The Workforce Implications of New Health Care Models

Healthcare Task Force Report to the Illinois Workforce Investment Board

September, 2014

Introduction and Overview

The Illinois Workforce Investment Board (IWIB) re-established the Healthcare Task Force in 2013 to develop recommendations for addressing workforce development needs in the healthcare sector in Illinois. The task force was asked to focus on identifying major trends and new directions in the healthcare sector, and to make recommendations for ensuring that the healthcare workforce is prepared to respond to those trends and directions.

The Healthcare Task Force is co-chaired by Stephen Konya, Chief of Staff of the Illinois Department of Public Health, and Francisco Menchaca, Director of the Division of Financial Institutions of the Department of Financial and Professional Regulation. The task force includes representatives from healthcare providers, employers, professional associations, unions, universities and community colleges, as well as state education, workforce development and economic development agencies. Task force members are listed in Attachment A.

The September 12, 2013 meeting of the IWIB Healthcare Task Force focused on identifying the major issues in health care delivery that have implications for the health care workforce in Illinois. During that meeting, task force members and invited discussants were asked to identify the most critical issues, and to highlight their implications for workforce development. Many participants raised issues regarding the implementation of new public health and coordinated, community-based healthcare delivery models in Illinois. These new models are being implemented in response to changing population and patient needs, federal and state healthcare reforms, and innovations in delivery models, professional practices and technology. These new models place stronger emphasis on prevention and primary care and use professional and paraprofessional healthcare workers in new roles with different skill requirements. Participants shared a wide variety of perspectives with no clear consensus on what new models are most likely to be implemented in the near future and their implications for workforce development.

At the meeting, the Task Force decided to examine these models, and to identify important aspects of their implementation for the future of the healthcare workforce in Illinois. Through the discussions of the task force, and of five working groups[1] consisting of task force members and other industry experts from across the state, a plan of deliberation was developed and executed. Each of these five working groups met at least 3 times between January and July of 2014 in order to develop this document, which was then reviewed and approved by the Healthcare Task Force itself.

The document consists of three sections: Section I examines current and ongoing changes in healthcare delivery, and the effects of those changes on Illinois' statewide and regional occupational demand and supply. Section II examines the implications of those changes for Illinois workforce development system moving forward. In particular, it

[1] Work Group 1: Implementing New Public Health and Coordinated Care Models: Changing Professional and Paraprofessional Roles and Skill Requirements; Work Group 2: Changing Roles in Healthcare Delivery and Scope of Practice Policies in Illinois; Work Group 3: Changing Roles in Healthcare Delivery and Front-line Paraprofessionals; Work Group 4: Coordinated Care and Inter-Professional Healthcare Education; Work Group 5: Regional Strategies for Addressing Workforce Shortages.

examines the coordination of healthcare professionals within the context of scope of practice frameworks, the development of the front-line healthcare workforce, and the implementation of inter-professional education and collaborative practices. Section III summarizes findings, makes recommendations, and considers next steps in the process of responding to trends and changes in the healthcare workforce.

Section I. Changes in Health Care Delivery: Effects on Statewide and Regional Occupational Demand & Supply

State and regional healthcare workforce development strategies must begin with a clear understanding of how new models of care will affect the future demand for certain types of healthcare workers and new skill requirements. Key to developing this understanding is an examination of the variables that will drive or hinder changes in health care models, and an understanding of the likely scenarios through which changes in health care will occur.

Healthcare Delivery Change: Variables

An initial requirement for this process was to examine the assumptions of current employment demand models and determine their applicability to the healthcare sector looking forward. The development of reasonable scenarios for possible change in the healthcare sector requires a framework based on relevant variables within the evolving legal and policy environment. Two key variables were quickly identified and discussed by the group:

1. How will the healthcare system be incentivized – both through reimbursement vehicles and through penalty structures -- in the future? In particular, how and at what pace will a "value-based"[2] healthcare purchasing system replace the current "fee for service" healthcare purchasing system (if at all)?

2. How will the legislative / regulatory / policy environment inhibit or stimulate healthcare innovation? Will innovation be actively encouraged through policy actions? Perhaps more importantly, will innovation be passively encouraged through the reduction of ambiguity within this policy environment?

These variables are not binary in nature, each will have a rate and gradation of change in coming years, and so the interaction of these two variables does not result in a tidy set of outcome quadrants. However, the interaction of the two will allow (or perhaps *force*) a greater amount of flexibility into the system.

Our starting point was that the interaction of these two variables moving forward will be the main motivator of sector change, and the chief driver of changes to current projections of occupational demand within the healthcare sector.

[2] "Value-based" purchasing brings together information on the quality of health care, including patient out- comes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers.

Care Delivery Models

An important initial finding is that the central setting for healthcare delivery model changes in the next ten years will be in the Ambulatory Care sector. While incentive and policy changes will have effects on all healthcare sectors – from Hospitals to Residential Care -- it is Ambulatory Care (Physicians Offices, Outpatient Clinics, Home Health Care, etc.) that is expected to have the highest rate of growth. Consider the accompanying chart (Figure 1), which outlines the most recent Bureau of Labor Statistics (BLS) annual growth rate projections for the six major healthcare employment sectors.

BLS Projected Annual Employment Growth Rates by Healthcare Sector: 2010-2020	Projected Annual Growth Rate 2010-2020
Ambulatory Health Care Services	2.06%
Offices of Physicians	1.71%
Offices of Dentists	1.34%
Offices of Health Practitioners	2.47%
Outpatient Care Centers	1.80%
Medical & Diagnostic Labs	0.58%
Home Health Care Services	3.30%
Other Amb. Health Care Srv.	2.92%
Hospitals	0.49%
Nursing & Residential Care Facilities	1.21%
Social Assistance	1.71%
Health & Personal Care Stores	0.30%
Employment Services	1.64%

Figure 1

Employment in Ambulatory Care is expected to grow faster than any other sector, and significantly faster than Hospitals. One should consider that these projections were made without the benefit of data, that would account for any of the changes in the key variables (policy framework & incentive framework) that are already in place in 2014 – much less those that are still in the offing. One of the BLS's stated assumptions for these projections is that "existing laws and policies with significant impacts on economic trends are assumed to hold throughout the projection period." With the passage of the Affordable Care Act, and with the ongoing implementation of "value-based" purchasing, this assumption is *already* inappropriate. Recent and ongoing efforts to focus on preventive care, to increase wellness benefits, and to effect changes in reimbursement rates are also all designed to encourage a focus on primary care delivery over hospital-based care (particularly emergency room visits).

In fact, many of the changes in the two variables discussed above are expected to greatly *increase* the significance of Ambulatory Care beyond what was accounted for in these relatively robust projections. It is expected that the "aging" of the population – due both to demographic shifts as the "baby boom" generation begins to reach their 70th birthdays and to increased life spans generally – will also serve to increase the importance of Ambulatory Care. As a result, the Task Force thought that the true annual growth rate of Ambulatory Health Care Services over this time period might be at or above 3%, rather than the 2.06% projected by BLS.

Within Ambulatory Care itself, many types of delivery model changes will be introduced, but the model considered by the working group to be the most likely to see widespread implementation is the "Patient-Centered Medical Home" (PCMH) model. As defined by

the Department of Health & Human Services, the PCMH model is characterized by comprehensive, patient-centered, coordinated, accessible, quality healthcare[3].

A 2014 article in the Annals of Family Medicine[4] further defines the basic principles of a possible PCMH model. Of particular interest are the two principles that specifically address the holistic nature of patient health needs – across their physical, mental and social facets:

- **Whole person orientation**. The original Joint Principles state, "The personal physician is responsible for providing for all the patient's healthcare needs...." Science has rendered untenable the artificial division of people into parts, particularly mental and physical parts. Given that over one-half of primary care patients have a mental or behavioral diagnosis or symptoms that are significantly disabling, given that every medical problem has a psychosocial dimension, given that most personal care plans require substantial health behavior change—a PCMH would be incomplete without behavioral health care fully incorporated into its fabric. A whole person orientation simply cannot be imagined without including the behavioral together with the physical.

- **Care is coordinated or integrated** across all elements of the complex health care system. Perhaps the single factor that most seriously harms the quality and integrity of our health care system is fragmentation. Fragmentation is the problem this particular principle addresses, since the most serious fracture in our health care system, the most fully institutionalized separation of elements of care, is the separation of behavioral health care from primary care. Health care must be coordinated and integrated via shared registries, shared medical records, (especially shared problem and medication lists), shared decision-making, shared revenue streams, and shared responsibility for the patient's care plan. The real and perceived barriers to communication among health care professionals must be clarified and addressed in a way that makes regular sharing of information for purposes of better care the rule rather than the exception.

As noted above, a defining characteristic of the PCMH model is the use of a team-based approach to care delivery. This team may include a mixture of primary care physicians, advanced practice nurses, registered nurses[5], physician assistants, pharmacists, psychiatrists, psychologists, mental health workers, behavioral health workers, social workers, community health workers, and a range of many other caregivers. In order to provide the whole person orientation that PCMH requires, all of these roles must be brought together and coordinated.[6]

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[3] http://www.pcmh.ahrq.gov/page/defining-pcmh. Additional information and definitions regarding Patient-Centered Medical Homes is included as Attachment B to this document.

[4] Joint Principles: Integrating Behavioral Health Care Into the Patient-Centered Medical Home. *Ann Fam Med* 2014; 12(2): 183-185.

[5] For a detailed examination of the roles of APNs and RNs within care coordination teams see "The Value of Nursing Care Coordination: A White Paper of the American Nurses Association," June 2012. http://www.nursingworld.org/carecoordinationwhitepaper .

[6] For an excellent discussion of the definition and principles of a care team see "Principles Supporting Dynamic Clinical Care Teams: An American College of Physicians Position Paper." Robert B. Doherty, and Ryan A. Crowley, for the Health and Public Policy Committee of the

To that end, the team will likely also include an evolving new category of health worker known as a "care coordinator." While this team member may come from any of the existing occupational categories (e.g., Registered Nurses, Social Workers, etc.) the *role* is evident from the name: a team member who is responsible for coordinating and directing connections between patient needs and team-based care. This flexible team-based PCMH model is designed to provide comprehensive care for a large number (or "panel") of patients, possibly in conjunction with a "value-based" reimbursement structure.

While the PCMH model is specifically built upon this team approach, team-based care is also a key to many other evolving delivery models as well. Regardless of the specific care delivery model it seems that team-based care will be characteristic of care delivery in the future.

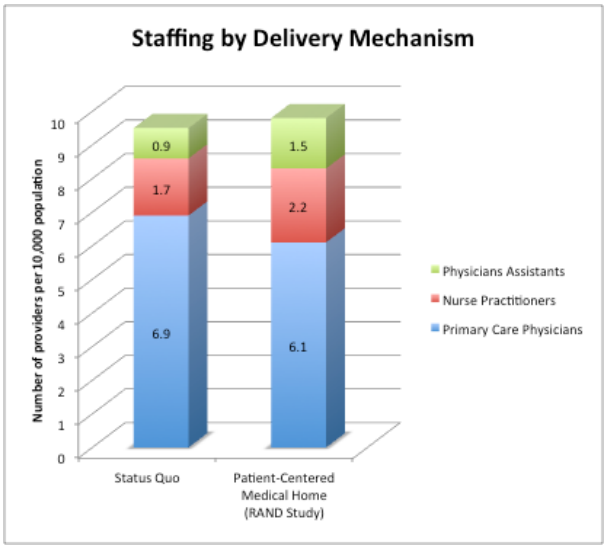

Figure 2

Ambulatory Care Staffing

The working group then looked at changes in workforce staffing *within* the Ambulatory Care sector. Again, changes in care delivery models have and will continue to point to this sector as the key implementation setting for ongoing changes in healthcare delivery – but what are the implications of that change for specific *occupational* groups?

To assist in this process, the working group utilized a recent RAND study[7] that examined workforce staffing changes within primary care given various combinations of delivery model implementation and utilization. The study proposed the staffing changes (per 10,000 population) shown in Figure 2, moving from current models ("Status Quo") to PCMH.

So even though demand for primary care will certainly increase, the shift to team-based delivery models and improved health information technologies will allow each primary care physician to efficiently and effectively manage a greater number of patients. Insofar as workforce staffing is concerned, the result of these changes will be the following associated shifts in demand:

American College of Physicians. *Ann Intern Med*. 2013; 159. These definitions and principles are appended to the PCMH definitions included in Attachment B to this document.

[7] David I. Auerbach, Peggy G. Chen, Mark W. Friedberg, Rachel Reid, Christopher Lau, Peter I. Buerhaus and Ateev Mehrotra. Nurse-Managed Health Centers And Patient-Centered Medical Homes Could Mitigate Expected Primary Care Physician Shortage. *Health Affairs*, 32, no.11 (2013):1933-1941

- A reduction in the rate of increase in demand growth for primary care physicians. While the demand for primary care services will grow due to the policy and incentive (and demographic) changes discussed above, the provision of those services will be shared across all of the team members, not exclusively by primary care physicians.

  However, it is still likely that demand for primary care physicians will continue to exceed the projected supply, and steps should continue to be taken to remedy this primary care physician shortage through efforts to attract medical students into primary care specialties such as internal medicine, family medicine and pediatrics.[8] Moreover, it is also important to note the need to continue efforts to attract and support those who do enter these primary care specialties to practice in rural areas, inner-city areas, and other underserved areas of the state.

- An increased demand for Advanced Practice Nurses (APNs) and Physician Assistants (PAs).

- A significantly increased demand for front-line occupations such as Community Health Workers, Home Health Aides and Medical Assistants.

However, through discussion within the working group, and through follow-up contact with key working group members it was determined that the RAND study was, if anything, too conservative in its estimate of how thoroughly the PCMH model will change staffing arrangements away from the status quo. In the PCMH implementation model supported by some, the number of primary care physicians needed to manage a patient population in a team-based format may fall to 1-2 per 10,000 population by 2025, with APNs and PAs each maintaining at the 1-2 per 10,000 population estimated by RAND.

Regardless, it is expected that, as the PCMH model (and other team-based approaches) becomes more widely implemented, the roles of primary care physicians, APNs and PAs will become more tightly focused. These high- and mid-level professionals can be expected to provide direct care to the most complicated patient cases, while overseeing care to other patients via delegation and supervision to lower level professionals. Furthermore, in this PCMH implementation model there will be increased utilization of Registered Nurses (RNs) and other licensed staff to provide triage (including referral to the MDs, PAs and APNs when indicated) as well as routine patient care.

This team-based model will be supplemented by what is likely to be a greatly increased cadre of non-licensed personnel (such as Medical Assistants and Community Health Workers) with a focus on preventive care and minor acute issues. Occupations of this type may make up something on the order of 10 staffers per 10,000 population.

Furthermore, the venues for these preventive care and minor acute interactions will likely spread to less traditional sites such as schools -- schools at all levels are an increasingly important, yet often funding-deprived, site for the provision of primary care to students by

[8] See http://www.aafp.org/about/policies/all/student-choice.html for a listing of programs and incentives towards this end, endorsed by the American Academy of Family Physicians.

RNs and LPNs -- and school based health centers.[9] Additional alternate sites are widely dispersed (particularly in rural areas) locations through the use of telehealth[10] and virtual care, and possibly even a very traditional (but long under-utilized) site – the home.

Finally, it is important to note that team members may often require one or more certifications in order to qualify to execute their occupation. And the importance of certified occupations becomes even more apparent when you consider the full breadth of a team-based health care approach that may (and should) include mental or behavioral health professionals[11], rehabilitation counselors, physical & occupational therapists, and a number of other certified health care workers. The full implementation of a patient-centered, holistic team-based care approach will require the integration of roles and occupations across all aspects of care, from preventive care to diagnostic care to direct care to rehabilitative care.

Understanding the evolution of these processes will require mechanisms to track ongoing changes in the occupational makeup of healthcare, particularly within the widely disparate urban and rural regions that make up Illinois' labor markets.

Tracking Ongoing Statewide & Regional Occupational Change in Illinois

A key facet of the implementation of these new staffing models will be the variable rates of realization across the regions of the state. As Illinois tracks the changing sector and occupational employment environment, we must also be aware of the need to track this changing environment at the level of local and regional labor markets. As such, a key recommendation of the Task Force is to implement a statewide & regional data plan that will examine these changing labor markets on an ongoing basis.

Illinois has substantial experience in establishing a model framework for determining occupational employment demand and supply and determining labor surplus/shortage estimates. With the creation of the Illinois Longitudinal Data System (ILDS), disparate education, workforce, and human services data can be joined while protecting individual privacy and complying with applicable federal and state laws. The ability to yield pipeline performance indicators will be essential to telling the story of Illinois' shortage/surplus in critical healthcare areas.

The data plan that is included in the recommendations portion of this document consists of 18 specific recommendations to establish an ongoing mechanism to understand and track changes in occupational supply and demand for 36 selected healthcare occupations (Attachment C), particularly those resulting from the care delivery changes discussed previously. Recommendations are specific both to the types of data developed, and the infrastructure required to develop that data.

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[9] See http://www.hrsa.gov/ourstories/schoolhealthcenters/ for more information regarding school based health centers.

[10] Defined by HHS's Health Resources and Services Administration (HRSA) as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.

[11] Attachment D includes a listing of those behavioral health certifications offered by the Illinois Board of Certifications (IBC), along with a listing of health care occupations licensed by the Illinois Department of Financial and Professional Regulation (IDFPR).

Implications

All of these projected staffing changes presuppose a significant shift towards the team approach discussed earlier. And that shift towards a team approach – as well as the staffing changes themselves – have important implications for other issues extant within the Health Care sector. Several of these issues were examined by HCTF working groups, which developed findings and recommendations regarding:

- **Coordination of Healthcare Professionals: Scope of Practice Issues** -- This radically restructured staffing of ambulatory care settings is not tenable without full use of the opportunities for collaboration, delegation and supervision that are available in Illinois medical law and regulation.

- **Utilization of Front-Line Healthcare Workers** -- The increased demand for emerging front-line paraprofessionals occupations raises questions regarding their proper roles and their full utilization.

- **Implementation of Inter-Professional Education & Collaborative Practice** -- An increasing reliance on team-based delivery models requires the medical education community (at all levels) to consider seriously the importance of inter-professional education as the pre-requisite to the inter-professional practice that will increasingly be the vehicle for Ambulatory Care provision in the coming decade.

Section II. The Implications of These Changes in Health Care Delivery

A. Coordinating Healthcare Professionals: Scope of Practice Issues

"Scope of practice" is what defines the procedures, actions, and processes that are permitted for an individual working within a licensed occupation. A large number of healthcare occupations are licensed and regulated by the Illinois Department of Financial and Professional Regulation (IDFPR). While the bulk of that licensed workforce is found within five licensed occupations that are often key components of the team approach discussed in Section I -- Licensed Physician, Licensed Physician Assistant (PA), Advanced Practice Nurse (APN), Registered Professional Nurse (RN), Licensed Practical Nurse (LPN) – a full listing of IDFPR licensed occupations can be found in Attachment D. In essence, the scope of practice defines what individuals within these licensed occupations may do – and may not do – with regard to the treatment of a patient under their care.

Moreover, the scope of practice for each of these licensed occupations is located within an overall legal framework – a legal framework that is largely constructed by the Medical Practice Act of 1987, the Physician Assistant Practice Act of 1987 and the Nurse Practice Act. That legal framework consists of, for each occupation: 1) how it is defined in law; 2) how its scope of practice is defined in law; and, 3) How its interactions with the other occupations are defined in law through collaboration, delegation and supervision. Details regarding this legal framework -- for each of the occupations listed above -- can be found in the Attachment E.

It is a significant finding of this working group process that this last piece is almost certainly the most important of these three. While the legal definitions of the occupations and their scopes of practice are clear enough, the legal framework that provides for collaboration, delegation and supervision allows for a great deal of flexibility in the interactions between occupations. And that flexibility effectively transforms the literalness of the legally defined scopes of practice -- to the point that the legally identified scope of practice for an occupation will rarely comport closely with the scope of practice utilized in the practice of a particular health care provider.

In effect, scopes of practice are largely defined *in practice*, not in the law -- through the implementation of the collaboration, delegation and supervision aspects of the law. And these interactions between occupations will become increasingly vital under the team-based care models that are expected to gain importance during the next decade. The crucial issue for the effective implementation of team-based staffing approaches will be to ensure that all team members are able to work to the fullest extent of their professional ability in pursuit of the whole-person-oriented, coordinated, quality care that is expected to be the hallmark of team-based primary care methods.

The law defines the area of physician practice that is outside the realm of collaboration, delegation and supervision as "any patient care task or duty that is statutorily or by rule mandated to be performed by a physician." It appears that these mandated tasks or duties are actually quite small in number. Remaining patient care duties are currently able to be legally delegated to other team members, through collaborative agreements and supervision agreements.

Currently, however, they are often *not* delegated. Task Force members identified a number of reasons why this is so, including:

- Unease, on the part of physicians, regarding the loss of direct control over the care of their patients. This unease is very often driven by a concern over liability issues, but can also be cultural to the community of physicians.

- Also, physician uncertainty regarding the extent and adequacy of competencies made available to team members through their training curricula.

- A lack of collaborative competencies among physicians. Physicians often do not know *how* to effectively collaborate within a team approach because it has never been a part of their training process (with limited exceptions).

- Provider-mandated rules – again, often based on liability concerns -- that preclude maximum physician discretion to delegate and collaborate.

So it appears that the principal scope-of-practice-related obstacles to a wider implementation of the team-based approaches identified by the Task Force are not legal, but cultural. Wider collaboration and delegation are possible within the current legal framework, but the desire to do so must be increased – particularly among physicians and provider organizations.

B. Preparing and Utilizing Front-Line Healthcare Workers

The Task Force has identified three key front-line paraprofessional occupational categories: Community Health Workers, Homecare and Home Health Aides, and Medical Assistants. Each of these occupations is defined by their direct relationships to those in need of services (both medical and non-medical). The settings for these relationships -- in ambulatory care settings but also in home and community settings outside of traditional venues -- help distinguish the roles of each.

Community Health Workers

Definition: CHW is a quite new, and still evolving occupational category. As The American Public Health Association (APHA) has defined it:

> A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
>
> A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Roles: CHWs are unique in their breadth of roles, the different models of care within which they are utilized, and their number of job titles (in practice). Also unique is the fact that these roles, care models and job titles are not limited to the domain of health care. For instance, a 2007 study by the U.S. Department of Health and Human Services[12] identified five roles for CHWs:

- Member of Care Delivery Team
- Navigator
- Health Educator
- Outreach and Enrollment Agent
- Community Organizer / Advocate / Capacity-builder / Researcher

While an individual CHW may span more than one of those roles, they are clearly not limited to specifically medical settings or to the direct provision of medical care. Rather, given the focus on "community health," the roles of a CHW may include a much heavier emphasis on organizing and advocating for communities in order to increase *overall* health outcomes within a community.

Industries: A sense of this breadth can also be gained by examining the industries within which CHWs are found. The table in Attachment F displays 2012 national employment and wage estimates for CHWs. The industry category with the largest number of CHWs is Individual and Family Services (NAICS 624190) -- "establishments

[12] *Community Health Worker National Workforce Study*. U.S. Department of Health and Human Services, 2007. (http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf).

primarily engaged in providing nonresidential individual and family social assistance services." However, this industry only accounts for 1 in 5 CHWs. Many of the largest industry settings for CHW employment are completely outside of the health care arena, including local government and social advocacy organizations.

Alternate Job Titles: A final indicator of the breadth of this occupation is the fact that over 100 different job titles are in current use to describe jobs that correspond with the work done by CHWs (Attachment G).

Job Estimates: CHW job opportunities are expected to grow in coming years, as shown in the occupational profile at America's Career InfoNet (Attachment H). Nationally, CHW jobs are expected to grow by 2.5% per year through 2022. Moreover, the current Bureau of Labor Statistics job growth projections are based on existing models of health care delivery. Recall the conclusions of the Task Force that the continued implementation of team-based care models will serve to increase the importance – and the job growth – of frontline paraprofessionals such as CHWs. In all likelihood, the robust job growth currently projected for CHWs will be revised upward as new care delivery models are factored into projections data.

Core Competencies & Curricula: HB 5412, a bill that was recently signed into law, seeks to define and codify several aspects of the work and requirements of CHWs. Section 2310-685(b) of that bill describes core competencies for CHWs. A Task Force working group reviewed those competencies, suggested some minor language changes, resulting in the following core competency statements for CHWs:

> The "core competencies" for Community Health Workers include skills and areas of knowledge that are essential to bringing about expanded health in diverse communities and to reduce health disparities. As members of health teams, core competencies for effective Community Health Workers (CHWs) include, but are not limited to:
>
> 1. Outreach methods and strategies;
> 2. Client and community assessment;
> 3. Effective community-based and participatory methods, including research assistance;
> 4. Culturally-competent communication and care;
> 5. Health education for behavior change;
> 6. Support, advocacy and health system navigation and linkages for clients;
> 7. Application of public health concepts and approaches;
> 8. Individual and community capacity building and mobilization;
> 9. Oral, writing and technical communication skills; and
> 10. Inter-professional education and collaborative care competencies[13].

A limited curriculum has been approved within Illinois to teach CHWs to these competencies, but the group examined and discussed one in particular: a 3-tiered curriculum approved by the Illinois Community College Board for implementation at South Suburban College (SSC) in Markham. The three tiers include a Basic CHW

[13] This competency is not included in HB 5412, but the Task Force considered it an important additional competency given the key role of CHWs in the implementation of team-based care approaches.

Certificate of 20 hours of study, an Advanced CHW Certificate of 39 hours, and an Associates Degree of 69 hours of study. The Basic Certificate curriculum teaches to 8 of the HB 5412 competencies (all but #8 and #10, above). The Advanced Certificate and Degree curricula both teach to all of the HB 5412 competencies (all but #10, above). Each of these tiers are "stackable." A listing of courses, course descriptions and associated competencies are included in Attachment I.

Homecare and Home Health Aides

Definition: The following definition of Home Care and Home Health Aide (HHA) is based on the U.S. Bureau of Labor Statistics definition, and on the tasks supported by public long-term care programs:

> Home Care and Home Health Aides help people who are disabled, chronically ill, or cognitively impaired. Home Care and Home Health Aides assist clients with self-care tasks (also known as Activities of Daily Living, or ADLs) and with everyday tasks (also called Instrumental Activities of Daily Living, or IADLs); provide social supports related to these self-care and everyday tasks -- services that enable the consumer to take an active part in his or her family and community. Home Health Aides may perform paramedical tasks (such as ostomy/catheter hygiene, changing aseptic dressings, and administering non-injectable medications, where permissible).

Roles: Roles for Home Care and Home Health Aides are also evolving in response to changing health care delivery models. As with CHWs, Home Care and Home Health Aides are increasingly seen as important members of a healthcare team, particularly with regard to the implementation of preventive care models.

Industries: Home Care and Home Health Aides are much more concentrated in terms of industry settings. As might be expected, the largest share (37%) are found in the Home Health Care Services industry (NAICS 621600). In all, 80% of Home Care and Home Health Aides are found within the four largest industry settings shown in Attachment J.

Alternate Job Titles: As a more long-standing occupational category, the list of alternate job titles for Home Care and Home Health Aides is much shorter than that for CHWs (Attachment K).

Job Estimates: Job opportunities for Home Care and Home Health Aides are expected to grow significantly in coming years, as shown in the occupational profile at America's Career InfoNet (Attachment L). Nationally, Home Care and Home Health Aide jobs are expected to grow by nearly 5% per year through 2022. And, as was noted with regard to CHWs, the current Bureau of Labor Statistics job growth projections are based on existing models of health care delivery. While it is difficult to envision a growth rate much higher than that already projected, that growth rate may well be revised upward as new care delivery models are factored into projections data.

Core Competencies: Homecare and Home Health Aide core competencies vary somewhat by population being served and whether the services being provided are a long-term service or are more episodic in nature. To an extent, competencies required in some consumer-directed programs may depend on consumer preferences as well. For

homecare workers providing assistance with self-care and everyday tasks, the main competencies taught in training programs geared toward this part of the workforce include communication skills; understanding physical, emotional, and/or developmental needs of consumers; performing or assisting personal care in ways that are safe, efficient, and preserve the consumer's dignity; body mechanics and safe lifting; nutrition and appropriate exercise.

Competencies for certified Home Health Aides are defined according Title 77, Chapter I, Subchapter b, Section 245.70(d) of the Illinois Administrative Rules:

> The home health or home nursing agency is responsible for assuring that the individuals who furnish home health aide services on its behalf are competent to carry out assigned tasks in the patient's place of residence. The competency evaluation conducted by a registered nurse in the home health or home nursing agency shall address each of the following subjects:
>
> 1. Communication skills;
> 2. Observation, reporting, and documentation of patient status and the care or service furnished;
> 3. Reading and recording temperature, pulse and respiration;
> 4. Basic infection control procedures;
> 5. Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;
> 6. Maintenance of a clean, safe and healthy environment;
> 7. Recognizing emergencies and knowledge of emergency procedures;
> 8. The physical, emotional and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, his or her privacy, and his or her property;
> 9. Appropriate and safe techniques in personal hygiene and grooming that include:
>   a. Bed bath;
>   b. Sponge, tub or shower bath;
>   c. Shampoo − sink, tub or bed;
>   d. Nail and skin care;
>   e. Oral hygiene; and
>   f. Toileting and elimination;
> 10. Safe transfer techniques and ambulation;
> 11. Normal range of motion and positioning;
> 12. Adequate nutrition and fluid intake; and
> 13. Any other tasks that the agency may choose to have the HHA perform.

Enhanced Homecare Aides: An evolving variant to the Homecare Aide role is that of an “Enhanced” Homecare Aide. From the basic competencies above, a Homecare Aide may receive additional training and competencies to provide expanded care coordination and navigator services to clients with specific needs. With enhanced training built around targeted competencies, Enhanced Homecare Aides would become a more essential component of care coordination teams for patients (particularly seniors). Enhanced Homecare Aides would help clients in the management of chronic conditions such as diabetes or hypertension by assisting them with monitoring their health, engaging in physical activity, and eating healthy foods. In addition, they could alert the consumers’

primary health care providers to changes and deteriorations in the consumers' health care conditions.

Medical Assistants

Definition: The U.S. Bureau of Labor Statistics defines Medical Assistant as:

> Medical Assistants perform administrative and certain clinical duties under the direction of a physician. Administrative duties may include scheduling appointments, maintaining medical records, billing, and coding information for insurance purposes. Clinical duties may include taking and recording vital signs and medical histories, preparing patients for examination, drawing blood, and administering medications as directed by physician.

Roles: Jobs for Medical Assistants are most often found in Ambulatory Care settings, particularly physicians' offices (see below). As such, Medical Assistants should be a significant front-line part of the team-based care approaches discussed previously. Within clinical settings – per the findings discussed earlier -- it is expected that Medical Assistants will be increasingly responsible for attending to minor acute patient issues, as well as assisting patients with preventive care issues, and performing more traditional administrative functions.

Industries: In terms of industry settings, Medical Assistants are highly concentrated within Health Care. 94% are employed in Health Care (NAICS 621-30). By comparison, 74% of Home Health Aides are employed in Health Care, and only 31% of Community Health Workers are employed in direct Health Care settings. Nearly 60% of Medical Assistants are employed in the offices of Physicians. This far outpaces the next largest employment site, Private Hospitals. Medical Assistants are, generally speaking, an Ambulatory Care occupation. The ten largest industry sites for the employment of Medical Assistants are shown in Attachment M.

Alternate Job Titles: Although employment that concentrates on one particular facet of this occupation may be alternately titled (examples from the administrative facet of the occupation might include medical secretaries and receptionists, surgery schedulers, insurance billers and medical coders) Medical Assistant is the generally accepted job title for all of these types of occupations.

Job Estimates: Job opportunities for Medical Assistants are also expected to grow significantly in coming years, as shown in the occupational profile at America's Career InfoNet (Attachment N). Nationally, Medical Assistant jobs are expected to grow by nearly 3% per year through 2022. And again, the current Bureau of Labor Statistics job growth projections are based on existing models of health care delivery. As Medical Assistants are expected to be an integral part of team-based ambulatory care under a value-based reimbursement model, that growth rate may well be revised upward as new care delivery models are factored into projections data.

Core Competencies: The Curriculum Review Board of the American Association of Medical Assistants (AAMA) Endowment has identified a set of core competencies for Medical Assistants within a clinical setting.

1. Fundamental Procedures

a. Perform handwashing
b. Wrap items for autoclaving
c. Perform sterilization techniques
d. Dispose of biohazardous materials
e. Practice Standard Precautions

2. Specimen Collection
   a. Perform venipuncture
   b. Perform capillary puncture
   c. Obtain specimens for microbiological testing
   d. Instruct patients in the collection of a clean-catch, mid-stream urine specimen
   e. Instruct patients in the collection of a fecal specimen

3. Diagnostic Testing
   a. Perform electrocardiography
   b. Perform respiratory testing
   c. CLIA Waived Tests:
      - Perform urinalysis
      - Perform hematology testing
      - Perform chemistry testing
      - Perform immunology testing
      - Perform microbiology testing

4. Patient Care
   a. Perform telephone and in-person screening
   b. Obtain vital signs
   c. Obtain and record patient history
   d. Prepare and maintain examination and treatment areas
   e. Prepare patient for and assist with routine and specialty examinations
   f. Prepare patient for and assist with procedures, treatments and minor office surgeries
   g. Apply pharmacology principles to prepare and administer oral and parenteral (excluding I.V.) medications
   h. Maintain medication and immunization records
   i. Screen and follow-up test results

C. Preparation for Team Approaches: Inter-Professional Education & Collaborative Practice

Implementation goals reacting to the expected changes in ambulatory health care delivery have, to this point, been concerned with "demand-side" issues – those regarding how occupations and occupational demand will grow under these new delivery models. There is, however, an equally important set of implementation goals regarding the "supply" of workers to this changing landscape. In particular, the Task Force was eager to understand what changes might be necessary in the education and training of healthcare professionals and non-professionals in order to implement the team-based approaches that are so fundamental to these changes in care delivery models. The changing landscape of healthcare focuses on the need for a patient-centered, team-based approach to healthcare, as does the recognition that employers have and will

continue to demand these skills in the healthcare workforce. To accommodate this, our healthcare education programs need to incorporate inter-professional collaborative practice competencies as an essential component of programs for all healthcare occupations.

At the heart of these changes in training stands the implementation of inter-professional education. The Task Force sought to define what is meant by inter-professional education and collaborative practice, to identify the core competencies associated with the execution of collaborative practice, to identify existing models – at all levels of instruction – that implement inter-professional education, and to identify the scope and locus of collaborative practice readiness and realization across Illinois at this point.

Definition: Inter-professional education occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. Collaborative practice in health-care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers and communities to deliver the highest quality of care across settings.[14] Behind this fundamental definition, though, lies a paradigm shift in the means by which students in health care (professional and non-professional) are taught to understand their place in the provision of health care services to their patients and their communities. Inter-professional education facilitates knowledge, skill and competency attainment -- as does any healthcare education method. But it places this attainment within a framework that provides an understanding of the roles of other team members and, more importantly, an understanding of the connections and communication flows between those roles that result in the highest-quality patient care and community health. An educational institution (at any level) with a commitment to inter-professional education will seek to embed this framework into all aspects of its curriculum.

Core Competencies: The Task Force identified three sources for inter-professional healthcare core competencies that relate to different levels of the healthcare education pipeline. It is recommended that the competencies from these sources be examined in order to identify commonalities and distinctions. This should provide for the sequencing of content through the education pipeline, and ensure inter-professional education skills and skill pre-requisites are introduced and then reinforced throughout the healthcare education process.

> **Competencies for Secondary Health Science Curricula** – A comprehensive curriculum to orient students to health sciences has been developed and implemented in some high schools in Illinois. The content includes 'employability' and 'teaming skills' as well as other core competencies in healthcare, and can also be applied to bridge programs.
>
> **Competencies for Associates Degree Program Curricula** – The Health Careers Pathways (H2P) Consortium, a national consortium comprised of 9

[14] "Framework for Action on Interprofessional Education & Collaborative Practice." World Health Organization publication (2010), p 13. http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.3_eng.pdf?ua=1

community colleges and 6 partner organizations, is focused on the improvement of health professions training via career pathways and the development of competency-based core curriculum and core credentials. A description of this project, and the core curriculum developed to date is included as Attachment O to this document, as well as at:
http://www.nn2.org/images/H2P_Overview_March2013.pdf .

Competencies for Professional Program Curricula – In 2011 a panel of experts from six healthcare professional education associations [15] joined together to form the Inter-Professional Education Collaborative (IPEC). The report [16] developed by this group establishes a set of core competencies for inter-professional education and practice. The IPEC Core Competencies are organized around four competency domains:

- Values and Ethics for Inter-professional Practice
- Roles and Responsibilities
- Inter-professional Communication
- Teams and Teamwork

A listing of the 38 specific competencies attached by IPEC to these four competency domains is included as Attachment P to this document. The full text of this report, including the context for the development of these competencies, may be accessed at:
http://www.aacn.nche.edu/education-resources/IPECReport.pdf .

Pipeline Models - Interesting and then attracting more – and more diverse -- students and young adults to healthcare careers is an important aspect of 'priming the pipeline'. Better statewide organization of early educational programs to meet these needs is paramount. However, with ongoing changes to the healthcare delivery system requiring collaborative practice, it is equally important that the healthcare education pipeline provide appropriate levels of instruction leading to inter-professional competencies. Several models currently exist within Illinois that can be proffered as prototypes. Examples from each educational level include:

<u>High School</u>
Wheeling High School District 214 (Wheeling)
Chicago Academy of Health Sciences (Chicago)

<u>Post High School (Non-Traditional / Credentialed)</u>
Instituto del Progresso Latino (Chicago)

[15] American Association of Colleges of Nursing; American Association of Colleges of Osteopathic Medicine; American Association of Colleges of Pharmacy; American Dental Education Association; Association of American Medical Colleges; Association of Schools of Public Health

[16] Inter-professional Education Collaborative Expert Panel. (2011). *Core competencies for inter-professional collaborative practice: Report of an expert panel.* Washington, D.C.: Inter-professional Education Collaborative.

Community College
Malcolm X College (Chicago)
South Suburban College (South Holland)

Graduate Medical Education and Undergraduate
Rosalind Franklin (North Chicago)

Readiness Assessment – In order to determine the scope and locus of collaborative practice readiness and realization across Illinois, the Task Force determined that an assessment of the readiness of major employers in the healthcare industry to use collaborative practices in their place of work would be beneficial in determining the scope of both current implementation and future need.

A survey instrument (Attachment Q) was developed, and invitations to respond were sent to a number of major healthcare employers across the state. 23 survey responses were received. It is not known if these responses came from 23 different sites or if there were multiple responders from a given site. All of the 5 responders that offered their contact information were from different health care organizations. Survey results include:

- Of those 23, over 90% identified their organization as hospitals
- 80% of those that responded (15 responded to this question) indicated that their organization's mission, vision, and/or core values reflected language of the 'Triple Aim', i.e., patient safety and their experience of care, the health of individuals and the community, reducing the per capita cost of health care.
- Over 70% of those that responded (15 responded to this question) indicated they were *not* knowledgeable or did *not* know about the knowledge level of their organization regarding the IPEC core competencies developed in 2011 (and discussed above).
- Over 93% of those that responded (15 responded to this question) indicated that collaborative practice is used consistently throughout their institution.
- Over 92% of those that responded (13 responded to this question) indicated that at least some professional development around collaborative practice was provided (46% characterized as each).
- The types of professional development provided were described as follows:
    - Workshops/ On-line seminars/ On-the-job training – 92%
    - Mentors, Coaches – 84%
    - Seminars – 77%
    - Credit-generating courses / Employer-paid conferences – 62%
- 70% of those that responded (13 responded to this question) indicated that more than half of the departments in their institutions were engaged in professional development around collaborative practice (50-75% = 46%; 75-100% = over 23%)
- Resources allocated to encourage teamwork and collaborative practice were identified as follows:
    - Time to build collaborative relationships – 85%

  - Facilities that are conducive to building collaboration – 85%
  - Financial Resources – 62%
  - Designated Staff – 54%

- 100% of those that responded (13 responded to this question) indicated that they believe inter-professional collaboration and teamwork would lead to enhanced patient safety
- 77% of those that responded (13 responded to this question) indicated that they believe their institution needs to implement stronger teamwork and collaboration practices.

Section III. Findings & Recommendations

The Task Force's chief finding during this project has been that the provision of healthcare is in the midst of a structural shift in the delivery of services to the population. This shift is being driven by a fundamental restructuring of reimbursement models, and by the implementation of healthcare policy changes – both governmental and non-governmental -- across society. This shift will result in an increasing importance for the ambulatory care sector of healthcare. As greater emphasis is being placed on encouraging and incentivizing health rather than responding to sickness, greater emphasis will be placed on those services that increase overall community health, assist populations in non-medical settings, and encourage the provision of non-intensive services by non-professional staff. This will require a coordination of care across settings, as well as a holistic approach to care including the integration of mental and behavioral health into an accessible service delivery configuration.

All of these changes are expected to have a significant impact on the occupational makeup of the healthcare sector, as growth of the Ambulatory Care sector skews currently projected occupational growth in specific directions. Moreover, changes to the Ambulatory Care sector itself will further skew that occupational growth, as team-based care delivery models are more fully implemented across the state and the nation. The Task Force expects that while demand for primary care itself increases, the use of team-based care and advancing health information technologies will allow each primary care physician to more efficiently and effectively manage a greater number of patients. As part of this team-based transition, the rate of increase in demand for primary care physicians may flatten somewhat, but only when coupled with the understanding that the demand for "midlevel" professionals such as Advanced Practice Nurses, Registered Nurses and Physicians Assistants is expected to increase, and demand for front-line occupations such as Community Health Workers, Home Health Aides and Medical Assistants are expected to increase significantly.

Recommendations

- *An initial general recommendation is that the implementation of all of the following recommendations must be closely coordinated with the implementation of the recommendations of the Illinois Health Care Reform Implementation Council's Workgroup on Workforce, and with the deliberations and recommendations of The Governor's Office of Health Innovation and Transformation's Healthcare Workforce Workgroup.*

- *A second general recommendation is that healthcare employers must be encouraged to take a greater role in the formulation of policy recommendations such as these, as well as a greater role in the implementation of these recommendations through active participation in the state's education and workforce development systems.*

Statewide & Regional Data Development

- *Illinois should implement the following 6-part, 17-point data plan in order to track ongoing statewide & regional occupational change within Illinois' healthcare sector. This data plan is to be coordinated with the Illinois Longitudinal Data System maintaining, among other data sets, all educational records on students from pre-K to post-graduate. In addition, coordination will be needed with the enhanced systems being developed under the Workforce Data Quality Initiative as they mature and expand with inclusion of workforce (training and employment) data.*

A. Occupational Demand

1. The Illinois Department of Employment Security's (IDES's) Occupational Employment Projections for 2012-22 by Local Workforce Investment Areas (LWIA) (planned for completion in the first half of 2015) should be converted to 10 Economic Development Regions (EDR) or larger regions of combinations of LWIAs to develop the annual job openings estimates for key health care occupations. This will more accurately conform to what are the true labor markets for healthcare occupations (particularly professional occupations).

2. Key regions should be designated that are chiefly rural or have a high concentration of HRSA designated areas (i.e., "Health Professional Shortage Areas" [HPSA] or "Medically Underserved Areas/Populations [MAU/P]) in order to explore key health care occupational shortage issues within those areas. Note that Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers.

3. Regions impacted by multi-state labor markets should be designated.

4. A roster of 36 selected healthcare occupations to be studied should be developed (Attachment B), and revisited as new projections are released.

B. Occupational Supply (Education & Training)

5. Five years of health care related educational and training program data (enrollment, completion and placement) should be developed for:
    - Illinois community colleges (48);
    - Illinois public and private colleges, universities, and misc. schools:
        - 9 public universities-12 campuses; 97 independent not-for-profit colleges and universities; 35 for-profit educational institutions; private business/vocational schools;
    - Illinois high school/career center career and technical education programs;

- Applicable Workforce Investment Act training programs;
- Licensed and certified healthcare positions tracked by the Illinois Department of Financial and Professional Regulation (IDFPR) and the Illinois Department of Public Health (IDPH).

C. Occupational Mobility

6. The movement of educational completers into the work force should be tracked using IDES employment and wage records data. Northern Illinois University (NIU) has a system and web portal completed for APN's, RN's, LPN's and Certified Nursing Assistants (CNA's) with data through 2010. Additional years of data should be added.

7. The NIU system to conduct research and analysis should be expanded and updated to include additional occupations. An initial priority for this expansion should be the frontline occupations identified in this report (Community Health Workers, Medical Assistants and Homecare and Home Health Aides). This system can provide information on training related leakage, completer related mobility, wage rates and employment history for key and high demand health care occupations, statewide and by regions.

8. A related priority, either through this expanded NIU system or through other mechanisms, should be to track any evolution in certification requirements for these frontline occupations. Currently, certification is available for MAs and HHAs, but is not required by all employers. As team-based approaches that include these occupations are more widely implemented, Illinois will need to understand and react to any systemic implementation of certification requirements – including possible CHW certification requirements – by health care employers. Additionally, as part of this process Illinois should ensure that information regarding training providers for these certifications is widely available, as well as information regarding options for financial assistance in obtaining this training.

D. Occupational Supply and Demand Analysis

9. An analysis should be conducted to identify occupational surplus and shortage issues for key and high demand health care occupations, statewide and by regions.

10. Local and regional input should be sought for review and feedback into this supply and demand analysis.

11. An analysis should be conducted to identify occupational training-related leakage, completer-related mobility, wage rates and employment history for key and high demand health care occupations, statewide and by regions.

12. Available data should be leveraged from the IDFPR/Center for Nursing and Board of Nursing.

E. Agreements Needed

13. Project-related agreements, with specific deliverables, should be secured amongst the following agencies in order to conduct supply and demand related analysis:
    a. Illinois Department of Commerce and Economic Opportunity (DCEO)
    b. Illinois Department of Employment Security (IDES)
    c. Northern Illinois University (NIU)
    d. Illinois Community College Board (ICCB)
    e. Illinois State Board of Education (ISBE)
    f. Illinois Department of Public Health (IDPH)
    g. Illinois Department of Financial and Professional Regulation (IDFPR), and
    h. Illinois Board of Higher Education (IBHE).

14. Possible agreements should be explored with the Federal Employment Data Exchange (FEDES), the Wage Record Interchange System (WRIS), National Student Clearinghouse (NSC) and cross state agreements with Missouri, Wisconsin, Indiana, Iowa and Kentucky to provide enhancements to the analysis.

F. Special Studies

15. A special study should be developed to examine the factors that affect medical student residency selection. This study should include a mobility study in order to develop a baseline data set of post-residency employment location and status. An additional study should examine factors that determine residents' future career plans, including the role of employment opportunities for their significant others in determining the physician's career plans.

16. Available data sources should be identified, and a potential study should be designed to track supply, demand and mobility within MD specialties, both statewide and regionally.

17. Original research should be conducted to provide baseline numbers of new and emerging occupations (e.g., Community Health Workers) in Illinois.

- *As this data plan is implemented, and statewide & regional occupational supply and demand is better understood, the IWIB and its Healthcare Task Force should provide leadership and assistance to local partnerships seeking to address identified supply shortages. The form of these partnerships will vary based on region and identified need, but the timely response to these identified needs should be the most important continuation of the process that developed this report.*

Coordinating Healthcare Professionals: Scope of Practice Issues

Some argue that the existing legal scope of practice framework for various licensed occupations can and should be expanded. However, it is beyond the ability or desire of

the IWIB Healthcare Task Force to make recommendations regarding what might be a very contentious process.

Rather, the recommendations regarding this issue that are included at the end of this document are focused on actions that can be taken *within the existing legal framework* to increase collaboration, delegation and supervision. The ultimate goal of the Task Force's recommendations is to assist Illinois to achieve the team-based healthcare approaches being engendered by the changes identified by the Task Force.

- *Evidence-based mechanisms should be developed in order to measure both the movement of healthcare delivery (particularly ambulatory care) towards team-based care, and the results of that movement in terms of patient-health outcomes and cost savings (if any).*

  Given the symbiotic relationship between team-based care approaches and scope-of-practice clarification – it will be difficult to implement the approaches without the clarification, it will be difficult to motivate clarification without the spur of the evolution of care approaches – it is important to establish mechanisms to measure the outcomes of changes to patient care approaches.

  If impediments to scope-of-practice clarifications are cultural and systemic, then the greatest spur to changing that culture and that system will be the increasing requirement to do so resulting from movement towards team-based approaches.

- *Access to information about team-based approaches -- including best-practice information regarding staffing arrangements and outcomes within ambulatory care settings -- should be made as widely available as possible. This might include a Public Service Announcement (PSA) campaign, but should at least include a website that would include relevant and useful information for ambulatory care providers, as well as for health care professionals, educators and students.*

- *As a vital part of such an information-sharing process, examples of collaborative agreements under which scopes-of-practice have been delineated to provide for more effective team-based approaches should be made available. The implementation of this recommendation would involve both a means of identifying examples of effective collaborative agreements, and a means of disseminating these examples to relevant audiences.*

- *A coterie of Level 3 NCQA-recognized practices – i.e., practices that meet the highest requirements under the National Committee for Quality Assurance's (NCQA) Physician Practice Connections and Patient Centered Medical Home (PPC-PCMH) Recognition Program -- already exist within the state. These practices should be queried or surveyed in order to help develop a baseline of best practices regarding staffing, staff functions, and collaboration & delegation procedures within team-based approaches.*

- *A visual representation of the overlapping scope-of-practice areas for licensed (and scope-of-work areas for non-licensed) staff should be developed. This should then be disseminated as part of the overall information-sharing approaches discussed above, in an effort to assist overall understanding of this issue.*

Additionally, the Task Force recommends the adoption of the following scope-of-practice recommendations of the Illinois Health Care Reform Implementation Council's Workgroup on Workforce:

- *Create a comprehensive formal, standardized, and concise method to deal with scope of practice changes and bills being introduced in Illinois. There process can be annual or bills can be referred to an advisory body as they are introduced. Consider models from other states such as Washington, Colorado, Texas, Minnesota, or Connecticut.*

- *Research is necessary regarding the privileging process for advanced practice nurses (APN) and the process to apply for an Illinois license with collaborating physician; the Illinois Department of Financial and Professional Regulation (IDFPR) may need to change wording on the current form or clarify language regarding privileging and prescribing medicine to align current and future legislation with IDFPR forms and processes.*

- *Explore regulation of Medical Assistants by professional board or IDFPR; consider transfer of credential of veterans into this profession as now happens with the CNA profession.*

- *Establish an unbiased clearinghouse on scope of practice information and research; up-to-date and reliable information on scope of practice proposals, modifications, demonstrations, innovations evaluations and model practice acts.*

- *In lieu of further attempts to create a new paraprofessional to administer medication, explore ways such as certified training to expand scope of practice for certified nursing assistants (CNA) or Licensed Practical Nurses (LPN), thus utilizing existing capacity. Alternatively, IDFPR develop and implement rules for the training, certification, and employment of certified medication technicians in nursing homes to administer medications to nursing home residents under the direction of a duly licensed registered nurse.*

- *Strengthen bridge programs to enhance the career ladder within the nursing profession, for example, from CNA to Registered Nurse (RN), Bachelor of Science in Nursing (BSN), etc., especially for veterans entering the civilian workforce.*

- *Explore the various avenues for identifying the emergence of new job niches and the potential need for control of the practice standards.*

<u>Preparing and Utilizing Front-Line Healthcare Workers</u>

- *Illinois should adopt and/or develop career pathway models for Community Health Workers, Home Health Aides (including Enhanced Home Health Aides) and Medical Assistants. As part of this process, Illinois should support the increased publicity of CHW as a health career option, as a means for launching a career pathway in health care, and as a means for increasing diversity within the health care workforce.*

- *Illinois should support adoption of Community Health Worker curricula – such as the 3-tiered curricula developed at South Suburban College and approved by the ICCB – at community colleges in all regions of the state.*

Additionally, the Task Force reviewed and adopted the recommendations of the Illinois Health Care Reform Implementation Council's Workgroup on Workforce regarding Community Health Workers. Those recommendations include:

- *Adopt the American Public Health Association's definition of Community Health Worker.*

- *Establish a CHW State Advisory Board at IDPH to assist in the development of training, curriculum and certification of CHW.*

- *Support legislative action to formalize and standardize CHW training, curriculum, and certification.*

- *Once developed, provide training through various levels of educational and geographic settings; consider a tiered system of classifications within the CHW field; develop a "grandfathering" protocol for existing CHW ensuring adequate levels of competency; and identify positions for CHW to transition from and into the entire health care system's career ladder (nursing, physicians, consultants, etc.).*

- *Educate across the spectrum of health professions about the definition and role of CHW; many professions are unclear of the role of CHW and how the ACA supports funding for this group of health care workers.*

Preparation for Team Approaches: Inter-Professional Education & Collaborative Practice

- *A comprehensive, statewide communication strategy should be developed and implemented to share information about inter-professional education and collaborative practice models and resources.*

  This strategy should include: 1) the development of a website and network of educators (including adult education and training providers) and employers – an Inter-professional and Collaboration Network – in conjunction with the Health Science Learning Exchange website; and 2) a series of symposiums for the purpose of discussing the need and methodology behind the implementation of pipeline models and experiences.

- *The development of pipeline models and experiences that emphasize inter-professional education and collaborative practice should be continued, and professional development should be provided for educators and health care professionals to assist in expanded implementation of these models. Illinois should, to the extent possible, incentivize and prioritize the development of inter-professional education programs. Teaching hospitals where MDs and NPs receive clinical training need support to enhance these environments for clinical training. This should be coordinated with existing state initiatives (e.g. STEM programs of study, TAAACT grant programs in health sciences, etc.).*

- *The IPEC survey should be disseminated again through a state sponsored site in order to attempt to gain additional responses. While initial survey responses were enlightening, the response rate (including the rate of successfully delivered invitations) was insufficient to draw specific conclusions.*

ATTACHMENT A

IWIB HEALTH CARE TASK FORCE MEMBERS

Stephen Konya (Co-Chair)	Illinois Department of Public Health
Francisco Menchaca (Co-Chair)	Illinois Department of Financial & Professional Regulation
Jenny Aguirre	Illinois Department of Public Health
Darby Anderson	Addus HealthCare
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ATTACHMENT A

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Jay Landau	Employment and Economic Advancement | Heartland Alliance
Jon Lavin	AgeOptions
Mary Ann Lebold	Chicago Bilingual Nurse Consortium
Martin Lipsky	University of Illinois College of Medicine
Dave Lowitzki	Service Employees International Union (SEIU)
Mary Beth Luna	Joliet Junior College
Jennifer McGowan	Governor's Office
Daliah Mehdi	AIDS Foundation of Chicago (AFC)
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Lavon Nelson	Illinois Community College Board
Laura Oberdorf	Illinois Department of Public Health
Evelyn Pagan	Rockford Health System
Jo Patton	AFSCME Council 31
Janet Payne	Presence United Samaritians Medical Center
Kirsten Peachey	Advocate Health Care/UIC-SPH
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ATTACHMENT A

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Greg Will	Service Employees International Union (SEIU)
Michael Williams	Rock River Training Corporation
Paul Zaremba	Southland Health Care Forum - IL workNet Center

ATTACHMENT B

DEFINITIONS FOR "PATIENT-CENTERED MEDICAL HOME"

The U.S. Department of Health & Human Services Agency for Healthcare Research & Quality (http://www.pcmh.ahrq.gov/page/defining-pcmh)

The medical home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. Building on the work of a large and growing community, the Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.

The medical home encompasses five functions and attributes:

1. Comprehensive Care
The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities.

2. Patient-Centered
The primary care medical home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.

3. Coordinated Care
The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.

4. Accessible Services
The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The medical home practice is responsive to patients' preferences regarding access.

5.Quality and Safety
The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

The Patient-Centered Primary Care Collaborative
(http://www.pcpcc.org/about/medical-home)

The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs.

The National Committee for Quality Assurance (NCQA)
(http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx)

The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care. NCQA Patient-Centered Medical Home (PCMH) Recognition is the most widely-used way to transform primary care practices into medical homes.

The American Academy of Family Physicians
(http://www.aafp.org/practice-management/pcmh/overview.html)

The Patient-Centered Medical Home (PCMH) model is an approach to providing comprehensive primary care for children, adolescents, and adults. The PCMH is a health care setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family.

This definition was laid out by the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Osteopathic Association in the 2007 Joint Principles for the Patient Centered Medical Home. This defines critical principles within the PCMH model:

- Access to a personal physician who leads the care team within a medical practice
- A whole-person orientation to providing patient care
- Integrated and coordinated care
- Focus on quality and safety

Through the medical home model, practices seek to improve the quality, effectiveness, and efficiency of the care they deliver, and to ensure that the activities within the practice are focused on meeting patient needs first. The PCMH model seeks to foster a relationship of trust between the care team and the patient, and to actively engage patients as partners in their health care.

Care Team Definition and Principles

American College of Physicians
(http://www.acponline.org/about_acp/chapters/ut/acppaperonclinicalcare.pdf)

Definition of Clinical Care Team

A clinical care team for a given patient consists of the health professionals -- physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals -- with the training and skills needed to provide high-quality, coordinated care specific to the patient’s clinical needs and circumstances.

Clinical care teams typically include, and are sup- ported by, personnel who have a wide range of clinical, administrative, managerial, financial, human resource, and other skills, each with distinct educational backgrounds, experiences, and competencies. Highly functioning teams typically assign responsibility and authority for distinct organizational domains to the person or persons most appropriate for the tasks required. Clinical care teams vary in composition depending on the medical specialty (for example, internal medicine or cardiology)

and clinical setting (such as inpatient, outpatient, small practice, or large institution) and will vary in function depending on leadership, institutional policies, available team members, and even individual talents and characteristics of specific team members. Optimal effectiveness of clinical care teams requires a culture of trust; shared goals; effective communication; and mutual respect for the distinct skills, contributions, and roles of each member.

Principles

1. Assignment of specific clinical and coordination responsibilities for a patient's care within a collaborative and multidisciplinary clinical care team should be based on what is in that patient's best interest, matching the patient with the member or members of the team most qualified and available at that time to personally deliver particular aspects of care and maintain overall responsibility to ensure that the patient's clinical needs and preferences are met. If 2 team members are both competent to provide high- quality services to the patient, matters of expedience, including cost and administrative efficiency, may contribute to division of that work.

2. ACP reaffirms the importance of patients having access to a personal physician who is trained in the care of the "whole person" and has leadership responsibilities for a team of health professionals, consistent with the Joint Principles of the Patient-Centered Medical Home.

3. Dynamic teams must have the flexibility "to determine the roles and responsibilities expected of them based on shared goals and needs of the patient."

4. Although physicians have extensive education, skills, and training that make them uniquely qualified to exercise advanced clinical responsibilities within teams, well-functioning teams will assign responsibilities to advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals for specific dimensions of care commensurate with their training and skills to most effectively serve the needs of the patient.

5. A cooperative approach including physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals in collaborative team models will be needed to address physician shortages.

6. A unique strength of multidisciplinary teams is that clinicians from different disciplines and specialties bring distinct training, skills, knowledge bases, competencies, and patient care experiences to the team, which can then respond to the needs of each patient and the population it collectively serves in a patient- and family-centered manner.

7. The creation and sustainability of highly functioning care teams require essential competencies and skills in their members.

8. The team member who has taken on primary responsibility for the patient must accept an appropriate level of liability associated with such responsibility.

ATTACHMENT C

State of Illinois
Key and High Demand Health Care Occupations *

SOC Code	Title	2010 Illinois Employment	2010 to 2020 Annual Growth	2010 to 2020 Annual Replacemt	2010 to 2020 Annual Job Openings
29-1111	Registered Nurses**	124,044	2,018	2,245	4,263
31-1012	Nursing Aides, Orderlies, Attendants	60,324	464	778	1,242
31-1011	Home Health Aides ***	34,616	1,442	446	1,888
29-1060	Physicians & Surgeons	30,773	328	610	938
39-9021	Personal & Home Care Aides	25,356	835	201	1,036
29-2061	Licensed Practical Nurses	23,367	212	623	835
31-9092	Medical Assistants	16,966	259	260	519
29-2052	Pharmacy Technicians	15,561	170	270	440
43-4171	HC Infor.Clerks & Recept.	12,889	179	390	569
31-9091	Dental Assistants	12,337	186	259	445
11-9111	Med. & Health Serv. Managers	11,797	93	288	381
21-1093	Soc. & Human Service Ast.	11,527	153	249	402
31-9099	Healthcare Support Workers, AO****	10,642	46	163	209
29-1051	Pharmacists	10,099	64	257	321
29-2021	Dental Hygienists	8,606	182	172	354
29-2037	Radiologic Technologsts/Technicians	8,464	105	131	236
29-1123	Physical Therapists	8,196	164	96	260
29-2071	Med Records & Health Info Tech	7,874	55	158	213
29-1020	Dentists & Dental Specialist	6,961	54	207	261
21-1014	Mental Health Counselors	6,123	124	131	255
19-3031	Clin., Couns., Sch., Psychologists	5,975	89	188	277
21-1029	Social Workers, all others	5,174	-	123	123
21-1023	Mental Health & Sub. Abuse Social Wks.	4,709	63	112	175
29-1122	Occupational Therapists	4,239	79	81	160
21-1022	Health Care Social Workers	4,101	71	97	168
21-1798	Comm. & Soc. Service Workers	3,936	48	85	133
21-1015	Rehabilitation Counselors	3,720	29	80	109
25-1071	Health Specialties Teachers, College	2,800	35	45	80
21-1091	Health Educators	2,065	47	45	92
21-1011	Substnce Abuse/Bhvrl Dsrdr Counsirs	1,981	31	42	73
19-2041	Environmental Scientists & Specialists	1,773	20	52	72
19-2012	Physicists	1,476	11	44	55
29-9011	Occupational Health & Safety Specialists	1,221	-	43	43
29-1066	Psychiatrists	874	11	17	28
19-3039	Psychologists, All Other	336	1	11	12
19-1041	Epidemiologists	174	3	1	4
Total Key & High Demand Health Care Occupations*		**544,409**			**18,295**

* Selected by IDES Research Economists based on employment size, percent increase 2010-2020 and importance to the Health Care Industry. IWIB Heath Care Task Force work group added 8 additional occupations related to Social Work, Mental Health & Home Health Care.

**Includes Nurse Anesthetists, Nurse Midwives & Nurse Practitioners.

*** Includes Home Hospice Aides and Home Health Attendants.

**** Includes Certified Compliance Technicians, Reimbursement Specialists, Clinical Account Techs., Coders & Data Specialists.

Source :IDES, Economic Information Analysis Division, & BLS National Occupational Employment Matrix

ATTACHMENT D

IDFPR Licensed Medical Professions by Group

Medicine
- Physician, Licensed
- Physician Limited Temporary License
- Physician Temporary License
- Visiting Professor
- Visiting Physician
- Physician, Controlled Substance
- Surgical Assistant, Licensed
- Surgical Technologist, Licensed
- Physician Assistant in Medicine, Licensed

Nursing
- Registered Professional Nurse (RN)
- Licensed Practical Nurse (LPN)
- Advanced Practice Nurse (APN)
- APN CE Sponsor
- APN Controlled Substance

Pharmacy
- Pharmacist, Registered
- Assistant Pharmacist, Registered
- Pharmacy Technician, Registered
- Pharmacy Controlled Substance

Psychology
- Clinical Psychologist
- Psychological Association, Licensed
- Psychological Partnership, Licensed

Social Work
- Social Worker, Licensed
- Clinical Social Worker, Licensed
- Social Worker CE Sponsor

Counseling
- Professional Counselor, Licensed
- Clinical Professional Counselor, Licensed
- Professional Counselor & Clinical Professional CE Sponsor

Dentistry
- Dentist, Licensed
- Dental Hygienist, Registered
- Specialty in Dentistry, Licensed
- Dentist, Temporary
- Dental/Dental Hygiene CE Sponsor
- Dentist, Controlled Substance

Optometry
- Optometrist, Registered

ATTACHMENT D

- Optometric Resident
- Approved Optometry CE Sponsor
- Optometry, Controlled Substance
- Optometry Ancillary Location Registration

Audiology/Speech Pathology

- Audiologist, Licensed
- Speech-Language Pathologist, Licensed
- Speech-Language Pathology Temporary, Licensed
- Speech-Language Pathology & Audiology CE Sponsor
- Speech-Language Pathology & Audiology Assistant

ICB Certifications by Group

Behavioral Health Certifications

- CADC Certified Alcohol and Drug Counselor
- CRADC Certified Reciprocal Alcohol and Drug Counselor
- CSADC Certified Supervisor Alcohol and Drug Counselor
- CAADC Certified Advanced Alcohol and Drug Counselor
- CARS Certified Assessment and Referral Specialists
- CPS Certified Prevention Specialist
- CSPS Certified Senior Prevention Specialist
- PCGC Certified Problem Gambling Counselor
- CCJP Certified Criminal Justice Professional
- MAATP Medication Assisted Addiction Treatment Professional
- ATE Adolescent Treatment Endorsement
- GCE Gender Competency Endorsement
- CFPP Certified Family Professional Partnership
- MISA I & II Mentally Ill Substance Abuser – Board Registered
- RDDP Registered Dual Disorder Professional
- CRSS Certified Recovery Support Specialist
- CAAP Certified Associate Addictions Professionals

ATTACHMENT E

Legal Scope of Practice, Collaboration & Delegation Framework for Selected IDFPR Licensed Occupations

Licensed Physicians

Instances Where Delegation or Collaboration Is *Not* Allowable

- No physician may delegate any patient care task or duty that is statutorily or by rule mandated to be performed by a physician.

Instances Where Delegation or Collaboration *Is* Allowable

- In an office or practice setting and within a physician-patient relationship, a physician may delegate patient care tasks or duties to an unlicensed person who possesses appropriate training and experience provided a health care professional, who is practicing within the scope of such licensed professional's individual licensing Act, is on site to provide assistance.
    - Any such patient care task or duty delegated to a licensed or unlicensed person must be within the scope of practice, education, training, or experience of the delegating physician and within the context of a physician-patient relationship.
    - The method of delegation may include, but is not limited to, oral, written, electronic, standing orders, protocols, guidelines, or verbal orders.
- Physicians may delegate care and treatment responsibilities to a physician assistant under guidelines in accordance with the requirements of the Physician Assistant Practice Act of 1987.
    - A physician may enter into supervising physician agreements with no more than 5 physician assistants
    - A supervising physician may, but is not required to, delegate prescriptive authority to a physician assistant as part of a written supervision agreement.
- A physician in active clinical practice may collaborate with an advanced practice nurse in accordance with the requirements of the Nurse Practice Act.
    - Collaboration is for the purpose of providing medical consultation, and no employment relationship is required.
    - A written collaborative agreement shall conform to the requirements of Section 65-35 of the Nurse Practice Act.
    - The written collaborative agreement shall be for services the collaborating physician generally provides or may provide in his or her clinical medical practice.
    - A written collaborative agreement shall be adequate with respect to collaboration with advanced practice nurses if all of the following apply:

        - The agreement is written to promote the exercise of professional judgment by the advanced practice nurse commensurate with his or her education and experience.
            - The agreement need not describe the exact steps that an advanced practice nurse must take with respect to each specific condition, disease, or symptom, but must specify those procedures that require a physician's presence as the procedures are being performed.
        - Practice guidelines and orders are developed and approved jointly by the advanced practice nurse and collaborating physician, as needed, based on the practice of the practitioners.
            - The collaborating physician periodically reviews such guidelines and orders and the patient services provided thereunder.
        - The advance practice nurse provides services the collaborating physician generally provides or may provide in his or her clinical medical practice.
        - The collaborating physician and advanced practice nurse consult at least once a month to provide collaboration and consultation.
        - Methods of communication are available with the collaborating physician in person or through telecommunications for consultation, collaboration, and referral as needed to address patient care needs.
        - The agreement contains provisions detailing notice for termination or change of status involving a written collaborative agreement, except when such notice is given for just cause.
    - A collaborating physician may, but is not required to, delegate prescriptive authority to an advanced practice nurse as part of a written collaborative agreement.

Physician Assistant in Medicine, Licensed

Physician Assistant Definition in Law

- "Physician assistant" means any person who has been certified as a physician assistant by the National Commission on the Certification of Physician Assistants or equivalent successor agency and performs procedures under the supervision of a physician as defined in this Act.
    - A physician assistant may perform such procedures within the specialty of the supervising physician, except that such physician shall exercise such direction, supervision and control over such

physician assistants as will assure that patients shall receive quality medical care.

- Physician assistants shall be capable of performing a variety of tasks within the specialty of medical care under the supervision of a physician.
  - Supervision of the physician assistant shall not be construed to necessarily require the personal presence of the supervising physician at all times at the place where services are rendered, as long as there is communication available for consultation by radio, telephone or telecommunications within established guidelines as determined by the physician/physician assistant team.
- The supervising physician may delegate tasks and duties to the physician assistant. Delegated tasks or duties shall be consistent with physician assistant education, training, and experience.
  - The delegated tasks or duties shall be specific to the practice setting and shall be implemented and reviewed under a written supervision agreement established by the physician or physician/physician assistant team.
  - A physician assistant, acting as an agent of the physician, shall be permitted to transmit the supervising physician's orders as determined by the institution's by-laws, policies, procedures, or job description within which the physician/physician assistant team practices.
  - Physician assistants shall practice only in accordance with a written supervision agreement.

<u>Supervision Agreements in Law</u>

- A written supervision agreement is required for all physician assistants to practice in the State.
  - A written supervision agreement shall describe the working relationship of the physician assistant with the supervising physician and shall authorize the categories of care, treatment, or procedures to be performed by the physician assistant.
  - The written supervision agreement shall promote the exercise of professional judgment by the physician assistant commensurate with his or her education and experience.
  - The services to be provided by the physician assistant shall be services that the supervising physician is authorized to and generally provides to his or her patients in the normal course of his or her clinical medical practice.
  - The written supervision agreement need not describe the exact steps that a physician assistant must take with respect to each specific condition, disease, or symptom but must specify which

authorized procedures require the presence of the supervising physician as the procedures are being performed.
    - The supervision relationship under a written supervision agreement shall not be construed to require the personal presence of a physician at the place where services are rendered.
    - Methods of communication shall be available for consultation with the supervising physician in person or by telecommunications in accordance with established written guidelines as set forth in the written supervision agreement.
- The written supervision agreement shall be adequate if a physician does each of the following:
    - Participates in the joint formulation and joint approval of orders or guidelines with the physician assistant and he or she periodically reviews such orders and the services provided patients under such orders in accordance with accepted standards of medical practice and physician assistant practice.
    - Provides supervision and consultation at least once a month.
- A copy of the signed, written supervision agreement must be available to the IDFPR upon request from both the physician assistant and the supervising physician.
- A physician assistant shall inform each supervising physician of all written supervision agreements he or she has signed and provide a copy of these to any supervising physician upon request.
- A supervising physician may, but is not required to, delegate prescriptive authority to a physician assistant as part of a written supervision agreement.
    - This authority may, but is not required to, include prescription of, selection of, orders for, administration of, storage of, acceptance of samples of, and dispensing over the counter medications, legend drugs, medical gases, and controlled substances categorized as Schedule III through V controlled substances, as defined in Article II of the Illinois Controlled Substances Act.
    - The supervising physician must have a valid, current Illinois controlled substance license and federal registration with the Drug Enforcement Agency to delegate the authority to prescribe controlled substances.
    - To prescribe Schedule III, IV, or V controlled substances under this Section, a physician assistant must obtain a mid-level practitioner controlled substances license.
        - Medication orders issued by a physician assistant shall be reviewed periodically by the supervising physician.

- The supervising physician shall file with the IDFPR notice of delegation of prescriptive authority to a physician assistant and termination of delegation, specifying the authority delegated or terminated.
    - Upon receipt of this notice delegating authority to prescribe Schedule III, IV, or V controlled substances, the physician assistant shall be eligible to register for a mid-level practitioner controlled substances license.
- In addition, a supervising physician may, but is not required to, delegate authority to a physician assistant to prescribe Schedule II controlled substances, if all of the following conditions apply:
    - The delegated Schedule II controlled substances are routinely prescribed by the supervising physician.
        - This delegation must identify the specific Schedule II controlled substances by either brand name or generic name.
        - Schedule II controlled substances to be delivered by injection or other route of administration may not be delegated.
    - Any delegation must be controlled substances that the supervising physician prescribes.
    - Any prescription must be limited to no more than a 30-day supply, with any continuation authorized only after prior approval of the supervising physician.
    - The physician assistant must discuss the condition of any patients for whom a controlled substance is prescribed monthly with the supervising physician.

Advanced Practice Nurse (APN)

APN Scope of Practice in Law

- Advanced practice nursing by certified nurse practitioners, certified nurse anesthetists, certified nurse midwives, or clinical nurse specialists is based on knowledge and skills acquired throughout an advanced practice nurse's nursing education, training, and experience.
- Practice as an advanced practice nurse means a scope of nursing practice, with or without compensation, and includes the registered nurse scope of practice.
- The scope of practice of an advanced practice nurse includes, but is not limited to, each of the following:
    - Advanced nursing patient assessment and diagnosis.
    - Ordering diagnostic and therapeutic tests and procedures, performing those tests and procedures when using health care equipment, and interpreting and using the results of diagnostic and

therapeutic tests and procedures ordered by the advanced practice nurse or another health care professional.

- Ordering treatments, ordering or applying appropriate medical devices, and using nursing medical, therapeutic, and corrective measures to treat illness and improve health status.
- Providing palliative and end-of-life care.
- Providing advanced counseling, patient education, health education, and patient advocacy.
- Prescriptive authority as defined in law.
    - A collaborating physician may, but is not required to, delegate prescriptive authority to an advanced practice nurse as part of a written collaborative agreement.
        - This authority may, but is not required to, include prescription of, selection of, orders for, administration of, storage of, acceptance of samples of, and dispensing over the counter medications, legend drugs, medical gases, and controlled substances categorized as any Schedule III through V controlled substances.
        - The collaborating physician must have a valid current Illinois controlled substance license and federal registration to delegate authority to prescribe delegated controlled substances.
    - To prescribe controlled substances under this Section, an advanced practice nurse must obtain a mid-level practitioner controlled substance license. Medication orders shall be reviewed periodically by the collaborating physician.
        - The collaborating physician or podiatric physician shall file with the IDFPR notice of delegation of prescriptive authority and termination of such delegation.
        - Upon receipt of this notice delegating authority to prescribe any Schedule III through V controlled substances, the licensed advanced practice nurse shall be eligible to register for a mid-level practitioner controlled substance license.
    - A collaborating physician may, but is not required to, delegate authority to an advanced practice nurse to prescribe any Schedule II controlled substances, if all of the following conditions apply:
        - Specific Schedule II controlled substances by oral dosage or topical or transdermal application may be delegated, provided that the delegated Schedule II controlled substances are routinely prescribed by the collaborating physician or podiatric physician.

- This delegation must identify the specific Schedule II controlled substances by either brand name or generic name.
- Schedule II controlled substances to be delivered by injection or other route of administration may not be delegated.
- Any delegation must be controlled substances that the collaborating physician prescribes.
- Any prescription must be limited to no more than a 30-day supply, with any continuation authorized only after prior approval of the collaborating physician.
- The advanced practice nurse must discuss the condition of any patients for whom a controlled substance is prescribed monthly with the delegating physician.
- The advanced practice nurse meets the education requirements of Section 303.05 of the Illinois Controlled Substances Act.
- License pending status shall preclude delegation of prescriptive authority.

- *Delegating selected nursing activities or tasks to a licensed practical nurse, a registered professional nurse, or other personnel.*

APN Collaborative Agreements in Law

- A written collaborative agreement is required for all advanced practice nurses engaged in clinical practice, except for advanced practice nurses who are authorized to practice in a hospital or ambulatory surgical treatment center.
- If an advanced practice nurse engages in clinical practice outside of a hospital or ambulatory surgical treatment center in which he or she is authorized to practice, the advanced practice nurse must have a written collaborative agreement.
- A written collaborative agreement shall describe the working relationship of the advanced practice nurse with the collaborating physician and shall authorize the categories of care, treatment, or procedures to be performed by the advanced practice nurse. Collaboration does not require an employment relationship between the collaborating physician and advanced practice nurse. Absent an employment relationship, an agreement may not restrict the categories of patients or third-party payment sources accepted by the advanced practice nurse. Collaboration means the relationship under which an advanced practice nurse works with a collaborating physician or podiatric physician in an active clinical practice to deliver health care services in accordance with (i) the advanced practice nurse's training, education, and experience and (ii)

collaboration and consultation as documented in a jointly developed written collaborative agreement.
    - The agreement shall promote the exercise of professional judgment by the advanced practice nurse commensurate with his or her education and experience.
    - The services to be provided by the advanced practice nurse shall be services that the collaborating physician or podiatric physician is authorized to and generally provides to his or her patients in the normal course of his or her clinical medical practice.
    - The agreement need not describe the exact steps that an advanced practice nurse must take with respect to each specific condition, disease, or symptom but must specify which authorized procedures require the presence of the collaborating physician as the procedures are being performed.
        - The collaborative relationship under an agreement shall not be construed to require the personal presence of a physician or podiatric physician at the place where services are rendered.
        - Methods of communication shall be available for consultation with the collaborating physician or podiatric physician in person or by telecommunications in accordance with established written guidelines as set forth in the written agreement.
- Collaboration and consultation under all collaboration agreements shall be adequate if a collaborating physician or podiatric physician does each of the following:
    - Participates in the joint formulation and joint approval of orders or guidelines with the advanced practice nurse and he or she periodically reviews such orders and the services provided patients under such orders in accordance with accepted standards of medical practice and advanced practice nursing practice.
    - Provides collaboration and consultation with the advanced practice nurse at least once a month.
        - In the case of anesthesia services provided by a certified registered nurse anesthetist, an anesthesiologist, physician, dentist, or podiatric physician must participate through discussion of and agreement with the anesthesia plan and remain physically present and available on the premises during the delivery of anesthesia services for diagnosis, consultation, and treatment of emergency medical conditions.
    - Is available through telecommunications for consultation on medical problems, complications, or emergencies or patient referral.
        - In the case of anesthesia services provided by a certified registered nurse anesthetist, an anesthesiologist, physician, dentist, or podiatric physician must participate through

discussion of and agreement with the anesthesia plan and remain physically present and available on the premises during the delivery of anesthesia services for diagnosis, consultation, and treatment of emergency medical conditions.

- The agreement must contain provisions detailing notice for termination or change of status involving a written collaborative agreement, except when such notice is given for just cause.
- A copy of the signed, written collaborative agreement must be available to the Department upon request from both the advanced practice nurse and the collaborating physician or podiatric physician.
- Nothing in [The Nurse Practice] Act shall be construed to limit the delegation of tasks or duties by a physician to a licensed practical nurse, a registered professional nurse, or other persons in accordance with Section 54.2 of the Medical Practice Act of 1987. Nothing in [The Nurse Practice] Act shall be construed to limit the method of delegation that may be authorized by any means, including, but not limited to, oral, written, electronic, standing orders, protocols, guidelines, or verbal orders.
- An advanced practice nurse shall inform each collaborating physician, dentist, or podiatric physician of all collaborative agreements he or she has signed and provide a copy of these to any collaborating physician, dentist, or podiatric physician upon request.
- A collaborating physician or podiatric physician may, but is not required to, delegate prescriptive authority to an advanced practice nurse as part of a written collaborative agreement.
    - This authority may, but is not required to, include prescription of, selection of, orders for, administration of, storage of, acceptance of samples of, and dispensing over the counter medications, legend drugs, medical gases, and controlled substances categorized as any Schedule III through V controlled substances, as defined in Article II of the Illinois Controlled Substances Act, and other preparations, including, but not limited to, botanical and herbal remedies. The collaborating physician or podiatric physician must have a valid current Illinois controlled substance license and federal registration to delegate authority to prescribe delegated controlled substances.
- To prescribe controlled substances, an advanced practice nurse must obtain a mid-level practitioner controlled substance license. Medication orders shall be reviewed periodically by the collaborating physician or podiatric physician.
- The collaborating physician or podiatric physician shall file with IDFPR notice of delegation of prescriptive authority and termination of such delegation, in accordance with rules of IDFPR. Upon receipt of this notice delegating authority to prescribe any Schedule III through V controlled substances, the licensed advanced practice nurse shall be eligible to

register for a mid-level practitioner controlled substance license under Section 303.05 of the Illinois Controlled Substances Act.

- In addition, a collaborating physician or podiatric physician may, but is not required to, delegate authority to an advanced practice nurse to prescribe any Schedule II controlled substances, if all of the following conditions apply:
    - Specific Schedule II controlled substances by oral dosage or topical or transdermal application may be delegated, provided that the delegated Schedule II controlled substances are routinely prescribed by the collaborating physician or podiatric physician. This delegation must identify the specific Schedule II controlled substances by either brand name or generic name. Schedule II controlled substances to be delivered by injection or other route of administration may not be delegated.
    - Any delegation must be controlled substances that the collaborating physician or podiatric physician prescribes.
    - Any prescription must be limited to no more than a 30-day supply, with any continuation authorized only after prior approval of the collaborating physician or podiatric physician.
    - The advanced practice nurse must discuss the condition of any patients for whom a controlled substance is prescribed monthly with the delegating physician.
    - The advanced practice nurse meets the education requirements of Section 303.05 of the Illinois Controlled Substances Act.

Delegation by APN in Law[*]

- Practical nursing includes assisting in the nursing process as delegated by a registered professional nurse or an advanced practice nurse.

- "Delegation" means transferring to an individual the authority to perform a selected nursing activity or task, in a selected situation.

- Nursing shall be practiced by licensed practical nurses, registered professional nurses, and advanced practice nurses. In the delivery of nursing care, nurses work with many other licensed professionals and other persons. An advanced practice nurse may delegate to registered professional nurses, licensed practical nurses, and others persons.

- A registered professional nurse or advanced practice nurse retains the right to refuse to delegate or to stop or rescind a previously authorized delegation.

[*] References to delegation within the APN Scope of Practice are italicized within the “APN Scope of Practice in Law” section (above).

ATTACHMENT E

Registered Professional Nurse (RN)

RN Definition in Law

- "Registered Nurse" or "Registered Professional Nurse" means a person who is licensed as a professional nurse under the Nurse Practice Act of 2007 and practices nursing as defined in that Act.
- "Registered professional nursing practice" is a scientific process founded on a professional body of knowledge; it is a learned profession based on the understanding of the human condition across the life span and environment and includes all nursing specialties and means the performance of any nursing act based upon professional knowledge, judgment, and skills acquired by means of completion of an approved professional nursing education program.
- A registered professional nurse provides holistic nursing care through the nursing process to individuals, groups, families, or communities, that includes but is not limited to:
    - the assessment of healthcare needs, nursing diagnosis, planning, implementation, and nursing evaluation;
    - the promotion, maintenance, and restoration of health;
    - counseling, patient education, health education, and patient advocacy;
    - the administration of medications and treatments as prescribed by a physician or as prescribed by a physician assistant in accordance with written guidelines required under the Physician Assistant Practice Act of 1987 or by an advanced practice nurse in accordance The Nurse Practice Act of 1987;
    - the coordination and management of the nursing plan of care;
    - *the delegation to and supervision of individuals who assist the registered professional nurse implementing the plan of care*; and
    - teaching nursing students. The foregoing shall not be deemed to include those acts of medical diagnosis or prescription of therapeutic or corrective measures.

RN Scope of Practice in Law

- Practice as a registered professional nurse means the full scope of nursing, with or without compensation, that incorporates caring for all patients in all settings, through nursing standards recognized by the Department, and includes, but is not limited to, all of the following:
    - The comprehensive nursing assessment of the health status of patients that addresses changes to patient conditions.
    - The development of a plan of nursing care to be integrated within the patient-centered health care plan that establishes nursing diagnoses, and setting goals to meet identified health care needs, determining nursing interventions, and implementation of nursing

care through the execution of nursing strategies and regimens ordered or prescribed by authorized healthcare professionals.

- *The administration of medication or delegation of medication administration to licensed practical nurses.*
- *Delegation of nursing interventions to implement the plan of care.*
- *The provision for the maintenance of safe and effective nursing care rendered directly or through delegation.*
- Advocating for patients.
- The evaluation of responses to interventions and the effectiveness of the plan of care.
- Communicating and collaborating with other health care professionals.
- The procurement and application of new knowledge and technologies.
- The provision of health education and counseling.
- Participating in development of policies, procedures, and systems to support patient safety.

Delegation by or to RN in Law*

- Practical nursing includes assisting in the nursing process as delegated by a registered professional nurse or an advanced practice nurse.

- "Delegation" means transferring to an individual the authority to perform a selected nursing activity or task, in a selected situation.

- Nursing shall be practiced by licensed practical nurses, registered professional nurses, and advanced practice nurses. In the delivery of nursing care, nurses work with many other licensed professionals and other persons. An advanced practice nurse may delegate to registered professional nurses, licensed practical nurses, and others persons.

- A registered professional nurse shall not delegate any nursing activity requiring the specialized knowledge, judgment, and skill of a licensed nurse to an unlicensed person, including medication administration.
    - A registered professional nurse may delegate nursing activities to other registered professional nurses or licensed practical nurses.

- A registered nurse may delegate tasks (not requiring nursing knowledge, judgment or decision-making) to other licensed and unlicensed persons.

- A registered professional nurse or advanced practice nurse retains the right to refuse to delegate or to stop or rescind a previously authorized delegation.

Licensed Practical Nurse (LPN)

LPN Definition in Law

- "Practical nurse" or "licensed practical nurse" means a person who is licensed as a practical nurse under this Act and practices practical nursing as defined in The Nursing Practice Act of 1987. Only a practical nurse licensed under that law is entitled to use the title "licensed practical nurse" and the abbreviation "L.P.N.".

- "Practical nursing" means the performance of nursing acts requiring the basic nursing knowledge, judgment, and skill acquired by means of completion of an approved practical nursing education program.

* References to delegation within the RN Definition and Scope of Practice are italicized within the “RN Definition in Law” and the “RN Scope of Practice in Law” sections (above).

- Practical nursing includes assisting in the nursing process as delegated by a registered professional nurse or an advanced practice nurse.
- The practical nurse may work under the direction of a licensed physician, dentist, podiatric physician, or other health care professional determined by the Department.

LPN Scope of Practice in Law

- Practice as a licensed practical nurse means a scope of basic nursing practice, with or without compensation, as delegated by a registered professional nurse or an advanced practice nurse or as directed by a physician assistant, physician, dentist, or podiatric physician, and includes, but is not limited to, all of the following:
  - Collecting data and collaborating in the assessment of the health status of a patient.
  - Collaborating in the development and modification of the registered professional nurse's or advanced practice nurse's comprehensive nursing plan of care for all types of patients.
  - *Implementing aspects of the plan of care as delegated.*
  - *Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of patients, as delegated.*
  - *Serving as an advocate for the patient by communicating and collaborating with other health service personnel, as delegated.*
  - Participating in the evaluation of patient responses to interventions.
  - *Communicating and collaborating with other health care professionals as delegated.*
  - Providing input into the development of policies and procedures to support patient safety.

Delegation to LPN in Law*

- Practical nursing includes assisting in the nursing process as delegated by a registered professional nurse or an advanced practice nurse.

- The practical nurse may work under the direction of a licensed physician, dentist, podiatric physician, or other health care professional determined by the IDFPR.

- Nursing shall be practiced by licensed practical nurses, registered professional nurses, and advanced practice nurses. In the delivery of nursing care, nurses work with many other licensed professionals and

* References to delegation within the LPN Scope of Practice are italicized within the “LPN Scope of Practice in Law” section (above).

other persons. An advanced practice nurse may delegate to registered professional nurses, licensed practical nurses, and others persons.

- A registered professional nurse may delegate nursing activities to other registered professional nurses or licensed practical nurses.

- A licensed practical nurse who has been delegated a nursing activity shall not re-delegate the nursing activity.

- A licensed practical nurse applicant who passes the Department-approved licensure examination and has applied to the Department for licensure may obtain employment as a license- pending practical nurse and practice as delegated by a registered professional nurse or an advanced practice nurse or physician.

ATTACHMENT F

COMMUNITY HEALTH WORKERS (CHWs) BY INDUSTRY					
Industry	CHWs Employed in This Industry	Percent of CHWs Employed in this Industry	Percent CHWs of Industry Employment	Hourly mean wage	Annual mean wage
Individual and Family Services	**7,960**	**19.7%**	**0.61%**	**$14.81**	**$30,810**
Local Government, excluding schools and hospitals (OES Designation)	5,700	14.1%	0.10%	$19.07	$39,670
General Medical and Surgical Hospitals	**2,920**	**7.2%**	**0.06%**	**$21.66**	**$45,040**
Outpatient Care Centers	**2,720**	**6.7%**	**0.43%**	**$16.23**	**$33,760**
Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities	**1,730**	**4.3%**	**0.30%**	**$13.76**	**$28,610**
Social Advocacy Organizations	1,690	4.2%	0.87%	$17.57	$36,540
Offices of Physicians	**1,650**	**4.1%**	**0.07%**	**$17.61**	**$36,620**
Community Food and Housing and Emergency and Other Relief Services	**1,520**	**3.8%**	**1.07%**	**$15.75**	**$32,760**
State Government excluding schools and hospitals (OES Designation)	1,400	3.5%	0.06%	$20.63	$42,910
Grantmaking and Giving Services	1,280	3.2%	1.00%	$20.55	$42,740

Industries in **BOLD** are those classified as NAICS 62: Health Care and Social Assistance (including private, state, and local government hospitals)

ATTACHMENT G

Alternate Job Titles in use for Community Health Workers

Addiction Treatment Specialist
Asthma Outreach worker
Asthma Educator
Asthma Family Support Worker
Asthma Peer Educator
Bilingual Family Outreach Specialist
Bilingual Family Advocate
Birth Assistant (Doula)
Birth Attendant
Birthing Family Support Worker
Case Management Technician
Care Coordinator
Career Coach
Case Worker
Case Managers SNAP
Certified Application Assistant (CAA)
Community Advocate
Community Care Worker (CCW)
Community Health Associate
Community Follow-Up Worker
Community Health Adviser
Community Health Advocate
Community Health Aide
Community Health Outreach Worker (CHOW)
Community Health Representative (CHR)
Community Health Specialist
Coordinator of Outreach
Community Health Educator (CHE)
Community Health Navigators
Community Health Outreach Worker (CHOW)
Community Health Promotion & Awareness Interns
Community Health Worker (CHW)
Community Organizer
Counselor
Cultural Case Manager
Cultural Counselor
Cultural Interpreter
Cultural Mediator
Diabetes Educator
Diabetes Family Support Worker
Diabetes Navigator
Direct Care Worker
Eligibility Worker
Enrollment Worker
Family Advocate
Family Planning Counselor
Family Support Worker
Family Advocate
Family Health Advocate
Family Health Promoter
Family Outreach Worker (FOW)
Family Support Specialist
Family Support Worker
Frontline Health Worker
Head Start Teacher Assistant
Health Advisor
Health Advocate
Health Educator
Health Facilitator
Health Exchange Navigator
Health Extension Workers
Health/Nutrition Support Worker
Health Information Specialist
Health Promoter
Health Liaison
Health Specialist
Health Workers
HIV/AIDS Educator
HIV/AIDS Family Support Worker
HIV Peer Advocate
HIV Risk Assessment/Disclosure Counselor
HIV Service Coordinator
HIV/STD Prevention Counselor
Independent Living Services Manager
Informal Counselor
Intake Coordinator
Intake Assistant
La Leche Peer Counselor (Breastfeeding support)
Lay Health Advisor (LHA)
Lay Health Advocate
Medical Concierge
Medical Interpreter
Men's Health Specialist
Men's Health Worker
Natural Researcher
Neighborhood Health Advocate
Nutrition Adviser
Nutrition Assistant
Nutrition Educator
Nutrition Support Worker Mental Health Aide
Outreach Worker
Outreach Educator
Outreach Specialist
Part Time Project Associates
Patient Experts
Patient Navigator
Peer Advocate
Peer Counselor
Peer Educator
Peer Health Advisor
Peer Health Educator
Peer Leader
Physical Activity Specialist
Preconception Peer Educator
Pre-Perinatal Health Specialists
Prevention Specialist
Program Coordinator
Promotor(a)
Promotor(a) de Salud
Promotores
Public Health Advisor
Public Health Aide
Public Service Aide
Social Worker Assistant
Street Outreach Worker
Team Advocate, Level I

ATTACHMENT G

Trabajadores Comunitarios
Trained Health Extension Workers
Village Health Worker (VHW)
Volunteers
Wellness Ambassadors
Women's Health Specialist
Youth Worker-Program Assistant
Youth Peer Councilor

ATTACHMENT H

Occupational Profile for Community Health Workers at America's Career InfoNet

Occupation Profile

COMMUNITY HEALTH WORKERS: ILLINOIS

Occupation Description

Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Excludes "Health Educators".

State and National Trends

United States	Employment		Percent Change	Job Openings [1]
	2012	2022		
Community Health Workers	40,500	50,700	+25%	20,800
Illinois	**Employment**		**Percent Change**	**Job Openings [1]**
	2010	**2020**		
Community and Social Service Specialists, All Other	3,840	4,300	+12%	130

[1]Job Openings refers to the average annual job openings due to growth and net replacement.

Note: The data for the State Employment Trends and the National Employment Trends are not directly comparable. The projections period for state data is 2010-2020, while the projections period for national data is 2012-2022.

Note that state-level projections data lags national projections data, and that Community Health Workers is a recently added Bureau of Labor Statistics occupational category. When Illinois projections are updated to 2012-2022, they will also include CHWs as a separate occupational category.

ATTACHMENT I

South Suburban CHW Curriculum Overview incorporated with HB 5412 Core Competencies

HB 5412 Competencies:

1-outreach methods and strategies; 2-client and community assessment; 3-effective community-based and participatory methods ; 4-culturally-based 5-health education for behavior change; 6-support, advocacy, and health system navigation for clients; 7-application of public health concepts and approaches 8-individual and community capacity building and mobilization; 9-writing and technical communication skills

Basic Certificate = 20 hours

Course Title	Course Descriptions	HB 5412 Competencies
Introduction to Community Health CHW 101	This course provides an overview of the health care system and community health work. Students will gain an understanding of the role of community health workers, the scope of their function and services, and how they interact with other health personnel and resources. It includes principles of effective verbal and non-verbal communication to assist students in encouraging positive interaction.	**1,7,9**
Accessing Community Resources CHW 105	This course will provide students with a brief overview of public health, its services and core functions in the protection and promotion of health and prevention of disease and injury. It will include selected international, national and local health organizations that influence the public health.	**1,3,7**
Community Health Development CHW 110	This course is designed to help students develop self, client and community capacities to protect and improve health. Emphasis is on building individual and community participation in health through information sharing, informal counseling social support, health skills instruction, community-wide assessments and promoting changes in negative behaviors.	**2,7,9**
Case Management Fundamentals CHW 200	This course is designed to provide the student with the basic case management skills. The focus of this course is on the main components of case management, outreach screening intake, referrals and follow-up. Students will learn about home visits and, universal precautions.	**1,2,7,9**
Mental Health and Substance Abuse CHW 109	This course will provide an overview of mental health stressors inherent to daily life and concerns of clients, families, communities and society at large. The course covers the most frequently identified disorders, such as depression, anxiety, phobias, and others. Include basic concepts of substance abuse, and classification. Description of the most used drugs, appearance, routes of administration, short and long terms effects signs of abuse .Use and abuse of prescription medications.	**4,5,6, 7**
Portfolio Development I CHW 112	This course provides the students with an opportunity to carefully select and, purposefully organize their professionally related academic accomplishments. It provides the students with evidence that they have met the entry-level competency skill standards for community health workers.	**1,6,7,9**

Field Work I CHW 220	This course is an introduction designed for entry-level workers in the health care field. This course will include field experience and basic skills for working effectively in working effectively with co-worker and agencies, and awareness of basic research and interviewing skills. It will provide basic skills in performing CPR and First Aid.	**3,4,5,7**

ATTACHMENT I

Advanced Certificate = 39 hours		
Course Title	**Course Descriptions**	**HB 5412 Competencies**
Computer Literacy and Applications MIS 101 (General Education req)		
Portfolio Development II CHW 212	This course provides the students with an opportunity to carefully select and, purposefully organize their professionally related academic accomplishments. It provides the students with evidence that they have met the entry-level competency skill standards for community health workers.	**1,6,7,9**
Introduction to Community Health Research CHW 215	The goal of this course is to develop basic “research literacy” and/or scientific literacy and to empower people as research team members. This course will use a workshop model where students work in teams, conceptualizing, designing questionnaires, conducting, analyzing data, and disseminating a small-scale research study.	**2,7,8,9**
Environ. Occup. Diseases	This course will provide students with an overview of communicable, environmental, and occupational disease. It will provide the student with information on prevention, referral sources and treatment.	**1,4,5**
CHW Leadership CHW 230	This course builds on the leadership skills taught in CHW 110 by blending leadership theory and practice. It empowers CHWs to identify their own leadership styles by exploring models such as service leadership, visionary leadership, transactional leadership and transformative leadership etc. Provided will be opportunities to enact the various leadership styles discussed in class through role plays and other interactive exercises. Students will be able to recognize their own leadership capacity and learn how to use it to improve themselves, their communities and the CHW movement.	**3,4,7,9**
Nutrition and Disease CHW 115	This course will provide students with the information necessary to promote healthy eating styles and proper food preparation for all age groups. This course gives the students information about identifying the relationship of diet to disease. Attention is given to the treatment of disease by diet modification.	**4,5**
Fieldwork II CHW 225	This course will focus on providing students with the most-up-to-date information and skills on parenting, including the concept and application of anticipatory guidance. The student will be able to help clients identify the importance of their role as parents in the health of their children and their family.	**3, 4,5,8**

ATTACHMENT I

Associates Degree = 69 hours		
Course Title	**Course Descriptions**	**HB 5412 Competencies**
ENG-101- Composition and Rhetoric (Gen. Ed. Req.)		**9**
MDR-102- Fundamentals of Medical Terminology (Gen. Ed. Req.)		
PSY-101- Introduction to Psychology		
SPE-108- Oral Communication (Gen. Ed. Req.)		**9**
SPN-115- Spanish for Health Care Providers (Gen. Ed. Req.)		**4**
PSY-211- Human Growth and Development (Gen. Ed. Req.)	This course provides students an overview of the physical, cognitive, and social and emotion components of human development from conception to old age. Students will gain an understanding of the various stages of human development and the difference and recognizing their role in working with the different age groups.	
BIO-115- Human Body Structure (Gen. Ed. Req.)		
HSA-113- Issues of Diversity (Gen. Ed. Req.)		**4**
Introduction to Community Health CHW 101	This course provides an overview of the health care system and community health work. Students will gain an understanding of the role of community health workers, the scope of their function and services, and how they interact with other health personnel and resources. It includes principles of effective verbal and non-verbal communication to assist students in encouraging positive interaction.	**1,7,9**
Accessing Community Resources CHW 105	This course will provide students with a brief overview of public health, its services and core functions in the protection and promotion of health and prevention of disease and injury. It will include selected international, national and local health organizations that influence the public health.	**1,3,7**
Mental Health and Substance Abuse CHW 109	This course will provide an overview of mental health stressors inherent to daily life and concerns of clients, families, communities and society at large. The course covers the most frequently identified disorders, such as depression, anxiety, phobias, and others. Include basic concepts of substance abuse, and classification. Description of the most used drugs, appearance, routes of administration, short and long terms effects signs of abuse .Use and abuse of prescription medications.	**1,6,7,9**
Community Health Development CHW 110	This course is designed to help students develop self, client and community capacities to protect and improve health. Emphasis is on building individual and community participation in health through information sharing, informal counseling social support, health skills instruction, community-wide assessments and promoting changes in negative behaviors.	**2,7,9**

Portfolio I CHW 112	This course provides the students with an opportunity to carefully select and, purposefully organize their professionally related academic accomplishments. It provides the students with evidence that they have met the entry-level competency skill standards for community health workers.	**1,6,7,9**
Nutrition and Disease CHW 115	This course will provide students with the information necessary to promote healthy eating styles and proper food preparation for all age groups. This course gives the students information about identifying the relationship of diet to disease. Attention is given to the treatment of disease by diet modification.	**4,5**
Environ. Occup. Diseases CHW 118	This course will provide students with an overview of communicable, environmental, and occupational disease. It will provide the student with information on prevention, referral sources and treatment.	**1,4,5**
Case Management Fundamentals CHW 200	This course is designed to provide the student with the basic case management skills. The focus of this course is on the main components of case management, outreach screening intake, referrals and follow-up. Students will learn about home visits and, universal precautions.	**1,2,7,9**
Portfolio Development II CHW 212	This course provides the students with an opportunity to carefully select and, purposefully organize their professionally related academic accomplishments. It provides the students with evidence that they have met the entry-level competency skill standards for community health workers.	**1,6,7,9**
Intro to Community Health Research CHW 215	The goal of this course is to develop basic “research literacy” and/or scientific literacy and to empower people as research team members. This course will use a workshop model where students work in teams, conceptualizing, designing questionnaires, conducting, analyzing data, and disseminating a small-scale research study.	**2,7,8,9**
Fieldwork I CHW 220	This course is an introduction designed for entry-level workers in the health care field. This course will include field experience and basic skills for working effectively in working effectively with co-worker and agencies, and awareness of basic research and interviewing skills. It will provide basic skills in performing CPR and First Aid.	**3,4,5,7**

Fieldwork II CHW 225	This course will focus on providing students with the most-up-to-date information and skills on parenting, including the concept and application of anticipatory guidance. The student will be able to help clients identify the importance of their role as parents in the health of their children and their family.	**3, 4,5,8**
CHW Leadership CHW 230	This course builds on the leadership skills taught in CHW 110 by blending leadership theory and practice. It empowers CHWs to identify their own leadership styles by exploring models such as service leadership, visionary leadership, transactional leadership and transformative leadership etc. Provided will be opportunities to enact the various leadership styles discussed in class through role plays and other interactive exercises. Students will be able to recognize their own leadership capacity and learn how to use it to improve themselves, their communities and the CHW movement.	**3,4,7,9**
Choose 2 electives:		
CHW-115 Nutrition and Disease	115- This course will provide students with the information necessary to promote healthy eating styles and proper food preparation for all age groups. This course gives the students information about identifying the relationship of diet to disease. Attention is given to the treatment of disease by diet modification.	**CHW 115: 4,5**
CHW-235 Intro to Maternal / Child Health	235- This overview of maternal and child health allows students to gain an understanding of the various stages of human development and the difference and recognizing their role in working with the different age groups. This course will provide students with information on the course of pregnancy and newborn care.	**CHW 235: 4,5,6**
CHW-205 Parenting Skills	205-This course will focus on providing students with the most-up-to-date information and skills on parenting, including the concept and application of anticipatory guidance. The student will be able to help clients identify the importance of their role as parents in the health of their children and their family.	**CHW 205: 4,5**
CHW 100 Health and the Public		
CHW 120 Public Health Epidemics		

ATTACHMENT J

HOME HEALTH CARE AIDES BY INDUSTRY			
Industry	Home Health Care Aides Employed in This Industry[1]	Percent of Home Health Care Aides Employed in this Industry	Percent Home Health Care Aides of Industry Employment
Home health care services	**323,000**	**36.9%**	**26.9%**
Services for the elderly and persons with disabilities	141,200	16.1%	18.3%
Residential intellectual and developmental disability facilities	**121,800**	**13.9%**	**31.9%**
Continuing care retirement communities and assisted living facilities for the elderly	**116,400**	**13.3%**	**14.7%**
Nursing care facilities (skilled nursing facilities)	**33,600**	**3.8%**	**2.0%**
Employment services	28,700	3.3%	0.9%
Self-employed workers	19,400	2.2%	0.2%
Residential mental health and substance abuse facilities	**17,600**	**2.0%**	**8.9%**
Other residential care facilities	**15,200**	**1.7%**	**9.6%**
General medical and surgical hospitals; private	**9,400**	**1.1%**	**0.2%**

Industries in **BOLD** are those classified as NAICS 621-30: Health Care

[1] 2012 BLS National Estimates

ATTACHMENT K

Alternate Job Titles in use for Home Health Aide

Caregiver
Certified Home Health Aide
Certified Medical Aide
Certified Nurses Aide
Elder Care Provider/Companion
Enhanced Home Health Aide
Home Attendant
Home Health Provider
Habilitation Training Specialist
Residential Counselor

ATTACHMENT L

Occupational Profile for Home Health Aides at America's Career InfoNet

HOME HEALTH AIDES: ILLINOIS

Occupation Description

Provide routine individualized healthcare such as changing bandages and dressing wounds, and applying topical medications to the elderly, convalescents, or persons with disabilities at the patient's home or in a care facility. Monitor or report changes in health status. May also provide personal care such as bathing, dressing, and grooming of patient.

State and National Trends

United States	Employment		Percent Change	Job Openings [1]
	2012	2022		
Home Health Aides	875,100	1,299,300	+49%	590,700
Illinois	**Employment**		**Percent Change**	**Job Openings [1]**
	2010	**2020**		
Home Health Aides	34,610	49,020	+42%	1,890

[1] Job Openings refers to the average annual job openings due to growth and net replacement.

Note: The data for the State Employment Trends and the National Employment Trends are not directly comparable. The projections period for state data is 2010-2020, while the projections period for national data is 2012-2022.

ATTACHMENT M

MEDICAL ASSISTANTS BY INDUSTRY			
Industry	Medical Assistants Employed in This Industry[1]	Percent of Medical Assistants Employed in this Industry	Percent Medical Assistants of Industry Employment
Offices of physicians	**332,900**	**59.4%**	**13.9%**
General medical and surgical hospitals; private	**60,100**	**10.7%**	**1.4%**
Offices of chiropractors	**24,200**	**4.3%**	**19.5%**
Offices of optometrists	**15,200**	**2.7%**	**13.1%**
Offices of all other health practitioners	**14,400**	**2.6%**	**12.6%**
General medical and surgical hospitals; local	**9,400**	**1.7%**	**1.4%**
Employment services	6,900	1.2%	0.2%
Nursing care facilities (skilled nursing facilities)	**5,300**	**0.9%**	**0.3%**
Continuing care retirement communities and assisted living facilities for the elderly	**5,300**	**0.9%**	**0.7%**
Colleges, universities, and professional schools; state	5,100	0.9%	0.3%

Industries in **BOLD** are those classified as NAICS 62: Health Care and Social Assistance (including private, state, and local government hospitals)

[1] 2012 BLS National Estimates

ATTACHMENT N

State and National Trends

United States	Employment		Percent Change	Projected Annual Job Openings [1]
	2012	2022		
Medical Assistants	560,800	723,700	+29%	26,990
Illinois	**Employment**		**Percent Change**	**Projected Annual Job Openings [1]**
	2010	2020		
Medical Assistants	16,970	19,620	+16%	530

[1]Projected Annual Job Openings refers to the average annual job openings due to growth and net replacement.

Note: The data for the State Employment Trends and the National Employment Trends are not directly comparable. The projections period for state data is 2010-2020, while the projections period for national data is 2012-2022.

ATTACHMENT O

Health Careers Pathways (H2P) Consortium
Department of Labor TAACCCT Funded
H2P Grant Overview

On September 26, 2012 the Department of Labor awarded a $19.6 million grant to fund a Health Career Pathways initiative to 9 community colleges in 5 states. The grant was one of the largest ever awarded by the Department of Labor through a discretionary grant from the DOL Trade Adjustment Assistance Community College and Career Training (TAACCCT) program with the aim of better preparing the target population of trade displaced and lower skilled workers, and other beneficiaries for high-wage, high-skill employment and ultimately increasing attainment of degrees, certificates and other industry recognized credentials.

The H2P Consortium is led by Cincinnati State Technical and Community College and is comprised of 9 community college co-grantees and 6 partner organizations. In addition, the consortium colleges partner with local employers, community and workforce agencies.

Community College co-grantees:

- Anoka-Ramsey Community College, Coon Rapids MN
- Ashland Community and Technical College, Ashland KY
- Cincinnati State Technical and Community College, Cincinnati OH
- City Colleges of Chicago, Chicago IL
- El Centro College, Dallas TX
- Jefferson Community and Technical College, Louisville KY
- Owens Community College, Perrysburg, OH
- Pine Technical College, Pine City MN
- Texarkana College, Texarkana TX

H2P Partners:

- Hipcricket - Text Messaging/Communication provider
- I-Seek – Promoting implementation of Virtual Career Network for co-grantees
- National Network of Health Career Programs in Two-Year Colleges (NN2)
- National Association of Workforce Boards (NAWB)
- Office of Community College Research and Leadership (OCCRL) – Grant evaluator
- Teaching Institute for Excellence in STEM (TIES) - Technical assistance provider

What we do:

The H2P is working collaboratively via sharing best practice, building upon unique skills and learning and accessing rich resources provided by national consulting partners and technical assistance specialists to dramatically improve health professions training via career pathways and the development of core curriculum and core credentials.

To achieve these goals, H2P colleges are replicating a comprehensive model of best practices centered on a career pathways framework and competency-based core curriculum. Strategies have been developed in eight core areas to frame our efforts.

H2P Core Strategies:

1) Online assessment and career guidance
2) Contextualized developmental education
3) Competency-based core curriculum
4) Industry-recognized stackable credentials
5) Career guidance and retention support
6) Training programs for incumbent healthcare workers
7) Enhanced data and accountability systems
8) Galvanize a national movement: “Achieving a National Consensus on Core Curricula in the Health Professions”

Progress to Date:
Since October 1, 2011, co-grantees have been working to develop Programs of Study (POS) representing the three pathways in healthcare: Therapeutics, Diagnostics and Informatics. The POS are being developed or modified to include contextualized learning, core curriculum and stackable credentials whenever possible. To date over 2,000 participants are being served by the nine co-grantee colleges with over 67 new, revised or modified POS launched. For year two, the focus will be to develop core curriculum for co-grantee colleges and a draft of a national model, develop and implement innovative intrusive advising for program participants including text messaging, and incumbent worker training programs in collaboration with industry partners. Through development and implementation of the eight core strategies, the H2P Consortium has a blueprint that is anticipated to result in increased capacity, retention and employment of much needed health professionals within our communities. The established data collection protocols and evaluation in collaboration with OCCCRL in year one are foundational.

Evaluation Plan:
In addition to improving outcomes for students and increasing job placement in needed health occupations, the H2P is a research study under the capable direction of the Office of Community College Research and Leadership (OCCCRL). The goal of this significant investment will be to capture model outcomes that will support transformative change in the education and industry partnership.

Sustainability and Scaling Strategies:
A National Advisory Council has been established to help us meet one of our core strategies "to galvanize a national movement to improve health professions education and training programs". This advisory council has a strong, influential Health Care representation including national and regional employers, community colleges, trade and professional associations, accreditation and credentialing organizations, private foundations, workforce development agencies, and state community college systems. Additionally, the H2P National Advisory Council is teaming with the American National Standards Institute (ANSI) who is convening a Panel on Health Care Evidence Based Credentialing to work toward a collective goal of improving health education needed for the future workforce.
The National Advisory Council is working with the Consortium to validate core curriculum as relevant to the needs of a future healthcare workforce.

In December 2012, the H2P Consortium was selected as one of eight TAACCCT consortia nationally to participate in a Community College Transformative Change Initiative. This two year project funded by Gates, Lumina and Joyce Foundations is studying the best practices and outcomes being generated by these innovative collaboratives and determining how they can be successfully scaled. The H2P Consortium has been hard at work with a representative team of Consortium leadership to further develop our plan to share our innovations that will help to support the transformative change necessary to meet the changing landscape of the healthcare industry.

If you would like any further information feel free to contact:

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(revised 2.25.13)

ATTACHMENT P

IPEC Core Competencies for Inter-professional Collaborative Practice

General Competency Statement-VE. Work with individuals of other professions to maintain a climate of mutual respect and shared values.
Specific Values/Ethics Competencies:

VE1. Place the interests of patients and populations at the center of inter-professional health care delivery.

VE2. Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.

VE3. Embrace the cultural diversity and individual differences that characterize patients, populations, and the health care team.

VE4. Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.

VE5. Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services.

VE6. Develop a trusting relationship with patients, families, and other team members (CIHC, 2010).

VE7. Demonstrate high standards of ethical conduct and quality of care in one's contributions to team-based care.

VE8. Manage ethical dilemmas specific to inter-professional patient/ population centered care situations.

VE9. Act with honesty and integrity in relationships with patients, families, and other team members.

VE10. Maintain competence in one's own profession appropriate to scope of practice.

General Competency Statement-RR. Use the knowledge of one's own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.

Specific Roles/Responsibilities Competencies:

RR1. Communicate one's roles and responsibilities clearly to patients, families, and other professionals.

RR2. Recognize one's limitations in skills, knowledge, and abilities.

RR3. Engage diverse healthcare professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.

RR4. Explain the roles and responsibilities of other care providers and how the team works together to provide care.

RR5. Use the full scope of knowledge, skills, and abilities of available health professionals and healthcare workers to provide care that is safe, timely, efficient, effective, and equitable.

RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.

RR7. Forge interdependent relationships with other professions to improve care and advance learning.

RR8. Engage in continuous professional and inter-professional development to enhance team performance.

RR9. Use unique and complementary abilities of all members of the team to optimize patient care.

General Competency Statement-CC. Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.

Specific Inter-professional Communication Competencies:

CC1. Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.

CC2. Organize and communicate information with patients, families, and healthcare team members in a form that is understandable, avoiding discipline-specific terminology when possible.

CC3. Express one's knowledge and opinions to team members involved in patient care with confidence, clarity, and respect, working to ensure common understanding of information and treatment and care decisions.

CC4. Listen actively, and encourage ideas and opinions of other team members.

CC5. Give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.

CC6. Use respectful language appropriate for a given difficult situation, crucial conversation, or inter-professional conflict.
CC7. Recognize how one's own uniqueness, including experience level, expertise, culture, power, and hierarchy within the healthcare team, contributes to effective communication, conflict resolution, and positive inter-professional working relationships (University of Toronto, 2008).

CC8. Communicate consistently the importance of teamwork in patient-centered and community-focused care.

General Competency Statement-TT. Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.

Specific Team and Teamwork Competencies:

TT1. Describe the process of team development and the roles and practices of effective teams.

TT2. Develop consensus on the ethical principles to guide all aspects of patient care and team work.

TT3. Engage other health professionals—appropriate to the specific care situation—in shared patient-centered problem-solving.

TT4. Integrate the knowledge and experience of other professions—appropriate to the specific care situation—to inform care decisions, while respecting patient and community values and priorities/ preferences for care.

TT5. Apply leadership practices that support collaborative practice and team effectiveness.

TT6. Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among healthcare professionals and with patients and families.

TT7. Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care.

TT8. Reflect on individual and team performance for individual, as well as team, performance improvement.

TT9. Use process improvement strategies to increase the effectiveness of inter-professional teamwork and team-based care.

TT10. Use available evidence to inform effective teamwork and team-based practices.

TT11. Perform effectively on teams and in different team roles in a variety of settings.

ATTACHMENT Q

Interprofessional Education & Collaboration Readiness Survey

Background & Organization Type

Background

The Illinois Health Care Task Force, sponsored by the Department of Commerce and Economic Opportunity and the Illinois Workforce Investment Board, has established a task force to address the changing landscape of healthcare and the need for a patient-centered, team-based approach. One work group is exploring inter-professional education among education and training providers and collaborative practice among healthcare employers in the State of Illinois.

As a part of this effort, the work group is surveying leading healthcare organizations in Illinois to assess the readiness and or status of healthcare providers in their use of collaborative practice and teamwork strategies has been identified.

This brief survey consists of eleven questions and may necessitate responses from a variety of individuals in your healthcare organization as there may be differences from department to department in the implementation and use of collaborative practice and teamwork. For the purpose of this survey, the definition of inter-professional education and collaborative practice follows.

Definition of Inter-professional Education and Collaborative Practice:

Inter-professional education and collaborative practice occur when individuals from 2 or more professions learn about, from, and with each other to enable effective collaborations - working together from different professional backgrounds with patients, families and communities - to deliver the highest quality of care. (Revised/merged from WHO, 2010)

*1. Which of the following best describes your organization? (Check all that apply)

- ☐ Ambulatory
- ☐ Hospital
- ☐ Nursing and Residential Care
- ☐ Social Assistance
- ☐ Other (please specify)

Interprofessional Education & Collaboration Readiness Survey

IPEC

*2. Does your institution's vision, mission and/or core values emphasize the importance of the 'Triple Aim' (patient safety and their experience of care, the health of individuals and the community, reducing the per capita cost of health care)? (Check all that apply.)

- ○ Yes
- ○ No
- ○ Don't Know

*3. Are you or others in your organization knowledgeable of the Inter-professional Education and Collaboration (IPEC) core competencies that were developed by six professional healthcare associations in 2011?

- ○ Very knowledgeable
- ○ Somewhat knowledgeable
- ○ Not knowledgeable
- ○ Don't know

4. To what extent does your institution engage in collaborative practice to ensure the patient receives the highest quality of care? (Check all that apply.)

- ○ Collaborative practice is used consistently throughout our institution.
- ○ Collaborative practice is used minimally throughout our institution.
- ○ To my knowledge, there is no use of collaborative practice in our institution.
- ○ Don't know, unable to assess.

Interprofessional Education & Collaboration Readiness Survey

IPEC Detail

*5. Does your institution provide professional development/continuing education on inter-professional collaboration and teamwork skills/competencies?

- ○ Yes, extensive professional development is provided.
- ○ Yes, some professional development is provided.
- ○ No professional development is provided on these topics.
- ○ Don't know

*6. What resources are allocated to encourage development and improvement in inter-professional collaboration and teamwork skills/competencies. (Check all that apply).

- ☐ Time to build collaboration and teamwork.
- ☐ Facilities are conducive to working as teams and collaborating.
- ☐ Designated staff for inter-professional collaboration
- ☐ Financial resources
- ☐ No, resources are not provided for this effort.
- ☐ Don't know

*7. Has your institution adopted a specific packaged curriculum or program for the implementation of collaborative practice and teamwork?

- ○ Yes
- ○ Partially
- ○ No
- ○ Don't know

8. Please identify the name of the curriculum/program that you use (or partially use).

Interprofessional Education & Collaboration Readiness Survey

Interprofessional Collaboration & Teamwork

*9. Do you believe that inter-professional collaboration and teamwork will lead to increased patient safety?

- ○ Yes, large impact
- ○ Yes, small impact.
- ○ No impact
- ○ Don't know

*10. Do you believe your institution needs to implement stronger teamwork and collaboration to improve patient safety and overall health?

- ○ Yes
- ○ No
- ○ Don't know

11. What Department in the Organization do you Represent?

12. What is your Position / Occupation?

13. If you are willing to respond to survey follow-up questions, please provide your contact information below.

Name:

E-Mail:

Phone:

Organization: