

Legislative Commission on Primary Care Workforce Issues

November 21, 2019 2:00-4:00pm at the NH Hospital Association –Conference Room 1,
125 Airport Road, Concord

Call in information:

(267) 930-4000

Participant Code: 564-395-475

Happy National Rural Health Day!

Agenda

- | | |
|-------------|--|
| 2:00 - 2:10 | Welcome and Introductions |
| 2:10 – 2:50 | Endowment for Health Workforce Grant – Yvonne Goldsberry |
| 2:50 – 3:40 | Age-Friendly Health Systems – Keliene Totten, M.Ed., MCHES, Vice President of Community Engagement, Concord VNA and Betsey Rhyhart, MPH, Executive Director, NH-Cares ACO and Vice President, Population Health, Concord Hospital |
| 3:40 - 4:00 | Updates <ul style="list-style-type: none">• LSR• SLRP Summit• UNH Nursing Project• AHEC mailing list |

Next meeting: Thursday December 19, 2:00-4:00pm

State of New Hampshire
COMMISSION ON PRIMARY CARE WORKFORCE ISSUES

DATE: November 21, 2019

TIME: 2:00 – 4:00pm

LOCATION: New Hampshire Hospital Association (Rm 1)

Meeting Notes

TO: **Members of the Commission and Guests**

FROM: Danielle Weiss

MEETING DATE: November 21, 2019

Members of the Commission:

Rep. Polly Campion, NH House of Representatives

Laurie Harding – Chair

Alisa Druzba, Administrator, Rural Health and Primary Care Section – Vice-Chair

Stephanie Pagliuca, Director, Bi-State Primary Care Association

Mike Auerbach, New Hampshire Dental Society

Mary Bidgood-Wilson, APRN, NH Nurse Practitioner Association

Donald Kollisch, MD, Dartmouth-Hitchcock Medical Center

Kristina Fjeld-Sparks, Director, NH AHEC

Mike Ferrara, Dean, UNH College of Health and Human Services

Bill Gunn, NH Mental Health Coalition

Pamela Dinapoli, NH Nurses Association

Guests:

Danielle Weiss, Health Professions Data Center Manager, Rural Health and Primary Care

Leslie Melby, NH Medicaid

Paula Minnehan, NH Hospital Association

Nancy Frank, Executive Director, NNH AHEC

Mike Padmore, NH Medical Society

Anne Marie Mercuri, QI Nurse – Maternal and Child Health Section, DPHS

Barbara Mahar, New London Hospital

Geoff Vercauteren, Director, Workforce Development-CMC

Kristine Stoddard, Bi-State Primary Care Association

Peter Ames, Foundation for Healthy Communities

Maggie Pritchard, Lakes Regional Mental Health Center

Marcy Doyle, UNH IHPP

Meeting Discussion:

2:00 - 2:10 **Welcome and Introductions** – Laurie Harding – Chair, NH Commission on Primary Care Workforce Issues

- UNH received \$9m from state to address nursing workforce
 - o Working with admissions office on recruitment
 - o Will use certified simulation lab – up to 50% of clinical hours in that learning environment
 - o A way to overcome the barrier of limited space in clinical sites
 - o Working with a contractor to establish this

- Adding new programs
 - 2 NP programs in acute care and psychiatric mental health
 - OT doctorate
- \$200k for scholarships for education
 - First behavioral health scholars group will be announced in December
- Grant funding received
 - Able to pay for 8 part-time and full-time-students' tuition
 - Used for housing too
 - Telepresence and substance use and behavioral integration
 - Demoing bot on 12/5
 - Delivery of care
 - Partnering with AHECs etc. to look at needs of preceptors, NP specialists, etc.
 - Developing another ECHO next year

2:10 – 2:50 **Endowment for Health Workforce Grant** – Yvonne Goldsberry

Refer to presentation “Endowment for Health Workforce Grant.”

2:50 – 3:40 **Age-Friendly Health Systems** – Keliame Totten, M.Ed., MCHES, Vice President of Community Engagement, Concord VNA and Betsey Rhynhart, MPH, Executive Director, NH-Cares ACO and Vice President, Population Health, Concord Hospital

Refer to presentation “Age-Friendly Health Systems.”

3:40 - 4:00 **Updates**

- **LSR**

Refer to “LSR 20-2958.”

- Reauthorization bill to extend Commission for 4 more years
 - Duties updated
 - Likely sponsors: Grey, Bradley, Sherman, Campion, Hennessey
 - At least 1 Republican sponsor
 - Commission on Commissions reached out about reports
 - Danielle Weiss to link to SLRP and Data Center reports on the DHHS Commission webpage

- **SLRP Summit**

- Slotted for 12/3
 - 47 external, 11 internal RSVPs
 - Alisa to send out agenda next week
- Exact funding for SLRP is up in the air
 - Back of the budget cuts from DHHS, \$25m
 - Unsure of how much they'll come for, if any at all

Next meeting: Thursday December 19, 2:00-4:00pm

Workforce Grant Program Stakeholder Recommendations

Legislative Commission on
Primary Care Workforce Issues

November 21, 2019



“The transferred funds will be held as part of the Endowment for Health’s permanent fund, with the income only to be used to promote aid to health care providers servicing medically underserved populations.”

Stakeholder Overall Guidance:

Criteria for Evaluating Opportunities

- Address “pinch points” in the system
- Allow us to achieve the greatest impact for the scale of dollars available
- Address what makes sense sequentially
- Build on/leverage work already being done
- Have both short-and long-term benefits
- Fill a gap not covered by the State or other partners
- Support the complicated and less popular things that others won’t fund
- Align with the Endowment’s values and the field’s underlying principles about the type of workforce we need

Stakeholder Overall Guidance:

Guiding Principles




- Benefit underserved communities
- Build cross-disciplinary teams
- Support coordination of care
- Benefit New Hampshire
- Benefit potential workers who would not be able to enter the field without financial support
- Take full advantage of the talents and skills of the diverse members of our community

Stakeholder Overall Guidance:

Definitions

- Interpret “aid to health care providers” broadly.
- Define “medically underserved” as including organizations that serve “medically underserved” even if the organization itself is not physically located in a designated “medically underserved” area.

Stakeholder Recommendations

- Focus on student placements/preceptors
- Leverage existing work 
- Be realistic 
- Recognize that student placement is just the starting point 

AGE-FRIENDLY HEALTH SYSTEMS

Betsey Rhynhart, MPH, Vice President of Population Health, Concord Hospital and Executive Director, NH-Cares ACO

Keliane Totten, M.Ed, MCHES, Vice President of Community Engagement, Concord Regional VNA



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Age-Friendly Health System

Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement in partnership with the American Hospital Association and the Catholic Health Association of the United States.

The goal of the initiative is to develop an Age-Friendly Health Systems framework and rapidly spread to 20 percent of U.S. hospitals and health systems by 2020.



Age-Friendly Health Systems

Four Core Organizations

- The John A. Hartford Foundation
- Institute for Healthcare Improvement (IHI)
- American Hospital Association (AHA)
- Catholic Health Association of the United States (CHA)

Five Age-Friendly Health Systems Pioneers

- Anne Arundel Medical Center (Headquarters: Annapolis, MD)
- Ascension (Headquarters: St. Louis, MO)
- Kaiser Permanente (Headquarters: Oakland, CA)
- Providence St. Joseph Health (Headquarters: Renton, WA)
- Trinity Health (Headquarters: Livonia, MI)



New Hampshire

- Capital Region Health Care
- Elliot Health System
- Dartmouth Hitchcock Centers on Aging
- Parkland Medical Center



What is an Age-Friendly Health System?

An Age-Friendly Health System is one in which every older adult:

- Gets the best care possible;
- Experiences no health care-related harms; and
- Is satisfied with the health care he or she receives.

In an Age-Friendly Health System, value is optimized for all — patients, families, caregivers, health care providers, and the overall system.



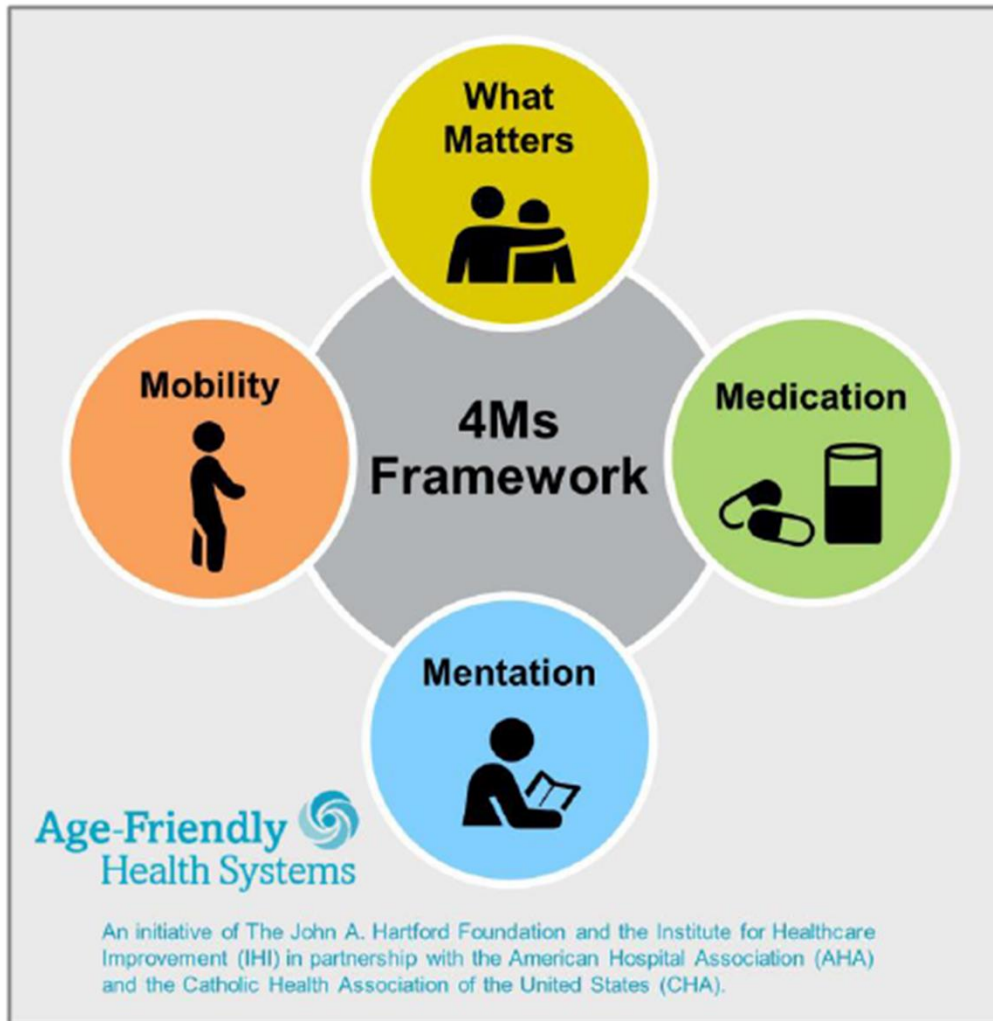
IHI Action Learning Community

- 7-month Action Community started in September 2018
- Participating as Capital Region Health Care
- Monthly Interactive Webinars
- Ability to test age-friendly interventions
- Shared data on a set of standard age friendly measures

- CRHC's team during this Action Learning Community phase is: Concord Regional VNA, CH Nursing, Care Management, CH Pharmacy, CH Population Health, CH Emergency Department



4M's Framework of an Age-Friendly Health System



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

For related work, this graphic may be used in its entirety without requesting permission.
Graphic files and guidance at ihi.org/AgeFriendly

Example Provided by Mary Tinetti, MD

The goal is to have the “4 Ms” become the focus of decision making not an add on. For example, if some one has heart disease and lung disease, find out what activities the person wants to do (the What Matters).

Then you decide what care helps them accomplish these activities and which medications may be impeding these activities (stop them)and what medications for their heart or lung disease may help them achieve their activities better or easier Start them.

Then determine whether cognitive impairment or mobility issues are impediments to achieving the activities that matter most. If so, consider what care such as home aides or PT can be added.

This is not something that occurs in one visit but becomes the focus for all encounters.



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What is Capital Region Health Care?



Our Reach in New Hampshire



Concord Regional VNA

Primary Service Area: 42 towns
FY17 Community Benefits: \$4.3M
Total job impact: 400
Average Daily Census: 2,000

Primary Service Area: 28 towns in 30-40 min drive
FY17 Community Benefits: \$54M
Total job impact: 6,500
Unique patients: 118,000
Hospital admissions: 20,000; **ED visits:** 68,000
Outpatient visits: over 500,000

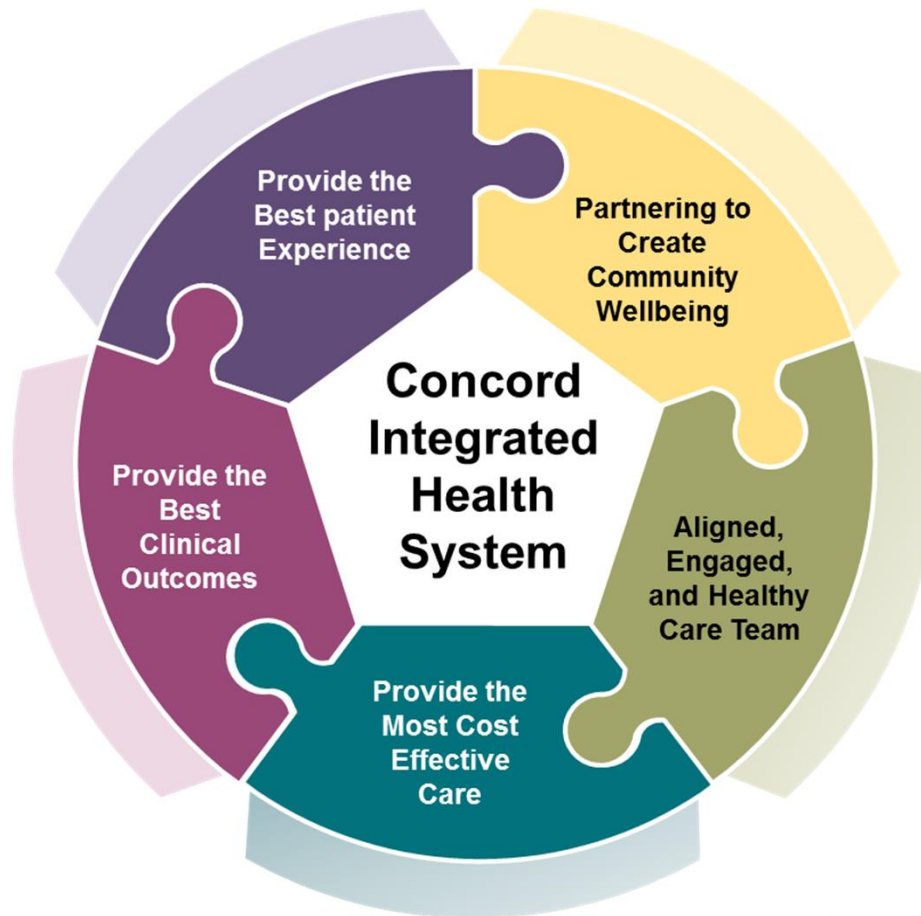


ROUTE SYMBOLS / LOCATION ICONS: © ThinkStock, Inc., 2014. All Rights Reserved.

10 Primary Care Practices in **13** locations | **7** Satellite Laboratory sites | **2** Imaging Centers | **3** Satellite Specialty Care Clinics

What are we trying to achieve across all Populations?

An integrated model of exceptional service delivery, sustainable resource stewardship, a highly engaged and healthy care team, and partnerships to create community wellbeing.



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Why? What we know about our Older Population

Aging:

- ✓ The 65+ population is projected to grow by 17% over the next five years. This growth will impact the demand for and type of healthcare services needed.
- ✓ More than 1 in 10 adults in the service area is a veteran and more than half are 65 or older.

Chronic Conditions:

- ✓ A high percentage of Medicare beneficiaries suffer from one or more chronic conditions.

Social Vulnerability:

- ✓ While social vulnerability exists in census tracts across the service area some of the highest levels of vulnerability primarily exist within the city of Concord:
 - Many of the Concord census tracts with higher % of individuals over 65, also have higher rates of poverty, transportation challenges, higher rates of disability and housing challenges

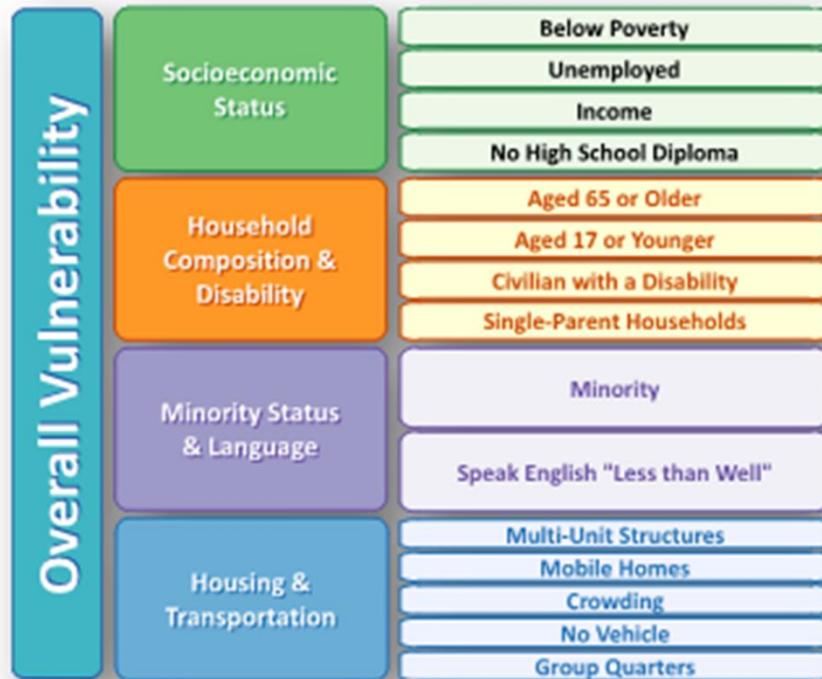
Behavioral Health & Substance Use:

- ✓ Impact of depression, social isolation, substance use



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Vulnerable Population



The Social Vulnerability Index (SVI) uses U.S. Census data to determine the social vulnerability of every census tract. The SVI ranks each census tract on 15 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes:

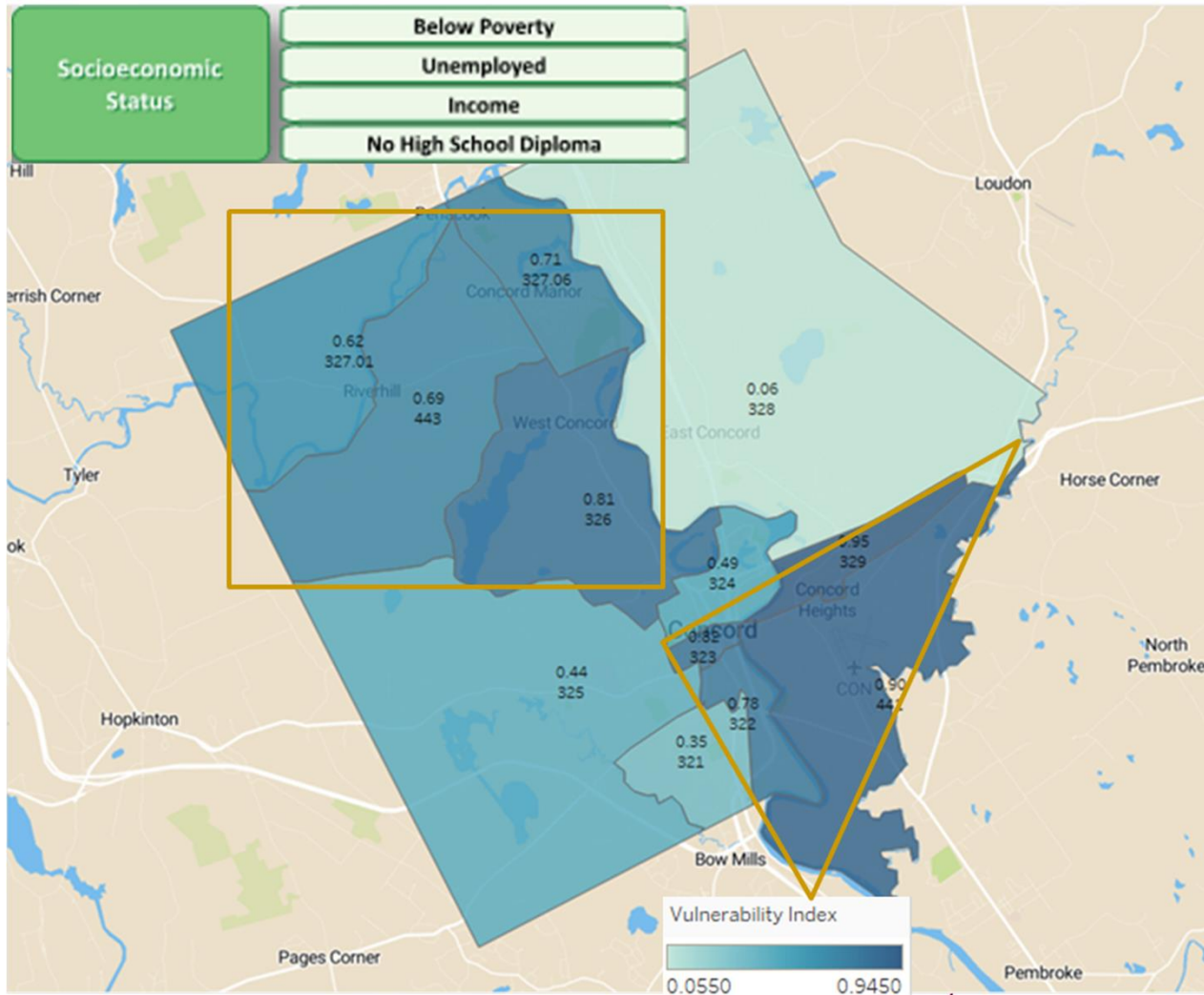
- Socioeconomic
- Housing Composition and Disability
- Minority Status and Language
- Housing and Transportation

Percentile ranking values range from 0 to 1, with higher values indicating greater vulnerability.

At-risk populations defined as "individuals with social risk factors for poor health outcomes such as low socioeconomic position, social isolation, residing in a disadvantaged neighborhood, identifying as a racial or an ethnic minority, having a non-normative gender or sexual orientation, and having limited health literacy."

Vulnerable Population – Older Residents

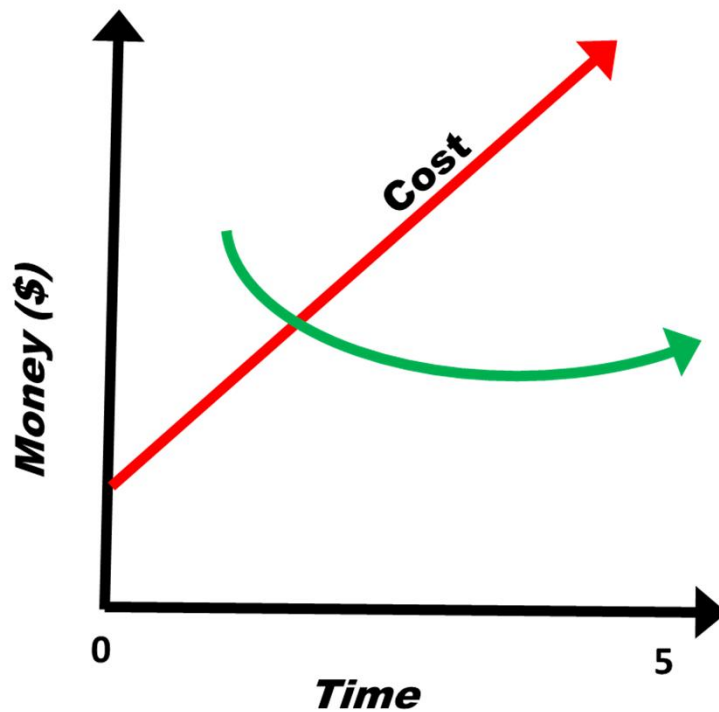
Concord Census Tracts - Social Vulnerability Index - Socioeconomic Theme



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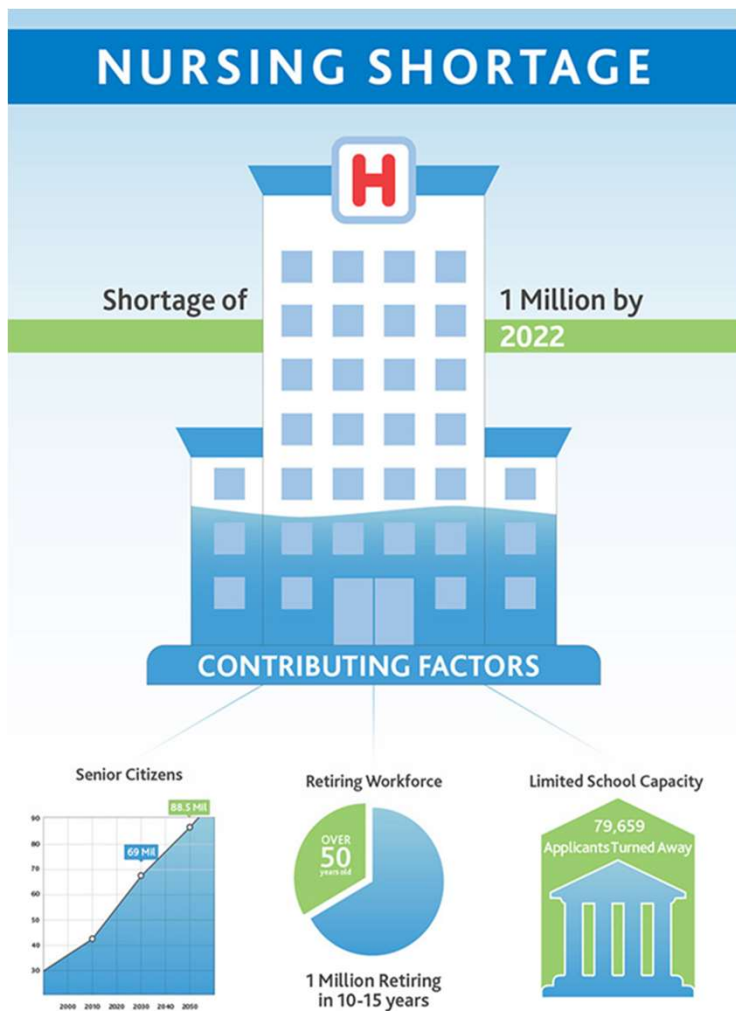
Financial Pressures – Do More for Less

21	14	7	0	7	14
Y_0	Y_1	Y_2	Y_3	Y_4	Y_5



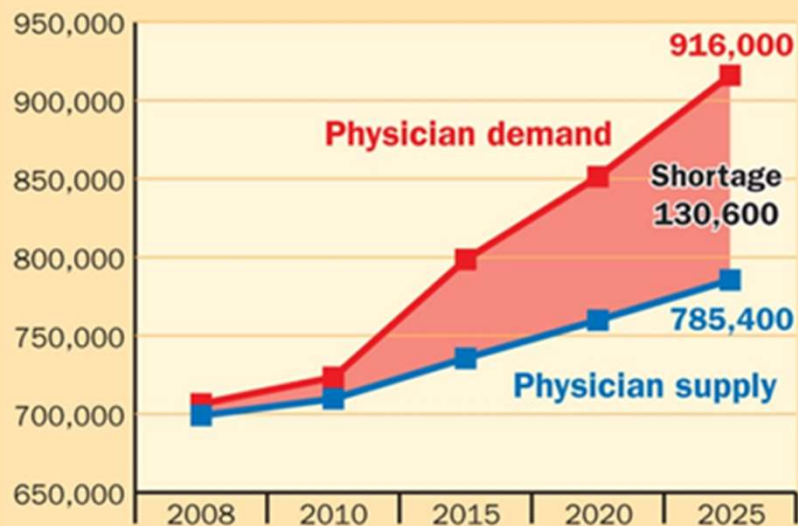
**3% shift
annually
from
Commercial
to Medicare
= \$7M loss**

Workforce Shortages



Projected doctor shortage

Aging baby boomers, limited federal funding for residencies and other factors contribute to a widening gap between doctor supply and demand.



SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES

KEVIN O'NEILL / STAFF ARTIST

Age Friendly Health System Key Performance Indicators

Age Friendly Measure	Current State - CRHC
% 30-day readmissions, 65+	13.34%
Emergency Department visits, 65+	511 per month
% High Risk Delirium, 65+	50% (Medical/Surgery Unit Study 2018)
% Screened Positive Delirium, 65+	43% (Medical/Surgery Unit Study 2018)
% Screened Delirium	100% ICU only
% of Inpatient Admissions, 65+	50%
% Depression screening, Medicare	70% (Based on historical data, CHMG practices only)

* Reporting period: Jan-Oct 2018 unless noted otherwise



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Capital Region Health Care – Our Approach

Initial Workgroups formed in Fall 2018:

- Inpatient
- Emergency Department
- Transitions in Care

Projects identified based on:

- ✓ Data
- ✓ Build on existing work to more deeply understand current state of 4Ms:
 - Connect with existing inpatient Delirium Initiative
 - Connect with pilot of pharmacist in Internal Medicine
 - Connect with strategic priorities (reducing falls, avoidable ED, patient experience, population health)
- ✓ Interest across all groups to know What Matters



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Project 1: Inpatient 4Ms Current State Assessment

Approach:


- ✓ Data analysis
- ✓ Direct observation of 2 of the 4Ms in workflow in Emergency Department, Floor, Discharge
 - 2 M's: Mentation, Mobility
 - Nursing, Physicians, PT, Support
 - Screening & assessment, documentation, decision support in medical record, team communication
- ✓ Completed end of February, final report is in process
- ✓ Continued expansion of Delirium Initiative



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Mentation/Delirium Screening Current State



- **ER:** Provider assesses if patient is at high risk for delirium  Delirium Order Set placed
- **ICU:** Nurses consistently perform a CAM-ICU delirium screening every 12 hours and document findings in Cerner.
- **Other Inpatient Units:** Nurses assess mental status and if a change is noted, notify the provider and, if needed, the Delirium Nurse Specialist.

Mentation/Delirium Provider Current State

Provider

- Delirium Order Set initiated if at high risk for delirium
 - Initiate Delirium Nursing Guidelines
 - Address sensory impairment
 - Keep awake with lights on /shades open during day
 - Toileting q 2 hrs
 - Safe Sleep Protocol
 - Medication order support
 - Notify Therapeutic Arts and Holistic Services



Is my patient at *risk* for Delirium

Any patient Age 70 or older, with:

Any history from List A + one or more triggers from List B= **HIGH RISK**

List A

- Dependence on alcohol or sleeping meds
- Cognitive impairment
- Prior stroke
- Visual impairment
- Hearing impairment
- Prior delirium
- Impaired mobility
- Malnutrition
- Advanced age
- Dependency in 3 or more ADLs
- Active medicines if not for schizophrenia:
Haldol, Seroquel, Risperidal, Zyprexa
- Medicines that cause withdrawal if stopped: Lorazepam, Clonazepam, Ambien
- Medicines for dementia treatment:
Aricept, Namenda

List B

- Severe illness, e.g. sepsis
- CNS infection, bleeding, stroke
- Drug withdrawal
- Pain
- Hypoxemia
- Fluid/electrolyte imbalance
- Anticholinergic medicines
- Surgery
- Use of restraints
- Prolonged sleep deprivation
- Fecal impaction
- Urinary retention or UTI

Remember:

Delirium can be displayed as too agitated or too quiet!



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Mentation/Delirium Nursing Current State

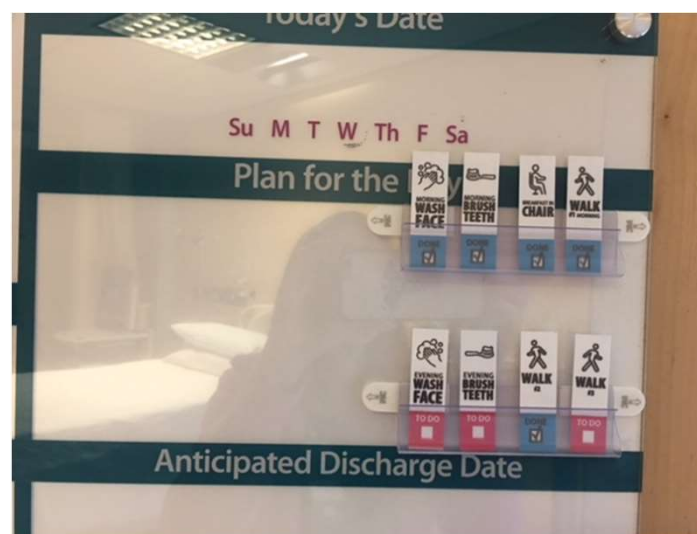
Nursing

Delirium Prevention on all inpatients:

- **UP BY 10**
 - Lights on/shades up
 - Correct vision and hearing
 - Face washed/oral care given
 - OOB to chair
- **Visual Management System**



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Mentation/Delirium Nursing Current State

Nursing

If suspect delirium or ICU-CAM positive:

- ✓ Notify provider
- ✓ Initiate Delirium Nursing Guidelines (Protocol)
- ✓ Encourage healthy sleep/wake cycle
- ✓ Encourage early mobilization
- ✓ Encourage activities that promote or sustain attention
- ✓ Safe Sleep protocol
- ✓ Initiate Delirium IPOC in Cerner
- ✓ Educational brochure for families



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Mentation/Delirium Support Current State

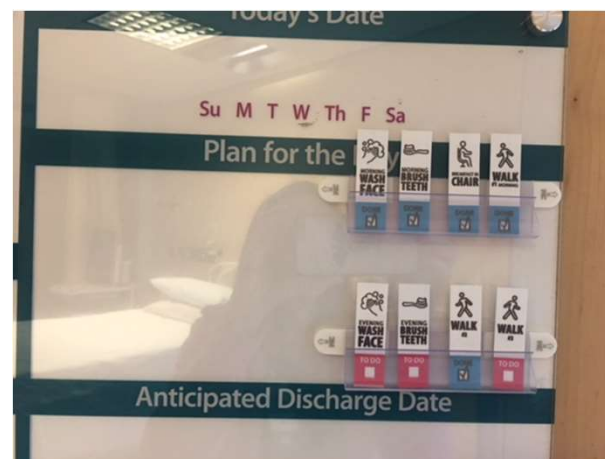
Support:

- Delirium Prevention Committee**
- Delirium Nurse Specialist**
- ABCD carts on each unit**
- Reverie Harp on each unit**
- Therapeutic Arts and Holistic Services**



Mobility Current State

- ✓ Nurses do not currently screen for mobility with a validated tool.
- ✓ Assessing for safe mobilization varies nurse to nurse.
- ✓ UP BY 10
 - VMS ambulating TID
- ✓ Physical Therapy referrals
- ✓ Avoidance of indwelling catheters
 - Remove early
 - VMS
 - Length of time in place discussed during daily rounds



Potential Opportunities



- ✓ Create a process for obtaining and documenting baseline mental and mobility status
- ✓ Screening tool for delirium
- ✓ Screening tool for mobility status upon admission and with any change



Project 2: Patient Experience, What Matters

Approach:

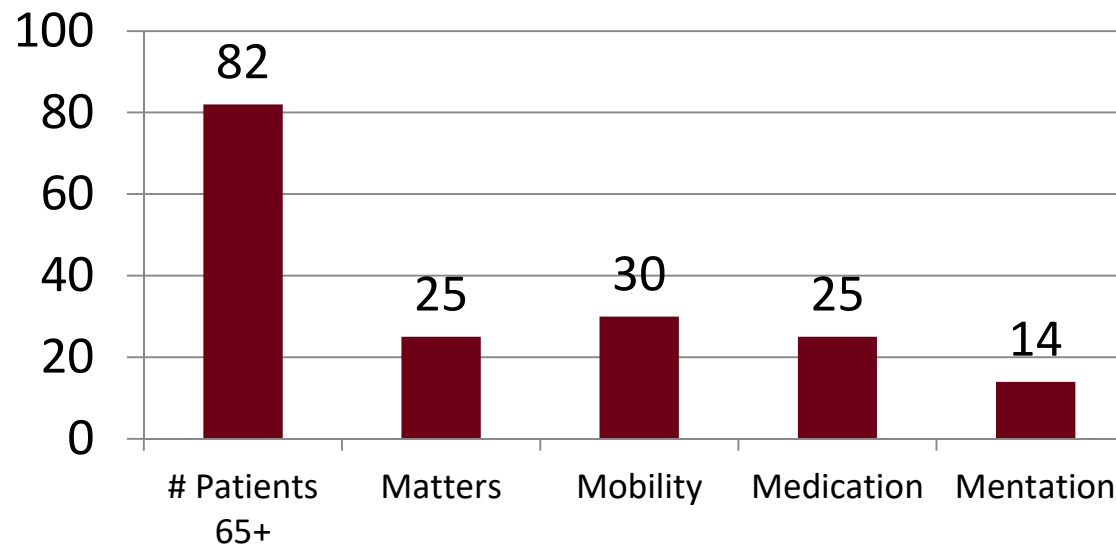
- ✓ Data analysis
- ✓ Direct observation of patient and team interaction related to “What Matters” across inpatient settings
 - Multidisciplinary Team Board Meeting on 10 units: Observed to evaluate for the presence of the 4M’s in the content of the individual reports on each patient.
- ✓ Patient Surveys:
 - IHI “collaboRATE” tool: Slightly modified to use with inpatients following visit from doctor on unit
 - Community-based (CRVNA, Center for Health Promotion): borrowed Anne Arundel Medical Center *What Matters Survey*. 6 questions about what matters to them when they are in the hospital
- ✓ Observation completed, Surveys still in process



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What Matters - Hospital Current State, Team Board Meetings

of times mentioned



82 patients age 65 and older

- Matters: Patient preference for dc plan or plan of care mentioned 25/82 times. DPOA or decision maker (1x). DNR status (1x).
- Mobility: PT/OT referral mentioned 30/82 times. Mention of mobility needs at discharge (2x).
- Medication: Medication discussed relative to inpatient treatment 25/82.
- Mentation: Alert or aware 14/82. Ability to make own decisions (1x). Delirium Protocol (1x).



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collabo**RATE**TM

10 point anchor scale

Thinking about the appointment you have just had ...

1. How much effort was made to help you understand y

0 1 2 3 4 5 6
No
effort
was
made

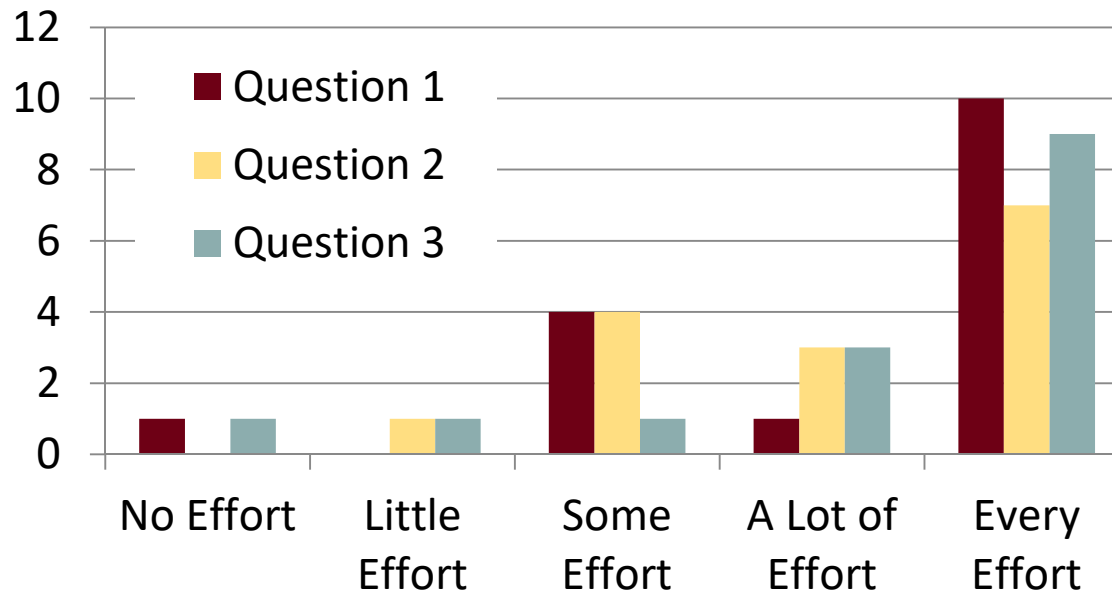
**2. How much effort was made to listen to the things tha
your health issues?**

0 1 2 3 4 5 6
No



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What Matters - Hospital Current State, CollaboRATE Survey Results



15 respondents: 10 patients/3 Family Members/ 2 Both

- All 4 ICU patients indicated “Every Effort”
- Patients in general seemed grateful and hesitant to say anything negative.
- Patients answering on day of discharge indicated “No effort” or “Little Effort”

Concord's What Matters Survey (Based on Anne Arundel Medical Center Survey)

Please take a moment and think about a time or time
Answer these questions based on those experiences.

1. When you are in the hospital, what is the most important thing

Check One

When am I going home? ____
What will happen to me during my stay? X
What is the plan for the day? ____
What are the names of the people caring for me and what do they

2. What is the one thing your doctors and nurses should know about

Check One

Who is important to me ____ My plan
What is important to me as a person ____ My medicine
What makes me feel comfortable at home ____

For the following questions answer on a scale of 1 to 5:
best describes how you feel.

1. The doctors and nurses know what is most important to me as

3. The doctors and nurses know what makes me feel comfortable at home" (like my favorite food, music, etc...)

Not Important 1 2 3 4 Very Important

4. The doctors and nurses know who is important to me (like spouse)



What Matters - Hospital Current State, Community Survey Results

45 responses, Ages 65-93

- ✓ When you are in the hospital, what is the most important thing you want to know?
 1. 58%: What will happen during my stay
 2. 20%: When am I going home
 3. 17%: What is the plan for the day

- ✓ What is the one thing your doctors and nurses should know about you?
 1. 33%: My medical history
 2. 30%: My plan of care
 3. 28%: What is important to me as a person
 4. 5%: What makes me feel comfortable at home
 5. 5%: What is important to me



What Matters - Hospital Current State, Community Survey Results

45 responses, Ages 65-93

On a scale of 1 (Not Important) to 5 (Very Important)

- ✓ The doctors and nurses know what is most important to me as a person: **100% answered ≥ 4**
- ✓ The doctors and nurses know my medical history and plan of care: **100% answered ≥ 4**
- ✓ The doctors and nurses know what makes me feel comfortable in the hospital and “at home” (like my favorite food, music, etc...): **69% answered ≥ 4**
- ✓ The doctors and nurses know who is important to me (like spouse, son, daughter, friend...): **100% answered ≥ 4**



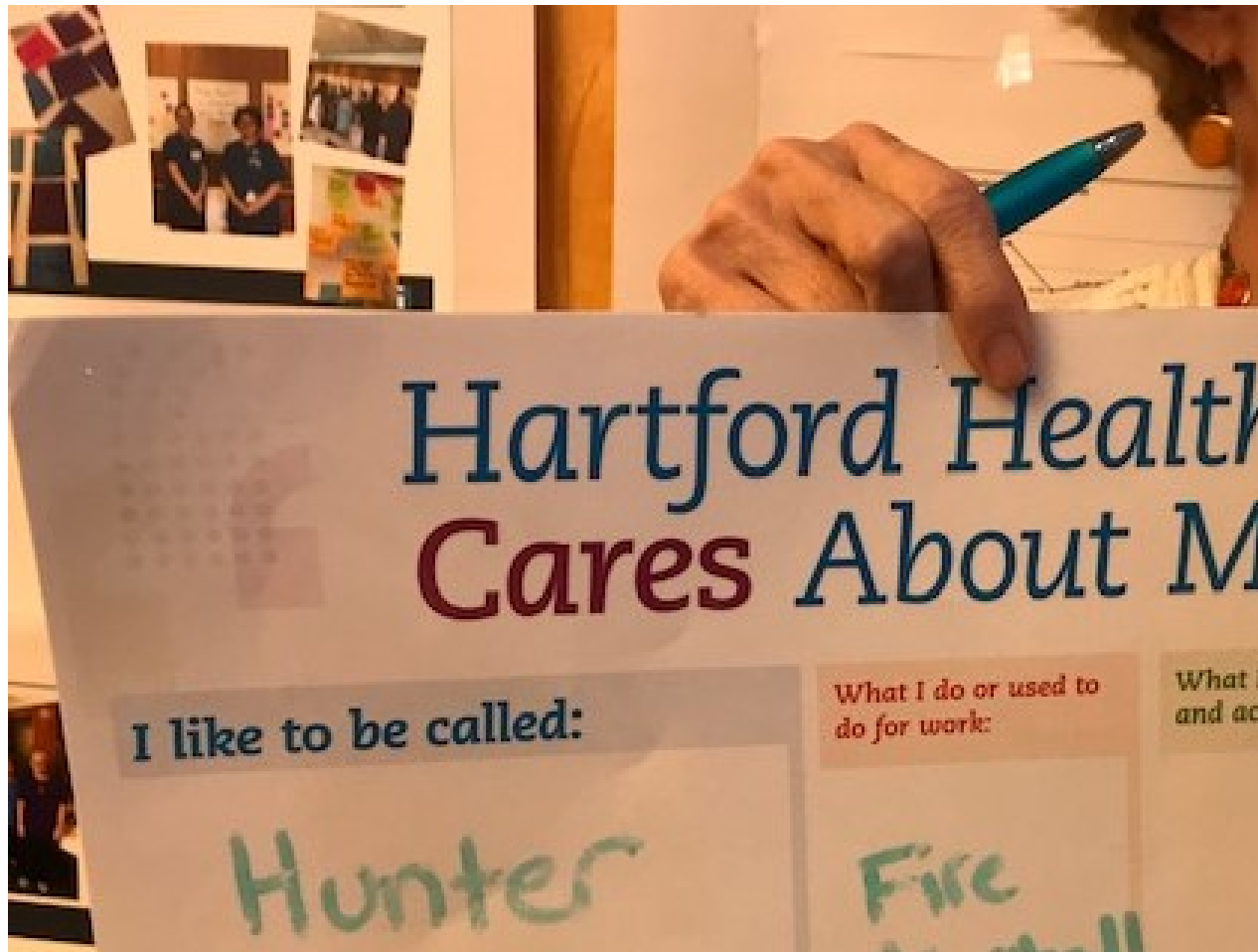
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What Matters - Hospital Current State, Community Survey Results

- ✓ Develop a 4 M's framework for how the clinical providers present information about each of their patients.
 - Foster an awareness of the 4 M's philosophy and support future initiatives.
- ✓ Use the Collaborate Tool in the ambulatory setting to begin evaluation of practices and outpatient services relative to the 4 M's.
 - The tool as adapted for inpatient was not as effective given the circumstances of team care. Patients see many providers and this created confusion.



What Matters - Opportunities



Project 3: What Matters to Patients Regarding Medication

Approach:

- ✓ Small scale test of change to determine the patient's priority goals and identify medication related issues affecting these goals in 25 patients admitted to the CH
- ✓ Internal Medicine pharmacist worked with Dr. Vanderlinde's patients who are 65+ yo and hospitalized. Excluded if only an Emergency Room visit or Pharmacist is not able to meet with patient in the hospital
- ✓ Objectives:
 - Create priority goals for older adults admitted to the hospital
 - Identify medication related issues that may interfere with these goals
 - Implement a customized medication care plan in these patients once discharged from the hospital
- Started project January 2019, in process, only < 5 patients to date, applied learning to other patients not hospitalized



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What's Next?

- Will internally review decision to apply for 1st Level IHI Age-Friendly Health System recognition
- Will develop and implement small tests of change where there is a natural affinity for age-friendly work, for example:
 - CHMG Nurse Navigation Program
 - CRVNA Transitional Care Nurse Program
 - CHMG Family Health Center – Elders Program
 - CH Delirium Project
 - CH Patient Relations Work
- Explore opportunities for small tests of change across CRHC



More to Come!

COMMENTS & QUESTIONS



Section 1 Header

2020 SESSION

20-2958.0

01/03

SENATE BILL *[bill number]*

AN ACT relative to the commission on primary workforce issues.

SPONSORS: [sponsors]

COMMITTEE: [committee]

ANALYSIS

This bill extends the repeal date of the commission on primary workforce issues and clarifies its duties.

Explanation: Matter added to current law appears in ***bold italics***.
Matter removed from current law appears ~~in brackets and struckthrough.~~
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty

AN ACT relative to the commission on primary workforce issues.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 1 Commission on Primary Workforce Issues; Duties. Amend RSA 126-T:3, I-IV, to read as
2 follows:

3 I. Reviewing the impact of existing policies related to strengthening New Hampshire's
4 primary care workforce and making recommendations relative to appropriate use of funds for
5 **workforce retention**, training, education, and recruitment.

6 II. ~~[Assessing the degree to which insurers, managed care organizations, and state and
7 federal payment sources may present inequities and problems regarding payment for primary care
8 services which may serve as a barrier for attracting and retaining the providers necessary for
9 network adequacy.]~~

10 ~~[III.]~~ Collecting and reviewing data and information that informs decisions and planning for
11 the primary care workforce and looking for innovative ways for expanding New Hampshire's primary
12 care resources including, but not limited to, interstate collaboration **and the use of telehealth**.

13 ~~[IV.]~~ **III.** Assembling and ~~[including]~~ **disseminating** in its reports, **as** required under RSA
14 126-T:4, data ~~[on the]~~ **related to** availability, accessibility, and effectiveness of primary care in New
15 Hampshire, with special attention to such data in rural and underserved areas of the state **in order**
16 **to inform state policy and planning**.

17 **IV. Exploring and developing strategies to further the integration of primary care,**
18 **oral health, and behavioral health.**

19 2 Commission on Primary Workforce Issues; Reports. Amend RSA 126-T:4 to read as follows:

20 126-T:4 Reports. The commission shall make an interim report on November 1, ~~[2018]~~ **2020**
21 which shall focus on the status of the New Hampshire state loan repayment program and the New
22 Hampshire division of public health service's health professions survey, and a final report on
23 November 1, ~~[2020]~~ **2024**, including its findings and any recommendations for proposed legislation,
24 to the speaker of the house of representatives, the president of the senate, the governor, the
25 oversight committee on health and human services, and the chairpersons of the senate and house
26 executive departments and administration committees.

27 3 Commission on Primary Care Workforce Issues Extended. Amend 2010, 114:4, I as amended
28 by 2015, 238:4 and 2018, 248:3 to read as follows:

29 I. Section 3 of this act shall take effect November 1, ~~[2020]~~ **2024**.

30 4 Effective Date. This act shall take effect upon its passage.