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

Wednesday, February 3, 2016; 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
1	3:00-3:05	Welcome and Introductions	Mary Val Palumbo Robin Lunge	N	• Attachment 1: 2-3-16 Meeting Agenda
2	3:05-3:10	Approval of Meeting Minutes	Mary Val Palumbo Robin Lunge	Y	• Attachment 2: 10-21-15 Meeting Minutes
3	3:10-3:30	VHCIP updates: 2015 Year in Review Review of 2016 WFWG Work Plan	Georgia Maheras, AoA Sarah Kinsler, DVHA	N	• Attachment 3a: 2015 Year In Review • Attachment 3b: 2016 Work Force Work Group Work Plan
4	3:30-3:40	Updates: - Demand Modeling update - Brainstorming session at legislature – psychiatric nursing shortage - Barriers to licensure – mental health clinicians	Mary Val Palumbo Robin Lunge Group Discussion	N	
5	3:40-3:55	Workforce Supply Data Proposal – Next Steps	Dawn Philibert, VDH	Y	• Attachment 5 - Proposal for Analyzing Vermont Workforce Supply Data
6	3:55 – 4:20	Presentation and Discussion: Care Management Inventory	Pat Jones, GMCB Erin Flynn,	N	• Attachment 6 - Care Management Inventory Presentation

			DVHA		
7	4:20-4:55	Discussion : Strategic Plan - Improving, Expanding and Populating the Educational Pipeline	Mary Val Palumbo Robin Lunge Group Discussion	N	• Attachment 7 - Strategic Plan Priorities Matrix (Educational Pipeline)*
8	4:55-5:00	Public Comment/Wrap Up/Next Steps	Mary Val Palumbo Robin Lunge	N	

* Please note: for this discussion we will be focusing on Recommendations #7-17 of the Work Force Strategic Plan

Attachment 2: 10-21-15 Meeting Minutes

Vermont Health Care Innovation Project
Workforce Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, October 21, 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 3:00pm. A roll call attendance was taken and a quorum was not present.	
2. Approval of August minutes	Due to the lack of a quorum, approval of August 2015 minutes will be postponed until December 2015 meeting, with a correction to the minutes from Dawn Philibert: Chris Winters is not within the AHS Secretary's office, but at the Secretary of State's office.	
3. Updates: Demand Modeling; NASHP conference on Community Health Workers; Future of Nursing Grant Relicensure Survey—2015; Other updates	*Demand Modeling update:* Amy Coonradt provided an update. The State and its selected vendor have negotiated a contract, but the contract is still pending at CMMI for approval. We hope to execute a contract by the end of the calendar year. *NASHP conference on Community Health Workers:* Georgia was not able to attend, but provided a written update, which Amy relayed to the group. 1. CHWs will be a big part of the APHA meeting in November 2. There is still a lot of disagreement about what a CHW actually is and it seems like states are all over the place in defining roles and responsibility. 3. Medicaid recently changed their reimbursement structure (allowing more flexibility) and they are encouraging states to pursue more SPAs and waivers to support this work. Note: this isn't really applicable to Vermont due to our waiver, but a good information to have. 4. HRSA has interest in this area, but is concerned that we can't really count CHWs so therefore we can't change how we pay them or credential them. 5. CDC was non-committal, other than to say that integration of CHWs is important and we need to better understand what they do around the country. *Future of Nursing Grant Relicensure Survey:*	

Agenda Item	Discussion	Next Steps
	Mary Val provided an update. The project has received two additional years of funding, and will select two positions to receive Community Health Worker training through the Community College of Vermont. There are currently discussions on how the CHWs can help the nurses with various populations and different settings. Questions still remain regarding how to count CHWs and hand off patients to them safely. The community health workers for this grant were identified by the VNA of Chittenden county. *Other statewide updates:* Paul Bengtson shared that the Robert Wood Johnson Foundation visited St. Johnsbury as part of their rethinking about redirecting future foundation investments in healthcare reform. They expressed interest in Accountable Communities for Health work in St. Johnsbury and how these structures can function and bring together carious community and social services to address issues for the future. Lorilee Schoenbeck gave an update on the development of postgraduate career training and resident training program for naturopaths. Tom Alderman discussed a work group established by the legislature that will function with federal funds that come through the Agency of Education. The work group will work to create statewide programs of study and establish common outcomes instead of having different programs at different technical centers, and will also take an inventory of currently successful programs and try to replicate them around the state and scale them up.	
4. Update: Work Force Supply Data/Surveys at VDH	Dawn Philibert gave an update on provider reports and surveys and led a discussion on next steps for the work group. The following points were discussed: - At present VDH has completed surveying and reporting on the 2013 Dentist relicensure surveys. For larger professions (also including physicians and physician assistants) VDH tries to see a census (close to 100% response rate as possible) - There is still a backlog of data and professions to survey, but need to discuss going forward how to best analyze and use this work force supply data - The group discussed ways to flesh out the quantitative findings from the survey data with more qualitative information to paint a fuller picture of Vermont's provider supply landscape and any potential shortages. - An "insider" opinion of each profession's data would be helpful, as well as any legislative/environmental/regulatory changes that could be affecting the data. - Discussed fleshing out data for each profession in this way and then presenting it to the work group. However, it would not be feasible to do this for all 58 professions currently being surveyed, on a rolling basis. - Dawn Philibert will put together a straw man proposal for fleshing out data with input from Peggy Brozicevic and Moshe Braner from VDH. - Discussed where on the VDH website this information on all 58 provider types will be housed—the VDH website is currently being redesigned, and the information can be put wherever is most useful and meaningful.	**Dawn Philibert to put together a proposal with input from other VDH staff on moving ahead with these reports**

Agenda Item	Discussion	Next Steps
5. Discussion: Strategic Plan – Recruitment and Retention recommendations	Mary Val led the work group in a discussion of the three "Recruitment and Retention" recommendations from the Health Care Work Force Strategic Plan. The group discussed the following: *Recommendation #4:* - Need to be able to look at regions, not the state as a whole, when designating shortage areas: Northeast Kingdom may have more of a PCP shortage than Chittenden County - Vermont at a disadvantage (compared to other, larger states), due to road system and difficult terrain. Though there may be a provider within the 25 mile radius cut-off, they may be more difficult to get to than in other states with more navigable road systems. - Various players in the state have been working on this initiative for 10+ years, with heavy support from Bernie Sanders' office. This item is currently on the back burner, and the group will table it and revisit it every year to monitor status and potential future action. *Recommendation #5 & #6:* - How are students in high schools/technical centers being advised in this area [that selection criteria at Vermont colleges should include an assessment of qualities which make a student more likely to specialize in primary care and practice in rural, underserved areas], and is there an extra level of consideration that should be given to students around this? What do teachers in the technical center health programs know about this, and what do high school guidance counselors know about this? - Through the example of dentists and dental residency programs, it has been shown that 50% of those in a dental residency program remained in Vermont, and that 60% of dentists in Vermont are recruited out of dental residency programs. - Suggested that the group could do more monitoring of how many students come to the state, and how many end up staying to practice. - Lorilee Schoenbeck suggested that the work group write a letter to the deans of the Medical Schools, recommending that any school preparing students for primary care should consider students from a rural area and have rotations in rural areas. - Students are more apt to go on to practice in a rural area if they had a rural rotation during residency/training; a significant barrier to ensuring more rural training is lack of preceptors and rotation opportunities in rural areas. Is there a possibility of finding some funding from the budget to support more rural rotations? - The group will further discuss possibilities of increasing preceptors at the next meeting, along with other ways to create a culture of primary care.	

Agenda Item	Discussion	Next Steps
6. Public Comment, Wrap-Up, Next Steps, Future Agenda Topics	There was no public comment. **Next Meeting:** December 16, 2015, 3:00-5:00pm; 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier, VT	

Attachment 3a: 2015 Year In Review

Vermont Health Care Innovation Project 2015: Year in Review

January 2016

Successes: Payment Model Design and Implementation

- Medicaid and Commercial **Shared Savings Programs** (SSPs): Year 2 program implementation; Year 1 savings analyses and distribution; State Plan Amendments approved for Years 1 and 2 of Medicaid SSP; continued provider capacity development.
- Analyses to select and develop **Medicaid Episodes of Care**.
- Continued implementation of Blueprint for Health and Hub & Spoke programs.
- Research to explore and define **Accountable Communities for Health**.
- Collaboration to support development of new payment models for DLTSS providers, including a **Prospective Payment System for Home Health Agencies** and **Medicaid Value-Based Purchasing for Mental Health and Substance Abuse providers**.

Spotlight on PMDI: Counting our Beneficiaries

- Summer 2015 – Stakeholders and CMMI requested we develop unduplicated counts of Vermonters in alternatives to fee-for-service (FFS).
- VHCIP staff worked with payers and other State staff to identify this new number, and to develop a denominator of Vermonters eligible to participate in payment reforms.*
- Total number of Vermonters in an alternative to FFS: 317,922 or 55% of all eligible Vermonters (no duplicates across programs).

* Non-eligible: Medicare Advantage enrollees, Military personnel, uninsured individuals, incarcerated individuals

Successes: Practice Transformation

- **Integrated Communities Care Management Learning Collaborative** continued first cohort and launched second and third cohorts.
- **Disability Awareness Briefs** developed.
- Continued implementation of **Regional Collaboratives**.
- Continued implementation of **Sub-Grant Program**, including two well-attended symposiums.
- **Care Management Inventory** finalized.
- Contractor selected to perform **Workforce Demand Modeling** work.
- **Workforce Supply Data Collection and Analysis** is ongoing.

Spotlight on Practice Transformation: Integrated Communities Care Management Learning Collaborative

- Learning Collaborative is now statewide – expanded to 8 additional communities (11 total).
- Communities are developing processes and tools to better serve at-risk individuals, and engaging in continuous quality improvement.
- Key lessons learned identified:
  - Some of most complex individuals do not have a case manager.
  - Lead case manager may change as individual's needs change.
  - Some individuals have many community partners working with them without realizing this.
- Communities are reporting positive anecdotal results and starting to explore more formal evaluation.

Successes: Health Data Infrastructure

- **Gap Analyses** for ACO and DLTSS providers completed.
- **Gap Remediation** begun for ACO member organizations and Designated Mental Health and Specialized Service Agencies.
- **ACO Gateways** for OneCare and CHAC completed.
- **Data Quality** improvement efforts launched for ACO providers and Designated Agencies.
- **Telehealth Strategic Plan** finalized; RFP for **Telehealth Pilots** released and vendors selected.
- **EMRs acquired** for five Specialized Services Agencies (SSAs) and for the Dept. of Mental Health/State Psychiatric Hospital.
- Contract executed for **Vermont Care Network Data Repository**.
- Business and technical requirements developed for **Universal Transfer Protocol** and **Shared Care Plan** solutions.
- **Event Notification System** contractor selected.
- **Health Data Inventory** completed.

Spotlight on HDI: Shared Care Plans

- Business requirements gathering through the Shared Care Plan/Universal Transfer Protocol project uncovered significant community enthusiasm for a solution:
  - Says one team member: “It not only turned up the pressure on the team to provide a useful tool but really energized us to deliver a high performing solution that would change the way health care was being delivered in those communities.”
- The project completed initial requirement-gathering (both business requirements and technical requirements) and is currently developing a proposal for a solution, to be piloted in 2016.

Successes: Evaluation and Project Management

Evaluation

- **Self-Evaluation Plan** draft submitted to CMMI.
- New **Self-Evaluation Contractor** selected based on revised self-evaluation scope.

Project Management and Reporting

- Launched **Outreach and Engagement** activities, including work toward website redesign.
- Successfully overhauled **Project Governance** structure to support robust stakeholder engagement and expedited decision-making.

Challenges

- Delayed Year 2 budget approval.
- Shift to new governance structure.

Looking Ahead: 2016

- **Payment Model Design and Implementation:**
  - Final year of Shared Savings Programs.
  - Discussion with CMMI regarding launch of 3 Medicaid Episodes of Care.
  - Peer learning opportunity to develop Accountable Communities for Health.
  - Continued work to launch new payment models for Home Health Agencies and mental health/substance abuse providers.

- **Practice Transformation:**
  - Core Competency Trainings focused on general care management skills and DLTSS-specific competencies.
  - Wrap up Integrated Communities Care Management Learning Collaboratives.
  - Wrap up Sub-Grant program.
  - Workforce Demand Modeling, Supply Data Collection and Analysis.

Looking Ahead: 2016 (Continued)

- **Health Data Infrastructure**:
  - Continue Data Quality efforts for DAs.
  - Launch Telehealth pilots.
  - Continue work on DA/SSA Data Warehousing solution, and begin to implement cohesive strategy for developing data systems to support analytics.
  - Launch Shared Care Plan solution pilot, launch Universal Transfer Protocol solution.

- **Evaluation**:
  - Launch of new self-evaluation contract.
  - Implementation of Self-Evaluation Plan.

Looking Ahead: 2016 (Continued)

- Also: **Population Health Plan** development;
- **Sustainability Planning**;
- Launch of final **suite of HDI projects** that could include additional gap remediation (all pending Core Team approval).
- Gathering **lessons learned** from across the project.

Attachment 3b: 2016 Work Force Work Group Work Plan

Vermont Health Care Innovation Project
2016 Workforce Work Group Workplan

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Demand Data Collection and Analysis						
1	Perform demand analysis and develop recommendations.	Execute contract for micro-simulation demand model.	December 2015	Develop demand model and develop recommendations from analysis (DOL).		Not yet started,	Consultant contract in place. Functional micro-simulation demand model. Recommendations based on analyses from model; information to be shared between Vermont Department of Health (VDH), Office of Professional Regulation (OPR), and DOL.
2		Provide input into development of micro-simulation demand model.	Q1-Q2 2016			Not yet started,	
3		Assist with reporting related to demand analysis, and guide vendor activities as appropriate.	Q2-Q3 2016			Not yet started.	
4		Subgroup to develop initial recommendations from analysis of demand model information.	Q3-Q4 2016			Not yet started.	
	Supply Data Collection and Analysis						
5	Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan.	Receive regular presentations of supply data (at least 3 times by 9/30/16).	Quarterly	Obtain and analyze workforce supply data (VDH/OPR).		Ongoing.	Supply data incorporated into workforce planning and updates to Workforce Strategic Plan.
6		Publish data reports/analyses on website by 12/31/16.	December 2016			In Progress.	
7		Support distribution of reports/analyses to project stakeholders.	December 2016			Ongoing	
8		Support identification of lessons learned for incorporation into VHCIP Sustainability Plan.	December 2016			Not yet started.	
	Ongoing Work Group Activities						
9	Perform updates to Workforce Strategic Plan.	Perform updates to Workforce Strategic Plan as needed.	Ongoing		AOA and Green Mountain Care Board	Ongoing.	Updated Workforce Strategic Plan.
10		Provide Agency of Administration with Strategic Plan Status Report by end of current administration.	Q4 2016		AOA	Not yet started	Completed Strategic Plan Status Report.
11	Renew and update membership.	Renew and update membership every three years basis according to process outlined in Executive Order #07-13.	Every three years		Secretary of Administration	Not yet started.	Membership updated.

	Ongoing Updates, Education, and Collaboration						
12	Reporting on all milestones related to Workforce, in conjunction with Practice Transformation Work Group.	Review one-page monthly status updates for all Workforce-related work streams.	Monthly			Ongoing.	Written and verbal monthly updates on all payment models.
13	Review 2016 Workforce Work Group Work Plan.	Review and discuss draft workplan, developed with DLTSS and Population Health staff and co-chair input.	December 2015-January 2016				Work plan finalized.
14	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups. Specific projects of interest include: • Care Management Inventory (Practice Transformation Work Group) • Core Competency Trainings (Practice Transformation Work Group) • Health Information Exchange/Data Interoperability (Health Data Infrastructure Work Group)	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).		Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities across VHCIP.
15		Provide updates to other work groups on Payment Model Design and Implementation Work Group activities.	Ongoing			Not yet started.	
16		Obtain regular updates from other work groups.	Monthly	Obtain regular updates on work groups' progress as appropriate.		Not yet started.	
17	Provide input into VHCIP Population Health Plan and Sustainability Plan.	Review and comment on VHCIP Population Health Plan Draft.	Late 2016	Plan outline or draft developed by Population Health Work Group.	Population Health Work Group; Steering Committee; Core Team	Not yet started.	Work Group input incorporated into VHCIP Population Health and Sustainability Plans.
18		Review and comment on VHCIP Sustainability Plan Draft.	Late 2016	Plan outline or draft developed by project leadership.	Core Team	Not yet started.	
19	Contribute to VHCIP Webinar Series.	Contribute topic, speaker, and moderator suggestions for VHCIP's optional monthly educational webinars for staff and participants.	Monthly			Not yet started.	Twelve webinars conducted on staff- and participant-developed topics.

Attachment 5 - Proposal for Analyzing Vermont Workforce Supply Data

Proposal for Analyzing Vermont Workforce Supply Data

Dawn Philibert Vermont Department of Health

January 25, 2016

Act 79 of 2013 contributed to health workforce planning by requiring the collection of demographic and practice data from health professionals when they renew their professional licenses every two years. Since the enactment of Act 79, the Department of Health has been developing surveys for every health profession, analyzing the descriptive data provided, and creating summaries of the data by profession. Although these analyses provide information about the supply of each type of health care professional in Vermont, the supply data alone are not enough to draw conclusions about shortages, demand and unmet need.

Summary of Proposal: Create a small and focused task group composed of key stakeholders to review continuously information about health workforce supply and demand. The information to be reviewed will include, but will not be limited to:

- Quantitative supply data by profession
- Qualitative information and perspectives about shortages from key informants
- Other information about specific shortages and trends from literature, research, etc.
- Information from the Microsimulation model

The purpose of the task group would be to develop conclusions about existing or projected workforce shortage areas for the provision of input into planning and policy initiatives related to health workforce.

Task group membership: The task group would consist of up to eight individuals, some of whom would come from the VHCIP Workgroup and some of whom would be other key stakeholders. Expert witnesses could be called upon to provide information as needed. The task group would report to the Workforce Work Group and seek their input as needed.

Attachment 6 - Care Management Inventory Presentation

VHCIP Care Management Inventory Survey

VHCIP Health Care Workforce Work Group

February 3, 3016

Erin Flynn, MPA, Senior Policy Advisor, DVHA

Pat Jones, MS, Health Care Project Director, GMCB

VHCIP Practice Transformation Work Group (previously Care Models and Care Management)

- Key tasks:
  - Map current landscape of care management activities in Vermont
  - Identify redundancies, gaps, and opportunities for innovation and coordination in order to address unmet needs, minimize duplication and improve alignment

- These tasks accomplished through:
  - Presentations by those performing care management activities
  - Care Management Inventory Survey

Care Management Inventory Survey

- Fielded from May 23rd – July 23rd 2014
- 42 organizations responded, representing the following categories:
  - ACOs
  - Blueprint Community Health Teams
  - Health Plans
  - State Agencies
  - Community Service Providers
  - Health Care Providers
- 481 FTEs identified as working on care management
- Results are snapshot in time for responding organizations

Contents of Resulting Report

- Description of Responding Organizations
- CM Services Provided by Responding Organizations
- Estimated Number of People Receiving CM Services
- Staffing of CM Services
- Relationships Among CM Organizations
- Program Accreditation
- Challenges Facing CM Organizations
- Conclusions
- Link to Report:
  http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/CMCM/CMCM%20Survey%20Report%202015-03-09%20FINAL.pdf

Responding Organizations by Geographic Area

County	# of Organizations	% of Responses
Statewide	13	31%
Addison County	6	14%
Bennington County	4	10%
Caledonia County	2	5%
Chittenden County	4	10%
Essex County	2	5%
Franklin County	4	10%
Grand Isle County	2	5%
Lamoille County	2	5%
Orange County	7	17%
Orleans County	1	2%
Rutland County	4	10%
Washington County	6	14%
Windham County	5	12%
Windsor County	6	14%

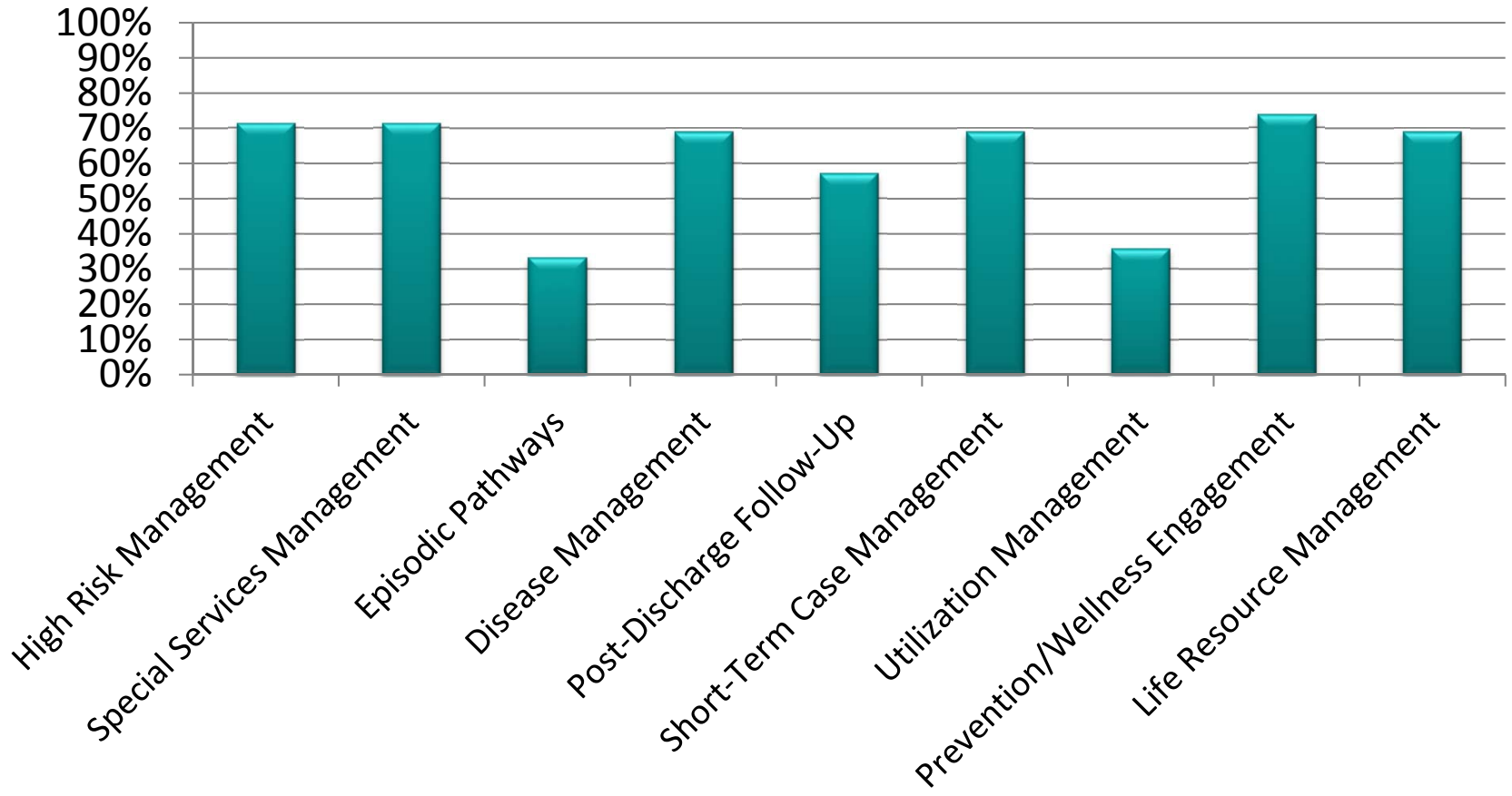
Care Management (CM) Services Definitions

- **High Risk Management** is the deliberate organization of care activities for high risk individuals, designed to improve their health status and reduce the need for expensive services. High risk people may include individuals experiencing serious illness, high utilization of health care services and/or transitions in care (e.g., changes in setting, service, practitioner, or level of care).
- **Special Services Management** is the deliberate organization of care activities for a specified population requiring ongoing management (other than high risk individuals and those receiving disease management services), for an undetermined time frame. Examples of specified populations include people with mental health or substance abuse needs, and children with special health needs.
- **Episodic Pathways** are standardized care processes used to promote organized and efficient care based on evidence-based practice for a specific group of individuals with a condition that is characterized by a predictable clinical course with a limited time frame (e.g. pregnancy, joint replacements). The interventions involved in the evidence-based practice are defined, optimized and sequenced; they are also known as clinical pathways, care pathways, critical pathways, integrated care pathways, or care maps.
- **Disease Management** is a system of coordinated interventions and communications for specific groups of people with chronic conditions for which self-care efforts can have significant impact. Disease management supports the practitioner/person relationship, development of a plan of care, and prevention of exacerbations and complications. It is characterized by evidence-based practice guidelines and strategies that empower people.

CM Services Definitions (Continued)

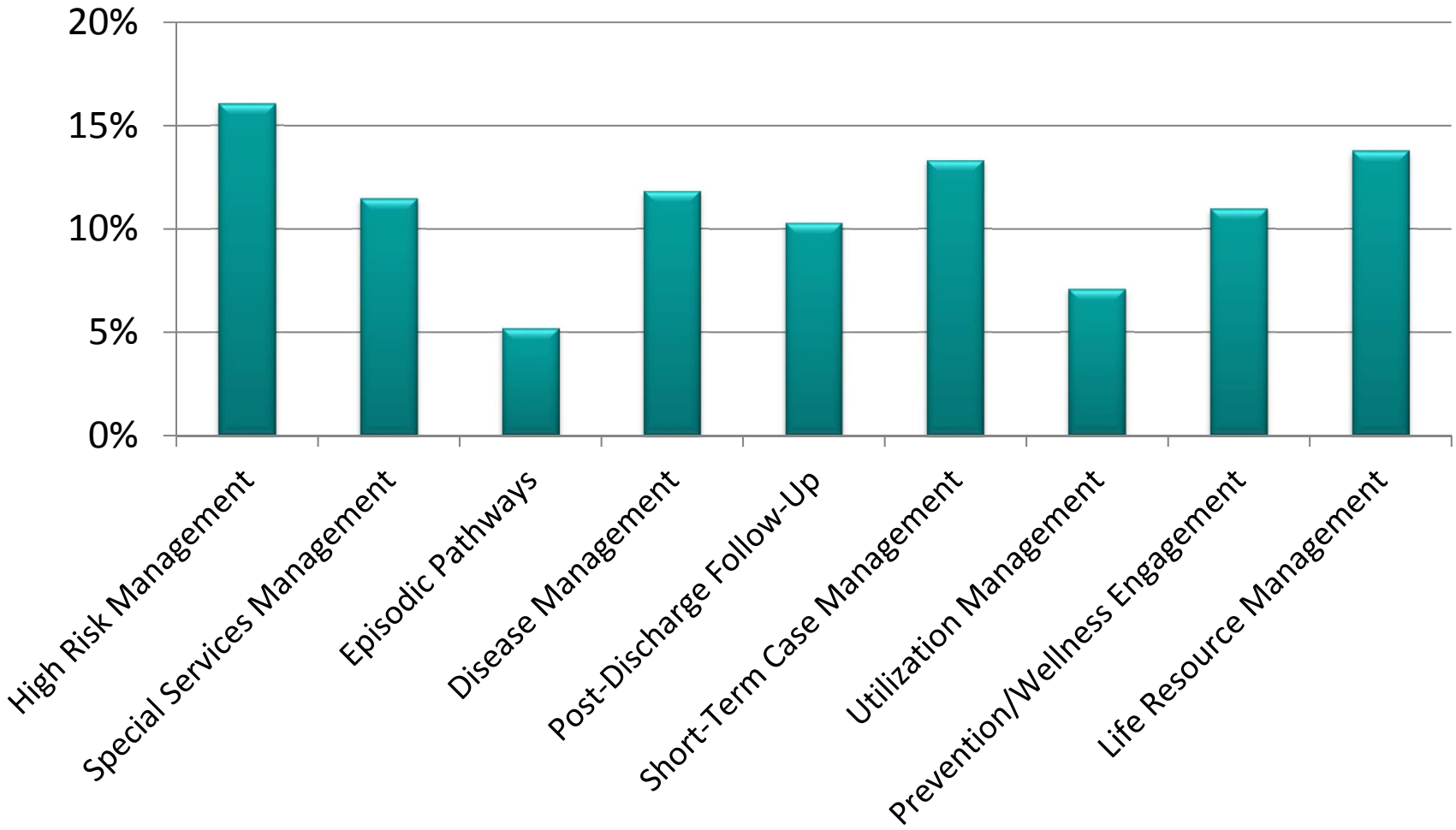
- **Post-Discharge Follow-Up** consists of a phone call or visit to discharged individuals within 48 to 72 hours of their departure from a care facility. The purpose is to ask about the individual's condition, adherence to and understanding of medication orders and other treatment orders, general understanding of his or her condition, and intent to attend follow-up appointments. Post-discharge follow-up is for individuals other than those served by High Risk Care Coordination, Special Services Care Coordination, Episodic Pathways, or Disease Management.
- **Short-Term Case Management Programs** are targeted and short term (30-60 days maximum) interventions with the goals of empowering individuals to better understand their illnesses and manage their own conditions, and coordinating care between individuals, providers and the community.
- **Utilization Management** is the set of organizational functions and related policies, procedures, criteria, standards, protocols and measures to ensure appropriate access to and management of the quality and cost of health care services provided to health plan members or other populations.
- **Prevention/Wellness Engagement activities** are interventions designed to increase engagement and activation and promote positive behavior across populations, such as obtaining preventive care, exercising regularly, and modifying dietary habits. These activities may draw on the principles of positive psychology and the practices of motivational interviewing and goal setting (e.g., health coaching).
- **Life Resource Management** involves providing resources and counseling to help mitigate acute and chronic life stressors; and may include health care as well as social and/or community services.

Percentage of All Responding Organizations Providing CM Services By Type of Service

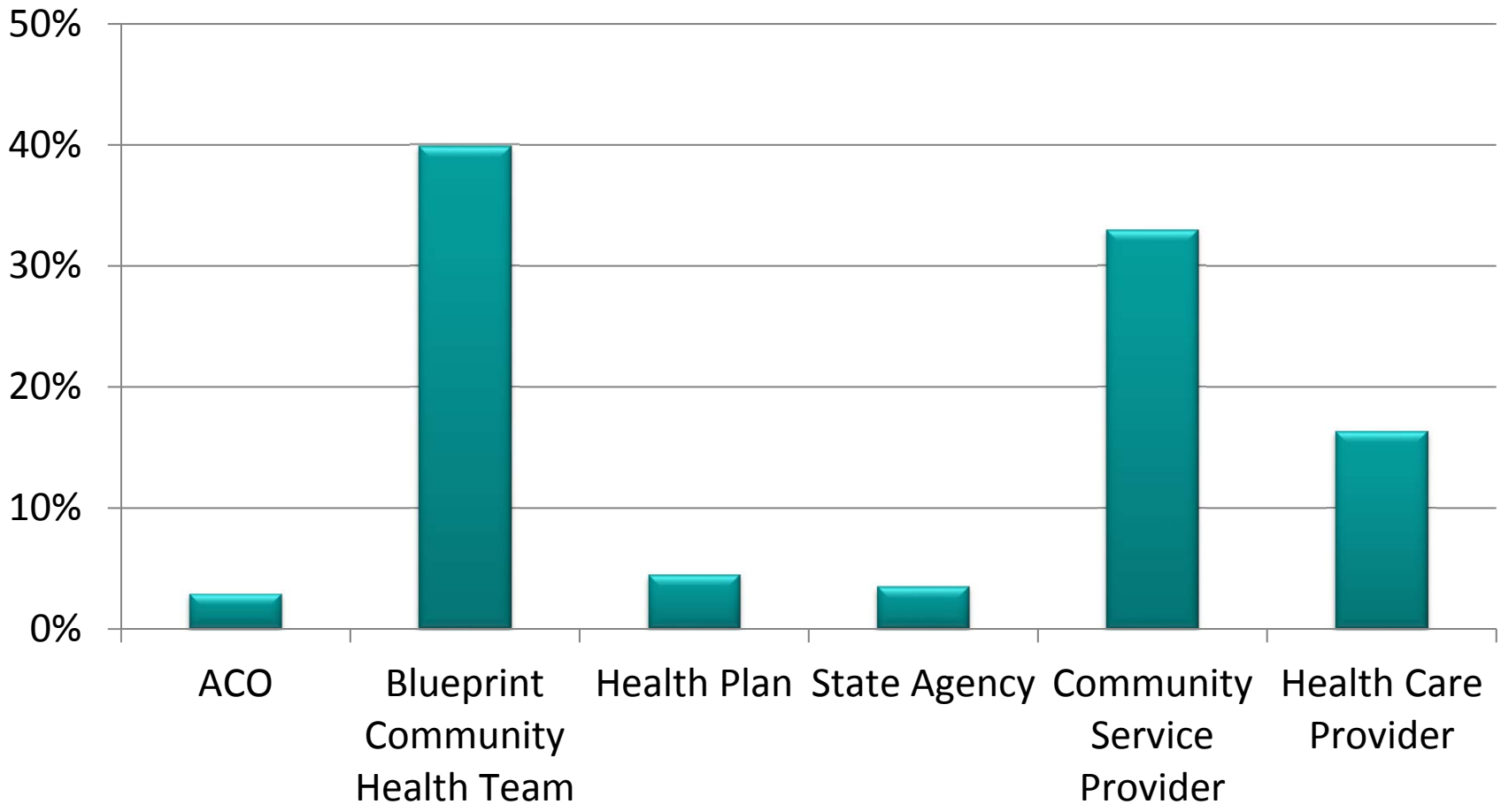


Number of Respondents: 42

Estimated Percentage of People Receiving CM Services by Service Type



Estimated Percentage of People Receiving CM Services by Type of Organization

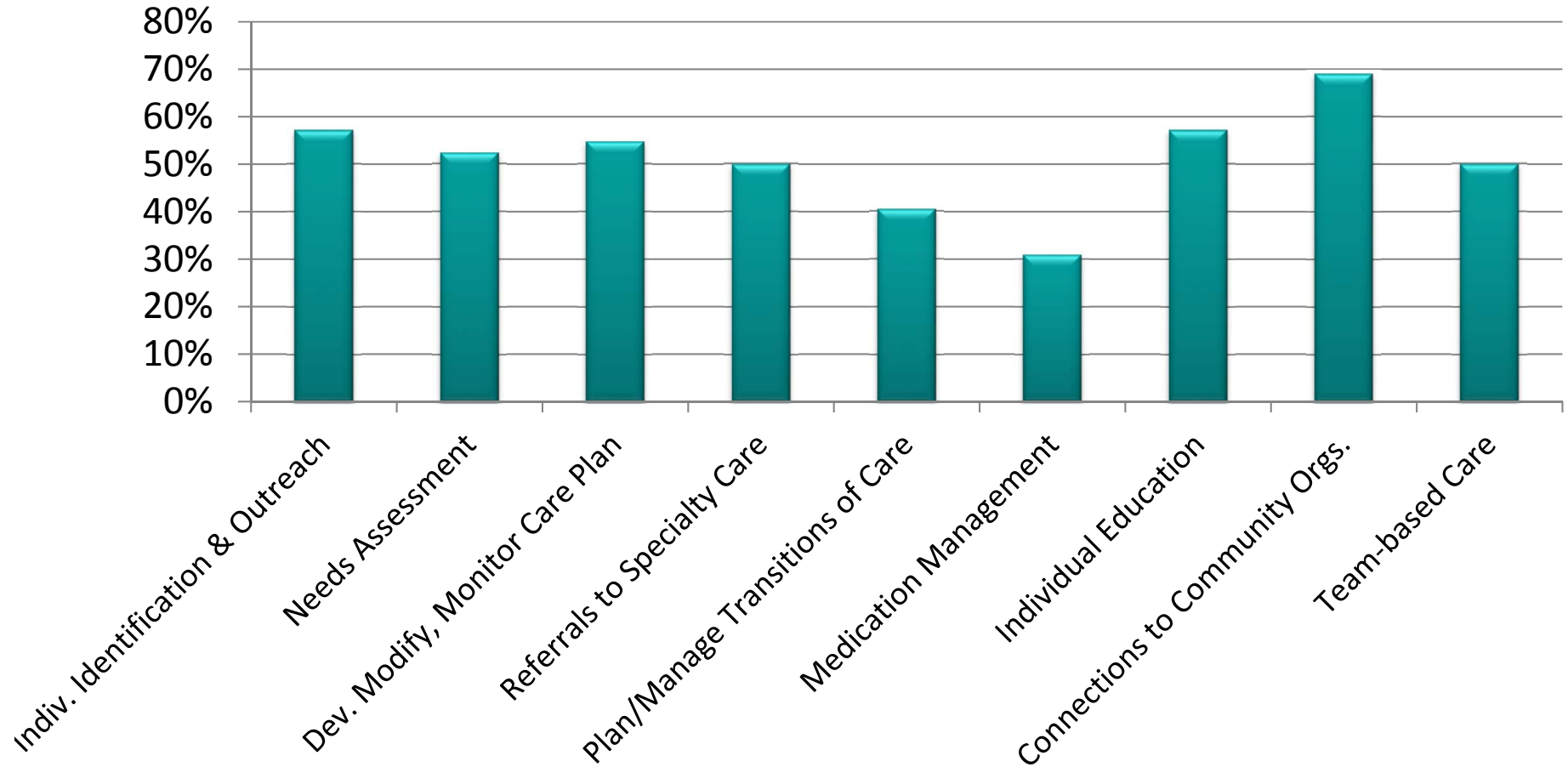


Key Care Management Functions

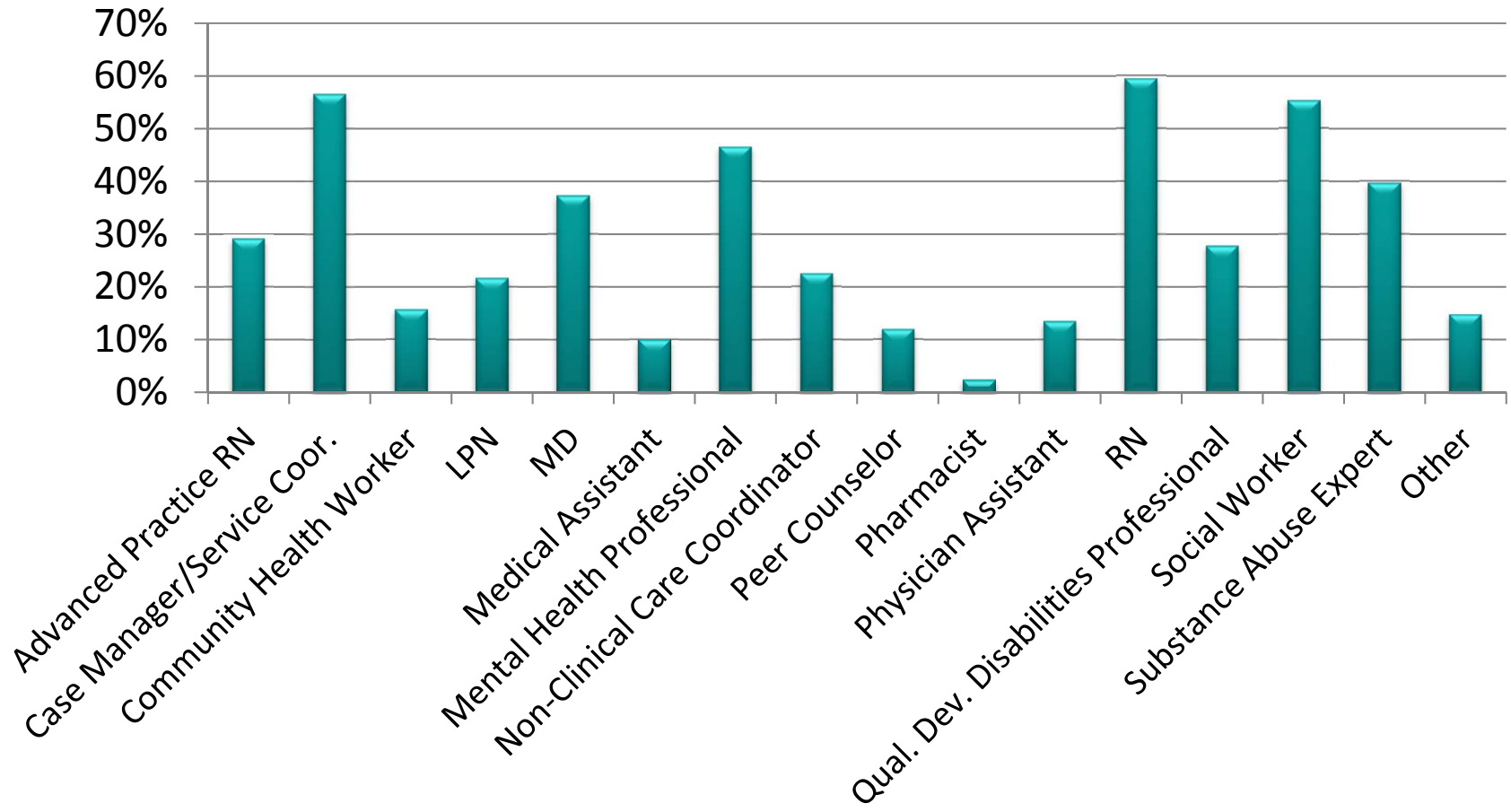
Center for Medicare and Medicaid Innovation

- Individual Identification and Outreach
- Needs Assessment
- Developing, Modifying, Monitoring Care/Support Plan
- Referrals to Specialty Care
- Planning and Managing Transitions of Care
- Medication Management
- Individual Education
- Connections to Community/Social Service Organizations
- Team-based Care

Percentage of Responding Organizations Performing Key CM Functions



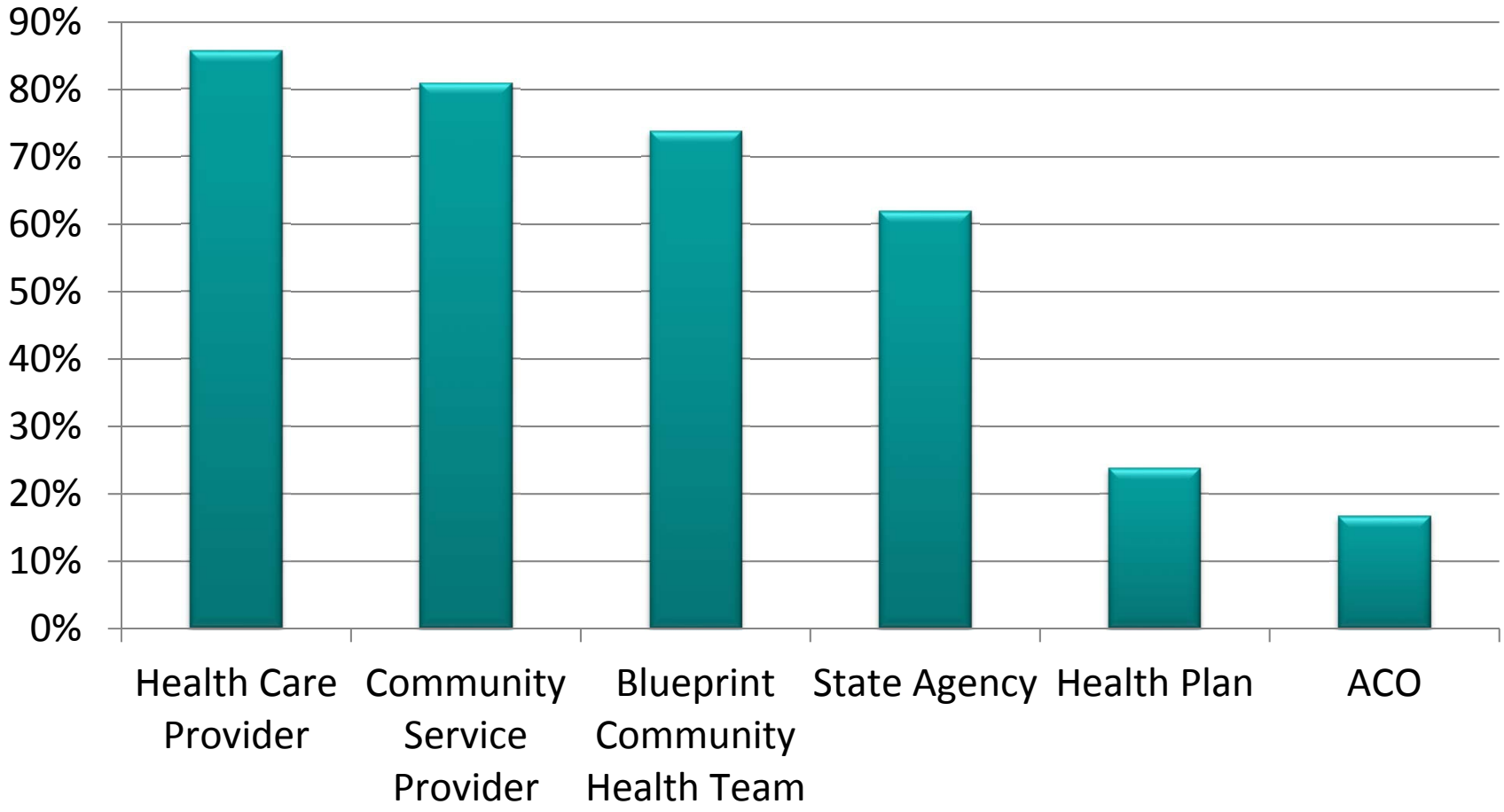
Percentage of FTEs by Staffing Type



Frequency of Interaction by Type of Interaction and Type of Organization

Organizations with which responding organizations Indicated interactions	Percent of all responding organizations indicating that they share information with this organization	Percent of all responding organizations indicating that they share resources with this organization	Percent of all responding organizations indicating that they make referrals to this organization	Percent of all responding organizations indicating that they receive referrals from this organization
ACO	62%	19%	17%	29%
Blueprint Community Health Team	83%	64%	74%	71%
Community Service Provider	88%	62%	81%	88%
Health Care Provider	90%	60%	86%	88%
Health Plan	55%	21%	24%	36%
State Agency	83%	40%	62%	67%
Count of Organizations Reporting	42			

Frequency With Which Responding Organizations Answered, "We make referrals to this organization," by Organization Type



Top Four Challenges Experienced by CM Organizations (In Bold)

- **Difficulty identifying individuals**
- Insufficient funding
- **Challenges in recruiting qualified staff**
- Services not currently reimbursed by payer
- Lack of communication mechanisms with other organizations
- Challenges to developing relationships between organizations
- **Technical barriers to sharing information between organizations**
- Privacy barriers to sharing information between organizations
- Privacy concerns
- **Challenges in engaging individuals**
- Challenges in engaging providers

Recommendations

- Opportunity to train care managers on key care management functions, including Team-Based Care
- Organizations that have relied on ad hoc relationships have opportunity to establish more formal and structured relationships
- Examining roles that various disciplines can play in improving care management could impact resource allocation
- Opportunity for CMCM Work Group and VHCIP to address identified challenges

Attachment 7 - Strategic Plan Priorities Matrix (Educational Pipeline)*

	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: IMPROVING, EXPANDING AND POPULATING THE EDUCATIONAL PIPELINE										
Recommendation #7: The state college system, including the University of Vermont College of Medicine and the Residency Program at UVM MC ~~Fletcher Allen Health Care~~ , UVM CNHS, should prepare health care profession students for practice in a health care reform environment (as called for by, for example, IOM, Blueprint for Health, ACO initiatives, and Act 48) through post-secondary curriculum redesign.	Many: UVM-OPC, AHEC					Little progress to date: the work group should coordinate a meeting with these stakeholders (see Tasks column), and identify a contact from the technical school system.		1. Potential curricular redesign could include: emphasis on population management, interprofessional practice 2. This curricular redesign should also include nursing and social work.	low	LOW
			WFWG	7.1. Workgroup should coordinate DOE/DOL/VSC to attend a work group meeting and speak about their top priorities and activities around this recommendation.		Little progress: work group to convene stakeholders	Late 2015			
			WFWG	7.2. Workgroup should identify a contact from the technical school system		No progress: staff/co-chairs to identify contact	Q3 2015			
Recommendation #8: The ~~Department~~ Agency of Education , VSC system, and the UVM and Regional AHEC Programs should coordinate activities which increase student enrollment in AHEC health career awareness programs and expose students to health care careers through hands on experiences through programs which promote internships, externships and job placements with health profession organizations	AHEC (to lead), AOE, UVM, VSC					Some progress has been made, but more cordination between stakeholders is needed to maximize resources, in current fiscally constrained environment		1. AHEC programs with middle and high schools 2. MedQuest 3. CollegeQuest, AHEC HCOP; C-SHIP, 4. Future of Nursing grant 5. Current programs are limited by funding; there is room for expansion of these and new programs 6. See proposal to WFWG Committee from NVAHEC re: CollegeQuest (Jan, 2014)	low	LOW
			WFWG	8.1. Workgroup discussion needed re how to narrow this to doable tasks. (Stakeholders should maximize existing resources and focus on coordination in the event that funds for new programs is not available.)		No progress: work group discussion needed	Late 2015			
Recommendation #9: The ~~Department~~ Agency of Education should accelerate efforts to align secondary education coursework with skills necessary for entry into the field of health care and to define career paths in terms of post-secondary education requirements. These efforts should consider coursework offered K-12.	AOE	Tom Alderman				No progress to date: work group should receive update from groups below				MOD
			WFWG	9.1. Workgroup shall coordinate meeting from AOE to give Workgroup a sense of DOE's short and long-term plans on this topic		No progress to date: work group to convene meeting for AOE to give status report.	Late 2015	Who from AOE would be suitable to give this update? Tom Alderman?		
			WFWG	9.2. Workgroup needs an update re flexible pathways and personal learning plans in Act 77.		No progress: who should give this update?	Late 2015/Early 2016	Who should give this update?		
Recommendation #10: The ~~Department~~ Agency of Education, Department of Labor and the UVM and Regional AHEC Programs should develop continuing education opportunities for guidance counselors to better prepare them to assist students considering a career in health care.	AOE, DOL, UVM, AHEC		WFWG		COMPLETED: AHEC outreach to guidance counselors. Promotion of AHEC programs and www.vthealthcareers.org, and October as Health Care Careers Awareness Month. AHEC has reached out to VT guidance counselors' association and offered presentations for in-service days and/or conferences.	Considerable progress has been made: AHEC conducts ongoing outreach to guidance counselors through its website and presentations		1. Guidance counselors have been added as a specific target for HCOP grant under review (announcement expected fall 2015)	low	LOW
Recommendation #11: Vermont state colleges and tech centers should develop career ladders by facilitating enrollment of Vermont students into health care educational programs. Strategies include but are not limited to articulation agreements and dual enrollment.	VT State Colleges, AHEC Nsg	Nancy Shaw, MV Palumbo			COMPLETED: Future of Nursing State Implementation Program Grant (11/13-10/15). COMPLETED: Community Health Worker certification being considered by Center on Aging.	Some progress to date: see completed tasks; work group to strategize on how to move forward on this recommendation.		Include the ed centers. Career ladders need to link to workforce needs…	Marketing plan - Mod cost	
			WFWG	11.1. Workgroup discussion regarding developing specific tasks--what shortage or problem are we trying to solve?		No progress: work group needs to have discussion	Q4 2015/Q1 2016			
New Proposed Sub-recommendation #11a: *Hospitals and FQHCs should identify opportunities for joint continuing education that could take place through the state college and University of Vermont educational system. This could include, but not be limited to, identifying the needs of employees for training and communicate/coordinate on a regular basis.*	Hospital associations, home health, DOL, DOE	Paul Bengtson				No progress to date: this is a new recommendation.				
			WFWG	11a.1. Workgoup discussion regarding developing specific tasks--note that we already have a continuing education system that offers training to a wide variety of audiences. What are the specific unmet needs?		No progress to date: work group needs to have discussion	Q4 2015/Q1 2016			

Recommendation #12: Vermont higher education institutions ~~state colleges and the Fletcher Allen Medical Residency program~~ should evaluate the potential to expand enrollment in health profession education, training and residency programs.	UVM, VT State/Community Colleges					Progress has bee made in the following areas/activities: 1. previous work exploring rural residency in NEK 2. New FM residency in Plattsburg 3. PA program in Rutland College of St. Joseph 4. Grant opportunity for NP residency in Rutland?		1.This is an ongoing needs assessment with a high degree of complexity 2. Expansion of PA/NP programs lead to competition for preceptors.	low	MOD	
			WFWG	12.1. Monitor progress of stakeholders		Some progress to date - this is an ongoing, complex task (see Progress column above for list of initiatives to date)	Ongoing				
Recommendation #13: Vermont higher education institutions should evaluate the potential to create abbreviated education and training programs.	VT State Colleges/UVM	Nancy Shaw, MVP				No progress to date: work group staff to research what other areas around country are doing, and coordinate with VSC contact.		How to push discussion about undergrad work in less than 4 years? Med school in less than 4 years? Innovate… Shorter programs, infuse workforce more quickly, less ed debt (and also less reveue to the high ed institution).			
			WFWG	13.1. Workgroup staff to research and find examples from around the country, to inform Vermont		No progress to date: work group staff to research.	Q3/Q4 2015				
Recommendation #14: Vermont higher education institutions should make easier the transition of health career students and their existing academic credits from one state college to another.	VT State Colleges/UVM	Nancy Shaw, MVP				Some progress: barriers to credit transfer and transition of students have been identified, but further coordination and communication is needed in order to develop concrete next steps.		1. Are there specific examples where this is not working?			
			WFWG	14.1. Future of Nursing Grant - Academic Progression barriers, challenges, and incentives are being studied		Some progress: grant is studying barriers/challenges/incentives.					
Recommendation #15: Within each Vermont state college, departments should collaborate to develop coursework where health care profession students can be educated together, allowing for interdisciplinary learning.	VT State Colleges/UVM	Nancy Shaw; Mary Val Palumbo						1. College of Nursing & Health Sciences (Palumbo IPP HRSA grant 2013-16) 2. IPE Task Force in College of Medicine (Jan 2014) 3. SAMHSA grant (UVM Kessler) Also online learning and distance learning opps.			
			WFWG	15.1. Discussion re any tasks for Workgroup?		No progress: work group should discuss its role in this recommendation.	Q4 2015				
Recommendation #16: The Department of Labor in collaboration with the UVM and Regional AHEC Programs should expand programming of its Regional Career Centers to include guidance and counseling for individuals seeking to pursue a career in health care.	DOL, UVM, AHEC	Mat Barewicz									
			WFWG	16.1. Workgroup to invite representative from DOL to inform the work group on initiatives at the RCCs on this topic		Some progress to date: staff has asked that WFWG DOL rep ask if someone could come to work group meeting to report on RCCs	Q3/Q4 2015				
Recommendation #17: State programs, such as those within the ~~Department~~ 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	AOE, DOL, AHEC, State Colleges	Palumbo				Some progress has been made with Future of Nursing grant					
			WFWG	17.1. UVM Future of Nursing Grant (school outreach, LNA SL tutoring)		Some progress with FON grant - should work group hear report from FON grant on status?					

Additional Materials

Table 1. Overview of Risks and Barriers related to Mental Health Clinical Licensure

Interpretation of Language Regarding Licensure	Barriers	Risk to Licensee	Risk to Supervisor
Employment with agency that can provide clinical supervision.	Employment is often offered at low wages, not comparable with student debt and level of education.	Agencies may be requiring contractual agreements for terms of employment post licensure. Unable to get supervised employment in their field of interest. Unable to find suitable employment post-master's degree.	Licensees utilize these positions as a means of obtaining a license often without the intention of continuing to work in the setting afterward. High rate of turnover is being experienced by these agencies.
Employment with small private practice under the umbrella of a not-for-profit.	Terms of employment are individually negotiated.	Question legitimacy of "work around"; supervision hours may not be accepted.	Question legitimacy of "work around"; potential for financial penalties and/or loss of license to practice.
Employment with private practitioner and accessing outside clinical supervision.	This is a cost to the licensee which can prove to be significant; practice models, theories, and therapy tools may differ from employer to supervisor.	Risk that supervised hours do not qualify for licensure.	Potential conflict between supervisory foundations of practice and employer's model for clinical practice.
Employment with private practitioner and accessing third party billing services externally.	This is a cost to the licensee which can prove to be significant.	Client may not recognize receiving services from billing party.	Billing party is NOT provider of direct services, which could lead to financial risk.
Independent contractual employment and supervision with private practitioner.	Terms of contractual agreement are individually negotiated; Licensee may need to furnish office space and insurances.	Clinical supervision hours may not be deemed acceptable for licensure application.	Reliant on licensee to submit tax information or could be liable for tax fraud; Potential for loss of license to practice.

Table 2. Overview of Mental Health Professionals' Licensing Pathways

Professional Title	Education Requirements (Assumes Bachelor's Degree)	Licensing Process
PhD Psychologist	400 hour PhD coursework, 1 year internship, 1 year residency.	4000 hours of supervised practice, 2000 of which must be post degree and must have a minimum of 500 hours with at least two separate supervisors.
Psychiatrist	4 years of medical school and 4+ years of residency.	Exam to pass boards and earn license to practice.
Psychiatric-Mental Health RN	2 year associates, 3 year nursing diploma, 4 year bachelors in nursing.	Examination post-graduation to earn license to practice
Psychiatric-Mental Health Advanced Practice Nurse	Master's or doctoral degree	
Licensed Independent Clinical Social Worker	2 year FT Master's including. at least 900 hours of internship.	3000 hours of clinical supervision; 2000 must be in the provision of "psychotherapy."
Licensed Mental Health Counselor	2 year FT Master's including at least 600 hours of internship.	3000 hours of clinical supervision; 2000 must be direct services.
Licensed Alcohol & Drug Counselor	2 year FT Master's (non-specific).	2000 hours of clinical supervision; 1000 must be substance use related direct services.
Licensed Marriage & Family Therapist	18 of 36 graduate credits must be in courses identified as utilizing a marriage, couple, or family therapy/systems/relational perspective; at least 500 hours of internship.	3000 hours of clinical supervision; 2000 must be direct service and 50% of direct service must be with couples and/or families.
Psychiatric Physician Assistant	2 year FT PA school, plus one year of psychiatric residency.	Examination post-graduation to obtain license.