VT Health Care Innovation Project
Health Care Workforce Work Group Meeting Agenda
Wednesday, August 3, 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	Robin Lunge Mary Val Palumbo	N	• Attachment 1: 8-3-16 Meeting Agenda
2	3:05-3:10	Approval of Meeting Minutes	Robin Lunge Mary Val Palumbo	Y	• Attachment 2: 6-8-16 Meeting Minutes
3	3:10-3:25	Membership/Co-Chair Renewals	Robin Lunge Mary Val Palumbo	Y	
4	3:25-3:40	Updates: - Demand Modeling update - SIM update – CMMI approval for PP3	Georgia Maheras Group Discussion	N	
5	3:40-4:10	Follow-Up Discussion: 2014 Physician Assistant Supply Data	Molly Backup Miki Hazard Group Discussion	N	• Attachment 5a – Blueprint Practice Staffing Levels • Attachment 5b – Blueprint HSA Profiles
6	4:10-4:55	Discussion : Strategic Plan - Improving, Expanding and Populating the Educational Pipeline	Robin Lunge Mary Val Palumbo Group Discussion	N	• Attachment 6a - Strategic Plan Priorities Matrix (Educational Pipeline) AOE comments* • Attachment 6b – Strategic Plan Educational Pipeline - AHEC comments
7	4:55-5:00	Public Comment/Wrap Up/Next Steps	Robin Lunge Mary Val Palumbo	N	

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

Attachment 2: 6-8-16 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, June 8, 2016, 3:00-5:00pm, 4th Floor Conference Room, Pavilion Building, 109 State St., Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Robin Lunge called the meeting to order at 3:03pm. A roll call attendance was taken and a quorum was not present.	
2. Approval of April 2016 Meeting Minutes	Tabled until next meeting due to lack of quorum.	
3. Updates	*Micro-Simulation Demand Modeling Update:* Amy Coonradt provided a brief update on Demand Modeling. The State had a kickoff at the end of May with contractor IHS Global. IHS will be working with staff and stakeholders to develop the micro-simulation demand model through early 2017 based on the scope of work drafted and approved by the Workforce Work Group in 2014. The Work Group will have numerous opportunities to give feedback during that period. Amy included a table of when Work Group members will be able to contribute feedback on various project activities. Staff will also perform outreach to Work Group members/professions to inform and refine the model. A final demand projections report will be presented in December 2016. NOTE: Staff are working to schedule an additional Work Group meeting in November 2016. • Janet Kahn noted that this is a 10-to-15-year projection based on existing data, which leaves out integrative health and emerging professions. Robin Lunge noted that this isn't the last modeling the State will ever do. Charlie MacLean added that IHS will also contribute knowledge from other states. A smaller future contract with IHS could add new inputs to the model. Mat Barewicz added that we should include an understanding of previous staffing patterns – the changes in staffing/replacing certain professionals with other professions will be informative data points. • Amy noted that we will be working with VHCURES data; the State is working with IHS to get a Data Use Agreement. • Rick Barnett noted that OPR is taking on the licensure of Licensed Alcohol and Drug Abuse Counselors. Peggy Brozicevic noted that there isn't yet a complete census of those providers but VDH is working with OPR to	

Agenda Item	Discussion	Next Steps
	transfer information.	
4. Discussion: Workforce Supply Data – 2014 Physician Assistant Survey Deep Dive	Molly Backup introduced the discussion (see summary distributed at meeting). She highlighted high-level trends: • Primary care PAs practicing in primary care are more likely to be older and closer to retirement. • The profession is aging, but less so than MDs. *Education:* Marge Bower provided an overview of PA education. Key challenges are clinical rotations (burden on providers), lack of programs for part-time students. Clinical rotations require a variety of specialties, with a focus on primary care (family and internal medicine). Majority of PAs practice at the Masters level. Delegation agreement – an agreement between PA and physician at same practice to delegate responsibilities to PA and provide a support system, consultation, and supervision to allow PA to work at top of license and capabilities with support of a physician– is filed with Board of Medical Practice. • Will Hosner noted that the team approach is being modified at the national level. The American Academy of Physician Assistants has put out a modernization proposal; Vermont is one of only four states nationally that meet all conditions of this proposal. This is increasing PA accountability and supporting more effective team-based care. • Molly noted that Vermont's efforts in this area reflects national trends. She suggested that Vermont has room for more PAs working in primary care. • Janet Kahn asked whether some schools have higher rates of students graduating into primary care. Molly responded that this is the case, and that nationally there is a push toward moving more students to primary care, and helping them find rotations and jobs in primary care. Molly noted that it's very challenging to find rotations in primary care, and suggested this might be an area where Vermont can impact PA workforce. There are also PAs who are interested in primary care and qualified to work in primary care but can't find primary care jobs in Vermont, which is a disconnect. She suggested that practices with soon-to-retire doctors or PAs could open up for rotations as a way to support new PAs being hired into primary care in the state. She suggested that financial incentives could support practices in providing initial training and support needed in PAs first year-plus of practice. An underlying issue is comparatively low primary care salaries. • There had been a plan to launch a PA program at St. Joseph's in Rutland, but lack of contracts to guarantee rotations in part led to abandonment of this plan. • Rick Barnett asked about the role of larger health systems. Molly replied that UVM has considered launching a PA program multiple times, but has not come to fruition. Lack of rotation sites, in part due to competition among programs and providers, is a major barrier. Charlie MacLean noted that there is fierce competition for clinical sites across the country and across health professions; he also commented that sending students to different states provides a diversity of experience, which can be beneficial. *PA Demand in Vermont:* Mat Barewicz provided an Occupational Profile on Physician Assistants (distributed at meeting). DOL uses federal definitions of occupations and breaks the state down into Burlington region (boundaries are Northern Addison County, Southern Franklin County, and Waterbury); Northern Vermont Balance of State; and	**Additional handouts will be distributed via email.**

Agenda Item	Discussion	Next Steps
	Southern Vermont Balance of State. Mat noted that DOL tries to account for students and residents in reviewing compensation rates. DOL projects very high growth compared to other fields (2% annually – 2.5x greater than average growth – doesn't reflect intra-professional churn which also results in job growth). • Molly Backup asked how or whether this reflects changes in practice or movement from physician to PA/NP within practices. Mat noted that this is a job forecast for the field. He suggested that these forecasts likely do less of a good job at predicting staffing patterns in fields like health care where national Bureau of Labor Statistics job categories are relatively broad. • Peggy Brozicevic asked whether providers who practice at multiple sites are de-duplicated. Mat replied that this is based on employer surveys regarding unique individuals, not FTEs, so likely reflects duplicates. • Stephanie Pagliuca contributed via email: The Bi-State Recruitment Center would be happy to work with others to support getting more PAs into primary care in areas of need. Janet Kahn suggested identifying disincentives and barriers to providing clinical sites for PAs, or hiring PAs. • John Olson asked how many Federally-Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) are providing clinical settings or hiring PAs. Marge noted that the first year of PA practice is often an unofficial residency; official residency requires accreditation, charging money, etc. • Molly Backup and Marge Bower identified a few issues: 1) Older, later career physicians, especially in solo practice, have limited exposure to PAs (who could help to replace them as they retire); 2) Many physicians are afraid of legal supervision aspect of working with PAs. • Charlie MacLean suggested looking at what proportion of practices of various sizes have PAs, NPs, or none, and tracking trends over time; this might give insight on whether there are cultural barriers. Molly Backup noted that PAs in primary care have plateaued; numbers are increasing slightly in primary care, but FTEs are decreasing slightly. Peggy Brozicevic added that primary care FTEs are growing very slowly, and that VDH is starting to map NPs and PAs. Beth Tanzman noted that the Blueprint tracks practice staffing and credentials within practices. **Charlie requested Beth or someone else at the Blueprint develop a report on this at the next meeting, and offered to help.** Molly believes this would be helpful. • John Olson noted that he hears from small practices that are struggling with low Medicare and Medicaid reimbursement rates in comparison to commercial rates, and are interested in becoming Rural Health Clinics to qualify for enhanced reimbursement. RHCs are required to employ mid-level providers; this could support transition and succession planning for small practices. Molly believes this would be a good strategy. • Rick Barnett suggested partnerships with nursing homes that work with primary care practices to do geriatric care within nursing homes. This is a learning environment with very complex needs. Many nursing homes are near medical practices or hospitals that could embed and supervise a practitioner in the nursing home. Feedback on process/presentation format: All agreed this was very helpful and it was nice to have a summary sheet to inform people on basics on the profession. Robin suggested that this could be a template for future presentations.	
5. Discussion: Workforce Strategic	*Recommendations #7-#17: Improving, Expanding, and Populating the Educational Pipeline:* Previously discussed #7. • Recommendation #8-11: Nicole LaPointe discussed the AHEC's role in providing health education. Vermont has	

Agenda Item	Discussion	Next Steps
Plan	three regional AHECs, linked to the UVM system. Early in the education pipeline: The AHEC is currently focusing on high-school students who have identified health sciences as an interest to encourage them and help them prepare to be competitive in post-secondary opportunities. Linking to Vermont education quality standards focused on measurable competencies and skills. The AHEC is working to bring post-secondary students on the pathway to certification to underserved rural areas to expose them to areas with need and encourage team-based practice, with the goal of encouraging students to consider careers in these areas. Students are also working with inter-professional mentors. The AHEC has observed an increase in interest in working in Vermont and with rural and underserved populations due to these efforts. There are still opportunities to do more, especially for those who face barriers to post-secondary education. Pathways that include stepped credentialing (e.g. nursing) is a key strategy. Two recommendations: 1) Support students in the lower half of the pipeline (secondary students, and undergraduates in pre-health programs) to help them to explore, build professional networks, and earn certifications that augment education and increase earning potential; and 2) Work to support well-coordinated stepped pathways (Certification-Associates-Bachelors-Masters, etc.). o VSC and AOE are represented on this Work Group but those members are not here today. o Charlie MacLean noted that we're constrained by available funding for AHEC. He suggested this group encourage continued conversations on Nicole's two recommendations with VSC and AHEC and continue to submit grants for additional funding. o Nicole added that the New Skills for Youth planning project includes the possibility of using health careers as the focus cluster/model for piloting, to build a technical education system that allows students to graduate from high school with certification or Associates Degrees to be a Medical Assistant (MAs) or Licensed Practical Nurse (LPNs). Molly Backup suggested that PA certification developed based on people with skills but without certifications (former medics, APRNs), and many people still come to PAs with previous skills and experience. This could be a good model for other professions. Molly also suggested that mentoring in-practice can be a good opportunity for mature high school students or older students. o Robin commented that we need to get key members at meetings at the same time to ensure conversations and updates can happen. This Strategic Plan is focused on visioning, rather than actual tasks. She suggested that we identify key people for each area and make sure they're at meetings. Charlie MacLean noted that recommendations #7-11 are relevant to a specific group of individuals and suggested that these players meet together one or two times per year to ensure coordination. Molly suggested members could either attend the next meeting or have the option of coordinating and developing a report prior to the meeting to inform the group. o Marge and Molly suggested the AHEC could partner with Franklin Pierce's PA program.	
6. Public Comment, Wrap-Up, Next Steps, Future	There was no public comment. **Next Meeting:** August 3, 2016, 3:00-5:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	

Agenda Item	Discussion	Next Steps
Agenda Topics		

VHCIP Workforce Work Group Member List

Roll Call: 6/8/2016

Member		Member Alternate		Minutes		
First Name	Last Name	First Name	Last Name			Organization
	1		0			
David	Adams ✓					UVM Medical Center
Molly	Backup ✓	Margery	Bower ✓			Physician Assistant
Mat	Barewicz ✓					Department of Labor
Rick	Barnett ✓					Vermont Psychological Association
Colin	Benjamin	Laura	Nelson ✓			Office of Professional Regulation
Ethan	Berke					Dartmouth Institute for Health Policy & Clinical Practice
Peggy	Brozicevic ✓					AHS - VDH
Wade	Carson					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			AHS - DAIL
Robin	Lunge ✓					AOA, Co-Chair
Charlie	MacLean ✓	Elizabeth	Cote			University of Vermont
Madeleine	Mongan					Vermont Medical Society
Stephanie	Pagliuca					Bi-State Primary Care
Mary Val	Palumbo	Jason	Garbarino			UVM - College of Nursing and Health Sciences
Jerry	Ramsey					Agency of Education
Roland	Ransom					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	27					

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VHCIP Workforce Work Group Participant List

Attendance: 6/8/2016

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	phone	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	here	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	here	AHS - VDH	M
Wade	Carson		Asst Professor, UVM Dept of Med. Lab & Radiation Svcs	M
Denise	Clark		Consumer Representative	M
Peter	Cobb	phone	VNAs of Vermont	M
Amy	Coonradt	here	AHS - DVHA	S

Laura Nelson

Elizabeth	Cote		Area Health Education Centers Program	X
Karen	Crowley		AHS - Central Office - IFS	X
Kathy	Demars		Lamoille Home Health and Hospice	X
Tim	Donovan		Vermont State Colleges	M
Terri	Edgerton		AHS - Central Office - IFS	X
Erin	Flynn		AHS - DVHA	S
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Ellen	Grimes		Vermont Technical College	M
Lory	Grimes		Northeastern Vermont Regional Hospital	M
Karen	Hein		UVM	X
Lindsay	Herbert	here	Dentist	M
Deanna	Howard		Dartmouth	X
Joelle	Judge	here	UMASS	S
Janet	Kahn	here	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		AHS - DAIL	M
Robin	Lunge	here	AOA	IC
Charlie	MacLean	here	University of Vermont	M
Carole	Magoffin		AHS - DVHA	S
Georgia	Maheras		AOA	S
Jackie	Majoros		VLA/LTC Ombudsman Project	X
Angel	Means		Visiting Nurse Association of Chittenden and Grand Isle Countie[s]	X
Sarah	Merrill		DNH	X
Madeleine	Mongan		Vermont Medical Society	M
Meg	O'Donnell		UVM Medical Center	A
Stephanie	Pagliuca		Bi-State Primary Care	M
Mary Val	Palumbo		University of Vermont	C
Annie	Paumgarten	here	GMCB	S
Luann	Poirer		AHS - DVHA	S
Jerry	Ramsey		Agency of Education	M
Roland	Ransom		DA - HowardCenter for Mental Health	M
Lori Lee	Schoenbeck		Consumer Representative	M

Will [illegible] - PA

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	Phone	AHS - DVHA - Blueprint	M
Tony	Treanor		DA - Northwest Counseling and Support Services	X
Deborah	Wachtel		Consumer Representative	M
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Ben	Watts		AHS - DOC	X
Kendall	West		Bi-State Primary Care/CHAC	X
James	Westrich		AHS - DVHA	S
	63	0	63	63

Attachment 5a – Blueprint Practice Staffing Levels

Blueprint Practice Primary Care FTEs by Health Service Area

Health Service Area:	MD/DO FTEs:	APRN FTEs:	PA FTEs:	ND FTEs:	Total PCP FTEs:	Claim-attributed primary care patients	Patients per FTE
Barre	21.75	6.95	5.25	1	34.95	33,002	944.26
Bennington	25.21	7.54	4.96	0	37.71	16,407	435.08
Brattleboro	17.6	8.48	3.8	2.8	32.68	14,674	449.02
Burlington	118.07	43.81	19.06	6.8	187.74	93,393	497.46
Middlebury	22.42	6.78	1.8	0	31	18,064	582.71
Morrisville	19.05	6.09	0	2	27.14	16,575	610.72
Newport	12.5	7	6	0	25.5	12,616	494.75
Randolph	25.57	7.18	5.64	0	38.39	11,237	292.71
Rutland	24.84	11.23	10.9	1	47.97	26,825	559.20
Springfield	13.4	6.7	8.75	0	28.85	12,660	438.82
St. Albans	32.1	11.9	9.4	0	53.4	22,658	424.31
St. Johnsbury	16.77	10.8	1.8	0	29.37	14,186	483.01
Upper Valley	8.76	7.59	0	0	16.35	3,886	237.68
Windsor	17.5	2.98	8.15	0	28.63	9,630	336.36
Totals	375.54	145.03	85.51	13.6	**619.68**	305,813	493.50 *

*** represents the average number of patients per Blueprint practice primary care FTE in Vermont**

Attachment 5b – Blueprint HSA Profiles

BARRE HEALTH SERVICE AREA

Project Manager – Mark Young, RN

MEDICAL HOME PRACTICES

OneCare Vermont
CVMC Adult Primary Care - Barre
CVMC Adult Primary Care - Berlin
CVMC Family Medicine - Berlin
CVMC Family Medicine - Mad River
CVMC Family Medicine - Waterbury
CVMC Green Mountain Family Practice
CVMC Integrative Family Medicine - Montpelier
CVMC Pediatric Primary Care - Barre
CVMC Pediatric Primary Care - Berlin
Green Mountain Natural Health
UVMMC Family Medicine - Berlin

Community Health Accountable Care
The Health Center - Plainfield

PRIMARY CARE FTES:

MD/DOs:	21.75
APRNs:	6.95
PAs:	5.25
NDs:	1.0

At a Glance:

- 33,002 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 14.3 FTE Community Health Team Staff
- 5.5 FTE Spoke Staff
- 15 Community Self-Management Workshops offered
- 5.5 SASH Teams; 414 Participants (Capacity = 550)
- 1835 CHT referrals
- 372 patients treated by MAT staff

Highlights

UCC name: Community Alliance for Health Excellent (CAHE)
The majority of community partners are represented on the CAHE steering committee. Our group uses a decision matrix tool to help prioritize proposed projects. The state-wide learning collaboratives help guide active QI projects chosen by the CAHE. The CAHE community partner collaboration has created a balanced focus on health care and social determinants of health, both of which are crucial factors to recognize in the care management process.
Spotlight QI Project: Chronic Care Management Project
This project began as a six-month pilot involving a small panel of patients, half receiving care management and the other half receiving usual care. A certain set of criteria determined participants chosen. They received care management based on certain evidence-based guidelines. While the initial pilot patient population was small, results showed evidence of increased home health use, falls risk screening, care plan completion, and advance directive completion, as well as a decrease in PCP and inpatient utilization. The CAHE voted to expand the pilot and use the regional Integrated Communities Care Management Learning Collaborative as a venue for organizing and implementing the larger care management project.
Major achievement: CVMC received a great to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) in medical homes. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for patients at risk for alcohol or other substance use dependence. Two (2) full-time SBIRT clinicians currently provide support to patients at six (6) of our medical homes.

BENNINGTON HEALTH SERVICE AREA

Project Manager – Jennifer Fels, RN, MS

MEDICAL HOME PRACTICES

Keith Michl, MD
Brookside Pediatrics and Adolescent Medicine

OneCare Vermont
Avery Wood; MD
Bennington Family Practice
Eric Seyferth; MD
Mount Anthony Primary Care
SVMC Deerfield Valley Campus
SVMC Medical Associates
SVMC Pediatrics
SVMC Northshire Campus
Shaftsbury Medical Associates

HealthFirst
Green Mountain Pediatrics

OneCare Vermont and Community Health Accountable Care
Battenkill Valley Health Center

PRIMARY CARE FTES:

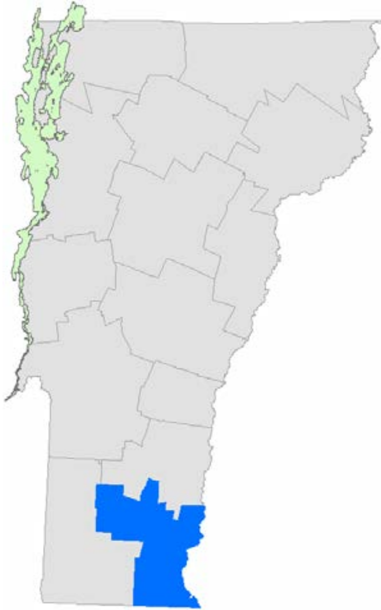
MD/DOs:	25.21
APRNs:	7.54
PAs:	4.96
NDs:	0

At a Glance:

- 16,407 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 6.75 FTE Community Health Team Staff
- 5.2 FTE Spoke Staff
- 10 Community Self-Management Workshops offered
- 3 SASH Teams; 295 Participants (Capacity = 300)
- 8582 CHT referrals
- 304 patients treated by MAT staff

Highlights

UCC name: Regional Clinical Performance Committee
We have 24 organizations and services represented. Our goals for 2016 include implementing a pre-diabetes coaching program and aligning ACO and Blueprint measures and initiatives. We are fortunate to have medical and human services partners willing to work together to improve the health of our population, improving the person experience, and reducing healthcare costs. Our partners are also moving towards a data-driven network to support the health of the community.
Spotlight on QI Projects:
For the MAT teams, we are working on the implementation of a common SPOKE patient contract and a referral and communication process among obstetric services and office-based opioid treatment. For reduction of hospital admissions and readmissions, we are developing a heart failure admission reduction program, implementing a pulmonary rehabilitation program, and focusing on medication reconciliation across the continuum of care. For Emergency Department (ED) utilization, the Community Care Team, made up of multiple agencies, has been formed to address patients with high use of the Southwestern Vermont Medical Center (SVMC) ED.
Major achievement: The Aging and Disability Resource Connection (ADRC) is a Vermont pilot project to support a program of "no wrong door" options counseling. Key stakeholders include SVMC, SASH, Council on Aging, VCIL, Brain Injury Association, transitional care nurses, and Bennington Blueprint patient-centered medical homes. This team has developed common data elements, known as a Universal Transfer Protocol, for a shared care plan.



BRATTLEBORO HEALTH SERVICE AREA

Project Manager – Wendy Cornwell, RN, BS, BSN

MEDICAL HOME PRACTICES

OneCare Vermont
Brattleboro Family Medicine
Brattleboro Internal Medicine
Brattleboro Primary Care
Grace Cottage Family Health
HeartSong Health: Ani Hawkinson
Just So Pediatrics
Maplewood Family Practice
Putney Family Healthcare
Windham Family Practice

PRIMARY CARE FTES:

MD/DOs:	17.6
APRNs:	8.48
PAs:	3.8
NDs:	2.8

At a Glance:

- 14,674 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 9.07 FTE Community Health Team Staff
- 3.5 FTE Spoke Staff
- 40 Community Self-Management Workshops offered
- 5.5 SASH Teams; 306 Participants (Capacity = 550)
- 1671 CHT referrals
- 297 patients treated by MAT staff

Highlights

UCC name: Windham County Health Service Area Regional Clinical Performance Committee
All primary care practices in the Brattleboro HSA are participants in the OneCare Vermont ACO. Our HSA has established an ACO Steering Committee that meets regularly. Our RCPC has provided an opportunity to strengthen community partnerships, leading to improved collaboration. Our goal is to provide comprehensive "wrap around" community care for Windham County residents.
Spotlight on QI Projects:
For primary care patient panels with a history of chronic controlled substance use, there is a QI project in progress that ensures these patients have a controlled substance agreement with provisions for pill counts and urine drug screens. The goal is to lower MED scores for these patients. Through the Integrated Communities Care Management Collaborative, we are working with patients that have both mental health and substance abuse disorders and who are high utilizers of the ED. Our workgroup includes 15 community agencies and organizations. Our RCPC is also focusing on improvement in Medicare hospice utilization and the improvement of quality of life at the end of life.
Major achievement: Brattleboro Memorial Hospital's Diabetes Self-Management Education Program has maintained certification from the American Diabetes Association and thus continues to provide excellence in evidence-based diabetes care to our population.

BURLINGTON HEALTH SERVICE AREA

Project Managers – Pam Farnham, Penrose Jackson

At a Glance:

- 93,393 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 40.98 FTE Community Health Team Staff
- 9.25 FTE Spoke Staff
- 25 Community Self-Management Workshops offered
- 16.5 SASH Teams; 1660 Participants (Capacity = 1650)
- 5676 CHT referrals
- 422 patients treated by MAT staff

MEDICAL HOME PRACTICES

Mountain View Natural Medicine
Champlain Center for Natural Medicine
Frank Landry, MD, PLC

OneCare Vermont
Adult Primary Care – Burlington
Adult Primary Care – Essex
Adult Primary Care – South Burlington
Adult Primary Care – Williston
Burlington Primary Care
Family Medicine – Colchester
Family Medicine – Hinesburg
Family Medicine – Milton
Family Medicine – South Burlington
Pediatric Primary Care – Burlington
Pediatric Primary Care – Williston
Timberlane Pediatrics North
Timberlane Pediatrics South

HealthFirst
Alder Brook Family Health
Charlotte Family Health Center
Chris Hebert, MD
Essex Pediatrics
Evergreen Family Health
Gene Moore, MD
Good Health
Hagan, Rinehart and Connolly Pediatricians; PLLC
Richmond Family Medicine
Thomas Chittenden Health Center
Winooski Family Health

Community Health Accountable Care
Community Health Centers of Burlington

Highlights

- Our UCC, called the Chittenden County Regional Clinical Performance Committee, currently includes 20 community partners, has developed mission and values statements, and has a leadership team. We currently focus on 3 QI projects.
  - Increase hospice and palliative care in Chittenden County by 5% in the next year
  - Decrease potentially avoidable Emergency Department visits for URI, UTI, diarrhea, and vomiting
  - Test team-based shared care management interventions with at-risk populations
- 25 new MAT prescribers in 2016
- Opioid task force aimed to address the wait list for opioid treatment:
  - Developed values and a shared purpose
  - Team developed and prioritized strategies to increase MAT capacity

PRIMARY CARE FTES:

MD/DOs:	118.07
APRNs:	43.81
PAs:	19.06
NDs:	6.8

MIDDLEBURY HEALTH SERVICE AREA

Project Manager – Susan Bruce

At a Glance:

- 18,064 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 7.25 FTE Community Health Team Staff
- 1.5 FTE Spoke Staff
- 5 Community Self-Management Workshops offered
- 3.5 SASH Teams; 259 Participants (Capacity = 350)
- 3000 CHT referrals
- 130 patients treated by MAT staff

MEDICAL HOME PRACTICES

OneCare Vermont
Bristol Internal Medicine
Little City Family Practice
Middlebury Pediatric and Adolescent Medicine
Neshobe Family Health
Porter Internal Medicine
Rainbow Pediatrics

HealthFirst
Middlebury Family Health Center

Community Health Accountable Care
Mountain Health Center

PRIMARY CARE FTES:

MD/DOs:	22.42
APRNs:	6.78
PAs:	1.8
NDs:	0

Highlights

UCC name: Community Health Action Team (CHAT)
In partnership with all three Vermont ACOs and approximately 30 agencies and organizations throughout the Middlebury Health Service Area, we formed the CHAT Unified Community Collaborative committee. To date, our UCC has elected to take part in the Integrated Communities Care Management Learning Collaborative. We are exploring other QI projects, such as increasing hospice utilization, implementing SBIRT, and decreasing ED utilizations.
Spotlight on QI Project: Integrated Care Coordination
Begun on August 19 as part of the statewide care management learning collaborative, we have 15 health and human services agencies and departments involved in this project. For those who would benefit from wrap-around services, our goal is to form an integrated care team that develops a shared plan of care for individuals and families identified as having moderate to high utilization rates, multiple chronic conditions, and social determinants impacting their health. Barriers of the engagement process are being analyzed currently.
Major achievement: We hired a new QI Facilitator (Alexandra Jasinowski, pictured above on right) in our HSA, and she completed her first successful NCQA recognition process with a practice. She has also serves as the facilitator for the Care Management Learning Collaborative project, achieving active participation from the UCC sub-committee for this project.

MORRISVILLE HEALTH SERVICE AREA

Project Manager – Elise McKenna, RN, MPH

MEDICAL HOME PRACTICES

Cambridge Family Practice Associates
Dr. Bisbee Personalized Healthcare
Stowe Natural Family Wellness

HealthFirst
Paul Rogers, MD

Community Health Accountable Care
Hardwick Area Health Center

OneCare Vermont and Community Health Accountable Care
Morrisville Family Practice
Stowe Family Practice

PRIMARY CARE FTES:

MD/DOs:	19.05
APRNs:	6.09
PAs:	0
NDs:	2

At a Glance:

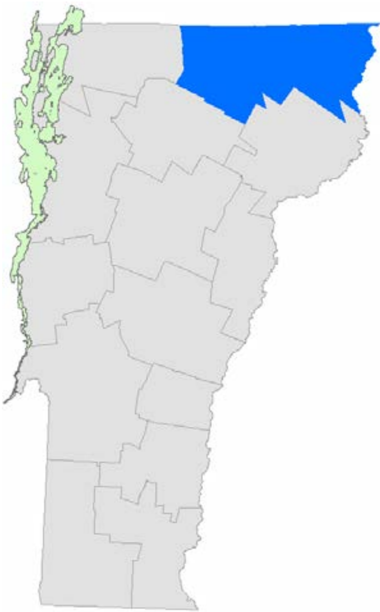
- 16,575 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 6.45 FTE Community Health Team Staff
- 3.6 FTE Spoke Staff
- 5 Community Self-Management Workshops offered
- 2 SASH Teams; 189 Participants (Capacity = 200)
- 1400 CHT referrals
- 194 patients treated by MAT staff

Highlights

UCC name: Executive Community Healthcare Organization (ECHO)
There are a total of six (6) HSA-wide QI initiatives integrated through the UCC, including 100% all cause readmission reviews by hospital and primary care, home visits for medication reconciliation post-hospitalization, Care Management Team Learning Collaborative for complex patients, ED visit follow-up calls by care coordinators, developmental screenings for all children under three (3) years old, and PCP referral request from patients seen in the ED.

Spotlight on QI Projects:
In partnership with Community Health Services of Lamoille Valley (CHSLV) and Lamoille Home Health and Hospice (LHHH), all patients 65 and older receive a home visits for medication reconciliation after being discharged from Copley Hospital. A transportation pilot program that serves over 30 unique patients was completed this year. It fills the gaps for patients needing transportation not covered by existing programs. The funding is now supported by all medical homes in the HSA. In partnership with LHHH, a new 24-hour ED Hot Line has been established to perform next-day follow-up home visits for patients discharged from the ED. Calls to the Hot Line are made by ED staff after identifying patients who could benefit from a home visit.

Major achievement: Two new medical home practices, Dr. David Bisbee Personalized Healthcare and Appleseed Pediatrics, participated in the NCQA engagement pilot and will receive recognition status.



NEWPORT HEALTH SERVICE AREA

Project Manager – Julie Riffon, LICSW, PCMH CCE

At a Glance:

- 12,616 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 4.8 FTE Community Health Team Staff
- 1 FTE Spoke Staff
- 7 Community Self-Management Workshops offered
- 3.5 SASH Teams; 310 Participants (Capacity = 350)
- 1780 CHT referrals
- MAT staff shared with St. Johnsbury HSA

MEDICAL HOME PRACTICES

OneCare Vermont
North Country Pediatrics
North Country Primary Care Barton
Orleans
North Country Primary Care Newport

Community Health Accountable Care

PRIMARY CARE FTES:

MD/DOs:	12.5
APRNs:	7
PAs:	6
NDs:	0

Highlights

UCC name: Newport Health Service Area RCPC/UCC
Our UCC formed and began to meet this year. We identified several community quality improvement priorities, including improving outcomes for people with COPD, increasing the number of referrals to hospice services and doing so earlier in the process, decreasing ED utilization for non-emergent reasons, and decreasing the rate of obesity.
Spotlight on QI Projects: Hospice Utilization
Our UCC has set a goal to increase the number of referrals to hospice and increase the length of stay (LOS) from a baseline of 3 referrals and an average LOS of 20 days. In Phase 1, our primary care practices improved their in-office referral process workflow, including use of the EHR. Key hospice staff provided education to these providers and their staff on the importance of early referrals. Public education events were also extended to the community to explain hospice benefits to increase knowledge of these services among patients and their loved ones. Referrals increased to 17 during the measurement period, and the average LOS increased to 22 days. In Phase 2, panel management of patients with a diagnosis that might indicate an opportunity for discussion of an early referral to hospice as one option for care will occur through a report developed in the EHR used by North Country primary care physicians.
Major achievement: Two of our primary care practices achieved Level 3 recognition by NCQA as patient-centered medical homes, using the more challenging 2014 NCQA PCMH standards. They were the first practices in Vermont to do so.

RANDOLPH HEALTH SERVICE AREA

Project Manager – Jennifer Wallace

At a Glance:

- 11,237 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 4.5 FTE Community Health Team Staff
- 1.4 FTE Spoke Staff
- 6 Community Self-Management Workshops offered
- 2 SASH Teams; 144 Participants (Capacity = 200)
- 449 CHT referrals
- 97 patients treated by MAT staff

MEDICAL HOME PRACTICES

South Royalton Health Center

OneCare Vermont and Community Health Accountable Care
Bethel Health Center
Chelsea Health Center
Gifford Health Center at Berlin
Gifford Primary Care
Rochester Health Center

PRIMARY CARE FTES:

MD/DOs:	25.57
APRNs:	7.18
PAs:	5.64
NDs:	0

Highlights

UCC name: Randolph Executive Community Council (RECC)
Our UCC passed a charter that focuses on learning how to best serve all segments of the Randolph HSA population through person-centric, wrap-around support. We aim to address the social determinants of health, including the availability of housing, food, education, employment, health care services, community-based resources, transportation, and social supports in our HSA. Our UCC is evolving with a lot of enthusiasm from community partners. All people are considered neighbors, and generational relationships are essential building blocks to our community.

Spotlight on QI Project: Uncontrolled Diabetes
The purpose of this project is to decrease the number of patients with uncontrolled diabetes, defined as having an Hba1c level greater than 9. The team convened to examine management of diabetic patients at Gifford, including review and revision of the existing policy for the diabetic clinic and treatment of diabetic patients. The team is currently exploring several changes at the diabetic clinic, as well as diagnosis-based scheduling for labs and follow-up appointments. The primary outcome measure for the project relates to Hba1c control. Measures are tracked quarterly on the Primary Care Dashboard.

Major achievement: With a new Project Manager on board since June, the Randolph HSA Blueprint program has undergone a “reboot”. An entirely new CHT team was hired this year, and together they have achieved quick successes in dramatically increasing referrals to CHT and designing and using a shared care plan in the Gifford EHR for every person served. Additionally, the Extended Community Health Team (ECHT) meets monthly with an average of 20 agencies in attendance. A multi-agency release of information form was created by the ECHT and is used to coordinate care amongst agencies. Many members of the ECHT also participate in the state-wide learning collaborative, focusing on shared care plans for individuals with complex health conditions.

RUTLAND HEALTH SERVICE AREA

Project Manager – Sarah Narkewicz, RN, MS

At a Glance:

- 26,825 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 13.5 FTE Community Health Team Staff
- 4.5 FTE Spoke Staff
- 44 Community Self-Management Workshops offered
- 5 SASH Teams; 470 Participants (Capacity = 500)
- 1600 CHT referrals
- 247 patients treated by MAT staff

MEDICAL HOME PRACTICES

Drs. Peter and Lisa Hogenkamp

OneCare Vermont and Community Health Accountable Care
Brandon Medical Center
Castleton Family Medical Center
Mettowee Valley Family Health Center
Pediatrics Associates
Rutland Community Health Center

HealthFirst
Marble Valley Family Medical Center

PRIMARY CARE FTES:

MD/DOs:	24.84
APRNs:	11.23
PAs:	10.9
NDs:	1.0

Highlights

UCC name: Rutland Regional Incubator for Health System Improvement & Collaboration (RRIHSIC)
Our QI workgroup (RCPC) focuses on COPD and reducing readmissions, increasing appropriate referrals to palliative care, developing and distributing common education materials across the community, and developing a registry. The Medicare readmission rate has decreased from 16.67% at the end of 2014 to 14.2% at the end of 2015.Over 10 local health and human services organizations participate in our Integrated Community Care Coordination Collaborative, which identifies high users of hospital services, appoints a lead care coordinator, engages the patient, and uses a shared care plan. Providers from RRMC and CHCRR also meet monthly as a Clinical Integration Committee to work together on quality of care. Efforts include using secure texting, electronic transfer of discharge information, closing the loop on referrals for lab testing and specialty consultation, improved lab and diagnostic imaging ordering for medical necessity, and development of a common opioid treatment contract.

Spotlight on QI Project: Pediatric Care Coordination Collaborative and Pediatric Referral Committee
This project identifies families that can benefit from shared care planning via a scoring tool. A system and team are under development for meeting with these families to create the shared plan of care. The Pediatric Referral Committee convenes staff from multiple programs in the region that provide services for children and families. The format of monthly meetings involves discussing systems, participating in case discussions, hearing educational presentations from service providers, and sharing updates from each organization.

Major achievement: The Core CHT participated in a four-state CMS Innovation Grant called the Pediatric In Home Asthma Program. This program identifies pediatric patients with uncontrolled asthma and provides tailored asthma education to the family, including medication review and a home environmental assessment with modifications for reducing asthma triggers. Improvements have resulted in decreased ED utilization in this population.

SPRINGFIELD HEALTH SERVICE AREA

Project Manager – Trevor Hanbridge

At a Glance:

- 12,660 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 4.63 FTE Community Health Team Staff
- 1.5 FTE Spoke Staff
- 9 Community Self-Management Workshops offered
- 1 SASH Team; 116 Participants (Capacity = 100)
- 1275 CHT referrals
- 129 patients treated by MAT staff

MEDICAL HOME PRACTICES

OneCare Vermont and Community Health Accountable Care
Charlestown Family
Chester Family Practice
Ludlow Health Center
Rockingham Medical Group
Springfield Community Health Center

PRIMARY CARE FTES:

MD/DOs:	13.4
APRNs:	6.7
PAs:	8.75
NDs:	0

Highlights

UCC name: Springfield Unified Community Collaborative
Our UCC elected a leadership subcommittee responsible for the agendas and facilitation of meetings. This subcommittee will organize, present, and support the work of the UCC and meets between UCC meetings to track collaboration and action items from the UCC work. It includes leaders from the Council on Aging, Adult Day, Springfield medical staff leadership, the Designated Agency, and Valley Health Connections and Home Health.
Spotlight on QI Project: Integrated Communities Care Management Learning Collaborative QI Project
Formed as a subcommittee of our UCC, the Integrated Communities Care Management Learning Collaborative has outlined criteria for the population to study and develop interventions for as part of the collaborative. These criteria include adults with five (5) or more ED visits in a one-year period who have a mental health diagnosis and at least three (3) chronic medical conditions.
Major achievement: Through our HSA's Adverse Childhood Experience (ACE) group, known as *Aces-in-Action*, we are a statewide leader in support of the ACEs initiatives, services, and programming. We work and plan collaboratively with many local agencies, including the Designated Agency, DCF, the Parent Child Center, VDH, AHS leadership, the local school system, and Project Action. We coordinated and hosted several public forums on ACEs where a local panel of experts and providers presented on region-wide collaboration in support of early identification, prevention, and interventions for trauma-informed work and ACEs. We also expanded and sustained our *HealthTransit* transportation initiative with the award of a HRSA grant that provides education and direct transportation services for health and wellness.

ST. ALBANS HEALTH SERVICE AREA

Project Manager – Lesley Hendry

At a Glance:

- 22,658 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 8.95 FTE Community Health Team Staff
- 6.6 FTE Spoke Staff
- 10 Community Self-Management Workshops offered
- 2.5 SASH Teams; 183 Participants (Capacity = 250)
- 1753 CHT referrals
- 330 patients treated by MAT staff

MEDICAL HOME PRACTICES

OneCare Vermont
Cold Hollow Family Practice
Enosburg County Pediatrics
NMC – Northwestern Primary Care
Northwestern Georgia Health Center
Richford Health Center
St. Albans Primary Care
St. Albans Health Center
Swanton Health Center

HealthFirst
Max Bayard; MD; PC
Mousetrap Pediatrics – Enosburg
Mousetrap Pediatrics – St. Albans

Community Health Accountable Care
Alburg Health Center

Highlights

UCC name: St. Albans Regional Clinical Planning Committee
All ACO participating providers and affiliates meet once a month to plan for community-wide quality improvement projects, resource allocation, and governance planning for the next phases of payment and delivery reform. Providers are sharing quality improvements and new tools to improve population management. We use Basecamp to provide a platform for sharing processes and tools.

Spotlight on QI Project: Blueprint ACO Learning Collaborative
Our HSA is running a learning collaborative to improve ACO measures and implement population management. The five-session collaborative began May 15, 2015 and reports results to the UCC. Eleven (11) participating teams come from primary care, inpatient case management, home health, the mental health designated agency, and VDH. We are grouping the 42 Vermont ACO measures by type of measure and learning about the process for improving on each type of measure. To date, we have completed 3 of 5 sessions, and the teams have addressed the screening, prevention, and at-risk population measures. The fourth session to address utilization measures is scheduled for January 29, 2016.

Major achievement: Our Care Management and Coordination Workgroup reports directly to the St. Albans UCC. It includes 12 teams from a variety of practices and organizations that participate in bi-weekly meetings, as well as the statewide Integrated Communities Care Management Learning Collaborative.

PRIMARY CARE FTES:

MD/DOs:	32.1
APRNs:	11.9
PAs:	9.4
NDs:	0

ST. JOHNSBURY HEALTH SERVICE AREA

Project Manager – Laural Ruggles, MBA, MHA

At a Glance:

- 14,186 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 7.25 FTE Community Health Team Staff
- 9 Community Self-Management Workshops offered
- 2 SASH Teams; 146 Participants (Capacity = 200)
- 4301 CHT referrals
- 95 patients treated by MAT staff

MEDICAL HOME PRACTICES

OneCare Vermont
Corner Medical
Kingdom Internal Medicine
St. Johnsbury Pediatrics

Community Health Accountable Care
Concord Health Center
Danville Health Center
St. Johnsbury Family Health Center

PRIMARY CARE FTES:

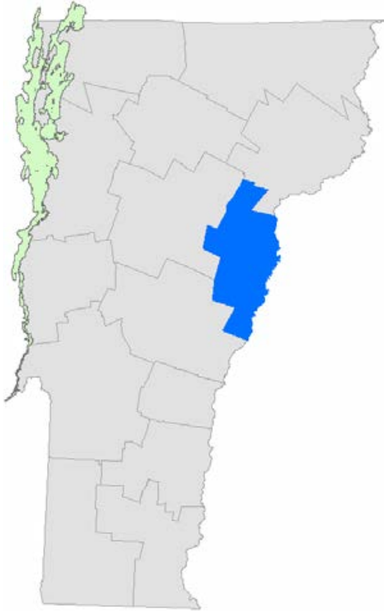
MD/DOs:	16.77
APRNs:	10.8
PAs:	1.8
NDs:	0

Highlights

UCC name: The "A Team" (pictured above)
Leaders from NVRH and key community organizations have come together to create a common set of goals, share data on important health measures, and pool their talents and resources to improve health and the quality of life in our region. While each organization brings its own set of services and programs to the table, the leaders are committed to unifying, aligning, and focusing their strategic plans and visions to create a true accountable health community. We have chosen to focus on the health and social needs of people with COPD and vulnerable families and children.

Spotlight on QI Project: Pediatric Care Coordination
St. Johnsbury Pediatrics is leading an effort to improve pediatric care coordination for 25 identified patients and families. The project includes a welcome letter introducing care coordination, a shared care plan and patient summary, a monthly QI meeting with the care team, including two (2) family health partners, relationships with community resources and schools, and a partnership with a social worker specializing in children with special health care needs from VDH. The Family Experience Questionnaire assesses the family's experience of the care they are receiving, including a measure for if their provider's office created a shared care plan. To date, 6 shared care plans, 18 questionnaires, and 4 care conferences have been completed.

Major achievement: The A Team received a grant from the Laura and John Arnold Foundation to support Collaborating for Clients, a groundbreaking initiative brining nonprofit organizations together in an effort to reduce hunger and improve the lives of low-income families. This partnership will work to address food insecurity and help families find affordable housing, job training, steady employment, and health care services.



UPPER VALLEY HEALTH SERVICE AREA

Project Manager – Donna Ransmeier

At a Glance:

- 3,886 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 1.75 FTE Community Health Team Staff
- 4 Community Self-Management Workshops offered
- 1 SASH Team; 47 Participants (Capacity = 100)
- 1024 CHT referrals
- 15 patients treated by MAT staff

MEDICAL HOME PRACTICES

Newbury Health Clinic
Upper Valley Pediatrics

Community Health Accountable Care
Bradford
E. Corinth
Wells River

PRIMARY CARE FTES:

MD/DOs:	8.76
APRNs:	7.59
PAs:	0
NDs:	0

Highlights

UCC name: Upper Valley Health Service Area Unified Community Collaborative/Regional Clinical Performance Committee (UCC-RCPC)
The formation of a UCC was a natural progression for our Upper Valley Blueprint Advisory Committee. We decided to work on the measure "follow-up to mental health inpatient hospitalization within 7 days of discharge". Our medical and mental health providers, ACO representatives, housing and elderly assistance agencies, VDH, and our pediatric service providers are all equally invested in researching and developing an improvement plan for this metric. We believe that better communication between hospitals, mental health agencies, independent mental health providers, and primary care is necessary.

Spotlight on QI Project: Panel Management
Our goal has been to establish and maintain regular and consistent patient panel management in all of our medical homes. Patients monitored include those with diabetes who have an HgA1c over 8.0 and no visit for 3 months, hypertension patients (BP of 140/90 or higher) and no visit for 3 months, children due for well-child visits and adults due for yearly physicals, and pneumonia and influenza vaccination reminders. Due to these efforts, the number of patients with uncontrolled diabetes and no visits for 3 months dropped by 45% in 2015. Over 80 children received well-child exams for which they were overdue.

Major achievement: Our Regional Coordinator for self-management workshops revitalized the program, attracting participants through creative efforts, such as scheduling workshops at convenient times and places (Senior Centers and workplaces at lunch time) and offering small incentives, such as healthy snacks and walking shoes, which were donated from local merchants.

WINDSOR HEALTH SERVICE AREA

Project Manager – Jill Lord, RN

At a Glance:

- 9,630 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 7.35 FTE Community Health Team Staff
- 2.5 FTE Spoke Staff
- 13 Community Self-Management Workshops offered
- 1 SASH Team; 123 Participants (Capacity = 100)

MEDICAL HOME PRACTICES

OneCare Vermont
Mt. Ascutney Hospital Physician Practice
Ottauquechee Health Center

HealthFirst
White River Family Practice

PRIMARY CARE FTES:

MD/DOs:	17.5
APRNs:	2.98
PAs:	8.15
NDs:	0

Highlights

UCC name: Windsor HSA Coordinated Care Committee
A leadership team has been formed, made up of key representatives recommended by the Blueprint and the ACOs, and meets on a quarterly basis. Two (2) key priorities have been identified through data review and adopted, including ED readmissions and COPD readmissions, quality of life, and best practice approach.

Spotlight on QI Projects
Through our Adolescent Depression Screening project, White River Family practice has screened over 350 adolescents this year and referred appropriate patients to local counseling services, including an onsite Blueprint counselor from the Clara Martin Center. Some of our providers have expanded their practice by prescribing antidepressants when indicated while an adolescent awaits counseling. Through the SIM grant, we are following a panel of patients with the goal of decreasing ED and hospital admissions through close care management. For Well Child Visits for Adolescents, we send informative letters to families explaining the importance of these visits.

Major achievements: We organized regional community health team meetings to share information and build collaboration between the teams in proximity to our boundaries. Two (2) satellite, community-based clinics were established to assist individuals with completing their advance directives. Our medication assisted treatment (MAT) staff worked with the pediatricians of the Mt. Ascutney Hospital Physician Practice to plan services for addicted moms in recovery. We provide support groups for elderly residents to fight loneliness and isolation due to disability and poverty, and we started a new group for those with cognitive impairment.

Attachment 6a - Strategic Plan Priorities Matrix (Educational Pipeline) AOE comments*

	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										
<u>Recommendation #7:</u> The state college system, including the University of Vermont College of Medicine and the Residency Program at UVM MC , 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. Part of broader project to create state-wide allied health/health careers program of study within secondary CTE system, and ensure content is reflective of current/upcoming workforce needs/skillsets - AOE to spearhead		The Agency of Education, as part of it's project to develop state-wide programs of study in "priority sectors" will lead a convening of educators, business & industry, and post-secondary partners will convene these stakeholders to discuss program and curricular needs.	Late 2015			
		Jay Ramsey	WFWG		Point of contact identified.	See above comment	Q3 2015			
<u>Recommendation #8:</u> The 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			
<u>Recommendation #9:</u> The 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	Jay Ramsey				No progress to date: work group should receive update from groups below				MOD
	AOE	Jay Ramsey	WFWG	9.1. AOE to lead efforts to develop state-wide program of study development/implementation in health science		No progress to date: work group to convene meeting for AOE to give status report.	Late 2015	AOE working under New Skills for Youth Grant to create 3 year career readiness plan that will influence the work related to this recommendation		
	AOE	Jay Ramsey	WFWG	9.2. Workgroup needs an update re flexible pathways and personal learning plans in Act 77.			Late 2015/Early 2016			
<u>Recommendation #10:</u> The 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
<u>Recommendation #11:</u> 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	Industry recognized credentials? Registered apprenticeship opportunities?		
New Proposed Sub-recommendation <u>#11a:</u> *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. Workgroup 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 - 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.		Is there a potential to rely on adult technical education offered through the regional CTE centers to offer this?			
			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						AOE envisions this as part of larger concern of "career pathways" projects that are related to federal funding through WIOA, and as part of the development of state-wide programs of study			
			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 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		AOE envisions this as part of larger concern of "career pathways" projects that are related to federal funding through WIOA, and as part of the development of state-wide programs of study			
			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?					

Attachment 6b – Strategic Plan Educational Pipeline - AHEC comments

Nicole LaPointe, Executive Director, Northeastern Vermont AHEC

Email correspondence re: Work Force Strategic Plan

1.) Please describe the current status of the Educational Pipeline recommendations from the Strategic Plan at your organization:

Northeastern Vermont AHEC is leading the AHEC statewide on improving and developing programs to fill in the health workforce development gaps and meet needs along the educational pipeline. See the attached infographic for a summary of our work. We are doing as much as we can within our current staff capacity. I am continuously scanning for grant opportunities and am interested in partnering on funding proposals to support any of AHEC's work along the education continuum.

In the coming academic year, NEVAHEC will test a campus-based health careers club at Johnson State College. This will expand our workforce development and career preparation programs to undergraduate students. We are partnering with Vermont Afterschool on one aspect of this program which would engage pre-health undergraduate students as instructors and mentors to middle school aged children. If this effort proves successful, the Vermont AHEC is interested in replicating the model to other campuses across the state.

Northeastern Vermont AHEC has aligned its programs for 9th – 12th grade students to meet the Vermont Education Quality standards. NEVAHEC is using competency-based education methods to support the implementation of personalized learning plans for high schools students. NEVAHEC is part of a Vermont Expanded Learning Provider network that is working to create systems for increasing community engagement and employer involvement in K-12 education.

I have been involved in some conversations with AOE and partners involved in the New Skills for Youth planning grant to create programs of study at the secondary level, including health science and medical. This work is valuable and will hopefully strengthen and expand the capacity of the CTE health care programs in Vermont.

I think the recommendations provide a good framework for discussion. I would be interested in participating in collaborative work toward any of these aims.

3.) Your proposed "actionable tasks" for the Educational Pipeline recommendations going forward:

1. Provide infrastructure and support to high schools for translating community-based learning to academic credit, and integrating career exploration and preparation into the regular curriculum. Twinfield Union School is one exemplary model.
2. Ensure that postsecondary certification programs being developed for health and medical occupations conform to industry standards and are approved by Vermont health care employers.
3. Identify demand for skilled workers in technical and administrative occupations in health and medicine throughout Vermont.
4. Catalog and promote the health and medical certifications available in Vermont and the occupations to which they lead.
5. Articulate technical certifications to AAS degrees, and Associate Degrees to Bachelors in health and medical fields across the state colleges.

6. Provide at least one LNA training per year that includes scaffolded instruction for English language learners as part of adult career and technical education. I know an ELL instructor who would love to support this effort.
7. Provide particular attention to workforce development efforts in communities that are under-resourced, underserved or historically disadvantaged. Research demonstrates that health professionals who grow up in underserved communities tend to practice in places with similar demographics; in other words, the places with perennial health workforce shortages are where we should focus on “growing our own.”