Approved 4/1/12

Oregon Healthcare Workforce Committee
Meeting Summary

January 25, 2012
9 a.m. - Noon

Committee Members in Attendance

John Moorhead (Chair)
Ann Malosh (Vice-Chair, via phone)
Peter Angstadt (via phone)
Lisa Dodson
Mary-Rita Hurley
Terri Johanson
Donna Larson
David Nardone
David Pollack
Daniel Saucy
Kristen Simmons (via phone)
Judith Woodruff
Jennifer Valentine (via phone)

OHA and OWHI Staff in Attendance

Jo Isgrigg (OHWI)
Lisa Angus (OHPR)

Committee Members not in Attendance

June Chrisman
Paula Crone
Lita Colligan
Sara Hopkins-Powell
Kelly Morgan
Mark Richardson
Karen Sanders

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

Dr. John Moorhead convened the meeting.

The October 27, 2011 meeting summary was approved.

General Updates

- The Health Policy Board's implementation proposal for Coordinated Care Organizations (CCOs) was finalized over two Board meetings in January and will be delivered to the Legislature shortly. A waiver will be submitted to CMS as soon as possible after the Legislature has approved the plan, with the goal of issuing a request for proposals and model contract in the spring and certifying the first CCOs to start operations by July 1, 2012.
- OHA has started to recognize Patient-Centered Primary Care Homes (PCPCH) that meet the Oregon standards; over 90 clinics have applied for recognition so far. The PCPCH

program is doing some communications/publicity work with news releases, information in organization newsletters, and email outreach to potentially interested clinics. The state is in discussions with CMS regarding providing an additional PMPM fee for PCPCHs taking care of Medicaid clients with two or more chronic diseases (an opportunity available under Section 2703 of the ACA), as well as other OHP members. The program is also moving forward with creating an "Institute" to provide technical assistance to support clinics; an RFP is expected to be issued in the next month or two in collaboration with the Northwest Health Foundation.

- It appears that Board of Licensed Clinical Social Workers and Board of Professional Counselors and Therapists will begin participating in the healthcare workforce database this spring (on a voluntary basis). The Board of Psychologists Examiners is interested but cannot commit at this time due to staffing shortages. More and more of the 7 original boards are choosing to use a centralized online questionnaire developed by OHPR, rather than embedding the required workforce items into their own systems, which should increase the comparability and timeliness of the data.
- OHWI is aware of five Oregon applications submitted CMS "Innovation Challenge" grant, which would provide up from $1-30 million to support rapid delivery system and payment change. The grant guidance includes a requirement that applicants identify new models of workforce development and deployment. Awards are supposed to be announced in early April.
- Oregon AHEC will submit an application for future funding shortly; the co-chairs wrote a letter of support on behalf of the Committee. This would be a 5-year grant, rather than 3 years.
- Portland-area local Workforce Investment Boards have received a Dept. of Labor grant to encourage nurses to work in long-term care settings.

<u>CCO implementation proposal – workforce connections or implications</u>

Committee members made the following comments about workforce implications for the CCO implementation proposal:

- CCOs are given relatively little workforce development responsibility; inserting or referring to the recommendations developed by Workgroup 1 (workforce models for new systems of care) may give them some guidance
- Rolling non-traditional health workers into the CCO concept may not be straightforward; they have been used somewhat differently in the past
- As Workgroup 2/SB 879 work (standardized prerequisites for student clinical rotations) moves toward implementation recommendations, there should be an explicit call for CCOs to participate/use the common standards.
- Dental providers and systems are not visible in the proposal, given the optional inclusion of dental care organizations before 2014.
- In evaluating the potential impact of CCOs on workforce, consider:
    - The proportion of providers who are employed (rather than self-employed) – does it increase over time?
    - Proportion of providers operating in inter-disciplinary teams

- The physician workforce survey traditionally fielded by OHA (Medicaid) in partnership with the OMA is one potential data source for evaluation of these and other trends, at least among physicians

Next steps for Workgroup 1 (workforce models and competencies for new systems of care)
The workgroup's draft report was presented to the Health Policy Board on January 10th. The feedback was that many of the recommendations made sense but that it was not clear how they could or should be implemented, or which should be acted on first. Key points in Committee members' discussion included:

- The report did reveal that people in leadership positions in health care delivery and health professional education are at least willing to work more collaboratively, which is an important piece of information. The degree of consensus on this point was significant.
- There was some debate about whether OHA would be the appropriate starting place for all the recommendations – some perhaps, but not all.
- The report's suggestion of a an additional round of information gathering on priorities and needs from people and organizations actually implementing system changes was seen as reasonable; there is so much going on and so little of it is coordinated that this step would be helpful to see which gaps need filling first. (It was also suggested that checking in with systems not yet ready to adopt new models of care would be worthwhile; are workforce barriers part of the equation?) Collecting this information as CCOs are forming (after the March RFA) might be useful timing.

Next steps for the group will be to:

1. Clarify action assignments for the existing recommendations
2. Have the full Committee participate in a prioritization exercise for the recommendations
3. Develop a survey or other instrument to collection additional information from people on the ground, who have not been as involved in policy discussions to date
4. Consider the possibility of a summit or other structured conversation with nascent CCOs in the spring to develop implementation plans – coordinate with the PCPCH Institute (and CCO learning collaborative) to bring in any technical assistance needed

Medical Liability Reform Options
Dr. Jeanene Smith, Administrator of the Office for Health Policy & Research, gave an overview of several studies of possible options for medical liability, conducted as required by Section 16 of HB 3650. (Dr. Smith's presentation is available with the meeting materials.) Comments made during discussion included these:

- Most of the studies predict relatively little savings from different options (caps on non-economic damages, medical panels, extension of the Oregon Tort Claims Act to CCO providers for their Medicaid patients, expansion of joint-and-several liability reform law). An administrative court system (similar to Worker's Comp) offers the greatest potential for change but there are political and legal challenges.
- Taking action on medical liability—even if potential savings are modest—is a chance to send a signal to providers that Oregon is serious about reform. It would be a useful tool

for recruitment and retention, since Oregon's reform is one thing that attracts providers to the state.

- Even the modest savings predicted from some options could do a lot of good in other parts of the system (e.g. education)
- Liability reform and defensive medicine have implications for the whole workforce – not just physicians. (If defensive medicine is reduced and physicians order fewer tests, the impacts will be felt by nurses, imaging technicians, facilities, etc.)
- Work to develop more and better clinical guidelines is underway with the Health Evidence Review Commission

Input on developing recommendations for Non-Traditional Health Workers (NTHW)
Subcommittee co-chair Donna Larson gave an overview of NTHW recommendations-in-progress that were presented to the Health Policy Board on January 10th (powerpoint presentation is available with the meeting materials). She noted that the Subcommittee is still debating what might be an appropriate minimum number of training hours, supervision requirements, and the best entity to review and approve NTHW training programs. Comments made during discussion included these:

- There are some parallels with CNA training – traditionally, that has been done by employers although some community colleges now offer it
- A consortium model may be a good fit for the recommended central entity to review and approve training programs
- The chart of basic roles and competencies for NTHWs helps clarify that NTHWs aren't taking the place of nurses or social workers, etc. so should help allay those concerns
- Where NTHW roles overlap with a given discipline, perhaps someone trained in that discipline would be a relevant supervisor (e.g. motivational interviewing is often done by social workers, so a social worker might be the best supervisor for a NTHW who uses that technique)

Update on Workgroup 2 (Standardizing prerequisites for student clinical placement – SB 879)
Terri Johanson reported that a stakeholder meeting had been held the day before and a second one was scheduled for February 3rd to try to identify a working set of standard requirements. Consensus seems to be stronger in some areas (e.g. immunizations) than others (e.g. drug testing) but the group's goal is to identify something that will reduce work better for students, schools, and clinical sites. After the February 3 meeting, it's possible that there will be the need to consult with just a few stakeholders to develop a working set of requirements / a straw plan and to identify implementation questions to address in a third large stakeholder meeting. When the straw plan is prepared, it would be helpful to get the Committee's input on how best to communicate it to organizational leaders and get their feedback.

Update on Workgroup 2 (Strategic plan for primary care provider recruitment – HB 2366)
Dr. Lisa Dodson reported that the group had a lively stakeholder meeting in December with about 30 participants. Participants identified two kinds of issues: 1) conditions that must be created to improve recruitment and retention, e.g. payment reform; and 2) potential actions

that could be taken in a range of settings (including communities) to improve recruitment and retention (e.g. targeted marketing to students who left the state for training). The group hopes that some regional conversations being organized in connection with the state's grant to increase retention of National Health Service Corps clinicians (see updates from October 27, 2011 meeting) will provide some additional input and options to consider.

Update on Workgroup 4 (revising adverse impact regulations or interpretation)
Ann Malosh reported that the group had a fruitful opening conversation with 20+ representatives from proprietary schools in early December; the meeting was largely about information sharing rather than specifics. Everyone seemed willing to continue conversations. A second meeting (TBD) will focus more specifically on adverse impact issues and Ann and Donna Larson are working to invite the proprietary schools to the regular meetings of the community college healthcare deans.

Public Comment
No public comment was offered.

Dr. Moorhead adjourned the meeting at noon.