



**Department
of Health**

Workforce Workgroup Meeting #5

June 17, 2016



**Department
of Health**

**Innovation
Center**

Workforce Workgroup Agenda

Topic	Timing	Lead
Welcome and Introductions	10:30 – 10:35	Patrick Coonan
Summary from previous meeting	10:35 – 10:40	Patrick Coonan Wade Norwood
Subcommittee 1 Reports	10:40 – 11:15	Wade Norwood Doug Lentivech
Subcommittee 3 Reports	11:15 – 12:15	Jean Moore
DSRIP Updates <ul style="list-style-type: none"> Questions and Answers 	12:15 – 12:45 12:45 – 1:00	Peggy Chan
Next Steps <ul style="list-style-type: none"> Where do we go from here? How do we keep the momentum going? 	1:00 – 1:30	Patrick Coonan Wade Norwood
Adjournment	1:30	Patrick Coonan



Summary from previous meeting

Subcommittee Reports

Subcommittee 1: Progress to Date

- Built a common set of functions to be used by all 3 subcommittees
- Reached consensus on a set of functions and licensed titles for review
- Engaged the relevant NYSED Board Secretaries to support a shared vision and common work
- Completed review of statutory/regulatory barriers for selected licensed titled workers
- Launched review of statutory/regulatory barriers for non-licensed individuals



Subcommittee 1: Early Lessons Learned

- The set of functions selected is somewhat arbitrary – we had to start with something.
- The difference between a function and a task is just as debatable; as a result, we stopped debating it.
- We are well served by “eating the elephant one bite at a time.” We will start with the Licensed health workers but will identify barriers that impede effective care coordination by Certified and Lay workers.
- This is not an easy task for the subcommittee and we expect our need for full Workgroup engagement will be around “the very not easy tasks.”



Subcommittee 1: Next Steps

- Report statutory/regulatory barriers for licensed titled workers to Subcommittee
- Determine scope of certified and lay titled workers for analysis
- Report statutory/regulatory barriers for certified and lay titled workers to Subcommittee
- Deliver Subcommittee report on statutory/regulatory barriers for all “in-scope workers” to full Workgroup for review and refinement
- Receive and, as needed, incorporate recommendations from other subcommittees with regard to workforce preparation and/or on-going development

Subcommittee Reports

Workforce Workgroup members agreed on need to “develop core competencies and/or training standards for workers in care coordination titles”

Three subcommittees convened to focus on different aspects of effective care coordination

- **Subcommittee 1:** Identification of core competencies and functions and regulatory barriers that could impede effective care coordination
- **Subcommittee 2:** Identification of curricular content for educating the health workforce on core concepts in care coordination (embedded in health professions education curricula and to use for continuing education)
- **Subcommittee 3:** Identification of recommended core curriculum for training workers in care coordination titles



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- **Subcommittee 3:** Identification of recommended core curriculum for training workers in care coordination titles



Subcommittee of the Workforce Workgroup Was Formed to Identify Recommended Core Curriculum for Training Workers Who Provide Care Coordination Services

Charge:

- Review curricula used by groups across the state for training workers in care coordination titles
- Examine overlap in core content of these training programs
- Identify key curricular components to include in all basic training programs for workers in care coordination titles



Subcommittee Membership

- **Center for Health Workforce Studies**, Jean Moore and Bridget Baker
- **Fort Drum Regional Health Planning Organization**, Tracy Leonard
- **New York Alliance for Careers in Healthcare**, Shawna Trager
- **State University of New York, Office of Academic Health & Hospital Affairs**, Heather Eichin
- **JFK, Jr. Institute for Worker Education, City University of New York**, Carrie Shockley and William Ebenstein
- **1199SEIU/League Training & Upgrading Fund**, Sandi Vito, Becky Hall and Selena Pitt
- **Paraprofessional Healthcare Institute**, Carol Rodat
- **Office of Mental Health**, Jhoney Barnes
- **Home Care Association of NYS**, Alexandra Blais



Progress to Date

Primary focus of curricula review:

- New York Alliance for Careers in Healthcare Training
- North Country Care Coordination Certificate Program
- 1199SEIU Care Coordination Fundamentals
- CUNY Credited Course Sequence in Care Coordination and Health Coaching

Reviewers found a great deal of consistency in content across the different training curricula

Worked collaboratively to create training guidelines for workers who provide care coordination services

Core Curriculum Guidelines Developed

Consists of 9 modules that include:

- topics
- learning objectives and
- resources

Estimated completion time for all modules between 36-45 hours

Designed to be adapted to fit local circumstances

- Could be embedded in medical assistant or home health aide training
- Adjusted for geography, educational level of trainees, patient population served
- Could serve as a base for care coordination training worth college credit



Summary of Modules

- Introduction to New Models of Care and Health Care Trends
- Interdisciplinary Teams
- Person-Centeredness and Communication
- Chronic Disease and Social Determinants of Health
- Cultural Competence
- Ethics and Professional Behavior
- Quality Improvement
- Community Orientation
- Technology, Documentation and Confidentiality

Reference Materials

List of and links to (where available) all training programs reviewed

Resources

- Textbooks
- Supplemental readings
- Documentaries/programs
- On-line resources

Solicited Feedback on Guidelines from Stakeholders

- Are guidelines needed?
- Was anything missing from content?
- Are there additional stakeholders who should review guidelines and provide feedback?
- What strategies could be used to encourage use of the guidelines?
- How can the guidelines be kept current?



Feedback from Stakeholders

- Generally positive
- Thought guidelines make sense – like the flexibility associated with ‘guidelines’
- Provided recommendations for additional content and resources
- Suggestions were reviewed by subcommittee and, where appropriate, guidelines were revised to reflect this input

For Today's Discussion

- How can we make these guidelines readily accessible to NY's providers and educators?
- What strategies could be used to encourage use of the guidelines?
- How can the guidelines be kept current?



**Department
of Health**

Medicaid
Redesign Team

DSRIP Update

SHIP/DSRIP Workforce Workgroup

Peggy Chan, MPH

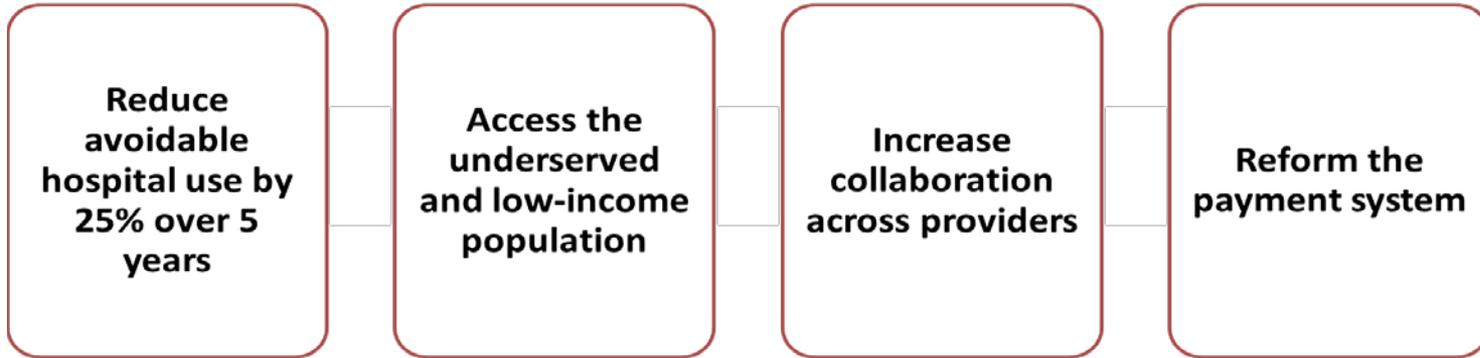
Delivery System Reform Incentive Payment (DSRIP) Program Director
Office of Health Insurance Programs
New York State Department of Health

June 17, 2016

DSRIP Recap to Date

DSRIP Overview and Goals

DSRIP is an incentive payment program that rewards providers for performance on delivery system transformation projects that improve care for low-income patients



DSRIP was built on CMS and State goals in the triple aim: Better Care, Better Health, Lower Costs

Over 5 Years, 25 Performing Provider Systems (PPS) Will Receive Funding to Drive Change

A PPS is composed of regionally collaborating providers who will implement DSRIP projects over a 5-year period and beyond

Each PPS must include providers to form an entire continuum of care

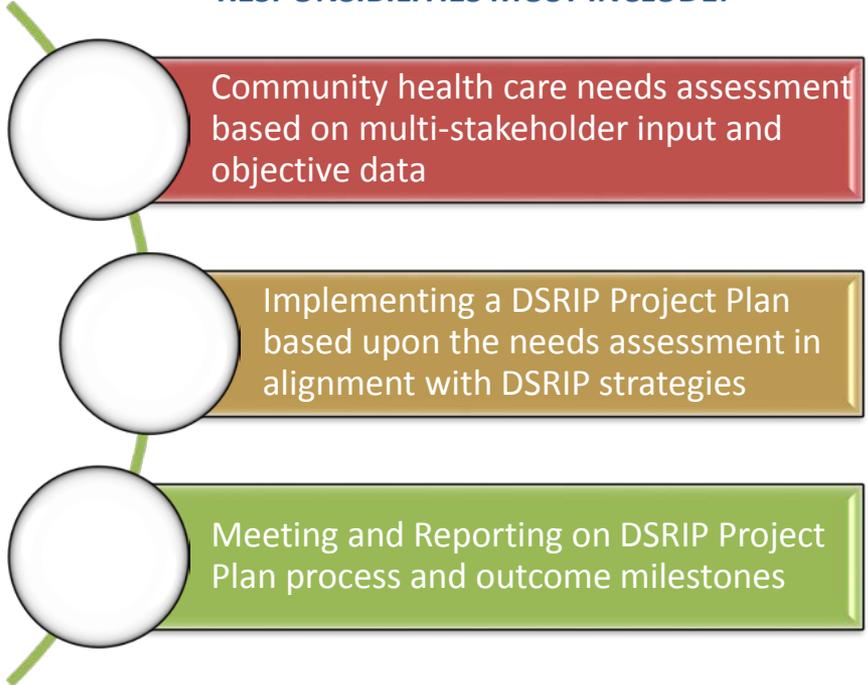
- Hospitals
- PCPs, Health Homes
- Skilled Nursing Facilities (SNF)
- Clinics & FQHCs
- Behavioral Health Providers
- Home Care Agencies
- Community Based Organizations

Statewide goal:

- 25% of avoidable hospital use ((re-) admissions and ER visits)
- No more providers needing financial state-aid to survive

Current State – Work in progress

RESPONSIBILITIES MUST INCLUDE:



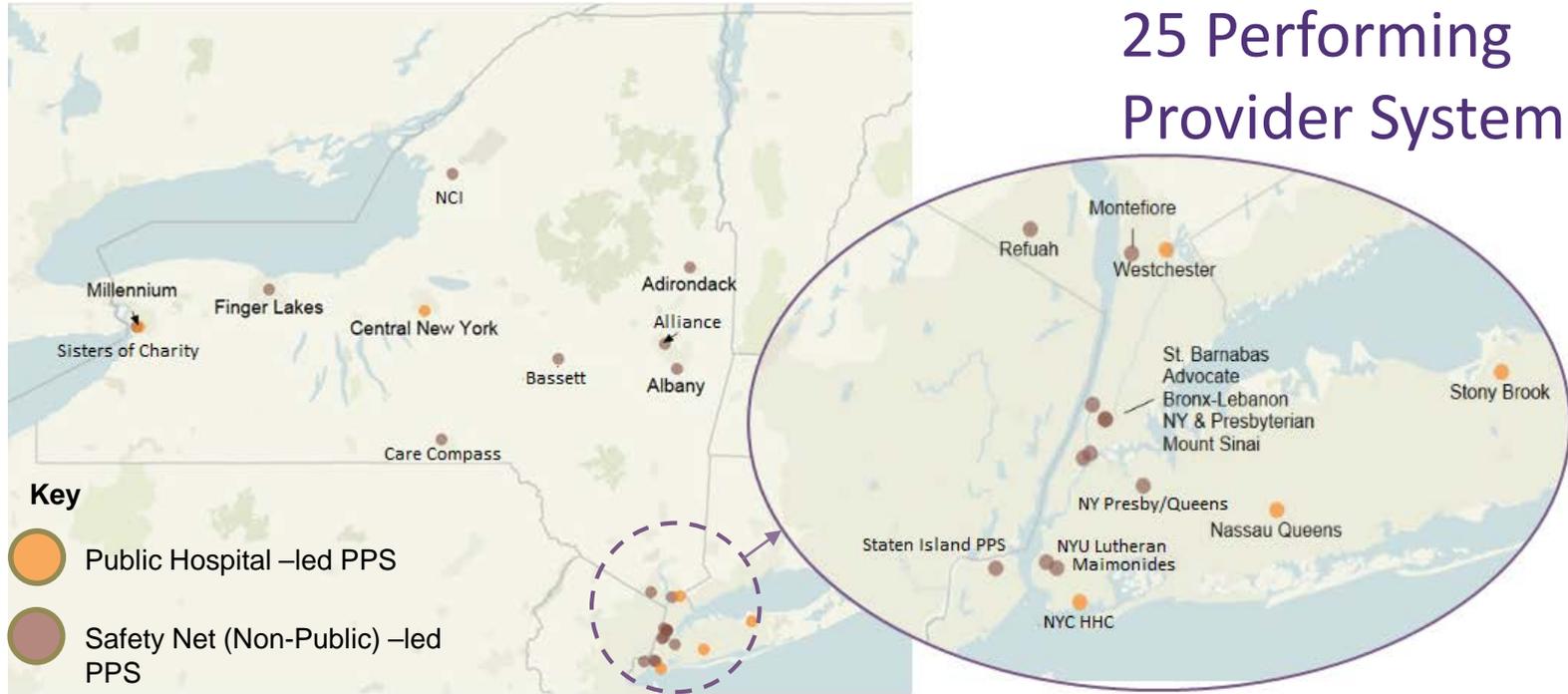
Community health care needs assessment based on multi-stakeholder input and objective data

Implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies

Meeting and Reporting on DSRIP Project Plan process and outcome milestones

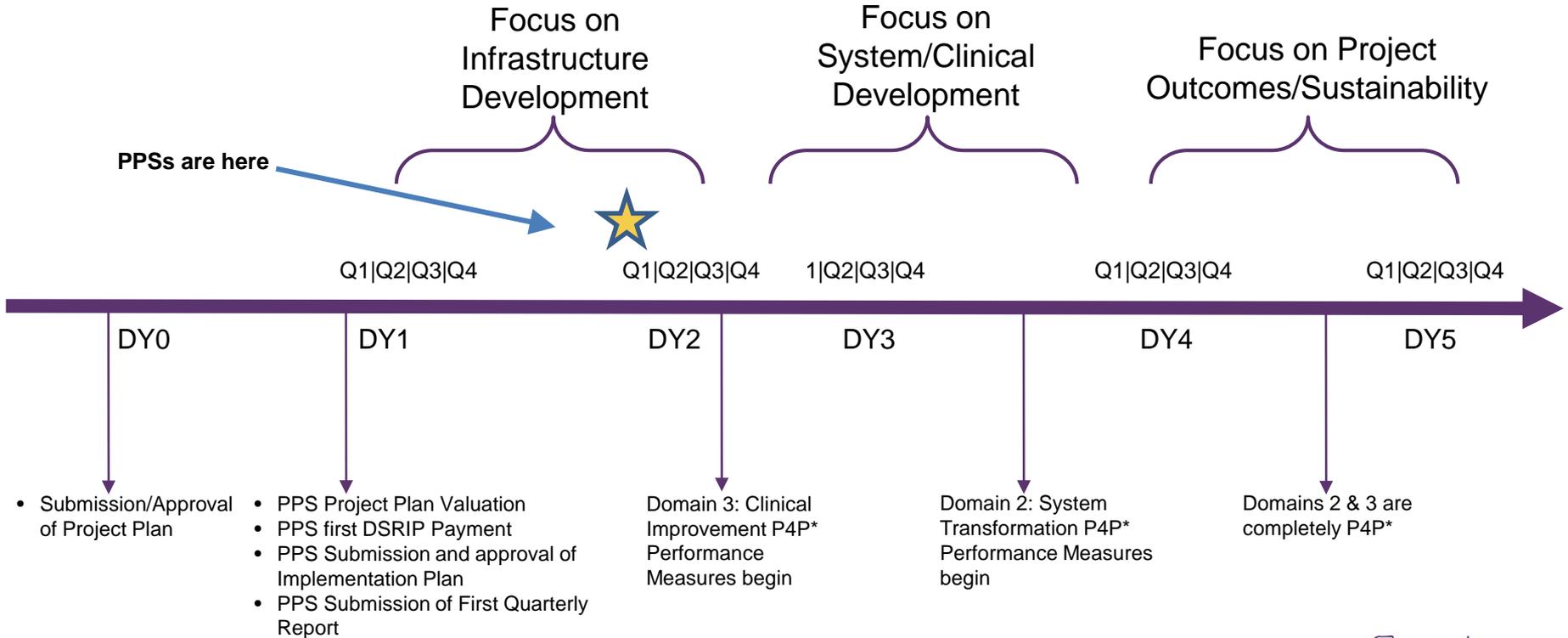
Performing Provider Systems (PPS)

25 Performing Provider Systems



Where We are Now

PPSs have transitioned from planning to implementing projects



Source: Independent Assessor Project Approval and Oversight Panel Presentation. Nov 9 – 10, 2015. NYS DSRIP Website.

* P4P = pay for performance



DSRIP Achievements to Date

- **119,226** providers have become affiliated with DSRIP across the 25 PPSs
- **5,283,175** Medicaid members have been attributed to the 25 PPSs
- First payments totaling **\$866,738,947** were made to PPSs for successful application submission on **April 23, 2015**
- **98.6%** (\$165,992,310) of available payments \$168,387,230 were earned by the 25 PPS for activities targeted to building PPS organizational foundation performed in April – September 2015
- **\$1.2 Billion** in CRFP awards to support DSRIP goals announced March 4th, 2016!

* Statistics as of December 2015

Implementation – Building What Wasn't There

- ***Project Implementation Start-up***
- ***New Partnerships and Business Relationships***
 - ❖ Prelude to the “value” in value-based payment paradigm.
 - ❖ Community-based providers and smaller CBOs feel challenged for VBP.
- ***Current Capacity vs. Capacity-building***
- ***Funds Flow***
- ***New Friends and Mutual Interests***
- ***Reaching into Workforce***
- ***Fact-based Optimism***

DSRIP Demonstration Year 2 (DY2)

- **Pay for Performance** - PPS deliverables will begin to shift to P4P at the end of DY2.
- **Mid-Point Assessment** - mandated under the Standard Terms and Conditions (STCs) governing DSRIP.
 - The DSRIP Independent Assessor will begin the process in the Fall 2016.
 - The Mid-Point Assessment reviews PPS progress towards the implementation of the approved DSRIP Project Plans for compliance with the program requirements identified in the STCs and to determine any modifications necessary to ensure PPS success through the remaining years of the program.
 - Recommendations for changes will be provided for public comment, to the DSRIP Project Approval and Oversight Panel and then to the Commissioner of Health.
 - Commissioner of Health submits final recommendations to CMS for approval.

Value Based Payments – Current Efforts

Various efforts are currently underway for value based payment, including the release of an updated VBP Roadmap for public commentary and the launch of the VBP pilot program

VBP Roadmap

- VBP Roadmap was released for a **public commentary period** from March 18th to April 18th
- Submission of the **VBP Roadmap to CMS for final review and approval** is scheduled for May (deadline for approval is 7/22)

VBP Workgroup

- VBP Workgroup held its third meeting on April 28th, to **review the comments received during the public comment period**
- VBP Roadmap has been updated to **reflect the recommendations** developed by the **VBP subcommittees**

VBP Pilot Program

- Support the **immediate adoption of VBP arrangements** and the State's transition to a VBP model
- Implement the VBP arrangement for two years, **moving to Level 2 by Year 2** (pilots may start at Level 1 in 2016)
- Receive technical and administrative assistance (e.g. target budget assistance, data analysis)
- Approximately **10-15 pilots will kick off in Summer 2016**, with a time frame of about two years
- Pilot VBP arrangements include Maternity, Total Cost of Care, IPC/Chronic, HIV/AIDS, and Health and Recovery Plans (HARPs)

VBP Bootcamp

- DOH will be hosting a **regional VBP learning** series called VBP Bootcamps that will help provider communities plan and gain more knowledge on VBP to ensure smooth transition to implementation
- The Bootcamps will **commence in June 2016**

Medicaid Analytics and Performance Portal (MAPP)

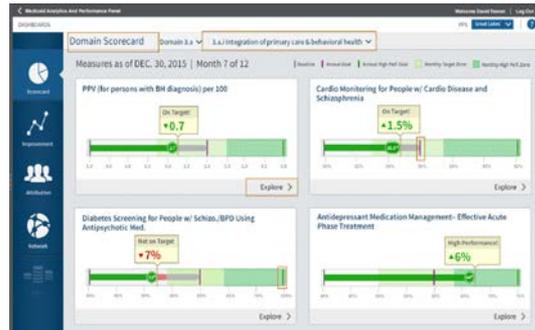
A performance management system that provides tools and program performance management technologies to PPSs in their effort to develop and implement transformative projects in DSRIP

Performance Dashboards, which are accessed by PPSs through MAPP, have been designed to provide insight and actionable information to help visualize and manage performance.

Monitor Project Requirements



Track Gap to Goal for Performance Measures



Gain Population Insight



Workforce Success Through Innovation and Collaboration

PPSs are engaging in new and innovative strategies as they work to transform their workforces to meet the goals of DSRIP projects

PPS	Strong Efforts to Date
North Country Initiative	<ul style="list-style-type: none"> • Collaborating with institutions of higher education to increase the future workforce pipeline of key roles required in DSRIP projects (e.g. nurse practitioners, social workers) • Leveraging statewide initiatives, such as Doctors across New York (DANY), and developing incentive programs to attract new providers to the North Country region, where there is currently a shortage of primary care providers
Staten Island	<ul style="list-style-type: none"> • Developed a new Community Health Worker training program in partnership with 1199 TEF and the College of Staten Island (CSI) • Program lasts 26 weeks and results in college credits and a Community Health Worker certification
St. Barnabas Hospital (dba SBH Health System)	<ul style="list-style-type: none"> • Developing training and curricula to support the Care Management Model • Designed and launched training certification program for Medical Office Assistants • Developing Curricula for <i>Care Coordinator</i> and <i>Nurse Care Management Supervisor</i> roles with Primary Care Development Corporation (PCDC) and National Council on Behavioral Health

DSRIP Workforce

PPS Workforce Barriers

PPSs were asked to share information on workforce barriers that they are facing, as a means to help understand where this workgroup's involvement might help to address some of these barriers

- PPS feedback focused on “on the ground” issues and barriers they are facing as they transition to project implementation, and provided examples of broad issues taking place across much of their network
- Much of the feedback focused on issues affecting the implementation of DSRIP Project 3.a.i, which has the goal to integrate primary care and behavioral health services

PPS feedback on workforce barriers was organized into three categories:

**Issues related to hiring
and training**

**Issues related to
reimbursement**

**Issues and delays in
licensure and reciprocity**

PPS Workforce Barriers

Specific examples of workforce barriers faced by PPSs are demonstrated in these excerpts that were pulled from their feedback

Issues related to hiring and training

- The workforce shortage is with experienced registered nurses (RNs)
- The role and function of community health workers is unclear (e.g. navigation versus health education)
- Need to find solutions to staffing shortages in primary care

Issues related to reimbursement

- Primary Care (PC) practices can only receive reimbursement for Licensed Social Workers but do not have capacity to hire them
- RNs are performing services in PC settings but cannot bill for them
- Mental health providers can bill out of Article 31 facilities, but not out of PC offices

Issues and delays in licensure and reciprocity

- There is a 3+ month wait to take the nurse licensing exams after graduation
- Reciprocal licensing process is lengthy, taking 8-16 weeks for reciprocity to occur after submitting application
- NYS does not belong to the nursing compact which could expedite reciprocity for experienced RNs

How can the involvement of this workgroup begin to address some of the workforce barriers raised by PPSs?

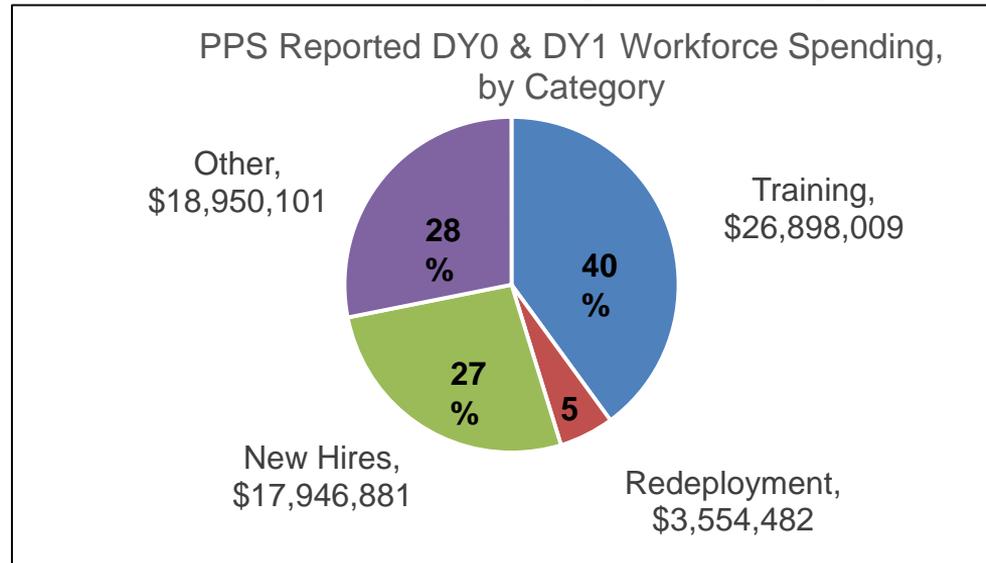
PPS Workforce Spending Update

PPSs reported on workforce spending to date in their DY1 Q4 quarterly report, and this was compared to the workforce spending commitments from their 2014 PPS applications

23 PPSs met the workforce spending threshold required for achieving the workforce achievement value

- PPS reported workforce spending (as of April 2016): ~\$67M
- Spending represented 93% of the total DSRIP Year 1 spending commitment made in PPS applications

PPSs spent most heavily on training and retraining efforts



On the Horizon for DSRIP Workforce

Deadlines for submitting additional PPS workforce data are approaching, as are events designed to support PPSs in their effort to complete required workforce deliverables and milestones

Upcoming Workforce Milestones and Deliverables

- **PPSs must submit by July 31, 2016**
 - Workforce Staff Impact and New Hire Analysis (Baseline)*
 - Compensation and Benefits Analysis*
 - DSRIP Target Workforce State
- **PPSs must submit by October 31, 2016**
 - DSRIP Workforce Gap Analysis
 - DSRIP Workforce Transition Roadmap
 - DSRIP Training Strategy
 - Updates to Workforce Strategy Spending (Actuals)*
 - Updates to Workforce Staff Impact and New Hire Analysis (Actuals)*

Upcoming Workforce Event

- **6/21 All-PPS Meeting: Strategies for Addressing the Emerging Workforce**
 - A forum for PPS workforce leads and stakeholders to share knowledge of practical ideas and strategies towards meeting DSRIP workforce requirements
 - Designed to promote collaboration and knowledge sharing between PPS workforce counterparts across the State
 - Presentation and discussion topics will include developing training programs, collaborating with higher education, rapid cycle transformation, and care coordination training

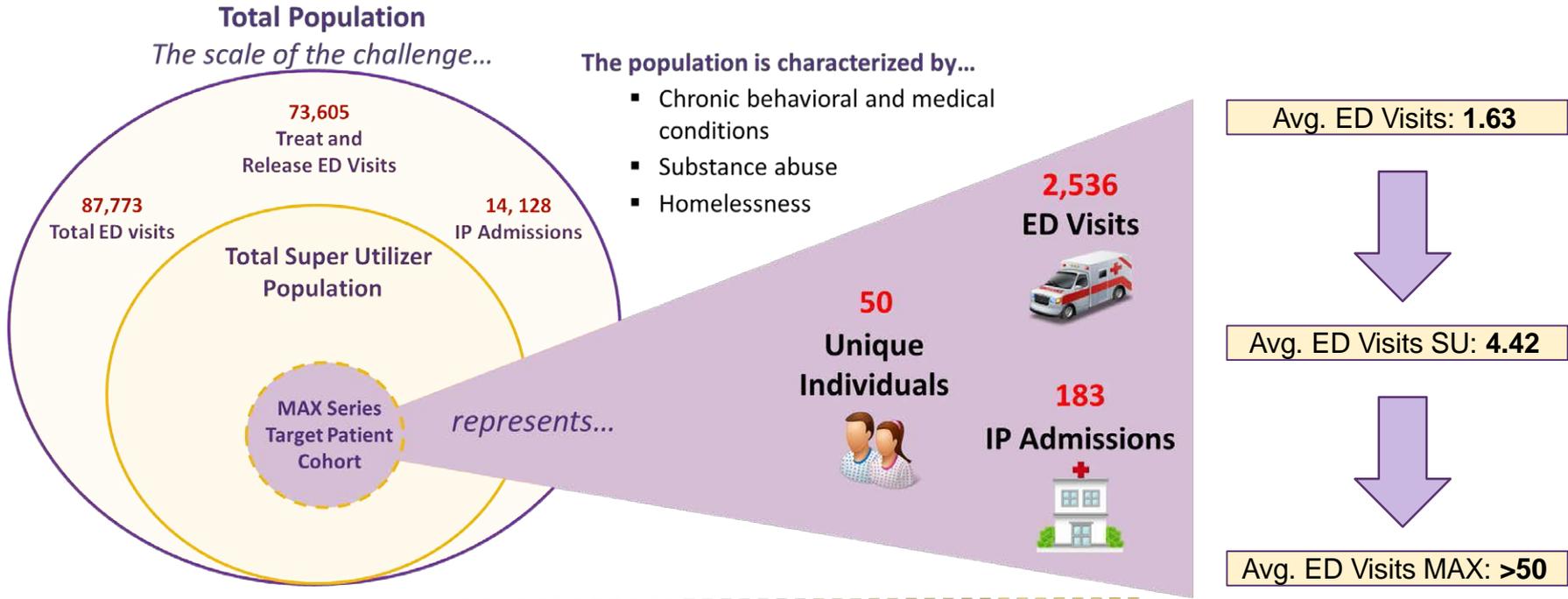
* Indicates that this milestone is achievement value (AV) driving and can impact performance payments if not met

DSRIP Teams in Action

- **Integrated Delivery Systems**
- **Coordination of Care**
- **Population Health**

Identifying Super Utilizers

Hospital data was used to identify each Action Team's cohort



MAX Series Super Utilizer Case Study

MAX Action Teams are changing the trajectory of Medicaid members' lives

 **Quality improved** – John had **82 ED visits and 2 inpatient admissions** over an 11 month period. Because he was identified as a Super Utilizer in the MAX Series, the Action Team has been able to connect him with a settlement house based in the Bronx. **He has not been back to the ED as of January 20, 2016.**

 **Time saved** – **Three provider shifts are projected to be saved** over the course of the year. The **~90 ED visits** diverted is equivalent to 36 provider hours

 **Dollars saved** – The total charges were > **\$68,000**



MAX Series Action Team Progress: Case Study

- **Goal** (identified by the Action Team): **Reduce ED Visits by employing a multi-disciplinary, standardized approach and ensuring that appropriate alternatives are accessible to maximize long-term outcomes**
- **Action Plans**
 - Care Navigation Services to be available 11am-7pm - 7 days per week
 - Educate ED providers regarding Opioid Administration and writing prescriptions for Chronic Pain Diagnosis Patients presenting to the ED
 - Standardized and Cohesive approach to Opioid Administration and writing prescriptions for Opioids in the Emergency Department
- **Projected Outcomes**
 - **Reduction in ED Visits:** 1095 visits annually (50% decrease from 2,190 visits annually)
 - **Time Saved:** Average 2 hours per visit for 1,095 visits = 2,190 hours
 - **Fiscal Savings to the System:** \$589,100 Savings Annually (2,190 visits)

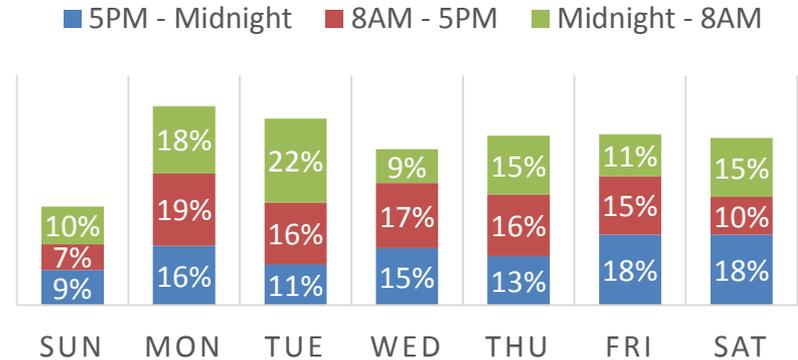
Staten Island PPS

Use Case: ER/EMS Initiative, Focus on Super Utilizers

USER PROFILE

EMS User Profile	Description
Inclusion Criteria	Patients with 6 or more <u>visits</u> to hospital partner in FY 2014
Data Period	1/1/2014 – 12/31/2014
Data Source	EMS tracking system
Results Set	46 unique patients ; 455 visits identified.
Descriptive Statistics	<ul style="list-style-type: none"> • Average Visits per patient : 9.9 • Median Visits per patient: 7.0 • Max Visits per patient: 30

VOLUME BY DAY OF WEEK & TIME OF DAY



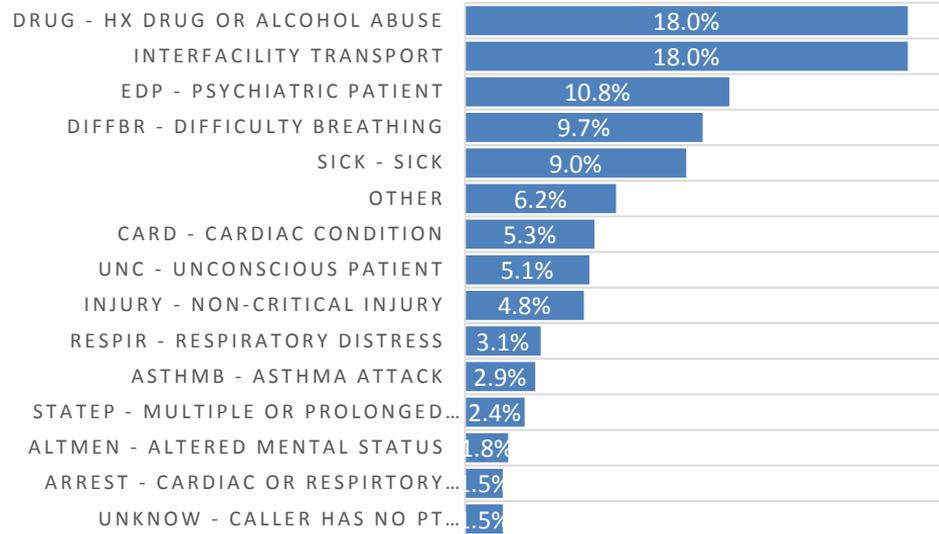
- Monday has the highest volume of calls from EMS.
- Weekdays except Tuesday has the highest volume during 8AM – 5PM. Tuesday’s volume peaked at Midnight - 8AM.
- On the weekends (Friday & Saturday) had higher volume between 5PM – Midnight.

Staten Island PPS EMS User Analysis: Volume by Dispatch Code, Chief Complaints

Volume by Dispatch Code

Dispatch Codes with volume less than 5 were grouped into the "Other" category, including:

Major Injury ; Sick Pediatric, <5 Year Old ; Unknown Condition ; Seizures ; Minor Illness ; Minor Injury; Asthma Attack - Fever&Cough; Reaction To Medication ; Abdominal Pain ; Diff Breathing-Rash & Fever ; Miscarriage ; Seizures - Fever & Cough ; Internal Bleeding



Top 10 Chief Complaints

Chief Complaints	Counts	Percent
No Medical Problem	85	19%
Alcohol Intox	61	13%
Intox	26	6%
Psychiatric Emerg.	21	5%
Asthma Symptoms	19	4%
Dyspnea-SOB	15	3%
Alcohol Intox Severe	13	3%
Headache (no trauma)	10	2%
Behavioral Disorder	10	2%
Weakness	10	2%

DSRIP Year 2 Theme:

Proceed With Fact-based Optimism

DY2 Challenge : Incorporate Fact-based Optimism

Year Round: Use data, experience to date and relationships with partners, to inform your plan of action to continue DSRIP success. Operate in a culture of possibility.

May: Regional Learning Symposiums – be generous with ideas, communicate with other PPS, collaborate to problem-solve perceived obstacles.

July: Release of Phase 2 MAPP Dashboards – more opportunity to dig in to data to enhance understanding. Use dashboards to continue to problem solve from a “perspective of possibility.”

August-December: Mid Point Assessment – an opportunity to take a comprehensive look at where your PPS finds success and address challenges.

Questions?

DSRIP e-mail:

dsrip@health.ny.gov



Next Steps

Where do we go from here?

How do we keep the momentum going?

Workforce Workgroup Priority Focus Areas

- Strengthen the State's health workforce monitoring system.
- Develop more reliable information regarding the numbers and types of workers that may be needed to support the APC practice model under SHIP and integrated delivery models under DSRIP and ability of the existing educational system to supply them.
- Increase attractiveness of primary care careers throughout the State, including in underserved areas.
- Increase care coordination capacity.
- Clarify functional job classes related to care coordination and associated competencies for envisioned delivery system and assure available training and certification as deemed necessary.
- Provide technical assistance to providers for transformation effort.
- Develop support for existing workforce in building team-based health, behavioral health prevention effort, performance management and HIT skills.



Adjournment