Proceedings: Workforce Summit on Ensuring a Workforce to Care for People with Serious Illness in the Community

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Abstract

In May, 2018, 40 national leaders and experts were convened to make workforce development recommendations that address the needs of persons living with serious illness in community settings. Over the course of two and a half days, attendees offered sixteen broad recommendations that included detailed guidelines for their implementation. This report describes the planning and organization of the Workforce Summit, the attendees, the convening proceedings, and the final recommendations. It also includes an evaluation of the Summit and a description of other steps being taken to disseminate the results.

Acknowledgements

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Chapter 1 – Introduction

As the older population of the United States continues to grow, it is increasingly important to develop and expand systems of care to meet the needs of individuals living with chronic and serious illness. Numerous analyses and health care leaders have identified the lack of an adequately prepared workforce as a barrier to the delivery of high-quality serious illness care in the community.[1]

In May, 2018, a Workforce Summit was convened in Napa, California, to focus on identifying both barriers and facilitators of workforce development for serious illness care, assessing gaps in research that must be filled to support programs and policies, and developing specific recommendations that can be undertaken within the next five years to accelerate progress toward an adequate workforce. The Gordon and Betty Moore Foundation (GBMF) provided support for the Summit and subsequent activities to disseminate the results of the Summit. Joanne Spetz, Professor at the Philip R. Lee Institute for Health Policy Studies and Associate Director for Research at Healthforce Center at UCSF was the Director of this project.

The 40 Summit attendees included representatives of delivery organizations, professional association leaders, advocacy group leaders, researchers, educators, public officials, and leaders of private insurance companies. The Summit was designed to generate ideas and facilitate a critique of potential recommendations in order to attain consensus regarding the most important steps for the future. The convening was shaped by seven commissioned papers that discussed the current state of knowledge and policy regarding the health workforce, recommendations that have been made to date, and the things that either facilitate or serve as a barrier to their implementation.

This Proceedings report provides detail regarding the planning process, organization, and execution of the Summit and resulting recommendations. Attendees' evaluation of the Summit is presented, based on daily surveys and a post-Summit survey. Early dissemination efforts and plans for additional dissemination are described.

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[1] IOM (Institute of Medicine). 2008. Retooling for an aging America: Building the health care workforce. Washington, DC: The National Academies Press.

Chapter 2 – Meeting Planning

The Workforce Summit was a two-and-a-half-day-long convening that brought together field experts, health care organization leaders, and policy leaders to develop a plan of policy change, organizational change, and research to ensure the adequacy of the health care workforce to meet current and future care needs of persons with serious and complex illnesses living in the community. The central focus of the convening was the development of recommendations that can be acted upon over the next five years.

Planning committee

The planning of the convening and invited discussion papers was guided by a committee composed of a small group of health workforce leaders and experts selected by UCSF with input from Project Officers at GBMF. This committee determined the discussion paper topics, recommended authors and reaction speakers, and recommended attendees. Two faculty from UCSF (Dr. Spetz and Susan Chapman, PhD, RN) and two Project Officers from GBMF were part of the planning committee. Invitations were extended on September 7, 2017, to six national leaders to join the committee; all accepted the invitation within 24 hours. One member stepped down on October 13, 2017, due to unanticipated time demands from other commitments. All but one member of the planning committee attended the Summit. (Dr. Chapman of UCSF was unable to attend.) Table 1 lists the final planning committee members.

Table 1: Workforce Summit Planning Committee

NAME	TITLE	AFFILIATION
Joanne Spetz, PhD	Professor, Associate Director for Research at Healthforce Center	University of California, San Francisco
Susan Chapman, PhD, RN	Professor	University of California, San Francisco
Diane Schweitzer, MPPM	Acting Chief Program Officer	Gordon and Betty Moore Foundation
Sutep Laohavanich, MSG	Program Officer	Gordon and Betty Moore Foundation
Jennie Chin-Hansen, RN	Immediate Past President	American Geriatrics Society
Karen Donelan, ScD, EdM	Associate Professor & Senior Scientist	Massachusetts General Hospital & Harvard Medical School
Robyn Stone, DrPH	Senior Vice President for Research, Co-Director, LeadingAge LTSS Center @UMass Boston	LeadingAge
Michelle Washko, PhD	Acting Director	National Center for Health Workforce Analysis, Health Resources and Services Administration
Heather Young, PhD, RN	Dean* and Professor, Associate Vice Chancellor for Nursing*	Betty Irene Moore School of Nursing, University of California, Davis

* Dr. Young is now Dean Emeritus and no longer Associate Vice Chancellor.

The planning committee met by conference call every two to four weeks from September 18, 2017 until the Summit. They had one post-Summit call. Most calls did not include the full planning committee, as members often had other obligations. However, regular progress updates that included information regarding the details discussed during each call, the status of potential paper authors and Summit attendees, meeting logistics, and other pertinent topics were provided to each committee member via email. Planning committee members provided important guidance during conference calls and in response to the update emails.

Venue selection and management

The ideal location for the Summit was described as a venue within two hours of a major airport, not in a city where participants would be likely to have other business that would distract them from focusing on the Summit goals, and one that would be viewed as a desirable place to visit. The process of identifying an appropriate meeting venue began in early September. Dr. Spetz was referred to Michael Jahn of Location Solvers for assistance in selecting a venue and negotiating the contract. Mr. Jahn had previously worked with several programs at UCSF, and the UCSF procurement office approved his work.

The Summit was originally scheduled for March, which required a location with a mild winter. A summary of potential venues in Arizona, South Carolina, California, Florida, and New Mexico were identified by Mr. Jahn. Approximately six weeks after this process began it was determined that May would be a better time for the Summit, with targeted dates during the week before Memorial Day. Mr. Jahn then researched venues in mild-climate zones, including Napa Valley, Sonoma County, coastal southern California, Georgia, and northern Virginia. In early November, five venues were selected for detailed comparisons, and Mr. Jahn developed a table comparing room costs, meal costs, ground transportation costs, and other relevant parameters. The Andaz Napa, which was a relatively new hotel, offered an excellent rate for rooms, and its proximity to UCSF and GBMF was desirable because airfare costs would be reduced. Mr. Jahn negotiated the contract, which included estimates for meal costs, complimentary upgraded guest rooms, and costs for audio-visual equipment. In late December, the contract was finalized.

In early January, UCSF staff worked with the Andaz to determine room layouts and meals. They also researched venues for two off-site dinners. One dinner was held at Tarla Restaurant, which was next door to the hotel and offered a semi-private room with a fixed family-style menu. The second dinner was held at the tasting room of a small winery; catering was provided by an outside vendor. For this venue, a mini-bus was chartered to transport guests. All other meals were at the Andaz.

As the attendee list was developed and confirmed, UCSF staff prepared a rooming list for the hotel and offered to help attendees make travel arrangements. Attendees were asked to purchase airfare directly within UCSF guidelines. UCSF staff helped attendees identify ground transportation options and researched ride-share services. It was determined that the least expensive options from both Oakland and San Francisco International Airports were ride-sharing services (Lyft and Uber) or car rental. Attendees were asked to share their air travel schedules, and UCSF staff helped those arriving at similar times coordinate with each other to share rides or rental cars. UCSF staff also helped coordinate return transportation at the end of the Summit.

UCSF staff selected small gifts for attendees including non-spill wine glasses that were used during mini-bus transport to the winery and snacks for return flights.

Summit themes and discussion papers

The initial work of the planning committee was to identify themes for the meeting, potential discussion paper topics and authors, and potential meeting attendees. In advance of the first planning call on September 18, the Committee was provided with a document summarizing the goals of the Summit and a preliminary list of potential attendees. At this meeting, some potential themes were identified, including the use of technology in training and care delivery, pedagogy in health professions education and training, care management models in primary care for those with serious illness, federal workforce data collection, patient-directed care, family caregivers, and palliative care. Over the following month, the Committee refined the themes and added new ones, identified topics and related articles that would be provided to attendees as background reading, and began development of a meeting agenda (described below). By mid-December a list of potential paper authors was determined, and seven

invitations were extended on December 19 and 20; an eighth invitation was extended in late January. For some paper topics teams of authors were invited, while for other topics invitations were extended to single individuals, who were offered the opportunity to identify their own coauthors. These individuals were informed that the planning committee would need to approve coauthors before they were finalized (all were approved). The invitations requested: "We would want the paper to discuss the current state of knowledge and activity regarding the health workforce in this area, current examples of models of practice and education, recommendations that have been made to date, barriers and facilitators of implementing recommendations, and/or opportunities to advance progress in the next two to five years. We also expect that you attend the meeting in May."

One initially-invited author declined the invitation; the planning committee identified a new team of authors for that paper. For another paper, one of the two selected coauthors declined but identified another coauthor. The individual who received the eighth invitation (on the topic of characteristics of well-functioning teams) was unavailable and an acceptable substitute was not identified. Instead, attendees were given published papers on the topic to prepare for the Summit.

The discussion paper topics and authors were:
- Advanced care planning and integration of care planning into primary care: Steven Bartels and Ellen Flaherty
- Clinician communications regarding prognosis and patient preferences: Tony Back and Erik Fromme
- Cultural competency: VJ Periyakoil
- Palliative Care: Arif Kamal and Christine Ritchie
- Family caregivers: Janice Bell, Heather Young, and Robin Whitney.
- Direct care workers: Robyn Stone
- Linking patients with social services: Robyn Golden

In early February, UCSF staff began the process of developing consulting agreements with paper authors for payment of honoraria. Authors were offered $15,000 total, with half payable upon receipt of an acceptable discussion paper and half payable upon submission of the paper to an academic journal (discussed below). Coauthors were allowed to determine the division of their payment.

The initial invitations asked authors to submit papers in mid-March in order to provide ample time for late submissions. In late March, Dr. Spetz asked all authors to provide draft papers in mid-April so attendees would have four to six weeks to read the papers in advance of the Summit. The first paper was submitted on April 20, and the last one was received on May 7. Dr. Spetz requested minor revisions to all but two papers before sharing them with attendees. The requests for revisions generally focused on providing more clarity about barriers to progress and/or more specificity in recommendations. Revisions were generally completed within one to two weeks. All papers were provided to attendees through the Summit website (described below) as they were completed.

Attendee selection

The planning committee was asked to help select Summit attendees who, together with paper authors and planning committee members, would result in a total of 40 to 45 attendees. For the first planning committee meeting, a list of 36 specific individuals and 14 organizations or program types from which an attendee might be identified was circulated. Potential attendees were categorized as follows:
- Home care worker organization representatives or experts (e.g., Eldercare Workforce Alliance, PHI)
- Private payers (e.g., Centene, Kaiser Permanente)
- Care delivery organizations (e.g., OPTUM, Consumer Direct, National Association of Home Care and Hospice)

- Federal government (e.g., Centers for Medicare and Medicaid Services, Health Resources and Services Administration)
- Geriatricians and gerontologists (individual experts and organizations)
- Palliative care (individuals and organizations)
- Experts on specific professions (e.g., family medicine, social work)
- Foundations (e.g., Hartford Foundation, Macy Foundation)
- Other (including consumer organizations such as AARP, individual advocates, researchers, educators and organizations representing education)

Initial invitations were issued to 21 individuals in late January, 2018. The planning committee identified additional attendees as invitations were declined. A total of 46 invitations were extended to confirm 22 attendees. There were an additional 16 paper authors and 7 people from GBMF and the UCSF team, resulting in total attendance of 45. A few attendees left the proceedings early due to scheduling issues.

A list of the attendees and their affiliations is provided in Appendix A.

Website and meeting materials

A website was designed to provide information about the Summit and efficiently distribute information and documents to attendees. The website URL https://workforcesummit.ucsf.edu/ was secured in January, 2018, and the site was populated with a summary of the project and tabs for the Summit program and travel information, background materials, discussion papers, and reimbursement forms.

The background readings were selected by the UCSF team with input from the planning committee. The background papers included prior research reports and analyses related to care for persons with serious illness living in the community. The topics included population demographics, models of care, quality of care, financing and payment, training and education of the direct care workforce, state policy and regulation, team practice, cultural competence, and technology. For some sources, the UCSF team excerpted specific sections of the original publication. For others, only the executive summary was included. A total of 28 documents were posted, most at least one month before the Summit to allow attendees ample time to read them.

The draft agenda was posted on April 14, and all attendees were sent an email with a copy of the agenda and information about the website. The commissioned discussion papers were disseminated through the website on May 14. They were password-protected and attendees were asked not to share them in order to ensure there would not be any issues with later publication.

Organization of the Summit

Process of designing the agenda

Once the planning committee identified the conference themes and discussion paper authors, it turned to the creation of a structure for the Summit that would achieve the goal of developing concrete recommendations that would address the need for a better prepared workforce to care for persons with serious illness living in the community. Early drafts of the agenda proposed 1.5 to 2-hour segments focused on each discussion paper's theme, with 30 minutes for presentation of the paper and prepared comments from a "reaction" panel, 30-45 minutes for small group breakout discussions, and 45-60 minutes for full-group debriefing and discussion. The "reaction" presentations would be provided by attendees selected by the planning committee.

However, in mid-March the UCSF team and GBMF Project Officers held a meeting and reorganized the agenda to create more time for the small group breakout sessions, and to allow for the refining of recommendations over the course of the Summit. A preliminary agenda was distributed to attendees in mid-April. The final Summit agenda is provided in Appendix B.

Overview of Summit design

The agenda provided attendees with a mission and timeframe:

> *Mission: Identify and prioritize recommendations to ensure an adequate workforce to support the care of people with serious illness in the community.*

> *Timeframe: Recommendations should focus on overcoming barriers and accelerating health workforce development activities in the near term (next one to three years).*

The Summit began with a reception and dinner intended to be an informal opportunity for attendees to greet each other and relax after a long day of travel.

Tuesday (all day) and Wednesday morning consisted of three modules intended to present and develop initial recommendations within three thematic areas:

(1) Focus on the clinical team: Advanced care planning, geriatrics, and palliative care
(2) Focus on the clinical team: Clinician communication and cultural competency
(3) Focus on the home: family caregivers, direct care workers, and connection with social services

Each module had four components: (1) 15-minute presentations for each of two or three discussion papers, (2) 30-45 minutes for a "reaction panel" composed of three attendees, (3) breakout groups of five to six attendees, and (4) reports from the breakout groups.

Authors were provided 15 minutes for presentation of their discussion papers (which were distributed in advance) and were asked to focus on their recommendations.

The "reaction panels" were composed of three attendees who were asked in advance to serve. The invitation stated:

> *We hope the panelists will take about five minutes to reflect on the papers (which will be distributed in a couple of weeks), provide additional insights regarding recommendations that flow from the papers, additional challenges or opportunities that exist, etc. This does not need to be a formal presentation – we view it as an opportunity to have people who are "in the field" add to the initial content that will launch breakout groups to begin the development of recommendations.*

The breakout groups were given one hour to consider the presentation and reaction, with the following instructions:

- *Select one person to take notes and one person to report out*
- *Discuss:*
    - *In the conversation so far, what has been missed and what else should be considered?*
    - *What recommendations would you prioritize to have the biggest impact?*

    o   *What is achievable in two to three years?*
    o   *What will take longer but is too important to ignore?*

Breakout groups were provided a Post-it flip chart and markers to take notes and prepare a presentation of their discussion.

The reports from the breakout groups were scheduled for one hour. Each group was asked to present for five minutes, with the goal of having a full-room discussion after each group report.

After the three thematic modules, Wednesday afternoon was devoted to "deep dive" breakout groups. These groups were given the following instructions:

> *For one of the domains of recommendations, work together to consolidate the recommendations that were put forward by the breakout groups. Then, prioritize them – which would you do first? Which would you do last?*

Each of these breakout groups was assigned to one thematic area: two groups focused on geriatrics/palliative care/annual wellness visits, two groups focused on communications/cultural competence, one group focused on social work, one group focused on direct care workers, and one group focused on family caregivers.

The breakout groups were allotted one and a quarter hours to consider the recommendations that emerged from the morning sessions, followed by one and a quarter hours to report out and engage in a full-room discussion, with the goal of reaching consensus about prioritization of the recommendations.

Thursday morning's agenda focused on developing the recommendations in greater detail. After a brief recap, attendees selected "nuts-and-bolts" breakout groups based on their expertise and preferences. Their instructions were:

> *Starting with the top priorities in each domain, what are the next steps? Who would be responsible for implementing the recommendation? What resources would be needed to move the recommendation forward? What are the barriers and how can they be overcome? What are the facilitators and how can they be leveraged? What challenge was identified as the greatest? What recommendation seems the easiest (but might be deceivingly so)? What are our next steps? Where should the discussion papers go next?*

These groups were allotted one hour for deliberation, followed by one and a quarter hours for reporting their results and discussion with the full group.

Thursday's session closed with a brief discussion of the next steps to be undertaken to disseminate the results of the Summit.

Organization of breakout groups

Attendees were assigned to one of six tables for the duration of the Summit. At least one planning committee member was at each table. The attendees were assigned to breakout groups that rotated for each breakout session, except the Thursday morning sessions, which were self-selected. There were seven groups and all had at least one planning committee member at each. The groups were created to facilitate attendee interaction, to avoid potential conflicts of interest, and to avoid redundancy (such as having two attendees from the same organization in the same group).

Note-taking and retention of Summit materials

UCSF staff took notes throughout the Summit, which were reviewed each evening to guide the next day's work. In addition, UCSF retained the Post-it flip chart display sheets used by breakout groups to record and report on their discussions.

Daily evaluations

At the end of Tuesday and Wednesday, attendees were asked to complete a survey evaluating that day's program, including ratings of the content and quality of the session, organization and pace of session, practical value of session, as well as a rating for each specific presentation regarding its conciseness and quality, clarity of presentation of key issues, and effectiveness in launching discussion.

Chapter 3 – Meeting Execution and Results

Opening dinner

The Summit began with a reception and dinner held at the Andaz Napa in a private space adjoining a semi-public patio. The reception offered appetizers and wine, and the dinner was a buffet with open seating. Approximately 35 attendees were at the dinner; some attendees experienced flight delays, and a few had conflicts, which were known in advance.

Discussion paper presentations and breakout groups

The first component of the Summit consisted of presentations of the discussion papers, reaction panels, and small-group breakout sessions.

Presentations on advanced care planning, geriatrics, and palliative care

Ellen Flaherty and Stephen Bartels presented "The Geriatric Healthcare Workforce: Leveraging the Potential of Interprofessional Teams." They framed their presentation around the importance of redesigning health care systems to be centered on (older) people. They identified barriers to implementing such a system, including difficulty integrating team-based models of care, scaling and sustaining successful programs, payment mechanisms that provide contradictory incentives, and challenges related to organizational change. Their submitted discussion paper made multiple recommendations to advance interprofessional patient-centered care, including the following:

- Increase geriatric competence across the general health workforce by including criteria of geriatric competence as part of all licensure, certification, and maintenance of certification for health care professionals, across all specialties and fields. This includes any professional that is a part of the continuum of care for older adults, including medical residents and other trainees; those at institutions such as nursing homes and assisted living facilities; and direct care workers and informal caregivers in patients' homes.
- Provide training, education, and support for patients' families and caregivers to help them become better equipped to make informed decisions regarding a patient's health and reduce stress and burnout.
- Continue to provide support for initiatives such as the Geriatric Workforce Enhancement Program (GWEP) that aim to increase the number of skilled professionals with geriatric competence, and use the GWEP program to establish a network of "improvement communities" that could bring together people interested in scaling up models of care to investigate what works and does not work in different care delivery settings.
- Increase the adoption and implementation of care models that focus on increasing value and improving quality of care and health outcomes for older adults. In addition, determine what gaps exist in preventive care, long-term care, palliative care, and models, in terms of incorporating key stakeholders who are not medical professionals (caregivers, family, social workers, etc.).
- Work with state and federal agencies, private insurers, and health systems to encourage the widespread adoption of payment mechanisms that incentivize the use of care models best suited for target populations and service settings.
- Determine measurement and evaluation strategies to identify effective models of care for specific patient populations and service settings.
- Work on recruiting and retaining direct care workers by increasing wages, providing more training, and incorporating them into models of care.
- Develop ways to make the geriatrics field more attractive to potential healthcare professionals. This can be done in the form of financial incentives at the educational level (loan forgiveness, scholarships, grad

school payments, etc.) or at the professional level (incentivizing payers to reimburse for clinical services delivered to older adults by professionals who have certification or specialize in geriatrics).

Flaherty and Bartels then described their work on a model program, the Geriatric Interdisciplinary Team Transformation for Primary Care program (GITT-PC), which was initially funded by the Hartford Foundation in the 1990s. They noted that this model is not just about training, but also transforming primary care teams to maximize reimbursement through task reallocation and team work. This is achieved through boot camps, tool kits and a Virtual Learning Collaborative that focuses on data dashboards tied to patient outcomes. Their data show this model has led to increases in both annual wellness visits and advance care planning conversations. They also described the Reducing Avoidable Facility Transfers (RAFT) program, which is a systematic approach to goals of care conversations. In addition to eliciting goals of care, the model has a team of clinicians who are familiar with patients and available on call, biweekly care reviews, and controlled communication with families before any transfers. A demonstration program implemented in two skilled nursing facilities achieved cost savings of $70 million.

Arif Kamal and Christine Ritchie presented "Championing the Champions: Promoting Primary Palliative Care for Those with Serious Illness." They began by observing that there exists a strong evidence base supporting the use of palliative care specialists to improve patient outcomes, but they suggest that the current model of care, in which specialty palliative care dominates the market for serious illness, is unsustainable in the face of growing demand and a projected shortage of specialists. They note that an estimated five to ten percent of practicing palliative care clinicians neither completed fellowship training nor hold board-certification, citing this as evidence that the supply of specialists is inadequate to meet demand for palliative care services. They describe a framework for palliative care delivery with three distinct levels of care, differentiated by the intensity of patient needs: primary (least intense), secondary, and tertiary (most intense) palliative care. Because primary palliative care is sufficient for most patients, but tertiary care delivered by specialists may not be available to patients who need it, the authors conceived of a role for "Palliative Care Champions" who would provide "needed secondary palliative care." Examples of primary palliative care include routine cancer-associated pain ameliorated by first-line interventions and discomfort associated with complex and chronic conditions managed by a primary care provider. When a primary care provider (or general specialist provider) is unable to provide adequate palliation, they could turn to a champion, who would have additional palliative care training and address more complex situations, including conflict management between clinicians. Finally, particularly complex palliative care needs would be managed by a specialist palliative care team. The "champion" level is the new recommendation, entailing formal training in conducting structured palliative care assessments, familiarity with moderately complex management approaches, access to other care providers with some palliative care training (such as a social worker), and training in counseling loved ones on the dying process. Specific examples of a champion's role and services were provided.

Breakout groups for advanced care planning, geriatrics, and palliative care

The breakout groups had one hour to discuss the presentations, identify additional recommendations to consider, and, ideally, identify the recommendations that were most likely to be feasible to implement in a short time period and/or were of greatest importance.

Additional recommendations included:
- Disseminate VA system innovations in geriatric and home-based care, which have been evaluated extensively and could be adopted by other organizations.
- Invest in scaling up the team-based care models that have been shown to work, such as Independence at Home, UCLA's Dementia Care Model; Grace Model; Care Management Plus; CAPABLE; and Kaiser programs.

- Generate more health services research on team-based care outside of ICU and hospice to learn how meaningful teams are created, and why they have the orientation and dynamics that they demonstrate.
- Develop tools that facilitate comprehensive home assessment for complex care (e.g. dementia care model) in order to understand what is happening in the home and share that information with the clinical team. These tools need to be aligned with community programs.
- Develop resources to support self-management by patients and family caregiver management and support, including tool kits and websites.
- A defined share of graduate medical education (GME) funds – such as 10 percent – should be dedicated to support multidisciplinary training and community-based care, particularly experiential team-based learning in the community.
- Develop performance and outcomes measures that can be used to demonstrate value to C-suite, including patient-related outcomes and family-related outcomes.
- Tie provider payments to the palliative experience; insurance companies could advance this now.
- Extend CMS billing codes to more non-physician providers and develop codes that incentivize team-based care.
- CMS should mandate assessments of functional and cognitive status for Medicare Advantage plans and Accountable Care Organizations.
- All providers engaged in serious illness care need to have minimum competencies, including mapping community resources to support individuals/patients and motivational interviewing. The specific competencies require definition.
- Integrate serious illness care standards into health system accreditation.
- Develop validated approaches to collecting information about family caregivers that can be shared across providers, including home care workers.

The breakout groups identified other themes and generated additional ideas that could be developed into concrete recommendations:

- There is too much focus on competencies for geriatrics and palliative care in both training programs and the existing workforce. There is a need to focus on serious illness competencies that would apply to a wider scope of caregivers.
- CMMI should share more knowledge around what it has learned about what makes a good care delivery strategy within a value-based purchasing system (e.g. ACO).
- There is a need to identify specific approaches to promote integration of serious illness care processes into outpatient practice (e.g. advance care planning, polypharmacy). These approaches could include accreditation and quality measurement. Are there particularly good opportunities in ACOs, Medicare Advantage, etc.?
- Tools need to be developed for person-centered care and family-centered care and, in the longer term, methods need to be developed to make sure that providers are connected to tools to facilitate communication.
- Leadership development is needed across all stakeholder groups: education, policy, healthcare systems.
- Patient/provider matching/stratification needs to be more patient/family driven in order optimize resources.
- The experience of the retired workforce needs to be leveraged.
- There is a need for quality of care measurement that is patient-reported (what matters to patients), measuring function as what is optimal to the patient.

Underlying issues identified by the breakout groups included:

- Tasks can be shifted to optimize the delivery of care – home care aides can almost certainly do more and there are a lot more of them.

- The fragmented care delivery system does not support good care and is confusing to everybody.
- Good models of care will reduce provider burnout, which is an important issue.
- Integration of principles of team-based care is essential in education and training programs, with the team defined broadly.
- Technology should be leveraged when possible to support these efforts.
- The challenges associated with reimbursement are too big to be addressed in the near term, so focus on what is achievable.

Presentations on clinician communication and cultural competency

Tony Back and Erik Fromme presented "Equipping Clinicians with Communication Skills for Serious Illness" after lunch on Tuesday. Their presentation emphasized the fact that suboptimal communication is a cause of low-quality care for those with serious illness, noting that poorly-trained clinicians can inadvertently misguide patients, which contributes to poor outcomes. At present, there are no standards for communication skills training in clinical education, but there are successful models that can be leveraged to increase training capacity, both for those in pre-professional education and in continuing education. The authors proposed seven straightforward recommendations:

- Evidence-based communication training should be made widely available.
- Faculty development should create a national cadre of skilled communication teachers.
- Health systems should embed communication teachers as expert consultants and coaches.
- Communication training should be combined with system workflow redesign.
- Social marketing to increase awareness training should address clinicians and leaders differently.
- Public reporting for measures of system capacity and clinician training should drive accountability.
- Research should better define use of emerging educational technologies.

VJ Periyakoil then presented "Building a Culturally Competent Workforce to Provide Equitable Care for Diverse Older Americans." She observed that the aging population in the U.S. is becoming more diverse – the "silver-brown tsunami" – and highlighted the fact that racial disparities persist into end of life, with underutilization of hospice care by non-White racial and ethnic groups. Numerous studies have reported that eliminating health disparities – including in end-of-life care – would reduce overall health care costs by eliminating wasteful spending. She then described the In-reach for Successful Aging and End of Life (iSAGE) program, which offered patient-centered, family-oriented care, holistically integrating biological, psychological, sociological, spiritual, and cultural aspects of care to promote well-being of patients. The program involved training individuals from the community in scientific principles of aging and end-of-life issues, followed by training in ethno-geriatrics. Program participants completed a mentored, community-based project aimed at helping at least five older adults with limited health literacy. Half of the trainees were primarily laypeople recruited from specific underserved, non-White communities, many of whom were caregivers or direct care workers; the other half were health professionals including geriatricians, palliative care clinicians, and nurses. Dr. Periyakoil recommended that this type of scalable program, which can incorporate both in-person and web-based components, be replicated to provide culturally competent local resources for navigating serious illness and end-of-life care, alongside well-prepared clinicians. Her discussion paper provided more specific recommendations:

- Health care organizations should implement Culturally and Linguistically Appropriate Services (CLAS), as sponsored by the U.S. Department of Health and Human Services Office of Minority Health. This includes successfully engaging medical interpreters as members of the health care team.
- Health professions education programs should provide cultural competence training.
- Multi-ethnic lay health advisors should be trained and utilized to assist patients in the communities in which they live.

Breakout groups on clinician communication and cultural competency

The breakout groups had one hour to discuss the presentations, identify additional recommendations to consider, and, ideally, identify the recommendations that were most likely to be feasible to implement in a short time period and/or were of greatest importance.

Additional recommendations included:
- Simplify, harmonize, and provide guidance for the myriad clinician communication tools/skills/approaches in existence.
- Develop and use technology (including natural language processing) to help clinicians in real-time communications with patients/families.
- Develop and optimize technology for clinician communications training (e.g., web-based education, online simulation) to increase uptake.
- Add home care workers to huddles and discussions, and increase number of care models using these workers effectively.
- Require communication training/measurement and/or cultural competence training/measurement as part of the license renewal process for clinicians and/or health care delivery organizations.
- Apply implementation science, including quality improvement strategies, to help encourage wider use of evidence-based cultural competence and communication tools/strategies/education across a broader range of provider types and settings.

The breakout groups identified other themes and generated additional ideas that could be developed into concrete recommendations:
- EHR portals should be used more effectively for within-team communication and communication with families. What are the issues that need to be addressed (e.g. training, regulatory) to encourage use? What EHR design changes might support this work?
- Encourage the idea of team-based cultural competence and/or communication competence training – not all team members are equally good at communicating different things with different patients/families.
- There is a need to create/ensure engaged clinical leaders to support cultural competence and/or communication skills.
- Patients and families should be involved in co-designing interventions for conversations and communication strategies. How do you get patients more connected to the communication process? The flipped classroom could provide an approach in which the family is given tools to prepare and then have the conversation.
- It is important to think about the pipeline to build diversity in our healthcare workforce.
- There is a need to develop tools and data that better measure whether communication efforts are successful in addressing patient needs and link these efforts to outcomes.
- Develop strategies to leverage community organizations in promoting the importance of advance care planning and frank discussions with care providers.
- Address the fact that HIPAA is sometimes misunderstood and can be a communication barrier.

Underlying issues identified by the breakout groups included:
- Team competencies and communications are rarely discussed holistically.
- Think about the team as including everybody from the janitor to the physician.
- Cultural subgroups are important – to address issues of cultural competence we need to think about more than four racial/ethnic groups (e.g., racial/ethnic subgroups, LGBTQ, native language, cognitive function).
- Cultural competence and communications education is ongoing, not one-time; it needs refreshing and is lifelong.
- Clinicians and systems should have a customer service perspective when talking about communication.

- There is a need to improve care providers' understanding of how professional language is context-dependent: Provider to provider (within the levels of the system) versus provider to family caregiver (between the levels of the system).
- Non-verbal communication needs to be included in education.
- The theory of trauma-informed care can be incorporated into cultural competence and communication training; the concept of "what happened to you" can make a big difference in approaching patients, who are often victims of health system "logistical sufferings."
- The challenges associated with reimbursement are too big to be addressed in the near term, so focus on what is achievable.

Presentations on family caregivers, direct care workers, and connection with social services

The Wednesday morning panel started with a presentation by Janice Bell, Robin Whitney, and Heather Young, "Family Caregiving in Serious Illness." They began by noting they would use the term "family caregiver" to include individuals who are associated with the care recipient by strong social ties, in addition to those related by kinship or marriage. There are nearly 40 million caregivers in the U.S., who provide billions of dollars of value in services to those for whom they care. More than half of family caregivers help with medical or nursing tasks in the home, most commonly administering medications, assisting with mobility, and performing wound care. Nearly half of those who perform medical/nursing tasks report that they have not been adequately prepared to perform these tasks. To better support this important workforce, they offered six recommendations:

- Improve preparation and support of family caregivers across the serious illness trajectory. This first requires identifying the caregivers, followed by offering training and engaging them in care planning for their family member. Employers should be involved in offering support to caregivers because many need flexibility in their work arrangements to accommodate their caregiving role.
- Increase awareness of existing policies, supports, and resources. Information about resources and relevant policies and supports is difficult to find and interpret, both for family caregivers and for health care professionals. There should be alignment among agencies supporting caregivers and improved communication to increase awareness of relevant policies, supports, and resources that exist. There are a number of major national organizations dedicated to supporting family caregivers, such as AARP, the Family Caregiver Alliance, Alzheimer's Association, National Alliance for Caregiving, the Betty Irene Moore School of Nursing Family Caregiving Institute, and the Caregiver Action Network; these need to be coordinated to expand this work. There are also dedicated programs within federal, state and local organizations to support caregivers. Many of these organizations and agencies function as clearinghouses offering toolkits, hotlines and other resources for family caregivers. Yet, public awareness of such resources falls short of the need. Improving the "no wrong door" function across agencies can assist with closing this gap. There also should be research to measure use and associated outcomes of these assets.
- Support multicultural caregiving. Promising interventions should be tailored for diverse cultural groups, and community stakeholders should be engaged as research partners to evaluate best practices.
- Comprehensive family caregiving interventions need to be developed, tested, and evaluated. These should include evaluation of the impact of programs on stress and coping, health (mental, physical, spiritual, and financial), support received and perceived, and education quality. Specific aspects to be addressed include the optimal intervention "dose," variation in effects across different serious illness conditions, economic analysis, team roles, the role of technology, and community-based interventions.
- Adopt and use consensus-based guidelines. Quality standards exist but need to be adopted by health care payers and organizations.
- There needs to be ethical discussion about the burden placed on family caregivers and advocacy for family caregivers. About half of all caregivers say they have no choice in assuming the role; best practices are needed to support caregivers as they exit or opt not to continue in the caregiving role.

Robyn Stone then presented "The Future of the Home Care Workforce: Training and Supporting Aides as Members of Home-Based Care Teams." She began by describing the low level of training required for the complex tasks and responsibilities taken on by home health aides and home care aides. There are numerous barriers that prevent the home care workforce (also called the "direct care" workforce) from being included in team-based care, such as a lack of awareness of the complex nature of the job, inadequate attention to training, and limited scopes of practice established by many state boards of nursing. However, Stone noted that some states have established an advanced home care aide role (see New York's Advanced Home Health Aide position and Washington State's Advanced Home Care Aide Pilot program), and acknowledge that there are other examples of direct care workers being integrated as care-team members, including one program that leverages technology to provide apps that allow aides to share data with nurse managers. Three recommendations were proposed:

- Standardize competency-based training requirements across states. This will require identifying the specific knowledge and skills that aides need to operate effectively and within care teams. Existing model programs should be evaluated for their potential to expand to larger scale.
- Increase investments in training. Some Geriatrics Workforce Enhancement Programs include training for home care workers within teams, and there have been Medicare and Medicaid programs that address the training needs of the home care workforce. These types of programs should be expanded.
- Provide career development opportunities for aides. Home care aides provide valuable services but find that their work is not rewarded and they have little or no opportunity to advance professionally. Career development opportunities could come from ensuring an appropriate degree of nurse delegation to aides across all states, scaling of advanced home care aide programs, and intentional development of alternative career ladders and lattices.

The final discussion paper, "Connecting Social Services with Clinical and Home Care Services for Persons with Complex Illness in the Community," was presented by Erin Emery-Tiburcio and Robyn Golden. They acknowledged there are myriad challenges to coordinating social and clinical services, including low reimbursement for home and community-based services, a lack of social care providers including mental health, social work, and direct care professionals, and long waiting lists for services. There are some model programs such as PACE, GRACE, VA Home-Based Primary Care, and OACIS, but reimbursement and sustainability is a challenge. The authors described a Bridge Model at Rush University Medical Center that linked patients with social services and achieved significant reductions in readmissions and emergency department visits. The key components of such a program are integrated biopsychosocial assessments, individualized care plans with shared goals developed collaboratively with the patient and family, care provision and management that ensures continuity of care over time and across settings, and quality measurement and continuous improvement using tools that capture the overall performance of the team as well as the contributions of each team member. This approach led to three domains of recommendations:

- People. All individuals on the care team should be empowered to use the highest level of skill they can. Non-clinicians should be engaged in the care team, which should include licensed clinical social workers, psychologists, psychiatrists, primary care providers (ideally with geriatric training), direct service workers, and community health workers. Each team member has a unique role, and all should be engaged in support of the care plan, be paid fair wages, and leverage health information technology to share information with each other and patients.
- Skills. Geriatrics and palliative care competencies are needed by all members of the care team. Other essential skills include the ability to elicit older adults' and family members' goals of care and preferences, assess in the context of diversity and family dynamics, and understand cognitive impairment. Training to develop these skills should be interprofessional and include material related to team communication and collaboration, as well as the social determinants of health. All members of the team should be aware of

community-based organizations and the tools used to find such organizations in order to connect patients to needed services.

- System. Multiple improvements are needed in the health care system, including better workforce data to track labor supply, electronic health record access across settings, quality of life measurement, payment models that incentivize team care, and research on the cost savings of coordinated care programs.

Breakout groups on family caregivers, direct care workers, and connection with social services

The breakout groups had one hour to discuss the presentations, identify additional recommendations to consider, and, ideally, identify the recommendations that were most likely to be feasible to implement in a short time period and/or were of greatest importance.

Additional recommendations included:
- Develop a standardized screening that determines whether the caregiver is ready to do the job. Key questions include: Who is the family caregiver? Is it the person the family member wants? Is the caregiver prepared adequately? This is a patient safety issue, and somebody on the care team needs to be in charge of this. This needs to be ongoing and not a one-time assessment.
- Develop a structure to assess caregiver health needs that measures caregiver comorbidity on a longitudinal basis.
- Develop training to engage advocacy groups such as the American Medical Association with curated tips and resources for family caregivers so they can help push information out to clinicians. Examples can be used from how pediatricians engage parents, to how skilled nursing implements care conference models.
- Education should be designed to ensure that traditional care teams have skills to include family caregivers and that family caregivers have training to work with the clinical team.
- Resources are needed to make it easier for families to find existing tutorials and videos on skills; this largely would involve leveraging existing resources.
- Consider family caregivers as a potential pipeline of future health care providers (front-line or clinical or social work).
- Provide direct care workers with team communications training. (They need to know the escalation process to use to convey important information, and to understand which information is most important.)
- Establish career ladders to capitalize on the potential for "levels" of direct care workers.

The breakout groups identified other themes and generated additional ideas that could be developed into concrete recommendations:
- Evidence from paid family caregiver programs could be evaluated and applied to development of programs with training requirements.
- Respite care needs to be available to improve family caregivers' well-being and reduce burnout.
- Co-ops should be engaged where they exist.
- There is a need to invest not just in the workforce but in the organizations that train the workforce.
- It may be valuable to have a public campaign on the importance of this workforce to elevate awareness of them.
- Patients and families need resources to know whether they are hiring a well-vetted worker, but this kind of data is not available.

Underlying issues identified by the breakout groups included:
- A lot of good work in this area has already been done, and there are existing resources that can be leveraged. Disseminate these; don't reinvent the wheel.
- Specific strategies are needed for caregivers who live in rural and other outlying areas.

- There is a need to address the cultural norm of the physician as "the captain of the ship."
- The full care team should be used to help support family caregivers.
- Implementing coordination roles requires system-level work first. Whoever is doing this work needs to understand system design, dissemination, evaluating success, billing and revenue streams, and human resources. They need to consider incentives not just for the provider but also staff and family.
- There are many international models from which to learn.
- Increasing peer-to-peer communication among caregivers would be valuable to support them.
- Immigration policy has important implications on this workforce.

Deep-dive breakouts

After Wednesday's lunch, attendees were divided into "deep dive" breakout groups, with instructions to consolidate the recommendations and prioritize them. Each breakout group was assigned one thematic area: two groups focused on geriatrics/palliative care/annual wellness visits, two groups focused on communications/cultural competence, one group focused on social work, one group focused on direct care workers, and one group focused on family caregivers.

In preparation for the Wednesday afternoon session, UCSF staff prepared "breakout summaries," which consolidated recommendations from the breakout groups on Tuesday and Wednesday morning. These summaries included all of the recommendations and were organized as they have been presented here.

The following broad recommendations were identified by each deep-dive breakout group as those that should be considered for prioritization:

Geriatrics/palliative care/annual wellness visits
- Lobby to NIH/AHRQ to fund more research on team-based care/roles.
- Provide training in functional assessment.
- Disseminate curricula for evidence-based team models.
- Recruit, retain, and train a diverse geriatrics and palliative care workforce.
- Expand support for GWEP and GACA, extend support to palliative care.
- Mandate experiential continuing education for health professionals' initial licenses and for license renewals.
- Leverage the retired workforce.

Communications/cultural competence
- Accrediting bodies should include communications training for license/certification.
- Establish a workgroup to identify specific communications competencies for each team role.
- Establish a workgroup to identify existing evidence on cultural humility training programs.
- Advocate for expanding the team members who can bill for advance care planning and chronic care management.
- Identify, consolidate, evaluate, and then disseminate the best communications and cultural competency training programs.
- Implement communication technology that adheres to standards of high-quality culturally and linguistically appropriate communication.

Social work
- Provide technical assistance to enable organizations to use existing health information technologies to promote coordination.

- Conduct a job analysis of the role of coordinator/navigator and tie to educational resources.
- Identify and translate best practices of health systems and community collaboration and offer peer mentorship to support adoption of these best practices.

Direct care workers
- Develop a structure of foundational training, with stackable credentials and modular education tools.
- Identify and promulgate programs, policies, and public awareness to increase the respect and safety of the front-line worker.
- Offer front-line workers peer support and better connections to supervisors to mitigate isolation.
- Offer compensation that makes the job attractive.
- Measure impact of front-line worker education and skills on emergency department use, hospitalizations, and other costly services.

Family caregivers
- Identify the caregiver and assess their competencies/needs.
- Engage the caregiver with a competent care team.
- Increase awareness of family caregiver support resources.
- Support the caregiver by ensuring access to respite, payment, and training.

Voting

The goal of the full-room discussion following the deep-dive breakout session was to achieve consensus regarding which recommendations to prioritize. However, consensus was not achieved in the allotted time due to the attendees' need to engage in a wide-ranging, rich discussion of the issues that had arisen over the course of the convening.

Thus, the UCSF team asked attendees to use the comment space for that day's program evaluation to report which of the broad recommendations they felt were most important. There was no limit to the number of recommendations they could list. The UCSF team distributed an email to all attendees that included the recommendations and a link to the evaluation survey, and attendees were asked to submit their responses prior to dinner that evening; the UCSF team followed up with each attendee to ensure that everyone responded.

The resulting order of prioritization and vote counts are presented in Table 1. After voting was complete, the UCSF team organized the recommendations with the largest numbers of votes into themes.

Table 1. Recommendation rankings and vote totals

Ranking	Recommendation	Votes
1	Offer compensation that makes the [direct-care worker] job attractive	16
2	Develop a structure of foundational training, with stackable credentials and modular education tools	15
3	Mandate experiential CE in communities for professionals' licenses	9
3	Recruit, retain, and train a diverse geriatrics and palliative care workforce	9
5	Engage the caregiver with a competent care team	8
5	Expand support for GWEP and GACA, extend to palliative	8
7	Provide technical assistance to enable organizations to use existing health information technologies to promote coordination.	7
7	Conduct a job analysis of the role of coordinator/navigator, and tie education resources to this	7
7	Identify and promulgate programs, policies, and public awareness to increase the respect and safety of the front-line worker	7
7	Measure impact of front-line worker education and skills on emergency department use, hospitalizations, and other costly outcomes	7
7	Support the caregiver by ensuring access to respite, payment, and training	7
7	Establish a workgroup to identify specific communications competencies for each team role	7
13	Identify, consolidate, and evaluate the best communication and cultural competency training programs, and then push them out	6
13	Offer front-line workers peer support and better connections to supervisors to mitigate isolation	6
13	Identify the caregiver and assess their competencies/needs	6
13	Disseminate curricula for evidence-based team models	6
13	Accrediting bodies should include communications training for license/certification	6
18	Lobby to NIH/AHRQ on more research on team-based care/roles	5
19	Advocate for expanding the team members who can bill for advance care planning and chronic care management	4
19	Provide training in functional assessment	4
21	Identify and translate best practices of health systems and community collaboration, and offer peer mentorship to support adoption of these best practices	3
21	Leverage the retired workforce	3
23	Establish a workgroup to identify existing evidence on cultural humility training programs	2
23	Increase awareness of family caregiver support resources	2
25	Use existing quality measurement tools to advise improvement and implement education/training	1
25	Implement communication technology for culturally and linguistically appropriate standards	1

Nuts-and-bolts breakouts

Thursday morning's nuts-and-bolts breakout groups were intended to start the process of developing a detailed plan to implement the priority recommendations. Thirteen attendees had flights that prevented them from participating in the full session.

The morning began with a presentation of the 12 highest-ranked priorities and the thematic groupings the UCSF team generated for the Thursday morning breakout groups. Attendees were then asked to select a group that would focus on a single topic and recommendations:

1. Direct care 1
    -   Compensation for direct care workers that makes the job attractive.
    -   Develop strategies through which states have incentives to compensate direct care workers well.
2. Direct care 2
    -   Training for direct care, potentially including stackable credentials, modular tools.
    -   Respect, safety of the front-line worker.
3. Communications and cultural competence
    -   Workgroup to identify specific communication competencies for each team role, both within team and with patients.
    -   Accrediting bodies must include communication training as element for license/certification/CE, including managed care/ACO contracts.
4. Provide technical assistance to enable organizations to use existing HIT to promote coordination (e.g., social work). Deploy modules among EHR to document/share, identify web-based resources. Could include standardized assessment in this.
5. Recruit, retain, and train a diverse geriatrics and palliative care workforce through incentives and leveraging experiential training across all settings.
6. Family caregivers
    -   Engage the family caregiver with a competent care team.
7. Support family caregivers – respite care, payment, training, services to address caregiver health and stress
8. Government recommendations
    -   Job analysis of the role of coordinator/navigator, educational resources tied to this.
    -   Expand support for GWEPs and GACA, PCHETA.

The groups were prompted with a set of questions to consider for their action plans:

-   What are the next steps for these recommendations?
-   Who would be responsible for carrying this forward – what professional groups, policy organizations, stakeholders, etc.?
-   What resources are needed to move forward?
-   What are the barriers and how can they be overcome?
-   What are the facilitators and how can they be leveraged?
-   If you have spare time: how can your work on this feed into the discussion papers?

The two direct care worker groups decided to merge together.

The results of this work are presented in Chapter 4.

Thursday's session closed with a brief discussion of the next steps for the Workforce Summit project, primarily focused on the plan to disseminate the results of the Summit, which includes the planned publication of a special journal (not yet finalized at the time of the Summit) and conference presentations. Attendees were invited to continue to engage in the development and dissemination of the recommendations.

Chapter 4 – Recommendations for the Workforce

The prioritized recommendations address issues that challenge multiple aspects of the workforce and will require action by numerous stakeholders. The recommendations and action plans are intended to provide opportunities for measurable improvement within a few years, although some may take longer to be fully realized.

Direct care workers

The general recommendations are:

- Compensate direct care workers well in order to make the job attractive.

- Develop strategies through which states have incentives to compensate direct care workers well.

- Provide training for direct care – can include stackable credentials, modular tools.

- Prioritize respect for and safety of the front-line worker.

The breakout group defined "direct care workers" broadly to include home care aides, personal care aides, home health aides, home hospice workers, and others who provide assistance with activities of daily living and instrumental activities of daily living. Multiple specific steps were proposed to advance the recommendations:

1. Develop strategies through which states have incentives to compensate direct care workers well.

   a. Focus on opportunities within dual-eligible plans, for which the financial return-on-investment of higher quality home care is received by the state. For Medicaid enrollees in general, greater spending on Medicaid-supported home care services would produce benefits that would be received by private insurance companies or the federal government through Medicare. Programs targeted at those who are dual-eligible for Medicaid and Medicare would align with state incentives.

   b. Training programs, such as that established in Washington State, appear to be relatively inexpensive, and thus the barrier to implementation would be low.

   c. Organizations such as the National Association for State Health Policy and the Eldercare Workforce Alliance would be key partners in developing, testing, and evaluating programs.

2. Build direct care workers into teams and empower them.

   a. There are existing models of team-based care that have effectively incorporated direct care workers. These models must be highlighted and disseminated. An important challenge is how to scale up these models. Two potential approaches are to tie into the national demonstration of Independence At Home and/or expand the scope of Medicare Advantage to include provision of home-based, chronic care programs that utilize direct care workers.

   b. Medicare home health regulations require aides to be part of a trained team; however, the regulation is not specific regarding what constitutes the team or training. There is a need to develop a funding source that will support an evaluation of this regulation.

3. Achieve national scope of direct care worker training.

   a. CMS could convene a workgroup with worker representatives, providers, and other key stakeholders to develop scope of work standards (including team training) for new direct care workers.

    b.   The VA trains a large share (reported up to 60 percent) of the workforce in geriatric-type care. The VA has primary care at every site, home-based primary care at many sites, and a strong presence in rural areas. The VA could be engaged to help develop and test direct care worker training and would be well-positioned to provide technical assistance to local programs. The VA often uses community agencies to provide home health services, which provides another opportunity for the VA to disseminate best practices.

    c.   The Independence At Home demonstration should be engaged to provide opportunities to spread good training models.

It was observed during the discussion of these recommendations that direct care workers are often not employed directly by health care systems; they are typically employed by home care and home health agencies that are contracted by payers and systems (including the VA). Integration of direct care workers with the clinical team may require that medical providers employ home care workers directly.

It was also noted that the Home Alone Alliance of AARP could be a key ally for implementation of these recommendations regarding direct care workers, and their engagement would have the benefit of bringing a consumer-driven component to the work.

Cultural Competency and Communications

The general recommendations are:

- Establish a workgroup to identify specific communication competencies for each team role, both within teams and with patients.

- Accrediting bodies must include communication training as an element for license/certification/continuing education. This requirement also could be established by payers, including managed care/ACO contracts.

Multiple specific steps were proposed to advance these recommendations:

1. Commission a workgroup to define minimum cultural humility and communications competencies.

    a.   This work should focus, initially, on a single profession and/or specialty, such as family medicine or internal medicine.

    b.   The requirements should define "team" broadly to include family and community partners and provide guidance regarding what mechanisms for such training are effective. This information would provide the foundation for adaptation and development of tools and training.

    c.   Convene a national summit with the aim of identifying competencies and educational standards as a starting point for this work. Existing competencies and curricula could be used to help inform the agenda.

2. Accrediting bodies must include communication training as an element for license/certification/continuing education. This requirement also could be established by payers, including managed care/ACO contracts.

    a.   The group argued that a mandate would be needed to ensure adoption. Multiple paths for a mandate could be used, including requirement of training for licensure and license renewal and mandated coursework included for accreditation of education program.

b. There are widespread requirements regarding training for mandated reporters for abuse and for opioid treatment and prescribing training. These can provide a model for how to disseminate the training and establish requirements.

c. Professional membership organizations should be early partners in this effort. They would be essential partners for supporting new mandates and also to provide continuing education through their own platforms.

d. The approach to defining cultural competence, cultural humility, and communication training standards should be progressive. Start with a single profession and/or a single state, and have a strategic plan to progressively advance the requirement nationally.

The workgroup also recommended using electronic health records (EHR) systems as a vehicle for sustaining high quality communication and cultural competence standards among providers:

3. Within three years, develop an EHR platform within Epic, Cerner, and the other top five EHRs that includes a "Goals of Care module" (at no extra cost for health care organizations).

a. Convene a workgroup to define a manageable set of standards that provide more information than a simple checkbox. Epic has an advance directive module now, which could potentially be modified for this new interoperable platform. In order to support integrated care across the health system, all EHR vendors should adopt the module and standards recommended by the workgroup. The standards should focus on eliciting and documenting patients' goals of care.

b. Launching this effort would require philanthropic support; EHR vendors are unlikely to do this on their own.

c. Payers should be included early in the effort and could help pressure EHR vendors to implement and distribute the standards. Managed Medicare programs could mandate use of the platform. Currently existing Epic/Cerner user groups also could be a vehicle to move this forward.

d. Once the module is established, training modules will be needed to ensure its use and viability. Care team members would need communications training to effectively work with patients to elicit and record information.

e. In the long term, public reporting of outcomes/indicators would be a key goal.

Attendees noted that LeadingAge built a data input system for their randomized controlled trial on "Housing with Services" to capture goal-setting from motivational interviewing about how the resident coordinator, nurse, and client develop the care plan. This platform was homegrown because there is nothing existing for housing programs now.

The Diverse Elders Coalition would be very interested in this work; they are now interested in family caregiving and developing education and instructions to providers on working with family caregivers.

It was noted that there is knowledge about the relationship between cultural competence and care providers' attributes and behavior. Those engaged in this work should be cautious conflating all aspects of cultural competence into communication. There are some knowledge gaps and attributes that need to be addressed related to cultural competence first to help move the communication recommendations forward. Thinking specifically about the context of culture from a broader aspect of diversity is important. It also is important to consider the diversity of the workforce and how to improve it.

Provide technical assistance to use health information technologies to promote coordination between health care and social services

The general recommendation is:

- Provide technical assistance to enable organizations to use existing health information technology to promote coordination between health services and social services, including deploying modules in EHRs to document data on patients' social situation, share such data with care navigators and social workers, and identify community resources to address social care needs. This could include standardized assessments.

The group noted that this is part of broader conversations about using HIT to promote team-based care. Within this context, assessment of the patient is vital and needs to include patient goals, family caregiving needs, and capacity. It also was noted that some EHRs now include data fields/elements and forms on these issues, but the presentation and visualization of the data is not helpful. Thus, there is a need to first figure out what data and information exist and then how to integrate the data to produce useful visualization.

The specific recommendations are:

1. Establish a pilot learning collaborative, following the model of the Cooperative Extension program of the U.S. Department of Agriculture. Lessons from that program, including how to best design the program and develop specifications and functionality, could be used to incorporate HIT and community-based databases.

   a. Find organizations and geographic areas that have developed effective HIT-based coordination platforms that bridge clinical care and social care. It would be easier to build from models that exist now than to start from scratch. There are community resource locator technologies that can be leveraged; many of these are developed and operated by community-based organizations who need to be engaged since the data would ideally be shared both ways.

   b. Create a technical assistance team to facilitate spread of systems and facilitate ongoing work. The team could include people who are technically competent, consumers, physicians, and community groups. The team would identify best practices and strategies to work with vendors. The technical assistance work should consider workflows and the user experience, and how to best integrate platforms into the work of specific types of care providers and teams.

   c. Partners in the work should include the GWEPs and OCHIN, particularly in the preliminary phase. Other partners and early adopters (e.g., VA) could also be added. The partners would then work with large organizations that represent the systems that ideally will be brought together; these large organizations would be key advisors to the work.

   d. Multiple funding sources could be pursued, including federal funding, health plans, payers, and foundations.

There are some barriers that will challenge progress on this recommendation, including making establishment of a coordination platform a priority for the C-suite of healthcare organizations (given all the other HIT demands they face), data sharing restrictions associated with HIPAA, and workflow issues.

Recruit, retain, and train a diverse geriatrics workforce

The general recommendation is:

- Recruit, retain, and train a diverse geriatrics and palliative care workforce through incentives and leveraging experiential training across all settings.

The group discussed the Independence At Home demonstration program and its potential to draw people into the geriatrics workforce by providing students and early-stage clinicians with exposure to a highly-functioning team-based care model focused on elders. The Independence At Home programs is a "best practices" approach in which social work is involved; there is experiential learning; and providers consider the work gratifying. The model also has the potential to increase compensation to geriatricians and palliative care providers, who now earn less than non-specialty-trained primary care providers. The preliminary evaluation results of the program are very positive.

The specific recommendations are:

1. Actively disseminate the results of Independence At Home, including supporting widespread implementation of the approach. A concerted effort to provide technical assistance on how the model works and how to evaluate it would be needed.

   a. Conduct cost analyses as a wider range of local programs are developed and implemented to assess how program variation and real-world implementation affect the return on investment and outcomes.

   b. Funding would be needed for technical assistance and marketing to disseminate the models, as well as for ongoing research. Marketing should include personal stories from this program, which are quite vivid, and can be designed in a way that connects to both executives and clinicians. Stories often can move leaders more effectively than data because stories have an emotional impact.

2. A learning collaborative should be established to share and disseminate the wide range of experiential learning strategies now being used.

   a. There are multiple examples that can be brought forward, such as the interprofessional education clinic of Virginia Commonwealth University. Many health sciences campuses have interprofessional student-run clinics, which could become experiential centers and also be connected to community-based settings.

   b. Health professions education programs could draw from the models identified by the learning collaborative to have a community setting be a student's first clinical placement.

   c. Education and training modules should be developed to address differences in home-based programs for people who live alone versus people who live with or near family.

Key partners in dissemination would include the American Academy of Home Care Medicine, Home Care Centered Institute, and American Geriatrics Society, as well as foundations such as the Hartford Foundation.

Family caregivers

The general recommendations are:

- Engage the family caregiver with a competent care team.

- Support family caregivers – respite care, payment, training, services to address caregiver health and stress.

The group noted that there are numerous programs that effectively incorporate caregivers into teams and provide them with support. However, there is a weak evidence base to support any specific program, and knowledge is widely dispersed and thus difficult to access. Thus, the recommendations include both organizing and disseminating what is now known and generating the evidence base needed for long-term improvement.

1. Commission reviews of best practices for identifying, assessing, supporting, and incorporating caregivers into teams. International models should be included in the reviews, and family caregivers should be part of the review teams. To date, such reviews have not been systematically conducted.

    a. Hospitals should be considered as a starting point for strategies to identify and educate family caregivers because they have greater resources and infrastructure.

    b. Organizations vested in this area should be central to education efforts, including the Family Caregiver Alliance. Education for family caregivers on safety, ADLs, mindfulness, behavioral issues, and medical and nursing tasks should be compiled and best-in-class programs should be made readily available.

2. Assess and disseminate social, clinical, and financial support such as the VA's benefits to caregivers.

    a. Identify best practices for phases of caregiving, beginning with patients at highest risk and expanding from there.

Government regulations

The general recommendations are:

- Conduct a job analysis of the role of coordinator/navigator, and then tie educational resources to the definitions.

- Expand support for GWEPs, the Geriatric Academic Career Award (GACA) program, and the Palliative Care and Hospice Education and Training Act (PCHETA).

There are many occupations emerging that enhance the capacity of health and social care teams, but they are poorly defined and not well-understood. Data on these emerging occupations do not exist and thus it is difficult to understand the composition of care teams, geographic variation in workforce models, and the economic status of those working in emerging occupations. Recommendations sought to address this gap.

1. Conduct a structured job analysis of the roles of coordinator, navigator, health coach, community health worker, and other related positions. These occupations span a range of educational and professional preparation from high school students and community volunteers to advanced practice nurses.

    a. The Health Resources and Services Administration could commission this study, and it should include analysis of the types of individuals in these roles across different care settings. It should be noted that some degree of overlap may be inevitable and also may be desirable. HRSA could use their existing Health Workforce Research Centers to conduct this work.

    b. An analysis of current policy on Community Health Workers and differences across state regulations and certification is needed. Other occupations could be examined after this group, which is anticipated to be the largest of the emerging occupations.

    c. The analyses should be vetted by and disseminated to employers, state Workforce Development Boards, the National Council of State Boards of Nursing, and other stakeholder groups.

      d. A formal effort could be built from the analyses that would seek to consolidate and standardize job titles, which could lead to the establishment of codes in the Standard Occupational Classification. This would facilitate long-term research on the occupations.

2. Advocate for continuation of GWEPs, the re-establishment of the GACAs, and the passage of PCHETA. The GWEPs have been innovative and community-focused, and have connected communities and health care teams in new and innovative ways.

      a. The GWEP program is now in 44 communities within 29 states; this program needs to be expanded.

      b. Ideally the GWEPs will offer technical assistance beyond their current geographic boundaries.

After the Summit, Congress passed bipartisan legislation that reauthorized the GWEPs and re-established GACA. PCHETA has not yet passed.

Chapter 5 – Evaluation of the Meeting

Daily evaluations were provided to attendees through the Workforce Summit website; attendees were asked to complete their evaluation of the day before leaving the meeting room. The daily evaluation including ratings of the session as a whole as well as the speakers. A summative evaluation was emailed to all attendees several days after the end of the Summit.

Daily evaluation results

The daily evaluation surveys began with questions about the each session, asking attendees to rate the content of the session, the organization and pace of the session, and its practical value (i.e., usefulness for workforce planning).

Figure 1 presents ratings for the session on annual wellness exams, palliative care, and geriatrics/gerontology competencies. Nearly all respondents (31 of 32) rated the *content of the session* excellent or very good, and one rated it good. None rated the content as fair or poor. Twenty-nine rated the *organization and pace of session* as excellent or very good, and none rated these as fair or poor. Ratings were lower for the *practical value of the session*, with 25 rating it excellent or good, 6 rating it good, and 1 rating it fair. None rated it poor.

Figure 1. Ratings of Tuesday Morning Session: Annual wellness exam, palliative care, geriatrics/gerontology competencies
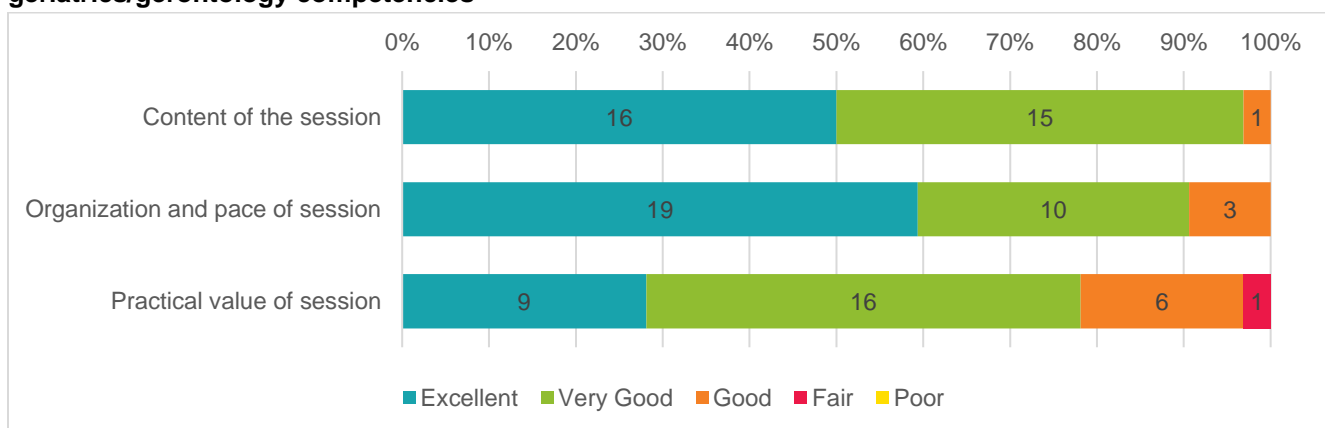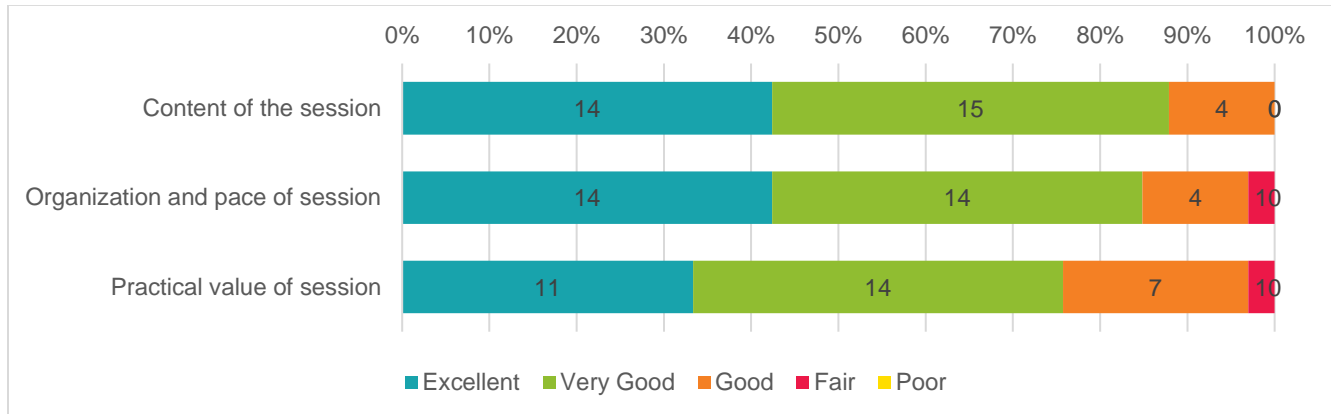

Respondents were provided an opportunity to offer open-ended comments about the session:

- Love the broad perspectives and rich conversations.
- Report outs are taking too much time.
- Loved these papers, very rich.
- I was able to pull themes and recommendations together for day 2 priorities.
- Assuming that everyone has read the papers, why not start with the reactors and have more time for comments related to reactions of the group as a whole and the breakouts? My rating of the presentations (below) does not reflect the high quality of the papers. The papers and not the presentations were much better for stimulating discussion.
- Had trouble seeing how wellness exam fit.
- Content was excellent. Organization great. Assuming tomorrow and Thursday will pull together and prioritize.
- Are we getting to the big drivers of current and longstanding workforce shortages? Such as societal and system ageism, reasonable payment?

Figure 2 presents ratings for the session on clinician communications, advance care planning, and cultural competence. This session was not rated as highly as the first session. Twenty-nine of 33 respondents rated the *content of the session* as excellent or very good, 4 rated it as good, and none as fair or poor. The *organization and pace of the session* were rated as excellent or good by 28 respondents, 4 rated it as good, and one rated it as fair. The *practical value of the session* was rated as excellent or very good by 25 respondents, as good by 7, and as fair by 1 respondent.

Figure 2. Ratings of Tuesday Afternoon Session: Clinician communications, advance care planning, cultural competence

Respondents were provided an opportunity to offer open-ended comments about the session:

- Last hour was the best. Too much time in breakouts and report outs. More time in group dialogue coming to answers.
- Long - I was hitting the wall at the last breakout.
- Could have used more about team or system communications.
- As mentioned may have gotten to clinically focus, and needed to pull to larger workforce (team).
- See above re whether the presentations are necessary.
- Needed more focus on team approach and application to workforce development.

The evaluation survey on Tuesday also asked for open-ended comments regarding the breakout groups and recommendations to improve them. Responses included:

- Great reaction panels – breakout groups were very productive/helpful. Need to push more for focus on recommendations - what, who, when for accountability.
- Reiterate the charge for two to three years; email out the questions so we can all look at them on our devices.
- Best part of the day - many great ideas. I worry about how translatable this will be when we finish Thursday.
- I'm not finding them helpful. Would rather have whole group conversation. Or have us each work in separate topics so report outs are useful and engaging. Otherwise feels like just living through breakout six times.
- Facilitators have been excellent at moving conversation forward and trying to focus on questions posed to the group.
- Discussions were fascinating. So many perspectives to consider.
- I think the discussion after the speakers was very robust and engaging - maybe more time for that and shorter time for breakout.
- Hard to think about recommendations. Is anything on the table or just achievable or realistic goals?

- I appreciated that the presentations were short enough to allow for ample discussion. I would love if there could be a reflector, after all the groups report out, who could synthesize and report out major themes at that moment.
- Consider having three teams work on a set of Qs and the other three on a different set of Qs.
- Just right!
- Make sure it's warm and sunny! Afternoon great.
- No changes.
- Allow some more time by eliminating the presentations.
- Good discussion in breakout groups. Each had their own personality. Followed slightly different structure/format. But ended in good places.

Figure 3 presents ratings for Wednesday morning's session on family caregivers, direct care workers, and social work. No respondents gave a rating of fair or poor for any of the items. The *content of the session* was rated as excellent or very good by 27 of 29 respondents. The *organization and pace of the session* was rated as excellent or very good by all respondents. The *practical value of the session* was rated as excellent or very good by 24 respondents and as good by 5 respondents.

Figure 3. Ratings of Wednesday Morning Session: Family Caregivers, Direct Care Workers, and Social Work
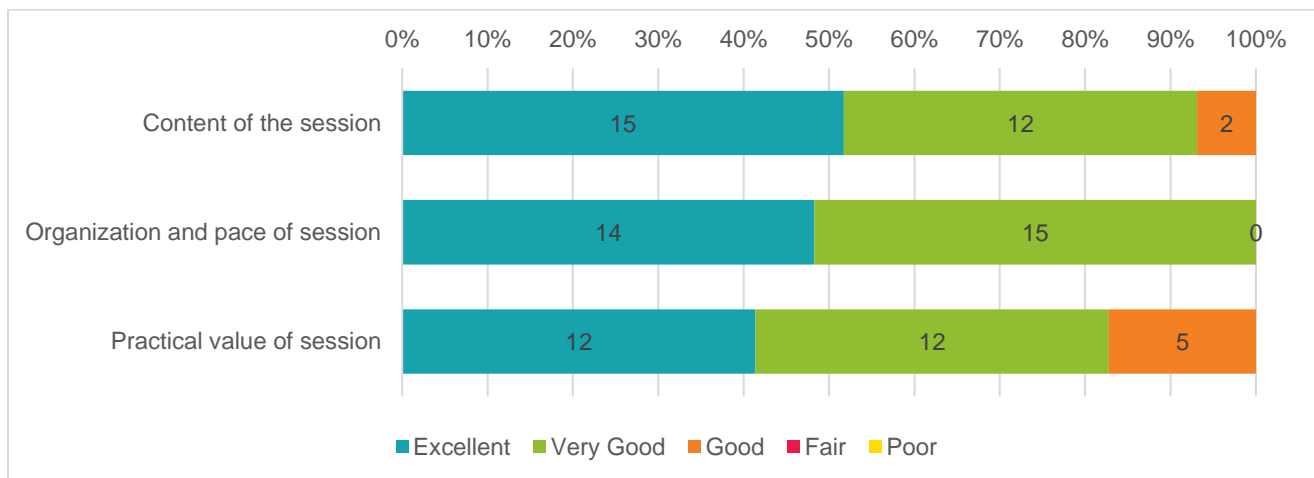
Respondents were provided an opportunity to offer open-ended comments about the session:

- Very good group conversation.
- Felt like discussion before session started was facilitated in a way that invited overly broad recommendations that were beyond the scope of the problem were supposed to addressed.

Comments about Wednesday's breakout groups and recommendations for change included:

- They worked well.
- None. Done very well.
- Value is very variable depending on who is in your assigned group.
- No change.
- Good discussion. Good facilitation. Lots to cover and prioritize.
- It's great to have the items listed for review; thanks to Joanne for working so diligently to capture the dialogue in real time.

- I would have the paper writers (i.e., currently available experts related to each workforce domain) stay with their respective area of expertise for the breakout sessions. This helps tremendously to guide and focus the conversation given limited time availability. I understand the rationale to "shuffle" the breakout groups to enhance collaboration and generation of novel ideas, but having been on breakout groups with an "expert" in the topic and breakout groups where that expertise was not present, the discussion was much deeper and more robust with that expert present as part of the small group.
- Need focus.
- Breakout groups have been good. No changes.
- It seems we may have lost track of a few notable items: Many discussions seemed to reach similar enthusiasm for a need for robust interdisciplinary teams in practice, as part of required training and engaged with direct care workers but barely evident in our prioritizations.

Final evaluation results

The final Workforce Summit evaluation survey was distributed by email early in the week following the Summit. Figure 4 presents ratings of the Summit overall, the venue, location, travel, and meals. The overall ratings were high, with 19 rating the Summit as excellent and 9 rating it as very good. None provided a rating of poor, fair, or good. The *overall preparation for and organization of the meeting* was also rated very highly, with 24 ratings of excellent, 4 ratings of very good, and 1 rating of good.

The components that received the lowest satisfaction ratings were the *Wednesday dinner at the Winery*, and the intertwined components of *ease of travel to and from the meeting*, and *location in Napa*. Some attendees felt that travel time to Napa, which is not close to a major airport, was too long. However, many rated the location highly because it provided an escape from their normal work environment and encouraged them to focus intently on the work of the Summit. The dinner at the Winery was disappointing to the UCSF planning team, as we hoped it could include a tour or discussion of the recovery from the prior year's devastating wildfires. Not only were these experiences not provided, the Winery ran out of several menu items. While the Andaz Napa was rated highly in general, there was some noise from an adjacent meeting room on one day that was disruptive to the Summit.

**Figure 4. Ratings of Summit Location, Meals, Travel, and Organization**
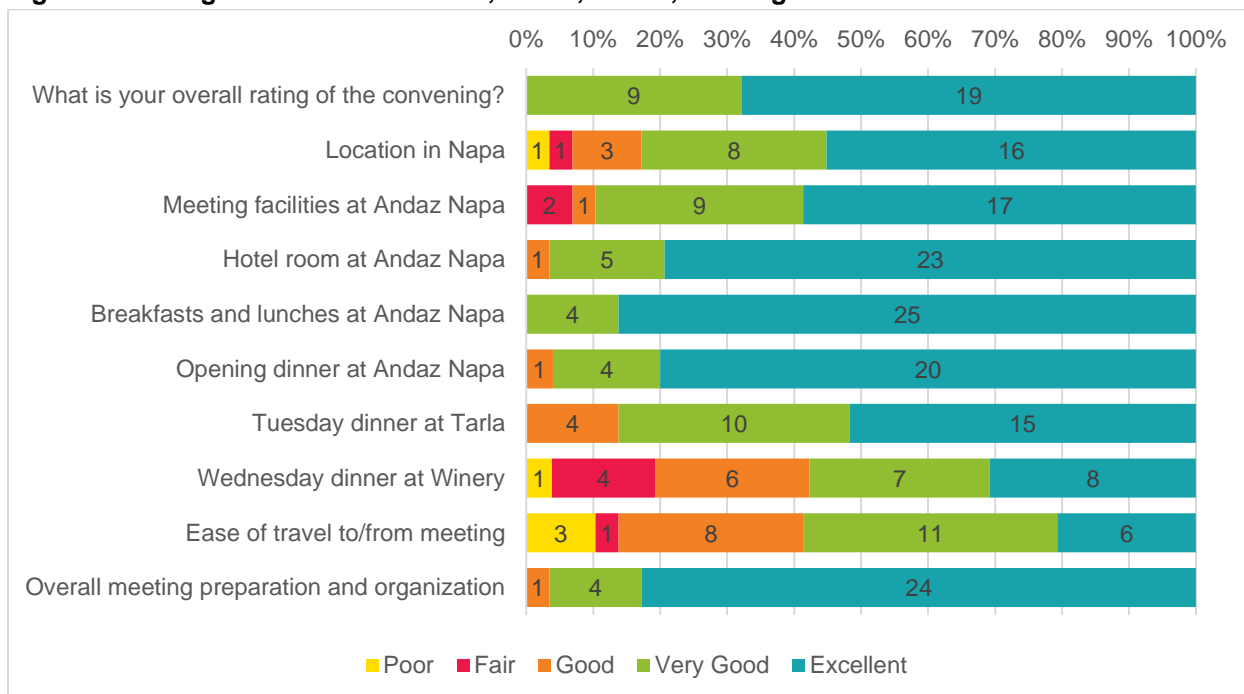
Respondents were provided an opportunity to offer open-ended comments about the venue, meals, and/or general meeting preparation and organization. These included:

- General/organization
  - Fantastic venue, delicious meals, and great meeting preparation.
  - You anticipated everything incredibly well. Most impressive.
  - Location was great - lots of chat time available. Thank you for the veggie-centered food selections too!
  - Organization was outstanding.
  - Everything was excellent. Extremely organized and well-run meeting!
  - Hard to provide negative feedback as you all did such an amazing job---I know how much work it takes to pull off a meeting like this.
  - Great location. The meeting was incredibly well organized!
  - Well done.
  - One of the most well-organized and nicest locations for a meeting I've been to in a long time!
  - Meetings of this caliber do not just happen -- they take a great deal of preparation and planning. I was very impressed by all of the pre-planning that took place but also the amount of staff work that was done in the evenings to ensure that meeting attendees could build on discussions from the day before. Great job!
  - Thanks a lot for helping to coordinate rides to/from the airport and Napa. That made things much easier for travel.
- Hotel/location
  - Napa is lovely but a little out of the way from the airport.
  - Overall great. Noise was a problem at Andaz.
  - Hotel was excellent, but would have -strongly- preferred to spend our long days in the sun room or other room with natural light. The darkness of our room was hard to take.
  - It was a hard location to get to.
  - My only piece of constructive feedback would be the location. Napa is very hard to get to if you don't live in CA. Would love to have it at a more central travel hub in the future. It was a lot to fly five hours and then drive another two. Since we are in a conference room anyway, we can do it anywhere. Overall great experience!
  - Lovely spot but a bit out of the way. Still, it was worth it!
  - Although beautiful, too hard to get to and had to spend an entire day to midnight to get back home.
- Food
  - The food at Andaz was delicious.
  - Food at winery offered no veg option, and since there was no kitchen there, staff had no way to accommodate.
  - The winery dinner was a disappointment -- I was sorry not to see more of the winery and we had such amazing food all week the quality of the dinner was a letdown.
  - Disappointed at the vineyard trip -- it was so beautiful driving there, thought we would have been outside or tour a vineyard a bit with wine tasting. Food was just ok there.
- Content
  - I really enjoyed the papers. They are right on point.
  - Meeting was very well organized and I felt like we covered a lot of good ground. I especially liked how the second day got refocused to make better use of the breakout sessions.

Figure 5 presents ratings regarding the effectiveness of the Summit. The format was rated as extremely effective at *enabling everybody's ideas to be heard and considered* by 13 of 28 respondents, as very effective by 10 respondents, and as moderately effective by 5 respondents. The process was rated extremely effective by 7 respondents in *leading to the development of recommendations*; 16 rated the process as very effective, 4 rated it as moderately effective, and one rated it as slightly effective. Eight people rated the process as extremely

effective in *leading to clear next steps for progress*, 8 rated it as very effective, 10 rated it as moderately effective, and one rated it as slightly effective. No respondents provided a rating of "not at all effective" for any of the items.

Figure 5. Ratings of the effectiveness of the Summit
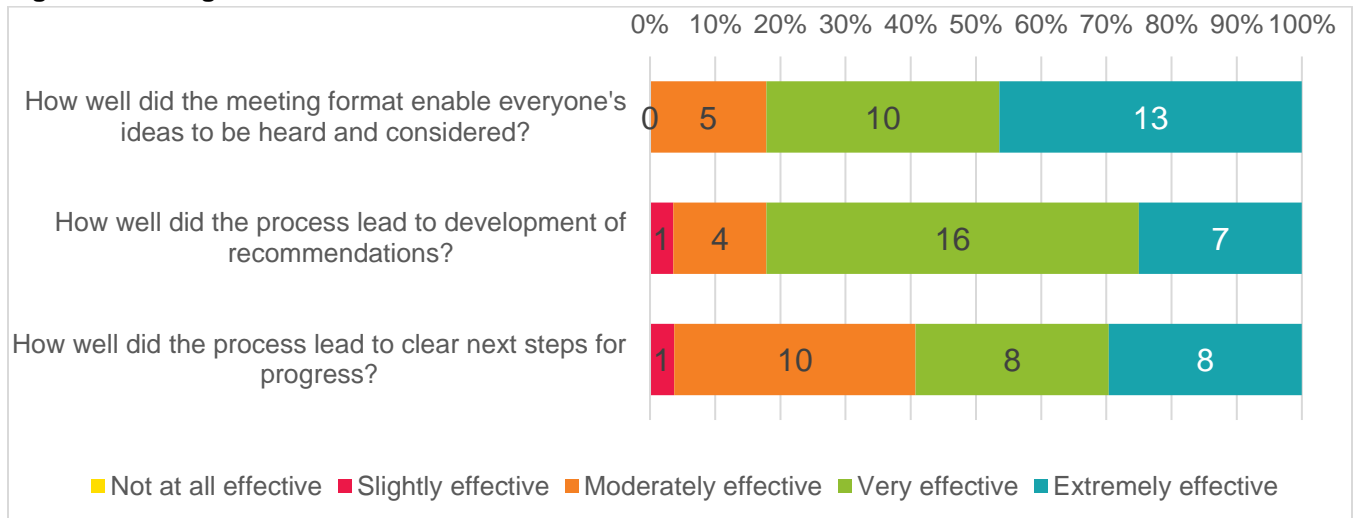
Respondents were asked the open-ended question: What did you find especially effective/worthwhile/compelling about the convening? Responses were sorted by their general topic, and included:

- People in attendance
    - Connecting to other leaders in workforce\care of older adults.
    - Being in the room with diverse people with a common goal.
    - Different voices and perspectives.
    - Meeting of people across roles and disciplines made for rich discussion.
    - Many different perspectives/disciplines represented.
    - Bringing together so many experts.
    - Hearing from so many different perspectives.
    - Interdisciplinary with key stakeholders.
    - Good cross section of professions and sectors.
    - The perspectives of the attendees representing various backgrounds and perspectives added greatly to the perspective of the discussion.
    - The guest list was excellent. And just the right size to spur on meaningful group discussion.
    - Learning from many with tremendous experience/expertise.
    - Funders and researchers present.
    - The broad diversity of expertise of the participants was outstanding.
    - Diverse set of voices. I didn't know a third of the people there.
    - Great diversity in participants really added to the discussion.
    - Stimulating group of attendees.
- General format
    - Very effective process/format for coming to consensus on the recommendations.
    - Very well organized and the structure kept people engaged and energized.
    - Very well organized with thorough preparation.
    - Discourse among providers.
    - Opening warm up - unusual and very effective.
    - Plenty of time to discuss.
    - Discussions were great with varied perspectives.
    - Lots of participation, heard all voices in the room multiple times.

- o The organization of the days was helpful to move from overview of topic to recommendations and next steps.
- o The long days at first seemed intimidating, but I felt we could have kept going for another day given the topic.
- o Clear directions about priorities.
- o The meeting was structured to explore the issues from the various perspectives in the room...I only wish we would have had more time to go from surfacing issues to recommendations but that is the limitation of a two-and-a-half day meeting.
- o Everyone had the chance to have their voice heard, even novices like myself!
- o Variety of topics allowing different expertise to surface.
- o Everyone had the opportunity to participate in the dialogue.
- o The organizers did an amazing job.
- o Very well organized.
- o Thoughtful organization of the session, overall.
- o I appreciated the hard work of the planners to synthesize learnings after each day.
- o Opportunity for networking.
- o The physical space in the hotel was great for a convening of this size, as was the location of Napa.
- Breakout sessions
  - o The small group breakouts seemed best for making progress.
  - o Opportunity for small group discussion with multiple participants.
  - o Love that the meeting prioritized breakouts and discussions with others. Appreciated the pre-mixing of participants in advance.
  - o The breakout sessions were quite helpful to allow more detailed discussion of topics.
  - o The workshops following panels.
  - o Small group discussions were really productive, especially assigning unusual suspects to each group.
  - o Breakout group format enabled less vocal individuals to contribute ideas.
  - o Small groups.
  - o The mixing of the groups.
- Large group discussion
  - o I thought the main room discussions after the papers was the best.
  - o The large group discussions after presentations.
- Papers/presentations
  - o Presentations helpful to stimulate discussion/thinking.
  - o Reaction panels.
  - o Outstanding papers. Appreciated the opportunity to review the papers before the meeting.
  - o The papers beforehand were of some use, especially having their recommendations up front as a starting point.
  - o Pre-conference papers and presentation.
  - o Having the papers available in advance.
  - o Appreciated the brevity of the presentations of papers.
  - o The groupings of the discussion papers and the commenters.
  - o Excellent discussion papers.
- Content/topics/results
  - o Need for better collaboration with healthcare and CBOs.
  - o Development of solutions on workforce issues.
  - o Learning what is going on in different areas to address workforce.
  - o Critical need for further study and recommendations.
  - o Movement towards collaboration on these issues.
  - o Focus on two to three year doable steps.

Respondents were asked: What did not work well for you? Responses included:

- People in attendance
  - I did feel that PHI should have been included in the meeting.
  - The meeting seemed to turn to a heavy focus on physicians.
  - Physician orientation around coordinate care.
  - I was sorry that several people did not commit to the whole meeting.
  - There needs to be more representation from the "front line." I felt the conversation was often large academic center focused and again not translatable to the world I've practiced in for the last 20 years.
- Breakouts
  - Some of the breakouts were dominated by either a strong personality or the person who had their agenda to push, without a designated "leader" to ensure broad discussion; it felt like these turned into sessions to promote an individual's agenda, rather than get at the best recommendations.
  - The breakouts were just a bit too long.
  - The broad scope of the small groups on the first day was a bit too much for good progress. The second day's small group approach of assigned topics seemed to work better.
  - Day 1 breakouts were overdone but corrected on day 2.
  - Think it was hard to get to operationalize steps under recommendations, at least in our group.
  - Some of the small group breakout leaders did not seem well prepared for their responsibilities.
  - Lack of integration of paper recommendations with small group recommendations in consistent manner.
  - Could we have done with less breakouts?
  - I felt certain personalities dominated the conversation.
- Focus/direction
  - I think it would have been helpful to define the population (serious illness) and what care was being discussed. Without those anchors people were all over the place.
  - There is a huge gap between the research being talked about and its applicability in the field.
  - The exclusive focus on two to three years from the outset precluded more creative thinking - consider starting with big ideas then identify steps to get there.
  - It was a little challenging to figure out the "scope" of the recommendations we were supposed to come up with.
  - It felt like there were too many large topics (geri/pal care, cultural competence, direct/family CG's) to cover in the amount of time available.
  - Unclear format for recommendations and next steps.
  - Need to continually refocus on the workforce purpose of the activity--many participants did not understand the difference between model development and workforce development.
- Time
  - Very long days.
  - There really wasn't any element of the meeting that didn't work for me. I just wish we had had more time to discuss and flesh out the recommendations.
  - Not enough time to converse with table mates.
  - I wish we had just a bit more down time--there was a lot of thinking to do and I found that I needed more time to decompress.
- Results
  - Findings similar to other recent convenings in different areas.
  - The issue of multidisciplinary teams came up frequently in our discussions, I wish we had had time to flesh this out in detail.
  - Too many recommendations--some not specifically tied to workforce improvement.
  - Unclear how recommendations will be disseminated and made public.
  - Again, it wasn't that it didn't work for me but since the role of CBOs was new to many in the room, I think this was one element that was certainly highlighted in the papers and agenda that did not get much focus in the recommendations.

- Compliments/other
  - Everything worked well.
  - I actually enjoyed it very much; so sorry I had to leave on Weds eve.
  - For a meeting where recommendations were the expectation, nothing!
  - My conflicts-so sorry I couldn't stay longer/participate more fully.
  - Next door group was noisy.
  - Only complaint was the lack of natural light in the main room. Only a minor issue.
  - It all worked well.

Respondents were asked for suggestions for improving the format for future convenings. Their responses included:

- A little more down time.
- More front-line representation, and some more moderation to keep the more dominant personalities from driving the content - give the front line a voice.
- From my feedback, I'd say assign a group leader to breakouts.
- I love data, so would have liked just a bit more for us to look at together. Other suggestions covered elsewhere in my responses.
- Less breakouts.
- Perhaps few large topics to cover which might allow for more focus.
- Maybe a bit more discussion on culture and SES as a group.
- Clearer final outcomes, arranging recommendations by targeted actors.
- Try the East Coast :).
- Format was great. As I said at the meeting my only concern was lack of diversity.
- Format was great. I just wish we had more time.
- Might have some roving staff around the breakout groups to make sure everyone is on track
- A little more networking time - the initial reception was good format but not knowing who might be important to connect with yet limited this.
- Repeat!

Finally, respondent were asked to provide any other thoughts or ideas they had about the Workforce Summit. Their responses included:

- I look forward to the follow up conversations and working towards solutions.
- For the most part the week was fantastic. I loved the enthusiasm and diversity of approach. I loved the enthusiasm and eagerness for expansion of the "team" through inclusion and training, and that may be transformative.
- Thanks so much to the team who planned, organized, executed. Really excellent.
- Thank you for all your efforts!
- The expertise brought together for this convening was remarkable. The organizing team did a great job of moderating and moving discussions along in a timely manner.
- Thank you.
- Continue to work on the cultural vs. the SES factor.
- I am really looking forward to reviewing the notes and recommendations. This was a great meeting. I was honored to be a part of it.
- Great atmosphere and humor for grappling with tough subjects. Was much appreciated.
- Really liked the meeting and the diversity of participants. I learned a lot from many new colleagues and had great opportunity to network. Am hoping that recommendations will have some legs.
- Thank you for all the thoughtful planning and inclusive way you went about organizing the experience.

Chapter 6 – Dissemination

The results of the Summit are now in a dissemination phase. The main dissemination activity is the publication of a special issue of the Journal of the American Geriatrics Society (JAGS). This issue will include all of the discussion papers. In addition, seven attendees in practice and policy jobs were asked to write brief commentaries for the discussion papers. There will be an introductory paper summarizing the recommendations and a brief introduction to the Gordon and Betty Moore Foundation's serious illness care program. The issue will be available open-access, and UCSF will promote its publication widely through Healthforce Center's blog and newsletter, as well as the Philip R. Lee Institute for Health Policy Studies newsletter.

A post that briefly summarized (thematically) the 16 recommendations generated at the Summit was published in November, 2018 on the Health Affairs blog. Additional blog posts will be written to coincide with, and follow the release of, the special issue of JAGS.

The UCSF team has had a preliminary discussion with one of the attendees who represents the American Association of Colleges of Nursing about coauthoring a paper for a nursing journal, focusing on the nursing implications of the recommendations. The UCSF team will also explore publication in collaboration with an attendee who represents the American Occupational Therapy Association and look for other opportunities to publish in an allied health workforce journal.

The Summit process and results were presented in a joint session of the Health Workforce and Long-Term Services and Supports Interest Groups of AcademyHealth in June, 2018. An abstract was submitted to the American Geriatrics Society annual meeting.

Webinars will be a key dissemination venue in the future. In January, 2019, UCSF will summarize the project in a webinar for the Serious Illness Quality Alignment Hub. Additional potential webinar venues include the regular webinar series organized by the Health Workforce Technical Assistance Center (funded by HRSA).

The UCSF team will communicate with attendees that represent key stakeholder groups regarding opportunities to present webinars and write blog posts to continue dissemination of the recommendations. It is anticipated that dissemination activities will be continuous through summer 2019 and then be opportunistic.

Appendix A: Summit Attendees

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Appendix B: Summit Agenda

Mission: Identify and prioritize recommendations to ensure an adequate workforce to support the care of people with serious illness in the community.

Timeframe: Recommendations should focus on overcoming barriers and accelerating health workforce development activities in the near term (next 1-3 years).

AGENDA

MONDAY, MAY 21: ARRIVALS

5-6pm Reception
6-8pm Welcome dinner, with framing of the meeting days ahead.

TUESDAY, MAY 22: FOCUS ON THE CLINICAL TEAM

7-8am	*Breakfast in Farm House*
8-9:30am	Introductions with icebreaker, purpose of meeting
9:30-9:45am	Ellen Flaherty and Steve Bartels – Advanced care planning and improved annual wellness exam
9:45-10:00am	Christine Ritchie and Arif Kamal – Specialty primary care intersection with primary palliative care; geriatrics intersections with serious illness care, pain and symptom management
10-10:30am	Reaction panel and discussion: Joan Weiss, Steve Schoenbaum, Kyle Kircher
10:30-10:45am	*Instructions to breakout groups, snack break*
10:45-11:45am	Breakout groups (3-6 people each): Discuss and prioritize recommendations related to primary care and palliative care. What is achievable in two to three years? What will take longer but is too important to ignore? What barriers need to be addressed?
11:45am-12:15pm	Report out from groups
12:15-1:15pm	*Lunch*
1:15-1:30pm	Tony Back and Erik Fromme – Clinician communications about prognosis and trajectory, patient goals and preferences, advance care planning
1:30-1:45pm	VJ Periyokoil – Cultural competency
1:45-2:15pm	Reaction panel and discussion: Denise Stahl, Ann Cary, Kathy Kelly

TUESDAY, MAY 22: FOCUS ON THE CLINICAL TEAM

2:15-3:15pm   Breakout groups (3-6 people each): Discuss and prioritize recommendations related to communicating with patients and cultural competence. What is achievable in two to three years? What will take longer but is too important to ignore? What barriers need to be addressed?

3:15-3:30pm   Break

3:30-4:00pm   Report out from groups

4:00-5:00pm   Full room discussion: What recommendations overlap? Which recommendations can be done in two years? Which will take longer? What do we want to discuss more tomorrow?

5:00-5:15pm   Charge for tomorrow

5:15-6:30pm   Free time

6:30-9:00pm   Dinner at Tarla

WEDNESDAY, MAY 23: FOCUS ON THE HOME

7:00-7:45am   Breakfast in Farm House

7:45-8:15am   Debrief from prior day

8:15-8:30am   Janice Bell, Robin Whitney, and Heather Young – Family caregivers: What are the barriers to their full engagement and how can we overcome them?

8:30-8:45am   Robyn Stone – Direct care workers: How do we ensure direct care workers are best prepared to serve their clients? How do we support front-line workers in the home/community? What roles should they have in care teams?

8:45-9:00am   Robyn Golden and Erin Emery-Tiburcio – Connections with social services: Incorporating broad community supports, how do we get "medicine" and "community" together? Roles of social work, CHWs, promotoras, care coordination and navigation

9:00-9:45am   Reaction panel and discussion: Rebecca Miller, Lars Peterson, Tom Edes

9:45-10am   Break

10-11am   Breakout groups (3-6 people each): Discuss and prioritize recommendations related to family caregivers, front-line workers, and connecting to social services. What is achievable in two to three years? What will take longer but is too important to ignore? What barriers need to be addressed?

11am-12pm   Report out from groups

12-1pm Lunch

WEDNESDAY, MAY 23: FOCUS ON THE HOME

1-1:15pm	Instructions for deep-dive breakouts

1:15-2:30pm   Deep-dive breakouts (3-6 people each): For one of the domains of recommendations, work together to consolidate the recommendations that were put forward by the breakout groups. Then, prioritize them – which would you do first? Which would you do last?

2:30-2:45pm   Break

2:45-4:00pm   Report out from the deep dive, consensus about prioritization (full room)

4:00-5:30pm   Free time

5:30-6:15pm   Bus to arrive to drive to Winery

6:30-8:30pm   Dinner at Elizabeth Spencer Winery

8:30-9pm   Bus return to hotel

THURSDAY, MAY 24: REVISIT RECOMMENDATIONS AND ACTIONS

7:45-8:30am   Breakfast in Farm House

8:30-8:45am   Instructions for nuts-and-bolts breakouts

8:45-9:45am   Nuts-and-bolts breakouts: Starting with the top priorities in each domain, what are the next steps? Who would be responsible for implementing the recommendation? What resources would be needed to move the recommendation forward? What are the barriers and how can they be overcome? What are the facilitators and how can they be leveraged? Where should the discussion papers go next?

9:45-11am   Report out from nuts-and-bolts groups: What challenge was identified as the greatest? What recommendation seems the easiest (but might be deceivingly so)? What are our next steps?

11-11:30am   Next steps and farewell