



Rural Health Workforce Issues Challenges and Opportunities



National Rural Health Association

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NATIONAL RURAL TASK FORCE
RURAL HEALTH WORKFORCE ISSUES
CHALLENGES AND OPPORTUNITIES

Meeting summary
July 15 - 16, 2009

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Executive Summary

Background

The National Rural Health Association (NRHA) is dedicated to assuring access to high quality health care in all rural and frontier communities of the United States. In an effort to support this goal, the NRHA has established a multi-disciplinary National Rural Task Force (NRTF). The purpose of the task force follows:

To help rural communities move toward the improvement and expansion of access to health care, it is important to continue partnering with other organizations in order to expand and improve access to culturally competent, quality health care and to ensure services are appropriately available to rural and frontier patients, including primary and preventive services, as well as enabling services.

Task force mission

To discuss rural issues and communication strategies, and to build partnerships to promote the long-term growth and sustainability of rural community/migrant health centers (C/MHCs).

Through collaboration, task force members develop common goals. Additionally, members share their varied work and life experiences, and then as a group develop policy recommendations. The end result is to advance the national goal for access to a “health home” for all rural Americans.

NRTF had its third annual meeting July 15 and 16, 2009, in Arlington, Va., and this summary describes the discussion and outcomes of the meeting.

Day 1 - July 15, 2009

Opening: Marilyn Kasmar, chair, and Mike Samuels, vice chair

Kasmar and Samuels thanked NRTF members for their commitment to the work. They stated their appreciation for the good attendance for the six teleconferences which took place between annual face-to-face meetings. The topics and presenters for the 2008-09 teleconferences came directly from recommendations made at the 2008 annual meeting.

Welcome: Alan Morgan, NRHA CEO

Morgan stressed the importance of NRTF to NRHA and its partner organizations. He stated that he is looking forward to the policy recommendations to help support the work of NRHA and its government affairs activities.

Meeting goals and ground rules: Carol Miller, facilitator

Miller stated the goal of the meeting was to develop a brief but hard-hitting, one-page policy statement to be completed quickly and integrated into current health reform discussions.

Miller thanked the group for the respect the members show each other. Now that the group has worked together and grown strong, the only ground rule is that everyone must participate. She stated that there would be three “round robins” where participants are asked for comments and then time to break into small groups for further discussion.

Introductions

Members and guests of the task force introduced themselves and stated their individual goal for the meeting. Ideas and key points raised were written on a flip chart, annotated below.

Update: The Obama Administration’s efforts on behalf of rural C/MHCs

Health Resources and Services Administration (HRSA) leaders, Donald Weaver and Michael Berry, briefed task force members on current initiatives and plans specifically related to the workforce needs of rural community health centers.

Presentation and discussion:

Donald Weaver, MD, Deputy Associate Administrator, Bureau of Primary Health Care (BPHC), HRSA

Weaver’s key points follow:

- Once everyone has health insurance, where will they go to get care?
- Health centers are a great place for primary care.
- There are a whole host of things we need to think about, such as the importance of interdisciplinary teams that are going to make a difference.
- We need community-oriented primary care.
- Current reform efforts provide opportunities for putting together all pieces of the puzzle. BPHC is encouraging CHCs to work with critical access hospitals and other community programs.
- There continues to be problems coordinating care for behavioral and mental health. There are barriers to integrating these systems.
- What pieces of the puzzles do you have? “Grow your own.” Look at how the health center movement is or is not involved in developing a workforce to serve the population.
- Be at the table with what you have to offer; listen to what others have to offer.
- We need to train administrative staff and management; this is the team that makes it work.
- BPHC wants to hear what is working and what barriers CHCs have when working with vulnerable and underserved rural populations.

Comments following Weaver’s presentation:

- Charlie Alfero: I hope the Bureau will look at the complex environment of filling out numerous applications and simplify all procedures. It will take an enabling system to save costs and alleviate suffering as the system moves toward becoming patient-centered. HRSA needs to think about other approaches as medical coverage is expanded.
- Michael Samuels: There are problems with accessing all necessary data for research and analysis.

Presentation and discussion:

Michael Berry, Policy Director, Bureau of Clinician and Recruitment Service (BCRS), HRSA

Berry's key points follow:

- There are currently 7,800 vacancies in the system at BCRS.
- The American Recovery and Reinvestment Act's (ARRA) goal is a field strength of 8,000.
- The demand for loan repayment is great. I don't know what/where the end is for the numbers we can attract for loan repayment as an incentive for health care professionals.
- There are already more than 3,000 applications for loan repayment. There will be 1,400 new loan repayment (LRP) recipients by the end of the fiscal year on Sept. 30, 2009.
- ARRA funding in this area will be \$10 million. I don't know if states will be able to match for loan repayments, so any unallocated dollars may go to scholarships.
- Recruitment opportunities are out there. Prior limits on where National Health Service Corps (NHSC) loan recipients can go are off; all that qualify will be included for repayment. Health professional shortage area (HPSA) scores don't matter.

Comments following Berry's presentation:

- Laura Rowen: ARRA-funded clinicians will cycle through. Will amendments/extensions be awarded to people after ARRA funds are expended? This will become an extremely competitive process.
- Rowen: What was the strategy for raising the HPSA score to 17?
 - o Berry's response: This is not a strategy, but a law that changed in 2004 moved from the 60:40 split between loan repayment and scholarship to 80:20. HRSA is looking at 90:10. As loan repayment increases, fewer scholars are available. This raises the HPSA score to be a designated site.
- Rowen: I have had to tell scholars not to come back to Idaho if they have accrued loans as they won't qualify for loan repayments in their home state. This problem also exists in North Dakota.
- Rowen: How many dentists participate in NHSC?
 - o Berry's response: Since 2007 NHSC has a field strength of 48, around 1 percent.
- Rowen: Explain the BPHC rule that full-time means 32 hours per week seeing patients with eight hours administrative time. OBGYN and mental/behavioral health is different.
- Carol Miller: There is a problem with the require-

ment for 32 hours a week seeing patients for people who are medical directors and/or faculty, especially in rural areas. They are doing more work but might not meet the NHSC 32-hour requirement. It's unfair for those medical directors and educators seeing patients fewer than 32 hours per week to have a doubled service obligation; four years for \$50,000. Providers that meet the 32 patient hours with fewer leadership/training obligations will have only a two-year service obligation for the same amount of loan repayment.

- Donald Weaver: What other disciplines would the task force add for NHSC participation?
- Aurelia Jones-Taylor: There's a need for other professionals including certified diabetes educators, mental health providers and dietitians. It might be necessary to change the definition of primary care to focus on nutrition, diet needs, obesity, diabetes, exercise and other wellness programs.
- Bob Bowman: The goal is to train and deliver the physicians and care that is needed.
- Wagih Michael: I would like the NHSC to monitor the relationships between sites and providers and assure that goals are met for both.
- Marilyn Kasmar: If BRCS had an unlimited budget, what would the program look like?
 - o Berry's response: The site has to work to retain the clinicians; they are less likely to leave when they have a longer obligation period.

Update: HRSA Office of Health Information Technology (HIT) and discussion of open source software

Presentation and discussion:

Johanna Barraza-Cannon, Director, Division of HIT Policy, HRSA

See Attachment C, "Introduction to HRSA's Office of Health Information Technology" for the slide presentation. Key points of Barraza-Cannon's comments follow:

- HRSA established its own HIT program because most HIT development was focused on the private sector. HRSA wanted representation for the public sector, especially those that work with the underserved.
- Benefits of HIT to safety net providers: improve quality of care, decrease medical errors, reduce the

digital divide between haves and have-nots.

- HRSA awards grants to implement telehealth. Initially grants provided seed money. With ARRA, there is more money going towards grants.
- HRSA also provides technical assistance. It is not enough to just provide a check; implementation is difficult. Are people able to meet the reporting and measurement requirements for grants?
- When purchasing from a proprietary vendor there is a benefit to forming a network.
- HRSA manages both grants and congressional earmarks.
- With telehealth grants, one barrier is where clinicians are licensed. It raises interstate issues.
- Broadband and telemedicine funds are available in ARRA. Money will go toward improving current and certain systems to share information between providers and health and human service agencies.
- Study of efficacy of open-source is relevant to rural communities.
- Office of the National Coordinator and Centers for Medicare and Medicaid Services (CMS) are working collaboratively, but ultimately CMS has to come up with definitions and guidelines for meaningful use.
- Concern about coordinating and not duplicating payments. A provider has to decide between Medicare and Medicaid and bill accordingly.
- Open source government HIT/electronic health records (EHR) systems were discussed.

- These programs have been around since the 1980s and continue to be improved.

- VistA software used by the Veterans Administration has received attention and is highly rated.

- Some CHCs and other providers are using VistA or modified VistA systems.

- Because the software is available at no cost, it can be an affordable option. It is also not copyrighted facilitating customization.

- At this time, there is no perfect system that will work for every situation. Maybe in the future, but we are not there yet.

Comments following Barraza-Cannon's presentation:

- Carol Miller: How will money be split between rural and urban areas?

- Marilyn Kasmar: Explain certified versus uncertified medical records and meaningful use.

Roundtable discussion of primary care association (PCA) workforce development activities

Moderator: Marilyn Kasmar

At NRTF's 2008 annual meeting, members learned each state PCA had been awarded a \$50,000 HRSA grant for activities focused on CHC workforce. Originally, NRTF was going to receive an update on those grants, however last week, two new reports were released.

Morgan was asked if there was a special place for state PCAs within NRHA. He replied that CHCs typically join the Community Operated Practices Constituency Group. The possibility of beginning a PCA interest group was discussed, and Morgan stated that it would provide a great opportunity for NRHA and the PCAs to work more closely together on behalf of rural CHCs.

Kasmar distributed two workforce development reports for review and discussion:

1. State Workforce Incentive Program, National Association of Community Health Centers in Conjunction with State Primary Care Associations and State Primary Care Offices (Attachment D)
2. State and Regional Primary Care Association Workforce Survey, Best Practices and Lessons Learned (Attachment E)

Key points of the discussion follow:

- Is there a way to brand community health centers and their efforts?
 - o There is a marketing committee within the National Association of Community Health Centers that has been working on this for a couple of years. Kasmar will follow up on its status.
- Workforce issue is the crux of community health centers' success.
- Use social media such as Facebook and Twitter to get the word out on community health centers in the state of Michigan.
- NRTF is strongly committed to the highest level of global branding for CHCs.
- The two reports show there is a great deal of activity and creativity on the state level. This is

encouraging as so many good national ideas begin at the grassroots level.

- Frustration was expressed about the small amount of funding provided to the PCAs because addressing workforce is really a very high level, macro problem. How have the members of PCAs reacted to these efforts?
- We run the risk of saying the same things over and over, but the question is when do any of these initiatives actually become policy?
- How many providers are trained with the current “trickle down” system to get one primary care provider to a CHC? In the past it was as high as 30:1.
- How do we get beyond the status quo?

Goal: Create social marketing that elevates the health center movement for young people to the level of awareness and excitement of the Peace Corps and Teach for America.

Key points of the discussion follow:

- The PCA reality is member services, and members are struggling to fill provider vacancies. These reports encourage people that something is being done, that PCAs are also policy focused.
- It is important to remember every provider recruited helps a community and improves access to health care for that community.
- Who is taking on the global branding? NRTF has raised that question several times as very important and should be part of its recommendations.
- There is a double-edged sword to highlighting vacancies and recruitment problems that must be overcome. If a CHC or satellite is short providers, it might not meet uniform data systems and other evaluation criteria and might be considered a weak or even failing center. This can have a snowball effect so that rather than getting extra help and/or incentives, it ends up losing funding or even closing.
- Places that consistently cannot recruit are sometimes seen as not being very good rather than an exceptionally needy community that needs extra help.
- Tom McWilliams spoke of the importance of osteopathic medicine. Just as health centers are a “best-kept secret” so is osteopathic medicine, which since its founding as a medical practice has

stayed committed to general primary care practice and much higher rates of rural practice. Output is twice as likely to produce primary care providers, targeted recruiting at DO residency programs and schools. Osteopaths still represent only 6 to 8 percent of total physicians, but the numbers of colleges are increasing.

- No one on the task force is attending the HRSA Workforce Summit.
- Has any outcomes research been done on various initiatives; from Healthy Communities Access Program (HCAP), to Student/Resident Experiences and Rotations in Community Health (SEARCH), to Health Extension? Some programs possibly start too early (elementary and high school) others start too late. (Area Health Education Centers were mentioned in this category for waiting until residency). What do we know about what works to actually get providers into health centers?
- Bowman stated that too many piecemeal programs make outcomes studies difficult, especially if data on birth location, high school, undergraduate education and training is not collected/documented.

Workforce policy paper development in small groups

NRTF members divided into two groups. One consisted of members from community health centers and state PCAs. The other consisted of an interdisciplinary group of the other attendees including state Primary Care Offices (PCOs), medical educators and a professor of rural health policy. A decision was made to begin with small group reports in the morning.

Discussion: Overview and feedback

In keeping with task force policy to provide opportunities to all members to speak, a “round robin” discussion was held. Every member provided feedback on the day and what they hoped to accomplish on the second day of the meeting.

Key points of the discussion follow:

- Tremendous amount of information provided. Learned many things did not know before. Plowing new ground, moving beyond the way things were done over the past 20 years.
- Very informative presentations. Small group format allowed us to hone in on the key points to be discussed in the morning.
- Presentations provided a good foundation for the

small groups. Small groups facilitate more focused discussion.

- This task force is helpful, informational and inspirational.
- Importance of the different disciplines and people from different types of institutional backgrounds is key to the success of this group. We all learn from each other in ways we have not before.

- Publicize the work of NRTE. Ask NACHC and NRHA to publicize through e-newsletters and NRTE presentations at meetings and conferences. Encourage widest possible circulation of the policy statement to be completed tomorrow.
- We all agree that our job is to come out with a great product.

Three important things learned:

1. Health reform must be based on prevention and primary care. Reforms will only be successful if built on that platform.
 2. Very helpful to learn where NHSC is going. It would be nice to see some strategic retirements within NHSC and bring people in with recent field experience; less business-as-usual and more visionary. Didn't get a good answer to the question, if you can do anything you want with the NHSC what would it be?
 3. HIT presentation was very useful.
- Still confused about what we are trying to do: work with current system and efforts and bend it to be better or trying to start something completely new?
 - Still frustrated with who is in the room; no one from NACHC and federal representatives did not stay for the whole meeting. We really missed the great involvement previously with John Sawyer from NACHC. No one was present from BPHC as a participant, but Don Weaver was a speaker. A lot of our work is in support of health centers, BPHC and NACHC but they were not present, which is disappointing. Kasmar had contacted Tracy Orloff at BPHC who shared her regrets that ARRA responsibilities and deadlines prevented her from attending.
 - It was important to be flexible with the agenda to take advantage of Johanna Barraza-Cannon's presentation on HIT. Her presentation was very dense and then there was the wonderful opportunity to have her answer questions.
 - Don Weaver seemed to be inviting task force involvement in the HRSA Workforce Summit.

Day 2 - July 16, 2009

The goal for the day is to create a policy statement on workforce. The flip charts developed by both small groups were posted in the front of the room.

Table one: CHC and PCA group

- **HHS/HRSA must lead the promotion of health centers.** A massive public relations/advertising campaign is needed, and it should come from the top. Health centers already do what they can through local events and the national Community Health Center Week, August 9 through 15 in 2009.
- **Keeping people healthy is the goal and purpose of CHCs.**
- **Health Home**
“CHCs: Your health home in your community”
Patient-centered care teams
“Deinstitutionalize” health care: More focus on prevention and primary care, less focus on care inside bricks and mortar.
- **Training/workforce issues**
Medicare should support CHC training sites even if not independently certified.
Training “pathways” via CHCs: clinical, administrative and financial.
- **EMS is a critical service in rural and frontier communities.**
- Rural people and programs are innovators.
Necessity is the mother of invention.
Look to rural for solutions i.e., Frontier Extended Stay Clinic; health aide programs, Promotoras, Mississippi transportation models.
- **CHC model needs flexibility to work well in rural and frontier communities, otherwise many communities have problems being funded and/or fulfilling the model.**
- **Outcomes: CHCs results are excellent.**
CHCs and BPHC have years of comprehensive data.
 - + Quality care/reasonable cost
 - + Documented savings to Medicaid/Medicare
 - + Encourage payments that reward health and keeping people healthy, through medical/health home or other models

Table two: Interdisciplinary group

Critical need for many more scholarships.

- Scholarships should be focused on minority and rural students.
- Historically, scholarships were the most successful way to increase numbers of minority providers.

Loan repayment vs. scholarships

- Offer incentives for administrative support and activities that support quality and integrity of care.
- Allow flexibility for medical leadership in the minimum clinical hours per week (currently 32) when quality commitments, training and other responsibilities reduce clinical time.
- Make more scholarships available, and expand the number of eligible sites so all states receive scholars.

Coordinate AHEC interdisciplinary training with physician residency programs.

Fund/support training of health professional students in community health centers.

- Increase reimbursement/compensation for primary care.
- Change outcomes and expectations.
- Change admissions, look for what we need.
- Prioritize medical school admission for people identified by the community.
- Management/public health training (MPH/MHA degrees) for CHC leaders.

Small group reports

CHC/PCA group report

Key points of the discussion follow:

- After brainstorming a lot of ideas, the group agreed that they clustered into two categories; first, an absolute commitment to improved health as the goal, and second, workforce: having the right people to meet the goal of better health.
- CHCs have well documented, positive outcomes, unlike most other parts of the health care system. Study after study shows the savings to Medicaid while providing quality care because of the care management/health home team delivery system long practiced in CHCs.
- HRSA/Health and Human Services has not done enough to promote the health center model.

Alfero: A program can't get reimbursed from Medicare for graduate medical education (GME) unless it is fully certifiable. In New Mexico, those of us who have training programs on site end up having to reimburse the training program for its lost revenue while the resident is doing a rural rotation. This is the exact opposite of what should be happening. There needs to be a new mechanism for reimbursement.

McWilliams: This is the first time I have heard of a health center actually paying. While having residents is a benefit or a liability can be argued; I happen to think it is a benefit.

Alfero: If we want to create an incentive for rural training, it has to come from Medicaid and Medicare directly to the training site.

The CMS waiver model implemented in Utah and soon in Nevada moves part of the funding from the academic medical centers to the rural hospitals participating in training. Medical Education Councils in Utah and Nevada also have a legislated role in workforce planning and implementation, not only GME. This model did not work in Arizona; it was unable to move any funding out of major medical centers.

This is a good example of where the rural hospitals and CHCs have a common interest in a Medicare reform that will take a legislative or regulatory change.

Decentralizing the urban-centric training model will always improve outcomes.

NACHC is advocating for direct reimbursement of training and that is a good thing for health centers. Our task force is looking at sustaining the whole rural health system with health centers as the key, the health home for direct medical, dental and mental health care enhanced by wrap-around, enabling and supportive services.

Training pathways for everyone from direct service providers to executive directors and key management staff.

Ericson: Clarified the statement calling for less focus on "bricks and mortar." In her area of North Dakota, there is an emphasis on loss of facilities, closure of rural hospitals, which she also worries about. However, even with pending critical access hospital (CAH) closures, many in North Dakota are in pretty dire conditions. Care will continue to be provided, often by the community health centers. The care is what is important, not which type of building (the bricks and mortar). If we aren't there, people will be traveling more than 60 miles for earaches and runny noses. In North Dakota there are only two CAHs in the same community as CHCs.

Samuels: There has been talk about the closure of rural hospitals for years and special programs to help them out have been created, but the research shows that hospitals almost never close.

The task force discussed the situation regarding emergency room use and the explosion of bad debt.

- The National Center for Health Statistics just released a study which found that 87 percent of the care in emergency departments (ED) was appropriate. Only 13 percent should have been delivered elsewhere, according to 2007 data.
- Surge in rural hospital ED use this winter related to both the economy and also fear of the "swine flu" has put a financial strain on many hospitals.
- For marginal rural hospitals, the use of the ED for primary care is essential to their business plan. They need enough revenue to cover their contracts, whether the contracts are directly with individual physicians or with a company that provides the physicians.

- These fixed costs create an incentive for many rural hospitals to encourage primary care through the ED. Many hospitals are no longer able to require coverage by local physicians; they have to staff the ED with salaried and/or contract providers.

The ability of large chains to come in and buy out small hospitals is basically over because profit has been squeezed out of the system.

There should be a critical mass of patients to have a hospital. Some rural hospital closures have not been a bad thing.

Rowen: Idaho has a number of communities with both CHCs and CAHs.

- Any future reform has to look at all the existing rules and regulations; some inhibit systemic approaches to change.
- Can't ignore economies of scale in this country. Education was established as a right in the United States, but not health care.
- The Hill-Burton program plunked down hospitals all over the country and many are still unsustainable. Regardless of health care economics, which keeps them on the financial brink, they are often the largest employer in the community so it is difficult for them to be allowed to close.
- Staff can't move and can't sell their houses.
- If the focus is turned to prevention, the need for critical care will lessen. There will always need to be subsidies to keep hospitals present in small communities.

This important discussion on hospitals brings to mind again the need for comprehensive health planning.

This discussion reflects the diversity of the very large country, understanding that there will be not one type of facility that works in every community. There are many places where the ambulatory care department of a CAH is effectively the same as a CHC. In fact, it feels the same to a patient.

Alfero: The payment system should not dictate the location of a reimbursable service. Why do services have to be delivered in an exam room? For example, if a school nurse calls to say a student is depressed, to be

reimbursed, the student must be referred to and seen at the clinic in an exam room. Can't go to the home, can't go out for a coffee, must be in a room in a certified setting licensed by the state of New Mexico.

Impact for reform. Will the medical home delivery system change this?

McWilliams has concerns about the medical home. Most private practice physicians do not have a team in place and those struggling in family practice will have a hard time with generating sufficient financial support for a whole team. It is a good fit for CHCs but will it work in small rural private practices, which are often one or two providers?

If the health home is the goal, it must be supported.

Jones-Taylor: A good source of outcomes data are the collaboratives because they have been around long enough that every CHC has participated in one or more.

Bowman: There is a danger going beyond the personnel that are sustainable. A small rural practice might support a doctor, maybe a PA or NP, and a nurse. Adding in more people to become a medical home in many cases will threaten the practice because there are not enough patients over which to spread the additional costs.

This gets back to the payment system; a primary care office visit now pays \$80, but a cardiologist will get \$800 for providing the same office visit. If the family practice doctor got \$180, it would provide additional revenue to hire an outreach worker or care manager. And the cardiologist could still get \$700 for their visit; over time payments could be equalized.

We need to promote a lot of innovations that have happened in rural; necessity is the mother of invention.

- o Promotora, community health worker
- o Frontier Extended Stay Clinic
- o First HMO, Elk City, Okla.

BPHC often doesn't really understand rural and its realities. Rural can't afford transportation or even OB care that is part of the "preferred model."

Initially the CHCs were all urban. In the 1970s a rural health initiative first developed rural CHCs. Despite the time that has passed, the CHC model is still predominately urban and in large rural communities.

Decentralize the urban-academic training model; getting residents to rural areas is important.

Discussion on how to develop a training model that distributes residents statewide. It's hard to implement in states where there is only one academic training area like New Mexico.

Interdisciplinary group report

Key points of the discussion follow:

This group spent a lot of time discussing the pros and cons of loan repayment versus scholarship. There was some disappointment in Michael Berry's response that we are in a crisis and loan repayment can be implemented more quickly.

The small number of scholarships is one reason we are in the current situation without enough minority physicians. Minority and low-income students need to know about the availability of scholarships early when they are making education decisions.

There was a recommendation that HRSA reconsider how time is counted for loan repayment.

There should be financial support for rural training for all disciplines; a nurse won't make decisions for a rural migrant practice if they have never seen one. Migrant health centers have a 76 percent rate of retaining nurses who trained there.

There is a need for training in the management of public health and CHCs; provide specialized master's degree.

Forty years ago the U.S. system decided certain kinds of care were more valuable than others, and they still are paid as if they are more valuable. The system doesn't value family practice. It's not just financial, but it has lower status. This is America, people follow the money.

Most people start in health careers for altruistic reasons. This motivation is altered during the education process. They get directed to specialty care; told they are "too smart" for family practice or "would you want to stop there". Training system pushes people to specialty care.

Most medical students are science majors and most members of admissions committees are specialists. This injects bias before the education process even begins by tilting the admissions to those

most likely to choose specialty care. Historically, general and family practice come from the bottom of the class.

Bissell: Mister is in medical school right now. She has been told by her mentor, "why would you go into family practice and not oncology, you are so bright." The student was distraught by this. She wants a support system on her campus to say "here are a group of top students who are choosing family practice."

Ericson: Family medicine doctors no longer practice or are encouraged to practice the breadth of medicine included in their training. Everything has been up-sourced; hospital care (to hospitalists) procedures, deliveries, etc.

Bowman led a discussion based on a presentation of an analysis of 316,000 graduates using four independent variables to determine impact on choice of family medicine and/or rural practice. The complete analysis is Attachment F: Analysis of Four Independent Variables: Most Needed to Improve Health Access and Rural Location, Robert Bowman, MD, Professor of Family Medicine, A.T. Still University.

- The analysis shows the differences between exclusive origin/exclusive school/exclusive students vs. everyone else, referred to as "normal." Exclusive origin factors include parents are professionals, higher income, most urban, attend most exclusive schools.
- Whole design of medical education in the United States is based on super-centers.
- Even the historically best programs like Duluth are facing market forces leading to decline in family medicine. Since the Duluth program began in 1971 until last year 2008, family medicine choice was 45 to 52 percent; last year it fell to 36 percent.
- Once students leave the state, few return. In Nebraska only 30 percent stay in state; it used to be 60 percent. In New Mexico, 25 percent stay in state.
- There's an extreme mismatch between patient location and physicians; 75 percent of physicians are concentrated in 4 percent of the land area while 65 percent of the patients live elsewhere.

People in medical school now are completely different from the majority of the population of the United States by every parameter that can be measured. They are the least diverse, highest income, exclusive origin, exclusive schools, and these graduates have expectations for higher income.

Schools overwhelmingly admit the people least likely to serve the underserved. The country needs people to provide preventive and primary care with its lower costs to the system and more importantly better quality of life for patients.

Developing a rural CHC workforce policy

The end of the meeting was reserved for synthesizing two and a half years of work on the staffing needs of rural community and migrant health centers, now and into the future. As the members spoke, the ideas raised were placed on a flip chart. Every idea was included for

the first round. Ideas ranged from the birth and high school location of applicants for health professions, to professional education and training of executive directors and other CHC manager/leaders.

Results of this brainstorm session are below.

Policy priorities brainstorm

Goal: Access to high quality rural health care

Meeting the workforce needs of rural CHCs requires a multi-faceted approach.

- Specialized education/training for primary care
- No cap on family medicine residencies
- Admissions policies and training location are critical for growing the rural primary care workforce
- Payment for training and practice
- Increase incentives also for primary care PAs/NPs

HRSA policy improvements

- Correct loan repayment and scholarship assignment designation problems
- HPSA: eliminate 30 percent @ 200 percent FPL
- Allow flexibility for percent of time counted towards direct services

Medicine needs to get back to basics

- Prevention and primary care
- Patient-centered health models
 - Match resources with needs through incentives for outcomes, better health.
 - See Attachment B: The Role of Federally Qualified Health Centers in State-led Medical Home Collaboratives.
Note: NRTF prefers the term “health home” rather than “medical home”.
 - Michigan PCA has a study showing cost effectiveness, high quality and savings by CHC health home model.

Recognize that there are “political determinants of poor health.”

Medicare payments drive the whole health care system

End current incentives linked to volume and intensity.

Access/volume adjustment

There must be affordable rural access to HIT.

Personal responsibility has a role in both expanding access and lowering cost.

Current system rations entry, not high-end, late care.

Finding: There must be a national commitment to sustain the rural health system.

- Market-based solutions will never resolve rural health needs.
- Ensure enough providers to guarantee access to care.
- Commit to bold changes and incentives; limit endless tinkering.
- New programs must be designed to meet the national health care needs.

- Because the current system does not train enough family physicians for urban areas, there will never be enough for rural areas.

Incentives are preferred to punitive actions.

Incentive: Target and reward programs that document pathways to practice in rural underserved communities. For example, provide incentives for more state institutions to implement the Duluth model. Reward existing programs that make changes. Provide

incentives to new programs dedicated to training primary care and family medicine for rural practice.

- Take the cap off of payments for family medicine.
- Currently there already is no cap for rural programs, but they are still not blossoming.
- The capacity for very rural areas is limited. In a low-volume practice it is not always easy to keep medical residents busy.
- There need to be incentives for academic training centers to emphasize and promote family practice. This would result in more centers training residents and might lead to a trickle-down effect.
- Rural programs can only have two residents, which make the programs very fragile. They can't respond to change or different needs the way a program with six or eight residents can.
- It is difficult to set up a new program, have the needed faculty and exposure to specialty care.
- This is a very expensive way to train for rural; train 30 to get one rural.

Incentive: Introduce new idea for training programs. If pediatric and internal medicine residencies hold 50 percent of their residents in primary care and don't go on to fellowships, the program will receive \$50,000 each per primary care resident. Could test if this would change the incentives that now encourage students to leave primary care.

At this point in the discussion, Jones-Taylor read the seven recommendations from an April 2009 meeting supported by the Josiah Macy Foundation. The full report is at Attachment G: Developing a Strong Primary Care Workforce, Meeting Summary, Josiah Macy Foundation.

Summary of recommendations – Josiah Macy Foundation

- New entities, to be called teaching community health centers, should be established. These centers would serve as sites for the training of health care professionals and would work with primary care practices to raise standards of care. These teaching community health centers will require strong, collaborative ties with traditional teaching hospitals, continuing the theme that collaboration is essential for better patient care and for preventing disease.
- AHECs should be designated and well supported to coordinate the educational experiences of health professions students and primary care residents in teaching community health centers and in other

primary care, community-based clinical settings.

- Title VII of the U.S. Public Health Service Act must be expanded to direct more financial support to education in primary care professions.
- Private and federal insurance program payment policies must be changed to reduce income disparities between primary care providers and other specialists.
- NHSC, with substantially increased funding, should become a focus of efforts to alleviate the burden of debt that discourages medical students from selecting primary care and to increase the numbers and diversity of primary care professionals who practice and teach in underserved communities.
- Criteria for admission to medical school should be changed to attract more and more diverse students who are likely to choose primary care and to care for patients in inner cities, small towns and rural areas.
- The graduate medical education system needs to be better aligned to meet physician workforce needs.

Note: No priority ranking is implied by the sequence of these recommendations. This paper represents the views of those who attended the Macy Foundation-supported conference in Washington, D.C., on April 20, 2009, and does not necessarily represent the views of the organizations with which the participants are affiliated.

While these recommendations are valuable, they do not completely dovetail with the recommendations of NRTE. Meeting rural needs and providing rural training both require special focus and attention.

Medicare payment methodology

- The payment system needs to reflect a back-to-basics focus, emphasizing preventative and primary care services.
- Do we want to raise primary care salaries without bringing down others' salaries? Payment system pays for services, not salaries. The number of services provided creates the compensation.
- Leveling the slope in relative value units over time is a way to bring change, resulting in changes in salary expectations and provider type status.
- This is a money-driven society. If we pay for the changes we want, they will be done.

Medicaid: It is a fact that in almost every case, the costs per patient are higher in rural areas. For CHCs the only system that actually covers costs is Medicaid.

Rural health care can't be based on volume because the capacity isn't large enough. There must be other support; subsidies, low-volume adjustments to payments.

Medicare: Medicare payment methodology needs to change, and the rest of the payers will follow. All payments are based on Medicare. For example some private insurers base their payment on 125 percent of Medicare, 95 percent of Medicare, etc. Therefore, again, the changes need to happen in Medicare.

For CHCs to cover their costs through Medicare requires a lot of visits. Rural and frontier CHCs rarely meet the threshold that will result in the costs for Medicare beneficiaries being covered. For example, HMS in southwestern New Mexico loses money on every private pay and private insurance patient they see. Private insurance pays way under the cost for a rural site, which has lower volume and therefore higher cost. The private insurance system is designed to work in urban areas and is another way rural health financing suffers.

Because the basic payment system doesn't support primary care, rural is especially hurt. If a private provider had incentives would they stay in primary care? The problem is the payment system does not support primary care.

Fee-for-service payment needs 40 patients a day to break even. This is beyond the capacity of most rural practices. The money to cover costs has to come from somewhere; grants, subsidies, Title VII.

Want to show low-volume provider due to size of community versus a provider who doesn't work hard. There are a lot of anti-doctor, doctor-as-crook sentiments.

CMS and intermediaries make errors too.

How do we make sure small rural practices can be medical homes? Communities need basic access to primary care or they will not be sustainable.

NRTF is unconditionally committed to the long-standing national goal of having primary care located within 30 minutes.

Assisted by recent CHC expansions, 239 Alaska communities now have access points that meet this. The state of Alaska has accepted that these access points are only sustainable with permanent support.

NHSC and HPSA designation issues

- PCO hands are tied by policy, 1999 letter by Bob Arrindell for shortage area designation. As system changed and infrastructure is improved, these geographic designations change to population designation.
- Tarrango: Recommend NHSC policy changes to sustain rural access points
 - o Allow more than two NHSC loan recipients at a site.
 - o Allow medical directors to be eligible for loan repayment.
- NHSC has to continue to fund site visits and face-to-face interviews at the facility. A paper review is unsatisfactory.
- Baseline "in or out" rule is a problem. Have to justify priority for resources. For example, a practice that qualifies but doesn't take Medicaid. It doesn't matter if you are there if you don't take care of everyone who needs care.
- Programmatic benefits should go to those who agree to serve everyone, from HPSA bonus payments to any future forms of support.
- There should be a requirement to see those that need care, "take all comers."
- It is not enough to be in a shortage area, actually be a part of the problem but still get a shortage area incentive payment.
- NRTF must include some recommendations like these above that are easy to fix and that will help communities relatively quickly.
- Ericson: Valley Community Health Centers in Northwood, N.D., has a dental HPSA score of 1, because there are other dentists in the community. This makes them a very low priority for NHSC, but none of the other dentists in the area take Medicaid. Many communities appear on the surface to be adequately served, but no one advocates for the underserved, Medicaid, etc.
- Designation issues are a problem and create barriers, but they are more relevant to placement, not workforce development.
- Until such time everyone is guaranteed access to health care, almost everyone is underserved.

Conclusion of policy improvements discussion: Goal is high quality rural health care.

- Designation problems: eliminate the 30 percent of 200 FPL.
- Increase scholarships and loan repayment.

- Percentage of time covered for medical leadership and administrative responsibilities.
- Resources must match needs with incentives for improved outcomes.

Setting priorities

The goal is access and improved health.

- Change education and training.
- Back to basics; health is the goal; patient-centered health care
- Getting the appropriate resources out to the community; removing barriers such as HPSA and scholars. The rule of no more than two sites per scholar needs to be more flexible.
- Resources are needed to match needs and outcomes.

New Mexico Medicaid is encouraging medical home models that are certified by the National Committee for Quality Assurance (NCQA). First CHCs had to get Joint Commission on Accreditation of Health Organizations, now NCQA. Some of the benefits of certification are that it will let services by promotoras be reimbursed and will allow self-credentialing of providers.

Training dollars should follow the resident to each training location, not stop at the parent institution.

More than 65 percent of the nation has been left behind by primary care. The presence of physicians is almost completely extinguished in communities where 18 to 20 percent of the population lives in poverty.

Incentive examples and options

Looking at the Oklahoma Model Family Practice Residency Program: Oklahoma pays family practice residents \$1,000 per month extra. There is a three-way match: feds pay \$1,000, state pays \$1,000, and if they match with an underserved community they get an extra \$1,000. So they can get an extra \$3,000 per month incentive for choosing family practice.

There still needs to be a practice incentive. It could be low in the beginning but increase with 5 and 10 year retention bonuses. If providers are lost to family practice in the beginning of their career, they are usually lost for the duration.

Incentives should be extended to PAs and NPs to encourage them to stay in family practice.

Recommend paying bonuses to the training programs that succeed in getting people into rural and underserved, possibly a five-year payment reward.

Keep in mind that it is hard to organize around bad news.

Plan for remainder of meeting

The assigned task for the remainder of the meeting is to reach consensus on a policy statement that articulates the two or three most important points:

The focal point must be the patient and the outcomes; change from widgets to health outcomes.

CHC model is a round peg in a square hole. We are struggling. Despite serving 14 million people, we are in an irrational system that purports to serve 300 million.

We understand our model; we love our model; we even work for less for the privilege of working in our model. We are trying to say “we are here,” and the way we provide comprehensive care really goes against the flow of the bigger wave.

History repeats itself. CHCs create an environment so that the right system will be available to underserved communities. In the 1960s and 70s, the United States thought there was a right to care. The Hill Burton program assured that there would be a facility; NHSC that there would be a provider.

The system has become so tiered. Access to insurance is not access to care.

Let's create an environment where costs will be managed and payments among providers leveled.

National Rural Task Force Vision Statement

The goal is better health for all.

Call to action:

- Grow access to care in the United States through community-operated community health centers (CHCs).
- Promote the CHC model with its well-documented record for improved outcomes and health status at lower costs.
- Encourage the expansion of the CHC model of chronic disease management, reduced use of emergency department services for non-emergency care, patient education, enabling services and other proven strategies for reducing Medicaid expenditures for CHC patients.
- Acknowledge the social and political determinants of poor health and commit to their elimination.

Support rural care teams to meet the goal of better health

Access to rural health care cannot survive in a purely market-driven system because of sparse and older populations, disproportionate poverty and isolation.

Therefore, a national commitment to rural health care must:

- Steadily improve financial and geographic access to care for rural populations.
- Compensate rural primary care providers through reimbursement enhancements.
- Reward primary care providers that address a broad range of supportive services.
- Direct support to training programs that actually serve rural populations by rural location of training and by graduates that choose and remain in rural locations at the highest levels.
- Reward rural primary care providers through reimbursement enhancements.

History repeats itself. If the nation returns to its 1960s and 70s level of commitment to health care for all, we already know what to do. Restore and build on the successful programs established then: including the National Health Service Corps, community and migrant health centers, Medicaid and Medicare.

Enact policies to guarantee a rural workforce

Success requires a multi-faceted, holistic approach.

Selection and admissions:

The process for improving a professional choice of rural practice begins with selection and admissions decisions made by medical schools, PA and NP training programs.

- Implement well documented best practices for selecting students with the highest probability for rural primary care practice.

Financial support and incentives for education:

- Expand National Health Service Corps (NHSC) scholarships for primary care. As well as being an attractive incentive to all students, it is a proven method for increasing recruitment and graduation rates of minority and low-income students.
- Increase the types of providers eligible for NHSC and other training support to meet changing health needs, including pharmacists, optometrists, certified diabetes educators, a broader range of mental health practitioners, exercise physiologists and dieticians.
- Eliminate graduate medical education caps on programs that educate and train family medicine residents.

Finance meaningful rural training to meet current and future needs:

- Provide financial support and incentives to students, rural residency/rotation sites and sponsoring training programs.
- Have training dollars follow the student/trainee.
- Provide incentives for training at rural CHCs.
- Train for the full breadth of family medicine required for rural practice.
- Train in the “health home” model of interdisciplinary care teams.

continues

Enact policies to guarantee a rural workforce

continued

Ongoing support for rural practice:

Improve NHSC placement in rural areas through policy and statutory changes:

- Eliminate the policy for determining population group Health Professional Shortage Area designations which requires 30 percent of the population be at or below 200 percent of the federal poverty level.
- Remove the language in U.S. code which confines site match opportunities for placement of NHSC scholars at a ratio that cannot exceed 2 to 1 (two sites per available scholar).
- Provide annual bonuses to sites that retain NHSC providers beyond the initial service obligation.
- Increase the loan repayment program to help assure the rural workforce.

Improve reimbursement for primary care, and create additional recruitment and retention bonus payments

- Make necessary changes to the reimbursement system to support low-volume providers. Current incentives reward volume and intensity, but rural practice is by definition low volume and less specialized.
- New models of care that require additional providers and/or provider types will need subsidies to compensate for low volume.
- Provide recruitment and retention bonuses to rural providers whether or not they are participating in NHSC scholarship and loan repayment programs.
- Provide incentives for documented quality of care and improved health status outcomes whether through CHC collaboratives, health home or other outcomes-focused models.
- After five years retention in rural practice, and every five years thereafter, provide a cash award to the program and institutions where the rural primary care provider had trained.

Forum: Comment by each participant and next steps

Do you feel your ideas are reflected in our broad outline? If not, how will you communicate that so that we can reflect your ideas?

Miller: We have worked really hard. We are trying to hold up the flag for the underserved in the face of a big tidal wave that is coming. We won't even know some of the changes for years, until regulations and policies are written and implemented.

1. Our goal is the people. We need a paradigm shift to patient-centered care with incentives to keep people healthy and improve health.
2. Who gets trained? Who pays for the training to guarantee that there is access? Providers must be where they are needed.

Need to talk about the "political determinants" of health.

This is the time to put forth a rural agenda.

Never stop emphasizing the savings to the system by using primary care. Procedures, such as stress tests and others, can be done in CHCs for much lower cost.

Other countries ration high-end care. The country is upside-down and rations access to the low-cost, front-end of the system; public health, prevention and primary care.

Samuels: The task force has a broad representation, and we have worked together enough to trust each other and work through our differences. I have learned things I believed for many years are actually not true. I am now even more committed to creating a master's degree in community health.

Morgan: I look forward to seeing the summary report and the condensed recommendations.

Meeting evaluation

Samuels urged members to complete their meeting evaluations. He stressed the importance of the evaluation process to the current and future work of the task force.

Attachment A

**National Rural Health Association
National Rural Task Force meeting
July 15 – 16, 2009
Hilton Crystal City at National Airport**

Rural Workforce Issues: Challenges and Opportunities

AGENDA

Tuesday, July 14, 2009

7:00 p.m.

Optional, informal group dinner for early arrivals

Meet in Hilton lobby

Wednesday, July 15, 2009

8:00 a.m. – 9:00 a.m.

Networking Breakfast

9:00 a.m. – 9:30 A.M.

Opening

Marilyn Kasmar, Chair and Mike Samuels, Vice-Chair

Welcome

Alan Morgan CEO, NRHA

9:30 a.m. – 9:45 a.m.

**Goals of the Meeting, History, Outline
and Ground Rules**

Carol Miller, Facilitator

9:45 a.m. – 10:30 a.m.

Introductions and Round Robin

Each participant will introduce themselves and briefly describe their top goal for the meeting.

10:30 a.m. – 10:45 a.m.

Break

10:45 a.m. to 12 p.m.

Speakers:

Donald Weaver, MD, Deputy Associate Administrator, Bureau of Primary Health Care, HRSA

Michael Berry, Bureau of Clinician and Recruitment Service, HRSA

The HRSA representatives will discuss the Administration's efforts on behalf of rural Community and Migrant Health Centers.

12:00 p.m. – 12:30 p.m.

Question and Answer

12:30 p.m. – 1:30 p.m.

Lunch

1:30 p.m. – 1:45 p.m.

Break

1:45 p.m. – 2:45 p.m.

Speaker:

Johanna Barraza-Cannon, Director, Division of HIT Policy, HRSA

The HRSA representative will introduce the HRSA HIT organization and discuss the study on HIT open source software as discussed in the ARRA. Questions and answer to follow.

2:45 p.m. – 3:15 p.m.

Primary Care Association Roundtable Discussion

Moderator: Marilyn Kasmar, Chair

PCA task force members will provide an update on the one-time Workforce grants from BPHC.

3:15 p.m. – 3:30 p.m.

Question and Answer

3:30 p.m. – 3:45 p.m.

Break

3:45 p.m. – 5:00 p.m.

Workforce Policy Paper Development

Small Groups – by Sector (CHC/Other)

5:00 p.m. – 5:30 p.m.

Open Discussion

5:30 p.m. – 5:45 p.m.

Day 2 Overview and Task Force Feedback

7:00 p.m.

Optional, informal group dinner

Meet in Hilton lobby

Thursday, July 16, 2009

8:00 a.m. – 9:00 a.m.

Networking Breakfast

9:00 a.m. – 9:30 a.m.

Reports from Small Groups

9:30 a.m. – 10:30 a.m.

Workforce Policy Paper Discussion

Workforce Small Groups 2 – across Sectors

10:30 a.m. – 10:45 a.m.

Break

10:45 a.m. – 11:45 a.m.

Open Discussion

11:45 a.m. – 12:45 p.m.

Forum: Brief Comment by Each Participant Task Force Member “Assignments”

Next Steps

12:45 p.m. – 1:00 p.m.

Complete Evaluations

1:00 p.m.

**Boxes lunches available for people heading straight
to the airport**

NOTES AND BACKGROUND

PARTICIPANT GROUND RULES:

- **This is a Task Force and EVERYONE is expected to be an active participant.**
- **A survey requesting information on organizational policies and /or work plans addressing rural workforce needs has been provided to every participant in advance of the meeting.**

We are gathering this information in advance so that we have a baseline at the beginning of the meeting. It is our goal to create an action plan and policy priorities before the meeting adjourns on July 16th.

The small groups will be assigned by the facilitator to mix-it-up as much as possible.

The Closing Forum is similar to the opening introductions because we will go “round robin” and ask every person to provide a closing comment.

NOTE: The Day 2 Box Lunch is optional. We will order a nutritious lunch the morning of July 11 for any participant requesting one. It is hoped that this will encourage people NOT to leave the meeting early.

THE ROLE OF FEDERALLY QUALIFIED HEALTH CENTERS IN STATE-LED MEDICAL HOME COLLABORATIVES

By Mary Takach

JUNE 2009

THE ROLE OF FEDERALLY QUALIFIED HEALTH CENTERS IN STATE-LED MEDICAL HOME COLLABORATIVES

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EXECUTIVE SUMMARY

The medical home is a model of care that is taking root in both public and private payer programs in an effort to improve quality, control costs and increase both patient and provider satisfaction. Since 2006, more than 30 states have been leading efforts to advance medical homes³ in their Medicaid and Children's Health Insurance Program (CHIP). Several states are leading multi-payer medical home collaboratives to spread this model in the private sector.⁴

States have used multi-payer collaboratives to convene disparate groups of purchasers, payers and providers to discuss health delivery system reform aimed at improving outcomes and lowering rising costs. Having the state as a neutral convener can allay both payers' and providers' fears that anti-trust issues will be raised by having a common effort.

Using telephone interviews with public and private stakeholders in Pennsylvania, Rhode Island and Vermont, this report will describe each state's multi-payer medical home collaboratives and the role that federally qualified health centers (FQHCs) play. We hope this report will be of value for other state policy makers looking to develop similar pilots, as well as describe opportunities for FQHCs, primary care associations and others who want to become engaged in state efforts to advance patient-centered medical homes.

Three state-led medical home collaboratives in Pennsylvania, Rhode Island and Vermont share many common elements. Each state included federally qualified health centers in the stakeholder planning process and valued the leadership they brought to the table, based on their experience with Health Disparities Collaboratives (HDC)⁵ and team-based comprehensive care. They also shared a common definition and recognition tool to help guide practices. The collaboratives diverged on elements such as patient populations, practice criteria, reimbursement and practice support.

PENNSYLVANIA

The origins of Pennsylvania's multi-stakeholder collaborative began with an executive order creating the Chronic Care Commission to help address the rising costs of caring for the chronically ill. The first rollout of the Chronic Care Initiative began in Southeast Pennsylvania, in May 2008, with plans to penetrate the rest of the state, region-by-region, by April 2009. The state is funding faculty and expenses for a yearlong learning session that focuses on the management of diabetes (adults) and asthma (children) for participating practices. State support includes practice coaches, web-based registry, data flow and evaluation.

The payers in the collaborative include six major commercial payers, Medicaid managed care and Medicare managed care. Participating payers make a three-year commitment to provide enhanced payments in the form of lump sums to participating practices. The payments are aligned with the stepwise achievement of the three National Committee for Quality Assurance (NCQA) Physician Practice Connections–Patient Centered Medical Home (PPC-PCMH)⁶ levels. In addition, payers are responsible for providing infrastructure development payments to help with the cost of practice transformation.

The Southeast rollout includes 32 practices, including three FQHCs and 11 sites. All practices that applied to participate were included; subsequent rollouts have a competitive application process. Practices agree to send a team to learning sessions on either diabetes or asthma, reach NCQA level 1 by year one, and provide monthly data reports to the state.

RHODE ISLAND

Rhode Island's multi-payer medical home pilot got its start because of a confluence of events: the state's strong culture of public/private collaboration; a chronic care collaborative driven by the state's Department of Health and HRSA's Health Disparities Collaboratives experience; the Office of the Health Insurance Commissioner (OHIC) statute that holds insurers responsible for addressing costs and quality; and a grant to cover project management to begin the Chronic Care Sustainability Initiative (CSI-RI) pilot. OHIC's role as convener has been pivotal to getting key stakeholders to the table and sustaining their involvement. In addition to OHIC, Quality Partners of Rhode Island, the state's Quality Improvement Organization, provides technical support to the project.

Participating payers represent 67 percent of insured residents, all Medicaid-contracted health plans and all Rhode Island-based commercial payers. Payers agree to sign a two-year contract with providers and pay fee for service plus \$3 per member per month to enhance services and to support the salary and benefits of a nurse case manager located in each practice.

The pilot began in October 2008 and includes five practices, including one FQHC. Providers agreed to reach NCQA level 1 by nine months and level 2 by 18 months. They also agree to participate in disease collaboratives and submit quarterly reports from an electronic medical record (EMR) or electronic registry on clinical measures for diabetes, coronary artery disease and depression. Practices also agree to conduct patient engagement and education activities.

VERMONT

Vermont's multi-payer medical home collaborative was spun from 2006 health care reform legislation that codified a statewide chronic disease management program called Blueprint for Health. In 2007, additional legislation called for a small number of pilots to test the efficacy and sustainability of payment reform across *all* payers (public and private), focusing on three chronic conditions and the health management of the general population, to prevent chronic conditions from occurring.⁷ Through a competitive application process, three communities were chosen to participate. The first pilot began in July 2008 in the St. Johnsbury community. It includes four FQHCs, and two other community pilots are underway.

Legislation defines the state's role, provides pilot funding and requires all insurers to participate. The Blueprint pilots have a strong emphasis on community prevention that integrates the traditionally distinct cultures of public health and healthcare delivery.⁸ Each pilot has a Community Care Team that includes a Public Health Prevention Specialist (state-funded). Providers can access a state-funded web-based registry called the Health Information Exchange Network, as well as Clinical Microsystems training.

All three major commercial insurers and the state Medicaid program participate and share proportionally in the costs of the enhanced provider payments and Community Care Teams. The state will also subsidize Medicare's share of the cost. Providers receive enhanced payments up to \$2.39 per member per month, based on the points scored on the NCQA PPC-PCMH. Providers must also report data through the registry and incorporate Clinical Microsystems training in their delivery of care.

CONCLUSION

States play an instrumental role in initiating, convening, and sustaining multi-payer medical home collaboratives. Collaboratives in Pennsylvania, Rhode Island and Vermont all involved FQHCs in the stakeholder planning process. Each state found that the FQHC culture of care provided insight and leadership to the

stakeholders, based on their experience with HDC, comprehensive care to populations at risk and care integration.

FQHCs have benefited from their involvement in medical home collaboratives by way of enhanced reimbursement for care they are already delivering. In addition, FQHCs gained additional infrastructure support (registry, care coordinators and practice coaches), ongoing education and an enhanced working environment. Most FQHCs had little trouble attaining level 1 on the NCQA scale, but many found that reaching higher levels requires significant upgrades of existing EMR systems to interface with multi-payer databases and to use web-based electronic health records.

All three state medical home collaboratives are undergoing extensive evaluations to determine whether their investments will yield improved patient outcomes, provider and patient satisfaction and a reduced rate of growth in health care costs. Waiting for the outcome of the evaluations may not deter some states from further investing in primary care to improve health system delivery reform.

INTRODUCTION

The medical home is a model of care that is taking root among public and private payers in an effort to improve quality, control costs and increase both patient and provider satisfaction. This model has the potential to better support the primary care workforce, which suffers from chronic shortages caused by pay disparities between specialty and primary care and by job dissatisfaction and disillusionment.⁹ Both can be improved through enhanced reimbursements and infrastructure practice support.

State efforts that emphasize a primary care-oriented system through the provision of medical homes, often begin with Medicaid and CHIP, which covered more than 64 million poor and low-income people in 2006.¹⁰ Since then, more than 30 states have been seeking to improve these programs by adopting the medical home model.¹¹ Many states are advancing medical homes as a core component of comprehensive health care reform, and several are using their clout to drive changes that advance medical homes in state health benefit plans, the private sector and multi-payer collaboratives.

Multi-payer collaboratives can be critical to gaining provider and purchaser support for medical home initiatives. Providers are more likely to adopt a system of care that treats all patients the same regardless of payers. Purchasers of care—including insurers, employers and states—want to share the cost and risk of up-front investments in enhanced provider rates and other elements of primary care practice redesign. This risk, they hope, will yield a return on investment that can be demonstrated through evaluations of both patient outcomes and the costs of delivering care. Multi-payer collaboratives have a larger provider and patient base, which allows for more thorough evaluations on whether this model improves care and contains costs.

FQHCs have helped to plan and implement several state-led multi-payer collaboratives. They bring valuable insight to the stakeholder table, based on their participation in chronic care collaboratives (see text box, page 8) and efforts to deliver team-based comprehensive primary care, which are core aspects of the medical home. According to the states interviewed for this report, FQHCs are often best positioned and most enthusiastic about medical home practice transformation, and states hope this will translate to better outcomes. According to the FQHCs interviewed, not only do enhanced payments improve participation, but FQHCs gain needed support for learning collaboratives, dedicated nurse care managers, health information technology with information sharing, population management, documentation and other support.

This report will describe three states—Pennsylvania, Rhode Island, and Vermont—that have well-developed, state-led multi-payer medical home collaboratives, which provide insight into the role that FQHCs play in these initiatives. This report was produced using telephone interviews with state officials, primary care associations and FQHC representatives from each state, and through web-based research. We hope this report will provide useful lessons for other state policy makers looking to develop similar pilots, as well as describe opportunities for FQHCs, primary care associations and others who want to become engaged in state efforts to advance medical homes.

BACKGROUND

First advanced by the American Academy of Pediatrics (AAP) in the 1960s, the concept of the medical home initially referred to a central location for archiving a child's medical record and for connecting the many disparate practitioners who treat children with special health care needs.¹² AAP evolved the medical home concept to become an accessible, continuous, comprehensive, family-centered, compassionate and culturally effective place of health care.¹³ It is clear now that the medical home concept has further evolved to include a broader expanse of patients, particularly those with limited resources and the greatest health care needs.

DEFINING A MEDICAL HOME

Medical homes are often described in terms of valued principles or characteristics. Although states do not agree on one definition of a medical home,¹⁴ most definitions reflect these core primary care values:

- Having a personal physician or provider who provides first contact care or a point of entry for new problems,
- Providing ongoing care over time,
- Offering comprehensive care, and
- Coordinating care across a person's conditions, providers and settings.¹⁵

In 2007, four major physician groups joined large employers, commercial insurers and other organizations to form the Patient Centered Primary Care Collaborative (PCPCC) and agreed to a common Patient-Centered Medical Home (PCMH) model.¹⁶ The PCMH model is defined by seven "Joint Principles" (Appendix A). Eleven states have adopted or based their medical home definition on these principles.¹⁷ This broad agreement on the medical home definition, along with new resources to advance its adoption, has presented opportunities for states.

RECOGNIZING PRACTICES AS MEDICAL HOMES

Public and private payers that reimburse medical practices as high functioning medical homes need to translate a medical home definition into measurable standards and then develop a process for recognizing which practices meet those standards. Without that, payers will not know which practices to reimburse, or they will spend money on practices that are not high functioning medical homes. Defining and recognizing a medical home helps establish concrete expectations that can motivate practices to improve how they deliver care.

There are a variety of tools that states can use to identify practices that meet medical home standards. No single tool has been identified as ideal, but there is general agreement that the tools or processes used should recognize and measure the four pillars of primary care: access (first contact care), continuity (longitudinality), comprehensiveness and coordination.¹⁸

Standards and recognition processes are shaped by a state's medical home definition. The Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) is probably the most widely used in recent medical home initiatives. The National Committee for Quality Assurance (NCQA) developed this tool in collaboration with the PCPCC, which also developed and promotes the Joint Principles. (See text box, page 7)

National Committee for Quality Assurance PPC-PCMH Tool

The PPC-PCMH builds on many elements developed by the Chronic Care Model. It takes a systems approach to recognition by assessing practice performance on nine standards: access and communication, patient tracking and registry functions, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communications. Within each standard there are between two and five structural elements, all with point values, which indicate the kinds of documentation required to pass or achieve points. There are some elements that practices must pass before receiving certain recognition levels.

NCQA administers the recognition process. Practices that choose to undergo the process may be awarded one of three recognition levels. A fee based on the number of physicians in a practice is required for the survey tool license, NCQA review and recognition, each level advancement and recognition renewal.¹⁹ The three recognition levels are:

- Basic level 1 recognition: the practice scores must be within 25-49 and include 5 out of 10 “must pass” elements;
- Intermediate level 2 recognition: the practice scores must be within 50-74 and include all 10 “must pass” elements; and
- Advanced level 3 recognition: the practice scores must be within 75-100 and include all 10 “must pass” elements, as well as a fully functional electronic medical record.²⁰

FORMING MULTI-STAKEHOLDER COLLABORATIVES

States play a key role in advancing medical homes. Most, however, have found that they cannot do this alone and are partnering with other stakeholders, such as payers, primary care providers (including FQHCs) and the organizations that represent them (including Primary Care Associations), patients, and advocacy groups. These stakeholders play a variety of roles in program design, implementation and operation.

Partnering with other payers in multi-stakeholder collaboratives helps spur provider buy-in and increases practice penetration while spreading transformation costs. Practices are more inclined to participate if they can treat all patients the same, regardless of payers, and report on common measures. Some state agencies are convening the collaboratives, while some states are joining efforts convened by other stakeholders.

Pennsylvania, Rhode Island and Vermont are three states with multi-stakeholder collaboratives in which the state is the lead convener. This has given these states extra leverage in forming and sustaining the collaboratives. Having the state as a neutral convener can allay payers' and providers' fears that anti-trust issues will be raised by their common effort.

PARTNERING WITH FQHCs

Federally qualified health centers have been at the stakeholder table in Pennsylvania, Rhode Island and Vermont's multi-payer medical home collaboratives. Rhode Island and Vermont also included the state's

Health Disparities Collaborative (HDC)

In 1998, HRSA's Bureau of Primary Health Care partnered with the Institute for Healthcare Improvement (IHI) to form the Health Disparities Collaboratives. The goal was to eliminate disparities in health care through better chronic disease management. FQHCs typically spend 12–13 months learning and applying new models of care designed to decrease or delay complications of disease, decrease the economic burden for patients and communities and improve access to quality chronic disease care for underserved populations.²¹ Eighty-eight health centers formed the first HDC focused on diabetes.

HDCs have three main components adapted from IHI's Breakthrough Series:

1. *Learning model:* The learning model is the education component that trains interdisciplinary teams from each health center, using learning sessions, monthly conference calls and progress reports.
2. *Chronic care model:* This six-part component employs patient self-management; clinical decision support (such as evidence-based guidelines); clinical information system (for instance, the use of a registry for population management); delivery system design; organization of health care (such as involving executive leaders in the collaboratives); and community resources (including the use of space, resources and education).
3. *Improvement model:* This component trains teams to use the Plan, Do, Study, Act (PDSA) methodology to test and implement positive changes quickly before they are finalized.²²

primary care associations in the planning process. Each state found that FQHCs brought valuable experience based on their participation in HRSA's Health Disparities Collaborative, which often caused other providers' "jaws to drop" at the stakeholder table. Learning collaboratives have been an important part of the FQHC learning culture, and FQHC providers were eager to continue in that direction.

In addition, the FQHCs in Pennsylvania, Rhode Island and Vermont were generally ahead of other practices in their use of electronic medical records (EMRs)—a fundamental criteria in the NCQA PPC-PCMH qualifications. Although FQHCs widely employed EMRs, each state found that infrastructure and technology assistance were still needed to get most FQHCs' systems to interface with multi-payer databases and make use of web-based registries.

PENNSYLVANIA: CHRONIC CARE INITIATIVE

The origins of Pennsylvania's multi-stakeholder collaborative began with an executive order from Gov. Edward Rendell, creating the Chronic Care Commission. Data that illustrated the staggering cost of caring for those with avoidable chronic illnesses helped embolden the commission's work. This data included:

- In 2007, Pennsylvania hospitals charged \$4 billion for avoidable hospitalizations for those with chronic conditions, and
- Eighty percent of medical expenses go to 20 percent of the population with chronic illnesses.²³

The commission is charged with establishing an infrastructure to change the way chronic care is delivered. The 37-member commission represents a broad cross section of health care-related fields and represents all geographic areas of the state. In addition, the secretaries of health, public welfare and insurance, as well as the director of the Governor's Office of Health Care Reform (GOHCR), serve as *ex-officio* members. Several FQHCs' representatives are members as well.

The commission met for three months in 2007 and developed a strategic plan that called for implementing the Chronic Care Model developed by Dr. Ed Wagner and the MacColl Institute in all primary care practices across the state. In the initial discussions, this model was not linked to any medical home efforts. After discussions with payers, it became clear that a tool was needed to validate practice transformation to justify additional provider payments. The NCQA PPC-PCMH became a useful tool for the state to help establish a framework for supplemental payments based on a practice's level of achievement.

The first rollout of the Chronic Care Initiative began in Southeast Pennsylvania in May 2008. The state plans to penetrate the rest of the state region-by-region by November 2009. The policies for each region will vary to allow for flexibility. In the Southeast rollout, all 32 practices that applied to participate, including three FQHCs with seven sites, were included. In subsequent rollouts, there is a competitive application process based on funding and other limitations placed by payers.

One of those limitations is ensuring that participating providers have a proportional mix of payers to help spread the transformation costs. With a high dependence on Medicaid as a payer, FQHCs have been challenged to participate in subsequent rollouts. The South Central rollout did not include any FQHCs, although the Southwest rollout does. In addition, the Chronic Care Initiative seeks to focus efforts on practices that are not yet transformed, and many of the Pennsylvania FQHCs are much further along in this process than other practices because of their participation in HDC and their use of electronic medical records. The state's primary care association agrees that many FQHCs already are functioning as advanced medical homes, but it believes that the stakeholder process requires leaders or champions in the room to share lessons learned: "It's one thing to say 'do this'—but another to say 'it can be done. I've done it.'"

STATE RESPONSIBILITIES

The state is providing faculty and facilities for a yearlong learning collaborative that focuses on the management of diabetes (adults) and asthma (pediatrics) for participating primary care practices. Practice support includes providing practice coaches through Improving Performances in Practices (IPIP) (a state-based, nationally led quality improvement initiative) to help practices implement the required action steps.

Practices can use a patient registry through IPIP if they do not have an EHR or if their EMR does not have registry functions. The state is responsible for coordinating the flow of supplemental payments to the practices, as well as coordinating the data collection, evaluation and reporting activities through IPIP. At 18 and 36 months, a formal evaluation will be conducted to assess whether the rollouts are achieving desired quality and cost containment goals and whether the program should be continued.

PAYER RESPONSIBILITIES

The payers in the collaborative include 16 major commercial payers, Medicaid managed care and Medicare managed care. Payers make a three-year commitment to provide enhanced payments in the form of lump sums to participating practices. The payments are aligned with stepwise achievement of the three NCQA recognition levels. Payments are proportionate, based on the percentage of the payer's beneficiaries diagnosed with either asthma or diabetes. FQHCs continue to receive wrap-around payments from Medicaid to cover the difference between the managed care FFS payment and their cost-based reimbursement rate. The commission is charged with determining a common set of performance pay measures that insurers may use to help sustain and spread practice transformation.

Payers are also responsible for providing infrastructure development payments that include support for data entry to the registry, the cost of the NCQA survey tool and the application fee, as well as lost revenue for attending seven days of learning collaborative meetings in the first year.

PRACTICE RESPONSIBILITIES

All practices must sign a three-year commitment to participate and, in year one, send a practice team to seven days of learning sessions. Within 18 months, practices must apply for NCQA level 1 recognition and provide monthly data reports to the state. Practices report on either the asthma or diabetes measures (asthma for pediatrics and diabetes for family practice and internal medicine). They must manage that population the same regardless of payer and track patient care through a registry. FQHCs declare that they do not pay attention to payer type and treat all patients the same, including those who are uninsured and Medicare FFS (although they do not submit data on these patients).

All supplemental payments need to be reinvested into the practice site, including adding case management services when practices do not have that resource in place.

DISCUSSION

The Governor's Office of Health Care Reform (GOHCR) found that FQHCs provide a great deal of leadership as members of the Chronic Care Commission, based on their experience participating in HDC, providing comprehensive primary care, often under one roof, and using a team-based model of care. However, the GOHCR found that FQHCs have faced challenges adapting to a business model that requires, for example, finance and office practice redesign to eliminate waste and streamline workflow.

Two of the participating FQHCs in the Southeast Pennsylvania rollout are nurse-managed health centers. There are more than 250 nurse-managed health centers in the U.S. that are run by nurses, operate in partnership with their communities and offer a full range of comprehensive primary care services.²⁴ Pennsylvania's Family Practice & Counseling Network represents one of the nurse-managed FQHCs in the Southeast rollout. The executive director agreed that their experience with HDC and their overall model of delivering care has brought valuable insight to the commission's work. In addition, all of the network's practices use electronic medical records and participate in continuous quality improvement activities—criteria emphasized in NCQA recognition.

Although the state offers practices use of a registry that provides many new and desirable features, adapting to the new registry has been a challenge for some of the Family Practice & Counseling Network health centers. They hope to address this barrier by updating their own EMR to provide similar features to the collaborative's registry. They also want to provide new features, such as providing patients with access to their lab results online.

Another challenge for nurse-managed FQHCs is that NCQA only recognizes physician-led practices. GOHCR was able to gain NCQA acceptance to score the nurse-managed FQHCs' applications and provide the results that were used to qualify the FQHCs for supplemental payments. The Family Practice & Counseling Network hired a part-time Master of Public Health-level employee to assist with the application process, at a cost of approximately \$25,000.

The health centers also had trouble offering patients access to the provider of their choice—another NCQA requirement. In many of the nurse-led practices, nurse practitioners are part-time, balancing work and family, but this is something that FQHCs are working to address in order to meet continuity requirements.

The state's primary care association has been an active stakeholder on the regional rollout committees. (The Chronic Care Commission limited stakeholder involvement to providers but not their representative associations.) The PCA actively sought membership on the steering committees and has played a role educating other providers and insurers about the Chronic Care Model. The PCA also found many misconceptions about FQHCs among providers and insurers. Having a stakeholder role helped address these misconceptions and ensure that subsequent rollouts do not include parameters that preclude the participation of FQHCs. The PCA values the role that the state played as a convener, particularly in its ability to get agreement on common reimbursement and measurement strategies. Although there are major insurers at the table, the PCA noted there are still many who have declined to participate.

RHODE ISLAND: CHRONIC CARE SUSTAINABILITY INITIATIVE

Rhode Island's multi-payer medical home pilot started after a confluence of events. First, Rhode Island has a strong culture of public/private collaboration on quality improvement activities; one noteworthy example is the Rhode Island Chronic Care Collaborative (RICCC).

In 1997, a partnership between the Department of Health and Thundermist Health Center (an FQHC) began with the HDC for diabetes. From this early partnership, a statewide collaborative developed, adding 10 more FQHCs and a hospital-based practice.²⁵ In 2003, the Department of Health and Quality Partners of Rhode Island (the state's quality improvement organization) received a grant from the Robert Wood Johnson Foundation to train more physician practice teams based on the HDC model, and RICCC was launched. Although RICCC showed promising results, many providers struggled to sustain the work in the fee-for-service environment.

Second, unique to Rhode Island is the Office of the Health Insurance Commissioner (OHIC).²⁶ Under OHIC statute, the commissioner is charged with holding insurers accountable for efforts to improve affordability, accessibility and quality in the health care system,²⁷ providing leverage to convene payers.

Finally, securing a grant from the Center for Health Care Strategies (CHCS) provided financial support for project management to begin the multi-payer pilot known as the Chronic Care Sustainability Initiative (CSI-RI).

In July 2006, OHIC convened purchasers, payers and providers to translate medical home principles into a payment pilot. Purchasers include the state's two largest employers, Medicaid and state employees. Participating payers represent 67 percent of insured residents, Medicaid-contracted health plans and Rhode Island-based commercial payers (Medicare FFS is not included). OHIC wanted a mix of the providers participating in the pilot to include private practices, academic/teaching settings and FQHCs. Also at the table are organizations that represent providers, including the Rhode Island Health Center Association (the state's PCA), as well as other provider groups. Technical assistance and project management is provided by Quality Partners of Rhode Island, based in large part on their experience with the RICCC.

In October 2008, the two-year pilot began, involving five practices, one of them an FQHC. The pilot will serve at least 25,000 covered lives and include all adults diagnosed with diabetes, depression or coronary artery disease.

STATE RESPONSIBILITIES

OHIC's role as a convener has been pivotal in getting key stakeholders to the table and sustaining their involvement. OHIC provides project management, which includes organizing quarterly stakeholder meetings that provide input to the steering committee on project direction and developing consensus on key project decisions. The Rhode Island Department of Health and Department of Human Services is also at the table and brings expertise from its Primary Care Case Management program.

PAYER RESPONSIBILITIES

Participating payers sign a two-year contract with providers and pay using a common reimbursement method:

- FFS plus \$3 per member per month for enhanced services. The FQHC continues to receive wrap-around payments from Medicaid to cover the difference between the managed care FFS payment and their cost-based reimbursement rate.

- Payment for the salary and benefits for nurse case managers located in practices who serve all patients regardless of payer, share data and report measures regularly.

Payers also agreed to use common measures, including NCQA PPC-PCMH outcome measures for three chronic conditions (based on national standards) and cost and utilization measures, such as emergency room, prescriptions and inpatient admissions from plans.

PROVIDER RESPONSIBILITIES

Participating providers agree to reach NCQA PPC-PCMH level 1 by nine months and level 2 by 18 months, verified through a self-audit. Reaching these levels requires participation in the existing RICCC and its collaborative learning model, as well as quarterly reports—shared with one another—from an EMR or electronic registry on clinical measures for diabetes, coronary artery disease and depression.

Practices also agree to conduct patient engagement and education activities. The Department of Human Services provides assistance by placing patients in the Stanford Chronic Disease Self-Management Program patient workshops.

DISCUSSION

According to OHIC, Thundermist Health Center has contributed greatly to CSI-RI stakeholder meetings, especially by sharing its expertise around chronic care and population-based health management. The initial meetings of the project were focused on engaging private practices that had been the least engaged in the RICCC's work, and those that had found it particularly hard to sustain the work in a fee-for-service reimbursement environment. Also, OHIC's statutory authority is based in commercial insurance regulation. As the project took shape, the all payer imperative—including Medicare and Medicaid—became clearer. The value of including FQHCs in the project was recognized because of the depth of their experience with the Chronic Care Model, as well as the need to incorporate the treatment issues more common among FQHC populations in the all payer model. Participation by the Primary Care Association, all parties agreed, was important but not sufficient. Thundermist—by virtue of its leadership role in the RICCC and HDC, and its persistent interest in the project—was a logical choice.

The health insurance commissioner noted that both FQHCs and private practices do not have many convening opportunities, and the CSI-RI meetings allowed them opportunity to dispel myths, share experiences and collaborate on common goals. Thundermist Health Center's executive director stated that although stakeholder meetings are often long and tedious, participating in discussions at that level with other providers and policymakers is invaluable. She noted that it is an enormous benefit for FQHCs to be a part of health care reform efforts.

Participation in CSI-RI has enabled Thundermist Health Center to continue providing innovative services to its entire patient population—services that may have been eliminated with state budget cuts. In addition, providers have benefited tremendously from participating in RICCC, which contributes to higher provider satisfaction.

The Rhode Island Health Center Association stated that participation in CSI-RI has allowed it to rethink Joint Commission accreditation. FQHCs in the state have struggled with Joint Commission ambulatory accreditation, believing that it is not suitable and too expensive. Now Rhode Island FQHCs are leaning towards the NCQA as an accreditation model, based on Thundermist Health Center's participation in CSI-RI.

The new executive director of the Rhode Island Health Center Association perceived a “missed opportunity” in the early stakeholder meetings and did not actively advocate for more FQHCs to be included in CSI-RI. (One other FQHC was involved in stakeholder meetings, but it eventually stopped participating.)

There are 10 FQHCs in Rhode Island, and each already participates in RICCC. Six have robust EMRs, and all have registries. All RI FQHCs are poised for future involvement.

Rhode Island FQHCs may not have to wait long. OHIC wants to expand this model to other practices before the pilot ends. Although payers may be reluctant to approve an expansion until confirming a return on investment, OHIC is considering building primary care investments into health plan requirements for every insurer in the state to further spread expansion of medical homes.

VERMONT: BLUEPRINT INTEGRATED PILOT PROGRAM

Vermont's multi-payer medical home collaborative was built on Vermont's 2006 sweeping health care reform legislation. Known as the Blueprint for Health, the goal is to reform the state's health delivery system. Through a competitive process, six "Blueprint" communities (organized as hospital service areas) were selected to begin the transformation by improving diabetes care and prevention through provider training and incentives, expanded use of information technology, evidence-based process improvement through Clinical Microsystems training, self-management workshops and support for community activation and prevention programs.²⁸

In 2007, additional legislation called for a small number of pilots to test the efficacy and sustainability of payment reform across *all* public and private payers, as well as for several chronic conditions (diabetes, hypertension and asthma). This included health management of the general population to prevent chronic conditions from occurring.²⁹ The Blueprint wanted to test not only a financial model, but also a delivery model, so it considered different settings and practice types during its selection process. Through a competitive application process, three Blueprint communities from the original six were chosen to participate in the Blueprint Integrated Pilot Program.

Vermont has a strong history of fostering public-private collaboration. This culture was reinforced in the Blueprint for Health by legislation that mandated that the executive committee include a broad range of stakeholders, including a representative "serving low income or uninsured Vermonters."³⁰ The executive committee has had representation from an FQHC and additional representation is seen from FQHCs and the PCA in the five statewide workgroups that advise and assist Blueprint staff with planning and evaluation of the pilots. At the community level, each pilot site has its own stakeholder group. FQHC representatives stated that they were involved in the Blueprint pilot design and had considerable input throughout the whole process.

The first pilot began in July 2008, in the St. Johnsbury community of the Northeast Kingdom. The result of a partnership with the area hospital, the pilot includes four FQHCs and one hospital-owned medical practice. The second pilot began in October 2008 in the Burlington community (no FQHC included). The third pilot is in the Bennington community (details regarding the practice sites are not yet available).

STATE RESPONSIBILITIES

The Blueprint for Health operates under the umbrella of the Department of Health, which is responsible for implementing the Blueprint pilots. The legislature provided funding for the pilots, including support for building the infrastructure needed to make the pilots successful. The legislature set out an aggressive implementation timeline and requested to be updated with regular reports.

There are several distinguishing characteristics about the Blueprint pilots. One is the emphasis on community prevention, which integrates the traditionally distinct cultures of public health and healthcare delivery.³¹ Each Blueprint pilot has a Community Care Team (funded by the payers) that includes a public health prevention specialist (funded by the state) based in local Department of Health district offices. The public health prevention specialist works closely with the healthcare delivery members of the Community Care Teams and other key stakeholders in their community to:

- Provide structured assessments of the risk factors and conditions that contribute to the prevalence of morbidity from chronic disease, and

- Plan and implement interventions that are designed to reduce the prevalence and impact of chronic disease.³²

Blueprint will continue to support Healthier Living Workshops, Vermont's version of the Stanford Chronic Disease Self Management Program, which are offered throughout the state. Future work will involve training multi-disciplinary teams to support practices to help patients set self-management goals, such as achieving a healthy weight.

Another distinguishing characteristic is the state's plan to establish a health information environment that will support patient care and population management. There are many components to this plan that involve collaboration with private partners:

- A web-based registry (DocSite), supported by the Blueprint and Vermont Program for Quality in Health Care (VPQ), which will produce reports for all health maintenance and chronic disease measures integral to clinical operations, population management and program evaluation. Providers without an EMR can use DocSite to support individual patient care.
- A health information exchange network, developed with Vermont Information Technology Leaders (VITL), Blueprint and technology teams at each organization. The network will establish data transmission from available sources (such as EMRs and hospital data warehouses) to DocSite, and
- Clinical Microsystems³³ and VPQ Coordinated Training³⁴ to affect practice transformation (part of the initial groundwork laid by the six original Blueprint Communities).

The state Blueprint budget is funding the NCQA practice audit. An independent reviewer will assess providers at six-month intervals.

PAYER RESPONSIBILITIES

All payers, including Medicaid, proportionally share the costs of enhanced provider payments and Community Care Teams. The state is subsidizing Medicare's share of the cost.

Providers receive enhanced payments based on the points scored (not the level reached) on the NCQA-PPC-PCMH. This allows practices to be rewarded for smaller incremental changes every six months. Practices must score at least level 1 recognition (25 points, which includes 5 out of 10 must pass elements) to trigger a \$1.20 per member per month payment. They may earn up to \$2.39 for scoring 100 points.

Payers also share the cost of the local Community Care Teams, whose function is to engage the entire community in effective health maintenance, prevention and care for chronic disease.³⁵ The team composition varies by community, but payers generally fund a chronic care coordinator at each practice site, a community health worker and a care integration coordinator. Other teams may include new or existing practice staff, such as medical social workers, behavioral health specialists and dietitians. The care integration coordinator runs the team and works across practices with Medicaid, social services, etc., as well as the public health prevention specialist. It is the hope that after the Blueprint pilot concludes, insurers will be able to shift expenditures from their current disease management services to support statewide expansion of the Blueprint Integrated Pilot program.³⁶

PROVIDER RESPONSIBILITIES

Providers must agree to become advanced medical homes through NCQA PPC-PCMH recognition. All practices must score at least level 1 to receive enhanced reimbursement, which FQHCs had very little difficulty achieving. Three out of four FQHCs scored level 3 on the NCQA scale. Providers must also report

data regularly through the DocSite registry and incorporate Clinical Microsystems training in their delivery of care.

DISCUSSION

According to state officials, FQHCs have partnered with an area hospital and played a leadership role throughout the entire Blueprint development. They provided testimony to the legislature, describing the challenges that primary care practices—especially fee-for-service practices (non-FQHCs) —would face becoming advanced medical homes without significant financial reform. This testimony helped craft the 2007 Blueprint pilot legislation. During state workgroup meetings, the FQHCs helped break some of the resistance by stakeholders reluctant to change and contributed to the design of the Blueprint pilots.

Although the Northern County Health Centers in the St. Johnsbury Community share a common EMR, they have a number of issues that require extensive system updating before taking part in the data exchange and getting them to do high-level population management. The state provided financial and technical support for this revamping. FQHCs explained that the Blueprint has high expectations and asked providers to track more than 100 clinical elements. Many providers have been resistant to taking the time to do this. This is compounded by the existing pressure—or “push and pull” —of a payment system that rewards providers who see more patients yet expects them to spend more time tracking and managing patient care. In response, Blueprint leaders have visited FQHCs to explain how these data will help with the vision for a healthier state.

From the FQHC perspective, the addition of the Community Care Teams has relieved some of this pressure. One FQHC representative stated that they have contributed greatly to their mission by giving their patients “a better chance of improving their lives.” The additional funding, used to hire a care integration coordinator, add more hours to an existing behavioral health specialist’s schedule and access a public health prevention specialist, has contributed greatly to problem solving and identifying resources to help patients. As one FQHC representative summarized, the Community Care Teams have made addressing difficult patient problems like hitting the “easy button.” FQHCs also found that having a state-funded, independent auditor for NCQA accreditation has been a tremendous help in getting through the laborious recognition process. Blueprint pilot FQHCs are working to help other Vermont FQHCs prepare for NCQA recognition.

In that same vein, the Bi-State Primary Care Association has been securing federal and state funding to form a network called the Vermont Rural Health Alliance. The alliance was developed in partnership with the Department of Health and the state and federal Offices of Rural Health to support participation in the Blueprint for Health and other quality improvement initiatives. Membership includes Bi-State Primary Care Association, FQHCs, a critical access hospital, other community clinics, VPQ and VITL. The alliance provides support to Blueprint pilot providers to “stretch their Blueprint dollars” and to give providers not part of Blueprint Communities an opportunity to participate in “virtual Blueprint Communities.” For the latter group, the alliance hopes to take the lessons learned in the Blueprint Communities and prepare providers for future Blueprint initiatives.

CONCLUSION

There are a number of lessons to be shared from the three state-led multi-stakeholder medical home collaboratives.

Leadership and commitment is needed from the top.

The Pennsylvania Chronic Care Initiative began with an executive order; Rhode Island's Chronic Care Sustainability Initiative was empowered by an Office of the Health Insurance Commission statute; the Vermont Blueprint was launched by the governor in 2003; and the Integrated Pilot Program has a legislative mandate. Being the lead convener has given these states extra leverage in forming and sustaining the collaboratives. Rhode Island and Vermont had statutory or legislative authority, respectively, requiring insurers to participate in their collaboratives. Vermont initially tried to accomplish payer reform voluntarily, without success. Having the state as a neutral convener can allay payers' and providers' fears that anti-trust issues will be raised by having a common effort.

"[FQHCs] bring assurance that we're building a model that can work for a whole population, not just for people who have the money to go get the best. That's invaluable. We are bringing the safety net health system into the same model that is being driven by commercial businesses—having it work is a real test to the model."

Vermont state policymaker

FQHCs participation in stakeholder and workgroup meetings brings valuable experience to the medical home collaboratives. Each state wanted a variety of practices to test their models. Including an FQHC was intended from the start. One state policymaker explained, "They bring assurance that we're building a model that can work for a whole population, not just for people who have the money to go get the best. That's invaluable. We are bringing the safety net health system into the same model that is being driven by commercial businesses—having it work is a real test to the model."

State policymakers were surprised by the misconceptions other providers had about FQHCs during the stakeholder process. Their images about both the services FQHCs provide and the people they serve were often far from reality. FQHC representatives benefited from these stakeholder meetings as well, because they do not often have the opportunity to share what they do with private practices and do not always appreciate the pressures unique to a fee-for-service practice. One state policymaker noted that another benefit of an all-payer project is to permit private practices, FQHCs and practices in other kinds of primary care settings to identify and focus on common concerns—such as the adequacy of funding for primary care services—possibly creating a broader primary care provider coalition out of groups generally defined by specialty or FQHC status.

Each state policymaker agreed that FQHCs' culture of care, reinforced by their experience with the Health Disparities Collaboratives, comprehensive services and care integration, provided significant leadership and helped persuade other stakeholders to consider the patient-centered medical home model.

FQHCs benefit from their involvement in medical home collaboratives. Most notably, they receive added payments for care they believe they are already delivering. Each state differed in their payment amounts, but all used the NCQA-PPC-PCMH to develop the payment framework. Most FQHCs had little trouble attaining level 1 on the NCQA scale. But most FQHCs interviewed found that reaching higher levels will require significant upgrades of existing EMR systems. In addition to enhanced reimbursement, FQHCs gained additional infrastructure support (including registry, care coordinators and practice

coaches), ongoing education through learning collaboratives and improved working environment. All three state Primary Care Associations wanted more FQHCs to be involved at the start, but looking ahead, they are preparing FQHCs to be ready for state spread of the collaboratives.

Evaluations are important, but investments in primary care are needed. All three states have extensive evaluations in place that they hope will document improved patient outcomes, cost-containment and improved patient and provider satisfaction. They hope that these factors will be enough to sustain the payers' ongoing commitment. Pennsylvania is evaluating its program at 18 and 36 months to assess whether the rollouts should be continued. Vermont is hoping that the investment return from the Blueprint pilots will be able to convince payers to shift expenditures from their current disease management services and spread the approach statewide. Rhode Island is convinced that the investment in primary care is the right direction and may not wait for the pilot's evaluation. The health insurance commissioner is considering building primary care investments into health plan requirements for every insurer in the state to further spread expansion of medical homes.

APPENDICES

APPENDIX A: JOINT PRINCIPLES OF THE PATIENT CENTERED MEDICAL HOME

The “Joint Principles” that define the Patient Centered Medical Home model are:

1. *Personal physician*—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
2. *Physician directed medical practice*—a personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
3. *Whole person orientation*—a personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services and end of life care.
4. *Care is coordinated and/or integrated* across all elements of the complex health care system. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.
5. *Quality and safety are hallmarks of the PCMH*. This includes practices going through a voluntary recognition process, ongoing education, use of evidence based medicine and clinical decision-support tools to guide decision making, as well as other necessary elements to improve quality and safety.
6. *Enhanced access to care* is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.
7. *Payment appropriately recognizes the added value* provided to patients who have a patient-centered medical home. This framework would reflect the value of physician care management work that falls outside of a face-to-face visit. It would pay for services associated with coordination of care, support adoption and use of health information technology for quality improvement and support provision of enhanced communication access. It would also recognize the value of physician work associated with remote monitoring of clinical data (using technology), allow for separate fee-for-service payments for face-to-face visits, and recognize case mix differences in the patient population being treated within the practice.

APPENDIX B: THE ROLE OF FQHCs IN STATE-LED MULTI-PAYER MEDICAL HOME COLLABORATIVES

	Pennsylvania	Rhode Island	Vermont
Lead State Agency	Governor's Office of Health Care Reform	Office of Health Insurance Commissioner	Blueprint for Health Vermont Department of Health
Dates	<ul style="list-style-type: none"> • May 2008 (1st rollout of statewide plan) • May 2009 (3rd rollout in southwest PA) • 3 years to implement each roll out 	<ul style="list-style-type: none"> • October 2008 • 2 year pilot 	<ul style="list-style-type: none"> • July 2008 (Pilot 1) • 2 year pilot
Origins	<ul style="list-style-type: none"> • Executive Order created Chronic Care Commission 2007 • Commission developed a strategic plan to merge PCMH with Chronic Care work 	<ul style="list-style-type: none"> • OHIC statute to direct health plans to work on affordability issues • FQHC/HRSA work in Health Disparities Collaboratives. • Chronic Care Collaborative begun by QIO • CHCS grant to convene payers and provide financial support for project management 	<ul style="list-style-type: none"> • Grew from 2006 legislation (Act 191) establishing 6 original Blueprint communities charged with improving health care and prevention for the most prevalent chronic conditions. • Legislation in 2007 (Act 204) called for multi-payer approach (sustainable financial reform) including mandate for commercial insurers to participate.
FQHC and/or PCA stakeholder participation	<ul style="list-style-type: none"> • Governor's Chronic Care Commission • Steering Committees 	<ul style="list-style-type: none"> • Chronic Care Sustainability Initiative (CSI) stakeholder group • Steering Committees 	<ul style="list-style-type: none"> • Executive Committee for the Blueprint • Blueprint Advisory groups • Local workgroups
Payers	<ul style="list-style-type: none"> • 16 commercial payers that include Medicare Advantage & Medicaid managed care 	<ul style="list-style-type: none"> • Medicaid FFS, Medicaid Managed Care, all RI-based commercial payers, Medicare Advantage 	<ul style="list-style-type: none"> • Medicaid, Medicare (costs subsidized by state), 3 major commercial insurers
Diseases Targeted	<ul style="list-style-type: none"> • Asthma (pediatrics) or diabetes (adults) 	<ul style="list-style-type: none"> • Diabetes, depression, coronary artery disease (adults) 	<ul style="list-style-type: none"> • Diabetes, hypertension, and asthma. In addition, health management for general population

	Pennsylvania	Rhode Island	Vermont
<p># practices/ FQHCs</p> <p>Selection of practices</p>	<ul style="list-style-type: none"> • In first roll-out (Southeast PA) 32 practices including 3 FQHCs (Family Practice & Counseling Network, Philadelphia Health Management Corporation, Quality Community Health Care) • In first roll-out, all practices that applied were accepted. Subsequent rollouts have competitive process. 	<ul style="list-style-type: none"> • 5 practices including 1 FQHC (Thundermist). • Practices self-selected. 	<ul style="list-style-type: none"> • 3 Blueprint communities (hospital service areas). One community includes 4 of the 6 FQHC sites of Northern Counties Health Care and a provider-based RHC, Corner Medical. • Practices selected through a competitive process.
<p>Infrastructure support</p>	<ul style="list-style-type: none"> • Learning collaboratives • Web-based patient registry • Practice coaching 	<ul style="list-style-type: none"> • Chronic Care model training (collaborative) • EHR or Electronic Disease Registry • Practice coaching • Care management nurse at each practice • Evidence-based guidelines embedded in clinical practice • Self-management support for patients 	<ul style="list-style-type: none"> • Chronic care model training • Funding for expanded EMR use including population management/data sharing/web-based clinical tracking system with eRx • Practice coaching • Care Integration Coordinator at each practice • Each practice has support through multidisciplinary community care teams including VDH Public Health Prevention Specialists
<p>Reimbursement</p>	<ul style="list-style-type: none"> • In Southeast PA lump sum payments on proportionate share of payer mix based on NCQA level achieved. Payment varies per region/practice based but up to \$4 PMPM for NCQA level 3 • Infrastructure development payments (includes funding for lost revenue time for teams to attend collaboratives, NCQA application cost, data entry cost) 	<ul style="list-style-type: none"> • \$3 PMPM • Shared payer support for nurse care manager at each practice 	<ul style="list-style-type: none"> • Varies based on NCQA score. Up to \$2.39 PMPM. • Shared payer support for Community Care Teams • State subsidizes Medicare share of payment

	Pennsylvania	Rhode Island	Vermont
Expectations of Providers	<ul style="list-style-type: none"> • Go through Chronic Care Model Collaborative • Progressive level of NCQA PPC-PCMH recognition (self audit). Must reach Level 1 PLUS (includes care management) by 18 months. • Track care through registry or EMR linked to registry • Report data through registry 	<ul style="list-style-type: none"> • Go through Chronic Care Model Collaborative • Progressive level of NCQA PPC-PCMH recognition (self audit). Must reach Level 1 by 9 months. Level 2 by 18 months. • Report data through registry or EMR linked to registry • Patient engagement and education activities 	<ul style="list-style-type: none"> • Go through Clinical Microsystems training • Progressive level of NCQA PPC-PCMH recognition (independent audit). Must reach Level 1 to trigger first payment. Reassessed every 6 months. • Track care through registry or EMR linked to registry • Report data through registry or EMR linked to registry
Evaluation	<ul style="list-style-type: none"> • Multi-payer database • Engaged providers • Patient self-care knowledge and skills • Patient function and health status • Primary care practice satisfaction • Appropriate and efficient utilization of services • Clinical quality of care • Cost of care 	<ul style="list-style-type: none"> • Multi-payer database • PCMH process measures (NCQA PPC-PCMH score) • Health outcomes for 3 chronic conditions • Patient experience of care • Clinical quality of care • Cost of care 	<ul style="list-style-type: none"> • Multi-payer database • PCMH process measures (NCQA PPC-PCMH score) • Health status measures using age, gender, preventive assessments • Clinical quality of care • Cost of care

ENDNOTES

1 As part of NASHP's National Cooperative Agreement from HRSA's Bureau of Primary Health Care, six states were selected through a competitive process to help guide and participate in the project work of this grant. The six states chosen were Missouri, New Mexico, Oregon, Pennsylvania, Rhode Island and Tennessee. In addition, 10 of our academy members, all state officials, serve as project advisors.

2 The contents of this document are solely the responsibility of the author and do not necessarily represent the official views of HRSA/BPHC.

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4 Many states use the term "health home" or "health care home" rather than medical home to include a greater range of providers and a broader array of health care services.

5 To read more: <http://www.healthdisparities.net/hdc/html/home.aspx>

6 National Committee for Quality Assurance Physician Practice Connections-Patient Centered Medical Home. For more information, please see: <http://www.ncqa.org/tabid/631/Default.aspx>

7 Vermont Senate Bill 283, Acts of 2007, Act 204, section 7. Accessed 13 March 2009. <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT204.HTM>

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13 Ibid

14 Many states use the term "health home" or "health care home" rather than medical home to include a greater range of providers and a broader array of health care services.

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- 16 American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association; "Joint Principles of the Patient-Centered Medical Home." February 2007. Patient-Centered Primary Care Organization. Retrieved November 14, 2008. <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>.
- 17 National Academy for State Health Policy, *Results of State Medical Home Scan* (Portland, ME: National Academy for State Health Policy, 2008) Accessed 13 March 2009 http://www.nashp.org/_docdisp_page.cfm?LID=980882B8-1085-4B10-B72C136F53C90DFB
- 18 Ann O'Malley, *How do we know a practice is a PC-MH?* (PowerPoint presentation for National Academy for State Health Policy webcast, Center for Studying Health System Change, April 2008). Accessed 13 March 2009 http://www.nashp.org/Files/PCMH_Infrastructure_April2.pdf
- 19 National Committee for Quality Assurance Physician Practice Connections-Patient Centered Medical Home. For more information, please see: <http://www.ncqa.org/tabid/631/Default.aspx>
- 20 Ibid
- 21 To read more: <http://www.healthdisparities.net/hdc/html/home.aspx>
- 22 Institute for Healthcare Improvement *Health Disparities Collaboratives: Improving Diabetes Care in 3,400 Sites* (Cambridge, MA: Institute for Healthcare Improvement). Accessed 13 March 2009. <http://www.ihl.org/IHI/Topics/Improvement/SpreadingChanges/ImprovementStories/HealthDisparitiesCollaboratives.htm>
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- 24 National Nursing Centers Consortium *Annual Report* (Philadelphia, PA: National Nursing Centers Consortium). Accessed 8 May 2009. http://www.nncc.us/NNCC_Publications/nnccannualreport.pdf, p. 16.
- 25 Rhode Island Quality Partners, Rhode Island Department of Health, et al. *Rhode Island Chronic Care Collaborative* (Providence, RI: Rhode Island Quality Partners, 2007) Accessed 13 March 2009. http://www.riqualitypartners.org/2/Site/CustomFiles/Qty_DocMgr/EXsummFINAL.pdf
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- 27 Chris Koller, *The Rhode Island Chronic Care Sustainability Initiative (CSI-RI): Translating the Medical Home Principles into a Payment Pilot* (PowerPoint presentation, State of Rhode Island Office of the Health Insurance Commissioner) http://www.ohic.ri.gov/documents/Press/InTheNews/CSI-RI/3_CSI%20Translating%20Med%20Home%20Principles%20into%20a%20Pmt%20Pilot.pdf

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32 Ibid

33 A microsystem in health care delivery can be defined as a small group of people who work together on a regular basis to provide care to discrete subpopulations, including the patients. It has clinical and business aims, linked processes, shared information environment and produces performance outcomes. Developed by Dartmouth-Hitchcock Medical Center, Clinical Microsystems provides practices with free tools to become high-performing clinical microsystems. www.clinicalmicrosystem.org/



34 Vermont Program for Quality in Health Care (VPQ) developed the VPQ Learning Community, which coincided with the initiation of the Blueprint for Health and funding for provider training in six Blueprint communities. This enabled VPQ to accommodate small practices unable to attend the Learning Sessions but that wanted to incorporate and spread the quality improvement methods into their daily work. VPQ Learning Community consists of three components: centralized, statewide Learning Forums; multiple, community based mini-learning sessions (the Collaborative on Wheels); and a virtual Learning Community dimension. <http://www.vpqhc.org/2008QR/LearningCommunity.htm>

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HRSA's Office of Health Information Technology

Johanna Barraza-Cannon
U.S. Department of Health and Human Services
Health Resources and Services Administration
Office of Health Information Technology



Office of Health Information Technology (OHIT)

- **Formed in December 2005**
- **Mission:**
The Office of Health Information Technology (OHIT) promotes the adoption and effective use of health information technology (HIT) in the safety net community.
- **OHIT Includes:**
 - Division of Health Information Technology Policy
 - Division of Health Information Technology State and Community Assistance
 - Office for the Advancement of Telehealth

HIT Goals for the Safety Net Providers

Bring HIT to America's safety net providers which will:

- Improve quality of care
- Reduce health disparities
- Increase efficiency in care delivery systems
- Increase patient safety
- Decrease medical errors
- Prevent a digital divide
- Allow providers to participate in pay for performance

What OHIT Does

- Award planning and implementation grants for telehealth, electronic health records, and other health information technology innovations
- Provide technical assistance to HRSA grantees and staff (e.g., project officers and Office of Performance Review) related to effective HIT adoption and Federal and state policies and legislation
- Provide leadership and representation for HRSA grantees with Federal and state policymakers, researchers, and other stakeholders

4

Funding History (In Millions)

<u>FY 2006</u>	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>
Health Center			
Controlled Networks			
\$0.0	\$31.0	\$25.8	\$125
Telehealth			
\$6.8	\$6.8	\$6.7	\$7.55

HRSA Health Center Controlled Networks (HCCN)

- Led by HRSA-funded health centers
- Supports the creation, development, and operation of networks of safety net providers to ensure access to health care for the medically underserved populations through the enhancement of health center operations, including health information technology

6

HCCN Funding Summary FY 2007

	HIT Planning	HIT Innovation s	HIT EHR	High Impact EHR	Total
Number of Awards	8	13	8	18	47
Total \$ Awarded	\$931,001	\$3,295,397	\$5,455,468	\$23,061,642	\$32,743,508
Number of Urban/ Rural Grantees	3 Urban 3 Rural 2 Both	6 Urban 3 Rural 4 Both	2 Urban 1 Rural 5 Both	15 Urban 1 Rural 2 Both	-

HCCN Funding Summary for FY 2008

	HIT Planning	HIT Innovations (3 yr + High Impact)	HIT EHR (3 yr + High Impact)	Total
Number of Awards	6	10	12	28
Total \$ Awarded	\$739,765	\$3,770,561	\$14,372,054	\$18,882,380
Number of Urban/Rural Grantees	2 Urban 4 Rural	4 Urban 6 Rural	2 Urban 6 Rural 4 Both	-

DSCA FY 09 Grant Opportunities

- Division of HIT State and Community Assistance offers the following grant opportunities in FY 2009:
 1. Electronic Health Record Implementation for Health Center Controlled Networks Grant
 2. Health Information Technology Implementation for Health Center Controlled Networks Grant

Advancing HIT through Networks

- Why Networks?
 - Collaboration of health centers and other safety net providers
 - Economies of scale/cost efficiencies/volume
 - Enhanced efficiencies in business and clinical core areas
 - Higher performance and value
 - Sharing of expertise and staff among collaborators

HRSA Telehealth Grant Awards

- First awards made by ORHP in 1989
- Awarded over \$250 million in grants since 1989
- HRSA created Office for the Advancement of Telehealth as a focal point for Telehealth activities in 1998
- Competitive and Congressionally-mandated projects

11

OAT FY 09 Grant Opportunities

- Office for the Advancement of Telehealth (OAT) offers the following grant opportunities in FY 09:
 - Telehealth Network Grant Program
 - Licensure Portability Grant Program
 - Telehealth Resource Center Grant Program

12

President Obama's Pledge

- On January 8, 2009, President-elect Barack Obama pledged to have electronic medical records for all Americans within 5 years:

"To improve the quality of our health care while lowering its costs, we will make the immediate investments necessary to ensure that within five years, all of America's medical records are computerized," Obama said. "This will cut waste, eliminate red tape and reduce the need to repeat expensive medical tests. But it just won't save billions of dollars and thousands of jobs, it will save lives by reducing the deadly but preventable medical errors that pervade our health care system."

13

Summary of American Recovery and Reinvestment Act (ARRA) HIT

- Total \$19.2 billion for **Funding**:
 - \$2 billion for ONC
 - \$17.2 billion for incentives through Medicare and Medicaid reimbursement systems
 - Providers must demonstrate meaningful use of certified EHR technology
- Codifies: ONC; HIT Standards Committee; HIT Policy Standards
- Provides grant and loan programs to assist providers and consumers in adopting/utilizing HIT
- Privacy and security provisions in HIPAA for electronic health info

14

Summary of ARRA HIT Funding (cont)

- Additional HIT funding
 - \$4.7 billion for Broadband Technology Opportunities Program (NTIA)
 - \$2.5 billion for US Department of Agriculture Distance Learning, Telemedicine, Broadband Program
 - \$500 million for Social Security Administration
 - \$85 million for Indian Health Service
 - \$50 million for Veterans Administration

15

ONC Spending Plans	
	Total Appropriated*
• Privacy and Security	\$24.285
• National Institute of Standards and Technology (NIST)	\$20.000
• Regional HIT Exchange	\$300.000
• Unspecified	\$1,655.715
• Total, HIT	\$2,000.000
*(Dollars in millions)	

HRSA ARRA
<ul style="list-style-type: none"> • The Recovery Act has directed \$2 billion to HRSA to expand some of our primary health care programs • Another \$300 million is intended to support the National Health Service Corps • An additional \$200 million will support our health professions programs

HRSA ARRA
<ul style="list-style-type: none"> • On March 2, HRSA announced grants worth \$155 million to establish 126 new health centers <ul style="list-style-type: none"> – Those grants mean another 750,000 people in 39 states and two territories will have access to health care • On March 27, HRSA released \$338 million to expand services offered at the nation's community health centers <ul style="list-style-type: none"> – The grants -- titled Increased Demand for Services (IDS) grants -- will be distributed to 1,128 federally qualified health center grantees – Health centers will use the funds over the next two years to create or retain approximately 6,400 health center jobs • Later this year, HRSA will award about \$1.5 billion in health center grants under the Capital Improvement Program (CIP) to fund capital improvements and support HIT and EHR investments

- \$850M one-time, 2-year project/budget period FY 2009 grants to support
 - Construction
 - Renovation and equipment
 - Acquisition of health information technology and EHR
- Grantees must
 - Demonstrate improvements in access to health services for the underserved populations
 - Create health center and construction-related jobs
- 2-Year project/budget period (July 1, 2009 – June 30, 2011)
- Maximum funding based on CY 2008 UDS Data Formula
 - All section 330 grantees eligible for \$250K base amount
 - Plus \$35 per patient served based on 2008 UDS as of 04/24/2009
 - New Start grantees without 2008 UDS data will have \$250K maximum

Medicare and Medicaid Health IT Provisions in the Recovery Act

- Goal: to promote and provide incentives for the adoption of certified electronic health records (EHRs).
- To achieve this goal, the Recovery Act authorized bonus payments for eligible professionals (EPs) and hospitals participating in Medicare and Medicaid as an incentive to become meaningful users of certified EHRs.

Medicare and Medicaid Health IT Provisions in the Recovery Act

- The law established maximum annual incentive amounts and includes Medicare penalties for failing to meaningfully use EHRs beginning in 2015 for professionals and hospitals that fail to adopt certified EHRs.
- The statute includes three broad criteria for demonstrating one is a “meaningful EHR user” which will be defined as the implementation process moves forward: (1) Meaningful use of certified EHR technology; (2) information exchange; and (3) reporting on measures using EHR. The statute grants the Secretary discretion in defining these terms.
- Specific understanding of what constitutes meaningful use will be determined through a process that will include broad stakeholder input and discussion

Federal HIT Funding Opportunities

Incentives Programs

• Section 4101 Medicare FFS Eligible Professionals

- Payments can begin in 2011
- Last year to join the program-2014
- Last year of payments 2016
- Maximum of 5 years of payments and \$44K
- Penalties begin in 2015
- Caps increased by 10% in a Health Professional Shortage Area
- Also incentives for Medicare Advantage professionals
- Criteria to be defined for meaningful EHR User

Source: CMS May 2009

Federal HIT Funding Opportunities

Incentives Programs

• Section 4102 Hospitals

- Payments can begin in fiscal year 2011
- Last year to join the program-2015
- Last year of payments 2016
- Maximum of 4 years of payments
- Penalties begin in 2015
- Also incentives for Medicare Advantage hospitals
- Criteria to be defined for meaningful EHR User

Source: CMS May 2009.

Federal HIT Funding Opportunities

Incentives Programs

• Section 4201-Medicaid Incentives

- Incentive payments for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) by Medicaid providers.
- No start date specified for Medicaid, probably 2011 similar to Medicare.
- The definition of "meaningful use" must be established through a means that is approved by the State and acceptable to the Secretary.
- The definition must be in alignment with the one used for Medicare.

Source: CMS May 2009.

Who Are Medicaid Eligible Professionals?

- Medicaid providers eligible for funding are defined as:
 - A non-hospital-based professional who has at least 30 percent of the professional's patient volume attributable to individuals who are receiving medical assistance under this title;
 - A non-hospital-based pediatrician who has at least 20 percent of his/her patient volume attributable to individuals who are receiving medical assistance under this title;
 - An eligible professional who practices predominately in a Federally-qualified health center or rural health clinic and has at least 30 percent of the professional's patient volume attributable to needy individuals.

Source: CMS May 2009.

What Type of Hospitals Qualify for Medicaid HIT Incentives?

- Acute care hospitals with at least 10 percent Medicaid patient volume
- Children's hospitals (no Medicaid patient volume requirement).

Source: CMS May 2009.

How Much is the Medicaid Incentive Payment? Penalties?

- The State is authorized to make payments to Medicaid eligible professionals totaling no more than 85% percent of net average allowable costs for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology).
- The statute specifies maximum amounts but the Secretary will determine through studies the actual amounts of the provider incentive payments
- Unlike Medicare, no reductions in Medicaid payments are to be made if a provider does not adopt certified EHR technology; i.e., adoption is voluntary, not mandatory in the federal statute.

Source: CMS May 2009.

Relationship Between Medicaid and Medicare EHR Incentives?

- Eligible Professionals can only receive either the Medicare or Medicaid Incentive, not both
- Hospitals that qualify for the Medicare and Medicaid incentive can receive both.
- The legislation instructs the Secretary to ensure the coordination of incentive payments to providers through Medicare and Medicaid.
- Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers.

Source: CMS May 2009.

HIT TA Toolboxes/Modules

- Overview on why we create toolboxes
 - Current Toolbox
 - Health IT Adoption Toolbox
 - Upcoming Toolboxes
 - Rural Health
 - Telehealth
 - Children's Health IT Toolbox
 - Upcoming Modules for the Health IT Adoption Toolbox
 - Network Development
 - Personal Health Records
 - e-prescribing
 - Quality through HIT

Topic-specific Modules

- The toolbox is organized into the following eleven modules:
 - Introduction to Health IT
 - Getting Started
 - Opportunities for Collaboration
 - Project Management and Oversight
 - Planning for Technology Implementation
 - Organizational Change Management and Training
 - System Implementation
 - Evaluating, Optimizing, and Sustaining
 - Advanced Topics
 - Open Source and Public Domain Software
 - Privacy and Security
- Cover the life cycle of a typical health IT implementation project, from learning the basics to evaluating and optimizing a system
- Each module contains various resources including sample project documentation and white papers
- Question-and-answer framework is designed to help users find the information they need at various phases of a health IT implementation project

HITTAC One to Many TA

- Webinars
 - HRSA holds monthly webinars on various HIT-specific topics
 - Webinars are all archived:
<http://healthit.ahrq.gov/login>
 - A password and log in is required to access the portal. To obtain this, email the request to healthit@hrsa.gov

HITTAC One to Many TA Webinars

- Over 3,000 HRSA grantees and staff have participated in a wide range of webinars including:
 - HIT 101
 - Important Factors to Consider When Selecting an EHR System
 - Collaboration (e.g., with networks, other groups, state entities, etc.)
 - Telehealth 101
 - Financing HIT
 - Readiness Assessments for HIT
 - HIE 101
 - HIT for Special Populations
 - Using EHRs to Drive Quality Improvement
 - Personal Health Records
- Upcoming – Disaster Recovery and Public Health Informatics

HRSA Health IT Community Portal

- HRSA Health HIT Community Portal
 - Developed in collaboration with the AHRQ National Resource Center for Health IT (NRC)
 - Designed to provide news, tools, and access to research for HRSA's safety net providers interested in health IT.
 - Includes a searchable internet database that contains literature articles about the costs and/or benefits of health information technology
 - Request log on password: healthit@hrsa.gov
 - Log in to the Portal: <http://healthit.ahrq.gov/login>

HIT Workshops

- OHIT partners with Health Center Controlled Networks and other HRSA grantees who have implemented HIT to provide Regional workshops around the country to foster learning and network development among HRSA grantees who have not implemented HIT

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HIT Workshops 2009

In 2009 OHIT is planning to provide at least 12 regional workshops:

- EHR implementation
- HIE
- Open source EHR solutions
- EHR that focuses on child health and pediatric EHR functionality
- E-prescribing or tele-pharmacy
- "Meaningful use" of EHRs to improve quality and patient outcomes
- Sustainability, personal health records, and other advanced topics for operational networks
- Critical Access Hospitals and other Rural HIT
- Telehealth for rural and urban communities and health centers

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Future of OHIT

- Promote effective HIT adoption and meaningful EHR use in the safety net to improve quality of care, patient outcomes, and access to care in support of ARRA activities
- Provide oversight, monitoring, and technical assistance to grantees to promote successful adoption of HIT
- Continue to develop and promote effective technical assistance tools such as toolbox modules, webinars, and workshops
- Promote the adoption of certified, interoperable, and fully functional HIT for meaningful use
- Continue to build partnerships internal to HRSA, with external organizations, and within the grantee community

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Contact Information

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<http://www.hrsa.gov/healthit/>

Attachment D

STATE WORKFORCE INCENTIVE PROGRAMS NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS IN CONJUNCTION WITH STATE PRIMARY CARE ASSOCIATIONS AND STATE PRIMARY CARE OFFICES

June 1, 2009

Executive Summary

Background and Purpose

The United States health care system today faces many pressing challenges, including inadequate access to health care for medically disenfranchised individuals. The recent Access Denied report (National Association of Community Health Centers, 3/2007) established that 56 million Americans—nearly 1 in 5—lack adequate access to health care because of shortages of physicians in their community. This alarming finding underscores that health care reform must include efforts to increase the number of health professionals working in medically underserved communities and that a multi-faceted approach to train, recruit and retain a sustainable primary care workforce is needed.

To provide the solid foundation needed to ensure a sustainable primary care workforce, the National Association of Community Health Centers (NACHC) supports change at each level of the education continuum and recognizes that there are opportunities to positively influence the course of a health professional's career as he or she moves through the stages from pre-professional to post-training. As an example, Federal states and territories use various forms of incentives to encourage health professionals to practice in Health Professional Shortage Areas (HPSA), urban or rural areas designated by the Health Resources and Services Administration (HRSA) as having a shortage of primary medical, dental or mental health providers. Incentives can put practice in an urban or rural HPSA within reach for some health professionals by reducing the significant amount of debt incurred while obtaining an education, providing funding to support a move to a new location, providing an extra stipend or bonus, or guaranteeing income for a certain period of time.

NACHC recently undertook the task of creating an inventory of the application of incentives used by states and territories, with the goal of disseminating the inventory via the NACHC website and other channels. It is NACHC's expectation that the inventory will both foster the sharing of innovative ideas among states/territories

and increase health professionals' awareness of incentives available to them along their career continuum.

Survey Process and Details

To develop the inventory of incentives, NACHC surveyed state Primary Care Offices (PCO) and State/Regional Primary Care Associations (S/RPCA). PCOs are federally supported offices within state governments that work to identify and address the needs of the medically underserved in their states. PCOs support the application process for designation as a Federal HPSA (primary care, dental and mental health), or Medically Underserved Area/Population. S/RPCAs are private, nonprofit membership associations representing federally supported programs and other community-based providers of care to the underserved. Both PCOs and S/RPCAs are engaged in some level of health professional recruitment and placement and are sources of information about relevant activities within their states and territories.

PCOs: The first round of data collection took place during Fall 2008 from state PCO offices. The director of each state PCO (N=53) was contacted by e-mail and asked to respond to the following open-ended question: "What incentive programs does your state offer its clinicians to encourage them to enter, establish, and/or maintain primary care practices within their particular state, focusing on the medically underserved?" This effort yielded a 62% PCO response rate, and a listing of state workforce incentive programs most often identified by PCOs to be in use in their respective state as part of the HC's recruitment and retention efforts in the State.

PCAs: A second round of data collection from S/RPCA offices occurred during Winter and Spring 2009. The director of each S/RPCA (N=52) was sent by e-mail a list of common incentive programs and, for each incentive program, the PCA was asked to indicate whether or not it was in use as part of the state's recruitment and retention efforts. Additionally, S/RPCA respondents were asked to share open-ended reviews of incentive programs not

included in the list but in active use. This second round of data collection yielded an 85% PCA response rate.

COMBINED PCA and PCOs: The two rounds of data collection combined resulted in data from 52 states and territories or 98 % of those surveyed.

Findings

States and territories employ multiple incentive programs that enable health care professionals to work as primary care providers in medically underserved communities, as can be seen in Table 1 below.

Table 1: Incentive Programs Most Commonly Used by States and Territories in medically underserved communities:

Incentive Program	Percentage of respondents reporting the Incentive Program in use
National Health Service Corps (NHSC)	90%
Federal/State Loan Repayment Program (FLRP/SLRP)	90%
J1 Visa (Non-immigrant US Visa)	90%
National Rural Recruitment & Retention Network (3Rnet)	69%
Academic Scholarship (Health Professional Student Scholarship)	54%
National Interest Waiver (NIW)	31%
Rural Health Scholars Program (RHSP)	

Other Incentive Programs: In addition to noting participation in the specific incentive programs listed in Table 1 above, 63% of respondents described a variety of other incentive programs in use. These other programs are targeted toward health professionals practicing in HPSAs and are not classified into one of the above categories. A few of these “Other” programs are given as examples and outlined below.

- Arkansas pays for 30 dental slots at universities outside of the state. If the student returns to Arkansas to practice, he or she does not have to repay the state.
- The Finance Authority of Maine purchases 20

admission seats at 3 out-of-state medical schools for Maine residents. Participants are eligible for a variety of low-interest loans and loan forgiveness options.

- Louisiana Department of Health and Hospitals operates the Greater New Orleans Area – Health Service Corps (GNO Health Corps), which offers a variety of incentive programs including loan repayment, sign-on bonus, malpractice premium payment, relocation expenses and income guarantee for eligible health care professionals. Recipients can receive \$10,000-\$110,000 in funding.
- The Wyoming Department of Health operates the Wyoming Physician Recruitment Program through which hospitals, clinics, physicians and other appropriate Wyoming agencies can apply for up to \$80,000 in state funds to assist in physician recruitment with emphasis given to primary care physicians and areas of greatest need. The money has specific uses pertaining to recruitment costs, signing bonus, malpractice and moving expenses, with specific funding limits in each category.

Refer to [Appendix 1](#) for a definition of each incentive program, and refer to [Appendix 2](#) for an Inventory of Incentive Programs and Other Recruitment and Retention Strategies Offered in Each State and Territory. An additional incentive program resource can be found online.

Closing

In summary, to generate a primary care workforce committed to practicing in medically underserved areas necessitates rejuvenation through a variety of means. Incentive programs are a useful means to draw increased numbers of health care professionals to practice in areas where they are most needed. This report documents various incentive programs used to recruit and retain primary care health professionals in each state. It is hoped that this information will improve the primary care workforce by facilitating 1) the sharing and/or replication of ideas among states, and 2) its availability as a resource for primary care health professionals, and primary care health professional students.

Chevonne Salmon, M.D.

*Fellow, Georgetown University Community Health Center
Director Development Program*

APPENDIX 1

DEFINITIONS

INCENTIVE PROGRAMS USED BY STATES AND TERRITORIES TO INCREASE THE PRIMARY CARE WORKFORCE IN HEALTH PROFESSIONAL SHORTAGE AREAS

National Health Service Corps (NHSC)

- The NHSC supports distribution of primary health care clinicians to communities of greatest need: The NHSC Scholarship Program – In exchange for 2 to 4 years of service in an NHSC-approved site in a Health Professional Shortage Area of greatest need, the NHSC provides support for tuition, fees, other reasonable educational costs and living stipend for students in training to become primary care physicians, dentists, nurse practitioners, certified nurse-midwives or physician assistants.
- The NHSC Loan Repayment Program – In exchange for 2 years of service in an NHSC-approved site in a Health Professional Shortage Area, the NHSC provides for primary medical care clinicians, dental care clinicians, and selected behavioral/mental health clinicians up to \$50,000 toward repayment of bona fide student loans and potential for additional years of support.

Federal/State Loan Repayment Programs (FLRP/SLRP)

- Programs that are either federally or state funded and offer loan repayment in exchange for commitment to service in an underserved area. These programs may also be called Loan Forgiveness or Loan for Service Programs.

J1 Visa Waiver (Non-immigrant U.S Visa)

- A J1 visa allows foreign students to train in the U.S.; however, upon completion of their studies they must return to their home country for at least 2 years. A J1 Visa waiver enables foreign primary care physicians to remain in the U.S. without returning home provided they practice for 3 years in a HPSA. Upon completion of this obligation, they may apply for permanent residence status.

National Rural Recruitment & Retention Network (3Rnet)

- A Network consisting of many not-for-profit organizations whose aim is to assist health professionals find practice opportunities in rural and underserved area.

Academic Scholarship (Health Professional Student Scholarship)

- Funding offered to a variety of health professional students to subsidize their education.

National Interest Waiver (NIW)

- A waiver that allows foreign health professionals to obtain permanent residence status if they are able to demonstrate that it is in the national interest for them to do so based on their qualifications. Professionals must commit to practicing in a HPSA for 3-5 years.

Rural Health Scholars Program (RHSP)

- An intensive academic summer program designed for rural high school students interested in the medical field.

APPENDIX 2

INVENTORY INCENTIVE PROGRAMS AND OTHER RECRUITMENT AND RETENTION STRATEGIES OFFERED IN EACH STATE AND TERRITORY

An inventory of state by state recruitment and retention incentives provided by the PCA and PCO responders, (A), including additional state incentives, the “Other” category, (B), are described here.

A. Table: Incentive Programs Responses by State

An inventory of the state by state recruitment and retention incentives reported by PCA and PCO responders.

State	Responder	NHSC P	JI Visa Waiver	3RNet Academic Scholarship	NIW	RHSP	Other
Alabama	PCA	x		x		x	
Alabama	PCO	x	x	x			x
Alaska	PCA	x		x	x		x
Arizona	PCO	x	x	x	x		x
Arkansas	PCA	x	x	x	x		x
California	PCO	x	x		x		x
Colorado	PCA	x	x	x	x		x
Colorado	PCO	x	x	x			x
Connecticut	PCA	x	x	x	x	x	
Connecticut	PCO		x				
Delaware	PCO		x				
District of Columbia	PCA	x	x	x			x
Florida	PCO		x	x			
Georgia	PCA	x	x	x	x		x
Hawaii	PCA	x		x			x
Idaho	PCA	x	x	x	x	x	x
Idaho	PCO						x
Illinois	PCA	x	x	x	x	x	x
Illinois	PCO	x	x	x	x		
Indiana	PCA	x		x	x	x	
Indiana	PCO				x		
Iowa	PCA	x	x	x			
Iowa	PCO	x	x	x	x		
Kansas	PCA	x	x	x			
Kansas	PCO	x	x		x		x

Kentucky	PCO		x	x					
Louisiana	PCA	x	x	x	x	x		x	x
Louisiana	PCO	x	x	x					x
Maine	PCA	x	x	x	x	x	x		x
Maine	PCO	x		x		x			
Maryland	PCO	x	x	x			x		
Massachusetts	PCA	x	x	x	x	x			x
Michigan	PCA	x	x	x	x	x			x
Minnesota	PCO	x	x	x		x			
Mississippi	PCA	x		x	x			x	
Missouri	PCA	x	x	x	x		x		x
Missouri	PCO		x						x
Montana	PCA	x		x	x				x
Montana	PCO			x					x
Nebraska	PCA	x	x	x	x				
Nebraska	PCO		x			x			
Nevada	PCA	x	x	x	x	x	x	x	x
New Hampshire	PCA	x	x	x	x			x	
New Hampshire	PCO	x	x	x	x			x	x
New Jersey	PCA	x	x	x	x				
New Mexico	PCA	x	x						x
New Mexico	PCO	x	x						x
New York	PCA	x		x	x	x	x		x
New York	PCO	x	x	x					x
North Carolina	PCA		x						x
North Dakota	PCA		x						x
Ohio	PCA	x	x	x	x				
Ohio	PCO	x	x	x					
Oklahoma	PCA	x	x	x	x	x			x
Oregon	PCA	x	x	x	x				
Pennsylvania	PCA	x	x	x	x				
Pennsylvania	PCO		x	x			x		x
Puerto Rico	PCA	x	x						
Rhode Island	PCA	x	x	x					
South Carolina	PCA	x	x	x	x		x		
South Carolina	PCO		x						
South Dakota	PCA	x	x	x	x	x	x		x
South Dakota	PCO	x	x	x	x	x			x
Tennessee	PCA	x		x	x	x			
Texas	PCO	x	x	x		x			x
Utah	PCA	x	x	x	x				x
Utah	PCO		x	x					
Vermont	PCA	x	x	x	x				
Vermont	PCO		x			x			x
Virgin Islands									

Virginia	PCA	x	x	x	x	x			
Virginia	PCO	x	x	x		x	x		
Washington	PCA	x	x	x	x	x	x		x
Washington	PCO		x	x		x			x
West Virginia	PCA	x	x	x		x		x	x
Wisconsin	PCA	x	x	x	x				
Wyoming	PCA	x	x	x	x	x			x
Wyoming	PCO	x	x	x		x			x

Legend	
Academic Scholarship	Health Professional Student Scholarship
FLRP/SLRP	Federal/State Loan Repayment Program
J1 Visa	Non-immigrant U.S. Visa
NHSC	National Health Service Corps
NIW	National Interest Waiver
PCA	Primary Care Association
PCO	Primary Care Office
RHSP	Rural Health Scholars Program
3RNet	National Rural Recruitment & Retention Network

B. “Other” Recruitment & Retention Strategies Offered in Each State and Territory

Find here a complete inventory of PCA and PCO responses identified as “other” programs (see the “Other” column in Table A above) offered in a particular state beyond the most commonly used incentives outlined in the table. Contact information for each responding state’s Primary Care Association (PCA) and/or Primary Care Office (PCO) representative is provided here as well.

Alabama

State Income Tax Credit

- Annual Funding: \$5,000 per year; up to 5 years.
- Description: Eligible physicians who practice in defined Health Professional Shortage Areas.

Indian Health Service Loan Repayment Program

- Annual Funding: Up to \$20,000 per year and up to 20% of federal taxes repaid on the loan amount; minimum 2 years.
- Description: Alabama has one IHS clinic for eligible clinicians to practice.

Additional Incentives

- Description: Smaller scholarships offered by local entities such as hospitals and the medical board; Incentives such as office considerations and equipment are also available at the local level.

PCA contact: Khrist Robinson, Recruitment & Retention Coordinator; khrist@alphca.com; (334) 271-7068

PCO contact: Charles Lail, PCO Director; clail@adph.state.al.us; (334) 206-5438

Alaska

Indian Health Service Loan Repayment Program

- Annual Funding: Up to \$20,000 per year and up to 20% of federal taxes repaid on the loan amount; minimum 2 years.
- Description: Alaska offers several IHS clinic sites to practice.

The Western Interstate Commission for Higher Education (WICHE)²

- Description: A commission whose purpose is to provide support and resources to increase higher education availability among 15 states in the West.

WWAMI Medical Program³

- Annual Funding: loan repayment; minimum 3 years in rural location or 5 years in urban location.
- Description: A program whose goals are 1) to make public medical education accessible and 2) to encourage graduates to choose careers in primary care medicine for the underserved and to locate their practices in their respective home states.

PCA Contact: Marilyn Kasmar, Executive Director; marilyn@alaskapca.org; (907) 929-2722

Arizona

Arizona Health Education Centers

- Description: A program that links educational resources with health care delivery systems within medically underserved counties of Yuma, La Paz, and Mohave through

² **The Western Interstate Commission for Higher Education (WICHE):** The commission provides high-quality, cost-effective education to 15 states; this enables states to share cooperatively their higher education programs and facilities for training new professionals, conducting research, and sponsoring continuing education to sharpen the skills of current professionals. The goal of the commission is to increase the availability of higher education in the West, to assist states to have the professionally and technically trained persons they require, and to help states increase the effectiveness and efficiency of their higher education programs.

³ **WWAMI Medical Program:** WWAMI is a cooperative program of the University of Washington School of Medicine and the states of Wyoming, Alaska, Montana and Idaho. This program has two main goals: The first is to make public medical education accessible to Wyoming, Alaska, Montana and Idaho residents. The second is to encourage graduates to choose careers in primary care medicine and to locate their practices in their respective home states with an emphasis on medically underserved areas lacking an adequate number of physicians. The tuition paid by students in the participating states is the same as that paid by Washington state residents. Most states have established Rural Physician Incentive Funds, which assess fees to all students participating in the WWAMI and/or WICHE programs; these funds are then used to repay the education debts of physicians who practice primary care medicine in medically underserved areas of their home state.

the provisions of Student Field Placements, Continuing Education, Health Career Counseling and Recruitment, and the Enhancement of Learning Resource Systems.

The Western Interstate Commission for Higher Education (WICHE) ⁴

- Description: A commission whose purpose is to provide support and resources to increase higher education availability among 15 states in the West.

PCO Contact: Patricia Tarango, PCO Director; tarangp@azdhs.gov; (602) 542-1436

Arkansas

Arkansas Office of Oral Health

- Annual Funding: grant-in-aid \$10,000 for dentists and \$2,500 for dental hygienists; minimum 2 years
- Description: Recipient must be a new Arkansas practitioner and serve in an underserved health center.

Medical Application of Science for Health program

- Description: A program to assist high-school students interested in health care as a career.

Rural Community Match Funding

- Description: Provides federal funding to communities in rural Arizona.

State Pays for Out-of-State Dental Slots

- Description: Arkansas pays for 30 dental slots: 18 at the University of Tennessee, and 12 at the University of Missouri, University of Oklahoma, University of Alabama, Texas A&M (Baylor) University, Louisiana State University, University of Louisville, and Meharry Medical College. The dental student does not have to repay the state if they return to Arkansas to practice.

Additional Incentives

- Description: A bill was recently introduced for community health centers to receive funding from additional tobacco tax.

PCA Contact: Betty Gay Shuler, Recruitment / Resource Development Consultant; bshuler@seark.net; (870) 866-6006

⁴ **The Western Interstate Commission for Higher Education (WICHE):** The commission provides high-quality, cost-effective education to 15 states; this enables states to share cooperatively their higher education programs and facilities for training new professionals, conducting research, and sponsoring continuing education to sharpen the skills of current professionals. The goal of the commission is to increase the availability of higher education in the West, to assist states to have the professionally and technically trained persons they require, and to help states increase the effectiveness and efficiency of their higher education programs.

California

The Health Careers Training Program

- Description: A program that helps to facilitate the training of underrepresented individuals for health professions in underserved areas and helps generate a culturally and linguistically competent healthcare workforce.

The California Dental Pipeline Program

- Description: A program to increase the number of underrepresented minority and low-income dental students working in community health center dental clinics by providing community-based education, mentoring and clinical experience.

Health Workforce Pilot Projects Program

- Description: A pilot program to improve the effectiveness of healthcare delivery systems by utilizing healthcare professionals in new roles to reallocate health tasks to better meet the health needs of Californians.

California Student Aid Commission

- Description: The commission offers programs to encourage registered nurses and students who will become registered nurses to seek employment in state-operated 24-hour facilities with a registered nurse vacancy rate of greater than 10%.

Foundations and Endowments

- Description: California has several foundations and endowment programs to increase the diversity and improve the distribution of their health workforce.

PCO Contact: Angela L. Minniefield, PCO Director; aminnief@oshpd.ca.gov; (916) 326-3700

Colorado

Colorado Rural Outreach Program

Total Funding: Up to \$10,000 matched.

- Description: A program for local communities and/or facilities to match dollar-for-dollar the governmental funding rewarded to clinicians working in rural, public, nonprofit, or private institutions.

Colorado Provider Recruitment Program

- Description: A provider placement program for clinicians to serve underserved and rural communities.

Privately Funded Physician Loan Repayment Program

- Total Funding: Up to \$150,000; minimum 3 years.
- Description: The Colorado Health Foundation funds a private Physician Loan Repayment Program for physicians serving in urban underserved and rural areas.

PCA Contact: Tanah Wagenseller, Health Center Ops & Workforce Coordinator; tanah@cchn.org; (303) 861-5165 Ex. 241

PCO Contact: Stephen Holloway, PCO Director; steve.holloway@state.co.us; (303) 692-2582

Connecticut

PCA Contact: Rebecca Willis, Workforce Program Manager; rwillis@cheact.org; (860) 667-7820

PCO Contact: Janet Brancifort, PCO Director; janet.brancifort@ct.gov; (860) 509-8074

Delaware

PCO Contact: Kathy Collison, PCO Director; katherine.collison@state.de.us; (301) 744-4555

District of Columbia

Workforce Development Task Force

- Description: A new learning Community for education and sharing of best practices that meet quarterly. A list-serve and an electronic library of resource tools and documents have been developed for this community.

PCA Contact: Gwen Young, gyoung@dcpcpa.org; (202) 638-0252

Florida

PCO Contact: Glen Davis, PCO Director; glen_davis@doh.state.fl.us; (850) 245-4446 x2709

Georgia

PCA Contact: LaShun C. Wright, Director of Clinical Quality; lcwright@gaphc.org; (404) 659-2816

Hawaii

Native Hawaiian Health Scholarship Program

- Description: A federally supported program that is similar to the NHSC scholarship program but priority for assignment of scholars for service obligation goes to the Native Hawaiian Health Care Systems. Scholars must be part ethnic Hawaiian.

PCA Contact: Beth Giesting, Executive Director; bgiesting@hawaiipca.net; (701) 221-9824

Idaho

Rural Health Care Access Program

- Annual Funding: Up to \$35,000 per year; maximum 3 years.
- Description: A program that helps rural Idaho Health Professional Shortage Areas improve access to primary medical and dental health care. Applicants must submit grant proposals that improve access to health care in any of four assistance categories, one of which is the area of recruitment and retention, thereby allowing some of the grant funding to go directly to practitioners.

The Western Interstate Commission for Higher Education (WICHE)⁵

- Description: A commission whose purpose is to provide support and resources to increase higher education availability among 15 states in the West.

WWAMI Medical Program⁶

- Total Funding: Up to \$50,000 over 5 years
- Description: A program whose goals are 1) to make public medical education accessible and 2) to encourage graduates to choose careers in primary care medicine for the underserved and to locate their practices in their respective home states. Idaho medical students at the University of Washington School of Medicine are assessed a fee equal to 4% of the annual average medical support fee paid by the state. The fees are deposited into the Rural Physician Incentive Fund to repay the education debts of rural physicians who return to practice primary care medicine in medically underserved areas of the state that demonstrate a need for assistance in physician recruitment.

PCA Contact: Katrina Hoff, Director of Workforce Development; khoff@idahopca.org; (208) 898-3824

PCO Contact: Laura Rowen, PCO Director; rowenl@dhw.idaho.gov; (208) 334-5993

Illinois

Student/Resident Experiences and Rotations in Community Health:

- Description: A program for students and medical residents to obtain direct training in health centers; stipends and priority for future job placements are given to participants.

Residency Programs in Health Centers

⁵ **The Western Interstate Commission for Higher Education (WICHE):** The commission provides high-quality, cost-effective education to 15 states; this enables states to share cooperatively their higher education programs and facilities for training new professionals, conducting research, and sponsoring continuing education to sharpen the skills of current professionals. The goal of the commission is to increase the availability of higher education in the West, to assist states to have the professionally and technically trained persons they require, and to help states increase the effectiveness and efficiency of their higher education programs.

⁶ **WWAMI Medical Program:** WWAMI is a cooperative program of the University of Washington School of Medicine and the states of Wyoming, Alaska, Montana and Idaho. This program has two main goals: The first is to make public medical education accessible to Wyoming, Alaska, Montana and Idaho residents. The second is to encourage graduates to choose careers in primary care medicine and to locate their practices in their respective home states with an emphasis on medically underserved areas lacking an adequate number of physicians. The tuition paid by students in the participating states is the same as that paid by Washington state residents. Most states have established Rural Physician Incentive Funds, which assess fees to all students participating in the WWAMI and/or WICHE programs; these funds are then used to repay the education debts of physicians who practice primary care medicine in medically underserved areas of their home state.

- Description: In Illinois, several health centers are affiliated with primary care residency programs, which are an important recruitment tool for health centers. Additionally, health center staff affiliated with residency programs helps increase recruitment of providers.

Illinois Job Opportunities Website

- Description: An online resource for health professional job opportunities with an emphasis of medically underserved areas. The site also provides financial assistance information. www.illinoishealthpro.org

PCA Contact: Ashley Colwell, Recruitment Specialist; acolwell@iphca.org; (217) 541-7309

PCO Contact: Mark Gibbs, PCO Director; marc.gibbs@illinois.gov; (217) 782-1624

Indiana

PCA Contact: Sharon Kramer, Administrative Specialist; skramer@indianapca.org; (317) 630-0845

PCO Contact: Patrick Durkin, PCO Director; pdurkin@isdh.IN.gov; (317) 233-7846

Iowa

Area Health Education Centers

- Description: Iowa funds local AHEC programs which are used to teach individuals about healthcare careers, to offer clinical training sites for health professional students, and to support health care practitioners with continuing education programs.

PCA Contact: Julie Blum, Senior Program Director; julieblum@aol.com; (515) 244-9610

PCO Contact: Bobbie Buckner Bentz, PCO Director; bbuckner@idph.state.ia.us; (515) 281-7223

Kansas

PCA Contact: Cathy Harding, Executive Director; charding@kspca.org; (785) 233-8483

PCO Contact: Robert Stiles, PCO Director; rstiles@kdheks.gov; (785) 368-8110

Kentucky

PCO Contact: Chris Workman, PCO Director; chris.workman@ky.gov; (502) 564-8966 Ext. 3773

Louisiana

Louisiana Tax Credit for Physicians and Dentists

- Annual Funding: Up to \$5,000 per year; maximum 5 years
- Description: A tax reduction for eligible physicians and dentists.

Medicare Bonus Payments

- Description: Physicians in geographic Health Professional Shortage Areas can receive a 10% Medicare bonus payment for some services, while those in Physician Scarcity Areas can receive a 5% Medicare bonus payment.

The Greater New Orleans Area – Health Service Corps

- Total Funding: Up to \$10,000-\$110,000
- Description: Programs include loan repayment, sign-on bonus, malpractice premium payment, relocation expenses and income guarantee in order to attract and retain eligible health care professionals.

Med Job Louisiana

- Description: This is a recruitment service that offers statewide recruitment services to all Health Professional Shortage Areas in Louisiana.
- Website: www.medjoblouisiana.com.

Louisiana Rural Loan Fund:

- Description: Provides capital to health professionals, hospitals, local and tribal governments and nonprofit organizations for rural health care projects. Banking experts offer technical assistance in the development of funding applications, business planning and other advice.

PCA Contact: Angela Sheffie, Deputy Director; angela@lpca.net; (225) 927-7662

PCO Contact: Dorie Tschudy, PCO Director; dtschudy@dhh.la.gov; (225) 342-1583

Maine

Rural Medical Assistance Program

- Description: A program to increase the number of obstetrical and prenatal care providers in Health Professional Shortage Areas.

Finance Authority of Maine

- Description: A program with several functions, one of which is to expose individuals to the health profession. FAME compiled a booklet to further educate Maine residents on medical education and available financial assistance in their state.

Finance Authority of Maine Access to Education Program

- Description: A program that purchases 20 admission seats at 3 out-of-state medical schools for Maine residents. Participants are eligible for a variety of lowest-interest loans and loan forgiveness options.

Finance Authority of Maine Loan Repayment/Forgiveness

- Description: A variety of options are available to Maine residents who return to complete a Maine primary care residency and/or to practice primary care in ME.

Dentist Tax Credits

- Annual Funding: \$15,000 per year; maximum 5 years
- Description: Tax credit for eligible dentists who are new practitioners in designated underserved.

Maine Medical Association

- Description: Loans through the Maine Medical Education Foundation that are repayable with no service/loan forgiveness provisions.

Main Hospital Incentives

- Description: Most hospitals offer some form of loan repayment, loan forgiveness or other incentives; all which vary widely from one hospital to another. Many hospitals serve designated health shortage areas through their outpatient clinics.

PCA Contact: Kevin A. Lewis, Executive Director; kalewis@mepca.org; (207) 621-0677

PCO Contact: Charles Dwyer, PCO Director; charles.dwyer@maine.gov; (207) 287-5503

Maryland

PCO Contact: Elizabeth Vaidya, PCO Director; evaidya@dhmh.state.md.us; (410) 767-5695

Massachusetts

PCA Primary Care Loan Repayment Program

- Annual Funding: \$25,000 per year for existing and some new physicians, and \$15,000 per year for new nurse practitioners; maximum 3 years.
- Description: The Massachusetts League of Community Health Centers offers loan repayment funding.

PCA Contact: Ellen Hafer, Executive VP and COO; ehafer@massleague.org; (617) 426-2225

Michigan

Medical Opportunities in Michigan

- Description: A program of the Michigan Health Council, a non-profit organization that specializes in healthcare education and healthcare workforce issues; their website lists health professional job opportunities in Michigan. Website: www.mimom.org

Nurse Icon

- Description: A program of the Michigan Health Council; their website specifically lists nursing job opportunities in Michigan.
- Website: <http://www.nurseicon.org/>

PCA Contact: Kim Sibilsky, Executive Director; ksibilsky@mpca.net; (517) 381-8000 Ext. 211

Minnesota

PCO Contact: Debra Jahnke, PCO Director; debra.jahnke@health.state.mn.us; (651) 201-3845

Mississippi

PCA Contact: Linda Young, Workforce Development Consultant; lindaY@mphca.com; (205) 995-0089

Missouri

The Primary Care Resource Initiative for Missouri

- Description: A program that begins with high school students by encouraging exploration of the health profession, offers guidance to students for college preparation, and provides financial assistance to students pursuing professional health careers.

PCA Contact: Joe Pierle, CEO; jpierle@mo-pca.org; (573) 636-4222

PCO Contact: Marie Peoples, PCO Director; marie.peoples@dhss.mo.gov; 1-800-891-7415

Montana

Eastern Montana Area Health Education Center Preceptorships

- Description: Program for health professional students to obtain community-based preceptorships in rural, frontier and underserved areas of Montana.

WWAMI Medical Program⁷

- Description: A program whose goals are 1) to make public medical education accessible and 2) to encourage graduates to choose careers in primary care medicine for the underserved and to locate their practices in their respective home states.

PCA Contact: Marge Levine, Data and Information Manager; mlevine@mtpca.org; (406) 442-2750

PCO Contact: John Schroeck, PCO Director; jschroeck@mt.gov; (406) 444-3934

Nebraska

PCA Contact: Julie Blum, Senior Program Director; julieblum@aol.com; (515) 244-9610

PCO Contact: Thomas Rauner, PCO Director; thomas.rauner@dhhs.ne.gov; (402) 471-0148

⁷ **WWAMI Medical Program:** WWAMI is a cooperative program of the University of Washington School of Medicine and the states of Wyoming, Alaska, Montana and Idaho. This program has two main goals: The first is to make public medical education accessible to Wyoming, Alaska, Montana and Idaho residents. The second is to encourage graduates to choose careers in primary care medicine and to locate their practices in their respective home states with an emphasis on medically underserved areas lacking an adequate number of physicians. The tuition paid by students in the participating states is the same as that paid by Washington state residents. Most states have established Rural Physician Incentive Funds, which assess fees to all students participating in the WWAMI and/or WICHE programs; these funds are then used to repay the education debts of physicians who practice primary care medicine in medically underserved areas of their home state.

Nevada

The Western Interstate Commission for Higher Education (WICHE) ⁸

- Description: A commission whose purpose is to provide support and resources to increase higher education availability among 15 states in the West.

PCA Contact: Judi Corrado, Clinical Training and Technical Assistance Coordinator; jcorrado@gbpca.org; (775) 887-0417

New Hampshire

Recruitment Center Contract

- Description: A service of the Bi-State Primary Care Association that provides recruitment support and candidate referrals to practices in New Hampshire and Vermont.
- Website: <http://www.dhhs.nh.gov/DHHS/RHPC/default.htm>

PCA Contact: Stephanie Pagliuca, Program Director; spagliuca@bistatepca.org; (603) 228-2830 Ext. 11
PCO Contact: Alisa Butler, PCO Director; agbutler@dhhs.state.nh.us; (603) 271-5934

New Jersey

PCA Contact: Leslie A. Morris, Director of Community Relations; lmorris@njpca.org

New Mexico

New Mexico Health Service Corp

- Total Funding: Up to \$40,000; minimum 2 years.
- Description: Must be a New Mexico resident enrolled in an eligible program of study and be within 2 years of program completion.

Indian Health Service Loan Repayment

- Annual Funding: Up to \$20,000 per year and up to 20% of federal taxes repaid on the loan amount; minimum 2 years.
- Description: New Mexico participates in this program.

New Mexico Rural Health Care Practitioner Tax Credit Program

- Annual Funding: \$3,000-\$5,000 per year.
- Description: A state income tax credit for eligible health care professionals working in designated rural underserved areas/facilities.

⁸ **The Western Interstate Commission for Higher Education (WICHE):** The commission provides high-quality, cost-effective education to 15 states; this enables states to share cooperatively their higher education programs and facilities for training new professionals, conducting research, and sponsoring continuing education to sharpen the skills of current professionals. The goal of the commission is to increase the availability of higher education in the West, to assist states to have the professionally and technically trained persons they require, and to help states increase the effectiveness and efficiency of their higher education programs.

New Mexico Medical Board Application Fee Waiver

- Description: Beginning July 1, 2008, the New Mexico Medical Board will waive the \$400 licensure application fee for applicants who choose New Mexico as their first state of licensure.

NM Higher Education Department

- Description: The department administers several programs under its Financial Aid and Scholarship programs including Loan for Service Programs (similar to National Health Service Corps scholarships) for Allied Health, Medical and Nursing students in training, as well as minority doctoral and nurse educators.

The Western Interstate Commission for Higher Education (WICHE)⁹

- Annual Funding: \$22,000 per year; up to 4 years.
- Description: A commission whose purpose is to provide support and resources to increase higher education availability among 15 states in the West. New Mexico residents enrolled at selected out-of-state professional programs not offered at NM public universities are eligible for funding once they return to the state to practice.

PCO Contact: Kim Kinsey, PCO Director; kenbaht.kinsey@state.nm.us; (505) 841-5871

PCA Contact: Suzan Martinez de Gonzales, Deputy Director; suzan@nmpca.org; (505) 880-8882

New York

New York State Limited Medical and Dental Licensing Program

- Annual Funding: Up to \$10,000 per year; minimum 3 years.
- Description: Non-U.S. citizens who have successfully met all requirements can apply for “limited” medical licenses. These licenses allow physicians to practice medicine but only in Regents-designated shortage areas or facilities. Service may be extended provided the physician is actively seeking a green card.

Doctors across New York Loan Repayment Program

- Total Funding: Up to \$150,000; minimum 5 years.
- Description: A loan repayment to physicians of any specialty in exchange for service obligation in New York State’s underserved areas.

Doctors across New York Practice Support Program

- Total Funding: Up to \$100,000; minimum 2 years.
- Description: Program provides practice support funding to facilities and physicians of any specialty in exchange for a service obligation in New York State’s underserved areas.
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⁹ **The Western Interstate Commission for Higher Education (WICHE):** The commission provides high-quality, cost-effective education to 15 states; this enables states to share cooperatively their higher education programs and facilities for training new professionals, conducting research, and sponsoring continuing education to sharpen the skills of current professionals. The goal of the commission is to increase the availability of higher education in the West, to assist states to have the professionally and technically trained persons they require, and to help states increase the effectiveness and efficiency of their higher education programs.

The Regents Physician Loan Forgiveness Award Program

- Annual Funding: \$10,000 per year.
- Description: Program provides funding to physicians who agree to practice in an area of New York State designated by the Board of Regents as having a shortage of physicians.

PCO Contact: Barry Gray, PCO Director; bmg01@health.state.ny.us; (518) 473-4700

PCA Contact: Rebecca Gaige-Troxell, Program and Planning Coordinator; rgaige@chcanys.org; (518) 473-4700

North Carolina

High Needs Service Bonus

- Total Funding: Up to \$15,000-\$35,000; minimum 3-4 years.
- Description: Program designed for those with small loan amounts or no loans and, in some cases, may be combined with loan repayments.

PCA Contact: Benjamin Money, CEO; moneyb@ncchca.org; (919) 469-1116

North Dakota

The State Community Matching Physician Loan Repayment Program

- Total Funding: \$90,000; minimum 2 years.
- Description: A matching program in which the community (usually a community hospital or clinic) must match the state payment but may pay more and may negotiate with the physician for a period of service longer than 2 years. Preference is given to physicians who will practice in rural underserved areas.

The Medical Personnel Loan Repayment Program

- Annual funding: Up to \$10,000; minimum 2 years.
- Description: A state financed and administered program designed to encourage midlevels to practice in North Dakota and to serve in areas of need. The community (usually a community hospital or clinic) pays half of the loan repayment award. Preference is given to people who will work in rural underserved areas.

PCA Contact: Shelly Hegerle, Human Resources Specialist; shelly@communityhealthcare.net; (701) 221-9824

Ohio

PCA Contact: Shawn Frick, CEO; sfrick@ohiohc.org; (614) 884-3101

PCO Contact: Coleen Schwartz, PCO Director; coleen.schwartz@odh.ohio.gov; (614) 728-3700

Oklahoma

Physician Assistance Loan Forgiveness Program

- Annual Funding: \$1,000 per month.
- Description: A state loan forgiveness program with a month for month practice obligation in rural communities of 20,000 or less population.

Nursing Student Forgiveness Award

- Description: Program for nurses practicing in Oklahoma, with emphasis on rural communities.

Tax Incentives

- Description: Tax credits given for physicians who practice in rural areas of the state.

PCA Contact: Allison Williams, Workforce & Communications Coordinator; awilliams@okpca.org;
(405) 424-2282 Ext. 103

Oregon

PCA Contact: Jalaunda Granville, Recruitment and HR Coordinator; jgranville@orpca.org; (503) 228-8852

Pennsylvania

Community Primary Challenge Grant Program:

- Total Funding: Tier 1— \$200,000 over 2 years. Tier 2— \$500,000 over 2 years.
- Description: A grant program to increase access to health care and to encourage community-based development and expansion of integrated systems of primary medical and dental care. Potential applicants are not-for-profit community-based organizations and health centers, local county and municipal government entities and community health improvement partnerships. Eligible applicants may apply for one of two Tiers of funding. Tier 1 – Funds new or expanded primary care medical or dental programs. Funds may be used for practitioner salaries as well as expenses related to direct patient care (supplies & equipment, etc.). 25% of funds must be matched. Tier 2 – Funds the establishment of a new community health center in a service area where a clinic does not exist. Funds may be used for community health center implementation expenses, practitioner salaries as well as expenses related to direct patient care. 25% of funds must be matched.

PCA Contact: Cindi Christ, COO; cindi@pachc.com; (717) 761-6443 Ext. 204
PCO Contact: Martin Raniowski, PCO Director; mraniowski@state.pa.us; (717) 772-5298

Puerto Rico

PCA Contact: Sandra Serrano, Coordinator of Clinical Services; sserrano@saludprimariapr.org; (787) 758-3411

Rhode Island

PCA Contact: Mary Evans, Senior Director of Operations and Clinical Support; mevans@rihca.org;
(401) 274-1771 Ext. 211

South Carolina

PCA Contact: Peter A. Leventis, Dept Head for Admin Services & Operations; peterl@scphca.org;
(803) 788-2778
PCO Contact: Mark Jordan, PCO Director; jordanma@dhec.sc.gov; (803) 898-0766

South Dakota

The Health Professional Recruitment Incentive Program

- Total Funding: \$5,000; minimum 2 years.
- Description: Incentive funding given to health professionals working in an eligible facility.

Reimbursement Programs

- Annual Funding: Varies; minimum 3 years.
- Description: These programs provide qualifying health professionals a payment in return for full-time practice in an eligible rural community.

The Western Interstate Commission for Higher Education (WICHE) ¹⁰

- Description: A commission whose purpose is to provide support and resources to increase higher education availability among 15 states in the West.

PCA Contact: Shelly Hegerle, Human Resources Specialist; shelly@communityhealthcare.net; (605) 357-1515

PCO Contact: Mark Jordan, PCO Director; jordanma@dhec.sc.gov; (803) 898-0766

Tennessee

PCA Contact: Kathy Wood Dobbins, CEO; kathy@tnpca.org

Texas

Texas Health Service Corps

- Description: A stipend program for resident physicians pursuing primary care specialties and willing to practice in medically underserved communities in Texas.

Medically Underserved Community-State Matching Incentive Program

- Description: A program that provides matching funds to cover the costs of establishing a physician's practice site.

The Rural Communities Health Care Investment Program

- Description: A program for health professionals who practice in qualifying medically underserved communities in Texas. The program works as either a loan reimbursement program or a stipend program.

¹⁰ **The Western Interstate Commission for Higher Education (WICHE):** The commission provides high-quality, cost-effective education to 15 states; this enables states to share cooperatively their higher education programs and facilities for training new professionals, conducting research, and sponsoring continuing education to sharpen the skills of current professionals. The goal of the commission is to increase the availability of higher education in the West, to assist states to have the professionally and technically trained persons they require, and to help states increase the effectiveness and efficiency of their higher education programs.

Exchange Visitor Program

- Annual Funding: minimum 3 years.
- Description: A program that allows waiver of the J1 Visa “two-year return home rule” if the physician agrees to work in a Rural Health Clinic, Federally Qualified Health Center or Indian Health Services Center located in certain health professional shortage areas.

PCO Contact: Patrick Lipford, PCO Director; patrick.lipford@state.tn.us; (615) 741-0388

Utah

AmeriCorps

- Annual Funding: Stipend and tuition credit
- Description: Deploys trained lay health workers into community based settings. Participants are encouraged to pursue health care education and/or careers in underserved communities after completing their service.

PCA Contact: Bette Vierra, Executive Director; bette@auch.org; (801) 716-4600

PCO Contact: Don Beckwith, PCO Director; dbeckwith@utah.gov; (801) 273-6619

Vermont

Recruitment Center Contract

- Description: A service of the Bi-State Primary Care Association that provides recruitment support and candidate referrals to practices in New Hampshire and Vermont.
- Website: <http://www.dhhs.nh.gov/DHHS/RHPC/default.htm>

PCA Contact: Stephanie Pagliuca, Program Director; spagliuca@bistatepca.org; (603) 228-2830 Ext. 11

PCO Contact: Denis Barton, PCO Director; dbarton@vdh.state.vt.us; (802) 951-4006

Virginia

PCA Contact: Thomas Gaskins, Director of Recruitment Services; tgaskins@vacommunityhealth.org; (804) 378-8801 Ext. 13

PCO Contact: Kathy Wibberly, PCO Director; kathy.wibberly@vdh.virginia.gov; (804) 864-7426

Washington

The Washington Recruitment Group

- Description: A program that recruits for rural areas, tribal settings, correctional facilities and urban sites that provide care to the medically underserved.

Northwest Dental Residency—Advanced Education in General Dentistry

- Total Funding: \$40,000 stipend and \$3,000 housing allowance.
- Description: Recently, the state of Washington passed legislation to offer a dental license to anyone who successfully completes an Advanced Education in General Dentistry in the state of Washington; thereby allowing the person not to have to take the state or national dental board. The program focuses on rural oral health issues.

University of Washington Dental School Regional Initiatives in Dental Education Program

- Description: Program creates regional training sites in areas lacking dental schools by partnering with regional universities, dentists and dental associations, community health centers and others.

AHEC's Volunteer/Retired Providers Malpractice Insurance Program

- Description: Program encourages dentists and dental hygienists to volunteer in Washington state by paying their malpractice insurance premiums if they provide non-invasive dental care to underserved patients.

Access to Baby & Child Dentistry Program

- Description: Program trains dental offices serving young children and certifies them to receive increased Medicaid reimbursement levels for certain services.

Washington State Dental Association's Rural Internship in Private Practice (RIPP)

- Description: A program intended to highlight the differences in rural and metropolitan practices. Students work as dental assistants in the dental practice while experiencing a rural lifestyle.

Health Occupations Preparatory Experiences Project

- Description: A student internship funded through the Higher Education Coordinating Board, sponsored by the Washington State Department of Health and facilitated by the Area Health Education Centers in Washington (AHEC).

Rural Outreach Nursing Education Project

- Description: A partnership program between local community colleges and hospitals for students to earn an Associate Degree in Nursing; this is a distance-learning program in pilot.

Dental Residency Program within a Health Center

- Description: A program that trains dental students directly in community health centers.

PCA Contact: Mary Looker, CEO, mlooker@wacmhc.org, (360)786-9722

PCO Contact: Sam Watson-Alvan, PCO Director; sam.watson-alvan@doh.wa.gov; (360) 236-4546

West Virginia

Practicelink

- Description: A recruitment firm that supports West Virginia's recruitment efforts.
- Website: <http://www.practicelink.com/>

PCA Contact: Louise Reese, CEO; louise@wvpc.org; (304) 346-0032

Wisconsin

PCA Contact: Stephanie Harrison, Executive Director; sharrison@wphca.org; (608) 277-7477

Wyoming

Wyoming Physician Recruitment Program

- Total Funding: \$80,000
- Description: Program allows entities in the state to apply for state money to use in recruiting physicians with emphasis given to primary care physicians and areas of greatest need. The money has specific uses pertaining to recruitment costs, signing bonus, malpractice and moving expenses, with specific funding limits in each category.

Wyoming Physician Recruitment Grant Program

- Description: Grants given to selected recipients to recruit physicians into Wyoming.

The Western Interstate Commission for Higher Education (WICHE) ¹¹

- Description: A commission whose purpose is to provide support and resources to increase higher education availability among 15 states in the West.

¹¹ **The Western Interstate Commission for Higher Education (WICHE):** The commission provides high-quality, cost-effective education to 15 states; this enables states to share cooperatively their higher education programs and facilities for training new professionals, conducting research, and sponsoring continuing education to sharpen the skills of current professionals. The goal of the commission is to increase the availability of higher education in the West, to assist states to have the professionally and technically trained persons they require, and to help states increase the effectiveness and efficiency of their higher education programs.

WWAMI Medical Program¹²

- Description: A program whose goals are 1) to make public medical education accessible and 2) to encourage graduates to choose careers in primary care medicine for the underserved and to locate their practices in their respective home states

PCA Contact: Anne Siebert, Recruitment and Retention Coordinator; anne@wypca.org; (307) 632-5743 Ext. 14

PCO Contact: Sharla Allen, PCO Director; sharla.allen@health.wyo.gov; (307) 777-7293



¹² **WWAMI Medical Program:** WWAMI is a cooperative program of the University of Washington School of Medicine and the states of Wyoming, Alaska, Montana and Idaho. This program has two main goals: The first is to make public medical education accessible to Wyoming, Alaska, Montana and Idaho residents. The second is to encourage graduates to choose careers in primary care medicine and to locate their practices in their respective home states with an emphasis on medically underserved areas lacking an adequate number of physicians. The tuition paid by students in the participating states is the same as that paid by Washington state residents. Most states have established Rural Physician Incentive Funds, which assess fees to all students participating in the WWAMI and/or WICHE programs; these funds are then used to repay the education debts of physicians who practice primary care medicine in medically underserved areas of their home state.

Attachment E

STATE AND REGIONAL PRIMARY CARE ASSOCIATION (PCA) WORK FORCE SURVEY

Best Practices and Lessons Learned

The following provides survey results from the January 2009 PCA Work Force Survey. Highlights of PCA responses specific to Best Practices and Lessons Learned are provided.

Best Practices--Highlights

- Recruitment & Retention
 - Outreach to/Activities with AHECs, residencies, medical and dental schools
 - Developed a State Strategic Workforce Plan, with targeted initiatives
 - Partnered for recruitment activities, including 3R Net as well as other partners
 - Partnered for loan repayment coordination
 - Job bank linked to other sites for recruitment efforts
 - Developed/Updated provider profiles
 - Developed a ***Physician Recruiting: Write Great Position Posting*** handbook for FQHCs.
 - Provided direct recruitment
 - Pay network subscription with the web-based Medical Opportunities in Michigan (MOM) for all Michigan FQHCs (partner is Michigan Health Council)
 - Co-funded the launch of a Dentist Recruiter through the Office of Rural Health
 - Worked collaboratively with PCO and rural health on issues related to loan repayment, J1s, etc.
 - Developed a CHC orientation toolkit
 - Provided training through various modalities
 - Implemented a Medical Director Advisory Committee to help bridge clinical leadership and administrative management approaches
 - Worked with 4 medical schools and hospital association to develop a new non-profit The Rural Partnership to encourage graduates of TN residencies to practice in state's underserved areas.
 - Developed a stipend program using GME dollars
- Pipeline/Overall System
 - Created small, focused, and strategic collaborations between partners.
 - Developed regional reports addressing CHC salary and benefits levels, turnover rates, vacancy rates, recruitment resources, etc. (some data is available every two years, some annually)
 - Convened Recruitment & Retention Committee (*various names, 3 PCAs identified*) that discusses both short term and long term strategies for addressing CHC workforce shortages
 - Convened/planning a work force summit in partnership with several other key organizations;
 - Proposed and award a contract to the Louisiana State University Health Sciences Center to develop a standardized academic residency/rotation program model for CHCs that is transferable across clinical programs, i.e. medical, dental, allied health.
 - Worked with Medicaid and U of M Dental School to establish contracts to rotate 100% of 4th year dental students through health centers with the contract costs carved out of PPS
 - University of Missouri-Kansas City, School of Dentistry clinical rotations. Every 3rd and 4th year Dental Student completes a 4 day clinical rotation at a CHC
 - Piloted an “early exposure” field trip for dental students in their 1st or 2nd years of dental school to give them a frame of reference for alternative practice settings. In conjunction with the “early

- exposure” pilot, we are working to incorporate CHCs into the curriculum as part of the “Practice Settings” course and are currently engaged in discussions with the relevant faculty and the Dean
- Identified and sharing best practices for recruitment, retention and work force development
 - Focused on developing an A.T. Still Univ. site
 - Collaborated with residencies and medical schools to provide early introductions to health centers
 - HR Managers meet monthly to workforce issues – recruitment, retention, state policy issues, performance reviews, salary negotiations, etc.
 - Developed health center learning teams/roundtables. Teams participate in monthly discussion groups/learning events with health center staff. The groups are organized by their discipline such as the Financial Directors Roundtable (FDR), Medical Directors Roundtable (MDR), the Billing Learning Team (BLT) and the Medical Assistants Learning Team (MALT).
 - Use of SEARCH program

Lessons Learned--Highlights:

- General Recruitment & Retention Strategies:
 - Investigate cost/value of workshops, job fairs before attending.
 - Data management:
 - Keep information on CHCs¹³ current—for optimal recruitment/retention.
 - Data collection is most important and most difficult.
 - Clinician compensation reporting that can be shared with health centers to better prepare them for presenting competitive wages
 - There is not good data on why professionals turnover so rapidly in the CHC setting, it is not all a compensation issue.
 - Many CHCs fall short when projecting needs/vacancies which creates frenzied recruiting and settling for candidates that may not have strong retention potential nor are they a good fit for the CHC. The lack of a “steady state” accession plan often results in a costly recruiting action.
 - Improve web sites for the CHCs is critical to the effectiveness of the recruitment process. Today, candidates make preliminary decisions about opportunities based on the center’s web site.
 - Build a network of PCA workforce personnel. We all have the opportunity to refer candidates to PCAs in other states so that we keep good Providers at CHCs.
 - Having a “job board” and applicant referral system is not sufficient.
 - Loan repayment gets the health care workforce to consider working in a shortage area but rarely is it the deciding factor.
 - Loan repayment for J1 visa practitioners would aid with retention.
 - A solid direct recruitment program requires a minimum of 1 full FTE. The position should include the development of a recruitment and retention plan and have full support of the board of directors. Funds must be set aside for specified recruitment activities such as sourcing and tools that allow the recruiter to communicate with potential candidates at all times (such as a Blackberry) and allow for flexible work hours to accommodate the hours generally kept by busy physicians.
 - CHCs are at various levels of capacity for recruitment and retention activities.
 - Health centers need to pay much more attention to retention. It is a lot easier to retain than recruit. Also, if you are not paying on production basis health centers simply won’t be attractive to many potential providers
 - Recruit regionally

¹³ community, migrant, homeless & public housing health centers

- PCA/CHC Collaborations and Strategies
 - Create a PCA/CHC workforce strategy to identify the top workforce needs of your states' CHCs and develop a specific plan of action with roles, responsibilities & time frames.
 - Have a PCA Board of Directors workforce committee. This keeps the PCA in the loop as to major workforce issues CHCs face.
 - Be very clear about the role of the PCA and the role of the work group/Committee (e.g., HR Managers, Social Work Group, etc). Many times the work group wants the PCA to take on roles and responsibilities that are not appropriate. It should be spelled out in the first meeting what the PCA can and cannot do
 - Working with the HR Managers, it is easy to get entrenched in HC day-to-day operations. Recommend that the PCA staff member overseeing the workforce initiative not participate in the daily exchange of emails and other information through the listserve. In the way, the PCA can still do its advocacy work without becoming entrenched in the daily struggles of the HR Managers.
 - Get buy-in from members, in the form of commitment letters and/or \$ deposits before starting on projects, to make sure they are engaged and will participate.
 - If the PCA takes on too much responsibility, the health centers will take less responsibility for recruiting providers. It was a huge mistake and good lesson learned.
 - Make sure the programs meet the most urgent needs of the health centers first.
 - Maximize the PCA/CHC partnership by identifying areas for group efforts, such as contracts with recruiting firms.

- Building Partnerships and Collaborations:
 - Create key collaborations and partnerships with the state office of rural health, the states' primary care office and AHECs.
 - It takes a lot of discussion and discernment in a complicated area like workforce, to be able to learn what parts of the system you can most impact with the limited resources available
 - If you are working collaboratively with other organizations, have very specific goals and measurements of success and details worked out in MOAs before the work begins. Also have clear exit strategies agreed upon by all parties for ending the collaboration if it does not work.
 - Medicaid is a critical "finance" partner with a strong vested interest in health center success in placement of health professionals.
 - Continuously work on the PCO/PCA relationship.
 - When collaborating, it should be asked: is there a benefit for health centers?
 - If you are going to recruit dentists you must engage with the state dental society and individual dentists in your state
 - Collaborate with your state's Workforce Initiative but don't assume that all participants placed at CHCs are ready and able to function in a work environment. PCAs must be clear in their advocacy for competent workers when collaborating with Workforce Programs.
 - Develop a selective admissions process for medical school students who are most likely to practice in underserved areas.
 - There will likely be competing issues among partners. *Understand competing issues*, acknowledge competing issues then move on and focus efforts on the commonalities
 - Celebrate the successes - loudly!
 - *Understand your State environment* (advantages, challenges) - Undertake a full environmental scan of opportunities, prior successes and failures prior to approaching potential partners
 - Ask current HC employees how they came to the health center world and why they stay

ATTACHMENT F

Most Needed Health Access - Rural Location

Robert Bowman, MD, Professor of Family Medicine, A.T. Still University

Generally four independent variables can be loaded to describe rural practice location in physicians using complete populations of 1987 – 2000 graduates in 2005 locations (n = 316,000). The factors are origins, career choice, training, and age at medical school graduation.

Lower or middle income, rural, and all but the most exclusive origins are associated with 1.5 to 3 times odds ratios of rural practice location. Those most associated with lower concentrations have the highest probability of rural practice location. Origin factors are more than just rural. The most urban origins that are most urban and highest income county origins are associated with 0.5 odds ratios or half of the probability of rural location.

Odds Ratio Probability of Rural Practice Location

	Exclusive	Normal	Least Exclusive
Origin	Highest income, most urban, foreign born, Asian	Upper middle income or population density	Lower or lower middle income, lower or middle population density
Origin	0.5	1.2	2 to 3
Age at Graduation	Younger than 26	26 - 27	28 to 32 years
Age at Graduation	0.7	0.8 – 0.9	1.2 – 1.6
Career	Subspecialty or Hospital Support Specialty	Office Internal Medicine Office Pediatrics	Family Medicine
Career	0.4 – 0.6	1.1 – 1.2	3 – 3.5
	3 – 4% rural and usually in rural zip codes with 75 – 500 docs	4 – 8% rural 6% avg But leaving primary care and moving to specialty	14 – 30% rural 20% avg. Remaining Steady
Training	Allopathic private, Top 20 MCAT schools	Allopathic public or Osteopathic	Rural Focused Health Access Schools such as Duluth and West Virginia School of Osteopathic
	0.5 – 0.6	1.2 – 1.6	1.8 – 2
	3 – 4% rural	8 – 20% rural	30 – 40% rural

But the exclusive schools also admit the most exclusive students in income and population density and parents, admit the youngest students, graduate the fewest family physicians in addition to the most exclusive training.

And schools such as Duluth or West Virginia Osteopathic admit the least exclusive students from rural and lower and middle income origins or the least densely populated urban origins, admit the oldest students, graduate the most family physicians, and train in the least exclusive environments with the least exclusive physicians.

1987 – 2000 Graduates	Duluth	WVSOM	University of Washington	Cornell, Columbia, Yale Harvard
% Rural Outcomes	30%	42%	15%	3 - 4%
Standard Primary Care Years per Grad	16	14	8	2 - 3
Rural Standard Primary Care Years per grad	6.4	6 - 7	1 - 2	0.1
Instate Office Primary Care	40%	16%	23%	2 – 6%
% FM Graduates	40 – 50%	38%	10%	2%
% Rural Origin	40%	40%	19%	5%
% Older	30%		24%	17%
Mean Age at Graduation	29	32	29.2	28
Born in Med School County	41%	44%	58%	80 – 86%
Instate Born	60%	70%	42%	20 – 30%
MCAT score average of matriculants	9.2	8	10.4	11.3 - 12
Foreign origin	3%	2%	10%	15 - 18%
Asian	2%	3%	10%	15%
Researchers 1965 - 1994	0%	0%	3%	6 - 10%
Practice in Super Center with 200 or more docs	27%	20%	42%	62 - 67%

2009 Class Year Estimates	Duluth	WVSOM	University of Washington	Cornell, Columbia, Yale Harvard
Expected % Rural Outcomes	25%	30%	8%	2%
Expected Rural Outcomes for Primary Care Grads	35%	40%	15%	4%
Standard Primary Care Years per Graduate	13	9 - 10	6	1.5
Rural Standard Primary Care Years per grad	4	4	0.6	0.06
Estimated Rural Origin	30%	20%	10%	3%
Estimated Foreign Origin	4%	5%	15%	18%
Estimated Asian	4%	6%	25%	30%

Rural, urban underserved locations, and family physicians are the most needed health access careers. Multinomial logistic regression equations can be generated for rural practice location for the 316,792 most recent additions to the 2005 Masterfile who graduated from 1987 – 2000, giving time to complete residency training and distribute to representative careers and locations. Logistic regression studies assist in the understanding of the most important health access outcomes, variables, and relationships. Multiple variables can be loaded. This is an improvement over the bivariate studies that are far too common and easily abused.

Rural workforce is a good place to begin. Numerous studies nationally and internationally demonstrate the important experiential place of rural origin in a physician that doubles rural practice location. Studies also point out a number of other interventions related to this area.(ref new study) What is missing is a more comprehensive approach not only to rural workforce, but to all in need of health access. The health access workforce literature, like health access itself, fails nations where most of their population needs the greatest assistance.

One of the great distractions of bivariate studies is the relationship of rural origin to rural practice location. By focusing on this very small part of the solution for rural workforce, many other more important solutions are minimized. As an illustration, caffeine consumption has been associated with various cancers until studies identify the associations between caffeine use and tobacco use.

Rural origins appear to be most important, but rural origin physicians also tend to be older and also are more likely to choose family medicine. In addition osteopathic or allopathic public schools are more likely to have rural origin, older, and family practice graduates. Bivariate studies comparing rural origins to rural outcomes without considering these interactions magnify the rural origin effect.

With only 6% of the physicians entering the workforce from rural origins and with only 18% of rural origin physicians found in rural practice (compared to 8% for urban origin), it is easy to see why other solutions are more important. Older graduates and family physicians that are urban origin have greater rural distribution and have substantially greater numbers. Only the most exclusive medical education fails in rural workforce production as allopathic public and osteopathic graduates have greater than average rural distribution.

With multiple variables added, the stability of the equations can be illustrated. Once again studies in major journals fail to demonstrate the relationships and concepts that must be understood. Multiple factors are involved in health care and health care workforce. Journal articles are trying to hit home runs when a number of factors are important contributors. This is true in basic health access, basic health care costs, and basic health care quality.

When new variables are added to most logistic regression equations, one or more other variables lose significance. This is common when small numbers of subjects are involved in a research study. But when studies include complete populations of hundreds of thousands of physicians, the problems of sampling bias and small numbers go away. Various factors can be compared to one another or within one another as in younger versus older age graduates.

Greater understanding of most needed health access is required. Few understand that most of the United States population is distant from the concentrations of health services generated under the current national design. This is certainly not apparent in workforce studies or reports to Congress. Numerous variables demonstrate the challenges of health access.

Rural populations and rural workforce outcomes can use various geographic coding systems, population density, or coding by physician concentrations. It would seem to be common sense

that physicians distribution by concentrations of physicians but studies commonly utilize concentrations of people (urban, rural; metro, non-metro) or concentrations of income (highest, higher, poverty). Health care coverage is a consideration that involves geographic considerations, income factors, and employment. A consideration of physicians concentrating in concentrations of physicians is helpful, particularly when 75% of physicians are found practicing in zip codes with 75 or more physicians where 90% of the health resources related to physicians are directed according to US health care design and policy.

Logistic Regressions Involving Rural Practice Location

Parameter Estimates	% of Docs	B	Std. Error	Wald	df	Sig.	Exp(B)	95% Confidence Interval for Exp(B)	
								Lower Bound	Upper Bound
All Rural Physicians(a)	9.5%								
Intercept		0.159	0.024	42.68	1	6.46E-11			
Older than 29 Yrs at MS Grad	20.9%	0.289	0.014	431.7	1	7.03E-96	1.336	1.300	1.373
Family Medicine	13.8%	0.920	0.014	4495.8	1	0.00E+00	2.509	2.442	2.577
Rural Birth Location	8.4%	0.693	0.021	1081.9	1	2.82E-237	1.999	1.918	2.084
Born Bottom Income Quartile County	9.6%	0.238	0.020	135.8	1	2.22E-31	1.269	1.219	1.321
Born in a County/City with a Medical School	55.6%	-0.185	0.013	211.36	1	6.95E-48	0.831	0.811	0.852
Bottom 30 Medical Schools By MCAT	31%	0.410	0.012	1112.2	1	7.38E-244	1.506	1.471	1.543

Generally four factors are loaded with age, career choice, training, and an origin factor. With fewer variables the 2 or 3 variables acquire greater odds ratios as is common when understanding is limited.

More variables can be loaded for origins and each variable still retains a contribution. This tends to confirm multiple dimensions of origins as related to health access rather than a single variable such as income or geographic origins or race or ethnicity or proximity to concentrations of physicians.

Probabilities of rural practice location (shaded column) are generated along with 95% confidence intervals. Physician distribution to rural areas is more than just rural origins. Actually family medicine choice contributes more to rural workforce and there are far more family medicine graduates compared to rural origin physicians entering the workforce. The other variables (too many loaded in the above) provide more than adequate controls to assure a valid result for the major factors (shaded rows). Older age at medical school graduation, lower income origins, and graduation from a lower MCAT medical school (not a special admission school such as in Puerto Rico, Osteopathic, Historically Black, Early Admission, or Military) also increase contributions to rural and to rural underserved locations. Highest status origins, birth in a city or county with a medical school, younger age, and graduation from a higher ranking MCAT school are related to lower levels of physician distribution to rural areas.

A focus on higher concentrations involving preparation of medical students, medical school admission, physician training, and health policy will continually be seen as an impediment to physician distribution and most needed health access in primary care, rural, and underserved components.

In regression equations involving ever more challenging rural locations, family medicine contributions increase to 3.2 times odds ratios for rural areas outside of major medical centers,

3.95 for rural whole county primary care shortage areas, 4.3 times for isolated rural locations, and 4.6 times for isolated and underserved locations. Even with dependent location variables including predominantly African-American, Hispanic, or Native counties that are also rural counties (arguably the most challenging health care access areas involving 6 million people in the nation), family medicine career choice doubles location.

Current trends indicate declining rural contributions from international medical graduates (declining J-1 Visa Waivers, short duration, rapid decrease in primary care), physician assistants (1 percentage point per year in rural locations), nurse practitioners (also departing the family practice mode that contributes above average to rural workforce), pediatricians,^{2,3} and internists (declines in primary care retention). These physicians and practitioners have become less dependable sources of primary care and rural health access. These trends only increase the need for family physicians, the best trained family physicians, the most specifically trained family physicians for needed health access, and the family physicians with the characteristics related to the highest levels of long term rural retention. Family practice physician assistants could meet these needs as they have 30% rural location rates, but departures from the family practice mode during training, at graduation, and each year after graduation defeat rural workforce for physician assistants.

The nation's workforce is moving a different direction toward combinations of concentration and away from most needed health access. Family medicine itself is moving a different direction. It continues to look internally for problems. Throughout this material the consistency of family medicine with regard to most needed health access will be demonstrated. It is not family medicine that needs to change. The United States needs to change in birth to admission, admission, training, and health policy to graduate more family physicians. It is the only way that the nation will address cost, quality, and access although once again it is not family physicians that will make the difference. The changes in children that will result in more lower and middle income children doing well will improve graduation rates of family physicians as well as improve health care quality. Each of the following will improve the graduation rates of family physicians, but will result in much needed improvements in even more important areas.

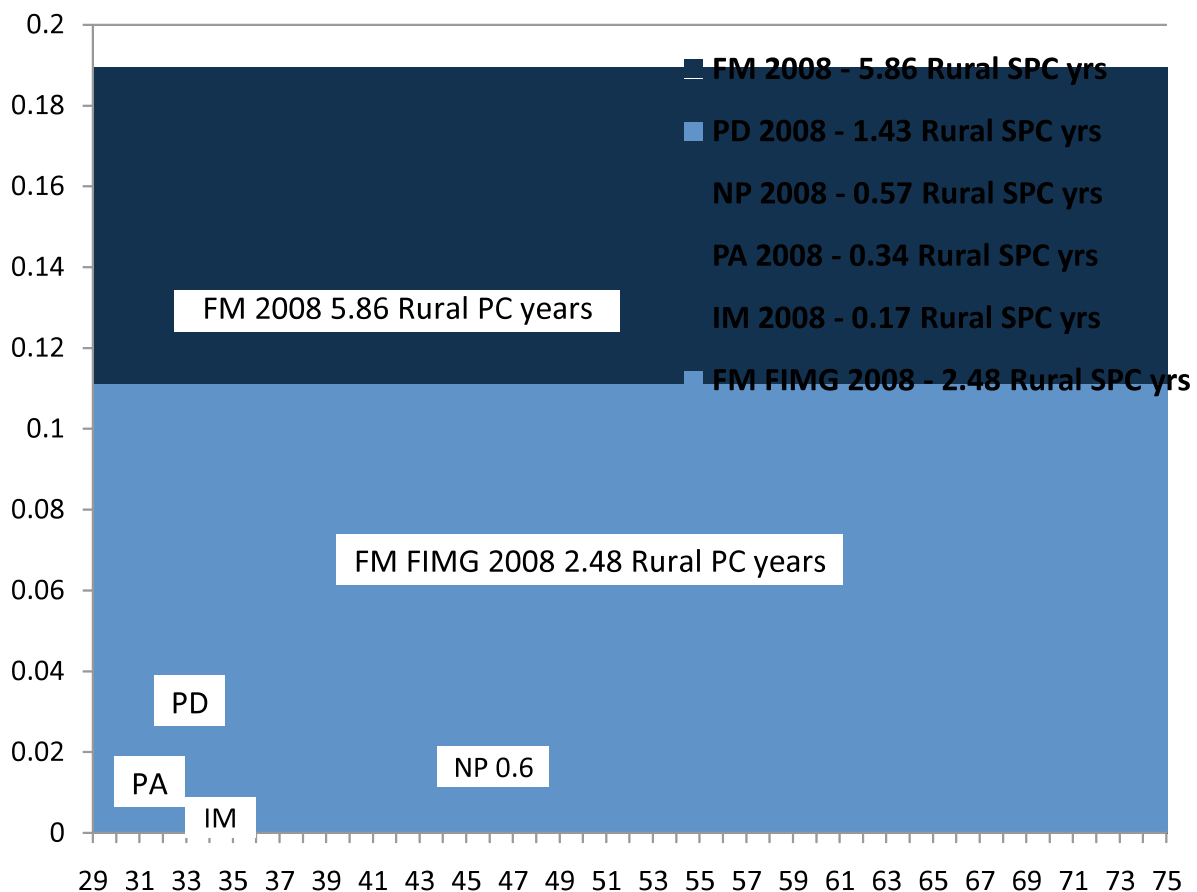
- Improvements in the lower and middle income children with higher probability of family medicine choice - Children who do better in the early years of life do better in education, jobs, and the most important decisions such as when to access health care and when not to access health care.
- Changes in medical education to admit more who will become family physicians as well as health access schools – The admission and training changes most likely to increase family medicine graduates also rural and underserved workforce, result in pediatric and internal medicine graduates most likely to remain in primary care, contribute to care of the elderly, address mental health, increase women's health workforce, and address other needed career choices. The best example is Duluth with a complete health access family physician focus and the ability to meet all of these needs at much higher levels. Medical education focused on the exclusive can address only the exclusive careers and locations.
- Medical students must trust health policy to be able to choose most needed health access careers such as family medicine, rural careers, or careers serving the underserved - Changes in health policy to shift funding to lower and middle income populations for basic health care and to shift funding to primary care also help restore health care

infrastructure for lower and middle income people, improve economics and jobs for lower and middle income people, and increase the efficiency and effectiveness of health care.

A focus on lower and middle income children also is a focus on more and better teachers, nurses, and public servants as these are the other essential infrastructure required by the nation that also requires better lower and middle income children for optimal performance at minimal cost. There is no waste in a focus that results in more of the physicians most needed for health access. The benefits are far more than physician and health system benefits.

A narrow perspective of rural focus in admission misses the many different types of physicians found in rural areas in higher concentration including those who are older (20%), those born outside of medical school cities and counties (30%), physicians with lower and middle income origins (30%), physicians from schools with lower MCAT scores (30%), and physicians trained in specific types of schools and programs (full scope, procedural focus) who are likely to be comfortable only in practice in a smaller or rural location where they can use all of their training and preparation.

When closer examination of rural workforce is needed in the area of primary care, the Standard Primary Care year measuring tool can be combined with the percentage found in rural practice to obtain a Rural Standard Primary Care Year contribution. The advantage of a family practice form with enhanced rural distribution is seen.



Summary of the Meeting



Developing a Strong Primary Care Workforce

The United States does not have enough health professionals in primary care to meet the anticipated demand. To have any hope of meeting that demand, major changes in the education and reimbursement for primary care professionals will be required. Any effort at healthcare reform must place healthcare workforce issues front and center.

In April 2009, the Josiah Macy, Jr. Foundation convened a meeting in Washington, DC, to discuss the nation's healthcare workforce. Individuals representing four organizations with expertise in primary care and prevention were in attendance. These professionals work in the trenches of primary care, representing groups that recruit high school and college students into the health professions, nudge medical education toward a greater appreciation of primary care, and guide training for physicians, nurse practitioners, physician assistants, and others on the front lines of healthcare delivery. Their insights are compelling.

Representatives of these groups have been working in primary care for years. Their experience is substantial, and their ideas about what needs to be done to train thousands of new primary care professionals are grounded in that experience. The organizations they represent play a key role in recruiting and educating primary care providers, encouraging participation in the National Health Service Corps, managing community health centers, and advancing prevention education and research. These are the groups that will help make an expansion of primary care feasible. The following are brief descriptions of the organizations represented at the meeting:

- The National Area Health Education Centers (AHEC) system is a network of 54 coordinating program offices and 229 centers located in 48 U.S. states. Its mission is to recruit young people to careers in the health professions, guide their educational choices, and place them in

locations where they can train and eventually become members of the healthcare safety net workforce.

- The National Health Service Corps (NHSC) is a major player in this primary care world because it offers scholarships to students and loan repayment to healthcare professionals in return for work in underserved communities. The NHSC's scholarship and loan repayment programs are funded by the federal government and administered by the Health Resources and Services Administration.
- The National Association of Community Health Centers (NACHC) is the coordinating organization for the community health center system (often referred to as the nation's healthcare safety net). Included under its umbrella are more than 7,000 facilities that provide care to underinsured and uninsured populations. New programs and funds to increase training opportunities at community health centers are ways to begin the process of responsibly increasing the healthcare workforce.
- The Association for Prevention Teaching and Research (APTR) is the professional organization for the academic healthcare and public health communities. The APTR is dedicated to interprofessional prevention education and research. Tying prevention to primary care and to the healthcare safety net system is vital to achieving the twin goals of better health and lower costs.

The meeting's participants unanimously agreed that the ideal model for primary care in the twenty-first century would include extensive collaboration among teams of caregivers and that changes would be needed in health professionals' education to achieve this goal. Exemplifying the collaboration they espouse, the participants arrived at the following set of recommendations that should be implemented to advance the health of the nation.

Summary of Recommendations*

- New entities, to be called “teaching community health centers,” should be established. These centers would serve as sites for the training of healthcare professionals and would work with primary care practices to raise standards of care. These teaching community health centers will require strong, collaborative ties with traditional teaching hospitals, continuing the theme that collaboration is essential for better patient care and for preventing disease.
- AHECs should be designated and well supported to coordinate the educational experiences of health professions students and primary care residents in teaching community health centers and in other primary care, community-based clinical settings.
- Title VII of the U.S. Public Health Service Act must be expanded to direct more financial support to education in the primary care professions.
- Private and federal insurance program payment policies must be changed to reduce income disparities between primary care providers and other specialists.
- The National Health Service Corps, with substantially increased funding, should become a focus of efforts to alleviate the burden of debt that discourages medical students from selecting primary care as a specialty and to increase the numbers and diversity of primary care professionals who practice and teach in underserved communities.
- Criteria for admission to medical school should be changed to attract a larger and more diverse mix of students who are likely to choose primary care and to care for patients in inner cities, small towns, and rural areas.
- The graduate medical education system needs to be better aligned to meet the physician workforce needs of the country.

* No priority ranking is implied by the sequence of these recommendations.

Healthcare Reform: Innovations in Education and Reductions of Financial Disparities Are Vital to Producing a Sufficient Number of Primary Care Providers to Meet the Healthcare Needs of the Nation

The United States must reduce the amount of money it spends on healthcare if it is not to bankrupt the country. Simultaneously, the country must find ways to insure the estimated 48 million people who are either uninsured or underinsured, not only because it makes economic sense but also because a moral imperative exists to provide care to those who do not have ready access. The education and practice patterns of the healthcare workforce need to adapt to this new reality to serve the health of the nation.

Both Congress and the Administration are engaged in serious discussions about healthcare reform. One of the greatest challenges to reform is this: There are not enough family doctors, general internists, general pediatricians, primary care nurse practitioners, physician assistants, and others to take care of the U.S. population.

Increasing the number and diversity of primary care providers will mark an important milestone in matching the healthcare workforce with the needs of the nation. These changes will also require an extraordinary commitment of money, imagination, and collaboration to recruit, educate, and pay for the corps of primary care professionals essential to the success of any reform.

As the Macy Foundation conference participants noted, the Accreditation Council on Graduate Medical Education recognizes 26 specialties and 100 subspecialties. Fifty years ago, 50 percent of graduating physicians chose to specialize in the primary care disciplines of family medicine, general internal medicine, and general pediatrics. Today, only 37 percent of doctors practice in one of those fields, which carry less prestige, pay less than other specialties and demand long hours. Only 30 percent of graduating medical students are choosing these primary care specialties, and this percentage continues to decline (1,2). Not only are there too few primary care providers, but they are also unevenly distributed (3–5). Healthcare reform cannot succeed without commensurate workforce reform that reverses these trends.

Given the ever-increasing trend toward ambulatory care, an emerging consensus exists among educational reformers and leaders of the primary care community that health professions students need to spend less time training in tertiary care hospitals and more time in community settings. This shift would help prepare doctors and other health professionals to address the needs of the nation as patients spend less and less time in the hospital and more time seeing healthcare providers in private practices or in community health centers.

Although the heroic treatment of serious disease in this country may be the envy of the world, our health status indicators are worse than those of other nations that spend far less on healthcare and high-technology interventions. Healthcare reform is also about improving the overall health of the population, and that requires a primary care workforce that is large and diverse enough to do the job. A stronger educational foundation in clinical prevention and population health is critical to this endeavor.

Representatives from the NACHC, George Washington University, and the Robert Graham Center in Washington, DC, presented data showing the ways in which the primary care workforce needs to grow. An estimate made in 2008 indicates that community health centers need more than 1,800 additional primary care providers. If the community health center system is to serve 30 million patients by 2015, as described in the “Access for All America” plan (6), almost 16,000 more primary care providers and 12,000 to 14,000 more nurses will be needed. Training men and women to fill these positions is a daunting but vital task that requires important changes in the way health professionals are educated and, of equal importance, changes in the ways they are paid. We will not succeed unless the income disparity between the primary care and other specialties is drastically reduced.

Rationale for Recommendations

Teaching Community Health Centers

In a reconfigured healthcare system, community health centers could become part of the health professionals’ educational mainstream by aligning themselves, where possible, with academic programs and teaching hospitals to become primary sites of education and residency training not only for physicians but also for nurse practitioners, physician assistants, and others. In short, these entities could become teaching community health

centers for the training of physicians and other health professionals. This initiative would elevate the status of individuals in primary care practice and augment opportunities for learning beyond what academic health centers already provide.

The Macy conference participants unanimously endorsed the idea of aligning community health centers more closely with health professions education programs and with AHECs to establish teaching community health centers. Evidence indicates that healthcare professionals’ ultimate career choices are strongly influenced by their educational experiences, leading to the assumption that if more health professions students are trained in ambulatory care settings as members of healthcare teams, more will be attracted to careers in primary care. Even those students who eventually choose careers in non-primary care specialties will have gained invaluable experience through this broader educational exposure.

The Macy conference participants acknowledge the cultural, territorial, financial, and administrative barriers standing in the way of these changes and recommend the development of a plan to create teaching community health centers and disseminate information about these educational venues.

Connecting Community Health Centers and Other Primary Care Teaching Sites with Health Professions Educational Programs

Simply designating community health centers as teaching community health centers is not sufficient in itself. An infrastructure is required to coordinate the linkage between the educational programs located at academic health centers and programs developed for the teaching community health centers. The national AHEC system, with program offices and centers in 48 states and close affiliations with academic health centers and community health centers, is well positioned to serve in this role and assist with the development of the teaching community health center concept. A substantial increase in federal and state funding for AHECs and community health centers will be needed to fully realize the educational potential of teaching community health centers..

The Title VII Program

Title VII of the U.S. Public Health Service Act provides funds to support a range of programs that focus on education for primary care, interprofessional education, and increased diversity in the healthcare workforce. As one Macy Foundation contributor has written, “Any serious proposal to reform medical practice in the United States must start with reinventing and reinvigorating Title VII funding for the purpose of creating educational pathways that will support the training of students for primary care, rural health, diversity, and social mission.” Title VII is also important for physician assistant training, and Title VIII is similarly critical for nurse practitioner training. In recent years, the Title VII program has received between \$200 million and \$300 million, down from \$2.5 billion (in 2009 dollars) in the 1970s. As part of the 2009 American Recovery and Reinvestment Act (ARRA), the administration has added more money to existing programs, including \$300 million for the National Health Service Corps (Title III) and \$200 million for primary care physician training under Title VII and to nursing training under Title VIII. More substantial levels of support for these programs will be needed in the coming years.

Debt and the National Health Service Corps

As many experts have noted with distress, students often graduate from medical school with debt in excess of \$150,000, and this level of debt is a distinct disincentive at present to elect primary care practice (7). Senator Max Baucus (D-MT) has concurred that primary care physicians are grossly underpaid compared with many other specialists (8,9). Private and federal insurance programs, including Medicare and Medicaid, must make a commitment to reduce the disparities that exist in pay between primary care providers and those other specialists whose lifetime income is estimated to be \$3.5 million higher (10).

Expanding the NHSC is another imperative to support growth in the primary care workforce. Established 35 years ago to reduce medical school debt in exchange for a fixed term of practice in an underserved area, the NHSC has been vital through its efforts to enable students to attend medical school and to provide doctors to communities that do not have them. There could not be a better time for reinvigorating the NHSC with both money and prestige.

President Obama and the U.S. Congress have already reaffirmed their commitment to the notion of service to the nation. Legislation to triple the size of the AmeriCorps program, whose members work to rebuild communities affected by natural disasters, to restore parks and other public spaces, and to tutor children, was recently signed into law. The new legislation authorizes \$1.1 billion so that AmeriCorps can grow to 250,000 by 2017, up from 75,000 members now, signaling a commitment to service careers that has not been seen in decades. The NHSC could become the avenue of choice for those desiring to serve by addressing the healthcare needs of the nation.

The NHSC must acquire the prestige needed in order to inspire and enable young people to enter the health professions and experience the rewards of primary care. Not everyone who becomes a NHSC scholar will choose to remain in a health professions shortage area after their service obligation has been completed, but many will and the nation will be well served. Increased focus on mentorship and special training opportunities for NHSC scholars would surely increase the appeal of this career path and increase retention in underserved areas. Four thousand clinicians now serve in the NHSC as scholarship and loan repayment beneficiaries. The new economic stimulus package will infuse \$240 million more recruitment dollars into scholarships and loan repayment contracts for primary care clinicians to enter into the NHSC, doubling the number of clinicians to 8,000 in underserved communities during the next several years.

Those attending the Macy Foundation–supported conference recommend a sustained increase in support for the NHSC beyond the two years of funding from the American Recovery and Reinvestment Act.

Changing Admission Policies

The Macy Foundation group identified another important element in the disparity between physicians who choose primary care and those who choose non–primary care specialties—an element that is also important in creating a cadre of healthcare providers that more closely resembles the U.S. population. Because medical schools have long valued basic science and research, it follows that medical school admission has increasingly become dependent on high science grades in high school and college, along with high scores on admissions tests, such as the Medical College Admissions Test (MCAT). Although this system helps to

identify students who are good at math, science, and test taking, it does not always do equally well at identifying students whose basic intelligence and personal qualities, such as empathy and a desire to serve, would make them good doctors. As one participant observed, “Some students give up even thinking about medical school because they get one C in a chemistry course. They think that is enough to shut them out. And maybe they are right.”

The group recommends changing admissions criteria to increase the selection of more students whose personal, demographic, and intellectual characteristics are associated with choosing careers in primary care and providing service to underserved communities.

Graduate Medical Education

Data suggest that post-graduate or residency training is the key determinant influencing career paths for the healthcare workforce. Funding for graduate (or residency) medical education through Medicare is provided to hospitals to help offset the cost of training physicians. At present, most hospitals base decisions about the specialty residency programs they will support and the number of residents they plan to train on the specialty needs of hospitalized patients rather than on the needs of patients from their communities who may lack the care they need. Therefore, hospitals determine the number of residents they will train based on their entirely rational desire to fully staff their wards and emergency rooms. In a reformed system, the needs of the population being served—especially the need for healthcare providers in underserved areas—would be a component of the Medicare graduate medical education calculus and would help create a thoughtful system for anticipating and meeting local, regional, and national needs.

At present, there is no such entity as a National Health Care Workforce Commission. The Macy Foundation group recommends the creation of such a commission that would provide advice about the important policy issues pertaining to both graduate medical education and the overall configuration of the nation’s future healthcare workforce.

Conclusion

President Obama seems to understand the importance of support for novel approaches to reinventing the workforce. In an interview published in the *New York Times Magazine* on May 3, 2009, the President spoke

about workforce issues. Although his remarks were not directed specifically at healthcare, they reveal his frame of mind: “...somehow we have not done a good job of matching up the training with the need out there.” The very fact that members of the current Administration and Congress are vitally interested in healthcare reform in all its aspects adds to the importance of this and other reports that outline the way to a better future for the health of the nation.

Some of the ideas presented here are novel. Many are variations on themes that have been identified by others, framed by the unique viewpoint of front-line healthcare professionals and educators. Collectively, they speak to the urgent need to change the way we train the healthcare workforce as well as how we pay for and deliver healthcare services. These issues need to be addressed if we stand a chance of reaching the ultimate goal of excellent, affordable, accessible care for the entire nation. This is just a start.



The Josiah Macy, Jr. Foundation is dedicated to advancing the education of health professionals in the interest of the health of the nation. For many years, the Foundation has gathered a broad range of experts to study and recommend ways to enhance the training of doctors, nurses, and other health professionals who constitute the backbone of the healthcare workforce in the United States. The Foundation has pointed to the planned expansion of medical schools and other educational programs for healthcare professionals to focus on the health needs of the nation by emphasizing primary care and the importance of training professionals to work together as collaborative teams to care for all members of the population.

List of Participants in the Healthcare Workforce Meeting

Supported By
The Josiah Macy, Jr.
Foundation

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Citations

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NATIONAL RURAL TASK FORCE MEETING

July 15 – 16, 2009
Hilton Crystal City
Arlington, VA

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