

Vermont Health Care Innovation Project

Health Care Workforce Work Group Meeting Minutes

Pending Work Group Approval

**Date of meeting:** Wednesday, May 17, 2017, 3:00-5:00pm, Oak Conference Room, Waterbury State Office Complex.

| **Agenda Item** | **Discussion** | **Next Steps** |
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| **1. Welcome and Introductions** | Mary Val Palumbo called the meeting to order at 3:03. A roll-call attendance was taken and a quorum was not present.  |  |
| **2. Approval of Meeting Minutes** | Rick Barnett moved to approve minutes from the February 2017 meeting by exception. Peggy Brozicevic seconded. The minutes were approved with one abstention (Beth Tanzman).  |  |
| **3. Updates:**  | *VDH Provider Reports on Website*: Peggy Brozicevic provided an update. A number of recent surveys have been posted on the VDH website and the VHCIP website. OPR is transitioning to a new online relicensing system. Hoping for an easy transition. *SIM/Post-SIM Updates*: The SIM Sustainability Plan and Population Health Plan are out for public comment through Friday, 5/19. Please submit any comments either in writing or verbally to Georgia or Sarah Kinsler. Georgia also introduced Mary Kate Mohlman. Mary Kate is the Director of Health Care Reform at AHS. *Other Updates*: * Susan Barrett announced that the Green Mountain Care Board is doing some work around pay parity between independent physicians and the academic medical center. There is not currently any active legislation on this, but it was a significant topic of interest this legislative session. The Board is convening stakeholders over the next few months to talk about the challenges facing independent providers and to discuss potential solutions in this area. Susan invited members of the this group to be in touch if they have interest.
	+ Right now, this work will focus on primary care and specialty care.
	+ GMCB is also looking at how Vermont compares to other states. This is part of a trend across the country, but the trend may be stronger in Vermont than elsewhere. Peggy Brozicevic noted that AHRQ put out a recent report with national data.
	+ Charlie McLean suggested looking at hospital-owned, academic, independent, and FQHC models. He added that the AHEC has a good database with those categorizations for primary care practices.
 | **Members should email Marisa Melamed (**marisa.melamed@vermont.gov**) to participate in GMCB’s upcoming pay parity work with stakeholders.**  |
| **4. Presentation and Discussion: Draft Vermont Health Care Workforce Demand Modeling Report** | Terry West, Tim Dall, and Will Iaccobucci from IHSMarkit presented the draft Demand Modeling Report (see Attachments 4a and 4b).* Modeled multiple scenarios – one assumes that the current environment stays constant, the rest model how delivery system changes, population changes, and economic changes could change demand.
* IHSMarkit adapted existing models for Vermont. Can provide details on the model and model development if requested.
	+ First step: Build a population file. Construct a representative sample based on this information: If every person in Vermont lived somewhere else, what care would they use? And then: How is Vermont different? Also use population characteristics to consider disease onset over time, and consider how delivery system changes and population health initiatives would change this.
* Findings have not changed much since draft findings were presented in December, though the ability to use VHCURES data has impacted a number of projections.
* Projections are described in Attachment 4a, and the report itself provides greater detail on each area.
* Scenarios:
	+ Greater use of integrated care delivery models: Didn’t see a large shift in the number of providers, but saw shifts in the types of providers needed.
	+ Expanded access to mental health and substance abuse services: Saw demand for clinical social workers and care managers in patient-centered medical home settings, but lower demand for inpatient and ED nurses.
	+ Improving care transitions to reduce ED use: Saw lower demand for ED providers, and increased demand in primary care settings.
	+ Improved evidence-based chronic disease management: Higher demand for PCPs and health coaches.
	+ Medicaid population care patterns same as privately insured: Currently, Medicaid members have higher utilization patterns than privately insured. Under this scenario, demand is reduced for all provider types.
	+ Improved population health: This is a new scenario. Results in short-term decreases in demand for providers because of improved health status, but longer lives and an increase in elderly population leads to longer-term increase in number of providers. The scenario includes sustained body weight loss for overweight and obese adults, improved blood pressure, cholesterol, and blood glucose levels, and smoking cessation. In many case, the models shows short-term decreases with delayed onset of chronic disease over time.
* This is a complex model, and will be impacted by emerging care delivery models and other market and economic factors. There is limited evaluation data on the impact of emerging care models on workforce needs.
* Highest priority professions predicted to experience future shortages: generalist disciplines, mental health and substance use disorder practitioners, clinicians specializing in areas with increasing illness burden.

Discussion: * Molly Backup noted that the report includes language that says the supply of APRNs and PAs will help blunt shortages in physicians, but projections keep percentages of physicians vs. APRNs/PAs. Molly Backup suggested that percent increase in PAs and NPs over past 20 years has been huge, whereas trend for physicians has been stable, and suggested changing projections to match this prediction. Georgia Maheras commented that we have historically been flexible in Vermont about how these positions are filled to meet the service need. Molly noted that we historically have met these service needs with a mix of physicians and NPs and PAs, and that we should expect the makeup of that group to change to include a higher proportion of NPs and PAs and a lower proportion of doctors. Unless the report reflects this, it will push the system toward hiring physicians and away from PAs and NPs, and make the report less useful. IHS noted that this report seeks to model demand, not supply, but that they will update the language to indicate this report models a group of professions, not one in isolation. Molly suggested the report state that it carries forward current proportions of physicians, NPs, and PAs if that’s the intention. Georgia and IHS will work together to draft language and run it by Molly and Jessa Barnard.
* Rick Barnett agreed with Molly’s points and asked whether there is a preferred way to provide feedback. Georgia requested feedback via email but also welcomed work group members setting up a call with her and IHS to discuss. **Please send all feedback to Amy Coonradt (**amy.coonradt@vermont.gov**) by May 24th.**
* Monica White made a comment related to nursing home data. Georgia will follow up with Monica.
* Susan Aranoff asked whether any scenarios include increased use of advanced directives and other care planning documents for end of life care, an area where Vermont is not ranked highly compared to other states. This would likely decrease care in institutional settings like hospitals, and increases in hospice services. Right now the model reflects national data on use of advanced directives.
* Mary Val Palumbo asked about projected need for dental services, which remains nearly flat. The report reflects utilization demand, which is unlikely to change, even though need is likely greater.
* Peggy Brozicevic noted that optometrists are also relatively flat – is this also a demand vs. need question? Demand vs. need is true in every case. Higher demand for opthamologists, but flat for optometrists.

This report will be wrapped up by May 31st. This group has control over how it gets rolled out. Please provide comments as soon as possible. Mary Val suggested scheduling a subcommittee meeting in June to talk about how this report will be used. **Please let Amy Coonradt know if you would like to participate.**  | **Please send all feedback on the draft report to Amy Coonradt at** amy.coonradt@vermont.gov **by Wednesday, 5/24, and indicate whether you would be interested in participating in a sub-group to discuss this in June.**  |
| **5. Discussion: Mental Health/Substance Abuse Workforce** | Jolinda LaClair, the Director of Drug Prevention Policy for Governor Scott, led the discussion. This position was created through Executive Order (02-17). * During the Governor’s budget address in January, he charged Vermont State Colleges, Jolinda’s position, and ADAP with creating a cross-profession steering committee.
* The Governor held a Summit on Vermont’s Substance Use Disorder Workforce last month as a forum.
	+ Attempt to look at SUD workforce across settings, training levels, and more.
	+ Multiple perspectives: student, health care organizations, leadership. Attempting to align educational pathways to support increasing workforce.
	+ Licensure was a major issue. Colin Benjamin and Barbara Cimaglio played a major role in helping to define the set of questions and content for each panel.
* The summit resulted in two working groups:
	+ Affordability and Professional Development, chaired by Ginger Cloud at CVMC and Peter Epenshade from the Vermont Association for Mental Health and Addiction Recovery. This group launched on Wednesday, and is looking at best practices from around the country including provider student debt and loan repayment, models for supervision, training models, and long-term employment agreements.
	+ Higher Education and Licensure, chaired by Colin Benjamin from OPR and Annamarie Cioffari from SNHU. This group will launch the week of 5/22 with a broad mix of providers to discuss streamlining licensure and renewal, aligning education and licensure requirements with career pathways, recovery and peer coaching, and integrative health.
* Barbara Cimaglio added that the summit was very informative in identifying challenges in SUD workforce. There was a theme of lack of integration in education and workforce preparation, licensure, and employment. Alignment is critical. Pathways to career development are also important for keeping people in the workforce. From the employer and State view, recruitment and retention are major barriers; providers work with the highest risk population, are often grant funded or mainly Medicaid funded, and demand is outpacing supply. Peer providers are a newer area. Barbara suggested that the number of PAs and NPs prescribing MAT could also cause an increase in demand for these provider types.
* Jolinda added that she oversees the Opioid Coordination Council.
* Jolinda invited anyone to join work groups or stay informed through minutes or other resources.
* Barbara added that while this work has focused on opioids, this could be relevant to all addictions, and many individuals with opioid disorders have cooccurring disorders as well.
* Mary Kate added that under the All-Payer Model, we’ll need flexibility to change assumptions about demand, to reflect new utilization patterns and care delivery models, and increased integration. As funds flow differently through the system, our workforce needs will shift. Mary Kate thanked Jolinda for attending, and noted that they are looking at workforce initiatives across state government, including DOL and others.
* John Olson added that this is a reminder about the economic role of health care providers in local communities. Communities with hospitals or other providers are a source of well-paying jobs in communities. Mary Kate added that this is about 17% of employer-based jobs in the state. John is also looking forward to the upcoming report on licensed alcohol and drug counselors. Only about 25% of each of the professions are doing alcohol and drug counseling – this is an area for growth! We need to help providers get the training they need to help with this work.
* Susan Aranoff commented that there is a bill, S. 133, that creates a workforce task force that includes SUD, mental health, and developmental disabilities. It’s very hard to separate developmental services workforce from SUD and mental health because of the way DAs and SSAs are staffed. Mary Kate noted that she has already met with Commissioner Bailey to address duplicative groups. Susan also noted that there is likely to be a significant increase to wages for direct service workers.
 | **Members should email Rose Gowdey (**rose.gowdey@vermont.gov**) to participate in the Affordability and Professional Development or Higher Education and Licensure work groups.**  |
| **6. Public Comment**  | There was no public comment.  |  |
| **7. Next Steps, Wrap Up and Future Meeting Schedule**  | **Next Meeting:** September**Follow-Up:** Sub-committee to discuss demand modeling report rollout in June.  |  |