

Oregon Healthcare Workforce Committee
June 4, 2014 from 9:30-12:30
At Wilsonville Training Center
Meeting Summary

Committee Members in Attendance:	Daniel Saucy David Pollack Lisa Dodson Lita Colligan Ann Buchele David Nardone	Theresa Mazzaro Robyn Drebelbis Mary Rita Hurley (phone) Andrew Janssen (phone) Jennifer Valentine (phone)
Committee Members Not in Attendance	Agnes Balassa Sharmilla Bose	Jordana Barclay
OHA and OHWI Staff	Lisa Angus, OHA Cathryn Cushing, OHA Marc Overbeck, OHA	Jo Isgrigg, OHWI Chad Johnson, OHWI
Others	Carla McKelvey, Oregon Health Policy Board Joan Kapowich, PEBB and OEBC	

1	Welcome
	Lisa Dodson welcomed everyone to the meeting.
2	Approval: April 2, 2014 meeting summary
	Meeting Summary was approved.
	<i>Action Steps:</i> <ul style="list-style-type: none"> • <i>Staff will finalize the summary</i>
3	Announcement, leadership transition
	<u>Objective:</u> Committee will decide on a new Chair <u>Background:</u> Lisa Dodson has accepted a new position in Wisconsin. This is her last Healthcare Workforce meeting. <u>Discussion:</u> The HCWF Committee thanked Lisa for her service to the group as did Dr. Carla McKelvey on behalf of the Oregon Health Policy Board. The Committee then confirmed Ann Buchele as Chair and will leave the Vice-Chair position open until new members are recruited and the Health Policy Board has given the Committee new deliverables.
	<i>Action Steps:</i> <ul style="list-style-type: none"> • <i>Staff will make changes to Committee lists that reflect the change in leadership.</i>

4	<p>Workgroup B: Review final draft of GME Expansion Policy Options Memo and the proposal to Moda Health</p>
	<p><u>Objective:</u> To review the latest draft of the Policy Option Memo and give the HCWF Committee an opportunity to comment and provide edits. Also, to share the proposal Lisa Dodson and Robyn Dreibelbis will make to Moda Health for funding on June 10th.</p> <p><u>Background:</u> The Oregon Health Policy Board asked the HCWF Committee to submit a policy options memo on expansion of Graduate Medical Education on July 1st. The GME Expansion Workgroup has met several times and developed a matrix of options and a draft memo for the Committee’s consideration. This draft memo and matrix provided the backbone of the proposal to Moda Health.</p> <p><u>Discussion:</u> Lisa Dodson provided an update on the state of GME in Oregon. Issues included:</p> <ul style="list-style-type: none"> • Oregon will most likely need at least two family medicine residency programs (with 30 resident slots each) to reach the 50th percentile among states. • This year, only 9 of 24 OHSU graduates going into family medicine residents are staying in Oregon. This means the state will need to recruit physicians to practice in Oregon. • Establishing residency programs is too expensive for most individual health systems or hospitals. • Hospitals designated “Sole Community Hospitals” or “Critical Access Hospitals” are not eligible for Indirect Medical Education payments from Medicare since they are already receiving enhanced Medicare funding. Medicare considers IME payments to these hospitals “double dipping”. <p>A GME consortium focusing on primary care specialties could address many of the issues stated above. A consortium would create shared ownership of, and investment in, a new residency program or programs. Efforts to establish a consortium in the past have floundered due to the lack of a sponsoring organization and start up funding.</p> <p>Joan Kapowich updated the Committee on the offer from Moda Health to entertain a proposal for expanding primary care GME. The offer is time sensitive and a proposal is due to Moda on June 10th. Moda’s interest and investment could spur the other carriers to invest as well.</p> <p>AHEC SW has agreed to be the sponsoring organization in order to take advantage of any Moda investment. Lisa Dodson and Robyn Dreibelbis will continue to develop the proposal for presentation to Moda Health on the 10th.</p> <p>Committee questions and concerns included:</p> <ul style="list-style-type: none"> • How will the HCWF Committee be involved in the consortium and who will take

	<p>ownership going forward? This is a very technical area and the Committee probably doesn't have the expertise or resources needed for implementation. AHEC SW has agreed to be the initial sponsor, however, once the consortium is developed, the members are the owners. Committee members recommended that the eventual consortium could report to the HCWF Committee.</p> <ul style="list-style-type: none"> • Members agreed that a planning process including the community stakeholders would be critically important. • The Moda Health investment could provide the needed energy and resources to get over initial start-up barriers. This is a great opportunity to encourage buy-in from other stakeholders. • The Committee needs to be careful about the hand-off of this process and aware that some stakeholders may not be acting with the best of intent. All stakeholders need to be actively involved, not just standing back and watching or, in the worst case scenario, sabotaging the process. • This should be the starting point and should include the possibility of expanding into other residency shortage areas, not just family medicine. • The Committee should investigate other, back door options for getting around the Sole Community Hospital problem. Teaching Health Centers could be a solution, or using FQHCs, however, FQHCs may not have enough Medicaid volume to bring in funding for many residency slots. The Veteran's Administration Hospital also sponsors residencies – there may be a partnership opportunity with them. <p>GME Expansion has evolved from an intellectual exercise to a real world project possibility with the offer from Moda Health. The Committee still needs to produce a policy option memo for the Health Policy Board as well as being supportive of the proposal to Moda. Dr. McKelvey suggested that the memo to the Board include the options matrix developed for discussion to assist the Board in understanding the options presented.</p>
	<p><i>Action Steps:</i></p> <ul style="list-style-type: none"> • <i>Staff will send the GME Expansion policy options memo to the Committee on the afternoon of June 4th with a reminder and due date for comments.</i> • <i>Committee members will review and provide feedback by Wednesday, June 11th.</i> • <i>Staff will finalize the memo and submit it to the Oregon Health Policy Board by July 1st.</i> • <i>Robyn Dreibelbis and staff will report back to the Committee on the outcome of the proposal to Moda Health and any progress in developing a residency consortium.</i>

6	Workgroup C: Review financial incentives draft report
	<p><u>Objective:</u> To review and discuss the report on the various financial incentives the state has available for practitioners who agree to practice in rural or underserved areas of the state.</p> <p><u>Background:</u> The Oregon Health Policy Board asked the HCWF Committee to review the range of financial incentives available in Oregon and recommend criteria for monitoring and evaluating the programs as well as strategies for sustaining, expanding or re-targeting the programs if needed.</p> <p><u>Discussion:</u> The report includes a literature review and background on the wide variety of incentive programs offered in Oregon. As requested, there are recommendations for the Board to consider. Also included is an analysis of what Oregon’s programs offer, how many practitioners they serve and information on their funding streams. There are several appendices – a matrix of information on programs in other states is still in development. Questions from staff to the Committee include:</p> <ul style="list-style-type: none"> • Is the review of evidence helpful? • Are the observations fair and generally impartial? • Is anything missing from the report? • Does the Committee have any recommendations or input? <p>In Oregon, as in other states, programs are not coordinated. It appears that incentive programs were developed to address particular issues brought forward to legislators by constituents. As legislators involved in specific programs move on, historical perspective is lost. There should be a “place” for both program history and data collection and analysis – possibly Office of Rural Health or the Oregon Healthcare Workforce Institute.</p> <p>Additionally, since many of the incentive programs began, there have been significant changes in the landscape of healthcare. For example, when the malpractice insurance subsidy was developed, most practitioners were solo practitioners. Now, most are employees of a health system.</p> <p>Incentive program funding is siloed and some practitioners become eligible for several programs while others aren’t eligible for any program. One idea to address this issue is to take some money (possibly a percentage of each state-sponsored program) and establish a stream of flexible funding to help break down the silos.</p> <p>There is very little systemized data collection so program evaluation is limited. There is no organization or program tasked with, and funded for, data collection on incentive programs. Total funding in Oregon for incentive programs is only \$16 million per year, a small percentage of any health system’s budget. The Committee suggested that current funding is inadequate.</p>

	<p>The Committee strongly recommends that these programs be evaluated based on outcomes, not just on whether they are able to distribute the money. However, it is important that the outcomes measured are based in reality. For example, the average person changes careers five times in his or her lifetime. It is unrealistic to expect that a recipient of an incentive will stay in the same job or community for the remainder of their career.</p> <p>The Committee discussed whether or not the funding streams had reached capacity. The Office of Rural Health has distributed all available funds for the State Loan Repayment program to date. The State Loan Repayment Program is limited by the requirement of a community match and 10 percent overhead, however they are distributing seven more awards based on carry over funds. The incentive program for faculty has not reached capacity. The National Health Service Corps funding is growing as the Primary Care Office continues to reach out and promote the programs and assist with applications for Health Professional Shortage Areas.</p> <p>There is a question of the Committee’s ongoing role in this work. Committee members agree that as the recommendations are operationalized, the work should be handed off to another organization, possibly the Office of Rural Health or the Oregon Healthcare Workforce Institute.</p> <p>Committee recommendations for the report:</p> <ul style="list-style-type: none">• Prioritize the seven recommendations, unless they are all of the same magnitude.• Add to recommendations who will do the work.• Add a recommendation about a flexible funding stream.• Make the matrix more user friendly by breaking it out by discipline.• Group the rural programs and non-rural programs in the matrix.• Make the recommendation about evaluation more specific with performance measures, targets, etc.
	<p><i>Action Steps:</i></p> <ul style="list-style-type: none">• <i>Staff will incorporate Committee recommendations into another draft of the report.</i>• <i>Staff will send the new draft to the Committee for comments and edits on June 11th.</i>• <i>Committee will return edits to the report by June 18th.</i>• <i>Staff will finalize the report and submit it to the OHPB by July 1st.</i>

7	<p>Membership</p>
	<p><u>Objective:</u> Discuss membership gaps and suggest potential new members</p> <p><u>Background:</u> Membership has been decreasing and several members have not been regular in meeting attendance. All members received a letter informing them of the new bylaws requiring a minimum attendance record and participation on at least one workgroup. As a result, the Committee is down to 14 members.</p> <p><u>Discussion:</u> David Pollack believes the Committee needs more representation from OHSU when Lisa Dodson leaves. Carla McKelvey suggested a person from Rogue Community College who works primarily with entry level positions. Some members think that we have broad representation from education and need more members with links to the healthcare industry side of workforce.</p> <p>Theresa Mazzaro suggested another representative from PeaceHealth, perhaps someone hired specifically for Primary Care.</p> <p>Lance McQuillan from Samaritan was suggested. He is a Co-Program Director for Family Medicine and is a member of the American Academy of Family Physicians Board.</p> <p>The Committee recommended again that we invite members from health system administration and management as well as from Coordinated Care Organizations and the commercial payers.</p>
	<p><i>Action Steps:</i></p> <ul style="list-style-type: none"> • <i>Staff will update the membership interest form to reflect staffing changes.</i> • <i>Staff will send invitation letters out to individuals recommended or who have targeted areas of expertise that will assist in meeting future deliverables.</i> • <i>Staff will include membership as a standing agenda item to discuss at least twice a year.</i>

8	Updates: Workgroups A , D - Workgroup Leads and Staff
	<p><u>Objective:</u> Make the committee aware of the progress of workgroups.</p> <p>Workgroup A - Centralized tracking system for clinical placement standards</p> <p>The Workgroup is leaderless at the moment, however, Ann and staff are discussing bringing together a group of stakeholders who are involved in clinical placements and seeing if a group or consortium of groups arises to carry the development of a tracking system. This work is needed now as every institution is developing, and becoming invested in, its own system.</p> <p>One option is to wait for the Common Credentialing work to be completed. A Request for Proposals is about to be released asking for a proposal for a system that will track practitioner credentials. Once that system is established a module could be added to track administrative requirements as well. Although this would be a practical and efficient solution, it will not be ready for new modules until at least 2016.</p> <p>Oregon Institute of Technology is interested in bringing this forward as a student project. Lita Colligan set up a call with Cathryn Cushing and Lisa Angus and OIT faculty on June 5th to discuss this option.</p> <p>The deliverable the Committee must submit to the Health Policy Board is a business plan for a centralized tracking system. Ann Buchele has a request in to the Community College Workforce Development department for some funding for this process.</p> <p>The Committee agrees that this work should be handed off to another organization to implement. A suggestion was made that either the Oregon Education Investment Board or the Higher Education Coordinating Committee could be that organization, however, Lita Colligan said that they were both policy related organizations and wouldn't be interested in implementing a tracking system.</p> <p>Some members thought that because of lack of interest in the Request for Information, vendors weren't available, however, many organizations do not answer RFIs due to the lack of certain funding for a Request for Proposals. Both Ann Buchele and Theresa Mazzaro have vendors handling their administrative requirement tracking. The main barrier is one of leadership and ownership, not technology.</p> <p>Workgroup D – Emerging trends in the healthcare workforce</p> <p>Ann Buchele updated the Committee on the progress of the workgroup – the Crystal Ball Workgroup! The Workgroup has completed a literature review and is preparing to conduct key informant interviews with industry and education experts. Since health system transformation is still new, it is difficult for industry experts to predict what roles or how many of which roles will be needed in the future. Although the Board will want hard</p>

numbers, these will be difficult to find.

Dr. McKelvey believes the Board will want the Committee to think broadly about the healthcare workforce. Healthcare will need to move into the community and we need to think about non-traditional community partners.

David Pollack noted that we do see a shift to more primary care and more collaborative care. There will also be more focus on early intervention and prevention so we should focus on the types of roles and skills needed for these types of interventions.

Ann Buchele acknowledged that trend is toward a less physician-based workforce, however, we need to be careful about recommending numbers or particular roles so that we don't repeat the mistake of training of too many of a particular profession, such as Community Health Workers, before payment methodologies are established.

David Pollack told the Committee that OHSU is adding curriculum on the social determinants of health to the medical student education. Cathryn Cushing asked that members send her any information they might have on pilot projects focused on changing workforce roles or responsibilities.

A draft of the report due to the Health Policy Board will be available for Committee review by the August meeting.

9 Updates: OHA and General – All

Objective: Ensure that the Committee is up to date on workforce-related issues.

Oregon Health Policy Board Update: Discussion at the Board meeting on June 3rd centered on the Future of Public Health Task Force. Due to health reform, there will be changes in the responsibilities traditionally held by local public health workers. There will be some overlap between changes in the public health workforce and the work of the Healthcare Workforce Committee. The public health workforce should be included in the report on Emerging Trends.

David Pollack mentioned that health care practitioners needed a better understanding of what public health workers actually do.

OHA update: Since the last meeting, Tina Edlund has stepped down as OHA Director to

	<p>manage the transition from Cover Oregon to the federal exchange and the reintegration of Medicaid enrollment into OHA. Suzanne Hoffman, the former OHA Chief Operations Officer has stepped in as Interim Director. Leslie Clements is acting Policy Director for the agency.</p> <p>Enrollment in Medicaid has exceeded 900,000. Enrollment in Qualified Health Plans is at approximately 48,000. A report on the transition to the federal exchange and an update on the numbers are available on the Oregon Health Policy Board’s website as a part of the June 3rd meeting materials.</p>
10	Public Comment
	<p><u>Objective:</u> Give members of the public time to share with the Committee. <i>There was no public comment at this meeting.</i></p>