## GOAL A: INCREASE ACCESS TO QUALITY, PREVENTIVE, DENTAL, BEHAVIORAL

Goal A focuses on ensuring Medicaid beneficiaries within the Integrated Delivery System have access to care, an assigned provider, and the ability to receive care.

<table>
<thead>
<tr>
<th>Strategy Name</th>
<th>Strategy Descriptor</th>
<th>DY2, Q1 Update</th>
<th>DY3, Q2 Update</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1 DY1</strong></td>
<td>Expand Graduate Medical Education in the Tug Hill Seaway Region</td>
<td>Draft proposal shared with workforce governing body. Timeline created based on DSRIP funding, deliverables &amp; Match Day. Summer interns (Medical Student) drafting agreements, budget, promotional materials &amp; informational resources associated with the proposal. Working with Chair of workforce governing body &amp; Director of local GME to identify gaps in rotations and regional capacity to support program expansion. Anticipated GoLive - July 2017.</td>
<td>In Progress. Work from DY2,Q2 continues. Samaritan Medical Center submitted a grant application for the Rural Residency Program. This would allow us to not only grow the existing GME Program through the use of DSRIP funds, but also to leverage those other grant dollars to build a rural tract into the program, obtain full time staff to assist with the project and move towards a more sustainable GME model for the future (with increased residency cap as an urban program with a rural track). While work continues under the DSRIP initiatives, further work regarding matching and residency placements has been delayed as we'd like to align these initiatives if awarded. Award announcements are expected in DY3,Q3.</td>
</tr>
<tr>
<td><strong>A2 DY1</strong></td>
<td>Engage, leverage, utilize, and align with NYS program efforts (i.e. Doctors Across NY)</td>
<td>While coordination and connectivity with community-based services is critical, the most significant immediate modification is the number of the community is to increase the number of primary care, psychiatry and dental providers in the region. We cannot connect people to primary and preventive care that does not exist. The region has fewer than 75 primary care providers per 100,000 population compared to the NYS rate of 121. This target is included in the Integrated Delivery System (IDS) strategy. To offer quality care and coordinate efforts with NYS initiatives like Doctors Across NY, Samaritan Medical Center (Samaritan) is working to address this regional need.</td>
<td>In Progress. NCI continues to share state programs efforts with partners, students &amp; healthcare professionals exploring employment in our region. Additionally, NCI worked to ensure the NCI Provider Incentive Program did not interfere with eligibility for these state programs.</td>
</tr>
<tr>
<td><strong>A3 DY1</strong></td>
<td>Expand Federally Qualified Health Center (FQHC) &amp; Urgent Care service area &amp; capacity</td>
<td>The NCI has supported the recruitment, training &amp; retention of healthcare professionals at two FQHCs. With awarded funds from the NCI Provider Incentive Program, the North Country Family Health Center (NCFHC) has recruited a psychologist and 2 dentists. Similarly, the Community Health Center of the North Country has completed training for 150 staff in the following: Bridges Out of Poverty, Chronic Care Professional, DSRIP 101, Performance Reporting, Clinically Integrated Network, SBIRT, PAM, IMPACT, Care Coordination Certificate Program, Community Health Worker, Health Literacy, etc.</td>
<td>In Progress. Both FQHCS have submitted and have been certified as 2014, Level 3 PCMH clinics. Ongoing support is being provided to these clinics during their transformation efforts. Staff from both facilities continue to participate in ongoing training initiatives to include completion of the NCI customized videos (Introduction to the Medicaid Health Home, Standardized Care Transition Protocols, and Healthcare Literacy, Cultural Competency &amp; MEB promotion, prevention &amp; treatment). Additionally, both FQHCs hosted physician residents for visits during the IHA Take a Look Tour which was noted above. The Community Health Center of the North Country has purchased a building location in Ogdensburg and is currently under renovation to prepare for the opening of the Ogdenburg FQHC site. Additionally, the North Country Family Health Center will be renovating their main building to ensure a more coordinated, systematic and patient-centered work flow.</td>
</tr>
</tbody>
</table>
Co-locate behavioral health & primary care services

Mental illness is the single highest cause of preventable inpatient admission and emergency department visit. Additionally, it is clear that there is a disconnect between behavioral health services and primary care services.

Primary care providers report being unable to get their referred patients appointments for behavioral health care and behavioral health providers report being unable to get access to primary care for their behavioral health patients. Behavioral Health patients have high rates of co-occurring diabetes, cardiac and respiratory illnesses. The unbridgeable gap for the region is precisely this state and Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. There is clear and compelling evidence that integrating primary care and behavioral health at the primary site of care for the patient is needed. Training for staff on collaborative care (IMPACT Model), Patient Centered Medical Home, Systematic Brief Intervention and Treatment (SBIRT) and Depression Screenings will be necessary.

In Progress

In Progress

In Progress

In Progress

In Progress

In Progress

In Progress

A4

DY3

Primary care practices continue to receive technical support from the NCI/FRDHPO project team. 3 practices in region have received PCMH Level 3, 2014 standards and others are in the moving in this same direction. Of these practices, 9 have received training on collaborative care in collaboration with the University of Washington AIMC Center (IMPACT Model).

3 have completed the PCMH content expert training. 50 partners completed the IMPACT Model webinar with the University of Washington AIMC Center. 5 individuals have been trained as Depression Care Managers and 3 are in the process of completing the training. 4 primary care practices including physicians, nurse practitioners, care managers and a psychiatrist (approximately 25 total) will complete full day, onsite training with the University of Washington AIMC Center on July 8th. Subject Matter Experts for each of the three models of integration have been identified. The IMPACT Model SME are also practicing in a NYS Learning Collaborative for this model. The consulting psychiatrist continues to serve the IMPACT Model sites. The NCI launched CDE Incentive Program on 9/30 to assist partners with the growth or recruitment of CDEs. We will also be developing an RFP for partners to ensure a CDE is included in PCP interdisciplinary teams for project 3. We will continue to work with St. Joe's on patient recruitment, training resources and EHR templates for the 5 A's of tobacco control and we have distributed resources/information to assist with the implementation of the NDPP. We will continue to explore ways to incentivize patients to complete programs such as the NDPP.

B1

DY3

A consultative psychiatrist was hired on June 10th. The NCI has identified at least 4 CDEs in the region. We will continue to explore a CDE consult agreement. The NCI is working with a representative from St. Joe's to develop training resources and EHR templates for the 5 A's of tobacco control.

Nearly all primary care practices will receive technical support from the NCI/FRDHPO project team. 3 practices in region have received PCMH Level 3, 2014 standards and others are in the moving in this same direction. Of these practices, 9 have received training on collaborative care in collaboration with the University of Washington AIMC Center (IMPACT Model).

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A5

DY2

Approximately 40 people from the PCPs attended a HANYS PCMH training/conference at the Edgewood Resort on 9/30. IMPACT Model work is noted above. Additionally, 10 individuals are expected to complete the chronic care professional training program in December with an additional 25 individuals to commence on Oct. 12th.

Throughout the needs assessment, it was clear that respiratory disease and in particular, COPD needed a concentrated prevention strategy as this is a leading cause and emergency room visits for the target population. More than 20% of the region’s population smokes and prevention efforts need to be improved. Colorectal cancer mortality rates exceed NYS rates and colorectal cancer screening rates are significantly lower than NYS. A concerted effort to advance respiratory disease prevention and in particular smoking prevention and cessation is needed. A concerted effort to engage the region in cancer prevention screenings is also needed. Both of these activities will impact total health as the region moves from a healthcare system to a system for health. A consulting tule-psychiatrist will need to be located, as well as a consulting certified diabetes education. Providers will also need to be trained on the 5 A’s of tobacco control.

GOAL B: IMPROVE WORKFLOW WITH THE USE OF EVIDENCE-BASED, QUALITY AND OUTCOME DRIVEN STRATEGIES.

Goal B focuses on the data collected during the Community Needs Assessment and how it will be used to help us understand the community we seek to serve, how the health care delivery system functions and key populations to be served.

<table>
<thead>
<tr>
<th>Strategy # and Target Date</th>
<th>Strategy Name</th>
<th>Strategy Description</th>
<th>EY5, Q1 Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>Implement Patient Centered Medical Home for all primary care practice</td>
<td>Patient Centered Medical Home Certification 2014 and Advanced Primary Care requires that primary care be patient oriented, most quality standards, be meaningfully utilizing health information technology (coordinated care and improve quality of care), and adhere to best-practices for prevention screenings and follow-up. In addition, specific patient engagement activities are required. The combination of requirements for PCMH will ensure that prevention and best practices will be standardized and universally applied resulting in lower Preventable Preventable Visits (PPVs) and Preventable Preventable Admissions (PPAs). The NCi is supporting PCMH content expert training for our OMRP support staff as well as for our hospitals and Federally Qualified Health Centers. This PCMH staff, along with primary care practices, are also receiving training on collaborative care in collaboration with the University of Washington AIMC Center (IMPACT Model).</td>
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<td>B5</td>
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</tbody>
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### Goal C: Ensure Effective, Smooth, Systematic, and Secure Care Management/Transition

#### Strategy # and target date

<table>
<thead>
<tr>
<th>Strategy Name</th>
<th>Strategy Description</th>
<th>NYS/Case Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>Implement standardized care coordination across the care continuum including care management at primary care practices</td>
<td>Ongoing</td>
</tr>
<tr>
<td>C2</td>
<td>Ensure there are care coordinators in the point of care transition from the acute care setting</td>
<td>Ongoing</td>
</tr>
<tr>
<td>C3</td>
<td>Standardize and implement evidence-based protocols for cardiovascular disease, diabetes, COPD and mental illness</td>
<td>In progress</td>
</tr>
<tr>
<td>C4</td>
<td>Cardiovascular disease, diabetes, COPD and mental illness can be effectively treated in the outpatient setting</td>
<td>In progress</td>
</tr>
<tr>
<td>C5</td>
<td>The Medical Management Committee agreed upon and approved standardized, evidence-based protocols for blood pressure screenings</td>
<td>In progress</td>
</tr>
<tr>
<td>C6</td>
<td>Over 230 individuals have completed the Blood Pressure Measurement training in this quarter.</td>
<td>In progress</td>
</tr>
<tr>
<td>C7</td>
<td>Implement standardized care transition and care coordination for high-risk patients once they leave the “teaching/engaging” moment at the hospital, the health home care managers are unable to find them to arrange them in outpatient services and active participation in their care plans that would prevent future hospital and emergency department use.</td>
<td>In progress</td>
</tr>
<tr>
<td>C8</td>
<td>There is a need to support smooth transitions from hospital to outpatient settings for at risk patients with chronic disease and mental illness within the PPS. Due to the rural geography and presence of many high-risk patients once they leave the “teaching/engaging” moment at the hospital, the health home care managers are unable to find them to arrange them in outpatient services and active participation in their care plans that would prevent future hospital and emergency department use.</td>
<td>In progress</td>
</tr>
<tr>
<td>C9</td>
<td>Protocol development is underway. Once adopted, appropriate staff will be trained.</td>
<td>In progress</td>
</tr>
<tr>
<td>C10</td>
<td>The NCI will train, hire and resource care transition staff in the hospitals, primary care settings and in the community. Those care coordinators will need to be focused on the standardized protocols adopted by the PPS.</td>
<td>In progress</td>
</tr>
</tbody>
</table>

#### GOAL C: ENSURE EFFECTIVE, SMOOTH, SYSTEMATIC AND SECURE CARE MANAGEMENT/TRANSITION

**Goal C** focuses on standardized protocols and capacity needs to grow care management/coordination to ensure patients receive care at the right time, in the right place, and in the most cost-effective way.
Ongoing Protocol development is underway. Each partner entity participating in project 2biv received an implementation plan indicating that they must identify and refer health home eligible patients. This will be incorporated into the standardized protocols as well. The number of health home downstream providers has increased based on the increase of referrals and utilization of the health home. Downstream providers in Jefferson County include: ACR Health, Chronic Care Management, Health Home Care Management, and Transitional Living Services. Emboldened care managers are also placed at Jefferson Medical Center, Dr. Mary's practice, the North Country Family Health Center, Watervliet Urban Mission and Jefferson County Public Health. ClintonHughes Medical Center and Carthage Area Hospital are also exploring the emboldened care manager opportunity.

C3 DV1

Utilize community health workers to build with identified high-risk "hot spot" communities Community Health Workers serve as liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. They also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy (American Public Health Association, 2009). The PPS, in collaboration with the Community Health Worker Network of the North Country will need to be trained and provided ongoing support to ensure they are successful in their role. Community health workers must have completed a training in the specific skills they need to accomplish this role. The NCI Community Health Workers will be trained by the Seaway Valley Prevention Council, the RFP awardee, provided a summary of findings to the Health Literacy and Cultural Competency Committee. Common themes were incorporated into the Health Literacy and Cultural Competency strategic plan for a Community Health Worker Network of NYC. Also the NCI will launch an Intro to the Medicaid Health Home training video and a Protocol training video via SurveyMonkey. Hospitals reviewed, approved and adopted the protocols this quarter. Protocol training for staff also took place this quarter. Policies and procedure development is underway with implementation timeline on track to alignment with 2biv plan. The North Country Health Home has signed agreements with all the hospitals which allows the care managers access to the patients prior to discharge. Finally, the health home has enrolled new care managers in public health, primary care offices and 5 of the 6 hospitals that are part of 2biv. The NCI continues to assist with the training of these care managers through the North Country Care Coordination Certificate Program.

C3 DV2

Revive Health Home care coordination with community-based resources The PPS will adopt standardized protocols to ensure that patients are identified in the acute care setting and referred to the North Country Health Home based on the presence of one or more chronic conditions or one single-qualifying condition of either HIV/AIDS or Severe Mental Illness. By increasing awareness of, and developing the health home and home care agencies, we will focus on both clinical and social determinants of health that are highly correlated with admissions or readmissions. Hospital-based staff will need to be trained in these protocols and as the need for health home care management grows, the number of downstream providers may need to grow to meet this demand. In addition, the PPS will ensure that all safety net providers are actively sharing electronic health record systems with the health information exchange (HealtheConnections) and through the Health Information Exchange, appropriate data will be securely shared throughout NYS via the SHIN-NY. HealthConnections will be the standard method for sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, and all participating providers will be connected by the end of DV3. Partners within the PPS will need to be trained on workflow, security, privacy and compliance associated with this technological infrastructure.

C3 DY3

Leverage technological infrastructure to focus & improve systematic referral processes The PPS will ensure that all entity staff providers are actively sharing electronic health record systems with their vendor-specific ERP systems (EHR systems). The PPS will adopt standardized protocols to ensure that patients are identified in the acute care setting and referred to the North Country Health Home based on the presence of one or more chronic conditions or one single-qualifying condition of either HIV/AIDS or Severe Mental Illness. By increasing awareness of, and developing the health home and home care agencies, we will focus on both clinical and social determinants of health that are highly correlated with admissions or readmissions. Hospital-based staff will need to be trained in these protocols and as the need for health home care management grows, the number of downstream providers may need to grow to meet this demand. In addition, the PPS will ensure that all safety net providers are actively sharing electronic health record systems with the health information exchange (HealtheConnections) and through the Health Information Exchange, appropriate data will be securely shared throughout NYS via the SHIN-NY. HealthConnections will be the standard method for sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, and all participating providers will be connected by the end of DV3. Partners within the PPS will need to be trained on workflow, security, privacy and compliance associated with this technological infrastructure.

C3 DY3

Utilize community navigators to engage the non-users, low users, and the uninsured Community Health Workers serve as liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. They also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy (American Public Health Association, 2009). The PPS, in collaboration with the Community Health Worker Network of the North Country will need to be trained and provided ongoing support to ensure they are successful in their role. Community health workers must have completed a training in the specific skills they need to accomplish this role. The NCI Community Health Workers will be trained by the Seaway Valley Prevention Council, the RFP awardee, provided a summary of findings to the Health Literacy and Cultural Competency Committee. Common themes were incorporated into the Health Literacy and Cultural Competency strategic plan for a Community Health Worker Network of NYC. Also the NCI will launch an Intro to the Medicaid Health Home training video and a Protocol training video via SurveyMonkey. Hospitals reviewed, approved and adopted the protocols this quarter. Protocol training for staff also took place this quarter. Policies and procedure development is underway with implementation timeline on track to alignment with 2biv plan. The North Country Health Home has signed agreements with all the hospitals which allows the care managers access to the patients prior to discharge. Finally, the health home has enrolled new care managers in public health, primary care offices and 5 of the 6 hospitals that are part of 2biv. The NCI continues to assist with the training of these care managers through the North Country Care Coordination Certificate Program.

C4 DY1

Approximately 85 individuals have been trained in the PAM. Another 75 individuals completed PAM training in this quarter.

C4 DY1

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C4 DY1

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C4 DV2

Approximately 85 individuals have been trained in the PAM. Another 75 individuals completed PAM training in this quarter.
Increase utilization of remote monitoring for patients with chronic diseases

Telehealth remote monitoring gives clinicians the ability to monitor and measure patient's health data and information. It decreases access to health services, improves disease management and ensures early intervention. It is self-directed and cost-effective, aligning with the overall goal of preventing potentially incurable admissions or emergency department visits. The NCI will work with PPS partners to select a remote monitoring vendor as well as engage partners and patients on the adoption and implementation of the devices. This will require training for healthcare professionals who use this strategy.

In Progress

The FDRHPO developed a Remote Monitoring User Collaborative and is hosting monthly meetings. The plan is to develop and increase process development with engaged hospitals, primary care providers and specialists. Two established partners include Jefferson County Public Health and St. Lawrence Valley Hospital. The internal team (through a rural health network grant) is currently working to secure a contract with our preferred vendor, Vivicity. Upon contractor execution, trainings will be conducted for healthcare professionals who chose to adopt and implement the telehealth devices.

Goal D: ENGAGE AND LEVERAGE STAKEHOLDERS AND RESOURCES FOR ORGANIZATIONAL/SYSTEMATIC CHANGE MANAGEMENT IN THE INTEGRATED DELIVERY SYSTEM

Goal D focuses on engaging stakeholders in the planning and implementation of system change.

<table>
<thead>
<tr>
<th>Strategy Name</th>
<th>Strategy Descriptor</th>
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</thead>
<tbody>
<tr>
<td>D1</td>
<td>Engage frontline workers, regional stakeholders &amp; labor/union representatives throughout planning, development &amp; implementation of strategies</td>
</tr>
<tr>
<td>D2</td>
<td>Collaborate with proven workforce vendors such as Iroquois Health Alliance, the Northern Area Health Education Center &amp; the Fort Drum Regional Health Planning Organization</td>
</tr>
<tr>
<td>D3</td>
<td>Analyze the Integrated Delivery System, identify workforce gaps &amp; leverage community resources</td>
</tr>
<tr>
<td>D4</td>
<td>Identity &amp; leverage resources needed to support &amp; equip healthcare professionals with the skills &amp; training to operate in a preventive, community-based system</td>
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</tbody>
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### D1

**DY1**

**Strategy Name:** Engage frontline workers, regional stakeholders & labor/union representatives throughout planning, development & implementation of strategies

**Strategy Descriptor:** The role of the one delivery system (ODS) includes workforce modifications - hiring, retaining and deployment. To effectively engage the healthcare workforce and ensure smooth transitions during system reconfiguration, labor unions serve healthcare workers used to be involved in the development of PPP strategies. Ongoing

**DY2**

The NCI Project Advisory Committee is advising the PPP on project plans and includes representation from PPS partners as well as workers and relevant unions to include the Civil Service Employees Association (CSEA), the NYS Nurses Association (NYNAA), and the Service Employees International Union (SEIU). As members of the PAC, these union representatives offer recommendations and feedback on PPP initiatives and are involved in various facets of the developing project plans (i.e. training initiatives that are designed to meet the needs of the transforming system) to include the integrated workforce strategy. They have been consulted and will continue to remain engaged in the implementation and oversight of the project plans.

### D2

**DY1**

Collaborate with proven workforce vendors such as Iroquois Health Alliance, the Northern Area Health Education Center & the Fort Drum Regional Health Planning Organization

NCI will leverage existing partnerships with the Fort Drum Regional Health Planning Organization and the Northern Area Health Education Center to increase awareness of health education pathways, job placement and career exploration resources, and clinical rotations. We will also work with these vendors to conduct training-needs assessments and select training or academic partners to create and deliver training modules or curricula. SIBS has successfully demonstrated the ability to identify eligible candidates for training programs, organize appropriate trainings, and assist with retention and employment for training individuals in the health sector. The ISS also has an existing partnership with HealthUpstate to deliver online training to PPS employees, specifically as it relates to ongoing and training frontline workers to improve outcomes due to tailored competency challenges, population health, transitional care, process improvement, and care coordination.

Ongoing

The NCI continues to leverage existing partnerships with the FDRHPO and NAHEC to increase awareness of health education pathways, job placement and career exploration resources, and clinical rotations. SIBS has conducted our compensation and benefits analysis and continues to serve as a daily resource as it relates to DSRIIP workforce related activities. The NCI has chosen not to pursue a contractual agreement with HealthUpstate, but rather to develop other internal strategies to deliver key training programs for DSRIIP (i.e. development of DSRIIP training videos using SurveyMonkey or using Vimeo to create and launch a Cultural Competency video). The NCI also worked with SUNY Jefferson & SUNY Canton to develop the North Country Care Coordination Certificate Program. NCI will continue to work with partners to identify, and when feasible, create new programs to meet the needs of the transforming system.

**DY2**

The NCI continues to leverage partnerships with the Community Colleges in the area to offer appropriate, DSRIIP related training opportunities such as the Bachelors of Social Work, the Masters of Social Work, NP, HIT, Care Coordination, etc. The NCI continues to monitor and assess the needs of the workforce. Various training opportunities have and will continue to take place including: PAM, Community Health Worker, Health Literacy, Depression Care Manager, Chronic Care Professional, Care Coordination Certificate, HIT, PCMH, Cultural Competency, MEB health promotion, prevention and treatment, etc. The NCI will work with partners such as NAHEC and DSRIIP to develop new programs as identified/needed.

Continuation of efforts as outlined in DY2 Q1.

### D3

**DY1**

Analyze the Integrated Delivery System, identify workforce gaps & leverage community resources

The NCI will perform a future state staffing strategy analysis across the PPS by reviewing and assessing workforce commitments made in the PPS Organizational and Project applications in relation to defining the target workforce state.

Complete

In consultation with workforce partners, the NCI outlined the current state of the workforce against the future needs to identify new hires or new training requirements. The transition roadmap, the compensation and benefits report and a detailed assessment of the job titles by licensure requirement were used to inform this process.

See DY2 Q1.

### D4

**DY1**

Identity & leverage resources needed to support & equip healthcare professionals with the skills & training to operate in a preventive, community-based system

The NCI strategy will aim to leverage existing resources and enhance active interventions to prevent work slowdowns and reduce stress related to attrition. Retraining and retraining professionals through strategic, effective methods such as human resource planning, incentivizing providers, providing education, training and career advancement, as well as workforce projections will improve the practice environment within the Tug Hill Seaway region.

Ongoing

The NCI continues to monitor and assess the needs of the workforce. Various training opportunities have and will continue to take place including: PAM, Community Health Worker, Health Literacy, Depression Care Manager, Chronic Care Professional, Care Coordination Certificate, HIT, PCMH, Cultural Competency, MEB health promotion, prevention and treatment, etc. The NCI will work with partners such as NAHEC and DSRIIP to develop new programs as identified/needed.

Continuation of efforts as outlined in DY2 Q1.

A contract has been secured with Vivicity. The implementation is ongoing with Jefferson County Public Health. The team has been identified and assigned roles (clinical champion, executive champion). The units have been onboard and should be arriving in DY2 Q3. Training will also take place in Q3.
| **D5** | Increase awareness of health education pathways in collaboration with academic institutions in the region. | Ongoing | The NCI will work with Jefferson Community College, SUNY Canton, the State University of New York and the Lake Superior Health Alliance to conduct training needs assessments and select training or academic partners to create and deliver training modules or curriculum. |
| **DY1** | In consultation with workforce partners, the NCI continues to monitor the workforce, identify gaps and leverage resources based on community need. To date, existing program offerings meet the needs of the region as it relates to DSRIP. Some trainings are still under development but will depend on the adoption of protocols by the committees and boards. | Ongoing | Continuation of efforts as outlined in DY2 Q1. |
| **D6** | Leverage career exploration resources to facilitate & support regional clinical rotations & job placement | Ongoing | In consultation with workforce partners, the NCI continues to monitor the workforce, identify gaps and leverage academic partnerships to bring exploration or curriculum programs to the region. |
| **DY1** | The FDRHPO and NAHEC continue to identify, support and monitor local students who are engaged in the pipeline. While this is a long-term strategy, we are beginning to see success from years past. For example, one of the students we worked with while she was in high school has recently come back to the area as a PCP via the NCI Provider Incentive Provider Program. | Ongoing | 64 students completed MASH Camp this summer. 3 students completed the Job Shadow Program and 4 additional students are scheduled to do the Job Shadow Program next quarter. Classroom presentations have been scheduled for next quarter in 10 high schools in the region. Additionally, during the next quarter, FDRHPO’s Outreach Coordinator will participate in Higher Ed Day at JCC and Workforce 2020. |
| **D7** | Conduct training needs assessment to understand the number of people that will need to be trained/retrained by level, role & department-setting | Ongoing | Utilizing the compensation and benefits analysis, the workforce calculation will include data between current and future state positions, taking into account job roles, functions and location. Where there are vacancies related to the chosen project deliverables/commitments, the NCI will identify local resources to provide necessary training or education to ensure we fill this gap. |
| **DY2** | The compensation and benefits analysis for year 1 is complete. Findings are consistent with strategies noted throughout this roadmap. NCI will continue to monitor changes over the course of DSRIP. | Ongoing | The NCI has utilized the compensation and benefits data to help inform partners of average salary ranges specific to newly defined roles at facilities such as care coordinators, Community-based care managers, community health workers, peer supports and patient navigators surfaced as areas of need. The NCI is ensuring partners with deliverable-based funds to assist with the training, education and tools needed to successfully prepare and utilize these roles for project related tasks. Other areas include CDEs, Home Health Aides, NAs, L/CWs, NPs and PCPs. This quarter, the NCI launched a CDE and L/CW incentive program for the growth and/or recruitment of these professionals. NCI/FDRHPO is partnering with BOCES, local hospitals and the community colleges to address the Home Health and CNA needs of the region. JCC offers a NP program through Upstate and the Provider Incentive Program continues to receive dollars to NCI Partners for the recruitment of PCPs, NPs, PAs, Psychologists, Psychiatrists and Dentists. 10 additional awards were announced in DY2 totaling approximately $1.5M for 7 PCPs, 1 PA, 1 Psychologist and 1 Psychiatrist (in addition to DY1 awards totaling $1.2M for 2 NPs, 4 PCPs, 2 PAs, 1 Psychologist, 1 Psychiatrist and 2 Dentists). |
| **D8** | Collaborate with partners to identify, & when feasible, create new courses where curriculum gaps exist | Ongoing | The NCI will continue to monitor the status of the workforce and develop new programs where gaps exist. This roadmap will be used as a guide for the process. |
| **DY2** | Utilizing the defined target workforce state, the training needs assessment, the compensation and benefits analysis and other key data, the NCI will work with community partners to develop, implement, track, monitor and evaluate education or training programs in the region to ensure our regional healthcare professionals are prepared, supported and equipped to operate in the Integrated Delivery System. | Ongoing | Continuation of efforts outlined in DY2 Q1 and noted above through other strategies. |