Advanced Training Initiative (ATI) 2020 -2021

This Application is for the 2020/21 ATI Participants.

The listing of eligible facilities and their award amounts for each year has been posted on the Health Care Financial Data Gateway.

General Instructions

This application form should be used by pre-qualified Skilled Nursing Facilities in New York State seeking consideration to participate in the Advanced Training Initiative (ATI) program. Only those facilities contacted through this email have pre-qualified to apply based upon their above-average staff retention as determined by analysis of the **2019 and/ or 2018 cost reports**, Schedule P.

Eligibility Requirements

Skilled Nursing Facilities in New York State with direct-care staff retention above the state median are eligible to apply for funding, with the exception of hospital-based skilled nursing facilities and facilities that have received quality improvement grants through the New York State Department of Health Value Access Provider Pool.

Reference Material

The following reference materials may be of assistance when completing this application: **Dear Administrator Letter – Included in email sent to pre-qualified facilities.**

Submission Requirements

Please complete one survey for your facility. Resubmissions to correct errors are allowed, the last survey received will be the survey used.

Completeness Review

If the application is determined to be incomplete it will be returned for revision and resubmission. All applications, to be considered, must be **fully completed and submitted by January 27, 2021**. Applications that do not meet this criteria will not be considered for ATI pool payments. As part of the review process, applicants should be aware that additional information may be requested.

Whom to Contact for Assistance

Any questions concerning the application process should be directed to the Bureau Of Residential Health Care Reimbursement, New York State Department of Health by email at **NFRates@health.ny.gov**, Subject **Advanced Training Initiative.**

1. Facility Information *

Provider Name	Shaker Place Rehabilitat
Rate Setting Opcert/ Certificate Number (eg. 1234567N)	0153302N
MMIS#	00309260
Street Address 1	100 Heritage Lane
Street Address 2	
City /Town	Albany
State / Province	New York
Zip /Postal Code	12211

2. Administrator and Contact Person Information *

Administrator Name	Larry I. Slatky
Administrator Phone	518-213-8940
Administrator Email	larry.slatky@shakerplace.
Application Contact Person	Larry I. Slatky
Contact Person Phone Number	518-213-8940
Contact Person Title	Executive Director
Contact Person Email	larry.slatky@shakerplace.

3. What organization, if any, will the provider partner with to develop and conduct their early detection training? *

- [ ] 1199 Training and Employment Funds
- [ ] Leading Age New York
- [x] New York State Health Facilities Association
- [ ] Interact-I Team

- [ ] None
- [ ] Other - Please Specify

*

4. What Curriculum will the Provider Use? *

- [ ] Geriatric Nursing Assistant Development Project (GNACD)
- [ ] INTERACT Stop and Watch
- [ ] Consistent Assignment (AHCA Tools/Resources)
- [ ] Oasis Behavior Management Training
- [x] Growing Strong Roots
- [ ] Caring Communication at the End of Life
- [x] Pathways to Leadership; Peer Mentoring for Long Term Care Nurses
- [ ] NYSDOH Electronic Dementia Guide for Excellence
- [ ] 1199 SEIU Resident Decline Detection Program
- [ ] Palliative / End of Life Training for Caregivers (One Day Train-The-Trainer)
- [ ] Care Process for Residents with Dementia and Other Special Needs
- [ ] Teaching and Encouraging Pain Management in Long Term Care
- [ ] Diligent Inquiry Prevention Program
- [x] DISC Training: Building Collaborative Caring Teams
- [ ] Resident Care Assistant Program
- [ ] Pressure Ulcers Training for CNA - Prevent Nosocomial Ulcers in SNF
- [ ] Paid Feeding Assistant Program Implementation
- [ ] Sepsis Prevention Program Train-the-Trainer
- [x] Patient Driven Payment Model (PDPM) Impact and Readiness Training
- [ ] Other - Include Title of the Program and Objectives/Outline(Required)

*

5. Please confirm that the program will focus on the role of Certified Nursing Assistants in

identifying early patient decline. *

- [x] Yes
- [ ] No

6. What other titles, if any, will be included in the training? (Click all that apply) *

- [x] License Practical Nurses
- [x] Registered Nurses
- [x] Dietary Aides
- [x] Housekeeping Personnel
- [x] Physical Therapists
- [x] Physical Therapy Aides
- [x] Occupational Therapists
- [x] Occupational Therapy Aides
- [ ] None of the above

7. Please list the number of staff in each title who will receive the training *

Certified Nursing Assistants	70
Licensed Practical Nurses	25
Registered Nurses	20
Dietary Aides	15
Housekeeping Personnel	15
Physical Therapists	2
Physical Therapy Aides	2
Occupational Therapists	2
Occupational Therapy Aides	2

8. Please list the percentage of each job title that this represents. (eg. 55% CNAs, 95% of CNA staff) *

Certified Nursing Assistants	95%
Licensed Practical Nurses	95%
Registered Nurses	95%
Dietary Aides	95%
Housekeeping Personnel	95%
Physical Therapists	100%
Physical Therapy Aides	100%
Occupational Therapist	100%
Occupational Therapy Aides	100%

9. Will the facility involve direct care staff and/or other other representative in planning or implementing this initiative? *

- (●) Yes
- ( ) No

10. What percentage of the total participants listed in Question 5 will have completed the training by 3/31/2021? *

100%

11. How many sessions will the training program consist of? *

Certified Nursing Assistants	6
Licensed Practical Nurses	6
Registered Nurses	6
Dietary Aides	6

Housekeeping Personnel	6
Therapy Professionals	6
Therapy/Activity Aides	6

12. How many total hours will individual participants be required to attend? *

Certified Nursing Assistants	6
Licensed Practical Nurses	6
Registered Nurses	6
Dietary Aides	6
Housekeeping Personnel	6
Therapy Professionals	6
Therapy /Activity Aides	6

13. Which strategies will the facility employ to sustain the program in subsequent years (Check all that apply)? *

- [x] Continuing Education
- [x] Train the Trainer
- [x] New Employee Orientation
- [ ] Other - Please specify

14. Does the facility have consistent staff assignment for resident care? *

- (●) Yes
- ( ) No

15. If yes, how long are direct-care staff consistently assigned? *

- ( ) Weekly

- ○ Monthly
- ○ Yearly
- ◉ Indefinitely
- ○ N/A

16. If yes, does your facility measure and assess consistent assignment? *

- ◉ Yes
- ○ No
- ○ N/A

17. If yes, what consistent assignment tool is used? *

- ○ Advancing Excellence /EDGE
- ◉ AHCA Tools
- ○ N/A
- ○ Other - Please specify

18. I hereby attest that that this report was completed to the best of my knowledge and ability and is true and complete. I will provide any supporting documentation requested by the Department of Health, Department of Labor, The Office of Medicaid Inspector General or any other enforcement, audit or oversight agency and or body. *

Name	Larry I. Slatky
Title	Executive Director
Date	January 15, 2021

Submit

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Slatky, Larry

From: SurveyGizmo <noreply@surveygizmo.com>
Sent: Friday, January 15, 2021 7:13 AM
To: Slatky, Larry
Subject: Advanced Training Initiative Survey Response Receipt

Dear Administrator:

Thank you for taking time to participate in DOH's 2020/21 Advanced Training Initiative Survey. Your responses have been received and recorded.