

Attachment 1 - Health Care
Workforce Work Group Meeting
Agenda 6-18-14

VT Health Care Innovation Project
Health Care Workforce Work Group Meeting Agenda
Wednesday, June 18th 2014; 3:00 PM to 5:00 PM
EXE - 4th Floor Conf Room, Pavilion Building, Montpelier, VT
Call-In Option: 1-877-273-4202; Passcode: 9883496

| Item | Time Frame | Topic | Presenter | Relevant Attachments |
|-------------|-------------------|---|---------------------------------|--|
| 1 | 3:00 – 3:05 | Welcome and Introductions | Mary Val Palumbo Robin Lunge | <ul style="list-style-type: none"> • <u>Attachment 1</u>: Meeting Agenda |
| 2 | 3:05 – 3:50 | Presentation: Payment Reform | Betty Rambur | <ul style="list-style-type: none"> • <u>Attachment 2</u>: Presentation Slides |
| 3 | 3:50 – 3:55 | Financial Update | Robin Lunge | |
| 4 | 3:55 – 4:00 | Approval of Meeting Minutes | Mary Val Palumbo Robin Lunge | <ul style="list-style-type: none"> • <u>Attachment 4</u>: 5-14-14 Meeting Minutes |
| 5 | 4:00 – 4:05 | Update: Demand Modeling | Amy Coonradt | |
| 6 | 4:05 – 4:55 | Survey Results and Discussion: Criteria for Prioritizing Budget Requests | Mary Val Palumbo Robin Lunge | <ul style="list-style-type: none"> • <u>Attachment 6</u>: Survey Results |
| 7 | 4:55 – 5:00 | Public Comment/Next Steps/Wrap Up | Mary Val Palumbo Robin Lunge | |

Attachment 2 - Health Care Workforce and Payment Reform Presentation

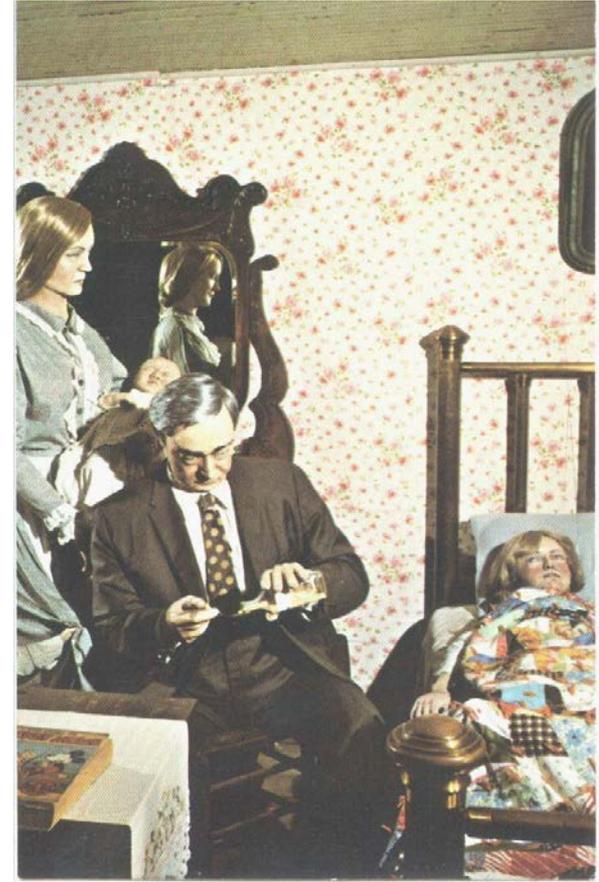
HEALTH CARE WORKFORCE AND PAYMENT REFORM

How did we become the way we are, where are we going, and where should we be going?

Background

- Health care labor intensive
- Yet growth of professions fueled by fee for service
- What does this mean in an age of payment reform and a “volume to value” transition?

How Did Health Care Become the Way it Is? A Spin Through History



Baylor and Teachers, 1929



Pre-Paid Hospital Insurance

21 Days/Year

\$6/Year

Employer based

Great Depression Deepened

- Private hospital occupancy fell to 62%
- Similar plans grew
- AHA built on this prepayed movement and established free choice of hospitals
 - ▣ Rather anticipated HMOs by limiting to a particular hospital
- **By 1940, 39 Blue Cross plans** enrolled over 6 million people



Great Depression



- Also reduced what patients could pay physicians
- California Medical Association—first Blue Shield in 1939
- Followed Blue Cross in spreading across the nation

What Does this Mean? Reimbursement Provider Driven—to insure income

- Europe—Consumer Driven
- US-Provider Driven—(Starr, 1982)



Flexner Report—Another Force

- Commissioned by Carnegie Foundation at the urging of the AMA in response to quality concerns
- Flexner influenced by biomedical model he saw at Johns Hopkins
- Using John Hopkins as his model he concluded that “... The situation can improve only as weaker and superfluous schools are extinguished” (Flexner, 1910).

Flexner Effect

- Resulting criteria for medical education forced the closure of most of the schools serving black and female medical students
- In the years following the Flexner report there was an increase in both the numbers and proportions of white male medical students and a decrease in others
- Near elimination of women in the physician workforce between the years 1920 and 1970 (Barkin, S., Fuentes-Afflick, Brosco, & Tuchman, 2010).

Post-Flexner

- Medical education following the Johns Hopkins also became longer and more expensive (Harley, 2006).



Flexner's Era

- Flexner's model was biological and physiological focused--reductionalistic
 - ▣ Created a shift away from and eventual closure of what we now call “complementary and alternative medicine” oriented hospitals, colleges, and teaching programs
 - ▣ 80% of the programs in homeopathy, naturopathy, eclectic therapy, physical therapy, osteopathy, and chiropractic closed. (Stahnisch & Verhoef, 2012).

Consequence

- Standard education for medicine became the template for standard education for other professions
 - ▣ Microbiology, allopathic anatomy/physiology
 - ▣ Disease model rooted in mind/body split
 - ▣ Management with pharmaceuticals/surgery
 - ▣ Little to no attention to care coordination, chronicity, end of life support, antecedents to illness etc.

Conceptualization of Care Deserving Payment

- Reductionalistic
- Biomedical model
- Physician and hospital-centric
- Thus supported evolution of episodic, acute and emergent MEDICAL services

Who is left out with employer based Insurance?



Social Climate of the 1960s



Solutions to unintended consequences of employer based insurance

--Medicare

--Medicaid

Within the milieu of "The Great Society"

Unintended Consequences

- Guaranteed revenue stream for those “guaranteed” to be ill or in need of health services
- All within fee-for-service
- Per diem for hospitals
- What are the incentives?



FFS Fueled

- Unbundling of services
- Increased income for physicians, particularly invasive, high tech specialization (*the more is better* approach)
- Corollary growth of health professions
- Growth in nursing specialties/ICUs
- An insatiable appetite for treatment
 - Americans, in general, expect high tech interventionist approaches
 - Increasing questions about the value of this orientation

Impetus for Change:

- Growing understanding of the difference between health and health care
 - Social determinants of health

Spending Mismatch: Health Care and Other Key Determinants of Health

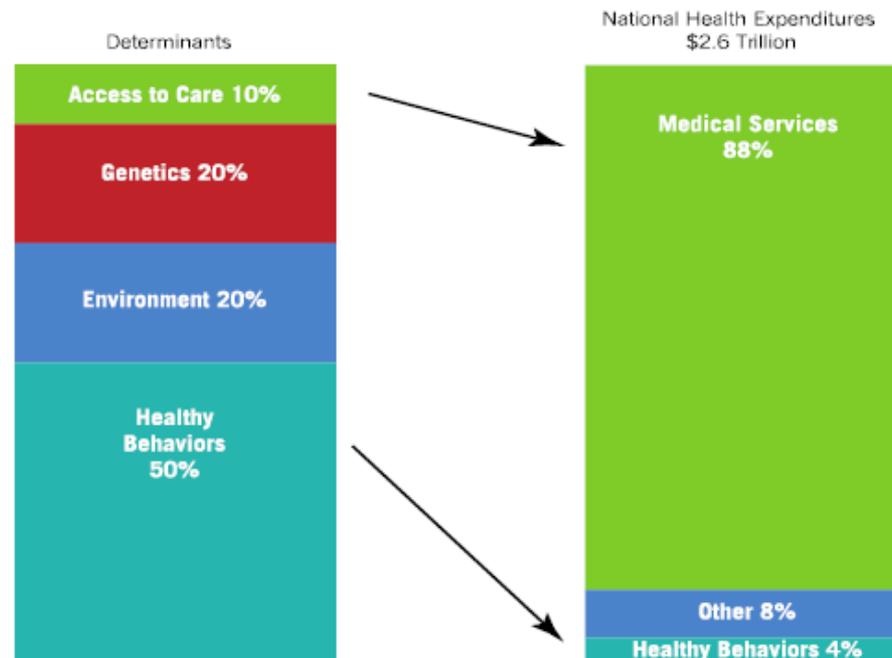


EXHIBIT 1**Estimates of Waste in US Health Care Spending in 2011, by Category**

| | Cost to Medicare and Medicaid ^a | | | Total cost to US health care ^b | | |
|---|--|----------|------|---|----------|-------|
| | Low | Midpoint | High | Low | Midpoint | High |
| Failures of care delivery | \$26 | \$36 | \$45 | \$102 | \$128 | \$154 |
| Failures of care coordination | 21 | 30 | 39 | 25 | 35 | 45 |
| Overtreatment | 67 | 77 | 87 | 158 | 192 | 226 |
| Administrative complexity | 16 | 36 | 56 | 107 | 248 | 389 |
| Pricing failures | 36 | 56 | 77 | 84 | 131 | 178 |
| Subtotal (excluding fraud and abuse) | 166 | 235 | 304 | 476 | 734 | 992 |
| Percentage of total health care spending | 6% | 9% | 11% | 18% | 27% | 37% |
| Fraud and abuse | 30 | 64 | 98 | 82 | 177 | 272 |
| Total (including fraud and abuse) | 197 | 300 | 402 | 558 | 910 | 1,263 |
| Percentage of total health care spending | | | | 21% | 34% | 47% |

SOURCE Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *JAMA* 307, no. 14 (April 11, 2012):1513-6. Copyright © 2012 American Medical Association. All rights reserved.

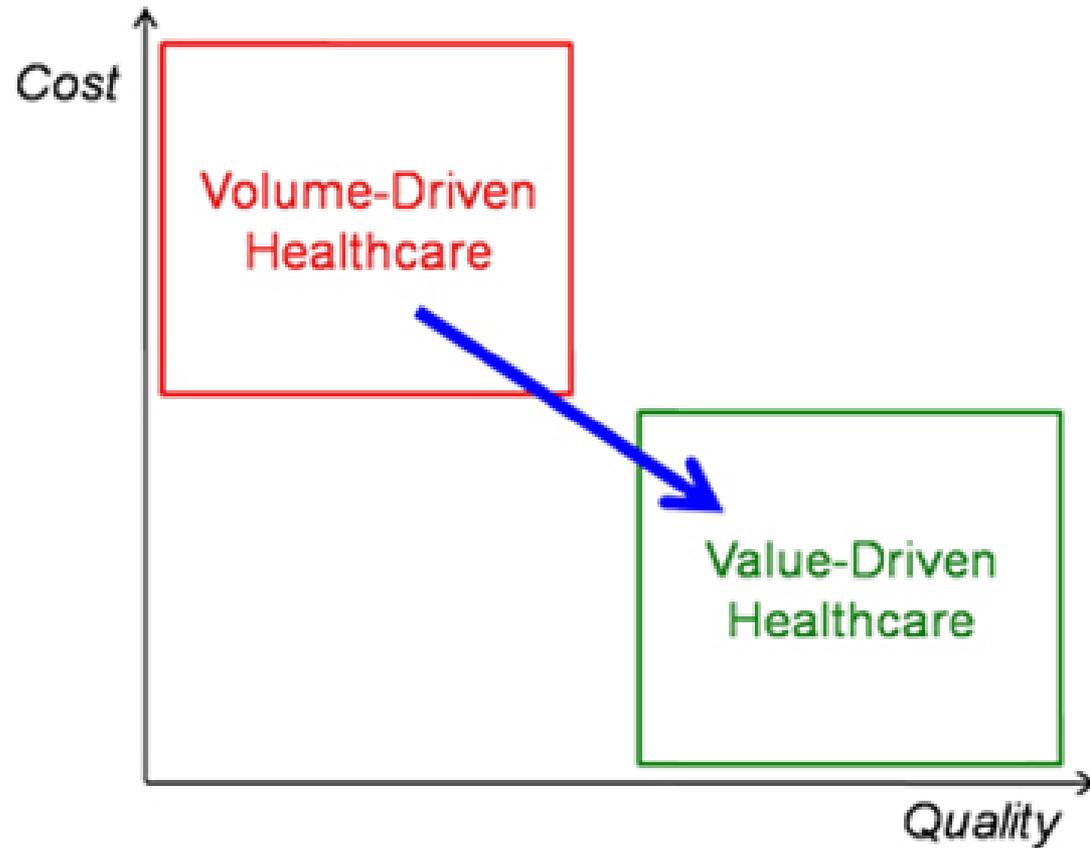
NOTES Dollars in billions. Totals may not match the sum of components due to rounding. ^aIncludes state portion of Medicaid. ^bTotal US health care spending estimated at \$2.687 trillion.

But what is wrong with fee for service????

- Incentives in FFS push toward higher volumes
- Creates payment silos
- Fragments care
- Rewards providers that provide *more* rather than *better*
- Creates disincentives for coordination and integration
- Contributes to inability to control costs



Emerging Model



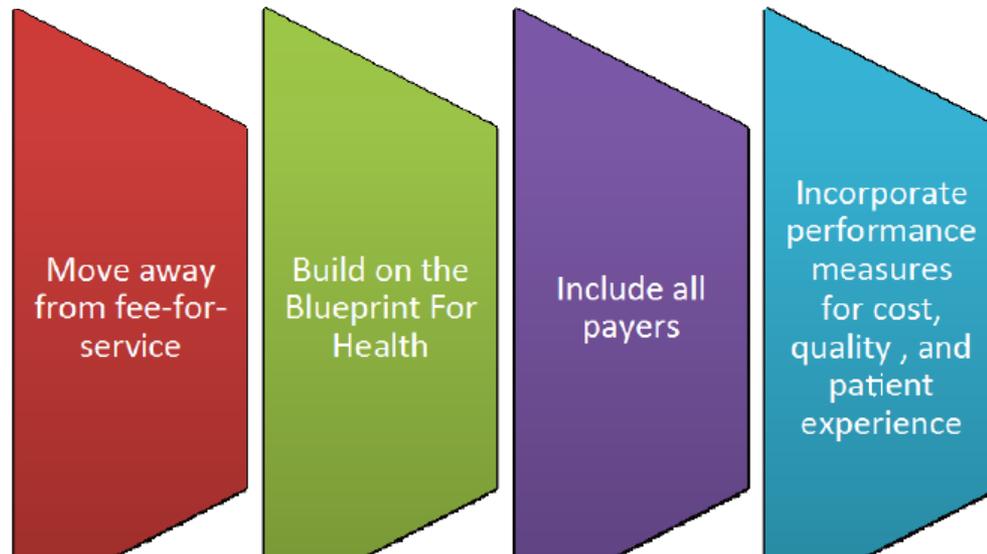
Ethics/Ethinomics

- Ethics of cost containment
 - Ponder impact of \$8,500/year in medical costs in three income levels
 - \$30,000/year
 - \$95,000/year
 - \$200,000/year
 - Fair equality of opportunity (Saloner & Danials, 2011)

Goals of Payment Reform

Offers one of the greatest areas for practitioner influence
Many providers seem unaware of the dramatic opportunities

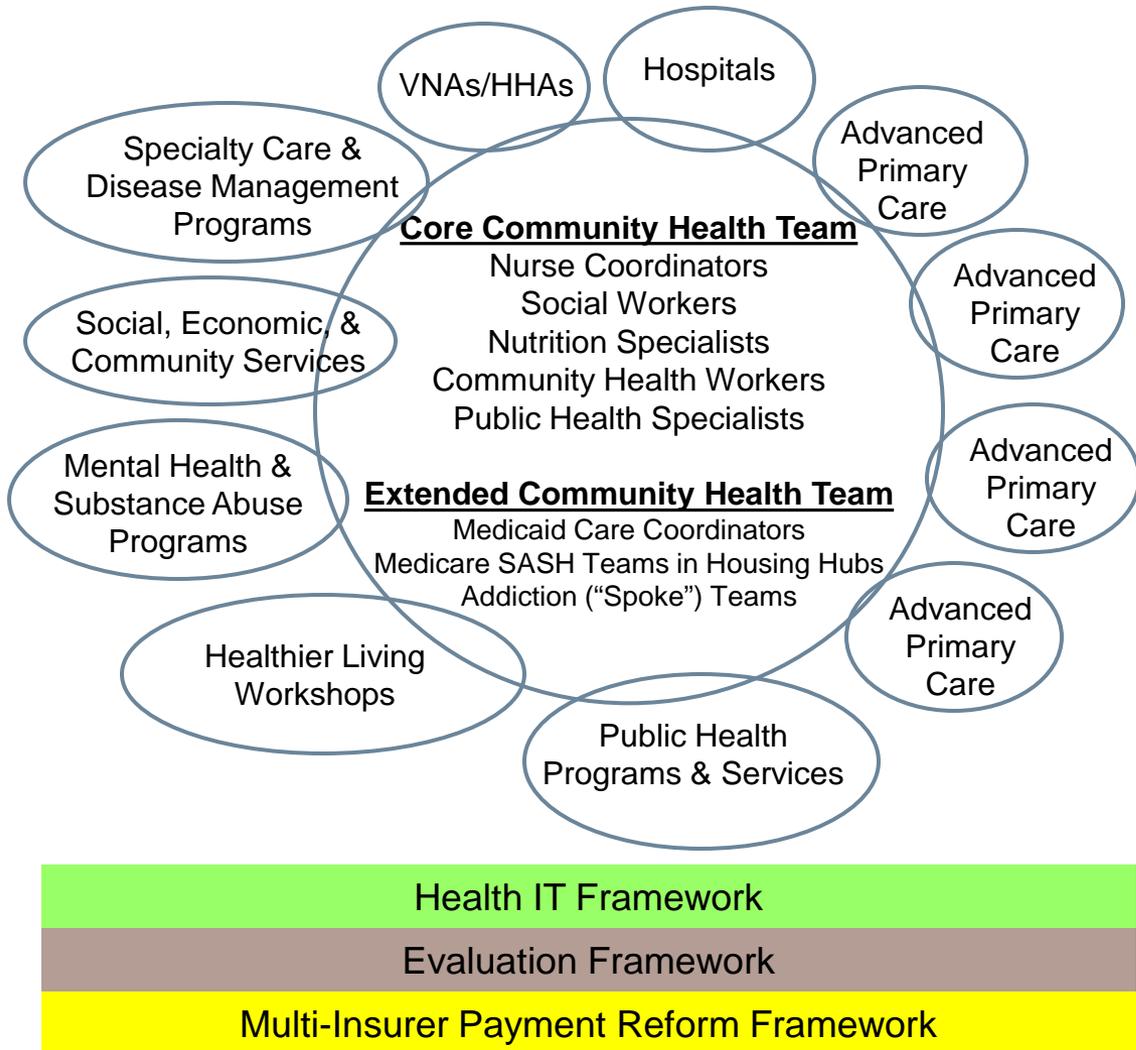
Goals of GMCB Delivery System and Payment Reform Efforts



The Blueprint for Health: Building A Foundation For The Future

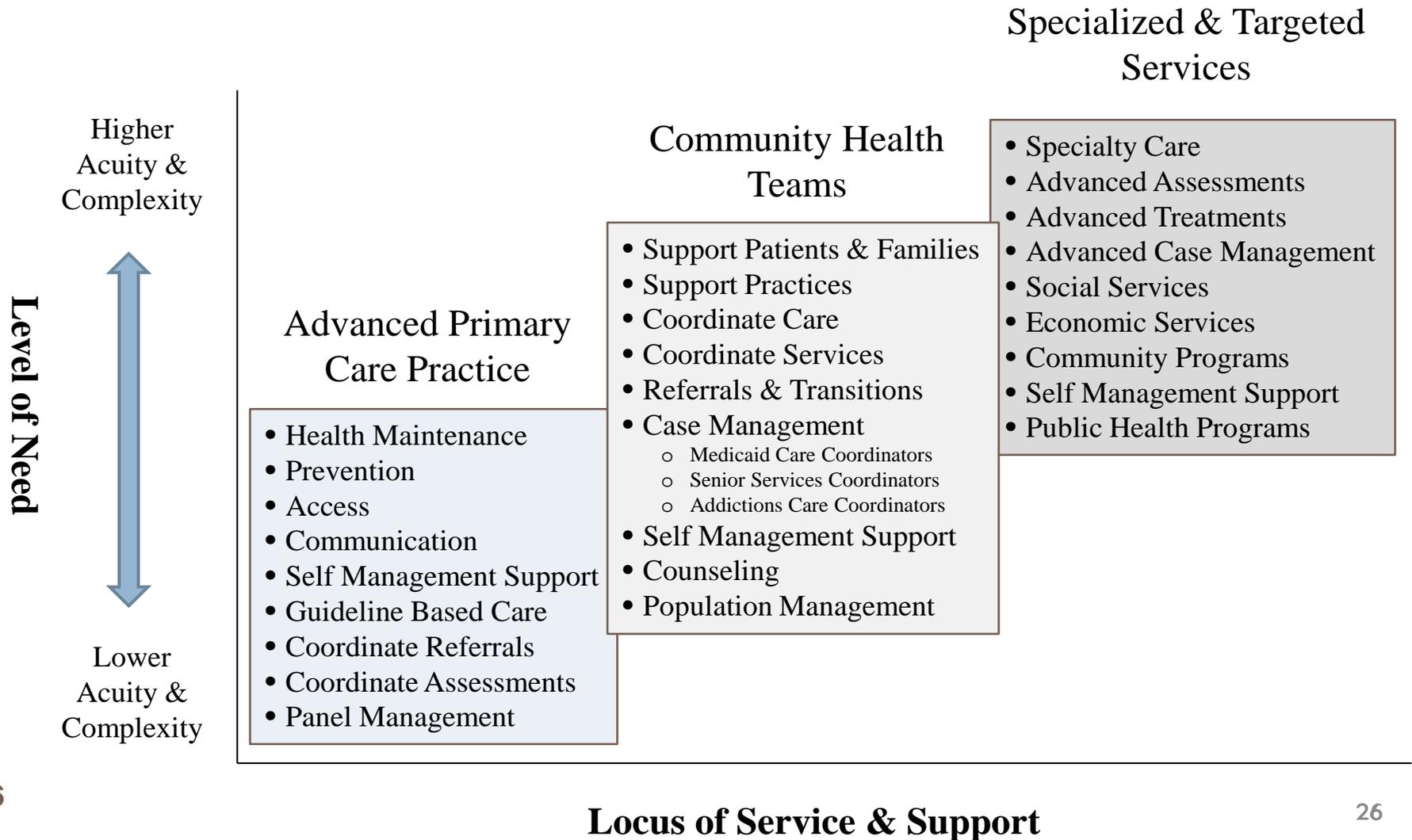
- Advanced Primary Care Practices (Patient Centered Medical Homes)
- Practice Facilitators (assist with preparation for NCQA scoring and ongoing quality improvement)
- Community Health Teams (core teams and extenders)
- Self-Management Programs (Healthier Living, Tobacco Cessation, Diabetes Prevention, Wellness Recovery)
- Multi-Insurer Payment Reforms
- Health Information Technology Infrastructure
- Evaluation and Reporting Systems
- Learning Health System Activities

BLUEPRINT STRUCTURE WITHIN A SINGLE HEALTH SERVICE AREA



- A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services
- Multi-insurer payment reform that supports this foundation of medical homes and community health teams
- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact

Continuum of Health Services



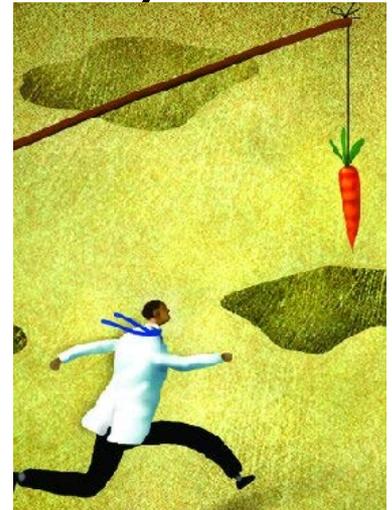
Examples of CHT Team Members

27

- Care Coordinators
- CHT Managers
- Registered Nurses
- Social Workers
- Mental Health/Substance Abuse Clinicians
- Nutrition Specialists and Registered Dietitians
- Health Educators and Health Coaches
- Certified Diabetes Educators and Asthma Educators
- Tobacco Cessation Counselors
- Community Health Workers
- Panel Managers
- Medical Assistants
- And of course, physicians, nurse practitioners, and PAs

Pay for Performance (P4P)

- Complementary health care reimbursement
- Offers financial rewards to providers who achieve or exceed specified quality benchmarks
- Most approaches adjust aggregate payments to physicians and hospitals on the basis of performance on a number of different quality measures.
 - ▣ Payments may be made at individual, group, or institutional level



What is an ACO?



Accountable Care Organizations (ACOs)

are comprised of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population.

These providers work together to manage and coordinate care for their patients and have established mechanisms for shared governance.

*SIM Payment Standards Work Group Definition 2013

VERMONT STATE INNOVATION MODEL

What is an ACO Shared Savings Program (SSP)?

A performance-based contract between a payer and provider organization that sets forth a value-based program to govern the determination of sharing of savings between the parties.



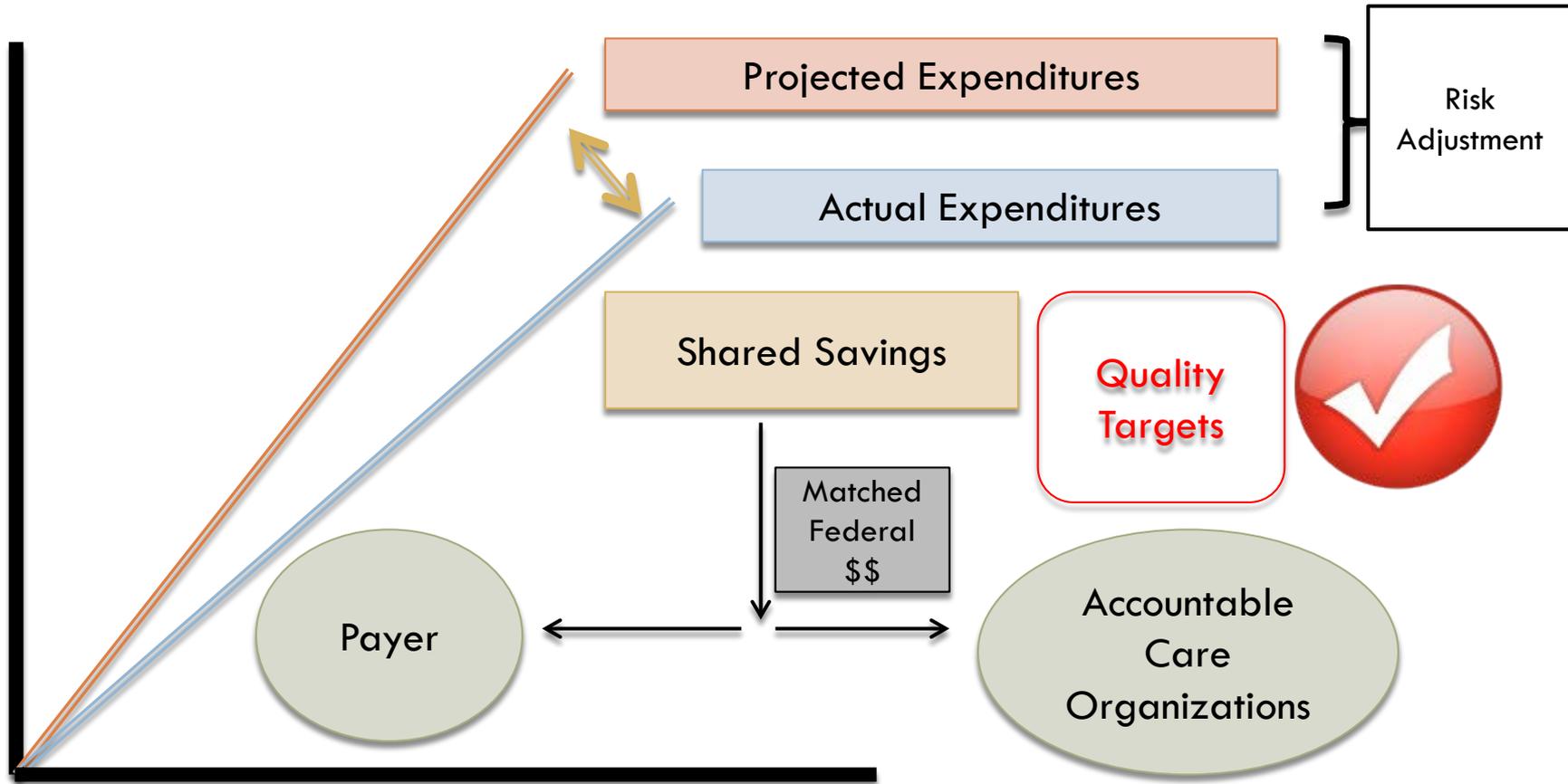
ACO model graphic property of the Premier health care alliance.
© 2010. All rights reserved.

VERMONT STATE INNOVATION MODEL



http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2012/Aug/1618_Forster_accountable_care_strategies_premier.pdf

Calculating Shared Savings



VERMONT STATE INNOVATION MODEL

Bundled Payments--GOALS

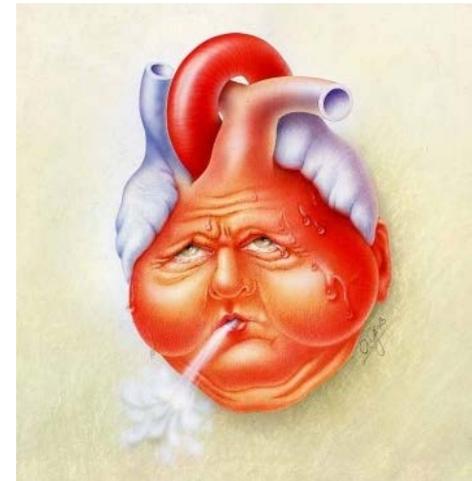
To remove FFS incentives and replace with those which reward collaboration and evidence-based practices across specialties and primary care providers for targeted episodes or types of care which represent opportunities for high return on investment. (SIM Narrative)

Note: Nursing care has always been bundled in hospital charges



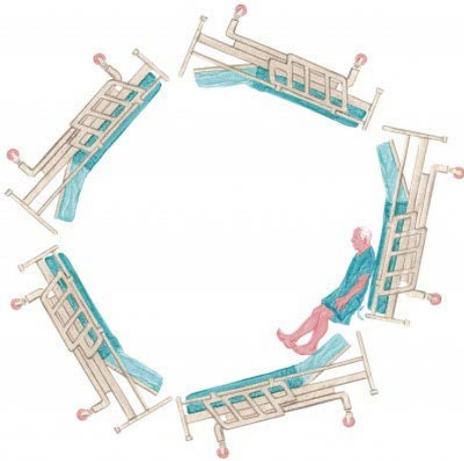
Congestive Heart Failure-Bundled Payment Example

- Goal: Improve care for patients with CHF inpatient admission via integrated care delivery
- Participants: Rutland Regional, VNA, SNF, Pulmonologist, Cardiologists, FQHC
- Scope: 120 patients DX/year
 - ▣ expenditures of \$1.9 M
- Preliminary results: 30 day readmission
 - ▣ now averaging 12-13%
 - ▣ down from historic rates of 24-25%



Another Example—Super-utilizers

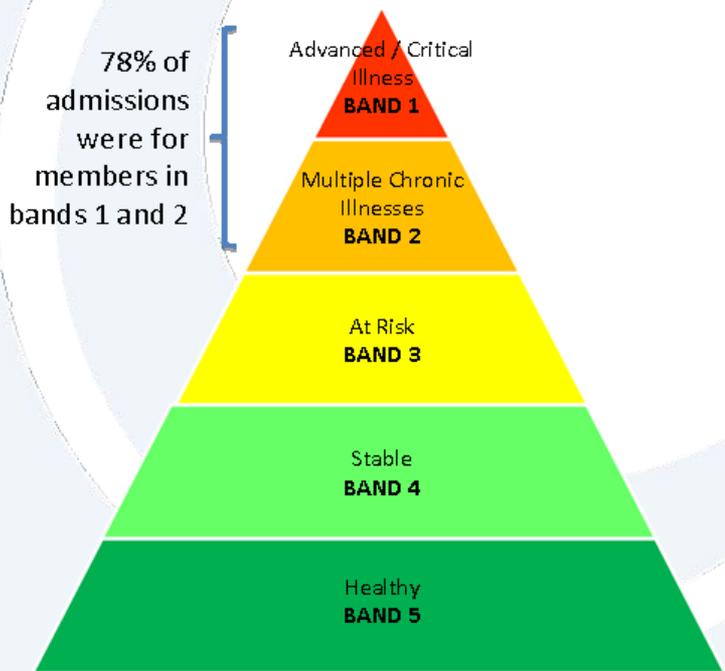
- Super utilizers—1% of pop/22% annual costs
- Medicaid even more dramatic—5%/55% of costs
- Under FFS, no disincentive for hospitals/providers to see and treat, even if it the ED.
- But remember, society paying, through taxes and insurance premiums



What are the population relative costs of the seriously ill?

35

Illness Pyramid – The Rosetta Stone



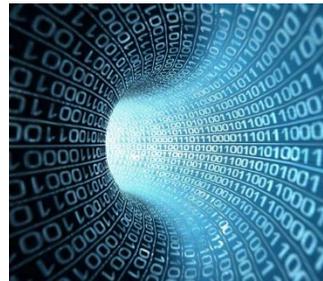
Source: CareFirst HealthCare Analytics – 2012 Data

| Percent of Population | Percent of Cost | PMPM Cost | Illness Burden Range |
|-----------------------|-----------------|-----------|----------------------|
| 3% | 29% | \$4,436 | ≥ 5.0 |
| 8% | 23% | \$1,160 | 2.00-4.99 |
| 12% | 21% | \$578 | 1.00-1.99 |
| 27% | 20% | \$218 | 0.25-0.99 |
| 50% | 7% | \$49 | 0-0.24 |



Vermont Chronic Care Initiative

- Team of nurses and social workers for individual and population management
- Need data, so local and centralized data analytic staff
- Field based care managers and care coordinators
- CARE BASED, not CURE BASED model



Examples of VCCI Services

RNs and MSWs:

- Encourage and support healthy behaviors
- Help with related issues such as housing, food security, and transportation to medical appointments
- Assist beneficiaries in talking with their health care providers
- Meet with beneficiaries and providers to develop and support a plan of care

VCCI's Tiered Approach

- Beneficiaries with complex health problems receive face-to-face case management from an RN or MSW to coordinate care among providers and connect with other resources in communities and from the state.
- Beneficiaries at lower risk receive health education and coaching from RNs by phone.
- The goal is for all VCCI participants to learn to better manage their own health conditions and to work with their health care providers.

Outcomes (FY 12)

- 11.5 M savings, after expenses
- 8% reduction in inpatient utilization
- 4% decrease in ED utilization
- 11% decrease in 30 day readmission



FY 13 preliminary--
\$23.5 M Eileen Girling, RN

Global Budgets

- Why?
 - ▣ Need to move away from fee for service to more comprehensive cost control mechanism
 - ▣ Way to link payment system to goals of population based health care
 - ▣ Hospital—service area match
 - Over time represent the total amount community willing to spend on hospital care
 - Give providers flexibility to allocate resources in community responsive way
 - ▣ Like a household budget, there are strong incentive to reduce unnecessary care and coordinate services
 - PMPM

How Big of A Change is This?

“Major changes in culture, business strategy, and relationships would be required if hospitals were to shift from celebrating full beds to celebrating empty ones. The greatest technical challenge in removing waste from US health care will be to construct sound and respectful pathways of transition from business models addicted to doing more do only what really helps.”

(Berwick & Hackbarth, 2012)



Skills Needed in the Era of Health Reform

- Care coordination
- Care process reengineering
- Dissemination of best practices
- Team-based care
- Continuous quality improvement
- Use of data (Fraher, Ricketts, Lefebvre, and Newton, *Academic Medicine*, 2013)

Everything Has Changed But Way We Think

- Limited by “physician-centric models with unimaginative use of NPs and PAs” (Nutting, Crabtree & McDaniel, (*Health Affairs*, 2012) & nurses and other providers (Rambur)
- Places enormously heavy burden on physicians that can be alleviated by having those with care coordination expertise at the table

High Functioning 1 Care: Study of 23 Practices “In Search of Joy”

- Innovations include:
 - ▣ Proactive planned care, with previsit planning
 - ▣ Shared clinical care among a team
 - Expanded protocols, standing orders, panel management
 - ▣ Shared clerical tasks
 - Collaborative scribing, nonphysician order entry, streamlined prescription management
 - ▣ Improved communication
 - Verbal messaging and in-box management
 - ▣ Improved team functioning
 - Co-location, team meetings, and work flow mapping.

Sinsky, Willard-Grace, Schutzbank, Sinsky, Margolius, & Bodenheimer, 2013

- “Our observations suggest that a shift from a physician-centric model of work distribution and responsibility to shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice” (p. 272).
- Yet, AMA lashes out at Joint Commission, saying “we’re the head of the medical household” (Robeznieks, 2014).

Primary care delivery models

'Traditional Practice'

Patient-Centered Medical Home (PCMH)

Nurse-Managed Health Center (NMHC)



MD: 6.9; NP+PA: 2.6

MD: 6.1; NP+PA: 3.7

MD: 0.8; NP: 10.4

Staffing per 10,000 patients

7

Challenges

- Payment policies tend to be “physician-based,” radiate out to other practitioners” (Matherlee, 2003)
- Workforce modeling uses FFS fueled baselines
- Educational programs pay little attention to new fundamentals: economics/ethnomics/care coordination/health rather than medical orientation

Rethinking our socialization



- Providers have been socialized in an episodic, fee-for service milieu
 - ▣ “Sim labs” and high tech practice
 - ▣ Little to no practice in “watchful waiting”
- Have not been held accountable for the cost of care quality beyond immediate errors care (MD and NP accountable for revenues)
- Accountability horizon narrow and short-term
 - ▣ No population based or temporal accountability
- Little questioning of underlying assumptions of care

Nurses Pivotal

“Because of sheer numbers—the U.S. health care system employs 2.7 million registered nurses—it is nurses who are arguably in the most pivotal position to drive system change. ...More attention needs to be given, first, to identifying the competencies nurses need in these new roles and, then, to providing continuing professional development opportunities for nurses who wish to undertake the new functions.”

(Fraher, Ricketts, Lefebvre, & Newton, 2013)



Vermont RNs

- IOM recommends 80% BS prepared by 2020
- Vermont at 40%
- What preparation do BS RNs have that AD don't?

Required education in:

- ▣ Health assessment
- ▣ Community and population health
- ▣ Evidence based practice
- ▣ Health policy/financing
- ▣ Working with diverse populations

Reconceptualize services then determine staff needs

- Workforce in APC HSAs include:
 - Registered nurses
 - Note difference in preparation by education
 - Skill set matters in a post episodic/fee for service system
 - Mental health clinicians including psych NPs
 - Social workers
 - Dieticians
 - Health coaches
 - Health educators
 - Panel managers
 - Data analysts

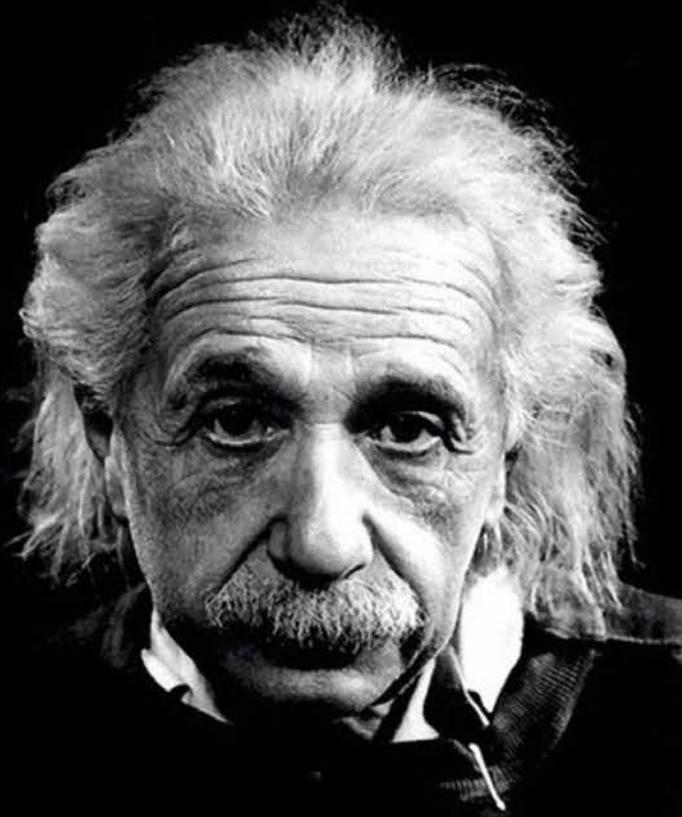
Workforce Planning

- What are the knowledge, skills, and abilities needed?
- Who has those attributes?
 - ▣ EXAMPLE: All BS and higher degree RNs have been prepared in care of aggregate populations
 - ▣ New or (re)newed skills
- Decades of evidence in Transitional Care

Workforce Reflects Service Area

- Exact configuration of providers would reflect population needs, demographics, etc. Examples:
- Service area with high proportion of elderly may benefit from services with a higher proportion of geriatric nurse practitioners/physical therapists
- Service area with a high proportion of families of child bearing age may benefit from a lactation consultant and community courses on parenting

Post Flexner, Post FFS Planning



We can't solve problems
by using the same kind
of thinking we used
when we created them.

Attachment 4 - Health Care
Workforce Work Group Meeting
Minutes 5-14-14



***VT Health Care Innovation Project
Health Care Workforce Work Group Meeting Minutes***

Date of meeting: Wednesday, May 14, 2014 2:00-4:00pm; ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier.

Attendees: Mary Val Palumbo and Robin Lunge, Co-Chairs; Georgia Maheras, AoA; Dawn Philibert, VDH; Peter Cobb, VNAs of VT; Stephanie Pagliuca, Bi-State Primary Care; Tom Alderman, Dept. of Education; Rick Barnett, VT Psychological Assoc.; Ellen Grimes, VT Tech College; Lori Grimes, NVRH; Charlie MacLean, UVM; Madeline Mongan, VMS; Chris Winters, OPR; Mat Barewicz, Dept. of Labor; Lori Lee Schoenbeck, Consumer Representative; David Blanck, Consumer Representative; Amy Coonradt, DVHA; Tony Treanor, NW Counseling & Support; , Jennifer Woodard, Stuart Schurr, DAIL; Jackie Majoros, VT Legal Aid; Nancy Tiletz, Consumer; David Adams, FAHC; Jessica Mendizabal, George Sales, Project Management Team.

| Agenda Item | Discussion | Next Steps |
|--|--|---|
| 1. Welcome and Introductions | Mary Val Palumbo called the meeting to order 2 pm. | |
| 2. Webinar: Data, Methods, and Tips for Health Workforce Supply and Demand Modeling | <p>The group participated in the webinar <i>Data, Methods, and Tips for Health Workforce Supply and Demand Modeling</i>.</p> <p>Q&A with the presenter:</p> <ul style="list-style-type: none"> • Regarding lack of data: to model characteristics for rural counties they used CDC information and reweighted population samples so it looked more like the county they were modeling. • Margins of error: AMA master file, they run a year of the projection to retire up some of the older people and age distribution looks more like one would expect for the pattern of retirement. Some older groups may appear active even though they're not (active is | Webinar slides were distributed to all participants via email. |

| Agenda Item | Discussion | Next Steps |
|-------------|--|------------|
| | <p>defined as 20 or more hours per week).</p> <ul style="list-style-type: none"> • Nursing workforce data testing: states haven't been confirmed but Vermont will participate. They want a small number to participate in the beta test and then open up to everyone. • Some services are specific to an episode but others are more general. Sometimes specialists do take on role of PCP. In supply they try to use traditional PCP. But it's not in the model they do this after the result. • Forecasting: nothing readily available. The (Sheps) Center is working on an open force model. HRSA is working on the nursing component only. IHS is developing a web based model. • Share with relevant stakeholders: workforce reports need to be updated more frequently. HRSA covers multiple occupations and it's easier to maintain, with more frequent and accurate representation, which makes it possible to see real-time surpluses or shortages. • For special types of providers, like Community Health Workers and ACOs etc., the roles will continue to be refined. We need workforce models that can be quickly updated and refined. They are often not included in the supply side because of the low barriers for entry and exit into the work force. The focus is on those professions that require more training etc. • Minimum data for workforce data collection: age, gender, specialty occupation and location. Additionally helpful: work pattern, intention to retire; move in or out of the state. <p>The group discussed the presentation and the following points were noted:</p> <ul style="list-style-type: none"> • The Department of Labor is focused more on the demand side. • Vacancy rates are often difficult to nail down because there may be more vacancies than what is being recruited for. • Robin indicated there will likely be more actuarial analysis around demand as benefits increase. Actuarial analysis looks at utilization but may not accurately reflect need, as certain populations don't consume healthcare even if they need it. It's not certain if the data would show that patients chose to see a PCP verses going to the ER. • Group needs to consider spending on Primary Care and social determinants and how it relates to modeling. | |

| Agenda Item | Discussion | Next Steps |
|---|--|---|
| 3. Discussion of Demand Proposals | In order to allow more time for discussion this agenda item will be discussed at the next meeting. | |
| 4. Approval of Meeting Minutes | Rick Barnett moved to approve the minutes and Charlie MacLean seconded. Peter Cobb abstained since he was not present at the last meeting. The motion passed. | |
| 5. Criteria for Prioritizing Budget Requests | <p>AHEC is applying for a federal grant with the Department of Health to increase funding for loan forgiveness. The Legislature has appropriated additional money for loan forgiveness related to workforce issues if the state is awarded this federal matching grant.</p> <p>A survey will be sent to the work group to develop criteria and give feedback on how to prioritize the proposals.</p> <p>The group proposed modifications to the following criteria:</p> <ul style="list-style-type: none"> • A recommendation was made to change #6- the Federal State Loan Repayment Program, where they are going to award 40 and a state or territory can apply for it. We are relatively well populated with physicians with compared to other states. • Another recommendation was made to change #1- to “Strategies for meeting the healthcare needs of Vermonters.” | Further recommendations should be sent to Amy Coonradt, for both improvements to criteria and the RFI. |
| 6. VDH/OPR Report Update | <p>Dawn Philibert gave a brief update on the VDH workforce data collection. There was concern at the last meeting around staffing and that VDH might have then missed the timeframe to conduct surveys on certain professions. But at this time they have been able to capture all professions and don’t anticipate missing any.</p> <p>Dawn and Peggy reviewed the Steps for Collecting the Workforce Data: design survey tool; collect data during licensing or relicensing; analyze data; report on data. Conclusions and recommendations lead to planning and policy development. Surveys have already been conducted for some professions and they may have to prioritize analysis for some over others. After all professions have been captured they will conduct analysis. There are challenges with</p> | Dawn distributed the VDH Survey Design Analysis spreadsheet which was later distributed to participants via email. |

| Agenda Item | Discussion | Next Steps |
|---|--|------------|
| | <p>recruiting for analytical work. They received one response to the RFP and the committee did not feel the vendor response was adequate. Individuals are interested in the work but were intimidated by the components of the RFP. They are meeting with Georgia to retool the RFP. Regarding survey data they continue to refine instructions, methods, they have not held back on the licenses as a result yet.</p> <p>They have started preliminary analysis and have not finalized anything. The priority is to design the forms. VDH is already doing analysis utilizing current staff and needs a contractor to do their procedures and programs. The new recruit may also be able to assist with analysis.</p> | |
| <p>7. Membership Change Requests</p> | <p>LoriLee Schoenbeck formally nominated Dr. Janet Kahn as a member to the Workforce work group. Lorilee gave a brief introduction to the history of integrative medicine in VT:</p> <p><i>In 1997 a survey by FAHC found 54% of Vermonters used some form of complementary and alternative medicine. Many of these provider groups are invisible, yet important components of the health care workforce. Licensed chiropractic and naturopathic physicians, licensed acupuncturists and licensed lay midwives are not fringe professions, but rather front line primary and specialty care for thousands of Vermonters. For example there were 115,000 Acupuncture visits in 2010 in Vermont--and all were paid out-of-pocket by patients. Understanding how these provider types, which excel at chronic care such as the treatment of arthritis, heart disease, obesity and the non-narcotic management of chronic pain, is essential to envisioning a future health care workforce that fundamentally improves health delivery at lower cost. As example of provider recruitment and retention, since the 2008 implementation of naturopathic physicians (NDs) covered by all private and VT Medicaid plans, and the 2012 inclusion of their participation with the Blueprint for Health as PCMH's, we saw an influx from 20 to 50 ND PCPs by 2013. Vermont has a choice to pioneer the understanding and integration of these health professionals into health delivery systems--and these provider types do not need to be trained, recruited or retained, they are already here.</i></p> <p>Dr. Kahn's biography was provided in the meeting materials. Dr. Kahn exited the room before the group discussed. Dawn offered support from VDH noting the successful use of complementary medicine to manage chronic pain instead of narcotics.</p> | |

| Agenda Item | Discussion | Next Steps |
|---|--|------------|
| | Mat Barewicz moved to approve the nomination and Dawn Philibert seconded. The motion passed unanimously. | |
| 8. Public Comment, Next Steps, Wrap up | Next meeting: Wednesday, June 18, 2014 at EXE - 4th Floor Conf Room, Pavilion Building, Montpelier. | |

Attachment 6 - Workforce Work Group Survey Results (Data)

Workforce Work Group Survey: Ranking Criteria for Proposals (n=23)

Instructions: Please rank each of the criterion below according to how strongly you feel that they should be considered when prioritizing proposals from this work group to the Governor, from 1 (least important) to 5 (most important)

| Criteria | | 1 | 2 | 3 | 4 | 5 | Total | Average Rating |
|----------|---|---|---|----|----|----|-------|----------------|
| 1.) | Proposal reflects strategies for identifying the healthcare workforce needed to ensure patient access to highly reliable, evidence-based, team-based care. | 0 | 2 | 3 | 8 | 10 | 23 | 4.13 |
| 2.) | Proposal identifies the workforce needed for the care models and the payment models that will be part of the reformed health care system in Vermont. | 1 | 3 | 6 | 3 | 10 | 23 | 3.78 |
| 3.) | Proposal improves clinical education and leadership training for clinicians who deliver care to patients, focusing on delivery of highly reliable, evidence-based, team-based care. | 2 | 2 | 11 | 3 | 5 | 23 | 3.3 |
| 4.) | Proposal supports recruitment and retention of workforce needed to ensure patient access to highly reliable, evidence-based, team-based care | 1 | 0 | 3 | 8 | 11 | 23 | 4.22 |
| 5.) | Proposal includes a means to evaluate the proposal's impact on the healthcare workforce. | 0 | 1 | 5 | 10 | 7 | 23 | 4 |
| 6.) | The cost/benefit of the proposal (is the expense reasonable?). | 0 | 2 | 4 | 10 | 7 | 23 | 3.96 |
| 7.) | Proposal's fit with the specific recommendations of the Health Care Workforce Strategic Plan found here. | 0 | 2 | 3 | 8 | 10 | 23 | 4.13 |
| 8.) | The proposal has a manageable/realistic scope of work. | 0 | 1 | 6 | 6 | 10 | 23 | 4.09 |
| 9.) | Proposal's ability to track impact on the health care workforce. | 0 | 2 | 9 | 6 | 6 | 23 | 3.7 |
| 10.) | The proposal is for a one-time expense or has the ability to find sustainable funding elsewhere. | 4 | 6 | 4 | 6 | 3 | 23 | 2.91 |
| 11.) | The proposal addresses the health care workforce needs of communities within the next 12-24 months. | 3 | 7 | 6 | 3 | 4 | 23 | 2.91 |