Key Takeaways from Healthcare Workforce Transformation Discussion Groups

Primary Care (11/1)

1) Expansion of primary care is hampered by some provider shortages (low reimbursement compared to other specialties, work load, burnout are all cited as causes)
2) Reserve slots in medical schools for RIers; establish reciprocity with other state medical schools
3) Increase financial incentives to return to/stay in RI (eg, loan repayment, tax credits)
4) Develop team-based models of care; all staff working at top of license to increase productivity, job satisfaction, and access. Question: Can this training provided by higher education, or is it practice-specific?
5) Develop strategies to integrate behavioral and oral health care (co-locate; cross-train), and coordinate primary care with home care and long-term care
6) Expand use of NPs and PAs; partner with higher education programs; expand clinical placement opportunities
7) Train staff in IT, data analytics, quality, value-based payments (current and emerging workforce)
8) Elevate the role and status of Community Health Workers (CHW). Identify reimbursement options for certified CHWs. Use fee-for-service to support Community Health Teams, as warranted. Consider CHW apprenticeships. Develop education / advancement opportunities for CHWs. Enlist CHWs to increase cultural competency of other team members.
9) Incorporate telehealth to expand access to isolated patients; has also been successful model for school-based care.

Behavioral Health: Practice & Integration (11/3)

1) Develop team-based models of care; train all staff to work at top of license to increase productivity and job satisfaction
2) Integrate behavioral and physical health through co-location, cross-training, and/or consultation with primary care providers
3) Develop strategies to address shortages of licensed professionals, including e-consults, peer workforce (eg, recovery coaches and CHWs), expansion of prescribers (eg, clinical nurse specialists); telemedicine to assess, diagnose, and prescribe; and reimbursement issues
4) Develop a culture of continuing education/professional development especially regarding system transformation issues; emphasize on-the-job training, train-the-trainer
5) Promote behavioral health careers in high schools to counter stigma
6) Develop culturally competent and diverse BH workforce by targeting linguistic students who function as health navigators for their families.
7) Maximize loan repayment program opportunities

Social Determinants of Health & Cultural Competency (11/3)

1) Embed social determinants of health curricula in all health professional education programs; Expand practicum opportunities in community settings
2) Provide continuing education to train the current healthcare workforce to understand and screen for social determinants of health
3) Develop initiatives to increase diversity among higher education health professional programs, including outreach, financial assistance, mentoring, academic advising, and peer support
4) Expand/support the role of culturally competent and diverse Community Health Workers through training, certification, career advancement opportunities, and reimbursement strategies.
5) Promote healthcare education and health awareness in high school or earlier; Consider targeted outreach to immigrant children who frequently serve as CHWs for their families
6) Create career advancement opportunities for entry-level workers – such as apprenticeships, tuition assistance, stackable credentials, on-the-job training, and wage progression – to increase the cultural competence and diversity of the health professional workforce

Data, Quality, Reporting, Health Information Technology (11/15)

1) Increase understanding among the current and future healthcare workforce of the importance of documentation, health informatics, and data analytics, and their relationship to health system transformation and value-based payment models. Offer/require CEUs, as applicable.
2) Establish workforce development partnerships (eg, internships) between public health, health informatics, and other health professional education programs and healthcare provider and quality organizations.
3) Incorporate basic IT skills (eg, data entry) in all levels of healthcare workforce training.
4) Explore options for hands-on job training for entry-level IT positions.
5) Provide guidance counselors/job counselors with information about data analytics and HIT workforce education and career opportunities for students and job seekers.

Home & Community-Based Care (11/17)

1) Demands on the homecare workforce are significant and unique; however, training and compensation do not reflect these demands and hamper recruitment and retention.
2) CNA licensure requirements (i.e., training, testing, and scope of practice) should be revised to incorporate home care-specific knowledge and skills. CNA training and testing in languages other than English could help to increase the cultural diversity of the home care workforce.
3) Core competencies of CNAs and other entry-level healthcare workers should be clearly defined, and additional certifications (e.g, Alzheimers and dementia, substance abuse, pediatrics) should be offered to allow for further specialization and academic and career advancement.
4) Home and community-based clinical rotations and/or residency programs in health professional education programs need to be expanded. (e.g., The VNA of Care New England currently offers a HRSA-funded home care RN residency program.)
5) New occupations and new roles, such as Community Health Workers, Emergency Medical Technicians, LPNs, Medication Aides, and peer recovery workers all have potential to expand the capacity and diversity of the workforce to provide home and community-based care.

6) Pre-employment training programs for CNAs and other entry-level occupations need to improve recruitment, assessment, and counseling of trainees in order to improve employment outcomes.

Chronic Disease (11/22)

1) Interdisciplinary training among health professionals and students is important to preparing the workforce to address chronic diseases (eg, the URI Academic Health Collaborative and the RI College Institute for Education in Healthcare). Coordination of schedules among students from various schools and programs can be challenging due to incompatible academic schedules. Community-based clinical placements are also needed; however, supervision of students during clinical placements is a challenge for some community-based providers.
2) Community Health Workers and other entry-level workers can play a key role as members of Community Health Teams providing community-based, culturally-competent education and services to prevent and manage chronic diseases. Standardized "core competencies" are important to help to reduce confusion over roles and responsibilities among CHWs and other entry-level/emerging occupations.
3) RIDOH is developing "endorsements" in chronic diseases (e.g., heart disease, stroke, asthma, behavioral health) for Community Health Workers to increase their knowledge, value to patients and providers, and career advancement opportunities.
4) Nurse case managers and social workers can and are being trained in chronic disease prevention and management.
5) Continuing education for the current workforce is challenging due to cost and logistics, but could be bolstered by requirements and/or funding.
6) Telehealth is an important resource that can enhance the capacity of home and community-based caregivers to support individuals with chronic diseases.

Oral Health (12/1)

1. Nearly half of all Medicaid beneficiaries in RI are served by only 6 dental practices (all FHQCs). There are no oral surgeons in RI who serve Medicaid beneficiaries. Access is a major issue.
2. Recruitment of dentists is impeded by Medicaid and commercial rates. Federal loan forgiveness programs attracts dentists to FQHCs, but they often don't stay. Starting a public dental school is likely to be cost-prohibitive. Funding to expand dental residencies could help to recruit/retain new dentists. Financial support for out-of-state RI dental students could yield new RI dentists.
3. Newly-authorized role of Public Health Dental Hygienist may expand access to services at schools, nursing homes, public housing, community health teams, etc.
4. Dental Therapists (ie, Master's prepared Hygienists) could significantly expand access as they have in MN, but would likely face opposition from dentists and would need support from payers.
5. Dental Assistants and Lab Techs have no formal training or licensure requirements, which raises concerns about safety, quality, and oversight.
6. Establish/increase oral health training in non-dental healthcare education programs, such as MDs, RNs, LPNs, CNAs.
7. Establish referral system between dental providers & non-dental healthcare providers
8. Integrate oral health and primary care via Accountable Entities.
9. Increase population-specific (eg, special needs, geriatrics) education for oral health professionals.