RI EOHHS Healthcare Workforce Transformation Committee
HWT Chronic Disease 11/22/2016 (3:00 – 4:30 pm)
DLT Conference Room (73-1)

Facilitator: Rick Brooks
Presenter: Nancy Sutton, Chief, *Center for Chronic Care and Disease Management, Department of Health*
Prepared by: Cheryl Wojciechowski
Participants: Amy Chirichetti (Optum/United), Nancy Sutton (RIDOH), Judith Fox (BHDDH), Debra Servello (RIC), Catherine Taylor (URI/GWEP/GFC), Carmen Boucher (RIDOH), Sandy Curtis (EOHHS), Susanne Campbell (CTC-RI), Jessica Skaltsis (URI-College of Nursing), Lisa Tomasso (TPC)

Agenda Item	Key Discussion Points
Welcome & Introductions	Rick Brooks welcomed participants and provided background on today's subcommittee meeting. The full HWT Committee met on October 7th to begin to plan strategies to transform Rhode Island's healthcare workforce development system. Elizabeth Roberts, Secretary, EOHHS, Nicole Alexander-Scott, MD, MPH, Director, DOH, Rebecca Boss, Acting Director, BHDDH, and Marti Rosenberg, Director, RI SIM Project each spoke to provide a sense of direction and the overarching goals derived from Reinvent Medicaid and SIM. Seven HWT goals were extracted from that meeting: 1. Primary Care 2. Behavioral Health: Practice & Integration 3. Social Determinants of Health/Cultural Competency & Diversity 4. Data Quality, Reporting & HIT 5. Community and Home-Based Care 6. Chronic Disease 7. Dental Care This Chronic Disease subcommittee meeting is the sixth of the seven. The last subcommittee will meet to discuss oral health on December 1st and the full group will come together again on December 6th to develop concrete workforce development strategies with the likelihood of having the greatest impact and of being accomplished. Rick added that Jobs For the Future (JFF), a national non-profit with expertise in workforce development, will be conducting about two dozen one-on-one interviews with key informants after all subcommittees have met. The meetings will conclude by the end of February. JFF will be assist in distilling information from these interviews, the subcommittee meetings, and additional research to establish priorities and craft transformation strategies that will have the most impact.

Issue Overview (Nancy Sutton, Chief, Center for Chronic Care and Disease Management, *Department of Health*)	Nancy Sutton presented the population health goals adopted by RIDOH. She began by stressing that a well-trained healthcare workforce is needed for managing and preventing chronic disease. Nancy then went on to list the RIDOH initiatives supporting chronic disease self-management and care from a workforce development perspective include: ▪ Patient-Centered Medical Home Models of Care ▪ Palliative Care ▪ Certified diabetes and cardiovascular disease outpatient educators ▪ Pharmacists (efforts to increase the number of practices who use pharmacists as part of care team for MTM (Medication Therapy Management) ▪ Certified Community Health Workers (CHW) ▪ Endorsements for certified CHWs to address chronic diseases One participant stated that she would like to see collaboration on CHWs and peer recovery workers. Another participant from The Providence Center added that substance abuse and addiction should be viewed as chronic diseases. Nancy agreed and will add them to the list. Nancy was asked to define an "endorsement". She replied that it is an area of specialty and that a list of competencies and how they will be demonstrated need to be established. ▪ Diabetes Prevention Program ▪ Stanford Disease Self-Management Programs (chronic disease and diabetes) ▪ Home Asthma Response Program (HARP), a pediatric in-home program for asthma Nancy was asked how patients are referred for the various programs and she replied that there is a single point of referral for most. Rick informed the group that the need for core competencies across several entry level healthcare professions was identified at another subcommittee meeting. Nancy described HARP in more detail. Patients enter the program through the ED. Certified Asthma Educators and CHWs work with the family to educate them on the importance of the Physician Asthma Action Plan or help the family get a plan from their primary care doctor. Community Health Teams (CHTs) are multi-disciplinary healthcare teams that work directly within the environment to address factors that impact people's health (CTC, South County, and Blackstone Valley). Health plans and providers make referrals and do warm handoffs to CHTs. They are an extension of the primary care site. Medicaid has CHT-RI to support the Fee-For-Service (FFS) population. CareLink is their partner. Patients in CHT-RI typically are high risk and are impact-able. SIM is funding additional teams as well.
Large Group Discussion of Workforce Strategies	The group discussed proposed workforce strategies in a large group rather than breaking into small groups. The discussion included:

	1. Expand clinical practicum opportunities that focus on populations with chronic illnesses - including physical and behavioral. ▪ Rick asked the group, "to what extent does this happen or could this happen?" One participant responded that it is emerging at URI with the new academic health collaborative to train in interdisciplinary work. Another participant added that they are working with family medicine students at Brown and that this can be built upon. The group agreed that one challenge of interdisciplinary clinical placements is that different schools have different schedules for their students so it is difficult to schedule time together across disciplines. ▪ Rick asked about the feasibility of tapping into the CHTs for clinical placements. A participant from URI nursing school agreed this is a good idea. CTC is another opportunity to place students with nurse care managers in primary care. ▪ It was brought to light that one challenge is finding community based behavioral health providers such as those at The Providence Center that have the availability to make the time commitment needed to host students in clinical placements. These staff are already stretched to the max and supervising a student on top of that is a barrier. Another barrier in this setting that was voiced is the fee-for-service payment structure which results in insufficient funding to hire more clinicians – clinical placements "need to be a win-win situation". ▪ It was stressed that clinical placements need to include CHTs and community based care to prepare the healthcare workforce for healthcare system transformation. **2. Standardize core competencies across entry-level caregiver occupations, including awareness of chronic diseases and social determinants of health.** ▪ Rick asked how we know what entry-level folks are capable of doing, what should be expected of them, and what training/competencies are needed for them to be able to do this work. One response was that the core competencies of Peer Recovery Specialists and CHWs could be compared. Judy fox at BHDDH has developed a chart that compares the two. The same could be done for other entry-level positions to aid in the development of a uniform training. This type of uniform training is thought to be critical for sustaining the workforce. ▪ Another perspective that was voiced is that this is not just an entry-level issue. CTC has developed a core training program for medical assistants working in PCMHs because even though they have already been trained the PCMH environment is unfamiliar to them and they need additional skills. CTC has identified the same need for additional PCMH training for nurse case managers and social workers. They will be

	purchasing a core curriculum for nurse care managers and have already provided PCMH specific training for social workers in their practices ▪ Rick asked how much training is needed prior to being hired and how much training employers should be responsible for. A BHDDH participant described their internships for Peer Recovery Specialists (PRS) as transitional positions and that, currently, a block grant pays for the internships. Another participant added that URI has nursing students do core competency modules online and suggested something similar be developed for CHWs and PRSs. ▪ It was pointed out that a major struggle is that employers cannot afford to take their staff offline to go to a training even if the training is free. ▪ Lisa Tomaso from The Providence Center pointed out a good example from manufacturing. New employees take an entrance exam to ensure they have certain core skills coming into employment but once hired they are trained in a specialty or specific job function. ▪ It was pointed out that accreditation and regulations can drive employers to provide education. ▪ The group discussed a question about whether CHWs, medical assistants, etc. need different core competencies. ▪ The group also discussed the difficulty that many individuals whose primary language is not English encounter when taking written tests in English and that this can limit the pool of workers that represent Rhode Island's diverse population. ▪ Rick asked for ideas on how to provide opportunities for CHWs to get endorsements from RIDOH as the department will be convening a group to identify the competencies for different endorsements (what do they do, what role on CHT, etc.) Participants discussed that it is important for CHWs to be trained as part of CHTs because patients are often more receptive to a CHW rather than a clinician. In Boston, CHWs go into homes alone seven times to develop report before clinical team members go into the home. In Rhode Island Certified Asthma Educators go into homes with a CHW the first time to deal with clinical issues while the CHW deals with other issues. In other states, CHWs go into homes with handheld devices that connect them back to practices. ▪ One participant brought up the fact that we have so many "levels" of workers with different titles and that this is very confusing for patients. She added, "If we don't understand it how can we expect patients to

	understand it?" The different roles need clarification. For example, PRSs and CHWs have different training, there is no baseline, and a lot of job titles have sprung up for these roles. Another participant stated that a PRS is a specialty of a certified CHW. ▪ It was pointed out that now is the time to try to standardize roles because there is a lot of experimentation going on (Ex.: ACOs). ▪ A participant stressed that behavioral health needs to be put on the same level as primary care so both are viewed as part of the same healthcare system. The barrier is that addiction is not recognized as a chronic disease and behavioral healthcare doesn't sit on the same platform as primary care. ▪ It was pointed out that the URI geriatrics nursing curriculum includes modules on BH that have students going to the Providence Center soon. ▪ It was recognized that at the Providence Center, behavioral health clinicians are often used by patients as their primary source of health care. ▪ The group also recognized that primary care clinicians need training in treating behavioral health disorders such as depression. ▪ The fact that all Community Mental Health Centers are Health Homes lends itself to interdisciplinary practice because they collaborate with primary care providers. ▪ The Recovery Navigation Program, an ED diversion initiative at the Providence Center, was highlighted. The program serves chronic inebriates and starts December 1st. Interdisciplinary Teams will be cross-trained and will work closely with social service agencies in the Providence downtown area. Two clinicians embedded in the Providence Police Department. ▪ A URI nursing program participant stressed the importance of telemedicine. She described a program that supports adults with intellectual difficulties or Alzheimer's in which vitals can be taken at home and transmitted (as well as images) to clinicians but that these services are not yet covered in Rhode Island. It was pointed out that in The Providence Center's contract with BCBS, telehealth is covered in a "health path bundle".
Next Steps	Rick Brooks thanked participants for their time and input and reminded the group that there will one more subcommittee meeting on December 1st and that the next large HWT Committee meeting will be on December 6th.