# DHCC Health Workforce Subcommittee 2026 Goals

Dr. Kathy Matt

DHCC Commissioner and Subcommittee Co-Chair

# Focus Areas of Recommendations

- Expand breadth and capacity of training programs for Healthcare Providers
- Legislation/ Regulations
- Innovation and Technology
- Healthcare Workforce Data Collection

# Grow the Health Workforce

Expand breadth and capacity of training programs for Healthcare Providers (including but not limited to nurses, physician assistants, paramedics, dental hygienists, dental assistants, lab technicians, nutritionists, etc.

| Idea | Implementation Idea | Owner |
|---|---|---|
| **Increase the capacity** of existing programs | • Create a landscape analysis of programs and capacity to train and the barriers that imped expansion. | |
| Work to be sure all programs are **accredited** and achieve reaccreditation as needed so programs can be reinstated and programs are sustainable | | |
| Open new programs for new professions where infrastructure is already in place | | |
| **Fund the recruitment and hiring of new faculty** to teach in the programs. | | |
| **Creation of shared spaces** for wet bench and and clinical simulation spaces for training | | |
| Recruit clinical people to become **preceptors,** and create training programs to "train the trainers" | • Marketing campaign to attract those that are recently retired | |
| **Preceptors** should be compensated for their additional work in training through payment models or use training hours to fulfill CME requirements. | 1. Legislation being drafted to provide grants to preceptors<br>2. Legislation being drafted (Idaho) that allows the use of preceptor time for CME | |
| Create programs that **link academic institutions and clinical sites** so that cohorts of students ( approx. 25) | Bayhealth is currently using this model to train and recruit students. | |

# Grow the Health Workforce (cont.)

| | | |
|---|---|---|
| can be clinically trained in those specific locations, and as a part of the programs the students make a commitment to stay and work at the site for 3 – 5yrs after they complete their education. | | |
| **Recruit newly retired clinicians** and soon to be retired clinicians to be preceptors and instructors. Training is provided in part through training programs using simulation. | Legislation being drafted to encourage retired and soon to be retired to remain a part of the workforce by changing requirements for this group and encouraging their involvement in training. | |
| **Develop more training sites/ clinics** where students and trainers can learn and the sites are developed and supported through Economic development funding for buildings and equipment. | | |
| Develop **accelerated programs** that take advantage of individuals who already have workforce experience and are being re-educated and retrained in health fields which provides a shorter time to increase workforce. | | |
| Look at linking school programs to **early introduction of children to careers** in healthcare and link their school programs with apprenticeship programs and certificate programs. | | |
| **Embed entry level certifications** within current curriculum (those that are aspiring to become PA, Nurses, Physicians, etc. | | |

TC

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## II. Legislation/ Regulations

| Idea | Implementation Idea | Owner |
|---|---|---|
| **Scope of Practice :**Ensure that health care providers can practice at the top of their license through the development of legislation that expands their scope of practice. Particularly important for NPs, PAs, dental hygienists and dental assistants. | Legislation is being drafted to expand scope of practice for Pas, pharmacists, and dental hygienists. | |
| **Telehealth Reimbursement Parity** so all payers treat virtual visits equally and are reimbursed equally. | | |
| **Standardize requirements** Look at barriers to students training in clinical locations due to differences in needs for background checks, age restrictions, etc. by standardizing requirements. | | |
| **Review licensing requirements** for various health professionals that limit health care professionals from other states from practicing in Delaware. | | |
| Review possible engagement in **compact agreements** with other states which would bring more out of state people to our state to practice | | |
| | Changes in prior authorization requirements and process. | |
| | Prescription affordability | |
| | Caregiver support | |
| | Primary care reform | |

## III. Innovation and Technology

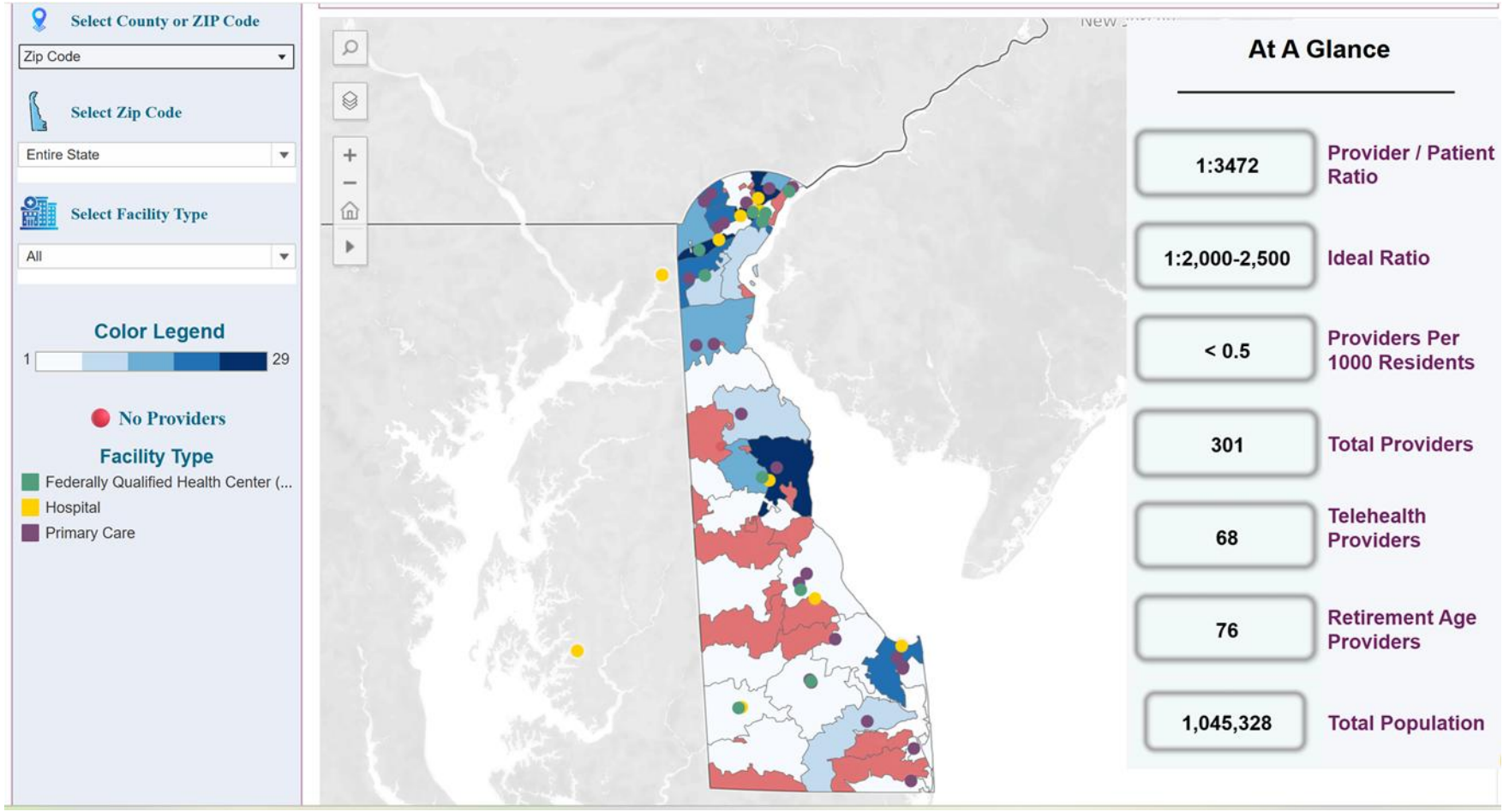
| Idea | Implementation Idea | Owner |
|---|---|---|
| **Telehealth,** use of technology to promote hospitals at home, monitoring and care delivery. Use of mobile units to provide rural health | | |
| Use of **online programs** for education paired with in person practicum experiences to reach more learners. | | |
| Purchase and **adoption of new technology** that enhances delivery of health care more effectively and efficiently. | | |
| Use of new technology that enhances **training programs.** | | |

**Healthcare Workforce Data Collection:**

a. Track healthcare workforce supply, distribution, with a focus on rural areas, and overlay areas of population density and chronic disease to determine supply and demand challenges

b. Create baseline data set and then track changes throughout deployment of the Rural Health Transformation Program.

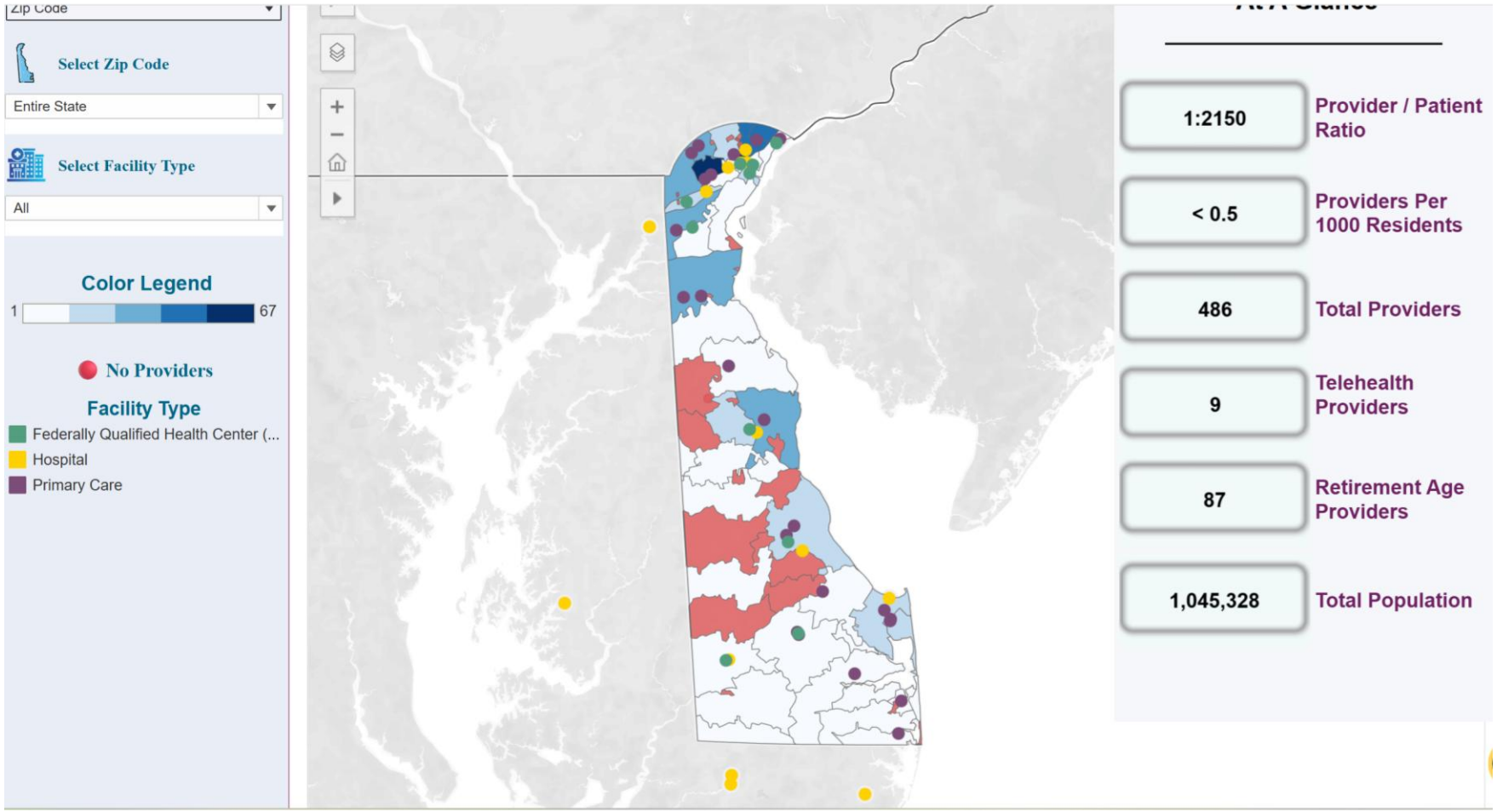
# Medical Practice/ MD/ Family Medicine




DHF Delaware Health Force

Analyze Data, Inform Policy, Enhance Health

# Dentistry/ Dentist

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# Healthcare Workforce Data Collection

| ARPA Funded | Dual Funded | RHTP Funded |
|---|---|---|
| • Data Use Agreement with Division of Professional Regulation<br>• Salesforce and Tableau Infrastructure<br>• Demographics: Age (DOB), gender identity, race, ethnicity, languages spoken.<br>• Credentials: License numbers, specialty, board certifications, education (degrees, institutions).<br>• Contact/Location: Practice address (city, ZIP), contact info, primary service area.<br>• Supply/Demand: Workforce supply, demand, and need projections.<br>• Employment: Employer, full/part-time status, FTE, employment status.<br>• Identifiers: National Provider Identifier (NPI)<br>• CMS enrollment data<br>• Data Use Agreement with Tapp Network and CHW Association<br>• Security: Strict HIPAA compliance, data encryption, access controls, and backup plans.<br>• Interoperability: Ability to share data securely across systems.<br>• Student loan management system (IVYTEK) and underlying loan pool | • SB122 data (starting this quarter)<br>• Practice Details: Area of practice, setting (hospital, clinic, long-term care), hours in direct patient care, types of services provided.<br>• Continued servicing of Chronic Disease data analytics from the DHIN<br>• Continued overall operations | • Retention: Retirement dates, turnover rates, reasons for leaving, burnout indicators (e.g., high sick/vacation days).<br>• Recruitment: Days to fill positions, application-to-hire timelines, recruitment sources.<br>• Productivity: In-service training, productivity metrics, service utilization.<br>• Insurance: Insurance types accepted (for planning access).<br>• Patient Outcomes: Quality indicators, patient satisfaction data (linked where possible).<br>• Socioeconomic: Indicators of socioeconomic class or underserved populations served.<br>• Social Drivers of Health Data (CDC Data)<br>• Health Profession Shortage Areas (HRSA)<br>• Chronic Disease Data (CDC, DHIN data)<br>• Transportation barriers (American Community Survey)<br>• Broadband Penetration (American Community Survey)<br>• Healthcare Access (American Community Survey)<br>• Rural Health Outcomes (Stroudwater)<br>• Limited English Proficiency (American Community Survey)<br>• Integration: Combining data from HR, licensing boards, surveys<br>• Analysis: Support for demographic analysis, geographic mapping, and predictive modeling.<br>• Access and Sharing: varies by stakeholder need<br>• Student loan management system (IVYTEK) could be extended to support various DHCC and RHTP needs |

**Other considerations from Delaware Health Force Leadership**

- Shortages can be viewed through various lenses: patient, institutional (hospital, FQHC, private practice), governmental (Federal, State, local). That optic matters when we are developing solutions.

- ARPA supported a statewide view, RHT needs to continue that model:
  - On the healthcare workforce side, we have over 50% of providers with multiple practice locations (as shown through license parcel data), in multiple counties.
  - On the patient side, we have patients from rural areas treated at peri-rural (Kent County) and non-rural (New Castle County) practices and institutions.
  - From an institutional service and catchment area perspective, we have a similar phenomena where primary New Castle County or Kent County institutions have locations in rural designated areas.
  - From a public health / population health optic, rural lines, like zip codes, are arbitrary constructs which have permeable membranes.

- Many types of caregivers are not licensed in Delaware at all – Medical and Dental Assistants and Director Service Providers are of particular interest. We recommend a remedy to accurately counting those providers who are working in direct patient/client capacity. They deserve to be counted so that we can see additional shortages, they also represent the potential start of a career ladder.

- **The 2026 Delaware Healthcare Workforce Summit** will be held on Wednesday, September 30th in Dover at the Bayhealth Conference Center. Focus will be Rural Health Transformation, with a secondary focus on statewide behavioral health workforce needs.