Questions Regarding the Health Job Opportunity Program Proposal

The Health Job Opportunity Program proposed by hospitals at the Commission's September 9, 2015 Public Meeting seeks to create community-based jobs that can contribute to improved community health as well as create employment opportunities in economically challenged areas.

The community health related jobs are highly consistent with expectations of the HSCRC Transformation Implementation Program under which proposals are due on December 7, 2015; however, the time to achieve a return on investment may take longer under the Job Opportunity proposal.

The workgroup can assist the HSCRC in deciding whether/how to create this program by reflecting on the following questions:

GENERAL

1. How does the proposal relate to the HSCRC's mandate/authority?

2. Does approval for a rate assessment for this program open the door for other HSCRC rate assessments under the broad umbrella of "population health?"

BENEFITS

1. What are the benefits to the health of the population? How will we measure those benefits and other kinds of success? How will costs be affected by the program?

2. Should the jobs targeted by the program be limited to certain positions, or at least those funded from rates? What is the distribution of jobs that would be expected to be funded?

3. Does hiring and training the workforce positions suggested in this proposal represent the typical HR function of a hospital?

VALUE AND FUNDING

1. Do hospitals need the work covered by the proposed jobs?

2. How much value can these additional 1000 positions have to the hospitals that create them, and how long would that take?

3. Will hospitals need a permanent subsidy to maintain these positions, or will the positions provide sufficient ROI to be self-sustaining or even produce a surplus that can create new jobs? How does this proposal relate to the reduction of avoidable utilization?

4. If funded, how long after job creation would support continue? What ROI would be expected over what timeframe? What reporting requirements, if any, should the HSCRC impose on hospitals that receive funding?

COSTS

1. Who should bear the cost of the program? Should some of the cost come from existing funds set aside by the Commission for implementation proposals? How much of the cost should be borne by payers and patients? How much borne by hospitals within the GBR? How much of the cost should be supported by increasing the GBR?

2. Is it reasonable to expect contributions to make this successful? For example, could funding be derived from a combination of hospital funds, "community benefit dollars," philanthropy, or other sources?

3. What are the specific goals of the program, and can they be accomplished at the scale suggested (1,000 jobs) and the timeline (1 year) suggested for the amount suggested ($40 million)? If not, what are the feasible scale, time, and costs? How would this affect the timing of providing funds?

4. If not funded through a new assessment, can we incorporate (some part of) this program into the proposals and competitive bids under the infrastructure implementation plan?

5. If the hospital were not able to retain the funded workers, would the funding be reduced?

DESIGN AND OPERATION OF PROGRAM (IN THE EVENT THAT HSCRC SUPPORTS SOME FUNDING OF THE PROGRAM)

1. How should the program be structured to assure it is serving the population it is intended to serve and achieving the value that is expected? Should there be a task force focus on the design of the program? Are there other jobs that might contribute to the success of the All Payer Model that have not been identified in the white paper draft?

2. Should the program be limited to new workers or individuals who have been unemployed for a lengthy period of time? If so, how can we ensure that the newly employed individuals under the program were previously unemployed or chronically unemployed.

3. Should the program be organized with an Area Health Education Center (AHEC)[1] or other educational program?

4. Should the employment begin upon graduation from AHEC training?

5. Could the workers be hired in a facility not located in the challenged zip codes?

6. How will issues like transportation and day care services (wrap around services to allow for employment) be addressed for those hired under the program?

7. The program states: "On an annual basis a reconciliation will be made between the amount granted in rates and the actual cost of the program costs, and an adjustment will be made to the GBR in the next rate year." If the costs exceed the initial grant, is it appropriate to increase the amount in the GBR? If the program generates an ROI, will rates be reduced?

8. Should any amounts provided be removed from efficiency calculations as proposed? Should rates be reduced for any savings accrued?

[1] The Area Health Education Centers (AHEC) Program enhances access to high quality, culturally competent health care through academic-community partnerships to ultimately improve the distribution, diversity, and supply of the primary care health professions workforce who serve in rural and underserved health care delivery sites. The AHEC Program awardees subcontract with community-based AHEC centers in one or more regions of a state.
Along with state and local partners, the AHEC programs and centers:

- Recruit and train students from minority and disadvantaged backgrounds into health careers;
- Place health professions students in community-based clinical practice settings - with a focus on primary care;
- Promote inter-professional education and collaborative teams to improve quality of care; and
- Facilitate continuing education resources and programs for health professionals - particularly in rural and underserved areas.