

State Innovation Model (SIM) Workforce Development Workgroup

Thursday, July 23rd 2015 - 1:00 p.m. – 4:00 p.m.
Marshall University Graduate College – South Charleston Campus – Room 116

MEETING SUMMARY NOTES

Today's Expected Results:

- Develop a clear understanding of the SIM project and workgroup member's role in developing the WV State Health System Innovation Plan (SHSIP)
- Strengthen working relationships among workgroup members
- Review and apply baseline documents ("Workgroup Charter," "Mutual Understandings and Assumptions" and "Baseline Trend Assumptions")
- Begin to address "Workgroup Charter" topics and key questions
- Select preliminary strategies around the focus areas of obesity, tobacco and behavioral health based on selected criteria
- Identify additional workgroup members, next steps and materials and expertise needed for future sessions

Co-Chairs: Dr. Dana King and Laura Boone

Facilitator: Leslie Stone

Participants: 26 people – 23 in person and 3 electronically

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
<p>Welcome, Introductions and Opening Remarks</p>	<p>The session opened with a welcome and opening remarks indicating that this is the first meeting to launch SIM workgroups, building on work that has been done through the WV Health Innovation Collaborative. Roles of the facilitator, co-chairs and workgroup members were reviewed. Joshua Austin, SIM grant project coordinator, was recognized for his role as liaison among the workgroups. The agenda with expected results for the meeting and ground rules were reviewed with workgroup members. A sign in sheet was distributed for any needed revisions.</p> <p>Workgroup members recorded on index cards their response to the following question: “If you had a Magic Wand and could change <u>one thing</u> that would significantly improve or transform ‘<u>your piece</u>’ of the health care system in West Virginia, what would that be?” Workgroup members were asked to identify what “their piece” of the health care system is and the one thing they would change. Workgroup members then found someone in the room that they did not know or did not know well and shared who they are, what entity they represent and their response to the Magic Wand question.</p> <p>Verbatim responses recorded on the index cards follow:</p> <ul style="list-style-type: none"> • Universal coverage • High quality providers in every county • Equal pay for equal work (experience) – rural providers paid the same as urban, minorities paid the same as non-minorities, women paid the same as men • Policies that make health a priority – increase the tobacco tax, restrict where people can smoke - illegal to smoke in cars with children, SNAP cannot purchase soft drinks or other zero nutritional products, expand recess / activity time in schools • Instill rural values of commitment, respect, sharing and humor into all future WV physicians’ training • Improve environment, access and education • Double the number of family physicians in WV • Establish fully functional, secure, interoperable HIT that physicians can effectively use

- All qualified providers are paid for providing services at the top of their qualifications, including; health promotion, case management, health education and health coaching
- Increase the number of health care providers through loan repayment programs and direct recruiting for health care facilities
- Increase the number of primary care providers
- Improve the health and well-being of all – one community at a time to be attractive to placing providers
- Expand financial incentives, scholarships and loan repayment opportunities to include entry-level providers such as nursing assistants, LPNs and medical assistants
- Transform the health care system to be truly whole-person centered and patient-centered, rather than perpetuation of the system
- Improve data collection on WV health care workforce (current capacity and demand, plus future needs and demands)
- Care would be provided in a coordinated, collaborative manner by community care teams that support providers
- Access to affordable health care and health education especially in rural areas of the state
- Keep more health professionals in WV willingly
- Encourage more medical students to go into primary care
- Utilize all members of health care delivery spectrum to full capabilities while mastering collaboration inter-professionally to maximize effectiveness and reduce redundant, duplicative services
- Make follow-up appointments easily accessible and available to all patients as they transition to the next level of care
- Would like to increase role for community health workers, with more certifications for them
- Would like to see the health care system more pro-active versus reactive – meaning insurance companies recognize the value of prevention and health promotion activities / strategies and offer ways of reimbursement for such activities
- I would create a WV center for enhanced primary care to support practice transformation to a Patient-Centered Medical Home model – a resource center, a learning collaborative and practice facilitation

<p>Setting the Context for Our Work: SIM Overview</p>	<p>A PowerPoint presentation was shared with workgroup members to set the context for their work. “Workgroup Charters” and “Mutual Understandings and Assumptions” documents were briefly reviewed with participants.</p>
<p>Review of Baseline Trend Assumptions: Small Group Discussion</p>	<p>In small groups, workgroup members discussed the “Baseline Trend Assumptions” document and recorded their responses to three (3) questions related to the document on flipchart paper. Small group discussion guidelines were provided to help direct workgroup interaction. Small groups provided a brief report to the larger group.</p> <p>The questions and verbatim responses follow:</p> <p>Is anything missing?</p> <ul style="list-style-type: none"> • Primary care distribution / compared to other states • Specific deficits / regional • Timely data • Forecast projections / predicted changes • Chronic pain / substance abuse should be considered as chronic illness • Demo data on substance abuse / OD rates • Aged population of WV • Is health a value to West Virginians? • Behavioral health data • Workforce data • Tobacco data <p>The following answers provided are grouped into themes based on the small group discussion / output:</p> <p>What do you see as the top three (3) strengths to transforming our current health care system?</p>

- West Virginia has three academic health centers offering a variety of health training programs, as well as those available at the community / technical college level
- West Virginia is a small state with engaged, collaborative health care stakeholders
- West Virginia has a strong federally-qualified health center, community-based health care system
- West Virginia has strong familial and community structures in place with which to effect change
- West Virginia has an approachable legislature regarding workforce development issues
- West Virginia has a comparatively low uninsured population
- West Virginia is undertaking multiple collaborative efforts to improve its health care system, including but not limited to the “Try This” initiative, the WV Health Innovation Collaborative and the SIM grant itself

What do you see as the top three (3) challenges to transforming our current health care system?

- West Virginia struggles to retain health care practitioners
- West Virginia’s practitioners can be resistant / hesitant to change
- West Virginia’s practitioners are not performing at the top of their license and board certification
- There is a lack of integration / coordination of care
- West Virginians can frequently have a fatalistic attitude—that is, nothing can be done to change a problem—and this perspective can create a road block to changing unhealthy behavior(s)
- West Virginia lacks the basic technical infrastructure to make significant changes to its health care system
- Disparate and fragmented recruiting efforts of health care professionals
- Poverty and other socio-economic issues create road blocks to change
- In West Virginia, there is often a cultural disconnect between provider and patient; many physicians are foreign-born
- Mental health is a missing component of the current health care delivery system
- There is a stigma associated with mental health care that prevents people from being diagnosed and treated

<p>Workgroup Charter Key Questions: Small Group Discussion</p>	<p>In small groups, workgroup members discussed “Workgroup Charter” Key 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 larger group.</p> <p>The answers provided below are grouped into themes based on the small group discussion / output:</p> <ol style="list-style-type: none"> 1. How are the staffing needs for a comprehensive coordinated care model different than the current workforce model in West Virginia? How do the shifting models of care delivery affect workforce needs in West Virginia? 2. How do recent changes in workforce, retirements, rurality, and other key variables impact the workforce needs of West Virginia? <ul style="list-style-type: none"> • Frontline health care worker redesign – data collection, community health workers • Care coordinator training is needed – role definition • Patient navigators are needed • Make sure every health care professional performs at the top of his / her license and board certification • Should make inter-professional training a priority • Loan repayment strategies should be tied to recruitment / retention of health care professionals <p style="text-align: center;">1 AND 2 COMBINED ANSWERS</p> 3. How can the skills required in the new models of care be integrated into higher education and training programs? Do these skills require diploma or certificate programs and are these classroom-based or can these be delivered on-line? <ul style="list-style-type: none"> • Include cultural competence, data analysis and health coaching training for entry-level health care workers • Different delivery systems may require educational programs mix online and on-the-job training
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- Increase medical residencies in community-based health care settings
- Develop APRN residency programs
- Have mechanisms to funnel newly-trained health care workers into community health systems
- Need to address capacity issue of clinical preceptorships

4. How can we address the barriers, costs, policies, traditions, and other structural obstacles that inhibit the workforce production needed to support new care models? What new (or changes to existing) policies, programs, courses, degrees, laws, telehealth payment reform, loans, scholarships, quotas, salaries, taxes, fees, or other incentives are needed to promote the right workforce balance?

- Enable health care professionals to work at the top of their licensure and board certification
- Increase the state tobacco tax to fund: 1. public education on healthy living and 2. fund health care workforce education
- Fund programs based on return on investment and other measurable outcomes
- Empower providers to encourage people to live healthier lives
- Deploy community care teams to provide support and education to health care consumers
- Expand state scholarship programs to include other health care professions

5. How can we leverage current resources, such as health professions education programs, residency programs, loan repayment programs, state and federal workforce funding, and others to provide workforce support?

- Ensure that loan repayment and scholarship programs are utilized to capacity
- Use funding earlier in the education / training pipeline (i.e., when entering residency programs)

6. How can we improve coordination among workforce partners to build the workforce the model demands? Do we really know what the workforce is ready to accomplish? What do we need to know regarding the current position we are in?

	<ul style="list-style-type: none"> • West Virginia needs a statistics / data warehouse to analyze the health care profession supply and demand
<p>Potential Strategies Around Areas of Focus: Small Group Discussion</p>	<p>In small groups, workgroup members discussed and identified potential key strategies for each of the three (3) State Health Improvement Plan areas of focus (1) obesity, (2) tobacco use and (3) behavioral health 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 larger group.</p> <p>The answers provided below are grouped into themes based on the small group discussion / output:</p> <p>Obesity</p> <ul style="list-style-type: none"> • Integrate information / health processes in classrooms K-12 • Explore what schools are doing- inventory regarding lunch, activity, etc. • Health coaches visit schools to improve processes and provide resources, as well as give teachers information from health care professionals • Integrate health and wellness education / PE into assessment(s) • Improve definition and measurements of obesity and specify to age groups • Incentivize healthy behaviors • Teach all health professionals motivational interviewing techniques and deploy this method to promote healthy behaviors • School lunch Program – West Virginia Bureau for Public Health, USDA collaborations, adding local foods, adding fresh options – comes from an educational outlook; we should start from inside the home and work synergistically with schools to address this condition • Worksite wellness programs: start with the health care workforce adopting a model that could lead by example • Obesity is a comorbidity with multiple other chronic conditions; solutions will likely be interoperable (e.g., diabetes and high cholesterol)

	<p>Tobacco Use</p> <ul style="list-style-type: none"> • Less workforce related: <ul style="list-style-type: none"> ○ Community health workers for pregnant women who smoke – workforce ○ Raise age to buy cigarettes to 21 ○ More comprehensive clean indoor air regulations ○ Pass a tobacco tax increase • Training health care providers to know how to identify and intervene when individuals are ready to stop tobacco use <ul style="list-style-type: none"> ○ Create environments that encourage people to stop using tobacco ○ Utilize motivational interviewing as a cessation technique • Workforce related: <ul style="list-style-type: none"> ○ More universal payment for tobacco cessation programming provided by non-physicians ○ Have a compendium of interventions that providers can pick from and choose one that is correct for a particular patient <p>Behavioral Health (LHF=”low-hanging” fruit, BI=biggest impact on health)</p> <ul style="list-style-type: none"> • Build and duplicate successful programs (LHF, BI outcomes) • Integrate behavioral health with primary care • Expand telemedicine (LHF, BI outcomes, BIH delivery) • Enhanced regulation for potentially addictive prescription drugs • Promote behavioral health professions as a career path (LHF) • Incentivize providers to pursue higher levels of education
Public Comments	None
Next Steps, Action Items and Assignments	The next Workforce Development Workgroup meeting will be held on Friday, August 21 st from 9 a.m – 12 p.m. at the Marshall University Graduate College in South Charleston, West Virginia.

Parking Lot	Items / questions identified at the workgroup session that need further attention are: <ul style="list-style-type: none">• None
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Suggested Ideas for Additional Workgroup Members:

- Rural Health Associations
- Behavioral Health – someone from the psychiatric perspective
- Rural Health Association
- Tobacco Prevention – James Vance
- Melissa Wheeler
- Monique Mahone
- Legislators
- WVMI – Terri Blitiozies
- WV Community and Technical Colleges