



Workforce Development Workgroup

Friday, August 21st 2015 - 9:00 a.m. – Noon
Marshall University Graduate College – South Charleston Campus – Room 116

MEETING SUMMARY NOTES

Today's Expected Results:

- Provide recommendations regarding the ideal, comprehensive, coordinated primary health care delivery system (establish a common vision)
- Explore a model for workforce development planning
- Explore a model for identifying types of workforce gaps
- Identify the gaps between West Virginia's current workforce and the workforce needed for the ideal comprehensive, coordinated primary health care delivery system
- Identify the initial steps to "retool" the workforce from what exists now to ideal staffing patterns for a transformed health care delivery system in West Virginia
- Identify additional workgroup members, next steps and materials and expertise needed for future sessions

Co-Chairs: Laura Boone and Dana King

Facilitator: Leslie Stone

Participants: 20 people – 16 in person and 4 electronically

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
Welcome, Introductions and Opening Remarks	The second SIM Workforce Development Workgroup meeting opened with welcoming remarks. Joshua Austin, SIM Project Coordinator, was recognized for his role as liaison between all workgroups. The agenda with expected results for the meeting and ground rules were reviewed with workgroup members.
Review of July Workgroup Meeting Results	<p>Mr. Austin shared a PowerPoint presentation with the workgroup to highlight the workgroup summary report process and key themes from the initial SIM workgroup meetings held in July. Key results from all five workgroups were put into a SOAR Chart; one main point from each section was highlighted.</p> <p><u>S</u>trengths: Engaged, well-connected health care stakeholders <u>O</u>pportunities: Adopting a value-based approach to health care payment at the federal level encourages / requires change(s) at the state level <u>A</u>spirations: Movement from a fatalistic attitude to one that places a high priority on health and wellness <u>R</u>esults: Standardize and align health care quality measures among all payors and providers</p>
Overview of the Workforce Planning Process	A document with a model of the workforce development planning process was distributed and reviewed with the workgroup. <i>The model was taken from <u>Migration Planning Best Practices</u>, page, 2, United States Office of Personnel Management, October 7, 2011.</i>
Workforce Development Proposal: Small Group Discussion and Reports	<p>In small groups, workgroup members discussed the Workforce Development Proposal, discussed key related questions and recorded their responses on flipchart paper. Small group discussion guidelines were provided to help direct workgroup interaction. Small groups provided a brief report to the whole workgroup.</p> <p>Verbatim responses provided below.</p> <ol style="list-style-type: none"> 1. What elements / components of this proposal do you like the best? <ul style="list-style-type: none"> • Medical neighborhood (ACO disguised) – How expansive and inclusive can it be? • Seamless approach to care – no fragmentation • Good core offerings – primary care, behavioral health, prescriptions, oral health and care management • Two approaches to managing the neighborhood • Integration of disciplines • Incentives through value

- (Care) Coordination
- Acknowledgement that laws can be repealed and changed
- Incorporates small, rural practices
- Patient-centered with primary care as the driver
- Terminology Medical Neighborhood is good, easy to remember; term is also holistic for each provider / person taking responsibility
- Increased use of HIT

2. What workforce challenges do you expect to encounter in transitioning to this type of health care delivery system? Please note what you believe to be the biggest challenge. The biggest challenge identified by each small group is bolded below.

The following answers provided are grouped into themes based on the small group discussion / output:

- **Unsure if West Virginia has the supply of workers to staff the basic elements of the model**
- **The system is focused on medical and symptom treatment – not a holistic approach to health and general wellness**
- **Lacks one-on-one connections with patients, particularly the elderly – need to identify and train people for these roles**
- Possibility that primary care could become little more than a referral conduit to various specialists
- Potential loss of interpersonal relationships as health care becomes virtual
- Uncertain if patients / consumers will accept being part of this model
- No clear definition of care coordination – Who works as one? What is their training and preparation? What do they do?
- Regional collaboration could be challenging, especially when there is risk
- There is a question about whether this model can reach all West Virginians, notably those in rural areas
- The “health” focus of the model is lacking; at present it does not address root cause drivers and social determinants of health
- Unsure if medical professionals are adequately trained to staff and participate in this model
- This model potentially consolidates control of the health insurance market
- Smaller and rural providers will find it difficult to survive under this model

	<ul style="list-style-type: none"> • The model does not keep the priority and focus on managing the entire population; it still looks at health care segments <p>3. What is missing from this ideal model from a workforce development standpoint?</p> <p>Verbatim responses provided below.</p> <ul style="list-style-type: none"> • Social / community supporters and partners • Definition of primary care and value-based • The health focus is not reflected (e.g., prevention, health education, wellness) • Training considerations are very limited – How do we get trained people integrated and paid? • Lacking a reporting / HIT infrastructure – real-time feedback and what to do with it • HIT personnel to actually make the HIT infrastructure useful and helpful • Scope of practice: taking a look at changing, evolving health care roles, including cross-professional training / recognition of skills and roles to foster respect and mutual understanding
<p>Exploring Workforce Gaps: Small Group Discussion and Reports</p>	<p>The workgroup members reviewed the Workforce Gap Analysis Model. In small groups, workgroup members discussed key related questions and recorded their responses on flipchart paper. Small group discussion guidelines were provided to help direct workgroup interaction. Small groups provided a brief report to the whole workgroup.</p> <p>The responses below have been lightly edited for clarity.</p> <p>1. Headcount gaps in the current system:</p> <ul style="list-style-type: none"> ○ What are the headcount gaps in the current system? <ul style="list-style-type: none"> ▪ Primary care gap; 50 of the state’s 55 counties are medically-underserved ▪ Behavioral health shortage – various levels ▪ Dentists ▪ Care coordinators ▪ Community health workers ▪ Counselors ▪ OB/GYN

- Faculty for nurses
- Workforce distribution around the state is a considerable problem – data we have currently do not reflect the true need
- Shortage of family physicians because of specialization; there is also a retirement crisis looming
- Social workers for gerontology – are we lacking these social workers and the training opportunity? (Potential data source: National Center for the Analysis of Health Care Data).
- Behavioral health providers – are we meeting the needs as of the system? Difficult to recruit providers to FQHCs and in rural primary care setting

○ What data are needed to accurately make this judgement?

- Rural health data needs to be tweaked – ex. working location
- Link the pharmacists / prescriptions back to the provider
- There is a payment gap in the current system; skills are there for care coordination, but there is no way to reimburse for care coordination and care navigation, etc.

○ Where are the data?

▪ How do we determine / identify all the various disciplines?

- AMA licensure
- Licensure boards
- Census data

- State workforce assessment (we need distribution data – not just how many but where); currently these data are collected only on professional personnel, we need to collect data on paraprofessionals as well
- Use GIS to locate where medical personnel are across all levels and fields

2. Skill gaps in the current system:

○ What are the competency skill gaps in the current system?

- Skills with HIT

- Person-centered care
 - Collaboration skills / team-building
 - Cultural competency
 - Holistic care – tearing down silos
 - Social determinants of health and how it is integrated into care
 - Is the Community and Technical College System focused on health occupations that are needed? Are we in tune with the needs that are being identified under this model?
 - Lacking skilled HIT / IT individuals; the data piece is already important and will become even more important in a value-based model
- Are there additional specializations, certifications or even new professions that are needed for the current system?
- Health coaches
 - Community health workers

3. Headcount gaps in the future system:

- What headcount gaps are likely in the future system?
- Due to an increasing elderly population, more geriatric care and more dementia-friendly programs
 - Care coordinator (people / professionals who are knowledgeable of the whole system)
 - Primary care: due to retirement of physicians
 - Lack of care managers / care coordinators
 - Exacerbation of shortage of skilled HIT / IT individuals
 - Could create further shortages of primary care providers in rural settings
- What data are needed to accurately make this judgement?
- Projection data – by population and disease
 - Existing Community and Technical College training programs currently exist
Editorial note: this is available; Laura Boone will share it with the workgroup.

○ Where are the data?

- HRSA data (patient to service ratio)
- BRFSS (vitality and mortality)
- Population projections needed
- Community Needs Assessment – to ensure specialization to a county or locale

1. Family Resource Networks conduct these every three years. Health Departments and Critical Access Hospitals are also required to conduct these assessments.
2. The FRN, health departments and Critical Access Hospitals focus their assessments on different topics / needs.
3. This data would be valuable in terms of determining staffing for a medical neighborhood.

- Department of Education: some certifications in the health field are offered (especially in elder care)

4. Skill gaps in the future system:

○ What will likely be the competency skill gaps in the future system?

- Substance exposed infants – more training to identify, treat and prevent
- Look at more generalization of care rather than specialization
- Profession that integrates the social determinates of health into care
- Look at best practices from other areas and states to identify the best skill sets
- Team-based care approaches and facilitation skills
- Geriatric skills
- Motivational interviewing
- Communication skills – interpersonal
- Networking skills
- Health informatics certification
- Consumer health literacy / education

	<ul style="list-style-type: none"> ○ What are the likely additional specializations, certifications and new professions are needed for the future system? <ul style="list-style-type: none"> ▪ Care management, including more than just physicians ▪ Care coordination ▪ Diabetic educators ▪ Dieticians ▪ Social Workers ▪ Health metrics specialists
<p>Retooling 101: Initial First Steps to Transforming the Health Care Workforce: Small Group Discussion and Reports</p>	<p>In small groups, workgroup members discussed criteria and key related questions and recorded their responses on flipchart paper. Small group discussion guidelines were provided to help direct workgroup interaction. Small groups provided a brief report to the whole workgroup.</p> <p>The responses below have been lightly edited for clarity.</p> <ul style="list-style-type: none"> ● Motivational interviewing training available in education and training programs (both institutional and CEU / on-the-job – online module) ● Standardized data collection by licensure boards ● Implement the SIM process and plan – getting buy-in from the Tomblin administration and legislature ● LPN program in high schools ● Shortened pathway to becoming a primary care physician ● Definition of new health care workforce roles and the needed skill sets ● Free, available access to family planning and wellness ● Gather all workforce data in one spot to analyze it and provide perspective of where we are going ● Expand on existing programs to recruit needed health care workers in rural areas ● Demonstrate political will to implement a new model or system ● Plan / Do / Study / Act – start implementation of the plan and get results, achieving the outcomes we identify
<p>Next Steps, Action Items and Assignments</p>	<ul style="list-style-type: none"> ● The next SIM Workforce Development Workgroup will be held on Monday, September 14, from 9 a.m. – noon at the Marshall University Graduate College in South Charleston, West Virginia.

	<ul style="list-style-type: none"> • Workgroup members may send potential agenda items to Mr. Austin, SIM Project Coordinator, at jaustin3@hsc.wvu.edu. Mr. Austin will forward the agenda items to the workgroup co-chairs for consideration. <ul style="list-style-type: none"> ○ Develop a workforce development plan where short- and long-term strategies are identified ○ Identify a tool to help guide the workgroup’s efforts; this tool should include purpose, strategies and roles that can be adapted for implementation in all West Virginia counties / regions
Parking Lot	None
Meeting Preference Times	Workgroup members identified their preference for future Workforce Development Workgroup meeting times after September. The workgroup preference is an afternoon or late morning (10 a.m. or 11 a.m. start) meeting. The SIM Project Coordinator will attempt to accommodate these requests when scheduling future workgroup meetings.

Group Checkout (Verbatim Responses)

<i>What worked well today?</i>	<i>What would you change for the next meeting?</i>
<ul style="list-style-type: none"> • Good scenario / vignette • Good to get scenarios / vignette in advance • Very good group participation • Tasks were clear and easy to understand • Online people had improved participation which was great • Good opportunities for input / networking • Meeting was well-organized and everything flowed very well • Momentum • Timing • Participation • The value of the collective brain is higher than the individual brain 	<ul style="list-style-type: none"> • Meeting time difference • More activities than time permitted – last exercise too little time to fully address • Many group members did not attend; # of attendees greatly reduced • Distribute meeting materials just a little earlier / sooner • Only water-based markers • More contextual information on the project • More focused discussion • Workgroup framework • Revisit the purpose of each workgroup for the project, why this work is important and what the role of the workgroup is • Clearly stated questions. No double-barrels. • What do you mean by “headcount”

<ul style="list-style-type: none"> • Small group discussion • Great facilitation / leader • Great work that is so important on the road to a successful plan • Lots of ideas • Use of groups to generate ideas • Opportunity to learn from diverse participants • Well-informed and engaged people • Very nice to see people who could come in person • Great discussion • Positive • Invigorating • Much better focus • Great productive work • Very productive • Activity flowed together well • Much more workforce focused than last time • Small, but engaged group • Interchange of ideas • Respect for others 	<ul style="list-style-type: none"> • Time seemed limited – focus on fewer things in order to take “deeper dives” • Data needed to drive the discussion – we come with our perspectives but may be missing things • Not enough time and clarity in instructions to address tough areas (people not able to work through issues – left some tension in the group) • A legislative change is needed to improve <u>immediate</u> workforce availability. It was not added to the list – perceived to be too difficult. This <u>IS</u> a requirement of the CMS grant • People still seem to want to discuss personal agendas and not focus on the initiative • Smaller group participating (this may be a positive) • Coffee for A.M. meetings • Coffee ☺ or afternoon meetings • Certain people talk <u>too</u> much – need to do more listening • Some full group discussion time • E-mail exercises and activities out in advance
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Suggested Ideas for Additional Workgroup Members

- None