Draft Strawman Recommendations for Taskforce Review

Contents

Recommendation 1

CONTEXT: Health drivers outside clinical care are typically addressed at the community level by human services organizations operating in the social services and nonprofit sectors, which are not usually coordinated with clinical care. Bringing partners together across multiple sectors can reduce health care use while improving outcomes. For health care delivery systems and providers who historically receive most of the health care dollars, the movement away from fee-for-service payments toward global payments tied to health outcomes demands that they begin to look for opportunities to achieve cost savings. Often these opportunities for cost savings come by creating conditions for people to be healthy in their homes and communities—work typically done by community social service providers and others outside the health care delivery system.

Health systems[1] should be more consistently engaged with communities and support the community-based workforce. Health systems/hospitals, Federally Qualified Health Centers (FQHCs) and community-based organizations[2] (CBOs) should create more formal and informal partnerships to enhance the use of their workforce in communities across the state, and to fill gaps in the health care and public health workforce. This work should be driven by social determinants of health data in addition to clinical data, which will address the medical and social needs of community residents. Health systems and CBOs can work together in the following ways to enhance the use of their workforces:

[1] The Compendium of U.S. Health Systems, 2016, defines a health system as an organization that includes at least one hospital and at least one group of physicians that provides comprehensive care (including primary and specialty care) who are connected with each other and with the hospital through common ownership or joint management.

[2] A CBO is a public or private nonprofit organization that is representative of a community or a significant segment of a community and works to meet community needs. Examples of CBOs include schools, housing agencies, food pantries, legal aid, faith communities, social justice organizations, organizations with youth and family-based missions, law enforcement, parks and recreation, Area Agencies on Aging, advocacy organizations, domestic violence shelters and homeless shelters.

1a) Utilize data from community health needs assessments (CHNAs) to drive priorities for the composition of the workforce needed on the community level. Health systems, DHEC and their partners should ensure inclusion of a broad variety of social determinants of health data in CHNAs to support this.

- Partners: Nonprofit health systems and DHEC should share and leverage the data they collect in the CHNA process
- Implementation timeline: within 1 year be prepared for future CHNAs to focus on environmental and social factors

1b) Health systems should use their community benefit/charity care resources to invest in needs outlined in CHNAs, including addressing initiatives, social determinants of health and workforce needs. The Tri-County CHNA, the SC Rural Health Action Plan and the SC State Health Improvement Plan can serve as examples.

- Partners: Health Systems, CBOs
- Implementation timeline: 1 year

1c) Develop county-based community advisory boards in each county across the state, connected to existing coalitions to support improved communication, shared problem-solving and increased accountability within and among the workforce of health systems/hospitals, FQHCs and CBOs. Each community shall decide what entity will serve as the administrative home (and health systems and DHEC should help to fund). This will require a professional public health outreach workforce with skills in communication, collaboration and population health. Utilize multi-sector collaboration and investment to support communities through improvement of health and social services.

These community advisory boards should hold reverse job fairs in each county of the state on a bi-annual basis to promote understanding of partnering organizations and encourage increases in the quantity and quality of partnerships. For example, consider a model such as the Pathways to Possibilities[3] program, a hands-on youth career expo that introduces 8th grade students to potential career paths and informs them about the education necessary to hold positions in various industries. The program has been implemented in Biloxi, MS and Myrtle Beach, SC.

Community advisory boards should also leverage existing community resources and develop connections to leverage these resources, identify the gaps in service and action plans to address them, develop common language, common definition of terms and common metrics to promote effective collaboration across sectors.

- Partners: South Carolina Area Health Education Consortium (AHEC), health systems/hospitals, FQHCs, CBOs
- Implementation timeline: 1 year to establish; full implementation within 2 years

[3] https://www.pathways2possibilities.org/about-p2p/

Recommendation 2

CONTEXT: Medical providers[4] should be more informed of their patients' social determinants of health. Medical providers, CBOs and agencies working with the same clients often do not share data and information that would improve the quality of care, allow for targeted interventions, save resources and improve health outcomes.

North Carolina's 1115 waiver has received CMS authorization for a five-year demonstration period for two to four pilots in which Medicaid funds can be used to address social determinants of health related to food insecurity, housing, transportation and housing. This work aims to adjust the current fee-for-serve payment model to a managed care model. State and federal Medicaid funding of up to $650 million has been authorized to support the pilots.[5]

To prepare for the upcoming pilots, NCDHHS is partnering with NCCARE360[6] to screen for social determinants of health and link health care entities with community-based organizations through the North Carolina Resource Platform.[7] The platform has been developed through a public-private partnership between health insurers, associations and nonprofits.

Similarly, Prisma Health is assessing the NowPow multi-level technology platform that drives community level collaborations across the entire continuum of care. The platform empowers providers to promote quality community resources, make data-driven referrals and track patient engagement and activation. The tool supports patients across the risk spectrum and supports many use cases while driving toward the goal of patient self-care and fosters collaboration between health providers and community organizations.[8]

2a) To better optimize the current health and social services workforce, electronic health records (EHRs) should include data on social determinants of health. Mechanisms for bidirectional data sharing should be implemented for community-based organization (CBOs) and medical providers. Additionally, stakeholders should be fully trained on administration of social determinants of health screening tools. Medical providers should have a consistent and trained individual on staff responsible for integrating, screening and entering social determinants of health into electronic health records. This will inform the approach to medical care and will support bilateral data sharing via mutually beneficial collaboration between medical providers and CBOs.

[4] Medical providers include health systems, hospitals, physicians/physician practices, rural health clinics, Federally Qualified Health Centers, free clinics and CBOs providing direct patient care.
[5] https://files.nc.gov/ncdhhs/SOCIAL DETERMINANTS OF HEALTH-HealthyOpptys-FactSheet-FINAL-20181114.pdf
[6] NCCARE360 is a joint-venture of United Way of North Carolina and its NC 2-1-1 information and referral system; Unite Us, the nation's leading care coordination platform integrating healthcare and social services; Expound Decision Systems, a leader in business intelligence, system integrations, and data repositories and Benefits Data Trust, a national nonprofit that provides streamlined benefits enrollment assistance.
[7] https://foundationhli.org/2018/08/21/ncccare360-selected-to-build-a-new-tool-for-a-healthier-north-carolina-the-nc-resource-platform/
[8] http://imph.org/wordpress/wp-content/uploads/2018/09/Risk-Reward-and-Population-Health-A-Health-System-Response-Angelo-Sinopoli-10-1-18.pdf

- Partners: AHEC, EHR vendors, medical providers, CBOs
- Implementation timeline: 6 months to establish; implementation by end of second year

2b) Medical providers should develop consistent referral processes (protocols) and data tracking systems to recommend clients to other providers/organizations that can help meet their needs when their screening results indicate they could benefit from additional resources. Additional tracking should indicate when and how these resources are utilized. South Carolina should have a contract for a common social determinants of health screening tool used by all organizations in the state.

- Partners: AHEC, medical providers
- Implementation timeline: 6 months to establish; implementation by end of second year

2c) Train and incentivize appropriate personnel at medical providers to screen for social determinants of health. Share the data with referral sources and make referrals to CBOs based on the results. AHEC can help to develop and support training needs for the existing workforce; their regional centers cover the entire state for medical provider continuing education.

- Partners: AHEC, medical providers, referral sources, CBOs
- Implementation timeline: 6 months to establish; implemented within 1 year

2d) The South Carolina Department of Administration's Office of Revenue and Fiscal Affairs, SCDHHS, health systems and other medical providers should use their public relations workforce and expertise to address fears around HIPAA and cultivate an acceptance of data sharing.

- Partners: the SC Department of Administration's Office of Revenue and Fiscal Affairs, SCDHHS, health systems, other medical practices
- Implementation timeline: Strategy conceptualized and implemented within 1 year

2e) The state should invest in an evaluation to demonstrate the effectiveness of data sharing between and among medical providers and CBOs. A formal data analysis process and administrative home are needed to demonstrate the return on investment (ROI) of data sharing. Members of the data analytics and informatics workforce are needed to perform many of the required functions, a factor also outlined in recommendation 4b.

- Partners: SCDHHS, medical providers, CBOs
- Implementation timeline: Outreach in year 1; implemented by year 2

Recommendation 3

CONTEXT: Volume-based payment mechanisms are shifting to value-based payment mechanisms and the cost and composition of the current health care workforce is unsustainable under the new value-based payment systems. More paraprofessionals, allied health professionals and nontraditional health

care professionals are needed to allow clinicians to perform at the top of their license and to increase access to care and improve health outcomes.

3a) Stakeholders should identify and implement payment mechanisms to support specific health roles needed to address social determinants of health and promote prevention, in order to encourage the growth and utilization of roles that are well-positioned to improve population health outcomes at an affordable cost. The South Carolina Office for Healthcare Workforce at AHEC can help identify emerging roles, track educational pipelines and supply and track how demand for these roles are changing across the state as a means of measuring progress.

- Partners: South Carolina AHEC Office for Healthcare Workforce, the South Carolina Legislature, CBOs, health systems, _____
- Implementation timeline: 5 years

The IMPH Workforce for Health Taskforce will identify the most critical health roles for consideration. Below is a draft list of roles that support value-based care models drafted by the Workforce for Health Advisory Committee on 12/17/18:

- CHWs
- Community paramedics
- Peer support specialists
- Health information technology specialist – analytics & data management
- Personal care assistants/direct care workers – unlicensed
- Social workers
- Addiction Counselors
- Psychologists
- Scribes – EHR data entry
- Pharmacists – med reconciliation
- Dentists/dental providers
- Case managers

3b) South Carolina should develop payment policies and procedures to support the development of emerging health roles within the context of value-based payment.

- Partners: Health insurance providers, other payers, the South Carolina Legislature, the South Carolina Department of Insurance, the South Carolina Hospital Association, health systems across the state
- Implementation timeline: Outreach through year 1; implementation by year 2

3c) Payers should implement the identified payment mechanisms.

- Partners: SCDHHS, South Carolina Blue Cross Blue Shield, _____
- Implementation timeline: 3 years

3d) Health systems that have accountable care organizations (ACOs) or fully at-risk population health models for their employees and/or the people they serve (Medicare Advantage, fully insured employee population, etc.) should employ these types of workers.

- Partners: Health systems, ____
- Implementation timeline: 4 years

Recommendation 4

CONTEXT: Training and education of health care professionals does not currently include enough focus on population health, social determinants of health, behavioral health, aging in place or community-based care. For example, in a 2017 Leavitt Partners poll of physicians[9], 69 percent said that physicians and insurers should not be responsible for addressing patients' transportation limitations. Ninety-one percent conveyed that finding affordable housing for patients should not be in their purview.

4a) Public and private education and training institutions (including degree and certification programs) should collaborate across disciplines and sectors to train health and human service students in population health, prevention and the effects of social determinants of health. Additionally, they should provide continuing education to members of the existing health care workforce on social determinants of health and community-based care. AHEC can serve as a neutral partner to pull together the collaborators for this in regional and/or statewide work groups.

- Partners: AHEC, public and private education and training institutions
- Implementation timeline: 3 years

4b) Public and private education and training institutions across South Carolina should develop educational and training curricula to match the needs of the population. An example of this is the South Carolina AHEC Scholars program, which is a part of a national initiative to prepare tomorrow's health professionals to become leaders in interprofessional, transformative practices that serve those who need it the most. The program consists of didactic and experiential training opportunities with a focus on interprofessional primary care and service to rural and underserved populations.[10] Institutions can use data, community health workers, community needs assessments and asset mapping to understand the needs and assets of a community (especially its aging population).

These organizations should also focus on the need for a workforce to perform the necessary data informatics and analytics. The legislature should help fund the expansion and development of these programs. For example, the Master of Health Information Technology (HIT) program at the University of South Carolina should be expanded in order to produce more health IT analysts. The program offers core requirements that include management of health information systems, project management,

[9] https://www.beckershospitalreview.com/population-health/physicians-say-social-determinants-of-health-are-not-their-responsibility.html
[10] https://www.scahec.net/students/ahecscholars.html

health care administration, systems analysis and design and health care database systems. AHEC can create and/or distribute continuing education modules for HIT professionals interested in career development, but not an advanced degree.

- Partners: AHEC, the South Carolina Legislature, public and private education and training institutions, the Commission on Higher Education, CBOs
- Implementation timeline: design within 6 months; implement within 1 year

4c) Public and private academic and training institutions, medical providers and CBOs should collaborate to offer all health and human services students hands-on interprofessional experiences in the community through formalized partnerships between the partners listed below.

- Partners: the South Carolina Technical College System, the Commission on Higher Education, Together SC, South Carolina Hospital Association (SCHA), South Carolina Primary Health Care Association (SCPHCA), South Carolina Office of Rural Health (SCORH), the SC Free Clinic Association, AHEC
- Implementation timeline: 2 years

4d) Public and private education and training institutions should coordinate student calendars to allow for ongoing interprofessional engagement to include more mixed and shared classes and for community-based experiences (including retraining and continuing education). These institutions should also use a team-based model for health care when possible (In rural areas where the supply of health care professionals is limited, team-based care may not always be possible; however, telehealth can augment care delivery. See recommendation 5c for more on telehealth.)

All relevant academic and training institutions

- Partners: AHEC, all preceptors and their affiliated universities, all health and human services education programs, public and private education and training institutions
- Implementation timeline: 2 years

4e) All relevant academic and training institutions should coordinate requests for student placement across disciplines through a registry/clearinghouse.

- Partners: AHEC, the South Carolina Commission on Higher Education (SCCHE), public and private academic institutions
- Implementation timeline: _____

4f) Remove cost as a barrier to education at all levels and create clear workforce pathways for students and the existing workforce. Consider the use of lottery funds to support the education of high-need, high priority health workforce roles. Develop pathways for underrepresented minorities, especially in rural areas, to develop a more diverse health care workforce.

For example, North Carolina has the National Health Service Corps State Loan Repayment Program which requires a dollar for dollar state match to draw down federal funds to offer student loan repayment to clinicians. Forty-two states are participating in the program. The option to opt in via a federal grant is only available every 4 years. South Carolina did not apply in 2018 and will not have another chance until 2022.

- Partners: The South Carolina Legislature, the South Carolina Commission on Higher Education (SCCHE), public and private academic institutions
- Implementation timeline: 5 years

4g) The South Carolina Legislature should support the creation of incentives, such as tax breaks, to attract primary care preceptors for in-state students. Budgetary challenges make it increasingly difficult to place public university students with preceptors in South Carolina. S.351 (Alexander) was written to address the issue by offering individual income tax credits for volunteer preceptors accepting medical, nursing and physician assistant students from public universities in the state. Tax incentives are one way to level the playing field for public institutions trying to compete with private or for-profit entities that can pay preceptors for accepting students. Criteria in the bill states that practitioners must volunteer with a public college in a qualified setting and must care for a minimum of 30 percent Medicare or Medicaid patients to fill the void in rural and underserved areas.[11]

- Partners: AHEC, members of the South Carolina Academy of Family Physicians (Trident Technical College, AnMed Health, McLeod Family Medicine Center, Prisma Health, Self Regional Healthcare, Tidelands Health, Seneca Lakes, Spartanburg Regional Healthcare System), the South Carolina Legislature
- Implementation timeline: 3 years

Recommendation 5

CONTEXT: Family caregivers require significantly more support than they currently receive, given that they provide a critical resource to the expanding aging population (in the U.S., approximately 10,000 people turn 65 every day[12]). As of 2015, about 43.5 million family caregivers provided free care to a patient in the previous year. Patients were, on average, 69.4 years old, with the average age of caregivers at 49.2. Fifteen percent of caregivers took care of 2 adults. A majority, 39.8 million, took care of patients with an illness or disability[13]. Many family caregivers experience compassion fatigue, "an extreme state of tension and stress that can result in feelings of hopelessness, indifference, pessimism and overall disinterest in other people's issues."[14] Unlike more formalized health care positions, family caregivers are unlikely to have peer support or the ability to take sick days or vacations. Additionally, the

[11] South Carolina Hospital Association update
[12] https://blog.caregiverhomes.com/stateofcaregiving
[13] https://www.caregiver.org/caregiver-statistics-demographics
[14] https://www.agingcare.com/articles/compassion-fatigue-caregivers-beyond-burnout-196224.htm

care provided by family members represents a significant health care expenditure. If skilled nursing care replaced family caregivers, the cost per year would total $642 billion.[15]

5a) Better support family caregivers, especially as it allows people to age in place, through the adoption of recommendations created through the technical assistance project with the Center for Health Care Strategies. Partners for this project are being identified in on ongoing basis; the state leadership team includes the South Carolina legislature, South Carolina AARP, the South Carolina Institute of Medicine & Public Health and the South Carolina Department of Health and Human Services (DHHS). South Carolina is one of five states selected to improve support for family caregivers. The Center for Health Care Strategies is providing twelve months of technical assistance in examining family caregiver capacity. There are five areas of opportunity:

(1) Support of communities in developing grassroots resources that support family care givers in those communities with resources right for those communities,
(2) Targeted training and direct technical support for family caregivers to provide them with the knowledge, tools and strategies necessary to support an aging relative with complex needs,
(3) Targeted incentives to promote family caregiving, including improvements to the availability and support of in-home respite care,
(4) Pursuit of Managed Long-Term Services and Support payment reform and
(5) Employment policies that support the efforts of family caregivers.

- Partners as of January, 2019: The Center for Health Care Strategies, the South Carolina Legislature, South Carolina AARP, the South Carolina Institute of Medicine & Public Health, SCDHHS
- AHEC can help develop training and/or make their training platform available.
- Implementation timeline: by January 2020, South Carolina will have a plan with measurable objectives and timelines for supporting family caregivers.
- Implementation timeline: _____

5b) In order to better support family caregivers and equip them for their jobs, implement the Caregiver Advise, Record, Enable (CARE) Act in South Carolina, utilizing the New York state toolkit detailing the state's experience with implementation.[16] According to AARP, "the CARE Act requires hospitals to: Record the name of the family caregiver on the medical record of your loved one; Inform the family caregivers when their loved one is to be discharged; and provide the family caregiver with education and instruction of the medical tasks he or she will need to perform for the patient at home."[17]

- Partners: South Carolina Legislature, South Carolina Hospital Association
- Implementation timeline: _____

[15] https://blog.caregiverhomes.com/stateofcaregiving
[16] https://www.nextstepincare.org/uploads/File/Guides/NYS_CARE_Act_Hospital_Toolkit.pdf
[17] https://www.aarp.org/politics-society/advocacy/caregiving-advocacy/info-2014/aarp-creates-model-state-bill.html

Recommendation 6

CONTEXT: The work provided by direct care workers (DCWs) is important, challenging and complex, but these workers often receive insufficient training. Training in South Carolina is not standardized, and requirements vary across care settings, funding source and occupational categories. Currently, DCWs certified as nursing assistants or home health aides have the most rigorous and defined training, due to federal training standards set by Medicare and Medicaid. There are no such federal training standards for other DCWs, which contributes to inconsistencies in training and variations in quality of care. In its landmark report "Retooling for an Aging America" the Institute of Medicine recommends that states should "establish minimum training requirements for personal-care aids."[18] With increasing numbers of individuals being served in home and community-based settings, these workers need adequate training because they may have less supervision in these settings, must work more independently and are increasingly dealing with more complex care needs. Training has been linked positively to higher job satisfaction, improved retention rates and decreases in turnover.[19]

6a) Establish the infrastructure for a comprehensive statewide training program for DCWs in home and community-based settings that will improve health outcomes. Given that direct-care workers are in a service profession and clients can be emotional, resistant, cognitively-impaired, etc., DCW training should include interpersonal communication and people skills.

A set of core competencies should be established for training purposes. For example, competencies may include hands-on education, communication, facilitation of individualized services, crisis prevention and intervention, dignity of risk, safety, professionalism and ethics, participant empowerment, cultural competency, supporting health and wellness and interpersonal and family relationships.[20]

The statewide training program should be responsible for outreach to diverse populations to increase diversity in the workforce pipeline. DCW positions can be framed as the first step in a life-long health provider career path. for example, working as a DCW can be the first step to eventually becoming a nurse practitioner.

Ongoing training and career counseling programs should be put in place to provide a career pathway for DCWs and expand their skill sets. Workers do not have an obvious career trajectory for promotions and higher-paying positions.

- Partners: SC AHEC, the South Carolina Technical College System
- Implementation timeline: _____

[18] IMPH Guide for Improving Long-Term Care in South Carolina
[19] Institute of Medicine (IOM). 2008. Retooling for an Aging America: Building the healthcare workforce. Washington, DC: The National Academic Press.
[20] Improving Professional Caregiving in the United States, United Healthcare

Recommendation 7

Context: According to HRSA, telehealth is, "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration."[21] Examples of telehealth clinical services include consultation with a patient at a distant clinical site or their home, consultation between two clinicians, remote monitoring of a patient and secure asynchronous electronic transfer of patient data (such as lab results) from one provider to another. Telehealth extends the capacity of the current healthcare workforce in many ways, including increasing access to expert care, decreasing door-to-needle time, reaching rural populations and decreasing unnecessary referrals.

7a) Implement telehealth policies that will extend the capacity of the workforce to meet the needs of communities, especially in rural parts of South Carolina. Train local providers to work with a remote workforce. Fund and implement the South Carolina Telehealth Alliance strategies.[22]

To fully benefit from telehealth, expanded broadband access is needed in rural areas of SC. Map all broadband capacity throughout the state, including residential and health care points of access, to identify gaps that need to be addressed in rural areas.

Additionally, payers should be responsible for reimbursement. The state should remove policy barriers, such as not reimbursing for same-day visits and altering the originating site eligibility requirement so patients can receive services in the home instead of only in a hospital or clinic.

- Partners: The South Carolina Rural Infrastructure Authority, the South Carolina Office of Rural Health, Palmetto Care Connections, the South Carolina Telehealth Alliance, SCHA, SCAHEC Office for Telehealth Education, the South Carolina Legislature, the South Carolina Telecommunications and Broadband Association
- Implementation timeline: 3 years

[21] https://www.healthit.gov/topic/health-it-initiatives/telemedicine-and-telehealth
[22] http://imph.org/wordpress/wp-content/uploads/2018/07/SC-Telehealth-Workforce_Jennifer-Bailey-and-Kathryn-Cristaldi-Presentation-71918.pdf