

Health Reform: Health Professional Workforce Workgroup
Friday, January 21, 2011
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:

Workgroup Members: Thomas Bacon (co-chair), John Price (co-chair), Joseph Crocker, Regina Dickens, Ned Fowler, Greg Griggs, Polly Johnson, Dontae Latson, James McDeavitt, Glenn Potter, Margaret Sauer, Justine Strand de Oliveira, Marvin Swartz, Stephen Thomas, Brian Toomey, Helen Wolstenholme

Steering Committee Members: Erin Fraher

NCIOM Staff: Thalia Fuller, Rachel Williams, Berkeley Yorkery

Other Interested Persons: Jessica Carpenter, Alisa Debnam, Nancy Easterday, Katie Eyes, Katie Gaul, Meredith Kimball, Eugene Maynard, Susan Mims, J. Carson Rounds, Kim Schwartz, Chris Skowronek, Tom Wroth

Welcome and Introductions

Thomas J. Bacon, DrPH, Director

NC Area Health Education Centers Program

John Price, MPA, Director

NC Office of Rural Health and Community Care

Mr. Price welcomed everyone to the meeting.

Employer Prospective: Existing Barriers to Achieving an Effective Mix of Health Professionals in Patient Centered Medical Homes

Tom Wroth, MD, MPH, Medical Director, Piedmont Health Services

Piedmont Health is a federally qualified health center (FQHC) consisting of six sites. Four of those sites have dental programs and/or nutrition and WIC programs. Health professionals on staff include physicians, nurses, physician assistants, dentists, dental assistants and a midwife. Piedmont provides cradle-to-grave care with the exception of delivering babies and providing hospital care. Dentists have been the hardest to recruit, however, the past two years it has been hard to recruit physicians as well. Providers give care to patients of all ages.

Piedmont Health plans for staffing using various factors including the physician-population ratio, infant mortality, HPSA rating, and internal data such as waiting lists and patient load. Piedmont uses some health professions data system data when making the case for adding a new location or otherwise expanding.

A major barrier to recruiting providers is compensation. A patient centered medical home usually cannot pay a provider as much as a private practice can. The National Health Service Corps loan repayment program has helped negate this factor but not completely. Another barrier is lack of exposure. Many new graduates from professional health programs have not been exposed to rural safety net practices. There is evidence that graduates are more likely to practice in a setting they were exposed to during their education.

Kim Schwartz, MA, CEO, Roanoke-Chowan Community Health Center

Roanoke-Chowan Community Health Center is a FQHC that serves Hertford, Bertie, Northampton and Gates counties. There are four sites with 17 providers including physicians, nurse practitioners, and physician assistants. The Center serves patients of all ages and uses the patient-centered medical home model of integrated care. To provide specialty services, the Center leases out space to specialists. The Center is also the first co-location of a community health center and a dental program through East Carolina University.

There are several barriers to recruiting providers including lack of space and funding. Other barriers include finding providers that can handle the generational poverty of the Center's population and who represent the population of the community. Local school systems also struggle which leads to challenges when recruiting doctors with young families.

To meet the needs of the patient population given the difficulties in recruiting, Roanoke-Chowan uses nurses to the fullest extent possible and employs a large number (30 RNs and LNs). Another educational barrier is that many nurses have not had primary care experience during their education. However, the North Carolina Community College System has been a huge help in educating nurses.

*John Carson Rounds, MD
Village Family Care in Wake Forest*

Village Family Care is a family medical practice that offers a full range of health services to patients of all ages to eliminate the need for multiple providers. Practitioners at Village Family Care include physicians, physician assistants, nurse practitioners, and certified medical assistants. The physicians provide most of the geriatric care and physician's assistants and nursing staff provide much of the pediatric care. Non-clinical staff work on administrative functions and lab analyses.

Until recently, Village Family Care had a reactive hiring model—when a new clinician or staff member was needed they were hired. Due to the economic downturn and problems with recruitment, the practice has begun a more reactive hiring model and looks at factors such as patient feedback and other metrics. If we could add a staff member whose role was on care coordination and connecting people to health resources that would be very

helpful, but there is no source of funding for this type of staff. More licensed nurses are needed, there is a need to integrate mental health, and more chronic disease management is needed.

One barrier to recruitment is compensation since many providers can make more money working for specialists. Another challenge is the changing needs of the office. These changes lead to new needs in staffing and staff training for existing staff. One change is the transition to a more patient-centered model as described by the ACA. Training is needed in the patient centered medical home model and in integration of mental health care.

Eugene H. Maynard, Jr., MD, Benson Area Medical Center

Benson Area Medical Center is a rural health non-profit clinic—which is somewhere in between a rural health clinic and a private practice. The Center serves over 11,000 patients and the majority of our patients are on Medicare and/or Medicaid. The Center’s staff includes family physicians, physician assistants, and a part-time pharmacist. Services include family medicine, medication management, diabetes education, and laboratory testing. The Center would like to offer nutritional counseling and mental health services on site but funds are not available.

The Center is becoming more proactive in recruiting new staff. Annual program evaluations, provider meetings and staff input are used to match services with their patient needs.

One barrier to recruitment for the Center is competition from other practices. Since the practice is located close to Raleigh, the Center has the benefits of recruiting from good schools and other amenities offered by the city, but also the challenge of offering competitive compensation. Another challenge is the increase in female providers. The Center has had many female providers go from full-time to part-time after having children, which creates a need for more physicians. Working part-time as well as changes in residency training have also had effects on the professionalism within the Center since part-time providers view work as shifts rather than as a career. This new outlook on professionalism makes it harder to find someone to cover after-hour shifts. A final barrier to providing services is coding and licensing. The pharmacist on staff cannot be reimbursed for diabetic education due to these issues.

Selected questions and comments:

- Q: Ms. Schwartz, can you expand on Roanoke-Chowan’s telemedicine program?
A: Remote monitoring is a tool we use for diabetes management. The equipment goes home with the patient and monitors glucose, blood pressure, pulse ox, and weight. The information is transmitted via Bluetooth and then downloaded to a nurse via the Internet. One nurse can manage about 200 patients. The nurses are alerted when a patient reaches certain markers, such as a high blood glucose level. A protocol is in place to handle those situations. Providers are also notified of a patient’s progress and the information is very helpful to have for 90-day visits. In

a four-year period, there has been a 70% reduction in hospitalizations for those using the monitors for six months. The system works for both urban and rural populations. We are currently working on a behavioral health system for chronically depressed patients.

- Q: What do payments look like for each of you?
 - Dr. Wroth: About 50% of our patients are self-pay, 30% Medicaid, 10% Medicare and the rest are private payers.
 - Ms. Schwartz: Twenty percent of our patients are self-pay, 30-40% are private payer and the rest is Medicare and Medicaid. Many of our pediatric patients are on Medicaid.
 - Dr. Rounds: About 20-25% of our patients are Medicare and/or Medicaid, 4-5% are self-pay and the rest have commercial insurance.
 - Dr. Maynard: Fifty-five percent are Medicare and/or Medicaid, 10% are SUB-pay, 3-4% are covered by a migrant worker grant, and the rest are privately insured.
- Q: What are the challenges of integrating behavioral health into medical practices?
 - Dr. Wroth: We are just starting to look at pilots of those models. We have not had a lot of experience with it in the past.
 - Ms. Schwartz: Reimbursement is an issue. For instance, Medicare patients do not have reimbursement for behavioral health. Group visits, which have been shown to be successful, are hard to do. In addition, paying for a behavioral health practitioner and educating providers on protocols is difficult.

Workgroup Discussion

Erin Fraher, PhD, Director, Health Professions Data System, Cecil G. Sheps Center for Health Services Research

The workgroup discussed the results of a survey conducted before the meeting. Workgroup members were asked what kinds of barriers they have experienced in recruiting health professionals. The survey resulted in the following themes:

1. Financial
 - a. Current financial crisis
 - b. Aligning reimbursement with the vision of PCMH
 - c. Sustainability
 - d. Providing competitive wages
 - e. Administrative overhead
2. Educational
 - a. Re-tooling the existing workforce to fit in with new models
 - b. Training the new workforce to fit in with new models
 - c. Clinical exposure for those that don't already receive it
 - d. Pipeline development
 - e. Diversity
 - f. Faculty shortages
 - g. Transitions from educational setting to clinical setting

- h. Scope of practice
- 3. Implementing integrated care
 - a. Scope of practice
 - b. Role definition
 - c. Cultural integration with other providers
 - d. Licensing
- 4. Skill mix
 - a. Dental
 - b. Behavioral health
 - c. Nutritional
 - d. Care coordination
 - e. Patient navigation
 - f. HIT/HIE
 - g. Patient education
- 5. Planning for changing workforce demographics
 - a. Aging workforce
 - b. Feminization of workforce
 - c. Generational effects
 - d. Recruitment and retention in rural areas
- 6. New models of care
 - a. Education around new models and new roles
 - b. Mining best practice models that already exist
 - c. Metrics and collecting information about populations

Selected questions and comments:

- How do we move beyond the statutory requirement for supervision for non-physician providers? There are restrictions on where non-physician providers can provide care and therefore restrict access to care. If that provider works in needy area and they cannot find a supervisor then it restricts care for the patients. Removing supervision does not mean people will work independently in the real world.
- There is no health care training to those in low-demand jobs. For example, technology experts losing jobs do not have training available to get a job in HIT.
 - Are the community colleges not prepared for that? Some are, but people do not want to spend money on training when they are not sure they are going to be laid off. After being laid off, they do not have the money for training.
- Retention depends on finding local providers. There should be more medical school slots opened to people from rural communities.
 - Other states have had success in recruiting people from certain areas. North Carolina has done very little of that since schools say it impedes their ability to accept the best students.

Public Comment Period

No further public comments were given.