

**NCIOM Health Professional Workforce Workgroup
Potential Recommendation Ideas
May 27, 2011**

Background: The NCIOM health reform workgroups are developing recommendations for inclusion in the final report to the legislature. The recommendations must be related to North Carolina's implementation of the Affordable Care Act. The workgroup discussed many topics over the past seven meetings. We have tried to take the ideas raised in them and divide them into topic areas rather than by type of provider (which is how we often discussed them). As you think about potential recommendations for the final report, please keep in mind these questions:

- What changes are needed to maximize North Carolina's ability to take advantage of federal funding opportunities for workforce development?
- What changes are needed to ensure the most people have access to high quality primary care as eligibility increases in 2014?
- What changes are needed to get to the kind of patient-centered, team-based care (health home) that is envisioned in the ACA?

Note: The charge to this group was to focus on short-term solutions (1-5 years) to issues raised by the ACA.

Recruitment and Retention: National Health Service Corp

Concern: The ACA included a large increase in funding for the National Health Service Corp (\$1.5 billion over 5 years). We know that loan repayment (state and national programs) are good at getting people into underserved health professional areas, but is there more that we could be doing to support/expand the ability of such programs? We need to ensure that the Office of Rural Health and Community Care maintains its ability to conduct these programs and related activities in NC.

Ideas Raised by the Workgroup:

1. Look at ways to use NC state funds to help communities improve their ability to recruit health professionals. The ORHCC currently does this to some extent but could be expanded.
2. To improve retention, could consider using retention bonuses to keep health professionals in underserved areas. This could be tied to incentive programs at the ORHCC if additional funding were made available.
 - a. Where would funding come from?
 - b. How could they be structured to keep health professionals more than an extra year or two?

Question raised by the workgroup: Are changes in current budget going to compromise ORHCC's recruitment activities negatively?

Barriers Identified by the Workgroup:

- There are good reasons that health professionals do not choose to stay in rural/underserved areas. Most deal with the lifestyle provided by the area for them and their families and can be difficult to change.

Planning for the Future

Concern: We have a changing workforce, and we are not proactively planning well. NC needs to be bringing people together to plan on local and regional levels on a regular basis to evaluate health professional data (and ideally population health data) to plan for workforce needs.

Ideas Raised by the Workgroup:

1. Create a State Health Workforce Planning Group of some sort
2. Need data on:
 - a. Projection of workforce needs based on the increase in newly insured 2014-2019.
 - b. Projection of areas of greatest need by specialty, location, and race/ethnicity.
3. For proactive planning, need more data on (rather than planning based only on number of practitioners per population)
 - a. Population health and community health (outcome measures)
 - b. Practice patterns- what types of professionals are in practices, the populations practices serve
4. Need information on what ECUs dental students are doing after graduation- where do they go, who do they serve, type of practice they are in so that admissions policies, new model of training, etc. can be evaluated. Currently the school is planning on doing this, we just do not know the extent of data collection and if they need any support for this work. Ideally would have this from all health schools.

Barriers Identified by the Workgroup: Funding and data limitations.

Billing and reimbursement: Medicaid Access

Concern: The Medicaid population is expected to grow by approximately 500,000 individuals (mostly adults) from 2014-2019. Medicaid reimbursement rates are critical to a variety of health professionals serving this population. Need to keep rates adequately high to keep providers participating. The group heard from Steve Owen in December that DMA is not planning on cutting rates at this time.

Idea Raised by the Workgroup:

1. Recommendation to maintain or increase current Medicaid reimbursement rates for various professionals/services.
 - a. Rates sometimes vary by the type of health professional providing the service rather than the service being provided.

- b. There are fairly large disparities in reimbursement based on credentials for mental health services. Should NC consider equalizing reimbursement rates for mental health services?
- c. May want to specifically discuss the Adult Medicaid Dental Benefit
 - i. Is it important for NC to continue?
 - ii. If considering cutting, do need to retain for certain high-need/hard to reach populations (e.g. those in long-term care, with special healthcare needs, pregnant women)

How to Restructure the Existing Workforce to Meet Demands in 2014

Concern: Need to expand the existing workforce's ability to care for the influx of 1.1 million newly insured individuals from 2014-2019. While some of this need may be met in the long-term by an increase in the size of the workforce, there are things that could be done to increase the ability of the existing workforce to meet the forecasted increase in need for primary care services. There are some barriers within the current system that restrict some health professionals from providing primary care services that are within their education and training to provide.

Additionally, the ACA focuses heavily on the health home (aka patient-centered medical home) as a model for providing care. The model of health care provision laid out in the ACA is one of integrated systems and team-based care. To get to this model, we need to reform billing codes to include all qualified professionals who might provide primary/preventive care in a health home.

Idea Raised by the Workgroup:

1. Need to encourage changes so that NPs, PAs, mental health professionals and others who may currently not be able to bill for certain primary care/preventive services are able to. What keeps some medical professionals from being able to bill for certain primary care/preventive services?
 - a. Oversight rules?
 - i. The workgroup talked specifically about the supervision requirements for nurse practitioners and dental hygienists, but there may be other health professionals affected by similar rules.
 - b. Licensing?
 - c. State regulations?
 - d. Insurance companies' policies?
 - i. Who can be reimbursed at what rates for which services?
2. Need to identify ways to fund care coordination, patient navigators, and other new staff roles. Per member per month payments are used in CCNC to support these services, how can this idea be expanded to non-CCNC practices?

Barriers Identified by the Workgroup:

- How do we work with dentists and physicians to increase their comfort with delegation, allowing other providers to practice to the top of their education and scope of practice?
- Why and how insurance company payment policies are set is unclear. This can be particularly challenging as each company sets their own policies.

Workforce Size

Concern: With an estimated 1.1 million currently uninsured North Carolinians gaining coverage between 2014 and 2019, demand for primary care and other health care will increase dramatically. Without increases in the current supply of health professionals these newly insured individuals may still be unable to access health care services due to shortage of providers. While demand will increase for a wide variety of health professionals, given the emphasis in the ACA on primary care, there is likely to be a great increase in demand for primary care providers. This is not limited to providers as it will also increase the demand for primary care support staff.

Additionally, the ACA focuses heavily on the health home (aka patient-centered medical home) as a model for providing care. We need to look at projections of the types of health care professionals and support staff that are needed in a health home model. This is somewhat difficult without knowing exactly what staff will be needed to support tomorrow's health homes. However, based on NC's experience with CCNC and FQHCs, we know that each home health network is likely to employ wide range of professionals including physicians, PAs, nurses, dentists, case managers/care coordinators, medical directors, pharmacists, psychiatrists, psychologists, social workers, quality improvement coordinators, informatics managers, and others as part of their team

Ideas Raised by the Workgroup:

1. Need to increase the number of primary care providers of all types.
 - a. Do any particular types of primary care providers need to be highlighted?
2. Need to increase the number/types of support staff
 - a. What types of support staff are needed in a health home model and what do we know about the numbers of those needed
3. What other types of health providers are critical to a health home?
 - a. Mental health (particularly with a focus on children)
 - b. dentist (particularly those trained to see children)
 - c. others?

Barriers: How should NC go about increasing the workforce in the absence of federal funding?

Increasing Health Professionals in Underserved Areas

Concern: Need workforce to more accurately reflect the NC population and need to increase primary care health professionals in rural/underserved areas of the state. The ACA includes many incentives to increase workforce diversity and to encourage primary care health professionals to spend time working in underserved areas through targeted scholarship and loan forgiveness programs.

Evidence from various presenters to the workgroup shows that minority health professionals, health professionals from rural backgrounds (particularly rural NC), and those with an altruistic orientation are more likely to serve in underserved health professional areas/safety net organizations.

Ideas Raised by the Workgroup: Could look at school admissions criteria

1. The workgroup could recommend changing health professional school admissions criteria at state schools. We should be defining the types of health professionals we need and then recruiting for these needs
 - a. Can we hold our public universities and the public funding they receive accountable for the health professionals they output
 - b. Tying medical school funding to the types of professionals coming out, where they serve, and who they serve could dramatically change outcomes
2. Need to start a lot earlier (stem cell approach) to give students opportunities. If students can meet certain benchmarks and meet requirements, then maybe schools can guarantee admission. Can do this across the range of programs and start with people across a broad range of communities and start earlier. "Provide opportunities to get on and off the train."

Ideas Raised by the Workgroup: Potential ways to incentivize practicing in underserved areas beyond student loan forgiveness programs:

1. Med society should work with groups in rural NC to discuss how we can enrich various communities to encourage people to live and stay in these areas. Some issues include area industries, economic development, schools, and employment opportunities for spouses.
2. Loan "forgiveness" (state pays them) for folks who set up practice in designated underserved areas for at least a certain minimum number of years and/or see a certain percentage of Medicaid patients in their practice.

Barriers Identified by the Workgroup:

- Need to respect medical school acceptance policies
- Long standing support for the current system of funding medical student education and residencies
- National residency placement program impact where medical students end up practicing
- There are good reasons that health professionals do not choose to stay in rural/underserved areas. Most deal with the lifestyle provided by the area for them and their families and can be difficult to change.

**Changes to Educational Training and Residency Programs to Increase Exposure
to primary care/underserved health areas/safety net practices**

Concern: Health professionals exposed to primary care/underserved health areas/safety net practices during training are more likely to serve in those settings after completion. How do we ensure more NC health professional schools are exposing students to these types of settings during training?

Ideas Raised by the Workgroup:

1. More residency settings outside of the hospital setting using teaching health centers and the federal funding that is available to support THCs. North Carolina did not get one of the THC grants, but are there other ways to pursue expanding residency programs to include more time in/options for training in community-based ambulatory patient care centers such as Federally Qualified Health Centers and Rural Health Clinics?

Barriers Identified by the Workgroup: Training students (medical, NP, PA, nursing) can exacerbate problems that primary care physicians are already having. Training students slows down productivity. More students = need for more preceptors = more pressure on community training sites. This can affect quality of care, finances, and level of stress on the preceptor. Keep this in mind as new education programs are developed (PA, DO...).

Concern: We need to change the way current health professionals are training so that we are training health professionals in integrated settings around team-based care. Current training models for most health professionals are siloed so doing this would require restructuring current training models. Training needs to incorporate how to work in interdisciplinary teams.

Ideas Raised by the Workgroup:

1. Need to invest as a state in curriculum changes and clinical training opportunities so that health professionals are prepared to practice in new models of care. Need to train in interdisciplinary teams.
 - a. There are existing models of interdisciplinary, team-based care and education programs, and we don't need to start from ground zero. Rehab teams and university-affiliated programs have been doing this. Teach people how to work in teams and to work with the patient and their family. We are not starting from ground zero, these programs have been doing this. The center for developing and learning is well known, but they are getting less and less attention because reimbursement around those team-based models has gone away.
2. Need to increase information about public health and incorporate more service learning.
3. Need to train health professionals about other types of providers and how different providers can help one another provide services
 - E.g. primary care providing dental varnishes, primary care behavioral screening

Barriers Identified by the Workgroup:

- Battling against ingrained systems and methods of training. Need to retrain the educators in order to correctly train upcoming workforce.

Concern: In order for health professionals to be prepared to go into underserved areas and run medical/dental practices, they need training in leadership and business skills. These are not typically a major component of medical/dental education. Need to better prepare medical students for realities of running practices- in a changing practice environment.

Ideas Raised by the Workgroup: Look at incorporating more leadership and business training into the standard medical/dental school education. The ECU dental school is going to do this with their students.

Barriers Identified by the Workgroup: This kind of education takes away from time spent on medical/dental education.

Dental Specific Considerations

- Do we need to expand dental hygienists scope of practice
- Need information on dental residency programs in NC
 - Where are they?
 - Numbers enrolled
 - Who is in them (demographics, educational background, etc)
- Making Board of Governors scholarships available to ECU students (in addition to UNC)
- Licensure by credentials policies