SHIP / DSRIP Workforce Workgroup

June 19, 2015

Agenda

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	Topic	Time	Leader
1	Welcome and Introductions	2:00-2:15	Patrick Coonan & Wade Norwood, Co-Chairs
2	Ground Rules	2:15-2:20	Hope Plavin
3	Goals for Today	2:20-2:30	Hope Plavin
4	Workgroup Mandate and Objectives	2:30-2:45	Co-Chairs
5	Leveling the Playing Field – What We Know Today 1) SHIP, SIM & DSRIP 2) What we know from PPS Applications and DSRIP Impact on Workforce 3) Overview of Workforce and Existing Resources 4) Reform Implications and Problems	2:45-3:15	Hope Plavin-SHIP Peggy Chan-DSRIP Barry Gray-Workforce Jean Moore-CHWS
	Break	3:15-3:30	
6	What Are We Solving For/Where Are We Going?	3:30-3:45	All
7	Discussion and Next Steps	3:45-5:00	All

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Welcome and Introductions

Ground Rules

Ground Rules

1. Come to the meeting with a positive attitude
2. Treat members with respect
3. Be prompt arriving to the meeting and returning from breaks
4. Turn cell phones off or to vibrate
5. If you must take urgent calls, take your conversation outside
6. Talk one at a time, waiting to be recognized by the Chairs
7. Limit side conversations
8. Stay on the topic being discussed
9. Address any concerns about the discussion or the meeting with the Chairs

Goals for Today

Goals for Today

1. Review and Discussion of Workgroup Mandate and Objectives
2. Leveling the Playing Field:
   1) Overview of SHIP, SIM & DSRIP
   2) What we know from PPS Applications and DSRIP Impact on Workforce
   3) Overview of Workforce and Existing Resources
   4) Reform implications and problems
3. What We Are Solving For/Where Are We Going?
4. Discussion and Next Steps

Workgroup Mandate and Objectives

Workgroup Mandate

Promote a New York State health workforce that supports comprehensive, coordinated and timely access to care that promotes health and well-being. Make recommendations to the Health Innovation Council and the DSRIP Project Approval and Oversight Panel regarding workforce needs to support the development and promotion of integrated care delivery to result in health improvement.

Workgroup Objectives

- Develop recommendations and provide guidance to DSRIP PPSs to support and evolve the health care workforce consistent with PPS goals and objectives.
- Provide guidance and recommendations on SIM-funded workforce initiatives including, but not limited to development of new rural primary care residency programs and demonstrations to retain physicians in the state.
- Identify existing educational and other resources available to educate, train and re-train individuals to promote a workforce that supports and promotes evolving care models, including integrated care delivery and primary care as supported in both SHIP and DSRIP
- Develop recommendations regarding education and training needs to ensure the development of capacities and capabilities needed to support integrated care delivery systems, including care coordinators, case managers and other roles as necessary to promote integration and access to care across the continuum.
- Examine data and analytic resources currently available to assess current and future workforce needs, identify gaps and make recommendations.
- Coordinate efforts with the Council on Graduate Education (COGME) regarding issues related to graduate medical education and with the Rural Health Council regarding rural health issues.

Leveling the Playing Field

Leveling the Playing Field:

1) SHIP, SIM, and DSRIP

Hope Plavin
Department of Health

New York State Health Innovation Plan

Goal	**Delivering the Triple Aim** – Better health, better care, lower costs

Pillars	1	2	3	4	5
	Improve access to care for all New Yorkers, without disparity	**Integrate care to address patient needs seamlessly**	**Make the cost and quality of care transparent to empower decision making**	**Pay for healthcare value, not volume**	**Promote population health**
	Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way	Integration of primary care, behavioral health, acute and postacute care; and supportive care for those that require it	Information to enable consumers and providers to make better decisions at enrollment and at the point of care	Rewards for providers who achieve high standards for quality and consumer experience while controlling costs	Improved screening and prevention through closer linkages between primary care, public health, and community-based supports

Enablers			
	Workforce strategy	A	Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities
	Health information technology	B	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation
	Performance measurement & evaluation	C	Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation

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Vision: Achieve the Triple Aim and Support a "Sustainable Health System"

A Sustainable Health System is one that:

- improves the health of our population overall
- uses new models of care delivery
- delivers care in the place and at the point of time or illness progression with a workforce working in new ways
- is financially responsible
- works within our communities
- values integration
- measures its results
- treats patients and families as partners in care
- drives change and improvement
- is transparent

Advanced Primary Care (APC) is a key tool for achieving a sustainable health system:

- a means, not an end
- not the only tool

Source: Dartmouth-Hitchcock http://www.dartmouth-hitchcock.org/about_dh/what_is_sustainable_health.html

New York Can Do Better*

- Less than half of adults receive recommended screening and preventive care
- Many patients do not have a “usual source of care” or single trusted provider
- New York ranks 36th nationwide for avoidable hospital use and cost
- Per capita costs are among the highest in the nation and increasing
  - Total health care costs are the 2nd highest in the nation ($163B)
  - Spending is forecast to rise by more than 50% by 2020
  - NYS’s large employers contribute higher share of premium costs than employers in any other state
  - Employer sponsored family health insurance cost in NYS rose 92% and employee premium contributions as a % of income doubled (over 10 years)
  - Without intervention, spending on benefits for state and local government (employees and retirees) and Medicaid will continue to outpace gross domestic product (GDP)

**Sources:* NYS Health Foundation – Health Care Costs and Spending in NYS (Chart Book) (http://nyshealthfoundation.org/uploads/resources/health-care-costs-in-NYS-chart-book.pdf); Commonwealth Fund Scorecard on State Health System Performance, 2014 (http://datacenter.commonwealthfund.org/scorecard/state/34/new-york/)

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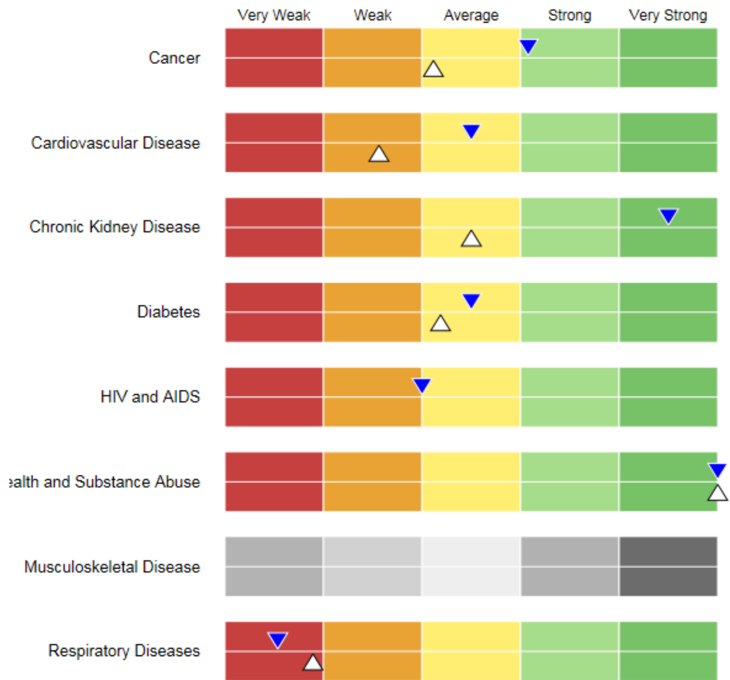
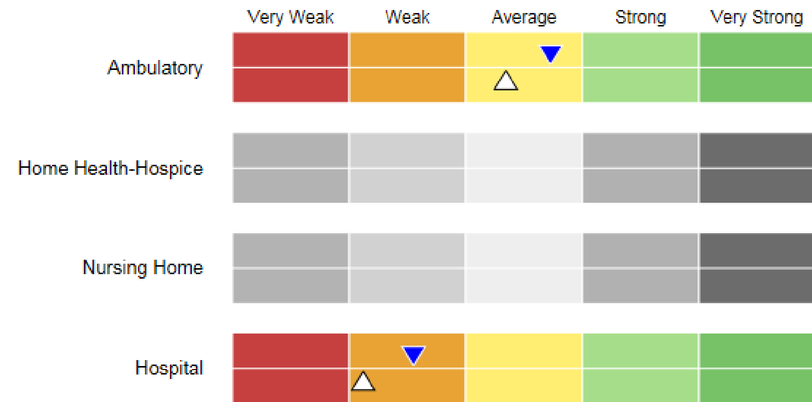
New York Performance on Some Key Quality Indicators





- National Healthcare Quality reports have found that NYS performs poorly or on average on key quality indicators. However, statewide performance over time is demonstrating improvement.

Source: 2013 AHRQ National Healthcare Quality Report

New York Summary of Key Indicators

Care Measure	2014 Scorecard	2009 Scorecard
Overall National Ranking	19	18
Access and Affordability *Insurance coverage & indicators of access and affordability of care.*	17	22
Prevention & Treatment *Effective care, coordinated care, and patient-centered care.*	28	20
Healthy Lives *Measures of long & healthy lives, including rates of smoking and obesity.*	12	21
Avoidable Hospital Use & Costs *Care that may have been prevented or reduced with appropriate care as well as Medicare costs and annual private insurance premiums.*	36	34
Equity *Performance associated with income level, type of insurance, or race/ ethnicity.*	7	12

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Source: Commonwealth Fund Scorecard on State Health System Performance, 2014.

SHIP Goals and Policy Objectives

Goals

1. Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement within five years;
2. Achieve high standards for quality and consumer experience;
3. Assure affordable care by reducing unnecessary care, shifting care to more appropriate settings, reducing avoidable hospital admissions and readmissions, and ensuring a clear link between cost and quality.

Policy Objectives

Systemic transformation to achieve the following:

1. 80% of the state's population receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral health care to promote health and well-being for all New Yorkers;
2. 80% of care paid for under financial arrangements that incent quality and value; and
3. Engaged consumers able to make informed choices about their care using readily available and understandable information on cost and quality.

For more information, visit the below webpage to view the SHIP: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_state_health_innovation_plan.pdf

SIM Grant Application

NYS was awarded $100 million to implement and test the SHIP.

New York will promote a tiered ***Advanced Primary Care*** (APC) model that is inclusive of behavioral and population health integration, coupled with an appropriately trained workforce, engaged consumers, supportive payment and common metrics.

The state will:

1) institute a state-wide program of regionally-based primary care practice transformation activities to help practices across New York deliver ‘advanced primary care’;
2) expand the use of value-based payments so that 80% of New Yorkers are receiving value-based care by 2020;
3) support performance improvement and capacity expansion in primary care by expanding New York’s primary care workforce through innovations in professional education and training;
4) integrate APC with population health through Public Health Consultants funded to work with regional Population Health Improvement Program (PHIP) contractors;
5) develop a common scorecard, shared quality metrics and enhanced analytics to assure that delivery system and payment models support three-part aim objectives; and
6) provide state-funded health information technology, including enhanced capacities to exchange clinical data and an all-payer database.

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DSRIP and SHIP: Unique but Complementary

	DSRIP	SHIP/SIM
Goals	• Integrated, value-based care through population health-based care delivery models and payment innovation • 25% reduction in avoidable hospital use over 5 years	• Integrated, value-based care through population health-based care delivery models and payment innovation • 80% of New Yorkers impacted within 5 years • Achieve the Triple Aim
Scope	• All providers that qualify as Safety Net providers, along with coalitions (PPS) of other proximate providers • All Medicaid patients attributed to those coalitions	• All primary care practices • All payers • All New Yorkers
Units	• Provider Performing Systems	• Primary care practices (of any size or affiliation)
Payment models	• Provider incentive payments based on project milestones and outcomes; Value Based Payment	• Range of payment models, including P4P, shared savings, capitation, etc.

Leveling the Playing Field:

2) What We Know From PPS Applications and DSRIP Impact on Workforce

Peggy Chan
Department of Health

DSRIP - Workforce Data from PPS Applications

- The 25 PPSs identified a combined workforce of over 717,000 statewide
- They estimated that:
  - 18,000 will need to be re-trained
  - 25,000 will need to be newly hired
  - 23,000 redeployed, and
  - 2,200 jobs may be eliminated
- PPSs expect to commit approximately $414.6 million on workforce initiatives
- *Note: Several PPSs did not provide select program impact estimates. Data is preliminary; more refined numbers will be submitted as implementation plans are developed.

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DSRIP - Number of New Hires in Select Titles

PPSs estimated they may need to hire approximately:

- 1,590 New Physicians
- 4,942 Mental Health Providers and Case Managers
- 2,375 Social Workers
- 668 IT Staff
- 3,150 Nurse Practitioners
  - * 2 PPSs included 1,000 each in 3,150 Nurse Practitioner estimate

Health Care Trends and DSRIP Impact on the Workforce

- **Trend:** Unprecedented transformation due to economic, demographic, technological and regulatory change.
- **DSRIP Impact:** Reduction of 25% Medicaid hospital admissions; greater coordinated care and integrations of systems
- **Trend:** Transition from pay-for-volume to pay-for-value and utilization-based reimbursement will continue to drive fundamental business model evolution
- **DSRIP Impact:** Shifting of care and services from emergency room settings to ambulatory care and clinic settings

Health Care Trends and DSRIP Impact on the Workforce (*continued*)

- **Trend:** Providers are working to provide better care for more people, while balancing quality, cost, and access.
- **DSRIP Impact:** Increased staffing among key positions, including care managers, case managers, social workers, and patient navigators.
- **Trend:** The emergence of technology innovations and business models that parallel the evolution of accountable care.
- **DSRIP Impact:** New skills for the workforce in working with decision aids, telehealth and other self-care technologies; and real-time information about patient experience.

Tie-in with Integrated Care Workgroup Goal

- Supports an evolved primary care workforce that meets future needs of an aging population with higher numbers of insured individuals;
- Manages chronic disease and population health;
- Effectively uses evolving health information technologies; and
- Participates on comprehensive care management teams

Leveling the Playing Field:

3) Overview of Workforce and Existing Resources

Barry Gray
Department of Health

Overview of Workforce – The Big Picture

- 12% of New York's workforce is employed in the health care sector (over 1 million people) vs. 10.6% nationwide
  - Health care employment is a vital component of New York's economy and continues to grow faster than most other employment sectors, especially in areas outside of New York City
  - Between 2000 and 2013, health care employment grew by over 18% statewide compared to less than 1% for all other sectors
  - Between 2000 and 2013, health care employment grew by 17% in areas outside of New York City while employment in other sectors declined by 6%
- In 2013, 42% of health sector jobs in the state were in hospitals (vs. 30% in ambulatory care, 14% in nursing and personal care facilities, and 14% in home health care)
  - Since 2000, jobs in home health care more than doubled (adding nearly 77,000 jobs)
  - Since 2000, jobs in ambulatory care have increased by more than 28% (adding 68,500 jobs)

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*source-Center for Health Workforce Studies

Select Health Care Professionals

Occupation	Number of Licensed Professionals (1)	Estimated Actively Practicing (2)
RNs	284,506	197,729
Physicians	92,984	82,178
LPNs	72,983	50,746
Pharmacists	24,541	18,438
Dentists	18,370	13,267
PAs	12,736	12,521
Dental Hygienists	11,073	10,317

(1) State Education Licensure Data, April 2014
(2) American Community Survey, 2009 – 2013 5-Year Estimates

Physician Maldistribution

- New York's physician to population ratio is 374 per 100,000 population – well above the national average of 252 per 100,000 population.
- There are 74.5 community-based, primary care physicians (PCPs) per 100,000 in New York, ranging from 53.7 per 100,000 in the Mohawk Valley to 79.5 per 100,000 on Long Island
- 7.5 million New Yorkers reside in 93 primary care HPSAs, representing 38% of its population.
- An additional 603 primary care physicians would be needed to remove the shortage status, and many more to provide adequate coverage in those areas.
- Respondents to the HANYS 2014 Physician Advocacy Survey (94 hospitals/health systems) identified a need for 942 physicians across the state, excluding New York City. Of that need, nearly 200 are PCPs.
- In the HANYS survey, 77% indicated that their primary care capacity is not sufficient to meet current needs and 75% are concerned about their ability to meet future needs.
- In the HANYS survey the specialists that were most reported as being in short supply included neurologists/neurosurgeons, surgical sub-specialists, medical specialists, orthopedists and general surgeons.

Health Professional Shortage Areas (HPSAs)- Primary Care

93 Primary Care HPSAs include:

- 23 Geographic
- 70 Medicaid

Basic Criteria:

- Physician to population ratio – Key determinant
- Also looks at contiguous areas – are they accessible, over-utilized or distant?
- Travel time to nearest source of non-designated care

Oral Health Supply

- Dentists and Dental Hygienists
- Maldistribution within New York
  - Long Island has approximately 98 dentists per 100,000 population while the Southern Tier has approximately 47 per 100,000
  - The Finger Lakes has approximately 100 dental hygienists per 100,000 population while New York City has approximately 23 per 100,000 population
- Most dentists and dental hygienists practicing in New York State were trained in New York State
- While New York State does not have a shortage of dentists compared to the national per capita average, some areas of the state have shortages of dentists serving Medicaid patients

Registered Nurses

- 42% of active RNs in New York work in hospitals while about 30% work in community based settings
- The demand for RNs is expected to grow in ambulatory care with more emphasis on care coordination
- New York's RN workforce is predominantly female and almost 60% are age 50 or older
- While RN graduations have steadily increased since 2002, much of the recent growth can be attributed to Bachelor of Science completers
- Since 2008, newly trained RNs have had difficulty finding jobs, especially RNs with Associate Degrees

Behavioral Healthcare Providers

- Reforms under the Affordable Care Act and DSRIP will increase the demand for behavioral health care providers
- The state's health care system is already stressed by a shortage of licensed behavioral healthcare professionals
- There are 148 mental health HPSAs in New York State
  - (16 geographic, 37 MA and 95 facility designations)
- Over 3 million people reside in these areas
- It would require 119 psychiatrists to eliminate these shortage areas
- The shortage of psychiatrists is particularly acute in rural upstate locations although steadily spreading statewide

Behavioral Healthcare Providers

- There is a shortage of psychiatrists with advanced credentials such as forensic psychiatry
- There is a shortage of psychiatric nurse practitioners
- Some state facilities have difficulty finding licensed psychologists and nurses (possible salary issue)
- The licensed mental health workforce is aging
  - Statewide 28% are 62 years or older and 54% are over age 50
  - Almost 68% of licensed clinical social workers are 50 years old and nearly 38% are at retirement age
  - Nearly 64% of psychiatrists are over the age of 50 and 38% are of retirement age

Licensed Mental Health Workforce

Discipline	Number	% of Total
Licensed Master Social Workers	25,086	32.8%
Licensed Clinical Social Workers	24,727	32.4%
Psychologists	10,732	14.0%
Psychiatrists	6,578	8.6%
Mental Health Counseling	5,081	6.7%
Other*	2,889	3.8%
Nurse Practitioners – Psychiatry**	1,292	1.7%
Total	76,385	100%

*Because of their smaller numbers, marriage and family therapists, psychoanalysts, and creative arts therapists are combined in the “Other” category in this analysis.
** Excludes all MH nurses other than nurse practitioners: OMH August, 2014

Recruitment and Retention Issues to Consider

Hospitals report the most difficulty recruiting and retaining:

- Clinical laboratory technologists and technicians
- Medical coders
- Physician assistants
- Nurse managers
- Experienced RNs

Nursing homes report the most difficulty recruiting:

- Experienced RNs
- Nursing managers
- Directors of nursing
- Minimum Data Set (MDS) coordinators

Nursing homes report the most difficulty retaining:

- Certified Nursing Assistants
- Personnel care assistants
- Registered Nurses

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Recruitment and Retention Issues to Consider (*continued*)

Home Health Agencies report the most difficulty recruiting:

- Occupational therapists
- Speech-language pathologists
- Dieticians/Nutritionists
- Experienced RNs

Home Health Agencies report the most difficulty retaining:

- Experienced RNs
- Respiratory therapists

FQHCs report the most difficulty recruiting:

- Psychiatric NPs
- Psychiatrists
- Primary care physicians

FQHCs report the most difficulty retaining:

- Psychiatric NPs
- Family NPs

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Major Sources of Workforce Development Funding

- DSRIP contains funding to support workforce development necessary to effectively implement PPS projects. PPSs committed to approximately $414.6 million to support workforce initiatives collectively in their project applications.
- The Managed Long Term Care Workforce Development Program includes $245 million to support recruitment, training and retention initiatives for long term care professional and paraprofessional staff.
- The Health Home Development Fund contains $190 million to improve and leverage Health Home infrastructure and improve performance. One of four areas for which funds can be used is workforce training and retraining.
- The New York State budget supports various programs that serve the goal of increasing the supply of various types of health care clinicians and non-clinician workers in underserved areas of the state as well as training health care workers in shortage occupations.

Workforce Programs – Recruitment, Training and Retention

- Doctors Across New York Physician Loan Repayment Program
  - Non-competitive program that provides up to $150k over 5 years in loan repayment to primary care and physician specialists who agreed to practice in HPSAs, MUAs and other underserved areas.
  - Provided loan repayment to 101 physicians between 2009 and 2015

- Doctors Across New York Physician Practice Support Program
  - Non-competitive program that provides up to $100k over 2 years in practice support to primary care and physician specialists who agree to practice in HPSAs, MUAs and other underserved areas.
  - Provided practice support to 165 physicians between 2009 and 2015

- New York State Primary Care Service Corp/State Loan Repayment Program
  - Competitive program that provides up to $60k over 2 years in loan repayment for non-physician clinicians to practice in HPSAs
  - 32 non-physician clinicians were funded in 2013

- National Health Service Corps Scholarship and Loan Repayment Programs
  - Federal program that provides up to $50k over 2 years in loan repayments or scholarships for physicians and non-physicians who provide primary, oral or behavioral health care in outpatient settings in HPSAs
  - There are currently 494 NHSC full and part-time clinicians practicing in New York State

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Workforce Programs – Recruitment, Training and Retention (c*ontinued)*

- Regents Loan Forgiveness Program
    - Provides up to $10k for up to 4 years in loan repayment to physicians who agree to practice primary care in Regents Physician Shortage Areas
- New York "State 30" J-1 Visa Waiver Program
    - Provides waivers of the home return requirement of the J-1 exchange visa for alien, non-immigrant physicians (primary care or physician specialists) who agree to practice in medically underserved areas
    - 30 waivers are granted each year
- Appalachian J-1 Visa Waiver Program
    - Provides waivers of the home return requirement of the J-1 exchange visa for alien, non-immigrant primary care physicians in federally designated HPSAs in counties within the Appalachian Region

Workforce Programs – Training

- Health Workforce Retraining Initiative
  - Competitive program that provides health care workers with the education and training necessary to address shortage occupations or need for new skills in the changing health care marketplace.
  - This program has provided grants to approximately 550 hospitals, nursing homes, home care service providers, union training funds and educational institutions since 1997 and trained over 185,000 health care workers.

- Doctors Across New York Ambulatory Care Program
  - Competitive program that provides medical schools, hospitals and clinics with funding to help them develop affiliation agreements and train residents and medical students in free-standing ambulatory care sites (clinics and private physician offices).
  - DOH provided $8 million over three years to 13 medical education institutions to train approximately 667 residents and medical students in ambulatory care sites.

Workforce Programs – Training

- Doctors Across New York Diversity in Medicine Program
  - Funding is made available to Associated Medical Schools of New York to administer 10 separate programs to assist minority and financially disadvantaged students in medicine and other health related fields.
  - Since 1991, 397 students have participated in this program and over 90% of students have enrolled in medical school.

- Area Health Education Centers (AHECs)
  - State funding is available to the AHECs to support health professions training programs and community-based training experiences for medical students, health professions students and post-secondary students.

- Empire Clinical Research Investigator Program (ECRIP)
  - State funding supports two-year awards to teaching hospitals to train physicians as researchers, advance biomedical research in the state and support projects with the potential to enhance the health of New Yorkers.

Leveling the Playing Field:

4) Reform Implications and Problems

Jean Moore
Center for Health Workforce Studies

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Workforce Implications of DSRIP

- Emerging patient care delivery models
- Team-based approaches to care are used extensively in these models
  - Team composition and roles vary, depending on the patient population
  - Teams may include: physicians, NPs, PAs, RNs, social workers, LPNs, medical assistants, and community health workers, among others
- Primary care team member roles are expanding, e.g. often including behavioral health and oral health assessments

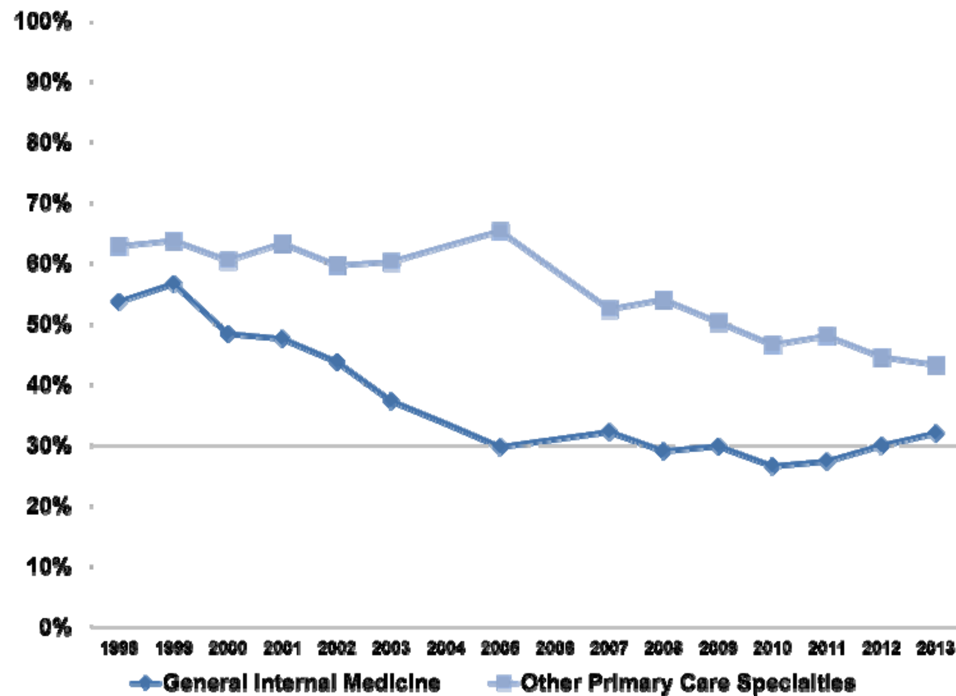
Multidisciplinary Teams Have Positive Impacts on Patient Outcomes

- “The provision of comprehensive health services to patients by multiple health care professionals with a **collective identity** and **shared responsibility** who **work collaboratively** to deliver patient-centered care.”
  - Source: Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington, D.C.: Interprofessional Education Collaborative.
- Research suggests health care teams with greater cohesiveness and collaboration are associated with:
  - Higher levels of patient satisfaction
  - Better clinical outcomes
- The most effective and efficient teams demonstrate a substantial amount of scope overlap – i.e., shared responsibilities

So What's the Problem?

- Primary care practitioners are not well-distributed in the state
- The health workforce is not as diverse as the population it serves
- Few health workforce education programs train in team-based models of care
- Many health professionals are not trained in emerging roles and responsibilities
- Health professionals are often not allowed to practice to the full scope of their professional competence

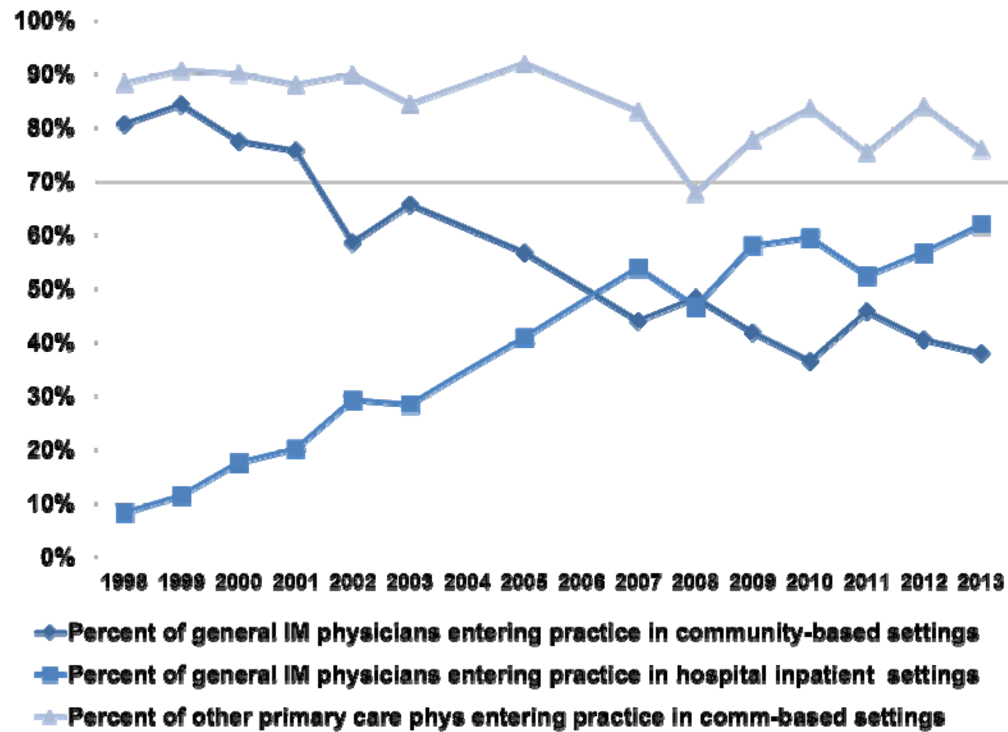
Steady Decline in the In-state Retention of New PC Physicians in New York



http://chws.albany.edu

Source: Center for Health Workforce Studies

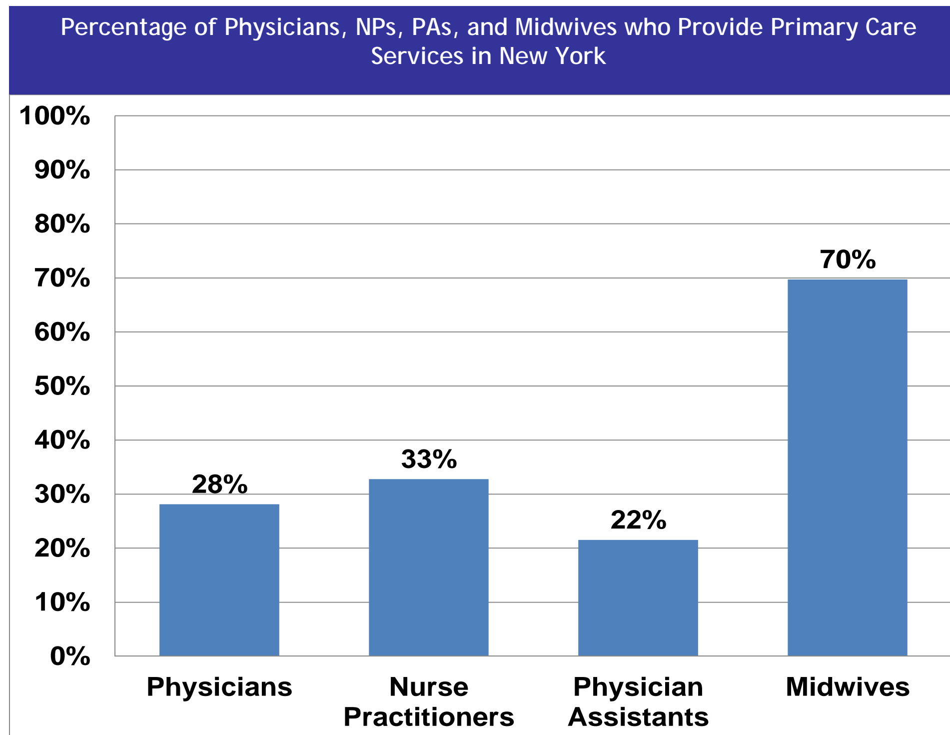
More New PC Physicians Plan to Work in Inpatient Settings in New York



Source: Center for Health Workforce Studies

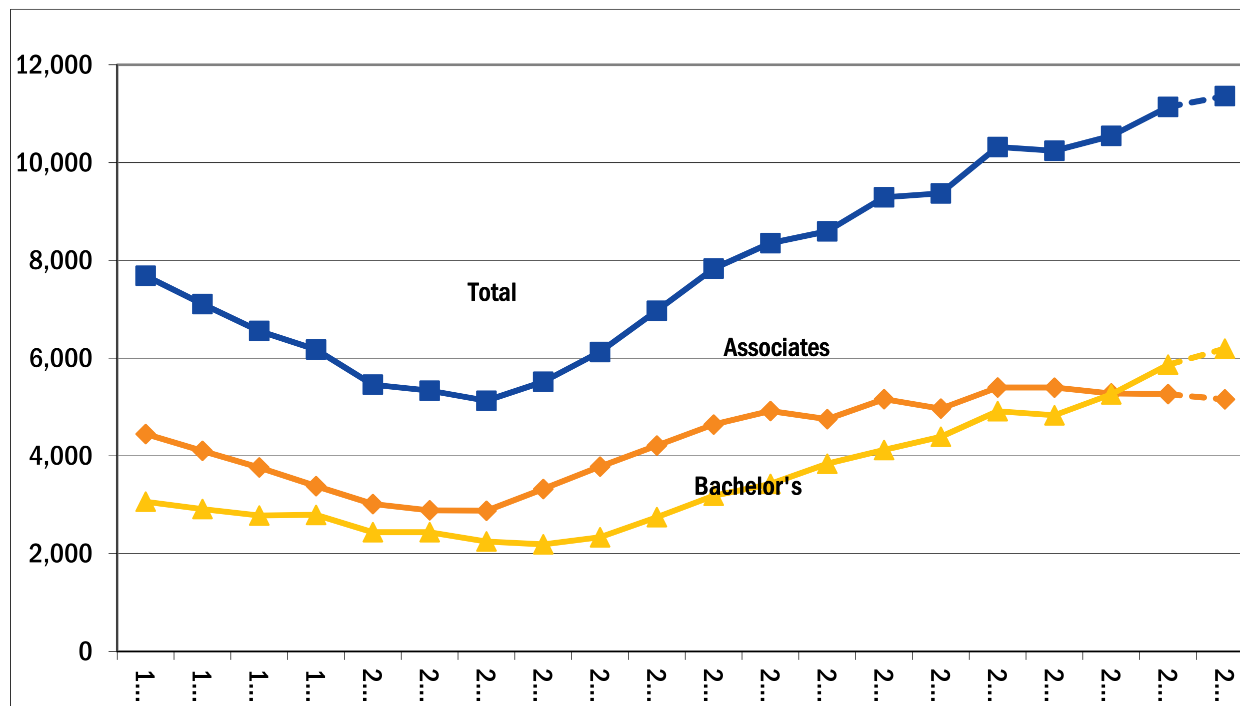
http://chws.albany.edu

Who Are New York's Primary Care Practitioners?



Source: Center for Health Workforce Studies

New York RN Graduations, by Degree Type, 1996-2015



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What Are We Solving For? Where Are We Going?

Key Workforce Issues

- Need to develop strategies to better prepare the state's health workforce for emerging models of care under DSRIP and the SHIP
  - Working on teams
  - New knowledge and skills – population health, data analytics, care coordination
  - Emerging titles

- Address regulatory barriers to effective team-based care

- Need for better data on the state's health workforce
  - Supply and distribution
  - Education
  - Practice characteristics

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What Problems Need Solving?

- Primary care and specialist physician shortages
- NY-educated physicians who leave the state after training
- Lack of reliable and timely data on the state's health workforce
- Lack of reliable data/information on the types and numbers of workers that will 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
- Confusion regarding the multiple types and tiers of care management and care coordination titles.
- Lack of student exposure to rural and non-hospital settings by helping rural providers to identify opportunities and create residency and other training programs
- Lack of information on why providers leave the state after training
- Planned transition of the health care workforce from in-patient to out-patient as part of system transformation under DSRIP
- Maintain and improve workforce income status where possible under systems transformation

Where Are We Going?

- 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

Where Are We Going? (*Continued*)

- Develop a regionalized approach to minimizing underutilization of workforce resources
- Test approaches to most effectively help small providers create networks of pooled training resources
- Develop the current workforce's clinical and patient-care capabilities
- Investigate peer credentialing models
- Collaborate with existing health care institutions and other organizations such as AHECs, Associated Medical Schools of New York (AMSNY), Iroquois Health Care Association and union training funds to address clinical and non-clinical training gaps

Next Steps

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