RI EOHHS Healthcare Workforce Transformation Committee
Primary Care Subcommittee Meeting
Meeting Notes: Tuesday, 11/1/2016 (3:00 – 4:30 pm)
DLT Conference Room (73-1)

Facilitator: Rick Brooks
Presenter: Peter Hollmann, MD, CEO University Medicine
Prepared by: Cheryl Wojciechowski
Participants: Susan Bruce (Optum/UHC), Andrea Galgay (RIPCPC), Caitlin Towey (Brown), Sandra Curtis (EOHHS), Deb Hurwitz (CTC), Charlotte Christ (BCBS RI), Cory King (OHIC/SIM), James Rajotte (RIDOH/ SIM), Steve Detoy (RIMS), Ailis Clyne (RIDOH), Tsewang Gyurmey (PACE-RI), Betty Rambur (URI), Carmen Boucher (RIDOH), Catherine Taylor (URI), Channavy Chhay (CSEARI), Brady Dunklee (Apprenticeship RI), Stephanie Burnham (RIQI), Yolande Lockett (RIC), Peter Hollmann (University Medicine), Randall Wilson (Jobs for the Future)

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 MA 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 Primary Care subcommittee meeting is the first of the seven. The six additional subcommittees will meet to discuss the other goals through 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.
Issue Overview (Peter Hollmann, MD Chief Medical officer, University Medicine)	Dr. Hollmann's presentation focused on the workforce challenges in primary care. He touched on the following topics: Environment: ▪ Changing payment from volume to value ▪ Primary care workforce satisfaction and recruitment are low

	Primary care workforce: (Healthcare transformation is most dramatic in primary care.) ▪ Focus of healthcare system transformation ▪ Lower relative pay ▪ EHR ▪ Changing culture ▪ Shrinking workforce ▪ Consolidation ▪ Do not work in isolation (specialists, hospitals) PCMH: ▪ Personal clinician ▪ Whole person orientation ▪ Care coordination ▪ Measure and improve quality ▪ IT (EMR and evidenced based medicine) ▪ Enhanced access ▪ BH integration Changing payment: (Is based on very large scale and system changes don't trickle down to the individual provider level.) ▪ FFS ▪ Enhanced FFS ▪ Alternative Payment based on FFS Architecture ▪ Population-based payment Teams: (Need to function at highest level for increased productivity and satisfaction.) ▪ Top of license (Needed to expand service capacity by skill set.) ▪ BH, NCM, special populations (Needed to expand capacity by setting.) ▪ Home/hospital/nursing home ▪ Long-term social supports and community supports Workforce: (All need proper training on how to work with all levels such as NP, PA, Medical Assistants, etc.) ▪ Clinical ▪ IT/Analytics/Quality ▪ Transformation & education ("practice engineers") ▪ Insurance/Coding for Risk Adjust/financial management (Now need to consider risk adjust factors.)

	Dr. Hollmann pointed out that education and income are considered the single most important determinants of health and spoke of the "whole world of health (housing, food, transportation) and medical industry." He provided an example in geriatrics that includes CNAs, advocates/care coordinators, support groups, and financial planners all potentially being part of a geriatric patient's care plan. Discussion ensued about: ▪ Providers not being very familiar with MACRA and MMIPS and whether it is better to be in an APM rather than MMIPS. ▪ The system becoming unmanageable for many physicians. ▪ Concierge and pre-pay practices that have scaled-down patient panels and reduced overhead which allows for more time with patients, but these practices can't take on risk. ▪ RIQI's Practice transformation grant.
Group Discussion of Workforce Strategies	After breaking into small groups to discuss a list of Primary Care proposed workforce strategies the group came back together. ▪ Discussion ensued on the following topics: ▪ How to best prepare the workforce to work differently in MACRA environment. ▪ The role of nurse practitioners. ▪ The need to also address expanding the supply of physicians and ensuring the current supply is not threatened. Ideas included reserving slots in medical schools, and a changing environment could attract physicians. ▪ Nurses also need training in using analytics in new ways and this should happen in both nursing education programs and on-going training. This is also a function of how nursing students are "socialized" to value and use analytics in practice. ▪ Training in team-based care is a strategy in and of itself. The group also discussed if most practices want to train their own team in addition to a set "base of skills". ▪ Is there something our schools should be doing that is more planned and coordinated with the practice community? ▪ It is important to focus on new and existing workforce – think "new and renew". ▪ Should the focus be on hi expense/hi impact chronic diseases? ▪ The co-location and cross-training necessary to include dental and also behavioral health services in primary practice. SIM's child psychiatric consulting project was discussed as an example of supporting the integration of pediatric behavioral health and primary care was discussed as well as "warm handoffs" to mental health supports.

	▪ Providers in specialty practices are paid more than primary care providers so it is more difficult to hard to encourage more to go into primary care. Financial incentives/loan repayment programs may entice more to work in primary care. ▪ Elevating the status of Community Health Workers (CHW) could work to reduce the stigma they often face as not being medical professionals. The group discussed having a billable code for services from a certified CHW, the use of FFS to spark things we want to see like CHTs but use sparingly and/or bundle, CHW apprenticeships, having CHWs train other team members in cultural competency, and the need to figure out how to fund continuing education for CHWs. ▪ Whose job is it to train those already in the workforce or if new to the workforce? Some sort of common consensus around core skills/competencies make sense but roles and responsibilities within a practice varies from practice to practice so each practice may want to do their own training. Additionally, many nurse care managers need clarity on their role. CTC is looking at developing a core curriculum/module as a test with the hope it will become a statewide program. ▪ Team based care does not always come naturally so training needed in this area. The group discussed whether this is something higher education can respond to. ▪ It was pointed out that staff need to be paid while they are attending training, that a learning collaborative is a rich environment that supports peer learning, and that the educational system needs to transform. ▪ A representative of the PACE-RI program feels the main problem is coordination of care, making sure that patients access the correct resource at the correct time. PACE patients have difficulty accessing the traditional primary care system and need supports like transportation. The PACE model revolves around an interdisciplinary team that meets every morning to review cases. The Team includes 11 disciplines including CNAs. ▪ It was pointed out that telehealth was not on the list of goals and is a means to bring access to isolated patients and has also been used in school-based care models so kids don't need to leaver school or access urgent care after school. ▪ There is a lack of workforce development for medical interpreters and their recognition as a vital part of the healthcare workforce. ▪ All strategies around primary care don't specifically address the shrinking physician workforce due to physicians reaching retirement age and exiting due to changes in the healthcare payment such as MMIPS. ▪ State sponsored medical schools tend to keep graduates working in the state. The logistics and time commitment to create such a school is problematic. Rhode Island used to have reciprocity with a few state medical schools. Maybe Rhode Island should go back to reciprocity and/or develop incentives for graduates to stay in the state. There are Physician Assistant (PA) schools in Rhode Island that could be tapped into by incentivizing PA graduates to stay in the state and work in primary care. Other ideas were social entrepreneur programs to finance individuals' medical education and ensuring that doctors are working at the top of their license.

Next Steps	Rick Brooks thanked participants for their time and input and reminded the group that there will be six other subcommittees throughout November and that the next large HWT Committee meeting will be on December 6th.