Oregon Healthcare Workforce Committee

AGENDA

June 24, 2010

Wilsonville Training Center, Room 111-112
29353 SW Town Center Loop E Wilsonville, Oregon 97070
1 – 4 pm

#	Time	Item and related material	Presenter(s)	Action Item
1	1:00	Welcome	Chairs	
2	1:05	Approval of May 26 meeting summary	Chairs	X
3	1:10	Update on Health Policy Board & other Board Committee activities	Sean Kolmer Lisa Angus	
4	1:15	Committee priority selection ▪ Draft priorities document	Chairs	X
5	2:15	Break		
6	2:30	Building a culturally competent and diverse workforce Tricia Tillman, Office of Multicultural Health and Services, OHA ▪ OMHS cultural competency legislative concept Gerardo Ochoa, Linfield College Kristen Wall, OHSU and Keith Walters, PSU	As noted at left	
7	3:30	Guiding questions for analysis of Oregon's healthcare workforce database	Committee workgroup Jo Isgrigg	
8	3:40	Committee feedback on Oregon Academy of Family Practice 2011 legislative package ▪ Summary of legislative package	Committee volunteer reviewers	
9	3:50	Public comment	Chairs	
10	4:00	Adjourn		

Next meeting: Wednesday July 21, 1 – 4 PM, Wilsonville Training Center

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Oregon Healthcare Workforce Committee
Meeting Summary

May 26, 2010
9 a.m. – noon

Committee Members in Attendance
John Moorhead (Chair)
Ann Malosh (Vice-Chair)
Peter Angstadt
Lita Colligan
Lisa Dodson (phone)
Sara Hopkins-Powell
Terri Johanson
Kelly Morgan (phone)
Marcus Mundy
David Nardone
David Pollack
Daniel Saucy
Kristin Simmons
Jennifer Valentine

OHPR and OWHI Staff in Attendance
Jo Isgrigg (OHWI)
Jennifer Swendsen (OHWI)
Sean Kolmer (OHPR)
Lisa Angus (OHPR)

Committee Members not in Attendance
Bonnie Bender
June Chrisman
Kris Campbell
Paula Crone
Dan Lange
Donna Larson
Mark Richardson
Karen Sanders
Kathyleen Tomlin
Judith Woodruff

Public Comment
Members of the general public who were present did not offer comment.

Meeting Summary (**Committee actions or decisions in bold**)

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The meeting was convened at 9:05am by Dr. Moorhead.

Ann Malosh reported on that the House Business and Labor Subcommittee on Workforce Development had asked for an update on this Committee's activities and that she and Sean Kolmer had given a brief presentation on May 24th. Of note, members of the Subcommittee:

- Explained that the legislative motivation for creating the Workforce Committee was that the Committee would help implement the strategic goals of the Health Policy Board through transformation of the workforce. The Committee's work should address not only the size of the workforce but also what it might look like in 10 or 15 years.
- Stressed that the Workforce Committee should be looking at the federal reform bill for opportunities to bring workforce funding to Oregon and should let the legislative Subcommittee know if it might play a supportive role.
- Requested that they be kept informed of the Committee's priorities and activities as they develop, so that they can be prepared to move work forward as appropriate.

Minutes from the April 29th meeting were approved.

Sean Kolmer and Lisa Angus gave a brief update on activities of the Health Policy Board and its committees, as well as the Oregon Health Authority (OHA). The Health Policy Board is moving into a new phase of work where it is beginning to consider and adopt first-stage recommendations from committees and workgroups – the Administrative Simplification workgroup's recommendations will be on the agenda for the June Board meeting. Like other state agencies, OHA needs to cut 9% from its budget for the current biennium and will likely need to make reductions for the next biennium was well.

Committee members reviewed a draft process for responding to external requests for review and feedback. **Committee members approved the process**, with the suggestion that a set of standard information be collected from each entity requesting review/feedback, so the requests can be tracked. A few members volunteered to review a package of legislative proposals from the Oregon Academy of Family Practice.

John Moorhead shared several news items or comments on the Committee's work that he had received:

- An op-ed by Thomas Aschenbrener titled *The Nurse in Your Health Care Future,* published in the May 24th Oregonian
- Some comments on the Committee's developmental strategic recommendations from Susan King, chair of the Oregon Board of Nursing, who attended the April 29 Committee meeting as a member of the public
- Comments on the Committee's developmental strategic recommendations from Joe Robertson, President of OHSU and the Committee's liaison on the Health Policy Board. Dr. Robertson's suggestions to the Committee included:

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    - Prioritize the strategic recommendations, perhaps by identifying which strategies require legislative funding, which legislative approval (but not funding), and which strategies can get started without legislative approval
    - In terms of legislative funding priorities, two stand out: the primary care services loan program created—but not funded—in the short 2010 short legislative session and the GME Consortium to train medical graduates in the regional communities where they are needed.

Dr. Moorhead also mentioned that he had had a conversation with Senator Wyden in which the Senator wondered if there would be some way for employers in Oregon to collaborate on recruiting healthcare workers to the state, to make the most efficient use of resources. The Senator offered to have one of this staff work with the Committee on this idea.

The Committee turned to the task of prioritizing strategic recommendations. Suggestions and comments made during this discussion included:

- The Committee should identify the things it is trying to impact (e.g. care delivery model) and then make 1 or 2 key policy recommendations in each area.
- Although the Committee wants to concentrate on things it can accomplish now, it should include important longer-term recommendations in its strategic plan.
- The Committee should encourage training models that support diversity.
- The Committee may want to align its short-term objectives with the stated priorities of the National Healthcare Workforce Commission that will be created this fall, namely:
    - Integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care professionals across disciplines.
    - An analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace.
    - An analysis of how to align Medicare and Medicaid graduate medical education policies with national workforce goals.
    - An analysis of, and recommendations for, eliminating the barriers to entering and staying in primary care, including provider compensation.
    - The education and training capacity, projected demands, and integration with the health care delivery system of each of the following workforces: nursing, oral health, mental & behavioral health, allied and public health, and EMS; and the geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.

Key themes that emerged from this discussion were:

- Integration of and collaboration on healthcare workforce development are essential – creating an environment that is coordinated, rather than competitive, will be necessary to achieve results.
- Healthcare workforce training, certification, recruitment, and retention (including practice support, reimbursement, etc.) should support professionals to work in emerging models of integrated, flexible, team-based care delivery.

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Committee staff will provide a tentative summary of priorities for Committee to review before its next meeting. Dr. Moorhead also challenged Committee members to come up with one recommendation for action to be taken in the next year that will help prepare Oregon's workforce for the anticipated increase in demand for healthcare, while recognizing the Committee's commitment to the emerging models of integrated care delivery. Members were asked to send this recommendation to Committee staff by June 2.

Jennifer Swendsen and Jo Isgrigg gave an overview of an almost-final inventory of current grants, resources, and investments (beyond state appropriations) in Oregon's healthcare workforce. More than 50 educational institutions, healthcare providers, associations, foundations, and workforce organizations provided details about their current activities and investments. In addition, the inventory lists:

- all health professional educational programs at public, private and proprietary educational institutions in the state;
- all public high schools with health science career programs;
- workforce development funding opportunities contained in the Patient Protection and Affordable Care Act.

Committee members approved the inventory, with the request that any last updates or corrections be sent to OHWI as soon as possible, so the inventory could be forwarded to the Health Policy Board in a timely manner.

Discussion of recommended next steps for the workforce database created by HB 2009 was postponed until the June meeting. A few members volunteered to work with staff between meetings to identify the kinds of analyses that would be most useful to the Committee and make suggestions for future database expansions.

Dr. Moorhead adjourned the meeting at 12 noon.

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OREGON HEALTH CARE WORKFORCE COMMITTEE
DRAFT Priorities and Short-Term Strategic Recommendations
June 2010

Established by House Bill 2009, Section 7 (3)(a), the Health Care Workforce Committee is chartered to coordinate efforts in Oregon to meet the demand for health care created by the expansion in health insurance coverage, system transformation and an increasingly diverse population. The Health Care Workforce Committee's role is to advise and develop recommendations and action plans for the Oregon Health Policy Board to guide efforts to train, recruit and retain a changing health care workforce to meet the needs of new systems of care.

Guided by Oregon's Triple Aim, the Committee recognizes the following principles for its work:

1. Build on collaborative and innovative partnerships within and across sectors (education, industry, government);
2. Value diversity in students, faculty and the workforce;
3. Maximize the efficient use of resources;
4. Promote the continuation and expansion of successful health profession education initiatives.

The Committee has identified three interrelated short-term priorities and related initial steps to build and transform Oregon's health care workforce:

PRIORITY 1: Prepare health care professionals to support system transformation via emerging models of integrated, team-based care delivery (e.g. primary care homes).

Recommendation: Fund a component of any delivery system redesign effort (e.g. primary care home pilot projects) to understand the workforce-related implications:

- Identify the functions, roles, skills, expertise, and knowledge needed for cross-disciplinary teams and care management/coordination;
- Inform the development of curricula for cross-disciplinary training and care management.

PRIORITY 2: Build the size and capacity of the health care workforce, particularly primary care, to help meet the anticipated increase in demand for health care services.

Recommendation: Fund the state's primary care practitioner loan repayment program.

Recommendation: Explore interests in and barriers to cooperative health care professional recruitment efforts for Oregon's rural and underserved communities to make the best use of finite resources for recruitment.

Priority 3: Strengthen the health care workforce pipeline to ensure that Oregon has enough health care workers with the right training in the right places.

Recommendation: Do not cut funding for health professions education (including innovative and cross-disciplinary education models, distance learning, etc.).

Recommendation: Remove the state's adverse impact policy that impedes the development of new health profession educational programs to address state and community health workforce needs.

Recommendation: Create standard, uniform student clinical training requirements (e.g. HIPAA training, CPR training, background checks, TB tests) across all Oregon clinical training sites and health profession education programs to increase clinical training opportunities, reduce waste of educational resources and decrease clinical training site/provider costs.

LC # OMHS-01 FIS? $yes	**Describe the Problem:** Culturally and linguistically appropriate services (CLAS) standards ensure health services that are respectful of and responsive to cultural and linguistic needs. Cultural sensitivity is the ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that have shared a common and distinctive racial, national, religious, linguistic, or cultural heritage. CLAS can decrease health care costs. A Kaiser Family Foundation study found language barriers can cause doctors to rely on extensive, costly, and unnecessary tests causing treatment to take 25 to 50 percent longer than treatment for English speaking patients. The Federal Office of Management and Budget's language services cost-benefit report discussed the benefits of language services, including improving provider–patient communication, thus increasing the rate of accurate diagnosis and patient compliance, and decreasing medical costs by decreasing unnecessary emergency room visits. **Proposed Solutions:** 1) Require providers (nurses, dentists, nurse practitioners, physician assistants, social workers, and alcohol and drug counselors) to receive cultural competency training prior to receiving, and as a condition of renewal, of state license. Identifies the necessary components of cultural competence such as: assuring knowledge of historical factors influencing cultural health beliefs and norms, culturally competent service delivery practices, cross-cultural communication techniques, and disparate risks relating to race, ethnicity, and socioeconomic status. Washington State ESB 6194 (see attached): Multi-cultural health is defined. The Department of Health is required to establish an ongoing multi-cultural health awareness and education program. Disciplining authorities that offer continuing education may provide multi-cultural health training. Education programs for health care professions are required to integrate instruction in multicultural health into the basic education preparation curriculum… Source:; McDonough, Gibbs, et al. "A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities," Commonwealth Fund, 2004
OMHS-02 FIS? $yes	**Describe the Problem:** The Institute of Medicine report on disparities in health care demonstrated that "[r]acial concordance of patient and provider is associated with greater participation in care processes, higher patient satisfaction, and greater adherence to treatment." The State of Oregon is underrepresented in representation of health care professionals of color. As it is documented that health care professionals of color are more likely to practice primary care in medically underserved areas, this workforce deficit contributes to a lack of access to care in communities experiencing health disparities.

Proposed Solution:

1) Replicate California's educational code section 92655.1 which encourages health professional education institutions receiving State of Oregon funding to report to the state legislature (and the Oregon Health Authority, and the Office of Multicultural Health and Services), to the extent feasible using existing or new resources, regarding efforts to recruit students to schools of medicine, nursing, dentistry, optometry, and allied health from communities and populations that are underserved. Requires the Office of Multicultural Health and Services to produce an annual report for general distribution of the opportunities available to Oregon's diverse populations for health professional education, as well as on the effectiveness of these programs in recruiting, retaining, and graduating health care professionals from underrepresented communities.

2) Replicate California's Education Code Section 92720-92726 which established the Community-Based Health Professions Education Partnership Program which expands provider coursework and practical training to assure providers understand the social, cultural, economic, environmental and educational contributors to health and disease in low income communities and communities of color. The program expands learning experiences beyond clinics and hospitals, to community based settings thereby encouraging learning experiences in health education, human services, and community involvement in order to develop a more complete understanding of entrenched community health problems, including teen pregnancy, substance abuse, and domestic violence. Benefits of the program include increasing the number of medical students who enter residencies in primary care and increasing the number of health professionals who practice primary care in low-income communities and medically underserved areas.

Health care training programs are requested to develop internship for credit for undergraduate students and clinical experience with participation in community based organizations in low income or medically underserved areas and/or on multidisciplinary teams that include other health, education and human services professionals charged with identifying and addressing community health problems. Programs should have culturally appropriate governance, staff, and services to support student and community success.

Universities establishing a Community-Based Health Professions Education Partnership Program should track and report all of the following factors:

- % of health care professionals providing primary care services in low-income communities or medically underserved areas.
- The rate of nurse practitioners and physician assistants who, after training, are employed in primary care practice or low income communities or medically underserved areas.
- Whether the program has resulted in an increase in the rate of graduates practicing in low-income communities or medically underserved areas.
- Whether the program has expanded to private colleges and universities who also train health care professionals.

Source: McDonough, Gibbs, et al. "A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities," Commonwealth Fund, 2004

2011 OAFP Primary Care Package SUMMARY

RECRUITMENT

The goal is to dramatically increase the number of primary care physicians in Oregon. (Primary care is defined as family medicine, general internal medicine and general pediatrics.) To increase primary care from 40% to 50% of the physician workforce, Oregon would need to add 1,355 new primary care physicians over the next 10 years.

1. **LOAN REPAYMENT** — $6 million would provide loan repayment for 8 physicians, 5 dentists, 5 nurse practitioners and 5 physician assistants each year.

2. **GME**
   - $1 million to help start a GME Consortium in 2011-13.
   - $6 million in 2013-15 to increase the number of family medicine residency slots in Oregon from 27 to 50 per year.
   - $9 million in 2015-17 to continue per slot support for the 50 existing family medicine slots and add 25 more family medicine residency slots.

3. **SCHOLARSHIPS FOR RURAL SCHOLARS** — $1.05 million for full scholarships ($35,000 per year) for five medical school students in the rural scholars program who agree to practice medicine in rural Oregon after graduation. Expand the program in future bienniums to include nurse practitioners, physician assistants and physicians agreeing to work in underserved areas.

RETENTION

It is much less expensive to keep existing primary care providers than to train and recruit new providers.

4. **MALPRACTICE PREMIUM SUBSIDY FOR RURAL PROVIDERS** — A new funding source is needed to provide $7.8 million to subsidize medical malpractice premiums for rural providers, primarily those who deliver babies.

5. **INITIATIVE FOR THE TRANSFORMATION OF PRIMARY CARE** — Designed to help urban and rural providers make the transition to the new medical home model.
   - Locum tenens to serve as transformation agents in rural practices. Think of them as medical extension agents. Cost: $300,000
   - Interdisciplinary CME at the community level. Deliver on-site training for clinics and medical providers. Cost: $700,000
   - Research and training on how to implement primary care homes. Could be combined with locum tenens. Cost: $400,000

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PAYMENT REFORM

6. **PRIMARY HOME PAYMENT** — The patient-centered primary home payment reform task force is developing new models to support the shift to medical homes. We support adding a per member / per month payment to primary care physicians who meet the criteria for patient-centered primary homes.

7. **NEW PRIMARY CARE PAYMENT CODES** — DMAP, OEBB and PEBB could develop and implement new codes to pay for primary care functions including consultations, e-mail and phone contact with patients, i.e., the components of a new primary care home.

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