

**Governor's Commission
on Health Care and Community Support Workforce**

**MEETING MINUTES
September 27, 2016
New Hampshire Hospital Association
Concord, NH**

Members Present: Susan Huard, Kathy Bizarro-Thunberg, Lisa DiMartino, Jon Eriquezzo, Todd Fahey, Mike Ferrara, Margaret Franckhauser, Yvonne Goldsberry, Brenda Howard, Judith Joy, Joelle Martin, Susan Reeves, Deb Scheetz

Guests: Chris Callahan, Exeter Health Resources; Suellen Griffin, West Central Behavioral Health, NH Community Behavioral Health Association; Patrick Miller, Pero Consulting Group; Peter Danles, NH Office of Professional Licensure

Staff: Leslie Melby, DHHS

Commission members approved the minutes of the August 23, 2016 meeting.

Dr. Huard announced that Manchester will be added as a public listening session for the Commission's draft recommendations.

PRESENTATION: Medical Assistant Training Initiative

Chris Callahan, Exeter Health Resources

In the face of the health care workforce shortage, the need for a team orientation with staff working to the top of their license, and the need to support population health management, Exeter Health's Core Physician Group (Core) changed the structure and staffing of their primary care offices. These changes necessitated hiring of more medical assistants (MAs). In addition, Federal "Meaningful Use" requires that only "certified" medical assistants can enter information into EMR systems in order to qualify for meaningful use dollars (\$3-4 million at Core practices).

Core immediately required 25 new MAs, but would have to wait two years for MAs with Associates degrees. Due to the low unemployment rate, there was no trained market from which to hire, and most MA training programs had been OJT, not certified eligible. Core partnered with Great Bay Community College (GBCC) to replicate a two-year Associates degree program based on a Navy medical clinic model that develops competencies within six months.

Program recruitment is a joint initiative: EH hires students based on employment criteria; GBCC screens students for educational readiness and completion of Work Ready Program. Clinical competencies were jointly developed into a 12-week program (8 weeks classroom; 4 weeks clinical rotation at Core offices). The program has evolved beyond Core, and includes other seacoast area providers.

Additional incentives were created to include guaranteed placement upon successful completion; training wage paid while in classroom and clinical rotation; full benefits during training; and 60% tuition paid by Core in exchange for work commitment for two years.

In 20 months, 34 students participated in the program, and 29 are still with Core. The MA vacancy rate at Core dropped from 20% to zero, and MA turnover rate was reduced to 15%. Core spent \$7000/student; student cost is \$2500. The total cost for Core was \$250,000.

Need to find a way within the educational system to take non-credit competencies and transition into credits toward advanced medical licensure status (LNA, LPN, RN). Need the ability to transition other traditional educational structures to more efficient models. Exeter Hospital has used this model to train LNAs through the Red Cross.

THE ASK:

1. Exeter Hospital is not eligible for DOL training funds due to “reimbursable status” of the unemployment compensation fund - a common problem among not-for-profit employers.
2. DOL is encouraging Apprenticeship Program participation without benefit to the healthcare industry as currently structured.
3. Financial assistance from Gateway to Work program would help students and employers underwrite the cost of training.
4. Ability to translate this education into credits toward advanced licensure status helps students
5. Ability to transition other traditional educational structures to more efficient models.

PRESENTATION: NH Community Behavioral Health Association (NHCBHA): Workforce Trends, Impacts and Solutions

Suellen Griffin and Patrick Miller, NHBHA

NHCBHA’s mission is to advocate for the sustainability of a high quality and effective system of behavioral health care in each of NH’s communities. Very few providers other than CMHCs offer services to individuals with severe and persistent mentally illness and Medicaid coverage. CMHCs serve 50,000 adults and children annually through a broad range of services.

CMHC Workforce Trends: NHCBHA is trying to understand workforce data at a more granular level. Data collection began in December 2015 and is the first longitudinal reporting summary. Includes reporting on Assertive Community Treatment (ACT) and Supported Employment (SE) postings under the CMH Agreement, and was expanded to all postings.

Vacant postings have increased from 155 February 2016 to 173 open postings in August 2016. Vacancies in September will likely reach 200. The most difficult positions to fill are APRNs and MDs - 8.5-9%, which are competing directly with FQHCs and hospitals. In terms of wages, the mean wage gap for APRNs is \$4,000-15,000, and MDs is \$22,000-\$48,000. 83% of postings are positions requiring BA and MA degrees. The wage gap for masters licensed therapists is even greater than for APRNs and MDs. Turnover rates are 19% statewide, and increasing to 27-37% by the end of 2016. Filling positions takes an average of 113 days, as high as 153 days in the North County.

The impact of vacancies on clients is significant - less individualized care, risk of decreasing timely access, increased wait list, reduced continuity of care, risk to patient quality of care with staff in constant training mode, and decreased ability to meet the requirements of the community mental health agreement which includes mobile crisis teams. The impact on the CMHCs is lower staff morale, increased turnover, an increased use of locums and overtime, increased cost of recruitment. Staff stay for much shorter periods of time. CMHCs are at risk of losing capitation for failure to meet Maintenance of Effort. Lack of funding impacts their ability to be competitive because they cannot raise salaries.

Proposed Solutions:

Financial: Increase Medicaid rates from 2006 levels; expand student loan forgiveness programs; provide incentives for graduate education; provide funding for Fair Labor Standards Act regulation (need to reduce overtime for staff making less than \$47,000).

State Policies: Remove impediments to licensing out-of-state providers (need reciprocity provisions to eliminate situations such as requiring an experienced social worker to provide original supervisory documents); reduce administrative paperwork (regulatory paperwork for CMHCs vs. private practice); eliminate silos within NH DHHS (different documentation and billing requirements for SUD and BH).

Federal Policies: Ask CMS to allow APRNs to sign treatment plans for services within their scope of practice; modify telehealth payment rules to reflect physician shortages in all geographic areas; eliminate “incident to” Medicare billing requirements for MD on-site.

Shared CMHC Practices: Allow shared resources for Assertive Community Treatment teams; online training programs (every day of training results in lost patient care and revenue); Continue to collect data on vacancies to share

Questions:

Q: Will the state’s Delivery System Reform Incentive Payment (DSRIP) Program modify these problems?

A: Every center is involved in DSRIP. They are hoping for solutions. However, costs are non-sustainable after five years.

Comment: The first DSRIP statewide workforce meeting was held last week. The state recognizes the need to make solid investments going forward. The integrated delivery networks (IDNs) are looking forward to working with CMHCs and working to align workforce efforts.

Q: Are CHMCs collecting data on people not receiving care and possibly ending up in jail?

A: No, but they know who’s on the waitlist and who are in hospital emergency rooms. They don’t tend to end up in jail.

PRESENTATION: New Hampshire Licensing

Peter Danles, Office of Professional Licensing and Certification (OPLC)

OPLC is a new agency and lacks a strategic plan. A lot of what IS done has no measurable output. There should be a process, timeline, and a way to determine how long it takes to get licensed. Once OPLC staff receive application materials, it should not take more than a week to complete a license.

A list of licensed health care workers was provided. Allied health professionals (radiology techs, respiratory therapists, PT, ST, OT, med techs will be forthcoming.

Q: Direct service providers are trained by consumers. If we wanted to have mandatory training for DSPs certification, how can we set this up?

A: There’s the risk that certification or licensure will limit the workforce; and if licensed, how will the state regulate and enforce that field?

Comment: How can we professionalize the DSP field? Licensing and certification do not necessarily accomplish that. What is the career lattice moving forward. Consider pros and cons.

Q: How many of the nurses licensed are practicing in NH? What is the breakdown among different types of nurses? We need a plan to know how many people are practicing. The list of licensees does not provide the right information to plan for the workforce shortage.

Q: How will OPLC solicit input from licensees to help inform your strategic plan since there are varying experiences in process and outcomes?

A: Will begin by bringing all boards into electronic interfacing process. Use My Licensing Online: internet licensing process.

Comment: As the strategic plan is developed, consider eliminating impediments to licensure in a state like NH where there's a workforce shortage. Consider annulment of criminal record where appropriate.

Comment: The application of these rules may be too rigid, for example, retired workforce may want to work part time. We should make it easier for retirees to enter the workforce.

A: need to be careful about people's competencies.

Comment: Board of Nursing staff are empowered to process a license if a nurse has submitted all the proper requirements. However, a physical therapist must wait for the Allied Health Board to meet in order for the license to be issued. If this is allowed for one Board, it should be allowed for all Boards.

A: Mr. Danles agreed.

Q: The problems in processing applications are due in part to reductions in staff. Since the Boards are self-funded, there's no reason to delay processing.

A: Licensing clerks are being cross-trained, and there will be three new positions (assigned to the Board of Medicine, Board of Allied Health and one floater for the technical boards).

Comment: Consider reducing barriers if you onboard new staff sooner. This should be a Commission recommendation.

WORK SESSION: DRAFT RECOMMENDATIONS

Draft recommendations were reviewed and discussed. The suggestion was made to collapse the categories into four themes (or pillars)

1. Licensure/regulations - financial support of boards
2. Data Collection
3. Education - recruitment/training ladders (innovative education and training programs)
4. Financial - salary, reimbursement rates, loan repayment (SLRP),

Include behavioral health practitioners/SUD treatment providers under each category
State loan repayment program goes under financial.

Suggestions:

Education/Training:

- Support innovative educational programs. However, more discussion is needed before a recommendation is made to replicate a particular training program.
- Develop mechanisms to evaluate outcomes.
- Develop another family medicine requirement

Data collection:

- Establish minimum data requirements - define what you need to know about
- Add DSPs to data collection. Under first recommendation, remove contractual obstacles to paying people a living wage.

Financial:

- Need affordable housing for workforce. Consider Accessory Dwelling Unit legislation

- Give homeowners a property tax credit to offer low rent units.

Licensure:

- Permit those individuals convicted of minor offenses to use the annulment process in order to be eligible to work
- Give older workers a break on the licensure fees.

Report:

- Place all presentations at the end of the final report with links to website where posted.
- Include the words, "Behavioral Health/SUD crisis"
- List examples of areas for further exploration; recommend another commission to examine specific issues.
- Offer innovative solutions for new leadership to start with which are not endorsements, but more than documenting the problems.

PUBLIC COMMENT:

Michele Peterson, Bi-State Primary Care. There was a home share program at the Moore Center, matching up elderly people who wanted to stay in their homes with workers.

Dave Ouellette, DD Council

The work on DSPs and home care is so important. In the past, the response has been that we cannot afford this service.

Next meeting: October 25, 2016

Presentations: NH AHECs, Office of Minority Health, NH Health Care Association

Work session on recommendations.

**Addendum
Minutes of September 27, 2016**

Presentation: Licensure

Q: NPI: In order to get a handle on the size of the workforce supply, and specifically, the number of actively practicing providers in New Hampshire, as well as to plan for the allocation of limited workforce development and recruitment resources, requests have been made to the Board of Medicine to collect NPI as part of the licensing process. Can the Board collect NPI on its licensure forms?

A: The Board, at its September 7, 2016 meeting, reviewed the request from Public Health and requested they include the request for NPI numbers on their survey they send to our licensees. The Board did not vote to collect the NPI numbers. If this was to happen in the future, a rule change would be required.

Q: Electronic licensure renewals; Continuing education: Providers have expressed concern about the lack of electronic licensure renewals for some specialties, as well as the lack of ability

to track their continuing education directly with the licensing boards. What do the Boards currently do regarding online applications and renewals, and are they considering electronic applications/renewals for all disciplines?

A: We have a semi-online process for initial application for physicians only. The physicians are required to complete the Federal Credentials Verification Service (FCVS) packet, then go online and complete the "Uniform Application" for New Hampshire licensure. The FCVS prepopulates the Uniform Application with a lot of the information submitted for the FCVS. We can then pick up the Uniform Application and the FCVS packet through the Federation of State Medical Boards' website, however, the remainder of the application requirements are sent in to the Board by mail.

As far as renewals for our licensees, we are in the beginning phases of moving to MLO. As I understand it, we will then be able to have licensees renew online. Continuing education for physicians is reported through the NH Medical Society, pursuant to RSA 329:16-g. Right now, that is done by snail mail, or e-mail. However, I have heard that the NH Medical Society is investigating the ability to track the CMEs electronically.