Legislative Commission on Primary Care Workforce Issues

November 29, 2018 2:00-4:00pm at the NH Medical Society Conference Room, Concord

Call in information:

866-939-8416

Participant Code: 1075916

Agenda

2:00 - 2:10	**Welcome and Introductions**
2:10 – 2:55	**Building a Rural Primary Care Workforce: National Perspective and Evidence-based Resources (Remote Presentation)** - Davis Patterson, PhD, Collaborative for Rural Primary Care Research, Education, and Practice (Rural PREP), Deputy Director, WWAMI Rural Health Research Center, University of Washington, and Randall Longenecker, MD, Professor of Family Medicine and Assistant Dean, Rural and Underserved Programs, Ohio University Heritage College of Osteopathic Medicine
2:55 – 3:35	**Lamprey NP Fellowship Update -** Nicole Watson, RN and Rosemary Smith, APRN and Silvia Hutcheson, NP Fellowship Coordinator
3:35 - 4:00	**Legislative Update -** Kristine Stoddard, Bi-State Primary Care Association and Jim Monahan, Dupont Group

Next meeting: Thursday December 20, 2:00-4:00pm

Building a Rural Primary Care Workforce: National Perspectives and Evidence-based Resources

New Hampshire Primary Care Commission

November 29, 2018

Davis G. Patterson, PhD
University of Washington

Randall Longenecker, MD
Ohio University and The RTT Collaborative

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centerforhealth workforcestudies
UNIVERSITY of WASHINGTON
Celebrating 20 years of research excellence

Rural PREP
Preparing for rural practice

WWAMI Rural Health Research Center – 30 years

- Policy-relevant research on rural health
- Focus areas: rural health workforce, access to high quality care
  - Primary care
  - Rurally-relevant specialties
  - Behavioral health
  - Home health
  - Prehospital emergency care
  - Cancer, OB care
  - Other topics
- Funded since 1998 by Federal Office of Rural Health Policy, HRSA, HHS

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University of Washington
Center for Health Workforce Studies

- Currently – hosts two HRSA-funded Health Workforce Research Centers
  - HWRC on the Allied health workforce (since 2013)
  - HWRC on Health equity and workforce diversity (new! Sept. 2018)
- Other studies funded by various sources (examples)
  - Washington Workforce Board, Governor Inslee, WA Health Care Authority,
  - Washington Center for Nursing, Maine Medical Center, Arcora Foundation
- Mission: to elevate the importance of workers in the delivery of healthcare in policy discussions. UW CHWS -
  - Conducts health workforce research to inform health workforce planning and policy
  - Provides consultation to local, state, regional and national policy makers on health workforce issues
  - Develops and refines analytical methods for measuring health workforce supply and demand

Rural PREP

- **The Collaborative for Rural Primary care Research, Education, and Practice**
- Mission: Improve and sustain rural health through community engagement and research in primary care health professions education
- Aims
  - Conduct and promote research
  - Disseminate research, tools, best practices
  - Build a community of practice
- UW, Ohio U, U of North Dakota + partners
- Funded by Division of Medicine and Dentistry, HRSA, HHS

Acknowledgments and Disclaimer

- This research was supported by
  - the Federal Office of Rural Health Policy (FORHP),
  - National Center for Health Workforce Analysis (NCHWA), and
  - the Division of Medicine and Dentistry (DMD),

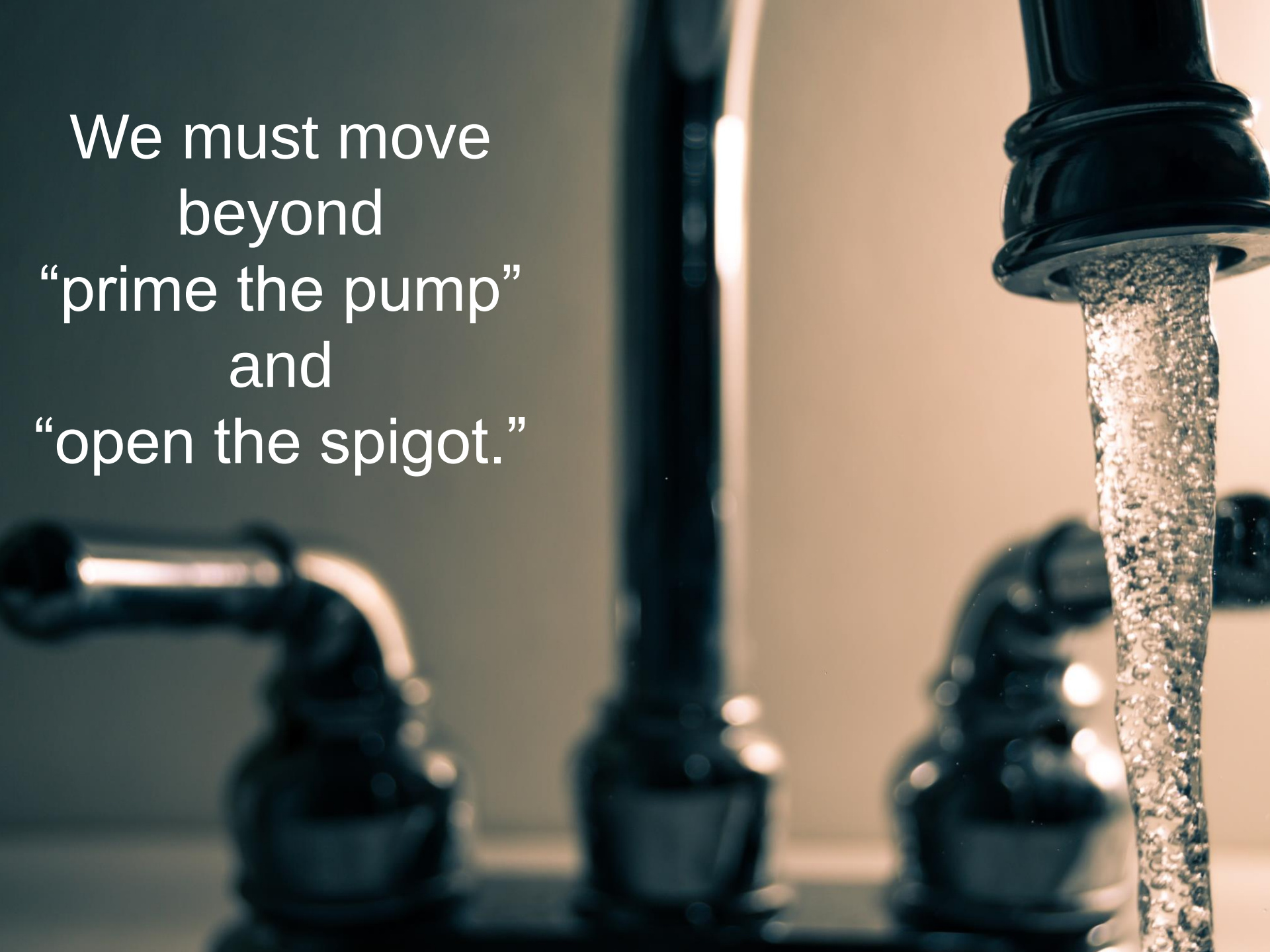
  in the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS)

  Under cooperative agreements #U1CRH03712, #U81HP27844, #UH1HP29966.

- The information, conclusions and opinions expressed in this presentation are those of the authors and no endorsement by FORHP, NCHWA, DMD, HRSA, or HHS is intended or should be inferred.

Outline

1. How has our thinking transformed about how to solve rural health workforce challenges?
2. Meeting rural primary care needs
3. Rural-centric health workforce education and training


We must move
beyond
“prime the pump”
and
“open the spigot.”

Health workforce policy and planning **then**

Then (and now)

- Health workforce planning in professional silos
- Physicians, dentists at the top ➔ focus on medical, dental schools
- Head counts to determine shortage/surplus

Health workforce policy and planning **now**

Then (and now)

- Health workforce planning in professional silos
- Physicians, dentists at the top ➔ focus on medical, dental schools
- Head counts to determine shortage/surplus

Now (and future)

- ***Integration***: healthcare teams
- Consider ***all team members*** (entry level to most highly trained)
- Focus on ***skills, roles, and training*** needed by incumbents and new entrants
- Measure adequacy by health ***outcomes*** and patient ***access***
- Think beyond health workforce ➔ ***human resources for health*** (includes support services)

New thinking:

Flexible use of human resources for health

Alone on the Range, Seniors Often Lack Access to Health Care

Paula Span
THE NEW OLD AGE APRIL 8, 2016

Mrs. Kolacny lives in a remote part of Wyoming, about 30 miles from Red Lodge, Mont.
Janie Osborne for The New York Times

Practice volumes and content: similarities and differences among rural NPs, PAs, and physicians (primary care)

- While PAs and NPs aren't substitutes for physicians, where scope of practices overlap, productivity is similar (esp. if control for age, sex and location).
- In addition, PAs and NPs see more Medicaid patients.

TABLE 2. Average Weekly Number of Outpatient Visits and Types of Visits Among Rural Primary Care Providers

	Physicians	PAs	NPs	*P*
n	788	601	918	
Mean weekly office visits (95% CI)	84.6 (81.4–87.7)	78.1 (74.3–82.0)	63.5 (60.8–66.2)	<0.001
Mean weekly hours of direct patient care (95% CI)	39.1 (38.1–40.1)	39.0 (38.0–39.9)	34.9 (34.1–35.6)	<0.001
Mean weeks not seeing patients (95% CI)	4.4 (4.1–4.8)	4.0 (3.6–4.4)	3.5 (3.4–3.7)	<0.001
Mean weekly well-child visits (95% CI)	12.6 (10.4–14.9)	8.0 (6.8–9.2)	7.4 (6.6–8.2)	<0.001
Mean weekly prenatal care visits (95% CI)	2.3 (1.3–3.3)	1.1 (0.5–1.6)	2.1 (1.5–2.7)	0.064
Mean weekly minor procedures (95% CI)	5.4 (4.7–6.0)	6.7 (5.8–7.6)	5.1 (4.4–5.7)	0.007

CI indicates confidence interval; NP, nurse practitioners; PA, physician assistants.

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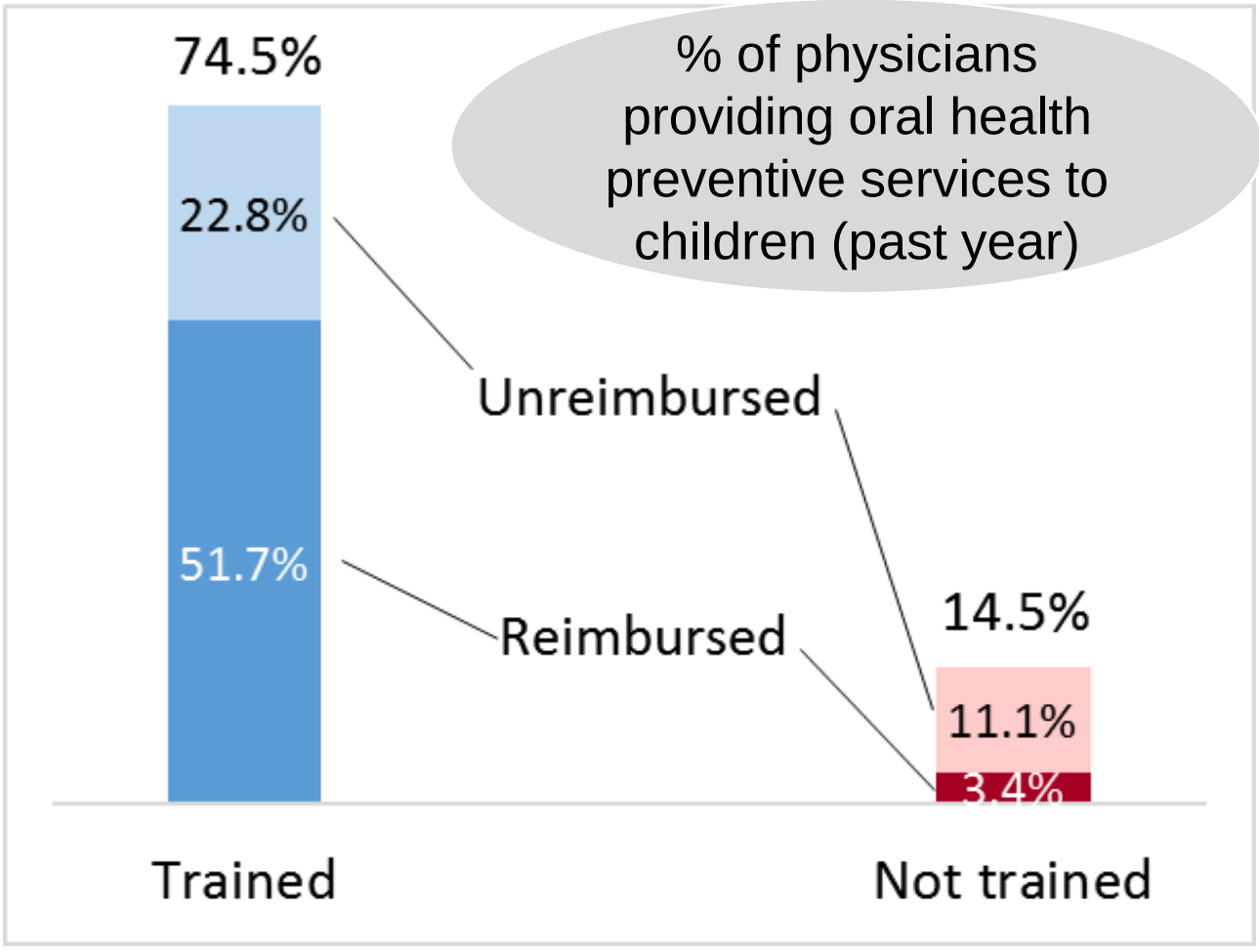
Doescher MD, Andrilla CHA, Skillman SM, Morgan P, Kaplan K. ***The contribution of physicians, physician assistants, and nurse practitioners toward rural primary care.*** Med. Care 2014;52(6):549-56.

WA family physicians and pediatricians ***with oral health training*** provide oral health services and get reimbursed more often than those ***without training***



Patterson DG, Andrilla CHA, Schwartz MR, Hager LJ, Skillman SM. ***Assessing the Impact of Washington State's Oral Health Workforce on Patient Access to Care.*** Seattle, WA: Center for Health Workforce Studies, University of Washington, Nov 2017.

Rural behavioral health workforce: opioid use disorder (OUD)

- Physicians, NPs, and PAs can all prescribe buprenorphine for OUD, with a Drug Enforcement Agency (DEA) waiver.
  - The initial authorization of NPs and PAs to prescribe (under the CARA Act) has recently been made permanent
- BUT many providers do not have waivers: **more than half** of all rural counties (56.3%) didn't have even a ***single*** waivered provider at the end of 2017.
- Providers with waivers don't always use them.

= Huge potential to expand access to OUD treatment

Andrilla CHA, Moore TE, Patterson DG, Larson EH. ***Geographic Distribution of Providers With a DEA Waiver to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder: A 5-Year Update.*** J Rural Health.Epub ahead of print. June 20, 2018.

Rural physicians report barriers to treating patients with OUD using buprenorphine

	Overall
Diversion/misuse concerns	48.5%
Lack of available mental health services	44.5%
Time constraints	40.6%
Lack of specialty backup	31.5%
Attraction of drug users to the practice	30.3%
Financial concerns	29.1%
DEA intrusion	13.7%
Resistance from practice partners	13.5%
Lack of confidence in ability to manage opioid use disorder	9.7%
Lack of patient need	2.3%

Andrilla CHA, Coulthard C, Larson EH. ***Barriers rural physicians face prescribing buprenorphine for opioid use disorder.*** Ann Fam Med. 2017;15(4):359-62.

New findings:
How rural physicians overcome barriers to OUD treatment

THE JOURNAL OF RURAL HEALTH

NRHA

ORIGINAL ARTICLE

Overcoming Barriers to Prescribing Buprenorphine for the Treatment of Opioid Use Disorder: Recommendations from Rural Physicians

C. Holly A. Andrilla, MS; Tessa E. Moore, BS; & Davis G. Patterson, PhD

WWAMI Rural Health Research Center, Department of Family Medicine, University of Washington School of Medicine, Seattle, Washington

Andrilla CHA, Moore TE, Patterson DG. ***Overcoming barriers to prescribing buprenorphine for the treatment of opioid use disorder: recommendations from rural physicians.*** J Rural Health. Epub ahead of print. October 19, 2018.

Flexibility: New ways to develop a health workforce and retool the existing workforce

- Medical assistants
  - **Apprenticeships** being used to gain new entrants as well as to upskill other incumbent workers
    - UW CHWS study in progress
  - MAs in Washington state: **New roles**
    - Behavioral health screening
    - Dual role translator
    - Patient navigator
    - Patient panel manager
    - Case manager

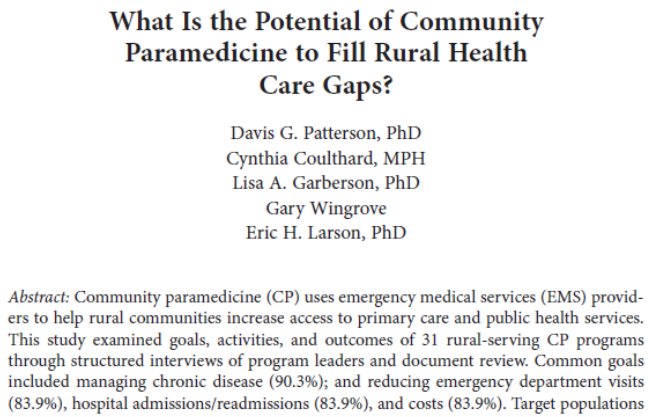
centerforhealth workforcestudies
UNIVERSITY of WASHINGTON
Celebrating 20 years of research excellence

Skillman SM, Dahal A, Frogner BK, Andrilla CHA. ***Frontline workers' career pathways: A detailed look at Washington State's medical assistant workforce.*** Medical Care Research and Review. (in press).

Community paramedicine connects patients to care and community resources

- Rural community paramedics (EMTs and/or paramedics) work to
  - improve disease management
  - reduce ED visits
  - reduce hospital (re)admissions
  - reduce EMS/healthcare use and costs
  - improve patient satisfaction

Patterson DG, Coulthard C, Garberson, LA, Wingrove G, Larson EH. ***What is the potential of community paramedicine to fill rural health care gaps?*** *J Health Care Poor Underserved*. 2016;27(4A):144-158.

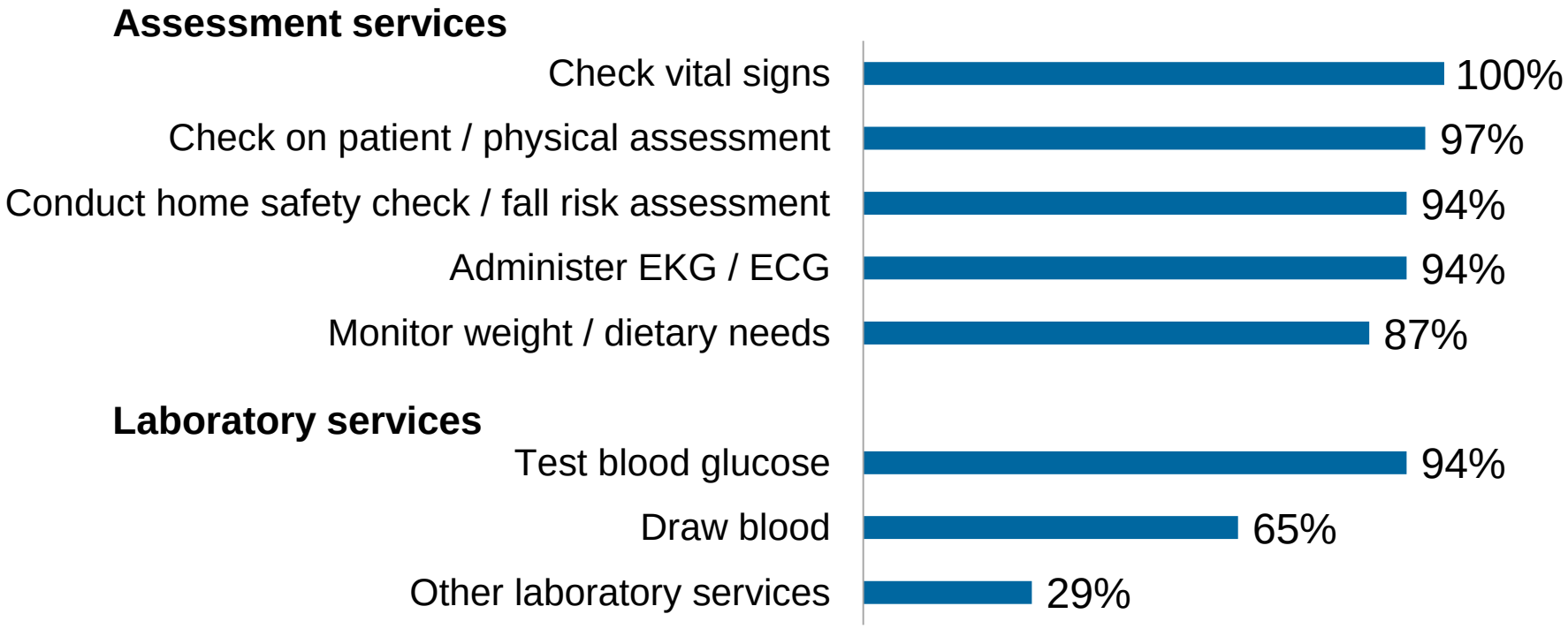


What Is the Potential of Community Paramedicine to Fill Rural Health Care Gaps?

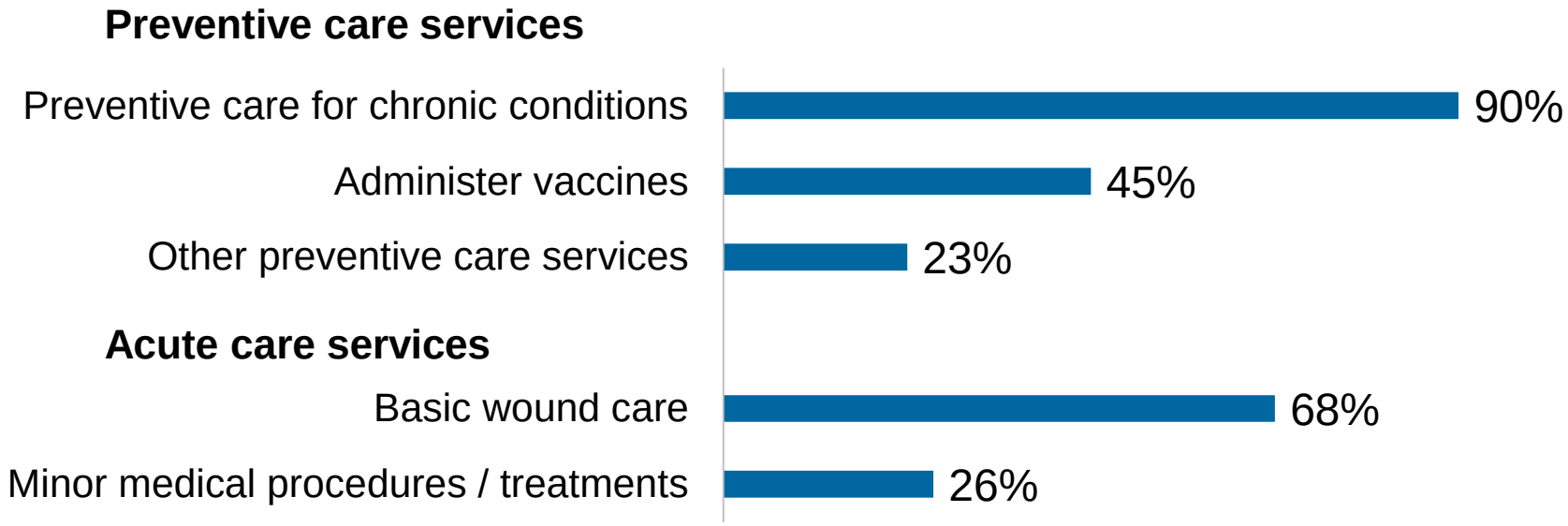
Davis G. Patterson, PhD
Cynthia Coulthard, MPH
Lisa A. Garberson, PhD
Gary Wingrove
Eric H. Larson, PhD

Abstract: Community paramedicine (CP) uses emergency medical services (EMS) providers to help rural communities increase access to primary care and public health services. This study examined goals, activities, and outcomes of 31 rural-serving CP programs through structured interviews of program leaders and document review. Common goals included managing chronic disease (90.3%); and reducing emergency department visits (83.9%), hospital admissions/readmissions (83.9%), and costs (83.9%). Target populations

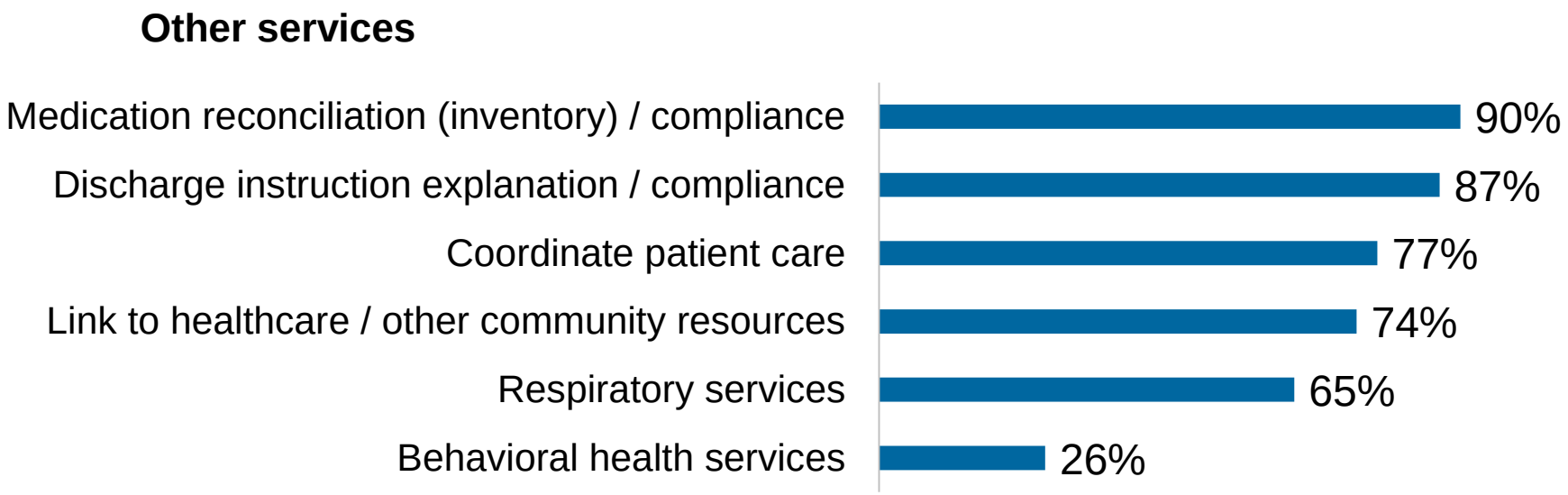
Rural Community Paramedicine Services



Rural Community Paramedicine Services



Rural Community Paramedicine Services




Rural-centric
health workforce
education and training

Rural-centric solutions needed

- Health equity requires us to put rural and underserved populations at the center
  - More rural health professionals
  - More urban providers who know the rural context of patients referred to them
- Create incentives to support rural place-based education/training
  - New funding models for rural training
  - Accreditation fixes (especially for GME)

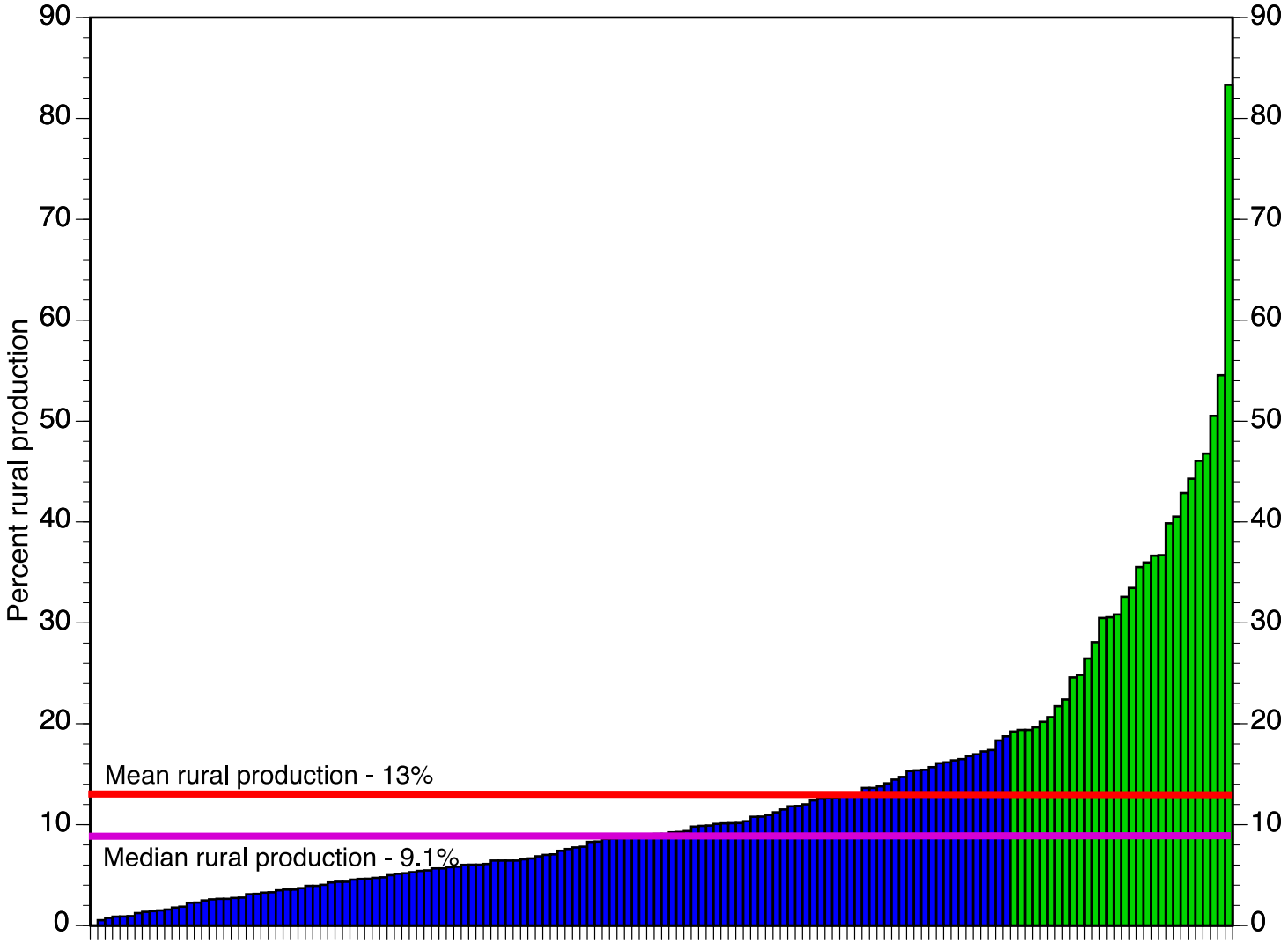
Conventional wisdom

- Recruiting students from a rural background is the most important way to build a rural workforce.

Conventional wisdom meets reality

- Not EITHER/OR but BOTH/AND:
  - Recruiting students from a rural background IS an important way to build a rural workforce
  - But rural students alone won't be enough:
    - Not enough rural students with preparation needed for health careers
    - Some rural students will be "lost" to urban practice
    - Rural exposure needed for all students/trainees:
      - Need to stimulate urban students to think about rural practice (esp. those with rural interest)
      - Need urban providers with rural competencies
  - Thus educational transformation needed, not just producing more

What program factors yield more rural physician assistants?



Programs with high production of rural PAs are more likely to…

- Report training rural PAs is “very important” to program goals/mission
- Actively recruit rural students
- Provide rural didactic curriculum
- Require rural family medicine rotations during clinical training

Larson EH, Coulthard C, Andrilla CHA. ***What Makes Physician Assistant Training Programs Successful at Training Rural PAs?*** Policy Brief #164. Seattle WA: WWAMI Rural Health Research Center, University of Washington, Jun 2018.

How can we support rural graduate medical education (GME)?

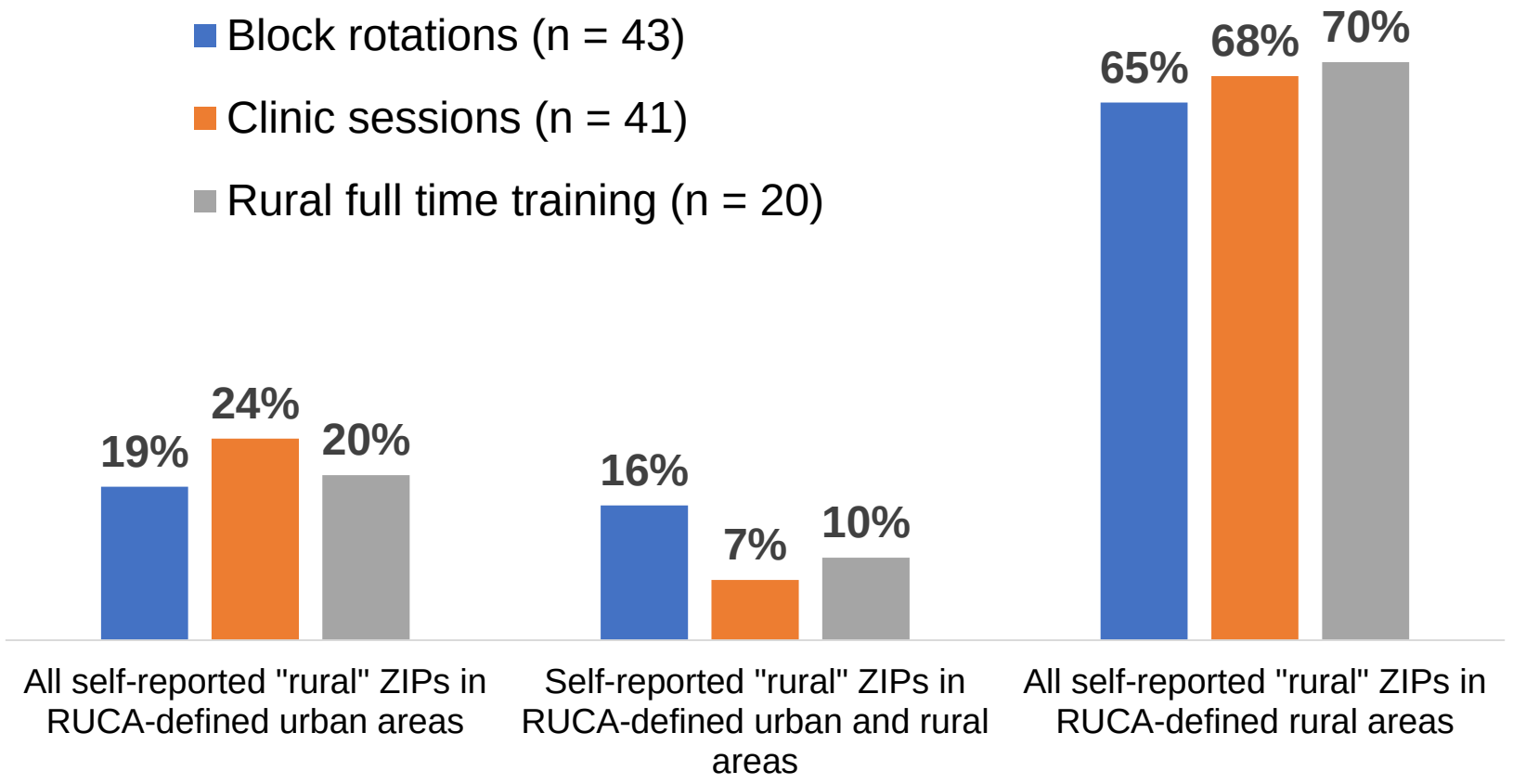
- Rural residency programs face significant financing, accreditation, and other challenges
- Family medicine “rural training tracks” and other rural-centric program models
  - Very few but better rural output than other programs
- Extremely few residency programs in other rurally-relevant specialties

Evans D, Patterson DG, Andrilla CHA, Schmitz D, Longenecker R. ***Do residencies that aim to produce rural family physicians offer relevant training?*** Family Medicine. 2016;48:596-602.

Patterson DG, Schmitz D, Longenecker R, Andrilla CHA. ***Family medicine Rural Training Track residencies: 2008-2015 graduate outcomes*****.** Seattle, WA: WWAMI Rural Health Research Center, University of Washington. Feb 2016.

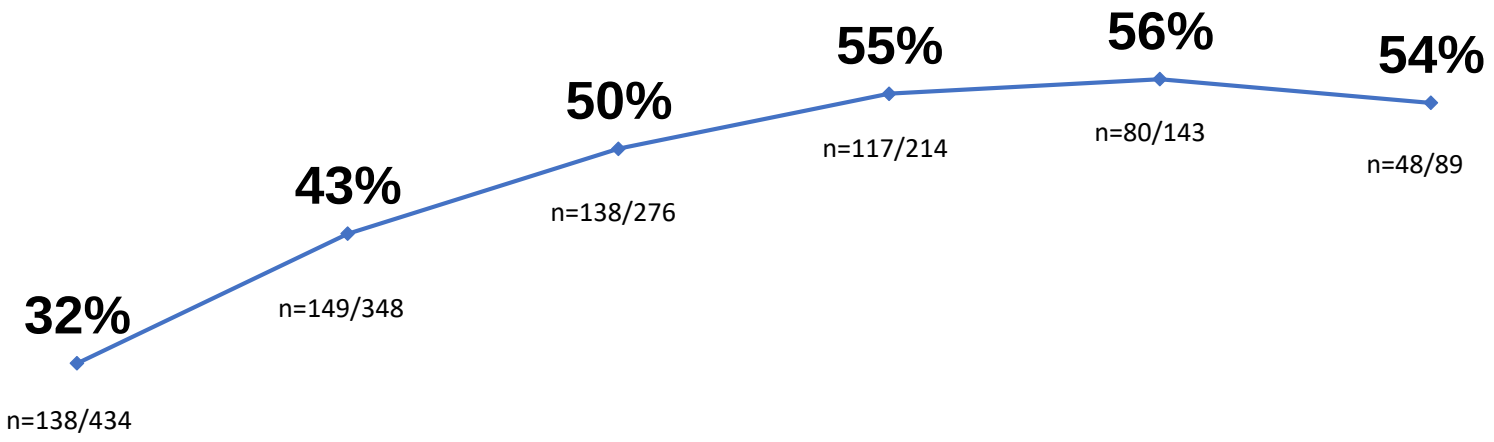
Patterson DG, Longenecker R, Schmitz D, Skillman SM, Doescher MP. ***Policy Brief: Training Physicians for Rural Practice: Capitalizing on Local Expertise to Strengthen Rural Primary Care*****.** Seattle, WA: WWAMI Rural Health Research Center, University of Washington; Jan 2011.

Quantifying rural dosage: “Rural” reported by FM residencies vs. RUCA* coding



*Rural-Urban Commuting Area coding

2-3 times as many recent graduates of ***rural-centric*** family medicine residencies in rural practice (vs. all FM physicians)



- (17% of all family medicine physicians in non metro counties in 2013 [AMA] – Hughes et al.)

Very little rural residency training available in rurally-relevant specialties

Specialty (duration in years)	Total programs*	Programs surveyed**	Respondents	**Rural-centric** programs***
Anesthesiology (5)	145	2	1	0
Emergency medicine (3-4)	214	18	13	5
Internal medicine (3)	492	35	27	13
Ob/gyn (4)	271	9	7	2
Pediatrics (3)	204	11	11	2
Psychiatry (4)	213	16	14	5
General surgery (5)	310	28	24	9
Total	**1849**	**119**	**97**	**36**
Percent of total		**6.4%**		**1.9%**

*Allopathic only, osteopathic only, dual-accredited

**In a rural location or urban with a rural training track

***Require at least 8 weeks total of rural training

Clinical training challenges

- Scarce rural clinical training sites:
  - How do we create incentives to develop more?
  - How do we use (ration) the ones we have?
  - Who “gets” to do rural training?
- Health system consolidation:
  - Rural clinical training viewed as a cost
  - Distant corporate decision-makers may not support rural training sites
  - Loss of clinical training programs a disincentive for rural clinicians motivated to be educators
  - Loss of teaching component - possible negative impact on quality of care
- States need regulatory levers to influence these arrangements.

The Rural Advantage

- Rural healthcare providers have always had to be flexible, stretch resources, and innovate.
- But they need partners and policies to achieve the goals of access to care and health equity.

Contact

- Davis Patterson davisp@uw.edu

  Director, Rural PREP https://ruralprep.org/

  Deputy Director, WWAMI Rural Health Research Center https://depts.washington.edu/fammed/rhrc/

  Investigator, UW Center for Health Workforce Studies https://depts.washington.edu/fammed/chws/

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RURAL RESIDENCIES: A PLACE BASED APPROACH

RANDALL LONGENECKER MD

EXECUTIVE DIRECTOR

THE RTT COLLABORATIVE

NOVEMBER 29, 2018

The RTT Collaborative

in rural health professions education and training

Growing our own...together

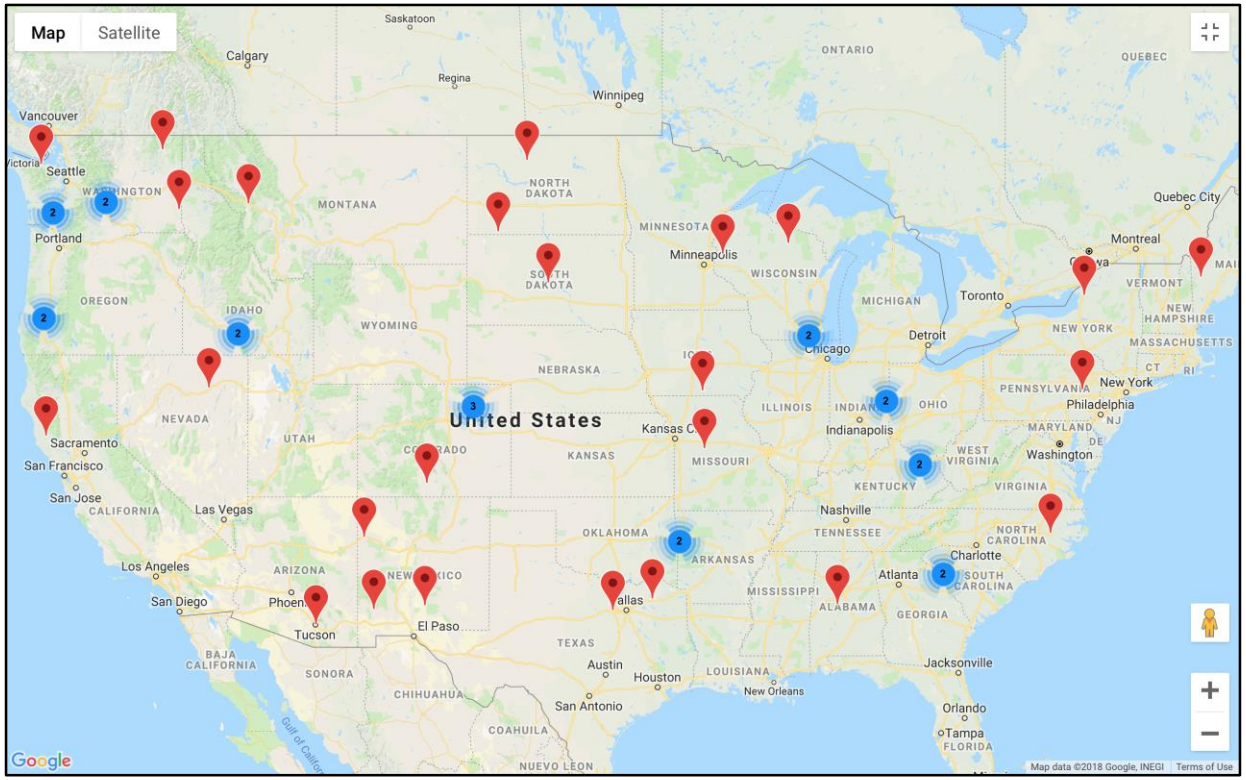
A rural health professions education network and a cooperative extension service

“a community of practice”

http://www.rttcollaborative.net

Our Programs

https://rttcollaborative.net/rural-programs/#participating-programs (11-21-2018)



RTTC 2018

Outline

- Rural Program Definitions
- An organic place-based approach to rural residency design, development, and sustainability
- The rural program landscape – Nationally, by States, and in New Hampshire
- Potential solutions to the rural primary care workforce shortage

A Place-Based Approach

Rural Training Track
technical assistance program

https://www.ruralhealthinfo.org/

Policy Brief • February 2016

Family Medicine Rural Training Track Residencies: 2008-2015 Graduate Outcomes

This policy brief is the latest in a series,[1,2] tracking the practice outcomes of family physicians who have completed graduate medical education (GME) in Rural Training Track (RTT) residency programs. We report the following key findings using new trend data on graduates' practice locations:

Key Points

- Family medicine RTT residency programs train physicians for practice in rural areas, which face a persistent shortage of primary care providers.
- In the seven years that RTT graduates were tracked after graduation (2008-2015), more than 35% of graduates were practicing in rural areas during most of that time, about twice the proportion of family medicine residency graduates overall. Rural practice choices were also persistent over time.
- A majority of graduates from RTT programs in this study were men, and about half completed undergraduate medical training outside the United States and Canada.
- 56% of RTT graduates provided health care in primary care Health Professional Shortage Areas (HPSAs) one year post-graduation and by seven years post-graduation, 50% were still in primary care HPSAs.
- Study findings suggest that graduates of RTT programs provide care to rural and underserved populations at higher proportions than family medicine residency graduates overall, and these practice choices persist over time.
- As policymakers encourage evidence-based practices to expand and enhance primary care, the RTT model may be worth replicating more broadly.

Background

The proportion of matriculating allopathic medical students in 2015 who said they intended to practice in a community of 10,000 or smaller population, including small towns and rural areas, was just 4.6%, a decline from 5.2% in 2013 and 2014.[3] Just 9% of physicians practice in rural areas, despite the fact that rural populations are almost 20% of the total U.S. population.[4,5] Increased access to health insurance through the Affordable Care Act (ACA) combined with an aging rural population raise concerns about rising health care demand worsening shortages in rural communities. The "1-2" family medicine rural training track (RTT) model prepares physicians for rural practice by combining up to one year of urban training with two years of rural training. The Rural Training Track Technical Assistance (RTT TA) Consortium has been funded for over five years by the Federal Office of Rural Health Policy to bolster the 1-2 RTT strategy, which has proven successful in the past, graduating residents who favor rural practice at levels as high as 76%.[6,7]

Data Sources

This policy brief adds new data from surveys of RTT program coordinators and directors in 2013 and 2015 to update a study that the RTT TA Consortium conducted in 2012,[1] using the following data sources:

- Survey of RTT Programs: The RTT TA Consortium has conducted four surveys from 2011 through 2015 of all RTT programs that were active at any time from 2007 through 2015 and that had graduated residents, a total of 42 RTTs. Twenty-eight (67%) programs responded to at least one survey. Twenty-one RTT programs identified 253 physicians graduating from

RURAL HEALTH RESEARCH CENTER

WWAMI Rural Health Research Center
University of Washington • School of Medicine • Department of Family Medicine
http://depts.washington.edu/uwrhrc/

Rural Program - Definition

An accredited residency program in which residents spend the majority of their time training (more than 50%, as reported to CMS and/or HRSA) in a rural place. The location of a rural program in Family Medicine is defined by the geographic location of the primary Family Medicine Practice (FMP) where residents meet the ABFM requirement for 24 months continuing practice.

CMS FY2004 regulations defining an integrated rural training track, Department of Health and Human Services, Center for Medicare and Medicaid Services. *Federal Register* August 2003; http://edocket.access.gpo.gov/2003/pdf/03-19363.pdf (Accessed 6-16-2016)

Am I Rural? A web-based tool using federal definitions that are regularly updated and hosted by the RHI hub in the North Dakota Center for Rural Health, https://www.ruralhealthinfo.org/am-i-rural. (Accessed August 1, 2016)

United States Department of Agriculture Economic Research Service Rural Classifications http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications.aspx. (Accessed August 1, 2016)

Integrated Rural Training Track (I-RTT):

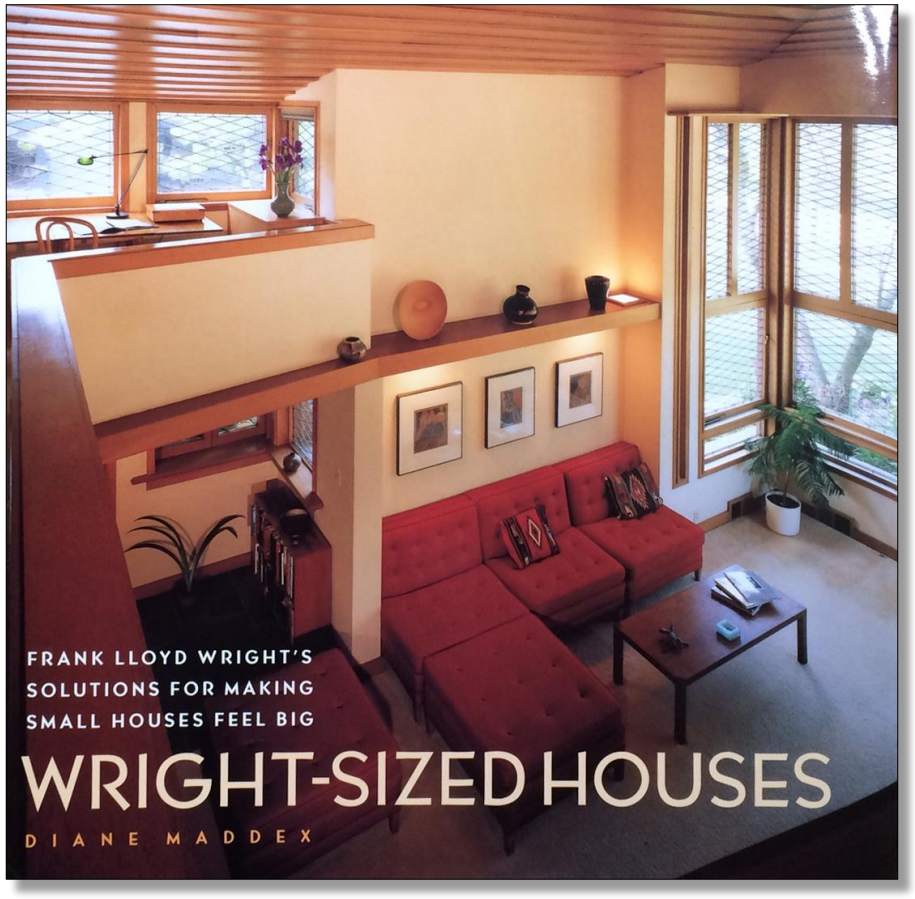
A **rural program** that is **separately accredited** and because of its generally smaller size is **substantially integrated** with a larger, often more urban residency program:

- **I** ntegrated in a substantive way
- **R** urally located and rurally focused
- Engaged in **T** raining and/or education – residency +/- medical school experiences
- A **T** rack or pathway – deliberately structured over at least 2-3 years in family medicine, including a 24-month continuity practice in a rural location (often in the 1-2 format)

Substantial Integration

- Structured interaction among the residents of both the RTT and the larger affiliated program,
- Some sharing of faculty and/or a shared program director,
- Shared didactics and/or scholarly activity, and
- at least 4 months of structured curriculum shared by residents of both programs.

An Organic Approach



Basic principles

1. Begin with a rural place
2. Establish a relationship and join the community
3. Explore the community's assets and build from there
4. Using best evidence and knowledge of the rules of accreditation and finance design for sustainability
5. Collaborate for mutual benefit and set in place a governance structure that supports mutuality

Community Engaged Residency Education (CERE-R)

1. Define the community
2. Engage the community
3. Determine assets & capacity
4. Design for accreditation
5. Build for sustainability
6. All at the same time!

CERE-R https://rttcollaborative.net/about/tools-and-assistance/

ACGME Accreditation, GME Finance, US Healthcare System

A Distributed Peer Network of Rural Medical Educators

Community Engaged Residency Education

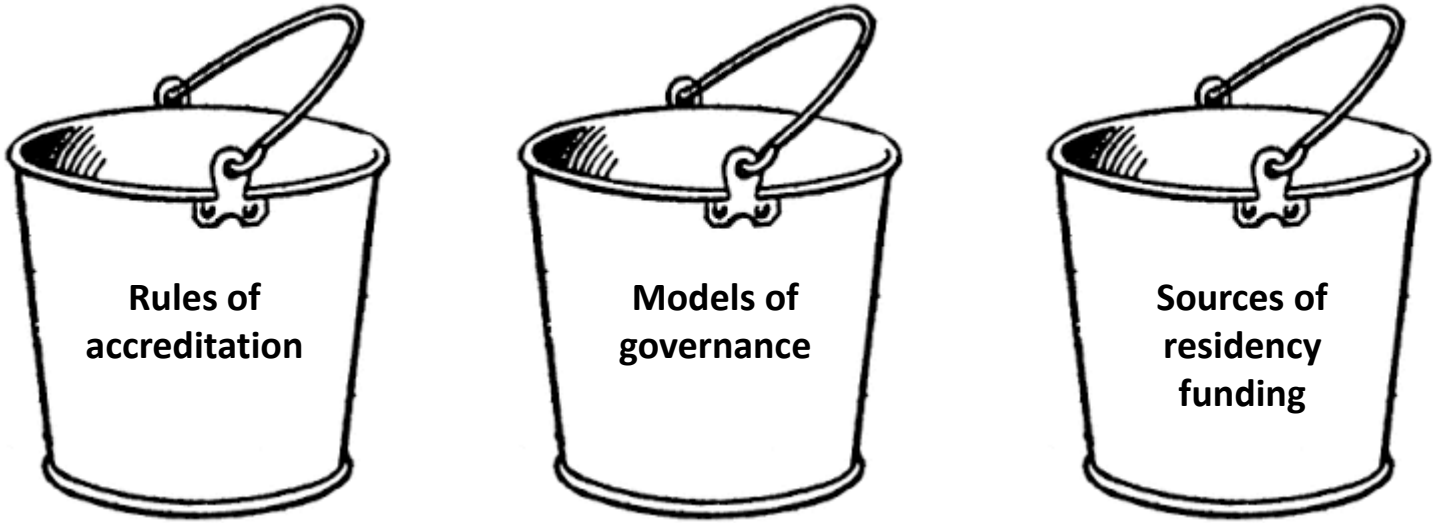
Community Engaged Residency Education (CERE-R)

CERE-R was developed by Drs. Longenecker and Schmitz, in collaboration with Western Montana Family Medicine Residency and funded in large part by a HRSA Residency Training in Primary Care grant #D58HP23226 and the RTT Technical Assistance Consortium, in a cooperative agreement with HRSA's Federal Office of Rural Health Policy.

CERE-R https://rttcollaborative.net/about/tools-and-assistance/

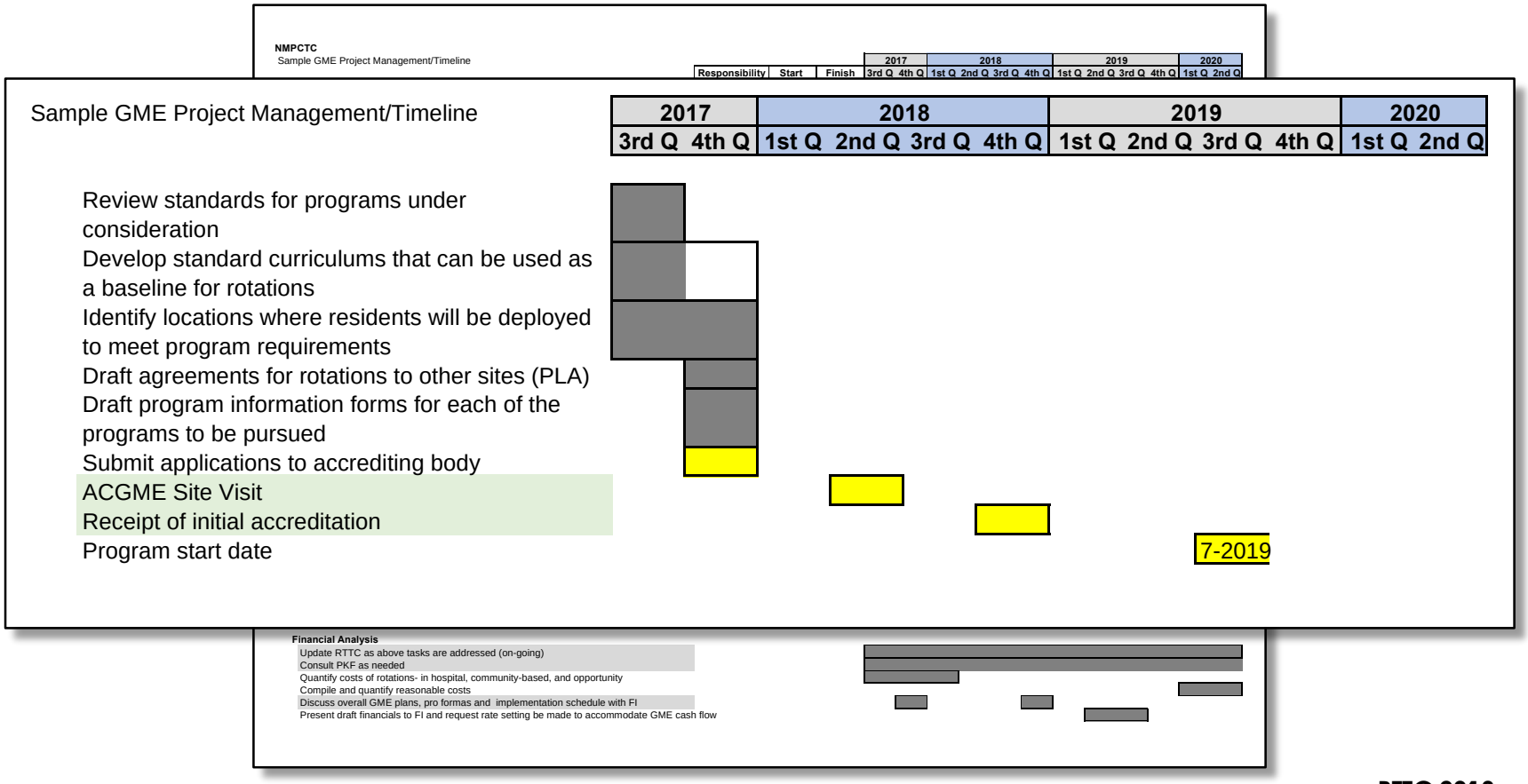
Designing a Sustainable Program

Creatively build upon community assets using:



Community Assets, Capacity, and Engagement

Timeline for Development



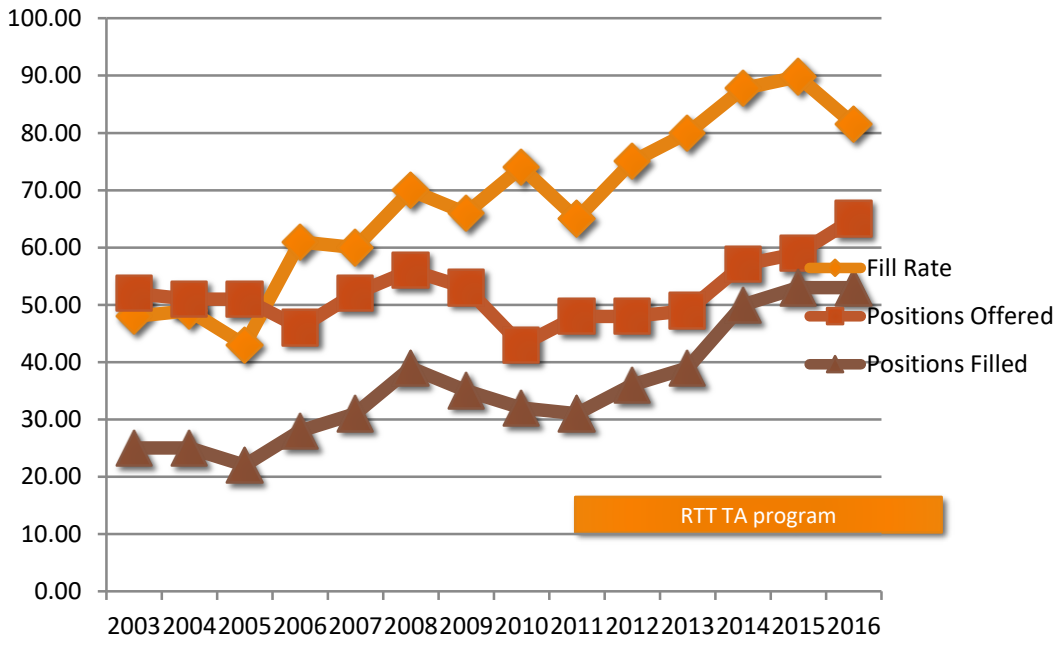
Specific Questions

- Funding – Requires diversified funding because of multiple challenges for rural programs and marked disparities under the current system of GME finance – CMS (Medicare), Medicaid, and other; e.g. State funding from $0 to $100,000 per resident
- Interprofessional, team-based care and behavioral health integration – e.g. RHC, FQHC and even private practice

National Rural Landscape 2017/2018

- 9 Rurally-located Medical Schools (out of 175)
- 39 rural programs in medical school (An organized and deliberate medical school strategy to produce physicians to rural practice according to 4 criteria)
- 92 accredited rural programs in family medicine (401 first year positions), 14 rurally located programs in internal medicine, 2 rurally located programs in pediatrics

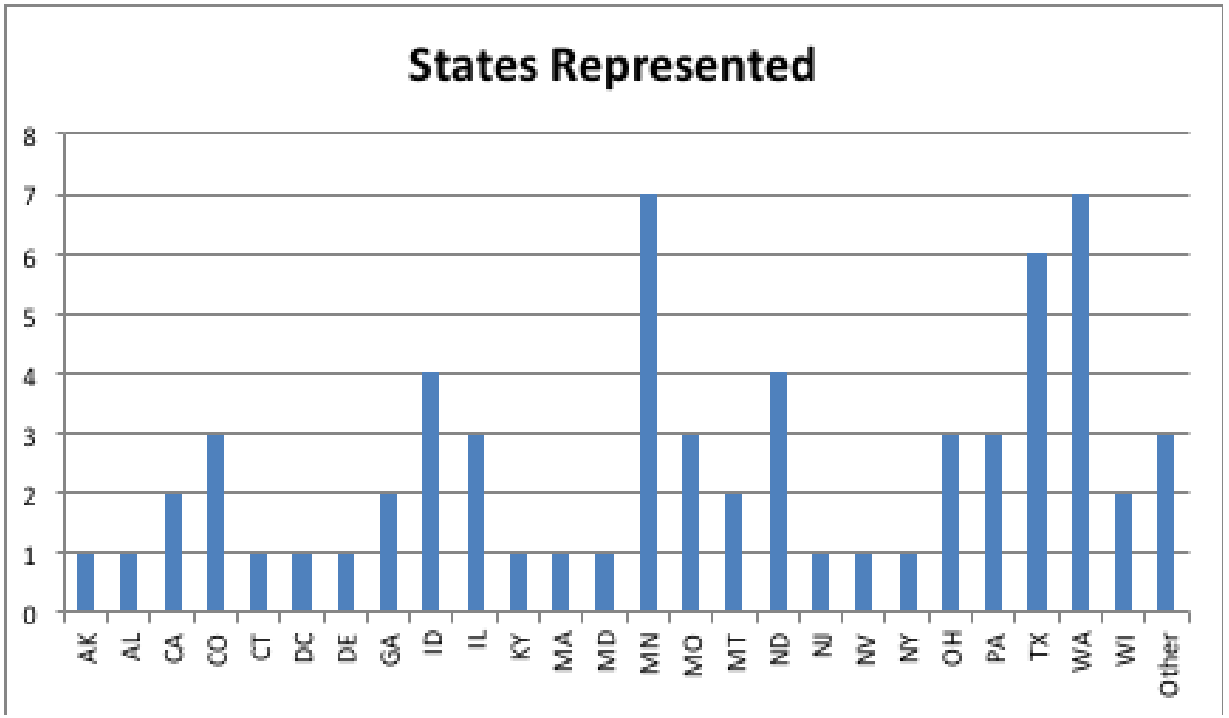
RTT Match Trends 2003-2016



Source: Personal communication from Randall Longenecker MD, Senior Project Advisor, the RTT Technical Assistance Program, March 22, 2016; revised May 23, 2016

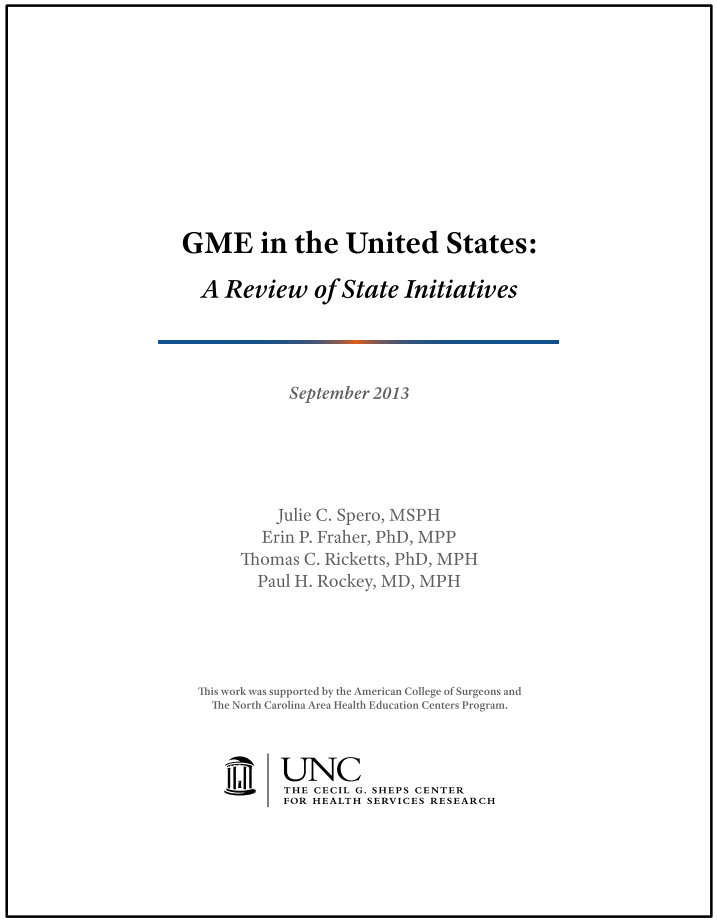
AAFP National Conference 2018

One measure of rural interest



65 individual student contacts through booth visits or student breakfast

States Context



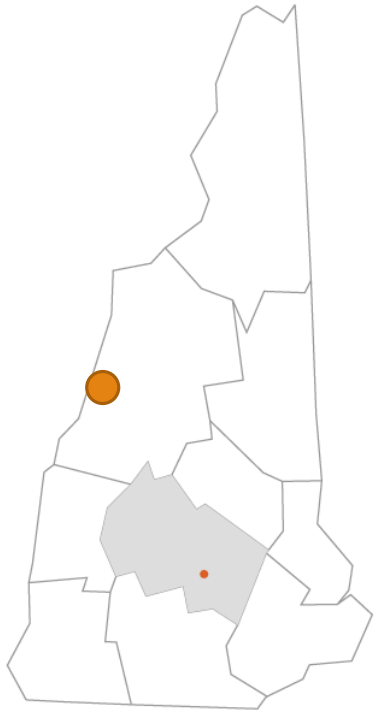
New Hampshire – Medical School

New Hampshire - Residency

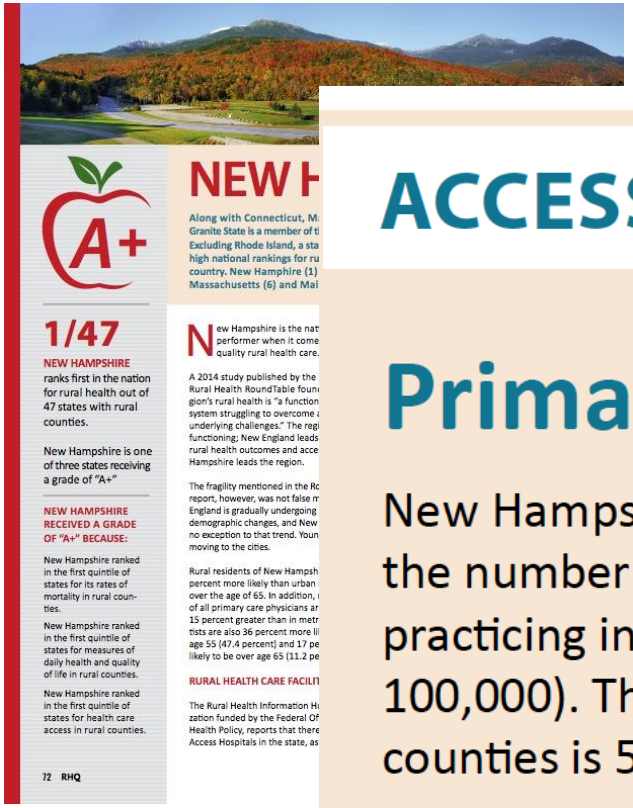
One rurally located FM program with a rural pathway – Concord (8 residents/yr)

One rurally located IM program with a rural primary care pathway – Lebanon (4 residents/yr in primary care track)

One rurally located Pediatrics program – Lebanon (8 residents/yr total)



New Hampshire – Practice



NEW H

Along with Connecticut, M
Granite State is a member of t
Excluding Rhode Island, a sta
high national rankings for ru
country. New Hampshire (1)
Massachusetts (6) and Mai

A+

1/47

NEW HAMPSHIRE ranks first in the nation for rural health out of 47 states with rural counties.

New Hampshire is one of three states receiving a grade of "A+"

NEW HAMPSHIRE RECEIVED A GRADE OF "A+" BECAUSE:

New Hampshire ranked in the first quintile of states for its rates of mortality in rural counties.

New Hampshire ranked in the first quintile of states for measures of daily health and quality of life in rural counties.

New Hampshire ranked in the first quintile of states for health care access in rural counties.

72 RHQ

New Hampshire is the nat
performer when it come
quality rural health care.

A 2014 study published by the
Rural Health RoundTable foun
gion's rural health is "a function
system struggling to overcome
underlying challenges." The regi
functioning; New England leads
rural health outcomes and acce
Hampshire leads the region.

The fragility mentioned in the Rc
report, however, was not false m
England is gradually undergoing
demographic changes, and New
no exception to that trend. Youn
moving to the cities.

Rural residents of New Hampsh
percent more likely than urban
over the age of 65. In addition,
of all primary care physicians ar
15 percent greater than in metr
tists are also 36 percent more li
age 55 (47.4 percent) and 17 pe
likely to be over age 65 (11.2 pe

RURAL HEALTH CARE FACILIT

The Rural Health Information H
zation funded by the Federal Of
Health Policy, reports that there
Access Hospitals in the state, as

ACCESS TO CARE

Primary Care: *A+*

New Hampshire ranks 1st in the U.S. for the number of primary care physicians practicing in rural counties (112.4 per 100,000). The national average for rural counties is 54.5 per 100,000.

[Rural Health Quarterly 2017]

New Hampshire – Practice

Rural PREP Medical School Commitment Study (2017) for the decade of graduates 2000-2010:

Geisel School of Medicine at Dartmouth

29th by percentage (3.2%) among 148 allopathic and osteopathic medical school, for an average of 2.2 graduates per year going into rural primary care practice

The Competition

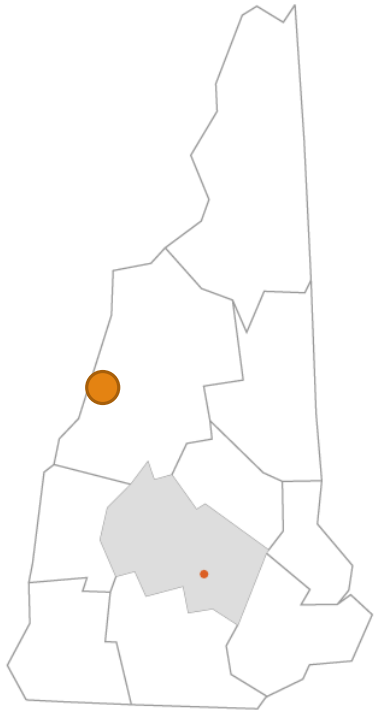
PRIMARY CARE

$300,000+ Proven Income Potential

4 DAY WORK WEEK

Additional Flexible Scheduling Options Available!

- Established group in the community for 20+ year
- **$250K guaranteed salary** + production bonus
- Aging physician population, **patient panels waiting**
- **Work at Only 1 Location – Choose Practice Style**
  - Join multi-physician clinic
  - Replace retiring physician in a solo clinic
  - Join a team of NP's and PA's clinic
- **Comprehensive benefits package** including Relocation, Health insurance, CME, **6 weeks PTO**, 401k match, and more!



Potential Solutions

1. An enlarging community of practice in rural primary care health professions education (The RTT Collaborative Annual Meeting, Aurora, ME, May 15-17-2019)
2. Alternative payment mechanism for federal GME (S3014) that can serve as a model for State funding of residency training; state primary care consortia (AR, CA, GA, OR, WI, NM, etc.)
3. HRSA Rural Residency Planning and Development (NOFO pending)

Questions?

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OHIO UNIVERSITY Heritage College of Osteopathic Medicine

The RTT Collaborative
in rural health professions education and training
Growing our own...together

References

Longenecker R. “Curricular Design: A Place-Based Strategy for Rural Medical Education,” in Bell E; Zimmitat C; Merritt J Eds. Rural Medical Education: Practical Strategies, New York: Nova Science, 2011.

Strasser R; Worley P; Cristobal F; Marsh DC; Berry S; Strasser S; Ellaway R. “Putting Communities in the Driver’s Seat: The Realities of Community-Engaged Medical Education,” Academic Medicine 2015 Nov;90(11):1466-70.

Community Engaged Residency Education for Rural Places (CERE-R) http://rttcollaborative.net/wp-content/uploads/2015/11/CERE-R-11-6-2015.pdf

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Spero JC, Fraher EP, Ricketts TC, Rockey PH. (2013 September). GME in the United States: A Review of State Initiatives. Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill.

AAMC Medicaid Graduate Medical Education Payments: A 50-State Survey, 2016.

Davis A. "'The GME Initiative' and GME in States: A report from the Association of Departments of Family Medicine," *Ann Fam Med* 2018;16:468-469. https://doi.org/10.1370/afm.2294.

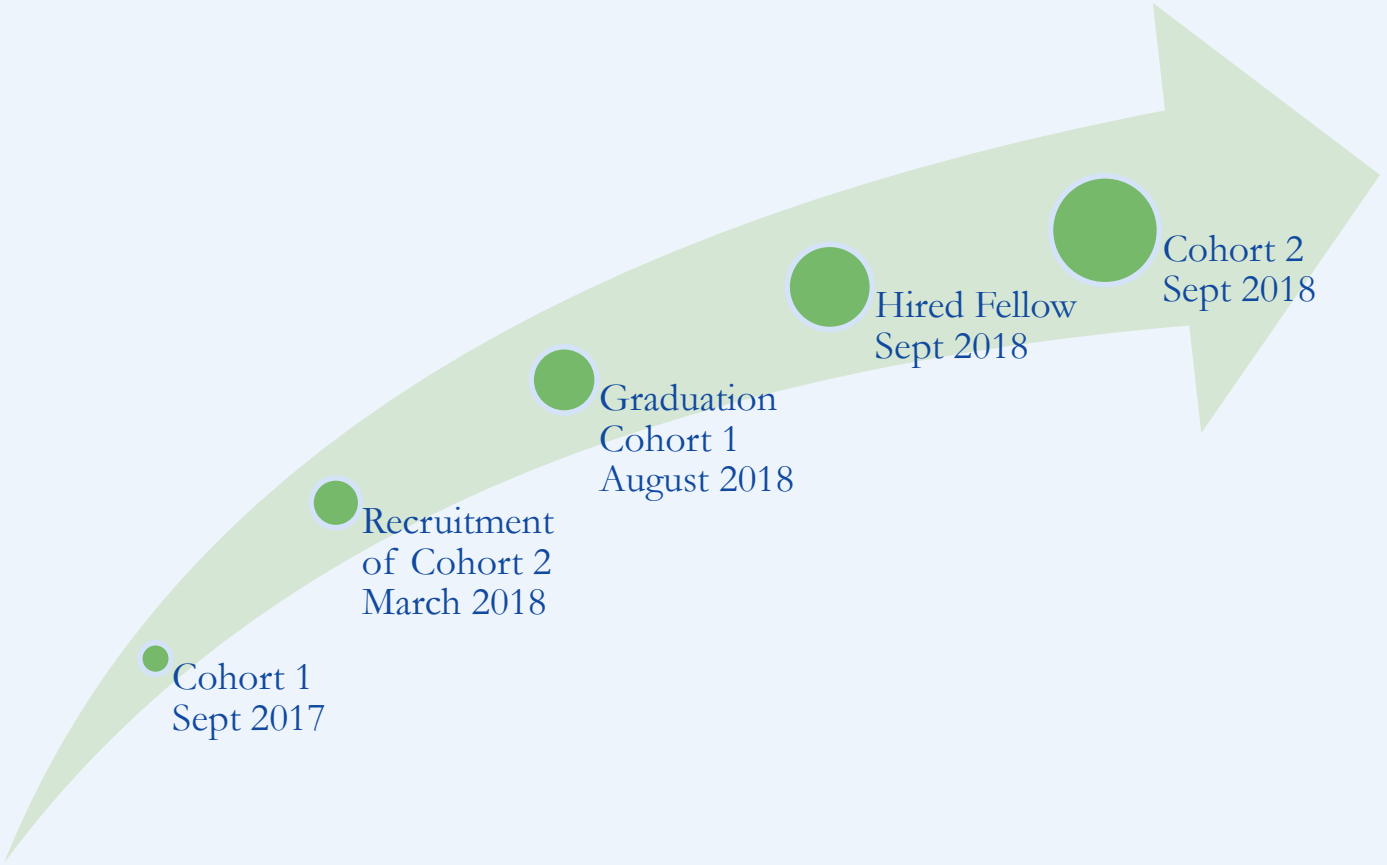
LAMPREY HEALTH CARE

NURSE PRACTITIONER FELLOWSHIP PROGRAM UPDATE

Legislative Commission on Primary Care Workforce

November 29, 2018

Overview


Cohort 1
Sept 2017
Recruitment
of Cohort 2
March 2018
Graduation
Cohort 1
August 2018
Hired Fellow
Sept 2018
Cohort 2
Sept 2018

Program structure

- **NP Fellowship Structure**
  - Continuity Clinic
  - Learning Session/Didactics
  - Mentored Clinics
  - Specialty Rotations
  - Reflections
  - Performance Improvement Project

Partnerships for Specialty Rotations

- **Community organizations:**
  - Exeter Hospital / Core Physicians
  - Southern New Hampshire Health System / Foundation Medical Partners
  - Northeast Dermatology Associates
  - Rockingham County Nursing and Rehabilitation Center
  - Dartmouth Hitchcock (Manchester)

Learning sessions

- Topics:
  - Case Studies
  - Review Research Articles
  - Clinical Topics

- Guest speakers: professors from regional universities

Ramp Up Policy: Continuity Clinic

Sept- Nov
1 patient/hr

Dec-May
Add patients per session

May-August
2 patients/hr

NP Fellow Patient Demographics

NP Fellow Patient Demographics

- **Top Diagnoses**
  - Diabetes
  - Hypertension
  - Upper respiratory infections
  - Attention Deficit Hyperactivity Disorder (ADHD)
  - Chronic Obstructed Pulmonary Disease (COPD)
  - Wellness exam/Immunizations

Financial Impact

- **Program Revenue:**
  - Patient Service Revenue
  - Grant support
- **Program Expenses:**
  - Salaries, Wages & Benefits
  - IT Equipment/Licenses
  - Program Costs
  - Allocation of Clinical Support Services

Evaluating Accreditation Options

- **Currently evaluating two organizations**
  - American Nurses Credentialing Center (ANCC)
  - National NP Residency and Fellowship Training Consortium

Lessons Learned

- Internal Communication
- Preceptor Expectations and Recognition
- Credentialing
- Fellow's experience
- Financial Support

Next Steps

- **Begin accreditation process**
- **Begin recruitment for third cohort**
  - Reaching out to regional universities
  - Applications are due in mid-March 2019
- **Continue to recruit specialty preceptors**
- **Reach out to additional organizations to host NP Fellows for specialty rotations**
- **Recruit new faculty to present at learning sessions**
- **Consider options for growth**

Questions

Thank you!!

For more information, please reach out:

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Niki Watson, RN, BSN (Director of Risk Management)

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Relative to a Graduate Physician Pilot Program

Cosponsors: Sen. Bradley, Gray, Rep. Knirk, Kotowski, Fothergill

1 New Chapter; Graduate Physician Pilot Program. Amend RSA by inserting after chapter 328-J the following new chapter:

CHAPTER 328-K

GRADUATE PHYSICIAN PILOT PROGRAM

328-K:1 Definitions. In this chapter:

I. "Graduate physician" or “GP” means a person who fulfills the requirements for physician licensure established by RSA 329:12 except for RSA 329:12, I(d)(5) and RSA 329:12 I, (d)(6), and:

(a) Has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination or the equivalent of such steps of any other board-approved medical licensing examination; and

(b) Has proficiency in the English language.

II. "Graduate physician collaborative practice arrangement" means an agreement between a physician licensed under RSA 329 and a graduate physician that meets the requirements of RSA 328-K:16.

III. "Medical school graduate" means any person who has graduated from a medical college or osteopathic medical college described in RSA 329:12, I(d)(4).

IV. “Board” means the board of medicine established in RSA 329.

V. “Department” means the department of health and human services.

VI. "Medically underserved area" means an area designated by the department as a designated Health Professional Shortage Area (HPSA), a Medically Underserved Area (MUA), or a Governor-Designated and Secretary-Certified (GDSC) shortage area.

VII. "Primary care" means physician services in family practice, general practice, internal medicine, pediatrics, and obstetrics. It shall also include gynecology if paired with obstetrics.

328-K:2 License Required.

I. No person shall practice as or hold himself or herself out to be a graduate physician or use any letters designating himself or herself as a graduate physician unless the person is licensed in accordance with this chapter.

II. The board shall license the first five applicants per year who satisfies the requirements under RSA 328-K:3. Upon payment of a license fee, the board shall issue to such person a license, which shall be prima facie evidence of the right to practice as a graduate physician in and only in a medically underserved area. A licensed graduate physician may use the letters "G.P." in connection with his or her name to denote licensure under this chapter.

III. Except as provided in RSA 328-K:15, persons licensed under this chapter shall be authorized to receive reimbursement from the Centers for Medicare and Medicaid Services (CMS) and other insurers as if they were licensed under RSA 329. If necessary to establish reimbursement for graduate physicians under Medicare or Medicaid, the commissioner of the department of health and human services shall apply for a Title XIX and/or a Title XXI state plan amendment to establish such coverage.

328-K:3 Conditions for Licensure.

I. To apply for licensure by the board as a graduate physician, an applicant shall file a written application on forms provided by the board and pay an application fee. The applicant to be licensed shall:

(a) Fulfill the requirements for physician licensure established by RSA 329:12 except for RSA 329:12, I(d)(5) and RSA 329:12, I(d)(6);

(b) Have successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination or the equivalent of such steps of any other board-approved medical licensing examination;

(c) Have proficiency in the English language; and

(d) Submit a complete set of fingerprints and a notarized criminal history record release form pursuant to RSA 328-K:4.

II. Circumstances that exist which would be grounds for disciplinary action under RSA 328-K:7 may be grounds for denial of a license.

328-K:4 Criminal History Record Checks.

I. Every applicant for initial permanent licensure or reinstatement shall submit to the board a notarized criminal history record release form, as provided by the New Hampshire division of state police, which authorizes the release of his or her criminal history record, if any, to the board.

II. The applicant shall submit with the release form a complete set of fingerprints taken by a qualified law enforcement agency or an authorized employee of the department of safety. In the event that the first set of fingerprints is invalid due to insufficient pattern, a second set of fingerprints shall be necessary in order to complete the criminal history records check. If, after 2 attempts, a set of fingerprints is invalid due to insufficient pattern, the board may, in lieu of the criminal history records check, accept police clearances from every city, town, or county where the person has lived during the past 5 years.

III. The board shall submit the criminal history records release form and fingerprint form to the division of state police which shall conduct a criminal history records check through its records and through the Federal Bureau of Investigation. Upon completion of the records check, the division of state police shall release copies of the criminal history records to the board.

IV. The board shall review the criminal record information prior to making a licensing decision and shall maintain the confidentiality of all criminal history records received pursuant to this section.

V. The applicant shall bear the cost of a criminal history record check.

328-K:5 Renewal of Licenses. Every person licensed to practice under this chapter shall apply to the board for annual renewal of license on forms provided by the board and shall pay a renewal fee as established by the board. A license issued under this chapter shall not expire until the board has taken final action upon the application for renewal.

328-K:6 Failure to Renew; Lapse.

I. Any licensee who fails to apply for renewal under RSA 328-K:5 shall pay double the renewal fee, provided the licensee applies and pays the renewal fee no later than 90 days after the expiration date. Any licensee who fails to apply for renewal of his or her license within the 90-day period after expiration, shall have his or her license lapse. A lapsed license shall be reinstated only upon payment of a reinstatement fee as established by the board, and upon showing evidence of professional

competence as the board may reasonably require.

II. If a license expires or lapses as a result of a licensee being ordered to active duty with the armed services, the licensee shall have 90 days from the date of discharge or release from the armed service to apply for renewal and all late fees shall be waived.

328-K:7 Grounds for Discipline. The board, after hearing under RSA 329:18-a, may take action against any person licensed under this chapter upon finding that the licensee:

I. Has knowingly provided false information on any application for professional licensure, whether by making any affirmative statement which was false at the time it was made or by failing to disclose any fact material to the application.

II. Is a habitual user of drugs or intoxicants or is afflicted with a physical disability, insanity, psychiatric disorder, or other disease deemed dangerous to the public health.

III. Has displayed a pattern of behavior which is incompatible with the basic knowledge and competence expected of persons in the practice of his or her profession.

IV. Has engaged in dishonest or unprofessional conduct or has been grossly or repeatedly negligent in practicing his or her profession or in performing activities ancillary to the practice of his or her profession or any particular aspect or specialty thereof, or has intentionally injured a patient while practicing his or her profession or performing such ancillary activities.

V. Has undertaken to practice independent of the referral or prescription, direction, or supervision of a physician licensed under RSA 329 or has undertaken to practice other than in a medically underserved area.

VI. Has failed to provide adequate safeguards with regard to aseptic techniques or radiation techniques.

VII. Has included in advertising any statement of a character tending to deceive or mislead the public or any statement claiming professional superiority.

VIII. Has advertised the use of any drug or medicine of an unknown formula or any system of anesthetic that is unnamed, misnamed, misrepresented, or not in reality used.

IX. Has willfully or repeatedly violated any provision of this chapter or any substantive rule of the board.

X. Has been convicted of a felony under the laws of the United States or any state.

XI. Has failed to maintain adequate medical record documentation on diagnostic and therapeutic treatment provided or has unreasonably delayed medical record transfer, or violated RSA 332-I.

328-K:8 Disciplinary Action. The board, upon making an affirmative finding under RSA 328-K:7, may take disciplinary action in any one or more of the following ways:

I. Administer a public or private reprimand.

II. Revoke, suspend, limit, or otherwise restrict a license.

III. Require the graduate physician to submit to the care, counseling, or treatment of a physician, counseling service, health care facility, professional assistance program, or any combination thereof which is acceptable to the board.

IV. Place the graduate physician on probation.

V. Require the graduate physician to participate in a program of continuing education in the area or

areas in which he or she has been found deficient.

VI. Assess administrative fines in amounts established by the board which shall not exceed $3,000 per offense, or, in the case of continuing offenses, $300 for each day that the violation continues, whichever is greater.

328-K:9 Appeals. Disciplinary action taken by the board under RSA 328-K:8 may be appealed to the supreme court under RSA 541.

328-K:10 Rulemaking.

I. The board shall adopt rules under RSA 541-A relative to:

(a) The scope of practice for a licensed graduate physician.

(b) Form and content of the application for licensure.

(c) Application procedures.

(d) Conduct of hearings under RSA 328-K:7.

(e) Standards for graduate physician education and training.

(f) Supervision of graduate physicians.

(g) Notification of changes in employment.

(h) Definition of supervision.

(i) Manner of recordkeeping under RSA 328-K:11.

(j) Except as provided in paragraph II, any other matter which is consistent with the legislative intent of this chapter and which is necessary to the administration of this chapter.

II. The board, in consultation with the New Hampshire pharmacy board, shall adopt rules under RSA 541-A relative to the prescriptions to be issued by a graduate physician.

328-K:11 Recordkeeping. The board shall keep a record of its proceedings under this chapter and a register of all persons licensed under it. The register shall list the name, last known business address, and last known residence address of each living licensee, and the date and number of the license of each licensed graduate physician. The board shall maintain and publish a list of licensed graduate physicians once a year.

328-K:12 Physician Liability. This chapter shall not be construed to relieve the responsible physician of professional or legal responsibility for the care and treatment of his or her patients.

328-K:13 Penalty.

I. Any person who, not being licensed or otherwise authorized according to the law of this state, shall advertise oneself or hold oneself out as a graduate physician, or any person who does such act after receiving notice that such person's license has been revoked, shall be guilty of a misdemeanor.

II. Any person who shall practice or attempt to practice as a graduate physician in this state without a license shall be guilty of a class A misdemeanor if a natural person or guilty of a felony if any other person.

328-K:14 Limitation on Action. A person, licensed or authorized to practice as a graduate physician under this chapter or under the laws of any other state, who, in good faith, renders emergency care at the scene of an emergency, shall not be liable for any civil damages as a result of acts or omissions by such person in rendering such emergency care, or as a result of any act or failure to act to provide or arrange for further medical treatment or care, as long as such person receives no direct compensation

for the care from or on behalf of the person cared for.

328-K:15 Rural Health Clinics. When working in a rural health clinic under the federal Rural Health Clinic Services Act of 1977, Public Law 95-210, as amended:

I. A graduate physician shall be considered a physician assistant for purposes of regulations of the Centers for Medicare and Medicaid Services (CMS); and

II. No supervision requirements in addition to the minimum federal law shall be required.

328-K:16 Graduate Physician Collaborative Practice Arrangements.

I. A physician may enter into collaborative practice arrangements with graduate physicians. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which shall be in writing, may delegate to a graduate physician the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the graduate physician and is consistent with that graduate physician's skill, training, and competence and the skill and training of the collaborating physician. Collaborative practice arrangements shall provide for graduate physicians to practice in medically underserved areas pursuant to funding under RSA 126-A:18-c.

II. The written collaborative practice arrangement shall contain at least the following provisions:

(a) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the graduate physician;

(b) A list of all other offices or locations besides those listed in subparagraph (a) where the collaborating physician authorized the graduate physician to prescribe;

(c) A requirement that there shall be posted at every office where the graduate physician is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by a graduate physician and have the right to see the collaborating physician;

(d) All specialty or board certifications of the collaborating physician and all certifications of the graduate physician;

(e) The manner of collaboration between the collaborating physician and the graduate physician, including how the collaborating physician and the graduate physician shall:

(1) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(2) Maintain geographic proximity; except, the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of 28 days per calendar year for rural health clinics under RSA 328-K:15, as long as the collaborative practice arrangement includes alternative plans as required in subparagraph (3). Such exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics if the provider is a critical access hospital as provided in 42 U.S.C. section 1395i-4, and provider-based rural health clinics if the main location of the hospital sponsor is greater than 50 miles from the clinic. The collaborating physician shall maintain documentation related to such requirement and present it to the board of medicine when requested; and

(3) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(f) A description of the graduate physician's controlled substance prescriptive authority in

collaboration with the physician, including a list of the controlled substances the physician authorizes the graduate physician to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(g) A list of all other written practice agreements of the collaborating physician and the graduate physician;

(h) The duration of the written practice agreement between the collaborating physician and the graduate physician; and

(i) A description of the time and manner of the collaborating physician's review of the graduate physician's delivery of health care services. The description shall include provisions that the graduate physician shall submit a minimum of 10 percent of the charts documenting the graduate physician's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every 14 days.

III. The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every 14 days a minimum of 20 percent of the charts in which the graduate physician prescribes controlled substances. The charts reviewed under this paragraph may be counted in the number of charts required to be reviewed under subparagraph II(i).

IV. The board under RSA 541-A shall adopt rules regulating the use of collaborative practice arrangements for graduate physicians. Such rules shall specify:

(a) Geographic areas to be covered;

(b) The methods of treatment that may be covered by collaborative practice arrangements;

(c) The requirements for review of services provided under collaborative practice arrangements, including delegating authority to prescribe controlled substances. Any rules relating to dispensing or distribution of medications or devices or controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. The board shall adopt rules applicable to graduate physicians that shall be consistent with guidelines for federally funded clinics.

V. The board shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to a graduate physician provided the provisions of this section and the rules adopted thereunder are satisfied.

VI. Within 30 days of any change and on each renewal, the board shall require every physician to identify whether the physician is engaged in any collaborative practice arrangement, including collaborative practice arrangements delegating the authority to prescribe controlled substances, and also report to the board the name of each graduate physician with whom the physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that arrangements are carried out for compliance under this chapter.

VII. A collaborating physician shall not enter into a collaborative practice arrangement with more than 3 full-time equivalent graduate physicians.

VIII. The collaborating physician shall determine and document the completion of at least a one-month period of time during which the graduate physician shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present.

IX. An agreement made under this section may govern hospital medication orders under protocols and

standing orders for the purpose of delivering inpatient or emergency care within a hospital if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

X. No contract or other agreement shall require a physician to act as a collaborating physician for a graduate physician against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular graduate physician. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any graduate physician, but such requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff.

XI. No contract or other agreement shall require any graduate physician to serve as a collaborating graduate physician for any collaborating physician against the graduate physician's will. A graduate physician shall have the right to refuse to collaborate, without penalty, with a particular physician.

XII. All collaborating physicians and graduate physicians in collaborative practice arrangements shall wear identification badges while acting within the scope of their collaborative practice arrangement. The identification badges shall prominently display the licensure status of such collaborating physicians and graduate physicians.

XIII. A graduate physician may prescribe any controlled substance listed in Drug Enforcement Administration (DEA) schedule III, IV, or V and may have restricted authority in schedule II, when delegated the authority to prescribe controlled substances in a collaborative practice arrangement. Prescriptions for schedule II medications prescribed by a graduate physician are restricted to only those medications containing hydrocodone. Such authority shall be filed with the board. The collaborating physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the graduate physician is permitted to prescribe. Any limitations shall be listed in the collaborative practice arrangement. Graduate physicians shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and schedule II hydrocodone prescriptions shall be limited use in an inpatient hospital setting or to a 5-day supply without refill. Graduate physicians who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

XIV. The collaborating physician shall be responsible to determine and document the completion of at least 124 hours in a 4-month period by the graduate physician during which the graduate physician shall practice with the collaborating physician onsite prior to prescribing controlled substances when the collaborating physician is not onsite. Such limitation shall not apply to graduate physicians of population-based public health services.

2 328-K:17 Graduate Physician Oversight Committee

There shall be established a Graduate Physician Oversight Commission to study whether graduate physicians have expanded access to healthcare in Medically underserved areas in both a safe and a cost effective manner.

I. The Commission shall be composed of 9 members, as follows:

(a) The Commissioner of Health and Human Services, or designee

(b) A representative of the Board of Medicine

(c) A representative of the Commission on Primary Care Workforce Issues

(d) A primary care physician, currently practicing in a medically underserved area, appointed by the NH Medical Society

(e) An APRN, currently practicing in a medically underserved area, appointed by the NH Nurse Practitioner Association.

(f) Three members of the house of representatives, appointed by the speaker of the house of representatives, at least one of whom shall be a member of the house health, human services and elderly affairs committee and one of whom shall be a member of the executive departments and administration committee.

(g) One member of the senate, appointed by the president of the senate.

II. Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

III. The commission's study shall include, but not be limited to, whether the Graduate Physician Pilot Program has expanded access to healthcare in medically underserved areas, whether it has been cost effective, and whether public safety is adequately ensured. The commission shall solicit information from any person or entity the commission deems relevant to its study.

IV. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named house member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Five members of the commission shall constitute a quorum.

V. The commission shall make an interim report annually on or before October 1 of each year, and make a final report of its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the president of the senate, the house clerk, the senate clerk, the governor, and the state library on or before October 1, 2024.

3 New Paragraph; Physicians; Person Excepted. Amend RSA 329:21 by inserting after paragraph XVI the following new paragraph:

XVII. To such graduate physicians as have been licensed under RSA 328-K while acting under the terms of that chapter.

4 Professionals Health Program; Graduate Physicians Added. Amend RSA 329:13-b to read as follows:

329:13-b Professionals' Health Program.

I. Any peer review committee may report relevant facts to the board relating to the acts of any physician [or], physician assistant, or graduate physician in this state if it has knowledge relating to the physician [or], physician assistant, or graduate physician which, in the opinion of the peer review committee, might provide grounds for disciplinary action as specified in RSA 329:17.

II. Any committee of a professional society comprised primarily of physicians, its staff, or any district or local intervenor participating in a program established to aid physicians impaired or potentially impaired by mental or physical illness including substance abuse or disruptive behavior may report in writing to the board the name of a physician whose ability to practice medicine safely is impaired or could reasonably be expected to become impaired if the condition is allowed to progress together with the pertinent information relating to the physician's impairment. The board may report to any committee of such professional society or the society's designated staff information which it may receive with regard to any physician who may be impaired by a mental or physical illness including substance abuse or disruptive behavior. In this chapter, "disruptive behavior" means any abusive

conduct, including sexual or other forms of harassment, or other forms of verbal or nonverbal conduct that harms or intimidates others to the extent that quality of care of patient safety could be compromised.

III. Notwithstanding the provisions of RSA 91-A, the records and proceedings of the board, compiled in conjunction with a peer review committee, shall be confidential and are not to be considered open records unless the affected physician so requests; provided, however, the board may disclose this confidential information only:

(a) In a disciplinary hearing before the board or in a subsequent trial or appeal of a board action or order;

(b) To the physician licensing or disciplinary authorities of other jurisdictions; or

(c) Pursuant to an order of a court of competent jurisdiction.

IV.(a) No employee or member of the board, peer review committee member, medical organization committee member, medical organization district or local intervenor furnishing in good faith information, data, reports, or records for the purpose of aiding the impaired physician [or], physician assistant, or graduate physician shall by reason of furnishing such information be liable for damages to any person.

(b) No employee or member of the board or such committee, staff, or intervenor program shall be liable for damages to any person for any action taken or recommendations made by such board, committee, or staff unless the person is found to have acted recklessly or wantonly.

V.(a) The board may contract with other organizations to operate the professionals' health program for physicians [and], physician assistants, and graduate physicians who are impaired or potentially impaired because of mental or physical illness including substance abuse or disruptive behavior. This program shall be available to all physicians [and], physician assistants, and graduate physicians licensed in this state, all physicians [and], physician assistants, and graduate physicians seeking licensure in this state, and all resident physicians in training, and shall include, but shall not be limited to, education, intervention, ongoing care or treatment, and post-treatment monitoring.

(b) [Repealed.]

VI. Upon a determination by the board that a report submitted by a peer review committee or professional society committee is without merit, the report shall be expunged from the physician's [or], physician assistant's, or graduate physician's individual record in the board's office. A physician, [or], physician assistant, or graduate physician, or authorized representative shall be entitled on request to examine the peer review or the organization committee report submitted to the board and to place into the record a statement of reasonable length of the physician's [or], physician assistant's, or graduate physician's view with respect to any information existing in the report.

5 Board of Medicine; Hearings Panel. Amend RSA 329:18-a, I to read as follows:

I. Allegations of misconduct or lack of professional qualifications which are not settled informally shall be heard by the board or a panel of the board, with a minimum of 3 members appointed by the president of the board. The panel for a hearing on a physician-licensee shall consist of a minimum of 2 physicians and one public member. The panel for a hearing on a physician assistant-licensee shall consist of a minimum of one physician, one physician assistant, and one public member. The panel for a hearing on a graduate physician licensee shall consist of a minimum of 2 physicians, and one public member. Such hearing shall be an open public hearing. Any member of the board, or other person qualified to act as a hearing officer and duly designated by the board, shall have the authority to preside at such a hearing and to issue oaths or affirmations to witnesses.

6 Repeal. Section 1 of this bill is repealed July 1, 2024. Section 2 of this bill is repealed October 1, 2024.

7 Effective Date. Sections 1 thru 5 shall take effect July 1, 2019. Section 6 shall take effect as listed in that section.

Dear Friend:

New Hampshire's economy is remarkably strong, with historic revenue estimates and a record-low unemployment rate. Businesses across the state, however, have difficulty filling vacancies due to a lack of workforce, which not only slows the state's economic potential, but also impedes the ability of for and nonprofit businesses to thrive, fulfill their missions, and serve those in need. The workforce shortage is most significant in the health care sector, where the shortage of clinicians and direct care providers limits patient access to services and causes a rationing of needed care. In 2019, the Granite State is uniquely positioned to make investments designed to recruit, retain, and advance our health care workforce in order to meet the heath care needs of our residents. That is why a coalition of provider organizations, health care advocates, and health policy experts created the proposal outlined below that will incent students to seek health care degrees and stay in New Hampshire upon graduation, incent current direct care providers to advance up the career ladder, and provide health care organizations the tools to recruit and retain clinicians.

The state recently made significant investments in our health care infrastructure through the integrated delivery networks and the hub and spoke model created to address opioid use disorder. The new 10-year mental health plan, released recently, indicates a need for significant investments to address the mental health needs of our state. The investments made are remarkable, but they do not address one fundamental problem: New Hampshire does not have the workforce necessary to fill the current vacancies or meet the current needs of our residents. Health care organizations across the spectrum report that they do not have the staff needed to accomplish the goals set forth by the state of truly integrated primary care, behavioral health, substance use disorder treatment, and oral health. The infrastructure created by the state will be meaningless without a strong health care workforce trained to provide services throughout the continuum of care.

In the 2018 legislative session, more than 50 bills were filed to address workforce shortages. These ranged from regulatory reform, criminal background checks, and licensing reciprocity, to increased funding for the State Loan Repayment Program. Most of these bills did not pass because the conversations, while earnest, were unfocused. More importantly, none of the bills addressed New Hampshire's health care workforce challenges systematically. Provider organizations and advocates across the state spent the past few months examining and measuring workforce needs, discussing how to address them from a state government perspective, and drafting potential solutions to best serve the needs of the health care workforce. To best tackle the health care workforce challenge in 2019, we propose drafting a legislative package that combines key policy and budget topics in a single bill that we ask the legislature to consider as one proposal. This concerted effort addresses the most immediate workforce needs, connects the facts and the data in support of both the shortage and the solutions, and links financial and economic considerations to these policies.

The need is known and measurable by those in the health care industry, and exists throughout the state and the health care industry. For example, within the state's 10 Community Mental Health Centers (CMHCs), there are 217 clinical vacancies. This vacancy rate grew by over 20% in the past 24 months. The lack of access to community-based care leads directly to emergency room

backup at local hospitals, while individuals in mental health crisis wait for beds at New Hampshire Hospital. The Recruitment Center, a service of Bi-State Primary Care Association, tracks clinical vacancies and reported that there are over 50 primary care clinician vacancies at community-based providers. More than a third of these vacancies exist at Community Health Centers, which are located in medically underserved areas throughout the state. The state's hospitals also face staffing vacancy rates in the thousands; and some nursing homes are taking beds offline due to the lack of staff. Our Area Agencies, which serve people with developmental disabilities and acquired brain disorders, have not received a Medicaid rate increase in over a decade. The developmental disabilities system has hundreds of job vacancies each month and providers cannot fill the vacancies with qualified staff. Without a rate increase in the next biennium, people with disabilities will continue to be put at risk of not receiving the services they need.

New Hampshire continues to be recognized as one of the oldest (by age) states in the country. The New Hampshire Center for Public Policy Studies (NHCPPS) found that by 2030, nearly half a million of the state's residents will be over the age of 65 and will account for nearly one-third of the total population. The vast majority of Granite Staters prefer to live in their own homes and communities for as long as possible; avoiding more costly placement in skilled nursing facilities, yet New Hampshire continues to struggle with providing adequate Long Term Supports and Services (LTSS) to support all of us as we age. The state continues to rank at the very bottom in the country as it relates to Medicaid spending on LTSS versus spending on Institutional Care. AARP reports that between the years of 2011 and 2016, New Hampshire actually spent less on LTSS even though the population of older people in the state is steadily increasing. This unbalanced approach to funding long term care can be felt strongly in the state's health care workforce. In SFY 2018, approximately $20 million in Home and Community Based Services (HCBS) were authorized through the Medicaid Choices for Independence Waiver (CFI) but not accessed and/or paid, in large part due to the scarcity of direct care professionals, nurses, and home health aids available to provide those essential services. New Hampshire simply cannot afford to ignore the lack of health care workforce any longer.

State government has the tools at its disposal to alleviate this workforce crisis, including the ability to invest in programs that already exist. Below is a brief outline of the solutions contained in this proposal that we believe will move the state forward.

1. Health Care Pipeline Investments: New Hampshire's communities have tried and tested a variety of programs to develop and grow the next generation of health care workers. These programs were traditionally funded by private foundations or federal grants and administered through agencies that specialize in this area such as New Hampshire Area Health Education Centers and the Citizens Health Initiative. However, our state needs consistent state capital and operating budget support to meet the workforce needs that exist today, and which demographics suggest will become even more challenging in the future. Our students need exposure to and experience with health careers in elementary, middle, and high schools through job shadowing experiences, volunteer opportunities, and summer educational and simulation programs. Students in associates or bachelor-degree programs need opportunities for mentorship, clerkship, and community-based learning. Our current health care workers who want to increase their education and skills

need access to training programs that can be fit into their existing work schedules as well as access to tuition reimbursement or continuing education funding, so they can advance and remain financially viable. We propose creating targeted scholarships with service commitments and career advancement programs designed to attract and retain the health care workforce. We believe that these programs will compliment Governor Sununu's proposal to reintroduce the Licensed Practical Nurse Program, increase the number of nursing and therapist graduates, and create Licensed Alcohol and Drug Counselor programs.

New Hampshire competes nationally to attract, recruit and retain primary care providers, including family physicians, psychiatrists, psychiatric nurse practitioners, and dentists. Health care practices across the state need support in promoting their vacancies to providers in training and in practice in other states. An efficient way to accomplish this is to develop a unified brand message, and a centralized marketing and outreach campaign that can be used by practices across the state to bring greater visibility for all New Hampshire vacancies. Bi-State Primary Care Association's Recruitment Center has established systems in place to reach out to potential candidates and to support practices with their recruitment needs. We propose making a targeted investment of $500,000 in the Recruitment Center for resources to collaboratively develop the brand message and allow the Recruitment Center to implement a robust national marketing and outreach campaign that will bring additional providers to the state.

The State Office of Rural Health, situated within the New Hampshire Department of Health and Human Services, offers technical assistance to rural health care providers and organizations and provides health care related information to rural health care stakeholders. The SORH is the only state agency tasked with tracking health care vacancies statewide and planning for current and future health care workforce needs. Current statute allows the SORH to collect data from willing licensees that it then uses to advise legislators, policymakers, and the Commission on Primary Care Workforce on the health care workforce needs of our state. However, the statute is written in such a way that response is considered optional. Thus, the response rate is so low that the data is rendered useless. We propose requiring health care professionals respond to the SORH survey during the licensure process to ensure that the State has accurate data that can inform our policymakers moving forward.

2. Advanced Training Programs: The majority of primary care, behavioral health, and substance use disorder treatment is provided in community settings, yet doctors, nurses and other advanced practitioners traditionally train in hospital-based residency and fellowship programs located in larger cities. New Hampshire needs to establish more accredited community-based advanced training in order to increase access to care in targeted communities to provide health professionals with formal educational and training in settings similar to where they will ultimately practice. One program that could be replicated in New Hampshire is the Teaching Health Center Graduate Medical Education Program, which provides training in community-based ambulatory care settings such as community health centers. Another is the Nurse Practitioner Fellowship Program hosted by Lamprey Health Care in Newmarket. Through a formal

mentoring and precepting program, Family Nurse Practitioners gain confidence and competence by working with complex patients. An investment in establishing accredited residency/fellowship programs will help our state compete to attract and retain these professionals to establish and maintain their careers in the state.

3. Investment in the State Loan Repayment Program (SLRP): This program is administered by the Department of Health and Human Services and provides funding to health care professionals who work in medically underserved areas for a minimum of three years for full-time clinicians. It is a best practice and the most effective tool for practices in rural and underserved areas of the state to attract and retain providers. However, the program is extremely limited both in size and scope: it currently offers fewer than 50 new contracts per year and has been historically funded at $169,000 per year. We propose investing $5 million in the next biennium that will enable DHHS to expand eligible clinician types, generate over 200 contracts with clinicians, add an additional FTE to assist in managing the contracts, and better position health care providers to recruit and retain clinicians in medically underserved areas across the state.

4. Investment in Medicaid providers: New Hampshire offers one of the lowest Medicaid reimbursement rates in the nation and many Medicaid providers have not received a rate increase in years. Low reimbursement remains a threat to New Hampshire's Medicaid program because it allows providers in other states to attract clinical staff away from organizations that serve our Medicaid enrollees. We propose that as a base line, the state increase reimbursement rates by 5% in 2020 and by 7% increase in 2021 for all Medicaid providers. This rate increase will cost an estimated $35 million in general funds in 2020 and $53 million in 2021. In addition to a base line increase, there is a need for more enhanced rate adjustments for some critical providers, including those who are working the SUD, mental health, and home care arenas. We also propose establishing a limitation on the county cap, freezing it at the current levels, to ensure that this Medicaid investment will not negatively impact county taxpayers.

5. Administrative relief: Administrative burdens weigh down the delivery of care, misdirecting staff time and dollars that could be used for direct services. The introduction of managed care into the Medicaid system has dramatically increased administrative costs for Medicaid providers. Therefore, we propose crafting a process to eliminate unnecessary and/or duplicative administrative requirements: in particular, a program offering providers or license holders the opportunity to petition JLCAR to have unnecessary and/or duplicative administrative rules suspended for up to a year. During this suspension period, state agencies would be able to edit, propose permanent elimination of, or argue for reinstatement of the rule. This process would likely require some additional staff and legal support to the Office of Legislative Services' Administrative Rules division. Cost is estimated at $1 million for the biennium to fund three to four FTEs to support this program.

6. Spend down: Spend down requirements within New Hampshire's Medicaid program obligate low-income consumers to spend down their limited monthly funds to qualify for Medicaid coverage. As a result, they churn "in and out" of Medicaid. The administrative

cost of managing this requirement is a burden on the consumer, providers, the Managed Care Organizations that manage the Medicaid program, and the state. Reforming the system to adjust the income requirements for this population will reduce the number of spend down consumers and thus reduce administrative burdens and improve care. We estimate the cost of reforming "spend down" is $8 million.

7. Background checks: Background checks for new employees should be a small item in the workforce challenge, but the current process is slow and requires applications to be reviewed at a central location in Concord. Meanwhile, recent changes in state law now require background checks for even more potential employees. In other states, these background checks are completed online and turned around quickly; and employers and potential employees are not delayed in the hiring process. We propose directing and supporting the Department of Safety in implementation of an online background check system as soon as possible.

8. Telehealth: Telehealth or telemedicine provides an opportunity to expand access to care and utilize existing health care resources more efficiently. However, legacy regulations and disputes over reimbursement rates have slowed the proper deployment of telehealth innovation in New Hampshire. We propose expanding the types of clinicians and facilities eligible to offer telehealth to Medicaid enrollees, reducing the regulatory burdens associated with telehealth, and creating incentives for capital investments needed for non-profit providers.

As outlined above, this legislative package of policy and budget initiatives includes an ambitious but achievable set of tools that will make real progress in addressing the state's health care workforce challenges. The goal of this effort is to build a strong consensus in both state government and the legislature to put health care workforce issues at the top of the agenda for the 2019 session. While some of cost of this effort is still under consideration, the necessary investment for this proposal from the state's general fund will likely sizable for the next biennium. However, some of these dollars will be one-time funds and some of the reforms to the system will help control costs in the future.

We developed this set of policies and approaches over the last several months, with the goal of developing a legislative and budget package for 2019. We hope that you will consider and support this systematic approach to addressing our health care workforce crisis. Our proposal builds on work that has been considered by a number of executive branch, legislative, and private sector research reports and reviews. This health care workforce campaign is supported by the following organizations:

{list organizations}