Legislative Commission on Primary Care Workforce Issues

May 23, 2019 2:00-4:00pm at the NH Hospital Association –Conference Room 1, 125 Airport Road, Concord

Call in information:

(267) 930-4000
Participant Code: 564-395-475

Agenda

2:00 - 2:10  Welcome and Introductions – Laurie Harding – Chair, NH Commission on Primary Care Workforce Issues

2:10 – 3:45  IDN 4 Workforce Initiatives – Geoffrey Vercauteren, Director of Workforce Development, Network4Health / Catholic Medical Center

2:45 – 3:45  DHMC Community Health Worker Model: partnering with primary care providers - Bryan A. L'Heureux, MPH, Community Health Partnership Coordinator, Sr, Dartmouth-Hitchcock & Carol Sarazin and Lindsey Lafond, Community Health Resource Specialists, Dartmouth-Hitchcock

3:45 - 4:00  Legislative Update

Next meeting: Thursday June 27, 2:00-4:00pm
State of New Hampshire
COMMISSION ON PRIMARY CARE WORKFORCE ISSUES

DATE: May 23, 2019
TIME: 2:00 – 4:00pm
LOCATION: New Hampshire Hospital Association (Rm 1)

Meeting Notes

TO: Members of the Commission and Guests
FROM: Danielle Weiss
MEETING DATE: May 23, 2019

Members of the Commission:
Laurie Harding – Chair
Alisa Druzba, Administrator, Rural Health and Primary Care Section – Vice-Chair
Stephanie Pagliuca, Director, Bi-State Primary Care Association
Mike Auerbach, New Hampshire Dental Society
Mary Bidgood-Wilson, ARNP, NH Nurse Practitioner Association
Donald Kollisch, MD, Dartmouth-Hitchcock Medical Center
Kristina Fjeld-Sparks, Deputy Director, NH AHEC
Jeanne Ryer, NH Citizens Health Initiative
Mike Ferrara, Dean, UNH College of Health and Human Services
Trinidad Tellez, M.D., Office of Minority Health & Refugee Affairs
Pamela Dinapoli, NH Nurses Association
Diane Castrucci, NH Alcohol & Drug Abuse Counselors Association

Guests:
Leslie Melby, NH Medicaid
Paula Smith, SNH AHEC
Paula Minnehan, NH Hospital Association
Thomas Wold, Portsmouth Regional Hospital
Barbara Mahar, New London Hospital
Geoff Vercauteren, Director of Workforce Development, Catholic Medical Center
Bryan L'Heureux, Community Health Partnership Coordinator
Carol Sarazin, Community Health Resource Specialist, Dartmouth-Hitchcock
Lindsey Lafond, Community Health Resource Specialist, Dartmouth-Hitchcock
Martha Bradley, Community Health Institute

Meeting Discussion:

2:00 - 2:10 Welcome and Introductions – Laurie Harding – Chair, NH Commission on Primary Care Workforce Issues

2:10 – 3:45 IDN 4 Workforce Initiatives – Geoffrey Vercauteren, Director of Workforce Development, Network4Health / Catholic Medical Center
Refer to presentation “IDN4 Work Initiatives.”
DHMC Community Health Worker Model: partnering with primary care providers - Bryan A. L'Heureux, MPH, Community Health Partnership Coordinator, Sr, Dartmouth-Hitchcock & Carol Sarazin and Lindsey Lafond, Community Health Resource Specialists, Dartmouth-Hitchcock

Refer to presentation “DHMC Community Health Worker Model.”

Legislative Update

Next meeting: Thursday June 27, 2:00-4:00pm
Overview of Workforce Initiatives in IDN Region4

Geoff Vercauteren
Director of Workforce Development
Network4Health
Presentation to the Legislative Commission on the Primary Care Workforce
5/23/19
About Network4Health

• Part of the NH 1115 DSRIP Waiver
• Region 4: Represents Greater Manchester – 19 cities and towns over 3 counties (Hillsborough, Rockingham, Merrimack)
• ~30% of Medicaid covered lives (48,000)
• 43 partners
• Lead partner: Catholic Medical Center
### FRAMEWORK FOR BUILDING THE BEHAVIORAL HEALTH WORKFORCE

#### Pipeline
- Attract people to all levels of the BH workforce
- Clarify career and education pathways
- Alignment between policy, education, and employer need

#### Professional Development
- Increase competence and confidence of workforce
- Financial support for key trainings and conferences
- Identify what exists vs. what needs to be created
- Leverage existing knowledge in IDN where possible

#### Advancement
- Identify high potential / high performing staff
- Clarify career paths within partners
- Support staff through further education and career advancement
- Remove barriers when possible

#### Retention
- Retention strategies (bonuses, education assistance, etc.)
- Improve capability and competency of managers and supervisors

---

**Build and Leverage Partnerships**

**Utilize DSRIP Funds for Pilots**

**Investment for Long-Term Change**
Behavioral Health Scholars Program

- **Goal:** Increase college access for partner employees; invest in current students
- **Commitment:** Between $50,000 to $100,000 in scholarship per year

<table>
<thead>
<tr>
<th>Manchester CC</th>
<th>Granite State College</th>
<th>UNH (pending)</th>
</tr>
</thead>
</table>
| • AS in Behavioral Science  
• AS in Human Service  
• **Certificates:**  
• Direct Support Services  
• Substance Misuse Prevention  
• Recovery Support Worker*  
• Mental Health Support* | • BS in Human Services  
• BS in Psychology  
• BS in Applied Studies – Human Services and Early Childhood Development  
• AS in Behavioral Sciences | Master’s level degree or certificate options in SW, SUD, and others. |

| 20 students | 23  
$34,500 | $22,500  
20+ students per year |
Mental Health First Aid

• Network4Health partnering with CMC and MHCGM
• Paying for 8 hours of Mental Health First Aid training for CMC’s new LNA apprenticeship
• Aligns with integrating BH awareness with direct service
Professional Development & Training

- **Partnership:** Granite State College
  - *Professional development, Advancement, Retention*

- **Fundamentals of Management**
  - October 2018
  - 3 classes over 3 months + 2 hours of online work per week
  - 25 applicants; 21 completers
  - 84% completion

- **Foundations of Leadership**
  - 4 classes over 4 weeks; March – April 2019
  - Over-Full: 28 students accepted

- **Project Management Essentials**
  - 3 classes over 4 weeks, starts in June 2019
  - 25 slots
Sponsorship of slots for workshops, conferences, etc.

- 2018 = 227 trainings (157% of goal); paid for 187 trainings with 625 people supported
- As of 5/2019 = 185 trainings marketed or ready to market (128% of goal for 2019); paid for 145 trainings with 546 people supported

Cherokee Health systems

- Partnership with regions 1 & 6
- 6 days of in person and 3 remote sessions since June 2018
Recruitment & Retention

• Prescriber Recruitment & Retention Initiative (PRRI)
  – Offers reimbursement of 50%, up to $10,000 towards the recruitment or retention costs of a prescriber: MD, DO or APRN
  – **Success:** 2 organizations reimbursed for 3 providers ($30,000)

• Clinician Recruitment & Retention Initiative (CRRI)
  – Starting late spring 2019
  – Offers reimbursement of 50%, up to $7,500 towards the recruitment or retention costs of a clinician: LICSW, MSW, LCMHC, LDAC, MLDAC, etc.
  – Committed $100,000
Other Activities

• RFP for Offset-Productivity
  – Up to $10,000 to reimburse hourly rates for staff to attend trainings or supervision

• Promotion of OT and Behavioral Health PA roles
  – Success: CMC is moving forward with a BH PA fellowship program
  – CLM hosted UNH OT intern to do interventions – very successful
Other Activities

- Workforce Wednesdays
- Mapped Educational Ladders
- Designed BH Career Lattice
- AHEC Healthcare Careers Guide
- BH Jobs at Statewide Groups
- BH Education Round Table
Questions?

Geoff Vercauteren
Director of Workforce Development
Network4Health / Catholic Medical Center
2 Wall Street, Suite 200
Manchester, NH 03101
Mobile: 603-851-9387
geoffrey.vercauteren@CMC-NH.org
Community Health Workers

Bryan L’Heureux, MPH
Kaelea Monahan, Community Health Resource Specialist, General Internal Medicine
What Factors Determine Health?

Which of these areas could be influenced/supported/improved upon through work with a trusted individual from the community with knowledge of community resources?

Which of these factors can be influenced in the clinical setting alone?

Adapted from Remington et al, 2015
Community Health Workers Positioned for Impact

Primary goals of community health worker programs often two-fold:

- **Address social determinants of health**
  - Address and surface latent non-clinical needs that preclude clinical stabilization
  - Navigate patients to relevant social services for long-term support

- **Drive chronic disease self-management**
  - Support patients in achieving personal goals leading to improved outcomes
  - Drive health system engagement; navigate clinical appointments

Source: Population Health Advisor interviews and analysis.
Unaddressed Social Needs Lead to Clinical Escalation

Maria’s story

Maria suffers from diabetes, experiences elevated blood sugar

PCP advises change in diet

Maria is unsure of which new foods to eat and unable to afford fresh produce; continues same diet

Maria’s blood sugar reaches critical level; she calls 911

Maria is admitted to hospital with acute hyperglycemia
CHW Addresses Social Needs and Drives Self-Care

How Maria’s story could end

<table>
<thead>
<tr>
<th>PCP advises change in diet</th>
<th>Maria is unsure which new foods to eat and unable to afford fresh produce; continues with same diet</th>
<th>Maria’s blood sugar reaches critical level; she calls 911</th>
</tr>
</thead>
</table>

Maria suffers from diabetes, experiences elevated blood sugar

PCP stresses importance of change in diet and refers patient to CHW for support

CHW performs social needs screening and identifies that Maria is food insecure and without nutritional literacy

CHW connects Maria to local food bank and helps her sign up for SNAP¹; offers connections and support with ongoing education, healthy eating, food storage, and cooking

Maria understands how to keep healthy and can purchase healthy food; blood sugar stabilizes

Source: Population Health Advisor interviews and analysis.

¹Supplemental Nutrition Assistance Program.
CHW Program

• **Our Reach**
  • 6 Upper Valley CHWs
  • 1 Manchester CHW
  • 3 Manchester Family Support Specialists
  • 1 Concord Resource Specialist
  • 3 Keene Population Health Workers

• **Our Goals**
  • Promote common competencies amongst people doing SDoH Work
  • Collect data to incite change (both at the system and community level)
  • **Most Importantly**: Improve health of our communities through addressing social determinants of health
Upper Valley Team

- Heater Road Primary Care
  - Emily Duff
  - Lexi Bly
- OBGYN
  - Lindsey Lafond
  - Carol Sarazin
- General Internal Medicine (GIM)
  - Kaelea Monahan
- Young Adults, YourTurn Program
  - Jose Rodriguez
Connecting with Patients

- SDOH Screener
- Direct referrals from Providers
  - Phone call
  - Inbasket message through Epic
  - Face to Face
- Nurses/RN Care Coordinator
  - Inbasket message through Epic
  - Face to Face

- Locations for meeting places with patients:
  - DHMC Clinics
  - At their home, community settings, Dunkin Donuts, etc.
We know that many things can affect your health. Please help us understand your health better by letting us know if you struggle with any of the following.

1. What is your housing situation today? (circle one)
   - I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, in a park)
   - I have housing today but I’m worried about losing housing in the next 90 days
   - I have housing

2. In your housing situation, do you have problems with any of the following? (circle all that apply)
   - Bug infestation
   - Mold
   - Lead paint or pipes
   - Inadequate heat or hot water
   - Oven or stove not working
   - No smoke detectors or not working smoke detectors
   - Water leaks
   - None of the above

3. How hard is it for you to pay for the very basics like food, housing, heating, medical care and medications? (circle one)
   - Not hard at all
   - Somewhat hard
   - Very hard

4. If ‘somewhat hard’ or ‘very hard’, what do you have trouble paying for? (circle all that apply)
   - Food
   - Housing
   - Utility Bills (electric, etc.)
   - Childcare
   - Medical Needs (Medicines, doctor, etc.)
   - Debts
   - Other

5. Do you ever need help reading health related materials? (circle one)
   - Yes
   - No

6. Have you someone you could call if you need help? (circle one)
   - Yes
   - No

7. In the past 12 months, has a lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (circle all that apply)
   - Yes, it has kept me from medical appointments or getting medications.
   - Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need.
   - No

8. What was your main activity during most of the last 12 months? (circle one)
   - Worked for pay
   - Attended school
   - Household duties
   - Unemployed
   - Permanent unable to work
   - Other

9. Do you have any legal issues that are getting in the way of your health or healthcare? (circle one)
   - Yes
   - No

10. In the last 12 months, are you or have you been threatened or abused physically, emotionally or sexually by a partner, spouse or family member? (circle one)
    - Yes
    - No

11. How confident are you that you can manage your essential needs? (circle one)
    - Very confident
    - Somewhat confident
    - Not very confident

12. Please select the kind of help you would like for these essential needs? (circle one)
    - I do not need help
    - I already have help
    - I would like information about help
    - I would like help

Your health team looks forward to reviewing your answers!
PATIENT COMPLETES HEALTH QUESTIONNAIRE

- DEMOGRAPHICS
- SUBSTANCE USE
  - ANXIETY
  - DEPRESSION
  - ALCOHOL USE
- SOCIAL DETERMINANTS OF HEALTH

PCP & PATIENT DISCUSS CARE OPTIONS & MAKE A PLAN

- GENERAL HEALTH/WELLNESS
- FALLS
- COGNITIVE FUNCTION
- ADL/IADL

PCP GUIDES CARE TEAM OVERSEES CARE PLAN

- PCP
- Behavioral Health Clinician
- Support Specialist

I need help. We can help.

Patient

PCP

Care Team Coordinator
Pathways

- Standardize the way that CHWs deliver assistance
  - Confirms that the clients social needs are being adequately addressed
  - Quality assurance: Allows us to track that outcomes have improved for the client

- Allows CHWs to track the clients through the process
  - Specific, standardized methodology allows CHWs to work with clients on multiple pathways at a time

- Standardization allows us to collect meaningful data!
  - Data can then be used to inform growth, program development, and advocacy
Data Derived from REDCap

- Validate Program Growth
  - Are we able to support all the patients with a positive screen?
  - How can we expand to reach more clients?

- Inform Quality Improvements Internally

- Show Areas of Need
  - Where could we use community reform, support, or policy change to improve social determinants of health
Takeaway Messages

- Community Health Workers are a critical workforce needed to help address the social factors effecting health and quality of life for our patients.

- We are currently self funding 5 Community Health Worker Positions at Dartmouth-Hitchcock.
  - We have reached the end of our budget capacity to fund more of these roles ourselves.

- In order for CHW program sustainability and growth, alternative funding sources need to be explored.
  - CHW Certification Process.