Delaware Center for Health Innovation

Workforce and Education Committee

Background, Accomplishments to Date

January 7, 2016

Committee Purpose and Goals

- Delaware will support delivery system transformation with a novel workforce strategy.

- We want to position Delaware as a “Learning State,” actively engaged in transforming our current workforce and training the next generation of workforce so it can provide a team-based approach to deliver coordinated integrated healthcare.

- The specific goals of the DCHI Workforce and Education Committee include:
  - Ensuring Delaware has the workforce capacity needed to deliver team-based, integrated care for the entire population (taking changing demographics into account)
  - Taking a forward-looking approach, with an understanding of market trends, new roles, and future needs to support the evolving delivery system
  - Understanding barriers to practicing and accessing care and designing programs to address them
  - Creating awareness about Delaware’s innovative approaches to workforce development to position Delaware as a national leader
  - Ensuring continuous improvement by sharing best practices

Core Areas of Focus

Retraining the current workforce: The core concept for Delaware's approach to retraining the current workforce is to develop a two-year learning and development program. This program will include developing common simulation-based learning modules, facilitating local workshops on "team-based care," developing core competencies for new roles (e.g., for care coordinators), and hosting symposia twice yearly to highlight innovative approaches to integrating care and identify cross-state retraining needs.

Building sustainable workforce planning capabilities. Delaware does not currently have a model to regularly assess the state's workforce requirements. The Workforce and Education Committee has responsibility for developing a sustainable model for workforce planning and identifying the organizations needed to carry forward this work over time.

Training the future workforce in the skills needed to deliver integrated care. In parallel with retraining the current workforce, Delaware also needs to ensure that Delaware is able to educate, attract, and retain new members of the workforce that have the skills and capabilities required to deliver team-based, integrated care.

Accomplishments to Date

1) Reviewed demographic trends for DE's Hispanic population and implications for the health care workforce.

- The University of Virginia Weldon Cooper Center for Public Service (WCCPS) projects Delaware's Hispanic population to increase 80% from 2020-2040.
- For 2010-2020 and 2020-2030, Delaware ranks 9th highest in the U.S. for projected annual percentage growth rate among the Hispanic population.
- For the 2030-2040 time interval, Delaware's state ranking shifts to sixth highest in the U.S.
- Delaware needs to move the needle on diversity in learning across the state.

2) Finalized Health Care Workforce Learning and Re-Learning Curriculum Consensus Paper

- Curriculum will specifically strengthen workforce competencies within the following six areas:
  - Communication and Counseling Skills
  - Collaborative Report Writing
  - Interprofessional Practice
  - Navigation and Access to Resources
  - Care Decisions and Transition of Care Planning
  - Health Information Technology

Accomplishments to Date (continued)

3) Developed Outline for Workforce Capacity Planning Paper

Introduction/Purpose

- Identification of future workforce needs to align with anticipated population changes
- Develop Sustainable workforce planning strategies
- Retrain current workforce and train the next generation of workforce so it can provide a team-based approach to deliver coordinated, integrated healthcare

Goals

- Analyze existing and potential sources of data (e.g., demographics, market trends) to anticipate future health care needs (including population characteristics such as primary language spoken, veteran status, etc.)
- Identify innovative cost-effective, efficient workforce arrangements for providing care in an effort to match health workforce skills to community needs.

Accomplishments to Date (continued)

4) Developed and reviewed draft consensus paper on recommendations for credentialing health care providers

- Outlines the rationale for condensing the health care credentialing process
- Summarizes credentialing strategies from peer states
- Recommends Delaware-specific guidelines for streamlining the health care credentialing processes

5) Working to Standardize the definition of a DE Community Health Worker (CHW)

- The Workforce and Education Committee would like to form a sub-committee with members from the Healthy Neighborhoods and Clinical Committees to identify additional CHW models and craft a solution that best meets the needs of the Delaware delivery system.
- Researched Al DuPont's model where community health workers serve as patient navigators and provide case management services to families with high needs.

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Behavioral Health Integration

Workforce Discussion materials

NOTE: These slides are draft, pre-decisional slides that reflect the process that was followed to gather stakeholder input and draft the Behavioral Health Integration Strategy. These slides do NOT reflect the final strategy, which is contained in the “Integration of Behavioral Health and Primary Care” consensus paper, and remains preliminary and subject to final DCHI board approval.

A reminder of the case for behavioral health integration in Delaware

PRELIMINARY

- There are a **significant number of individuals** with behavioral health needs and significant **overlap** of needs for individuals with multiple **behavioral and chronic physical** conditions
- **Better integration of behavioral health and primary care** will be required to serve these needs in Delaware
- **There are several successful integration models** that have been implemented within Delaware and across the country, but **few have been rolled out at scale**
- **There are a number of barriers limiting integration in Delaware today :**
  - Fee-for-service environment
  - Insufficient supply of BH clinicians[1]
  - Limited information sharing
  - Training needs
  - Funding

1 Sussex county has the least favorable ratio of persons to psychiatrists across the state (Mental Health Professionals in Delaware, Toth, 2014)

Current Challenges in Delaware

	Update
Fee-for-service environment	• The prevailing fee-for-service payment model impedes integration of behavioral health and primary care. • Providers describe ambiguity and variance in reimbursement for a range of integrated care services.
Access	• In Delaware, there is a shortage of behavioral health clinicians, and specifically a shortage of psychiatric prescribers with significant variation in access across the state. • Access issues limit the availability of behavioral health clinicians working with primary care practices to integrate, co-locate or build co-management agreements.
Structural Barriers	• Behavioral health and primary care clinicians typically do not work from common health records. • General lack of understanding of federal and state policies about sharing behavioral health information across organizations.
Training	• Many of today's clinicians have not been trained to work on integrated primary care and behavioral health teams. • Primary care clinicians may also need additional training to feel comfortable managing patients presenting with substance abuse or other behavioral health conditions

Examples of possible behavioral health integration models

	Remote collaboration	Co-location	Integration of behavioral health care into primary care	Integration of primary care into behavioral health care
Case exam-ples	**Washington** ▪ Stepped-care treatment plan where PCP is the center of services and care coordi-nators are used for integration	**Michigan** ▪ Onsite medical care provided by a nurse practitioner who rotates through CMHCs	**Missouri** ▪ Pairing of FQHCs and CMHCs to form Health Home providers that provide integrated services	Cherokee Health Systems ▪ Originally a community mental health agency before integrating care and becoming an FQHC
Out-come	▪ Clinical improvements for 49% of severe depression and 36% of severe anxiety patients	▪ Continuous decrease in community hospital admissions	▪ Improvements in care and quality of life along with cost savings to the system	▪ 20% increase in primary care visits, 68% decrease in ER visits, 22% decrease in costs

Source: AHRQ (Agency for Healthcare Research and Quality): Integration of Mental Health/Substance Abuse and Primary Care; Milbank Memorial Fund, Evolving Models of Behavioral Health Integration in Primary Care

Delaware's vision for Behavioral health integration

PRELIMINARY

Vision statement

Improve patient outcomes and experience by providing patients with the level of integrated care they require in the least restrictive manner – with special focus on patients with higher physical health needs- and also to create a system that enables providers to practice at the top of their license

Elements of vision

- Patients are able to access holistic coordinated care through multiple entry points
- Holistic care includes interventions for health behaviors, mental illness and substance abuse
- Clinician-to-clinician support enables access to care
- Care is delivered on an integrated continuum that meets all levels of behavioral health needs

Support for Achieving the Vision

DCHI anticipates that providers may require support to build the capabilities to transition to any of the models described previously or to move forward along the clinical integration continuum. DCHI recommends development of the following types of support for providers to adopt these models, some of which are already planned.

Existing or Planned Resources across DCHI program areas

- Electronic Health Records for Behavioral health clinicians.
- Practice transformation support
- Healthy Neighborhoods

Additional support specific to behavioral health integration

- Support for incorporating integrated care into practices
- Support for building telehealth capabilities
- Data and reporting to enable integrated care
- Guidelines and common templates for information sharing

Support for sustainability of integrated care

- Ongoing dialogue on reimbursement for integrated behavioral health and primary care
- Establishment of a knowledge community on integrated care
    - New Workforce Training
    - Sharing Best Practices
    - Research, Evaluation, and Planning

Current perspective on ideal model for Behavioral health integration in DE

PRELIMINARY

- **Primary care clinicians and behavioral health clinicians practice together when possible** (e.g., co-location, contractual agreements or integration)
- **Patients with behavioral health needs have access to follow-up care** or intensive treatment in the **least restrictive environment** (e.g., telemedicine, front-line treatment by PCP)
- **Core medical record information is electronically available** to both primary care and behavioral health clinicians (optimally through a common Medical record)
- **Responsibility for quality metrics, goals and incentive payments are shared** by primary care and behavioral health clinicians

Must consider how to implement this model for geographical regions with limited access to services due to workforce limitations and varying patient demographics

Workforce: options for consideration

PRELIMINARY **DRAFT**

Strategic initiatives	Description	Steps to operationalize	Examples	*Potential considerations* Resources required	Time to implement
Directory of resources	▪ A directory of available and recommended educational materials or training resources on key topics (e.g., billing information, motivational interviewing, training resources)	▪ Identify examples from other sites and determine approach on how to apply to DE	▪ State of Washington ▪ State of Maine ▪ State of Oregon		
Statewide training	▪ A series of webinars or in-person trainings that educate providers on how to operate in an integrated model. Topics may include – Billing for integrated services – Provider-to-provider communication and care plan development – Motivational interviewing and warm hand-offs – Developing co-management agreements – Use of telehealth	▪ Identify organizations public or private who develop and convene training ▪ Assess options to contract third-party training agencies to provide this service	▪ State of Washington ▪ Commonwealth of Massachusetts		

DCHI Website Launched

http://www.dehealthinnovation.org/Health-Innovation