiences and coaching
- **Conferences (DOH, PAC):** Messages that need to be disseminated to large groups in the PPS

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

General – DSRIP 101

‘Introduction to DSRIP’ course applies to almost all participants in the PPS

Content Topics

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

Delivery

- **Material:** DSRIP FAQ, DOH Whiteboard videos
- **Medium:** Reading of FAQ; Online coursework
- **Frequency:** Once; with ability for student to go back and refresh
- **Trainer:** 1199 SEIU TEF
- **Reporting:** Logs from online tool
- **Effectiveness:** (1) Percent of PPS that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project and PAC meetings
- **Setting:** Individual and Multi-Disciplinary Team

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

General – PPS Structure & Function

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

Content Topics

1. **Purpose:** Articulate the vision, goals, objectives, targets of the PPS; List short and long term vision
2. **Organization:** Clarify governance (board, committees, workgroups and project teams); relationship between partners and the PPS executive structure; SIPPS org. structure & responsibilities
3. **Resources:** Website, Newsletter, Location other resources; Meeting minutes; Funds Flow logic etc.
4. **Contact:** How and when to get in touch; Compliance hotline etc., all-PPS PAC meetings
5. **Services:** What services, funds, personnel assistance can PPS partners expect?

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP FAQ PPS section
- **Medium:** Recorded webinar
- **Frequency:** Once; with ability for student to go back and refresh
- **Trainer:** Director, HR & Workforce
- **Reporting:** Logs from online tool
- **Effectiveness:** 1) Percent of PPS that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project and PAC meetings
- **Setting:** [Individual]

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

2

General – Compliance

‘Compliance’ applies to individual PPS 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 PPS-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 PPS
- **Reporting:** Logs from online tool
- **Effectiveness:** (1) Percent of PPS that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project and PAC meetings
- **Setting:** [Individual]

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

2

General – Population Health Basics

‘Population Health Basics’ course applies to almost all participants in the PPS

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, workforce, payment reform, information technology.
5. **Resources:** Community health needs assessment, list of community-based organizations, PCP offices, etc.

Delivery

- **Material:** Power Point presentation, [Pre-read] – DSRIP FAQs
- **Medium:** NYS DOH whiteboard sessions on YouTube, DSRIP webinars
- **Frequency:** Once; with ability for student to go back and refresh
- **Trainer:** Director of Population Health, Care Management and Performance Management
- **Reporting:** Logs from online tool
- **Effectiveness:** 1) Percent of PPS that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project and PAC meetings (4) Increased collaboration with community-based organizations
- **Setting:** Individual and Multi-Disciplinary Team

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

2

General – Cultural Competence Basics

‘Cultural Competence’ course applies to almost all participants in the PPS

Content Topics

1. **Basics:** Essentials of language, age, and education materials and communication best practices
2. **Key Messages:** Instructions for condition management were easy to understand, description of caring guide, what to do if illness/condition got worse or came back
3. **Hotspots:** Medicaid beneficiaries tend to be located in the communities of Stapleton, St. George, Rosebank, and Mariner’s Harbor
4. **Intervention Strategies:** Motivational Interviewing, rational emotive behavior therapy, etc.
5. **Resources:** Available clinical providers, educational resources, and communication best practices

Delivery

- **Material:** Staten Island Community Health Needs Assessment, [Pre-read] DSRIP FAQ’s
- **Medium:** Webinar, classroom training (provider), workshops
- **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:** Director of Health Literacy, Diversity and Outreach
- **Reporting:** MAPP tool, online logs, paper-based method to show attendance in training sessions
- **Effectiveness:** (1) Percent of PPS that took the course (2) Results of participant survey
- **Setting:** Individual and Multi-Disciplinary Team

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

2

General – Career Counseling Basics

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

Content Topics

1. **Basics:** Purpose of DSRIP, impact on current and future positions, high-level PPS 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
5. **Additional Resources:** 1199 SEIU TEF training team, PPS training fund

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 PPS that took the course (2) Results of participant survey, (3) Number of retained employees, number of employees redeployed across PPS, new hires made
- **Setting:** Individual

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

Specific – Project 2.a.iii

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

Content

- **Advanced Concepts:**

  Training on full care management requirements:
  - Patient risk stratification
  - Referral criteria
  - Documentation of comprehensive care management plan
  - Standardized care management processes

  Training for integrated care teams:
  - Population health management processes
  - Evidenced-based guidelines

- **Basic Concepts:**
  - Care management structure
  - Availability of CM support

- **Cross Project Training - see "cross-project" training needs section):**
  - PCMH
  - EHR/Technology
  - Care Management
  - PPS Staff
  - Value-based Payments

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP Project Toolkit description for project 2.a.iii
- **Medium:** Recorded webinar, 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:** Director of Care Management, Director of Performance Management [PPS level], Information Technology and Compliance training teams
- **Reporting:** Logs from online tool
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

2

Specific – Project 2.b.iv

Care transitions intervention model to reduce 30 day readmissions for chronic health conditions

Content

- **Advanced Concepts:**

  TOC full-project requirements (providers doing the work):
  - Components of "Care Transitions Intervention Model"
    - Patient risk stratification
    - Documentation of 30 day transition of care plan
    - Use of social work services
    - Allow outpatient CM to visit patient prior to discharge
    - Use of CM IT platform and risk stratification functionality,
    - Assessment for eligibility for 2.a.iii program

  TOC process components (providers who are affected by the work):
  - Optimize access for post-discharge PCP office visit
  - Ability of transition coach to contact PCP office

- **Basic Concepts:**
  - What is Care Transition plan? Who manages this process? What impact does this project have on each individual stakeholder? How will communication linkages work?

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

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP Project Toolkit description for project 2.b.iv
- **Medium:** Recorded webinar, 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:** Director of Care Management, Director of Performance Management [PPS level], Information Technology and Compliance training teams
- **Reporting:** Logs from online tool
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

2

Specific – Project 2.b.vii

Implementing the INTERACT project (Inpatient Transfer Avoidance Program for SNF)

Content

- **Advanced Concepts:**

  INTERACT full-project requirements:
  - Comprehensive training on full spectrum of INTERACT program
    - Risk stratification, “stop and watch protocols”, etc.
    - Identification and role definition of facility champion

  Synergies with other projects:
  - How does INTERACT tie in to project 3.g.ii (Palliative Care)

- **Basic Concepts:**
  - What is purpose of INTERACT program? What are the key components? Who are the key stakeholders? How might a PPS provider be involved with this program, if at all?

- **Cross Project Training - see “cross-project” training needs section):**
  - EHR/Technology
  - PPS Staff

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP Project Toolkit description for project 2.b.vii
- **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:** Director of Care Management, INTERACT “train the trainer” experts
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

2

Specific – Project 2.b.viii

Hospital-Home Care Collaboration Solutions

Content

- **Advanced Concepts:**

  Hospital-Home Care Collaboration full-project requirements:
  - Comprehensive training on full spectrum of INTERACT program
  - Identify risk for readmission
  - Develop care pathways for managing chronically ill patients
  - Identify potential instability and interventions to avoid hospital transfer
  - Develop Advanced Care Planning tools and tele-health/telemedicine program
  - Educate family/caregiver and develop appropriate linkage with "transition coaches" from project 2.b.iv
  - Development of training programs for "Rapid Response" teams

- **Basic Concepts:**
  - What is purpose of INTERACT program? What are the key components? Who are the key stakeholders? How might a PPS provider be involved with this program, if at all?

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

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP Project Toolkit description for project 2.b.viii
- **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:** Director of Care Management, INTERACT "train the trainer" experts
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

Specific – Project 2.d.i

Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community-based care

Content

- **Advanced Concepts:**

  Patient Activation full-project requirements including:
  - Training for on use of the PAM tool
  - Training on interventions needed for patients with low PAM score
    - Connectivity to healthcare coverage and community healthcare resources
    - Patient education
    - Increase use of non-emergent care
  - Train providers located within "hot spots" on patient activation techniques
    - Shared decision-making
    - Measurements of health literacy and cultural competency
  - Training on policies and procedures for intake and/or scheduling staff to receive navigator calls
  - Training on clinic operations to ensure wider access to PCP

- **Basic Concepts:**
  - What is the purpose of PAM? Who gets the survey (patients)?
  - Who has the PPS retained to administer the survey?
  - How are results collected and shared across the PPS?

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

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP Project Toolkit description for project 2.d.i
- **Medium:** Recorded webinar, Web-based training sessions, In-person training in community
- **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:**
  - INSIGNIA Health trainers for PAM, "train the trainer" experts
  - Trainer for CBOs on connectivity to health coverage (i.e., educate CBOs on health resources on SI)
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

2

Specific – Project 3.a.i

Integration of primary care and behavioral health services

Content

- **Advanced Concepts:**

  Full-project requirements for Intervention Type 1 - embedding BH practitioner in a PCMH office:
  - Team training for full care delivery team in PCP office
  - Training for PCP office to attain PCMH level 3 recognition
  - Training in best practices for patient hand-offs, etc.
  - Training on coordinating with Health Homes and other stakeholders
  - Training on use of PHQ-9/SBIRT tools

  Full-project requirements for Intervention Type 2 – providing physical health services in a BH clinic:
  - 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 patient hand-offs, etc.
  - Training on coordinating with Health Homes and other stakeholders

- **Basic Concepts:**
  - How will a BH practitioner impact my practice? How can I coordinate care more seamlessly between the PC and BH settings?

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

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP Project Toolkit description for project 3.a.i
- **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:** PPS-hired training coordinator e.g., SEIU 1199 TEF or other vendor
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

Specific – Project 3.a.iv

Development of withdrawal management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs

Content

- **Advanced Concepts:**

  Training for Withdrawal Management components including:
  - Outpatient SUD sites with PCP integrated teams
  - Stabilization services including social services
  - Referral relationships between community treatment programs
  - Inpatient detoxification services with development of referral protocols
  - Community-based withdrawal management (ambulatory detoxification) protocols
  - Care management services within the SUD treatment program.
  - Initial focus on Opioid addiction

- **Basic Concepts:**
  - What will be the approach for improved treatment of SUD? Why is treatment appropriate? How does comprehensive withdrawal treatment impact avoidable hospital use? How might PPS providers coordinate efforts with and support this project?

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

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP Project Toolkit description for project 3.a.iv
- **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:** Credentialed Alcoholism and Substance Abuse Counselors, Licensed Clinical Social Workers, Psychiatrists, Psychologists
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

2

Specific – Project 3.c.i

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

Content

- **Advanced Concepts:**

  Training for clinical components:
  - Best practice treatment guidelines
  - Care pathways
  - Access to CDE's
  - CME for PCP's
  - PCMH transformation

  Training for operational components:
  - Best practice office processes
  - EMR optimization (i.e., hard-wired alerts, reminders, etc.)

- **Basic Concepts:**
  - How do refer patient into self-management classes? What are best practices for sharing data? What are best practices for meeting Meaningful Use standards?

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

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP Project Toolkit description for project 3.ci
- **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:** Local endocrinologists, Certified Diabetes Educators, Stanford Model certified trainers
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

2

Specific – Project 3.g.ii

Integration of Palliative Care into Nursing Homes

Content

- **Advanced Concepts:**

  Training for full project requirements including:
  - Integrate Palliative Care into practice model of participating Nursing Homes
  - Contract or develop partnerships with community and provider resources, including Hospice, to bring the palliative care supports and services into the nursing home
  - Develop and adopt clinical guidelines agreed to by all partners including services and eligibility
  - Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS
  - Engage with Medicaid Managed Care to address coverage of services
  - Training in technology/Healthix integration.

- **Basic Concepts:**
  - Why is palliative care important for DSRIP? What are best practices for communicating with patients and caregivers?

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

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP Project Toolkit description for project 3.g.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:** SNF nursing staff, dedicated nurse educators
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in Actively Engaged and clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

2

Specific – Project 4.a.iii

Strengthen mental health and substance abuse infrastructure across systems

Content

- **Advanced Concepts:**

  Training for full project requirements including:
  - Availability of Mental, Emotional and Behavioral Health promotion resources
  - Availability of Mental, Emotional and Behavioral Health prevention resources
  - Cultural and Linguistic training on MEB promotion/prevention activities
  - Best practices to build referral network

- **Basic Concepts:**
  - How does Mental, Emotional and Behavioral Health influence DSRIP? Which PPS providers are leading efforts in Staten Island? How do I get in touch with them

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

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP Project Toolkit description for project 4.a.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:** Credentialed Alcoholism and Substance Abuse Counselors, Licensed Clinical Social Workers, Psychiatrists, Psychologists
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

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:**

  Training for full project requirements including:
  - Chronic Disease not previously addressed in SIPPS projects
  - Prevalence rates of selected chronic disease in Staten Island
  - Hotspot areas
  - Referral pattern best practices from community to traditional care setting
  - Data sharing best practices

- **Basic Concepts:**
  - What should I do after I treat a patient referred to me by this project? How do I report results to PPS or state? What responsibilities do I have to provide outreach, if any?

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

Delivery

- **Material:** Power point presentation; [Pre-read] 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:** Director of Care Management, nurse educators
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** (1) Percent of PPS that took the course (2) Improvement in clinical metrics
- **Setting:** Individual and Multi-Disciplinary Team

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

Cross Project – Patient Centered Medical Home

Content Topics

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

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

- **NCQA 2014 Level 3 Training:**
  - Patient Centered Access
  - Team-Based Care
  - Population Management
  - Care Coordination and Care Transitions
  - Performance Measurement and Quality Improvement

Delivery

- **Material:** Power point presentation; [Pre-read] 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:** PCMH training vendor (HANYS, PCDC), PPS provider engagement staff (esp. those who are already certified as content experts)
- **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

Note: This training should never be an exhaustive list of details about all PCMH standards and the documentation that needs to be in place to show those standards are met. It would be more of a "PCMH 101", particularly for PCP practices with physician, nursing, and MA staff who have not had exposure to PCMH concepts in the past. It's clear that the contract with HANYS would include this kind of introduction.

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

2

Cross Project – EHR/Technology

Content Topics

- **Training for data sharing:**
  - Data security and Accuracy
  - HIPAA compliance
  - Data entry into EMR
  - Contractual obligations (e.g., participation agreement, business associate agreement, data use agreement, etc.)
- **Training for Meaningful Use best practices:**
  - 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
- **General EHR support**
  - Leveraging EHR in clinical redesign
  - Optimizing office workflows
- **Training for providers on Clinical Integration**
  - Tools
  - Communication methods for coordination

Delivery

- **Material:** Power point presentation; [Pre-read] 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 provider type. May be as much as monthly for 2 to 4 months for PCP sites, or only once for other provider types.
- **Trainer:** Director - Health Information Technology, IT Vendors
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness: (**1) Percent of PPS that took the course, (2) Percent of PPS providers that meet Meaningful Use, (3) Results of participant survey, (4) Fewer basic questions being posed at project and PAC meetings
- **Setting:** Individual and Multi-Disciplinary Team

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

Cross Project – Care Management

Content Topics

- **Training for Care Management Basic Concepts:**
  - Risk stratification
  - Chronic condition management
  - Transitions of care
  - Quality Support
  - Interdisciplinary care teams
  - Care planning
  - Basic care coordination and communication tools (for office staff)
- **Training for Care Management Advanced Concepts:**
  - Complex case management
  - Medication reconciliation best practices
  - Closing care gaps
  - Self-management action plans
  - Exacerbation management
- **Care Management Tools:**
  - Predictive modeling
  - Provider profiling
  - Telemonitoring
  - Patient portals

Delivery

- **Material:** Power point presentation; [Pre-read] 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 provider type. May be as much as monthly for 2 to 4 months for PCP sites, or only once for other provider types.
- **Trainer:** Director - Care Management, Care Management training vendors
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** 1) Percent of PPS that took the course (2) Results of participant survey, (3) Fewer basic questions being posed at project and PAC meetings
- **Setting:** Individual and Multi-Disciplinary Team

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

Cross Project – Value Based Payments

Content Topics

- **Provider training for Clinical Quality and Performance Reporting**
  - Key measures and data definitions
  - Standard performance reporting from the PPS
  - Best practice approaches to performance improvement
- **Value Based Payments Plan:**

  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:**

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

Delivery

- **Material:** Power point presentation; [Pre-read] DSRIP FAQs, VBP roadmap
- **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:** Director - Performance Management
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness:** 1) Percent of PPS that took the course (2) Results of participant survey, (3) Percent of contracts that are based on VBP
- **Setting:** Individual and Multi-Disciplinary Team

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

2 Cross Project – PPS Staff

Content Topics

- **DOH Reporting Concepts:**

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

- **MAPP Reporting Concepts:**

  Training for Medicaid Analytics Performance Portal (MAPP):
  - Purpose of MAPP
  - Member tracking
  - Billing support
  - Provider management
  - Interoperability
  - Medicaid claims data management

- **Project Management Office Concepts:**

  Training for Project Management:
  - DSRIP projects
  - Quarterly reporting
  - Functional committees/workgroups

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:** Director - Project Management Office, Performance Management
- **Reporting:** Logs from online tool, paper-based tracking system
- **Effectiveness: (**1) Ability of PPS to meet DOH quarterly reporting requirements, (2) Ability of projects to meet their expected speed and scale targets.
- **Setting:** Individual and Multi-Disciplinary Team

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

Table of Contents

3 “How” – Training Program Operating Model

Four Key Questions

Operationalizing the training program requires a coherent strategy 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

- SIPPS should consider a central training administration function (~1 project management FTE)
- Direct Report to Sr. Director of HR/ Workforce … with dotted lines to SIPPS CMO and Cultural Competence lead
- **Assumptions:**
  1. PPS shouldn’t reinvent the training wheel – rather leverage partners and vendors to source key training content
  2. PPS shouldn’t spend resources on creating a vast training bureaucracy; goal is to be lean but with some oversight

Key Functions

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

Excluded (since partners or vendors will deliver):

1. Creation of actual training content
2. Conduct clinical training

Options

Several choices exist (with trade-offs) if a FTE isn’t hired and dedicated for training:

- **Side of desk:** Training administration is an activity that gets managed part time by an existing resource (e.g., Sr. Director of HR/ Workforce)
- **Training Committee:** The training committee takes more of a hands on role in the execution and day-today oversight of the training plan
- **Volunteers:** A rotational program where volunteers from variety of PPS partners takes responsibility for this function for a period of time

Recommendation: It may be worth having a dedicated admin resource for managing training oversight given the importance of workforce training in the DSRIP program

3

"How" – Training Program Processes

❓ What are the top processes that should be in place?

Process	Description	Considerations
1. Directory	▪ Maintain a list of the PPS workforce and the list of trainings that are available through the PPS	1) **Keep processes lean** … minimize any non value-added overhead that creates more work that 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 provider training are conducted early mornings, late evening outside of patient hours 4) **Payments to PPS partners** … e.g., PPS can explore if it can link payment releases to PPS 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, for DSRIP IA inspection (these templates were circulated in Sep 2015)
2. Communications	▪ Develop an (automated) method for notifying PPS workforce about training alerts, deadlines, information etc.	
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 PPS 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 PPS	
7. Upward Management	▪ Share updates with Training and Workforce committees; ensure bi-directional communication with PPS stakeholders	

3 “How” – Training Program Technology Needs

❓ What technology considerations should be addressed?

Technology plays two important roles within the ‘Training Strategy’

a **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 SIPPS website or newsletter will enhance training transparency

b **Delivery**

- Online coursework (typically vendor produced) should be accessible to all PPS partners eligible
- Reports on coursework completion (or reminders about being stuck) should be generated by online course vendor
- PPS may want to maintain a webinar account (e.g., Webex) for PPS-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 the PPS create, maintain and deliver huge amounts of training content … there is a relatively moderate role for technology within the SIPPS

3 “How” – Training Program (Academia)

❓ What is the role of academic institutions?

Academia

- Relationship with academia can take one or more of the following forms:
  1. **Internships** – Rotate interns from medical, nursing, social work schools through PPS
  2. **Courses** – Get customized DSRIP courses created for PPs stakeholders
  3. **Career Counseling** – Leverage resources at local university career centers to facilitate placements
- PPS can leverage **free educational content** at KhanAcademy or Coursera and other online free courses
- PPS can leverage **cross-PPS training collaborations** (student exchange program, bartering course content etc.)

PCMH Training – Beyond NCQA

Achievement of NCQA PCMH Level III recognition is a critical component of DSRIP success… but a high performing PPS goes beyond "check the box" solutions to develop true Advanced Medical Homes

1. Highly coordinated care in the Primary Care setting has the potential to **significantly influence DSRIP outcomes**. To maximize results, the training resources dedicated to a small, focused group of high volume PCP practices/FQHCs should be commensurate with this potential and act as the foundation for a train-the-trainer model across SIPPS that can be sustained in the future
2. These training resources need to cover a **large body of information over a prolonged period of time** for implementation – usually 18 to 24 months. Therefore the cost of these services will be significant and will make up a significant proportion of the training budget.
3. Given that SIPPS has elected to pursue NCQA PCMH and not pursue APC; no training is needed for the latter

Steps to identify needed PCMH Training

1 Current State Baseline for Each Practice

- Self-reported survey
- Onsite interviews
- Rating on practice maturity grid dimensions
- Discussion with practice on ratings

2 Prioritized Action Plan (by practice)

- Identify key gaps in training prioritized by order of impact
- Best practices for building consensus at the site about the list and priorities
- Tailored action plan elements and timeline to meet the training needs of each PCP practice

Components of PCMH Training

3a Best Practice Team

- Address practice-specific improvements
- Implement all required PCMH elements

3b Monthly Meetings

- Coordinate monthly interdisciplinary care team meetings

3c Coaching & Mentoring

- Mentor site physician leadership (HANYS, PCDC may provide)

3d Reporting

- Training on DSRIP reporting best practices

Care Management Training - Immersion

To be successful in supporting clinical and utilization improvement in acute and chronic illness, care management staff will require immersion in a robust, dynamic training program.

1. **Key components of program include**:
   - Solid clinical training, knowledge of key chronic illnesses – CHF, Diabetes, CAD, Asthma, etc.
   - Skills required to create patient activation- readiness to change, motivational interviewing
   - Full knowledge of best practice clinical assessment tools, collecting information on care gaps, setting up and completing a care plan
   - Full knowledge of clinical quality and performance improvement processes
2. In addition, immersion training will develop a small, core team of CM staff to function as a **highly skilled response team across the entire PPS network**
3. Because of the **in-depth nature of this training**, the cost of training of these individuals will make up a significant proportion of the training budget

Immersion Training for CM's

- "Shadow" a CM at a high quality organization who is "best practice" at doing this work – such as Geisinger
- Real-time exposure to complex cases
- Exposure to reliable workflows
- Expertise developed in CM topics such as:
  - Medication Reconciliation
  - Motivational Interviewing
  - Nurse-Physician Interactions
  - Performing at "Top-of-License"
  - "Special Needs" cases

Creates…

Future State Care Management Model

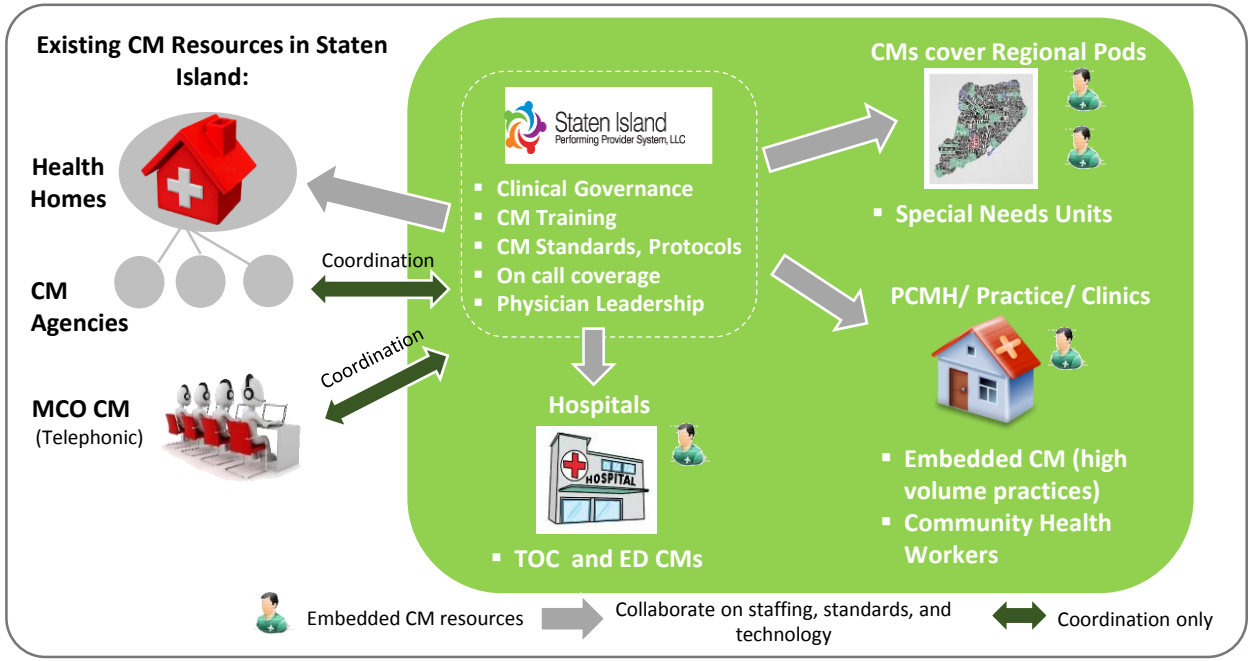


Table of Contents

4

Roadmap – Guidelines

Some guiding principles should inform the staging and rollout of training to PPS providers

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

- For e.g., the FQHCs and Victory IPA may be prioritized over smaller PCP office

DSRIP Timeline Mandates: DSRIP requires that certain requirements be achieved by a certain timeline; the PSS may also have made similar commitments for provider 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 PPS

- For e.g., NSLIJ has a robust internal L&D function; 1199 SEIU TEF has internal capabilities

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

- For e.g., PAM training to select CBOs for executing surveys

4 Roadmap – Quick Wins, Regulatory and Cross Project

Over the next six months, early wins can be achieved

Quick Win – Training activities that are easy to execute in the next 6 months

1. "DSRIP 101" for the entire PPS should be conducted via online video sessions
2. "Basics of Population Health" – online videos and series of articles
3. "Basics of Cultural Competence" – online videos and series of articles
4. Hiring of the 'training coordinator' for the SIPPS

Regulatory – Training activities that are a "must have" in the next 6 months (and possibly ongoing)

1. Compliance training as mandated by DSRIP

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 providers

Roadmap – Vendors & Educational Institutes

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

Vendors

Subject Areas to consider vendors:

1) **Core Skills for DSRIP success** such as care management training and PCMH training for practices
2) **Niche training** such as Insignia Health for PAM survey delivery and interpretation training

Timing to select vendors:

Vendor selection should occur by end of 2015 so that by the end of the year (or prior), a clear execution path exists

PPS Partners as vendors:

PPS 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:

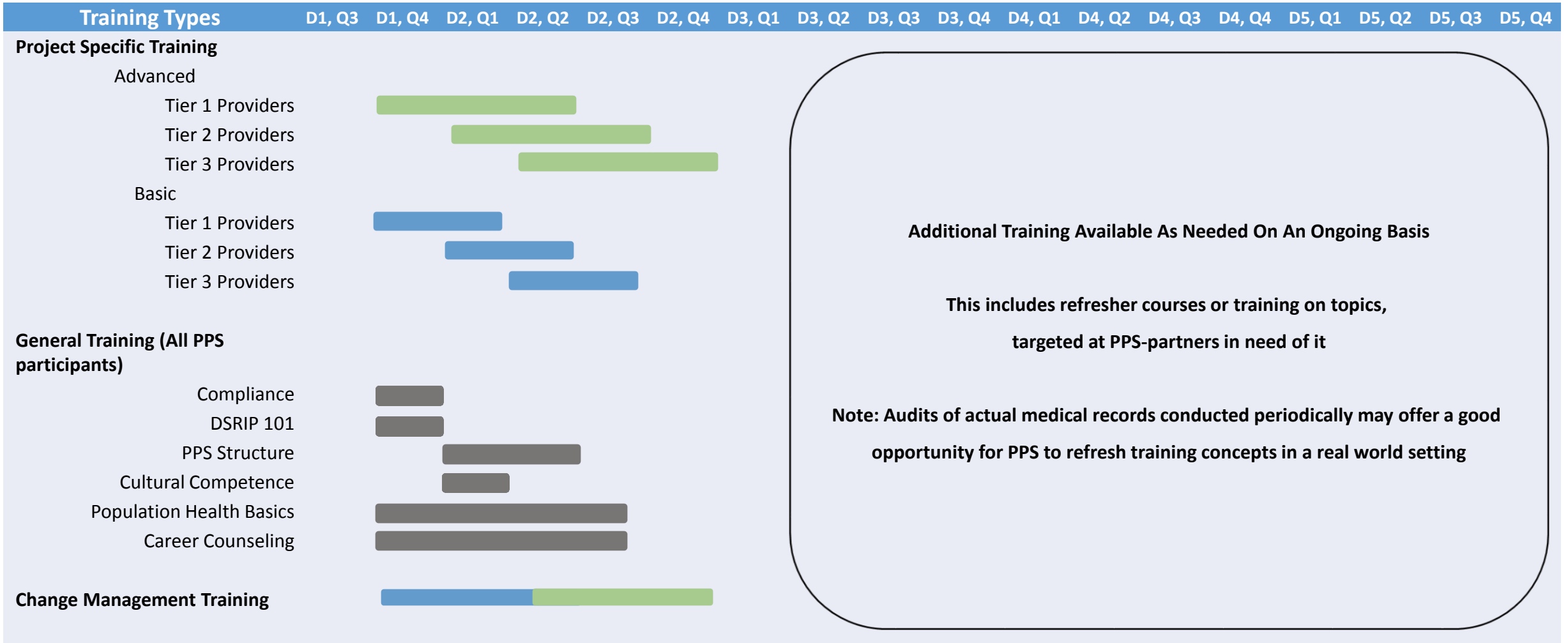
1) If the local / regional education institute is well-renowned for a particular training course, then explore a long term partnership to make that course work available to PPS partners
2) Explore free course work that may be available through premier educational institutions through websites like Coursera

Timing to select educational institutes:

Not an urgent priority for 2015; this activity can be initiated and pick up in 2016 and beyond

Roadmap – General and Project-Specific Timeline

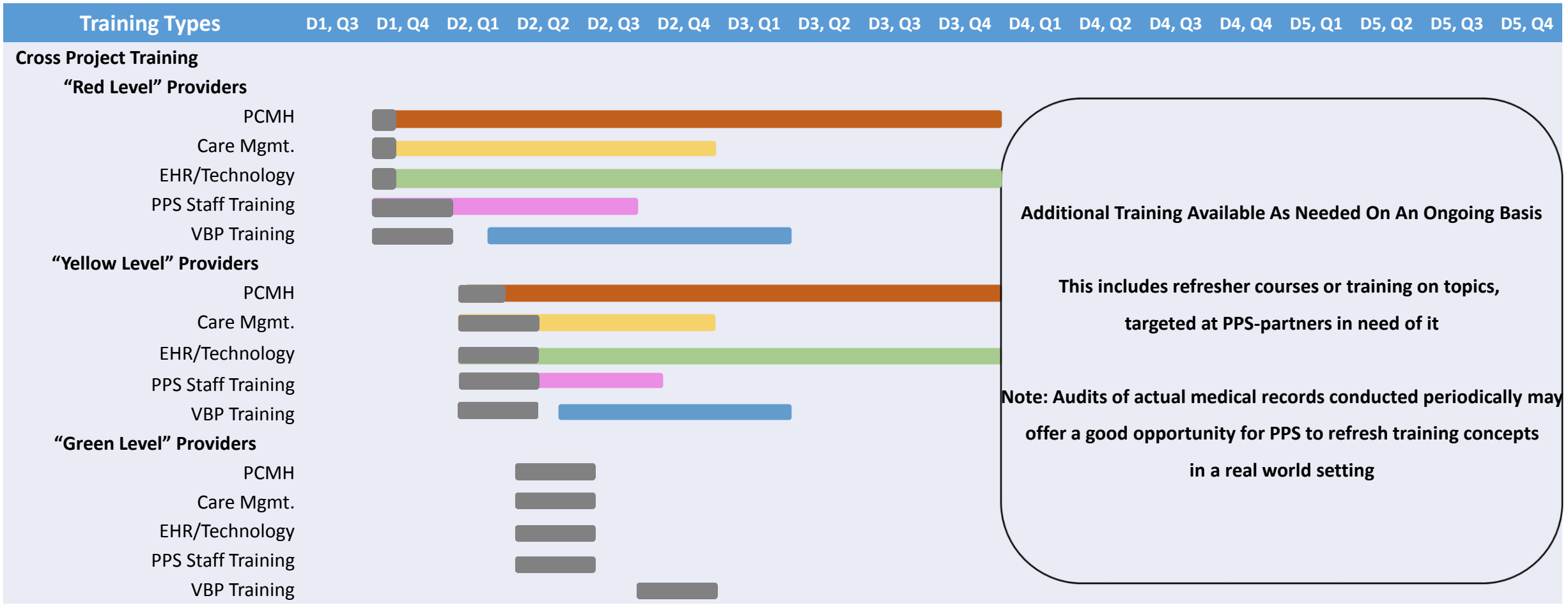
All components of the training strategy will require an initial burst of content training… followed by a long tail of refresher courses



Note: The length of training depicted in the roadmap is representative of the expected average. Some providers/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



4 Roadmap – Inpatient Hospital

Training focus on …

Tier 1 Providers

1. RUMC
2. SIUH
3. -
4. -
5. -

Sequencing

High

Low

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

	Project-Specific											Cross Project				
Employee Group	**2A3**	**2B4**	**2B7**	**2B8**	**2D1**	**3A1**	**3A4**	**3C1**	**3G2**	**4A3**	**4B2**	**PCMH**	**EMR**	**CM**	**PPS**	**VBP**
1. IP Hospital Executive Leadership	B	A	B	-	B	-	B	B	B	-	-	-	i, ii	-	-	i
2. IP CM Leadership	B	A	B	B	B	-	B	B	B	-	-	-	i, ii	-	-	
3. IP CM Staff (RN, SW)	B	A	B	B	B	-	B	B	B	-	-	-	i, ii	-	-	
4. ED Execs & Clinicians	B	B	B	B	B	-	B	B	B	-	-	-	i, ii	-	-	
5. Nursing Leaders & Staff	B	A	B	B	B	-	B	B	B	-	-	-	i, ii	-	-	
6. IP Enrollment Staff	-	B	-	-	B	-	B	-	-	-	-	-	-	-	-	-
7. IP Contracting Staff	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	i,ii

B Basic Concepts

A Advanced Concepts (includes Basic materials)

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)

4 Roadmap – SNF, Nursing Homes

Training focus on …

Tier 1 Providers

1. Carmel Richmond
2. Seaview Rehab
3. Eger Lutheran
4. Verrazano
5. Clove Lakes

Sequencing

High

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

Low

	Project-Specific											Cross Project				
Employee Group	**2A3**	**2B4**	**2B7**	**2B8**	**2D1**	**3A1**	**3A4**	**3C1**	**3G2**	**4A3**	**4B2**	**PCMH**	**EMR**	**CM**	**PPS**	**VBP**
1. SNF Clinical Lead/Facility Champion	-	-	A	-	-	-	-	-	A	-	-	-	i, ii	-	i	i, ii
2. SNF Exec. Leadership	-	-	A	-	-	-	-	-	A	-	-	-	-	-	i	i
3. SNF nurse aides	-	-	B	-	-	-	-	-	B	-	-	-	i, ii	-	-	-
4. SNF ancillary staff	-	-	B	-	-	-	-	-	B	-	-	-	i, ii	-	-	-
5. IP CM Leadership	-	-	B	-	-	-	-	-	B	-	-	-	i, ii	-	-	-
6. IP CM Staff (RN, SW)	-	-	B	-	-	-	-	-	B	-	-	-	i, ii	-	-	-
7. ED Execs & Clinicians	-	-	B	-	-	-	-	-	B	-	-	-	i, ii	-	-	-

B Basic Concepts

A Advanced Concepts (includes Basic materials)

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)

4 Roadmap – CBO (Non-licensed)

Training focus on …

Tier 1 Providers

1. -
2. -
3. -
4. -
5. -

Sequencing

High

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

Low

	Project-Specific											Cross Project				
Employee Group	**2A3**	**2B4**	**2B7**	**2B8**	**2D1**	**3A1**	**3A4**	**3C1**	**3G2**	**4A3**	**4B2**	**PCMH**	**EMR**	**CM**	**PPS**	**VBP**
1. CBO Clinical Leadership (RNs & SWs)	B	B	-	-	A	-	-	-	-	A	A	I	I	-	-	-
2. CBO Executive Leadership	B	B	-	-	A	-	-	-	-	A	A	I	i	-	-	-
3 . Community Navigators	B	-	-	-	A	-	-	-	-	A	A	i	I	-	-	-
4. Clinical Staff	B	-	-	-	A	-	-	-	-	A	A	-	i	-	-	-
5. Self-management trainers	B	-	-	-	B	-	-	B	-	A	A	I	-	-	-	-

B Basic Concepts
A Advanced Concepts (includes Basic materials)

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)

Roadmap – Outpatient BH (Article 31, 32)

Training focus on …

Tier 1 Providers

1. -
2. -
3. -
4. -
5. -

Sequencing

High

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

Low

	Project-Specific											Cross Project				
Employee Group	**2A3**	**2B4**	**2B7**	**2B8**	**2D1**	**3A1**	**3A4**	**3C1**	**3G2**	**4A3**	**4B2**	**PCMH**	**EMR**	**CM**	**PPS**	**VBP**
1. Exec. Leadership	A	B	-	-	-	A	A	B	-	A	A	I,ii	I,ii	I,ii	i	I,ii
2. BH and Medical clinical staff (MD. NP, RN, PA, LPN, etc.)	B	A	-	-	-	A	A	B	-	A	A	I,ii	I,ii	I,ii	-	-
3. Nursing leadership	A	B	-	-	-	A	A	B	-	A	A	-	I,ii	-	-	-
4. PPS Care Management staff	A	A	-	-	A	B	A	A	-	A	A	-	I,ii	I	-	-
5. Psychiatrists, Psychologists, Substance Abuse counselors and other BH/SUD staff	-	B	-	-	-	-	A	-	-	A	A	-	I	-	-	-
6. Health Home clinical leadership and CM staff	A	B	-	-	-	A	A	B	-	A	A	I	I	i	-	I,ii
7. Administrative support staff	B	-	-	-	-	_	B	B	-	B	B	-	-	-	-	-
8. ED Physicians and Nurses	B	-	-	-	-	_	B	B	-	B	B	-	I	-	-	-
9. IP Hospital staff ("enrollment staff", CM clinical leadership, IP CM's, etc.)	B	-	-	-	-	_	B	B	-	B	B	-	I	-	-	-

B Basic Concepts

A Advanced Concepts (includes Basic materials)

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)

Roadmap – Diagnostic Treatment Centers (Article 28)

Training focus on …

Tier 1 Providers

1. -
2. -
3. -
4. -
5. -

Sequencing

High

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

Low

	Project-Specific											Cross Project				
Employee Group	**2A3**	**2B4**	**2B7**	**2B8**	**2D1**	**3A1**	**3A4**	**3C1**	**3G2**	**4A3**	**4B2**	**PCMH**	**EMR**	**CM**	**PPS**	**VBP**
1. Ambulatory SUD Providers	-	-	-	-	-	-	A	-	-	A	-	-	I,ii	-	-	-
2. BH/SUD Exec. Leadership	-	-	-	-	-	-	A	-	-	A	-	I	I	-	-	I,ii
3. BH/SUD providers and medical staff (MD. NP, RN, PT, OT, etc.)	-	-	-	-	-	-	A	-	-	A	-	-	I	-	-	-
4. Nursing leadership	-	-	-	-	-	-	A	-	-	A	-	I	I	-	-	-
5. PPS Care Management staff	-	-	-	-	-	-	A	-	-	A	-	-	I	I,ii,iii	-	-
6. Psychiatrists, Psychologists,	-	-	-	-	-	-	A	-	-	A	-	-	I	-	-	-
7. Health Home clinical leadership and CM staff	-	-	-	-	-	-	A	-	-	A	-	-	I	-	-	-

B Basic Concepts

A Advanced Concepts (includes Basic materials)

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)

Roadmap – OPWDD Clinics (Article 16)

Training focus on …

Tier 1 Providers

1. -
2. -
3. -
4. -
5. -

Sequencing

High

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

Low

	Project-Specific											Cross Project				
Employee Group	**2A3**	**2B4**	**2B7**	**2B8**	**2D1**	**3A1**	**3A4**	**3C1**	**3G2**	**4A3**	**4B2**	**PCMH**	**EMR**	**CM**	**PPS**	**VBP**
1. Executive leadership	-	-	B	B	-	-	-	-	-	-	-	-	I	-	-	-
2. Rehab staff (physical therapists, occupational therapists, etc.)	-	-	B	B	-	-	-	-	-	-	-	-	-	-	-	
3. Dental staff	-	-	B	B	-	-	-	-	-	-	-	-	-	-	-	-
4. Medical staff	-	-	B	B	-	-	-	-	-	-	-	-	-	-	-	-
5. Ancillary services staff (dieticians, nutritionists, podiatrists, etc.)	-	-	B	B	-	-	-	-	-	-	-	-	-	-	-	-

B Basic Concepts

A Advanced Concepts (includes Basic materials)

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)

4

Roadmap – Primary Care Practice

Training focus on PCMH, Care Transitions, and functioning as a Care Team

Tier 1 Providers

1. -
2. -
3. -
4. -
5. -

Sequencing

High

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

Low

	Project-Specific											Cross Project				
Employee Group	**2A3**	**2B4**	**2B7**	**2B8**	**2D1**	**3A1**	**3A4**	**3C1**	**3G2**	**4A3**	**4B2**	**PCMH**	**EMR**	**CM**	**PPS**	**VBP**
1. PCP Exec. Leadership	A	A	-	-	A	A	A	A	-	B	A	I,ii	I,ii	I,ii	-	I,ii
2. Primary Care clinical staff (MDs. NP, etc.)	A	A	-	-	A	A	A	A	-	B	A	I,ii	I,ii	I,ii	-	I
3. Nursing Leadership	A	A	-	-	A	A	A	A	-	B	A	I,ii	I,ii	I,ii	-	I,ii
4. PPS OP CM Staff	A	A	-	-	B	A	A	A	-	B	A	I,ii	-	I,ii	-	I
5. Primary Care office Administrative Staff	A	-	-	-	A	A	-	-	-	-	B	I,ii	-	I,ii	-	-
6. Health Information Technology Staff	B	B	-	-	B	B	B	B	-	B	B	I	I,ii	I	I,ii	I
7. PCP Referral Coordinators	A	A	-	-	A	-	-	-	-	B	A	I,ii	-	I,ii	-	-
8. Non-PCP Exec. Leadership	B	B	-	-	-	B	-	-	-	B	B	I,ii	I	I	-	I,ii
9. Non-PCP Clinical Staff	B	B	-	-	-	B	-	-	-	B	B	I,ii	I	I	-	I

B Basic Concepts
A Advanced Concepts (includes Basic materials)

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)

Roadmap – Hospital OP Clinics (Article 28)

Training focus on …

Tier 1 Providers

1. -
2. -
3. -
4. -
5. -

Sequencing

High

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

Low

	Project-Specific											Cross Project				
Employee Group	**2A3**	**2B4**	**2B7**	**2B8**	**2D1**	**3A1**	**3A4**	**3C1**	**3G2**	**4A3**	**4B2**	**PCMH**	**EMR**	**CM**	**PPS**	**VBP**
1. PCP Exec. Leadership	A	A	-	-	A	A	A	A	-	B	A	I,ii	I,ii	I,ii	-	I,ii
2. Primary Care clinical staff (MDs. NP, etc.)	A	A	-	-	A	A	A	A	-	B	A	I,ii	I,ii	I,ii	-	I
3. Nursing Leadership	A	A	-	-	A	A	A	A	-	B	A	I,ii	I,ii	I,ii	-	I,ii
4. PPS OP CM Staff	A	A	-	-	B	A	A	A	-	B	A	I,ii	-	I,ii	-	I
5. Primary Care office Administrative Staff	A	-	-	-	A	A	-	-	-	-	B	I,ii	-	I,ii	-	-
6. Health Information Technology Staff	B	B	-	-	B	B	B	B	-	B	B	I	I,ii	I	I,ii	I
7. PCP Referral Coordinators	A	A	-	-	A	-	-	-	-	B	A	I,ii	-	I,ii	-	-
8. Non-PCP Exec. Leadership	B	B	-	-	-	B	-	-	-	B	B	I,ii	I	I	-	I,ii
9. Non-PCP Clinical Staff	B	B	-	-	-	B	-	-	-	B	B	I,ii	I	I	-	I

B Basic Concepts

A Advanced Concepts (includes Basic materials)

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)

4 Roadmap – Home Care

Training focus on …

Tier 1 Providers

1. -
2. -
3. -
4. -
5. -

Sequencing

High

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

Low

	Project-Specific											Cross Project				
Employee Group	**2A3**	**2B4**	**2B7**	**2B8**	**2D1**	**3A1**	**3A4**	**3C1**	**3G2**	**4A3**	**4B2**	**PCMH**	**EMR**	**CM**	**PPS**	**VBP**
1. Clinical Lead / Facility Champion	-	-	-	A	-	-	-	-	-	-	-	-	I,ii	-	-	-
2. Home Care Exec. Leadership	-	-	-	A	-	-	-	-	-	-	-	-	I,ii	-	-	I,ii
3. Home Health Aides / Ancillary Staff	-	-	-	B	-	-	-	-	-	-	-	-	-	-	-	-
4. ED Physicians and Nurses	-	-	-	B	-	-	-	-	-	-	-	-	-	-	-	-
5. Nursing Leadership	-	-	-	B	-	-	-	-	-	-	-	-	I	-	-	-
6. IP Clinical Leadership	-	-	-	B	-	-	-	-	-	-	-	-	I,ii	-	-	-
7. IP CMs (RNs and SWs)	-	-	-	B	-	-	-	-	-	-	-	-	-	-	-	-

B Basic Concepts
A Advanced Concepts (includes Basic materials)

Note: In addition to trainings listed above, everyone goes through the set of general training (e.g., DSRIP 101 etc.)

Table of Contents

5 General – Guiding Principles

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

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

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

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

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

Source: 1) Bershin

5

General – Team Based Training

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

When is 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 team based training?

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

Example:

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

5

General – Language

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

- **Key Languages:** English & Spanish + Tier 2 (Arabic, Russian)
- **Language Translation Services:** Establishment of language lines in the PPS 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

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

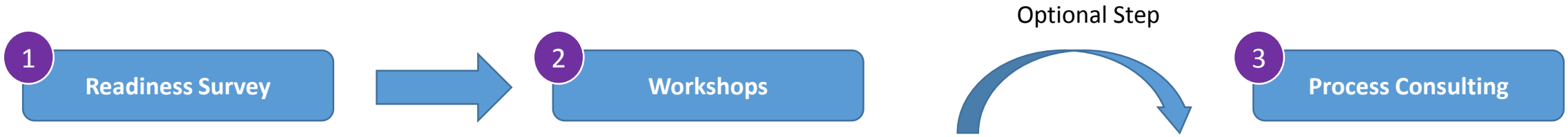
- Creating sustainable change involves reinforcement through numerous channels including:
  - Nomination of change mgmt. champion to monitor issues, troubleshoot unique situations and explain reason for change to per group and new hires
  - Produce periodic reports for executive leadership team

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

General – Change Management

A pragmatic, multi-step process is essential to building a sustainable change management strategy



- Designed to evaluate the initial readiness of the organization to enact change
- Survey will measure:
  - Current State Analysis
  - Target State Development
  - Roadmap for Change
  - Resources ((i.e., human capital, IT, etc.)
- Results of the readiness assessment will inform the content of the initial workshop

- Workshops consist of initial occurrence and ongoing refresher courses to reinforce behavior change
- **Initial workshop:**
  - **Frequency:** One-time
  - **Length:** 4-6 hours
  - **Content:** Communicate the reason for change, who will participate in change, and timing of interventions
- **Ongoing Refresher Courses:**
  - **Frequency:** Every six months
  - **Length:** 1-2 hours
  - **Content:** Reinforce message from initial workshop and provide re-training in best practices for selected interventions

- Process Consulting enlists subject matter experts to help guide the overall vision and the ongoing training workshops
- **Process Consulting Experience:**
  - **Frequency:** One-time or recurring
  - **Length:** Ongoing
  - **Content:** Facilitation of organizational communication plan, leadership vision and assessment of ongoing process improvement opportunities

5

General – Cultural Competence & Hotspots

The Cultural Competence deliverable will have a detailed ‘training’ section

- Details on the training for cultural competence are available in the **cultural competence training milestone;** That milestone addresses elements of language, diversity, health literacy in its entirety
- Addressing cultural competence requires that we **solve for unconscious bias** among providers & care givers
- Materials need to be created that address **reading skills at 5th grade level** for peer workers
- For physicians, nurses etc., it is critical to demonstrate cultural competence through **video or real life simulations**

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**	The PPS has a limited set of resources to establish workforce training	1. Leverage existing training that already exists within the PPS partners 2. Assess if PPS 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

Interview Feedback

Richmond University Medical Center

Current assets and capabilities of partners can be leveraged for DSRIP training across the PPS

Richmond University Medical Center

Training Assets

- Dedicated nurse educators to train nursing staff in “teach back” method

Training Gaps

- Standardized best practices in Care Transitions (i.e., need training to ensure seamless hand-offs every time, etc.)
- Motivational Interviewing and true integration of BH & Primary Care
- DSRIP 101

High Impact Positions for Training

- New Positions: Community Health Workers, Certified Diabetes Educators, Director for Care Management & Project Manager for DSRIP
- PAM workers

Training Constraints or Guidelines

- Limited communication between hospitals in PPS
- Model for collaboration still being designed by PPS partners – training needs to follow model design
- Ensure that webinars are recorded
- Ensure that feedback on training effectiveness collected
- Lunch time works better that early mornings or late evenings

Carmel Richmond Nursing House

Current assets and capabilities of partners can be leveraged for DSRIP training across the PPS

archcare

Training Assets

- Past experience in INTERACT training
- Access to palliative care training and best practices from the Avila Institute of Gerontology

Training Gaps

- Need training on how to manage family/caregiver expectations for SNF visit; INTERACT training in general
- Consistent training for all staff (i.e., length of training, timing, etc.)
- Backfill provisions when nurses are being trained

High Impact Positions for Training

- Nurse Aides
- Any new hires

Training Constraints or Guidelines

- Need to backfill positions during training limits ability to train large volume of staff at one time
- Model for collaboration still being designed by PPS partners and should be precursor for training
- Joint cross-organizational (hospital ER & SNF) training needed so all on same page re: protocols and capabilities
- Food at training sessions is a good motivator; 1 hour training sessions are about right

Seaview Hospital Rehabilitation Center

Current assets and capabilities of partners can be leveraged for DSRIP training across the PPS

Training Assets

- Four (4) INTERACT “train the trainer” resources could be made available
- Monthly in-service palliative care program

Training Gaps

- Scarcity of computer or other electronics to provide training
- Backfill for positions being trained

High Impact Positions for Training

- Any new hires

Training Constraints or Guidelines

- Need to backfill positions during training limits ability to train large volume of staff at one time
- Model for collaboration still being designed by PPS partners

Camelot of Staten Island

Current assets and capabilities of partners can be leveraged for DSRIP training across the PPS

Training Assets

- Access to best practices for substance use disorder (i.e., rational emotive therapy training, motivational enhancement therapy, cognitive behavioral therapy.)
- Experience with embedded Primary Care Provider in facility
- Logan Lewis (ex Adj. Professor at Stony Brook) is an expert in this field, passionate about he subject and could make a trainer across the PPS

Training Gaps

- No standardized training schedule
- Line staff has not been exposed to training in best practice (i.e., motivational interviewing, etc.)
- Expressed that training happens on the job – so the need is for more physician and nurse resources to do the job/ work with patients

High Impact Positions for Training

- Licensed Mental Health Worker
- Social Worker
- Credentialed Rehabilitation Counselor
- Clinical Supervisor

Training Constraints or Guidelines

- Not enough human capital (i.e., experienced clinical staff) to supervise and train new staff
- Model for collaboration still being designed by PPS partners
- Internet videos don't always cut it … apprenticeship model is necessary

Eger Lutheran Homes and Services

Current assets and capabilities of partners can be leveraged for DSRIP training across the PPS

Training Assets

- Optum provides embedded Nurse Practitioner to manage complex cases through Institutional Special Needs Plan – possibility to leverage Optum's training

Training Gaps

- Training in palliative care best practices for entire care team
- Training in role definition in palliative care (for e.g., nurse aides lack role clarity)

High Impact Positions for Training

- Nursing staff
- Nurse aides

Training Constraints or Guidelines

- Need to backfill positions during training limits ability to train large volume of staff at one time
- Difficult to send employees off-site for training
- Model for collaboration still being designed by PPS partners
- Leverage town hall meetings as a forum for select trainings

Verrazano Nursing Home

Current assets and capabilities of partners can be leveraged for DSRIP training across the PPS

Training Assets

- INTERACT training already in place
- Optum provides embedded Nurse Practitioner to manage complex cases through Institutional Special Needs Plan

Training Gaps

- Definition of palliative care and best practices
- Manage family/caregiver expectations for SNF visit
- DSRIP 101

High Impact Positions for Training

- None provided – Do not want to use DSRIP money

Training Constraints or Guidelines

- Need to backfill positions during training limits ability to train large volume of staff at one time
- Model for collaboration still being designed by PPS partners
- Need to build trust between hospitals and SNFs

Staten Island University Hospital

Current assets and capabilities of partners can be leveraged for DSRIP training across the PPS

Training Assets

- Existing programs for crisis prevention, diabetes management, leadership, and palliative care
- PAM training in place ; Robust diversity training program
- St. Pauls (local educational institute) sends interns to the Nursing & Medical Assistant training program

Training Gaps

- Information Technology (i.e., basic training in Microsoft Excel and advanced training in EMR systems)
- Training for Medical Assistants, clerical staff

High Impact Positions for Training

- Care Coordinators
- Community Health Workers
- Medical Assistants

Training Constraints or Guidelines

- Need to backfill positions during training limits ability to train large volume of staff at one time
- Difficult to send employees off-Staten Island for training
- Model for collaboration still being designed by PPS partners
- Frequency of refresher courses should be meaningful- ideally “audits of actual cases” is the best refresher
- Peer training where strong performers are paired with new team members for training is helpful

Victory Internal Medicine

Current assets and capabilities of partners can be leveraged for DSRIP training across the PPS

Victory Internal Medicine

Training Assets

- Experience exchanging data on the RHIO
- Advanced communication tools (Instacomm) to share data directly with providers

Training Gaps)

- Referral tracking (i.e., more accurate tracking of where patients go and where they come from)

High Impact Positions for Training

- Care Coordinators
- Medical Scribes

Training Constraints or Guidelines

- See no need for formal training program
- Model for collaboration still being designed by PPS partners

Clove Lakes Rehabilitation

Current assets and capabilities of partners can be leveraged for DSRIP training across the PPS

Clove Lakes Rehabilitation

Training Assets

- Four to six week training program in place for all newly hired nurses
- Monthly team based training sessions in place
- Optum provides embedded Nurse Practitioner to manage complex cases through Institutional Special Needs Plan

Training Gaps

- DSRIP 101
- Value-based Payments

High Impact Positions for Training

- Palliative Care Trainer
- IT nurse

Training Constraints or Guidelines

- Need to backfill positions during training limits ability to train large volume of staff at one time
- Model for collaboration still being designed by PPS partners

appendix

Survey Findings

Survey Results – Training

Summary:

1. Training programs for new hires are evident in 100% of PPS provider organizations who responded to the survey request

2. Additionally, all but one of the organizations indicated that they provide ongoing/continuing education to existing workforce. The one organization who lacked the ability to provide ongoing training stated that it was due to lack of resources (i.e., human capital) to provide sufficient training.

3. Every organization provided internal training resources for their workforce. About half of the organizations supplemented their internal resources with external vendors. There was no consistent pattern to vendors selected or the type of training provided by vendors.

4. Skilled Nursing Facilities and Home Care organizations were the most active in responding to the survey request and providing training materials

Survey Results – Training

Partner Organization	Is there training for new hires?	Is there ongoing training / continuing education?	Is tranining handled Internally / externally?	If External who provides training?
Camelot	Yes	No	Both	OASAS, ACS/OCFS, MCTAC
Carmel Richmond	Yes	Yes	Both	OmniCare, Northeast Networks, Loeb&Troper
Catholic Charities Community Services	Yes	Yes	Both	CUCS
CHCR	Yes	Yes	Both	NACHC, CHCANYS, Mayor's Office to Combat Domestic Violence, RAO Safety, various other orgs.
Eger Lutheran	Yes	Yes	Internally	
Ocean Breeze	Yes	Yes	Internally	
RUMC	Yes	Yes	Internally	
SEA View	Yes	Yes	Internally	
Staten Island Mental Health Society	Yes	Yes	Both	Various - No specific providers listed
SIUH	Yes	Yes	Internally	
Sky Light Center	Yes	Yes	Both	Relias Learning
Verrazano	Yes	Yes	Internally	
Clove Lakes	Yes	Yes	Internally	Survey indicated external training is used as needed - no specific providers listed.
UPG	Yes	Yes	Internally	
YMCA	Yes	Yes	Both	Various - No specific providers listed
Visiting Nurse Service of New York	Yes	Yes	Internally	

Number of surveys sent out: 49 **Training survey responses: 16**

appendix

Change Management Considerations

Overview

- Change Readiness Survey distributed to all providers to inform initial training curriculum
- Initial Full Day Workshops for all Program Directors, Managers and Supervisors involved in projects and all project leaders (Train-the-trainer option)
- Follow-up ½ day workshops at 30-60 day intervals for all project teams (dependent on timeline and progress)
- On site facilitation on project movement by workshop leaders (or train the trainer model) as needed (determined by timeline and progress)

Change Readiness Survey

- The Change Readiness Survey is a short survey that assesses the individuals perception of:
  - Their organizations willingness to change
  - Previous change success and failure
  - Effectiveness of leadership on change initiatives
  - Effectiveness of employees to manage change
  - Level of current change at their facility (# projects)
  - Their level of understanding of DSRIP/PPS/Projects
  - Benefits of current and future projects
  - Greatest concerns moving forward

Communication Plan

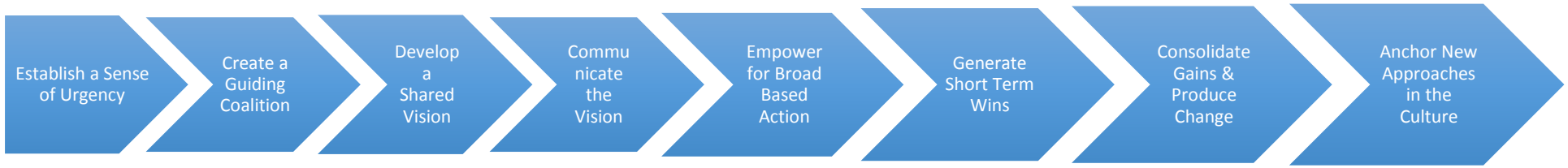
- Concurrent communication plan implemented to inform all PPS providers on project progress and successes.
  - Project kick-off meeting (may be combined with Change Management Workshop)
  - Email updates
  - E-Newsletter (quarterly)
  - Site meetings with project leadership

Full Day Workshop Outline

- Welcome and Introductions
- Course Overview
- Overview of DSRIP and PPS Structure
- Perception of Change Activity
- Goal Setting
- The Change Journey and Personal Change
- Introducing and Leading Change (Kotter Model)
- Building Consensus
- Forces and Sources of Change Resistance
- Integration and Conclusion

Change Models

- The Workshops will follow Kotter's 8 step model of change:



- As well as Zackrison and Freedman's model of change effort failure

Follow-Up Workshops

- Half-day workshops are to be held a minimum of twice for each project team, more if necessary
- The objectives of the half-day follow-up workshop on leading change are to:
  - review the integrated model for leading change
  - answer questions about the integrated model
  - discuss the progress the participants are making in helping people through organizational change
  - identify additional steps participants can take to enhance their change leadership abilities

Follow-Up Workshop Outline

- Welcome and Introductions
- Reflections on Project Progress and the Change Process
- Review of the Change Model and Group Discussion
- Exploring Questions and Issues
    - Project and Change Process Q & A
- Next Steps for Leading Change
- Integration and Next Steps

On-Site Facilitation

- Change facilitators will be available for on-site meetings and facilitation on an as needed bases
- It is recommended that a minimum of two on-site change facilitation sessions be scheduled for each project
- These may be combined (on the same day) as the follow up change workshops but will be focused on project specific facilitation and not change education
- Sessions will employ change acceleration methodologies and tools (i.e. GE's CAP model)

Measurement of Success

- Since the projects' success is directly correlated with the change strategy, the success of the change management program will be measured by the success of the individual projects

appendix

Lean Considerations

Overview

- Lean informational seminar to be held first quarter 2016 for all SIPPS members
- Lean educational workshops and intensives will be offered based on agency interest and requests
- Educational sessions will be offered in varying lengths:
  - 2 hour overview for senior leaders
  - 1 day intensive for those directing lean teams and projects
  - 4 ½ day lean leader course for those participating on lean teams (schedule will vary based on location of sessions)*
- Educational sessions are followed up by on site coaching and mentoring of lean teams, as well as consultation with senior leadership to ensure Lean alignment with DSRIP and PPS projects/goals

*On site sessions will be consecutive days while centralized sessions will be held over a two week period to allow for project time back at work site

What is Lean?

Lean is an ever-evolving philosophy based on proven principles and practices aimed at the elimination of wastes.

Lean is a compilation of world-class practices that will improve an organization through an evidence-based methodology.

- Lean focuses on eliminating waste in processes or systems
- Lean is not about eliminating people, but about using them more wisely
- Lean is about working with people to achieve continuous improvement activities to assist in reducing cost in an organization
- Lean is about understanding what is important to the customer

Lean Objectives

- Create a more defect-free product or service
- Reduce/Eliminate waste and increase efficiency
- Increase patient and employee satisfaction
- Reduce costs
- Increase patient safety
- Enhance leadership and communication skills

Lean in Healthcare

Although the concept of Lean and its various tools come from the manufacturing industry (popularized by Toyota), Lean has been used in healthcare for over 20 years. Today, hundreds of health systems and hospitals successfully use Lean to increase efficiency and reduce waste. A few examples include:

- Cleveland Clinic
- Denver Health Medical Center
- Virginia Mason Medical Center
- University of Michigan Medical Center
- Brigham and Women's Hospital

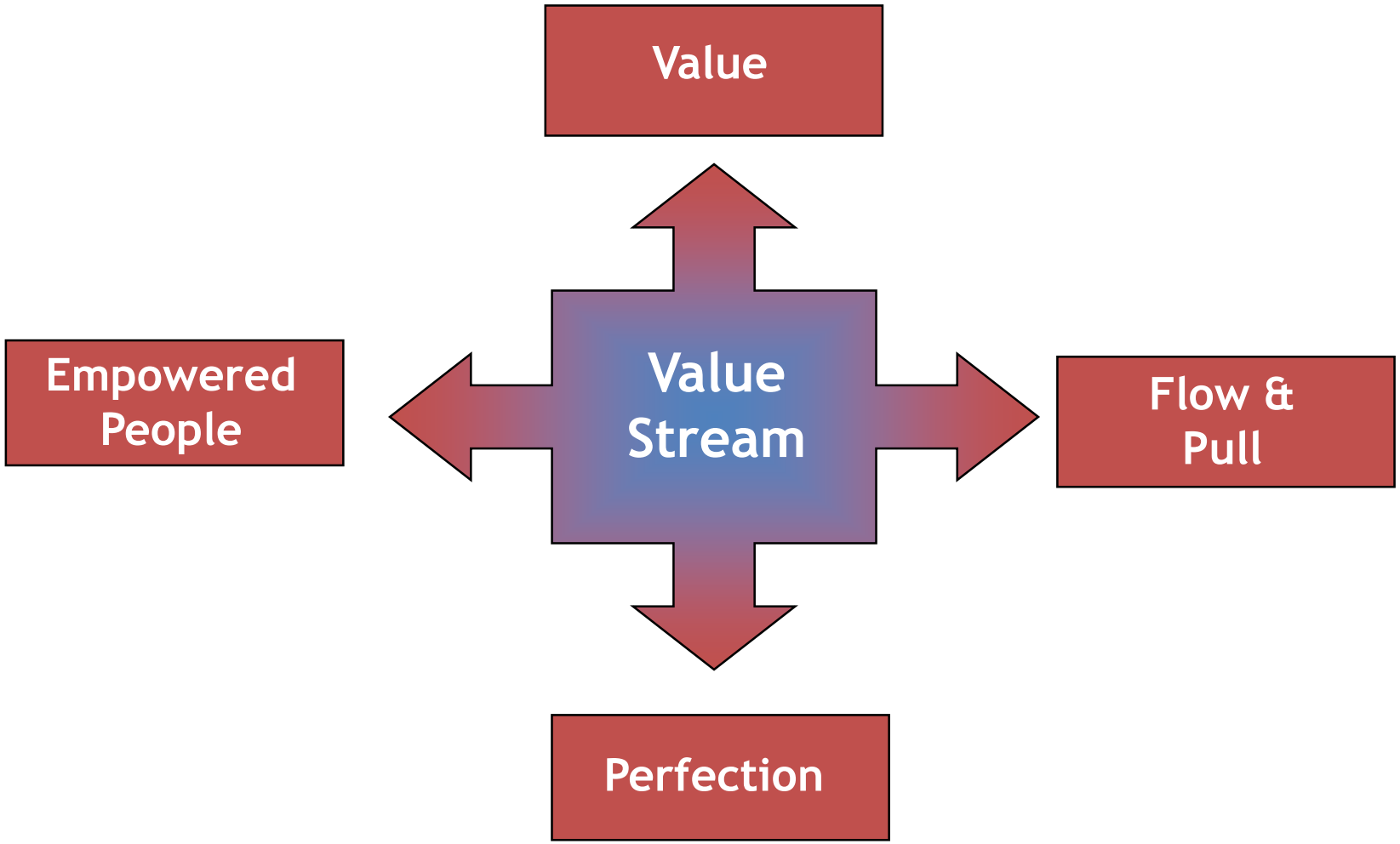
Two Hour and Full Day Topics

- What is Lean?
- Why Lean Healthcare?
- What is Lean Healthcare?
- Benefits of Lean Healthcare
- Implementing Lean Healthcare
- Leading Lean Healthcare Agencies
- Aligning Lean with DSRIP and PPS Priorities

4 ½ Day Lean Leader Topics

Monday	Tuesday	Wednesday	Thursday	Friday
• Welcome and Introductions • Meet the Team • Introduction to Lean Healthcare • Kaizen Events • Project Selection • Working in Teams	• Current State – Future State Analysis • Introduction to 5S • 5S Project Selection	• 5S Project Report-Out • Introduction to Standard Work • Standard Work Project Selection	• Standard Work Report-Out • Value Stream Mapping • Value Stream Mapping Project Selection	• Future State Value Stream Mapping • Report-Out Preparation
	5S Project	Standard Work Project	Value Stream Mapping Project	Final Report-Out to Senior Leaders

Lean Thinking Model



On-Site Facilitation

- Lean facilitators will be on-site to coach the Lean leaders for the first Lean project after the educational sessions
- They will also act as a liaison to organizational leadership to help with project selection and alignment with DSRIP/PPS projects
- Lean facilitators will be available for on-site meetings and facilitation on an as needed bases

Measurement of Success

Lean projects have measurable goals therefore success of the Lean program will be measured based on project goal attainment.

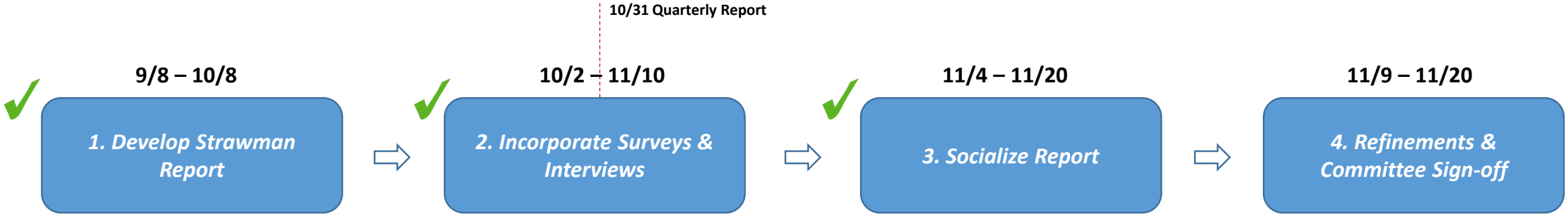
Additionally, Lean projects that are directly supporting a DSRIP/PPS projects will also be measured based on the results of the DSRIP/PPS project that they support.

appendix

Contact Us:

Approach & Current Status

Where we are in the development of the 'Training Strategy' at the end of week 9



Accomplished:
- Tr. Committee alignment on strategy Qs
- Overall deliverable structure
- Model for workforce impacted
- Detailed review of application

Pending or In Progress:
- Detailed review of implementation plans
- Full internal draft of who, what sections
- Other – State programs, funding, roadmap, change management, current state
- SIPPS leadership interviews

Help Needed:
- n/a

Accomplished:
NA

Pending or In Progress:
- Complete survey data analysis
- Conduct interviews
- Synthesize findings

Help Needed:
tbd

Accomplished:
NA

Pending or In Progress:
- Align with HL/CC training
- Circulate among Tr. Committee

Help Needed:
tbd

Accomplished:
NA

Pending or In Progress:
- SIPPS Leadership readout
- Final committee(s) meeting
- Submission to DOH

Help Needed:
tbd

For Questions on SIPPS Training Strategy

Contact Information

Samir D'Sa

Principal, NY DSRIP & Medicaid

xG Health Solutions (a Geisinger Company)

+1 (734) 546 2580

sdsa@xghealth.com

Chuck Baumgart

Sr. Medical Director

xG Health Solutions (a Geisinger Company)

cbaumgart@xghealth.com

Phil Wirtjes

Sr. Associate, NY DSRIP & Medicaid

xG Health Solutions (a Geisinger Company)

pwirtjes@xghealth.com

Alan Cooper

Consultant

Tudor Group, LLC

aCooper@tudorgroupllc.com