

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

**Wednesday, December 17, 2014; 3:00-5:00pm
EXE - 4th Floor Conf Room, Pavilion Building, Montpelier
Call-in Number: 1-877-273-4202; Conference ID: 420-323-867**

Topic	Notes	Next Steps
Welcome and Introductions	Mary Val Palumbo called the meeting to order at 3pm. Roll was taken.	
Approval of Meeting Minutes	Dawn Philibert moved to approve the minutes and Burt Wilcke seconded. There were no objections.	
2014 Healthcare Workforce Symposium debrief and discussion; Strategic Plan process discussion	<p>Charlie MacLean commented on the success of the symposium, the following were comments or suggestions on what to take from the event:</p> <ul style="list-style-type: none"> • Erin Fraher’s comments were what the group expected to hear: more of a focus on training, less on the actual discipline. If the Work Force Work Group wanted a model demonstration she would be happy to provide it to the group. The third section of the symposium on innovation was great, the group can take a lot from this information and progressive examples. • There was no requirement to complete a report post symposium, however the Core team has asked for a brief report. • Paul Bengtson agreed that a report would be helpful and could be used to inform the next Workforce Strategic Plan. Mary Val Palumbo asked for an example of what this would look like. Paul suggested an example of taking a workforce that is working in one environment and examining how that workforce can become more integrative to increase efficiency. • Lori Lee Schoenbeck discussed choosing a single topic to move forward on that is of particular concern to VT as we heard about a variety of ways to address medical issues, both through care coordination or case management. • In Feb we should ask visiting WGs to inform us on how they are working on 	

Care Coordination and Care Management for VT specific issues.

- Paul Bengtson spoke about how to link existing programs such as the Hub and Spoke to different providers and systems currently in place, and how they can be more integrative when working in the community
- Mary Val Palumbo discussed her surveying of Blue Print practices. Charlie MacLean and Paul Bengtson questioned Mary Val on the meaning of the results in relation to job titles, emerging jobs, and organization size.
- Molly Backup said that no longer can a medical provider be trained for one skill set. All fields now have to learn how to think through a medical issue in full, instead of just their immediate priorities as jobs and job priorities are so quickly shifting. The new standard is process thinking instead of memorization. Mary Val asked if this is reflective of older workers or those people who we are just starting to train in school. Molly Backup responded that it is both, and training them differently to expand their skill set.
- Lori Lee Schoenbeck noted that we're in the middle of a paradigm shift – moving away from sectionalized thinking and working.
- Burt Wilcke mentioned credentialing standards – we are operating as in the past and the standards need updating. Licensure laws often restrict what we can do and do not look at whole system needs. The reimbursement in place is also an issue and is leading to current practices..
- The shift from volume based to value based mirrors the transition of workforce nicely.
- Scope of practice is an issue in VT.
- Dawn Philibert discussed the importance of balancing the need for more credentialing with being flexible with the workforce to fill in where most needed
- Mary Val Palumbo reemphasized the importance of hearing from other WGs to clarify future direction for this WG
- Stephanie Pagliuca said that there were good examples given at the symposium but surveying needs to be done in VT to understand what people are looking for by way of a workforce and how health care teams currently look before

	<p>deciding on what future training looks like.</p> <ul style="list-style-type: none">• Beth Tanzman spoke to the importance of teams in the PCMH model and how teams are pulled together around forms of common measurement or goal, such as patient outcomes.• Burt Wilcke said there are a very small percentage of public health programs that get reviewed to see if they are actually doing what is promised. Concerned there is a lack of evidence-based practice in the larger light.• Mary Val asked if the sub grants will be evaluated. Yes, all will self-evaluate. Any “lessons learned” from these sub-grants should be shared with the work groups and leveraged.• Dawn Philibert asked about Mary Val Palumbo’s survey – and if the hurried atmosphere of a practice had something to do with the responses given. Mary Val agreed in the affirmative. The practice manager was the respondent and so the survey was intended to get answers about the project and questions were measureable so the practice managers would be able to answer.• Paul Bengtson reported that in the Northeast Kingdom they are building an Accountable Health Community, which requires organizations and diverse leaders together – taking time to figure out everyone’s role and how to best leverage what.• Rick Barnett commented that he doesn’t know if the strategic plan really needs updating and that the group needs time for more discussion. Mary Val Palumbo said that this should be a focus for next meeting• Georgia said that we are working to create a status report on the current strategic plan – we can then decide what the next steps around creating a new strategic plan will be	<p><u>Staff to inventory strategic plan recommendations and produce status report of what’s been</u></p>
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		<u>completed for February meeting</u>
Community Health Workers Discussion	<p>Jeanne Hutchins updated the group on Community Health Worker workforce in VT and presented on attachment 4, the following were questions or comments on the attachment:</p> <ul style="list-style-type: none"> • Dawn Philibert asked who she was working with – it’s been an internal project so far, but propose it be led by Vermont Department of Health • Mary Val noted that CHW jobs are seen as a stepping stone, not a long-term career, by many. Charlie noted that many who are considered CHWs are doing it on a volunteer basis. • Jeanne added that CHWs get curriculum training and that more specific training depends on the job, as CHWs can perform a range of duties. Also commented that it’s hard to determine who is a CHW, as many CHWs don’t even think of themselves as such. • Dawn Philibert asked if some CHWs were “peers”, like in substance abuse programs. • Mary Val Palumbo answered yes, CHWs perform in a wide range of roles— many in substance abuse/drug recovery/incarceration are peers who are now counselling. • Lori Lee Schoenbeck asked if CHWs could be tiered through different levels of certification or registration. • Paul Bengtson provided an anecdote about using grant money in the NE Kingdom to fund their CHW until it ran out, then funded it out of hospital bottom line, adding that Blue Print money has also helped. The community connectors they employ are varied and are representative of the population they serve. • Mary Val Palumbo talked about pros and cons of certification. How to count 	

	<p>people if they don't have a certification? Left unanswered. Dawn Philibert responded that a lot of the care is informal as well, overall this is a hard service to count.</p> <ul style="list-style-type: none"> • Peter Cobb mentioned that if we go the certification route the State will be impacted significantly. Dawn Philibert agreed. • Mat Barewicz said that this is a job title that has popped up in the past few years, working on finding a better way to track it – will report back in Feb. • Dawn Philibert said this is not an emerging group, but an emerging title. 	<p><u>Mat Barewicz to update group on further CHW research (if any) as well as panel manager research, in February.</u></p>
<p>Demand Modeling Update</p>	<p>Department of Labor to release RFP and manage contractor – they have appropriate staff and this model will help the department in the long run. Hope to release RFP soon, one challenge is that the VT Department of Labor is federally funded so there is extra clearance needed. Next steps are to wait until the New Year before RFP is released, anticipating that the whole project will take 6 months. Georgia Maheras went through the list of likely respondents to the RFP.</p> <p>Paul Bengtson asked what sort of knowledge we will have after the end of this model is completed. Georgia Maheras said that what we are hoping to be able to input the health status of our selected populations as well as any additional assumptions we'd like to include, and have the model predict what sorts of professions/skills will be needed to treat those selected populations.</p> <p>Potential for a sub-group to come out of this to help the chosen vendor make appropriate statewide assumptions.</p> <p>Mat Barewicz provided the benefit from the DOL point of view over time.</p>	

<p>Public Comment/Wrap Up/Next Steps Future Agenda Topics: February: - Presentations from other work groups - LTC Report Update - Strategic Plan Proposal Further discussion: CommunityHealth Workers</p>	<p>Dawn Philibert reported that on Jan 12, their analyst will be starting Georgia Maheras informed the WG that the 2015 workforce plan is under development, and will be distributed to them in early 2015. Lori Lee Schoenbeck would like to see some interaction with the CMCM WG.</p> <p>Next meeting: Wednesday, February 18, 2015 3:00 pm – 5:00 pm</p> <p>EXE - 4th Floor Conf Room, Pavilion Building 109 State Street, Montpelier</p>	

Trade Adjustment Assistance Community College and Career Training Grant

Program (TAACCCT) Grants -

- The first TAACCCT grant received by CCV targeted Medical Assisting, Applied Business and Digital Marketing
- TAACCCT 2 was awarded to VTC and concentrates on agribusiness. CCV is assisting VTC by offering entry-level courses, recruiting new students and introducing them to VTC's programs.
- TAACCCT 3 was awarded to UVM and focuses on actuarial science and computer certification. Work with UVM is just beginning. CCV will be offering entry level courses to expose students to opportunities in computer related fields and assist people who have gaps in skills and are not prepared for UVM's certificate programs. CCV may also be offering a "re-careering" course to help older/experienced workers transition into new careers.
- TAACCCT 4 was awarded to CCV and will target three areas:
 - 1) Manufacturing/Technology
 - 2) Healthcare, social and community services
 - 3) Business/Agri-business.

TAACCCT 4 will focus on shorter trainings, rather than full degree programs. Whenever possible, training will be linked to industry recognized credentials and/or curriculum. CCV will also focus on career pathway development in the three targeted areas. The goal is to help individuals get a skill and get back to work or change career fields and provide opportunities for individuals to move out of entry level positions and into better paying jobs in the career field of choice. CCV will be working with Vermont Tech to build more transfer pathways and help Vermont Tech expand opportunities for technical education across the state.

2012 PHYSICIAN ASSISTANTS SURVEY

Guidance • Support • Prevention • Protection

November, 2012



SURVEY DESCRIPTION

Survey mailed with the license renewal forms in the Fall of 2011.

Followed up via mail and phone calls.

The final response rate was 100%.

Anesthesiology assistants (AAs) were also included, unlike the 2004-2010 reports, and are not distinguished from PAs in this report.

SUMMARY

- There were 240 PAs working in Vermont.
- This includes 11 AAs.
- 57% (137) of the PAs were female.
- Ages ranged from 25 to 66, with a median of 44.

The Vermont Department of Health

2012 PA Survey

PRIMARY CARE

41% (98) worked mainly in primary care:

- 32% (77) in family practice
- 5% (12) in internal medicine
- 3% (6) in obstetrics and gynecology
- 1% (3) in pediatric primary care

The Vermont Department of Health

2012 PA Survey

PRIMARY CARE

- 88% of primary care PAs accept new patients.
- 78% accept new Medicaid patients.
- 82% accept new Medicare patients.

The Vermont Department of Health

2012 PA Survey

SPECIALTY CARE

59% (142) worked mainly in specialty care:

- 18% (43) in emergency medicine
- 14% (33) in orthopedic surgery
- 5% (13) in other surgery specialties
- 5% (12) in anesthesiology
- 4% (10) in internal medicine
- 13% (31) all other specialties

The Vermont Department of Health

2012 PA Survey

SUMMARY

- 62% of PAs have worked in Vermont 9 years or less.
- 14% have worked in Vermont 20 years or more.
- 14% of the PAs are age 60 or older.
- 22% of the primary care PAs are 60 or older as compared with 8% of those in specialty care.

The Vermont Department of Health

2012 PA Survey

CHANGES OVER TIME

- As compared with 2010:
 - There was a net increase of 27 (excluding anesthesiology assistants):
 - An increase of 15 in primary care
 - An increase of 12 in specialty care

The Vermont Department of Health

2012 PA Survey

CHANGES OVER TIME

- As compared with 2010:
 - There was a net increase of 9.6 FTEs (full time equivalents) in primary care, statewide.
 - Chittenden and Franklin Counties had the largest increases.
 - Orange and Rutland Counties had the largest decreases.

The Vermont Department of Health

2012 PA Survey

CHANGES OVER TIME

- As compared with 2002:
 - There was a net increase of 110 (85%):
 - An increase of 29 in primary care
 - An increase of 81 in specialty care

The Vermont Department of Health

2012 PA Survey

CHANGES OVER TIME

- As compared with 2002:
 - There was a net increase of 22.3 FTEs (full time equivalents) in primary care, statewide.
 - Franklin and Chittenden Counties had the largest increases.
 - Other Counties saw only small changes.

The Vermont Department of Health

2012 PA Survey

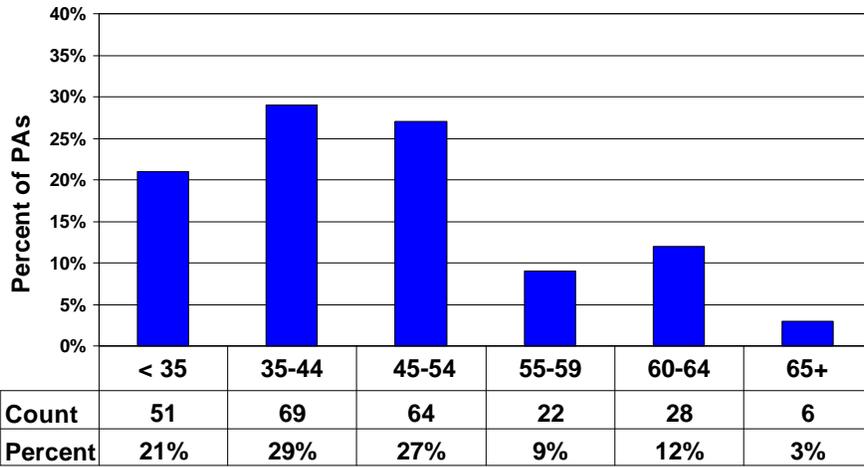
CHANGES OVER TIME

- As compared with 2002:
 - There was a net increase of 68.5 FTEs in specialty care, statewide.
 - Chittenden County had the largest increase, 38.9 additional FTEs.
 - Windsor and Rutland counties also had large increases.
 - Washington County lost 1.8 specialist FTEs.

The Vermont Department of Health

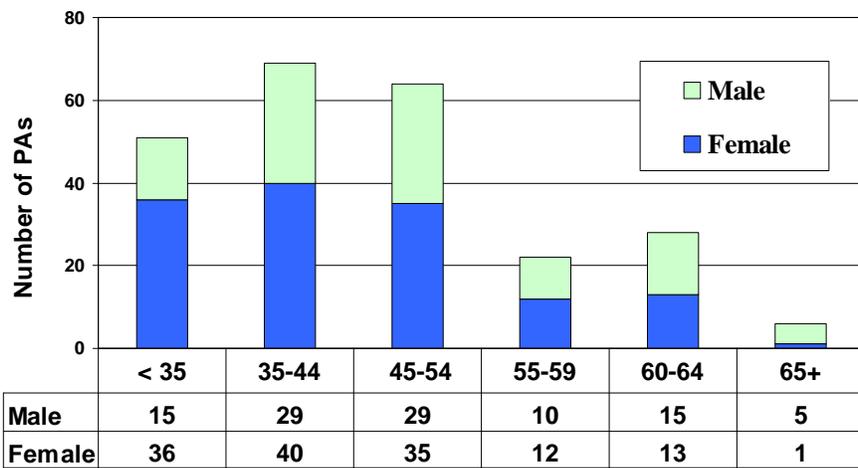
2012 PA Survey

AGE DISTRIBUTION

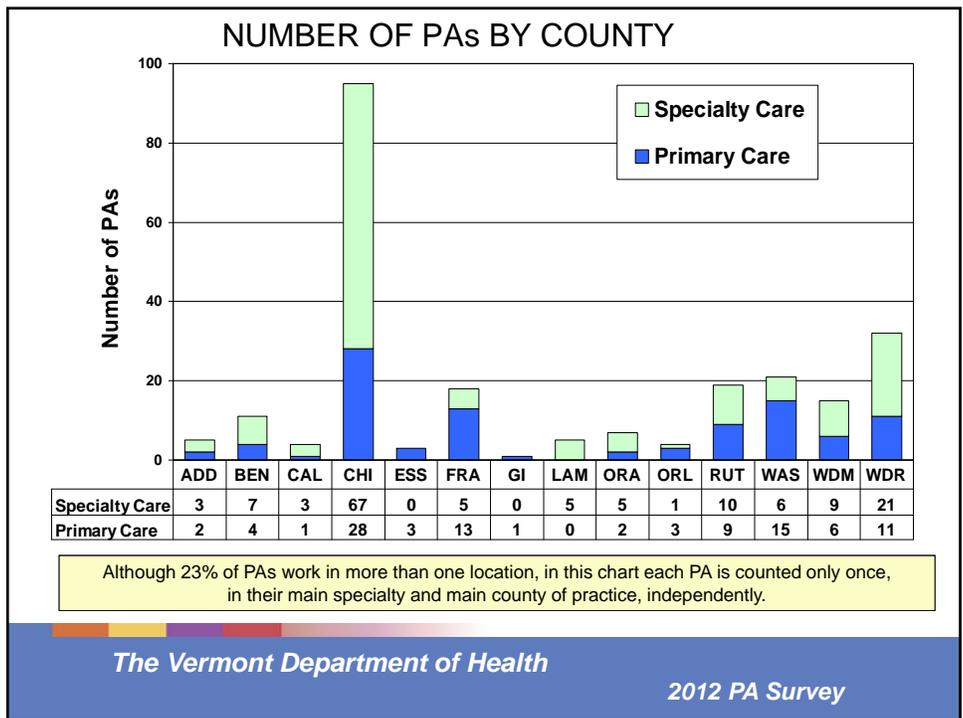
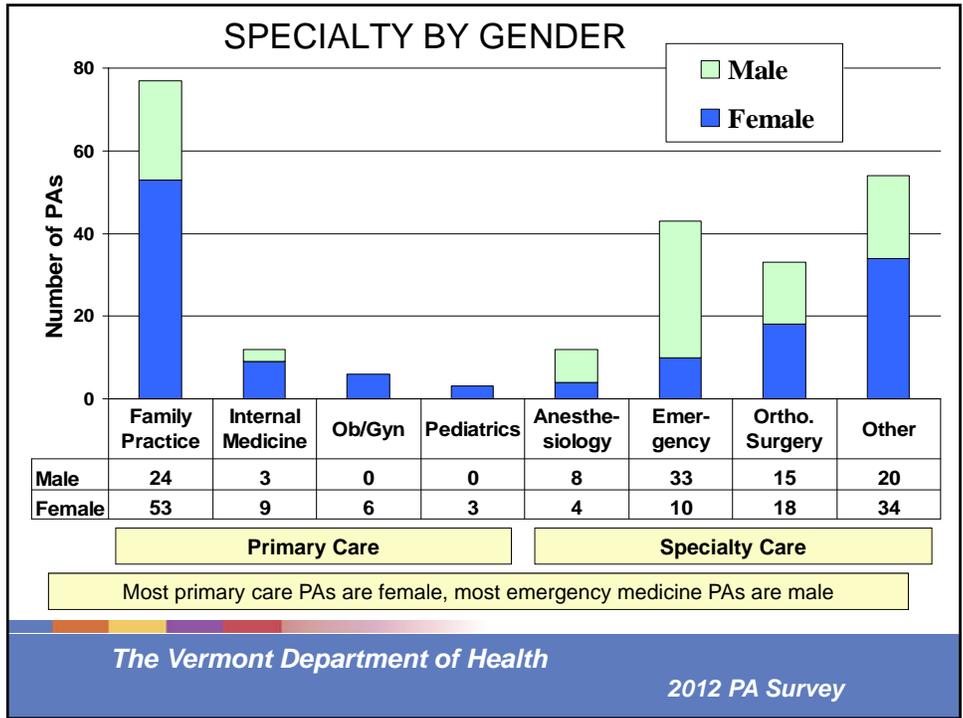


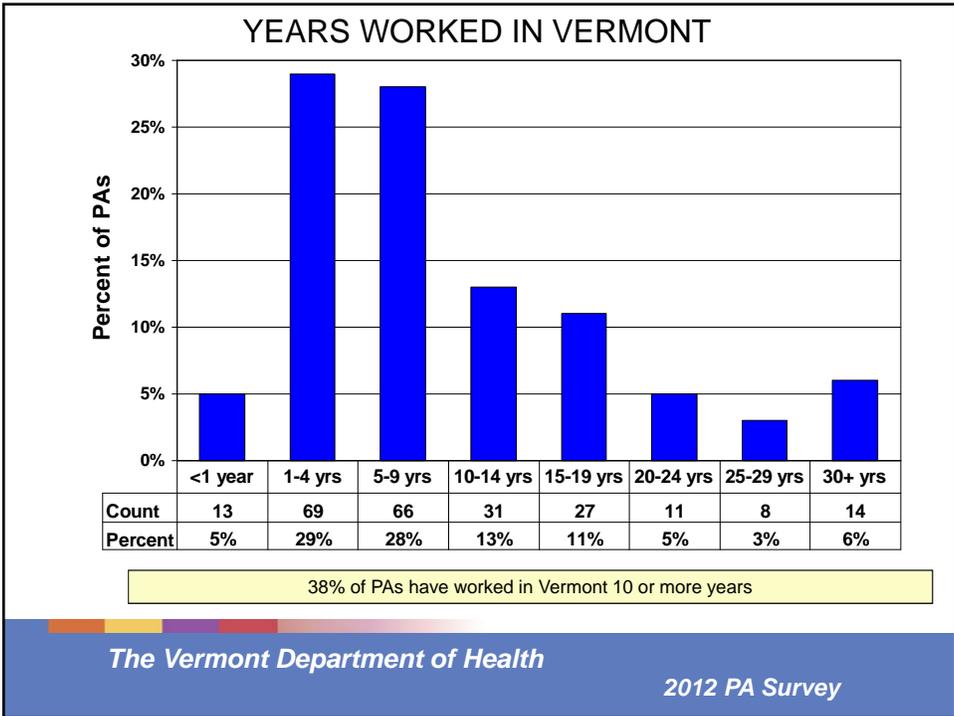
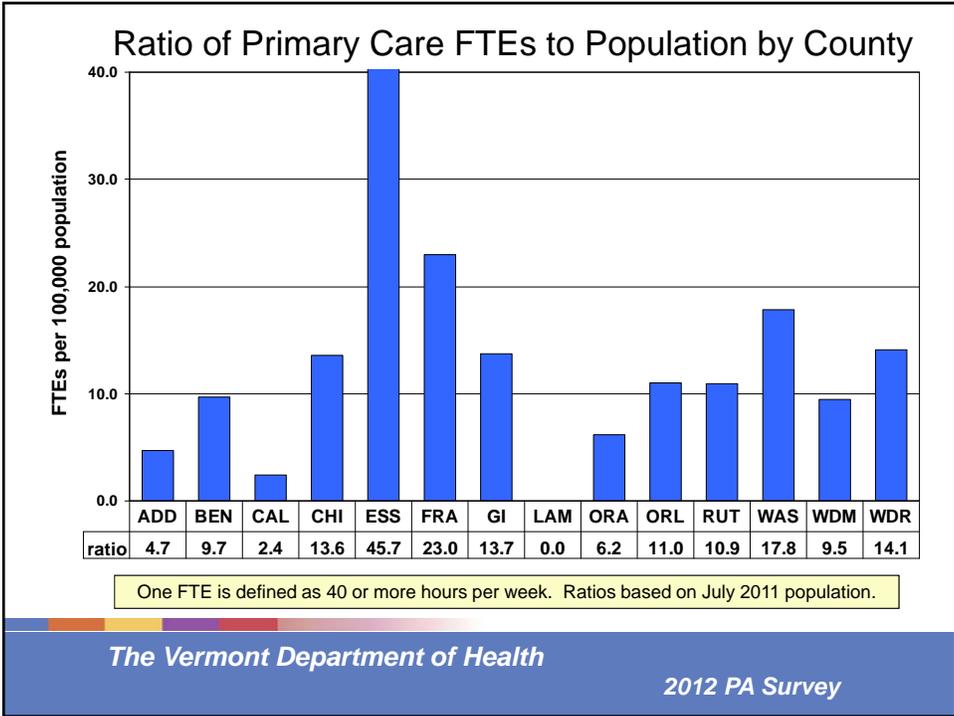
23% of all PAs are age 55 or more

AGE DISTRIBUTION BY GENDER

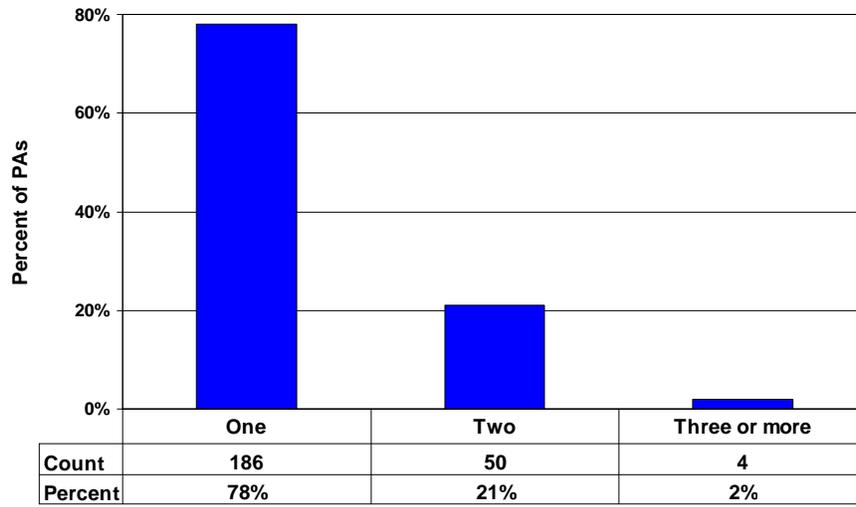


57% of all PAs are female; 71% of PAs under age 35 are female





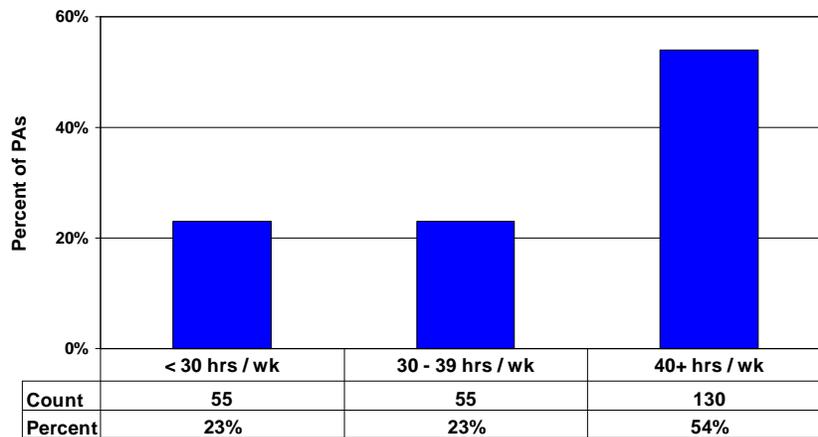
NUMBER OF SITES OF PRACTICE



The Vermont Department of Health

2012 PA Survey

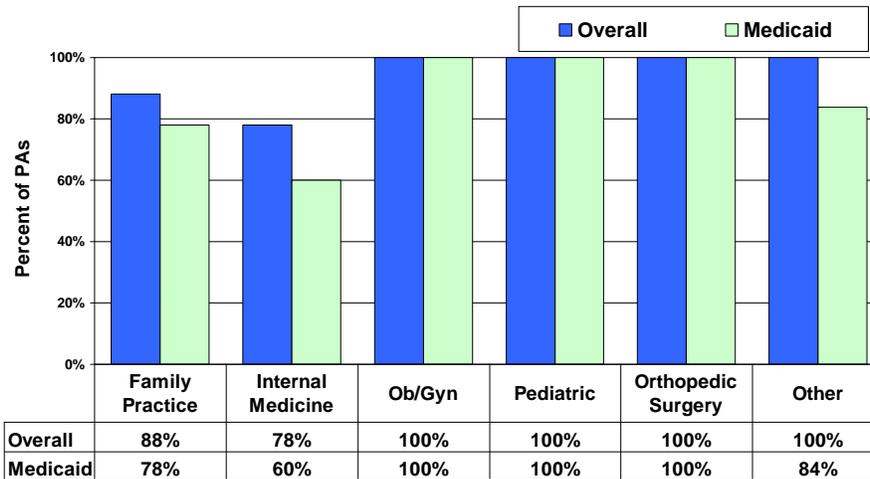
HOURS WORKED PER WEEK



The Vermont Department of Health

2012 PA Survey

PA's ACCEPTING NEW PATIENTS



Overall, 93% accept new patients, 83% accept new Medicaid patients, 89% accept new Medicare patients. Each PA is counted only once. Office settings only. Emergency medicine excluded.

The Vermont Department of Health

2012 PA Survey

COMPARISON WITH PREVIOUS SURVEYS

The Vermont Department of Health

2012 PA Survey

Primary Care Physician Assistants: 2002-2012

	2002	2004	2006	2008	2010	2012
Primary Care PAs	69	79	83	85	83	98
Family Practice	53	55	62	58	60	77
Internal Medicine	7	10	11	15	11	12
Ob/Gyn	8	10	8	9	6	6
Pediatric Primary Care	1	4	2	3	6	3
Primary Care PA FTEs	54.3	62.3	62.6	64.8	67.0	76.6
Family Practice	43.6	45.4	48.2	46.0	49.3	62.5
Internal Medicine	5.3	7.5	7.9	11.8	9.4	8.6
Ob/Gyn	4.5	5.6	4.4	4.8	4.4	3.6
Pediatric Primary Care	1.0	3.9	2.1	2.1	3.9	1.9

The Vermont Department of Health

2012 PA Survey

Specialty Care Physician Assistants: 2002-2012

	2002	2004	2006	2008	2010	2012
Specialty Care PAs	61	76	80	106	119	142
Emergency Medicine	33	37	30	35	40	43
Internal Medicine	1	5	4	9	11	10
Orthopedic Surgery	8	14	19	23	25	33
Specialty Care PA FTEs	54.8	69.2	70.2	93.9	105.7	123.3
Emergency Medicine	29.4	33.8	24.8	31.2	32.4	34.2
Internal Medicine	1.0	4.8	3.1	8.1	9.6	7.9
Orthopedic Surgery	7.5	12.9	17.8	20.7	23.5	31.6

The Vermont Department of Health

2012 PA Survey

Selected Indicators, 2002-2012

	2002	2004	2006	2008	2010	2012
Total PAs active in Vermont **	130	155	163	191	202	240
Percent female	59%	56%	57%	58%	60%	57%
Percent age 55 or older	9%	15%	20%	25%	23%	23%
Average patient care hrs/wk	36	37	35	36	36	35
Primary care PAs						
% accept new patients *	91%	97%	91%	85%	82%	88%
accept new Medicaid patients*	86%	92%	81%	66%	73%	78%
accept new Medicare patients*	86%	94%	83%	77%	73%	82%
FTEs/100,000 population	8.8	10.0	10.0	10.4	10.8	12.2

* Each PA is counted only once (in each year)

** AAs included in 2012 but not in 2004-2010

The Vermont Department of Health

2012 PA Survey

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The Vermont Department of Health

2012 PA Survey

EDUCATIONAL LOAN REPAYMENT FOR HEALTH CARE PROFESSIONALS is a critical and effective tool for recruiting and retaining primary care (family medicine, general internal medicine, ob-gyn, pediatrics, geriatrics, psychiatry) practitioners (physicians, nurse practitioners, and physician assistants), dentists, nurses, and nurse educators for practice in Vermont. This program has strengthened the Vermont health care delivery system by responding to statewide workforce needs impacting access to care for all Vermonters.

- **The Governor's FY16 budget proposal eliminates funding for the educational loan repayment (ELR) program.**
- The **VT Health Care Workforce Strategic Plan** (in accordance with Act 48, Section 12a) submitted to The General Assembly on January 15, 2013 by the Agency of Administration, states that the loan repayment program "should be expanded to include more resources and the flexibility to target a wider breadth of professionals." (page 29)
- **Because the workforce is foundational to health care access and delivery of care when and where it's needed for all citizens, we are requesting that funding for ELR be restored.**
- Funding ELR at the FY14 level of \$870,000 would cost approximately \$400,000 in state General Funds, with the difference from federal Global Commitment match funds.
- The 2014 ELR program received 447 applications (130 awarded, 317 not awarded); total educational debt of applicants was \$31,782,424. (See attached chart for awards since 2006.)
- Educational costs are increasing, corresponding educational debt is also increasing.
- Awards have prioritize the most pressing health care workforce needs in the state in areas which are underserved with special consideration for Vermont's most underserved and undersupplied areas (see federally designated Health Professional Shortage Areas (HPSAs) at <http://hpsafind.hrsa.gov>).
- Each ELR primary care/dental recipient enters into a contractual service obligation in exchange for an award and are required to accept patients with coverage under Medicare, Medicaid, Vermont's Children's Health Insurance Program (Dr. Dynasaur), or other state-funded health care benefit programs. Medicaid targets and monitoring is done in consultation with DVHA, using data provided by DVHA. Nurses and nursing faculty are required to stay in Vermont if they receive an award.
- Competing nationally: Vermont's primary care and dentist workforce is aging and younger replacements are needed. Nursing faculty shortages across the country are limiting student capacity at a time when the need for professional registered nurses continues to grow. Vermont must continue to be actively and competitively recruiting all these health care professional in order to implement its planned healthcare reform.
- Competing nationally: Other states offer generous loan repayment packages (including New Hampshire--\$75,000 for 3 years, Massachusetts—\$25,000 per year, and New York--\$150,000 over 5 years). Practicing in Vermont is attractive to many people, but the quality of life opportunity does not offset the burden of heavy student loan debt that health care clinicians frequently have.
- Competing nationally: A study published by Pathman et al of the Sheps Center in NC showed 93 educational loan repayment programs nationwide in 2010, an increase from 87 in 2007. "The study shows that states recognize the importance of loan repayment and other incentives and were willing to create more programs even during the early, toughest years of the recent recession when states' budgets were stretched thin." All states except Florida, Hawaii, and Mississippi offered at least one program. Published: *JAMA November 13, 2013, Volume 310, Number 18*
- A new federal "SLRP" grant secured in FY15 to fund 25 loan repayment awards (for primary care and dentist practicing at FQHCs and RHCs) statewide is a supplement to the existing ELR program. SLRP responds to additional unmet need and the need to expand and enhance the existing program; it, alone, is not an adequate replacement.

2014 Snapshot as of March 24, 2014	Allocation	Maximum annual award allowed	# of Apps received	Range of debt of applicants (lowest to highest)	Total debt of all applicants	% of 2014 allocation to total debt of applicants	Average (mean) debt of applicants (1)	# not awarded	# awarded	Average (mean) award in 2014
Primary Care	\$445,000	\$20,000	176	\$15,456-\$578,602	\$18,080,702	2.46%	\$131,976	119	57	\$7,946
Dentists	\$225,000	\$20,000	26	\$13,572-\$414,898	\$4,708,962	4.78%	\$224,236	9	17	\$13,235
Nurses	\$255,000	\$10,000	227	\$1,449-\$145,423	\$7,981,257	3.19%	\$35,315	175	52	\$4,904
Nurse Educators/Faculty	\$45,000	\$20,000	18	\$5,536-\$167,822	\$1,011,503	4.45%	\$56,195	14	4	\$11,250
TOTAL	\$970,000		447	\$1,449-\$578,602	\$31,782,424	3.05%	\$79,061	317	130	

The \$225,000 for Dentists includes additional \$100,000 from HIV/AIDs grant. (1) Removes unknown persons/recruitment applications from this calculation because debt is unknown (\$0) at this time

2013 Snapshot as of February 28, 2013	Allocation	Maximum annual award allowed	# of Apps received	Range of debt of applicants (lowest to highest)	Total debt of all applicants	% of 2013 allocation to total debt of applicants	Average (mean) debt of applicants (1)	# not awarded	# awarded	Average (mean) award in 2013
Primary Care	\$445,000	\$20,000	165	\$3,852-\$465,260	\$16,895,919	2.63%	\$125,155	40	125	\$3,560
Dentists	\$125,000	\$20,000	30	\$15,064-\$413,843	\$5,296,250	2.36%	\$189,152	9	21	\$5,952
Nurses	\$255,000	\$10,000	254	\$2,891-\$167,101	\$8,771,581	2.91%	\$34,554	143	111	\$2,297
Nurse Educators/Faculty	\$45,000	\$20,000	14	\$1,804-\$170,556	\$769,684	5.85%	\$54,977	2	12	\$3,750
TOTAL	\$870,000		463	\$1,804-\$465,260	\$31,733,434	2.74%	\$74,492	194	269	

2012 Snapshot as of August 22, 2012	Allocation	Maximum annual award allowed	# of Apps received	Range of debt of applicants (lowest to highest)	Total debt of all applicants	% of 2012 allocation to total debt of applicants	Average (mean) debt of applicants (1)	# not awarded	# awarded	Average (mean) award in 2012
Primary Care	\$445,000	\$20,000	160	\$4,364-\$381,118	\$14,243,530	3.12%	\$114,867	68	92	\$4,771
Dentists	\$125,000	\$20,000	23	\$50,544-\$398,975	\$3,430,411	3.64%	\$180,548	7	16	\$8,147
Nurses	\$255,000	\$10,000	187	\$2,491-\$208,463	\$6,716,807	3.80%	\$35,919	78	109	\$2,406
Nurse Educators/Faculty	\$45,000	\$20,000	13	\$6,981-\$174,936	\$931,849	4.83%	\$71,681	4	9	\$3,722
TOTAL	\$870,000		383	\$2,491-\$398,975	\$25,322,597	3.44%	\$73,827	157	226	\$3,878

2011 Snapshot as of Dec 1, 2011	Allocation	Maximum annual award allowed	# of Apps received	Range of debt of applicants (lowest to highest)	Total debt of all applicants	% of 2011 allocation to total debt of applicants	Average (mean) debt of applicants	# not awarded	# awarded	Average (mean) award in 2011
Primary Care	\$445,000	\$20,000	169	\$7,496 - \$385,392	\$11,321,344	3.93%	\$94,345	95	74	\$6,098
Dentists	\$125,000	\$20,000	23	\$14,149 - \$377,198	\$3,188,343	3.92%	\$167,808	10	13	\$13,077
Nurses	\$255,000	\$10,000	252	\$2,313 - \$169,319	\$7,893,654	3.23%	\$31,324	129	123	\$2,199
Nurse Educators/Faculty	\$45,000	\$20,000	11	\$9,205 - \$177,998	\$786,794	5.72%	\$71,527	3	8	\$5,975
TOTAL	\$870,000		455	\$2,313-\$385,392	\$23,190,135	3.75%	\$57,119	237	218	\$3,991

2010 Snapshot as of Feb 4, 2010	Allocation	Maximum annual award allowed	# of Apps received	Range of debt of applicants (lowest to highest)	Total debt of all applicants	% of 2010 allocation to total debt of applicants	Average (mean) debt of applicants (1)	# not awarded	# awarded	Average (mean) award in 2010
Primary Care	\$445,000	\$20,000	153	\$3,937 – \$401,882	\$10,884,196	4.09%	\$71,607 (93,829)	53	100	\$4,450
Dentists	\$125,000	\$20,000	22	\$20,632 – \$386,890	\$2,623,619	4.75%	\$119,255 (\$163,976)	7	15	\$8,333
Nurses	\$255,000	\$10,000	213	\$2,047 - \$208,480	\$6,714,457	3.80%	\$31,523	108	105	\$2,429
Nurse Educators/Faculty	\$45,000	\$20,000	23	\$2,100 - \$188,135	\$1,127,744	3.99%	\$49,032	11	12	\$3,750
TOTAL	\$870,000		410	\$2,047 - \$401,882	\$21,350,016	4.08%	\$52,073 (\$58,016)	178	232	\$3,750

In 2010 we received 36 Primary Care recruitment applications, compared to 37 in 2008 and 54 in 2009.

(1) If we remove unknown persons/recruitment applications for this calculation because debt is unknown (\$0) at this time, the average debt for primary care is \$93,829 (based on 116 retention applicants), and the average debt for dentists is \$163,976 (based on 16 retention applicants). TOTAL Average Debt of retention-only applicants is \$58,016 (based on 368 applications). Future reports will ONLY include applications where debt is known (currently the number in parentheses).

2009 Snapshot as of Jan 20, 2009	Allocation	Maximum annual award allowed	# of Apps received	Range of debt of applicants (lowest to highest)	Total debt of all applicants	% of 2009 allocation to total debt of applicants	Average (mean) debt of applicants (1)	# <u>not</u> awarded	# awarded	Average (mean) award in 2009
Primary Care	\$700,000	\$20,000	174	\$1,902 to \$293,104	\$10,025,071	6.98%	\$57,615 (\$83,542)	70	104	\$6,731
Dentists	\$195,000	\$20,000	19	\$20,105 to \$250,957	\$2,434,873	8.01%	\$128,151 (\$162,325)	3	16	\$12,188
Nurses	\$400,000	\$10,000	293	\$1,195 to \$147,474	\$8,207,261	4.87%	\$28,011	180	113	\$3,540
Nurse Educators/Faculty	\$115,000	\$20,000	15	\$3,909 to \$130,685	\$709,460	16.21%	\$47,297	2	13	\$8,846
NEW/TBD Before Aug 08 rescission	(\$50,000) \$25,000	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
TOTAL	(\$1,460,000) \$1,435,000		501	\$1,195 to \$293,104	\$21,376,665	6.60%	\$42,668	255	246	\$5,732

In 2009 we received 54 Primary Care recruitment applications, up from 13 in 2007 and 37 in 2008.

(1)If we remove unknown persons/recruitment applications for this calculation because debt is unknown (\$0) at this time, the average debt for primary care is \$83,542 (based on 120 retention applicants), and the average debt for dentists is \$162,325 (based on 15 retention applicants).

2008 Snapshot as of Mar 24, 2008	Allocation	Maximum annual award allowed	# of Apps received	Range of debt of applicants (lowest to highest)	Total debt of all applicants	% of 2008 allocation to total debt of applicants	Average (mean) debt of applicants (1)	# <u>not</u> awarded	# awarded	Average (mean) award in 2008
Primary Care	\$700,000	\$20,000	130	\$4,888 to \$319,700	\$8,332,622	8.40%	\$64,097	34	96	\$7,292
Dentists	\$195,000	\$20,000	19	\$12,500 to \$276,599	\$2,530,477	7.70%	\$133,183	1	18	\$10,833
Nurses	\$400,000	\$10,000	304	\$2,088 to \$103,150	\$7,164,571	5.58%	\$23,567	177	127	\$3,150
Nurse Educators/Faculty	\$75,000	\$20,000	13	\$5,759 to \$122,556	\$654,068	11.47%	\$50,313	4	9	\$8,333
NEW/TBD	\$50,000									
TOTAL	\$1,420,000		466	\$2,088 to \$319,700	\$18,681,738	7.33%	\$40,090	216	250	\$5,480

In 2008 we received 37 Primary Care recruitment applications, up from 13 in 2007.

(1)If we remove unknown persons/recruitment applications for this calculation because debt is unknown (\$0) at this time, the average debt for primary care is \$89,598 (based on 93 retention applicants), and the average debt for dentists is \$175,191 (based on 13 retention applicants).

2007 Snapshot as of Mar 23, 2007	Allocation	Maximum annual award allowed	# of Apps received	Range of debt of applicants (lowest to highest)	Total debt of all applicants	% of 2007 allocation to total debt of applicants	Average (mean) debt of applicants (1)	# not awarded	# awarded	Average (mean) award in 2007
Primary Care	\$370,000	\$20,000	106	\$7,834 to \$296,080	\$7,559,397	4.89%	\$81,284	34	72	\$5,139
Dentists	\$160,000	\$20,000	17	\$26,236 to \$286,344	\$1,990,195	8.04%	\$153,091	0	17	\$9,412
Nurses	\$300,000	\$10,000	246	\$1,541 to \$119,992	\$5,829,991	5.15%	\$23,699	125	121	\$2,479
Nurse Educators/Faculty	\$50,000	\$20,000	12	\$5,438 to \$130,166	\$620,446	8.06%	\$51,704	3	9	\$5,555
TOTAL	\$880,000		381	\$1,541 to \$296,080	\$16,000,029	5.5%		162	219	\$4,018

(1)If we remove unknown persons/recruitment applications for this calculation because debt is unknown (\$0) at this time, the average debt for primary care is \$81,284 (based on 93 retention applicants), and the debt for dentists is \$153,091 (based on 13 retention applicants).

2006 Snapshot as of Dec 31, 2006	Allocation	Maximum annual award allowed (1)	# of Apps received	Range of debt of applicants (lowest to highest)	Total debt of all applicants	% of 2006 allocation to total debt of applicants	Average (mean) debt of applicants (4)	# not awarded	# awarded	Average (mean) award in 2006
Primary Care (2)	\$250,000	\$20,000	107	\$2,039 to \$271,534	\$7,399,620	3.4%	\$69,155	47	60	\$4,167
Dentists	\$100,000	\$20,000	18	\$27,950 to \$274,441	\$1,879,655	5.3%	\$104,425	3	15	\$6,667
Nurses	\$190,000	\$10,000	197	\$1,948 to \$102,304	\$3,896,329	4.9%	\$19,778	129	68	\$2,794
Nurse Educators/Faculty (3)	\$50,000	\$10,000	10	\$10,117 to \$91,290	\$393,258	12.7%	\$39,325	5	5	\$10,000
TOTAL	\$590,000		332	\$1,948 to \$274,441	\$13,568,862	4.3%	\$40,870	184	148	\$3,986

(1)Per one-year service commitment; (2)Includes disciplines: Family Practice, General Internal Medicine, Pediatrics, Obstetrics/ Gynecology, and Psychiatry; eligible practitioners: primary care physician (MD or DO), Nurse Practitioner, Certified Nurse Midwife, or Physician Assistant. (3)New in FY 06; (4)If we remove unknown persons/recruitment applications for this calculation, the average debt for primary care is \$76,285 (based on 97 retention applicants), and the debt for dentists is \$134,261 (based on 14 retention applicants).

The ELR program has been administered since 1997 by AHEC; 100% of funds are used for awards. Contact Liz Cote at AHEC for details about the educational loan repayment program.

Feb 10.2015

To whom it may concern:

The Governor's Healthcare Workforce Advisory Group, was charged to use the VT Health Care Workforce Strategic Plan (in accordance with Act 48, Section 12a) which was submitted to The General Assembly on January 15, 2013 by the Agency of Administration, to guide its work. The first recommendation of this plan was as follows:

*Recommendation #1: Under the auspices of the Agency of Administration, the Secretary of Administration shall convene and staff from within the Agency a permanent health care workforce working group (Workgroup) to monitor workforce trends, develop strategic objectives and activities, **direct and pursue funding for health care workforce development activities, and advise and report to the Secretary on its efforts.** The Workgroup shall include state government interagency representation as well as representation from health care employers, clinicians, membership organizations, secondary and higher education, and other relevant interest groups*

The Strategic Plan also recommends the following:

*Sub-recommendation #1f: Assess and make recommendations regarding of the resources available to, and number of professions eligible for, **Vermont's Loan Repayment Program.** State resources currently available for loan repayment and loan forgiveness should be analyzed to assure that they are being directed to reducing the maldistribution and to enhancing recruitment and retention of health care professionals.*

Please see the attached document to review the benefits of the Vermont Educational Loan Repayment (ELR) Program for health care professionals. **Based on the vital role this program has in recruiting and retaining health care professionals in Vermont, the Advisory Group's representatives from health care employers, clinicians, membership organizations, secondary and higher education, and other relevant interest groups request that the ELR Program is restored to the FY 2014 funding level in the FY 2015 budget.** Having an adequate number of health care professionals is vital to the health care reform efforts that Vermont has embarked upon. Educational loan repayment is a value tool to ensure that this happens.

Sincerely,

Name	Title/Affiliation	Representing
David Adams, MD	Associate Dean of Graduate Medical Education, Fletcher Allen HealthCare david.adams@vtmednet.org	University of Vermont Medical Center
Molly Backup	Physician Assistant in private practice mollybackup@aol.com	Physician Assistants
Rick Barnett	Doctor of Psychology in private practice; President of Vermont Psychological Association dr.rickbarnett@gmail.com	Private-practicing mental health & substance abuse providers
Ethan Berke, MD	Associate Professor, Dartmouth Institute for Health Policy & Clinical Practice Ethan.M.Berke@dartmouth.edu	Dartmouth Hitchcock Medical Center
David Blanck, DDS	Dentist in private practice drblanck@gmavt.net	Dentists
Denise Clark	Pharmacist & lawyer deniseaclark@aol.com	Pharmacists
Peter Cobb	Executive Director, Vermont Assembly of Home Health Agencies vahha@comcast.net	Visiting nurse & hospice agencies
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Lory Grimes	Director of Physician Practices Northeastern Vermont Regional Hospital l.grimes@nvrh.org	Hospitals
Lorraine Jenne	Director of Human Resources, Howard Center LorraineJ@howardcenter.org	Designated community mental health agencies
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Charlie MacLean	Associate Dean for Primary Care, University of Vermont Medical School charles.maclean@uvm.edu	University of Vermont Medical School

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Mary Val Palumbo	Associate Professor, UVM College of Nursing & Health Sciences mpalumbo@uvm.edu	Nurses
Lori Lee Schoenbeck, ND	Naturopath in private practice llschoenbeck@comcast.net	Complementary & alternative medicine providers
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Burton Wilcke, Jr.	Associate Professor, UVM Dept. of Medical Laboratory & Radiation Sciences bwilcke@uvm.edu	Allied Health

Vermont's Integrated Communities Care Management Learning Collaborative

**Work Force Work Group Meeting
February 18, 2015**

Background

- The VHCIP Care Models and Care Management Work Group identified two key priorities:
 - ...to better serve all Vermonters (especially those with complex physical and/or mental health needs), **reduce fragmentation with better coordination of care management activities...**
 - ...[to] better **integrate social services and health care services** in order to more effectively understand and address **social determinants of health** (e.g., lack of housing, food insecurity, loss of income, trauma) for at-risk Vermonters...
- The Work Group designated a Planning Group to design a Quality Improvement Learning Collaborative to act on these priorities.
- The Core Team approved funding for the Learning Collaborative.

Learning Collaborative Snapshot

- Vermont's delivery system reforms have strengthened coordination of care and services, but people with complex care needs sometimes still experience fragmentation, duplication, and gaps in care and services.
- A number of national models have potential to address these concerns.
- **Health and community service providers were invited to participate in the year-long Integrated Communities Care Management Learning Collaborative to test interventions from these promising models on behalf of at-risk people in 3 communities: Burlington, Rutland and St. Johnsbury.**

Who: Potential Team Members

People in need of care management services and their families

Primary Care Practices participating in ACOs (including care coordinators)

Designated Mental Health Agencies and Developmental Services Providers

Visiting Nurse Associations and Home Health Agencies

Hospitals and Skilled Nursing Facilities (including their case managers)

Area Agencies on Aging

Community Health Teams and Practice Facilitators (Vermont Blueprint for Health)

Support and Services at Home (including SASH coordinators and wellness nurses)

ACOs (OneCare, CHAC, ACCGM/VCP)

Medicaid: Vermont Chronic Care Initiative (including case managers)

Commercial Insurers (BCBSVT, MVP, Cigna)

Agency of Human Services

What: Near-Term Goals

■ Near-term goals are to:

- Learn about and implement promising interventions to better integrate care management;
- Increase knowledge of data sources; use data to identify at-risk people and understand their needs;
- Improve communication between organizations;
- Reduce fragmentation, duplication, and gaps in care;
- Establish care management protocols to systematize referrals, transitions and co-management
- Provide tools and training for staff members who engage in care management; and
- Determine if interventions improve coordination of care.

What: Longer-Term Goals

- Longer-term goals mirror the Triple Aim and Vermont's Health Care Reform goals:
 - Improving the patient experience of care (including quality and satisfaction);
 - Improving the health of populations; and
 - Reducing the per capita cost of health care.
- While the Collaborative will initially focus on at-risk populations, the ultimate goal is to develop a population-wide approach.

How: Community Commitment

1. Form Integrated Community Teams to improve care management for at-risk people.
2. Identify current care management services and needs in the community (including gaps in services).
3. Agree on criteria to define at-risk people; identify people in need of integrated care management; conduct outreach to those people and their families.
4. Establish more effective communication and integration between team members, on behalf of people in need of care management services, using interventions such as shared care plans, care conferences, and care management rounds.
5. Develop tools to enhance integrated care services, such as care coordination protocols, referral guidelines, and data resources.
6. Participate in shared learning opportunities, including in-person learning sessions, webinars, and skills training for front-line care managers.
7. Develop performance measures to evaluate success of the interventions; collect, analyze and report data for those measures.

How we will do it – Learning Model:

Pre-Work
(November 22nd - January 12th)

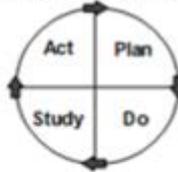
The Learning Collaborative will use the Plan-Do-Study-Act (PDSA) quality improvement model.

Learning Session I
(Teams gather for a face-to-face meeting)
(January 13th)

Action Period
community teams working together to implement change)

(January 14th - March 9th)

Learning Session II
(Teams gather for a face-to-face meeting)
(March 10th)

Action Period
community teams working together to implement change)

(March 11th - May 18th)

Learning Session III
(Teams gather for a face-to-face meeting)
(May 19th)

Spreading the Change

When: Proposed Timeline

- **Kick-Off Webinars were held on November 12 and 21:** Approximately 70 people attended
- **1st All-Day In-Person Learning Session was held on Jan. 13, 2015:** Approximately 90 people attended
- **Monthly Educational Webinars:** 1 hour (during months without in-person learning sessions)
- **First Action/Measurement Period:** Jan.-Feb. 2015
- **2nd In-Person Learning Session:** March 10, 2015; full-day
- **Second Action/Measurement Period:** March-April 2015
- **3rd In-Person Learning Session:** May 19, 2015; full-day
- **Third Action/Measurement Period:** May-June 2015
- **Core Competency Training for Care Managers;**
Continued Testing and Measurement: July-Nov. 2015
- **Final Results and Next Steps:** Dec. 2015

Jan. 13th Learning Session Agenda

Time	Topic
8:30-9:00	Registration
9:00-9:15	Welcome and Opening Remarks
9:15-10:00	Care Coordination: Benefits to the Family, the Practice and the Provider (<i>Hagan, Rinehart and Connolly Pediatricians</i>)
10:00-10:15	Break
10:15-11:45	Improving Care & Reducing Costs with Hotspotting & Community-Based Care Management (<i>Camden Coalition</i>)
11:45-12:30	Community Breakout Session 1
12:30-1:15	Lunch
1:15-2:15	Improving Care & Reducing Costs with Hotspotting & Community-Based Care Management (<i>Camden Coalition</i>)
2:15-2:30	Break
2:30-3:15	Community Breakout Session 2
3:15-4:00	Community Report Out and Closing Remarks

Next Steps for Learning Collaborative

- PDSA training and continued work within pilot communities
- Preliminary identification of at-risk people who could benefit from care management from multiple organizations
- Development of information sharing agreements and care coordination protocols among participating organizations
- February webinar with team reports and discussion of measures
- March in-person learning session

Workforce Related Takeaways

- As the health care system, clinicians and patients evolve, we need to continue to integrate new resources into the management of wellness, illness, and complicated aging.
- More services are available to meet health care and social services needs, but they often remain fragmented.
- Team based care and more formalized collaboration and communication mechanisms are key to reducing fragmentation through better coordination of care management activities.

Work Force Related Takeaways (cont'd)

- Current literature has identified tools that can assist in collaboration, including:
 - Use of data to identify people needing care management services;
 - Shared plans of care;
 - Identification of a lead care coordinator;
 - Transitions in Care including handoffs, timing, and communication;
 - Care conferences; and
 - Care management rounds and other communication strategies.
- The learning collaborative will test these interventions, and will build knowledge and experience that can be applied to other communities.

Work Force Related Takeaways (cont'd)

- Additionally, the learning collaborative will seek to offer skills-based training such as:
 - Person directed care;
 - Motivational interviewing;
 - Addressing social determinants of health;
 - Cultural/disability competency; and
 - Effective team based care.
- These skills and tools will assist the work force in better coordinating and collaborating across the system of care.