WMC Health | Performing Provider System (PPS)

Westchester Medical Center Health Network

Workforce Training Strategy

This document outlines:
A finalized workforce training strategy, approved by the PPS workforce governing body. The plan should identify:
-Plans for individual staff training.
-Plans for training new, multi-disciplinary teams.

ACKNOWLEDGEMENTS

The WMCHealth PPS Training Strategy was developed with assistance from the 1199SEIU Training and Education Fund.

The WMCHealth PPS Workforce Committee approved this document on 3/21/2017.

The WMCHealth PPS Executive Committee approved this document on 3/28/2017.

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Center for Regional Healthcare Innovation

WMCHealth PPS

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INTRODUCTION

The WMCHealth Performing Provider System (PPS) spans nearly 6,087 miles across eight counties in the Hudson Valley Region: Westchester, Rockland, Putnam, Dutchess, Orange, Ulster, Delaware and Sullivan. The PPS consists of the full spectrum of healthcare providers and social service agencies, including 10 hospitals and partners comprising of medical, behavioral and community-based providers. WMCHealth PPS vision is to enable coordinated social services and clinical care managed by local providers connected in what we refer to as Medical Neighborhoods within healthy communities.

DSRIP related care delivery and payment transformation will have an impact on healthcare employees across the Hudson Valley.[1] In 2010, SUNY published an extensive study of the physician supply in the Hudson Valley. The study concluded that the region is experiencing a shortage of doctors, particularly in primary care.[2] The SUNY study also documented medically underserved rural portions of the region and identified shortages in particular specialties such as behavioral health and psychiatry, where the current workforce is aging, and few replacements appear imminent.[3] The DSRIP emphasis on population health, prevention and primary care, combined with an aging population, will create demand for new, enhanced or expanded workforce roles/services particularly to meet needs for primary care, behavioral health and better care coordination in support of patients and families. Workforce strategies are essential to transformation of the healthcare delivery system in order to achieve the triple aim of better health, better care, and lower costs. The role of the WMCHealth PPS is to assess the current workforce, to project training needs, particularly as related to implementation of DSRIP projects, and in consultation with PPS partner provider organizations, to plan and allocate DSRIP resources to address the identified needs.

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[1] The New York State Department of Labor excludes Columbia and Greene Counties from the Hudson Valley regional data. New York State Department of Labor. (2010). Long-Term Industry Projections, Hudson Valley Region. Retrieved from https://labor.ny.gov/stats/lsproj.shtm. Lammot calculated the 2010 total in the 2010-2020-regional-long-term-occupational-projections.xlxs spreadsheet.

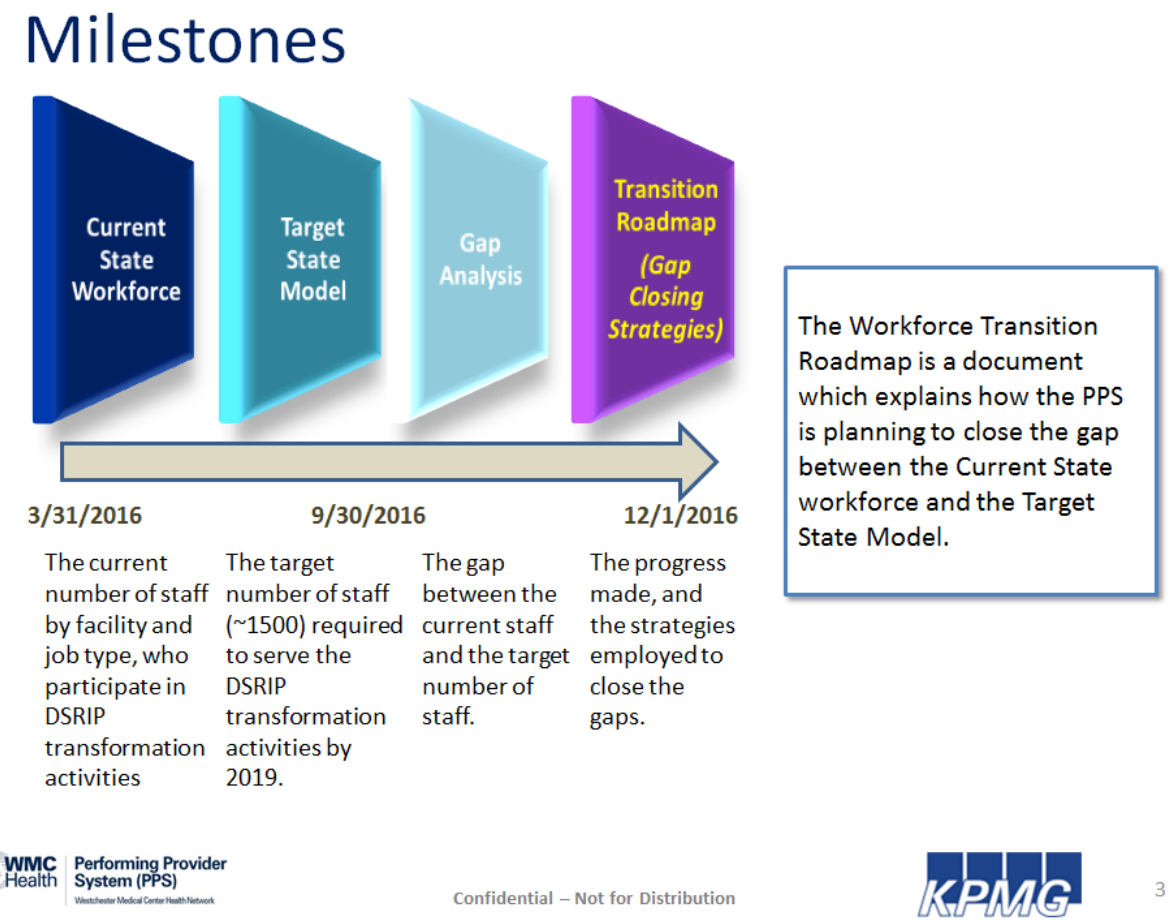
[2] Reed, K. (2010). Is there a Doctor in the House? Physician Recruitment and Retention in the Hudson Valley. Center for Research, Regional Education and Outreach (CRREO). New Paltz, NY. Retrieved from https://www.newpaltz.edu/crreo/discussion-brief-3-is-there-a-doctor-in-the-house.pdf.

[3] "Aging in the Hudson Valley," Hudson Valley Pattern for Progress. 2014. Hudson Valley is defined as Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester Counties.

Summary of Workforce Analysis

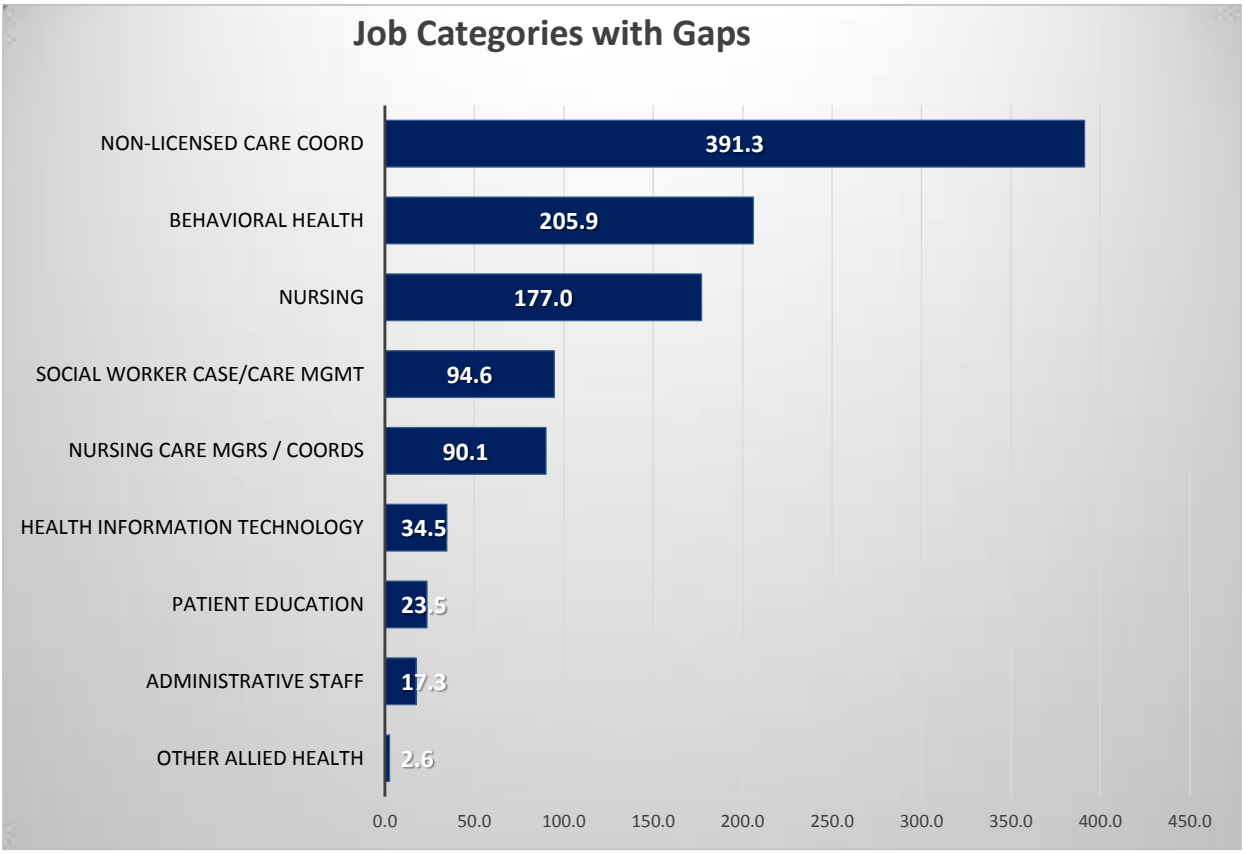
WMCHealth PPS with assistance from KPMG develops workforce analytic related milestones deliverables. In the fall of 2015, a comprehensive baseline workforce survey was distributed to a representative sample of network partners to assess the incumbent workforce and the capacity of partner organizations for workforce training and organizational development. The survey results provided baseline data for the WMCHealth PPS Comprehensive Current State Assessment and Gap Analysis report completed in the fall of 2016.

Figure 1: Workforce Milestones.



In the September 2016 Gap Analysis report nine job categories with identified workforce gaps to be addressed were determined. The non-licensed care coordinator job family had the highest number of gaps to be filled (37.7%).

Figure 2: 2016 Workforce Gap Analysis report. *Top Nine Job Categories with Gaps*



In December 2016, KPMG and the PPS developed a Workforce Transition Roadmap to address how deficits of workers in particular job categories could be addressed over the course of the DSRIP project. To develop this Transition Roadmap a sample of PPS partner organizations were surveyed and asked to review existing employees' roles and titles and to assign each existing employee in the surveyed categories to the corresponding DOH job category most closely describing the workers' roles or titles. Respondents were also asked to identify new hires and any employees who had been redeployed (moved to another position) or had received training to improve job skills. Finally, respondents were asked to project future new hires, and redeployments through 2019. Based on this new information the workforce gap was re calculated. The revised gap analysis demonstrated

a 31% reduction in the aggregate gap (across all job categories) from 1140 FTEs to 790 FTEs. Next, incorporating the collected workforce planning data on future new hires and redeployments the workforce gap was reduced an additional 15% from 790 FTEs to 667 FTEs through 2019.

In combination with the Workforce Transition Roadmap, the WMCHealth PPS training strategy offers a framework for training and staff development needed across the 11 DSRIP projects and work streams such as Cultural Competency and Health Literacy over the 5 yr. DSRIP period. The PPS Target State Report had identified staffing needs for 36 position types. The WMCHealth PPS Workforce Transition Roadmap showed that projected needs for 23 of these job types had already been met as of the December 2016 survey. Additionally, the PPS anticipates that projected new hires or redeployments will meet target numbers for health educators and physician assistants.

We anticipate producing an addendum to the Transition Roadmap following the review of the target state model. We will also produce an addendum to the gap analysis to update the current gap based on the inclusion of new partner workforce and revised calculations. Figure 3. Highlights anticipated gaps in 11 remaining Position Types after accounting for planned new hires, deployments, and training.

Figure 3: 2016 Transition Roadmap *Position Types that still have a Gap. PPS plans to address with various training and education strategies.*

No.	Job Category	Position Type(s)	Target	Remaining Gap (2019)
1	Non-Licensed Care Coordination/Case Management/Care Management (Except RNs, LPNs, and Social Workers)	Patient or Care Navigator/Community Health Worker/Peer Support Worker	397.7	-337.3
2	Nursing	Other Registered Nurses (Utilization Review, Staff Development, etc.)	116	-102.6
3	Nursing	Staff Registered Nurses	223.2	-67.6
4	Nursing	LPN Care Coordinator/Case Manager/Nurse Home Health	50	-45.5

		Coordinator		
5	Behavioral Health	Social Work Case Manager/Care Manager/Care Coordinator/Care Transition	91.4	-41.4
6	Patient Education	Certified Asthma Educators	29.9	-29.9
7	Physicians	Other Specialists (Except Psychiatrists)	36.9	-20.9
8	Nursing	RN Care Manager/Case Manager	42	-18.5
9	Other Allied Health	Nutritionists/Dieticians	10	-5.7
10	Clinical Support	Nurse Aide / Assistant	4	-2
11	Patient Education	Certified Diabetes Educators	0.3	-0.3

Purpose and Approach of Training Strategy

The WMCHealth PPS Workforce Training Strategy has been developed with consulting assistance from 1199SEIU Training and Employment Funds (TEF) and draws information, analyses and direction from the earlier WMCHealth PPS workforce documents referenced above (Workforce Current State Assessment and Gap Analysis, Workforce Transition Roadmap) and from the WMCHealth PPS Practitioner Education and Training Plan, Clinical Integration Strategy, Cultural Competency and Health Literacy Training Strategy, and the Project Implementation Plan.

The PPS recognizes the need for workforce development to achieve goals set for the DSRIP Program and more fundamentally to sustain transformation of the health care delivery system towards patient-centered, value-based care. The WMCHealth PPS focuses its training and education efforts on offerings that support quality care, and close the workforce gaps in an effort to achieve system transformation goals. Applying an intentional approach and employing multiple training modalities, this strategy includes a plan over the five year DSRIP timeline for training individuals and multi-disciplinary teams in the skill-sets required for health care workers in the new landscape; the training strategy is designed to drive change, increase knowledge, enhance skills, and improve the workers' ability to provide care. This document also discusses training for emerging jobs, mechanisms for reporting and evaluating training, additional workforce strategies

to address workforce gaps, and communication and collaboration strategies that facilitate stakeholder support and engagement.

TRAINING PLAN

The WMCHealth PPS partners play an essential role in developing models of care that will better serve communities to meet the needs of DSRIP projects and sustainable long-term delivery system transformation. PPS partners also contribute by responding to requests for workforce data and providing insight on DSRIP related training needs.

The PMO Workforce Team works with two key committees, which comprise of Members of the WMCHealth PPS' Workforce Committee and the WMCHealth PPS Community Engagement Quality Committee. These two groups represent leaders from community-based organizations, clinics, schools and hospitals i.e. Catskill Hudson Area Health Education Center, 1199SEIU, NYSNA, CSEA, SUNY Westchester Community College, Ulster BOCES, and other key stakeholders from the PPS Network. The Training and Employment Fund (TEF) of 1199SEIU is the PPS Workforce Consultant and offers training coordination, workforce consultation, curriculum development and a variety of trainings. KPMG is the PPS second Workforce Consultant particularly for data collection, statistical modeling and reporting on workforce.

The diversity of patients and the extent of healthcare-related reforms require the workforce to be trained to function in ever-changing work environments, to think critically and to provide effective solutions to problems. Trainings teach new ways to approach complicated situations and how actions influence health outcomes, improve patient engagement and patient self-management.

These approaches are applied using the following categories:

1. Learning Opportunities that encompass population health, care management, (multidisciplinary) care teams, and care coordination;
2. Learning Opportunities that support clinical and non-clinical staff understanding and working effectively in the new value-based and patient-centered delivery system;
3. Learning Opportunities directly related to successful staff implementation of PPS project protocols and/or best practices;
4. Learning Opportunities related to mastering information technology improvements; using technology to monitor and improve patient outcomes and

acquiring the knowledge and skills needed to comply with privacy and security regulations and other safeguards relative to use of technology;;

5. Learning Opportunities related to workforce Cultural Competency and promoting patient Health Literacy to improve patient experience and reduce access barriers;
6. Skill enhancement programs, certification preparation opportunities, organizational development l programs and adult education activities that allow for continuing education and open opportunities for current workforce to follow career pathways or transition to new jobs/emerging titles;
7. Training offered in innovative ways that encourage practitioner engagement and community engagement.

Emerging Job Titles

Workforce transformation is vital to meeting DSRIP goals. This may require new roles and functions for the existing workforce, which may lead to emerging job titles needed to meet the goal of building an infrastructure for more integrated care combining robust clinical services and population health management. Many of the emerging job titles are centered on care coordination. Some of the emerging care coordination titles include:

- Care managers/Case managers such as: RNs, LCSWs, and Behavioral Health Counselors
- Care navigators/coordinators such as: Community Health Workers (CHWs), Health Coaches, Patient/Care Navigators

Front line healthcare staff members are increasingly being asked to serve as a bridge between patients and providers. In some cases, this means new tasks for staff in existing roles and sometimes it means adding staff with emerging titles. As an example, front line staff need patient engagement and care coordination training. In 2015, New York State Department of Health (NYSDOH) formed a DSRIP/SHIP (NYS Health Innovation Plan) workforce workgroup to define care coordination and training for New York State. This workgroup is comprised of representatives that play a leading role in the State's workforce development efforts around care coordination education and training. This group created guidelines identifying core competencies in care coordination. These guidelines are based on national literature reviews of care coordination training provided around the U.S.

Consistent with the NYSDOH care coordination workgroup initiative, the PPS plans to meet DSRIP needs for enhanced care coordination. The PPS seeks to support partner organizations in this effort by developing appropriate training resources to develop the workforce to be qualified and

marketable for emerging job titles requiring care coordination or capable of taking on enhanced job functions (redeployment) related to care coordination and patient engagement. The PPS is also actively involved with the GNYHA DSRIP Workforce Workgroup, which offers the opportunity for cross-PPS statewide collaboration on strategies, needs and innovation.

Plan for Training Multidisciplinary Teams

WMCHealth PPS recognizes that workers have to be prepared to understand and take part in multidisciplinary teams and to deliver coordinated and culturally competent health care. Multidisciplinary care teams may include existing titles functioning in new care team roles as well as persons in new roles as reflected in the emerging job titles. Some examples of job titles to be found as emerging models of care are include RNs, LPNs, Medical Assistants, Certified Nursing Assistants, Home Health Aides, Registrars, Practice Managers, Discharge Planners, Administrative Support and Technology Support Staff. The PPS has sponsored training for multidisciplinary care teams from partner provider organizations who are working on DSRIP related quality improvement projects. Training offered has included: coaching and technical support for achieving Patient Centered Medical Home (PCMH) recognition, basics of Asthma and Diabetes management for care managers and care coordinators, methods for Quality Improvement (QI) such as the Plan Do Study Act (PDSA) and the NYSDOH sponsored MAX Series method. The PPS' Project Management Office (PMO) staff could itself be viewed as a multidisciplinary team whose members have also received PCMH and QI training as well as Organizational Development and Leadership trainings. Additional trainings under development for multidisciplinary teams include collaboration with MHA of Westchester and TEF 1199SEIU trainings to be launched in DY3 for PPS primary care teams on customer service, Motivational Interviewing, computer literacy, and Asthma & Diabetes care coordination for front line team members.

Community Health and Integrated Care

The WMCHealth PPS recognizes the importance of expanding care into the community. The focus on community health is embodied in the WMCHealth Network vision to link anchoring hospitals with other community development supporting housing, education, and economic development, in an effort to build vibrant healthy communities. The PPS views its Community Based Providers (CBP) partners as subject matter experts for the populations they serve and collaborates with the community in serving vulnerable populations such as those with behavioral health needs.

The community-based workforce includes many persons in non-clinical roles such as housing specialists and those working in food pantries or providing transportation. To better assist patients

and families in need of such services, and to assist community organizations in receiving referrals from health care providers, the PPS has engaged "Healthify" to provide an updated directory of community services and a platform to manage referrals.

The PPS has involved its Partners including CBP partners, in the development and identification of training needs. Training needs identified to date include comprehensive care plan training, motivational interviewing, creating care coordination protocols. The PPS also offers professional development trainings to CBPs workforce such as Soups. Soups are ways in which community based organizations "break bread" with one another and find ways to share information about organizational work, impact, accomplishments, best practices and gaps as a means to continue to build trust and relationships.

Patient-Centered Medical Homes

The PPS' Primary Care Plan details the main objectives to meeting this mandate: (1) expanding access to primary care, (2) enhancing capacity of existing providers to deliver high quality care, and (3) connect primary care to community resources through Medical Neighborhoods. WMCHealth PPS support the PPS network partners in workforce transformation for primary care through training and education, strategizing around staffing roles, and technical assistance to achieve PCMH Level 3 standards. The primary care workforce extends the full spectrum of providers, including, clinicians, care managers, care coordinators, ancillary and support staff and administrators. The primary focus of training and education for primary care transformation includes competencies intended to improve the ability of primary care teams to support patients and their families across this continuum: patient centered medical homes within effective Medical Neighborhoods within vibrant healthy communities. An example of PPS work to this end has been training around project protocols for Comprehensive Care Plan requirements.

Clinical leaders are critical to achieving sustainable health care system transformation. Examples of PPS activities to promote clinician engagement and education aimed at developing clinical leaders are seen through the PPS Medical Neighborhood Meetings and bi-monthly Primary Care Workgroup meetings. The Primary Care Workgroup consists of primary care physicians & lead administrative staff from practices that are in the process of transforming their practice sites towards attaining PCMH recognition status; agenda items include Value Based Payment, DSRIP project deliverables, performance measurement, care coordination, team based care, and how to share data and achieve Clinical Integration with other providers in the Medical Neighborhood.

Medical Neighborhoods as Coordinated Centers of Care

The primary objective of the WMCHealth PPS' Medical Neighborhood is to create highly coordinated local care transition pathways between clinical and community-based providers within target communities across the PPS. Care coordination is key in achieving better outcomes for patients and families. It supports transitions from hospital care to community care and collaboration between medical and behavioral health care providers.

Clinical care coordination roles include Clinical Specialty Providers such as Non-PCPs, Behavioral Health Specialists, Hospital-Based Clinicians, Substance Abuse Providers, Social Workers and Counselors. Examples of training topics are Care Coordination Protocols and Health Information Exchange Consent. Working with key stakeholders the PPS has begun offering trainings such on behavioral health best practices/protocols, asthma and diabetes education for care teams, care coordination training, motivational interviewing and providing care plan technical assistance to partners. This process begins with an assessment of each Medical Neighborhood to gather a precise understanding of the care needs of their community. This assessment involves mapping workflows and protocols, identifying the key staff and their current functions, and aligning those with patient care needs, project goals and quality measures.

Plan for Training Individuals

Crosscutting trainings address the courses needed to build the skills and competencies throughout the workforce across all DSRIP projects and are designed for multidisciplinary teams and individuals. These training are also specific to the deliverables of project 2.a.i, Creating an Integrated Delivery System, and 2.a.iv, Create a Medical Village. Crosscutting education and training opportunities include:

- ✓ Cultural competency and health literacy
- ✓ Compliance training
- ✓ Patient engagement
- ✓ Performance measurement and Quality Improvement (QI)
- ✓ Leadership training
- ✓ Training for workforce on the needs of vulnerable populations
- ✓ Approaches for better integration of Behavioral health, Mental Health and Substance Use with Population health management and using data to inform care.
- ✓ Computer Literacy related training, health information exchange (QE) trainings and training for other technology platforms

Project-Specific Training

These can range from basic to advance and can target augmenting incumbent staff skills. Workforce themes are centered on the following PPS approach to health care transformation:

1. Building Patient-Centered Medical Homes to ensure high quality, coordinated patient and family centered care;
2. Facilitating care coordination and health information exchange to link providers and improve transitions for patients in local Medical Neighborhoods; and
3. Working to promote healthy communities that go beyond health care delivery to engage with community organizations and stakeholders.

Key Workforce Functions across the DSRIP projects

2.a.iii. Health Home At-Risk Intervention Program
Project Objective: Active management of higher risk patients not currently eligible for Health Homes; provide access to high quality primary care and support services.

Key Workforce Functions

Key staff associated with this project includes integrated care teams and staff in agencies providing Health Home services. Core workforce functions required include patient engagement, data analysis to identify populations and guide clinical and social service delivery.

Skills, Knowledge and Competencies

- Chronic Disease Management
- Care Coordination
- Health Coaching
- Competence in patient navigation
- Patient Engagement skills
- Use of Registries
- Project Protocols

2.b.iv. Post Hospital Care Transitions - to reduce 30-day readmissions
Project Objective: Care transitions intervention model to reduce 30-day readmissions for chronic health conditions.

Key Workforce Functions

Key staff associated with this project are care managers and staff working with HIE (health information exchange) in hospitals, Health Homes and primary care settings—as well as post-acute setting staff, clinical leaders in hospitals, primary care and ambulatory behavioral health.

Skills, Knowledge and Competencies

- Risk assessment and care planning
- Documentation; change management skills to adopt new workflow as needed to incorporate risk assessment and HIPAA compliant use of HIE
- Competence in best practices in care transitions and adopted models including skills for patient engagement;
- Project protocols
- Medication Reconciliation

2.d.i. Patient Activation – integrate uninsured and low or non-utilizing Medicaid populations into community-based care

Project Objective: Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care.

Key Workforce Functions

Key staff associated with this project work in non-clinical roles whose primary role is to connect UI, NU and LU patients to care. They function directly in the community conducting outreach and coordination of services or in a Federally Qualified Health Center.

Skills, Knowledge and Competencies

- PAM training
- Outreach and Patient Engagement skills
- HIPAA compliant use of HIE

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

Project Objective: Integration of Primary Care and Behavioral Health Services.

Key Workforce Functions

Key staff associated with this project are part of integrated care teams in primary, ambulatory and behavioral health settings. Core functions include skills in patient engagement, patient screening, data analysis to identify populations and guide service delivery; linking patients/consumers to medical and behavioral health services in a culturally competent way; includes basic knowledge of behavioral health and common chronic conditions.

Skills, Knowledge and Competencies

- Interdisciplinary Care Team Training
- Basic knowledge of evidence-based practices for management of depressions, tobacco use, alcohol and other substance use, asthma and diabetes and patients on anti-psychotic medications
- Patient engagement skills
- Medication reconciliation
- Use of screenings
- Project protocols
- HIPAA compliant use of HIE

3.a.ii. Behavioral Health Community Crisis Stabilization Services

Project Objective: Behavioral Health Community Crisis Stabilization Services.

Key Workforce Functions Needed to Meet Project Objective

Key staffs associated with this project are clinical and non-clinical staff for example Peers Bridger's, LCSW, Case Managers, Care Coordinators, Nurses, Physicians and Clinical Leaders. In some instances, staff may function in multidisciplinary teams to intervene during a crisis and provide care coordination to prevent unnecessary emergency room services.

Skills, Knowledge and Competencies

- Crisis Intervention skills
- Intensive case management skills
- Use of registries
- De-escalation Skills
- Medication Reconciliation
- Psychopharmacology
- Trauma informed care

3.c.i. Diabetes Management

Project Objective: Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease. Evidence-based strategies for disease management in high risk/affected populations. Adult only.

Key Workforce Functions

The key staff associated with this project are part of care teams in primary care and specialty care, i.e. care managers, nurses, peers, and volunteers. Core functions required include knowledge of evidence based care protocols for management of diabetes, patient engagement and motivation skills, patient screening, data analysis to identify populations and guide service delivery; linking patients to specialty care and community resources for self-management support. Might require additional training for some staff.

Skills, Knowledge and Competencies Needed

- Knowledge of best-practices for diabetes management and diabetes self-management, i.e., Stanford Model
- Care management, care planning and goal setting skills
- Care coordination skills
- Patient assessment, engagement and motivational skills
- Competency in the use of data to identify patient populations and guide interventions to improve care
- Knowledge of project protocols and skills required for implementation
- Competent in HIPAA compliant use of HIE

3.d.iii. Asthma Care Management

Project Objective: Implementation of Evidence Based Medicine Guidelines for Asthma Management

Key Workforce Functions Needed to Meet Project Objective

The key staff associated with this project are part of integrated care teams. Core functions required include knowledge of evidence based care protocols for management of asthma; knowledge of patient and family engagement and motivation skills; data analysis; linking patients to specialty care as appropriate.

Skills, Knowledge and Competencies Needed

- Knowledge of evidence-based practices for Asthma management Documentation skills; change management skills to adopt new workflow as needed to incorporate Asthma Action Plans and, if appropriate, telemedicine;
- Certification as a Certified Asthma Educator (CAE) and Asthma Care Manager Training
- Patient and family engagement and motivations skills; care planning, data analysis

4.b.i. Tobacco Cessation

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

Key Workforce Functions

The key staff associated with this project are part of care teams in all clinical settings and non-clinical staff who conduct outreach in the community, offer preventative and cessation services. Some specialists also work with smokers with chronic conditions. Core functions include knowledge of the risks associated with smoking and effective ways to educate patients and promote smoking cessation.

Skills, Knowledge and Competencies Needed

- Knowledge of the risk of smoking and best-practices for smoking cessation, i.e. 5As of smoking cessation
- Outreach and Patient Engagement skills
- Knowledge of Project Protocols

4.b.ii Cancer Screening

Project Objective: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer).

Key Workforce Functions

The key staff associated with this project includes care team in all clinical settings and non-clinical staff who conduct outreach in the community. Core functions include knowledge of age and gender appropriate cancer screenings and effective ways to educate patients and promote cancer screening.

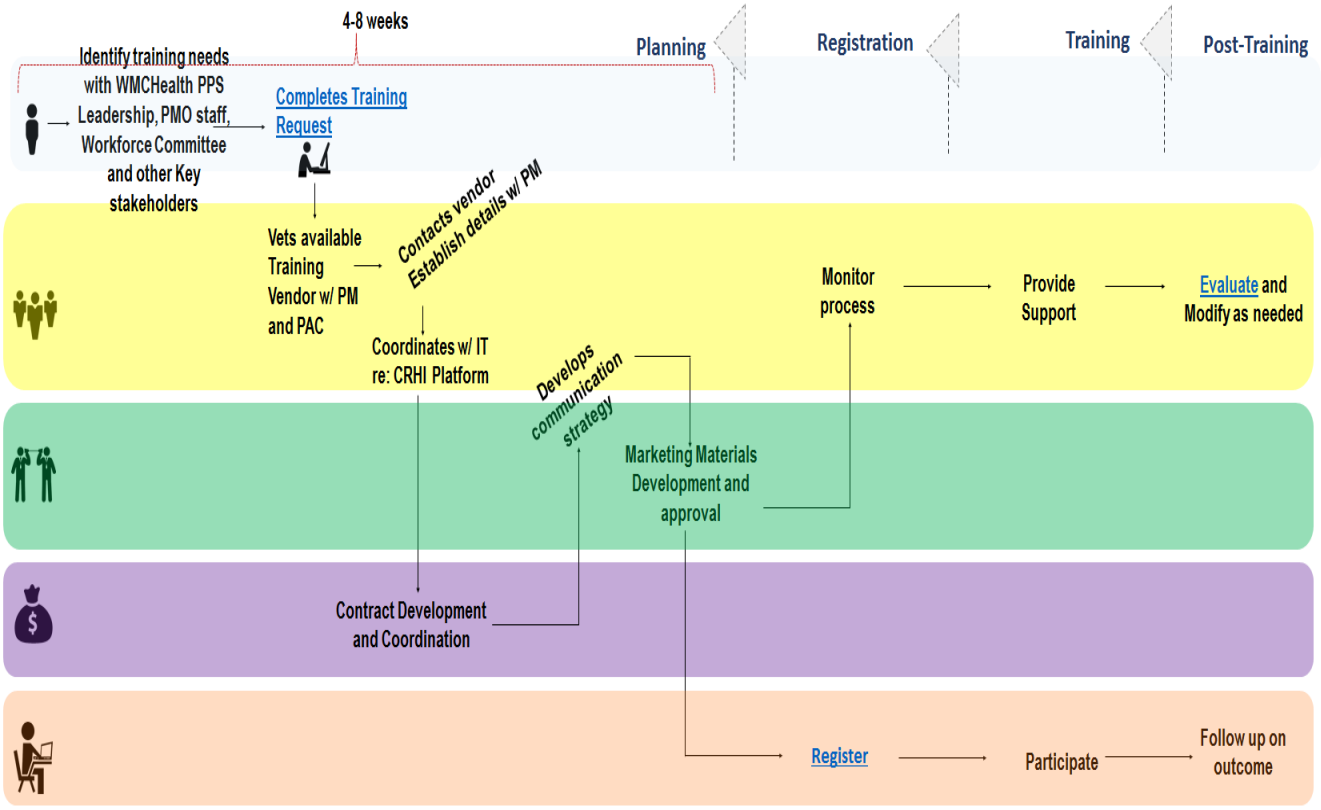
Skills, Knowledge and Competencies Needed

- Knowledge of age and gender appropriate cancer screenings;
- Outreach and Patient engagement skills
- Knowledge of Project protocols

Implementation and Process

The PPS applies principles of collaboration and inclusion across the PPS to maximize practitioner efforts and community engagement. Our PPS will continue to leverage development and promotion of training. Participants in committees and work groups represent stakeholders and partner provider organizations and can play the role of "training champions" who offer points of two-way communication with other segments of our PPS workforce. The PPS will create opportunities collected by the training request process in Figure 4.

Figure 4: *WMCHealth PPS Workforce Training Request Process*

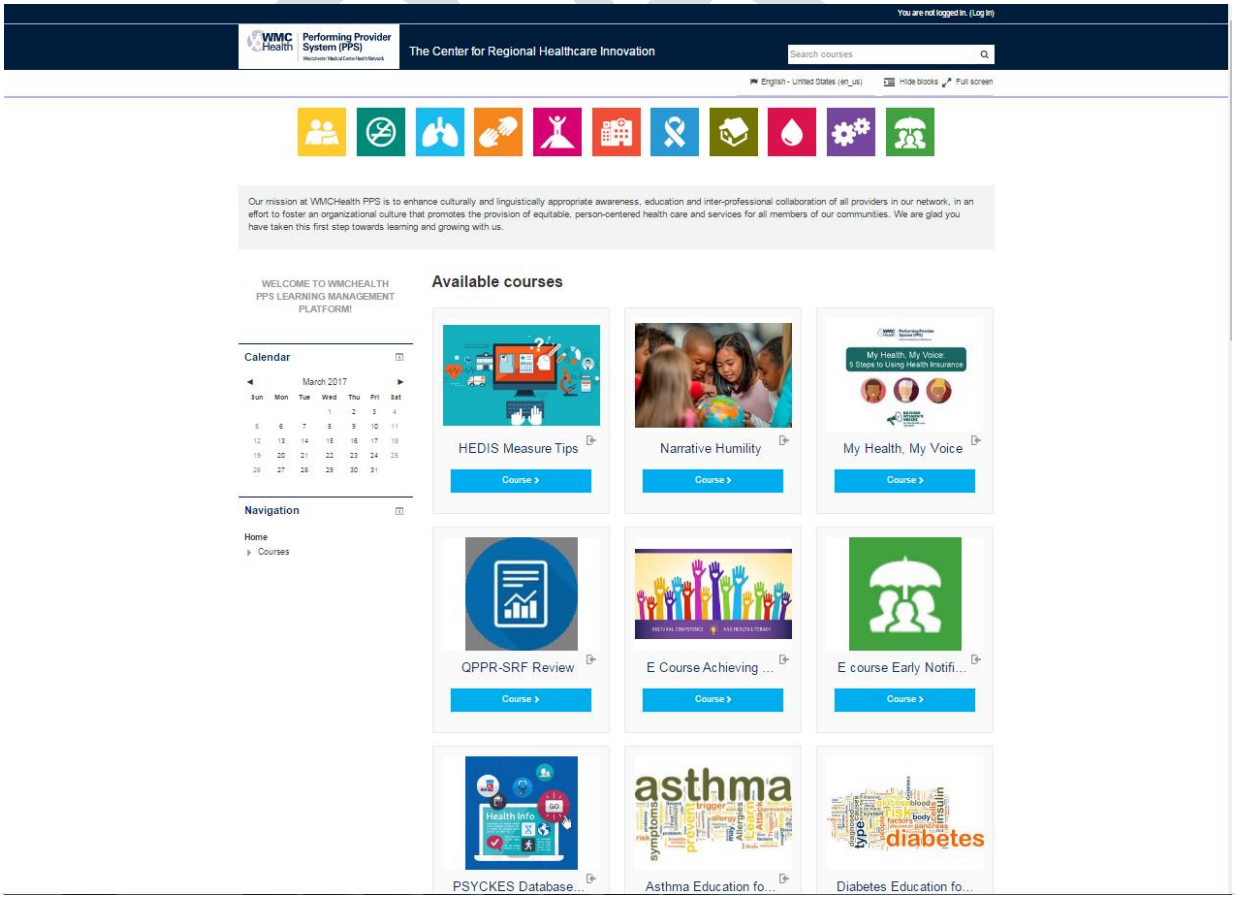


WMCHealthPPS On-line Learning Platform

We will continue to utilize adult-learning methods: Professional Development/ In-Service, Professional Continuing Education credits and trainings that prepare professionals for stackable certificate pathways. The larger goal of WMCHealth PPS Workforce Training strategy ensures that training is available and accessible for all workers who need new skills to meet DSRIP goals and the needs and requirements of WMCHealth PPS projects. The WMCHealth PPS has adopted the use of Moodle (PPS Learning Platform), which is an open source platform to develop and host e-courses, webinars and education materials. The platform is customizable by adding plugins that support reports such as attendance, and the ability to add more plugins creating a dynamic educational environment.

The Workforce, IT and Communications PMO team members continue to evaluate the PPS learning platform and adapt with powerful plugins. The PPS learning platform can supplement partners' workforce education offerings and is accessible to the entire PPS workforce. Users receive the link to the platform and can establish accounts. Users self-manage tasks on this platform, are notified of upcoming educational meetings, training, and complete evaluations.

Figure 5. *WMCHealth PPS Center for Regional Healthcare Innovation Training Platform – User Homepage showing available courses.* https://www.crhi.training.WMCHealthPPS.org



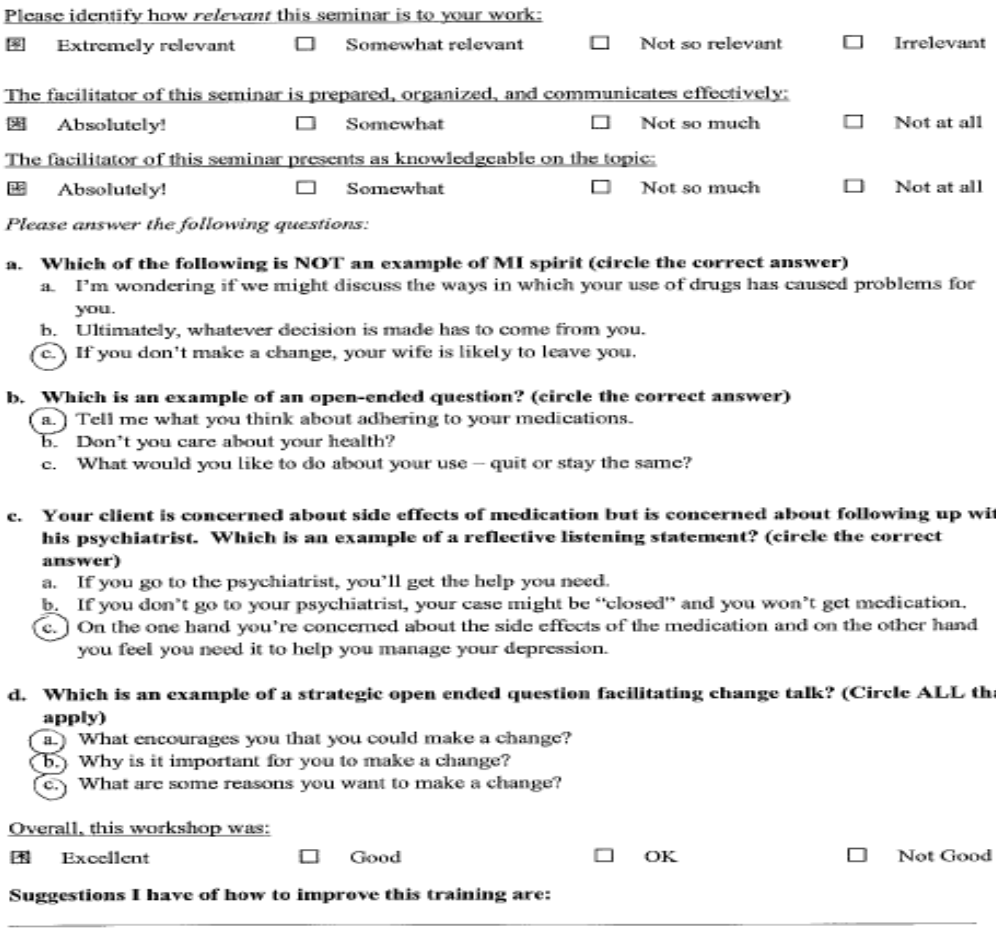
Curriculum Development Partners and Process

WMCHealth PPS recognizes that in some instances, training content may not be readily available to meet the knowledge and skill gaps identified. In these cases, the PPS will continue to engage in the development of appropriate content to address those gaps. The PPS will also collaborate with other experts via consultant agreements for project curriculum development such as with additional care management trainings, QE trainings for workforce to understand how to engage culturally and linguistically isolated communities, patient engagement trainings for CBP teams.

Modes of Evaluation

WMCHealth PPS is committed to ensuring that trainings delivered maintain quality standards and effectiveness. Overall training strategy effectives will be measured by participant testimonials, insight from our key stakeholders and will be reviewed by the PPS Workforce leads as a part of a continuous Plan Do Study Act (PDSA) cycle that will serve to modify training content and delivery periodically to optimize participant learning experience.

Figure 7. *Example of PPS Workforce Training Evaluation*



Please identify how *relevant* this seminar is to your work:

☒ Extremely relevant ☐ Somewhat relevant ☐ Not so relevant ☐ Irrelevant

The facilitator of this seminar is prepared, organized, and communicates effectively:

☒ Absolutely! ☐ Somewhat ☐ Not so much ☐ Not at all

The facilitator of this seminar presents as knowledgeable on the topic:

☒ Absolutely! ☐ Somewhat ☐ Not so much ☐ Not at all

Please answer the following questions:

a. Which of the following is NOT an example of MI spirit (circle the correct answer)

a. I'm wondering if we might discuss the ways in which your use of drugs has caused problems for you.
b. Ultimately, whatever decision is made has to come from you.
(c.) If you don't make a change, your wife is likely to leave you.

b. Which is an example of an open-ended question? (circle the correct answer)

(a.) Tell me what you think about adhering to your medications.
b. Don't you care about your health?
c. What would you like to do about your use – quit or stay the same?

c. Your client is concerned about side effects of medication but is concerned about following up with his psychiatrist. Which is an example of a reflective listening statement? (circle the correct answer)

a. If you go to the psychiatrist, you'll get the help you need.
b. If you don't go to your psychiatrist, your case might be "closed" and you won't get medication.
(c.) On the one hand you're concerned about the side effects of the medication and on the other hand you feel you need it to help you manage your depression.

d. Which is an example of a strategic open ended question facilitating change talk? (Circle ALL that apply)

(a.) What encourages you that you could make a change?
(b.) Why is it important for you to make a change?
(c.) What are some reasons you want to make a change?

Overall, this workshop was:

☒ Excellent ☐ Good ☐ OK ☐ Not Good

Suggestions I have of how to improve this training are:

Modes of Reporting

WMCHealth PPS uses Salesforce. The Salesforce customer portal provides the PPS the ability to track activity, analytical tools and other services including email alert, and access to customers' entitlement and workforce vendor records. All workforce task-related activity is registered in Salesforce. Related reports generated upon request, on all activity throughout the projects including all field training.

Further Workforce Transformation Strategies

Strategies for redeployed staff

The WMCHealth PPS recognizes that its workforce transformation efforts may include the need to redeploy staff in an effort to minimize any negative workforce impacts of the implementation of the WMCHealth PPS DSRIP projects. In reviewing redeployment and retraining efforts, the PMO Leadership with the consultation of the Workforce Committee will continue to identify existing training efforts and lessons learned from local, regional, and national efforts and provide recommendations on roles, responsibilities, program development, and communication strategies for workforce recruitment, curricula development, and training programs.

Career Pathways: Developing the Workforce for Healthcare Transformation

WMCHealth PPS has identified and committed to career pathways for network partners that have titles to be filled under DSRIP projects. The career pathways initiative targets adults and youth with interest in health careers. Current efforts are underway for emerging pathways for trending titles including, but not limited to health coaches, community health workers, care managers, and behavioral health specialists. Additionally, the PPS has begun engaging regional higher education institutions such as Westchester Community College to facilitate discussions on aligning educational programs with industry needs to support is career pathway initiatives.

The PPS collaborated with Catskills AHEC on a program called Scrubs Club and the with Mid Hudson Regional on a program for CNA to Home Health Aide Transitions and a full Home Health Aide program. Scrubs Club is a health career exploration program for all high school students consisting of lesson plans that are designed to introduce students to various healthcare careers and offer them the opportunity to experience them through engaging, hands-on activities and real-life experiences. The PPS will continue to explore and leverage with partners and educational partners who provide training, education and/or employment to offer additional opportunities to the PPS Career Pathway offerings.

Collaboration with Other PPSs for Workforce Training

WMCHealth PPS participates in the Hudson Region DSRIP Public Health Council (HRD-PHC). This collaboration is comprised of two other PPS – Montefiore Hudson Valley Collaborative and Refuah Health Community Collaborative. The HRD-PHC's primary role has been to lead work, education and training initiatives in public health related to DSRIP projects. Other examples of collaboration on workforce trainings occur in the BH (Behavioral Health) Crisis Leadership Committee, GNYHA Cross PPS workgroups, and the HealthlinkNY SDOH (Social Determinants of Health) and BH workgroups.

Workforce Communication and Engagement Plan

WMCHealth PPS has employed several partner engagement strategies. These strategies include the

- CRHI website—used to communicate and engage partners regarding a range of topics related to project implantation, training and education opportunities, and access to the project management office.
- Committee meetings & webinars—which include forums for discussion of implementation, planning, sharing-of best practices and specific partner engagement initiatives.
- Annual PPS Summit and Quality Meeting—which includes workshops related to DSRIP project implementation as well as work stream objectives, ,
- Medical Neighborhood meetings—, which are hyper-local partner networks that implement, care transformation strategies specific to their communities.
- Primary Care Physician Workgroups, --aimed at coordinating care delivery and sharing best practices.
- Behavioral Health Crisis stabilization meetings in collaboration with network partners, PPS and regional partners.
- Learning Management System—which provides an array of e-courses, webinars/lectures, and information resources to engage and enhance partner engagement and education.

The WMCHealth PPS project management office is comprised of Project Management team, Workforce Team, Communications Manager, and IT Team, Network Relations team and the Operations team. Depending on the need, cross-team collaboration—which typically includes Project Managers, IT and Workforce staff, develops and maintains the learning management system, e-course development, course promotion strategies, reporting and evaluation. Audience-appropriate messaging is an important element that is factored into all our partner engagement

communications—be it electronic or standard (paper)—that is distributed field. These materials include policies, oversight and compliance, upcoming training, forums, best practices, case stories from the field, highlight videos/pictures from events and advertising. The messaging maintains a consistency, aligns with DSRIP transformation—, and is cognizant of reading-levels to ensure usefulness of the communication.

The PPS will continue to leverage development and promotion of training through identified pathways with key stakeholders whose role of "Training Champions" offer points of two-way communication with other segments of our PPS workforce. The PPS Workforce and community key stakeholders can expect to be notified of upcoming trainings and/or engagement opportunities in one or more of the following ways:

Venue:

- Community engagement work: These activities intimately connect the team with communities throughout the PPS region for the bi-directional exchange of information between relevant parties.
- Partner and patient consumer comprised PPS committees – e.g. Workforce Committee, Hudson Region DSRIP Public Health Council, and Community Engagement Quality Advisory Committee.
- Existing Community Based Provider Network Meeting and Collaborative – e.g. New Rochelle Network Meetings, Nyack Youth Collaborative.
- PPS Summits, Medical neighborhood Meetings and/or Community Engagement Session – e.g. Medical neighborhood Meetings.

Modalities:

- PPS Website and Partner Portal
- Email blasts to network partners, registrants on PPS training platform
- PPS learning management online platform/Moodle
- Flyers distributed at key venues and placed on community bulletin boards
- Identified community based partners and our PPS training champions

Figure 8: Example of communication tool used to promote Care Transitions E Course

APPENDICES

Appendix A: Printed version of **Training Request form** also online via survey monkey

WMC Health | Performing Provider System (PPS)
Westchester Medical Center Health Network

DSRIP Training Request Form

1. Date: _____ 2. Contact Information: _____

3. List DSRIP Project name related to training request or activity:

4. Optional: List any DSRIP related milestones this training addresses:

6. What type of training needed or training name(Diabetes Management or Cultural Competency etc.):

7. Preferred location of training:

8. Do you have a preferred vendor?
If yes, provide contact information

9. Other relevant information: (Will this be offered at other sites? Will this be offered multiple times?)

10. Please indicate job title of workers identified for this training. i.e. (Care Manager, Clinical care teams)

11. Best estimate of total participants to be trained? _____
12. Format of desired training? _____
13. Any other relevant details about training? _____
14. What is the outcome measure for this training? _____

Please provide or email the above form to request any DSRIP related trainings requests to Bonnie Reyna at: bonnie.reyna@wmchealth.org/. Bonnie Office #914.326.1524 if you have any questions.

Appendix B. **Training Highlight**: In collaboration with Boston Children Health Physicians offered training on **Provider Asthma Care Plan** on March 2nd at Mt. Vernon Neighborhood Community Health Center. Trained 42 clinicians.

Appendix C. **Training Highlight**: PPS held onsite **Achieving Equitable Health Care Outcome Cultural Competency and Health Literacy group training** on March 2nd at Mt. Vernon Neighborhood Community Health Center. Trained group of 55 comprised of RNs and Medical Assistants.