	Healthcare Workforce Subcommittee Meeting Minutes
DATE	April 19, 2017
TIME	2:30 p.m. - 4:30 p.m.
FACILITATORS	Shelly Dunham, Co-Chair Jana Castleberry, Oklahoma State Department of Health (OSDH)
MEMBERS PRESENT	Jason Eliot, Randy Grellner, , Tandie Hastings, Teresa Huggins, Daniel Joyce, William Pettit, Shelly Wells, David Wharton, John Zubialde
MEMBERS ABSENT	Ted Haynes, Jeremy Colby
GUESTS	
HANDOUTS	

AGENDA

1. **Welcome and Introductions**
   Shelly Dunham, Co-Chair

2. **Health Care Transformation and State Priorities**
   Adrienne Rollins, Interim Director, Center for Health Innovation and Effectiveness (CHIE), OSDH
   Discussed the Oklahoma Plan: Health and Human Services (HHS) Agency Alignment (please refer to PowerPoint Presentation)
   - HHS joint initiatives to improve health in Oklahoma include OHIP 2020, the Oklahoma State Innovation Model (OHIP Road Map), and Interagency Governance (DISCUSS/Operational Committee and Quality and Evaluation Committee).
   - Initiatives within the Oklahoma Plan Portfolio: 1) Invest in Smart Coverage; 2) Pay for Performance; 3) Improve Community Health; 4) Preserve and Expand the Health Workforce; and 5) Empower Patients and Providers.
   - Discussed Healthcare Innovation and Redesign.
   - Health Transformation core measures are to 1) Improve Population Health – Reduce heart disease deaths by 11% by 2020 (2018 data); 2) Improve Quality of Care – Reduce by 20% the rate, per 100,000 Oklahomans, of potentially preventable hospitalizations from 1656 in 2013 to 1324.8 by 2020 (2019 data); and 3) Bend the Healthcare Cost Curve – By 2020, limit annual state-purchased healthcare cost growth, through both the Medicaid Program and the State Employee Group Insurance Plan (EGID), to 2% less than the projected national health expenditures average annual percentage growth rate as set by CMS.
   - OKStateStat is Oklahoma's performance informed budgeting website. OKStateSTAT Access to Care Goals are 1) Limit state-purchased health care cost growth to 2% less than the projected national health expenditures average every year through 2019; 2) Decrease the percentage of uninsured individuals from 17.7% in 2013 to 9.5% by 2019; 3) Increase the percentage of health care access to citizens within designated Primary Care Health Professional Shortage Areas from 64% in 2014 to 74% by 2019; and 4) Decrease the rate of preventable hospitalizations among Medicare beneficiaries from 76.9 per 1,000 in 2013 to 69.21 per 1,000 by 2019.

- Discussed the Inter-Agency Governance Structure, comprised of an operational committee and DISCUSS, which recently merged, and a Quality and Evaluation Committee. The goal of the Quality and Evaluation Committee is to establish common, agreed upon outcome metrics for the five highest healthcare cost drivers (hypertension, diabetes, tobacco, obesity and behavioral health), establish evidence-based policies for each condition/cost driver, integrate outcome measures and policies into as many waivers, contracts, and programs as possible to ensure investments in health improvement, and move payment mechanisms to 80% value/performance based payments. The quality measures will be aligned with the new Medicare payment and delivery reform and Alternative Payment Models adopted by commercial carriers to reduce provider burden and engender consensus from providers and commercial carriers.

3. Subcommittee Required Evaluation Metrics/Standards

Jennifer Kellbach, Health Planning Coordinator, OSDH

Governor's Priority Areas: Health, Wealth, and Justice (please refer to PowerPoint Presentation)

- Provided guidance and structure of the proposed process for identifying, researching, validating, and framing recommendations from the Healthcare Workforce Subcommittee to the larger Governor's council.
- Health Priority encompasses Health 360, which seeks to create an inventory of all health programs being funded by the state, which is then compared to a compendium of research for fidelity to evidence-based practices. The first metric addressed by Health 360 is obesity.
- Numerous health measures/programs are evaluated and scored according to their reach, cost effectiveness, strength of evidence, and socioeconomic level, and tiered recommendations are made according to this weighted score.
- Sources of evidence to be considered are 1) scientific research, 2) organizational evidence, 3) experimental evidence, and 4) stakeholder evidence.
- A breakdown of roles and responsibilities was provided.
  - Subcommittee Roles and Responsibilities: Determine priority areas; Define problems; Lead group dialogue; and Represent industry and region.
  - Workgroups (Critical Occupations, GME, and Teaching Health Centers) Roles and Responsibilities: Guide research and planning; Review group materials; and Present group-specific information to subcommittee.
  - OSDH Staff Roles and Responsibilities: Develop Workgroup materials; Gather and present research; Facilitate communication; and Develop issue briefs
  - Subcommittee Chairs Roles and Responsibilities: Facilitate between workgroups and subcommittee and make formal recommendations for the subcommittee.

3. Health Workforce Action Plan Check In

Jana Castleberry, Manager of Workforce Development, OSDH

Moving from Planning to Implementation (please refer to PowerPoint Presentation)

- The overarching need is comprehensive, high quality healthcare workforce data, as this data will inform policy recommendations, education and training strategies, and recruitment and retention strategies to achieve the goal of ensuring a well-training, adequately distributed, and flexible healthcare workforce.
- Core area strategies: 1) Coordination of Workforce Efforts; 2) Workforce Data Collection and Analysis; 3) Workforce Redesign; and 4) Pipeline, Recruitment, and Retention.
- Coordination of Workforce Efforts: Overarching guidance provided by the Governor's Council on

Workforce and Economic Development, which includes Oklahoma Works and the Workforce Investment and Opportunities Act State Plan. The Subcommittee will lead the development of the "right" research questions that will help link data to policy and program planning. CHIE will serve as the data coordinator and will work to facilitate collaboration and establish a centralized data repository and research clearinghouse. The OHIP Workforce Workgroup will be re-engaged to serve as an extended group of stakeholders.

- **Status update on Data and Collection Analysis efforts**
  In Progress: Identify and prioritize a list of critical health occupations.
- **Status update on Workforce Redesign efforts**
  In progress: Review and analyze findings from current research and statewide initiatives; Define positions and competencies required for emerging health professionals, focusing first on community health workers and care coordinators; Develop statewide training and education plan for the health care transformation (will be included in processes Health Care Industry Report); Develop a statewide telehealth plan, with ASTHO Technical Assistance; and Develop statewide policy recommendations.
  Planned: Develop training, policy and reimbursement recommendations that support new and emerging health professionals.
- **Status update on Recruitment and Retention efforts:**
  In progress: Sustain and leverage current state GME resources; Expand community-based residencies and rotations; Maximize impact of pipeline, recruitment and retention efforts; and Address community factors (e.g., economic viability, community support and quality indicators).

5. Health Care Industry Report Updates

Jami Vrbenec. Health Planning Coordinator, OSDH

Purpose of report: identify critical occupations, project supply and demand, forecast shortages and surpluses, and create strategies to close supply gaps (please refer to PowerPoint Presentation)

- Met with Stakeholder group on March 31, 2017 and discussed the recommendation to revise the 2006 report. Currently working to develop memorandums of agreement with agencies, gathering data from stakeholders, creating a data inventory, determining a "Critical Occupations" list with guidance from the Critical Occupations workgroup (list will determine what occupations will be included in the report)
- Once this list is approved, will be able to project supply and demand, forecast shortages/surplus, and develop strategies and recommendations to close supply/skills gaps.
- Provided timeline and list of current stakeholders.

6. Graduate Medical Education, National Governors Association (NGA) TA Grant

Adrienne Rollins

Benefits of NGA Technical Assistance

- The NGA is providing the Oklahoma Health Care Authority (OHCA) with examples of waivers and language that CMS states needs to be included in waivers. There will be a NGA site visit in May, hosted by the OHCA, where they will discuss different Teaching Health Center models that use Medicaid funds, and further discuss waiver language. In June the NGA is projected to publish a GME roadmap of best practice models.

Workgroup Break-Out and Discussion

- The workgroup was presented with a spreadsheet that was a combination of three critical occupation lists and discussion ensued regarding the positions.
- It was mentioned that housekeeping positions are much easier to fill than the other critical

occupations listed.

- Certified nursing was not included on the list and needs to be added.
- Wealth generation is shifting to high demand, high pay, and the positons that will bring the most return on investment to the State of Oklahoma.
- Staffing surveys and providers should be created and sent to the hospital association, find where the holes are in staffing and what positions the providers say are most critical.
- Limitations mentioned in the original 2006 report were the fact that it was acute-care focused.
- Would like a clear definition of critical, and how this will deliver o goals of the Governor to improve health of the population.
- Criticality is related to higher level degrees because it takes much longer to obtain the degree – this time is a constraint, i.e. you will not be able to educate/train a nurse in 8-12 weeks. Most occupations require at least a bachelor's degree.
- We must be forward-thinking in our design of the list/report.
- A Certified Nurse Assistant could fit within care coordination; care coordinator does not have a SOC code.
- The workgroup was given a list of parameters that Sandi Wright with the Oklahoma Office of Workforce might be able to use to help determine which occupations are critical, including (but not limited to): typical entry level of education, work experience required, age distribution, national growth, earnings.
- Training capacity is a very important aspect to determining the critical list.
- Location parameters are important to Oklahoma. The workgroup agreed that taking a regional approach to determining critical occupations would be the best method, rather than looking at it from a state-wide perspective. An occupation that is critical in one region may not be critical in another. It was also agreed that using the Key Economic Networks (KENs) utilized by Oklahoma Works would be a good approach to breaking down the regions.
- Some of the jobs on the critical occupations list may require more or less education with a slight change in occupation code, although they perform basically the same function.
- The group felt that the Department of Commerce list was more general than the other two lists in the combined spreadsheet, and that the Commerce list should not be used in the report.
- Emerging occupations need to be added to the report and list.
- Use 25 occupations to start, utilizing the 25 critical jobs pulled by Deidre Myers, as those jobs are still critical.
- Send a survey to the workgroup with the parameters, they will decide which ones are most important, and the Critical Occupations list will be determined based on the weighted parameters per each KEN. Additional parameters can be added based on workgroup feedback.
- It was asked if CMS required reporting could be added to the parameters, we will check with Sandi Wright about this.
- Home health aide and home health assistant certifications have different requirements, but the basic job duties are the same. It was mentioned that one recommendation would be to streamline these, but state regulations are making this difficult. This also includes care coordinator positions; there are several titles that do this same function.
- In the 2006 report, Physical Therapists were listed as critical; this position went from requiring a master's level degree to requiring a Ph.D.
- Once we have the critical occupations list determined, we will be able to more forward to supply and demand data.

- It was mentioned that BLS data has weaknesses. BLS occupational replacement need projections account for aggregate retirements and permanent job separations. These replacement needs are added to the projected growth. They do not include jobs changes within the same occupation.
- Career ladder – demand of nurses is greater because they are now pursuing higher level careers, such as APRN.
- The group wants to move forward with the KENs.
- Communication with the workgroup should be primarily via phone, as many have to travel long distances to get to Oklahoma City.

Next Steps

- Send survey to the workroup.
- Work with Sandi Wright regarding the parameters in weighing the Critical Occupations list and KEN placement.

Workgroup Breakout and Discussion -- Graduate Medical Education

- Question posed was how do we make Oklahoma a more practice-friendly state? What can we do that will make the biggest difference?
- Comments were made that we are not training enough doctors, state budget cuts are hampering recruitment and retention efforts, and we do not have adequate data on the true economic impact physicians have on the state. We have statewide data, but lack local and regional quality workforce data.
- Comment was made that it is imperative that we initiate robust data collection efforts.
- Comment was made that the most significant difference we can make today within our existing mechanisms is increased investment in recruitment and retention tools, such as student loan repayment programs and community sponsorships. Currently 40% of medical residents trained here are leaving Oklahoma – we need to make a greater effort to retain these professionals.
- Discussion was held regarding repeated cuts to higher education funding and STEM programs and the negative impact it has on recruiting students through the pipeline.
- Discussion held on PMTC, which currently provides scholarships and student debt loan repayment relief to health professionals who will work in underserved areas. Currently they are trying to leverage community sponsorships. They are pitching a bridge plan to allow a facility that is not publically owned to provide a state share (AG currently disagrees d/t perceived conflict of interest).
- PMTC plans to introduce a new scoring rubric in order to determine placements of loan repayment program participants.
- OSDH has identified $100,000 in funds to dedicate towards a health workforce modeling technical assistance project. The American Association of Medical Colleges (AAMC) could provide consulting services to help train states (OSDH) and local partners in the methodology of developing rigorous, locally-targeted projections of supply and demand for physicians.
- Additional funds are needed to pursue the consulting opportunity: GME committee members have been in communication with the Oklahoma State Medical Association (OSMA) on the proposal. Discussion was held around committee members developing a funding strategy to approach other health professional organizations to contribute to this effort in order to raise the necessary $250,000 for the health workforce analytics contract (OHA, OOA, OKPCA, Chambers of Commerce, Nursing Associations, etc.) Need to develop a unified communication strategy across the healthcare spectrum.
- The group agreed that many stakeholders represented at the table have a shared interest in

addressing shortages in the health workforce.

- Developing PMTC's ability to continue and innovate in its operations (community matching, leveraging federal/state funding) was reiterated as an important strategy for recruiting providers to rural and underserved areas.
- Key informant interviews with GME / THC subgroup members was identified as a method to pursue a greater understanding of the experiences and factors related to recruitment and retention.
- Key factors discussed related to success of recruitment and retention efforts:
  - Physician satisfaction (practice opportunities, salary, professional networking)
  - Employer/Hospital Factors (management support/relationships, "on-call / ER schedules, referral arrangements)
  - Admissions and recruitment (identifying talented rural students, consistent outreach)
  - Local economic conditions (housing, economic stability, and opportunities for family)
  - Next Steps:
  - Identify data/research as to what physicians and health systems contribute to the state economy.
  - Aim to define and create a physician-friendly state.
  - Compare GME regulations and working environment with other states (average student loan debt, working hours, incentive packages, etc.)

ACTION ITEMS

1. Email Critical Occupations data.
2. Email Health Workforce Action Plan.
3. Send meeting invites for the June 2017 Healthcare Workforce Subcommittee meeting.