VT Health Care Innovation Project
Health Care Workforce Work Group Meeting Agenda
Wednesday, April 6, 2016; 3:00-5:00pm
EXE - 4th Floor Conf Room, Pavilion Building
109 State St, Montpelier, VT
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: 4-6-16 Meeting Agenda
2	3:05-3:10	Approval of Meeting Minutes	Mary Val Palumbo Robin Lunge	Y	• Attachment 2: 2-3-16 Meeting Minutes
3	3:10- 3:20	Updates: - Demand Modeling update - HRSA Web-Based Supply/Demand Modeling for Nursing - Others?	Mary Val Palumbo Robin Lunge Group Discussion	N	• HRSA Modeling URL: http://www.healthworkforceta.org/webinars/introduction-to-hrsas-web-based-nursing-supply-and-demand-model/
4	3:20- 3:50	Discussion: Workforce Supply Data Proposal – Next Steps	Dawn Philibert, Peggy Brozicevic, VDH Group Discussion	Y	• Attachment 4a – Draft Template for Reporting • Attachment 4b – VDH Survey Status • 2014 Physician Survey Statistics Report URL:http://healthvermont.gov/research/HlthCarePrvSrvys/documents/phys14bk.PDF • Attachment 4d – 2014 Physician Census Report • Attachment 4e - Healthcare Data Maps
5	3:50 – 4:15	Discussion: Barriers to Licensure – Mental Health Clinicians	Nicole LaPointe, AHEC Group Discussion	N	• Attachment 5 – Mental Health Licensee Supervision – Multi-State

6	4:15- 4:55	Discussion : Strategic Plan - Improving, Expanding and Populating the Educational Pipeline	Mary Val Palumbo Robin Lunge Group Discussion	N	• Attachment 6 - Strategic Plan Priorities Matrix (Educational Pipeline)*
7	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: 2-3-16 Meeting Minutes

Vermont Health Care Innovation Project

Vermont Health Care Innovation Project
Workforce Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, February 3, 2016, 3:00-5:00pm, Conference Room 101, Vermont State Colleges, Stonecutters Way, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Robin Lunge 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	Mary Val Palumbo moved to approve by exception the minutes from the August and October 2015 meetings. David Adams seconded the motion. The minutes for August (6 abstentions – David Adams, Monica Light, Mary Val Palumbo, Jay Ramsey, Wade Carson, Liz Côte,) and October (7 abstentions – Dawn Philibert, Stephanie Pagliuca, Mat Barewcz, , Wade Carson, and Liz Côte) were approved. • Location will be corrected in October minutes.	
3. VHCIP Updates	*2015 Year in Review:* Georgia Maheras presented on progress and accomplishments during 2015 (Attachment 3a) *Review of 2016 Workforce Work Group Workplan:* Sarah Kinsler presented the 2016 Workforce Work Group workplan (Attachment 3b). The group discussed the following: • Robin Lunge noted that the majority of SIM funds conclude at the end of this calendar year, so sustainability is of particular interest for this group, which could continue on after SIM (depending on the new governor). • For more information about Core Competency Training, see slides presented at 2/2/2016 Practice Transformation Work Group. Slides will be shared with this group.	
4. Updates	*Demand Modeling Update:* Georgia Maheras provided an update on the Demand Modeling contract. The State is still in contract negotiations with the vendor; negotiations are nearly complete. Project leadership is working with the vendor and Attorney General's office to work through requested changes to the State's standard terms and conditions. *Brainstorming Session at Legislature – Psychiatric Nursing Shortage:* Mary Val Palumbo reported out on a	

Agenda Item	Discussion	Next Steps
	brainstorming session called by Sen. Claire Ayer. We currently have 388 psychiatric nurses in the state. They are overall older than other nurses, more are male, they have less education, and more are currently enrolled in nursing programs. This is an example of what we can get from supply data. This group will continue to meet over the coming months. Mary Val will provide written notes from the meeting upon request. • Psychiatric nurses are RNs with site-specific training. Most psychiatric nurses do not enter this care setting straight from nursing school; one idea is to expose nursing students to a psychiatric internship while in training. Challenges identified include perception that psychiatric settings are scary and dangerous places to work; clinical exposure might correct this perception. • There was also discussion of loan repayment directed toward students who choose to pursue psychiatric nursing. Liz Cote clarified that loan repayment is available for these nurses. Nurses working in psychiatric settings are the top priority for the Health Department in loan repayment this year. VDH is also considering scholarships and other incentives to support this area. • Molly Backup identified work content as a barrier. Nursing students learn a broad array of medical knowledge, while psychiatric nursing uses a small subset of that knowledge. She suggested joint appointments to support nurses who wanted to split time between psychiatric nursing as well as nursing in other settings. *Barriers to Licensure – Mental Health Clinicians:* Nicole LaPointe from the AHEC provided an update. The AHEC has been looking at supply and demand and has identified regulatory limitations in Master's prepared counselors and social workers from becoming licensed (~2 years of full-time work supervision required for licensing); only larger organizations can take on supervision of potential licensees, and many private practices in the region are being advised not to take on licensees. The AHEC has identified a series of barriers, risks, and strategies to work around these barriers. Nicole invited interested parties to work with the AHEC to expand upon these rules. • Pre-licensure salaries are artificially decreased, and many take on positions that are not ideal to obtain clinical education necessary for licensure, which results in high turnover. Added transparency and resources to support new graduates in identifying agencies that can provide robust clinical supervision. • More discussion at the next meeting on this topic; Robin will ensure OPR is present. Members should suggest any additional guests to Amy Coonradt (amy.coonradt@vermont.gov) before the next meeting. • Molly Backup requested more information on licensing standards for these clinicians in other states. Nicole will provide this at the next meeting.	
5. Workforce Supply Data Proposal – Next Steps	Dawn Philibert presented a proposal for analyzing Vermont workforce supply data (Attachment 5). • Dawn proposed a sub-group of people who are interested in and knowledgeable about this issue and the related data to meet on the months that the full work group does not meet. The sub-group would supplement the data for key professions with qualitative analysis and paint a fuller picture of the supply of these professions in Vermont. The sub-group would include members of this group as well as others from outside of the work group (especially those at VDH who work with this data full time). • Madeleine Mongan volunteered. DAIL would like to be at the table, as would the AHEC. Dawn recommended that Peggy Brozicevic or someone from her office at VDH also be part of the subgroup.	

Agenda Item	Discussion	Next Steps
	• David Adams asked whether this would be duplicative with the contract for demand modeling analysis. Robin noted that this work could inform the assumptions that will go into the demand model, and that the demand model will inform this process as well as any analyses that are completed. • Dawn is looking for people with expertise in a variety of areas, who have time to contribute. • VDH has published qualitative reports for a handful of professions for years which provides descriptive data. This could be a way to gather additional information about professions. • David Adams noted that methodology will be critical, and commented that ongoing assessment will support continued usefulness. • Liz Cote commented that VDH is relying on data fed through re-licensure process; for data to build quantitative report, doesn't exist for non-licensed workers like medical assistants. Need a mechanism to get data for those professions. • Mary Val expressed concerns that latest data is from 2013, and hard to reconcile a 2-year lag with what we're hearing on the ground. This is important to do, but we get into sticky issues by making global analyses without talking to all players—this is time-consuming. A full-time employee might be required to do this well. • Dawn noted that VDH is capturing the data—posting of data has been slowed down due to designs of surveys. Peggy Brozicevic will come talk to the group in April to give update of where data are and where reporting is, and fold that into next steps for reporting. Unless there is a process for using data, it's only descriptive. • Molly Backup recommended that the sub-group be identified specifically as a sub-group of this work group, even if it contains non-members. • Mary Val asked when staff support for this work group ends. Georgia Maheras replied that staff support from SIM ends in December 2016, but like all SIM work, this work will be wrapped into our sustainability planning. Mary Val asked where DOL fits into this type of work; Mat Barewicz replied that he will check. • Dawn suggested discussing this issue with Peggy prior to making a decision. Molly Backup suggested Dawn create a fuller proposal for sub-group membership and other issues for discussion at the April meeting.	**Peggy Brozicevic to attend April 2016 meeting with fuller proposal for subgroup and work.**
6. Presentation and Discussion: Care Management Inventory	Pat Jones and Erin Flynn presented results from the Care Management Inventory (Attachment 6). • Correction to Slide 13 – title should be "Percent of responding organizations using various staff types to perform key core management functions" (this will be updated in the version of these slides posted to the VHCIP website. • This report is a snapshot in time – a great deal has changed since this survey was fielded. The group discussed the following: • David Adams noted that Slide 13 highlights the complexity of Dawn's proposal (Item 5). He also commented that survey lag is an issue, and that this area is continually involving. Erin Flynn provided a Core Competency Training Update (slides will be distributed to the Work Group following the meeting). Additional information and registration materials for the free trainings will be shared in the coming weeks. • Molly Backup asked who is targeted by training. Pat replied that training is intended to augment training for	

Agenda Item	Discussion	Next Steps
	current front-line care managers, rather than new care managers. This could include nurses, social workers, unlicensed care coordinators, and other professions. Sessions will also be taped as modules so interested parties can access them online.	
7. Discussion: Strategic Plan	The bulk of this discussion was tabled for the next meeting. Mary Val Palumbo noted that this discussion was intended to focus on Recommendations #7-#17, and asked that members come prepared to discuss these at the next meeting. She requested volunteers to think through and take charge of each recommendation to generate questions, suggestions, and areas for further discussion, and suggested the group work this through via email. • Mary Val and Wade Ramsey- #7 • Molly Backup - #12 • Nicole LaPointe (and AHEC Directors) - #16 and #17	
8. Public Comment, Wrap-Up, Next Steps, Future Agenda Topics	There was no public comment. **Next Meeting:** April 6, 2016, 3:00-5:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Workforce Work Group Member List

Roll Call: 2/3/2016

Mary Val 1°
David A 2°
Motion to approve minutes by exception
Motion carried

Member		Member Alternate		Aug Minutes	Dec Min	
First Name	Last Name	First Name	Last Name			Organization
	1		0			
David	Adams ✓			A		UVM Medical Center
Molly	Backup ✓	Margery	Bower			Physician Assistant
Mat	Barewicz ✓				A	Department of Labor
Rick	Barnett					Vermont Psychological Association
Colin	Benjamin					Office of Professional Regulation
Ethan	Berke					Dartmouth Institute for Health Policy & Clinical Practice
Peggy	Brozicevic					AHS - VDH
Wade	Carson ✓			A	A	Allied Health - Radiology, UVM
Denise	Clark					Pharmacist/Attorney
Peter	Cobb ✓					VNAs of Vermont
Ellen	Grimes ✓					Vermont Technical College, Dental Hygiene Program
Lory	Grimes					Northeastern Vermont Regional Hospital
Lindsay	Hebert					Dentist
Janet	Kahn	Cara	Feldman-Hunt			UVM College of Medicine, Integrative Health
Nicole	LaPointe ✓					Northeastern Vermont Area Health Education Center
Monica	Light ✓	Stuart	Schurr	A		AHS - DAIL
Robin	Lunge ✓					AOA, Co-Chair
Charlie	MacLean	Elizabeth	Cote ✓	A	A	University of Vermont
Madeleine	Mongan ✓					Vermont Medical Society
Stephanie	Pagliuca ✓				A	Bi-State Primary Care
Mary Val	Palumbo ✓	Jason	Garbarino ✓	A		UVM - College of Nursing and Health Sciences
Dawn	Philibert ✓				A	AHS - VDH
Jerry	Ramsey ✓			A		Agency of Education
Roland	Randsom					DA - Howard Center
Lori Lee	Schoenbeck	Robert	Davis			UVM Integrative Medicine
Nancy	Shaw					Vermont State Colleges
Beth	Tanzman					AHS - DVHA - Blueprint
Deborah	Wachtel					Nurse Practitioner
Total	28			6	5	

Q ✓

VHCIP Workforce Work Group Participant List

Attendance: 2/3/2016

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

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

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

Mary Val	Palumbo	here	University of Vermont	C
Annie	Paumgarten	phone	GMCB	S
Dawn	Philibert	here	AHS - VDH	S/M
Luann	Poirer		AHS - DVHA	S
Jerry	Ramsey	here	Agency of Education	M
Roland	Ransom		DA - HowardCenter for Mental Health	M
Lori Lee	Schoenbeck		Consumer Representative	M
Julia	Shaw		VLA/Health Care Advocate Project	X
Nancy	Shaw		Vermont State Colleges	M
Nancy	Solis		Dartmouth Institute for Health Policy & Clinical Practice	A
Joy	Sylvester		Northwestern Medical Center	X
Beth	Tanzman		AHS - DVHA - Blueprint	M
Tony	Treanor	phone	DA - Northwest Counseling and Support Services	X
Deborah	Wachtel		Consumer Representative	M
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Kendall	West		Bi-State Primary Care/CHAC	X
James	Westrich		AHS - DVHA	S
	68	0	68	68

Pat Jones – here – GMCB

Attachment 4a – Draft Template for Reporting

(Healthcare Profession) Working in Vermont 20___

20___ Office of Professional Regulation Re-licensure Survey
Summary prepared by: Depat

Background

This summary provides supply information for _________working in Vermont in 20____.

Methods

Between January to March 20____, all ___________________in Vermont were required to answer workforce survey questions as part of their re-licensure application. These questions were embedded into the electronic re-licensure system but paper surveys were also available for those requested them. The data were prepared for analyses by the Vermont Department of Health. The number of ______________who completed a re-licensure survey in Spring 20___ was ______(response rate %); this report will analyze only those who reported that they were currently working in the state of Vermont (n=________) and exclude those who requested a paper survey.

Sample Demographics

Gender Male-% Female-% Not reported-%

Age – Average _____years Mode- ______years Range – ______years

Race/Ethnicity:

American Indian or Alaska Native ____%

Asian____%

Black or African American ____%

Native Hawaiian or other Pacific Islander ____%

White ____%

Other ____%

Prefer not to answer ____%

Hispanic

No ____%

Yes, Mexican, Mexican American, Chicano/a ____%

Yes, Puerto Rican ____%

Yes, Cuban ____%

Yes, another Hispanic, Latino/a, or of Spanish origin ____%

Prefer not to answer ____%

Education

In Vermont = ____%

Outside the USA = ________%

Highest Degree (n=_____)

_______% Diploma/certificate

_______% Associate Degree

_______% Bachelor's Degree

_______% Master's Degree

_______% Doctoral degree – practice focused

_______% Doctoral degree - (PhD)

Currently enrolled in Educational Program

_______% Bachelor's program

_______% Master's program

_______% Doctoral degree program (practice doctorate)

_______% Doctoral degree program (PhD)

_______% Certification programs (20)

_______% Not enrolled

<u>Practice</u>

Years worked as ___________: Average: ____ Mode: ______Range: _____

Active license: in 2 States: ______, 3 States ______

_____% are currently actively practicing in only one state

Employment status as an RN (select all that apply)*

Actively working – part or full time _______%
Working per diem _______%
Traveler _______%
Working only as a volunteer _______%
Working in a field other than ____________ _______%
Retired _______%

Setting of primary practice (choose one)*

%	N=	Hospital
		Nursing Home/Extended Care/Assisted Living Facility
		Home Health
		Correctional Facility
		Public Health
		Community Health
		Mental Health Center
		School Health Service
		Occupational Health
		Ambulatory Care Setting
		Academic setting
		Insurance Claims/Benefits
		Policy/Planning
		Regulatory/Licensing Agency
		Other Setting
		Missing

Commented [PMV1]: These will change based on profession

Employment Characteristics

_____% Working full time in patient care at all of their practice sites
_____% Working part time in patient care at all of their practice sites
_____% Working full time in "administration/teaching/research/supervision/other" responsibilities at all of their practice sites
_____%Work at a second practice site in VT
_____% Work at a third practice site in VT

Primary Position Title

Commented [PMV2]: These will change based on profession

Staff Nurse (patient care)		
Nurse Manager		
Nurse Executive		
Nurse Faculty		
Consultant/Nurse Researcher		
Other – Health-Related		
Other - Not Health-Related		
Missing		

Population served in primary position (check all that apply)

Adult -_________%

Geriatric -_________%

Pediatric -_________%

Neonatal – ______%

All Ages – ______%

Not applicable – ___________%

Discussion of these findings with qualitative input from educators, employers and HR professionals, as well as Dept of Labor employment data

Attachment 4b – VDH Survey Status

Date of Renewal	License Type	Profession	Licensing Organization	Minimum Dataset	Need for Desig	Priority
2013						
September 30, 2013	16	Dentists	OPR	N	Y	1
September 30, 2013	15	Dental Hygienists	OPR	Y	N	
September 30, 2013	13	Dental Assistants-certified	OPR	N	N	
September 30, 2013	14	Dental Assistants	OPR	N	N	
2014						
January 31, 2014	89	Clincial Social Worker	OPR	N	Y	1
January 31, 2014	48	Psychologist, PhD	OPR	Y	Y	1
January 31, 2014	47	Psychologist, MA	OPR	Y	Y	1
January 31, 2014	130	Psychologist trainee	OPR	Y	N	
January 31, 2014	91	Acupuncturist	OPR	N	N	3
January 31, 2014	120	Acupuncture detox tech	OPR	N	N	
January 31, 2014	25	Licensed Practical Nurse	OPR	Y	N	
January 31, 2014	55	Physicians Assistants	BMP	Y	N**	1
January 31, 2014	135	Anesthesiology Assistants	BMP	N	N	
January 31, 2014	134	Radiology Assistants	BMP	N	N	
March 31, 2014	27	Nursing Home Admin.	OPR	N	N	
May 31, 2014	72	Occupational Therapists	OPR	Y	N	3
May 31, 2014	73	Occupl Tx Assistants	OPR	N	N	3
May 31, 2014	74	Dieticians	OPR	N	N	
July 31, 2014	30	Optometrists	OPR	N	N	
July 31, 2014	28	Opticianry	OPR	N	N	
July 31, 2014	29	Optician trainee	OPR	N	N	
September 30, 2014	40	Physical Therapists	OPR	Y	N	
September 30, 2014	41	PT Assistants	OPR		N	
September 30, 2014	104	Athletic Trainers	OPR	N	N	
September 30, 2014	6	Chiropractors	OPR	N	N	3
September 30, 2014	99	Naturopathic Physician	OPR	N	N	2
September 30, 2014	32	Osteopaths	OPR	Y	Y	1
November 30, 2014	75	Licensed Nursing Asst.	OPR	Nurse	N	
November 30, 2014	122	Respiratory Care	OPR	N	N	
November 30, 2014	97	Psychotherapy	OPR	N	N	
November 30, 2014	98	Psychoanalysis	OPR	N	N	
November 30, 2014	100	Marriage & Family Therapy	OPR	N	Y	1
November 30, 2014	42	Physicians	BMP	Y	Y	1
2015						
January 31, 2015	107	Licensed Midwives	OPR	N	N	

January 31, 2015	68	Mental Health Counselors	OPR	Y	N	
January 31, 2015		Alcohol & Substance Abuse Counselors	ADAP	Y	N	2
March 31, 2015	26	Registered Nurse	OPR	Y	N	
	101	Advanced Practice Registered Nurse	OPR	Y	N**╧	1
May 31, 2015	49,50,51,53	Radiologic Technology	OPR	N	N	
June 30, 2015	56	Podiatrists	BMP	N	N	
July 31, 2015		Hearing Aid Dispensing	OPR	N	N	
July 31, 2015	33	Pharmacist	OPR	N	N	2
July 31, 2015	121	Pharmacy Technician	OPR	N	N	2
September 30, 2015	16	Dentists	OPR	N	Y	1
September 30, 2015	15	Dental Hygienists	OPR	Y	N	
September 30, 2015	13	Dental Assistants - certified	OPR	N	N	
September 30, 2015	14	Dental Assistants	OPR	N	N	
2016						
January 31, 2016	89	Clincial Social Worker	OPR	N	Y	1
January 31, 2016	48	Psychologist, PhD	OPR	Y	Y	1
January 31, 2016	47	Psychologist, MA	OPR	Y	Y	1
January 31, 2016	91	Acupuncturist	OPR	N	N	3
January 31, 2016	120	Acupuncture detox tech	OPR	N	N	
January 31, 2016	25	Licensed Practical Nurse	OPR	Y	N	
January 31, 2016	55	Physicians Assistants	BMP	Y	N**	1
January 31, 2016	135	Anesthesiology Assistants	BMP	N	N	
January 31, 2016	134	Radiology Assistants	BMP	N	N	
March 31, 2014	27	Nursing Home Admin.	OPR	N	N	
May 31, 2014	72	Occupational Therapists	OPR	Y	N	3
May 31, 2014	73	Occupl Tx Assistants	OPR	N	N	3
May 31, 2014	74	Dieticians	OPR	N	N	
January ??		Apprentice Addictions Professional	ADAP->OPR	Y	N	
10/30/2016?		Speech Language Pathologists/Audiologists	Dept of Ed (Bu	N	N	

╧Psychiatric nurse practitioners are needed for Mental Health Designations

* number of licensees are approximate, except for types with response rates listed
** proposal for revised designation process would include

# active * licensees	#NAME?
490	report complete
643	data collection completed, 41 missing, +-60 incomplete
115	data collection completed, 22 missing, +-10 incomplete
519	data collection completed, 85 missing, +-60 incomplete
996	821 responded, 250 returned follow-up, 15 missing
389	339 responded, 4 still in followup, 80 returned
193	156 responded, 4 still in followup. 52 returned
53	data collected, data not extracted yet
144	5 still in followup, 6 returned
	were not surveyed in 2014
1714	have some data (employment status) from 1444
278	report complete
10	report complete
	report complete
79	data collection completed, have data file, looks OK
327	253 responded, 28 still in followup, 67 returned
98	74 responded, 17 still in followup, 5 returned
155	data collection completed
104	95 responses, site 2 data lost due to skip pattern error
97	86 responses, site 2 data lost due to skip pattern error
20	17 responses, site 2 data lost due to skip pattern error
970	followup complete
175	156 responses - no followup
144	renewal complete, Survey Gizmo reports 126 responses
232	200 responses, 5 still in followup, 19 returned
257	followup complete
147	report complete
3848	2847 responses (74%) online+paper, 2415 active in VT - a few more to scan
264	7 still missing as of July 22
660	518 online responses, 466 active in VT
52	41 online responses - 16 active in VT + 8 paper forms
52	43 online + 1 on paper, 9 in followup - of which 6 returned
3067	report complete
29	paper renewals only - 4 still missing as of July 22

642	forms ready (both paper and online)
480+-	223 "complete" in SG, mailed 296 - about 150 replied
11034	list of 312 for second followup letter sent to OPR
547	1 still missing as of July 22
627	1 missing
36	complete
41	complete
1748	complete
1738	
526	followup complete
703	in followup, 7 missing
125	in followup, 2 missing
671	in followup, 5 missing
1142	in followup, 4 missing
454	in followup, 9 missing
208	in followup, 1 missing
187	in followup, 2 missing
13	in followup, 1 missing
2284	in followup, 57 missing
380	in followup, 7 missing
10	
79	In process
327	form in design
98	form in design
155	form in design

used to relicense every 3 years

Status - as of March 17, 2016

Attachment 4d – 2014 Physician Census Report

2014 PHYSICIAN CENSUS SUMMARY REPORT

VERMONT
DEPARTMENT OF HEALTH

February, 2016

SUMMARY

- There were 1933 physicians providing patient care in Vermont (1852 MDs and 81 DOs) in 2014.
- 38% (729) of the physicians were female, 62% male.
- 39% (763) have worked in Vermont less than 10 years, and 31% (605) have worked in Vermont 20 or more years.
- 32% attended medical school and/or completed residency training at the University of Vermont.

PRIMARY CARE

- 33% (636) worked mainly in primary care, including:
  - 15% (285) in family practice
  - 8% (163) in primary care internal medicine
  - 4% (68) in obstetrics and gynecology
  - 6% (120) in pediatric primary care
- There were 476.9 primary care Full Time Equivalents (FTEs) - 76.1 per 100,000 population statewide

SPECIALTY CARE

67% (1297) worked mainly in specialty care:

- 5% (97) in anesthesiology
- 7% (130) in emergency medicine
- 5% (95) hospitalists
- 10% (192) in specialty internal medicine
- 9% (179) in psychiatry
- 5% (106) in radiology (including tele-radiology)
- 8% (149) in surgery (44 general, 67 orthopedic)
- 18% (349) other specialties (32 neurology, 43 ophthalmology, 55 pathology, 21 urology)

AGE OF PHYSICIANS

- Ages ranged from 28 to 89, with a median age of 50.
- In 7 of 14 counties, at least 35% of the primary care physicians were over age 60
- 24% of specialists were over age 60, including:

  40% of psychiatrists

  34% of neurologists

  30% of ophthalmologists

  30% of general surgeons

CHANGES OVER TIME: PRIMARY CARE

As compared with the year 2004:

- There are 2 more primary care physicians, but 1.8 fewer FTEs.
- There was a net decrease of 10.2 FTEs in primary care internal medicine.
- Statewide, primary care FTEs per 100,000 population decreased, from 77.0 to 76.1.
- Outside of Chittenden County, primary care FTEs per 100,000 population decreased, from 72.3 to 71.4.

CHANGES OVER TIME: PRIMARY CARE

As compared with the year 2010:

- There are 8 more primary care physicians, but 15.2 fewer FTEs.
- There was a net loss of 6.4 FTEs in primary care internal medicine.
- Statewide, primary care FTEs per 100,000 population decreased, from 78.6 to 76.1.
- Outside of Chittenden County, primary care FTEs per 100,000 population decreased, from 72.8 to 71.4.

CHANGES OVER TIME: SPECIALTY CARE

As compared with the year 2004:

- There are 321 more specialty care physicians.
- Not counting radiology and pathology*, there are 276 more specialists, and 180.0 more specialty care FTEs.
- FTE increases were especially large in hospitalists, anesthesiology, emergency medicine, and specialty internal medicine.

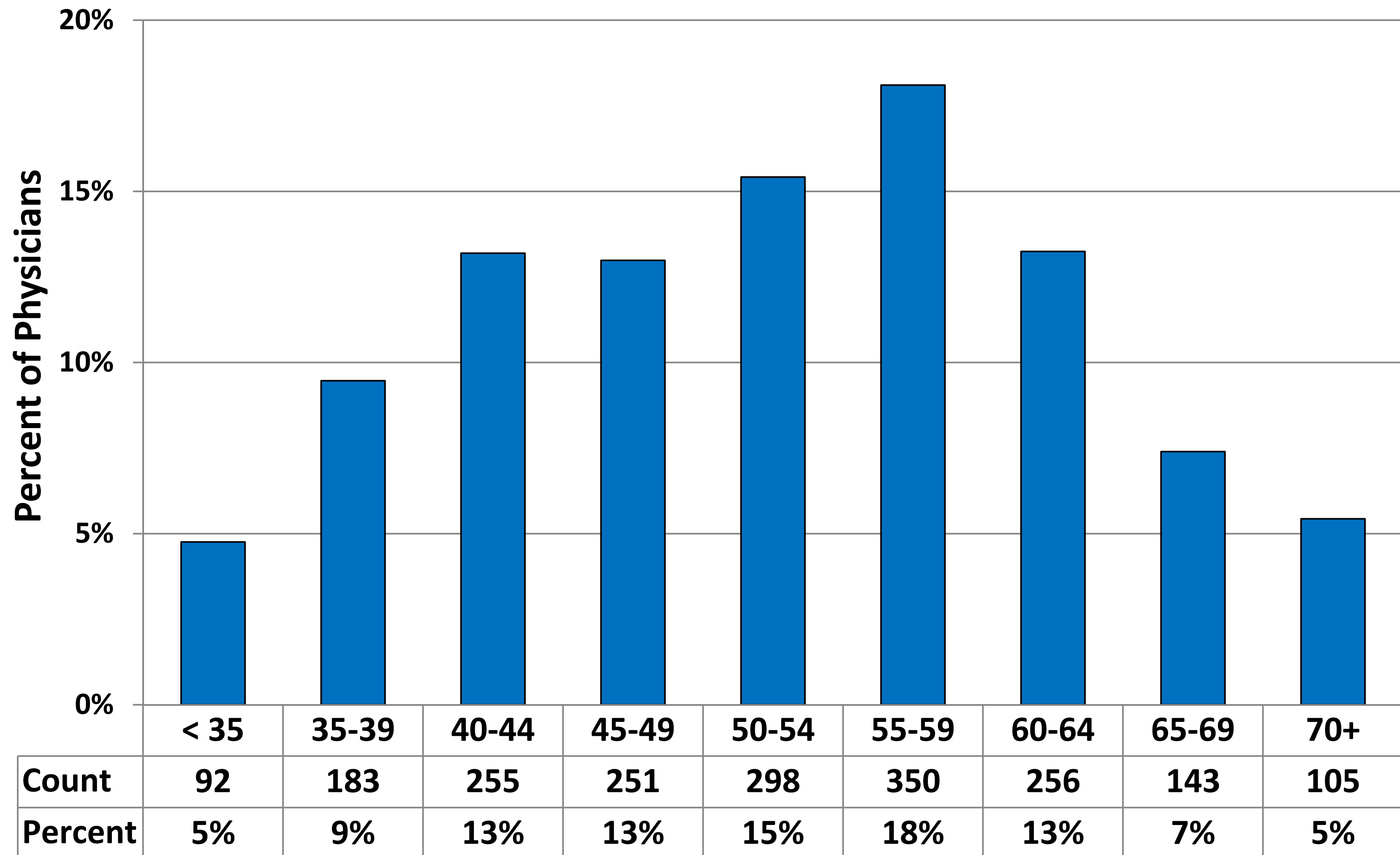
* Many radiologists and pathologists practice via telemedicine, and FTEs cannot be determined

CHANGES OVER TIME: SPECIALTY CARE

As compared with the year 2010:

- There are 48 more specialty care physicians.
- Not counting radiology and pathology*, there are 81 more specialists, but 7.6 fewer specialty care FTEs.
- FTE decreases were especially large in psychology and general surgery.

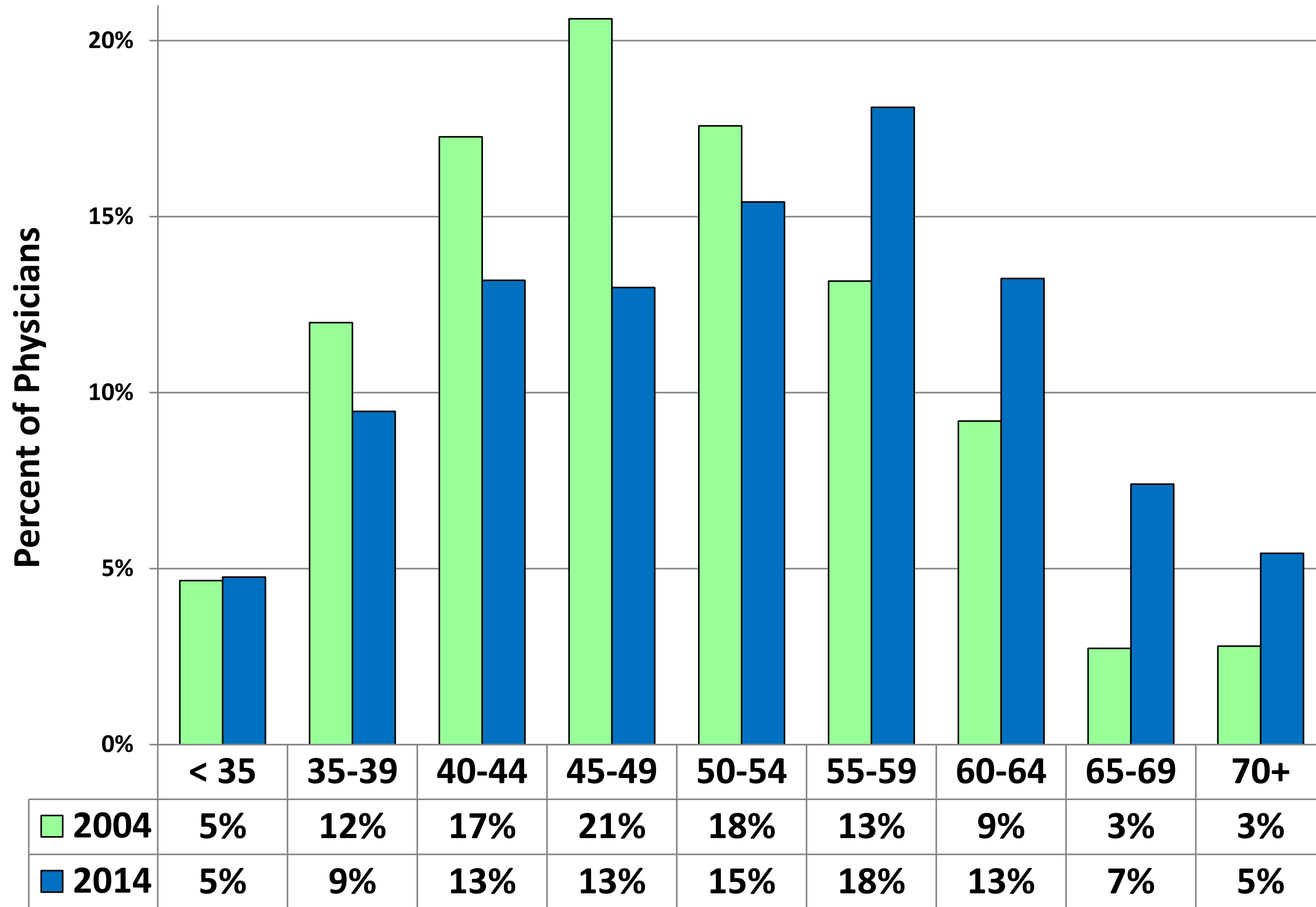
* Many radiologists and pathologists practice via telemedicine, and FTEs cannot be determined



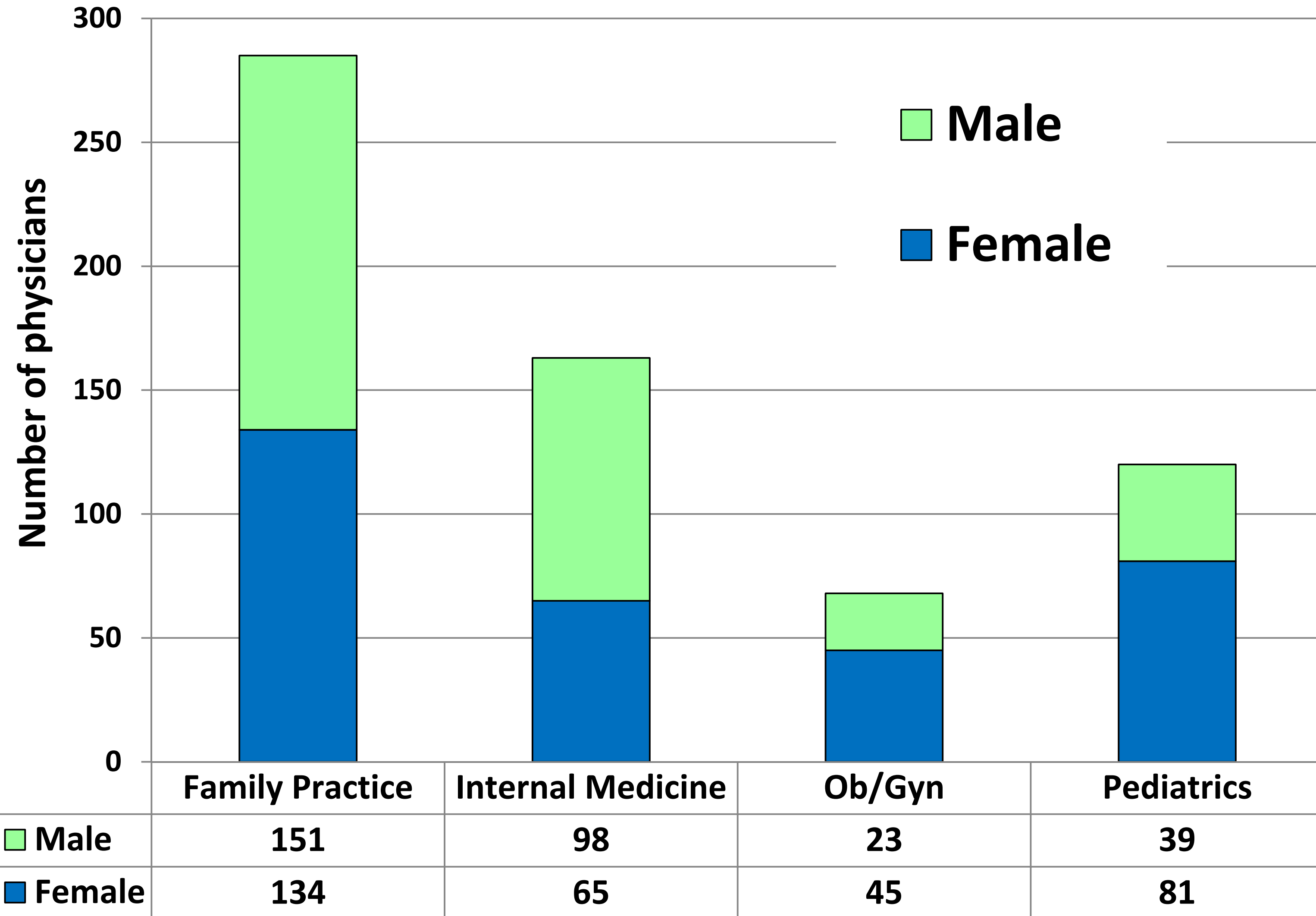
	< 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Count	92	183	255	251	298	350	256	143	105
Percent	5%	9%	13%	13%	15%	18%	13%	7%	5%

26% of all physicians are over age 60

Age Distribution Over Time: 2014 vs. 2004

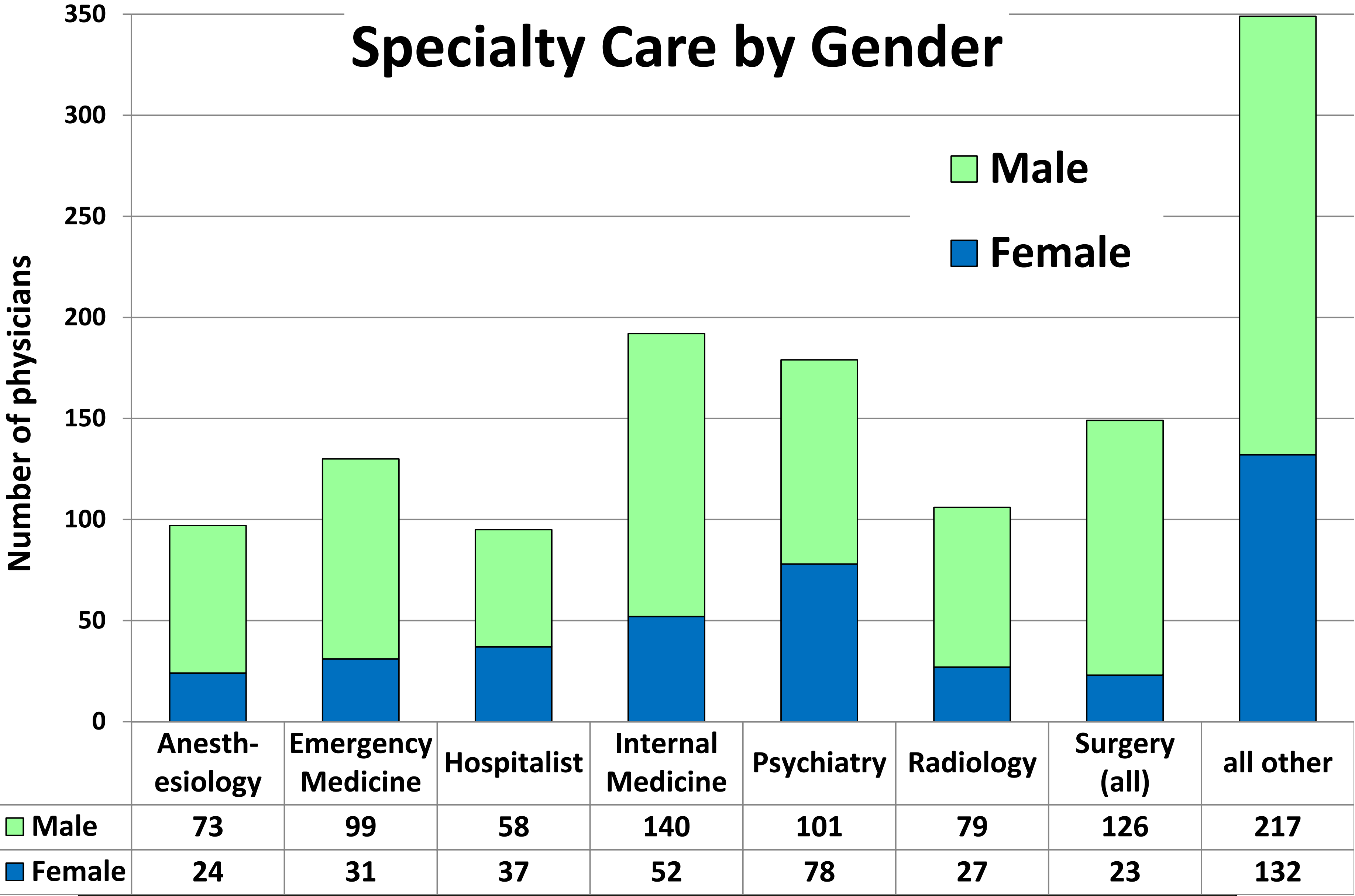


Primary Care by Gender



	Family Practice	Internal Medicine	Ob/Gyn	Pediatrics
Male	151	98	23	39
Female	134	65	45	81

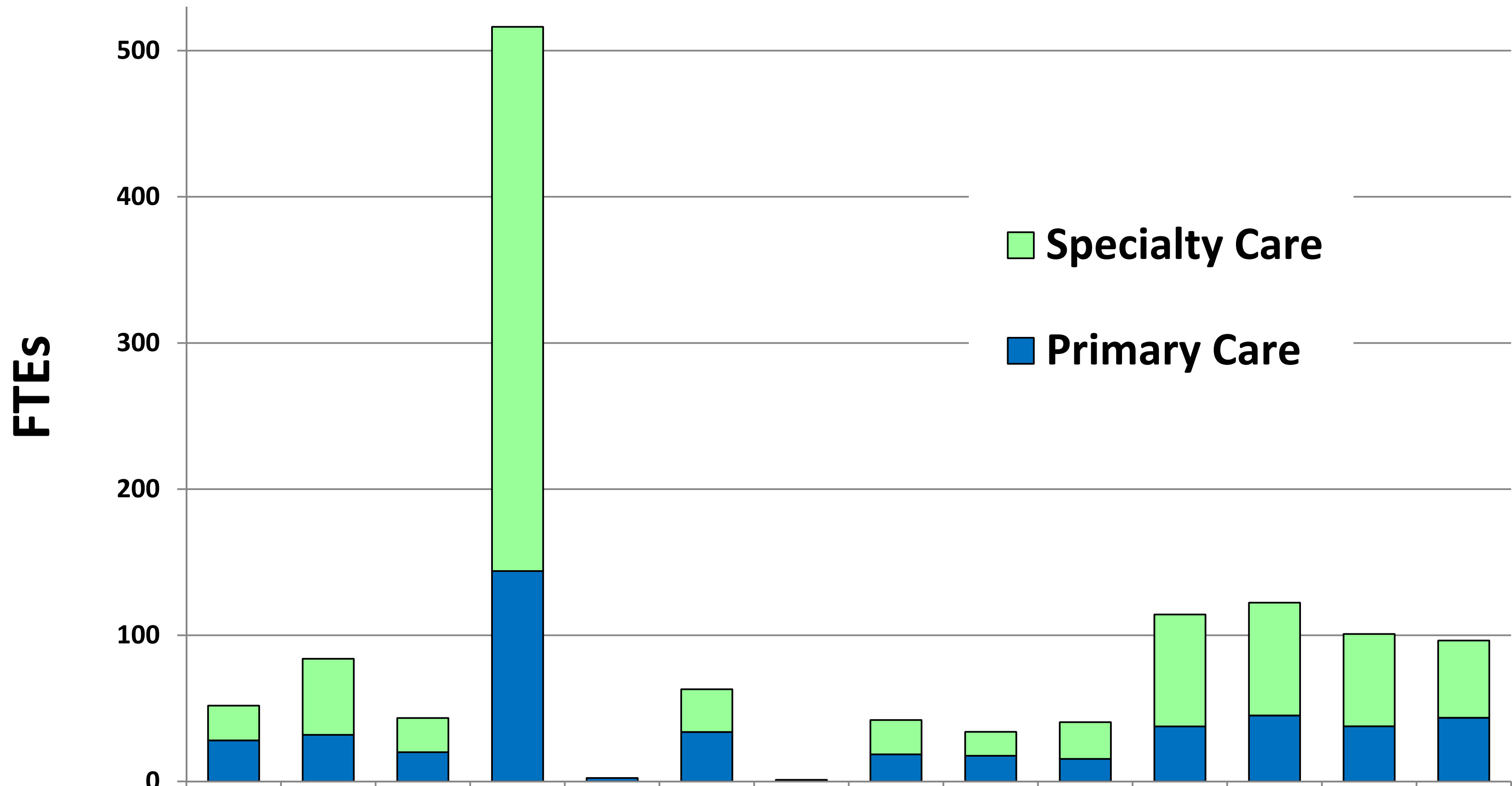
68% of pediatricians and 66% of OB/GYNs are female



	Anesth-esiology	Emergency Medicine	Hospitalist	Internal Medicine	Psychiatry	Radiology	Surgery (all)	all other
Male	73	99	58	140	101	79	126	217
Female	24	31	37	52	78	27	23	132

Most specialty care physicians are male

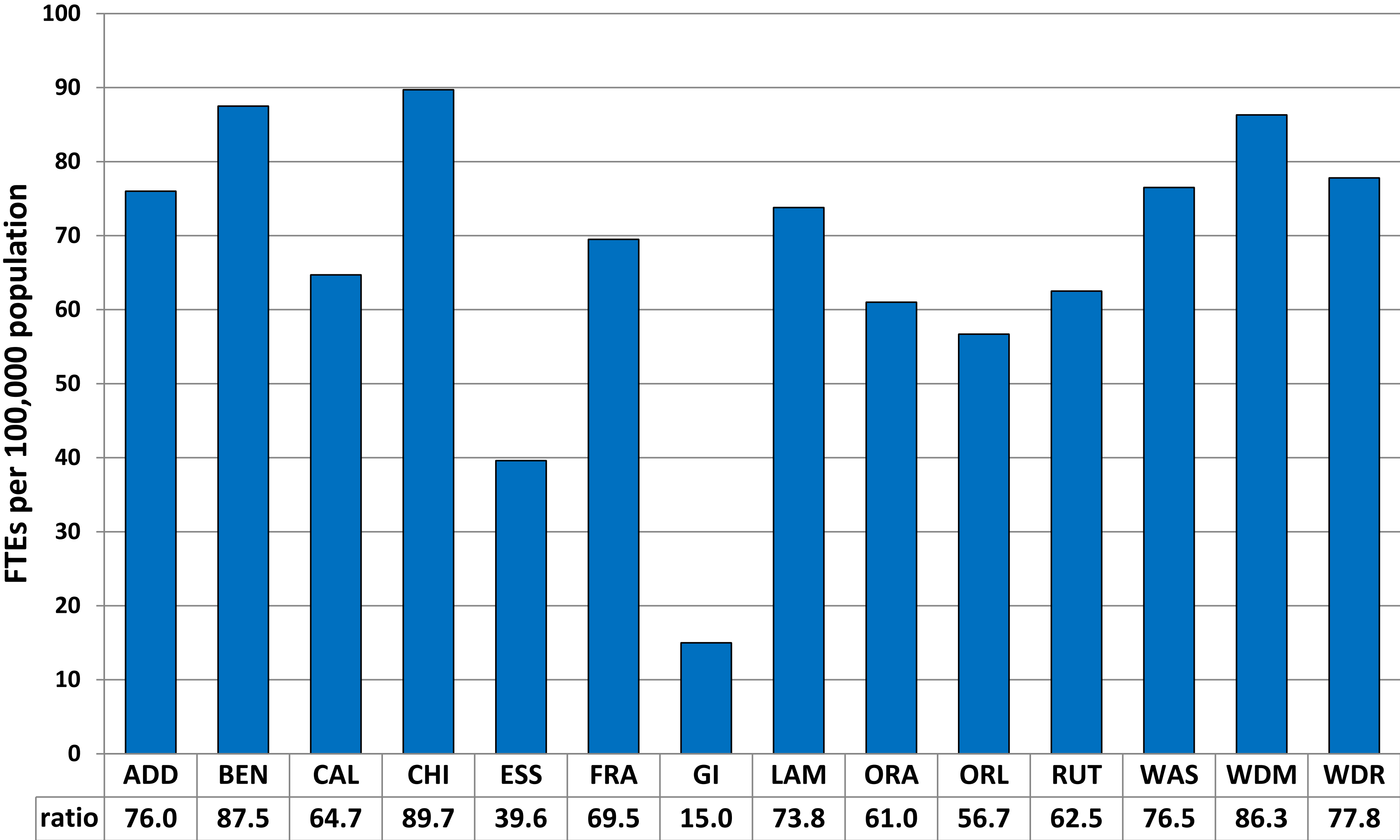
Full Time Equivalents (FTEs) by County



	ADD	BEN	CAL	CHI	ESS	FRA	GI	LAM	ORA	ORL	RUT	WAS	WDM	WDR
Specialty Care	23.8	52	23.4	372	0	29.3	0	23.5	16.3	25.2	76.6	77.2	63.2	52.8
Primary Care	28.1	31.9	20	144	2.4	33.8	1.1	18.5	17.6	15.4	37.6	45.1	37.7	43.6

Physicians are highly concentrated in Chittenden County

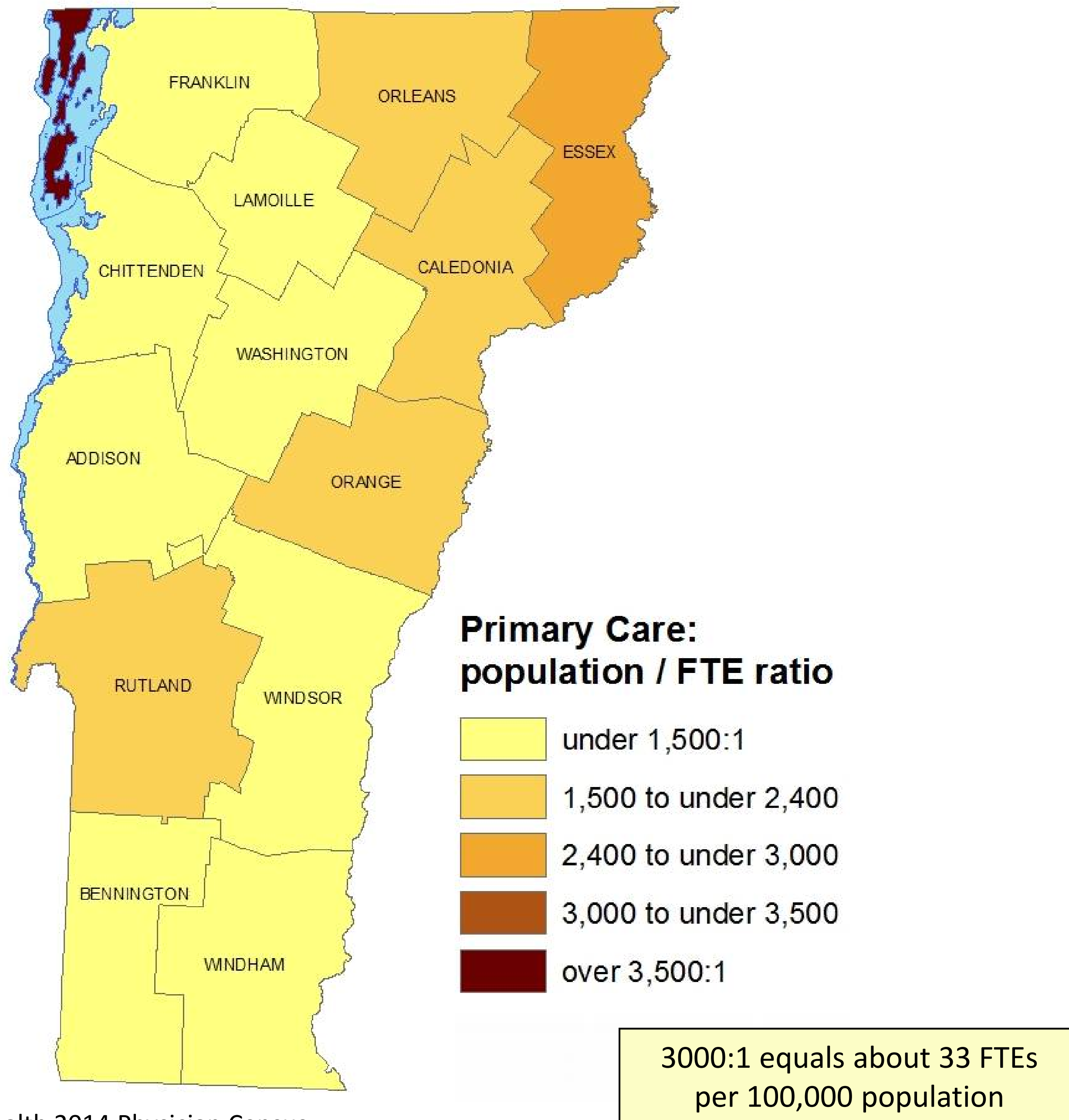
Primary Care FTE to Population Ratios by County



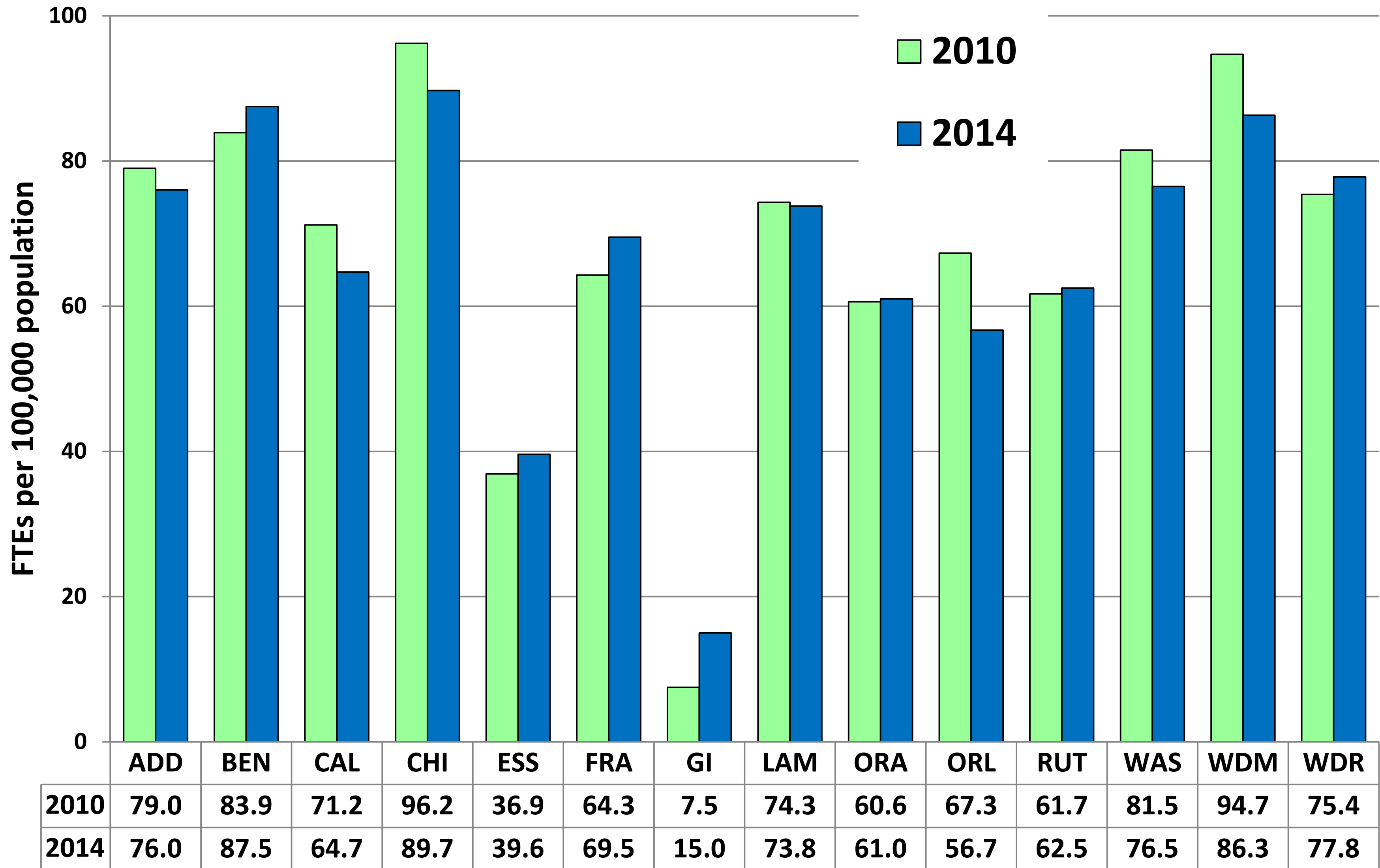
	ADD	BEN	CAL	CHI	ESS	FRA	GI	LAM	ORA	ORL	RUT	WAS	WDM	WDR
ratio	76.0	87.5	64.7	89.7	39.6	69.5	15.0	73.8	61.0	56.7	62.5	76.5	86.3	77.8

Several counties have a shortage of primary care physicians relative to their population

2014 Primary Care Physicians by County

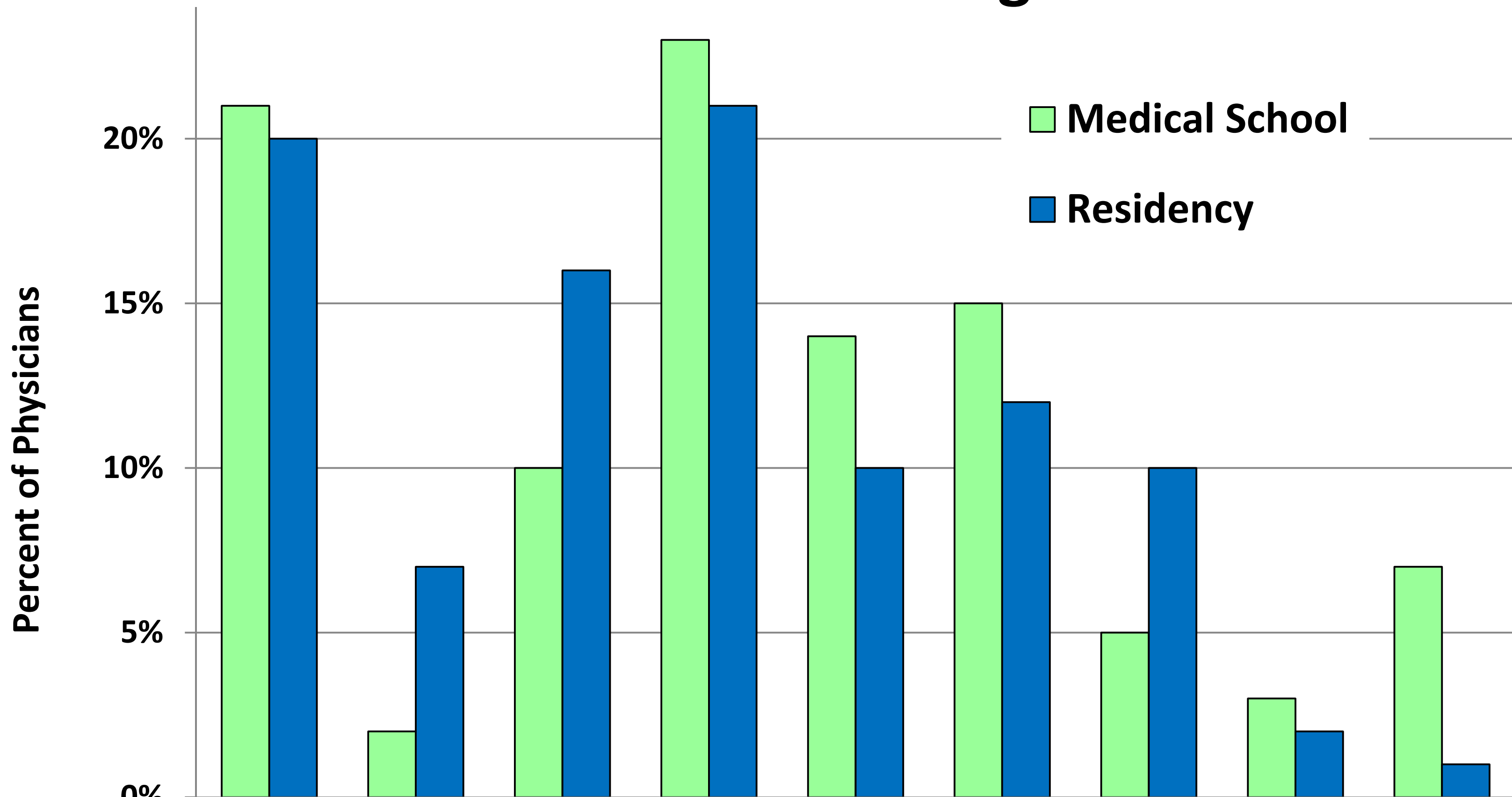


3000:1 equals about 33 FTEs per 100,000 population



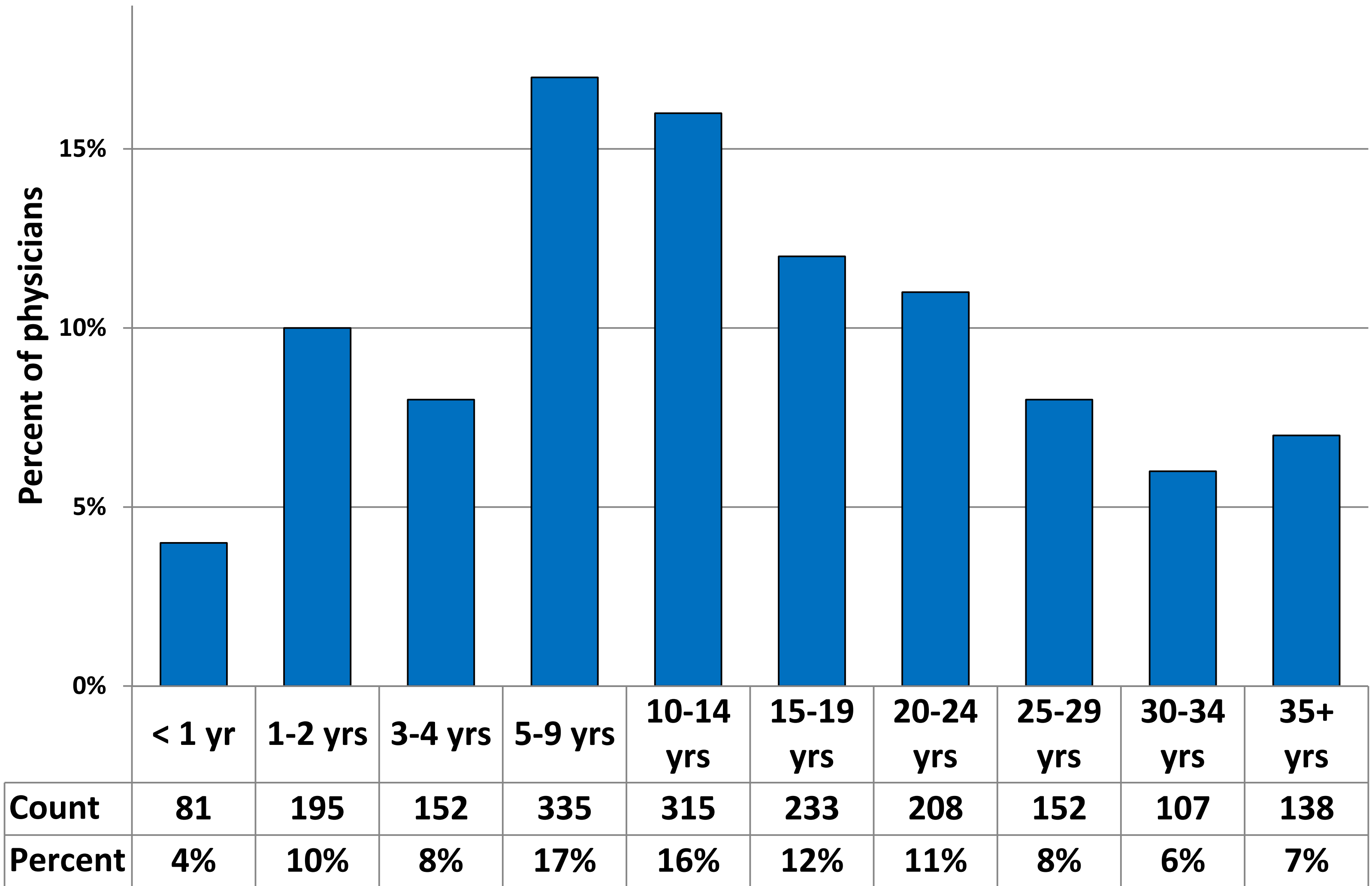
	ADD	BEN	CAL	CHI	ESS	FRA	GI	LAM	ORA	ORL	RUT	WAS	WDM	WDR
2010	79.0	83.9	71.2	96.2	36.9	64.3	7.5	74.3	60.6	67.3	61.7	81.5	94.7	75.4
2014	76.0	87.5	64.7	89.7	39.6	69.5	15.0	73.8	61.0	56.7	62.5	76.5	86.3	77.8

Location of Training



	VT	NH	New England	Mid Atlantic	South	Central	West	Canada	Other Foreign
Medical School	21%	2%	10%	23%	14%	15%	5%	3%	7%
Residency	20%	7%	16%	21%	10%	12%	10%	2%	1%

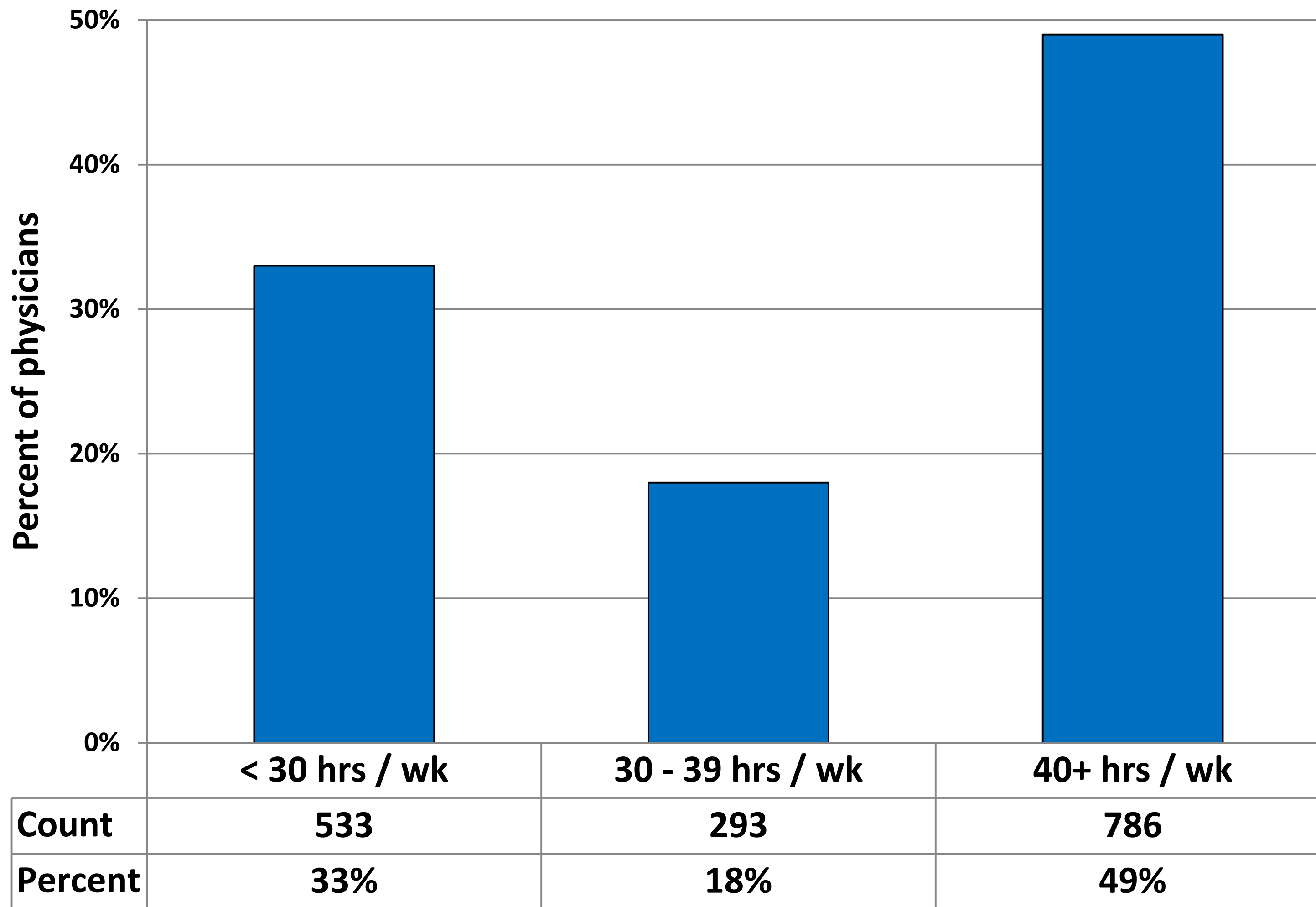
32% of physicians attended medical school and/or completed residency training at UVM



	< 1 yr	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+ yrs
Count	81	195	152	335	315	233	208	152	107	138
Percent	4%	10%	8%	17%	16%	12%	11%	8%	6%	7%

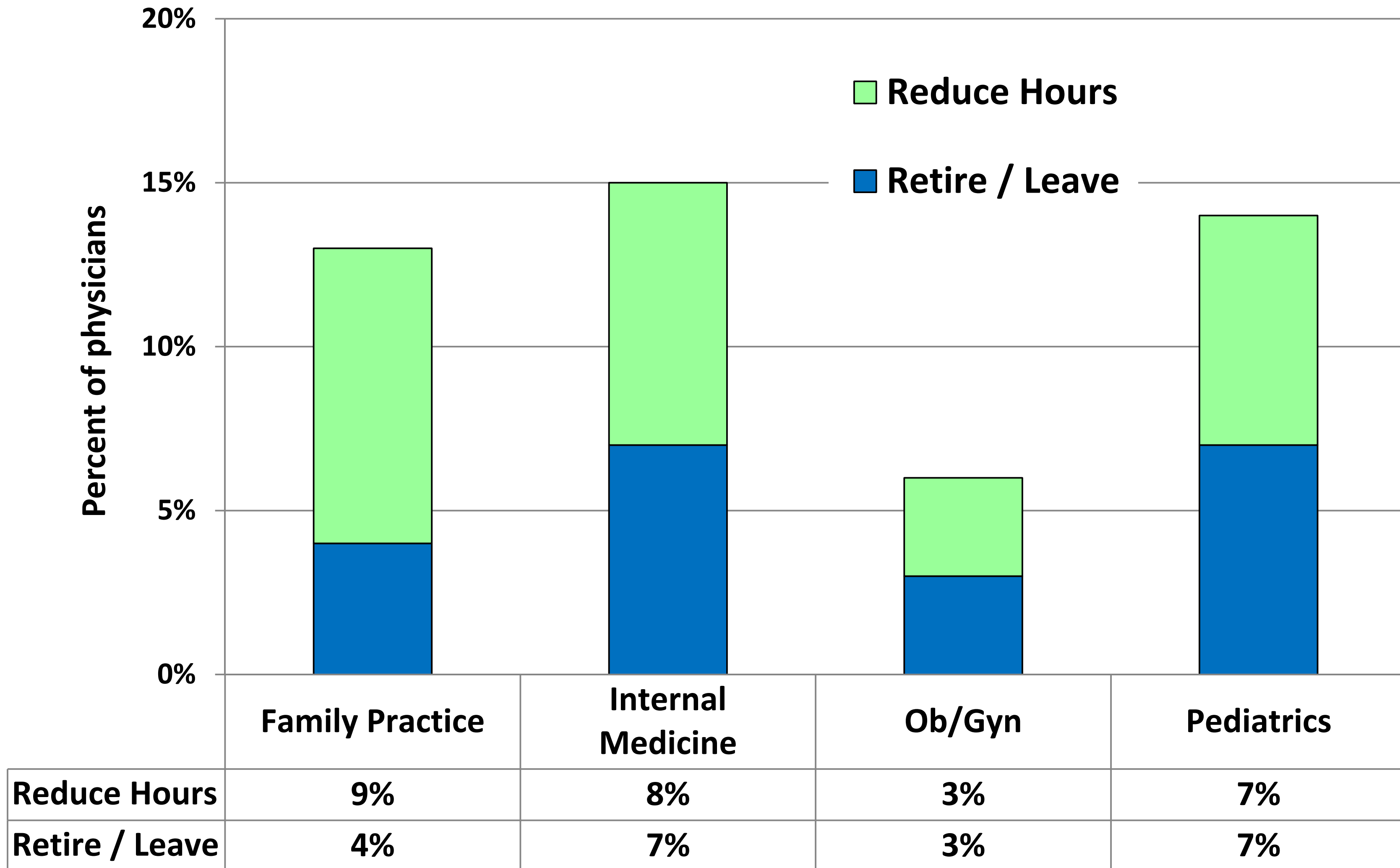
51% of the physicians have been in practice (anywhere) 20 years or more

Patient Care Hours Per Week

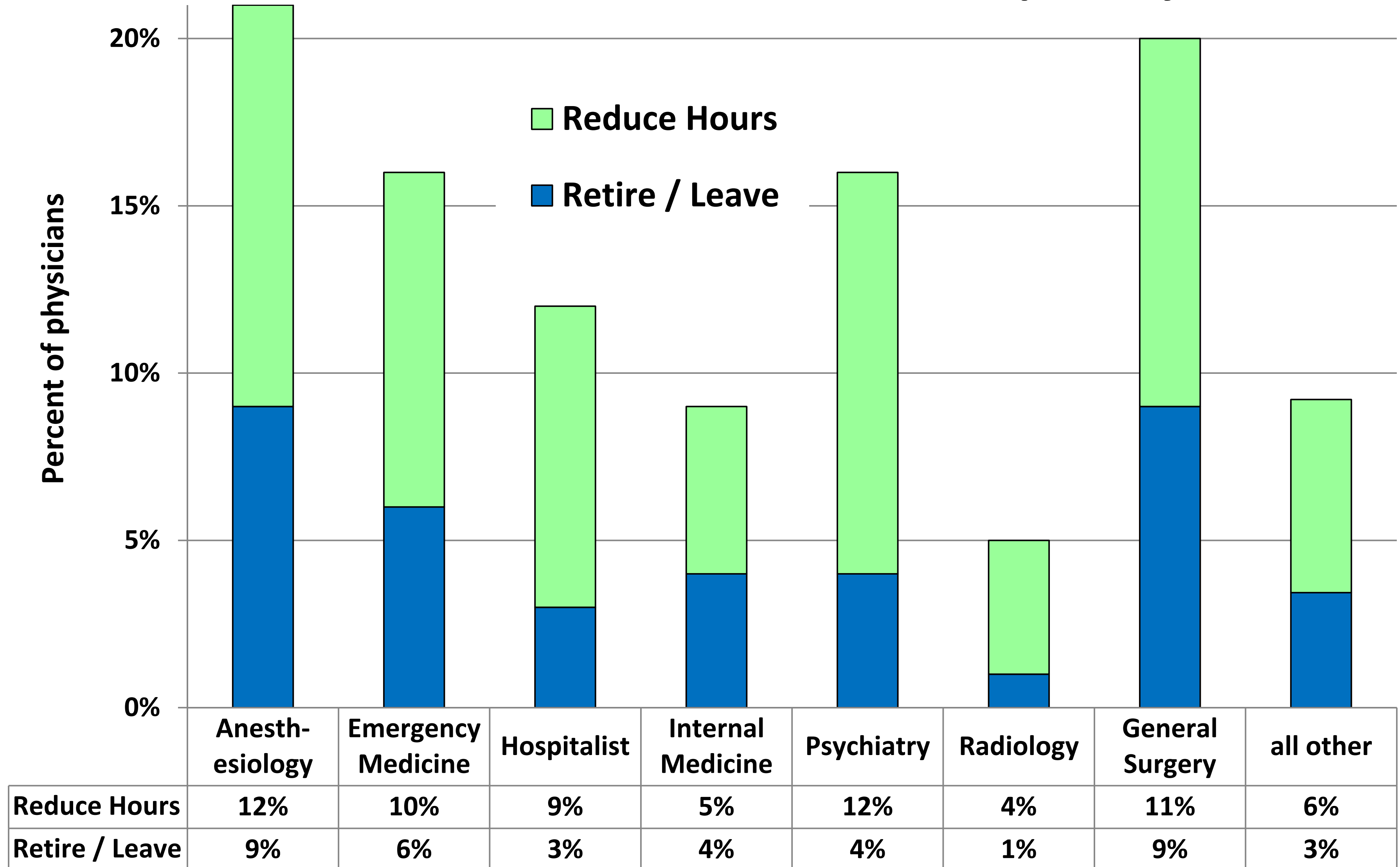


	< 30 hrs / wk	30 - 39 hrs / wk	40+ hrs / wk
Count	533	293	786
Percent	33%	18%	49%

Average patient care hours per week: 34 overall, 27 for ages 65 and older.
48% of males, and 38% of females, provide patient care 40+ hours per week.

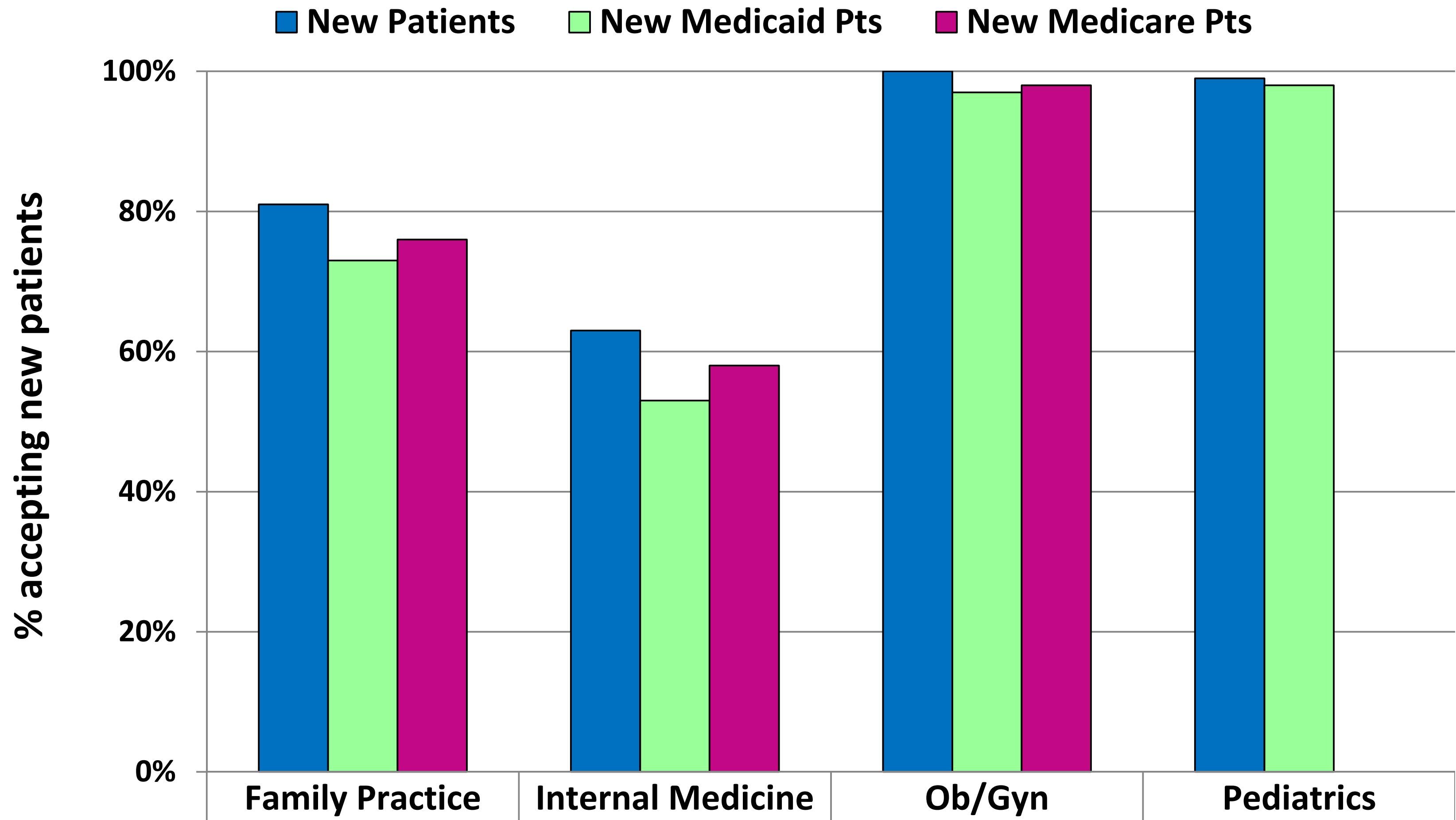


	Family Practice	Internal Medicine	Ob/Gyn	Pediatrics
Reduce Hours	9%	8%	3%	7%
Retire / Leave	4%	7%	3%	7%



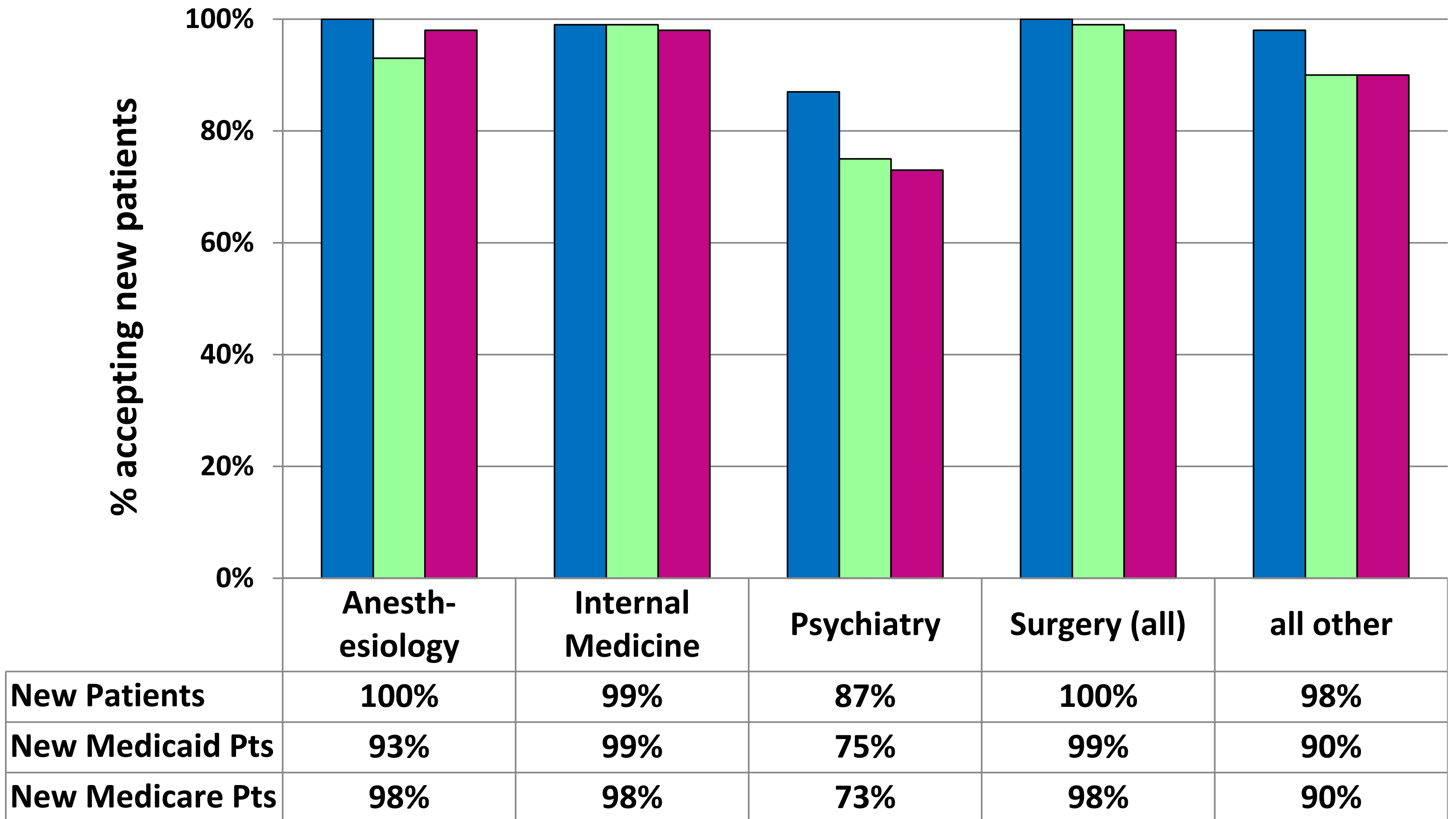
	Anesth-esiology	Emergency Medicine	Hospitalist	Internal Medicine	Psychiatry	Radiology	General Surgery	all other
Reduce Hours	12%	10%	9%	5%	12%	4%	11%	6%
Retire / Leave	9%	6%	3%	4%	4%	1%	9%	3%

Accepting New Patients – Primary Care



	Family Practice	Internal Medicine	Ob/Gyn	Pediatrics
New Patients	81%	63%	100%	99%
New Medicaid Pts	73%	53%	97%	98%
New Medicare Pts	76%	58%	98%	

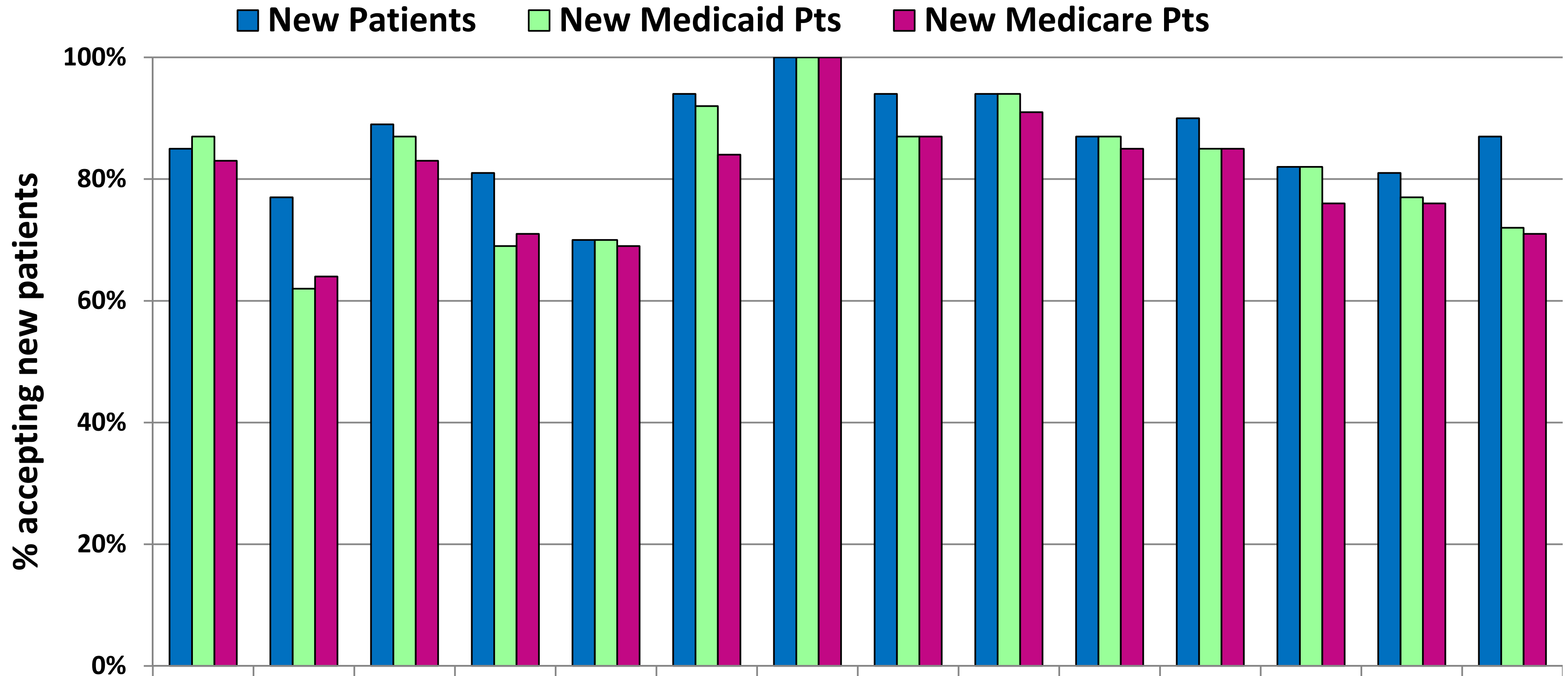
Accepting New Patients – Specialty Care



	Anesth-esiology	Internal Medicine	Psychiatry	Surgery (all)	all other
New Patients	100%	99%	87%	100%	98%
New Medicaid Pts	93%	99%	75%	99%	90%
New Medicare Pts	98%	98%	73%	98%	90%

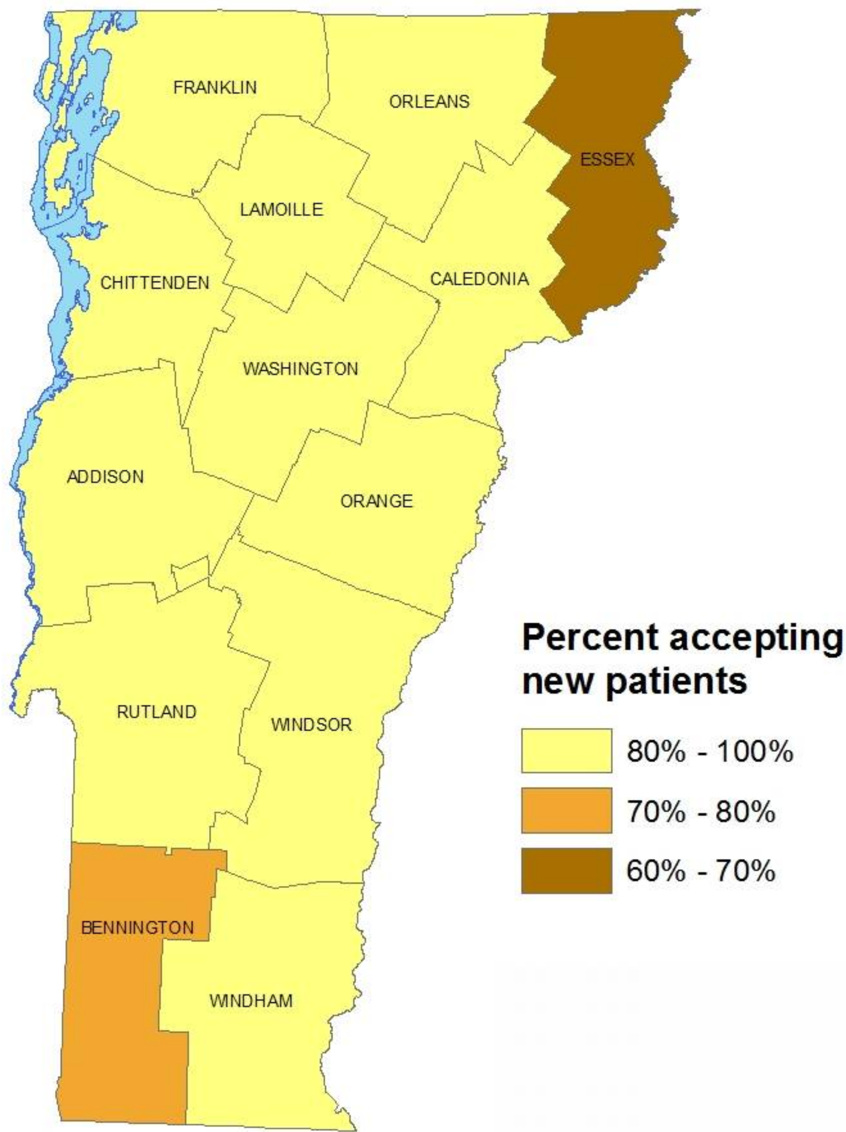
Office settings only. Emergency medicine, pathology and radiology excluded.

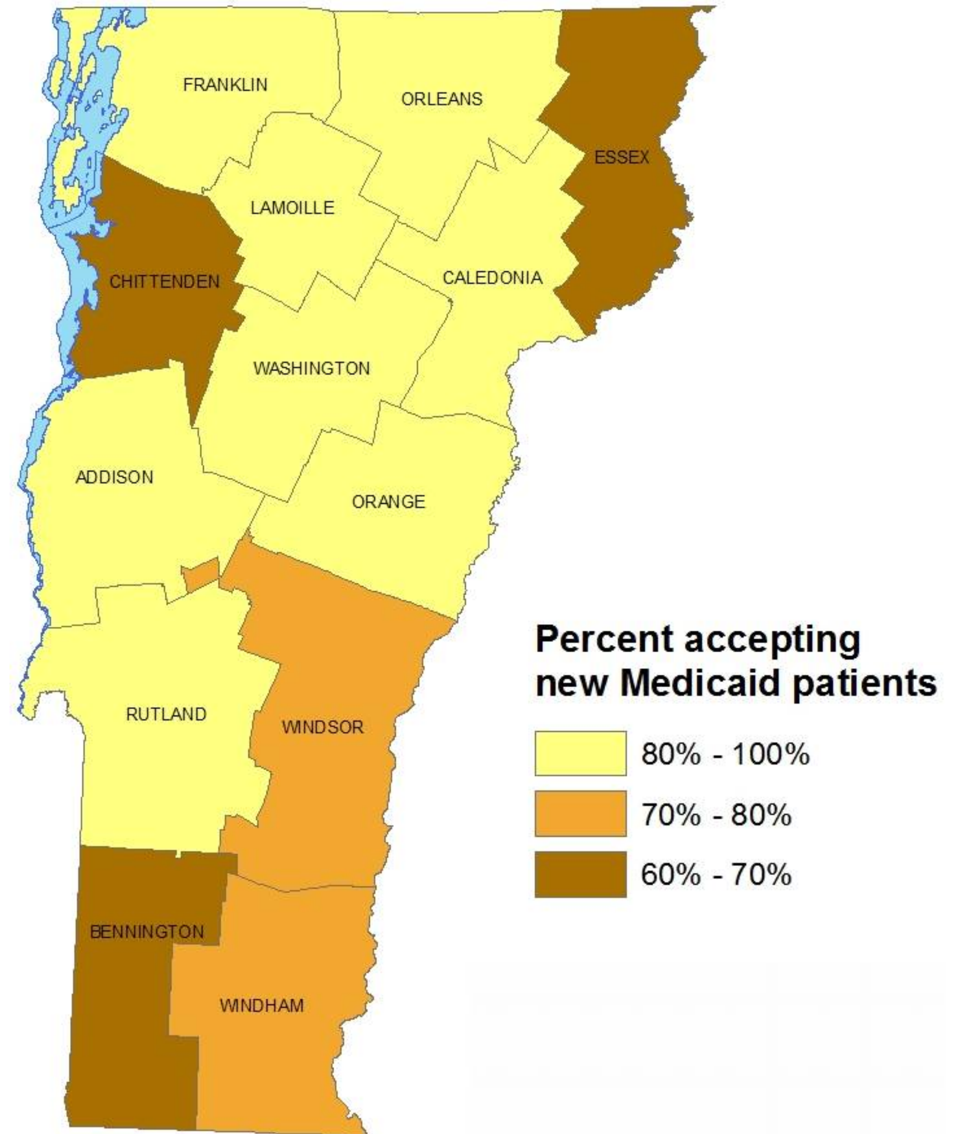
Accepting New Patients – Primary Care, by County



	ADD	BEN	CAL	CHI	ESS	FRA	GI	LAM	ORA	ORL	RUT	WAS	WDM	WDR
New Patients	85%	77%	89%	81%	70%	94%	100%	94%	94%	87%	90%	82%	81%	87%
New Medicaid Pts	87%	62%	87%	69%	70%	92%	100%	87%	94%	87%	85%	82%	77%	72%
New Medicare Pts	83%	64%	83%	71%	69%	84%	100%	87%	91%	85%	85%	76%	76%	71%

Primary Care Physicians: New Patients, by County





Comparison of Selected Physician Data, 2000-2014

	2000	**2004**	**2008**	**2010**	**2014**
Total active * physicians	1480	1612	1833	1877	1933
Percent female	26%	29%	31%	33%	38%
Primary care physicians	585	634	634	628	636
% accepting new patients	80%	81%	80%	83%	82%
accepting new Medicaid patients	73%	70%	69%	72%	76%
accepting new Medicare patients	74%	71%	69%	69%	72%
Primary care physician FTEs	472.2	478.7	498.2	492.1	476.9
PC Internal Medicine FTEs	128.5	124.5	126.5	120.7	114.3
PC FTEs per 100,000 Population	77.6	77.0	80.2	78.6	76.1
Specialist physicians	895	978	1199	1249	1297
Specialist physician FTEs **	621.3	656.1	818.1	843.7	836.1

* providing patient care in Vermont

** FTEs not computed for pathology and radiology

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Attachment 4e - Healthcare Data Maps

Registered Nurses in Vermont

2015 BOARD OF NURSING RELICENSURE SURVEY

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

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.

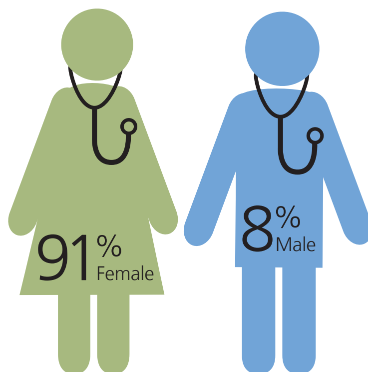
Demographics

Gender

Female: 91%

Male: 8%

Unreported: 1%



Age

Average age: 48 years

Mode: 61 years

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%

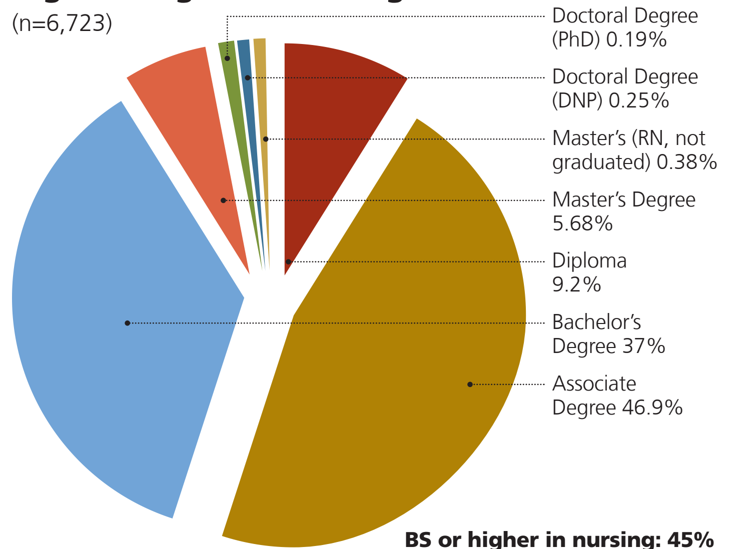
Education

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

Setting	Percent
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

Title	Percent
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

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

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

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).

Demographics

Gender

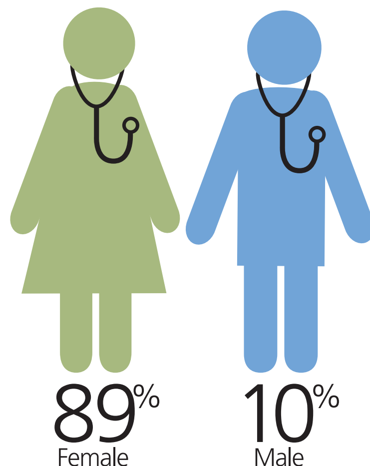
Female: 89%
Male: 10%
Unreported: 1%

Age

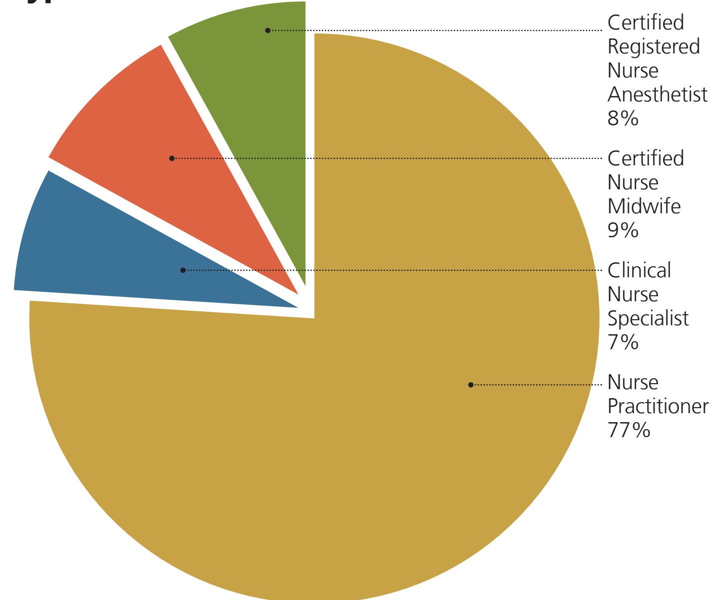
Average age: 51.5 years
Mode: 61 years
Range: 26-81 years

Race/Ethnicity

Caucasian: 95%
Hispanic: 1%



Type of APRN



Area of Credentials

Area	%
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

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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NWCSS

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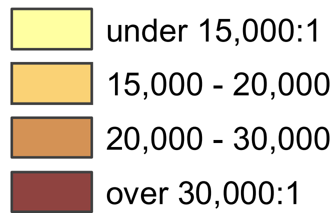
CMC

RMHS

HCRS

UCS

2014 Psychiatrists by Mental Health Care Areas: Population per FTE

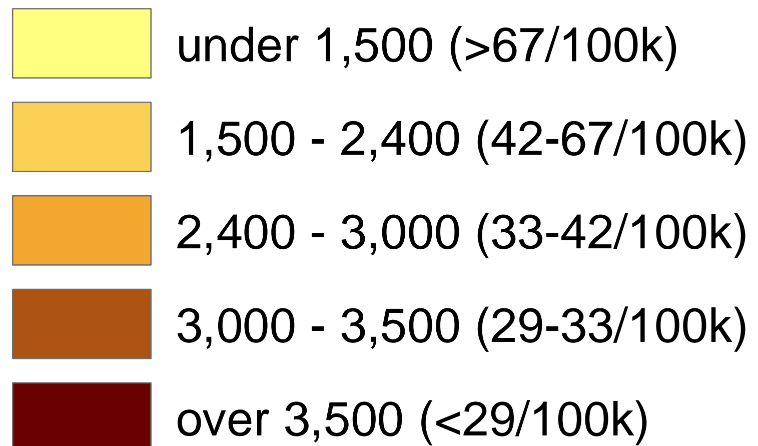


Source: Healthcare Provider Census
January 2016

2014 Primary Care Physicians by County

FRANKLIN
ORLEANS
ESSEX
LAMOILLE
CHITTENDEN
CALEDONIA
WASHINGTON
ADDISON
ORANGE
RUTLAND
WINDSOR
BENNINGTON
WINDHAM

Primary Care: population / FTE ratio

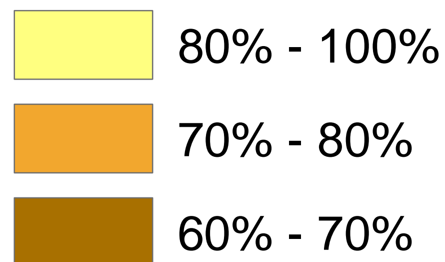


VERMONT
DEPARTMENT OF HEALTH
Office of Rural Health and Primary Care

2014 Primary Care Physicians by County

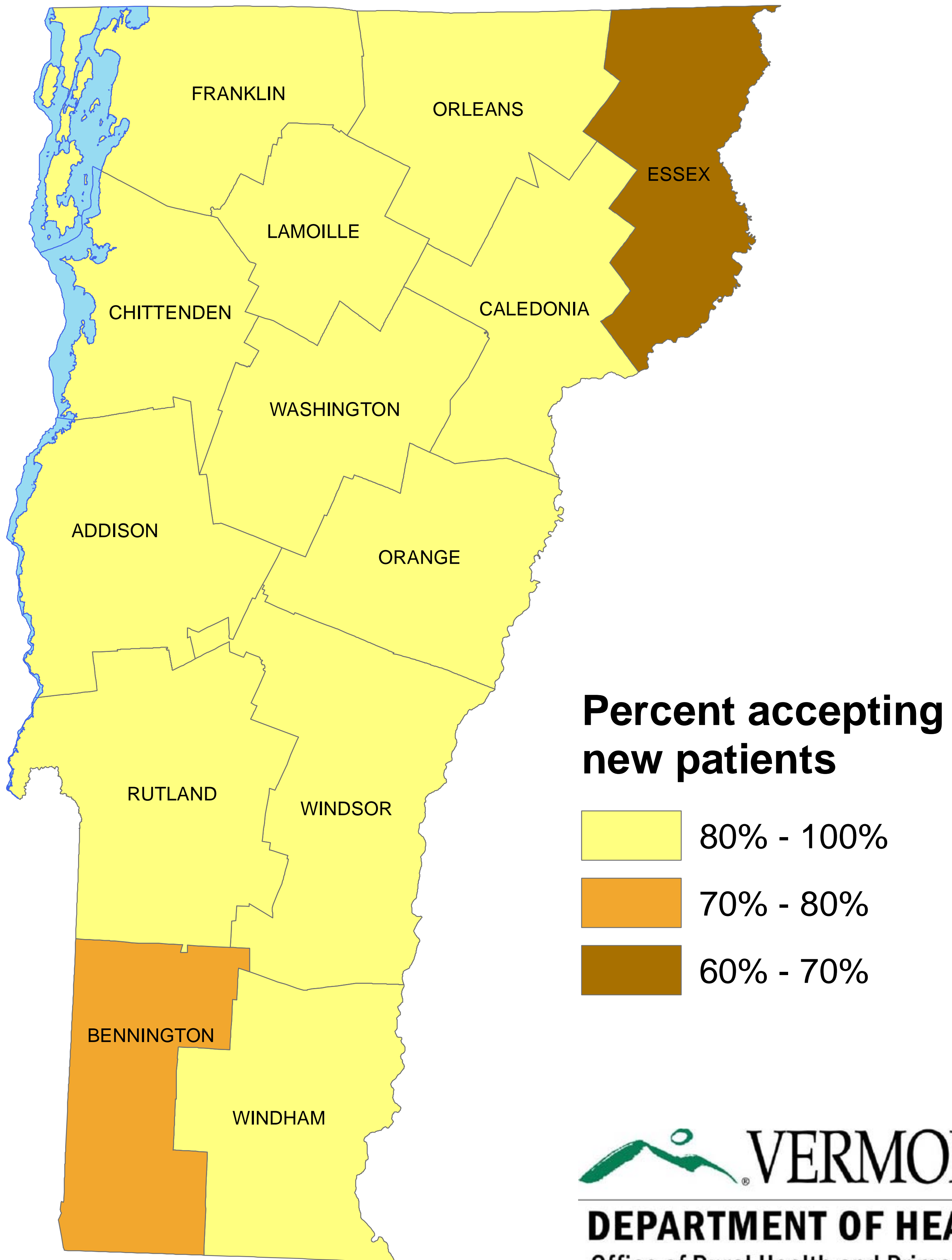
FRANKLIN
ORLEANS
ESSEX
LAMOILLE
CHITTENDEN
CALEDONIA
WASHINGTON
ADDISON
ORANGE
RUTLAND
WINDSOR
BENNINGTON
WINDHAM

Percent accepting new Medicaid patients



VERMONT
DEPARTMENT OF HEALTH
Office of Rural Health and Primary Care

2014 Primary Care Physicians by County



2013 Primary Care Dentists by Rational Service Areas: Population per FTE

- under 3000:1
- 3000:1 to 4000:1
- 4000:1 to 5000:1
- over 5000:1

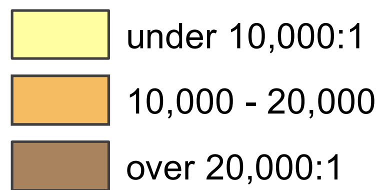
St Albans
Enosburg
Newport
Brighton
Milton/ South Hero
Cambridge
Morristown
Essex/ Williston
Stowe
Hardwick
St Johnsbury
Burlington
Waterbury
Montpelier/ Barre/Berlin
Waitsfield
Bristol
Vergennes
Bradford
Middlebury
Randolph
Chelsea/ Corinth
Brandon
Hartford
Castleton
Woodstock
Rutland
Windsor
Ludlow
Pawlet
Springfield
London- derry
Rockingham
Manchester
Arlington
Townshend
Bennington
Wilmington
Brattleboro

VERMONT
DEPARTMENT OF HEALTH
Office of Rural Health and Primary Care

Source: Healthcare Provider Census
January 2016

2014 Primary Care PAs by Rational Service Areas: Population per FTE

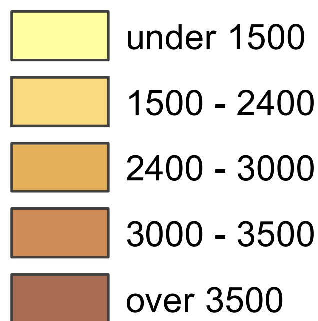
St Albans
Enosburg
Newport
Brighton
Milton/ South Hero
Cambridge
Morristown
Essex/ Williston
Burlington
Stowe
Hardwick
St Johnsbury
Waterbury
Montpelier/ Barre/Berlin
Waitsfield
Bristol
Vergennes
Middlebury
Randolph
Chelsea/ Corinth
Bradford
Brandon
Hartford
Castleton
Woodstock
Rutland
Windsor
Ludlow
Pawlet
Springfield
London-derry
Manchester
Rockingham
Arlington
Townshend
Bennington
Wilmington
Brattleboro



Source: Healthcare Provider Census
January 2016

St Albans
Enosburg
Newport
Brighton
Milton/
South Hero
Cambridge
Morristown
Hardwick
St Johnsbury
Essex/
Williston
Stowe
Burlington
Waterbury
Montpelier/
Barre/Berlin
Waitsfield
Bristol
Vergennes
Bradford
Chelsea/
Corinth
Middlebury
Randolph
Brandon
Hartford
Castleton
Woodstock
Rutland
Windsor
Ludlow
Pawlet
Springfield
London-
derry
Manchester
Rockingham
Arlington
Townshend
Wilmington
Bennington
Brattleboro

2014 Primary Care Physicians by Rational Service Areas: Population per FTE



Source: Healthcare Provider Census
January 2016

Attachment 5 – Mental Health Licensee Supervision – Multi-State

Mental Health Clinical Supervision in Vermont

Issues Preventing Supervisory Relationships

1. Regulatory language - Administrative Rules discourage sole proprietor practitioners from providing supervision to individuals working within their practice, due to potential conflict of interest.
2. Financial barriers - Third party supervision is common, but at the expense of supervisee. Large agencies are unable to pay competitive salaries and are currently acting as "training grounds" with high employee turnover.
3. Lack of Clarity - Unclear regulatory guidelines and no clear system of supervision affect the willingness of potential supervisors to engage, and potential agreements often require legal counsel.

Other State Supervisory Regulations / Structures

CALIFORNIA

1. Supervisory Plan must be submitted upon application for licensure.
2. Specific regulations protect the supervisee from unexpected termination of supervision, requiring notification of at least one (1) week.
3. Further protections are given to supervisees related to regulatory failures of the supervisor.
4. California allows a variety of acceptable mental health professionals, as defined in statute, to provide supervision.

COLORADO

1. Distinction is made between practice settings, and it is recommended that supervision occurring in a private practice setting should include a written letter of agreement. It is assumed that in agency settings such agreements are included in existing policies and procedures.
2. Conflictual dual relationships are addressed, but do not include relationships related to employment.

CONNECTICUT

1. Third party supervision is specifically allowed, and the NASW-CT maintains a database of potential supervisors. A fee is charged to individuals who wish to be listed in the registry.
2. Supervisory relationships must be profession specific, e.g. social workers can only receive clinical supervision from a licensed clinical social worker.
3. The Yale Program on Supervision was developed through a Federal grant to improve the standard of supervision and develop a "culture of supervision."

DELAWARE

1. In the event that a licensed supervisor is not available, an individual may submit a form that will allow consideration of alternative supervisors including non-licensed Master's level Social Workers. Applicants for licensure may NOT provide mutual supervision.

NEW HAMPSHIRE

1. Third party supervision is not allowed. The following excerpt is related to social work but is consistent throughout administrative rules for licensure.
   Mhp 304.02 Practical Experience Requirements for Social Workers (4) The supervision shall occur on site where the applicant delivers services and be provided by someone who is familiar with the applicant's work.
2. NH does not specify any financial conflicts of interest that prevent one's employer from providing clinical supervision. Language in administrative rules addresses that the clinical setting cannot be a sole proprietorship of the applicant him or herself, however.

NEW YORK

1. NY does allow third party supervision, but each case must include written contracts from the agency of employment, the supervisor, and the applicant. NY also specifies that all clients must be informed of the process through which any confidential information is shared.
2. Language from NY is consistent with VT and allows a variety of mental health practitioners to provide clinical supervision, though it specifies what qualifications are necessary for each license.
3. NY specifically states that a sole proprietorship owned by licensees is an acceptable setting in which to obtain supervision and experience requirements.
4. Each potential supervisor in NY must submit an application for approval to provide supervision and each supervisory relationship must have an approved plan.

MASSACHUSETTS

1. Clinical supervision must occur in approved "Clinical Field Experience Sites" with an "Approved Supervisor" or "Contract Supervisor" with accompanying written agreements.
2. The Massachusetts NASW does have a Member-to-Member Supervision program which assists in the process of matching supervisory relationships that are outside of the supervisee's worksite.

Potential for Change

1. Sole proprietors / private practitioners could be allowed to hire and supervise professionals seeking licensure. Language preventing this can be removed from Administrative Rule OR a structure for administrative oversight can be developed to mitigate any concern. Other states address this through contractual approval processes or an administrative body that provides oversight.
2. Larger agencies could be supported in their efforts to increase wages/benefits to increase workforce retention post-licensure. Individuals seeking employment and supervision within Designated Agencies or other large human services agencies should be recruited based on an interest in that practice environment and with those populations, not just as a means to a license.
3. Develop a structure, similar to other States (CT's Yale Program or MA's Member-to-Member), that is able to: a.) provide administrative oversight as necessary, b) approve supervisory settings and relationships, c) serve to match individuals into appropriate settings and supervisory relationships, d) consider technology for supervision purposes, such as video conferencing, and e) review processes and make changes as necessary.

References

Colorado Chapter – NASW. "Guidelines for Social Work Practice Supervision and Consultation." www.naswco.org/page/43/Guidelines-for-Social-Work-Practice-Supervision-and-Consultation

Connecticut LCSW Licensing Requirements (n.d.) www.ct.gov/dph/cwp/view.asp?a=3121&q=389602

Delaware, Department of State. Title 24 Regulated Professions and Occupations: 3900 Board of Clinical Social Work Examiners (n.d.). www.regulations.delaware.gov/AdminCode/title24/3900.shtml

New York LCSW License Requirements (n.d.). www.op.nysed.gov/prof/sw/lcsw.htm

Massachusetts 258 CMR 9.00: Licensure Requirements and Procedures (n.d.). www.mass.gov/ocabr/licensee/dpl-boards/sw/regulations/rules-and-requirements.html

State of California Statutes and Regulations Relating to the Practice of: Professional Clinical Counseling, Marriage and Family Therapy, Educational Psychology, Clinical Social Work (n.d.). www.bbs.ca.gov/pdf/publications/lawsregs.pdf

State of New Hampshire Administrative Rules Chapter Mhp 300 (n.d.). www.gencourt.state.nh.us/rules/state_agencies/mhp.html

Attachment 6 - Strategic Plan Priorities Matrix

	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?					