

**Health Reform: Health Professional Workforce Workgroup**  
**Wednesday, December 15, 2010**  
**North Carolina Institute of Medicine, Morrisville**  
**1:00pm-4:00pm**  
**Meeting Summary**

**Attendees:**

*Workgroup Members:* Tom Bacon (co-chair), John Price (co-chair), Joseph Crocker, Regina Dickens, Greg Griggs, Jill Hinton, Polly Johnson, Dontae Latson, John Perry, Glenn Potter, Tom Ricketts, Meka Sales, Margaret Sauer, Stephen Thomas, Brian Toomey, Helen Wolstenholme

*Other Interested Persons:* Richard Bostic, Myranda Broyles-Lewis, Alisa Debnam, Nancy Easterday, Katie Gaul, Rich Holdsworth, Tina Markanda, Catherine Moore, Cindy Morgan, Adebowale Odalana, Steve Owen, Donald Pathman, Chris Skowronek, Nzingha White

*Steering Committee Members:* Renee Batts, Erin Fraher

*NCIOM Staff:* Kimberly Alexander-Bratcher, Thalia Fuller, Berkeley Yorkery, Rachel Williams

**Welcome and Introductions**

*Thomas J. Bacon, DrPH, Director, NC Area Health Education Centers Program, Co-chair*  
Dr. Bacon welcomed everyone to the meeting.

**Impact of Medicaid Reimbursement Rates on Current Practitioners**

*Steve Owen, Chief Business Operating Officer, Division of Medical Assistance, North Carolina Department of Health and Human Services*

Mr. Owen presented an overview of Medicaid's reimbursement structure and how health reform could affect reimbursement rates. Some considerations the Division of Medical Assistance (DMA) has are the upcoming requirement that Medicaid primary care rates equal that of Medicare rates, the emphasis on medical homes, and the expansion of eligibility. Factors related to access such as payment incentives, performance measures, and pay for performance are also considerations. His presentation can be found here: [Medicaid Reimbursement Rates](#).

Selected questions and comments:

- Q: What options does Medicaid have to decrease costs? A: We don't believe rates will change; however, we are looking at what optional services we could stop covering. We are also looking at a combination of things such as modifying service options, changing usage patterns, giving incentives for using generic drugs, and increasing assessments.

- Medicaid is working on switching payment methods by using a more updated computer system. This new system will compensate more fairly and sustain the system.
- Medicaid rates are set in many ways. We would like to get away from cost-based rates because the differentials between two providers are significant. A competitive fee schedule we can sustain is currently the goal of Medicaid.
- Workgroup members were glad to hear that Medicaid is not currently talking about cutting primary care reimbursement rates as a way to meet budget cut requirements. They stressed the importance of reimbursement rates on primary care practices, particularly those with high Medicaid patient loads.

### **Strategies for Recruitment and Retention of Health Professionals in Rural/Underserved Areas**

*Donald Pathman, MD, MPH, Department of Family Medicine, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill*

Dr. Pathman reviewed two approaches to building the health workforce in North Carolina. One was to take full advantage of the National Health Service Corps (NHSC). The NHSC offers a loan repayment program for primary care providers, behavioral health specialists and dental practitioners who practice in a medically underserved area. North Carolina could combine the NHSC loan repayment program with its own state loan repayment program to help reduce state costs. The second strategy was to teach communities how to recruit and retain health care workforce. North Carolina could model a program based on West Virginia's Recruitable Community Program (RCP). This program consists of training communities on how to recruit practitioners through improving the community's image and enhancing community development. His presentation can be found here: [Recruitment and Retention](#).

Selected questions and comments:

- We would like to guide recruits to the NHSC first and then use the state program to cover the rest of the loan repayments.
- Q: How do you determine how many slots a state has? A: There is no specific amount allotted to each state. The country has a certain allotment so the number of recruits in North Carolina depends on how many of them work in the state.
- Q: What commitment is expected from a recruit? A: The length of term in an underserved area is two years. If you don't fulfill that commitment then you have to pay back the NHSC plus interest and a fee for each month you don't serve. After the initial two years it is a year by year basis.
- Even the most satisfied practitioners leave over the course of ten years. There is a natural turnover due to personal life changes, business changes, better opportunities, etc. We can't expect those in the program to stay forever.
  - Urban and rural areas have similar retention rates.

- A program similar to the West Virginia program in North Carolina would help with shortage areas by linking residents with communities in need. The communities are not organized to recruit. This program would also help a professional support group in the community and increase communication among local providers.

### **Some Engaging Models in Primary Care**

*Thomas C. Ricketts III, PhD, MPH, Deputy Director, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill*

Dr. Ricketts gave the workgroup a brief overview of retail clinics and how they could be integrated into the safety net system. Retail clinics, such as those in CVS, Wal-Mart, and Walgreens, offer a limited set of services focused on a small number of problems. While only 1.2% of people have used one in the past 12 months, about 16-27% of those were uninsured. A majority of patients are young, middle-class, and live in suburbs. There are three models of “minute clinics”: store owned, independently owned, and health system owned. Many retail clinics do not turn a profit which is why the number of new ones has leveled off over the past several years. North Carolina currently has 29 of these clinics. It appears that the third model, health system owned, is gaining popularity and is likely the future of such clinics.

“Minute clinics” have been viewed negatively in the past by health care professionals; however, that view might be changing. The Centers for Medicare and Medicaid Services (CMS) has already created a coding category for retail clinics. Health reform could provide the infrastructure needed to integrate retail clinics with other health care practices allowing for more coordination of care. It isn’t known what the draw on the regular system would be, but so far there has not been an impact on the practitioner supply in North Carolina. In fact, retail clinics have had no problem recruiting and they might even increase the demand for nurse practitioners and physician assistants in primary care. The Department of Health and Human Services and Medicaid are currently looking at how these retail clinics can be used to increase access.

Selected questions and comments:

- As a practitioner, I find that these clinics fragment the care I provide. If a patient uses a retail clinic and I have no way of coordinating with them then it not only interferes with my record but also generates more testing.
- These clinics are all about the business model, not about providing quality health care.
- We are talking about patient-centered care and if our patients want to go to Wal-Mart because it is more convenient then we should look into coordinating with these clinics more. There are variations on this theme that could do things the right way.

## **Innovative Strategies for Training, Recruiting, and Retaining Primary Care Health Professionals**

*Nzingha White and Debo Odulana, Students, UNC Gillings School of Global Public Health*

Ms. White and Mr. Odulana presented research on options to improve the health workforce in North Carolina. The first option is to create teaching health centers (THCs). THCs are community-based health centers for the underserved. They increase the number of primary care providers for the underserved, appeal to both community health centers and residency programs, and provide high quality training. Another option is to use innovative models to increase the workforce in underserved areas. Innovative models include graduate medical education, post-secondary education, and workplace initiatives. Their presentation can be found here: [Future Health Care Workforce for NC](#).

Selected questions and comments:

- Q: There have been similar studies in obstetrics in recruiting to underserved areas that found the workforce steadily declined due to self selection. Was there any controlling for that in these studies? A: No. Many residents that applied for the programs were seeking to work in community health centers.
- Q: What does the current nurse supply look like? A: The economic downturn has led to less recruitment because we do not have the faculty or capabilities of expanding nursing education at any level. People are hanging on to nursing jobs and not leaving.

### **Public Comment Period**

No further public comments were given.