VERMONT

WORK DISABILITY PREVENTION

SUMMIT

Work is a health outcome. Health is a work outcome.

PARTICIPANT WORKBOOK

RETAIN VERMONT

Retaining Employment and Talent After Injury/Illness Network

A program managed by the Vermont Department of Labor

Vermont RETAIN is funded by the U.S. Department of Labor and the Social Security Administration under a grant award of $21,600,000 to the Vermont Department of Labor that will be incrementally provided. 100% of grant funding is from U.S. Federal funds.

This workbook does not necessarily reflect the views or policies of the U.S. Department of Labor or the Social Security Administration, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

RETAIN VERMONT

Agenda

Overall Experience

We welcome you to an interactive, participatory experience focused on reducing work disability prevention in Vermont. You will be meeting, listening to and working with experts in a variety of fields and disciplines including state government, non-profit sector, healthcare, and academia.

You will use different ways to share information, ask questions, and capture themes and ideas. Throughout this collaborative problem solving process we will embrace some key design principles:

Always be capturing. We encourage active note-taking to keep critical observations visible and share ideas quicker. You will also sketch and draw - no talent required!

Divergent/emergent/convergent thinking. We have limited time together but we will not limit ideas. This will be an interdisciplinary space where we believe innovation can be cultivated simply by looking and hearing all possibilities from mixing perspectives. We will create a space for wide thinking that allows patterns and connections to emerge then converge on the most urgent and impactful solution areas.

Wifi network: TheHub-Members Wifi password: TheHubWireless

Summit website: sites.dartmouth.edu/vtworkdisabilitysummit

Contact information: Sarah Probst, labor.retain@vermont.gov

JUNE 12	MORNING
Introductions & Networking	9:00-9:30
Introduction to Work Disability in Vermont VT RETAIN and other experts present the work to date and describe the challenges and opportunities in the return-to-work (RTW) space.	9:30-10:50
Break	10:50-11:05
Exploring Opportunities Work with others to begin exploring possibilities guided by the presented themes and the call to action. Build on common areas to create multiple opportunity frameworks quickly. Present and discuss opportunity frameworks to define key problem areas the group is ready to work on. Prepare to select an opportunity for which to design solutions.	11:05-12:30
JUNE 12	**AFTERNOON**
Lunch	12:30-1:10
Identifying Potential Solutions - Breakouts Looking at your opportunity framework, work with your team to assemble solutions with curiosity and creativity.	1:10-2:40
Break	2:40-2:55
Preparing for Remote Team Work Start to define a plan, timeline and deliverables. Determine some logistics and checkpoints for the call to action. Review other groups' work plans and provide feedback.	2:55-4:30
Social (optional)	4:30-5:00

Acknowledgements

Thank you for joining us at the Hub CoWorks in Rutland Vermont. We begin with a moment to acknowledge our role as settlers who have made their home on the unceded territory of the Mahican (in southern Vermont) and Abenaki peoples as the traditional land caretakers of Ndakinna (En-DAH-kee-nah), which includes parts of Vermont, New England, and Quebec. We honor their ancestors, elders, and relations past, present, and emerging. We also concede that our nation has benefited from the uncompensated and exploited labor represented in the legacy of slavery and the present-day reality of migrant farmworkers.

As we work together to construct a map for equitable work disability prevention in Vermont, we will intentionally create an inclusive working environment for all who wish to work in our state. We are committed to extending grace, humility, and empathy to each other. We recognize that we are all on an individual and collective journey to dismantle oppression and discrimination from our culture and systems. Therefore, we pledge to cultivate dignity and respect even in moments of disagreement and discomfort. We expect and accept non-closure, and with that, we engage in courageous conversations with curiosity and an open mind. We dedicate ourselves to refrain from judgment, embrace active listening, and foster open communication.

In this space, we pledge to abide by each other's unique preferences, thereby building better relationships and collaboration. We come into this with good intentions and also recognize that even when we do not intend to do harm there is an impact. We commit to prioritizing our communities and acknowledge that there is no such thing as a single-issue struggle, our lives are interconnected and our work is interdependent. We vow to treat each other, our stories, our dreams and struggles with sacred care. We honor vulnerability. We embrace the spirit of co-creation; we affirm that we are the active agents of change, and we are committed to doing the work to create understanding amongst and with each other.

We would like to thank the Rutland Area NAACP for the guidance and language to develop the previous statement.

The Vermont Department of Labor and VT RETAIN would like to thank the Governor for supporting the Vermont workforce and this project and our partners, advisors, and contractors who worked with us to develop and implement the VT RETAIN project.

- Ammonoosuc Management Services
- BlueCross BlueShield Vermont
- Compacity Partners
- Culinary Rehab, LLC
- Dartmouth Health
- Haig Consulting
- HireAbility Vermont
- Invest EAP
- Mediation Works
- Northeastern Vermont Regional Hospital
- OneCare Vermont
- Recovery Vermont
- The University of Pittsburgh
- Vermont Blueprint for Health
- Vermont Collaborative for Practice Improvement & Innovation
- Vermont Chamber of Commerce
- Vermont Department of Health
- Vermont Department of Mental Health
- Vermont Disability Determination Services
- Vermont Division of Workforce Development
- Vermont Libraries
- Vermont Office of Racial Equality
- Vermont State University
- Vermont Vocational Services
- Workability Vermont

We especially thank the many individuals; primary care practices, their clinicians, and staff; and employers who participated in VT RETAIN programs and embraced work as a critical health outcome in Vermont.


VERMONT
WORK DISABILITY
PREVENTION
SUMMIT

Table of Contents

WHY A WORK DISABILITY PREVENTION SUMMIT?

Because this is a **NOW** opportunity

As RETAIN funding ends, we need a cross-sector solution unique to the needs of Vermonters. The Summit will help us define what that sustainable solution looks like and how to make it happen in Vermont.

Because this is an **EQUITY** opportunity

Work disability is a major cause of economic and health inequity. Only 38% of Vermonters with disabilities ages 18-64 years are employed versus. 79% of those without disabilities.

Because this is a **LABOR** opportunity

Vermont has untapped potential to expand the workforce. We have one of the highest rates in the U.S. of young people receiving Social Security Disability Insurance (SSDI) benefits. Work disability can often be prevented. If the percentage of Vermonters receiving work disability benefits was reduced to the national average, our workforce would increase by 3000 workers.

Because this is a **HEALTHCARE** opportunity

Unemployment is an independent risk factor for adverse physical and mental health outcomes (including higher rates of depression, suicide, chronic disease, and infant mortality) for both the unemployed person and their family. (Mathers 1998, McKee-Ryan 2005)

Because this is a **MENTAL HEALTH** opportunity

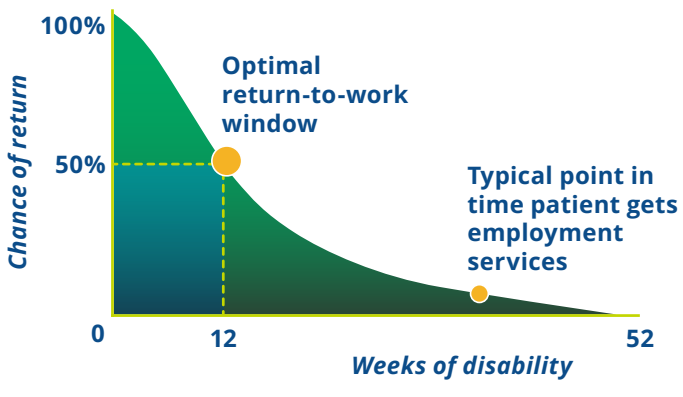
In Vermont, the most common reason for receiving SSDI benefits is a mental health diagnosis. Vermont has the third highest percentage of disabled workers with mental health diagnoses in the U.S. (49%) behind New Hampshire (50%) and Massachusetts (53%). The percent of beneficiaries who qualified for SSDI based on a mental health diagnosis has been increasing in Vermont for more than 20 years. (Social Security Administration, 2023)

Because this is an **INSURANCE** opportunity

Unemployment is associated with increased healthcare utilization.

Because this is an **EMPLOYER** opportunity

The longer an employee is out of work due to a health condition, the less likely they are to return. Early intervention can improve worker productivity, reduce employee absences, prevent loss of employees, reduce rehiring and retraining costs, and decrease HR time spent on disability paperwork.



Summit Objectives

1. Describe the current scope of work disability in Vermont and nationally.

2. Explain the strategies employed by VT RETAIN to fill gaps in existing stay-at-work and return-to-work services.

3. Identify the roles of each of the Summit participants in work disability prevention.

4. Work together to create a sustainable model for addressing and preventing work disability in Vermont that will meet the needs of Vermont's workforce, employers, clinicians, and other professionals involved in return-to-work. The sustainable model will:

    a. Equitably reach a broad population

    b. Identify appropriate providers and settings for services

    c. Identify funding sources

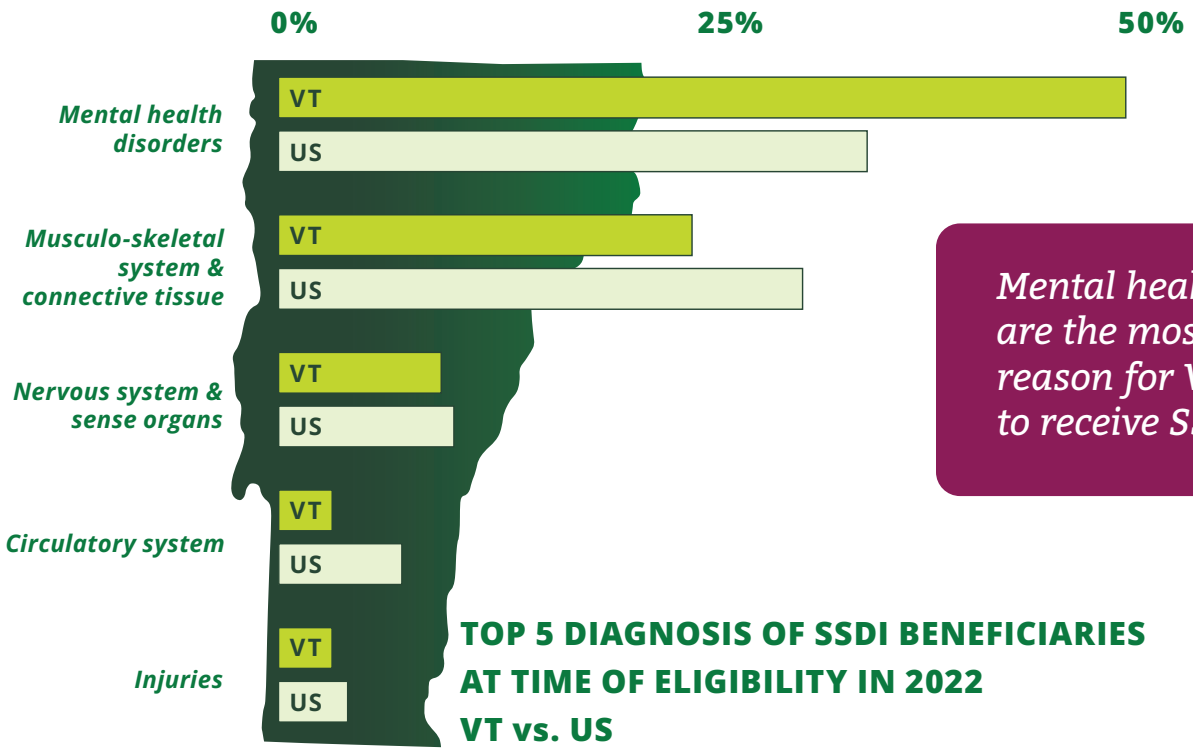
    d. Enhance public awareness

    e. Facilitate collaboration among constituents in the return-to-work process

What is Work Disablity?

Work disability is limitation in the ability to work due to a physical or mental health condition. Work disability often can be prevented and mitigated through Stay-at-Work and Return-to-Work strategies. Application for Social Security Disability Insurance benefits should be reserved for non-preventable work disability or when appropriate stay-at-work or return-to-work strategies have not restored ability to work.

Work Disability in Vermont



TOP 5 DIAGNOSIS OF SSDI BENEFICIARIES AT TIME OF ELIGIBILITY IN 2022 VT vs. US

Mental health disorders are the most common reason for Vermonters to receive SSDI benefits.

If the percentage of Vermont residents receiving SSDI benefits was reduced to the national average, our workforce would increase by 3000 workers.

5.4% of the Vermont population (21,215 Vermonters) aged 18-64 receive Social Security Disability Insurance (SSDI) benefits.

Nationally, 3.9% of the population (7,915,675 individuals) aged 18-64 receive SSDI benefits.

VERMONT HAS THE 8TH HIGHEST PERCENTAGE OF PEOPLE AGED 18-64 RECEIVING SSDI BENEFITS IN THE COUNTRY.

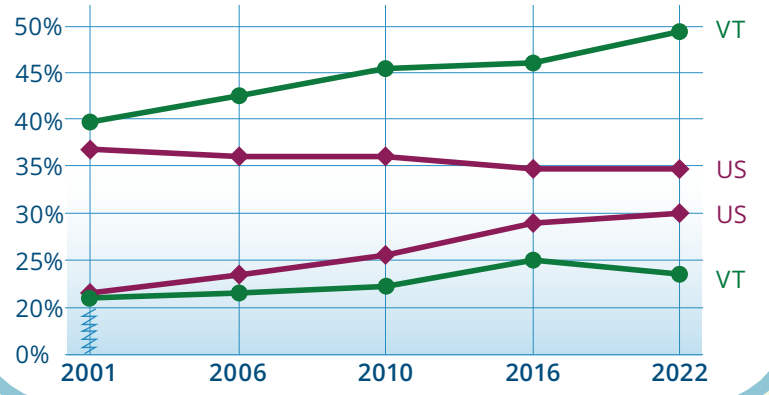
The percent of SSDI beneficiaries with mental health diagnoses in Vermont is 43% higher than the national rate.

While Vermont has the 5th best access to mental health services in the U.S., Vermonters are the least likely to seek mental health care *(United Way NCA, 2020).*

Vermont has one of the highest rates of young people receiving SSDI benefits.

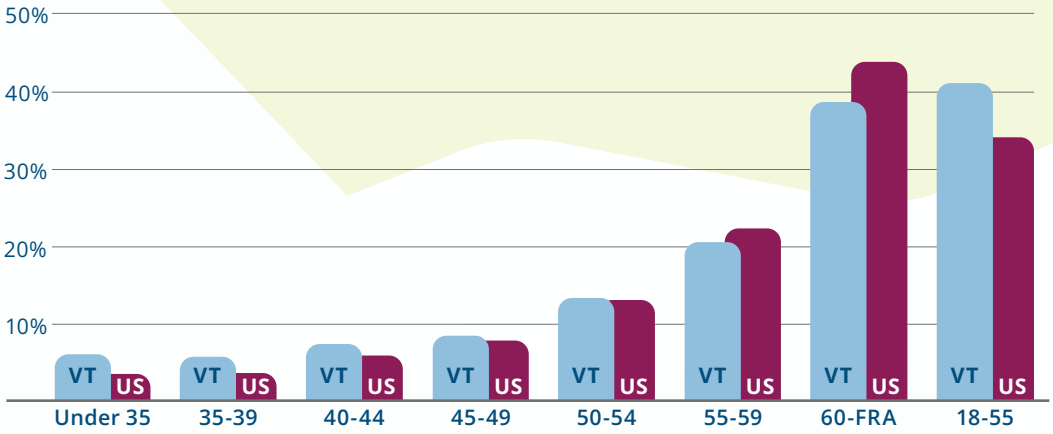
Vermont has the 3rd highest percentage of individuals receiving SSDI benefits for a mental health diagnosis in the country.

SSDI BENEFICIARIES WHO BECAME ELIGIBLE ON THE BASIS OF MENTAL HEALTH DISORDERS OR MUSCULOSKELETAL CONDITIONS



SSA Annual Report of SSDI Statistics 2001, 2006, 2010,2016, 2022

PERCENT OF SSDI BENEFICIARIES BY AGE GROUP RELATIVE TO TOTAL NUMBER OF SSDI BENEFICIARIES IN 2022
(SSA ANNUAL REPORT OF STATISTICS 2023)



In 2022, Vermont had the second highest percentage of SSDI recipients aged 18-55 in the country and the highest percentage aged 35-39.

IN VERMONT:

The employment rate in 2021 for residents with disabilities aged 18-64 was 37.9% compared to 79.3% for those without disabilities *(Paul, 2023).*

The employment gap between those with disabilities and those without is 5.5% higher than the gap nationwide (41.4% in Vermont versus 35.9% in the US) *(Paul, 2023).*

In 2021, 35.5% of the population with disabilities aged 18-64 in Vermont was living in poverty compared to 13% of those without disabilities *(Paul, 2023).*

The population with disabilities aged 18-64 living in poverty is 40% higher than the percentage nationwide (35.5% VT vs. 25.4% US) *(Paul, 2023).*

Identifying Unmet Work-Health Needs in Vermont

The roles of those who interact with an individual with a work-limiting health condition have different goals. These goals are rarely coordinated and return-to-work is not necessarily their focus.

- Clinicians focus on diagnosis and treatment
- Employers need to ensure work is able to get done when an employee is absent
- Workers focus on getting treatment and responding to their changed situation or crisis
- Insurers focus on containing the cost and duration of a claim

At the start of VT RETAIN, we conducted focus groups and interviews to understand existing services and unmet needs of constituents involved in the return-to-work process to design a program that would not duplicate efforts and would uniquely fill gaps within our state.

During the VT RETAIN focus groups, workers, clinicians, and employers consistently described four main gaps to successful return-to-work:

1. Knowledge of processes, rights, and responsibilities
2. Effective communication across roles
3. Ability to navigate systems
4. Access to services

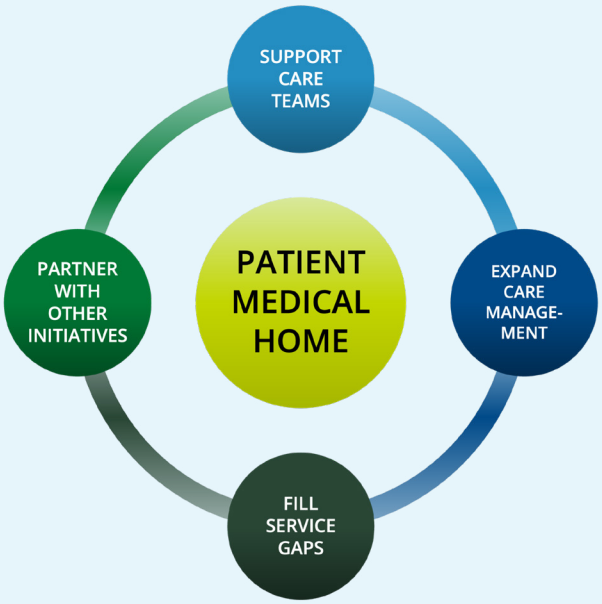
Notes

VT RETAIN's Solution for Addressing Unmet Needs

Statewide Work-Health Coach Team, Expert Hub Team, and Enhanced Early Return-to-Work Services

The VT RETAIN Return-to-Work Coordination Program was designed to bridge the gaps identified in the focus groups.

Specifically, return-to-work coordination (Work-Health Coaching) was integrated into the Vermont Patient-Centered Medical Home model to support primary care clinicians and to align with broader state care coordination initiatives. The program focuses on early identitifcation of workers at risk for or experiencing work disability and coordinating health and employment resources to increase workforce participation of Vermonters with work-limiting health conditions.



Our multidisciplinary Work-Health Coach team based throughout the state includes expertise in:

- public health nursing
- nurse case management
- social work
- physical therapy
- ergonomics
- employment
- hospital chaplaincy

Work-Health Coaches use a person-centered, strength-based approach to identify work-health goals and barriers, develop a customized work-health assessment and plan, and guide participants through their journey to stay at or return-to-work. Most coaching is able to be done remotely. Coaches are also available to attend appointments at the request of participants. The coaches are supported by our return-to-work expert hub team that includes:

- occupational medicine
- pain medicine
- physical medicine and rehabilitation
- internal medicine
- physical therapy
- occupational therapy
- pain psychology
- mental health counseling
- substance use counseling
- vocational rehabilitation
- employee assistance program (EAP) counselors
- employment law
- workers' compensation
- other specialties as needed

Over 120 primary care clinics are participating in VT RETAIN, consistent with our model of embedding work-health services in the medical home. In addition to coaching, clinicians at participating clinics have access to our Occupational Doctor "Occ Doc" Hotline for real-time work-health support. Examples of calls to the Occ Doc Hotline include questions about work disability paperwork, physical or cognitive work capacity documentation, treatment plans to improve function and support return-to–work, navigating employer or legal questions, and workers' compensation processes and rules. Our team also checks in with clinics on a regular basis to support work as a health outcome by reviewing cases, providing materials or training, and offering Staff Care sessions.

Return-to-work coordination is most successful when the right services are available in the right places at the right time. Our approach to addressing access to services includes coordinating or expanding access to existing services and creating new stay-at-work/return-to-work services that were identified as missing.

Examples of existing SAW/RTW services	Examples of services created or expanded to fill a need
Community Health Teams	State Occ Doc Hotline
HireAbility	Cognitive work capabilities form
Private Vocational Rehabilitation	Behavioral Screening and Intervention
American Job Centers	Reading Works (Responsive Librarianship Program)
Invest EAP	Community Functional Restoration Program
Individual Placement and Support (IPS)	Rehabilitation Team Assessment
Working Fields Peer Supported Employment	Resilient Workplace Certification for Employers

RETURN-TO-WORK COORDINATION

embedded in the Medical Home Model

Return-to-work coordination (Work-Health Coaching) is integrated into primary care to address work as a health outcome and identify workers at risk for or experiencing work disability. Work-Health Coaches coordinate health and employment resources to increase workforce participation of Vermonters with work-limiting health conditions.

Areas of need addressed:

Communication

Education

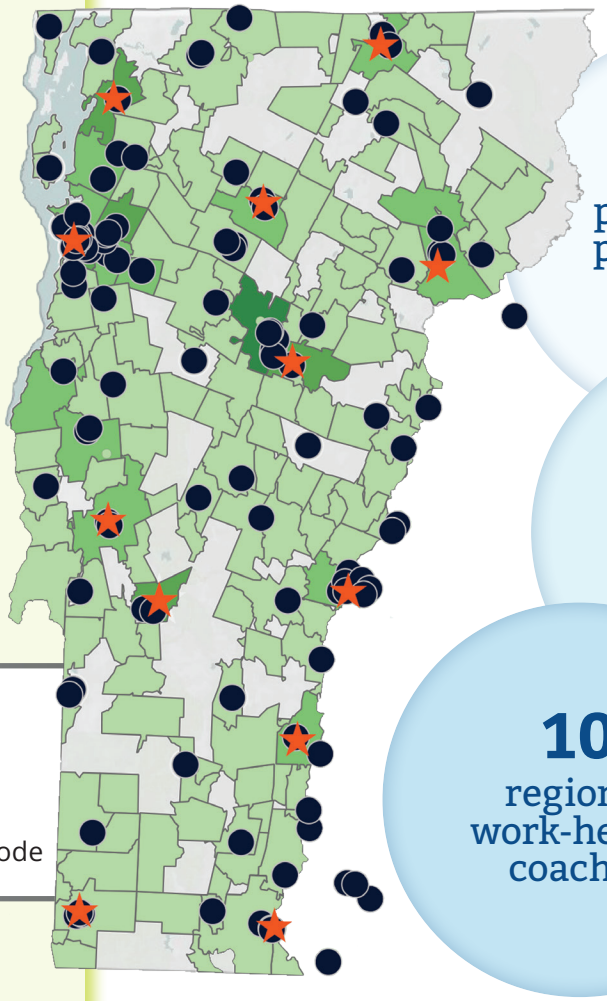
System navigation

Access

Risk identification

CLINICIAN SUPPORT

- State Occ Doc Hotline
- Free continuing education
- Staff Care sessions
- Tips and resources



120 participating primary care clinics

12 virtual RTW expert specialists

10 regional work-health coaches

Strength-Based Coaching:

1. **Perform intake assessment**
2. **Define health-job mismatch**
3. **Identify work-health barriers and goals**
4. **Collaborate on a work-health plan**
5. **Facilitate early communication**
6. **Provide resources and education**
7. **Motivate and prepare for services**
8. **Connect to appropriate existing or RETAIN-developed services**
9. **Support the care team**
10. **Ensure services are received**
11. **Monitor that goals are met**
12. **Make appropriate discharge plan**

It is wonderful to know, all in one place, the many resources available to those who are disabled. The resource document is a gold mine. You encouraged me to keep being strong and to continue to participate meaningfully in this world in spite of my limitations! Thank you very much for your calmness, professionalism, and above all, kindness in word and deed.

-Participant

I felt very heard by my contact person and the resources she gave were really helpful and pertinent to what I needed.

-Participant

I really appreciated the program. I felt like someone cared that I was struggling and there is such value in receiving kindness. That this comes from our state makes me feel loved by VT and makes me love VT even more. Thank you.

-Participant

830 WORKERS enrolled from all 14 Vermont counties

OVER 75% of those completing the program are employed*

OVER 85% of participants would recommend VT RETAIN services

- 10,000 people requested services
- 2,000 were eligible per federal grant requirements
- There were eligibility limitations due to federal grant requirements

*Data not final

New Stay-At-Work / Return-to-Work Services Created by VT RETAIN

Cognitive Work Capabilities Form

Gap: Lack of clear and appropriate job modifications for cognitive and mental health conditions puts workers at risk for work disability. Cognitive and mental health conditions are a leading cause of work disability. While physical work capacity forms are a standard tool to support employment, there are no standard cognitive work capacity forms.

Solution: VT RETAIN created a Cognitive Work Capabilities form to help clinicians systematically document cognitive work abilities and recommend job modifications for patients with cognitive impairment.

Scan the QR code to download the fillable form, quick guide, and manual with an example case study. The form is also in the Appendix.

Contact **Gregory.G.Morneau@hitchcock.org** to participate in a validation study of the form.

Reading Works

Gap: Access to mental health treatment can be a barrier to care and return-to-work. Mental health conditions are a leading cause of work disability.

Solution: Vermont has the most public libraries per capita of any state. VT RETAIN piloted Reading Works, a Responsive Librarianship Program using a neuroscience approach to develop coping skills, identify strengths, and build resilience through book-clubs at public libraries that used evidence-based reading lists and interaction with community-based experts. Reading and discussion helps participants learn by examples such as identifying with characters, situations, experts, or other book club participants. Several meta-analyses have concluded that bibliotherapy is effective in treating depression, even as effective as individual and group therapy *(Cuijpers et al. 1997, den Boer et al., 2004)* and as effective as psychotherapy for mild to moderate levels of unipolar depression *(Marrs, 1995).*

Behavioral Screening and Intervention (BSI)

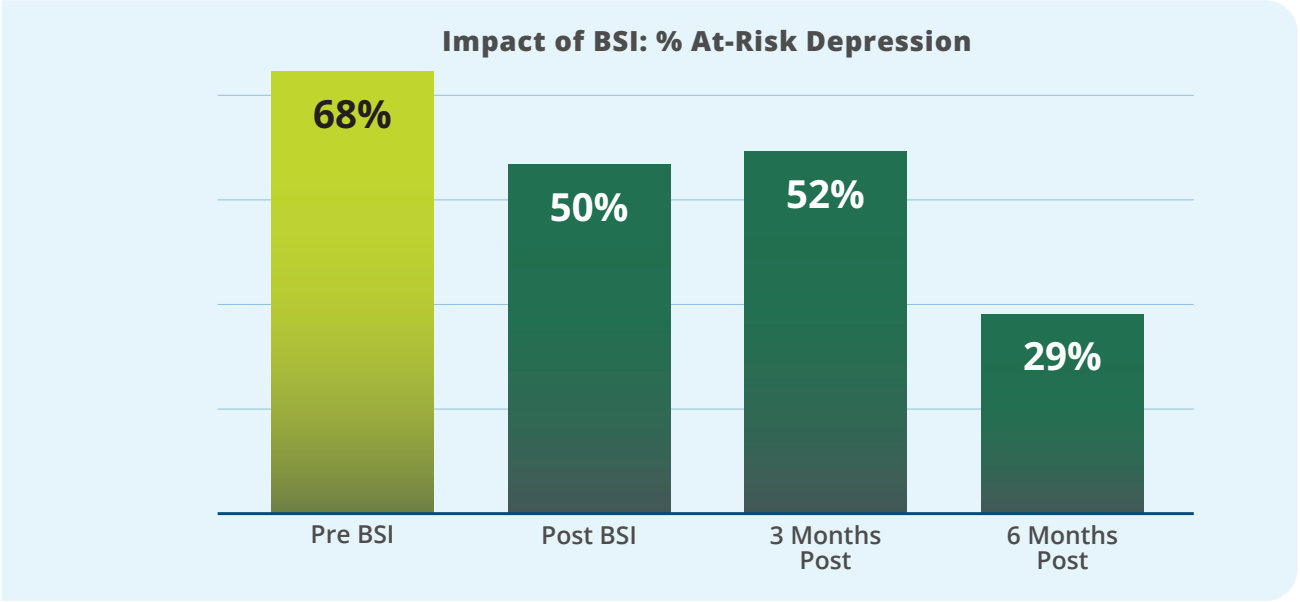
Gap:

Untreated behavioral risk factors can increase the costs associated with injuries and illnesses.

- Workers with injuries and illnesses are not routinely screened for behavioral risks that may have precipitated their injury or illness
- Individuals out of work due to injury or illness often become depressed or anxious due to their situation; substance use is not uncommon.
- Untreated behavioral risks limit the likelihood of workers with injuries or illnesses successfully returning to work.

Solution:

- Routine Behavioral Screening and Intervention (BSI) as performed by the Invest EAP Centers for Wellbeing proactively screens and treats people to reduce behavioral risks.
- Evidence-based interventions lead to considerable reductions in identified behavioral risk factors after an average of only four counseling sessions.



VT RETAIN partnered with Invest EAP to offer participants Behavioral Screening and Intervention (BSI). This screening identifies behavioral risk factors that can contribute to anxiety, depression, or substance use. Participants who screen positive without a history of mental health diagnoses are offered up to 12 motivational interviewing sessions with a health counselor to address risks. Participants with mental health diagnoses are assisted with finding appropriate treatment.

- 250 participants completed BSI screeners
- 60 participants met with a BSI counselor
- Participants attended an average of 3 sessions with their counselor

Resilient Workplace Certification

Gap: Many employers do not have the knowledge, resources, or tools to create psychologically safe workplaces. Existing employer trainings and support often focus on specific employee conditions (e.g., work injuries, mental health, substance use disorder, etc.) rather on holistic strategies for creating a work environment that promotes resilience for all employees.

- Mental health disorders are the most rapidly rising category of disorders leading to early exit from the workforce.
- Almost two-thirds (60%) of employees with low resilience and low psychological safety feel burned out, and 34% are thinking about quitting their job.
- One study estimated that between 17% and 35% percent of depressive disorders might be prevented by eliminating adverse psychosocial working conditions.
- As many as 10-13% of suicides are related to work.
- Nine out of 10 employees in the US want their employer to value their emotional and psychological welfare and provide relevant support.
- Stress and mental health disorders are an important contributing factor to workplace injuries and illness, healthcare costs, and decreased productivity.
- Research has found that the benefits of psychological safety at work include:
    - 27% reduction in turnover
    - 76% more engagement
    - 50% more productivity
    - 74% less stress
    - 29% more life satisfaction
    - 57% more collaboration among employees
    - 26% greater skills preparedness
    - 40% reduction in safety incidents

Solution: A Resilient Workplace Certification Program (RWCP) provides employers with the necessary knowledge, tools, and resources to create psychologically safe workplaces.

- Annually benchmarks employee and management assessments of the psychological health of their workplace.
- Offers in-depth trainings to increase supervisor and manager skills in creating a psychologically healthy workplace including, Mental Health First Aid training, best practices in stay-at-work/return-to-work, and in depth information on safety nets for workers with illness or injury.
- Provides training on best practices to ensure successful return-to-work and stay-at-work practices for workers with injuries or illnesses.
- Provides organizational consultation to help managers and employees develop plans to address identified risk factors.
- Employers receive recognition for creating psychologically healthy workplaces.

Community Functional Restoration (cFRP) and Rehabilitation Team Assessment (RTA)

Gap: There is a shortage of Occupational Medicine and Physical Medicine & Rehabilitation (PM&R) doctors in Vermont limiting access to medical functional assessments and plans. Functional Restoration Programs reduce opioid use and help people with chronic pain return to work but there are many barriers for patients to participate in these programs.

Solution: VT RETAIN developed a multidisciplinary rehabilitation team assessment (RTA) based in PM&R expertise to develop appropriate return-to-work plans for RETAIN participants with complex work-health needs beyond care coordination. VT RETAIN also developed a hub and spoke Community Functional Restoration program (cFRP) using telehealth to improve program access.

Thirty seven patients participated in an RTA. Unanticipated pertinent diagnoses were made in six cases. Eight of the 37 were RETAIN participants. Six of the eight had significant multiple mental health conditions. RTA resulted in an actionable return-to-work plan based on findings from the multidisciplinary team.

The cFRP physical rehabilitation team formulates rehabilitation plans based on specific patient functional goals. Patients who completed cFRP made excellent improvement in their function and either attained or came close to attaining their pre-program functional and work goals. Virtual Pain Neuroscience sessions with Dr. Mark Detzer were well received and very convenient for patients.

Notes

Vision for the Future

Expanding eligibility. Per federal funding requirements, enrollment into the VT RETAIN early return-to-work coordination program focused on individuals with injuries or illnesses that began or flared within the prior twelve weeks. Consideration should be given to providing services to people with chronic work disability because many people with stable chronic conditions could benefit from services.

Expanding beyond primary care. VT RETAIN services are embedded in the primary care medical home. More people could be served by expanding services to mental health, specialists, and other providers.

More services for underserved worker populations.

- Per federal grant requirements, only individuals with a social security number could enroll in the VT RETAIN study. This enrollment criteria limited our ability to support Vermont's undocumented and migrant worker populations.
- We experienced barriers remaining in contact with individuals without housing or with temporary housing. The program could be expanded to better serve those without stable housing.
- Although participants enrolled from every county and from all 25 Opportunity Zones in Vermont, more work needs to be done to ensure services are accessible and meet the work-health needs of all underserved worker populations in Vermont.

Duration of services. Per federal grant requirements, work-health coaching services ended six months after enrollment. Many participants needed services longer than six months due to the severity of their condition, complexity of their situation, or time needed to meet their goals or reach a plateau. Duration of services should be based on the need of the participant and not a set length of time.

Peer coaching. The program could also be expanded to include peer-coaching services as another layer of support for participants. Research indicates that peer coaching can be effective in reducing barriers individuals may have to accepting services.

Exploring health outcomes. Results of the RETAIN study are being analyzed and reported by an Independent Evaluator. Primary study outcomes focus on employment (i.e., employment status and SSDI claims one year post enrollment). There are many benefits to return-to-work beyond workforce retention. Health and healthcare utilization outcomes, other social determinants of health outcomes, and outcomes that support broader state health and workforce goals could be incorporated into future program evaluations.

Coordination and collaboration across RETAIN states. Each RETAIN program was developed independently and each program developed their own training and competencies for Work-Health Coaches and for front line clinicians and employers. There is now an opportunity for RETAIN states to work together to determine which areas are best addressed at an individual state level and which could be unified nationwide.

Emerging opportunities

- Minnesota RETAIN created a model for including work status in universal social determinants of health screening and for contacting and enrolling at-risk patients through the electronic medical record. This approach can be used to inform strategies for embedding work disability screening and intervention services into healthcare systems.
- The Rhode Island Workforce Agency leadership has determined that workers with new work disruption due to a health condition meet the definition of qualified workers with a disability under the ADA but are currently not eligible for any substantive worker-centered SAW/RTW services under existing programs. As such, they can be considered an "historically disadvantaged population" under existing Federal and state grant programs.
- The new 2024 CMS physician fee schedule includes payment for addressing social determinants of health. Future work can determine ways to integrate new payment models to provide work disability services.
- In September 2023, The National Institutes of Health identified people with disabilities as a population with health disparities. The Centers for Medicare and Medicaid Services (CMS) has framed the five priorities for addressing health inequities. Each priority reflects an area where underserved and disadvantaged communities have asked CMS to act. These priorities are:

    1. Expand the collection, reporting, and analysis of standardized data
    2. Assess causes of disparities within the CMS programs and address inequities in policies and operations to close gaps
    3. Build capacity of healthcare organizations and the workforce to reduce health and health care disparities
    4. Advance language access, health literacy, and the provision of culturally tailored services
    5. Increase all forms of accessibility to healthcare services and coverage

For further information on these opportunities as well as examples of state policies that support employment retention please see the Appendix.

VT RETAIN focuses on these five priorities to address the inequity in our state arising from the intersection of disability and unemployment. Both disability and unemployment contribute individually to health inequity. The intersection of these two issues is an opportunity for the work of VT RETAIN and our partners.

Partners

Invest EAP Centers for Wellbeing

The American Psychological Association's Stress in America 2023 reports:

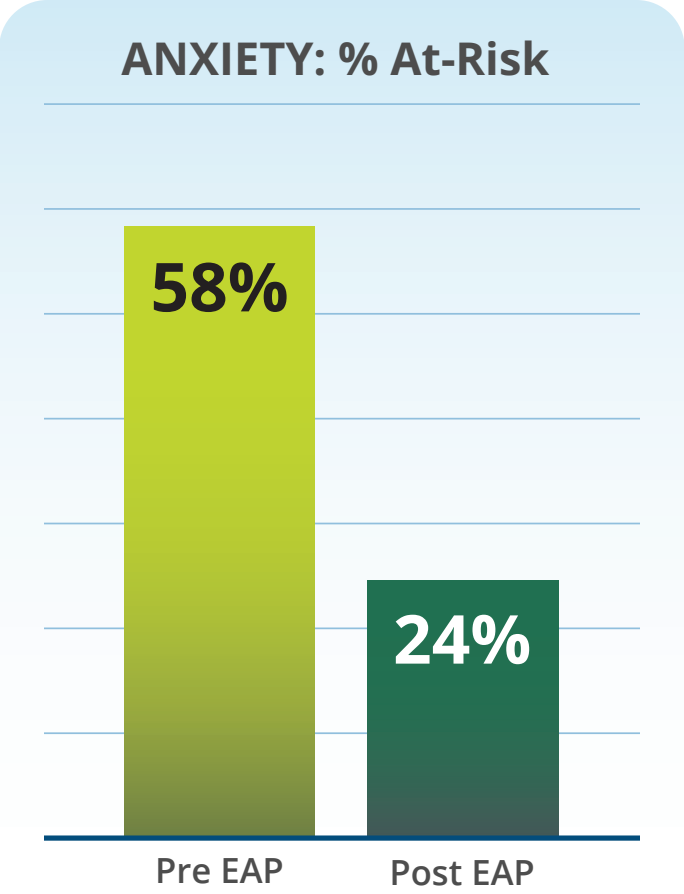
- More than one-third of adults (37%) report being diagnosed with mental health condition which is a 5% increase from pre-pandemic levels. Most cited anxiety disorder (24%) or depression (23%).
- Three in five adults (62%) said they don't talk about their stress overall because they don't want to burden others.
- Nearly half (47%) said they wish they had someone to help them manage their stress.
- More than one-third of adults (36%) said they don't know where to start when it comes to managing their stress.
- Two-thirds of adults (66%) said that, in the last 12 months, they could have used more emotional support than they received.
- Unaddressed stress leads to increased rates of chronic disease, increased healthcare costs, and negatively impacts workplace productivity.

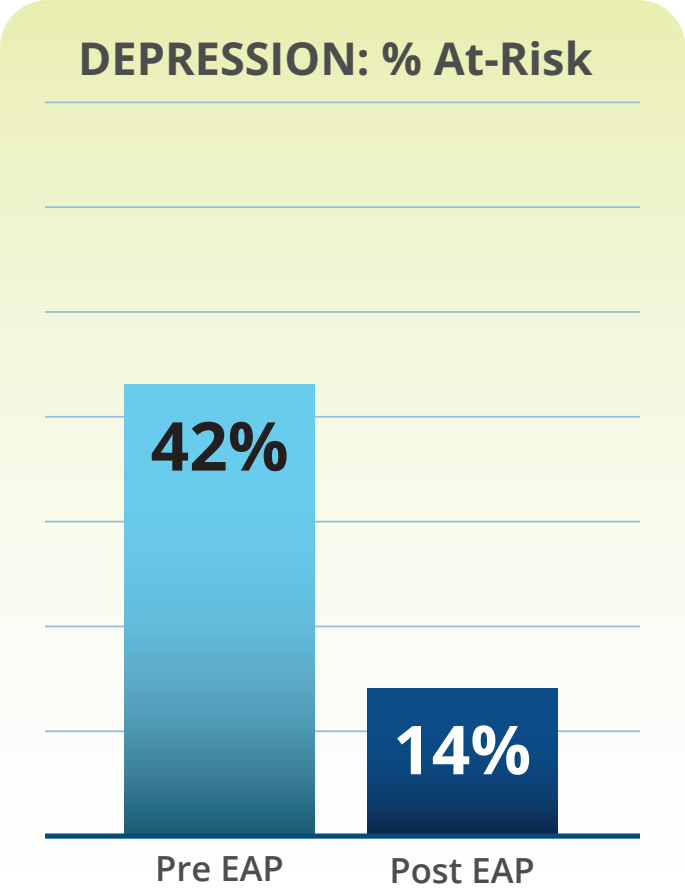
Solution:

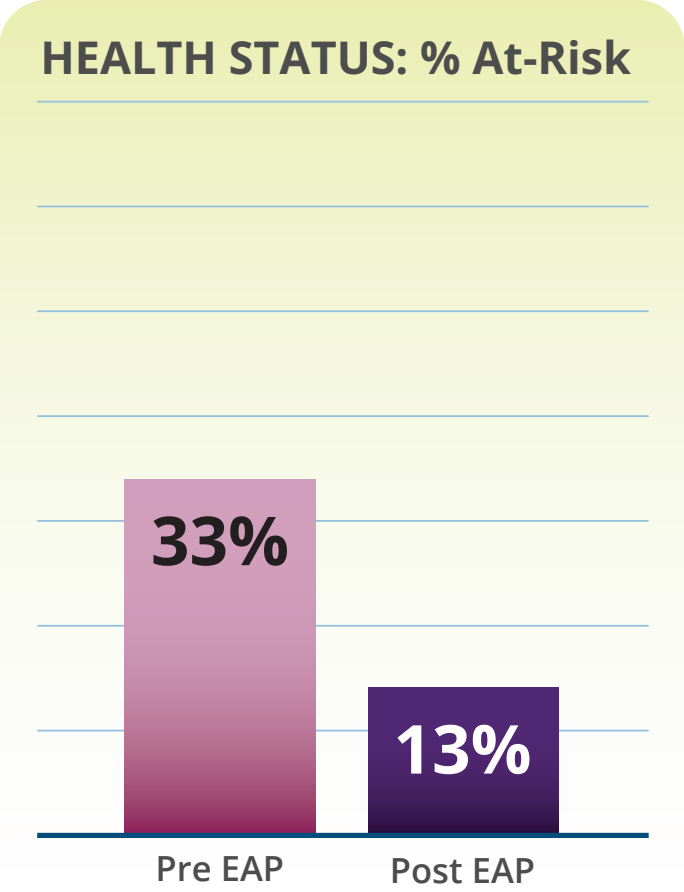
- Employee Assistance Programs (EAPs) provide employees and their family members with rapid access to free, confidential counseling.
- The Invest EAP Centers for Wellbeing provides EAP to over 300 Vermont employers representing over 162,000 employees and their household members.

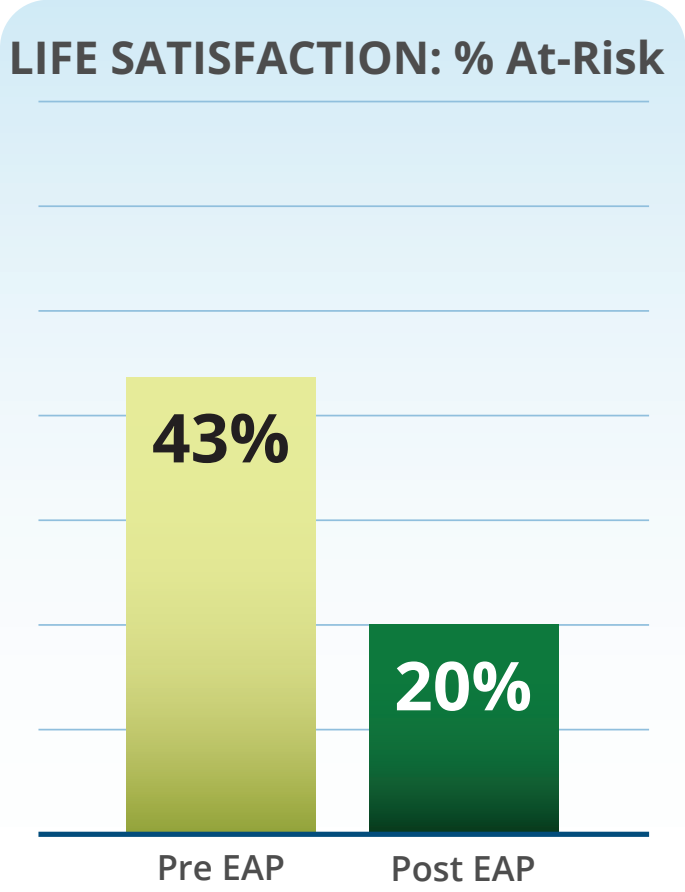
Outcome:

The charts on the next page depict the findings from a research study that analyzed Invest EAP's services and outcomes. *(Attridge, M and Dickens, S. 2022)*


ANXIETY: % At-Risk
58%
24%
Pre EAP
Post EAP


DEPRESSION: % At-Risk
42%
14%
Pre EAP
Post EAP


HEALTH STATUS: % At-Risk
33%
13%
Pre EAP
Post EAP


LIFE SATISFACTION: % At-Risk
43%
20%
Pre EAP
Post EAP

HireAbility Vermont

HireAbility is the public vocational rehabilitation program for the State of Vermont. HireAbility is funded and authorized through the federal Workforce Innovation and Opportunity Act (WIOA). Staff are State of Vermont employees. Services are available to individuals with all types of disabilities except those who are blind and visually impaired (who are served by the Division for the Blind and Visually Impaired).

HireAbility:

- has about 70 vocational counselors statewide, 25 of whom exclusively serve high school students and youth up to age 25 years
- has specialized Rehabilitation Counselors for individuals who are deaf and hard of hearing
- contracts with the Vermont Association of Business, Industry and Rehabilitation (VABIR) for about 60 job placement staff to support participants
- supports 12 Business Account Managers (BAMS) statewide to maintain continuous relationships with 2,500 employers annually
- deploys six Certified Work Incentive Counselors to assist SSI/SSDI beneficiaries manage their benefits as they go to work
- provides paid work experiences (PWE) for participants looking to try out employment
- pays for post-secondary training and education if it is tied to an employment goal and minimum wage during training for financial support
- operates a paid summer program called the Summer Career Exploration Program providing work experiences for about 130 students annually
- supports the JOBS supported employment programs serving youth with severe emotional disturbance in partnership with Department of Mental Health, Department for Children and Families, and Department of Corrections; JOBS services are provided locally through the Designated Community Mental Health Agencies and Community Justice Centers
- houses the Vermont Assistive Technology Program (AT) and funds AT services related to employment
- manages the Vermont Career Advancement Project (VCAP) funded through the federal Department of Education, Disability Innovation Fund that provides enhanced career pathways services for people with disabilities and includes a close partnership with Community College of Vermont and Vermont State University.

HireAbility applicants:

- must have a medically verified disability that is a substantial barrier to employment and require vocational rehabilitation services to become employed
- must have a goal of becoming employed
- who receive SSI/SSDI benefits are presumed to be eligible

HireAbility counselors:

- provide career assessment and counseling to explore career pathways
- have access to case services to cover needed goods and services including work clothing, transportation, technology and a whole range of other items
- are onsite in all Vermont High Schools
- create Individualized Plan for Employment (IPE)

Individualized Plan for Employment (IPE):

- IPE job goal/services are based on the consumer's interests and needs
- emphasis is on informed choice
- IPE are signed by the participant and the counselor

What is the difference?

HireAbility is different from the workers' compensation vocational rehabilitation program, which is funded through private insurance. Workers' compensations vocational rehabilitation services are provided by the counselors who are certified by the Vermont Department of Labor and work for private case management companies.

VERMONT
DEPARTMENT OF LABOR

Workforce Development

The Workforce Development Division operates 12 regional offices across the state. These offices are known as our local Job Center Network, and more information about each center is listed below. The Department's Burlington office is the State's federally-recognized One-Stop Job Center. This Job Center, which is operated by the Vermont Department of Labor, is part of the American Job Center Network through the U.S. Department of Labor.

Workforce development refers to activities and initiatives that match, educate, and train individuals to meet the needs of current and future businesses and industries and maintain a thriving economy. This includes individuals who are new to a company or occupation and those who are moving up within a company or organization. The Department provides workforce development services for both individuals and businesses.

Services for Job Seekers

- Find a Job
  - Get Help: Job Seeker Inquiry Form
  - Search Jobs with Vermont JobLink
  - Create a Vermont JobLink Profile
  - Resume Writing Tips
  - USAJobs.gov
- Veteran Services
- Registered Apprenticeship
- Vermont Youth Employment Program (VYEP)
- Labor Market Information
- Federal Bonding Program
- Layoff Support Services
- Federal Infrastructure Investments

Employer Services

- Contact VT Labor's Business Service Manager
- Post Job Openings
  - Get Help with Recruitment
  - Post a Job on Vermont JobLink
- Become a Training Provider
  - Registered Apprenticeship
  - Vermont Youth Employment
  - Workforce Innovation and Opportunity Act (WIOA)
- Hiring a Veteran
- Labor Market Information
- Layoff Support Services
- WARN and Notice of Potential Layoffs
- Work Opportunity Tax Credit (WOTC)
- Federal Infrastructure Investments

Available Resources

- Vermont Department of Labor
  - Unemployment Insurance
  - Workplace Safety
  - Workers Compensation
  - Wage and Hour
  - Labor Market Information
- External Resources
  - COVID-19
  - Agency of Commerce and Community Development
  - Agency of Education
  - Vermont State Colleges
  - VocRehab
  - Creative Workforce Solutions
  - AmeriCorps

Workforce Development provides a network of local job centers located in:

Barre-Montpelier	Newport
Bennington	Rutland
Brattleboro	Springfield
Burlington	St. Albans
Middlebury	St. Johnsbury
Morrisville	White River Junction

I was so impressed with the professionalism that was shown to me, and I am happy with the recommendations that have been made to me and my provider.

-VT RETAIN Participant

Notes

EXPLORING OPPORTUNITIES

MICHELLE HOBBS, REFRAME LAB

Call to Action

Opportunity Framework

From your vantage point, and the Call to Action presented, what specific problem is emerging that feels like an opportunity for you, your sector, or this summit for further exploration and focus?

***Who** is having the problem?*	***What** is the problem?*	***Where** does this problem occur?*
***When** does this problem occur?*	***Why** is the problem worth solving?*	**Who is having the problem?** This could refer to individuals, groups, or entire organizations. It is anyone (or anything) that is affected by the problem. **What is the problem?** This can be thought of as the gap that has formed between the current state and the desired state. Try to sketch out the boundaries of this gap and describe the unmet need that exists. **Where does this problem occur?** This could be a geographic location (such as a city or company), a physical object (such as a product), an entity (such as a marketing department), or even a process (such as commuting). **When does this problem occur?** Is there a certain time when the issue occurs? Is there a deadline by which it needs to be solved? **Why is the problem worth solving?** This should focus on the importance of fixing the problem. What kind of impact will it make? How will solving it affect customers, employees, and other constituents? In short, what makes a solution worthwhile? What does success look like?

Workgroup Planning Sheet

Start to create a plan, timeline and deliverables. Determine some logistics and checkpoints for the call-to-action. Review other groups' work plans and provide feedback.

Define the work			
Resources: What do we have?		*Resources: What are we missing?*	
Role	*Role*	*Role*	*Role*
Timelines/Key Milestones			
July			
Aug			
Sept			
Oct			
Re-establish success metrics.	*Questions to the larger group: <u>What</u> or <u>who</u> is missing?*	*How can we accelerate this through <u>this summit</u> network?*	
Short-Term Goals	*Medium-Term Goals*	*Long-Term Goals*	

Solution Sketch

Refine your idea by breaking it into three parts, like a story. It involves characters in a certain place who are engaged in the beginning, who then act along a timeframe, engaging people or using tools, and ultimately ends with a solution to resolving the problem. Experiment with this construct to shape a more vivid idea to share with your group.

Solution Beginning
Solution Middle
Solution End

Notes

Facilitator and Attendee Bios

Marc Adams:

Invest EAP

Dirk Anderson:

Dirk Anderson is Director of Workers' Compensation and Safety with the Vermont Department of Labor. Prior to that, he served as general counsel to the Vermont Department of Labor for sixteen years, as well as counsel to the Vermont Employment Security Board. His areas of responsibility include the administration of Vermont's workers' compensation program, the enforcement of the Vermont Occupational Safety and Health Act, workplace safety and health consultation, and the Passenger Tramway Safety Program. He obtained his law degree from the Vermont Law School, and a B.A. from the University of New Hampshire.

Connect with me about: HR and employment issues

Tarah Cantore:

Tarah is a physical therapist by background and graduated from the University of Vermont in 1988. Throughout her career, she has practiced in a variety of settings and specialties. Prior to working for VT RETAIN, she was an ergonomist at Dartmouth Hitchcock Health, working to prevent employees from getting injured. Tarah has a unique perspective when working with injured workers, as she was one herself. She injured her back eleven years ago when working with a patient, navigated the worker's compensation system, and received extensive back surgery.

Monica Caserta Hutt:

Monica has worked in human services for her entire professional career and in state government for the last 19 years. Throughout that time, she has worked with children and families in multiple positions, both in the community and in the Agency of Human Services. Most recently she served as the Commissioner for the Department of Disabilities, Aging and Independent Living. Currently, she is working in the Governor's office as the Chief Prevention Officer for Vermont and as a senior policy advisor to Governor Phil Scott.

Connect with me about: Human Services, Supported employment, Recovery, policy landscape

Donna Curtin:

Donna partnered with Brit McKenna in June 2022. Donna worked previously for a carrier as the Vocational Case Manager Supervisor, and for the State of Vermont HireAbility as the Field Services Manager. Donna has worked in the vocational rehabilitation case management field for approximately 15 years, as co-owner of a regional case management company and as a Vocational Counselor and Expert Witness on litigated cases. Donna has presented on the topic of Return to Work to employers, law associations, claims adjusters, state agencies, municipalities, and medical providers. Donna holds a Master's in Rehabilitation Counseling from Northeastern University in Boston, MA and a Bachelor's in Psychology from University of Massachusetts Lowell.

Donna embraces a dual customer focus of employee and employer in her practice towards Return To Work. Donna enjoys the field of workers' comp vocational rehabilitation, both to support hard-working Vermonters injured at work, to return to meaningful employment for a productive and fulfilling life, as well as collaborating with employers to sustain their stable workforce..

Connect with me about: ocational Rehabilitation eligibility/services for injured workers, return-to-work

Steve Dickens:

Steve Dickens is the Director of Research for the Invest EAP Centers for Wellbeing in Vermont. He oversees a variety of health-related grant projects operated by this innovative Employee Assistance Program (EAP). Steve holds an appointment as a Visiting Scholar at the Harvard T.H. Chan School of Public Health. He is a Licensed Psychologist-Master with over 30 years of experience in counseling, research and implementing key health prevention initiatives.

Connect with me about: Psychologically healthy workplaces; EAP

Nermin Elezovic:

Vermont Department of Labor, Workforce Development

Laura Flint:

Vermont Department of Mental Health

Carrie Frietag:

VT RETAIN

Monika Ganguly-Kiefner:

Monika Ganguly-Kiefner (she/her) works for the Vermont Department of Health in Rutland as a Public Health Supervisor with a health equity focus for structurally underserved populations including BIPOC, LGBTQIA+, and people with disabilities. She holds a Master of Sustainable Peacebuilding degree from University of Wisconsin-Milwaukee and a BA in both Sustainable Agriculture and Environmental Studies from Green Mountain College. Monika has focused her entire career on building healthier and happier communities whether it be through urban planning, supporting local food systems, advocacy for survivors of domestic violence, or public health.

Connect with me about: Health equity, Social Determinants of Health

Michael Harrington:

Michael Harrington was appointed Commissioner for the Vermont Department of Labor in 2020 by Governor Scott after serving three years as Deputy Commissioner. Michael also serves as chair of the board for the National Association of State Workforce Agencies. He received his bachelor's and master's degrees from the State University of New York at Plattsburgh and has professional experience in organizational development, economic and community development, and communications.

Connect with me about: Vermont's Workforce

Michelle Hobbs (Facilitator):

Michelle is a facilitator, designer, and partner at Reframe Lab [reframelab.co]. Reframe Lab offers creative methods to empower organizations by helping them see their best opportunities in a new way through strategic alignment of resources, processes, and culture, and utilizing compelling visual methods to tell effective stories that drive action.

Michelle has over 25 years of experience creating design that inspires engagement and impact for organizations and brands in a variety of sectors. As a facilitator, she partners with teams to harness their most creative ideas and co-create their future path together. The results can take the form of a new team vision, strategic plan, prototypes for new products or services, or process improvements.

Most recently, she worked as a designer within ICF, a global consulting firm, facilitating innovative design thinking workshops. In this role, she co-designed and facilitated online and in-person workshops for human services, energy, environmental, and transportation teams.

Prior to her facilitation work, Michelle spent two decades in corporate branding, marketing communications, and graphic design. She led an in-house creative team at VEIC and managed her own Burlington-based design studio, creating design campaigns for clients in healthcare, specialty foods, and in the non-profit sector.

She currently teaches design at Champlain College and is a member of the Board of Directors at Sara Holbrook Community Center.

Andrew Haig:

A specialist in Physical Medicine and Rehabilitation (PM&R), Pain Medicine and Clinical Neurophysiology practicing in Middlebury and Williston Vermont; Dr. Haig is professor emeritus at the University of Michigan. There he founded the spine and cancer rehabilitation programs, led the work rehab and institutional telemedicine programs, and taught leadership to corporate executives. As president of Haig Consulting LLC he works with governments, healthcare systems and payers in the US and Internationally. As founding president of the not-for-profit International Rehabilitation Forum, he leads global efforts to build medical rehabilitation in low-income and isolated regions of the world.

Dr. Haig's research has spanned basic nerve physiology, clinical care, work disability, and global health policy; resulting in over 150 peer-reviewed articles and a textbook. His work and advocacy have resulted in dozens of honors including the highest awards from the international Rehabilitation, Spine, and Neurophysiology societies and most recently American Academy of PM&R's Distinguished Advocate award. Within RETAIN Dr. Haig has acted as senior advisor and then co-principal Investigator for Sustainability.

Connect with me about: Efficient rehabilitation team assessments ('RTA's' in RETAIN) for complex care. prevention, detection and rehabilitation of persons at risk for disability.

Karen Huyck:

Karen Huyck is an Associate Professor of Medicine at Dartmouth in the Section of Occupational and Environmental Medicine (OEM) and co-founder and Medical Director of VT RETAIN, a statewide work disability prevention program funded by the U.S. Department of Labor. She received her MD and PhD from the University of Vermont. She

completed her residency, MPH, and post-doctoral fellowship at the Harvard School of Public Health. She served as a scientific advisor to Congresswoman Stephanie Tubbs Jones on health equity issues and has worked in diverse OEM settings. She is frequently invited to talk about work as a health outcome and has won many clinical, research, and teaching awards for her work, including the UVM Distinguished Academic Achievement Award. She joined the faculty at Dartmouth in 2010, where she could continue her passion for providing high quality care and improving work and health outcomes for Vermonters as a model for other states. The current focus of her work is equitable access to occupational medicine best practices and evidence-based stay-at-work/return-to-work strategies to support the physical and mental health of workers in their communities.

Connect with me about: Anything related to work disability in Vermont!

Sharanda Jackson:

Sharanda Jackson is a clinical research coordinator for VT RETAIN. She graduated with her bachelor's in Biological Sciences from NC State University and obtained her master's in Healthcare Administration at the University of North Carolina Wilmington, where she focused on population health and health equity. She has an extensive laboratory background and worked for ten years in laboratory science. She is passionate about creating a world where everyone has equal healthcare access. She loves reading, good food, and binge-watching TV in her free time.

Connect with me about: Health equity and Social Determinants of Health

Lorainne Jenne:

The Society for Human Resources Management

Stephanie Zak Jerome:

Stephanie Zak Jerome is a member of the Vermont House of Representatives and is the vice-chair of the Commerce and Economic Development Committee. She serves on the University of Vermont Board of Trustees, UVM Medical Center Cancer Advisor Board and New England Board of Higher Education. Stephanie has held prominent roles on the Brandon Planning Commission, Chamber of Commerce, Economic Development Committee, and Revolving Loan Fund, as well as the UVM Alumni Council and Vermont Arts Council. She was awarded a Presidential Management Fellowship and served as a Policy Analyst at NASA's Office of Space Sciences in DC. Stephanie is the president of Visual Learning Systems, science education publishing company. Stephanie was raised in Mendon, graduated from Barstow School, Rutland High School, and the University of Vermont, and received a Masters in Public Policy and Administration from UMass, Amherst. Stephanie and her husband live in Brandon and have three adult children.

Connect with me about: My work in the VT Legislature focuses on workforce development and training.

Ben Kidder:

Ben Kidder works in the Economic and Labor Market Information division of the Vermont Department of Labor. His primary areas of research include Vermont industry composition, employment trends, and wage analysis.

Connect with me about: The Vermont Labor Market, Economics, Data Analysis, Wages

Tatiana Lamia:

I completed medical school at George Washington University in 2005. I completed my Physical Medicine & Rehabilitation (PM&R) residency in 2009 combining studies at Johns Hopkins and Baylor University in Houston. Initially, I worked in private practice at a spine and pain focused clinic. I have worked in the VA system since 2010 in three locations: Alabama, the Bronx and now Vermont. I am the leader of the Vermont VA SCI, TBI and amputee clinics. While serving in the Bronx I was the New England & NY/NJ regional lead of the VA Amputee System of Care. I have supported and encouraged patients in the return-to-work process throughout my career.

Connect with me about: Veterans, Spinal Cord Injuries, Amputees, Traumatic Brain Injuries

Jon Lurie:

Dr. Lurie is a Professor of Medicine, Orthopaedics, and of Health Policy and Clinical Practice (TDI) at the Geisel School of Medicine at Dartmouth. He is a practicing general internist in the Section of Hospital Medicine, who also has extensive experience in health services and comparative effectiveness research with a primary focus on low back pain and rehabilitation. His overarching research interests are in evidence-based decision-making and decision-based evidence-making.

Connect with me about: Evaluation methodology

Christine McDonough:

Christine McDonough, PT, PhD, is an assistant professor in Physical Therapy, Orthopaedic Surgery, and Clinical and Translational Science at the University of Pittsburgh. Her research focuses on implementation of evidence-based practice in orthopaedics and geriatrics to prevent and treat disability. She has advanced training in outcome measurement theory and methods, disability theory, economic evaluation and commercialization. Dr. McDonough conducts health services, clinical, and implementation research in fracture and fall prevention, and return-to-work best practice. Her service activities focus on development of standardized methods and training for clinical practice guideline (CPG) development for the American Physical Therapy Association (APTA). She served as Editor of CPGs for the Academy of Orthopaedic Physical Therapy of the APTA for 10 years, and in a similar position for the Academy of Geriatric Physical Therapy.

Connect with me about: implementation of best evidence, implementation science

Gregory Morneau:

Greg is an occupational therapist at DHMC having spent the last 17 years specialized in return-to-work and neuro rehabilitation. He is a certified work capacity evaluator performing functional capacity evaluations. He has also incorporated his specialty of cognitive rehabilitation into work assessment offering cognitive functional capacity evaluations. Greg also is part of the work conditioning program and runs the wheelchair clinic offered at DHMC. He also is part of VT Retain as a clinical expert.

Connect with me about: physical and cognitive capability to return to work. Mental health's impact on cognitive performance to return-to-work.

Prudence Pease:

Pru Pease is the co-founder and co-executive director of Resources@Work, a new nonprofit in the Upper Valley Region, the program brings assistance to more than 4,500 clients across 10 companies in the Upper Valley through resource navigation This work brings awareness of poverty issues to companies

across the region as they support their struggling workforce. Her work is not limited to Vermont, however. She is a highly sought after speaker on the topic of socio-economic instability and has trained more than 20,000 individuals, human service providers, HR professionals, employers, healthcare professionals, and educators across the country. When she is not serving her community, Pru works on her family's farm in Tunbridge, Vermont.

Connect with me about: Resource navigation, employment stability, instability vs stability mindset in the workplace

Clark Potemski:

Disability RIghts Vermont

Becky Senesac:

Becky Senesac has worked for fifteen years as the Electronic Health Record Services Manager for Primary Care Health Partners. Becky manages eleven offices in VT and upstate NY.

Amanda Sidler:

Amanda Sidler is from Springfield, VT. She currently works for Springfield Regional Development Corp. She joined SRDC in the fall of 2020 to serve as the Business Navigator for the Restart Vermont Technical Assistance Program. Currently, her role focuses on Workforce Development, and she is the Working Communities Challenge Coordinator for the Springfield Region.

James Smith:

James has over 35 years of experience working to assist individuals with disabilities become employed. He started his career in New York City as job coach and then supported employment program manager. In 1995 he joined HireAbility Vermont. At HireAbility he has had a variety of roles including managing the work incentives program focused on assisting SSI/SSDI beneficiaries return to work. He is currently the Deputy Director of HireAbility.

Connect with me about: Employment services for people with disabilities, workforce development and SSI/SSDI return-to-work

Joyce Soublet:

"Hello, I'm excited about all of the accomplishments made through the RETAIN Phase 2 program."

I have 26 years of nursing experience as an LPN, a Bachelor of Science with a concentration in Healthcare Administration in 2019 and a certified clinical research professional (CCRP) with SOCRA. My research experience extending 10 years has been in the realms of pharmaceutical and oncology clinical trials and currently RTW/SAW study, RETAIN.

Remote opportunities in this field are unique which makes this position a challenge from my residing State of Virginia. My goal for the past 2 years has been to work remotely so that I can spend less time commuting to work and more time helping the participants in research trials and studies. What I enjoy most; time with family, church family, community, and diving into ministry activities.

Connect with me about: VT RETAIN Enrollment and Eligibility

Kate Tibbs:

I work with Goodwill of Northern New England as an Employee Life Navigator, contracted with three businesses in Rutland County. I assist the employees within these businesses to help access and navigate resources.

Connect with me about: Mental health, community engagement, health equity

Renee S. Weeks:

Renee Weeks has been the Director of Complex Care and Field Services since 2022. She holds a degree in Clinical Psychology and licensure in Mental Health Counseling and Substance Use Treatment. She has worked in the field of human services in Vermont since 1996 with Vermonters across the lifespan. She has worked in mental health and substance use treatment, correctional treatment and in services for people experiencing poverty and homelessness. She promotes a philosophy of treating the whole person and collaboration among health care providers. Renee is working in Vermont to enhance Team Based Care so help Vermonters have better care outcomes and more satisfaction with their care experience. She also believes continuous outreach is essential to those who may not be ready to engage in services. All of our work begins with trusting relationships with the people we serve and with fellow providers of care.

Connect with me about: Team Based Care, Health Related Social Needs, Integrated Care, Self-care for providers

Andrea Wicher:

Andrea Wicher holds a master's degree in social work from Marywood University. She joined the VT RETAIN team in April of 2023 as Program Director, bringing experience in social work, population health, value-based care, project management, quality improvement, and data analysis. She has worked with a wide array of populations in different care settings ranging from community based, hospital, and primary care. Andrea previously served as the Director of Population Health & Quality at a federally qualified health center. In addition, she facilitated the Rutland Community Collaborative from 2017 to 2022.

Connect with me about: Policy and mental health (also all the above)

Mickey Wiles:

Mickey Wiles is the CEO and Founder of Working Fields, a mission-driven staffing agency that helps individuals overcome barriers to employment — such as substance use disorder, justice involvement, resource challenges, or work history gaps — and build stable futures.

Mickey has combined his long career in business, his six years serving in the U.S. Navy with his own personal experience in recovery and after mistakes and poor life decisions, is a successful second chance person overcoming many obstacles and challenges. Although the majority of Mickey's career was in the private sector, Mickey did serve two years as the Executive Director of the Turning Point Center of Chittenden County where he developed the first Recovery Coaching program in the State of Vermont.

Connect with me about: Workforce development, recovery friendly workplace, recovery coaching and peer support

Carrie Wulfman:

OneCare Vermont

This is The Hub CoWorks

The Hub CoWorks is Rutland, Vermont's premier coworking space designed to foster creativity, collaboration, and productivity. Nestled in the heart of downtown Rutland, The Hub CoWorks offers a vibrant and inspiring environment for freelancers, entrepreneurs, remote workers, and businesses looking for a dynamic and flexible workspace.

Our Mission
At The Hub CoWorks, our mission is to create a community where professionals from diverse industries can connect, collaborate, and thrive. We believe that by bringing together innovative minds in a shared workspace, we can spark new ideas, drive business growth, and contribute to the economic vitality of Rutland.

The Space
Our thoughtfully designed coworking space features a variety of workstations to suit different working styles and needs. Whether you prefer a quiet desk for focused work, a high-tech class/meeting room for trainings/seminars/business meetings, or a cozy lounge area for informal meetings, The Hub CoWorks has it all. Our amenities include high-speed internet, lockers to store personal items, telecom rooms for confidential calls, access to select Hub events, printer services, an internal business directory, and a kitchen with complimentary coffee and tea.

Community and Networking
Being a member of The Hub CoWorks means more than just having a place to work. It means being part of a supportive community. We host networking events, workshops, and social gatherings to help our members build meaningful connections, learn new skills, and grow their businesses. Our diverse community includes professionals from fields such as technology, marketing, finance, and creative arts, providing ample opportunities for collaboration and knowledge sharing.

Welcome to The Hub CoWorks – where great ideas come to life!

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Appendix

COGNITIVE WORK CAPABILITIES FORM

This form is designed for health care providers to document work capabilities of patients with injuries or illnesses affecting cognitive function. To complete this form, use available information (e.g., from your interactions with the patient and information from the care team) to estimate the patient's work abilities.

Cognitive capabilities are divided into three categories: Cognition, Self-regulation, and Resilience. Rate performance in each category. Choose from the listed job modifications to help end users of this form, such as an employer, determine appropriate accommodations.

Patient's Name:_____ Date: _____

Please rate patient's ability on the following scale: **1 = no limitation; 2 = needs environmental modifications; 3 = needs close supervision or assistance; 4 = unable to perform despite close supervision or assistance; 5 = unable to estimate**

If a category is rated mostly with 4's, consider whether to select any job modifications within that category because it may not promote ability to work.

Cognition	**1**	**2**	**3**	**4**	**5**
Remember simple instructions	◯	◯	◯	◯	◯
Remember complex instructions	◯	◯	◯	◯	◯
Understand simple instructions	◯	◯	◯	◯	◯
Understand complex instructions	◯	◯	◯	◯	◯
Carry out an individual task	◯	◯	◯	◯	◯
Carry out multiple tasks	◯	◯	◯	◯	◯
Make simple decisions	◯	◯	◯	◯	◯
Perform complex decision making	◯	◯	◯	◯	◯
Maintain attention for extended periods	◯	◯	◯	◯	◯
Tolerate distraction in the work environment	◯	◯	◯	◯	◯
Manage time to be punctual	◯	◯	◯	◯	◯
Take appropriate precautions to workplace hazards	◯	◯	◯	◯	◯
Maintain an organized workstation or environment	◯	◯	◯	◯	◯

Job modification(s) related to cognition (choose all that apply):	
Needs written work task available to remember instructions	☐
Needs to take notes to remember details of non-routine work tasks	☐
Requires supervised repetition to learn work tasks	☐
New tasks should initially have limited steps	☐
Work tasks should be isolated to one task at a time	☐
Complex problem solving should not be required for any work tasks	☐
Complex problem solving should only be performed for practiced work tasks	☐
Needs assistance for all complex problem solving	☐
Need to limit to one computer monitor to decrease need for multitasking	☐
Reminders, such as on a cell phone, are needed to manage time and maintain a schedule	☐
Needs a more isolated work area to decrease auditory and visual distraction	☐
Wear earplugs or earmuffs to decrease auditory distraction	☐
Needs option to dim light to decrease visual strain, distraction, and reduce symptom triggers	☐
Needs supervision to create and maintain organization within the work environment	☐

Self-regulation	1	2	3	4	5
Interact with the general public	◯	◯	◯	◯	◯
Interact with coworkers or peers	◯	◯	◯	◯	◯
Responsive to feedback from supervisors	◯	◯	◯	◯	◯
Request assistance when needed	◯	◯	◯	◯	◯
Complete work without interruptions from psychological symptoms	◯	◯	◯	◯	◯
Adhere to basic hygiene and cleanliness standards	◯	◯	◯	◯	◯

Job modification(s) related to self-regulation (choose all that apply):

Working with the general public should not be an essential job function	☐
Direct interaction should be with a limited number of coworkers	☐
Employer performance feedback should be provided in writing at scheduled intervals	☐
Needs to work with someone to compensate for limited ability to ask for assistance	☐
Needs supervision with adhering to company hygiene/dress standards	☐

Resilience	1	2	3	4	5
Respond flexibly to changes	◯	◯	◯	◯	◯
Make and adjust plans independently	◯	◯	◯	◯	◯
Work with time pressure	◯	◯	◯	◯	◯
Manage daily work demands	◯	◯	◯	◯	◯
Maintain regular attendance	◯	◯	◯	◯	◯
Learn from adverse events	◯	◯	◯	◯	◯

Job modification(s) related to resilience (choose all that apply):

Needs check-in from supervisor to help process change in the work routine	☐
Needs check-in from supervisor to help process adverse events	☐
Working under time pressure should be limited	☐
Rest breaks are needed. Please specify:	☐
Unable to work consecutive shifts or needs alternate days off	☐
Please specify:	
Need to limit certain shifts such as day shifts, night shifts, or on-call shifts	☐
Please specify:	

Any other job modification recommendations not listed above:

Mark the appropriate <u>cognitive</u> work capability level (choose all that apply):	
Can work without job modifications	☐
Modified hours required: Can work _____ hours per day _____ days per week	☐
Requires job modifications other than modified work hours	☐
Can tolerate sheltered employment (working with someone) (*consider when most answers are 3*)	☐
Volunteering can be explored	☐
Does not have a cognitive work capability	☐
Cognitive work capability will be reassessed on date:_____	☐

Sources supporting this medical opinion (check all that apply):

Patient interview	☐
Observations during present or past visits	☐
Health care provider evaluation	☐
Administration or review of objective cognitive or psychological testing	☐
Discussion with care team or other treating provider	☐
Medical record review	☐
Review of work history	☐
Employer report of work performance	☐

Medical provider's name (print)_____ Date_____

Medical provider's signature_____

Medical provider's duration of role on care team: _____

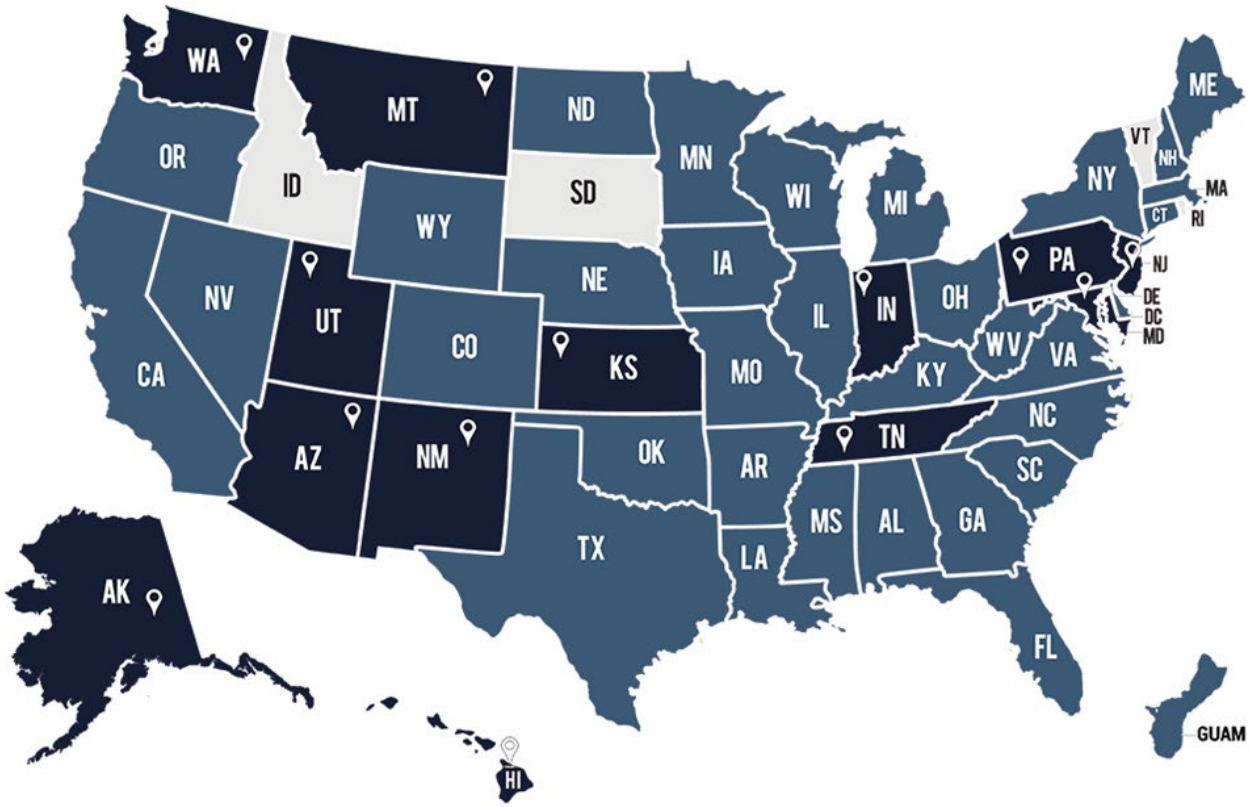
Examples of Stay at Work/Return to Work Policies in the US (this is not an exhaustive list)

Each state is unique, and stay-at-work/return-to-work interventions should take into account the specific state context. It is also important to keep in mind that the population of people at risk for or experiencing work disability is heterogenous. Employers and healthcare systems also are heterogeneous; what each needs to adopt stay-at-work and return-to-work strategies will vary and one size will not fit all. Finally, a person's ability to work can change over time. Thus, interventions also need to be adaptable and dynamic.

Examples of Stay at Work/Return to Work Policies in the US (this is not an exhaustive list)

The State Exchange on Employment and Disability Evaluation (SEED) is a part of the US Department of Labor's Office of Disability Employment Policy (ODEP). SEED assists state and local policy makers to develop meaningful policies related to the development of a disability-inclusive workforce.

This map shows states that have received SEED Policy Assistance between 2016 and 2020.



Received direct policy assistance from SEED

Work Matters Policy Action Plans Developed by the state teams

SEED works with the Council of State Governments to bring together state policy makers to address work disability. The following examples of state policies and programs were adapted from the Council of State Governments Stay-at-Work/Return-to-Work Toolkit to provide background and a framework for the work of this summit : https://seed.csg.org/wp-content/uploads/2020/06/seed_report_issuu.pdf. Many states, insurance carriers, and not-for-profit organizations also have Return-to-Work toolkits (See Appendix).

State policy frameworks designed to help workers return to work are focused in the following areas:

1) Return-to-Work Programs: Return-to-work programs provide support and services that help employees with a work-limiting health condition stay at or return to work within their medical restrictions. They can help prevent the employee from needing to leave work at all or allow the employee to return to the workforce sooner than might otherwise be possible using strategies such as modification of the worksite, work tasks, or work schedule; assistive technology or devices; and transitional or alternate work that is different than the employee's regular job.

- The Centers for Occupational Health and Education (COHE) in Washington state is an example of a comprehensive state return-to-work program for occupational injuries and illnesses. This program was the model for the national RETAIN initiative because COHE uses strategies that also are applicable to non-occupational work-limiting health conditions.

- Some states have implemented return-to-work programs specifically for state employees. Other states have implemented return-to-work programs by expanding services offered through their state vocational rehabilitation agencies.

2) Disability Benefits Programs that Support Return to Work: Many states have laws that provide partial disability benefits for employees who are making a transition back to work on a part time basis or are earning less than they did prior to their injury or illness. These programs help mitigate the association of disability benefits with disincentivizing work. These benefits are available through state workers' compensation and temporary disability programs as well as through private Short-Term Disability Insurance plans.

a. Virtually all states, including Vermont, provide partial disability benefits within their workers' compensation temporary disability programs. These programs only cover occupational injuries and illnesses.

b. California, Hawaii, New Jersey, New York, and Rhode Island have established temporary disability insurance programs that provide partial wage replacement for employees who are unable to work because of non-occupational illnesses or injuries and in connection to pregnancy.

c. The programs in California, New Jersey, and Rhode Island also allow employees to receive a reduced benefit if they are making the transition back to work or are back to work and earning less than their pre-disability income.

3) Employer Subsidies, Incentives, and Grants: States have taken different approaches to providing financial incentives for private-sector employers to invest in safely returning employees back to work after an injury or illness. These approaches include wage subsidies for employees returning to work; reimbursement, tax credits, or loans for expenses related to job accommodations or workplace modifications; grants for transitional work programs; and discounts on insurance premiums for implementing an approved return-to-work program.

a. Oregon pays wage subsidies to employers for 45% of return-to-work gross wages for up to 66 days. Oregon also has provisions to reimburse employers for the cost of workplace modifications, accommodations, and assistive technology.

b. Montana provides up to $2,000 to employees to support workplace modifications for workers with injuries

c. Texas employers may be eligible for reimbursement or advance for the cost of workplace modifications to facilitate an employee's return to work or alternative work following an injury.

d. Ohio provides employers with a bonus for using an approved transitional work plan to return employees with injuries to work. They also provide grants to help employers develop transitional work programs.

e. North Dakota includes an insurance premium exemption for its Preferred Worker Program, which provides benefits to workers with injuries, such as a work-search allowance and reimbursement for new tools and equipment.

f. Maine enacted legislation that prevents workers' compensation benefits from being reduced if the employee is actively participating in a prescribed rehabilitation plan.

g. Rhode Island's Temporary Disability Insurance program includes partial return-to-work benefits to encourage employees to return to their jobs sooner.

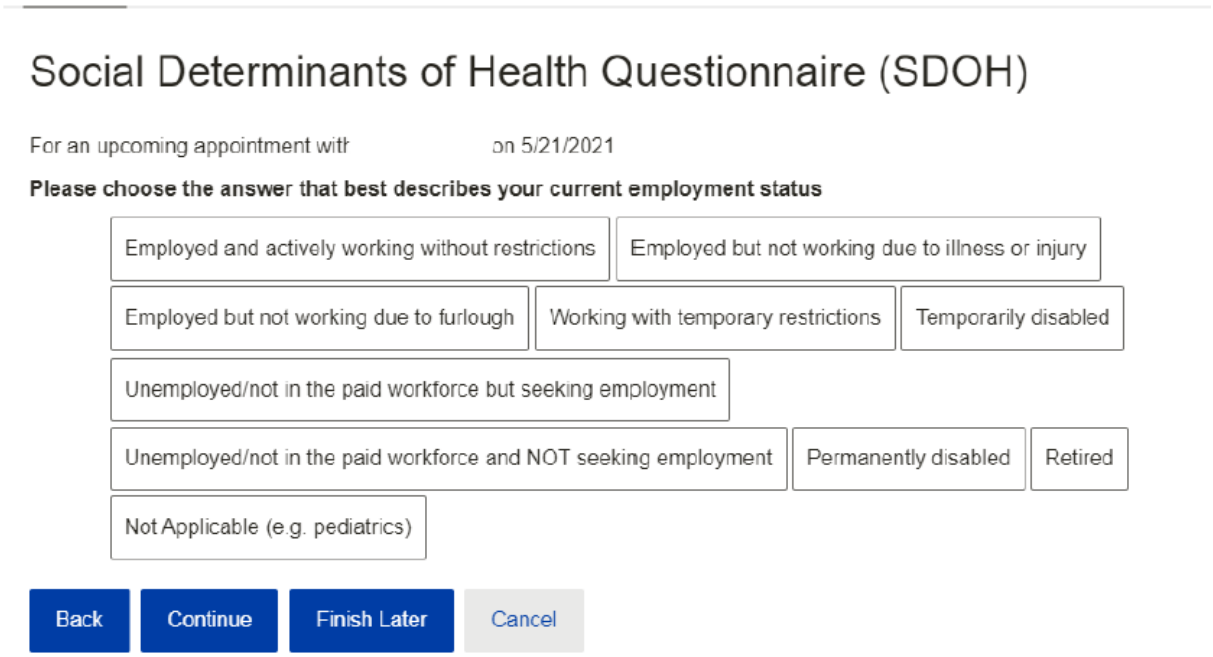
Comparison of RETAIN State Return-to-Work Programs

There are five other states with RETAIN programs: . These states are Kansas, Kentucky, Minnesota, Ohio, and Vermont. Each state developed their program independently of each other and operates independently. The following table compares some of the key features of each state's program.

	Kansas	Kentucky	Minnesota	Ohio	Vermont
State Population	2.9 million	4.5 million	5.8 million	11.8 million	647,064
Service Area	Statewide	Statewide	Statewide	3 metro areas	Statewide
Number Enrolled	927	3100	3200	4425	807
Enrolled as % of state population	0.03%	0.07%	0.06%	0.04% 0.11% of service area	0.13%
Lead grant recipient	Dept of Commerce Workforce Services (KDOC)	Dept of Workforce Investment in the Education and Workforce Development Cabinet	Dept of Employment and Economic Development (DEED)	Dept of Job and Family Services	Dept. of Labor
Healthcare Partner	The University of Kansas Health System Ascension Via Christi Stormont Vail Health	Norton Healthcare UK Healthcare U of L Health	Mayo Clinic	Bon Secours Mercy Health	State ACO 113 primary care practices
Employer Partner	Kansasworks AJC's	University of Kentucky	DEED	American Job Centers	Chamber of Commerce State EAP
Eligible Diagnoses	Any ICD-10 diagnosis impacting ability to work	ICD-10 Diagnosis; non-work related injury or illness that puts worker at risk of leaving job.	Any work-limiting mental or physical health condition including surgery	Musculoskeletal, cardio, surgeries, some mental health diagnoses	Any work-limiting mental or physical health condition

	Kansas	Kentucky	Minnesota	Ohio	Vermont
Main method for identifying clients	EMR data, provider referrals, and website self-referrals	Healthcare, employers, Office of Vocational Rehabilitation, self-referral, digital recruiting, community orgs.	Identification through healthcare lead fro EMR SDOH employment question	Identification through healthcare lead from EMR by ICD-10 codes+chart review	Self-screening at primary care clinics and in communities.
Most common diagnosis	**18% back** 14% Knee 11%UE 10% foot 5% mental health	**1. Mental Health** 2. CVA	**13% Knee Injuries** 12% Mental Health 8% Shoulder 8% Back	**1. Musculoskeletal** 2. Cardio 3. Bariatric Surgery 4. Mental Health	**41% Mental Health** 18% Other MSK 9% Back 4% Nerve Condition 4% Arthritis
Program participation incentive	Participant incentives for completing program activities. Provider incentives for completing training and program paperwork.	Participants receive a $100 gift card for completing intake interview and $50 after completing study	$100 at enrollment for all participants. $100 at completion for those in the intervention group. Free CME	$100 at enrollment for all participants	$50 for initial study forms and $50 for final study forms for worker participants; free CME for clinicians; Resilient Workplace certification for employers.
Age for eligibility	18-65 years old	18 years and older	18 years and older	18-65 years old	18 years and older
Residency requirements	Lives **or** works in KS	Lives **and** works in KY	Lives **and** works in MN	Lives, works, **or** treated in OH	Lives **or** works in VT
Employment status	Employed or active in the labor force	Employed in the last year	Employed or active in the labor force	Employed or active in the labor force	Employed or looking for a job

	Kansas	Kentucky	Minnesota	Ohio	Vermont
Injury or illness type	Injury or illness impacting employment	Non-work related injury, illness, or impairment	Injury or illness impacting employment (and no QRC or DCM if WC)	Injury or illness impacting ability to work (no WC claimants)	Injury or illness impacting employment
Injury or illness time frame	New or worsening condition in past 12 weeks (80%)	New or worsening condition in past 12 weeks	Worked at least one day in the past 3 months (80%)	New or worsening condition in past 3 months	New or worsening condition in past 6 months
Enrollment exceptions	Onset of work disability more than 12 wks (≤20%)		Onset of work disability within past 6 months (≤20%)	Supportive services funds (rent or utilities) after pay reduction for 2+ weeks	Out of work no more than 12 weeks (80%)
Enrollment restrictions			No legal representation/ litigation related to the medical condition at enrollment	Must agree to program staff contacting employer to discuss condition & return-to-work strategy	No untreated substance use disorder
SSI and SSDI status	No current SSI or SSDI benefits or pending application	No current SSDI benefits or submitted application	No current SSDI benefits or submitted application	No current SSDI benefits or submitted application	No current SSDI benefits or submitted application



This is the Minnesota RETAIN (Mayo clinic) Social Determinants of Health questionnaire employment question (Smart Phone and Web view).

mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Health Equity Services in the 2024 Physician Fee Schedule Final Rule

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

Table of Contents

We define health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes."

Our framework for health equity lists 5 priorities for reducing disparities in health. Each priority reflects a key area in which people from underserved and disadvantaged communities ask us to take action to advance health equity. The 5 health equity priorities are:

1. Expand the collection, reporting, and analysis of standardized data
2. Assess causes of disparities within our programs and address inequities in policies and operations to close gaps
3. Build capacity of health care organizations and the workforce to reduce health and health care disparities
4. Advance language access, health literacy, and the provision of culturally tailored services
5. Increase all forms of accessibility to health care services and coverage

Together we can advance health equity and help eliminate health disparities in rural communities, territories, Tribal nations, and geographically isolated communities. Find these resources and more from the CMS Office of Minority Health:

- Rural Health
- CMS Framework for Rural, Tribal, and Geographically Isolated Areas
- Data Stratified by Geography (Rural/Urban)
- Health Equity Technical Assistance Program

The 2024 Physician Fee Schedule (PFS) Final Rule has 4 services to help further address these priorities. These are:

Caregiver Training Services (CTS)

We created new coding to make payment when practitioners train and involve 1 or more caregivers to help patients carry out a treatment plan for certain diseases or illnesses, like dementia. For caregiver training services, we define a "caregiver" as "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation" and "a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition."

We'll pay for CTS when a physician or a non-physician practitioner (NPP) provides this training. NPPs include:

- Nurse practitioners
- Clinical nurse specialists (CNSs)
- Certified nurse-midwives (CNMs)
- Physician assistants (PAs)
- Clinical psychologists
- Therapists, including physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs)

We'll pay for CTS for patients under an individualized treatment plan or therapy plan of care, without the patient present. Use these CPT codes for CTS starting January 1, 2024:

- **96202:** Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes
- **96203:** Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service)
- **97550:** Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes
- **97551:** Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use 97551 in conjunction with 97550)
- **97552:** Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers

To bill for CTS, you should select the appropriate group codes, like CPT codes 96202, 96203, or 97552 or individual codes like CPT codes 97550 or 97551, based on the number of patients represented by caregivers receiving training. If multiple caregivers for the same patient are trained in a group, you won't bill individually for each caregiver. Where more than 1 patient's caregivers are trained at the same time, you must bill under the group code for each patient represented, regardless of the number of caregivers. The patient's or representative's consent is required for the caregiver to get CTS, and you must document this in the patient's medical record.

Social Determinants of Health Risk (SDOH) Assessment

We finalized a new stand-alone G code, G0136, to pay for administering an SDOH risk assessment, no more than once every 6 months:

G0136: Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every 6 months.

You may provide this service with:

- An evaluation and management (E/M) visit, which can include hospital discharge or transitional care management services
- Behavioral health office visits, such as psychiatric diagnostic evaluation and health behavior assessment and intervention
- The Annual Wellness Visit (AWV)

SDOH risk assessments that you furnish as part of an E/M or behavioral health visit isn't a screening. It may be medically reasonable and necessary as part of a comprehensive social history, when you have reason to believe there are unmet SDOH needs that are interfering with the practitioner's diagnosis and treatment of a condition or illness or will influence choice of treatment plan or plan of care. In these circumstances, patient cost sharing will apply, just as it does for any medical service. The risk assessment wouldn't usually be administered in advance of the visit.

Example: A patient who hasn't been seen recently requests an appointment at a specific time or on a specific date due to limited availability of transportation to or from the visit, or requests a refill of refrigerated medication that went bad when the electricity was terminated at their home. If the patient hasn't gotten an SDOH risk assessment in the past 6 months, you could have the patient fill out an SDOH risk assessment 7–10 days in advance of an appointment as part of intake to ensure that you have enough information to appropriately treat them. You may also furnish SDOH risk assessments as an optional element of the AWV, in which case it's a preventive service and cost sharing won't apply.

SDOH risk assessment refers to a review of the individual's SDOH needs or identified social risk factors influencing the diagnosis and treatment of medical conditions. Use a standardized, evidence-based SDOH risk assessment tool to assess for:

- Housing insecurity
- Food insecurity
- Transportation needs
- Utility difficulty

You may choose a tool or ask additional questions that also include other areas if prevalent or culturally important to your patient population. Some tools you may consider that are standardized and evidence-based include the CMS Accountable Health Communities Tool, Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE), and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment.

Note: G0136 is also added to telehealth services on a permanent basis.

Community Health Integration (CHI)

We created 2 new service codes describing CHI services that auxiliary personnel, including community health workers (CHWs), may perform incidental to the professional services of a physician or other billing practitioner, under general supervision. The billing practitioner initiates CHI services during an initiating visit where the practitioner identifies unmet SDOH needs that significantly limit their ability to diagnose or treat the patient. The same practitioner bills for the subsequent CHI services provided by the auxiliary personnel. Initiating visits are personally performed by the practitioner, and include:

- An E/M visit
  - Can't be a low-level (level 1) E/M visit performed by clinical staff
  - Can be the E/M visit provided as part of Transitional Care Management (TCM) services
- An Annual Wellness Visit (AWV)

You must see a patient for a CHI initiating visit prior to furnishing and billing CHI services. We created CHI service codes for auxiliary personnel, including community health workers, to provide tailored support and system navigation to help address unmet social needs that significantly limit a practitioner's ability to carry out a medically necessary treatment plan. CHI services include items like:

- Person-centered planning
- Health system navigation
- Facilitating access to community-based resources
- Practitioner, home and community-based care coordination
- Patient self-advocacy promotion

You may provide CHI services following an initiating visit where you identify unmet SDOH needs that significantly limit your ability to diagnose or treat the patient. During this visit you'll establish the treatment plan, specify how addressing the unmet SDOH needs would help accomplish that plan, and establish the CHI services as incidental to your professional services. Auxiliary personnel can perform the subsequent CHI services.

Since there isn't a Medicare benefit for paying community health workers and other auxiliary personnel directly, we'll pay their services as incidental to the services of the health care practitioner who directly bills Medicare. See 42 CFR 410.26 and 42 CFR 410.27 for more information. The auxiliary personnel may be external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs or other auxiliary personnel, if they meet all "incident to" requirements and conditions for payment of CHI services.

Auxiliary personnel must meet applicable state requirements, including licensure. In states with no applicable requirements, auxiliary personnel must be certified and trained in the following competencies:

- Patient and family communication
- Interpersonal and relationship-building skills
- Patient and family capacity building
- Service coordination and systems navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Development of an appropriate knowledge base, including of local community-based resources

You or the auxiliary personnel under supervision must get advance patient consent before furnishing CHI services. Consent can be written or verbal, so long as you document it in the patient's medical record. As part of consent, you must explain to the patient that cost sharing applies and that only 1 practitioner may furnish and bill the services in each month. You don't need to get consent again unless the practitioner furnishing and billing CHI changes.

Only 1 practitioner can bill for CHI services per month. This helps ensure a single point of contact for addressing social needs that may span other health care needs. It helps to avoid a fragmented approach and duplicative services.

We currently make separate payment under the PFS for a number of care management and other services that may include aspects of CHI services. Those care management services focus heavily on clinical, rather than social, aspects of care. You can furnish CHI services in addition to other care management services if you:

- Don't count time and effort more than once
- Meet requirements to bill the other care management services
- Perform services that are medically reasonable and necessary

You must document the patient's unmet social needs that CHI services are addressing in the medical record. Documenting ICD-10 Z-codes can count as the appropriate documentation. You can bill CHI services monthly as medically reasonable and necessary, billing for the first 60 minutes of CHI services (G0019) and then each additional 30 minutes thereafter (G0022). Also document the amount of time spent with the patient and the nature of the activities.

You don't necessarily need to perform these services in-person. We expect you to perform them using a combination of in-person and virtual via audio-video or via two-way audio since evidence shows that there should be some in-person interaction.

The new G codes for CHI:

- **G0019** – Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that significantly limit the ability to diagnose or treat problem(s) addressed in an initiating visit:
  - Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit
    - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that aren't separately billed)
    - Facilitating patient-driven goal-setting and establishing an action plan
    - Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan
  - Practitioner, home-, and community-based care coordination
    - Coordinating receipt of needed services from health care practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable)
    - Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
    - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities
    - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s)
  - Health education – helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of SDOH need(s), and educating the patient on how to best participate in medical decision-making
  - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment
  - Health care access/health system navigation
    - Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them

  - Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals
  - Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals
  - Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

- **G0022** – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019)

Note: Certain types of E/M visits, such as inpatient and observation visits, emergency department (ED) visits, and skilled nursing facility (SNF) visits, wouldn't serve as CHI initiating visits because the practitioners providing the E/M visit wouldn't typically be the one providing continuing care to the patient, including providing necessary CHI services in the subsequent months.

Principal Illness Navigation (PIN)

We created 4 new service codes describing PIN services that auxiliary personnel, including care navigators or peer support specialists, may perform incidental to the professional services of a physician or other billing practitioner, under general supervision. Two codes describe PIN services, and 2 codes describe Principal Illness Navigation-Peer Support (PIN-PS) services, which are intended more for patients with high-risk behavioral health conditions and have slightly different service elements that better describe the scope of practice of peer support specialists. In general, where we describe aspects of PIN, it also applies to PIN-PS unless otherwise specified.

The billing practitioner initiates PIN services during an initiating visit addressing a serious high-risk condition, illness, or disease, with these characteristics:

- 1 serious, high-risk condition and for PIN-PS, a serious, high-risk *behavioral health* condition expected to last at least 3 months that places the patient at significant risk of:
  - Hospitalization
  - Nursing home placement
  - Acute exacerbation or decompensation
  - Functional decline or death
- A condition that requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver

Examples of a serious, high-risk condition, illness, or disease include:

- Cancer
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Dementia
- HIV/AIDS
- Severe mental illness
- Substance use disorder

A health care practitioner initiates PIN services during an initiating visit where they identify the medical necessity of PIN services and establish an appropriate treatment plan. The same practitioner bills for the subsequent PIN services that auxiliary personnel provide. The billing practitioner personally performs initiating visits including:

- E/M visit, other than a low-level E/M visit done by clinical staff
- A Medicare AVW provided by a practitioner who meets the requirements to furnish subsequent PIN services
- CPT code 90791 (Psychiatric diagnostic evaluation) or the Health Behavior Assessment and Intervention (HBAI) services that CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168 describe

You must see a patient for a PIN initiating visit before furnishing and billing PIN services. We created PIN services for auxiliary personnel like patient navigators and peer support specialists to provide navigation in the treatment of a serious, high-risk condition or illness. These services help guide the patient through their course of care, including addressing any unmet social needs that significantly limit the practitioner's ability to diagnose or treat the condition. PIN services include items like:

- Health system navigation
- Person-centered planning
- Identifying or referring patient and caregiver or family, if applicable, to supportive services
- Practitioner, home, and community-based care coordination or communication
- Patient self-advocacy promotion
- Community-based resources access facilitation

The billing practitioner or auxiliary personnel may provide PIN services following an initiating visit where the billing practitioner addresses the serious, high-risk condition. During this initiating visit, the billing practitioner will establish the treatment plan, specify how PIN services are reasonable and necessary to help accomplish that plan, and establish the PIN services as incidental to their professional services. Auxiliary personnel can perform the subsequent PIN services.

Since there isn't a Medicare benefit for paying navigators and peer support specialists directly, we'll pay for their services as incidental to the services of the health care practitioner who directly bills Medicare. The auxiliary personnel may be external to, and under contract with, the practitioner or their practice, such as

through a CBO that employs navigators, peer support specialists or other auxiliary personnel, if they meet all "incident to" requirements and conditions for payment of PIN services.

Auxiliary personnel must meet applicable state requirements, including licensure. In states with no applicable requirements, auxiliary personnel providing PIN services must be trained or certified in the competencies of:

- Patient and family communication
- Interpersonal and relationship-building
- Patient and family capacity building
- Service coordination and systems navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Developing an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease being addressed

For PIN-PS services (HCPCS codes G0140 and G0146), if no applicable state requirements exist, the training must be consistent with the National Model Standards for Peer Support Certification published by Substance Abuse Mental Health Services Administration (SAMHSA). This is the most universally recognized standard for peer support specialists in the country and was developed and is maintained by SAMHSA, who has an expertise in this area.

The billing practitioner or the auxiliary personnel under supervision must get advance patient consent before providing PIN services, and annually thereafter. Consent can be written or verbal, so long as you document it in the patient's medical record. Explain to the patient that cost sharing will apply.

The billing practitioner can't furnish PIN services more than once per practitioner per month for any single serious high-risk condition. This avoids duplication of PIN service elements when utilizing the same navigator or billing practitioner. Don't bill PIN and PIN-PS services concurrently for the same serious, high-risk condition.

We currently make separate payment under the PFS for a number of care management and other services that may include aspects of navigation services. Those care management services focus heavily on clinical, rather than social, aspects of care. You can furnish PIN services in addition to other care management services if you:

- Don't count time and effort more than once
- Meet requirements to bill the other care management services
- Perform services that are medically reasonable and necessary

In the medical record, document the amount of time the auxiliary personnel spent with the patient and the nature of the activities. Document any unmet social needs that PIN services are addressing. Documenting ICD-10 Z-codes can count as the appropriate documentation.

The billing practitioner or auxiliary personnel don't necessarily need to perform these services in-person. We expect that many service elements will involve direct patient contact, especially for PIN-PS services, and may be most impactful when provided in-person.

We finalized the following PIN service codes:

- **G0023:** Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:
  - Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition
    - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that aren't separately billed)
    - Facilitating patient-driven goal setting and establishing an action plan
    - Providing tailored support as needed to accomplish the practitioner's treatment plan
  - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
  - Practitioner, home- and community-based care communication
    - Coordinating receipt of needed services from health care practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable)
    - Communicating with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
    - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities
    - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
  - Health education - helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making
  - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition
  - Health care access/health system navigation
    - Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them
    - Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable

  - Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals
  - Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals
  - Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

- **G0024:** Principal illness navigation services, additional 30 minutes per calendar month (List separately in addition to G0023)
- **G0140:** Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:
  - Person-centered interview, performed to better understand the individual context of the serious, high-risk condition
    - Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that aren't billed separately)
    - Facilitating patient-driven goal setting and establishing an action plan
    - Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan
  - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
  - Practitioner, home, and community-based care communication
    - Assisting the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors
    - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
  - Health education
    - Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making

- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition
- Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals
- Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals
- Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

- **G0146:** Principal illness navigation - peer support, additional 30 minutes per calendar month (List separately in addition to G0140)

Note: Certain types of E/M visits, like inpatient and observation visits, ED visits, and SNF visits wouldn't serve as PIN initiating visits because the practitioner providing the E/M visit wouldn't typically provide continuing care to the patient, including providing necessary PIN services in subsequent months.

Resources:

- Caregiver Training Services in 2024 PFS final rule
- CMS Health Equity
- Community Health Integration in 2024 PFS final rule
- Health Equity Fact Sheet
- Principal Illness Navigation in 2024 PFS final rule
- SDOH Risk Assessment in 2024 PFS final rule

The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper,[2] we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

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[1] United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm.

[2] Billioux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 1-9. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf.

- Interpersonal safety

In the final version below, we made small revisions to the original 10 questions based on cognitive testing we did since we shared the first version. In the final version we also included questions in 8 supplemental domains that we haven't shared before:

- Financial strain
- Employment
- Family and community support
- Education
- Physical activity
- Substance use
- Mental health
- Disabilities

Who should use the AHC HRSN Screening Tool?

The questions in the AHC HRSN Screening Tool are meant to be used for individual respondents who answer the questions themselves. A parent or caregiver can answer for an individual, too, if that makes more sense. Clinicians and their staff can easily use this short tool as part of their busy clinical workflows with people of all different ages, backgrounds, and settings.

In the next 5 years, hundreds of participating clinical delivery sites across the 32 AHCs will screen over 7 million Medicare and Medicaid beneficiaries using the 10 core domain questions. The AHCs can also choose to add any of the supplemental domain questions into their standard screening processes.

Who made the AHC HRSN Screening Tool?

We made this tool with a panel of experts from around the country including:

- Tool developers
- Public health and clinical researchers
- Clinicians
- Population health and health systems executives
- Community-based organization leaders
- Federal partners

We got permission from the original authors of the questions to use, copy, modify, publish, and distribute the questions for the AHC Model and our use only. Based on feedback from the original question authors, CMS has created this table to specify the citation and notification process for each screening question in the AHC HRSN Screening Tool if the questions are used outside of CMS and the AHC Model.

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

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[3] National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

[4] Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.

[5] Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Transportation

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**[6]
   - ☐ Yes
   - ☐ No

Utilities

6. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**[7]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. [8]

7. **How often does anyone, including family and friends, physically hurt you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

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[6] National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

[7] Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., . . . Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. doi:10.1542/peds.2008-0286

[8] Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. Family Medicine, 30(7), 508-512

8. **How often does anyone, including family and friends, insult or talk down to you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

9. **How often does anyone, including family and friends, threaten you with harm?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

10. **How often does anyone, including family and friends, scream or curse at you?**
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

A score of 11 or more when the numerical values for answers to questions 7-10 are added shows that the person might not be safe.

AHC HRSN Screening Tool Supplemental Questions

Financial Strain

11. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:[9],

- ☐ Very hard
- ☐ Somewhat hard
- ☐ Not hard at all

Employment

12. Do you want help finding or keeping work or a job?[10]

- ☐ Yes, help finding work
- ☐ Yes, help keeping work
- ☐ I do not need or want help

Family and Community Support

13. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?[11]

- ☐ I don't need any help
- ☐ I get all the help I need
- ☐ I could use a little more help
- ☐ I need a lot more help

14. How often do you feel lonely or isolated from those around you?[12]

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

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9 Hall, M. H., Matthews, K. A., Kravitz, H. M., Gold, E. B., Buysse, D. J., Bromberger, J. T., . . . Sowers, M. (2009). Race and Financial Strain are Independent Correlates of Sleep in Midlife Women: The SWAN Sleep Study. Sleep, 32(1), 73-82. doi:10.5665/sleep/32.1.73

10 Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July) Technical Expert Panel discussion conducted at the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

11 Kaiser Permanente. (2012, June). Medicare Total Health Assessment Questionnaire. Retrieved from https://mydoctor.kaiserpermanente.org/ncal/Images/Medicare%20Total%20Health%20Assessment%20Questionnaire_tcm75-487922.pdf

12 Anderson, G. Oscar and Colette E. Thayer. Loneliness and Social Connections: A National Survey of Adults 45 and Older. Washington, DC: AARP Research, September 2018. https://doi.org/10.26419/res.00246.001

Education

15. Do you speak a language other than English at home?[13]

- ☐ Yes
- ☐ No

16. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.[14]

- ☐ Yes
- ☐ No

Physical Activity

17. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?[15]

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7

18. On average, how many minutes did you usually spend exercising at this level on one of those days?[16]

- ☐ 0
- ☐ 10
- ☐ 20
- ☐ 30
- ☐ 40
- ☐ 50
- ☐ 60

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[13] United States, US Census Bureau. (2017). American Community Survey. Retrieved from https://www.census.gov/programs-surveys/acs/

[14] Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July) Technical Expert Panel discussion conducted at the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

[15] Coleman, K. J., Ngor, E., Reynolds, K., Quinn, V. P., Koebnick, C., Young, D. R., . . . Sallis, R. E. (2012). Initial Validation of an Exercise "Vital Sign" in Electronic Medical Records. Medicine and Science in Sport and Exercise, 44(11), 2071-2076. doi:10.1249/MSS.0b013e3182630ec1

[16] Ibid

☐ 90
☐ 120
☐ 150 or greater

Follow these 2 steps to decide if the person has a physical activity need:

1. Calculate ["number of days" selected] x ["number of minutes" selected] = [number of minutes of exercise per week]
2. Apply the right age threshold:
   - Under 6 years old: You can't find the physical activity need for people under 6.
   - Age 6 to 17: Less than an average of 60 minutes a day shows an HRSN.
   - Age 18 or older: Less than 150 minutes a week shows an HRSN.

Substance Use

The next questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if you have taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order to identify community services that may be available to help you. [17]

19. How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

☐ Never
☐ Once or Twice
☐ Monthly
☐ Weekly
☐ Daily or Almost Daily

20. How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes)?

☐ Never
☐ Once or Twice
☐ Monthly
☐ Weekly
☐ Daily or Almost Daily

[17] United States, U.S. Department of Health and Human Services, National Institutes of Health. (n.d.). Helping Patients Who Drink Too Much: A Clinician's Guide (2005 ed., pp. 1-34).

21. How many times in the past year have you used prescription drugs for non-medical reasons?

- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

22. How many times in the past year have you used illegal drugs?

- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Mental Health

23. Over the past 2 weeks, how often have you been bothered by any of the following problems?[18]

a. Little interest or pleasure in doing things?

- ☐ Not at all (0)
- ☐ Several days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

b. Feeling down, depressed, or hopeless?

- ☐ Not at all (0)
- ☐ Several days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

If you get 3 or more when you add the answers to questions 23a and 23b the person may have a mental health need.

[18] Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. Medical Care, 41(11), 1284-1292.

24. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?[19]

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

Disabilities

25. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?[20] (5 years old or older)

- ☐ Yes
- ☐ No

26. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?[21] (15 years old or older)

- ☐ Yes
- ☐ No

[19] Elo, A.L., Leppänen, A., & Jahkola, A. (2003). Validity of a Single-Item Measure of Stress Symptoms. Scandinavian Journal of Work, 29(6), 444-451.
[20] United States, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (n.d.). (2011). Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status. Retrieved from https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status
[21] Ibid.

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Vermont Work Disability Summit: Participant Workbook (2023). Montpelier, VT: Vermont Department of Labor, Vermont RETAIN.