VT Health Care Innovation Project
Health Care Workforce Work Group Meeting Agenda
Wednesday, October 5, 2016; 3:00-5:00pm
Vermont State Colleges, Conference Room 101, Montpelier
Call-in Number: 1-877-273-4202; Conference ID: 420-323-867

Item #	Time Frame	Topic	Presenter	Decision Needed? (Y/N)	Relevant Attachments
1	3:00-3:05	Welcome and Introductions	Robin Lunge Mary Val Palumbo	N	• Attachment 1: 10-5-16 Meeting Agenda
2	3:05-3:10	Approval of Meeting Minutes	Robin Lunge Mary Val Palumbo	Y	• Attachment 2: 8-3-16 Meeting Minutes
3	3:10-3:20	Updates: - Demand Modeling - VHCIP Sustainability Plan - Others?	Robin Lunge Mary Val Palumbo Group Discussion		
4	3:20 – 4:30	Discussion: Work Force Supply Data –Mental Health Professions Deep Dive	Rick Barnett Julie Tessler, VCP Peggy Brozicevic	N	• Attachment 4a – MH/SA provider discussion sub-agenda • Attachment 4b – MH SA provider overview • Attachment 4c – DA system presentation • Attachment 4d – VDH supply data
4	4:30-4:55	Presentation: Population Health Plan	Heidi Klein, VDH	N	• Attachment 5: Population Health Plan Presentation • Full Population Health Plan available at: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Vermont

					%20Population%20Health%20Plan%20-%20September%202016.pdf
6	4:55-5:00	Public Comment/Wrap Up/Next Steps	Robin Lunge Mary Val Palumbo	N	

Attachment 2 - 8-03-16 WF Meeting Minutes

Vermont Health Care Innovation Project
Workforce Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, August 3, 2016, 3:00-5:00pm, 4th Floor Conference Room, Pavilion Building, 109 State St., Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Mary Val Palumbo called the meeting to order at 3:02pm. A roll call attendance was taken and a quorum was present. New members: • Robert Davis replaces Lorilee Schoenbeck. • Jessa Barnard replaces Madeleine Mongan.	
2. Approval of April 2016 Meeting Minutes	Molly Backup made a correction to the June minutes: • On Page 4 – Many early PAs were former medics or RNs (not APRNs). David Adams moved to approve the June 2016 meeting minutes by exception. Mat Barewicz seconded. The minutes were approved with four abstentions (Monica Light, Stephanie Pagliuca, Mary Val Palumbo, Jay Ramsay).	
3. Membership/Co-Chair Renewals	Mary Val Palumbo reminded the group that Robin Lunge will not continue on as co-chair. Interested members should reach out to Mary Val, Georgia Maheras (georgia.maheras@vermont.gov), or Amy Coonradt (amy.coonradt@vermont.gov). • Mat Barewicz asked whether the group required two chairs. Georgia Maheras clarified that the Executive Order under which the group was formed requires two co-chairs. Molly Backup commented that she sees benefit to having a State official serve as co-chair to provide State policy guidance. Mat Barewicz concurred. • Mary Val noted that Amy Coonradt's support between meetings has been invaluable and reduces burden on the co-chairs and encouraged members to volunteer.	
4. Updates	Georgia Maheras provided two updates: *Micro-Simulation Demand Modeling Update*: IHS Global is the contractor hired to do the micro-simulation demand model; they have developed similar models for HRSA and other states.	

Agenda Item	Discussion	Next Steps
	Vermont stakeholders have been working with IHS Global to build a microsimulation demand model for projecting demand in an "ideal" health care environment for the state's health care workforce. A kick-off meeting was held in May, with check-in meetings occurring every month. To date, IHS has completed population projections through 2025, which it will use to project demand for various healthcare professions through that time (or 2030, if we choose). IHS has also begun running preliminary demand projections for both RN and MD professions in Vermont, by different subspecialties and HSAs, and will be refining these projections and completing projections for APRNs and PAs, and several behavior health professions in the next month. Projections will be shared with this group at the October meeting, as well as via email, and will review projections at the November meeting. These are opportunities to provide feedback where data and projections look incorrect; we'll also likely discover new information. Mat Barewicz added that this group will add unique information related to their profession or region. • Molly Backup asked whether dental care and home health will be included. Georgia replied that both will. • Mary Val Palumbo asked whether this will incorporate information from provider training programs, or whether this is considered supply data. Georgia will check with IHS. • Paul Bengtson asked who works with IHS. The team is Georgia, Amy Coonradt, Mat Barewicz, Peggy Brozicevic, and Charlie MacLean. If others are interested in joining this group, please contact Georgia. • Paul Bengtson asked what modeling means. Mat Barewicz clarified that IHS has a national model that they are customizing for Vermont that incorporates various data sources. Paul commented that innovation means we're trying new things – how are leading indicators developed? Georgia provided an example from New York, where IHS has also worked – IHS will be harnessing data from work in other states to inform Vermont's modeling. Mat added that the RFP calls for a best case scenario for utilization, which allows us to talk about changes to care delivery and profession mix. He noted that if we add clinicians of one type, we may need fewer of other provider types. • IHS will look at both medical services and related services which impact social determinants of health. Georgia also noted that IHS has not yet incorporated claims data, but will do so soon (data through VHCURES). Paul Bengtson asked whether the model will include data such as nutrition/food access, transportation, or housing. • Mary Val commented that this is exciting, and she looks forward to reviewing drafts. • Georgia commented that we will send out additional materials to the group. Molly Backup requested this be sent in chunks and multiple documents so it is less overwhelming; start with most recent information. Georgia added that she will bring the group's questions back to IHS so we can discuss them in the future. *SIM Update – CMMI Approval for Year 3*: We received CMMI approval for our final SIM performance year, Performance Period 3, which began on July 1, 2016. This means that our Operational Plan and timeline are in effect as planned; this document is available on the project website. • Georgia also noted that the website (www.healthcareinnovation.vermont.gov) has relaunched and is much easier to navigate than in the past; we'll be posting information from the Demand Modeling project as well as other projects there.	

Agenda Item	Discussion	Next Steps
	• Staff: Jess Moore replaces Matt Bradstreet at VDH, and will be working on workforce supply data collection and analysis. Kate O'Neill replaces Annie Paumgarten at GMCB, and will be working on program evaluation. Julie Corwin replaces Mandy Ciecior at DVHA, and will be working on Medicaid Pathway and other projects.	
5. Follow-Up Discussion: 2014 Physician Assistant Supply Data	Mary Val Palumbo introduced this item, which is continued from our last meeting. • Molly Backup described reviewing the PA data to consider why some areas have more or fewer PAs. Some underserved areas have very low PA rates. Molly suggested that the State or other organizations could work with practices in underserved areas that did not have PAs. • Mary Val added that loan repayment is a resource, but the loan repayment selection committee needs help knowing where to target funds. Charlie MacLean noted that parameters of loan repayment and factors for consideration are set in statute. This includes regional distribution. He noted that one idea might be for this work group, after a review of supply issues across professions, to develop a rubric the support the Legislature prioritizing where we spend scarce loan repayment funds. This could be a large project, though. Stephanie Pagliuca asked whether this includes possibly supporting new professions. Charlie replied that the group could provide medium-term guidance to provide a 3 to 5-year focus; data would be necessary to back up recommendations. Mary Val commented that the demand model could support this. • Mat Barewicz asked about the patient-per-FTE column, which shows Barre as an outlier. Molly noted that this data does not include all practices and shouldn't be considered complete: this data covers the 128 primary care practices that participate in the Blueprint for Health. She noted that anecdotally, the North and East areas of the State have few PAs; these areas have also been less willing to accept PA students on rotations, which may mean they are less likely to hire PAs. The Franklin Pierce program that serves VT and NH has requested this group provide support or incentive to practices that have not previously participated to participate and possibly open up future PA positions. Paul Bengtson commented that he believes this issue is more complex, and is skeptical of the numbers presented regarding primary care FTEs in the Northeast Kingdom. • Miki Hazard from the Blueprint for Health provided some additional insight on the data presented: there are 140-150 total primary care practices in the state at any time, so this data is fairly complete but doesn't capture every practice. Number of patients represents Blueprint-attributed individuals based on primary care utilization over two years. Regional Blueprint staff enter practice demographic information, including provider numbers and FTEs. The Blueprint collects vacancy data on community health teams and medication-assisted treatment staff, but not primary care practice staff. Stephanie Pagliuca asked whether this information would be included in the Demand Model. Georgia replied that it would. • Paul Bengtson noted that in the Northeast Kingdom, many people are not attributed to a primary care practice at all. He added that adding a PA to a practice does not necessarily allow the practice or physician to make more money; he has worked with surgical practices to add PAs, which can be a positive business decision. He noted that NVRH has pushed MDs, DOs, and NPs because they require less supervision than PAs. Molly clarified that PAs now require less supervision than previously under State law, and work in the same role as an NP. She noted that she has a full panel of patients, prescribes independently, and mentors new NPs and PAs. She believes that many PAs want to work in primary care and can fulfill primary care needs. PAs still need	

Agenda Item	Discussion	Next Steps
	to work collaboratively with physicians, but experienced PAs do not require on-site supervision. In the first year of practice, PAs and NPs both require supervision and training; after a year, PAs and NPs are likely to bring in additional practice revenue. She believes the initial training period is a barrier for many practices and would like to facilitate that period. Paul will take that message back to his community. Molly offered to come to the community and speak with providers to describe what she does. Stephanie Pagliuca added that this discussion is borne out in data from practices that have introduced PAs. She encourages practices to consider both NPs and PAs to find an individual who is a good fit for their practice, but that practices who have worked with NPs in the past are most comfortable continuing to work with NPs, and vice versa, and she works with practices to encourage them to consider both. Molly added that some practices may not think they want to hire NPs or PAs, but that in fact may be a good solution for them. She hopes that increasing awareness could support an increase in openings for PAs and NPs. Stephanie noted that it takes a long time to recruit primary care physicians. • Molly commented that she believes NPs and PAs both work best in a team with physicians who can be available for consultation, but that by utilizing NPs and PAs, we can expand the number of patients receiving high-quality primary care. Mary Val commented that the ratio question is interesting; she has seen a ratio of 4 doctors to one advanced practice provider, but commented that this ratio could be out of date. Charlie MacLean noted that the UVM Office of Primary Care has been developing an annual report on primary care workforce for years. Currently, we have approximately 500 FTE MDs/DOs providers in the State, and about 200 FTE NPs/PAs; this equals panel sizes of about 1,000/provider. It includes all practices (not just Blueprint data) but does not drill down by region; Charlie noted that panel sizes and rations vary significantly by region. • Feel free to call or email Molly with any questions or additional comments. Mary Val thanked Miki and the Blueprint for providing data. Mary Val commented that the group is ready for a deep dive into another profession. • Paul Bengtson requested we look at the mental health sector, including a variety of professions. He hears frequently that there isn't adequate access to psychiatry services or basic mental health services, and that there is high turnover in this sector. Stephanie Pagliuca commented that she is hearing similar things. • Peggy Brozicevic commented that she has recent supply data on psychiatrists and some other mental health professions. Mary Val suggested a presentation on psychiatrists and any other current mental health professions would be helpful. We will form a smaller group of interested parties for further study. David Adams commented that there are many other professions providing mental health services. • Georgia Maheras commented that VCN is currently working on their annual vacancy report, which is expected to be completed in September. Molly Backup suggested that this conversation would be most helpful if Rick Barnett and others did some significant thinking about the data Peggy supplies to provide some interpretation to the group; without this, the data is not as meaningful to the group. Stephanie suggested that it would be helpful to pull someone from additional mental health professions depending on what data Peggy provides.	

Agenda Item	Discussion	Next Steps
6. Discussion: Strategic Plan	*Recommendations #7-#17: Improving, Expanding, and Populating the Educational Pipeline:* Previously discussed #7-11. • Jay Ramsay distributed a handout on the Vermont's New Skills for Youth Initiative (NSYI). Previously, Nicole LaPointe mentioned this grant, and a priority programs of study initiative. • Two phases: o Phase 1 is six months, $100,000 to support planning. In Vermont, working to move closer to goal by implementing career readiness plans through strategies such as a Career Readiness Council. o Statewide program of study: Includes Health science/allied health programs. Reevaluating offerings in technical centers so that there are similar offerings and assessments across the State; in addition, allowing groups like this to help guide this work to develop future workforce. o Plan will feed application for Phase 2 of this grant, which would be for three years. Will be presenting grant plan in Washington, DC, in October. • Jay requested support and advice from this group and others to inform the vision for a modernized health education system so that this process is driven by the needs of the health care system, rather than by the education system. • Molly Backup suggested that the Demand Model data could support the grant. Jay clarified that there is another process around the priority programs of study efforts, and that the process is already including health careers broadly; but that this data could support future efforts. • Jay clarified that a broad range of professions and areas are included within the human services sector. The current focus on health services reflects limited funding available. He also clarified that there are other programs which focus on other sectors and job types. Molly Backup asked whether funds go to support LPNs or RNs. Jay clarified that some programs do. *Recommendation #17: State programs, such as those within the Agency of Education, Department of Labor, Refugee Resettlement Program and others should work with state colleges and Regional AHEC Programs to increase representation of disadvantaged and under-represented populations in health.* • Nicole LaPointe noted that AHEC is working on an LNA course for English language learners. She believes this would be an attractive project for funders. Jay will connect with Nicole after this; he believes the Burlington technical center could be a good place to pilot this. Mary Val noted that this may already be funded; Robin Lane in Essex has had a lot of interest in LNA training for New Americans, and found some funding for New Americans to attend LNA courses with a tutor. Nicole commented that some students in her area could benefit from this; language creates an artificial barrier for some. Mary Val will connect Nicole with Robin. Mary Val also noted a recent CCV course for New Americans to become community health workers with thirteen graduates; three are now embedded at the VNA in a program that is about to launch. CCV is looking to run an additional course with grant funding. • Nicole also recommends continuing ELL development at the post-secondary level to support ELL students in engaging in different types of careers. Nicole and Jay will connect on this topic after the meeting.	

Agenda Item	Discussion	Next Steps
	• David Adams noted that UVMMC is working on a project called Inclusive Excellence with its human resources department in departments as well as within the medical school. • Nancy Shaw noted that VTC has an interim president, as does Lyndon State. *Recommendation #12: Vermont higher education institutions should evaluate the potential to expand enrollment in health profession education, training and residency programs.* • Molly Backup noted that the PA program that was being considered in Rutland is not happening. • Ellen Grimes commented that the Dental Therapy bill did pass this year, and VTC is looking for funding mechanisms to begin the implementation of that program at the Williston campus. Mary Val asked how this will be captured in the relicensure survey since there are none at this time. They will be licensed; the Board of Dental Examiners is beginning to consider rules for licensure. There are not expected to be dental therapists for at least two years unless some come in from Minnesota, the only state where they are currently licensed. Educational requirements for this is dental hygienist training, plus an additional 12 months of education; it will be a baccalaureate degree. VDH will do a survey that is slightly different than for dental hygienists. Mary Val clarified that dental assistants receive a technical degree or on-the-job training. Some dental assistants (2-4 of 24 total in the VTC class) go on to become dental hygienists. The Workforce Strategic Plan does not need to go back to GMCB annually; Robin provides periodic updates to the Board. Georgia suggested updating GMCB in November/December and will loop back with Robin on this.	
7. Public Comment, Wrap-Up, Next Steps, Future Agenda Topics	There was no public comment. **Next Meeting:** October 5, 2016, 3:00-5:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Health Care Workforce Work Group Member List

David Adams 1°
Mat B 2°

3-Aug-16

Member		Member Alternate				
First Name	Last Name	First Name	Last Name	April Minutes	June Minutes	Organization
David	Adams ✓					UVM Medical Center
Molly	Backup ✓	Margery	Bower			Physician Assistants
Mat	Barewicz ✓					Department of Labor
Rick	Barnett					Private-practice mental health & substance abuse providers
Colin	Benjamin					Office of Professional Regulation
Ethan	Berke					Dartmouth Hitchcock Medical Center
Peggy	Brozicevic ✓					Department of Health
Wade	Carson					Allied Health--Radiology
Denise	Clark					Pharmacists
Robert	Davis					UVM Integrative Medicine
Ellen	Grimes ✓					Dental hygienists
Lindsay	Herbert ✓					Dentists
Janet	Kahn	Cara	Feldman-Hunt			Integrative Medicine
Nicole	LaPoint ✓					Northeastern Vermont Area Health Education Center
Monica	Light ✓	Stuart	Schurr		A	Department of Disabilities, Aging and Independent Living
Robin	Lunge					Agency of Administration
Charlie	MacLean ✓	Elizabeth	Cote			University of Vermont Medical School
Stephanie	Pagliuca ✓				A	Federally-qualified health centers
Mary Val	Palumbo ✓	Jason	Garbarino ✓		A	Nurses

Jay	Ramsey ✓				A	Agency of Education
Roland	Ransom					Designated Agencies
Nancy	Shaw ✓					Vermont State Colleges
Beth	Tanzman	Miki	Hagood ✓			Vermont Blueprint for Health
Deborah	Wachtel					Nurse Practitioners
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Jessa Barnard ✓ — Vermont Medical Society

IH Q ✓

VHCIP Workforce Work Group Participant List

Attendance: 8/3/2016

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	VHCIP Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	Workforce
David	Adams	here	UVM Medical Center	M
Susan	Aranoff		AHS - DAIL	S
Molly	Backup	here	Consumer Representative	M
Ena	Backus		GMCB	X
Mat	Barewicz	here	Department of Labor	M
Rick	Barnett		Vermont Psychological Association	M
Susan	Barrett		GMCB	X
Paul	Bengston	here	Northeastern Vermont Regional Hospital	X
Colin	Benjamin		Director, Office of Professional Regulation	M
Ethan	Berke		Dartmouth Institute for Health Policy & Clinical Practice	M
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X
David	Blanck		Consumer Representative	M
Peggy	Brozicevic	phone	AHS - VDH	M
Wade	Carson		Asst Professor, UVM Dept of Med. Lab & Radiation Svcs	M
~~Amanda~~	~~Ciecior~~		AHS - DVHA	S
Denise	Clark		Consumer Representative	M
~~Peter~~	~~Cobb~~		VNAs of Vermont	M

Amy	Coonradt		AHS - DVHA	S
Elizabeth	Cote		Area Health Education Centers Program	X
Karen	Crowley		AHS - Central Office - IFS	X
Kathy	Demars		Lamoille Home Health and Hospice	X
Tim	Donovan		Vermont State Colleges	M
Terri	Edgerton		AHS - Central Office - IFS	X
~~Gabe~~	~~Epstein~~		AHS - DAIL	S
Erin	Flynn		AHS - DVHA	S
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Ellen	Grimes	here	Vermont Technical College	M
Lory	Grimes		Northeastern Vermont Regional Hospital	M
Karen	Hein		UVM	X
Lindsay	Herbert	here	Dentist	M
Deanna	Howard		Dartmouth	X
Joelle	Judge	here	UMASS	S
Janet	Kahn		UVM - Integrated Medicine	M
Sarah	Kinsler	here	AHS - DVHA	S
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Nicole	LaPointe	phone	Northeastern Vermont Area Health Education Center	M
Monica	Light	here	AHS - DAIL	M
Robin	Lunge		AOA	IC
Charlie	MacLean	phone	University of Vermont	M
Carole	Magoffin	phone	AHS - DVHA	S
Georgia	Maheras	here	AOA	S
~~Jackie~~	~~Majoros~~		VLA/LTC Ombudsman Project	X
Mike	Maslack		Consultant	X
John	Matulis		Consumer Representative	X
Angel	Means		Visiting Nurse Association of Chittenden and Grand Isle Counties	X
~~Marisa~~	~~Melamed~~		AOA	S
Sarah	Merrill		DNH	X
~~Madeleine~~	~~Mongan~~		Vermont Medical Society	M
Meg	O'Donnell		UVM Medical Center	A
Stephanie	Pagliuca	here	Bi-State Primary Care	M

Mary Val	Palumbo	here	University of Vermont	C
~~Annie~~	~~Paumgarten~~		GMCB	S
~~Dawn~~	~~Philibert~~		AHS - VDH	S/M
Luann	Poirer		AHS - DVHA	S
Jerry	Ramsey	here	Agency of Education	M
Roland	Ransom		DA - HowardCenter for Mental Health	M
Lori Lee	Schoenbeck		Consumer Representative	M
Julia	Shaw		VLA/Health Care Advocate Project	X
Nancy	Shaw	here	Vermont State Colleges	M
Nancy	Solis		Dartmouth Institute for Health Policy & Clinical Practice	A
Joy	Sylvester		Northwestern Medical Center	X
Beth	Tanzman		AHS - DVHA - Blueprint	M
Tony	Treanor		DA - Northwest Counseling and Support Services	X
Deborah	Wachtel		Consumer Representative	M
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Kendall	West		Bi-State Primary Care/CHAC	X
James	Westrich		AHS - DVHA	S
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Jess Moore - ~~VDH~~

~~Becca Barnett~~

~~Beth Orb~~

Jessa Barnard - VMS

Kate O'Neill - GMCB

Attachment 4a – MH SA Discussion Sub-Agenda

VT Health Care Innovation Project
Health Care Workforce Work Group Mental Health Deep Dive Sub-Agenda
Wednesday, October 5, 2016; 3:20-4:30pm

Item #	Time Frame	Topic	Presenter
4.1	3:20-3:35	Mental health/substance abuse provider supply data overview; high-level presentation on MH/SA professions	Peggy Brozicevic, Rick Barnett
4.2	3:35-3:50	Overview of Designated Agency supply/vacancy data	Julie Tessler
4.3	3:50-4:25	Discussion: how can we utilize this data to help increase access and quality for MH SA providers in Vermont?	Rick Barnett, Peggy Brozicevic, Julie Tessler Group Discussion
4.4	4:25-4:30	Wrap up/next steps	

Attachment 4b - MH SA provider overview

VHCIP and Governor's Workforce Workgroup

Mental Health Workforce Overview

Rick Barnett, Psy.D., M.S., LADC

Mental Health and Substance Abuse
WHO – WHAT - WHERE

- Who provides mental health and substance abuse (MH/SA) healthcare service?
  - Most providers provide some form of MH/SA work.
- What are MH/SA services?
  - Medications (psych/MAT), Psychotherapy, Case Management, Self-Management, Emergency, Screening, Motivational Interviewing, Consults/Evals
- Where does MH/SA treatment take place?
  - Everywhere: Inpat/Outpat, FQHC, PCMH, Independent, Designated Agencies, ED, LTC, etc..

Workforce Issues and Questions

- Psychiatry
  - National
    - July 2016 Health Affairs article: 2003-2013 Decline
  - Local (VT Dept. of Health)
    - 179 VT Psychiatrists in 2014 and 40% were age 60+. Represents 116.6 FTEs, and 38% of the FTEs are 60+.
    - % Medicare Providers? %Independent Practice?
    - Projected decline despite demand – filled by Primary Care
- Non-MD Providers
    - PhD/PsyD, MA, LICSW, LMFT, LCMHC, APRN, RN, LADC
    - Expected 20% growth through 2024.
  - Unlicensed Providers
    - Rostered, Bachelor's, Associates, HS Dipl, Peer Recovery

Brainstorming Areas to Improve Access & Quality and Reduce Cost

- Integrated and Collaborative Care
  - Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost (JAMA Aug. 2016)
- Core Competency Training Models to re-engineer current workforce
- Telehealth, Prescriptive Authority (Scope of Practice – APRN's, PA's, ND's, PhD Psych)
- Education Pipeline (SNHU) and Continue Ed Reqs
- Financial Incentives
- Improved Connection between provider types
  - Role Understanding and Effective Communication

Attachment 4c - Designated Agency Presentation

Designated Agency Overview

Vermont Care Partners

Designated and Special Services Agencies – Finance Directors

October 5, 216

What Do We Do?

* ***Designated Agencies (DA's) have a statutory responsibility to meet all of the developmental and mental health services needs of their region within limits of available resource***

* ***Specialized Service Agencies (SSA's) provide a distinct approach to services or meet distinct service needs***

* ***Many Designated Agencies are also preferred providers of substance use disorder services***

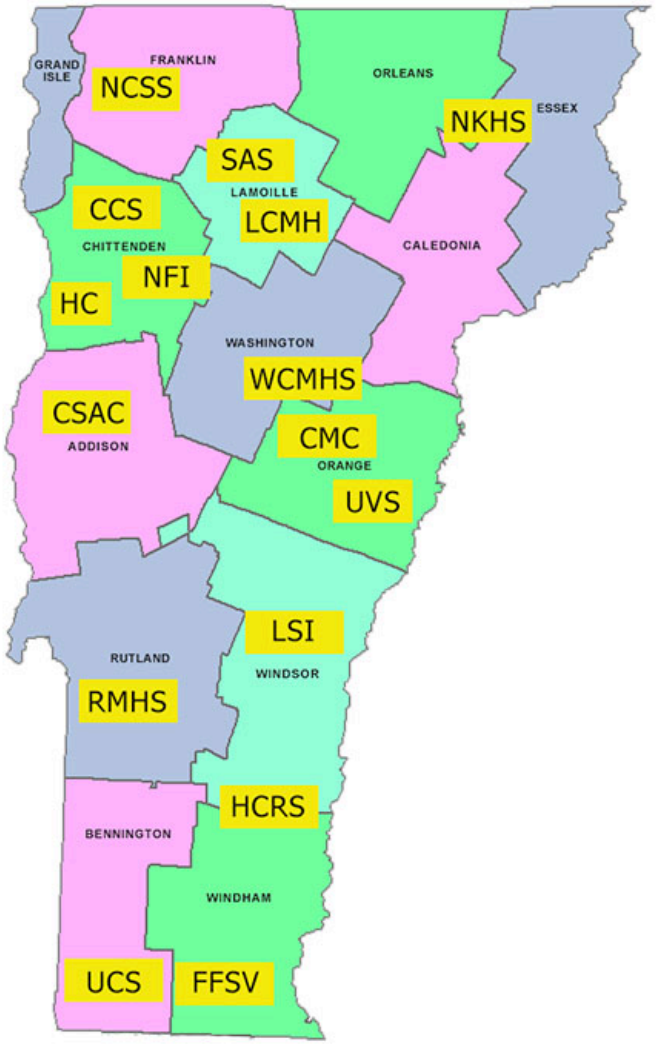
A STATEWIDE SYSTEM OF CARE IN VERMONT
DESIGNATED AND SPECIALIZED SERVICE AGENCIES

Designated Agencies

Clara Martin Center (MH only)
Counseling Services of Addison County
Health Care and Rehabilitation Services of Southeastern Vermont
Howard Center
Lamoille Community Mental Health Services
Northwest Counseling and Support Services
Northeast Kingdom Human Services
Rutland Mental Health Services
United Counseling Service
Upper Valley Services (DS only)
Washington County Mental Heath Services

Specialized Service Agencies

Champlain Community Services (DS only)
Families First (DS only)
Lincoln Street Inc. (DS only)
Northeast Family Institute (MH youth only)
Sterling Area Services (DS only)



A STATEWIDE SYSTEM OF CARE IN VERMONT DESIGNATED AND SPECIALIZED SERVICE AGENCIES

- ***This service system was created by a statute and is required to address the needs of its mandated populations. If the system fails it will have a profound impact on the safety net that was created to support vulnerable Vermonters and place additional demands on public safety services.***

- ***The needs and costs to support vulnerable Vermonters will not go away, they will show up in more costly interventions such as crisis services, criminal justice interventions and higher costs to schools.***

Community Programs

Program	Description
Adult Outpatient (AOP)	Provides services for adults who do not have prolonged serious disabilities but who are experiencing emotional, behavioral, or adjustment problems severe enough to warrant professional attention
Community Rehabilitation and Treatment (CRT)*	Provides services for adults with severe and persistent mental illness
Developmental Disabilities Services *	DDS provides comprehensive supports for children and adults who meet Vermont's definition of developmental disability and a funding priority as identified in the State System of Care Plan. Services may include home supports, respite, employment and community supports, clinical services, transportation, and/or family support. Service coordination ties all services and support needed by an individual
Children and Families (C&F)*	Provide services to children and families who are undergoing emotional or psychological distress or are having problems adjusting to changing life situations.
Emergency Services	Serves individuals who are experiencing an acute mental health crisis. These services are provided on a 24-hour a day, 7-day-per-week basis with both telephone and face-to-face services available as needed.
Advocacy and Peer Services	Broad array of support services provided by trained peers (a person who has experienced a mental health condition or psychiatric disability) or peer-managed organizations focused on helping individuals with mental health and other co-occurring conditions to support recovery

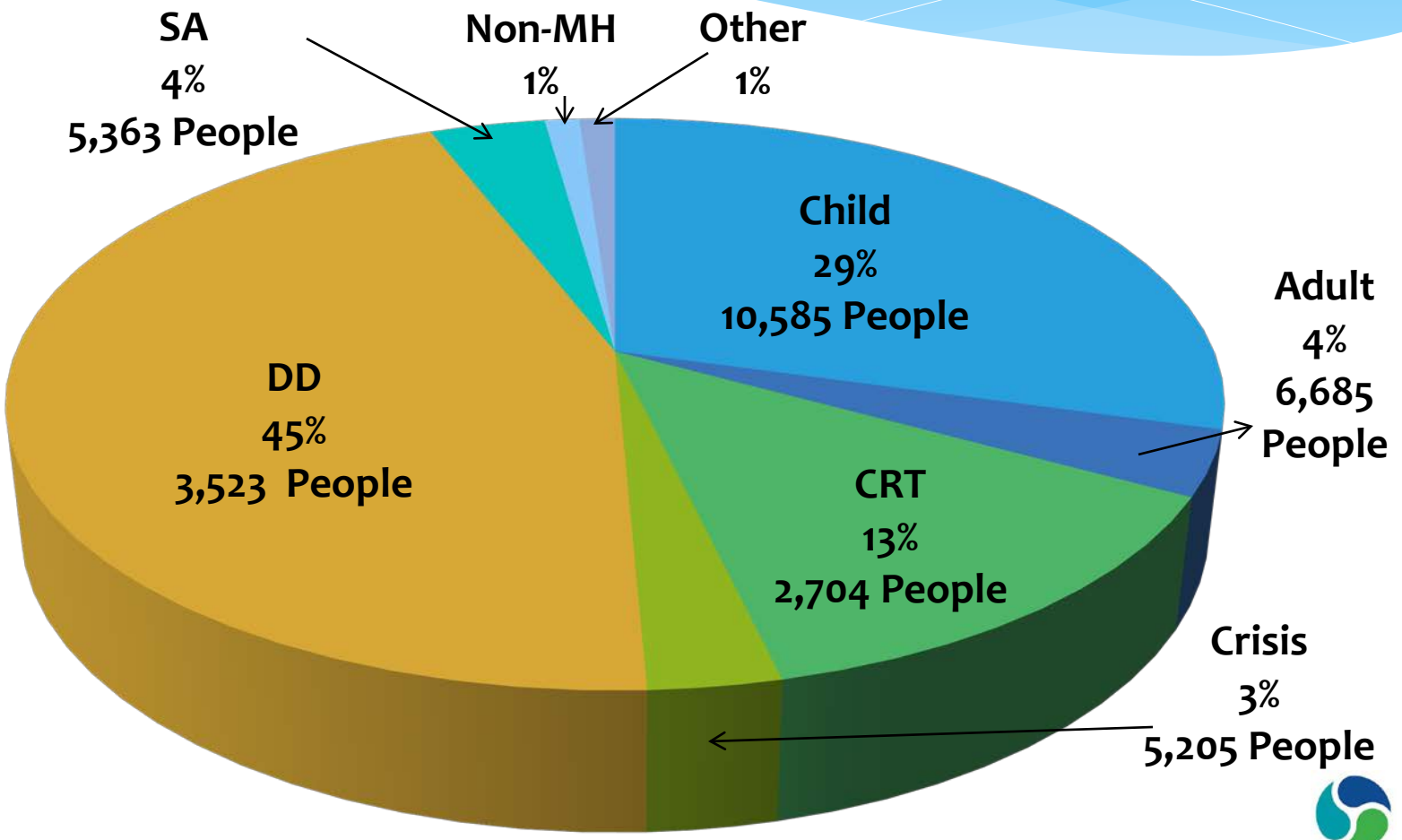
*mandated service population

A STATEWIDE SYSTEM OF CARE IN VERMONT DESIGNATED AND SPECIALIZED SERVICE AGENCIES

* **Cost Comparisons:**
  - ***Cost of hospitalization (RRMC, FAHC, BR) $530,710/yr***
    - ***Level 1 Daily Rates: RRMC : $1,484, BR: $1,424, Average: $1,454***
  - ***Cost of hospitalization (VPCH) $831,105/yr***
    - ***Daily Rate: $2,277***
  - ***Cost of incarceration $59,640/yr – in Vermont***
  - ****Cost of State Operated Institutions $255,692 (FY2013)***
  - ***Cost of Community Services for CRT Client - $19,389/yr***
  - ***Cost of Home and Community Based Services (HCBS) for people receiving Developmental Services $56,085/yr***
  - ***Cost of HCBS for Children receiving Waiver services $68,959/yr***

* Note: The HCBS cost is from the DS Annual Report for FY2014, and the institutional cost is the average state operated institutional cost from *The State of the States in Developmental Disabilities: Emerging from the Great Recession,* January 2015

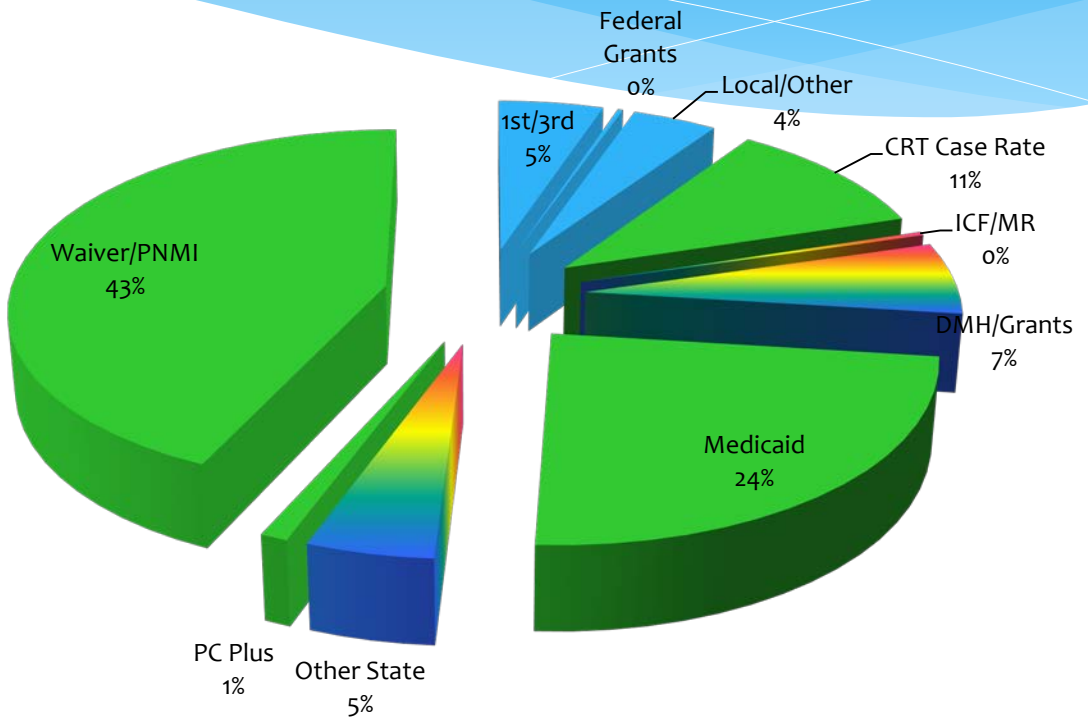
DA/SSA Expenses by Division



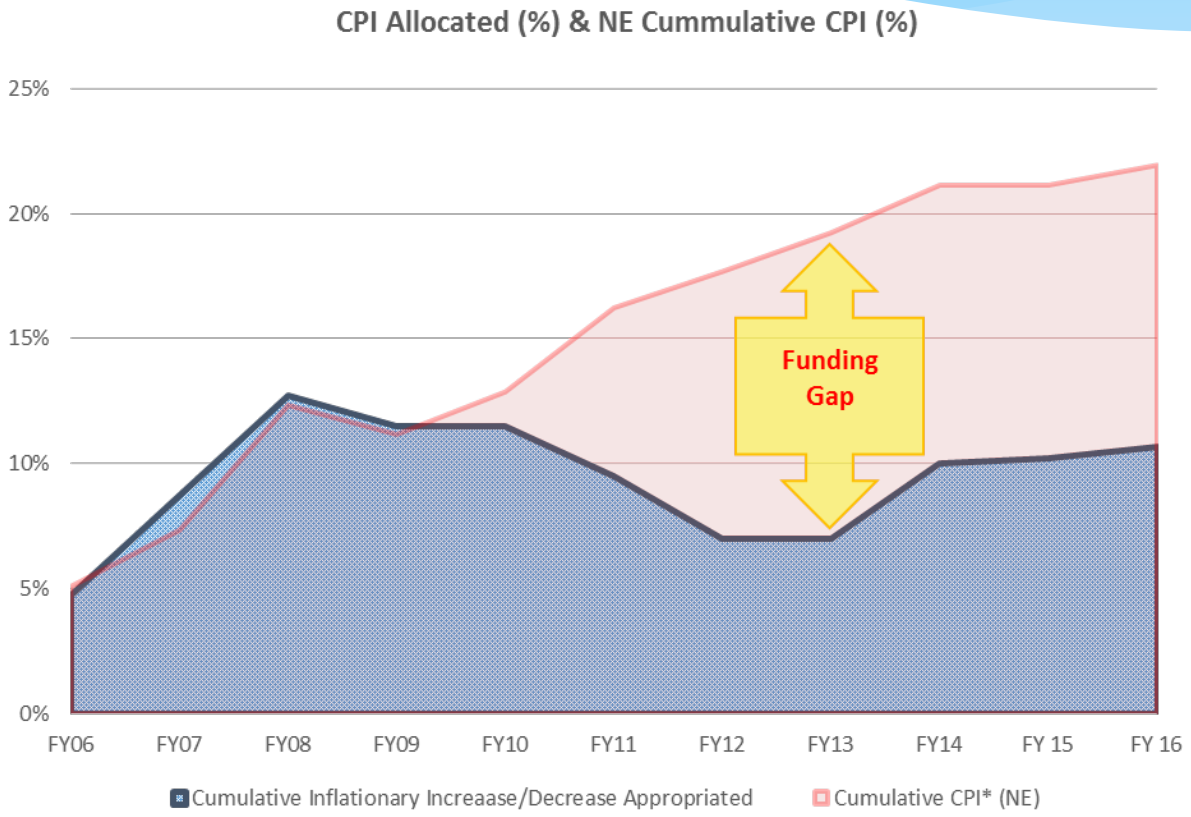
DA/SSA Revenues

FY2014

* **79% of DA funding is from varying Medicaid sources and 90% of all funding is from State sources.**



The Gap Between inflation and Funding for Designated Agencies



A STATEWIDE SYSTEM OF CARE IN VERMONT DESIGNATED AND SPECIALIZED SERVICE AGENCIES

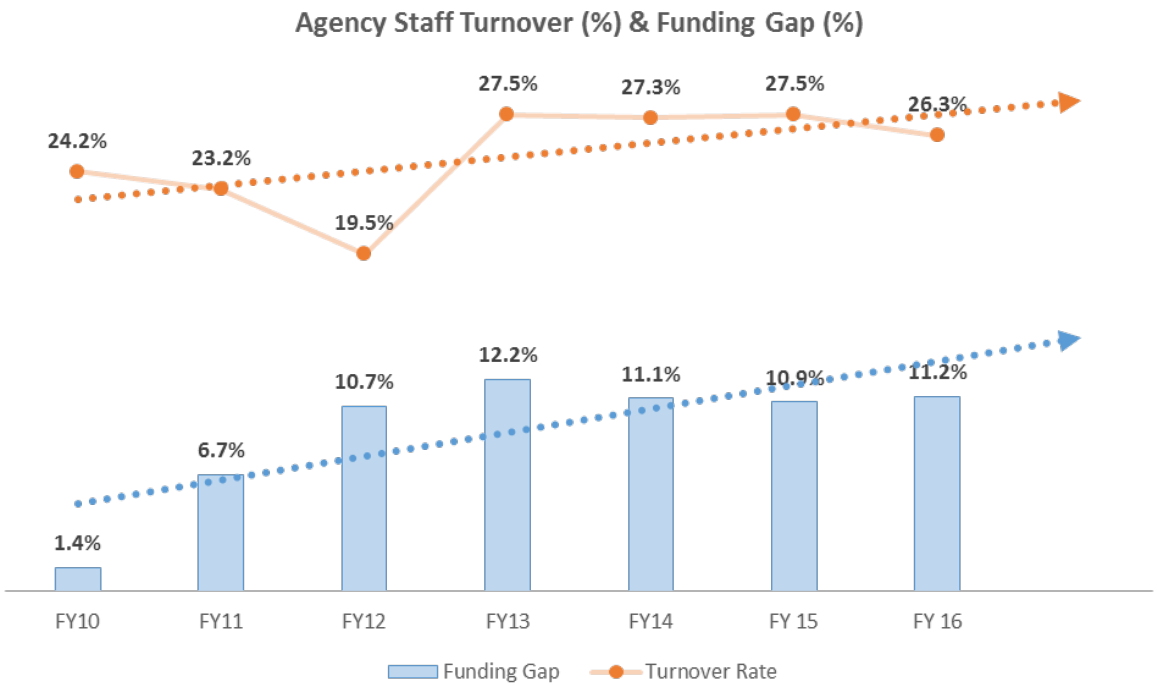
* ***13,412 Vermonters work for the Agencies as either employees or contractors***
* ***In FY15 Agencies had a total cost of- $262,498,664 for employees and in-state contractors***
* ***Agencies directly serve approximately 35,000 clients and "touch" at least 50,000 through all of our programs even though some are not registered as clients***

Staff Turnover

* ***Staff turnover in FY16 was 26.3%***
* ***A driving factor was uncompetitive compensation***
* ***Funds must be redirected from services to recruitment and training***

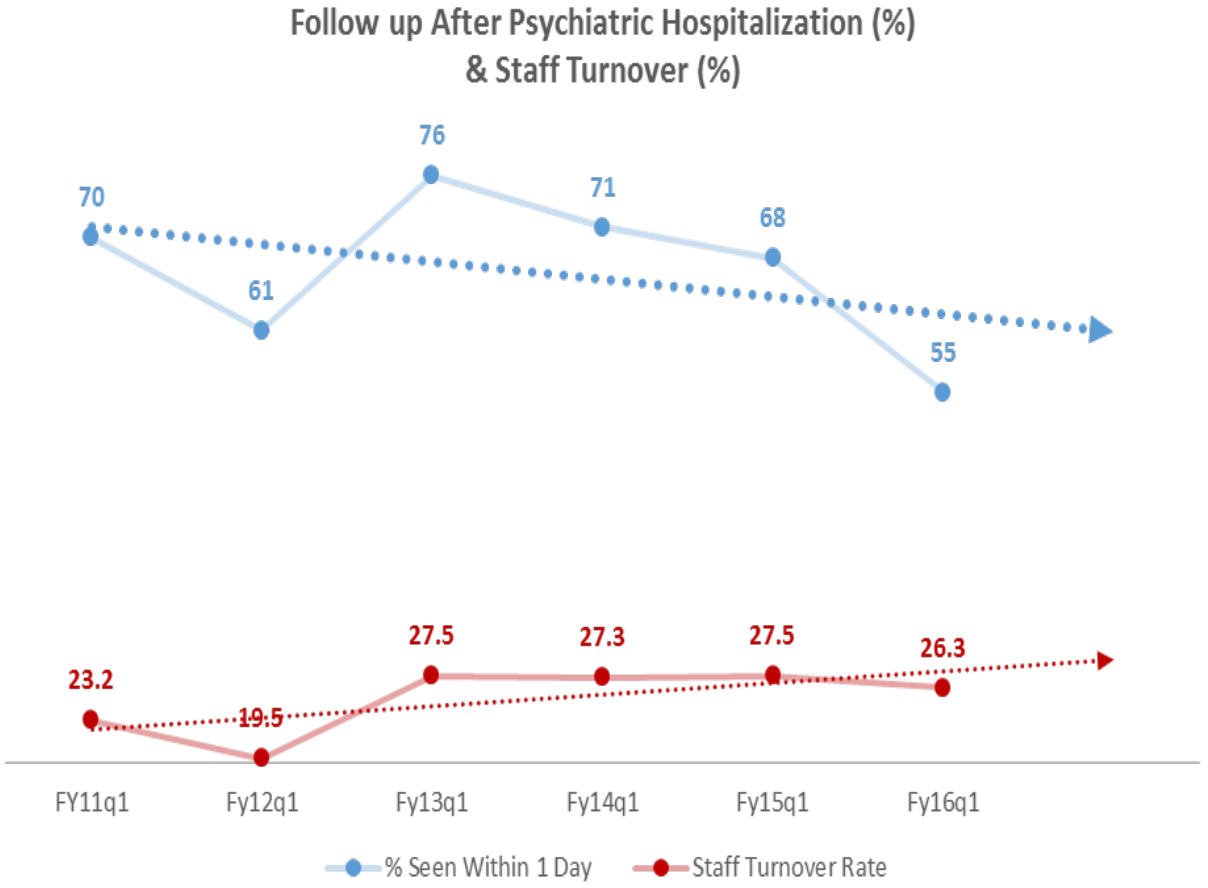
* ***The impact on the people we serve is reduced access, continuity and quality of care***

Funding and Staff Turnover Relationship



One Example Impact of Turnover on Quality of Care

The percent of CRT clients seen within 1 day of discharge and overall turnover rate within the DA and SSA system.



Attachment 4d - VDH data - MH SA providers




Mental Health Care Providers

VERMONT
DEPARTMENT OF HEALTH

October 5, 2016

Mental health provider types

- Physicians
- Advance Practice Registered Nurses
- Physician Assistants
- Alcohol and Drug Counselors
- Clinical Social Workers
- Marriage and Family Therapists
- Mental Health Counselors
- Psychoanalysts
- Psychologists
  - Master
  - Doctoral
- Psychotherapists*

*Rostered

Overlap among actively practicing professionals

Active in more than 1 survey

- 122 individuals
- 215.6 FTEs
  - 11% of total FTEs
- Apparent double counting of hours
- Surveys do not represent same moment in time

Majority of overlap

- Alcohol and Drug Abuse Counselors – 91
- Social Workers - 51
- Mental Health Counselors – 40
- Psychotherapists – 30

Psychiatrists – November 2014

N=

179

FTEs =

116.6

From 2014 Physician Census

9% Psychiatrists

- N = 179
- 116.6 FTEs

Psychiatrists – November 2014

Practice setting

- 24% - solo practitioner
- 21% - hospital inpatient
- 14% - community mental health clinic

Psychiatrists – November 2014

60 years of age and older

- 40% of psychiatrists
- 44.2 FTEs
  - 38% of total FTEs

Plans in next 12 months

- 4% plan to retire
- 18% plan to reduce hours

Psychiatric Nurse Practitioners – March 2015

N = 64

FTEs = 41.5

- 535 active APRNs
- 12% - psychiatric NPs
- N = 64
- 41.5 FTEs

Psychiatric Nurse Practitioners – March 2015

Practice setting

- 29% - mental health clinics
- 18% - independent solo practices
- 11% - community health centers
- 10% - correctional facilities

Psychiatric Nurse Practitioners – March 2015

60 years of age and older

- 42% of psychiatric nurse practitioners
- 13.6 FTEs
  - 33% of total FTEs

Plans to retire in next 12 months

- No data collected on plans to retire or reduce hours

Physician Assistants – January 2016

N = 3

FTEs = 2.6

- 310 active physician assistants
- 1% - psychiatric specialty
  - N = 3
  - 2.6 FTEs

Physician Assistants – January 2016

Practice setting

- 1 - single specialty care practice and VA
- 2 - hospital inpatient

Age and plans in next 12 months

- No PAs specializing in psychiatric care are over age 60 or plan to retire or reduce hours

Alcohol and Drug Abuse Counselors – January 2015

N = 332

FTEs = 194.1

- 89% response rate (434/489)
  - 76% active
    - N = 332
    - 194.1 FTEs
- 41% (n=38) of non-active counselors plan to start or resume direct patient care in the next 12 months

Alcohol and Drug Abuse Counselors – January 2015

Practice setting

- 33% – private practice
- 18% – substance abuse clinics

Alcohol and Drug Abuse Counselors- January 2015

60 years of age and older*

- 38% of alcohol and drug abuse counselors
- 31.7 FTEs
  - 16% of total FTEs

*Missing age for 57% of respondents

Plans in next 12 months

- 1% plan to retire
- 4% plan to reduce hours

Social Workers – January 2016

N = 794

FTEs = 635.5

- 99% response rate (1014/1020)
  - 78% active in direct patient care
    - N =794
    - 635.5 FTEs
- 39% (n=86) of non-active social workers plan to start or resume direct patient care in the next 12 months

Social Workers – January 2016

Practice setting

- 33% - independent solo practice
- 18% - mental health clinic
- 8% - hospital
- 8% - school or college

Social Workers – January 2016

60 years of age and older

- 32% of social workers
- 176.8 FTEs
  - 28% of total FTEs

Plans in next 12 months

- 1% plan to retire
- 5% plan to reduce hours

Marriage and Family Therapists – November 2014

N = 42

FTEs = 26.4

- 96% response rate (50/52)
  - 84% active in direct patient care
    - N = 42
    - 26.4 FTEs
- 50% (n=4) of non-active therapists plan to start or resume working as a therapist in the next 12 months.

Marriage and Family Therapists – November 2014

Practice setting

- 57% - independent solo practice
- 19% - independent group practice
- 12% - mental health clinic

Marriage and Family Therapists – November 2014

60 years of age and older

- 36% of marriage and family therapists
- 9.7 FTEs
  - 37% of total FTEs

Plans in next 12 months

- No one indicated plans to retire
- 5% plan to reduce hours

Mental Health Counselors – January 2015

N = 440

FTEs = 299.6

- 76% response rate (521/686)
  - 84% active in direct patient care
    - N =440
    - 299.6 FTEs
- 41% (n=34) of non-active counselors are planning to start or resume working in direct patient care in the next 12 months

Mental Health Counselors – January 2015

Practice setting

- 49% - independent solo practice
- 18% - mental health clinic
- 7% - independent group practice
- 7% - school-based
- 6% - community health center

Mental Health Counselors – January 2015

60 years of age and older

- 33% of mental health counselors
- 94.4 FTEs
  - 32% of total FTEs

Plans in next 12 months

- No one indicated plans to retire
- 4% plan to reduce hours

Psychoanalysts – November 2014

N = 18

FTEs = 8.1

- 95% response rate (54/57)
  - 33% active in direct patient care
    - N =18
    - 8.1 FTEs
- 19% (n=7) of non-active psychoanalysts indicated plans to start or resume working in the next 12 months.
- All were working in independent solo practice

Psychoanalysts – November 2014

60 years of age and older

- 83% of psychoanalysts
- 6.5 FTEs
  - 80% of total FTEs

Plans in next 12 months

- No one indicated plans to retire or reduce hours

Psychologists – January 2016

N = 489

FTEs = 355.8

- 99.8% response rate (590/591)
- Masters Level
  - 93% active
    - N =175
    - 131.3 FTEs
- Doctoral Level
  - 78% active
    - N = 314
    - 224.5 FTEs

Psychologists – January 2016

Practice setting

- Masters level settings
  - 54% - independent solo practice
  - 16% - mental health clinic
- Doctoral level settings
  - 49% - independent solo practice
  - 10% - independent group practice

Psychologists (masters) – January 2016

60 years of age and older

- 54% of masters level psychologists
- 65.5 FTEs
  - 50% of total FTEs

Plans in next 12 months

- 1% plan to retire
- 9% plan to reduce hours

Psychologists (doctoral)– January 2016

60 years of age and older

- 43% of doctoral level psychologists
- 90.1 FTEs
  - 40% of total FTEs

Plans to retire in next 12 months

- 2% plan to retire
- 8% plan to reduce hours

Psychotherapists – November 2014

N = 437

FTEs = 293.4

- 77% response rate (511/660)
  - 86% active in direct patient care
    - N = 437
    - 293.4 FTEs
- 49% (n=34) of non-active therapists plan to start or resume working in next 12 months
- Rostered, not licensed

Psychotherapists – November 2014

Practice setting

- 53% - designated agencies
- 18% - independent solo practice

Psychotherapists – November 2014

60 years of age and older

- 16% of psychotherapists
- 42.1 FTEs
  - 14% of total FTEs

Plans in next 12 months

- Less than 1% plan to retire
- 3% plan to reduce hours

HRSA designations for underserved areas

No current standards for how many mental health care professionals are needed.

- Core mental health professionals
  - psychiatrists
  - clinical psychologists
  - clinical social workers
  - psychiatric nurse practitioners
  - marriage and family therapists

HRSA designations, continued

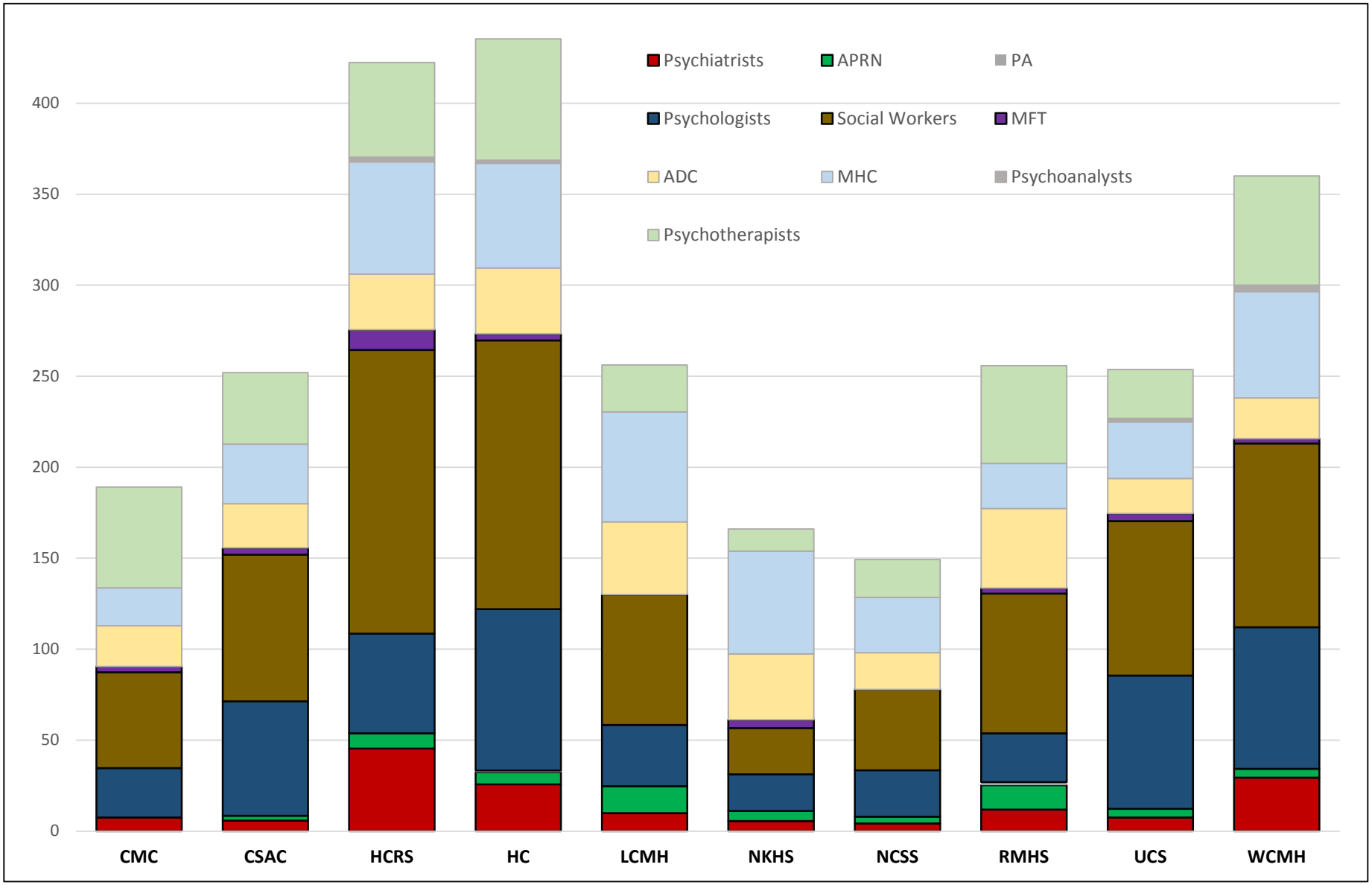
Population to provider ratio

- >6,000 :1 core mental health professional and >20,000:1 psychiatrist
- >9,000:1core mental health professional
- >30,000:1 psychiatrist

Provider to 100,000 population

- <16.7 FTE core mental health professionals and <5 FTE psychiatrists
- <11.1 FTE core mental health professionals
- <3.3 FTE psychiatrists

Professions by mental health catchment area
FTEs per 100,000 population



Professions by mental health catchment area
FTEs per 100,000 population

MHCA	advanced practice registered nurses	alcohol and drug abuse counselors	marriage and family therapists	mental health counselors	physicians	physician assistants	psychoanalysts	psychologists	psychotherapists	social workers
CMC - Randolph	--	22.4	3.1	20.9	7.5	--	--	27.1	55.4	52.7
CSAC – Middlebury	2.6	24.2	3.8	32.8	5.8	--	--	62.9	39.3	80.6
HCRS – Springfield, Brattleboro	8.4	30.4	11.2	61.8	39.8	--	2.6	54.7	52.0	155.9
HC – Burlington	6.6	36.2	3.6	57.5	25.8	1.0	1.7	88.6	66.6	147.7
LCMHS - Morrisville	14.8	39.9	--	60.4	5.9	--	--	33.6	25.9	71.7
NKHS – St. Johnsbury	5.5	36.1	4.7	56.4	5.6	--	--	20.1	12.2	25.4
NWCSS – St. Albans	3.6	20.1	--	30.4	4.3	--	--	25.6	20.9	44.4
RMHS – Rutland	13.4	43.8	3.0	24.7	10.8	1.7	--	26.9	53.7	76.7
UCS – Bennington	4.8	19.3	4.1	31.1	6.7	--	1.9	73.2	26.9	84.9
WCMH - Barre	4.8	22.4	2.7	58.4	27.6	--	3.5	77.9	60.0	100.9

Professions by mental health catchment area
Number of FTES

MHCA	advanced practice registered nurses	alcohol and drug abuse counselors	marriage and family therapists	mental health counselors	physicians	physician assistants	psychoanalysts	psychologists	psychotherapists	social workers
CMC - Randolph	--	7.2	1.0	6.7	2.4	--	--	8.7	17.8	16.9
CSAC – Middlebury	0.9	8.8	1.4	11.9	2.1	--	--	22.9	14.3	29.3
HCRS – Springfield, Brattleboro	7.7	27.8	10.3	56.7	41.6	--	2.4	50.1	47.7	142.8
HC – Burlington	10.7	58.1	5.8	92.2	41.4	1.6	2.8	142.3	106.9	237.1
LCMHS - Morrisville	3.7	10.0	--	15.2	2.5	--	--	8.4	6.5	18.0
NKHS – St. Johnsbury	3.5	23.2	3.0	36.2	3.6	--	--	12.9	7.8	16.3
NWCSS – St. Albans	2.0	11.2	--	16.9	2.4	--	--	14.3	11.6	24.7
RMHS – Rutland	8.1	26.3	1.8	14.8	7.1	1.0	--	16.2	32.2	46.1
UCS – Bennington	1.8	7.0	1.5	11.3	2.7	--	0.7	26.7	9.8	30.9
WCMH - Barre	3.1	14.5	1.7	37.7	19.0	--	2.3	50.2	38.7	65.0

Glossary

CMC = Clara Martin Center

CSAC = Counseling Services of Addison County

FTE = Full time equivalent

HC = Howard Center

HCRS = Health Care and Rehabilitation Services of Southeastern Vermont

HRSA = Health Resources and Services Administration

LCMH = Lamoille County Mental Health Services

MHCA = Mental Health Catchment Area

NCSS = Northwestern Counseling and Support Services

NKHS = Northeast Kingdom Human Services

RMHS = Rutland Mental Health Services

UCS = United Counseling Services

WCMH = Washington County Mental Health Services

Data Notes

- Surveys are completed at the time the provider relicenses, which is every two years.
- Different professions relicense at different times.
- Full-time Equivalents (FTEs) are defined as 40 hours per week and 48 weeks per year. Hours are patient care hours only.
- To determine number of active providers and FTEs a census is required. When the response rate is lower, the results will underestimate the number of providers and FTEs.
- Some individuals hold more than one license. They are completing the surveys for each of their licenses. A review of the data found 122 individuals with more than one license. The total FTEs for these individuals was 215.6, indicating that there is double counting of hours.

Questions?

Peggy Brozicevic

peggy.Brozicevic@Vermont.gov

Jessica Moore

jessica.moore@Vermont.gov

Moshe Braner

moshe.braner@Vermont.gov

Attachment 5 - Population Health Plan Overview Presentation

POPULATION HEALTH PLAN

Draft Overview for Discussion and Comment

October 2016

Discussion

- From your work group's point of view, how does this plan advance your work?
- How well do the goals and recommendations of the plan align with yours for moving ahead?
- What else would you want to see in order to get behind this plan?

INTRODUCTION AND BACKGROUND

"We need to shift from focusing on health care to focusing on health."

Karen Hein, MD

The Population Health Plan…

- Leverages and builds upon existing priorities, strategies, and interventions included in Vermont's State Health Improvement Plan (SHIP) and other state initiatives
- Addresses the integration of public health and health care delivery
- Leverages payment and delivery models as part of the existing health care transformation efforts

Building on State Innovation Models (SIM/VHCIP) and the State Health Improvement Plan (SHIP)

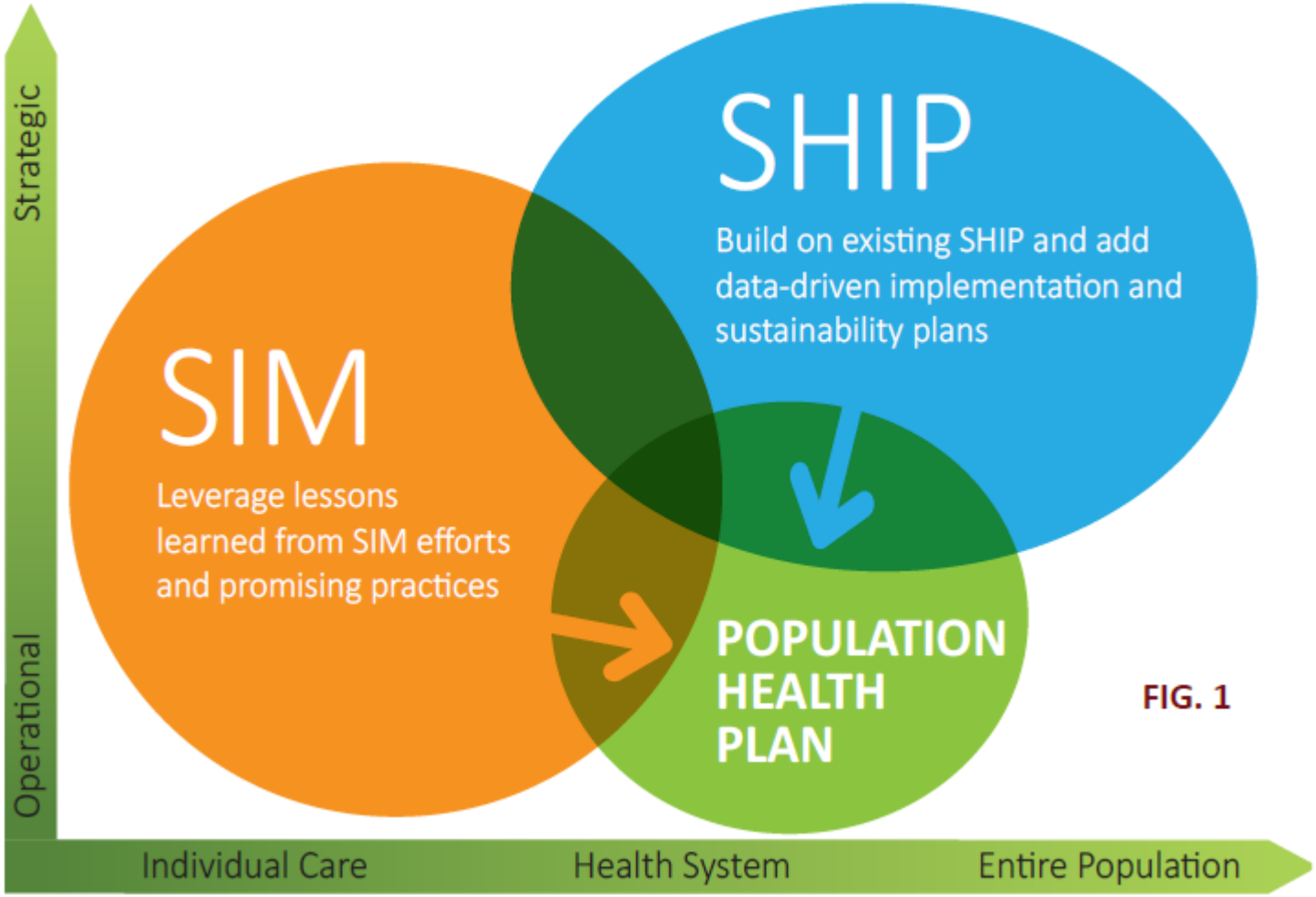


FIG. 1

FIVE PRINCIPLES FOR IMPROVING POPULATION HEALTH

Principles for Improving Population Health

Use Population-Level Data on Health Trends and Burden of Illness to Identify Priorities and Target Action.

Principles for Improving Population Health

Focus on Prevention, Wellness, and Well-Being at All Levels – Individual, Health Care System, and Community.

Principles for Improving Population Health

Address the Multiple Contributors to Health Outcomes

Principles for Improving Population Health

Community Partners are Engaged in Integrating Clinical Care and Service Delivery with Community-Wide Population Prevention Activities.

Principles for Improving Population Health

Create Sustainable Funding Models Which Support and Reward Improvements in Population Health, including Primary Prevention and Wellness.

RECOMMENDATIONS

Policy Levers:

Governance Requirements: include entities that have the authority, data/information, and strategies

Care Delivery Requirements and Incentives to move from acute care to more coordinated care

Metrics and Data of population health outcomes

Payment and Financing Methodologies towards value-based payment and alternative sustainable financing for population health and prevention

State: Governance Requirements

Embed governance requirements in Medicaid contracts with ACOs and other providers.

Require ACOs, through Act 113 of 2016, to include public health and prevention leaders in their governing entities.

Create a statewide public/private stakeholder group, similar to the Population Health Work Group, that recommends activities to State health policy leadership.

Expand partnerships to other sectors that impact health. Build upon the Governor's Health in All Policies Task Force.

Regional: Governance Requirements

Continue to expand partnerships to other sectors that impact health at the community or regional levels including housing, business, city and town planners, among others.

Expand existing Community Collaboratives to meet all of the components of Accountable Communities for Health.

SPOTLIGHT: Accountable Communities for Health

An ACH is accountable for the health and well-being of the entire population in its defined geographic area. It supports the integration of high-quality medical care, mental health services, substance use treatment, and long-term services and supports, and incorporates social services. It also supports community-wide primary and secondary prevention efforts.

Lever: Care Delivery Requirements and Incentives

- Current: Vermont is utilizing state policy levers to create the foundation for payment reforms and care delivery reforms to move our health care system from acute care to more coordinated care.

- Future: Expand upon the regional integration started with the Community Collaboratives.

Lever: Care Delivery Requirements and Incentives

1.0 Acute Care System

Episodic Non-Integrated Care

- Episodic health care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly coordinated chronic care management

2.0 Coordinated Seamless Health Care System

Outcome Accountable Care

- Person-centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- HIT integrated
- Focus on care management and preventative care

3.0 Community Integrated Health Care System

Community Integrated Health Care

- Healthy population-centered
- Population health-focused strategies
- Integrated networks linked to community resources capable of addressing psychosocial/economic needs
- Population-based reimbursement
- Learning organization that is capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

State: Care Delivery Requirements and Incentives

- Direct the overall flow and distribution of health resources within the State.
  - Certificate of Need program, Health Resource Allocation Plan, Insurance Rate Review, Hospital Budget Review, Professional Licensure, and contracting can help the State

- Set expectations to demonstrate success
  - Healthy Vermonters 2020, the All-Payer Model population health measures, and the Vermont Model of Care.

Regional Care Delivery Requirements and Incentives

- Incentivize Community Collaboratives to develop into Accountable Communities for Health

- Utilize *Prevention Change Packets* – developed by VDH in collaboration with OneCare – to incorporate prevention strategies to improve population health at all levels of the health system

Lever: Metrics and Data

- Require the collection of specific population health metrics
  - Track population health measures through the All-Payer Model Framework
- Set guidelines to move away from only using clinical, claims, and encounter-based metrics.

- Continue use of population health measures to drive statewide priority setting for improvement initiatives
  - for example, inclusion of screening measures for obesity, tobacco use, cancer into the payment and reporting quality measures for payment reforms.

Regional : Metrics and Data

- Use data gathered by hospitals through the Federally required Community Health Needs Assessments (CHNAs) to determine the highest priority health needs of the community and develop an implementation strategy to meet those needs.

- Provide regional-specific data, like that through the Blueprint Profiles to each hospital service area.

Lever: Payment and Financing Methodologies

- Payment methodologies – how health care providers and other organizations are paid for their work
- Financing methodologies – how funds move through the health system
- Two strategies to fund population health goals or social determinants of health:
  - Value-based payment models for providers
  - Alternative financing models for population health and prevention (not grant-based)

Lever: Payment and Financing Methodologies

A conceptual model for sustainable financing includes…

- Diverse financing vehicles
- Balanced portfolio of interventions
- Integrator or backbone organization
- Reinvestment of savings

State: Payment and Financing Methodologies

- The Green Mountain Care Board: support hospital investment in population health initiatives through its Community Health Needs Assessment Policy.
- The Department of Health and Department of Vermont Health Access: increase referral to population health management activities by allowing utilization of certain codes by clinicians for payment.
- The Agency of Human Services: incorporate mechanisms that encourage or require public health accountability in value-based contracts.
- Track population health measures through the All-Payer Model.

Regional: Payment and Financing Methodologies

- Pool resources within a region to support a target a specific initiative like food security or ending homelessness.

- Reinvest savings in community-wide infrastructure to enable healthy lifestyles and opportunity

MEASURING SUCCESSFUL PLAN IMPLEMENTATION

Signs we are on the path to success

- Health system actions are primarily driven by data about population health outcomes; goals and targets should be tied to these statewide data and priorities identified in the State Health Improvement Plan.

- The health system creates health and wellness opportunity across the care and age continuum and utilizes approaches that recognize the interconnection between physical health, mental health and substance use, and the underlying societal factors.

Signs we are on the path to success

- Payment and financing mechanisms are in place for prevention strategies in the clinical setting, through clinical/community partnerships, and for community wide infrastructure and action.

- An expanded number of entities are accountable for the health of the community including health care providers, public health, community providers and others who affect health through their work on housing, economic development, transportation, and more, resulting in true influences on the social determinants of health.

Discussion

- From your work group's point of view, how does this plan advance your work?
- How well do the goals and recommendations of the plan align with yours for moving ahead?
- What else would you want to see in order to get behind this plan?