

HEALTH WORKFORCE COUNCIL

Tuesday, August 6th – 1:00 p.m. to 5:00 p.m.

John A. Cherberg Building, Conference Rooms B/C

304 15th Ave SW, Olympia, WA 98501

Call in: (571) 317-3122 | Access Code: 398-108-469

AGENDA

- 1:00 p.m. **Welcome and Introductions**
Suzanne Allen, Council Chair
- 1:10 p.m. **Legislative Update & Health Workforce Implications**
Greg Attanasio, Senate Health & Long-Term Care Committee
- 2:00 p.m. **Washington’s Home Care Workforce: Perspectives & Discussion**
Bea Rector, Department of Social and Health Services
Kelley Lee, ResCare
Amy Persell, SEIU 775 Benefits Group
Briajsa (Bri) Bolden, Peer Mentor & Home Care Aide
- 3:30 p.m. **Break**
- 3:40 p.m. **Health Workforce Sentinel Network Update**
 - Sentinel Network Operations: Funding, responses to round 6, and proposed timing for round 7 – *Sue Skillman & Ben Stubbs, University of Washington Center for Health Workforce Studies*
 - Uses of SN Findings – *Sharon Afforde, WorkSource Seattle-King County*
 - Possible HWC actions based on recent SN findings – *Sentinel Network Steering Committee*
- 4:20 p.m. **Accountable Communities of Health: Year 3 Lessons & Challenges**
Carol Moser, Greater Columbia Accountable Community of Health
Jean Clark, Cascade Pacific Action Alliance
- 4:50 p.m. **Wrap-Up**
Suzanne Allen, Council Chair
Nova Gattman, Council Staff Coordinator
- 5:00 p.m. **Adjourn**

Health Workforce Bills and Budget Items of Interest As Passed the 2019 Legislative Session

Bills Passed

HB 1349 CLARIFYING THE DEFINITION OF A GERIATRIC BEHAVIORAL HEALTH WORKER FOR INDIVIDUALS WITH A BACHELOR'S OR MASTER'S DEGREE IN SOCIAL WORK, BEHAVIORAL HEALTH, OR OTHER RELATED AREAS

Prime Sponsor: Representative Schmick

- Allows a person to work as a geriatric behavioral health worker in a nursing home if they have a bachelor's or master's degree in social work or behavioral health.

ESHB 1768 CONCERNING SUBSTANCE USE DISORDER PROFESSIONAL PRACTICE

Prime Sponsor: Representative Davis

- Directs the Department of Health (DOH) to create a co-occurring disorder specialist enhancement for master's level mental health professionals and social workers which allows them to treat clients for substance use disorders who have a co-occurring mental health disorder.
- Renames chemical dependency professionals as substance use disorder professionals (SUDPs).
- Expands options for professionals who may provide supervision towards licensure for applicants for certification as an SUDP or co-occurring disorder specialist.
- Changes references to the goal of chemical dependency counseling from assisting clients to achieve and maintain abstinence to assisting clients in their recovery.
- Prohibits DOH from requiring an applicant to be an SUDP or substance use disorder trainee to participate in a voluntary substance abuse monitoring program after the applicant has one year of recovery from a substance use disorder.
- Prohibits DOH or a facility that cares for vulnerable adults from automatically denying certification or employment as a SUDP based on certain convictions after one year of recovery from a substance use disorder or untreated mental health disorder.
- Directs DOH to conduct a sunrise review to evaluate the need for creation of a bachelor's level behavioral health professional credential.

2SHB 1394 CONCERNING COMMUNITY FACILITIES NEEDED TO ENSURE A CONTINUUM OF CARE FOR BEHAVIORAL HEALTH PATIENTS

Prime Sponsor: Representative Schmick

- Requires the Health Care Authority (HCA) to assess community capacity to provide long-term inpatient care to involuntary patients and contract for such services to the extent that certified providers are available.
- Suspends the certificate of need requirement relating to construction of psychiatric beds or expansion of psychiatric bed capacity until June 30, 2021.
- Requires the Department of Health to license and certify intensive behavioral health treatment facilities, mental health peer respite centers, and to allow an enhanced rate to be paid to nursing homes that convert to assisted living or residential treatment facilities.
- Requires HCA to establish a daytime mental health drop-in center pilot in Yakima until July 1, 2022, and issue a report by December 1, 2021.

SB 5054 INCREASING THE BEHAVIORAL HEALTH WORKFORCE BY ESTABLISHING A RECIPROCITY PROGRAM TO INCREASE THE PORTABILITY OF BEHAVIORAL HEALTH LICENSES AND CERTIFICATIONS

Prime Sponsor: Senator O'Ban

- Creates a reciprocity and probationary license program for chemical dependency professionals, social workers, marriage and family counselors, mental health counselors, and psychologists licensed in another state.

SHB 1198 REQUIRING HEALTH CARE PROVIDERS SANCTIONED FOR SEXUAL MISCONDUCT TO NOTIFY PATIENTS

Prime Sponsor: Representative Caldier

- Requires a health care provider to notify patients if the provider has been sanctioned for acts of unprofessional conduct involving sexual misconduct and is subject to an order or stipulation issued by a disciplining authority.

HB 1432 CONCERNING HOSPITAL PRIVILEGES FOR ADVANCED REGISTERED NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

Prime Sponsor: Representative Cody

- Requires hospitals or health care facilities to collect certain information from physician assistants and advanced registered nurse practitioners before granting or renewing clinical privileges.
- Requires hospitals or facilities to notify the Nursing Care Quality Assurance Commission or Medical Quality Assurance Commission of any denied privileges.

HB 1554 CONCERNING DENTAL HYGIENISTS

Prime Sponsor: Representative Thai

- Allows the holder of an initial limited dental hygiene license to obtain a temporary endorsement to administer nitrous oxide analgesia.
- Requires the holder of a limited dental hygiene license to complete education on the administration of local anesthesia and nitrous oxide analgesia to renew their limited license.
- Adds a dental hygienist as a member of the Dental Hygiene Examining Committee.

HB 1753 REQUIRING A STATEMENT OF INQUIRY FOR RULES AFFECTING FEES RELATED TO HEALTH PROFESSIONS

Prime Sponsor: Representative Riccelli

- Requires the Department of Health and disciplining authorities to file a statement of inquiry prior to adopting any rules that set or adjust fees affecting health professions.

SHB 1865 REGULATING THE PRACTICE OF ACUPUNCTURE AND EASTERN MEDICINE

Prime Sponsor: Representative Cody

- Changes the terms "East Asian medicine" to "acupuncture and Eastern medicine" and "East Asian medicine practitioner" to "acupuncturist or acupuncture and Eastern medicine practitioner."
- Directs the Department of Health to adopt a rule requiring acupuncturists to complete continuing education.
- Repeals laws related to the approval of applications and requiring an examination fee for East Asian medicine practitioners and application of the East Asian medicine chapter to previously registered acupuncture assistants.

2SSB 5846 CONCERNING THE INTEGRATION OF INTERNATIONAL MEDICAL GRADUATES INTO WASHINGTON'S HEALTH CARE DELIVERY SYSTEM

Prime Sponsor: Senator Saldaña

- Creates the international medical graduate (IMG) work group to develop recommendations for the creation of an IMG assistance program.

SSB 5386 CONCERNING TRAINING STANDARDS IN PROVIDING TELEMEDICINE SERVICES

Prime Sponsor: Senator Becker

- Permits health care professionals who provide telemedicine services to complete a telemedicine training made available by the telemedicine collaborative.

SB 5387 CONCERNING PHYSICIAN CREDENTIALING IN TELEMEDICINE SERVICES

Prime Sponsor: Senator Becker

- Permits an originating site hospital to rely on a distant site hospital's decision to grant credentials and clinical privileges, when granting or renewing credential and privileges of any physician providing telemedicine or store and forward services.

Budget Items

Behavioral Health Tele-Consultation (Health Care Authority, \$4.8 million)

Funding to create and operate a tele-behavioral health video call center staffed by the University of Washington's department of psychiatry and behavioral sciences. The center must provide emergency department providers, primary care providers, and county and municipal correctional facility providers with on-demand access to psychiatric and substance use disorder clinical consultation.

Skilled Nursing Services Rate Increase (Health Care Authority)

Appropriate funding is provided to increase the hourly rate by ten percent for registered nurses and licensed practical nurses providing skilled nursing services for children who require medically intensive care in a home setting.

Tribal Dental Health Aid Therapist Reimbursement (Health Care Authority, \$6.65 million)

Funding to reimburse for dental health aid therapist services performed in tribal facilities for Medicaid clients.

SUD Peer Support Services (Health Care Authority, \$17 million)

Funding to implement the Medicaid state plan amendment which provides for substance use disorder peer support services to be included in behavioral health capitation rates beginning in fiscal year 2020. HCA must require managed care organizations to provide access to peer support services for individuals with substance use disorders transitioning from emergency departments, inpatient facilities, or receiving treatment as part of hub and spoke networks.

Online Behavioral Health Training (Health Care Authority \$550,000)

Funding for implementation of E2SHB 1874. Requires HCA to provide online training to behavioral health providers related to state law and best practices in family-initiated treatment, adolescent-initiated treatment, and other services.

SUD Model Programs and Curricula (Health Care Authority, \$1 million)

Funding for the University of Washington behavioral health institute to develop and disseminate model programs and curricula for inpatient and outpatient treatment for individuals with substance use disorder and co-occurring disorders. The institute must provide training to staff of behavioral health agencies to enhance the quality of substance use disorder and co-occurring treatment delivered.

Nursing Staff in LTC Settings (Department of Health, \$100,000)

Funding provided for the Nursing Care Quality Assurance Commission to continue a workgroup to develop strategies to address the shortage of nursing staff in long-term care settings.

Midwifery Supplemental Revenue (Department of Health, \$300,000)

Funding to supplement the midwifery licensure and regulatory program. Midwifery licensing fees are capped at \$525 annually.

Behavioral Health Clinical Training Workgroup (Department of Health, \$420,000)

Funding for a work group to develop policy and practice recommendations to increase access to clinical training and supervised practice for the behavioral health workforce.

Online Hepatitis Treatment Training (Department of Health, \$175,000)

Funding for an online tutorial and link to web-based continuing education funded by the CDC for training for the primary care health workforce regarding the protocols for perinatal monitoring, birth-dose immunization, early diagnosis, linkage to care, and treatment for persons diagnosed with chronic hepatitis B or hepatitis.

Acuity-Based Staffing At Eastern and Western State Hospitals (Department of Social and Health Services, \$135 million)

Funding to continue to implement an acuity-based staffing tool at Eastern and Western State Hospitals in collaboration with the hospital staffing committees. The staffing tool must be designed and implemented to identify, on a daily basis, the clinical acuity on each patient ward and determine the minimum level of direct care staff by profession to be deployed to meet the needs of the patients on each ward.

Assisted Living Providers Rate Increase (Department of Social and Health Services, \$27.6 million)

Funding to increase rates for assisted living facility providers.

Adult Day Care Providers Rate Increase (Department of Social and Health Services, \$1.5 million)

Funding to increase rates for adult day care and adult day health providers.

Washington's Health Workforce Sentinel Network

Examples of Findings from Behavioral/Mental Health and Substance Use Disorder Clinics

Representatives from behavioral/mental health and substance use disorder clinics provided information to the Washington State Health Workforce Sentinel Network six times between Summer 2016 and Spring 2019. This summary highlights some of the information they provided, with an emphasis on the most recently submitted data. Additional findings from behavioral health clinics can be found on the Sentinel Network dashboard (wa.sentinelnetwork.org) as well as for other types of health care facilities.

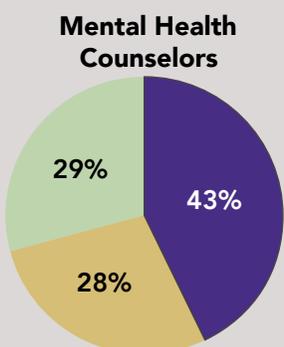
Behavioral health clinics* - Occupations with exceptionally long vacancies: 2016-2019

Top occupations cited as having exceptionally long vacancies by date of reporting					
Summer 2016	Winter 2016	Spring 2017	Fall 2017	Summer 2018	Spring 2019
Mental health counselor	Chemical dep. prof.	Chemical dep. prof.** Mental health counselor**	Chemical dep. prof.	Mental health counselor	Mental health counselor
Chemical dep. prof.	Mental health counselor	Social worker	Mental health counselor	Chemical dep. prof.** Peer Counselor**	Chemical dep. prof.
Social worker	Psychiatrist** Social worker**	Nurse practitioner	Nurse practitioner** Social worker**	Nurse practitioner	Social worker
Nurse practitioner	Nurse practitioner	Registered nurse	Peer Counselor	Psychiatrist** Social worker**	Marriage & family therapist
Registered nurse** Psychiatrist**	Marriage/Fam Couns.	Marriage/Fam Couns.** Lic. Practical Nurse**	Psychiatrist	Mult. occ.s cited at same frequency	Peer Counselor** Psychiatrist**
# facilities reporting	29	16	33	12	25

most cited ↑

*Behavioral-mental health clinics/outpatient mental health and substance use disorder clinics
** tied in rank (# of times occupation was cited by Sentinels) in reporting period

Reasons for exceptionally long vacancies for most frequently cited occupations (Spring 2019)



Mental Health Counselors

- 43% Not enough qualified applicants
- 28% Recruitment and retention problems not related to salary/wage/benefits
- 29% Salary/wage/benefits issues

Mental health counselors - Examples of reasons for exceptionally long vacancies

Not enough qualified applicants

- There are not enough qualified staff in the state.
- There are not enough licensed MHC's in the area and among interns who could potentially see clients, there is no reimbursement. We turn away requests for services daily.
- Less candidate volume, decreasing over the past year

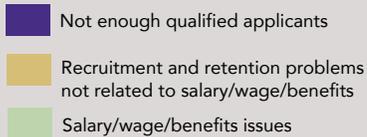
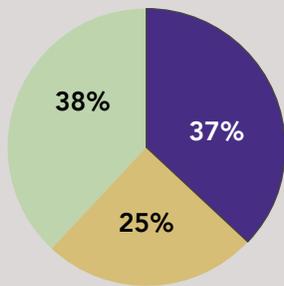
Salary/wage/benefits issues

- Individuals with Associate Licenses who still need to complete clinical hours cannot be hired because we cannot bill health insurance and have no other source of funds to pay them.
- BHOs / MCOs / Medicaid have not increased mental health rates for almost 3 years.

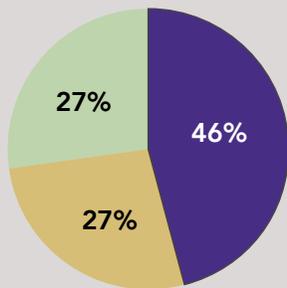
Recruitment and retention problems (not related to salary/wage/benefits)

- Most applicants do not meet the minimum qualifications.
- ...long delays in health plan credentialing and paneling have prevented providers we have hired from being able to see clients.
- We are referred a large number of people whose insurance is Medicare, but only licensed social workers can treat them.
- Difficulty finding affordable housing and childcare in the area.

Chemical Dependency Professional/ Substance Use Disorder Counselor



Social Worker – Mental Health and Substance Abuse



Chemical dependency professional/Substance use disorder counselor - Examples of reasons for exceptionally long vacancies

Not enough qualified applicants:

- There are not enough qualified staff in the state. Many older CDPs are retiring.
- Not enough local CDPs, and market wages are not sufficient to attract out of area candidates.

Salary/wage/benefits issues

- BHOs / MCOs / Medicaid have not increased SUD rates for almost 3 years.
- We have increased salaries and benefits but still do not get many qualified applicants

Recruitment and retention problems (not related to salary/wage/benefits)

- Rural areas have this challenge
- Many are CDPT (trainees) seeking hours to become qualified. This requires additional supervision hours and tasks on our part to manage them.

Social worker (Mental Health and Substance Abuse) - Example of reasons for exceptionally long vacancies

Not enough qualified applicants:

- Our county is very rural and difficult area to recruit staff to locate here. Wages are competitive and benefits are excellent. We have had positions open for over a year.
- Lack of applicants

Salary/wage/benefits issues

- There are not enough licensed LICSW's in the area and among interns who could see clients, there is no reimbursement. Among LICSW's who are becoming credentialed with insurance, very few are agreeing to see patients with Medicare. Our agency is committed to seeing people with this insurance, but we cannot get qualified therapists. We turn away requests for services daily.

Recruitment and retention problems (not related to salary/wage/benefits)

- Competition among all providers for qualified clinical social workers willing to work in public mental health and go to client's homes

Orientation and training changes for chemical dependency professional/Substance use disorder counselor (Spring 2019)

Examples of changes to orientation/onboarding for new employees

All employees: We have implemented a new more comprehensive New Hire Orientation for all employees. This is a 3 day orientation and CPI training that all employees go through. We have seen a significant increase in our retention rates as a result.

Multiple occupations: New rules and regulations and contract requirements. Significantly increased orientation to EMR.

Examples of changes in training needs for incumbent workers

Multiple occupations: New rules and regulations and contract requirements. Significantly increased training in EMR and clinical documentation

Mental health counselors: We have searching for ways to create externally funded programs for which we can hire interns, or associate-level therapists who need clinical hours toward licensure and to provide supervision so that they develop the skills needed to become good therapists. Prefer dually credentialed MHP/CDP.

Chemical dependency professional/SUD counselor: More exhaustive and detailed training to bring interns up to speed in ever-changing field

About the Washington Health Workforce Sentinel Network

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Why become a Sentinel? As a Sentinel, you can:

- Communicate your workforce needs and ensure that the state is prepared to respond to the transforming healthcare environment.
- Have access to current and actionable information about emerging healthcare workforce needs.
- Compare your organization's experience and emerging workforce demand trends with similar employer groups.

To view an interactive summary of findings and to provide information from your organization: www.wasentinelnetwork.org.

Contact: healthworkforce@wasentinelnetwork.org

Washington's Health Workforce Sentinel Network

Examples of Findings from Federally Qualified Health Centers or Community Clinics

Representatives from federally qualified health centers (FQHCs) or community clinics providing care free or on sliding fee scale provided information to the Washington State Health Workforce Sentinel Network six times between Summer 2016 and Spring 2019. This summary highlights some of the information they provided, with an emphasis on the most recently submitted data. Additional findings from these community health centers can be found on the Sentinel Network dashboard (wa.sentinelnetwork.org) as well as for other types of health care facilities.

FQHCs and community clinics* - Occupations with exceptionally long vacancies: 2016-2019

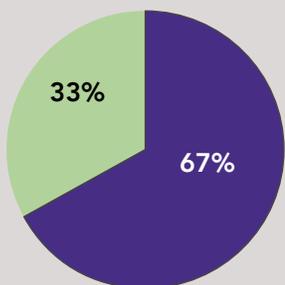
Top occupations cited as having exceptionally long vacancies by date of reporting					
Summer 2016	Winter 2016	Spring 2017	Fall 2017	Summer 2018	Spring 2019
Registered nurse** Physician/Surgeon**	Medical assistant	Physician/Surgeon	Medical assistant** Physician/Surgeon** Registered nurse**	Physician/Surgeon	Medical assistant
Mental health counselor	Nurse practitioner	Social worker, clinical	Dental assistant** Mental health couns** Nurse practitioner**	Registered nurse	Physician/Surgeon** Dental assistant** Registered nurse**
Medical assistant	Dental assistant** Registered nurse**	Mental health counselor	Mult. occ.s cited at same frequency	Medical assistant	Mental health counselor
Nurse practitioner	Physician/Surgeon	Mult. occ.s cited at same frequency		Dental assistant** Mental health counselor**	Chem. dep. couns.** Nurse practitioner** Dental hygienist**
Dental assistant** Social worker**	Mental health counselor	Mult. occ.s cited at same frequency		Mult. occ.s cited at same frequency	Mult. occ.s cited at same frequency
# facilities reporting	18	18	23	13	20

most cited ↑

*Federally qualified health centers and community clinics providing care free or on sliding fee scale
**tied in rank (number of times occupation was cited by Sentinel) in reporting period

Reasons for exceptionally long vacancies for most frequently cited occupations in FQHCs and community health clinics (Spring 2019)

Medical Assistants



Not enough qualified applicants
Salary/wage/benefits issues

Medical assistants - Examples of reasons for exceptionally long vacancies

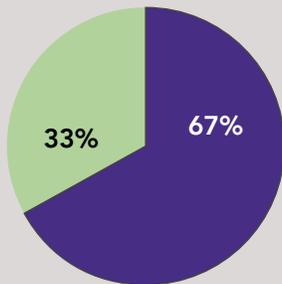
Not enough qualified applicants

- Not enough bilingual Spanish/English speaking certified MAs.
- Shortage of qualified candidates. Few schools graduating qualified candidates.

Salary/wage/benefits issues

- Better than dental assistants but still difficult to fill, we usually have to wait for externs to finish their rotation with us to then be able to hire them.

Dental Assistants



Dental assistants - Example of reasons for exceptionally long vacancies

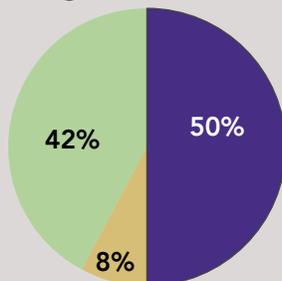
Not enough qualified applicants:

- This is the hardest position in the organization to fill. There are not enough DAs in the workforce right now!!!
- Not meeting Bilingual qualifications disqualified many applicants.
- Not getting hardly any candidates to even be able to make offers to, when we do they are looking for higher pay.

Salary/wage/benefits issues

- We also cannot pay what private practices are paying.

Registered Nurses



Registered nurses - Example of reasons for exceptionally long vacancies

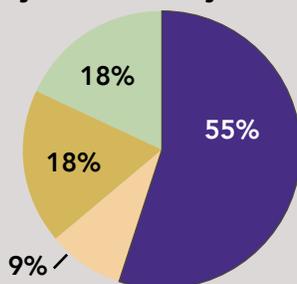
Not enough qualified applicants:

- Lack of Nurse in the Psych field

Salary/wage/benefits issues

- We get RN's applying, however, as a non-profit we are often told when they decline our offers that the pay is too low compared to the hospital systems.
- Hospital salaries are outpacing what an FQHC can provide.

Physicians - Family Medicine



Physicians: Family Medicine - Example of reasons for exceptionally long vacancies

Not enough qualified applicants:

- National shortage.

Salary/wage/benefits issues

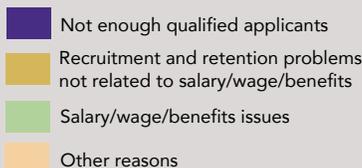
- We recently had to increase salaries for this position in order to stay competitive.

Recruitment and retention problems not related to salary/wage/benefits

- Location- desire to join practice with more than one Provider in specialty
- Offered 3 visa applicants and none of them accepted, still recruiting. Providers are getting hard to find.
- Intensity of job is challenging.

Other reasons

- We are also very rural and hospitals are struggling to keep ob services which makes candidates uncomfortable.



Orientation and training changes in FQHCs and community clinics (Spring 2019)

Examples of changes to orientation/onboarding for new employees

Medical assistants: Hired an MA trainer/manager to revamp our MA onboarding and skills training program

Multiple occupations: We added sections on diversity and inclusion as well as revamped the cultural competency and health disparity aspects.

RNs: Development of competency checklist for onboarding of new RNs as well as training of current RNs in case management and population health management.

About the Washington Health Workforce Sentinel Network

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Washington's Health Workforce Sentinel Network

Examples of Findings from Small Hospitals

Representatives from small acute care hospitals (25 beds or fewer) provided information to the Washington State Health Workforce Sentinel Network six times between Summer 2016 and Spring 2019. This summary highlights some of the information they provided, with an emphasis on the most recently submitted data. Additional findings from small hospitals can be found on the Sentinel Network dashboard (wa.sentinelnetwork.org) as well as for larger hospitals and other types of health care facilities.

Small Hospitals (<25 beds) - Occupations with exceptionally long vacancies: 2016-2019

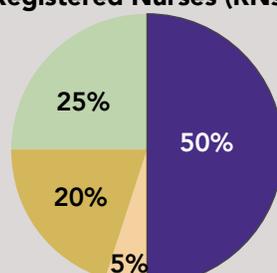
Top occupations cited as having exceptionally long vacancies by date of reporting					
Summer 2016	Winter 2016	Spring 2017	Fall 2017	Summer 2018	Spring 2019
Registered Nurse	Registered Nurse	Registered Nurse	Registered Nurse* Physical therapist*	Registered Nurse	Registered Nurse
Med/Clin lab technologist	Occ. therapist* Physical therapist* Physician/Surgeon*	Med/Clin lab tech.* Physical therapist*	Nursing assistant* Physical therapist assistant*	Physician/ Surgeon	Physician/ Surgeon
Medical assistant* Nursing assistant*	Mult. occ.s cited at same frequency	Mult. occ.s cited at same frequency	EMT	Med/Clin lab tech.* Nursing assistant*	Physical therapist
Mult. occ.s cited at same frequency			Mult. occ.s cited at same frequency	Mult. occ.s cited at same frequency	Nurse practitioner* Nursing assistant*
				Mult. occ.s cited at same frequency	Mult. occ.s cited at same frequency
# facilities reporting					
10	12	8	7	10	18

most cited ↑

* tied in rank (# of times occupation was cited by Sentinels) in reporting period

Reasons for exceptionally long vacancies for most frequently cited occupations (Spring 2019)

Registered Nurses (RNs)



- Not enough qualified applicants
- Recruitment and retention problems not related to salary/wage/benefits
- Salary/wage/benefits issues
- Other reasons

RNs - Examples of reasons for exceptionally long vacancies

Not enough qualified applicants

- Little to no qualified applicants, location, lack of housing, staff must wear multiple hats.

Salary/wage/benefits issues

- Some of the larger hospitals are able to pay a lot higher wages and the competition is great.
- Most of these qualified people go to Agency jobs due to getting more money in this area
- Hospital nurses are part of a union, and the contract is due to be renegotiated this year. Since the three years the contract has been in place, it has fallen behind market.

Recruitment and retention problems (not related to salary/wage/benefits)

- Lack of stability in the current rural/local job market within the medical field itself.
- Being in a rural area there is a lack of RN's in general, most applications we receive are for per diem work, only wanting to work one or two days a month, we do have full time openings and even though we try to fill with per diem we are not able to fill the positions.
- We are in an extremely rural area and our location has always been an issue with hiring and retaining staff. New RNs usually spend a year with us and then move on to work closer to home.

Reasons for exceptionally long vacancies for most frequently cited occupations (Spring 2019) (cont.)



Orientation and training changes in small hospitals (Spring 2019)

Examples of changes to orientation/onboarding for new employees

RNs: We had been lacking an effective orientation program for new employees. We developed a program which brings the subject matter expert into present their information to new hires. We standardized the process so we have orientation twice a month. We give the information verbally, visually and some of it is hands on in an effort to engage the new hires and help them feel part of a team.

RNs: Longer orientation period due to the enormous amount of stuff our RN's must know.

All employees: We have implemented a new more comprehensive New Hire Orientation for all employees. This is a 3 day orientation and CPI training that all employees go through. We have seen a significant increase in our retention rates as a result.

Examples of changes in training needs for incumbent workers

Multiple occupations: We implemented a new EHR in September 2018 which required more IT education by all relevant staff.

RNs: Requiring they are cross-trained to numerous skills/abilities/units.

RNs: More individualized focused training for staff, especially when we have to use agency.

New roles for existing workforce (Spring 2019)

Examples of descriptions of new workforce roles

Nursing assistant: Used as 1:1 sitters for SI [suicidal ideation]. Some are crosstrained in ward clerk duties.

Physician – psychiatrist: We have recently hired a Regional Medical Director to cover all the E&Ts in WA state. This is new. We used to have someone different assigned to each facility. This new model will provide continuity and more oversight for our programs.

Physician – emergency medicine: has more duties with admitting patients and providing transition orders or if a pt deteriorates on inpt.

Chemical dependency professional/substance abuse and behavioral disorder counselor: We have begun adding SUD Assessment Only services to our E&T license. The state has told us that we cannot use CDPs for co-occurring disorders unless we are licensed to provide SUD.

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Examples of Findings from Nursing Home or Skilled Nursing Facility

Representatives from nursing homes or skilled nursing facilities provided information to the Washington State Health Workforce Sentinel Network six times between Summer 2016 and Spring 2019. This summary highlights some of the information they provided, with an emphasis on the most recently submitted data. Additional findings from these long term care facilities can be found on the Sentinel Network dashboard (wa.sentinelnetwork.org) as well as for other types of health care facilities.

Nursing homes or skilled nursing facilities - Occupations with exceptionally long vacancies: 2016-2019

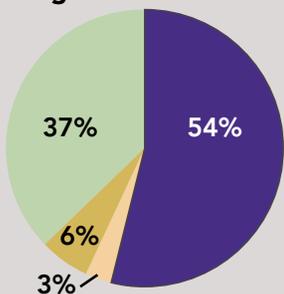
Top occupations cited as having exceptionally long vacancies by date of reporting						most cited ↑
Summer 2016	Winter 2016	Spring 2017	Fall 2017	Summer 2018	Spring 2019	
Registered nurse	Registered nurse	Registered nurse	Registered nurse	Registered nurse* Nursing assistant*	Registered nurse	
Nursing assistant	Nursing assistant	Nursing assistant	Nursing assistant	Lic. practical nurse	Nursing assistant	
Lic. practical nurse	Lic. practical nurse	Lic. practical nurse	Lic. practical nurse	Dentist* Physician/Surgeon*	Lic. practical nurse	
Social worker	Occ. therapist asst.* Physical therapist* Social worker*	Occ. therapist* Physical therapist*	Multiple occ.s cited at same frequency	Multiple occ.s cited at same frequency	Occ. therapist* Physical therapist* Psychologist* Social worker*	
Multiple occ.s cited at same frequency	Multiple occ.s cited at same frequency	Multiple occ.s cited at same frequency			Multiple occ.s cited at same frequency	
# facilities reporting	28	28	11	14	19	34

*tied in rank (# of times occupation was cited by Sentinels) in reporting period

Reasons for exceptionally long vacancies for most frequently cited occupations in nursing homes or skilled nursing facilities (Spring 2019)

Registered nurses - Examples of reasons for exceptionally long vacancies

Registered Nurses



- Not enough qualified applicants
- Recruitment and retention problems not related to salary/wage/benefits
- Salary/wage/benefits issues
- Policy or staffing model changes

Not enough qualified applicants

- We have a full time recruiter and she uses all possible resources but there aren't qualified candidates available
- Very competitive market for RNs. Director of Nursing position, MDS Coordinator, and various RN positions have remained open for a long period of time.
- Not enough experienced RNs or supply cannot meet demand.
- Dearth of applicants despite competitive wages, benefits and sign on / retention bonus of \$10K

Salary/wage/benefits issues

- Skilled facilities are competing with the local hospital, clinics, assisted living, and adult family homes. This is a more demanding level of care with a higher patient/nurse ratio. we also do not have the budget or reimbursement that the larger hospital has to offer high starting wages.
- Receive very few applicants ... offering the highest base wage we ever have often it is not enough.
- Our State reimbursement is inadequate. Our recent cost report proved that we were nearly \$35/per day under funded in our Medicaid rate. Without the necessary money we are struggling to be competitive in hiring licensed nurses and NAC's.

Recruitment and retention problems not related to salary/wage/benefits

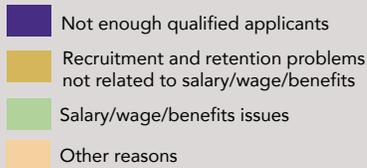
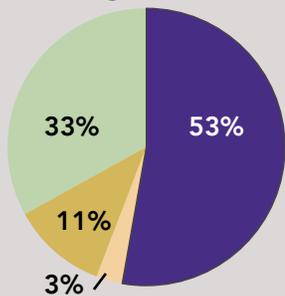
- Not enough applicants in rural areas.

Policy or staffing model change

- SNF recently were required to provide 24/7 RN coverage. That has increased demand.

Nursing assistants - Examples of reasons for exceptionally long vacancies

Nursing assistants



Not enough qualified applicants:

- We have a full time recruiter and she uses all possible resources but there aren't qualified candidates available.
- Current demand exceeds labor supply. We reached out to 26 state approved NAC/CNA schools to partner with them on hiring all graduates. However, they do not have the capacity to meet our needs today.

Salary/wage/benefits issues

- Our State reimbursement is inadequate. Our recent cost report proved that we were nearly \$35/ per day under funded in our Medicaid rate. Without the necessary money we are struggling to be competitive in hiring licensed nurses and NAC's.
- Hospitals are hiring NACs at a higher wage than Nursing Homes can pay.
- A small Medicaid facility does not have the revenue to offer top wages and benefits to compete with hospitals or larger nursing homes.

Recruitment and retention problems not related to salary/wage/benefits

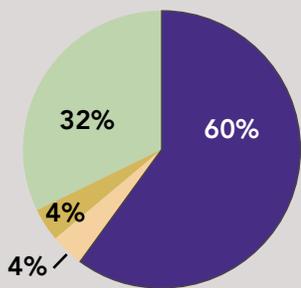
- Very difficult to find individuals who are willing to work these entry level positions. Low applicants recently. They are not typically reliable, want M-F or struggle with consistently working at one place past the ""honeymoon"" phase. Registry has also made it difficult for those CNAs who don't keep up enough working hours to maintain their license.
- Lack of applicants that stay and are committed.
- We run our own classes but the SNF environment is very difficult and many people cannot do it.

Other reasons

- In addition to CNAs job jumping looking for higher pay, because of the CMP's many facility's that once had CNA classes can no longer have them or have the program.

Licensed practical nurses - Example of reasons for exceptionally long vacancies

Licensed Practical Nurses



Not enough qualified applicants:

- Very competitive market for LPNs. Director of Nursing position, MDS Coordinator, and various LPN positions have remained open for a long period of time.
- Not enough experienced LPNs or supply cannot meet demand.
- Due to the shortages, licensed nurses have been job jumping to the facility or company that is willing to offer more.

Salary/wage/benefits issues

- Higher wages are difficult to provide when comparing to hospitals
- A small Medicaid facility does not have the revenue to offer top wages and benefits to compete with hospitals or larger nursing homes.

Recruitment and retention problems not related to salary/wage/benefits

- Our State reimbursement is inadequate. Our recent cost report proved that we were nearly \$35/ per day under funded in our Medicaid rate. Without the necessary money we are struggling to be competitive in hiring licensed nurses and NAC's.

Orientation and training changes in nursing homes and skilled nursing facilities (Spring 2019)

Examples of changes to onboarding for new employees

Licensed practical nurses: Poor supervisory skills noted with LPNs which require further training and support during orientation. Longer on the floor orientation for new hires that are new grads. Due to regulations we have also expanded the hours for new employee orientation and verification of competencies. All of which delay filling of open positions.

Nursing assistants: Redesign of orientation is in progress today. Longer orientation, putting new employee with an experienced mentor

Multiple occupations: State constantly adds requirements which extends the time from when a candidate is brought in to when they can do work

RNs: Orientation periods have increased, especially on the floor with scheduled orientation days working alongside a seasoned case manager to ensure full understanding of all aspects of the position and allowing the new employee to practice all aspects of their job before taking on a solo assignment.

About the Washington Health Workforce Sentinel Network

The Sentinel Network links the healthcare sector with policymakers, workforce planners and educators to identify and respond to changing demand for healthcare workers, with a focus is on identifying newly emerging skills and roles required by employers. The Sentinel Network is an initiative of Washington's Health Workforce Council, conducted collaboratively by Washington's Workforce Board and the University of Washington's Center for Health Workforce Studies. Funding to initiate the Sentinel Network came from the Healthier Washington initiative, with ongoing support from Governor Inslee's office and the Washington State Legislature.

Why become a Sentinel? As a Sentinel, you can:

- Communicate your workforce needs and ensure that the state is prepared to respond to the transforming healthcare environment.
- Have access to current and actionable information about emerging healthcare workforce needs.
- Compare your organization's experience and emerging workforce demand trends with similar employer groups.

To view an interactive summary of findings and to provide information from your organization: www.wasentinelnetwork.org.

Contact: healthworkforce@wasentinelnetwork.org

Washington's Health Workforce Sentinel Network Examples of Findings from Assisted Living Facilities

Representatives from assisted living facilities provided information to the Washington State Health Workforce Sentinel Network in Spring 2019, which was the first time assisted living was singled out for reporting separate from some other types of care facilities. This summary highlights some of the information they provided. Additional findings from these long term care facilities can be found on the Sentinel Network dashboard (wa.sentinelnetwork.org) as well as for other types of health care facilities.

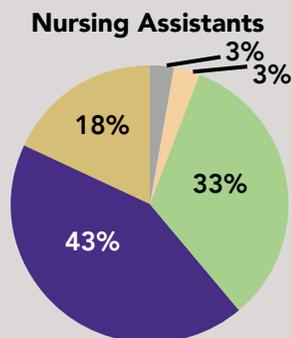
Assisted Living Facilities - Occupations with exceptionally long vacancies: Spring 2019

Top occupations cited as having exceptionally long vacancies	
Spring 2019	
Nursing assistant	most cited ↑
Licensed practical nurse	
Home health aide or home care aide* Registered nurse*	
Chemical dependency professional* Personal care aide* Social worker*	
# facilities reporting 27	

*tied in rank (# of times occupation was cited by Sentinels) in reporting period

Reasons for exceptionally long vacancies for most frequently cited occupations in nursing homes or skilled nursing facilities (Spring 2019)

Nursing Assistants - Examples of reasons for exceptionally long vacancies



- Not enough qualified applicants
- Recruitment and retention problems not related to salary/wage/benefits
- Salary/wage/benefits issues
- Facility growth/expansion
- [No reason for prolonged vacancies provided]

Not enough qualified applicants

- The cost to on board is about \$1,250 to get all DSHS approved certificates. Class are hard to get in and work some hours. Lack of teaching places in our area
- We've had to increase wages to be competitive in our market and still have low response to our recruiting efforts. It generally takes a few months to find qualified applicants. We have started looking for home care aides (HCAs) to fill these positions..
- NAC shortage in our area, skilled nursing facilities seen as preferred workplace options due to higher wages and education reimbursement.

Salary/wage/benefits issues

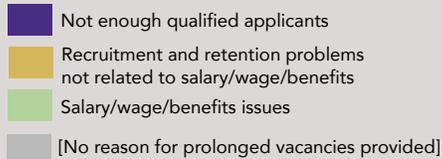
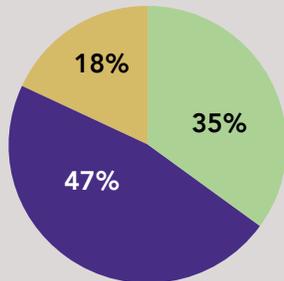
- Training requirements not completed due to cost. Not understanding the need for the training. Not being able to provide a livable wage. Not being able to provide benefits.
- CNAs are incredibly underpaid and their jobs are demanding. Many of them float around from company to company in search of better pay.
- Certification requirements are a barrier for some. Competitive wages on a Medicaid facility budget is challenging.

Recruitment and retention problems not related to salary/wage/benefits

- Our assisted living community is in a high-end market. many of our staff members live further away and must commute. I feel our pay is competitive for our industry; however we are also competing with skilled nursing facilities and hospitals.

Licensed practical nurses - Examples of reasons for exceptionally long vacancies

Licensed Practical Nurses



Not enough qualified applicants:

- Not enough qualified people to do the job and applicants not willing to work the schedule assigned.
- labor pool seems small; salary competition with skilled and acute care.

Salary/wage/benefits issues

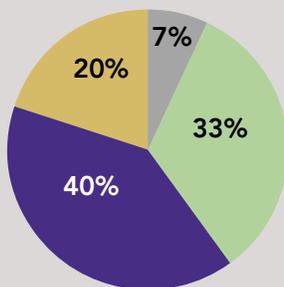
- Wage is always an issue.

Recruitment and retention problems not related to salary/wage/benefits

- LPN applicants that have applied are not willing to work the rotation or to work in the specific area of the building, memory care.

Home health aides/home care aides - Example of reasons for exceptionally long

Home Health Aides/ Home Care Aides



Not enough qualified applicants:

- HCA shortage in our area; often looking for flexibility of home care rather than traditional shifts.
- Due to difficulty recruiting NAC's, we have started recruiting home care aides (HCAs) though haven't hired any at this point.

Salary/wage/benefits issues

- Certification requirements are a barrier for some. Competitive wages on a Medicaid facility budget is challenging. Not being able to provide benefits.

Recruitment and retention problems not related to salary/wage/benefits

- Training requirements not completed due to cost. Not understanding the need for the training. Not being able to provide a livable wage.

Orientation and training changes in nursing homes and skilled nursing facilities (Spring 2019)

Examples of changes to onboarding for new employees

Nursing assistants: We are now having the safety and Orientation class done before they Start any paper work we pay for the class they do the time. If they complete it and come to work we will pay them 4 hours.

Multiple occupations: Company revised orientation/on-boarding to include more classroom training time vs a majority of online courses with the intent to improve quality of training.

Examples of changes in training needs for existing workforce

Multiple occupations: Continuing education training is more targeted and specific for staff members. Utilizing online courses to ensure every team member receives the same training.. Had previously preferred NAC with Dementia and Mental Health Specialty trainings already completed but now will train internally or pay for external training after hire.

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Workforce Development

Long Term Services & Supports

Direct Care Workers

Bea Rector, Director, Home and Community Services Division
Workforce Development Council
August 6, 2019





Home Care Aide Certification

- Long-term care (LTC) workers who are providing home or community-based services to the elderly or people with a functional or developmental disability must be certified within 200 days of their date of hire.
- Some LTC workers are exempt from certification based on their relationship to the person they are working for, their work experience or their licensing status.
- LTC workers may work while completing training and certification requirements.

Work Settings of Home Care Aides

They work in in-home settings:



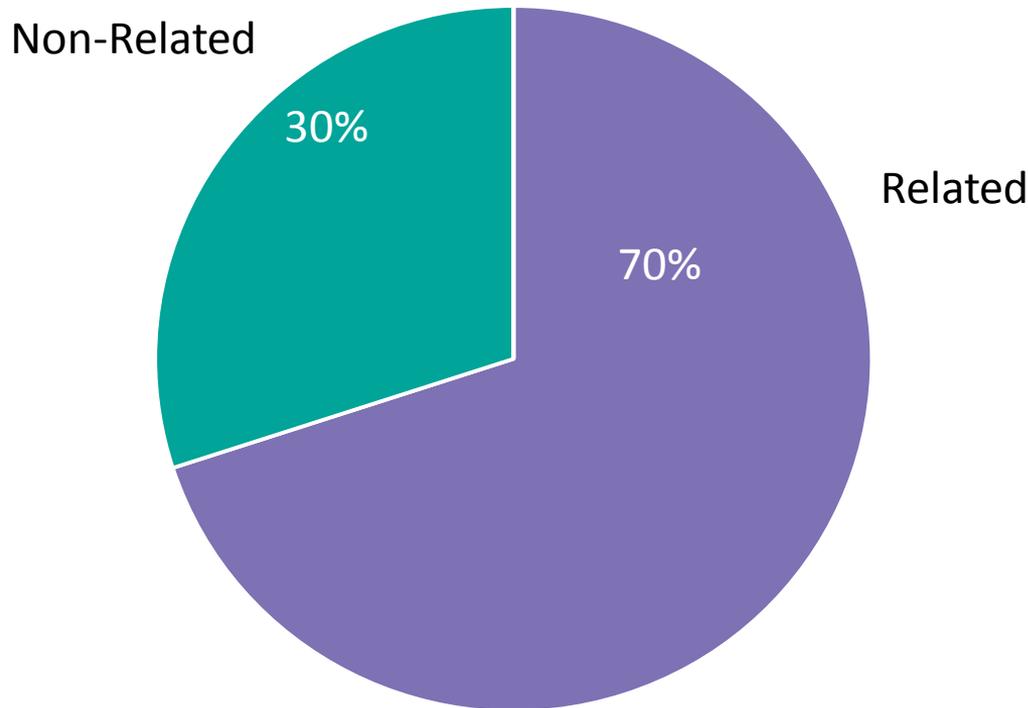
- Individual Provider (IP): works directly for a client in his/her home
- Agency Provider (AP): works for a licensed agency to provide care to a client in his/her home

And in community (multi-client) settings:



- Licensed Adult Family Home (2-6 adults)
- Licensed Assisted Living Facility (7+ adults)
- Enhanced Services Facilities (up to 16 adults)
- Community Residential

Relationship of in-home individual providers working with client in LTSS



Relationship	%
Child	44
Parent	7
Daughter/Son-in-Law	6
Sibling	5
Grandchild	4
Niece/Nephew	2

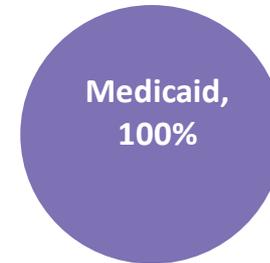
This data is from the payment system on 11/13/2017.

How LTSS is Funded in Community and Facility Settings

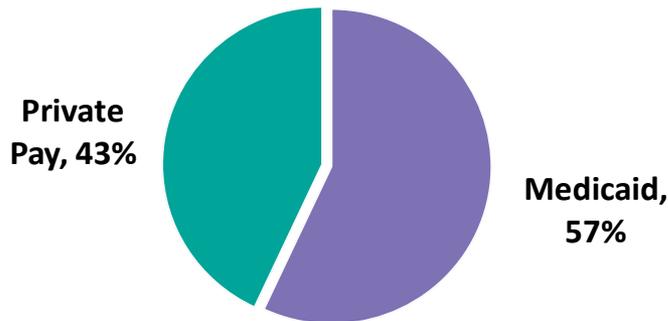
Nursing Homes



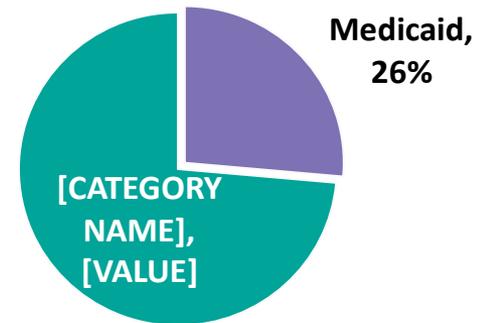
ICF/IID and Supported Living (Developmental Disabilities)



Adult Family Homes

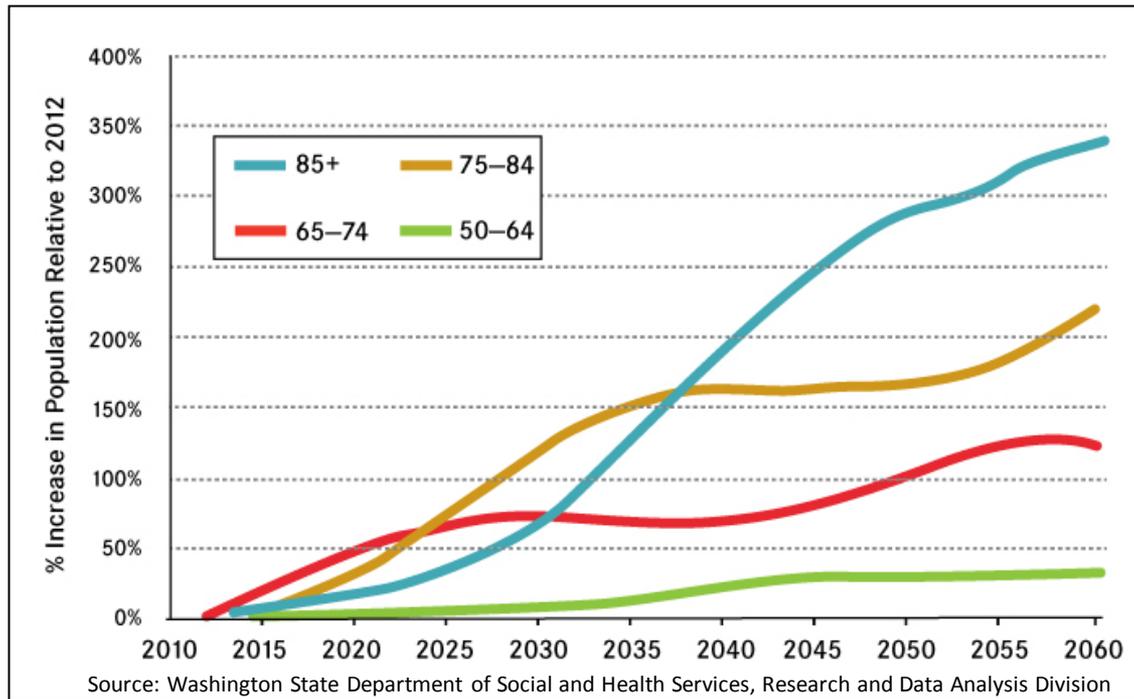


Assisted Living Facilities



Washington's Aging Population

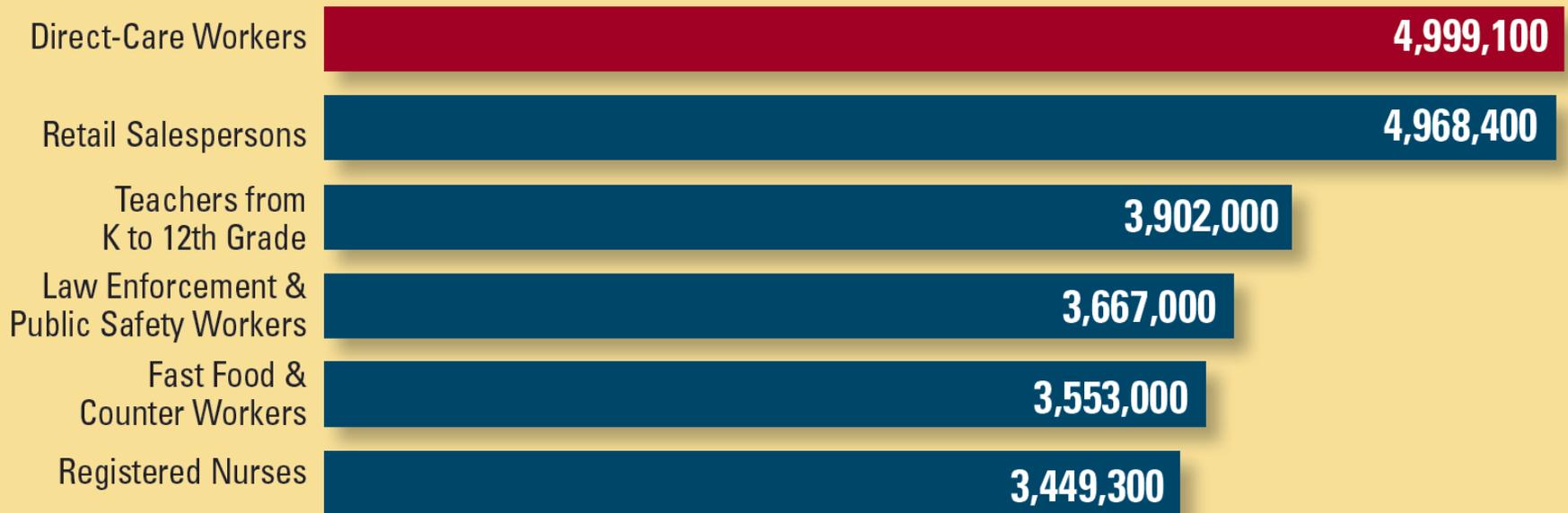
Projected Growth of Older Population in Washington as a Percent of the 2012 Population



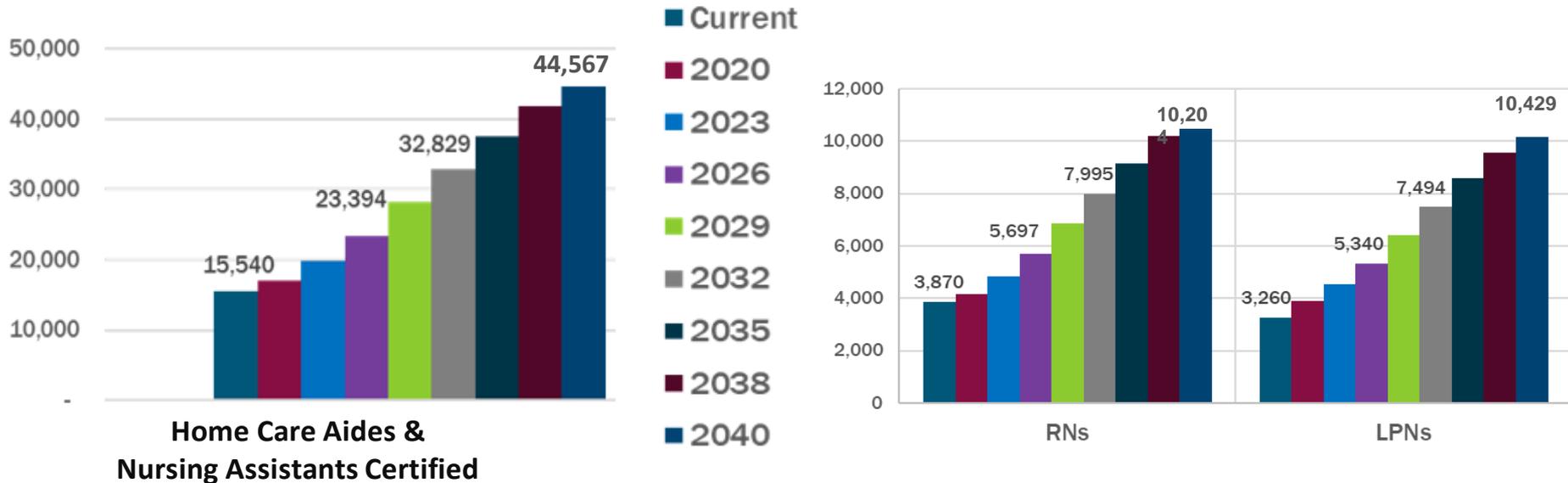
Direct-Care Workers

Largest Occupational Group in the U.S. by 2020

Largest Occupational Groups in U.S., 2020

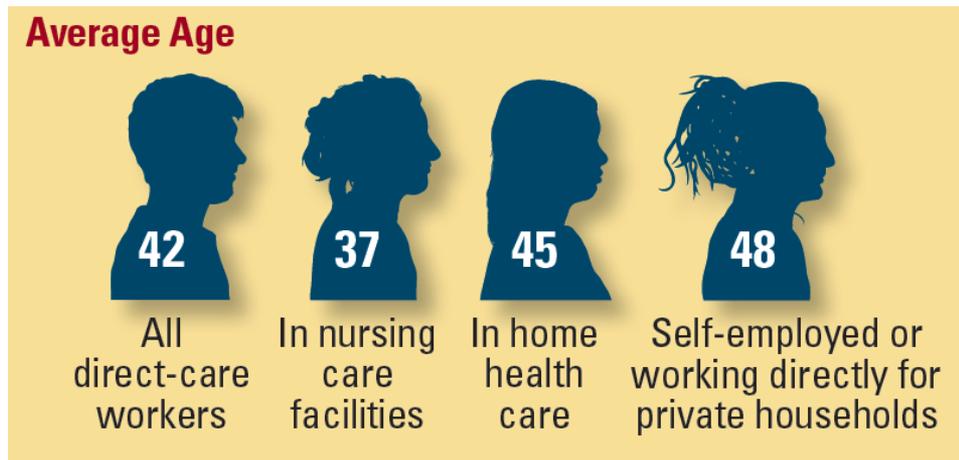
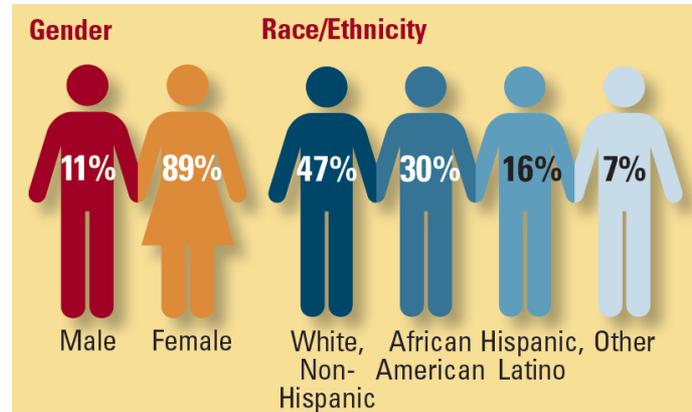


Increasing Need for Workers



Washington State Office of Financial Management, Forecasting and Research Division. "Excel utility to interactively summarize population by user-defined age groups" <https://ofm.wa.gov/washington-data-research/population-demographics/population-forecasts-and-projections/state-population-forecast>

Demographics of Direct-Care Workers Nationally



What Caregivers Want

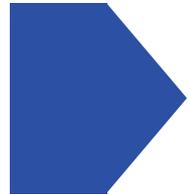


The VALUE Proposition: *What's in it for me?*

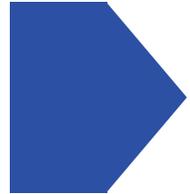
A combination of:

- Flexibility
- Benefits: health, vacation, sick leave
- Purpose, making a difference now & future
- Growth opportunities
- A good/fair wage

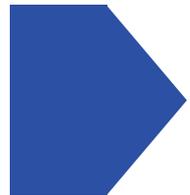
Barriers that Deter Entry into the Profession



Lack of information about this as a career choice



Complicated process of becoming a direct care worker



Working conditions can be a challenge

Washington Workforce Initiatives

Leading the
way to
recruit and
retain a high
quality
direct care
workforce



HCA Certification Testing Languages

[WA State Prometric Home Care Aide Exam Materials - 13 Languages](#)

- Arabic
- Chinese
- English
- Khmer
- Korean
- Laotian
- Russian

- Samoan
- Somali
- Spanish
- Tagalog
- Ukrainian
- Vietnamese

Sample Test and Exam Prep Materials

[WA State Prometric Home Care Aide Exam Materials - 13 Languages](#)

1. Đúng hay Sai: Quyền hợp pháp của bệnh nhân quan trọng vì chúng bảo vệ tự do và nhân phẩm của bệnh nhân. <https://vimeo.com/163696186>

(A) Đúng
(B) Sai

2. Đúng hay Sai: Khi nói chuyện với bệnh nhân đang bối rối điều quan trọng là hộ lý chăm sóc tại gia cần sử dụng giọng điệu bình tĩnh khi nói.

(A) Đúng
(B) Sai

3. Đúng hay Sai: Cơ chế vận động cơ thể đúng là gập đầu gối.



(A) Đúng
(B) Sai

Rửa Tay	
Khi bắt đầu phần thi thực hành, học viên được đánh giá về cách rửa tay của mình. Học viên sẽ không được nhắc nhở về việc rửa tay, nhưng phải tự biết rằng trước khi đụng chạm trực tiếp thân chủ, họ cần phải rửa tay.	
Học viên có:	
1	để hai bàn tay và cổ tay dưới vòi nước chảy để bắt đầu rửa tay không?
2	cho xà bông vào hai bàn tay để bắt đầu rửa tay không?
3	chà xà bông cho ra bọt trên tất cả mọi bề mặt của hai bàn tay và cổ tay không?
4	chà xát hai bàn tay đã xoa xà bông vào nhau ít nhất là 20 giây không?
5	xả hai bàn tay và cổ tay dưới vòi nước chảy cho sạch xà bông không?
6	để hai bàn tay theo hướng chỉ xuống dưới trong khi rửa và xả nước không?
7	dùng khăn giấy khô sạch để lau khô hai bàn tay và cổ tay không?
8	chỉ lau khô những chỗ đã rửa không?
9	dùng khăn giấy để tắt vòi nước sau khi đã rửa tay không?
10	bỏ khăn giấy đã dùng vào thùng rác không?
11	rửa tay xong với bàn tay sạch không để bị ô nhiễm (thí dụ như, đụng chạm trực tiếp để tắt vòi nước, đồ đựng khăn giấy, bồn rửa tay hay thùng rác) không?

PROMETRIC

WASHINGTON

Hộ lý Chăm sóc Tại nhà được Sở Y
tế Tiểu bang Chứng nhận

Thông cáo Thông tin cho Thí sinh

Có hiệu lực từ ngày 1 tháng 5 năm 2016

Xuất bản bởi Prometric
Cung cấp Kỳ thi Cấp phép cho Tiểu bang Washington

Bản quyền © 2016 Prometric, Inc., một công ty ở Delaware. Bảo lưu mọi quyền.
Hiệu chỉnh ngày 15 tháng 4 năm 2016

High School Home Care Aide Training Program

Prepare students for a future in health care!



High School Course Content



WA OSPI

Counts toward WA high school graduation requirements

Meets National Health Science Standards



WA DSHS

Meets Washington's 70-hour home care aide training requirements

- 80 hours: knowledge and skill practice
- 10 hours: practicum

90-Hour High School HCA Credentials

- High school diploma
- Home Care Aide certificates
- Orientation certificate
- Safety certificate
- Specialty dementia certificate
- Specialty mental health certificate
- CPR card
- Food handler's card

*Available in
Multiple
Languages*

Home Care Aide Career Lattice



- Nursing Assistant, Certified (NAC)
- HCA or NAC Lead; Medication Aide
- LPN, RN, Nurse, OT, PT, ST
- Med Techs, Lab Techs



- Adult Family Home Owner or Operator
- Assisted Living office, sales, marketing, activities or nurse manager; administrator



- Nurse Educator
- Educator or para-educator
- Ongoing education that leads to other careers
- Social Worker
- Advocate

Connecting the Workforce



<http://www.hcrr.wa.gov/>

To become an Individual Provider, contact your local Home Care Referral Registry for personal service. The HCRR coordinator will work with individuals to become IPs and to connect with clients through Carina.

[HCRR registry locations near you.](#)



WorkSource helps job seekers and employers. Their Employment Specialists can provide information on careers, training and possible funding.

[Find a WorkSource "One-Stop" center near me.](#)



Online employment websites are the #1 recruiting tool used by many employers.

Job seekers can also contact employers directly.

Retaining the Workforce:

Working with providers on retention strategies

Factors tied to successful retention:

- I know what is expected of me at work.
- I have the materials and equipment to do my work well.
- I have the opportunity to do what I do best every day.
- My supervisor and/or my co-workers care about me as a person.
- At work, my opinions count.



Washington's LTSS Workforce Goals



Have enough workers to meet growing demand



Build skills to meet changing needs of individuals served



Continue to support unpaid family caregivers



Continue to support careers with good pay, health care and other benefits

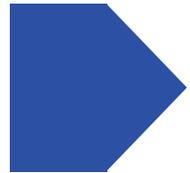


Support a diverse workforce

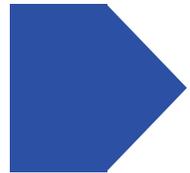


Establish a career path for LTSS workers

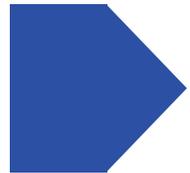
Recommendations



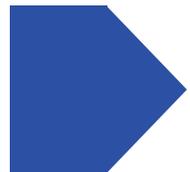
Continue to learn about the impact and importance of LTSS direct caregivers



Seek and encourage partnerships at all levels: strategic and tactical



Include incentives in plans/goals to grow the direct caregiver workforce: priorities, funding, programs, supports



Be a myth-breaker about direct caregiver roles!



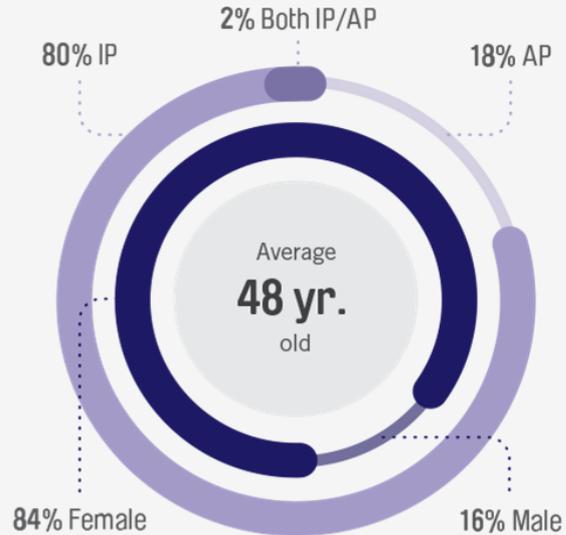


**HCA's are an Integral Part of the
Healthcare Workforce**



Who are caregivers?

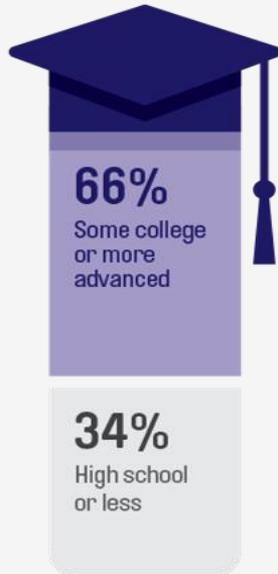
Our Workforce





Who are caregivers?

Understanding Who We Serve



have not begun planning
for retirement
as of 12/16





No longer a low wage job

Competitive Wages

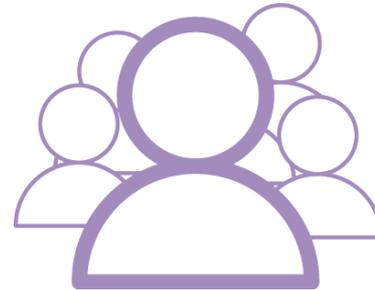
- Starting wage July 1 \$15.50 an hour
- Wages ceiling \$19.07 an hour
- Opportunities for pay differentials with certification and training bring wages to over \$20.00 an hour
- Average hours worked 100 a month

Robust Benefits

- Healthcare Co-premium \$25/month No deductible plan
- Employer funded retirement plan



How we serve Caregivers



Training



Health



Retirement



Jobs





How we serve caregivers



Training

1,262 classes/series offered.

908K total training hours.



Health

22,916 of people covered by HBT in 2018.

3,522 of new enrollees in 2018.



Retirement

80,000 + participants.



Jobs

9,000+ users

900+ job matches.



Health

- Low Premiums for HCAs (\$25/month) includes Medical, Dental Hearing, Rx, Hearing and Behavioral Health Coverage.
- All caregivers have access to an EAP and text based coaching.
- \$10 copay/\$0 in network copay for behavioral health.
- Low eligibility to qualify (80 hours per month, average worker works 100+ hours per month)
- Partner with carriers to provide population-based, integrated care- Kaiser, Willamette, Delta, Aetna and SaveRx
- Emphasis on primary care — 79% of members are paneled to a PCP.

Testing, piloting and creating innovative programs and interventions to improve the health and safety of caregivers. This includes a safety shoe program, and behavioral health innovations including mindfulness and online text based coaching.





Retirement

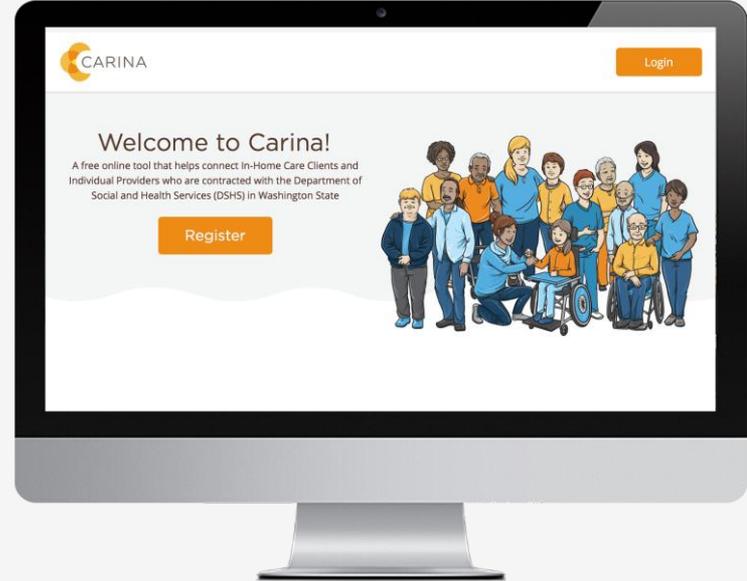
- Effective date was 3/1/2016
- A defined contribution profit sharing plan solely funded by employer contributions:
 - \$0.23/qualifying hour from July 2015 - June 2017
 - \$0.25/qualifying hour from July 2017 - June 2018
 - \$0.50/qualifying hour from July 2018 - June 2019
 - \$0.65/qualifying hour from July 2019 - June 2020
 - \$0.80/qualifying hour from July 2020 - June 2021
- First plan participants vested and can request a retirement benefit as of March of 2019





Carina

- Carina connects verified home care aides with Medicaid and state funded clients.
- Services include technology platform, marketing and customer service.
- Allows caregivers to find clients who need care and helps clients find care.
- Users can include information on types of care previously provided and any specialty training a caregiver may have.





Training Benefits

By the numbers



- Train in 45 cities, across 28 counties
- Provided training to more than 45K caregivers
- Offered over 962K total training hours; over 35K hours of in person training
- Twenty one (21) hours of new CE offered in 2018



- Nation's largest organization for home care workforce training and development
- Washington's second-largest learning organization
- Peer Mentors served 1,889 new mentees in 3,403 sessions in 2018



- Training offered in 13 languages
- Over 16K interpreter hours offered in 2018
- Over 1,300 class cohorts planned for this year
- Approximately 50 instructors providing training



Training Benefit

	Courses (hours)			
Required	Orientation & Safety (5 hours)			
Required	Basic Training 70	Basic Training 30	Basic Training 9	Parent Provider (7 hours)
Required	DOH Exam	Certification not required		
Required & Optional	Nurse Delegation (12 hours)			
Optional	Advanced Training (70 hours)			
Required & Optional	Continuing Education (12 hours a year)			



Permanent Training Locations





Orientation and Safety

Role of the HCA

Consumer Rights and Communication

Emergency Preparedness

Infection Control

Accident Prevention





Basic Training 70

The purpose of the Basic Training Curriculum (BTv3) is to assist the Home Care Aide (HCA) to integrate the skills that he or she has learned during basic training to specific conditions that may be encountered when working with a client. The Basic Training curriculum is based on the required knowledge and skills outlined for basic HCA training in WAC 388-112-0055. The WAC defines the following core knowledge and skills.

The HCA will be able to:

- Understand and use effective interpersonal and problem-solving skills with the client, family members, and other care team members.
- Take appropriate action to promote and protect client rights, dignity, and independence.
- Take appropriate action to promote and protect the health and safety of the client and the HCA.
- Correctly perform required personal care tasks while incorporating client preferences, maintaining the client's privacy and dignity, and creating opportunities that encourage client independence.
- Adhere to basic job standards and expectations.



Training Partnership

Continuing Education

Sample of online CE titles

Accident Prevention

Client use of marijuana in home care

Consumer Directed Care for common medical conditions: stroke

Dementia and personal care

Food allergies and sensitivities

Historical perspectives on the treatment of people with disabilities

Improving time management skills

Positive behavior support for young consumers with developmental disabilities

Understanding basic medical terminology





Training Partnership

Continuing Education

In Person Led Courses April 2019

Post-Surgical Care

Opioids and Client Use of Marijuana in Home Care

Medication Assistance

Supporting a Client with Hearing Loss

Managing Compassion Fatigue





Advanced Home Care Aide

Upon successful completion of the course, learners should be able to:

- Provide person-centered care.
- Use the ADAPT problem solving method.
- Practice motivational interviewing techniques to collaborate with a client.
- Recognize opportunities to forestall escalation and employ appropriate techniques when caring for escalated clients.
- Use the appropriate treatment and care plans in providing in-scope care for a client.
- Monitor and report changes in a client's physical and/or mental health status.
- Collaborate with a client to ensure that medication is appropriately managed in accordance with treatment and/or care plan(s).
- Promote health literacy and empower a client to be engaged and at the center of their own health.
- Collaborate with a client in organizing care activities.



Language Supports

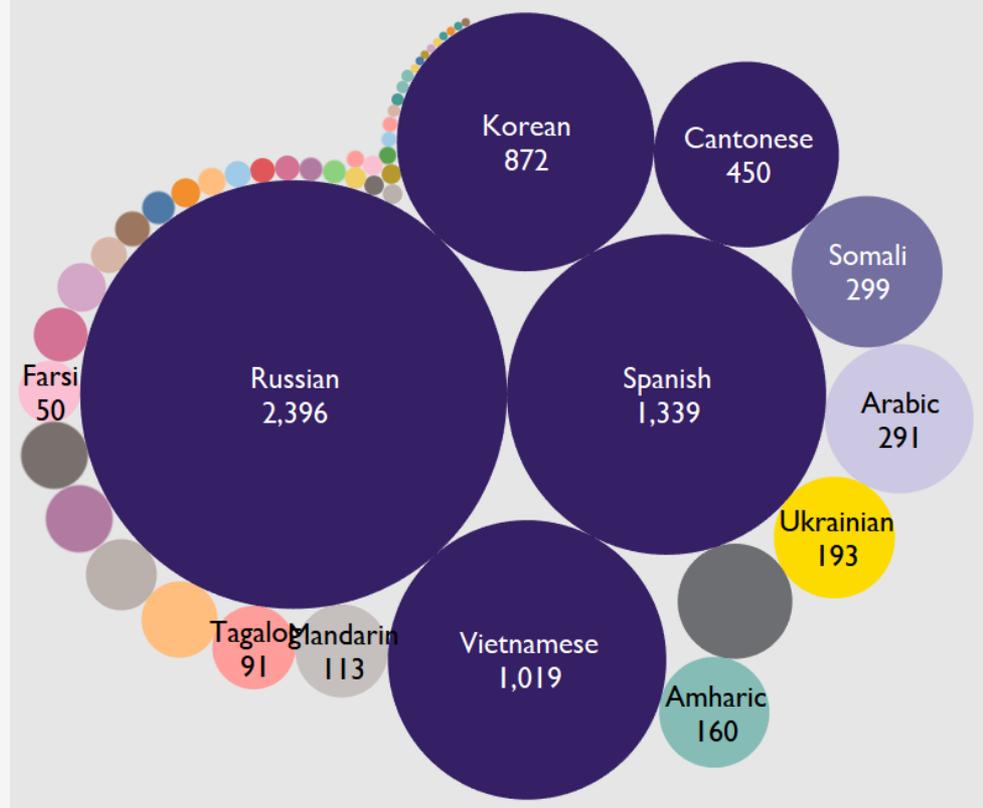
Translators provided for those not in a language class and for American Sign Language

Basic Training 70

- English
- Arabic
- Chinese
- Korean
- Russian
- Somali
- Spanish
- Vietnamese

Basic Training 30

- English
- Chinese
- Korean
- Russian
- Spanish
- Vietnamese



In Person Led Continuing Education

- | | |
|-----------|------------|
| English | Lao |
| Arabic | Russian |
| Cambodian | Somali |
| Chinese | Spanish |
| Korean | Tagalog |
| | Vietnamese |



Peer Mentor Support Strategies

Reduce Cognitive Overload Early On

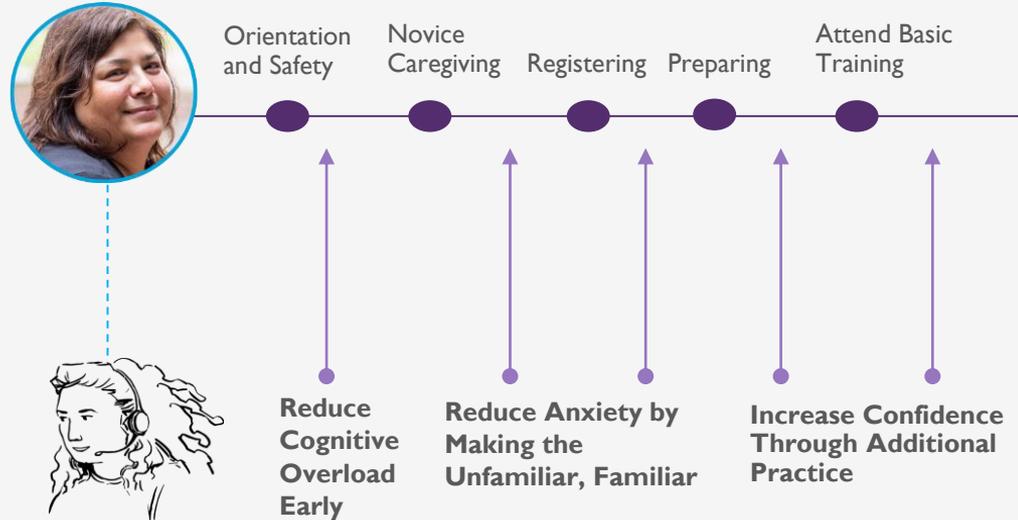
- Clarity through guided support.
- Just-in-time communications.
- Prioritization and proactive planning.

Increase Confidence Through Additional Practice

- Study support outside of class.
- Guided role play and practice.

Reduce Anxiety by Making the Unfamiliar, Familiar

- Study tips and strategies to practice at home.
- Guided walk through of training and test day.





Preparing for Tomorrow



Future Plans

Basic Training version IV

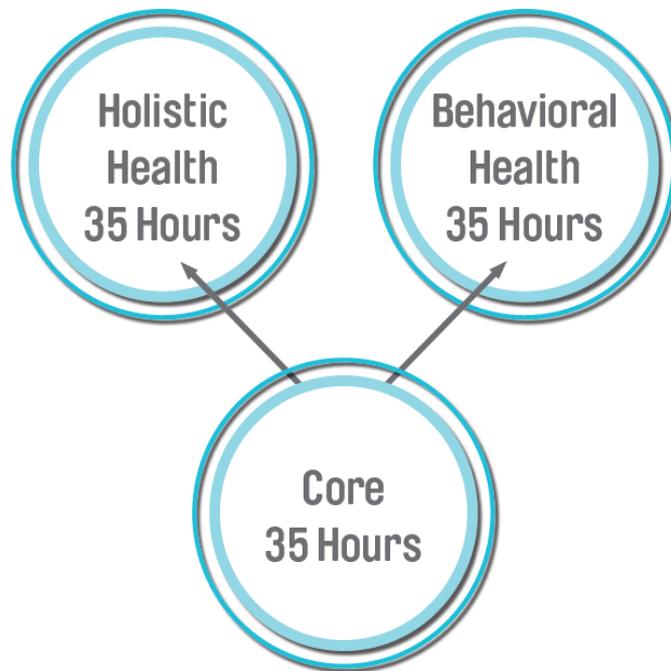
Revisions to Advanced Home Care Aide

Advanced HCA class access

Basic Training access to remote areas

Peer Mentor program growth

Future of Advanced Training





How can we partner?

Workforce Development



Recruitment

Home Care Aide jobs for Allied Health students



Workforce Stability

Turnover and retention efforts



Professionalization and opportunities for advancement

Audience of 54,000 Home Care Aides



Job Quality

Continued industry professionalization



Growth

24,000+ jobs in next 11 years



Together the future is bright



Thank you

Amy Persell

amy.persell@myseiubenefits.org

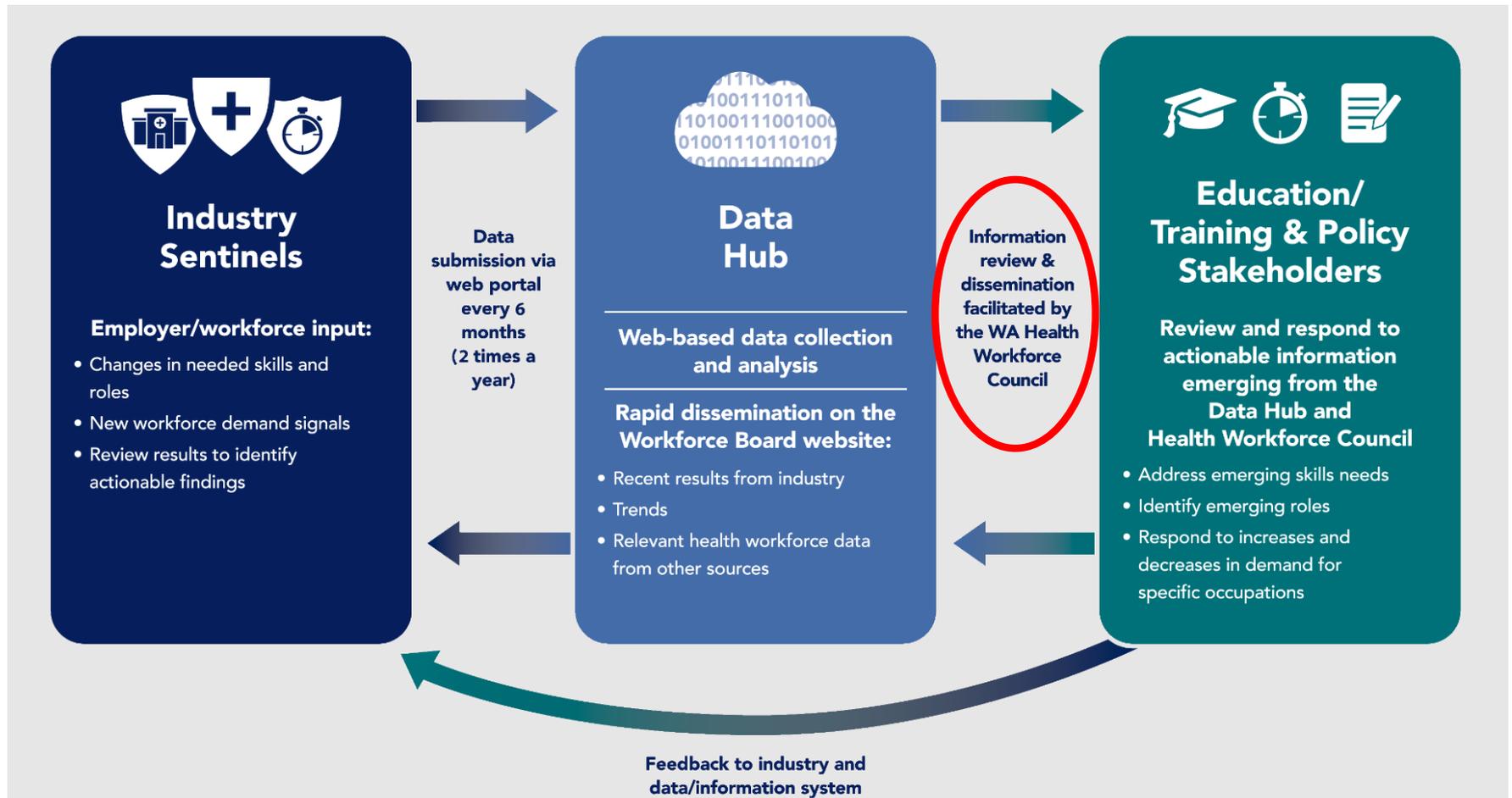


Washington State's Health Workforce Sentinel Network Update

Health Workforce Council Meeting
Olympia, WA
August 6, 2019

Sue Skillman, Deputy Director
Center for Health Workforce Studies
University of Washington

Washington's Health Workforce Sentinel Network



www.wa.sentinelnetwork.org

Sentinel Network Questions

With a focus on qualitative input about which, how, and reasons why

Recently (in the past 6 months):

- *Occupations experiencing exceptionally long vacancies*
- *Occupations with exceptional turnover*
- *Occupations with increased or decreased demand*
- *New occupations that they did not previously employ*
- *New roles for existing employees*
- *Changes in orientation/onboarding procedures for new employees*
- *Changes in training priorities for existing employees*
- *Does your facility serve primarily urban, rural or a mix of urban and rural clients?*

Data Collection Rounds

Washington's Health Workforce Sentinel Network

Ongoing funding from 2019 Legislature!



Responses by Facility Type

Reported to Sentinel Network (Spring 2019)

Facility Type	Number of Responses
Nursing home or skilled nursing facility	34
Assisted living facility	27
Behavioral-mental health clinic/outpatient mental health and substance abuse clinic	25
Federally qualified health center (FQHC) or community clinic providing care free or on sliding fee scale	20
Acute care hospital (25 beds or fewer)	18
Dentist office/dental clinic	16
Primary care medical clinic (not FQHC or community clinic)	16
Physical and/or occupational therapy	13
School	11
Retirement community/independent living facility	10
Public health	8
Specialty medical clinic	7
Acute care hospital (more than 25 beds)	6
Other	6
Home health care service and hospice	5
Medical/diagnostic laboratory	5
Other nursing/personal care facility	5
Psychiatric/substance abuse hospital	3
Total	235

Responses by Facility Type

Reported to Sentinel Network (Spring 2019)

Facility Type	July 2016	Nov 2016	May 2017	Sept 2017	July 2018	April 2019
Behavioral-mental health clinic/outpatient mental health and substance abuse clinic	26	30	16	33	12	25
Skilled nursing facility/nursing home	17	28	11	14	19	34
Federally qualified health center (FQHC) or community clinic providing care free or on sliding fee scale	19	18	19	23	13	20
Nursing & personal care facility (not a Skilled Nursing or Intermediate Care Facility)	7	15	6	4	11	5
Acute care hospital (25 beds or fewer)	10	12	8	7	10	18
Acute care hospital (more than 25 beds)	12	1	6	4	8	6
Education, School	10	10	5	1	11	11
Primary care medical clinic (not FQHC or community clinic)	19	7	8	4	21	16
Assisted living/Intermediate care facility/retirement community/independent living/other	1	7	5	2	3	37
Specialty medical clinic	29	6	6	3	8	7
Home health care service and hospice	11	4	7	6	3	5
Psychiatric/substance abuse hospital	3	4	0	10	0	3
Medical/diagnostic laboratory	5	3	5	4	3	5
Public health	4	3	5	2	3	8
Dentist office/dental clinic	3	3	0	4	20	16
Physical and/or Occupational Therapy (prev. in "Other")						13
Other	1	3	11	2	6	6
Total	177	154	118	127	154	235

Responses by Facility Type

Reported to Sentinel Network (Spring 2019)

Facility Type	Number of Responses
Nursing home or skilled nursing facility	34
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Other	6
Home health care service and hospice	5
Medical/diagnostic laboratory	5
Other nursing/personal care facility	5
Psychiatric/substance abuse hospital	3
Total	235

Number of Responses by ACH

Reported to Sentinel Network **Spring 2019**

Accountable Communities of Health (ACHs)	Number of Facility Responses
Greater Columbia	55
King	43
Cascade Pacific Action Alliance	42
Pierce	32
North Sound	30
Better Health Together	29
North Central	28
SW WA Regional Health Alliance	14
Olympic	12



Interpreting Sentinel Network Findings

Is the “signal” something that is a result of and/or could be addressed by:

- **Education/training:** Do we need more/less output from the education/training system? More/different skills?
- **Incumbent workers:** New, improved skills and training?
- **Policy or regulation:** Changes needed to scope of practice, licensing or practice requirements, from Dept. of Health, DSHS? Reimbursement adjustments from HCA?
- **Healthcare marketplace:** Imbalance/discrepancies in wages and benefits due to resources of larger systems vs. small practices?
- **Other?**

Washington's Health Workforce Sentinel Network

www.wa.sentinelnetwork.org

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Washington's Accountable Communities of Health Successes & Challenges

Health Workforce Council Meeting

August 6, 2019

Presenters:

Jean Clark, CEO of Cascade Pacific Action Alliance ACH

Carol Moser, Executive Director of Greater Columbia ACH

ACHs and the role they play

- ▶ Regional organizations that work with community partners on health needs and priorities
- ▶ Address health issues by:
 - ▶ Aligning resources and activities that improve whole-person health and wellness in their community.
 - ▶ Supporting system transformation, including Medicaid Transformation.
 - ▶ Implementing projects that improve population health outcomes.
- ▶ Provide oversight on distribution of earned incentives to providers as part of Initiative 1 of the Medicaid Transformation.

Map of the ACH regions



Medicaid Transformation priorities (continued)

▶ Opioid response

- ▶ All ACHs are working on regional strategies to promote awareness, prevention, treatment, and recovery supports. They are:
 - ▶ Providing prescribing practices and medication-assisted treatment training to hospitals, primary care providers, and behavioral health agencies.
 - ▶ Promoting the Prescription Monitoring Program and its linkage to electronic health records (EHR) systems to increase provider participation.
 - ▶ Established regional opioid workgroups and conducting regional opioid conferences.

Medicaid Transformation priorities (continued)

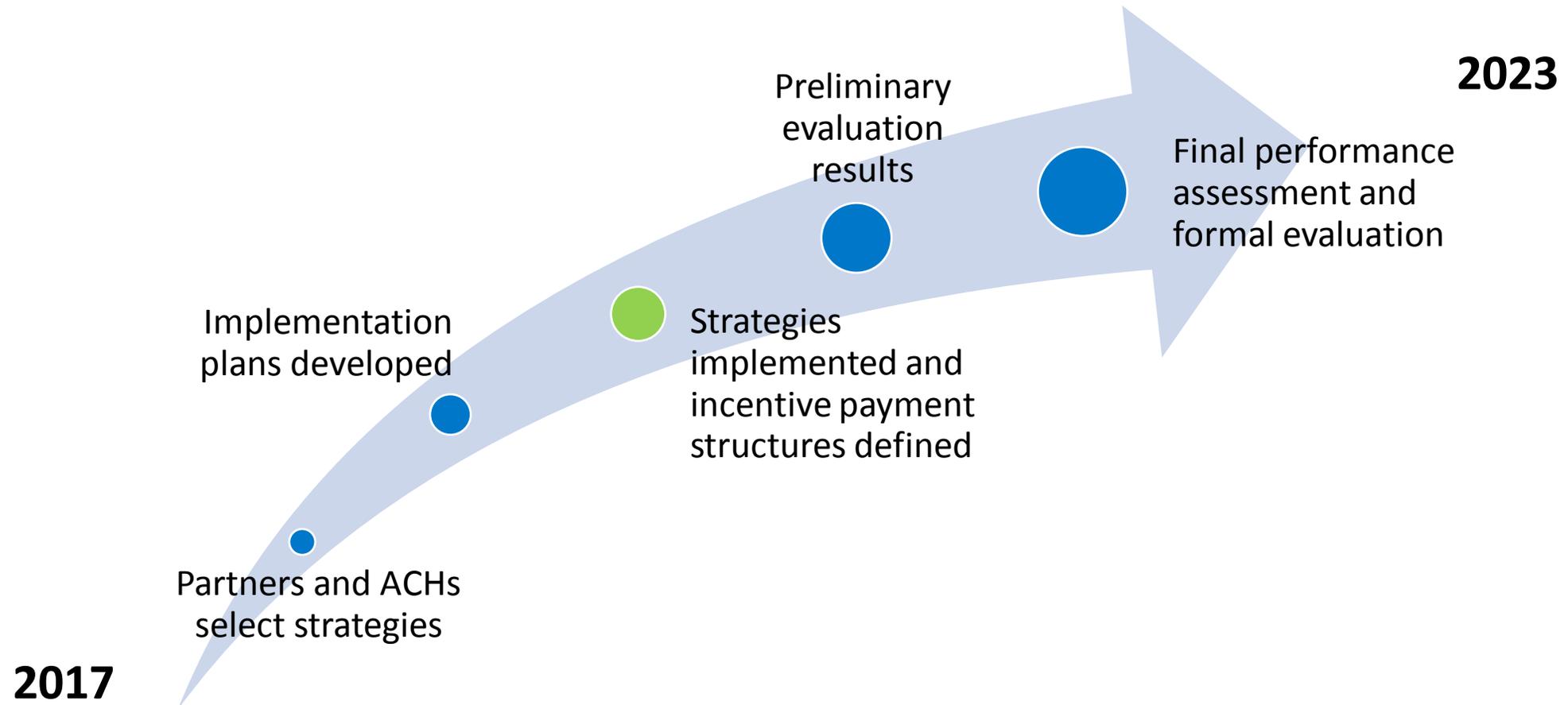
▶ Community care coordination

- ▶ Majority of factors tied to health fall outside the traditional health sector.
- ▶ Regional strategies provide continuity across organizations/providers/MCOs and ensure people have access to social supports and community resources.

▶ Health information exchange

- ▶ Efforts are underway to ensure providers have appropriate information technology infrastructure.
- ▶ ACHs are supporting connectivity among partners to enable coordinated care.

Medicaid Transformation timeline



Successes & Challenges

ALPHABETICAL ORDER





Integrated Managed Care (IMC Mid Adopter)

- Successes
 - Supporting 32 contracted providers and 3 Tribal behavioral health partners for IMC integration in January 1, 2020
 - 100% of providers currently have managed care contracts in place and are getting paid
- Challenges
 - Behavioral health reimbursement rates are impacting our region's ability to expand access
 - Continually hear from providers that community health workers/navigators **make a huge difference** in reducing costs and improving outcomes, but their work isn't currently reimbursable in Washington



Transformation Efforts

- Successes
 - 39 partnering providers, including 5 Tribal health partners, are implementing plans through pay-for-performance contracts
 - Represents 98% of the Medicaid delivery system
- Challenges
 - Severe shortages in behavioral health
 - Rural areas have difficulty keeping primary care positions filled
 - Lack of long-term funding mechanisms for care coordination in clinics and community



Community-Based Care Coordination

- Successes
 - Leveraged Medicaid \$1M from Bureau of Justice grant
 - Demonstrating a model to work across sectors with cost populations
- Challenges
 - Complex target population that interacts with many systems/sectors
 - Sustainable funding for any type of community based care coordination
 - Resources for housing and transportation to support stabilization of health







Integrated Managed Care (IMC)

- Successes
 - Hosted Adam Falcone's MCO Contracting Training
 - Contracted TA partner XPIO is working with 10 BHA partners
 - Provided funding to BHAs for EHR enhancements/implementation
 - Leading the Provider Readiness Committee
- Challenges
 - On-time adopters received **no** funding to support IMC
 - Two BHOs within CPAA's region
 - BHOs are on separate timelines with different approaches



Transformation Efforts

- Successes
 - 50 partners including all seven tribes, public health, social services, and community-based organizations
 - Over \$1.2m in braided funding to support Opioid Response and Chronic Disease projects
 - Regional training opportunities including trauma informed care, workforce retention, ACEs, motivational interviewing, quality improvement, harm reduction, buprenorphine waiver
 - Change Plans, interim measures, and reporting tool developed to track and monitor partner implementation and progress
- Challenges
 - Workforce shortages; hard to hire with state-wide efforts to increase capacity
 - Uncertainty on project sustainability
 - Lack of current data
 - Competing initiative

Community-Based Care Coordination

- Community CarePort Successes
 - Trained over 40 care coordinators across 12 Care Coordinating Agencies
 - Met annual goal of 400 clients in the first six months of implementation
 - Closed over 850 Pathways
 - Implemented system-wide quality assurance and improvement
- Challenges
 - Lack of resources to meet client needs (e.g. low availability of affordable housing, legal aid, etc.)
 - This program is the largest outlay of CPAA's MTP funding; sustainability is critical to safeguard this investment in the region



Integrated Managed Care (IMC Mid-Adopter)

Successes

- Diverse set of partners working toward the best care possible for clients
- 150+ providers participants part of IMC Network
- Held real-time Open Forum for providers to talk about and work together on issues, concerns, and solutions
- Established Primary Care Provider Network to provide assistance and resources with Western State discharges

Challenges

- Technology: many providers launched new EHR systems during go-live
- Delay of updated Service Encounter Reporting Instructions caused lag in providers building and testing claims systems
- When behavioral health organization sunsetted, there was a lack of information that left gaps unaddressed until after go-live

Transformation Efforts

Successes

- Hired and trained a team of clinical improvement advisors
- Created a strategic improvement toolkit to standardize quality improvement approach
- Led Regional Learning Collaboratives to help partners improve care delivery
- 100% Medicaid providers under accountability and risk-based contracts
- Built a multi-sector Community Resiliency Fund for sustainability and community health
- Building and leveraging capacity for transformation and outcomes-driven innovation
- Building a community information exchange to track performance

Challenges

- Lack of adjudicated claims are a barrier to tracking performance and improving outcomes
- Lack of a global consent process for patients is a barrier for data sharing
- Narrow window to demonstrate success without real-time data

Community-Based Care Coordination

Successes

- Developed Care Continuum Network for centralized and coordinated care
- Launched Pathways Community HUB with five community partners
- Launched Community Health Action Team to reduce utilization and readmission rates for vulnerable populations with complex health care needs
- Contracted with two community health centers as Care Coordination Organizations for Health Homes
- Enhancing technology applications for care management documentation
- Establishing a community asset - equitable workforce development and deployment

Challenges

- Technology solutions – variability in use of care coordination and social service referral tools within community
- Contracting for community-based care coordination, lack of long-term funding
- Misaligned incentives hindering the development of key workforce to support equitable whole-person health

Workforce

Successes

- Sent 15 staff across 7 organizations in Pierce County to the IHI improvement advisor course to increase capacity in improvement science for the region
- Train clinical teams in PDSA cycles and how to develop and document clinical workflows through learning collaborative curriculum
- Trained 8 community health workers and 6 supervisors across 5 organizations to deploy the Pathways-Community HUB model
- Funded transformation project to pilot Community Health Action Team: hired 2 community health workers; 1-integrated nurse specialist; 1-integrated mental health specialist and 1-program manager

Challenges

- Centralized community health worker training that is accessible and sustainable
- Limited incentives to create a centralized training and resource center for care coordination and other workforce development





Transformation Efforts

• Successes

- 62 clinics/hospitals (2 Cohorts) contracted with GCACH using the Patient Centered Medical Home model of care (3rd cohort to include Skilled Nursing Facilities)
- Clinical integration includes BH in Dental, MH in SUD, MH & PCP in Residential, MH in schools
- \$1.4 million distributed to CBOs to address Social Determinants of Health
- All clinics receiving hands-on technical assistance from Practice Transformation Team

Transformation Efforts

- **Successes** (continued)
 - All clinics have chosen behavioral health integration model
 - 1 Opioid Resource Network has started
 - Yakama Nation under contract for a Community Information Exchange project
 - 6 Local Health Improvement Networks working on community health priorities across the GCACH region (funded at \$30K/year)
 - Providers sharing updated procedures, recently developed job descriptions, and best practices

Transformation Efforts

- **Challenges**

- Access to Collective Medical Technologies (EDIE/PreManage)
- Attracting BH providers
- Many clinics going through EHR upgrades/changes
- Provider communication within own organization
- Staff turnover and recruiting barriers in rural areas



Transformation Efforts

- **Challenges** (continued)
 - Senior leadership and clinic sites not agreeing on which metrics to track
 - Provider leadership/buy-in to PCMH model, especially for organizations with a hospital participating in practice transformation
 - Technology implementation planned for later in the year that will allow for risk stratification, patient rostering, and population health management
 - Complying with 42 CFR for sharing information from Behavioral Health providers to Primary Care Providers or vice versa



HealthierHere



HealthierHere

IMC mid-adopter

■ Successes

- 19 BHAs participating in a 9 month VBP Academy
- 13 organizations (7 BHAs, 2 FQHCs, 4 hospitals) receiving training, TA and individualized practice coaching from the UW AIMS Center to implement and enhance models of integration thru Collaborative Care
- 27 organizations are receiving training, TA and practice coaching from Comagine Health to implement Collective Ambulatory (previously EDIE/PreManage). This includes 22 BHAs, 2 FQHCs, and 3 Hospitals that previously did not have access to the technology. In addition another 10 organizations are receiving similar support to optimize the use of the technology and integrate into clinical workflow

■ Challenges

- Lack of a shared vision for what clinically integrated care should look like across the continuum
- Lack of infrastructure/capacity of smaller behavioral health providers including sufficient financial reserves to support the transition
- Insufficient Medicaid reimbursement models to support integrated care, especially and including care coordination and peer support specialists/community health workers

HealthierHere

Transformation Efforts

▪ Successes

- *Have 27 Clinical, 55 Community Partners, 1 tribe (Cowlitz) and Seattle Indian Health Board engaged with HealthierHere to transform care*
- *27 Clinical partners are in pay for progress contracts to receive up to \$4M total this year based on progress in areas of Clinical; Population Health; VBP; and Equity*
- *Convened a Shared Care Plan Workgroup that is finalizing plans to pilot a shared care plan in our region by the end of the year*
- *Convened multiple funders/initiatives to develop a shared vision for a Community Information Exchange in the King County region and agreement to work together on a single system. Co-design work is happening this summer with a plan to begin launch in early 2020*
- *Led Clinical Learning Collaboratives to help partners improve care delivery in the areas of integrated care, opiate use prevention and treatment, prevention and management of chronic conditions and safe and successful care transitions.*

▪ Challenges

- *Lack of systemic structure for care coordination and lack of sustainable funding to support these roles*
- *Rushed timelines of the waiver interfere with the time it takes to build authentic and meaningful community and tribal engagement, threatening our potential to build stronger community-clinical partnerships and achieve our goals*
- *Providers are already overburdened with change and transformation so finding time and capacity to participate is difficult*

HealthierHere

Community-Based Care Coordination

▪ Successes

- *Partner are committed to increasing use of and capacity for peer support specialists and community health workers across the region*
- *Utilizing our innovation fund to support capacity building for community-based care coordination*
- *Engagement of 55+ community-based organizations that are in community and trusted leaders who can support capacity building and implementation*
- *Interest and momentum in King County region to support a Community Information Exchange*

▪ Challenges

- *Lack of systemic structure for care coordination and lack of sustainable funding to support these roles; Fear that we hire positions thru waiver and then have to lay them off when the waiver is done*
- *Lack of shared vision in region for what this should look like and how to align the many roles and functions of care coordination that currently exist*
- *Technology solutions to support community and clinical linkages*

HealthierHere

Workforce Development

▪ Successes

- *Sponsored 5 partner training webinars open to all providers and CBOs in our region on topics ranging from Harm Reduction to the new opiate overdose notification and many more*
- *Developed partnership with the regional Health Industry Leadership Table (HILT) focused on building health care workforce capacity and engaging youth in health care jobs*
- *Led Clinical Learning Collaboratives to help partners improve care delivery in the areas of integrated care, opiate use prevention and treatment, prevention and management of chronic conditions and safe and successful care transitions through shared learning*

▪ Challenges

- *Significant workforce shortages in region, especially behavioral health positions*
- *Salaries for many health/behavioral health positions are too low and do not support a healthy, qualified workforce*
- *Many of the workforce challenges require state policy/interventions to address; ACHs are limited in what they can do*
- *Lack of sustainable finance models for certain positions within the Medicaid program (Care Coordinators, Community Health Workers)*



North Central Accountable Community of Health



North Central Accountable
Community of Health

Integrated Managed Care (IMC) / Whole-Person Care Transformation

• Successes

- Created a system that allows 17 primary care and behavioral health agencies to interact and learn from each other (Whole Person Care Collaborative) – more partners working together.
- Quality Improvement (QI) successes: Increased technical capacity of teams through learning activities and coaching; lessons learned and tools will be shared with the region. Partners are finding significant value in regional practice facilitation.
- Successfully went to Integrated Managed Care in all 4 counties.

• Challenges

- Lack of understanding on the different payment models (e.g. VBP, Rural Payment Model) leads to fear of making costly changes that won't be reimbursed.
- Payment (including reimbursement) is different for Rural Health Clinics & Federally Qualified Health Clinics - change to whole person care does not address those clinic structures.
- Workforce Capacity & Shortages: higher turnover rates in rural positions makes it difficult to sustain QI changes.
- Lack of, or inadequate, Medicaid reimbursement for transitional care management, behavioral health integration and chronic disease care coordination.



North Central Accountable Community of Health

Community-Based Care Coordination

- Successes

- Successfully launched Pathways HUB and have engaged Care Coordination Agencies
- Early success has been strategically aligning the Health Home Care Coordination Organization (CCO) network with the Pathways Community HUB Care Coordination Agency (CCA) network. 33% of the new CCA network are experienced CCOs in the Health Home network

- Challenges

- Action Health Partners (AHP) contract negotiations with MCOs is limited due to funding restrictions created by HCA/Medicaid contracting rules restricting use of Per Member Per Month (PMPM) to pay for either of the current recognized community based care coordination models in our state
- Washington State Duals Health Home Model is recognized as a Medicaid Provider Program
- Pathways Community HUB is only considered a project and therefore not eligible to access vital data and supports that will allow strategic alignment for optimal success



North Central Accountable Community of Health

Information exchange

- Successes
 - Partners are exploring and implementing the Collective Medical® platform which provides real-time data to coordinate care for complex patients across settings.
- Challenges
 - Asset mapping: need a user-friendly, accurate and sustainable statewide solution that also integrates with care coordination IT platforms (e.g. Pathways Community HUB, Health Homes)
 - Lack of standardization in EHRs across providers leads to:
 - Inconsistent methods of collecting meaningful data.
 - Inefficient, time consuming and possibly manual data extraction.
 - Lack of statewide information exchange mechanisms continue to undermine MTP goals around whole person care and care coordination.
 - Policy decisions need to be made if Integrated Managed Care in WA is going to be sustainable.



North
Sound
A C H

Integrated Managed Care (IMC mid-adopter)

- Successes
 - Diverse set of clinical and CBO partners in each of 5 counties working to coordinate care for those impacted by BH, SUD
 - Providers are meeting regularly to address transition concerns
 - Additional non-MTP funds being leveraged to support opioid strategies
 - Dynamic Interlocal Leadership Structure, authorized by statute to oversee transition activities and challenges (includes counties, MCOs, tribes, ACH)
 - BHAs getting access to data through PreManage
- Challenges
 - Delay transition date to July 1 2019 compressed transition challenges to a shorter time period
 - Confusion re revised role of BHO as it transitioned to BH-ASO
 - Confusion re changes (or not) for FFS Medicaid enrollees

Transformation Efforts

- Successes
 - Forty-nine organizations under contract to implement initiatives
 - Strong clinical and community partners are in place in each of the region's five counties
 - All partners committed to tribal learning and advancing equity in order to achieve system transformation and innovation
 - Reporting by all contracted partners to quickly build on successes and provide TA in close to real-time as needed.
- Challenges
 - Lack of access to claims data (for individuals and for partners) is a significant barrier to tracking performance and improvement outcomes
 - Communicating that the funds are performance based rather than grants consumed a lot of time
 - Narrow window to demonstrate success without access to data that would inform mitigation strategies

Community-Based Care Coordination

- Successes
 - Launched Regional Care Coordination HUB based on Pathways model
 - HUB to be used across the region for all care coordination efforts
 - Significant partners in all five counties working together to coordinate services and strategies
- Challenges
 - Affordable technology solutions that support and enhance level of sophistication at partnering provider level
 - Long-term financial support for community-based care coordination
 - Acknowledgement of importance of SDOH, but that is not followed by adequate and consistent financial support

Olympic 
COMMUNITY *of* HEALTH

Integrated Managed Care (IMC)

The Olympic Region is preparing for on-time Integrated Managed Care adoption (January 2020)

- Successes
 - Strong engagement by Managed Care Organizations
- Challenges
 - Region includes 7 independent Tribal nations
 - Managed care is new to Clallam County (50% eligible for Medicaid) for all providers
 - Concerns regarding limited dollars to support under- and un- insured community members

Transformation Efforts

- Successes
 - 3-County Coordinated Opioid Response Project
 - Engagement by multiple sectors
 - Increase in Medication Assisted Treatment providers
 - Reduction in overdose deaths
 - 6 Building Blocks program in multiple provider organizations
 - New dental chair access in remote areas
- Challenges
 - Financial integrated managed care efforts superseding clinical transformation
 - Engagement in rural and remote areas of the region
 - Significant challenges in attracting and retaining a talented health care workforce

Community-Based Care Coordination

- Successes
 - Community Paramedicine program in Clallam County
 - Police Navigator program in Jefferson County
 - 50% reduction in Emergency Department visit at Forks Hospital due to internal care coordination strategies
- Challenges
 - Limited Health Information Exchange capabilities throughout the region



SWACH



Integrated Managed Care (IMC early-adopter)

- Successes
 - Supported successful transition with 14 behavioral health providers
 - Invested in behavioral health agency's administrative & infrastructure needs
 - Provided technical support & convening through IMC Core Group
- Challenges
 - Data submission
 - Changes in business practices & administrative workflows
 - Challenges with residential treatment authorizations



Transformation Efforts

- Successes
 - System Change & Improved Care
 - 20 organizations-physical/behavioral health integration
 - 15 participants in equity collaborative
 - 7 partners addressing social determinants
 - Community resiliency investments initiated in housing & health
- Challenges
 - Convening cross-sector stakeholders
 - Finalizing binding contracts with large systems
 - Shortage of behavioral health services in rural areas
 - Sustainability of community-based care coordination





Community-Based Care Coordination

- Successes
 - Care coordination partners in three counties
 - CHWs/peers support
 - Early results include:
 - 107 referrals
 - 1307 pathways initiated
 - 587 pathways completed
- Challenges
 - Limited community resources-rural areas
 - Technology competition
 - Long-term funding support





Workforce

- Successes
 - MAT Waiver Trainings to 80+ practitioners
 - Trained CHWs/peers through Pathways
 - Equity training
 - Quality Improvement training
 - Retention rates for middle schoolers
- Challenges
 - Resource limitations in partner organizations
 - Recruiting behavioral health workforce
 - Recruiting and sustaining a diverse workforce

