Project 2ai

Create an Integrated Delivery System Focused on Evidence-Based Medicine and Population Health Management

Training Needs Identified	Audience	Partners	Source	Timing	Comments
PPS trains staff on IDS protocols and processes.	All PPS partners		**Project Requirement #3**: Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	DY2	Project System Change; Written training materials; list of training dates along with number of staff trained
EHR training	Safety net providers	EHR vendors; Practice Facilitators	Ten key principles for successful health systems integration. Suter E, Oelke ND, Adair CE, Armitage GD. Healthc Q. 2009;13 Spec No:16-23. Review. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3004930/	DY3	**HIT/HIE**; Poorly designed or underutilized EHR systems may undermine IDS
Staff training on alerts and secure messaging functionality	Safety net providers	HealtheConnections, EHR vendors	**Project Requirement #4:** Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up.	DY3	**HIT/HIE**; list of training dates along with number of staff trained in use of alerts and secure messaging

Patient Centered / Whole Person Care o Development of effective, caring relationships with patients o Assessment of bio psychosocial needs across the life span o Patient-centered care planning, including collaborative decision-making and patient self-management o Cultural sensitivity and competence in culturally appropriate practice	PCMH eligible primary care practices	HANYS; Practice Facilitators; CNYCC Cultural Competency/Health Literacy Workgroup	1) BORKAN, JEFFREY. "Training the Primary Healthcare Team for Transformed Practices." RI Med J (2013): 22-5. 2) Competencies endorsed by non-profit Patient-Centered Primary Care Collaborative (PCPCC) Training Task Force to prepare health care professionals across disciplines and skill level in a medical home: https://www.pcpcc.org/content/primary-care-workforce-competencies	DY3	**PCMH**
System-Based Care o Advocacy for patient-centered integrated care o Business models for patient–centered integrated care o Care coordination for comprehensive care of patient and family in the community o Promotion of appropriate access to care (e.g., group appointments, open scheduling)	PCMH eligible primary care practices	HANYS; EHR vendors; Practice Facilitators	1) BORKAN, JEFFREY. "Training the Primary Healthcare Team for Transformed Practices." RI Med J (2013): 22-5. 2) Competencies endorsed by non-profit Patient-Centered Primary Care Collaborative (PCPCC) Training Task Force to prepare health care professionals across disciplines and skill level in a medical home: https://www.pcpcc.org/content/primary-care-workforce-competencies	DY3	**PCMH**

Practice-Based Learning	PCMH eligible primary care practices	HANYS; EHR vendors; Practice Facilitators	1) BORKAN, JEFFREY. "Training the Primary Healthcare Team for Transformed Practices." RI Med J (2013): 22-5. 2) Competencies endorsed by non-profit Patient-Centered Primary Care Collaborative (PCPCC) Training Task Force to prepare health care professionals across disciplines and skill level in a medical home: https://www.pcpcc.org/content/primary-care-workforce-competencies	DY3	• Analyze practice and improve using systematic methodology • Locate, appraise and apply scientific evidence • Apply knowledge of study designs and statistics • Obtain and use patient population data • Use information technology • Facilitate the learning of others
Teamwork & Interprofessional Training o Communication & Professionalism o Team leadership o Interprofessionalism and interdisciplinary team collaboration	PCMH eligible primary care practices	HANYS; Practice Facilitators	1) BORKAN, JEFFREY. "Training the Primary Healthcare Team for Transformed Practices." RI Med J (2013): 22-5. 2) Competencies endorsed by non-profit Patient-Centered Primary Care Collaborative (PCPCC) Training Task Force to prepare health care professionals across disciplines and skill level in a medical home: https://www.pcpcc.org/content/primary-care-workforce-competencies	DY3	**PCMH**

Chronic Disease, Practice & Population Management o Population-based approaches to health care delivery o Risk identification	PCMH eligible primary care practices	HANYS; EHR vendors; Practice Facilitators	1) BORKAN, JEFFREY. "Training the Primary Healthcare Team for Transformed Practices." RI Med J (2013): 22-5. 2) Competencies endorsed by non-profit Patient-Centered Primary Care Collaborative (PCPCC) Training Task Force to prepare health care professionals across disciplines and skill level in a medical home: https://www.pcpcc.org/content/primary-care-workforce-competencies	DY3	**PCMH**

CNY CARE COLLABORATIVE

Project 2aiii

Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for health homes through access to high quality primary care and support services

Training Needs Identified	Audience	Partners	Source	Timing	Comments
Staff training on alerts and secure messaging functionality	Safety net providers	HealtheConnections, EHR vendors	**Project Requirement #3:** Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange (RHIO) and sharing health information among clinical partners.	*See CNYCC Speed and Scale Commitments*	HIE functionality - direct exchange (secure messaging), alerts and patient record look up.
Create curriculum for training staff and providers on care plan process, and 'tip sheets' with screen shots to support learning. (5) Roll out training throughout clinic. (6)	PCMH Primary Care Practices and Health Homes	Health Home staff	**Project Requirement #6:** Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	*See CNYCC Speed and Scale Commitments*	Data source includes: Written training materials; List of training dates, including number of staff trained
Train providers and Health Home staff on using the evidence-based guidelines selected and share best practices. (8) Provide additional training and answer questions as needed. (11)	PCMH Primary Care Practices and Health Homes		**Project Requirement #9:** Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases.	DY1 and DY2	Project System Change. Data source includes: Written training materials; List of training dates; Chronic condition evidence-based practice protocols; Training materials
Outreach and educate partner organizations on HHRIP and referral process, begin engaging patients	Safety net providers, others?	Health Home staff	2aiii Health Homes at Risk Project Implementation: Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program	DY1	

CNY CARE COLLABORATIVE

Conduct meetings and trainings regularly. The purpose of the meetings is to discuss how to improve the functionality of the tools (for sharing care/patient info)	Safety net providers, others?	HealtheConnections, EHR vendors? Health Home staff?	2aiii Health Homes at Risk Project Implementation: Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	
Motivational Interviewing	PCMH Primary Care Practices and Health Homes		Comment section of CNYCC website	See Project Requirement #6: Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.

CNY CARE COLLABORATIVE

Project 2biii

ED Care Triage for At-Risk Populations

Training Needs Identified	Audience	Partners	Source	Timing	Comments
Triage protocols with ED dedicated – Patient Navigators and ED medical providers (especially if planning to divert patients from ED). (7)	ED providers, Patient Navigators, Current staff - TBN (e.g. Social work)		2biii ED Care Triage Project Implementation: Establish ED care triage program for at-risk populations	DY1 and DY2	***How are new protocols currently rolled out?*** *Notes from CNYCC Regional Meetings:* Emergency Medical Treatment and Active Labor Act (EMTALA); liability concerns; culture shift
Identify/develop and implement procedures and protocols that connect the ED with community PCPs and track the transition of the patient from the ED to the PCP. (6) Protocols must also establish connectivity between ED and PCP's/CBO's. (10)	Patient Navigators, Primary Care Practices (PCPs), Current staff - TBN (e.g. Social work)		2biii ED Care Triage Project Implementation: Develop process and procedures to establish connectivity between the emergency department and community primary care providers.	DY1 and DY2	***Will Patient Navigators be available 24/7? If not, will ED providers be trained? If so, who?*** Dependent upon the HIT capabilities re: open access scheduling, enabling others to utilize, particularly in after hours setting. FTEs required for 24/7 coverage > 1-3 FTEs; likely to expand scope/coverage with existing staff. PCP expressed concerns re: pts. with BH needs, some PCPs are not engaged in pursuing PCMH.
Use EHRs and other technical platforms to track actively engaged patients for project milestone reporting.	Patient Navigators, Current staff - TBN (e.g. Social work)	EHR vendors, HealtheConnections	**Project Requirement #5**: Use EHRs and other technical platforms to track all patients engaged in the project; and PIC participants (10/13/2015)	DY1 -	***Will Patient Navigators be available 24/7? If not, will ED providers be trained? If so, who (MD, NP, PA, RN)?*** Dependent upon the HIT capabilities re: open access scheduling, enabling others to utilize; not likely to be available in near term.

Develop and implement protocol for determining additional care management/community based (social) needs of triaged patients. (10)	Patient Navigators, Current staff - TBN (e.g. Social work)	Local Government Units (LGUs?), 211?	2biii ED Care Triage Project Implementation Plan: Develop process and procedures to establish connectivity between the emergency department and community primary care providers; PIC participants (10/13/2015)	DY1 and DY2	***Will Patient Navigators be available 24/7? If not, will ED providers be trained? If so, who (MD, NP, PA, RN)? How is this type of training currently delivered?*** Knowledge of other BH and community resources (housing, transportation, etc.) SJHHC: Pts are referred to HH and/or connected with social work, as they are not currently licensed to conduct assessments. List of resources - not embedded in EHR (to be confirmed). CBOs may be given access to patients in ED.
Health Home (HH) scope of services, eligibility criteria and referrals process	Patient Navigators, Current staff - TBN (e.g. Social work)	Health Homes	**Project Requirement #2:** Ensure real time notification to a Health Home care manager as applicable	DY1 and DY2	HH may be embedded within some EDs, training/education will occur informally.
Patient Navigator Competencies *Cultural competency, Customer service, Patient Advocacy*	Patient Navigators, Current staff - TBN (e.g. Social work)		PIC participants (10/13/2015)		Every hospital offers training/education re: cultural competency and customer service. ***Q: Will EDs be hiring new dedicated staff, or utilizing existing staff?***

CNY CARE COLLABORATIVE

Project 2biv

Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

Training Needs Identified	Audience	Partners	Source	Timing	Comments
Standardized protocol to manage overall population health	Intensive Care Transitions Teams	Home care, County LGUs, Hospice, MLTC, Health Homes, Pharmacies, or other CBOs	**Project Requirement #1:** Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	DY1 and DY2	Documentation of process and workflow including responsible resources at each stage of the workflow; written training materials; training documentation. ***Project Requirement #3:*** *Ensure required social services participate in the project - Local Gov't Units (e.g. DSS) and peer supports were cited as key partners.*
Standardized protocol to perform as an integrated clinical team	Intensive Care Transitions Teams	Home care, Hospice, Health Homes, MTLC, Pharmacies, or other CBOs	**Project Requirement #1:** Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	DY1 and DY2	Documentation of process and workflow including responsible resources at each stage of the workflow; written training materials; training documentation.
PPS protocol to identify Health Home eligible patients and link them to services as required under ACA	Intensive Care Transitions Teams	Medicaid Managed Care Orgs, Health Homes	**Project Requirement #2:** Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	*See CNYCC Speed and Scale Commitments*	Data Source: Written training materials; List of training dates along with number of staff trained. *At least one model exists where Health Homes (HH) have a presence on the ITT; other units in the inpatient setting require education on HH, eligibility, and referrals process.*

Policies and procedures for early notification of planned discharges	Primary Care Practices, Non Primary Care Practices, Hospitals, Long term care, Nursing homes, Rehab, HH, MLTC, Hospice, Behavioral Health providers		**Project Requirement #4:** Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	DY1 and DY2	Performance and success must be demonstrated at the provider level; Data Source: Written training materials; List of training dates; Number of staff trained. *Both inpatient teams and community-based partners will require education (training) on policies and procedures.*
Policies and procedures for including care transition plans in EHR and updating in interoperable EHR / primary care provider record	Non Primary Care Practices, Hospitals, Health Homes, Long term care, Nursing homes, Rehab, MLTC, Hospice, Pharmacies	HealtheConnections, EHR Vendors, PCPs	**Project Requirement #5:** Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	DY1 and DY2	Data Source: Written training materials; List of training dates; Number of staff trained
Develop Protocol Implementation Training, include cultural sensitivity training in the curriculum (13)	Intensive Transition Team members, Transition Coaches, Peer Coaches and Health Home Care Managers	***Onondaga Co:*** *Interfaith works?* ***Oneida Co.:*** *MV Resource Center for Refugees.* ***FQHCs*** *have well-estab cultural competency programs for care coordination*	2biv Care Transitions Project Implementation Plan: Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	DY1 Q3 (Dec 2015)	Cultural competency to support patient engagement and transition. *May be integrated with Project Requirement #4 - training on policies and procedures for notification must include cultural competency component.*
Motivational interviewing	Intensive Care Transitions Teams	*Health Homes*	Comment section of CNYCC website; PIC participants (10/08/15)		**See Project Requirement #4:** Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services. *MI: could be utilized with PAM training for 2di as well. HH utilize MI with their clients.*

Stages of Change Framework for patient activation	Intensive Care Transitions Teams		PIC participants (10/08/15)	*Identify where persons are in terms of their readiness to change; increased efficacy paired with MI.*
Use of telehealth for post-discharge monitoring?	Intensive Care Transitions Teams, Home Health Care, Skilled Nursing Facilities, PCPs, Specialty Care?	*SJHHC telehealth*	CNYCC Regional Partner Meetings Summary (March 2015)	Challenges: shortage of local community resources post-discharge and transportation, particularly in rural areas. *SJHHC: Resources available to assist with integrating telehealth into workflows. Identified need to consider telehealth capabilities outside of inpatient setting.*

Project 2di

Implementation of Patient Activation Activities to Engage, Educate, and Integrate the Uninsured and Low/Non-utilizing Medicaid Populations into Community Based Care

Training Needs Identified	Audience	Potential Partners	Source	Timing	Comments
Establish Patient Activation Measure (PAM) training team	CNYCC staff; PPS partners with expertise in patient activation and engagement	Insignia Health	**Project Requirement #2**: Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.	DY1 and DY2	Project System Change; organized and administered by the PPS lead
Patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency	PPS providers in UI, NU, and LU "hot spot" areas (e.g. emergency departments)	CNYCC PAM® trainers (and Insignia Health?)	**Project Requirement #5**: Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	*See CNYCC Speed and Scale Commitments*	Organized and administered by the PPS lead
Connectivity to healthcare coverage and community healthcare resources (includes primary and preventative services as well as patient education)	Community navigators	CNYCC PAM® trainers, CBOs	**Project Requirement #11:** Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources and patient education.	*See CNYCC Speed and Scale Commitments*	Performance and success must be demonstrated at the provider level
Patient activation and education, including assisting beneficiaries using the PAM®	Community navigators	CNYCC PAM® trainers, CBOs	**Project Requirement #13:** Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.	DY1 and DY2	Project System Change; performance and success must be demonstrated at the provider level
Insurance options and healthcare resources available to UI, NU, and LU populations	Community navigators	Medicaid Managed Care Organizations, 211?, NYS of Health (web resource - link to Insurance Navigators in their community)	**Project Requirement #15:** Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	*See CNYCC Speed and Scale Commitments*	Organized and administered by the PPS lead
Policies and procedures for timely intake of Community Navigator referrals	Intake/scheduling staff for primary and preventive service providers	CNYCC PAM® trainers, CBOs, CNYCC Clinical Governance Committee	**Project Requirement #16:** Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	*See CNYCC Speed and Scale Commitments*	Organized and administered by the PPS lead

Integration of flexible/open scheduling	Intake/scheduling staff for primary and preventive service providers		PIC participants (9/16/2015)		
Sensitivity to barriers for UI, NU and LU populations accessing care; cultural competency, awareness of own culture (medical)	Intake/scheduling staff for primary and preventive service providers		PIC participants (9/16/2015)		Participants committed to seeing what was out there in terms of curriculum/resources; may be a key element of Cultural Competency training for this project
Motivational interviewing	Community navigators	REACH CNY, Prevention Network	PIC participants (9/16/2015)		Transferable skill; may be applied in multiple projects
Sensitivity to power dynamics which occur in engagement processes; provider as authority figure and controlling access	Community navigators		PIC participants (9/16/2015)		May be a key element of Cultural Competency training for this project
Literacy level, knowledge of neighborhoods	Intake/scheduling staff for primary and preventive service providers		PIC participants (9/16/2015)		May be a key element of Cultural Competency training for this project

Project 3ai

Integration of Primary Care and Behavioral Health Services

Training Needs Identified	Audience	Partners	Source	Timing	Comments
Training in PC culture (BH practitioners); Training in BH culture and practice (PC practitioners)	PC and BH professionals	PC and BH professionals, Others?	**Project Requirement #1**: Co-location of behavioral health and primary care practitioners.	DY1 -	PPS Learning Symposium presenter suggested "culture piece is huge." Training recommendation cited in Lessons Learned.
Provider orientation to practice site	PC and/or BH professionals new to a practice	Practitioners, staff	**Project Requirement #2**: Develop collaborative evidence-based standards of care including medication management and care engagement process.	DY2 -	Practices will need to have a mechanism for onboarding new providers (PC or BH) once standards and processes are in place.
Provider training (PHQ-9 and/or SBIRT)	PC and BH professionals (Models 1 & 2)	OMH, SBIRT trainers, Syracuse Behavioral Healthcare Training Institute	**Project Requirement #3**: Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.	DY1 -	CNYCC working to coordinate local SBIRT trainings with other Upstate PPSs.
Patient coaching (behavioral activation), offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan (Model 3)	Depression Care Manager (Model 3)		**Project Requirement #3**: Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	DY1 -	

Use of EHR to document screening and "warm transfer" activities (Models 1 and 2), or demonstrating relapse prevention plans, patient coaching, and other IMPACT interventions (Model 3)	PC and BH professionals (Models 1 & 2), Depression Care Manager (Model 3)	HealtheConnections, EHR vendors	**Project Requirement #4:** Use EHRs or other technical platforms to track all patients engaged in this project.	DY1 -	
Use of telehealth (telepsychiatry) for consultation?	Depression Care Manager (Model 3)		**Project Requirement #2:** Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.		**Metric/Deliverable***: Policies and procedures include process for consulting with a Psychiatrist
Technical assistance for navigating regulatory processes and procedures	PC and BH professionals (Models 1 & 2)		PIC participants (10/08/2015)		Topics to include billing, etc.
Distinction between co-location and integration	PC and BH professionals (Models 1 & 2)		PIC participants (10/08/2015)		

Project 3aii

Behavioral Health Community Crisis Stabilization Services

Training Needs Identified	Audience	Partners	Source	Timing	Comments
Coordinated treatment care protocols	CPEP at SJHHC, outreach, mobile crisis, and intensive crisis service providers, Health Homes, EDs, substance abuse		**Project Requirement #4:** Develop written treatment protocols with consensus from participating providers and facilities.	DY1 and DY2	*What is being done to support release time for staff training (backfill positions?) Jessica Caruso - mobile crisis team training conducted on unit - contact for more information.* **Data source(s):** Written training materials; list of training dates along with number of staff trained
Coordinated evidenced-based care protocols for mobile crisis	Mobile crisis teams	Medical staff from partner organizations (outreach, mobile crisis, and intensive crisis, substance abuse)	**Project Requirement #7**: Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	*See CNYCC Speed and Scale Commitments*	**Data source(s):** Written training materials; list of training dates along with number of staff trained
Staff training on alerts and secure messaging functionality	Safety net providers (PCP, non-PCP, Hospital, Behavioral Health)	HealtheConnections, EHR vendors	**Project Requirement #8:** All PPS safety net providers have actively connected EHR systems with local HIE (RHIO) and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	DY3	**Data source(s):** Written training materials; list of training dates along with number of staff trained

Central triage service/protocol	Psychiatrists and behavioral health providers	Psychiatrists, behavioral health, and substance abuse providers	**Project Requirement #9:** Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	*See CNYCC Speed and Scale Commitments*	**Data source(s):** Written training materials; list of training dates along with number of staff trained
Use EHRs or other technical platforms to track all actively patients.	Mobile crisis teams	EHR vendors, HealtheConnectio ns	**Project Requirement #11:** Use EHRs or other technical platforms to track all patients engaged in this project.		
Diversion protocols	First responders (schools, police, fire, EMS)	CPEP at SJHHC, outreach, mobile crisis, and intensive crisis service providers, Health Homes, EDs, substance abuse providers, *peer respite*	3aii BH Crisis Stabilization Project Implementation Plan: 1d. First responders are trained in diversion protocols	DY2-DY4	*Consider role of peer supports. Crisis Intervention Team training wk of Nov. 9 with Syr PD and FD (~50), 1-week training; could be implemented in other communities, but staff release time is prohibitive factor; Utica police dept also receiving training in partnership with Mobile Crisis Assessment Team (MCAT) from The Neighborhood Center.*
Cultural competency		*Peer supports*	Workforce coordinator/consultant; PIC participants (10/15/2015)		

Project 3bi

Evidence-Based Strategies for Disease Management in High Risk/Affected Population (Adults Only) Cardiovascular Care

Training Needs Identified	Audience	Partners	Source	Timing	Comments
Staff training on alerts and secure messaging functionality	Safety net providers (PCP, non-PCP, BH)	HealtheConnections, EHR vendors	**Project Requirement #2:** All PPS safety net providers have actively connected EHR systems with local HIE (RHIO) and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	DY1 - DY3	Data source(s): written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
Use EHRs or other technical platforms to track all patients engaged in this project.	PCP providers and staff	HealtheConnections, EHR vendors	**Project Requirement #4:** Use EHRs or other technical platforms to track all patients engaged in this project.	DY1 and DY2	Data source(s): Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)
Training to incorporate the use of EHR to prompt the use of 5 A's of tobacco control; (for example tobacco use diagnosis, billing codes and patient referral response).	PCP providers	EHR vendors	**Project Requirement #5:** Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	DY1 and DY2	Data source(s): List of training dates along with number of staff trained; Written training material
Standardized treatment protocols for hypertension and elevated cholesterol.	PCP providers	Guideline sources: National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF)	**Project Requirement #6:** Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	DY1 and DY2	Data source(s): List of training dates along with number of staff trained; Written training materials.

Care coordination processes to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	PCP care coordination team (may include nurses, pharmacists, dieticians, community health workers and HH care managers where applicable)	Public health organizations, NYS Smokers' Quitline website	**Project Requirement #7:** Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	DY1 and DY2	***Motivational interviewing, cultural competency, tobacco treatment resources and treatment value in linking patients to CBOs cited in 3bi Project Implementation Plan.*** Data source(s): List of training dates along with number of staff trained; Written training material.
Protocols for blood pressure measurements	PCP staff		**Project Requirement #9:** Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	DY1 and DY2	Data source(s): List of training dates along with number of staff trained, if applicable
Effective patient identification (at-risk of hypertension)	PCP care coordination team, clerical staff	EHR vendors	**Project Requirement #10:** Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	*See CNYCC Speed and Scale Commitments*	Data source(s): List of training dates along with number of staff trained; Written training materials.
Person-centered methods for self-management (documentation in EHR)	PCP care coordination team	EHR vendors	**Project Requirement #12:** Document patient driven self-management goals in the medical record and review with patients at each visit.	*See CNYCC Speed and Scale Commitments*	***Motivational interviewing and cultural competency cited in 3gi Project Implementation Plan.*** Data source(s): List of training dates along with number of staff trained; Written training materials.

Warm referral and follow-up processes (CBOs); follow-up on home blood pressure monitoring (patient).	PCP care coordination team	HealtheConnections, EHR vendors, CBOs	**Project Requirement #13:** Follow up with referrals to community based programs to document participation and behavioral and health status changes; **Project Requirement #14:** Develop and implement protocols for home blood pressure monitoring with follow up support.	DY1 and DY2	***Motivational interviewing, cultural competency and treatment value in linking patients to CBOs cited in 3bi Project Implementation Plan.*** Data source(s): List of training dates along with number of staff trained; Written training materials.
If applicable… *1) Utilize race, ethnicity, and language (REAL) data to target high-risk populations; 2) established linkages to health homes for targeted patient populations; 3) implement Stanford Model through partnerships with CBOs.*	PCP care coordination team, CNYCC staff, CBOs	HealtheConnections, Health Homes, OASIS Chronic Disease Self-Management Program (Onondaga Co)	**Project Requirement #17:** Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	*See CNYCC Speed and Scale Commitments*	Data source(s): List of training dates along with number of staff trained; Written training materials.
Policies and procedures which reflect principles and initiatives of Million Lives Campaign.	PCP care coordination team		**Project Requirement #18:** Adopt strategies from the Million Lives Campaign.	*See CNYCC Speed and Scale Commitments*	Data source(s): Written training materials.

CNY CARE COLLABORATIVE

Project 3gi

Integration of Palliative Care into PCMH Model

Training Needs Identifi	Audience(s)	Partners	Source	Timing	Comments
Clinical guidelines agreed to by all partners, includes services/eligiblity	PCPs, Palliative care services	Hospice, *other community resources (?)*	**Project Requirement #3:** Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	DY1-DY2	***What are the current standards or practices for training on clinical guidelines among your practices?*** Regional leaders/champions: Dr. Kevin Mathews (MVHS/Utica), Dr. Ignacio (Oswego Hospital). Required data source: Training dates, materials, and number of staff attending.
DOH-5503 Medical Orders for Life Sustaining Treatment (MOLST) form	PCPs, Palliative care services	Hospice, *other community resources (?)*	**Project Requirement #3:** Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	DY1-DY2	Required data source: Training dates, materials, and number of staff attending
Role appropriate competence in palliative care skills.	PCPs, Palliative care services	Hospice, *other community resources (?)*	**Project Requirement #3:** Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	DY1-DY2	***What are the competencies palliative care skills? Is there any consensus on what these are? How do they differ, if at all, for MDs, NPs, PAs, RNs and other clinical staff? How is this type of training currently delivered?*** Regional leaders/champions: Dr. Kevin Mathews (MVHS/Utica), Dr. Ignacio (Oswego Hospital). Required data source: Training dates, materials, and number of staff attending
Staff training in appropriate palliative care skills training, including training on PPS care protocols. *Cultural competency cited in Project Implementation Plan.*	PCP staff	Hospice, *other community resources (?)*	**Project Requirement #4:** Engage staff in trainings to increase role appropriate competence in palliative care skills and protocols developed by the PPS.	DY2	***What are the competencies palliative care skills? Is there any consensus on what these are? What staff would require training? How is protocol training currently delivered to non-clinical staff?*** Required data source: Written training materials; List of training dates along with number of staff trained.

Use of EHR to track all patients engaged in the project	PCP	EHR vendor, HealtheConnections (RHIO)	**Project Requirement #6:** Use EHRs or other IT platforms to track all patients engaged in this	DY1-DY2	
What is Primary Palliative Care?	Primary care physicians and extenders; specialists? (Sometimes the patient is no longer seeing their primary care MD.)	Hospice, other community resources (?)	PIC participants (10/01/2015)	DY1-DY2	Need to educate physicians and physician extenders (as well as staff?) on the necessary cultural shift; Need to educate on symptom management; Advance Directives; Health Care Proxy (Powers of Attorney).
Care giver needs & preferences	Primary care physicians and extenders; front line staff.	Hospice, other community resources (?)	PIC participants (10/01/2015)	DY1-DY2	Identification of care giver stressors; Cultural acceptance of Health Care Proxy, Advance Directives, etc.; spritual aspects of hospice care.
Available Community Resources	Primary care practices	?	PIC participants (10/01/2015)	DY1-DY2	Discussion ensued with respect to who might create a repository of availability of community resources and how that information might be communicated to PCPs so that they are able to connect with existing resources.

CNY CARE COLLABORATIVE

Project 4aiii

Strengthen Mental Health and Substance Abuse Infrastructure Across Systems

Training Needs Identified	Audience	Partners	Source	Timing	Comments
Pending					

CNY CARE COLLABORATIVE

Project 4di

Reduce Pre-term Births

Training Needs Identified	Audience(s)	Partners	Source	Timing	Comments
Training on integrating tobacco screening and referral processes (per the 5As—Ask, Advise, Assess, Assist, and Arrange) into their scope of care/services targeting pregnant women who smoke	• Clinical providers (FQHCs, private practices) • Health Homes • Home visiting services • Community health workers • WIC	Tobacco-Free Coalition(s) and NYS Tobacco Control Program	4di Preterm Birth Project Implementation Plan: Training on 5A's, presumptive eligibility, prenatal care standards and current guidelines on the management of preterm labor	By DY2 Q2	Provider education and communication skills identified as a challenge at CNYCC Regional Partner Meetings.
Train entities to become qualified entities/providers for Medicaid presumptive eligibility, specifically targeting pregnant women	• WIC • FQHCs • Hospitals • Homeless shelters	Free NYS online training for enrollment staff (only available to Article 28 facilities)	4di Preterm Birth Project Implementation Plan: Training on 5A's, presumptive eligibility, prenatal care standards and current guidelines on the management of preterm labor	By DY2 Q2	Only Article 28 clinics are allowed to provide this service under current State regulations; need may be abated by current Medicaid enrollment patterns
Provide/coordinate trainings to enhance knowledge and competencies to work with pregnant women (e.g., deliver basic health education, promote health care service use, & provide social support)	Paraprofessionals (Community health workers)	U of R Center of Excellence? Healthy Families?	4di Preterm Birth Project Implementation Plan: Recruitment and establishment of a network of paraprofessionals	By DY1 Q4	Center for Excellence at U of R for CHW training. Healthy Families offers robust curriculum and strengths-oriented approach. Review prospective models for inclusion of cultural competency.
Conduct an information seminar for prospective CenteringPregnancy® sites	• Clinical providers (FQHCs, private practices) • Community organizations	Centering Healthcare Institute	4di Preterm Birth Project Implementation Plan: Expansion of CenteringPregnancy® and/or other innovative pregnancy education programs where none currently exist	By DY2 Q2	CenteringPregnancy® currently at Auburn Hospital, SUNY Upstate Perinatal Center; in development at SUNY Upstate Community Campus

Training on use of standard intake, enrollment, referral and follow-up forms & protocols	• Clinical providers (FQHCs, private practices) • Health Homes • Home visitation • Community health workers • WIC • Home Care • MCOs outreach staff	4di Preterm Birth Project Implementation Plan: Establishment and integration of common intake and enrollment protocols, referral, follow-up, and coordination of practices, and integration into information technology platforms	By DY3 Q4

Training Needs Identified	2.a.i IDS	2.a.iii DSRIP Care Mgmt	2.b.iii ED Care Triage	2.b.iv Care Transitions	2.d.i Patient Activation	3.a.i Integration of Primary Care & Behavioral Health Services	3.a.ii Behavioral Health Community Crisis Stabilization	3.b.i Evidence-Based Strategies for CVD Management	3.g.i Integration of Palliative Care into PCMH	4.a.iii Strengthen Mental Health & Substance Abuse Infrastructure	4.d.i Reduce Pre-term Births	Totals
Staff training on alerts and secure messaging functionality	X	X	X	X	X	X	X	X	X	X	X	11
Evidence-based guidelines, standards, or protocols	X	X	X	X	X	X	X	X	X	X	X	11
Cultural Competency & Health Literacy	X	X	X	X	X	X	X	X	X	X	X	11
Connectivity to healthcare coverage and community healthcare resources (includes primary and preventative services as well as patient education)	X	X	X	X	X	X	X	X	X	X	X	11
PPS trains staff on IDS protocols and processes.	X	X	X	X	X	X	X	X	X	X	X	11
Health Home (HH) scope of services, eligibility criteria and referrals process		X	X	X	X	X	X	X	X	X	X	10
Use EHRs and other technical platforms to track actively engaged patients for project milestone reporting.		X	X	X		X	X	X	X	X	X	9
Patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency		X	X	X	X			X			X	6
Chronic Disease, Practice & Population Management o Population-based approaches to health care delivery o Risk identification	X	X		X		X		X	X			6
Patient Centered / Whole Person Care o Development of effective, caring relationships with patients o Assessment of bio psychosocial needs across the life span o Patient-centered care planning, including collaborative decision-making and patient self-management o Cultural sensitivity and competence in culturally appropriate practice	X	X		X		X		X	X			6
Motivational Interviewing		X	X	X	X			X				5

X - Indicated or confirmed by Project Implementation Collaborative
X - Suggested based on principles of Integrated Delivery Systems and/or PCMH
? - Dependent upon project implementation

Training Needs Identified	2.a.i IDS	2.a.iii DSRIP Care Mgmt	2.b.iii ED Care Triage	2.b.iv Care Transitions	2.d.i Patient Activation	3.a.i Integration of Primary Care & Behavioral Health Services	3.a.ii Behavioral Health Community Crisis Stabilization	3.b.i Evidence-Based Strategies for CVD Management	3.g.i Integration of Palliative Care into PCMH	4.a.iii Strengthen Mental Health & Substance Abuse Infrastructure	4.d.i Reduce Pre-term Births	Totals
Practice-Based Learning	X	X				X		X	X			5
Teamwork & Interprofessional Training o Communication & Professionalism o Team leadership o Interprofessionalism and interdisciplinary team collaboration	X	X				X		X	X			5
Use of telehealth for monitoring or consultation (e.g.post-discharge, psych)				?		?						2
Create curriculum for training staff and providers on care plan process, and 'tip sheets' with screen shots to support learning. (5) Roll out training throughout clinic. (6)		X										1
Conduct meetings and trainings regularly. The purpose of the meetings is to discuss how to improve the functionality of the tools (for sharing care/patient info)		X										1
Triage protocols with ED dedicated – Patient Navigators and ED medical providers (especially if planning to divert patients from ED). (7)			X									1
Identify/develop and implement procedures and protocols that connect the ED with community PCPs and track the transition of the patient from the ED to the PCP. (6) Protocols must also establish connectivity between ED and PCP's/CBO's. (10)			X									1
Develop and implement protocol for determining additional care management/community based (social) needs of triaged patients. (10)			X									1
Standardized protocol to manage overall population health				X								1
Standardized protocol to perform as an integrated clinical team (hospitals and post-acute care providers) Cross continuum protocols?				X								1

X - Indicated or confirmed by Project Implementation Collaborative
X - Suggested based on principles of Integrated Delivery Systems and/or PCMH
? - Dependent upon project implementation

Training Needs Identified	2.a.i IDS	2.a.iii DSRIP Care Mgmt	2.b.iii ED Care Triage	2.b.iv Care Transitions	2.d.i Patient Activation	3.a.i Integration of Primary Care & Behavioral Health Services	3.a.ii Behavioral Health Community Crisis Stabilization	3.b.i Evidence-Based Strategies for CVD Management	3.g.i Integration of Palliative Care into PCMH	4.a.iii Strengthen Mental Health & Substance Abuse Infrastructure	4.d.i Reduce Pre-term Births	Totals
Policies and procedures for early notification of planned discharges				X								1
Policies and procedures for including care transition plans in EHR and updating in interoperable EHR / primary care provider record				X								1
Establish Patient Activation Measure (PAM) training team					X							1
Policies and procedures for timely intake of Community Navigator referrals					X							1
Integration of flexible/open scheduling					X							1
Sensitivity to power dynamics which occur in engagement processes; provider as authority figure and controlling access					X							1
Knowledge of community/ neighborhoods					X							1
Training in PC culture (BH practitioners); Training in BH culture and practice (PC practitioners)						X						1
Provider orientation to practice site						X						1
Provider training (e.g. PHQ-9 and/or SBIRT)						X						1
Patient coaching (behavioral activation), offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan (Model 3)						X						1
Use of EHR to document screening and "warm transfer" activities (Models 1 and 2), or demonstrating relapse prevention plans, patient coaching, and other IMPACT interventions (Model 3)						X						1
Technical assistance for navigating regulatory processes and procedures						X						1
Distinction between co-location and integration						X						1
Coordinated treatment care protocols							X					1
Central triage service/protocol							X					1
Diversion protocols							X					1

X - Indicated or confirmed by Project Implementation Collaborative
X - Suggested based on principles of Integrated Delivery Systems and/or PCMH
? - Dependent upon project implementation

Training Needs Identified	2.a.i IDS	2.a.iii DSRIP Care Mgmt	2.b.iii ED Care Triage	2.b.iv Care Transitions	2.d.i Patient Activation	3.a.i Integration of Primary Care & Behavioral Health Services	3.a.ii Behavioral Health Community Crisis Stabilization	3.b.i Evidence-Based Strategies for CVD Management	3.g.i Integration of Palliative Care into PCMH	4.a.iii Strengthen Mental Health & Substance Abuse Infrastructure	4.d.i Reduce Pre-term Births	Totals
Training to incorporate the use of EHR to prompt the use of 5 A's of tobacco control; (for example tobacco use diagnosis, billing codes and patient referral response).								X				1
Standardized treatment protocols for hypertension and elevated cholesterol.								X				1
Care coordination processes to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.								X				1
Protocols for blood pressure measurements								X				1
Effective patient identification (at-risk of hypertension)								X				1
Person-centered methods for self-management (documentation in EHR)								X				1
Warm referral and follow-up processes (CBOs); follow-up on home blood pressure monitoring (patient).								X				1
Policies and procedures which reflect principles and initiatives of Million Lives Campaign.								X				1
Clinical guidelines agreed to by all partners, includes services/eligiblity									X			1
DOH-5503 Medical Orders for Life Sustaining Treatment (MOLST) form									X			1
Role appropriate competence in palliative care skills.									X			1
What is Primary Palliative Care?									X			1
Care giver needs & preferences									X			1
Training on integrating tobacco screening and referral processes (per the 5As—Ask, Advise, Assess, Assist, and Arrange) into their scope of care/services targeting pregnant women who smoke											X	1
Train entities to become qualified entities/providers for Medicaid presumptive eligibility, specifically targeting pregnant women											X	1

X - Indicated or confirmed by Project Implementation Collaborative
X - Suggested based on principles of Integrated Delivery Systems and/or PCMH
? - Dependent upon project implementation

Training Needs Identified	2.a.i IDS	2.a.iii DSRIP Care Mgmt	2.b.iii ED Care Triage	2.b.iv Care Transitions	2.d.i Patient Activation	3.a.i Integration of Primary Care & Behavioral Health Services	3.a.ii Behavioral Health Community Crisis Stabilization	3.b.i Evidence-Based Strategies for CVD Management	3.g.i Integration of Palliative Care into PCMH	4.a.iii Strengthen Mental Health & Substance Abuse Infrastructure	4.d.i Reduce Pre-term Births	Totals
Provide/coordinate trainings to enhance knowledge and competencies to work with pregnant women (e.g., deliver basic health education, promote health care service use, & provide social support)											X	1
Conduct an information seminar for prospective CenteringPregnancy® sites											X	1
Training on use of standard intake, enrollment, referral and follow-up forms & protocols											X	1

X - Indicated or confirmed by Project Implementation Collaborative
X - Suggested based on principles of Integrated Delivery Systems and/or PCMH
? - Dependent upon project implementation