

State of Connecticut  
State Innovation Model  
Health Workforce Task Force Meeting  
June 25, 2013  
2:30pm-3:30pm

- Our charge
  - Commissioner Mullen: UConn/DPH partnership. Bi-institutional commitment to address the needs of CT to be healthy
  - Dean Torti: sense of partnership, challenge, short-time frame, creative energetic to get this done and we will
  - Ron: goes over the agenda, major elements of what we need to produce for SIM project and the application to follow
    - Address these statements fundamentally, frame the issue
- Discussion:
- What are the current CT health workforce challenges
  - Ann Ferris worked on this – difficult task because the data has never been collected in a real time way
  - Rob Aseltine has also worked on this data
  - Dean Torti: when we went to Storrs to have discussion we didn't have discussion about DPH
  - Report will be done on Friday – don't have the deliverable yet, did a preliminary report for the 18<sup>th</sup>, actual deliverable is the 28<sup>th</sup>
  - 61 professions that DPH licenses – much more about the places where people live rather than where they get there care
  - what will the workforce in the future look like?
    - there are bits and pieces – allied health workers, people aging in place rather than in a facility, we have to go beyond the workforce that we are licensing
  - Begin to define the broader view for the community
  - Who are the people that we might not have captured in the health worker community?
    - Great proliferation of certification – what does this array amount to? Are they doing training for the provider community and what the system needs and wants. How will these people fit with in the system in the future.
    - Career ladder issue – caste system
    - Health disparities issue – demographics
    - Dr. Silbart - 80 professions under Allied Health at UConn – spans a wide range of degrees, certificates, etc.

- Commissioner Mullen – probably too big to think about all of workforce in the state - Care model, scope of practice should not part of this, filling the gap for electronic health records – HIT helper
- Suzanne Rose – innovation and thinking about the future of health workforce
- What should CT’s workforce development priorities be – certain themes that occur, advanced primary care practice, community health workers that help navigate the system – approaches to health disparities
  - Dean Torti -What are the functions that we need served? Sets of people that might serve these roles
  - George Kuchel – focus on the needs of the patients/community. How can we predict the health care needs in the future? We only know what the needs are right now.
  - We presume that better health and quality of care leads to lower cost
  - Getting population health back and integrate it into care delivery
  - Team approaches to health care – how do you train physicians and nurses differently as part of the same team?
- What initiatives are now underway to address these priorities
- How might these initiatives best be enhanced and augmented? What are our available resources for the task
- What models should be included for funding in CT’s SIM plan and subsequent “model testing” proposal – preliminary ideas
  - Devise a better system than what we have now
  - Potential models of health care delivery –
    - “Population” model: look at problems we have now – aging population, define problems – define functions (primary care prevention), then look at the providers that we will need to take care of problems, do we need a team approach?
    - “Pod” model: Suzanne Rose: Primary Pods and satellite pods, specialty pods - of people working in different centers – prevention, cures, efficiency, electronic – would like to see the pods overlap more and communication and hand – offs throughout
    - “Healthy community” model: Ann Ferris: what things are needed to keep a community healthy? Define the baseline community to see what is needed for health care. Starting with the community and then what is really needed in addition.
    - Regardless of the model – what are the regulatory things that need to happen – allowing for flexibility – defining functions and competencies – looking at competencies for the “health model” and the “ill model” and how they overlap
    - DHMAS – managed medical homes – interact with primary care – struggling with present day workforce, need to speak primary care language – behavioral health – Public mental health – behavioral health integrated into primary care

- Wrap up and scheduling and agendas for future meetings
- CMMI guidance from McKinsey – looking for an answer among three major topics
- Capacity – people who can provide primary care services, model should reach 80% of population – address regional shortfalls
  - Put this onto a geographic map
  - Non-traditional capabilities – care coordination, whole-person centered, patient follow-up how do we create the capacity within non traditional roles
- Improve skill mix – people operating at the top of their license
- On going training: Real-time training for providers – practice transformation, learning collaborative
- PCP model:
- Care coordination:
- YEAR ONE: what would you do first? George Kuchel
  - Build on strength you already have, expand skill sets of providers from the education perspective – multi-disciplinary approach
  - How do you work in a team regardless of what your profession is?
  - Expand provider skill sets to move in a horizontal way
  - Focus on high priority populations – prevalence, cost, poor outcomes
- Product: what must this work group deliver and when?
  - Ron: Create a workforce section of the plan – how long a section should this be? 20 page workforce section as a larger part of the plan.
    - This is what the workforce is now and this is what needs to happen to fulfill the vision of the overall plan
    - CMMI – learns and grows as it goes along – population health is an example
      - There will still be some fee for service
    - Current capacity report of primary care workforce
- What do we want to achieve?
  - Commissioner Mullen – she knows how passionate people are about their students and the future – we should think about what we will do in the future
  - Dr. Zavoski – we can't spend too much time on the data, we know a lot, technology is important, health care growth is in the ER, if we think primary care is the answer then we need to make primary care look like the Emergency Department
  - Mark (DPH) – service mental health, primary care, mental health to see if they accept new patients, direct patient care, medicare, wait time to get an appointment and wait time in the waiting room, survey to see who will be retiring, recruitment and retention into the state and how to retain them, submit this data to HRSA – health professional shortage area

- HPSA – recruit professions from primary care service core – 5 counties in the state have mental health HPSA – severe shortages of psychiatrists – improve health outcomes of the residents
- Next steps: identify more answers for some of these questions, sit around to discuss the draft
  - Ron will be meeting again with folks individually
- Timetable: draft due by early August
- Meet as a group weekly to participate in the draft – define a group – engage as many people as possible to work on this – we need people from different areas of work
- If you are interested email Ron [preston@uchc.edu](mailto:preston@uchc.edu)
- Milestones: workforce analysis can be distributed from Ann, care delivery model, smaller team writing the draft
- Schedule two more meetings for the larger group before August
- Commissioner Mullen: you need input from different people, smaller areas of interest