NCFAHP Quarterly

Workforce: The Power Behind Accountable Care Communities

September 2015

In this issue...

Creating a Boundary-Spanning Workforce of Health

Over the past year, our newsletters have focused on the efforts of the Foundation and state and national leaders to transform health care. Success in these efforts will, in part, be measured by the transformation of our current and future workforce. Recently, NCFAHP hosted a national webinar with 3RNET, the National Recruitment and Retention Network discussing workforce needs in the current environment, New Models of Care and their Impact on Rural Workforce.

Dr. Erin Fraher, Ph.D* framed the conversation with her presentation: "The Workforce Needed to Staff Value-Based Models of Care". According to Dr. Fraher, new roles are emerging to provide enhanced care functions.

Dr. Fraher suggests that two of the common new roles are:

- Roles that focus on coordinating care within a health care system
- "Boundary spanning" roles that coordinate patient care between health care system and community-based settings

Improving patient care and population health is dependent on "boundary spanning." It's one thing to create a descriptive title for the process and quite another to engage the workforce in the process. Change is never easy. Yet, to Dr. Fraher's point we need to "Plan to provide a workforce of health not a healthcare workforce." Additionally, she makes the following points regarding boundary spanning roles.

- Workforce planning efforts that include workers who typically practice in community and home-based settings
- Embracing role of social workers, patient navigators, community health workers, home health workers, mental health workers, dieticians and other community-based worker
- Integrating health workforce and public health workforce and planning

Hmmmm, this sounds vaguely familiar… Our May newsletter focused on Accountable Care Communities, which are defined as: *"a collaborative, integrated, and measurable multi-institutional approach that emphasizes shared responsibility for the health of the community, including health promotion and disease prevention, access to quality services and healthcare delivery. The ultimate goal of the ACC is a healthier community*." (Healthier by Design: Creating Accountable Care Communities)

At the Foundation, we are impatiently awaiting the release of the Accountable Care Community model by the CMS Innovation Center. Fingers crossed, it will provide the opportunity for uniquely partnering these "boundary spanners" together with a payment model to support the work.

Again, in a previous newsletter, Dr. Jerome Grossman and Dr. Jason Hwang's "The Innovator's Prescription: A Disruptive Solution for Healthcare" presents a compelling argument regarding the common sense of a "boundary spanning" workforce of health, "Consider this equation, 2 + 8,758. These numbers reflect the hours spent annually by each of us on healthcare during the year. Two hours is the amount of time people spend annually in a traditional healthcare provider's office, versus 8,758 hours spent on self-care."

In the article "New Project? Don't Analyze-Act!" from the March 2012 edition of the Harvard Business review, authors Leonard A. Schlesinger, Charles F. Kiefer, and Paul B. Brown make this point regarding new endeavors:
"We acknowledge that action before analysis, learning instead of predicting, can be, well, unpredictable—and messy. And we concede that it's antithetical to the way most organizations work. However, in the long term, taking lots of small steps actually reduces risk, which makes such an approach ideal for tackling challenges and getting fledgling initiatives off the ground, particularly in today's skittish corporate environment."

Perhaps with "small steps" we can create a boundary spanning workforce of health. This newsletter describes some of the "small steps" at the Foundation. The team at NCFAHP strives to be entrepreneurial leaders. I would also call the Fellows boundary spanners in their own communities. Finally, from the same article:

"Entrepreneurial leaders are individuals who, through an understanding of themselves and the contexts in which they work, act on and shape opportunities that create value for their organizations, their stakeholders, and the wider society. Entrepreneurial leaders are driven by their desire to consider how to simultaneously create social, environmental, and economic opportunities. They are also undiscouraged by a lack of resources or by high levels of uncertainty. Rather they tackle these situations by taking action and experimenting with new solutions to old problems. Entrepreneurial leaders refuse to cynically or lethargically resign themselves to the problems of the world. Rather through a combination of self-reflection, analysis, resourcefulness, and creative thinking and action, they find ways to inspire and lead others to tackle seemingly intractable problems...The only way to lead in an unknowable environment is through action."
The Bernstein Fellows are entrepreneurial leaders. In fact, Sarah Thach is the Fellow who directed me to the Harvard Business Review article. In closing, I think it's only fitting to end with one of her quotes:

"Just try it…. early frequent failures keep you limber!"

Thanks Sarah, and our thanks to the Fellows current and past!

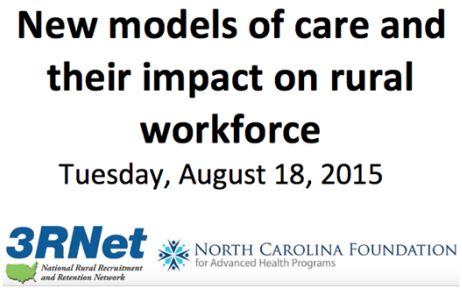
-Maggie Sauer

CEO & President

****Recently our Bernstein Fellows presented their projects to our Board of Directors. For two years, these extraordinary young healthcare leaders have spent at least 10% of their time focusing on healthcare leadership in rural North Carolina. The Foundation would like to gratefully acknowledge their commitment over the past two years as well as their employers' support of their participation.*

**Special thanks to Dr. Erin Fraher, assistant professor in the Departments of Family Medicine and Surgery, and director of the Program on Health Workforce Research and Policy at the Cecil G.Center for Health Services Research at UNC Chapel Hill.*

NCFAHP Begins the Conversation on New Models of Care

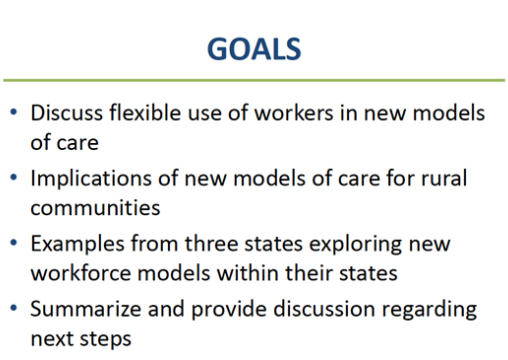


A flexible workforce is essential for the future of our health care system. A massive shift in the way services are reimbursed is coming. This prompts a similar shift in how we train the workforce that keeps our communities healthy. Federally funded insurance will pay providers based on the quality of care instead of the quantity. The Centers for Medicare and Medicaid is already funding pilot projects to encourage this change. These "value-based payment" projects are causing a bloom of experiments all over the country. The goal of these experiments is to provide patients with preventative and comprehensive care that is high quality and affordable.

It's a big challenge. But it will be easier to manage if healthcare providers learn from each other. On August 18, the NCFAHP, Practice Sights, and 3Rnet hosted the first of many webinars to begin a national conversation on the creative models in action across the country. Rural areas, because of their small size and their unique needs, are excellent places for experimentation.

The webinar is titled "New Models of Care and their Impact on Rural Workforce." The conversation was led by Erin Fraher, PhD, an expert on health workforce research at UNC-Chapel Hill, and representatives from three states presenting on projects in their community.

Erin Fraher set the stage for the discussion by explaining the difference between "old school" and "new school" workforce characteristics. In conventional, fee-for-service models, the healthcare workforce is trained to operate in isolated specialties instead of in coordinated teams. The "new school" workforce reaches patients in their community, rather than in a hospital or an acute care setting. This new workforce will maximize the responsibility of medical assistants, panel managers, dieticians, and health coaches. These teams will have a different work flow to accommodate new roles.



Fraher stresses that we will have to prepare and equip the 18 million members of our healthcare workforce for this change. Medical training will also need to include an emphasis on integrated care and include rotations with teams that are following a coordinated model.

The rural health centers from North Carolina, Oregon and Colorado are piloting a variety of projects in an attempt to launch value-based care. Every state is different, but all three are creatively addressing the unique needs of their community.

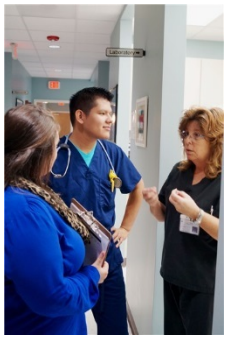
Chris Collins from the North Carolina Office of Rural Health & Community Care discussed the variety of loan repayment programs to attract medical workers to underserved areas, including therapists in integrated care settings. Collins also discussed the growth of telehealth services in North Carolina and the efforts to fill the gaps.

Melissa Bosworth of the Colorado Rural Health Center presented their work on creating a data bank to show the economic impact of their programs. Those programs include reducing the number of mentorship hours for nurse practitioners and introducing mediation services to improve office culture in clinics. The Colorado Rural Health Center is also pairing health IT students with rural clinics to help them transition to changing technologies.

Scott Ekblad from the Oregon Office of Rural Health highlighted the 16 coordinated care organizations across the state. Fourteen of these organizations are rural. These organizations have a "global budget," and are given the creative power to meet needs. They have an incentive to keep Oregon citizens well using community health teams. Medical assistants, dental hygienists and community paramedics have more responsibility and are well connected to patients in a community setting.

Practice Sights and the NCFAHP will continue the conversation on the efforts of states that are moving to value-based care. Stay tuned for the next webinar!

Training the Healthcare Workforce for Integrated Care



Most healthcare providers agree that mental health affects physical health and vice versa. However, integrating the two is not easy. Providers aren't trained to address both the mind and the body in one setting. As we transition towards value-based reimbursement, there's a greater incentive to improve quality for patients. The Center of Excellence for Integrated Care (COE) is an example of a creative approach to improving patient outcomes.

The imminent changes to our healthcare system will result in a workforce that operates differently—and that's where COE steps in. Housed in the NCFAHP, this small team provides the tools and training for integrating mental and physical health. "And we have our eyes on oral health specialists and pharmacists too." says Associate Director Christine Borst.

The COE team works in a broad range of settings, and not just traditional healthcare sites. "North Carolina is one of the most diverse states in the nation when it comes to putting teams together to meet the patient where they seek services," says Director Cathy Hudgins, "This can be a school-based clinic, a mental health or substance abuse clinic, homeless shelters, migrant worker camps and church basements."

COE breaks down the cultural and educational barriers between health sectors. This type of workforce development, dubbed cross-training, is crucial to better patient outcomes. "It's been exciting to work with universities," said Borst, "Conducting trainings early on is really helpful for developing that multidisciplinary lens."

In a healthcare practice with established workflows, cross-training requires a colossal team effort. "We work with everyone in the office, from the front desk 'eyes and ears' of the clinic, to the physicians and therapists in the back," said Borst, "Regardless of what kind of specialist you are, it's essential to work together as a team and develop a mindset of integration."

Every care site is different. Some have a behavioral health therapist in-house; others have close connections to one. Some have no partnerships or experience with behavioral health. Borst gave the example of smoking cessation or diabetes diagnosis. "These issues really require a behavioral health intervention," she said, "And not every clinic has the resources to provide that." Tailoring training to meet the needs of a care setting is part of COE's work. Every practice and every community has its assets, and COE works to create partnerships around those assets.

The biggest hurdle for integrating care is payment reform. "Everyone wants to know how to pay for it," said Borst. COE provides some direction on navigating the billing process, but it will take policy reform to dictate how behavioral health integration will be properly reimbursed.

Effective workforce training to integrate the siloes of care is an important step towards fully implementing value-based care. "There's a method to our madness," Borst said, "Laying a strong foundation for a multidisciplinary approach is the first step."

Power in Collaboration:
Rural Forward works with Communities to Uncover "Boundary-Spanners"

Rural communities are characterized by community strength and expertise on their unique needs. Rural Forward NC (RFNC) taps into that strength by bringing together rural health leaders and in some cases, highlighting leadership and unidentified community assets. The program, funded by Kate B Reynolds Charitable Trust and their Healthy Places NC initiative, supports counties in central and eastern North Carolina participating in the Initiative. Most importantly the team works with the community to expose opportunities for collaboration and leveraging community assets. Community organizations are critical to the identification of workforce "boundary spanners", individuals and organizations that provide critical connections to healthcare. These organizations can be the link between traditional healthcare setting and community self-care.

Lack of transportation, few physicians, and minimal employment opportunities make it hard for rural residents to maintain their health. Calvin Allen, Director of RFNC says, "Despite these challenges, small towns have a unique asset to build upon. People in rural communities often know each other and have established networks." Value-based care and the opportunity for community-based workers to actively participate in the health of their community recognizes the unique knowledge and influence they contribute, something the traditional healthcare system needs to successfully improve population health.

Currently, Rural Forward NC is working in Halifax County with leaders creating a community health home. The work is part of the Blue Cross and Blue Shield NC Foundation's Community Health Home initiative. Sharing data across department lines is one of the tactics that leaders in Halifax County are using to address the health of their populations, identify unmet need and create opportunities for the broader community to collaborate

During a three-hour meeting in the Halifax Regional Medical Center facilitated by the RFNC team in June, health professionals met to hash out ideas on how to get Halifax County healthier. Representatives from the community health center, public health department and hospital attended the meeting, as well as primary care physicians. They discussed further coordination to prevent the replication of services, the idea of a mobile care unit to reach frequent or repeat EMS callers, and a new data-sharing tool that the coalition has developed.

Data-sharing is an extremely useful way for communities to work together. "When you develop an intervention, data can tell you where the greatest need is, and where the greatest potentials are," says Allen. "The Halifax County team discovered a family with multiple visits to the health clinic and the emergency room for respiration problems, but had no idea until they combined data that one of the parents was a smoker." Information sharing across departments changes the intervention from treating symptoms to addressing the root cause in the household. This innovation helps departments streamline their efforts so that services aren't replicated, which makes greater economic sense, and more importantly, patients aren't receiving disjointed care.

Despite the benefits, sharing data like this can be very touchy. " A level of trust has to be established to cross long-held boundaries," says Allen. “Our local colleagues are doing an amazing job of respecting privacy and also pooling data across department lines. Fortunately, communities like Halifax County have come a long way in establishing that trust.”

In a health climate that is slowly shifting to value-based care, rural communities, especially the health care workforce, need to work even harder to collaborate around the health of the population as a whole. "It takes creative ideas, development, good case-management, and co-operation," says Allen, "We are seeing the value of crossing department lines when health leaders look beyond their departments and take a collective view of their community."

Bernstein Fellow Alumni Ron Gaskins Testifies to the Power of Team-Based Care

It takes a cooperative and effective workforce to accomplish value-based, quality-driven care. Ron Gaskins, executive director of Access East, is an alumni of the Jim Bernstein Fellows program. Gaskins is leveraging healthcare communities in the direction of team-based care.

Access East is a nonprofit located in Greenville, NC, whose mission is to improve the health status of the underserved and indigent in eastern North Carolina through enhancing access to quality health care and implementing and coordinating healthcare delivery models. Access East is part of Community Care of North Carolina, a care network that's evolved over 25 years, with support from the NCFAHP.

"We provide wrap around services for high-risk Medicaid patients with an interdisciplinary team focus," said Gaskins, "We deploy care managers to the home in a timely fashion in order to keep patients out of the hospital."

The interdisciplinary team at Access East and their partners collaborate with primary care providers in an ambulatory setting to proactively engage and manage chronically ill patients before their conditions become severe enough to merit care in higher-cost, more acute settings such as the emergency room. Access East uses a vast network of professionals (e.g., registered nurses, social workers, pharmacy technicians, pharmacists, patient advocates, health coaches, etc.) to support its initiatives, which encompass transitional care, medication management, pediatrics, chronic pain, palliative care, and behavioral health integration. The goal is to navigate patients to the right level of care.

"Workforce development is key," said Gaskins. “As value-based reimbursement becomes more and more prevalent, the right prescription of team-based care will be vital in effectively managing populations.” Access East has built a workforce infrastructure to ensure the transition to proactive and coordinated care. “This infrastructure requires a holistic framework around workforce diversity that taps into the many different backgrounds and experiences that professionals can bring to the job,” Gaskins added.

The constant need for more healthcare professionals looms in the background of every conversation on rural health. "More primary care physicians are needed, of course," said Gaskins, "but to meet the demands in care that the coming decades will bring with baby boomers retiring and medicine extending lives longer will require using mid-level providers (i.e., nurse practitioners and physician assistants) to fill in the gaps. Moreover, connecting support staff such as nurses, social workers, and community health coaches with direct providers, we will begin creating team-based care models that can further assist in engaging patients and improving health outcomes.”

Gaskins gives the example of boosting the role of pharmacists in the coordination of value-based care. "The data tells us that Medicaid patients on average visit their primary-care provider two to four times a year, while they see their community pharmacy close to 20 times a year," said Gaskins. "With this

frequency of exposure to the patient, it makes perfect sense to engage the pharmacist out in the community more on chronic disease management."

To accomplish this, Access East is partnering with Community Care of North Carolina on a project called Community Pharmacy Enhanced Services Network (CPESN) that financially rewards community pharmacists for conducting on-site education around medication management when people pick up their prescription, and reporting any important information back to the patients care manager and primary care provider. "We see the potential of expanding the medical home to more of a medical neighborhood mentality that encourages the cross-pollination of professional disciplines throughout the community," Gaskins said. What's needed to empower a workforce that drives value-based care? "Strong community connections, solid care coordination, and holistic, interdisciplinary teams," he said. "We're piloting projects to see what works."

The Foundation is excited to announce Ron Gaskins, Bernstein Class of 2011—2013, as the first Distinguished Fellows Award Recipient. Ron will receive this award at the 10th Annual Jim Bernstein Health Leadership Dinner on October 8th, 2015.

Zulayka Santiago Brings a Social Justice Background to the Oral Health Collaborative

The North Carolina Oral Health Collaborative brings together partners across the state to address oral health gaps. Zulayka Santiago joined our team as director in August. Her vast nonprofit experience includes working in the public, private, philanthropic, nonprofit and cooperative sectors. To learn more, we asked her some questions about her life's work and her interest in oral health:

What attracted you to the Oral Health Collaborative?
My career thus far has had some interesting twists and turns. Yet themes that are consistent throughout are a commitment to social justice, equity and community building. All you have to do is scratch the surface to understand that there are strong intersections between oral health and health equity. The people most directly impacted by the disparities in oral health are the same folks that are experiencing very similar health disparities in other areas: working class or poor people of color, our elders, folks in rural areas and people with intellectual and developmental disabilities. It is simultaneously heartbreaking and inspiring to know that dental caries remains the number one chronic disease of childhood, even though it is entirely preventable. This is part of the work of the NCOHC is to highlight the 'entirely preventable' aspect of this astounding fact and to work together to implement solutions.

Where were you before accepting this position?
I had been an independent consultant for almost 3 years immediately before starting this position. Prior to that I had taken a year to focus on being a full-time mother to my newborn daughter, and prior to that I had a brief, but significant role as a Program Officer in Health Disparities with the NC Health and Wellness Trust Fund.

How does your background in social justice and equity connect to the NCOHC?
There are many reasons why inequities in oral health exist including: lack of health literacy, limited English proficiency, cultural, societal and economic barriers. Part of these inequities are also linked to the workforce issues facing healthcare as a whole. Regardless of geography, socioeconomic background, race, ethnicity, age or mental/physical ability, it is tremendously important to ensure that all North Carolinians have access to good dental care, provided by someone they trust, in a timely and compassionate manner.

I think part of my role will be to find a way to help create space for and elevate the voices of the folks most directly impacted by these issues. I am all too familiar with 'outsiders' flocking into marginalized communities and dictating how and why things should be done. It is important that the work we lay out for this collaborative be relevant, respectful and considerate of the folks who have to grapple with these issues at a community level.

What are your hopes for the position?
I am a strong believer in the power of the collective. This type of transformative work requires us to work across difference of silos, sectors, political ideology, etc. towards goals that will benefit all of North Carolina. There is great potential in this work. Potential for dramatic change within our lifetime and that is very exciting to me. My hope is that we can build upon the wonderful work that has already been

done and develop a comprehensive plan of action that will bring to life NCOHC's mission of reducing oral health disparities and promoting improved oral health for all North Carolinians.

In your experience, what's been the best strategy for successful collaboration in the non-profit world? Building authentic and trusting relationships. Relationships are the key to so many things, and definitely for successful collaborations. Focusing first on the vision, mission and values that bring us together and then laying out a roadmap with some clear goals and outcomes that benefits our individual organizations and pushes the work of the collaborative forward. There is already an incredibly powerful, dedicated, and well-connected group of folks that make up the collaborative. Now it's just a matter of keeping them engaged and figuring out the best way to harness their brilliance towards achieving our collective goals.

Neftali Serrano Joins the Center of Excellence for Integrated Care as Associate Director

The Center of Excellence for Integrated Care adds another level of expertise by welcoming Neftali Serrano as Associate Director. The Center of Excellence aims to integrate patients' physical and behavioral health across health care settings. Serrano has years of experience doing just that, and we asked him a few questions to get to know him better:

What attracted you to the Center of Excellence?
After 14 years as a clinician and program developer I was looking for an opportunity to train a behavioral health workforce in primary care in a more efficient, scaled fashion. The Center of Excellence provides this opportunity to engage an entire state in developing an integrated care workforce. This is a really exciting opportunity.

Where were you before accepting this position?
Before coming to the Center of Excellence I was the director of behavioral health at Access Community Health Centers in Madison, Wisconsin where I developed a primary care behavioral health program that is one of the most mature and successful programs in the country. The team there is great and one of my proudest accomplishments professionally is that when I left the program was a strong as it ever was and will continue on in perpetuity as a result.

What are your hopes for the position?
I hope that in five years or so we are all able to look back and reflect how we were able to train hundreds of behavioral health professionals to provide integrated care to thousands of patients across the state of North Carolina and set a model for how to do so in a sustainable fashion for other states to follow.

In your experience, what's been the best strategy for successful behavioral health integration?
The keys to successful integration are actually pretty simple. First, it is essential to have a relatively healthy organization. No project of any kind thrives in a dysfunctional organization. Second, it is essential to have clear that one of the main goals of integration is to support the day-to-day work of primary care clinicians. In other words, whatever you do should make life easier for the main cogs of your workforce. Third, you need behavioral health professionals who are truly able and willing to adopt a new professional identity related to primary care. Mental health professionals who work in primary care become a new breed or type of professional and embracing this is core to working through all the inter professional issues that will arise. And of course it is essential the mental professionals remember the first key, which is the primary care clinician is their first customer.

Introducing the NC Rural Health Leadership Alliance

The NCFAHP is excited to announce the formation of the North Carolina Rural Health Leadership Alliance (NCRHLA). The Alliance is comprised of nonprofit and government leaders working in health and rural development. These rural health leaders have been meeting informally for 25 years. The original team included the following organizations and people: NC Office of Rural Health (Jim Bernstein), NC Medical Society Foundation (Harvey Estes) and NC Area Health Education Centers (Gene Mayer). They met at least monthly to discuss how they could partner regarding the rural health needs of North Carolina. Since 2014, the NCRHLA has grown and aligned itself to do the work as recommended by the North Carolina Institution of Medicine's Rural Health Task Force.

The present-day Alliance is now becoming an official organization with technical assistance and grants from the National Rural Health Association. The NCFAHP will serve as the administrative home for the Alliance. The health and flourishing of rural communities is of prime importance, as one-in-five North Carolinians reside in a rural area. Rural communities struggle with the challenges of economic depression, lack of health-care access, and substance-use risks. Despite these challenges, rural communities are resilient and grounded in a sense of place. The Alliance intends to find solutions to rural challenges by harnessing the strengths of these communities and mobilizing existing rural organizations and leaders. The purpose of the Alliance is to act as a base for collaboration and partnership. The structure and size of the Alliance will continue to be flexible, and will be guided by the work of the group. For now, the Alliance has structured itself into six work groups based on the goals outlined by the “North Carolina Rural Health Action Plan”;

1. Invest in small businesses and entrepreneurship to grow local and regional industries.
2. Increase support for quality child care and education (birth through age 8) and parenting support to improve school readiness.
3. Work within the formal and informal education system to support healthy eating and active living.
4. Use primary care and public health settings to screen for and treat people with mental health and substance-abuse issues in the context of increasingly integrated primary and behavioral health care.
5. Educate and engage people in rural communities about new and emerging health insurance options available under the Affordable Care Act and existing safety net resources.
6. Ensure adequate incentives and other support to cultivate, recruit, and retain health professionals to rural and underserved areas of the state.

Each of these work groups is made up of members who work in related fields and can lend their expertise and resources. The work groups meet between quarterly meetings of the collective Alliance to facilitate progress in their designated work areas and to develop communication materials regarding the needs and the efforts in the work area.

NCFAHP Team takes on the Komen Race for the Cure

Some of us walked, some of us strolled and some of us offered moral support from home, but together the NCFAHP staff and board members participated in the Triangle Komen Race for the Cure this year.

The Susan G. Komen Race for the Cure is the largest breast cancer fund and awareness initiative in the world, gathering thousands of participants all over the country in state-by-state events. The Triangle event was held early on June 13 at Meredith College. A sea of white and pink runners and walkers started on Hillsborough Street in Raleigh, and wound its way through tree-lined neighborhoods. Residents and supporters cheered on the participants, handed out water, and turned their sprinklers towards the road as the grateful crowd of runners passed by.

The NCFAHP participated as a team in support of former board member Laura Gerald, who was diagnosed with cancer in 2014. In her honor, the team raised close to $600. As of this month, we are happy to report that Laura's cancer is in remission! All proceeds from the Komen Race for the Cure are used for breast health education, breast cancer screening and prevention, and associated grant programs.