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

Wednesday, October 21, 2015; 3:00-5:00pm
Vermont State Colleges, Conference Room 101
575 Stone Cutters Way, Suite 101, Montpelier, VT 05602
Call-in Number: 1-877-273-4202; Conference ID: 420-323-867

Item #	Time Frame	Topic	Presenter	Decision Needed? (Y/N)	Relevant Attachments (describe document type: powerpoint, word, excel, etc…)
1	3:00-3:10	Welcome and Introductions – introduce new members and member alternates	Mary Val Palumbo Robin Lunge	N	• Attachment 1: 10-21-15 Meeting Agenda
2	3:10-3:15	Approval of Meeting Minutes	Mary Val Palumbo Robin Lunge	Y	• Attachment 2: 8-19-15 Meeting Minutes
3	3:15-3:25	Updates: - Demand Modeling update - NASHP conference on CHWs - Future of Nursing Grant Relicensure Survey - 2015	Mary Val Palumbo Robin Lunge Group Discussion	N	• Attachment 3a – APRN 2015 Survey • Attachment 3b – RN 2015 Survey • Attachment 3c – Nursing Dashboard 2015
4	3:25 – 3:50	Update: Work Force Supply Data/Surveys at VDH	Dawn Philibert	N	• Attachment 4a – Work Calendar • Attachment 4b – 2013 Dentist Survey Summary Report • Link to Provider Surveys at VDH: http://healthvermont.gov/research/HlthCarePrvSrvys/HealthCareProviderSurveys.aspx
5	3:50-4:50	Discussion : Strategic Plan – Recruitment and Retention recommendations	Group Discussion	N	• Attachment 5 - Strategic Plan Priorities Matrix (RecruitmentRetention)*
6	4:50-5:00	Public Comment/Wrap Up/Next Steps	Mary Val Palumbo Robin Lunge	N	

* Please note: for this discussion we will only be focusing on Recommendations #4-6 of the Work Force Strategic Plan

Attachment 2: 8-19-15 Meeting Minutes

Vermont Health Care Innovation Project
Workforce Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, August 19, 3:00-5:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Mary Val Palumbo called the meeting to order at 3:01pm. A roll call attendance was taken and a quorum was present.	
2. Approval of February, April, and June 2015 Meeting Minutes	Beth Tanzman moved to approve by exception the minutes from the February, April, and June 2015 meetings. Peter Cobb seconded the motion. The minutes for February, April, and June were approved with one abstention.	
3. Updates: Demand Modeling; Workforce-Related Initiatives/Grants around the State; Issues to Watch	*Demand Modeling Update:* Amy Coonradt provided an update. The State continues to work with the selected vendor to negotiate a contract and send the contract to CMMI for approval; we hope to execute a contract in October and to build the demand model this fall. The State and contractor are negotiating a variety of issues, including whether or not DOL would continue to be able to run the model following the close of the contract (the selected contractor's model is proprietary). • Mat Barewicz noted that the contract period still allows for a back-and-forth process between the State and contractor to run a variety of scenarios; we could re-engage the contractor in the future if we want to run additional modeling scenarios at a later date. He also commented that the bidder selection team prioritized contractor ability to develop and execute the model quickly; Robin Lunge commented that these models are usually proprietary and it is unlikely any vendor would allow the state to own the model following the close of the contract. Molly Backup suggested influencing this process to acquire the model following the close of the contract; however, Charlie MacLean noted that a bidder with national experience will continue updating assumptions and that this brings value to the model even if we don't own it after the contract term. • Janet Kahn expressed concern about the cost of this contract if we aren't able to continue working with the model after the contract term. Robin Lunge noted that the Work Group's SIM funding ends following the end of the SIM grant; because demand modeling is a goal of the SIM grant, there is significant value to doing the work even if we don't have the model for as long as we'd like.	

Agenda Item	Discussion	Next Steps
	Workforce-Related Initiatives/Grants around the State: • Mary Val Palumbo announced that UVM did not receive three federal Health Resources and Services Administration (HRSA) grants for which it had applied, but did receive the Futures of Nursing Grant for which it had applied. • Charlie MacLean announced that two UVM Medical School departments have partnered on a successful grant application to the Patient-Centered Outcomes Research Institute (PCORI) to perform a randomized controlled trial that tests co-location of behavioral health and primary care in 40 sites around the country. The total award is ~$18 million over 5 years. PCORI focuses research on patient-centered outcomes, and patients/health care consumers will be closely involved with research planning and implementation. It is not yet clear whether any of the chosen intervention sites will be in Vermont. • Mat Barewicz noted that there is no update on the WETF grant process. • Mary Val Palumbo provided an update on supply data collection: The nursing survey was completed in March, and data was available in June. VDH will continue to provide data without discussion, though AHEC will publish some discussion this fall on the AHEC website (copies to be provided to this Work Group in October). Robin Lunge suggested scheduling an update from VDH for a future meeting. *Issues to Watch:* No issues to watch were raised.	**Update from VDH at October meeting**
4. Update and Discussion: Work Group Membership Changes and Delegates	Robin Lunge led the group in a discussion of changes to the Work Group membership and delegate policies (Attachment 4). This group has, in the past, often lacked a quorum. Because this is an appointed Work Group, each member is limited to one voting delegate; these will be sent to Secretary of Administration Justin Johnson for approval. Members who wish to propose a delegate should email Amy Coonradt by September 18th, including delegate's name, a letter of interest and resume. Robin Lunge suggested that the group could vote to recommend Secretary Johnson accept members' self-appointed delegates, which would allow us to create a list afterward. Madeleine Mongan supports this. Robin plans to present a list of all proposed delegates to Secretary Johnson at once because of the paperwork and effort involved. Mary Val Palumbo suggested that all members should indicate delegates prior to the October meeting of this group, or we will expect members' attendance at every meeting. Charlie MacLean asked about the process for suggesting additional members. Robin Lunge noted that this has occurred in the past. Molly Backup noted that when regular meeting times change it is challenging for clinicians to reschedule. Robin Lunge entertained a motion to direct staff to collect a list of proposed member alternates and recommend to Secretary Johnson that these delegates be approved as alternates prior to the October meeting. Molly Backup moved	**Members should email Amy Coonradt (amy.coonradt@vermont.gov) by September 18th to propose member alternates. Please include delegate's name, letter of interest and a resume for**

Agenda Item	Discussion	Next Steps
	by exception. Mat Barewicz seconded. The motion was approved unanimously by exception with no abstentions. In addition, three members announced job changes. Two will be leaving the Work Group and proposed replacements: • David Blanck announced that he will be changing jobs and would be resign his appointment. He proposed a replacement, Dr. Lindsay Herbert, a family practice dentist in Montpelier. • Stuart Schurr also announced that he has changed jobs and would resign his appointment. DAIL proposes replacing him with Monica Light. • Chris Winters also announced that he has changed jobs, though he is still within the AHS Secretary's office. He plans to continue participating as a Work Group member until further notice, though the Secretary's office may eventually choose to propose a change. For now he proposes Colin Benjamin, OPR director, as a delegate. Charlie MacLean suggested Liz Cote, also from the OPR, be added as a new member. Molly Backup suggested that this group includes many clinicians who are administrators, rather than those who see patients. She suggested that if we add more administrators to the group, we should also add clinicians and non-clinicians who regularly practice. Lorilee Schoenbeck asked about the perspective of patients and community members. Robin suggested sending out the current membership list to allow members to review (this list is also posted on the VHCIP website); Molly Backup suggested annotating the list to include additional information about members' practice as available to allow for a more informed assessment. Charlie MacLean will formally suggest Liz as a new member prior to the next meeting.	**the proposed delegate.**
5. Payment Models – Updates and Discussion (Cont.)	Alicia Cooper presented on DVHA's current work on Episodes of Care (Attachment 5). This is continued from a presentation on the Shared Savings Program and Blueprint for Health payment reforms by Alicia and Jenney Samuelson at the June meeting. Her presentation defined episodes of care, provided episode examples, described the care improvement and cost savings opportunities presented by episode-based analytic and payment models, and discussed implementation challenges. The group discussed the following: • What episodes has Arkansas focused on? They have implemented ~18 episodes to date – it is the main focus of their SIM work. These are primarily acute episodes, with a few chronic episodes; the State chose this approach to complement their delivery system reforms, which focus on patient-centered medical homes. Alicia offered to provide a list of episodes to the Work Group. • What are MVP's episodes focused on? MVP has worked with a vendor that has allowed them to work with about 100 episodes. MVP has also engaged specialists in their episode analytics. Analytics development has been a meaningful and positive experience thus far even without a payment model, in large part because of intensive provider engagement activities. • Payment models around episodes could vary. Under the Arkansas episode-based payment model, providers continue to be reimbursed via FFS throughout the year, with an annual cost- or gain-sharing based on performance on cost and quality measures. Bundled payments are determined prospectively. • There is opportunity to engage providers in episode design. Arkansas had strong clinician participation in	

Agenda Item	Discussion	Next Steps
	episode design (for example, service inclusion or exclusion in episodes). • DVHA is currently looking at a short list of high-volume services where there is significant cost variation. A few potential episodes: Perinatal; acute exacerbation of asthma, upper respiratory infection, and ADHD. • Is there outcome data as part of this? Different initiatives using episodes have approached this in a variety of ways. Arkansas requires providers to meet certain quality standards in order to be eligible to share in savings. Molly Backup noted that clinicians are eager to review and incorporate good data; while money is a helpful incentive, good data is often motivation enough to change care. • Role of specialists in care – How does quality compare when ADHD, for example, is managed by primary care versus specialists? Molly Backup would welcome data on the best provider to treat episodes, how often to refer, how to refer more expeditiously, and more. • Episode-based models elsewhere exclude outliers to control for particularly challenging cases. • Providers need to participate in episode development, and may need time/coverage/financial support to do so. Providers also need support to help educate other providers. • Are there any results from CMS pilot for bundled nursing home payments (the Bundled Payments for Care Improvement initiative)? A number of Vermont nursing facilities participated in the initial information gathering phase of this pilot; however, to DVHA's knowledge, none of the facilities chose to participate in the second phase of the model which would have involved changes to payment models. • Most episodes currently draw on claims data. • How will workforce respond to episodes? Charlie MacLean noted that most of these episodes are non-disruptive, similar to bundled payments. Mary Val Palumbo noted that episodes are built on claims, which are submitted largely by physicians. This doesn't tell us about best practices for addressing an episode across the workforce. Kaiser has produced data to support work like this in the past, which might be helpful to review. Charlie agreed, but noted that workforce realignment isn't an expected outcome of episodes; we may have to look elsewhere for innovative practices. Kaiser data includes both clinical and claims data because Kaiser is the provider as well as the insurance company. Molly Backup suggested we look at data from Kaiser, and expressed concern that much of our data comes from insurance companies with a profit motive. Robin noted that Medicaid is not seeking a profit, nor are non-profit insurers in the state, but agreed that we could learn from Kaiser's data.	
6. Presentation: Core Competency Training	Pat Jones presented on the Core Competency Training initiative for front-line care managers currently being planned in conjunction with the Integrated Communities Care Management Learning Collaborative (Attachment 6a). The group discussed the following: • How much total time would the core competency training take? One of the more comprehensive trainings (from the Primary Care Development Corporation) was a 48-hour curriculum, without the disability competency focus we are looking for. Center on Aging also has funding to develop a community health worker training course. Mary Val Palumbo commented that some of the skills that are part of these trainings are academic, taught as part of four-year nursing programs but not two-year programs. Pat noted that even a 48-	

Agenda Item	Discussion	Next Steps
	hour training does not offer significant depth. Mary Val suggested that depth will also depend on trainees' prior experience, and that the training can be very meaningful if targeted toward the audience. • Pat noted that team-based care and the roll of a lead care coordinator are key concepts for the learning collaborative; the breadth of this training is based on community needs and requests. Molly Backup suggested that the curriculum be modular to support skill building for clinicians with varied past experience. Robin Lunge noted that SIM funds can support dissemination of the training in the future through recordings that would be available for clinicians at a later date.	
7. Public Comment, Wrap-Up, Next Steps, Future Agenda Topics	There was no public comment. **Next Meeting:** October 21, 2015, 3:00-5:00pm, 575 Stone Cutters Way, Suite 101, Montpelier, VT 05602.	

Attachment 3a – APRN 2015 Survey

Advanced Practice Registered Nurses Working in Vermont

2015 BOARD OF NURSING RE-LICENSURE SURVEY

Summary prepared by: University of Vermont AHEC Nursing Workforce, Research, and Development

UNIVERSITY OF VERMONT AHEC
AREA HEALTH EDUCATION CENTERS PROGRAM

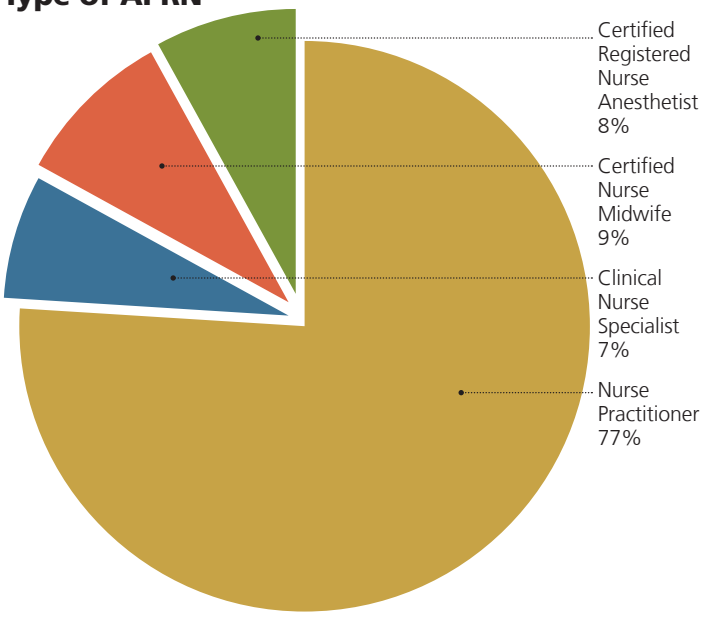
Background

This summary provides supply information for Advanced Practice Registered Nurses (APRN) working in Vermont in 2015.

Methods

In January to March 2015, APRNs in Vermont were required to answer survey questions as part of their relicensure application. The data were prepared for analyses by the Vermont Department of Health and UVM AHEC; this analysis was done by UVM AHEC. The number of APRNs who completed a relicensure survey in Spring 2015 was 610 (response rate 99%); this report will analyze only APRNs who reported that they were currently working in the state of Vermont (n=538).

Type of APRN



Demographics

Gender

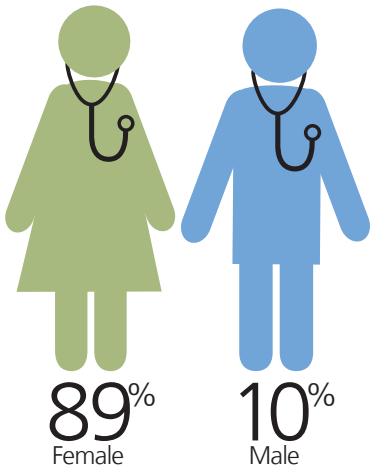
Female: 89%
Male: 10%
Unreported: 1%

Age

Average age: 51.5 years
Mode: 61 years
Range: 26-81 years

Race/Ethnicity

Caucasian: 95%
Hispanic: 1%



Area of Credentials

Family (234)	44%
Adult (109)	20%
Psych/Mental Health (75)	14%
Midwifery: Full Scope (48)	9%
Anesthesiology (41)	8%
OB/Gyn: Women's Health (40)	7%
Pediatrics (36)	7%
Gerontology (27)	5%
Acute/Emergency Care (13)	2%
Medical/Surgical (4)	1%
School (1)	<1%

Education

Undergraduate degree with certificate (Diploma: 2%, ADN: 2%, BSN: 3%)	7%
Graduate degrees (MS: 87%, DNP: 3%, PhD: 3%)	93%
Currently enrolled	4%
Post-Master's certificate (4)	0.6%
DNP program (20)	3%
PhD (1)	0.1%

Employment

Years worked as an APRN in Vermont*	11
Working in Vermont 1 year or less	16%
Working full-time in patient care across all practice sites	59%
Working part-time in patient care across all practice sites	41%
Working full-time with Faculty, Administrative, Research or other titles	9%
Working Per Diem	8%
Working as a traveler	1.5%
Working in a second practice site	15%
Working in a third practice site	1.5%
Have hospital privileges	40%

** Mode: 1 year. Range: 0-41 years*

Setting of Primary Position

Physician/APRN Practice (167)	31%
Hospital: Outpatient (93)	17%
Hospital: Inpatient (62)	12%
Other Setting (60)	11%
Community Health Center (45)	8%
Independent APRN Practice: Group (27)	5%
Independent APRN Practice: Solo (22)	4%
Mental Health Center (18)	3%
Nursing Home/Extended Care (9)	2%
School or College Health Service (11)	2%
Academic Setting (5)	1%
Occupational Health (7)	1%
Home Health (3)	1%
Correctional Facility (7)	1%
Public Health (2)	>1%

The vast majority of APRNs continue to be able to accept new patients (88%) regardless of type of insurance (Medicaid: 87% and Medicare: 77%).

Discussion of These Findings

There has been an increase (of approximately 80%) in the number of APRNs working in Vermont over the past 10 years. A steady growth in those prepared at a graduate level (now 93%) with a large increase in individuals with doctoral degrees (from 5 to 32) has been seen. Nurse practitioners (NP) are the largest group of APRNs and the number of NPs has doubled over the last decade. Many NPs (16%) have been practicing in Vermont for only a short period of time and this may represent an increased number of NPs coming to Vermont after an administrative rules change that allowed NPs a full scope of practice in 2011. APRN practice settings have remained fairly constant over the last decade with a decrease seen only in those in an MD/APRN practice (41% to 31%) and School/College Health (6% to 2%). Slight increases in the percent of APRNs working in independent APRN group practice (3% to 5%) were noted. Eleven percent of APRNs report working in "other" settings and this might need further analysis to determine if trends exist. In conclusion, APRNs are playing an increasing role in the delivery of health care services in Vermont, working in a wide variety of settings with patients across the lifespan.

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Visit **www.vtahec.org** to download workforce reports.

Attachment 3b – RN 2015 Survey

Registered Nurses in Vermont

2015 BOARD OF NURSING RELICENSURE SURVEY

Summary prepared by: University of Vermont AHEC Nursing Workforce, Research, and Development

UNIVERSITY OF VERMONT AHEC AREA HEALTH EDUCATION CENTERS PROGRAM

Background

This summary provides supply information for Registered Nurses (RNs) working in Vermont in 2015.

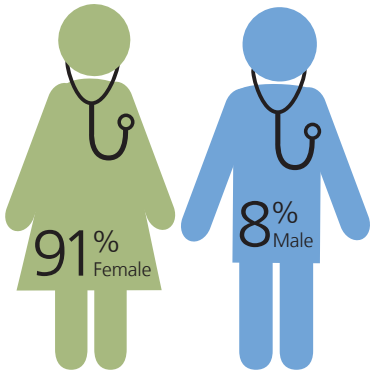
Methods

Between January to March 2015, all registered nurses (RNs) in Vermont were required to answer workforce survey questions as part of their relicensure application. These questions were embedded into the electronic relicensure system but paper surveys were also available to nurses who requested them. The data were prepared for analyses by the Vermont Department of Health. The number of registered nurses who completed a relicensure survey in spring 2015 was 10,164 (response rate 97%); this report will analyze only RNs who reported that they were currently working in the state of Vermont (n=6,723) and exclude 143 who requested a paper survey.

Demographics

Gender

Female: 91%
Male: 8%
Unreported: 1%



Age

Average age: 48 years old
Mode: 61
Range: 20-86 years

Race

American Indian or Alaska Native	0.8%
Asian	1.1%
Black or African American	0.6%
Native Hawaiian or other Pacific Islander	0.2%
White	93%
Other	0.8%
Prefer not to answer	4%

Ethnicity (Hispanic or Latino)

Non-Hispanic/Non-Latino	94%
Mexican, Mexican American, Chicano/a	0.2%
Puerto Rican	0.3%
Cuban	0.1%
Hispanic, Latino/a, or of Spanish origin	0.4%
Prefer not to answer	3.5%

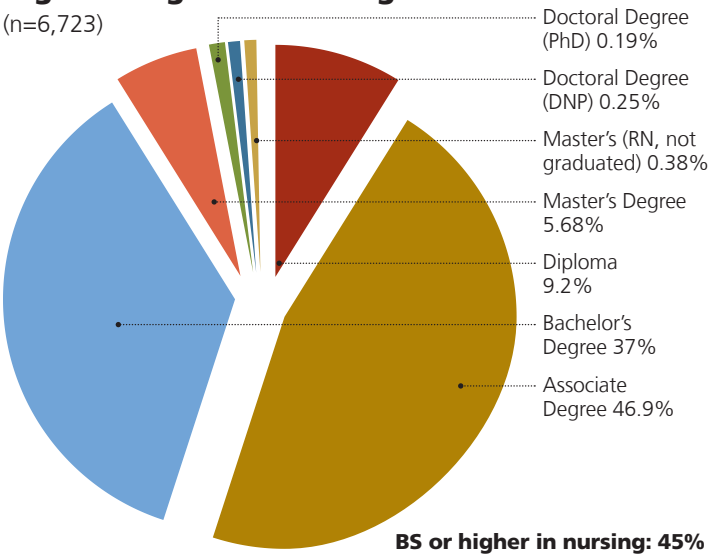
Education

51%
Educated in Vermont
(3,424 / 6,723)

2%
Educated outside the USA
(106 / 6,723)

Highest Degree in Nursing

(n=6,723)



BS or higher in nursing: 45%

Currently Enrolled in Nursing Programs

Bachelor's Program in Nursing (281)	4.17%
Master's Program in Nursing (253)	3.76%
Doctoral Degree Program: DNP (34)	0.50%
Doctoral degree Program: PhD (8)	0.12%
Certification Programs (20)	0.29%
Not enrolled (6051)	90%

Practice

Years worked as an RN* 19
Average 19
Active RN license in 2 States 23%
Active RN license in 3 States 6%
Actively practicing as an RN in only one state 98%

** Mode: 2 years. Range: 0-65 years*

Employment Status as an RN

Actively working in a nursing position – part or full-time (5,994) 89%
Working per diem as a nurse (910) 14%
Traveler (112) 2%
Working in nursing but only as a volunteer (54) 0.8%
Working in a field other than nursing (52) 0.7%
Retired (47) 0.7%

Primary Practice Setting

Hospital (3,482)	51.78%
Nursing Home/Extended Care/Assisted Living (591)	8.79%
Home Health (499)	7.42%
Correctional Facility (38)	0.57%
Public Health (117)	1.74%
Community Health (286)	4.25%
Mental Health Center (119)	1.77%
School Health Service (356)	5.29%
Occupational Health (30)	0.45%
Ambulatory Care Setting (587)	8.73%
Academic Setting (89)	1.32%
Insurance Claims/Benefits (73)	1.09%
Policy/Planning (9)	0.13%
Regulatory/Licensing Agency (22)	0.33%
Other Setting (407)	6.05%
Missing (19)	0.28%

Employment Characteristics

Working full time in patient care at all of their practice sites 52.5%

Working part time in patient care at all of their practice sites 47.5%

Working full time in administration, teaching, research, supervision or other responsibilities at all of their practice sites 29.8%

Work at a second practice site in VT 9%

Work at a third practice site in VT 1%

Primary Position Title

Staff Nurse: patient care (4,697)	70%
Nurse Manager (738)	11%
Nurse Executive (194)	3%
Nurse Faculty (195)	3%
Consultant/Nurse Researcher (126)	2%
Health-Related (742)	11%
Non Health-Related (12)	0.2%
Missing (19)	0.3%

Population Served in Primary Position

Adult (3,660)	54%
Geriatric (2,223)	33%
Pediatric (1,271)	9%
Neonatal (499)	7%
All Ages (1,886)	28%
Not applicable (277)	4%

Discussion of These Findings

Over the past decade, the nursing workforce in Vermont has adapted to a nursing shortage, an economic recession, and then an increase in nursing program enrollments with subsequent relief from workplace vacancies. In 2015, attention is now being focused on the "nurse of the future" as health care policy and payment reforms continue to change nurses' employment settings and responsibilities. As national demographics change to an older, more diverse population, the Vermont nurse workforce must adapt as well. Comparing 2005 to 2015, Vermont nurses are slightly more racially diverse (up 1%), male (up 3%), more are educated at the bachelor's (up 5%) and master's (up 1%) level, and more nurses report continuing their education in nursing (up 4%). The average age of the Vermont nurse has remained the same (48 years) and this might indicate the greater number of nurse graduates in Vermont (up approximately 158% since 1999) that are offsetting the large number of "baby boomer" nurses projected to retire in the next decade.

Work settings for Vermont nurses are changing too, but the number practicing in the hospital setting has been steady (currently 52%). Change was seen most in outpatient/ambulatory/community-based (up 5%); and school (down 2%) and home health (down 3%) settings. In summary, a decade of monitoring the nursing workforce has revealed education, policy and practice adjustments that have resulted in an adequate number of nurses with increasing educational preparation who are caring for Vermonters in many evolving practice settings. National and statewide health care reform will continue to demand that nurses are fully engaged, knowledgeable about what is good for the health of Vermonters, and flexible in their roles as changes occur.

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Attachment 3c – Nursing Dashboard 2015

Vermont's Future of Nursing

2015 DATA DASHBOARD

Data presented in this dashboard has been compiled by the Vermont Office of Nursing Workforce with support from UVM's Area Health Education Centers (AHEC), and a Robert Wood Johnson Foundation/AARP Future of Nursing State Implementation Program grant. Data sources include: the Vermont State Board of Nursing relicensure surveys of RNs, LPNs and APRNs from 2005, 2014 and 2015; Vermont Board of Nursing – Vermont Nursing Educational Programs Annual Report; and a telephone survey of Vermont hospitals conducted in June 2015 by Michelle Delaney from the UVM AHEC Nursing Workforce Program

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This "Data Dashboard" has been prepared to guide decision-making regarding the nursing workforce in order to assure an adequate and well-educated supply of nurses to meet Vermont's healthcare needs.

Progress is presented on the following goals, which were recommended by the Institute of Medicine (2010) *Future of Nursing – Leading Change Advancing Health* report and endorsed by the Vermont Blue Ribbon Commission on Nursing in 2012:

1. Produce an annual *Nurse Workforce Data Dashboard* encompassing Education, Practice, Leadership, and Supply and Demand data.
2. Increase the diversity of the nursing workforce.
3. Increase the proportion of nurses with baccalaureate in nursing degrees (BSN) to 80% by 2022.
4. Double the number of nurses with a doctorate by 2022.
5. Increase nursing representation on hospital and healthcare boards, executive management teams, government advisory committees, and in other key leadership positions.

Diversity Trends in Vermont Nurses

Vermont Board of Nursing Relicensure Surveys

Non-Caucasian RNs increased from 3% in 2001 to 7% in 2015.

Non-Caucasian LPNs increased from 4% in 2004 to 7% in 2014.

Male RNs increased from 5% in 2001 to 8% in 2015.

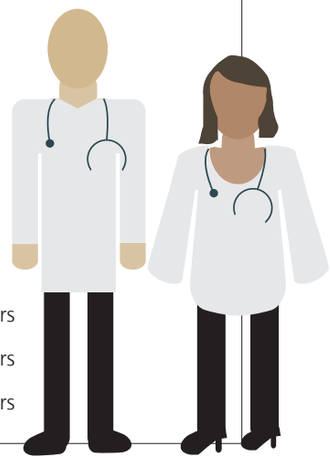
Male LPNs increased from 4% in 2004 to 6% in 2014.

MEAN AGE

LPN (2014)..... 49 years

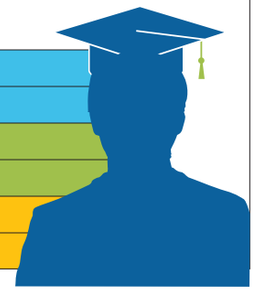
RN (2015)..... 48 years

APRN (2015)... 51.5 years

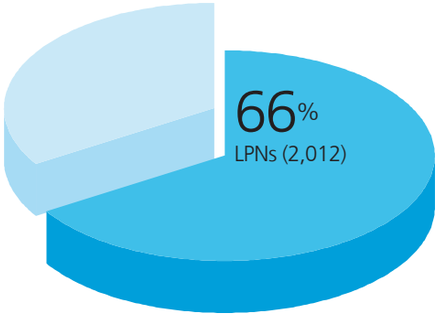


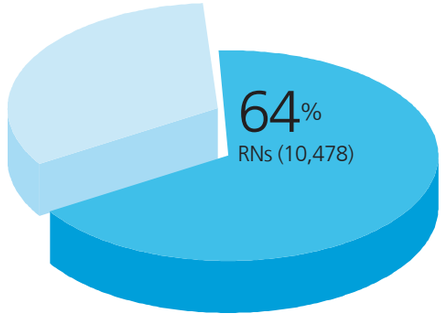
Highest Degree in Nursing (2015)

	DIPLOMA	ADN	BSN	MSN	DOCTORATE
RNs	9%	47%	37%	6%	0.7%
n=6,723	621	3,159	2,505	408	30
APRNs	2%	2%	3%	87%	6%
n=340	11	11	16	468	32
Working Vermont RNs with BSN or Higher = 44%					
VT Working RNs and APRNs with BSN or Higher = 48%					



Vermont Nurse Workforce Licensed versus Working in Vermont FY 2014-15





Report working as a nurse in Vermont

Source: Vermont State Board of Nursing licensee file and Relicensure Survey
Note: Not all nurses who are licensed in Vermont are part of the Vermont nurse workforce

Nursing Education

Since 2008 Vermont nursing program have graduated approximately 300 registered nurses per year (299 in 2015) with a low of 113 in 2000. More nurses are now continuing their nursing education (8% in 2015 compared to 4% in 2005). Sixty-two RNs and APRNs report having a doctoral degree in nursing and this is a fourfold increase from 14 in 2005.

All five nursing programs in VT now offer a bachelor's degree in nursing. Two programs offer a master's degree and one offers the doctor of nursing practice degree.

Demand for Hospital-Based RNs

During July 2015, a telephone survey of Human Resources Departments in 15 Vermont hospitals* yielded a response from 12 (80%). The open positions for RNs and the number of fulltime and part-time RNs on staff was requested. Vacancy rates were then calculated.

Average vacancy rate..... 6.5%

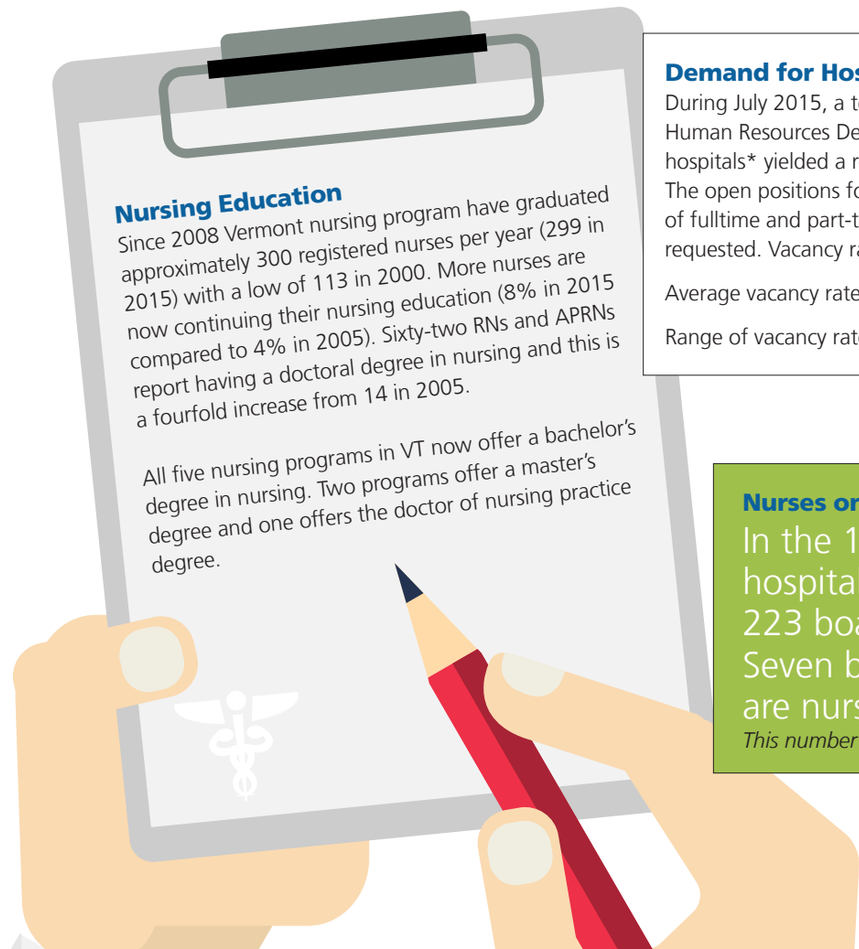
Range of vacancy rates..... 0-13%

** Includes VA hospital.*

Nurses on Hospital Boards

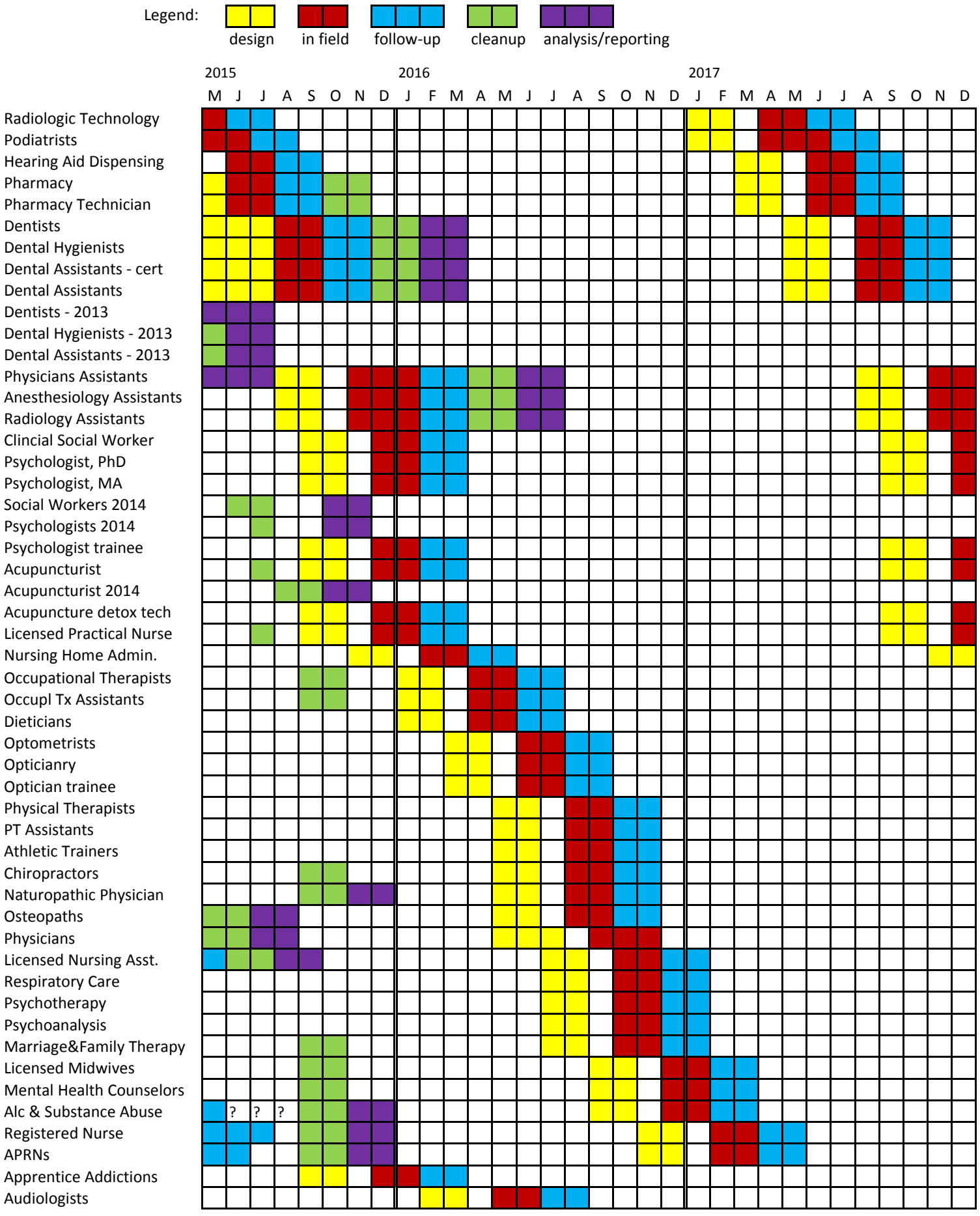
In the 14 Vermont hospitals, there are 223 board members. Seven board members are nurses (3%).

This number is unchanged from 2014.



Attachment 4a – Work Calendar

Workforce Censii Workplan Calendar



Attachment 4b – 2013 Dentist Survey Summary Report

The Vermont Department of Health

2013 DENTIST SURVEY SUMMARY REPORT

Guidance • Support • Prevention • Protection

July, 2015

VERMONT
DEPARTMENT OF HEALTH

OUTLINE

- **Overview and Key Findings**
- **Survey Question Analysis**
- **Comparison with Previous Surveys**

SURVEY OVERVIEW

SURVEY DESCRIPTION

Completed by most dentists online with the license renewal in late summer 2013

Followed-up via mail and phone calls

The final response rate was 99.5%

- 1 dentist refused, 1 left area and not reached

SURVEY DESCRIPTION (continued)

Questions asked of dentists included:

- Gender and age
- Specialty
- Location and hours of practice
- Whether they were accepting new patients
- Whether they work with hygienists
- Years worked in Vermont
- Efforts to hire an associate

KEY FINDINGS

- There were 369 dentists working in Vermont
- 81% were primary care dentists, including:
  - *286 general dentists*
  - *12 pediatric dentists*
- 23% work 40 or more hours per week, while 55% work between 30 and 40 hours per week. *(This only counts direct patient care and does not include practice management)*
- 15% practice in more than one location

KEY FINDINGS (continued)

- The 369 dentists correspond to 290.8 Full Time Equivalents (FTEs) (1 FTE = 40 hours/week)
- 48% of the dentists are 55 or older
- 21% are 65 or older
- 6 of the 12 pediatric dentists are 60 or older
- 8 of the 24 orthodontists are 60 or older
- 5 of the 11 endodontists are 60 or older

KEY FINDINGS (continued)

As compared with 2011:

- There is 1 more dentist in total
- There are 6 more dentists under age 35 – but 3 fewer in the age group 35-54
- There are the same total number of dentists age 55 or older
- However, in 2013 there are 13 fewer in the 55-64 age group, and 13 more who are 65 or older, than there were in 2011.

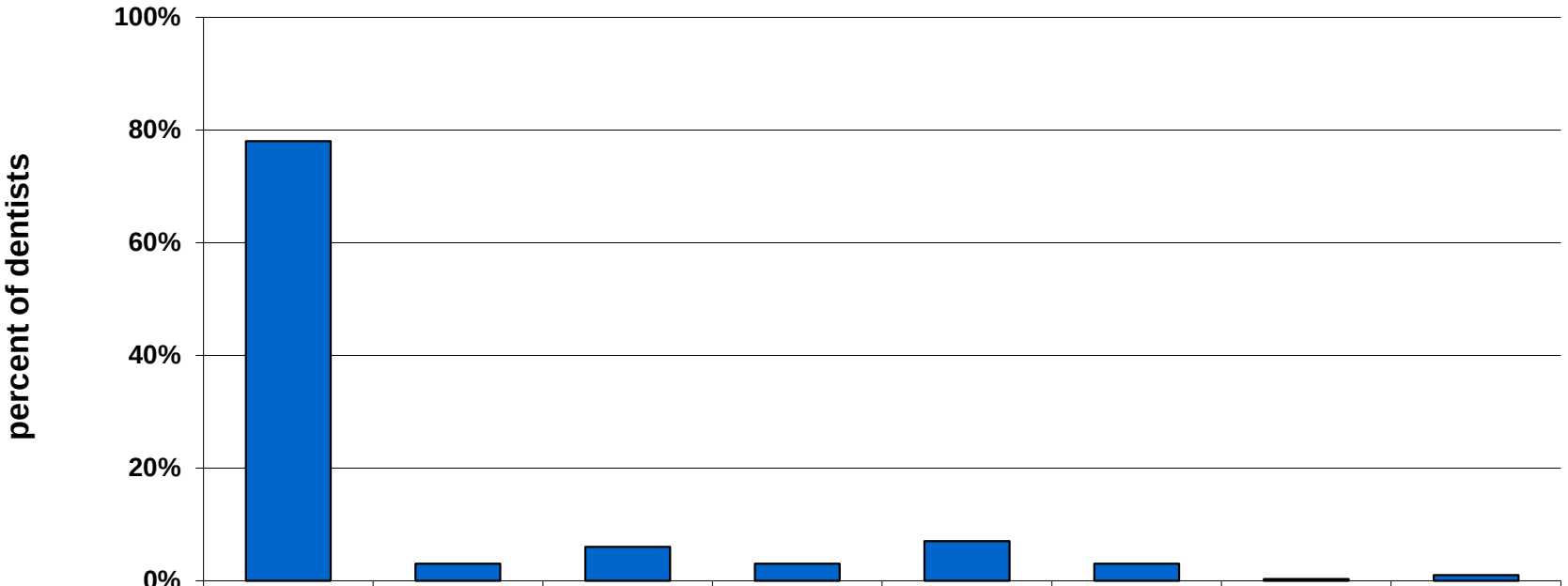
KEY FINDINGS (continued)

As compared with 2011:

- More dentists are working 40+ hours per week
- There are 9.4 more FTEs in primary care, and 0.3 more FTEs in specialty care
- Notable shift from 2-dentist to 3+-dentist practices
- Percentage accepting new Medicaid patients has decreased from 69% to 64%
- Only 36% accept 5+ new Medicaid patients / month
- Average wait time to primary care appointment has increased from 2.8 to 3.2 weeks

SURVEY QUESTION ANALYSIS

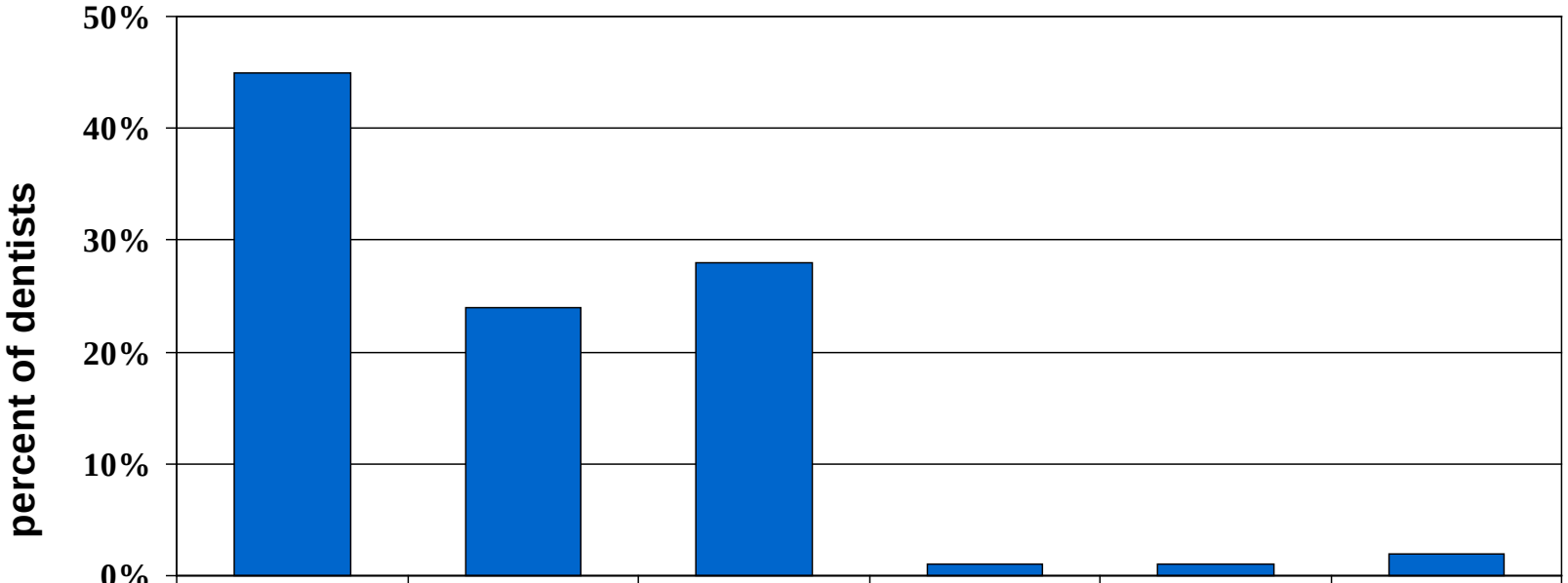
SPECIALTY



	General	Pediatric	Oral Surg	Endo-dontics	Ortho-dontics	Perio-dontics	Prostho-dontics	Other
Count	286	12	23	11	24	10	1	2
Percent	78%	3%	6%	3%	7%	3%	0%	1%

81% of dentists provide primary care (general or pediatric)

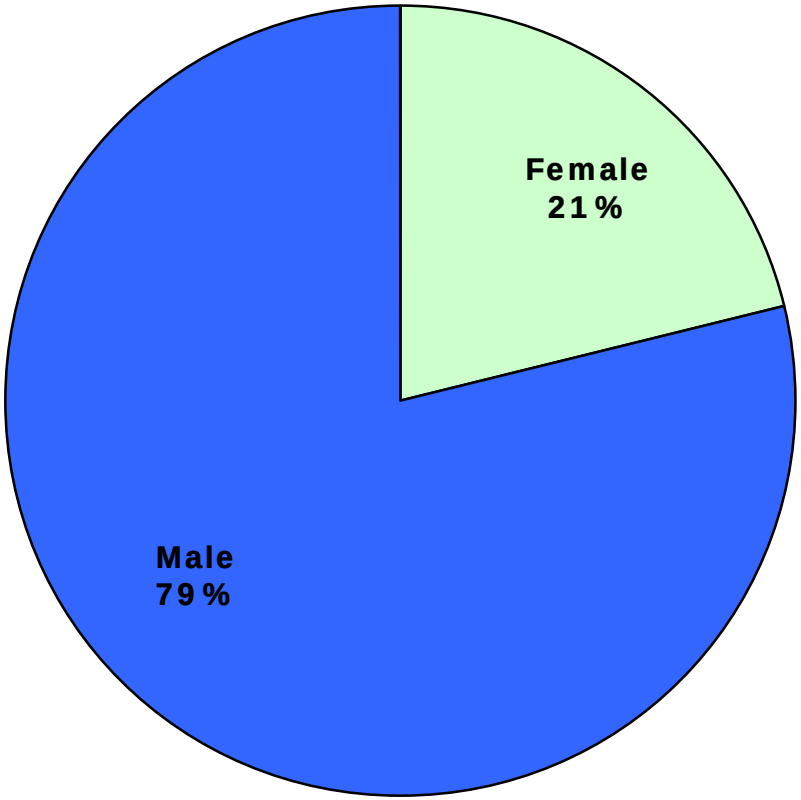
PRACTICE SETTING



	Solo Practice	Practice of 2 Dentists	Practice of 3 or more	Nursing Home	Volunteer Clinic	Other
Count	165	89	104	2	2	7
Percent	45%	24%	28%	1%	1%	2%

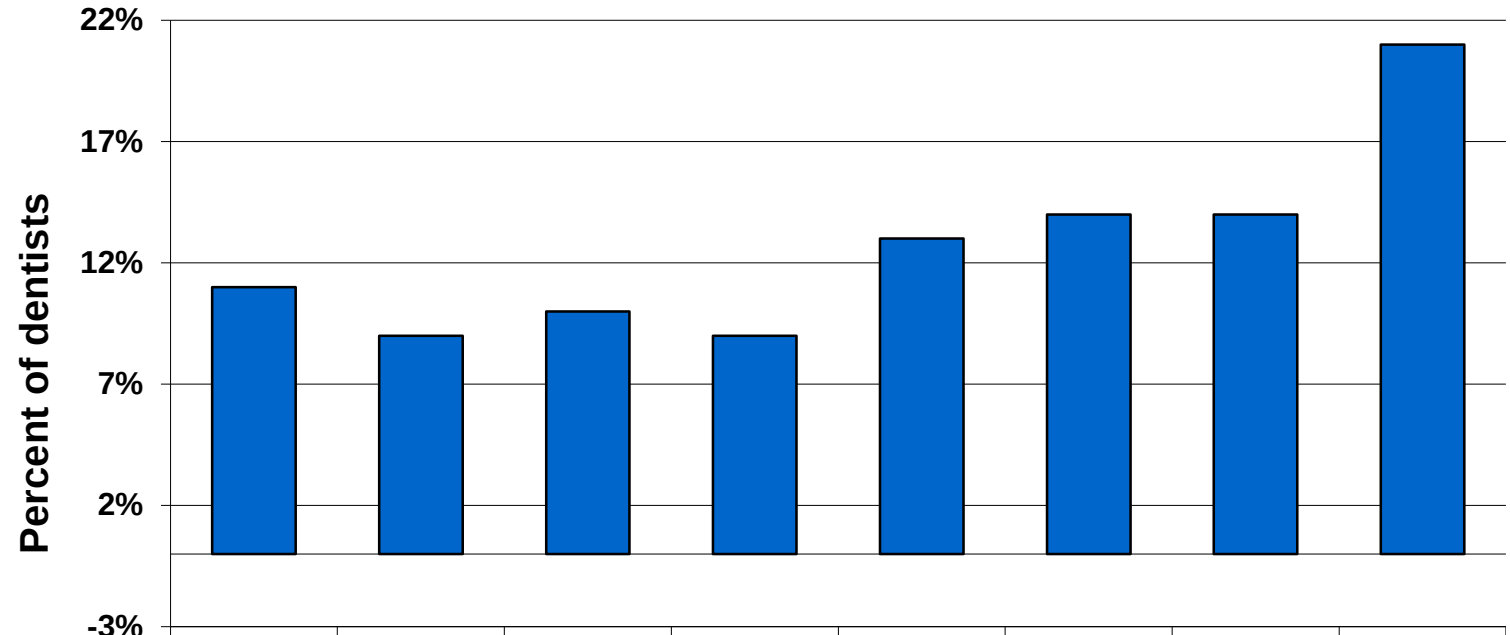
52% of dentists work in a group practice

GENDER



291 of the dentists are male, 78 are female

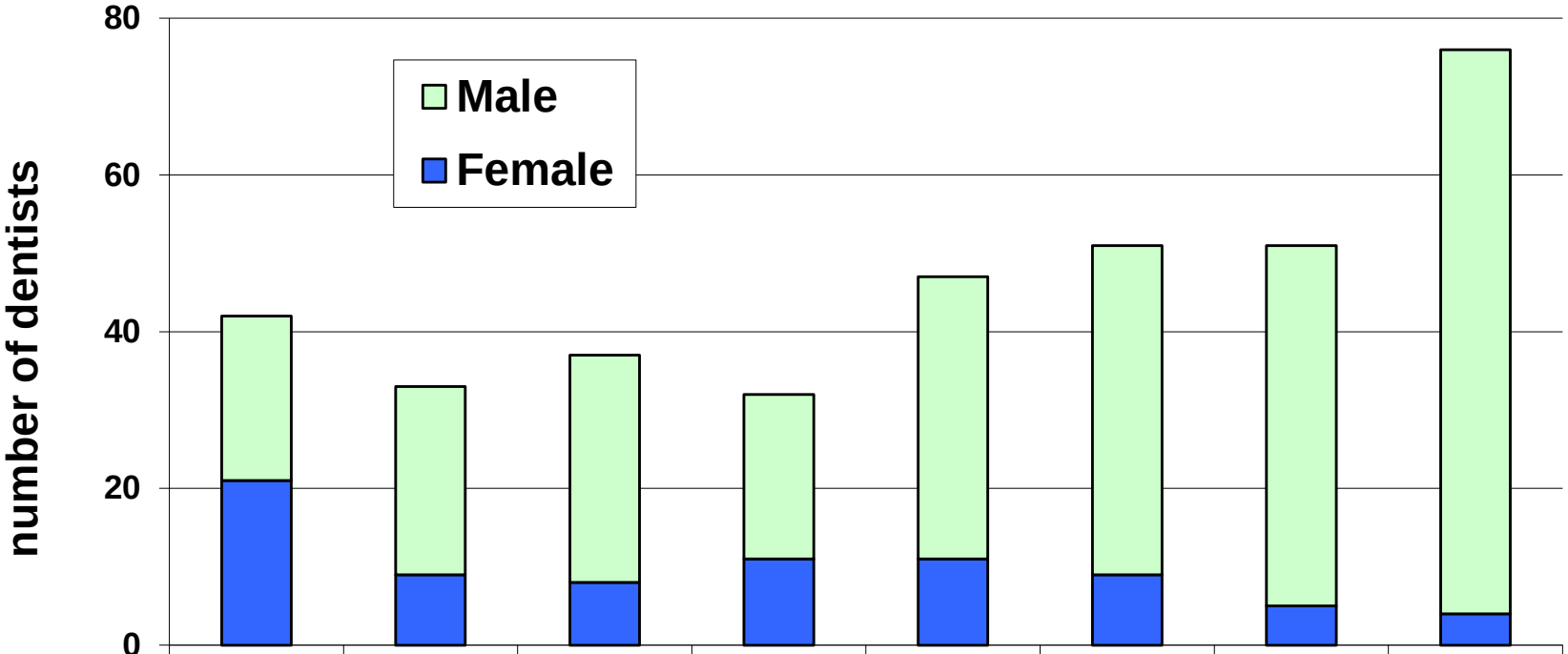
AGE DISTRIBUTION



	< 35	35-39	40-44	45-49	50-54	55-59	60-64	65+
Count	42	33	37	32	47	51	51	76
Percent	11%	9%	10%	9%	13%	14%	14%	21%

48% of all dentists are age 55 or older

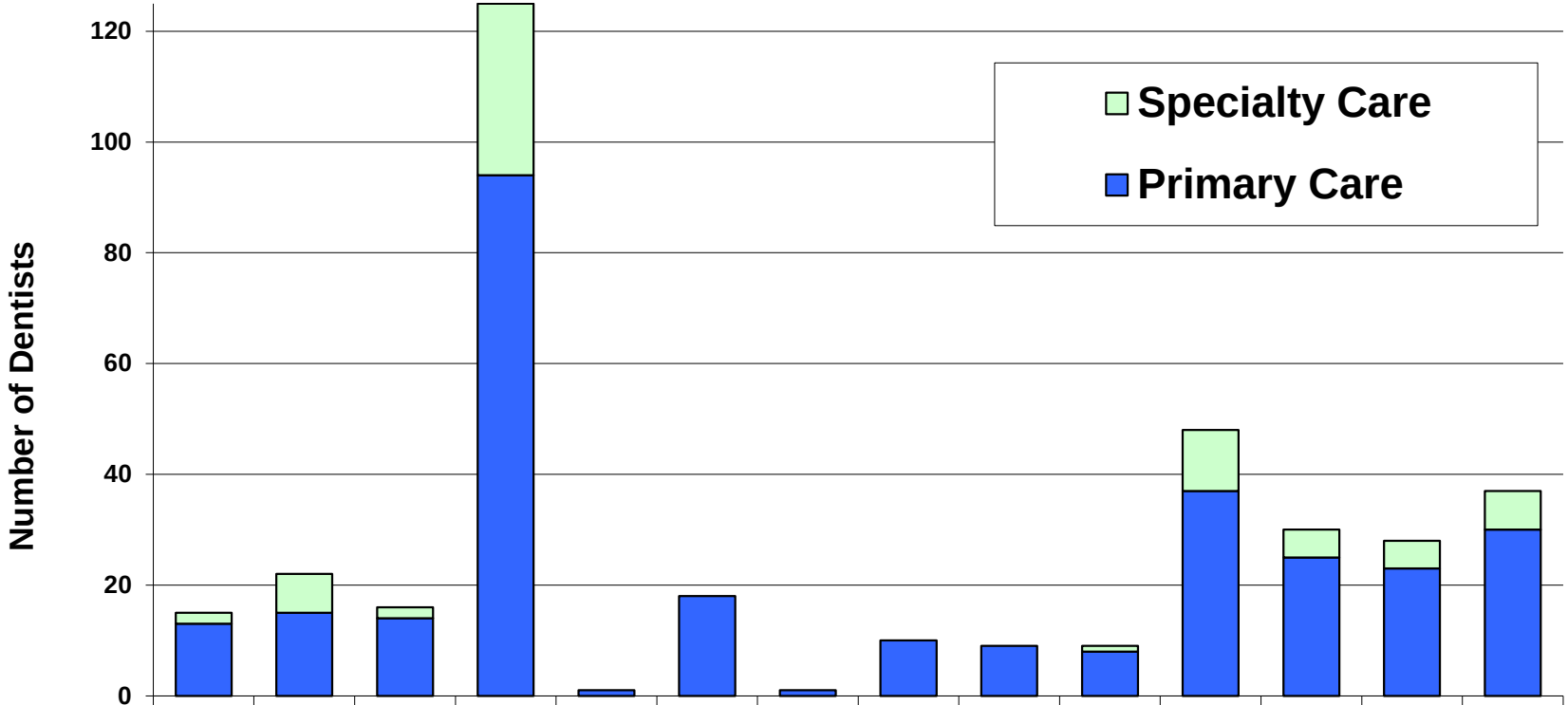
AGE DISTRIBUTION BY GENDER



	< 35	35-39	40-44	45-49	50-54	55-59	60-64	65+
Male	21	24	29	21	36	42	46	72
Female	21	9	8	11	11	9	5	4

41% of the males, but only 12% of the females, are age 60 or older

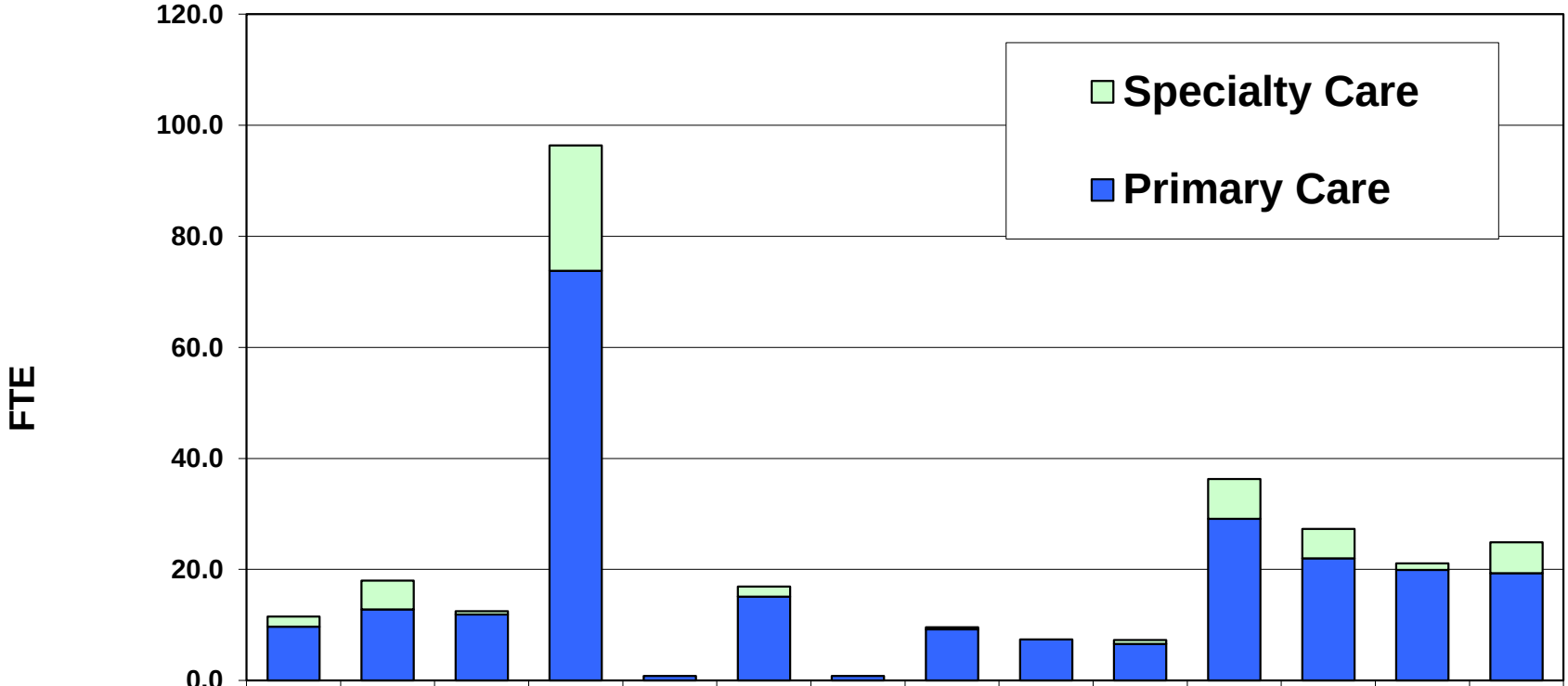
NUMBER OF DENTISTS BY COUNTY



	ADD	BEN	CAL	CHI	ESS	FRA	GI	LAM	ORA	ORL	RUT	WAS	WDM	WDR
Specialty Care	2	7	2	31	0	0	0	0	0	1	11	5	5	7
Primary Care	13	15	14	94	1	18	1	10	9	8	37	25	23	30

32% of primary care dentists, and 44% of specialists, work in Chittenden County

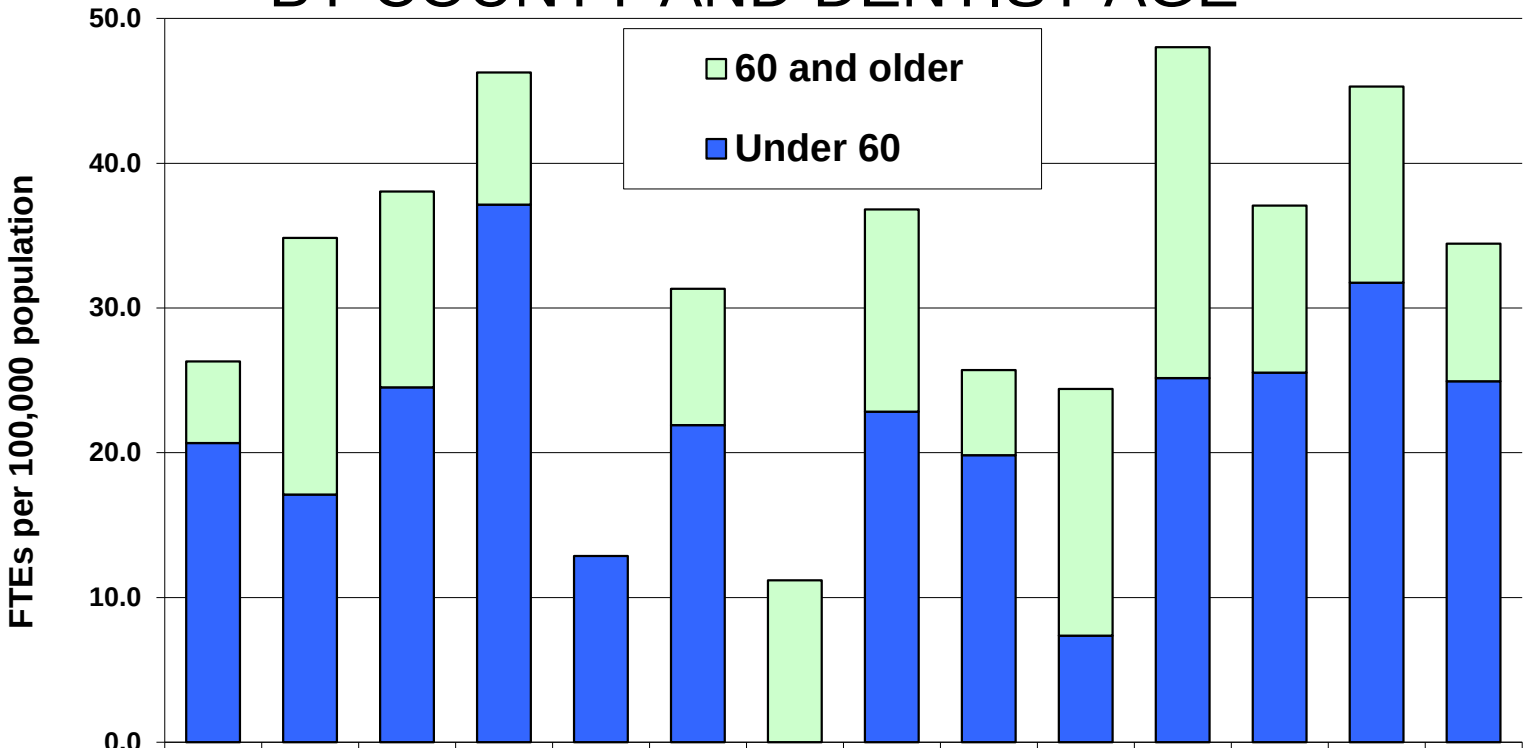
FULL TIME EQUIVALENT DENTISTS BY COUNTY



	ADD	BEN	CAL	CHI	ESS	FRA	GI	LAM	ORA	ORL	RUT	WAS	WDM	WDR
Specialty Care	1.8	5.2	0.6	22.6	0.0	1.8	0.0	0.4	0.0	0.7	7.2	5.3	1.2	5.6
Primary Care	9.7	12.8	11.9	73.8	0.8	15.1	0.8	9.2	7.4	6.6	29.1	22.0	19.9	19.3

31% of primary care FTEs, and 43% of specialists, are in Chittenden County

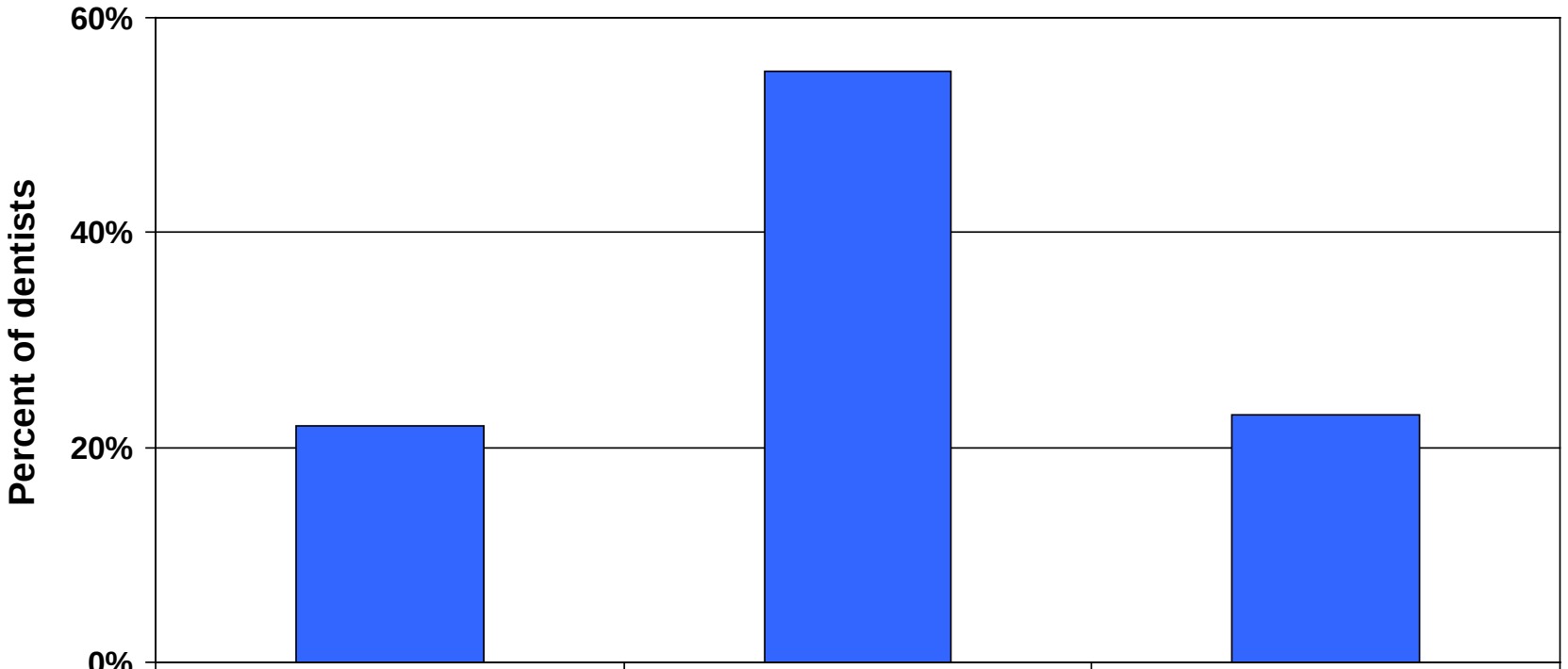
PRIMARY CARE DENTIST TO POPULATION RATIOS BY COUNTY AND DENTIST AGE



	ADD	BEN	CAL	CHI	ESS	FRA	GI	LAM	ORA	ORL	RUT	WAS	WDM	WDR
60 and older	5.6	17.7	13.5	9.1	0.0	9.4	11.2	14.0	5.9	17.1	22.8	11.5	13.6	9.5
Under 60	20.7	17.1	24.5	37.1	12.9	21.9	0.0	22.8	19.8	7.4	25.2	25.5	31.7	24.9

Rutland County has the highest ratio – but also highest ratio of age 60 and older

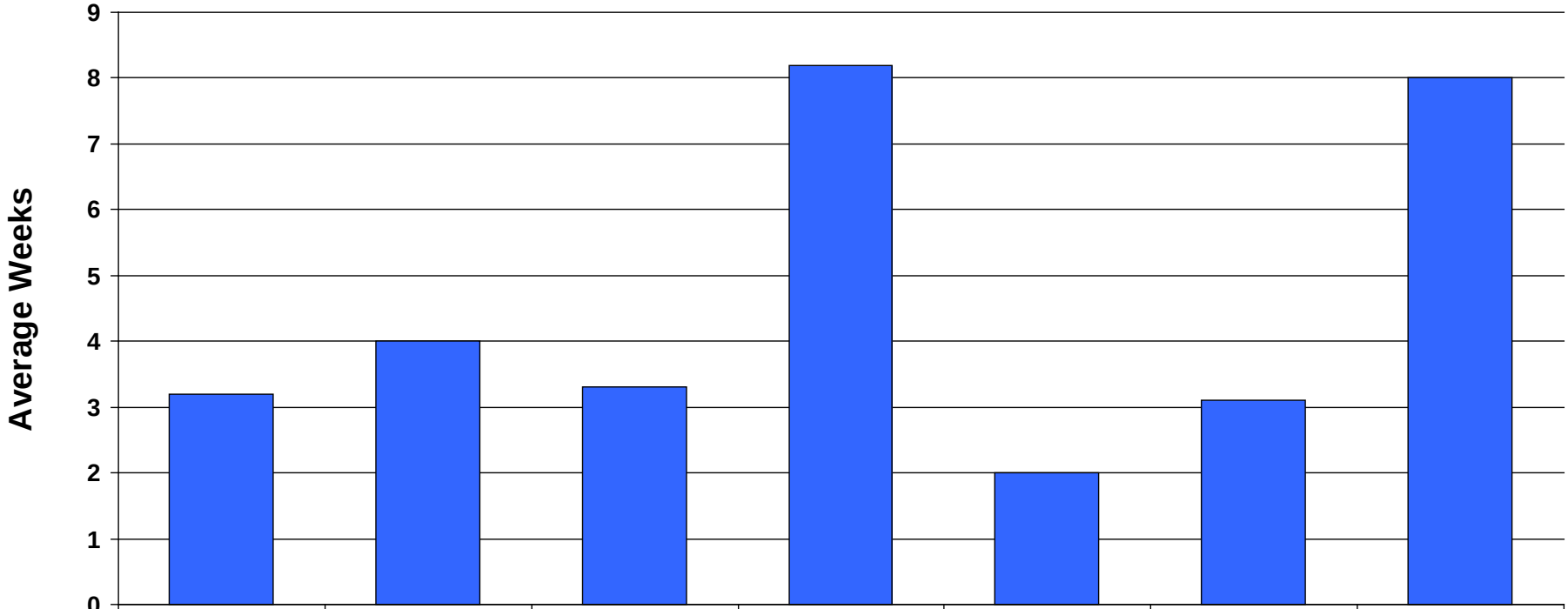
PATIENT CARE HOURS PER WEEK



	< 30 hrs / wk	30 - 39 hrs / wk	40+ hrs / wk
Count	81	204	84
Percent	22%	55%	23%

The average dentist provides 33 hours per week of patient care

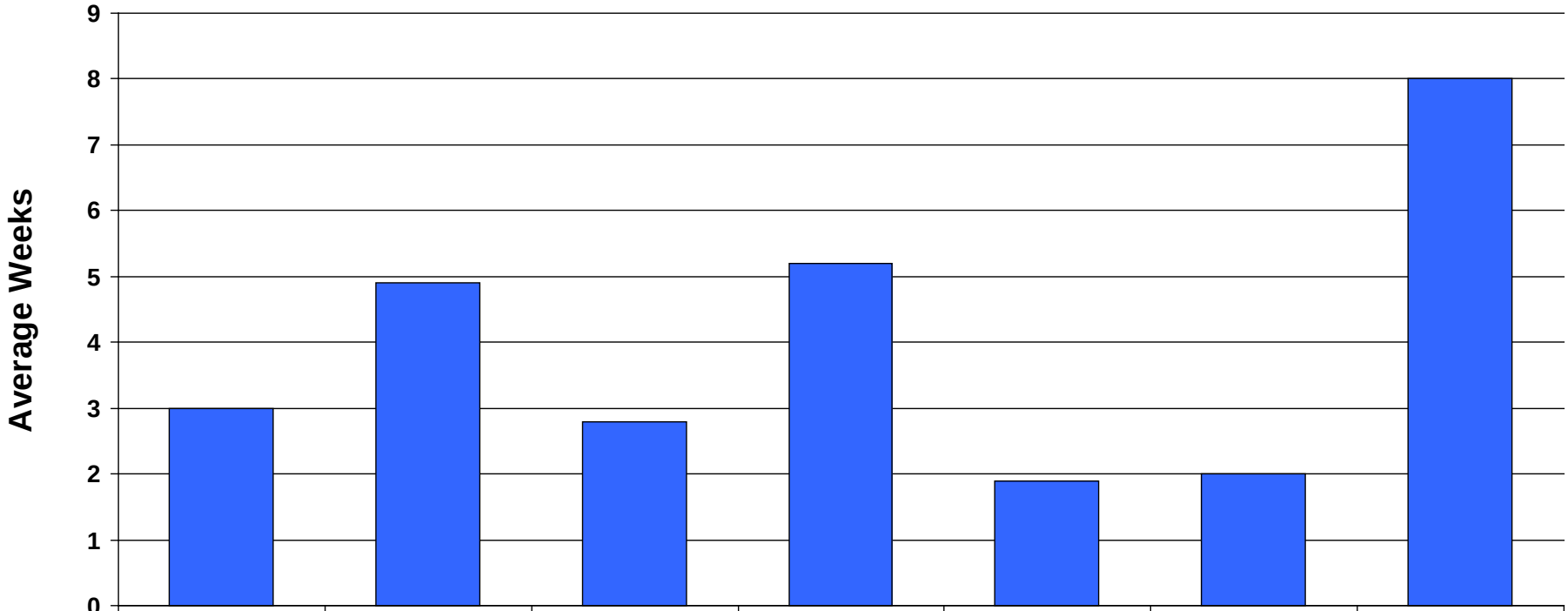
AVERAGE WAIT TIME FOR NEW PATIENTS



	General	Pediatric	Oral Surg	Endo-dontics	Ortho-dontics	Perio-dontics	Prostho-dontics
Weeks	3.2	4.0	3.3	8.2	2.0	3.1	8.0

Average wait times have increased since 2011

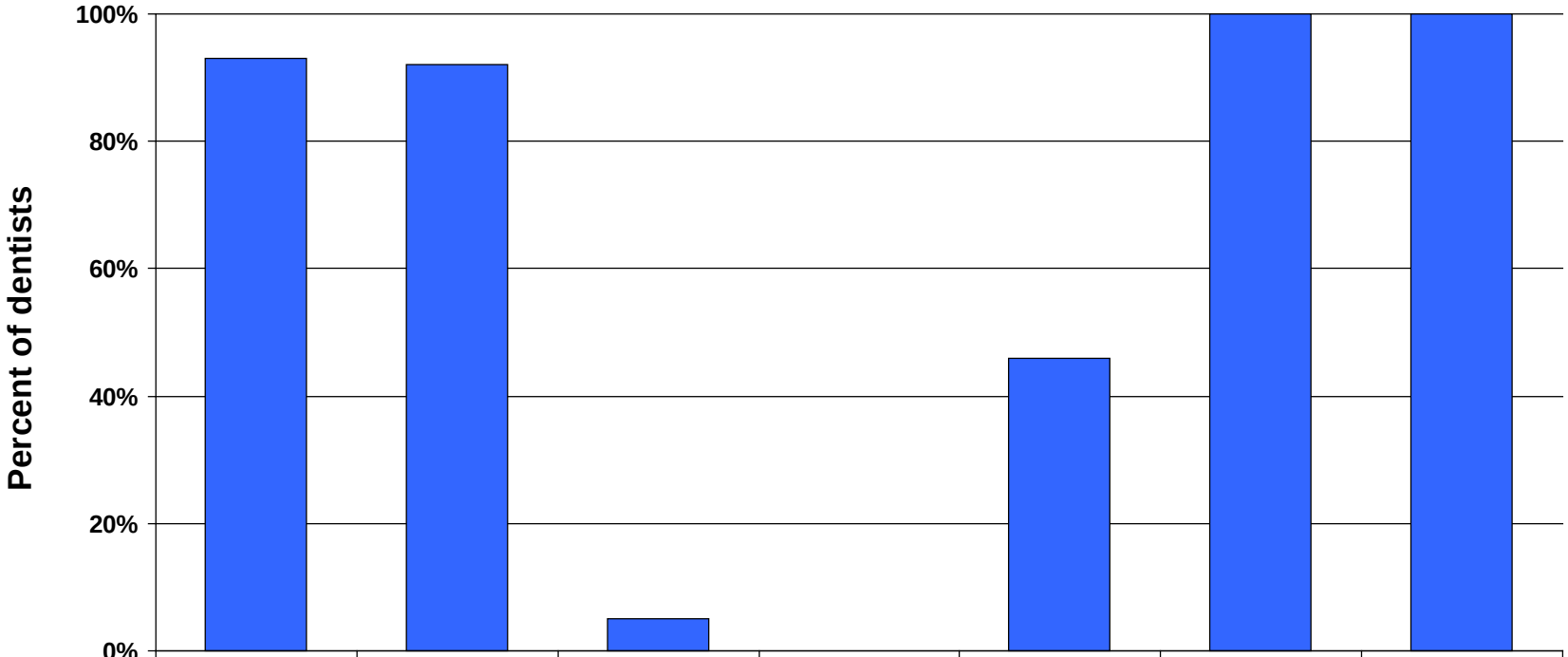
AVERAGE WAIT TIME FOR CURRENT PATIENTS



	General	Pediatric	Oral Surg	Endo-dontics	Ortho-dontics	Perio-dontics	Prostho-dontics
Weeks	3.0	4.9	2.8	5.2	1.9	2.0	8.0

Average wait times have increased since 2011

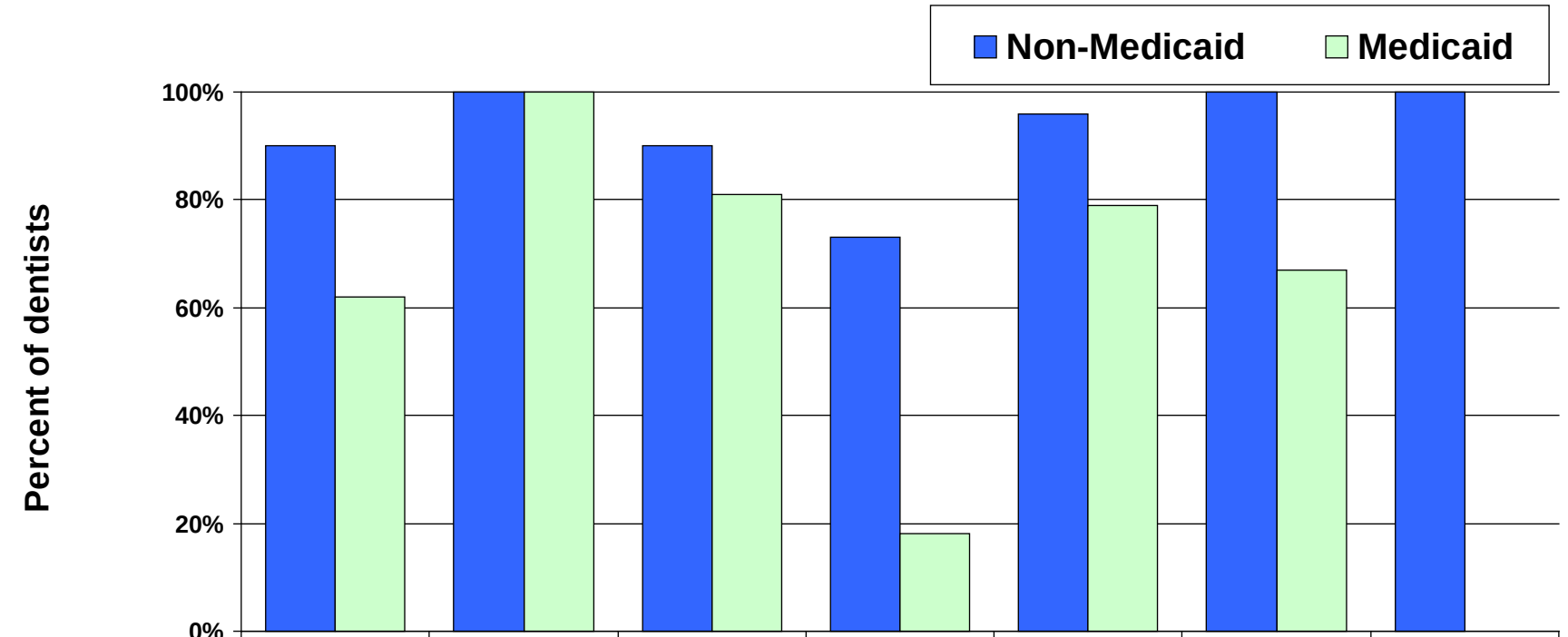
WORK WITH HYGIENISTS



	General	Pediatric	Oral Surg	Endo-dontics	Ortho-dontics	Perio-dontics	Prostho-dontics
Count	265	11	1	0	11	10	1
Percent	93%	92%	5%	0%	46%	100%	100%

Overall 82% of dentists work with hygienists

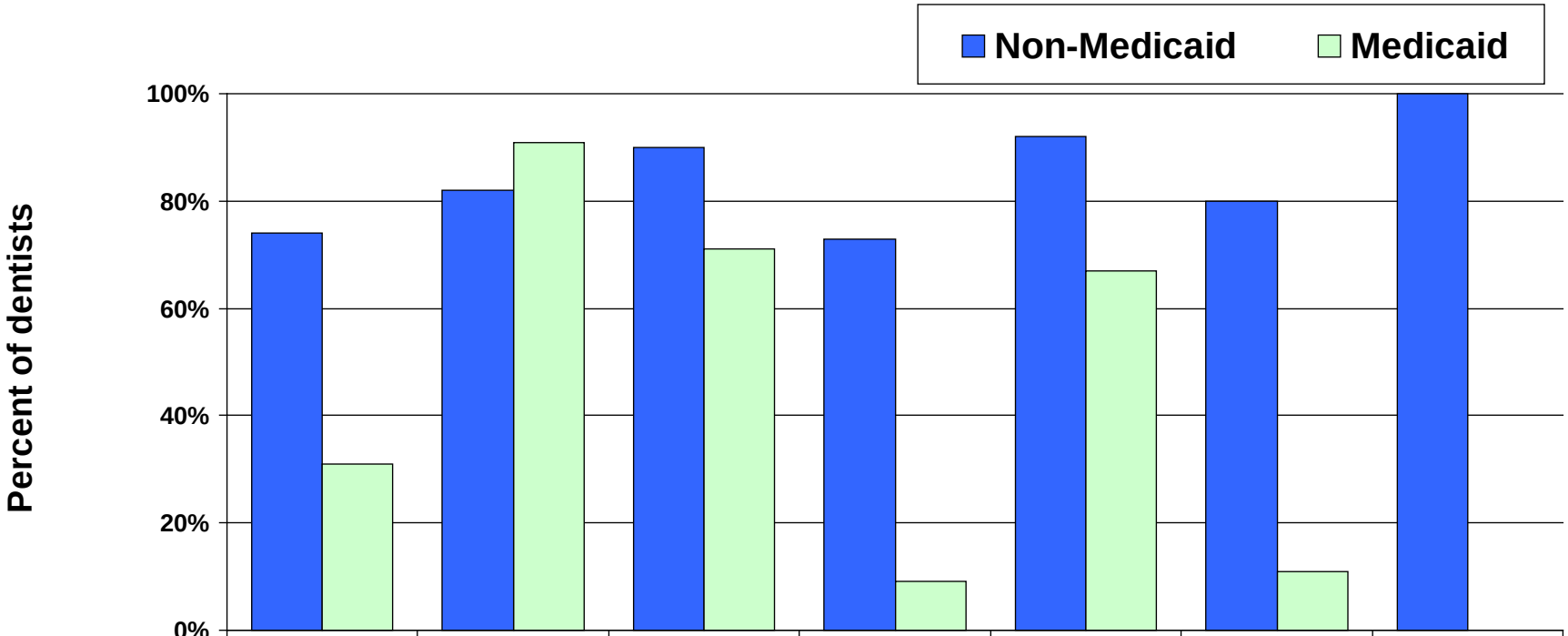
ACCEPTING NEW PATIENTS



	General	Pediatric	Oral Surg	Endo-dontics	Ortho-dontics	Perio-dontics	Prostho-dontics
Non-Medicaid	90%	100%	90%	73%	96%	100%	100%
Medicaid	62%	100%	81%	18%	79%	67%	n.a.

91% accepted new non-Medicaid patients, 64% accepted new Medicaid patients

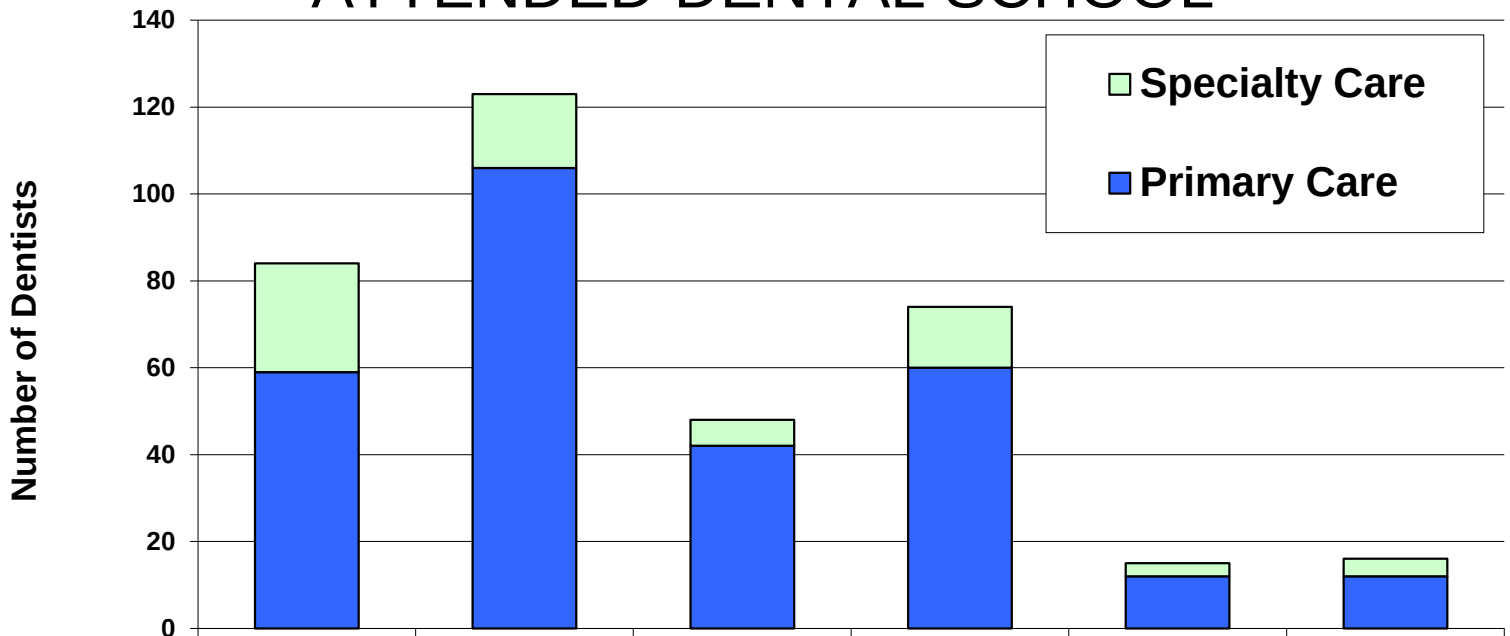
ACCEPTING 5+ NEW PATIENTS / MONTH



	General	Pediatric	Oral Surg	Endo-dontics	Ortho-dontics	Perio-dontics	Prostho-dontics
Non-Medicaid	74%	82%	90%	73%	92%	80%	100%
Medicaid	31%	91%	71%	9%	67%	11%	n.a.

77% accepted 5+ new non-Medicaid patients, 36% accepted 5+ new Medicaid patients

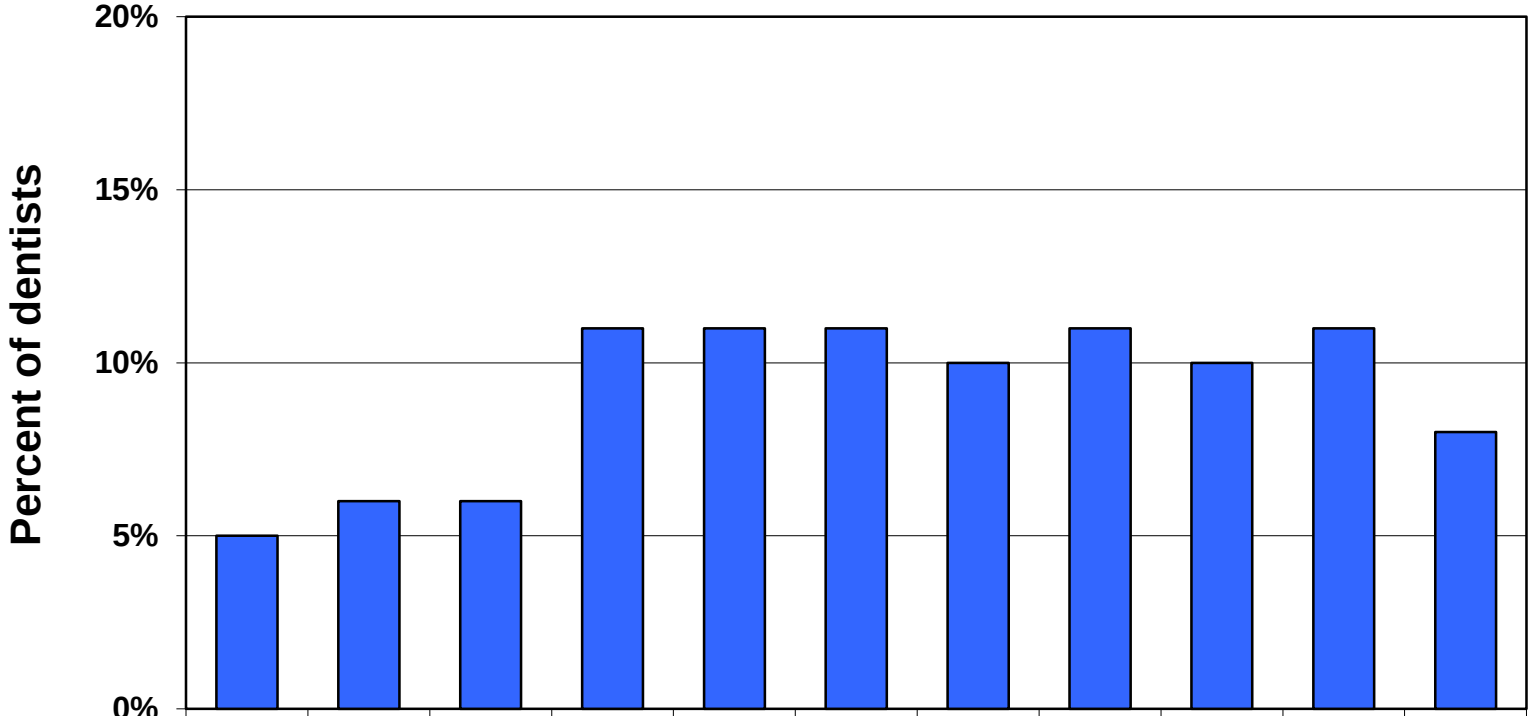
WHERE VERMONT DENTISTS ATTENDED DENTAL SCHOOL



	New England	Mid Atlantic	South	Central	West	Canada
Specialty Care	25	17	6	14	3	4
Primary Care	59	106	42	60	12	12

36% of primary care dentists were trained in the mid-Atlantic region.
36% of all specialty care dentists were trained in New England.

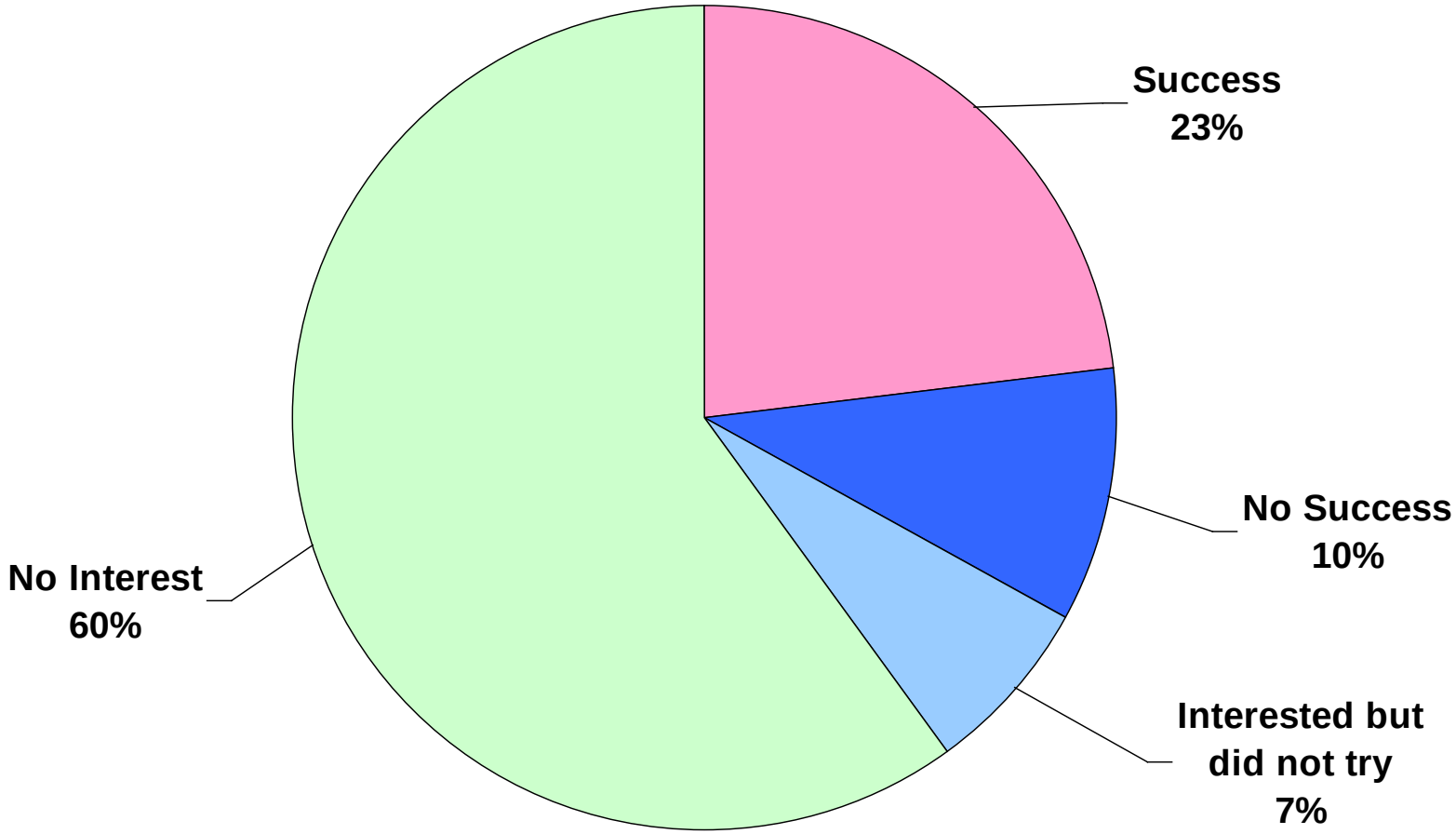
YEARS WORKED IN VERMONT



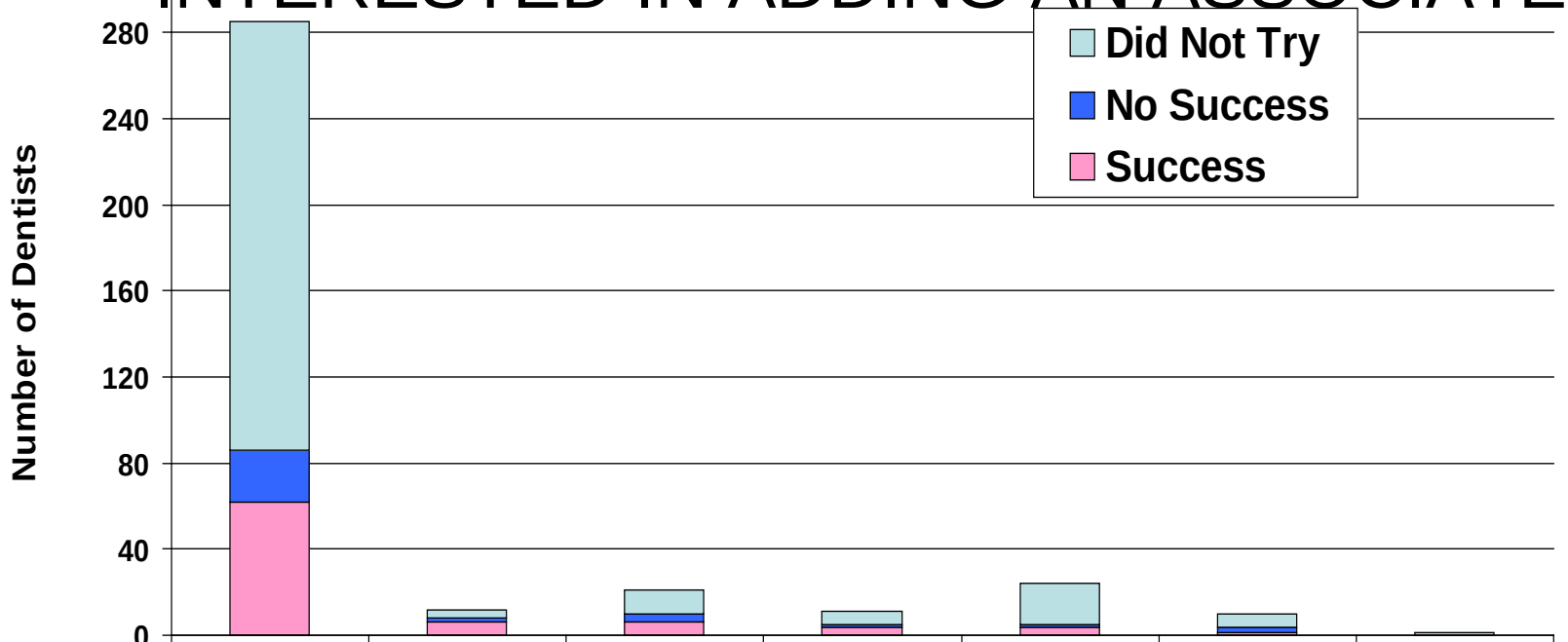
	<1 year	1-2 yrs	3-4 yrs	5-9 yrs	10-14 yrs	15-19 yrs	20-24 yrs	25-29 yrs	30-34 yrs	35-39 yrs	40+ yrs
Count	20	23	21	39	41	39	38	41	36	41	28
Percent	5%	6%	6%	11%	11%	11%	10%	11%	10%	11%	8%

40% of the dentists have worked in Vermont for 25 or more years.

INTERESTED IN ADDING AN ASSOCIATE



INTERESTED IN ADDING AN ASSOCIATE



	General	Pediatric	Oral Surg	Endo-dontics	Ortho-dontics	Perio-dontics	Prostho-dontics
Did Not Try	199	4	11	6	19	6	1
No Success	24	2	4	1	1	3	0
Success	62	6	6	4	4	1	0

Overall, 40% of dentists were interested in recruiting an associate

COMPARISON WITH PREVIOUS SURVEYS

Numbers of Dentists by Specialty, 2003-2013

	Count by main specialty					
	2003	**2005**	**2007**	**2009**	**2011**	**2013**
Total active dentists	367	352	355	366	368	369
Primary care dentists	293	278	282	292	297	298
General practice	284	269	272	280	288	286
Pediatric dentistry	9	9	10	12	9	12
Specialist dentists	74	74	73	74	71	71
Oral Surgery	22	19	24	26	23	23
Endodontics	10	9	7	9	10	11
Orthodontics	26	27	27	24	25	24
Periodontics	10	12	11	12	11	10
Prosthodontics	3	4	2	2	1	1
Other Specialties	3	3	2	1	1	2

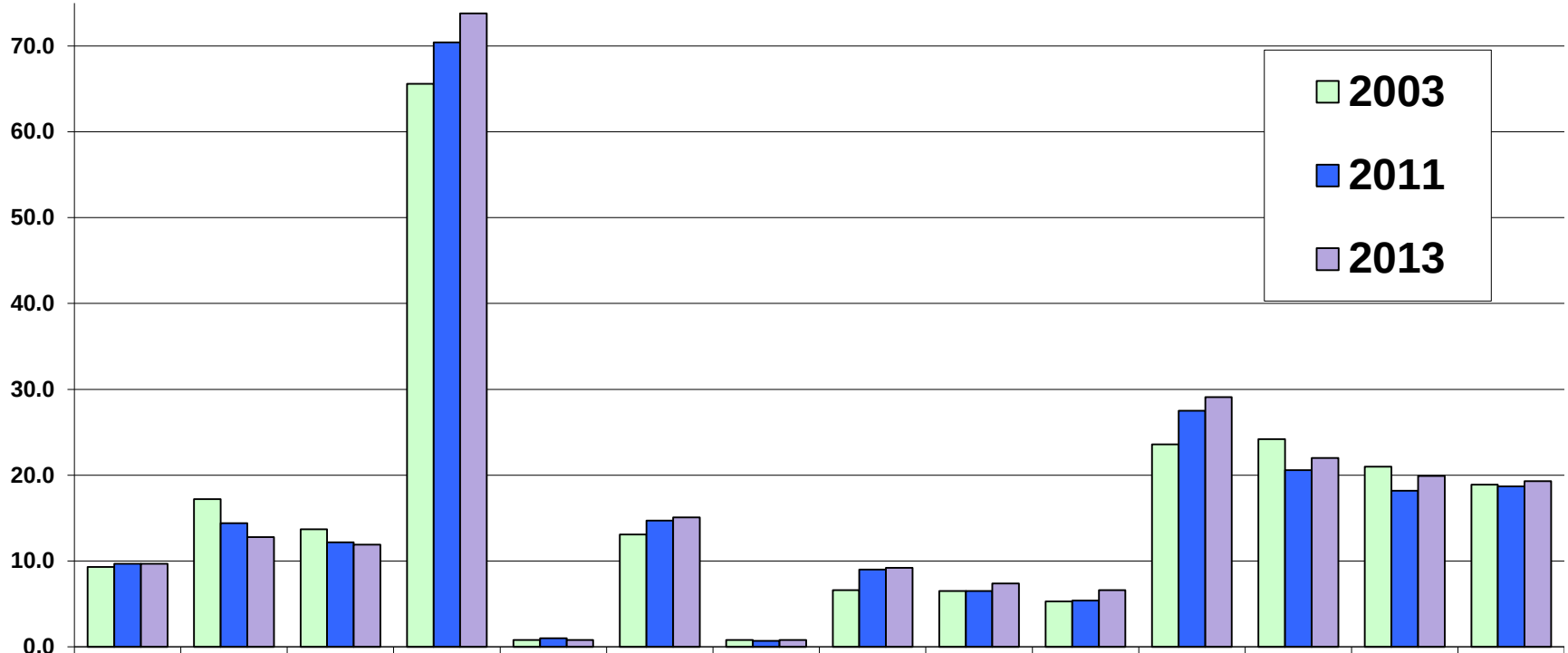
Full Time Equivalents by specialty, 2003-2013

	Full Time Equivalents (FTE)					
	2003	**2005**	**2007**	**2009**	**2011**	**2013**
Total active dentists	280.8	267.1	269.8	271.6	281.2	290.8
Primary care dentists	226.7	216.0	221.6	217.7	229.0	238.4
General practice	219.8	209.1	214.9	209.9	222.6	230.4
Pediatric dentistry	6.9	6.9	6.7	7.8	6.5	8.0
Specialist dentists	54.1	51.1	48.2	53.9	52.1	52.4
Oral Surgery	17.1	15.1	16.2	19.0	17.6	16.4
Endodontics	8.6	7.1	6.4	7.0	7.1	9.2
Orthodontics	17.5	16.9	17.2	17.4	17.9	17.1
Periodontics	6.5	7.2	5.7	7.8	7.7	7.0
Prosthodontics	1.7	1.9	1.5	1.6	0.9	0.9
Other Specialties	2.6	2.7	1.2	1.0	1.0	1.8

Selected indicators, 2003-2013

	2003	2005	2007	2009	2011	2013
Total number of active dentists	367	352	355	366	368	369
Percent age 55 or older	35%	41%	44%	47%	49%	48%
Percent age 60 or older	17%	22%	26%	30%	34%	34%
Percent age 65 or older	6%	9%	10%	13%	17%	21%
Average patient care hours per week	31	31	31	30	31	33
Primary care:						
FTEs / 100,000 population	36.7	34.8	35.5	34.8	36.6	38.0
% accepting new patients	88%	88%	90%	92%	92%	90%
% accepting new Medicaid patients	57%	59%	60%	65%	69%	63%
Average weeks wait - new patients	3.2	3.6	3.5	2.9	2.8	3.2
Percent working with dental hygienists	88%	88%	90%	91%	92%	93%
% of FTEs in Chittenden County	29%	29%	30%	31%	31%	31%
Specialty care:						
FTEs / 100,000 population	8.8	8.2	7.7	8.6	8.3	8.4
% of FTEs in Chittenden County	44%	44%	44%	42%	41%	43%

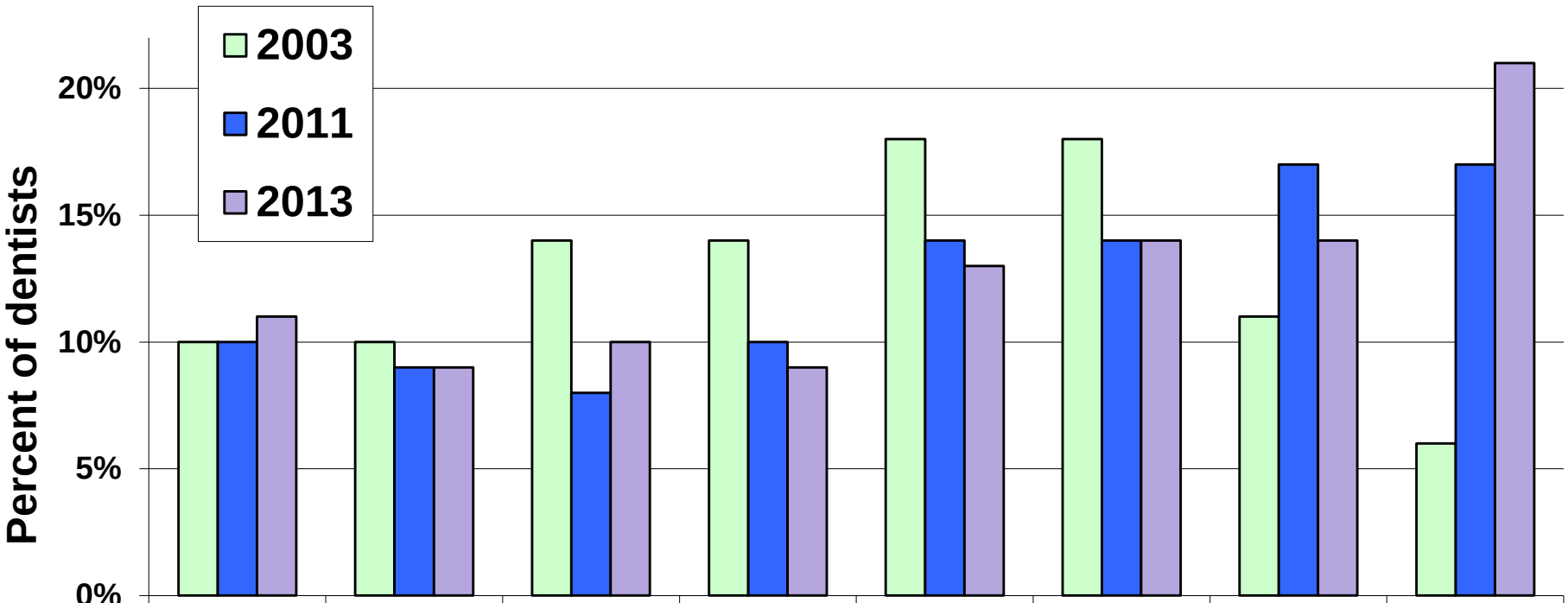
PRIMARY CARE FTEs, BY COUNTY, 2003-2013



	ADD	BEN	CAL	CHI	ESS	FRA	GI	LAM	ORA	ORL	RUT	WAS	WDM	WDR
2003	9.3	17.2	13.7	65.6	0.8	13.1	0.8	6.6	6.5	5.3	23.6	24.2	21.0	18.9
2011	9.7	14.4	12.2	70.4	1.0	14.7	0.7	9.0	6.5	5.4	27.5	20.6	18.2	18.7
2013	9.7	12.8	11.9	73.8	0.8	15.1	0.8	9.2	7.4	6.6	29.1	22.0	19.9	19.3

Bennington County saw a marked decline in FTEs

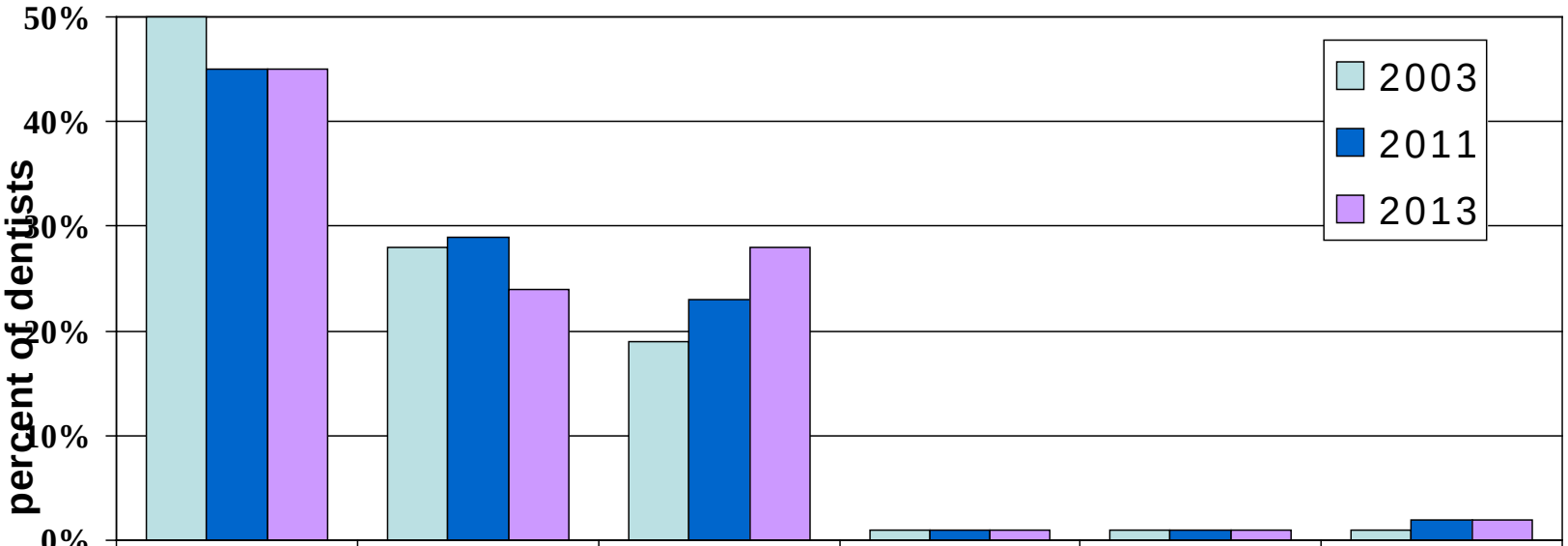
AGE DISTRIBUTION, 2003-2013



	< 35	35-39	40-44	45-49	50-54	55-59	60-64	65+
2003	10%	10%	14%	14%	18%	18%	11%	6%
2011	10%	9%	8%	10%	14%	14%	17%	17%
2013	11%	9%	10%	9%	13%	14%	14%	21%

The dentist workforce is getting older

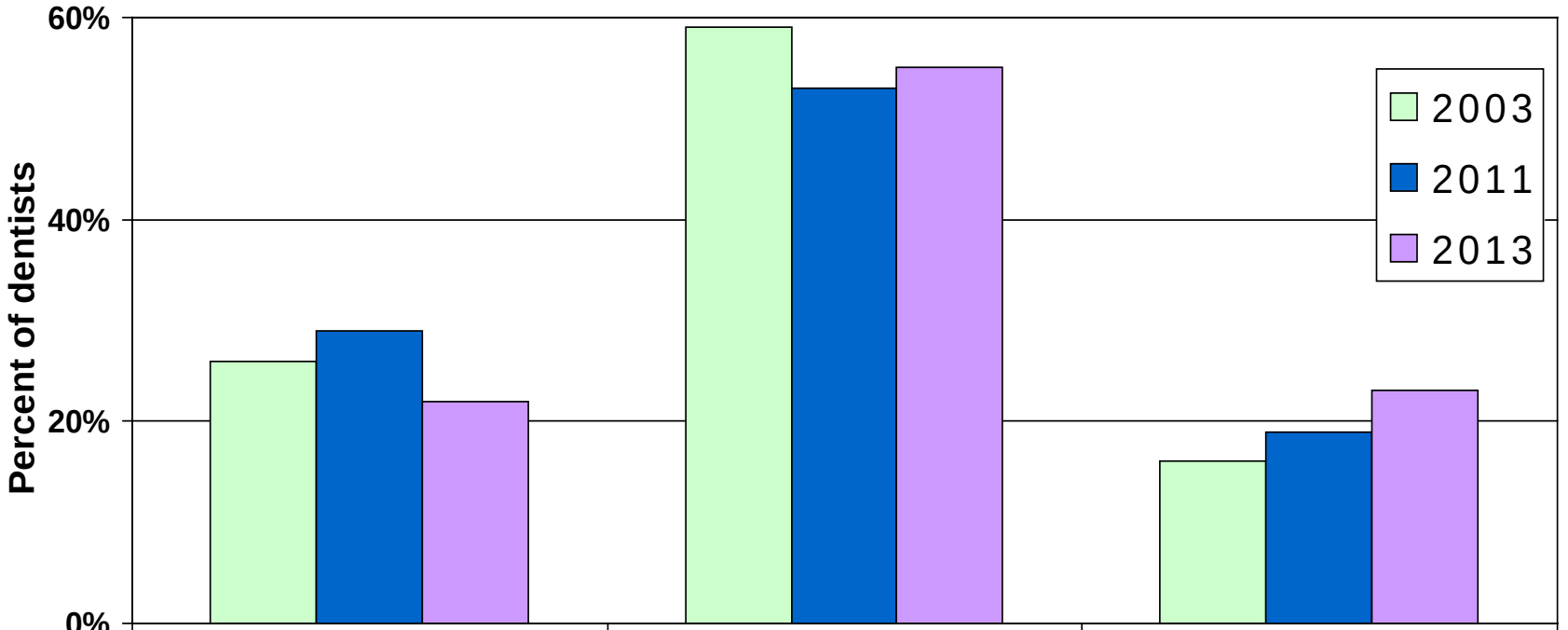
PRACTICE SETTING, 2003-2013



	Solo Practice	Practice of 2 Dentists	Practice of 3 or more	Nursing Home	Volunteer Clinic	Other
2003	50%	28%	19%	1%	1%	1%
2011	45%	29%	23%	1%	1%	2%
2013	45%	24%	28%	1%	1%	2%

Many dentists shifted from a 2-dentist to a 3+-dentist practice since 2011

PATIENT CARE HOURS PER WEEK



	< 30 hrs / wk	30 - 39 hrs / wk	40+ hrs / wk
2003	26%	59%	16%
2011	29%	53%	19%
2013	22%	55%	23%

More dentists work 40+ hours a week than in the past

Attachment 5 - Strategic Plan Priorities Matrix (RecruitmentRetention)*

	Who has been working on it	Contact person or entity (primary responsiblity)	WFWG / Other	Tasks (pending and ongoing)	Tasks (completed)	Progress	Timeline or due date	Questions/Comments	Cost (Low, Mod, High)	Priority
RECOMMENDATIONS: RECRUITMENT AND RETENTION										
Recommendation #4: Based upon input and documentation from the Workgroup, the Vermont Department of Health, Area Health Education Center (AHEC) and Bi-State Primary Care Association ~~the Secretary of Administration~~ should educate and work with Vermont's congressional delegation to encourage changes in how National Health Service Corp assignees are placed. The delegation should work with other similarly affected states' delegations in this effort.	UVM-OPC, VDH, AHEC, Bi-State	Elizabeth Cote	WFWG		COMPLETED: Work done by David Reynolds, UVM-OPC/AHEC, congressional delegation (spec. Bernie Sanders) and Bi-State over several years. Resulted in VT eligibile for consideration in the federal NHSC SLRP program, based on adjusted guidelines.	Considerable progress: work was done by UVM-OPC/AHEC, which led to Vermont's eligibility for consideration in the federal NHSC SLRP program, based on adjusted guidelines. Continued work on this item is of low priority and should be revisted annually.	revisit annually	Additional work on the NHSC federal LRP is not high priority at this time due to political climate and change very unlikely.	low	LOW
Recommendation #5 : In the selection criteria and admission of qualified students, the state college system, UVM (including the UVM Medical School and the UVM Medical Center Medical and Dental Residency Programs) should include assessment of the qualities which make a student more likely to specialize in primary care and practice in rural, underserved areas.	UVM-COM, VSC	Charlie MacLean/Nancy Shaw?				Some progress has been made: an update has been requested at UVM-COM, but work group needs to discuss how to move forward.			low	LOW
			WFWG	5.1. Workgroup discussion regarding how to narrow this to do-able tasks.		No progress: work group to discuss.	Q4 2015			
Recommendation #6: In the education and training of students in the health field, the state college system, including the UVM Medical School and UVM Medical Center Residency Program, should create a culture which promotes primary care specialties, serving disadvantaged populations and practicing in rural areas.	UVM-COM; UVM-MC GME					Some progress has been made: regional AHECs do some of this work, but the group could develop a method to track the initiatives that support this recommendation (there are many supporting programs)		There are issues surrounding limited educational capacity of preceptors and competition for preceptors	low	low
			WFWG	6.1. Workgroup discussion regarding how to narrow this to do-able tasks. For example could we focus here on the rural rotations in Family Medicine (task for GME?) OR are there no actual tasks for the Workgroup??? (other than hearing a report-out?)		No progress to date: work group to determine if this task is actionable by work group, or just hearing a report out from UVM/VSCs.	Q3/Q4 2015			