



**Health Professional Workforce Workgroup Meeting Summary**  
**Thursday, August 19, 2010**  
**NC Hospital Association, Cary**  
**1:00-4:00**

*Workgroup and Steering Committee Members:* Tom Bacon (co-chair), Alan Mabe (co-chair), John Price (co-chair), Graham Barden, Renee Batts, Danielle Breslin, Joseph Crocker, Paul Cunningham, Regina Dickens, New Fowler, Erin Fraher, Catherine Gilliss, Jill Hinton, Mary Johnson, Alex Parker, John Perry, Glenn Potter, Tom Ricketts, Maggie Sauer, Dennis Sherrod, Sandy Spillman, Justine Strand de Oliveira, Marvin Swartz, Lorie Williams

*Staff and Interested Persons:* Richard Bostic, Sally Cameron, John Dervin, Michelle Goryn, Catherine Liao, Tina Marcanda, Catherine Moore, Cindy Morgan, Chris Skowronek, Pam Silberman, Carl Taylor, Berkeley Yorkery

**Introductions**

Alan Mabe welcomed everyone and thanked them for the important work they were about to undertake. Each co-chair gave a brief introduction and then other workgroup members and guests introduced themselves.

**Overview of Health Reform, Structure of the Workgroups, and the Charge of this Workgroup**

*Pam Silberman, JD, DrPH,  
President and CEO, North Carolina Institute of Medicine*

Dr. Silberman gave an overview presentation of the main provisions in the Patient Protection and Affordable Care Act (“Affordable Care Act or ACA”) and the structure of the health reform workgroups. Click here to view the presentation: [Reform](#) .

**Overview of Workgroup’s Specific Provisions from the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010**

*Berkeley Yorkery, MPP  
Project Director, North Carolina Institute of Medicine*

Berkeley Yorkery gave an overview presentation of provisions of the ACA that deal with the health professional workforce and the charge to this workgroup. Click here to view the presentation:  or a summary of the

*Selected Comments/Questions:*

- Comment: Reminder that many of the provisions to be considered by this workgroup have been authorized only and not appropriated. Grants that came out this summer came down very fast with little notice and little turnaround time. Part of our challenge is looking at all of this in a systematic, organized, and planned way; we may or may not decide to bring some resources into the state depending on what is best for our state.
- Q: Is it on someone’s worry list to track the grant funding and alert relevant groups?

- No one is looking at this in a systematic way. The overall advisory group will be discussing this.
- Comment: Right now at the federal level a lot of what is happening is proposed rulemaking. The Department of Health and Human Services, Health Resources and Services Administration, and the Centers for Medicaid and Medicare Services have to come up with 500+ new rules. The next step is reviewing the rules and being aware of what the rules are saying. The [redistribution](#) came out 3-4 weeks ago about how to redistribute residency programs. It's not grants.gov; it's the federal register that has to be monitored. This is done best by the federal liaisons and lobbyists with national associations. That will come to you as part of your federal relations folks. The allocation of GME or the Public Health Services Track would depend on a definition of rurality or underservice or some other definition we ought to comment on. We need to be cognizant of those things that are going to affect us based upon new rules.
- Q: Built into this bill is leveling the playing field, but the playing field is not currently level, particularly in the ability to respond to grants. Some of our neediest communities have no capacity to take advantage of the opportunities. What are the rational logical ways of putting our arms around what seems to be magnified community effort?
  - How do we mobilize resources in places in the state that have the fewest resources? It's a challenge for funders and agencies and others. Your other point about the lack of formal connections between a lot of our systems is the nature of US health care and education. The advantage of a group like this is at least at a collaborative level we can make those connections in a more rational and informed way.
- Q: What is going to be the interaction between the various health reform workgroups? For example, this workgroup overlaps with the new models of care workgroup, as their provisions will impact on the health professional workforce.
  - NCIOM is staffing all of them, so we will try to relay information between workgroups. You are welcome to participate in other workgroup meetings, particularly online, and you can check our website.

### **Existing Implementation Efforts: National Health Service Corp Update**

*John Price, MPA*

*Director, North Carolina Office of Rural Health and Community Care*

John Price gave an overview of the National Health Service Corp (NHSC) including its mission, how the program works, and areas targeted by the NHSC. He also provided information about ARRA and ACA funding for the NHSC. Mr. Price also provided information about state medical, dental, and psychiatric provider incentives. Click here to view the presentation: [\\_ .](#)

#### *Selected Comments/Questions:*

- Q: How are health professional shortage area (HPSA) and medically underserved area (MUA) determined?
  - In 1968, 1971, and 1974, Congress create HPSA and MUAs (medically underserved area) that will allow for a population or institution to be designated

as a critical shortage area. Now, anything that's been designated has been grandfathered into place. Two years ago, a proposal came out to change the formula and to designate dental and mental health shortage areas.

- For more details, click here: [\\_](#)
- Comment: You can see that there are a lot of counties that are actually shortage areas that are not designated as such. That doesn't mean they don't have a health professional shortage. Also, the mental health workforce can get federal loan repayment. It's not clear how well-known that is. If we could recruit someone who's new and still has loans, the Office of Rural Health could help link them with the NHSC.

### **Two Views on Health Reform and the Workforce**

*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 an overview of health reform's possible impacts on the health professional workforce including summarizing the major changes that health reform will likely bring to the health professional workforce. Click here to view the presentation: [Views on Health Reform and the](#)  
[the](#)

#### *Selected Comments/Questions:*

- Q: Can you describe the NC planning grant that was submitted this summer?
  - In early July, a state workforce planning grant became available to address primary care workforce. The grant application was a collaboration among AHEC, community colleges, UNC system, and others. At this point, it's a planning grant. There may be funding later on to actually expand the primary care workforce. We should hear in September.
- Q: What are the community colleges doing?
  - The community colleges were a partner on the workforce planning grant. We've also applied for HRSA 10-288 grant: personal and home care aide state training program; DHHS took the lead. \$2 million, three-year grant to develop competency training program for direct care workers. Certification for a med tech. Hopefully we'll hear by September 30.
- Q: How will the unused GME slots that are going to go to states that have a high population/low residents be assigned?
  - Under the proposed rules have been issued by CMS three weeks ago. NC doesn't fit in any of the three categories, so NC will not be eligible for extra GME slots. Click here to view: [Proposed Rule \(1504-P\)](#)
- Q: How do new teaching center residents fit into our existing GME slots?
  - Those slots are not tied to Medicare. It's a direct-funded residency program, but there's a cut-off. If these are implemented and succeed, there will be pressure to bring them into the Medicare program. There's intense pressure in Congress to reform GME. MedPAC has made recommendations, so Congress will likely take up this issue next year.

- Comment: We have heard that community health centers should partner with accredited entities to acquire teach center GME slots. That should be coming down the pike soon because funding was appropriated. Need to think about that now instead of waiting.

### **Discussion of Workgroup Goals**

Alan Mabe facilitated a workgroup discussion around the goals of this workgroup moving forward.

- Comment: This is the workgroup with the greatest possibility of contention. Is there any benefit to start with guiding principles, with our goal being doing what's best for NC?
  - General agreement that guiding principles would be good. To do this, the group feels they need more information about the state of North Carolina's health professional workforce and the areas of greatest need.
  - It's going to be a combination of where is the greatest need and what has the most potential in health reform?
  - We can't just think of geography but a need for new organizations and getting the right people into them. Can't think of just where but think of how we'll meet needs.
- Comment: With health reform there is also going to be an emphasis on collaboration among Dept of Labor, HHS, etc. We need to have discussions about how we integrate agency missions. The new focus is on direct care; we need to think outside traditional primary care providers.
- Comment: Everyone is focused on how to make more docs and ancillary folks. We also need to look at our current workforce and how to not lose what we already have. Changes in payment can dramatically affect providers, particularly those serving in rural areas who have large Medicaid caseloads. How do we create less uncertainty for practicing docs?

### **Public Comment Period**

There were no public comments.