**Legislative Commission on the Interdisciplinary Primary Care Workforce**

**December 17, 2020 2:00-4:00pm – Zoom Conference**

**Call in information:**

https://nh-dhhs.zoom.us/j/91831406477?pwd=MzBoaWtSbi8veXZDczlGekdrazhXQT09

Or by telephone: Dial (for higher quality, dial a number based on your current location): +1 312 626 6799, +1 646 558 8656, +1 301 715 8592, +1 346 248 7799, +1 669 900 9128, or +1 253 215 8782

Meeting ID: 918 3140 6477
Passcode: 590858

**Dial *6 to mute or unmute if you connect by phone**

## Agenda

2:00 - 2:15 **Read Emergency Order #12 Checklist and Take Roll Call Attendance**

2:15 – 3:10 **DSRIP Behavioral Health Workforce IDN Work** – Hope Worden Kenefick, Consultant for the Endowment for Health

3:10 – 3:50 **Health Professions Data Center Update** – Danielle Weiss, MPH, Health Professions Data Center Manager

3:50 - 4:00 **Updates & Adjourn**

**Next meeting: Thursday January 28, 2:00-4:00pm**

# State of New Hampshire
**COMMISSION ON PRIMARY CARE WORKFORCE ISSUES**

DATE: December 17, 2020

TIME: 2:00 – 4:00pm

LOCATION: Zoom Conferencing

## Meeting Notes

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

**FROM:** Danielle Weiss

**MEETING DATE:** December 17, 2020

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**Members of the Commission:**
Mary Bidgood-Wilson, ARNP – Chair
Alisa Druzba, Administrator, Rural Health and Primary Care Section – Vice-Chair
Stephanie Pagliuca, Director, Bi-State Primary Care Association
Kim Mohan, Executive Director, NH Nurse Practitioner Association
Don Kolisch, MD, Geisel Medical School
Bill Gunn, NH Mental Health Coalition
Pamela Dinapoli, NH Nurses Association
Laurie Harding, Upper Valley Community Nursing Project
**Guests:**
Danielle Weiss, Program Manager, Rural Health and Primary Care Section
Paula Smith, SNH AHEC
April Mottram, Executive Director, NNH AHEC
Paula Minnehan, NH Hospital Association
Marcy Doyle, UNH, Health Policy & Practices
Geoff Vercauteren, Director of Workforce Development, Catholic Medical Center
Peter Mason, Geisel School of Medicine, IDN region 1
Kristine Stoddard, Bi-State Primary Care
Ann Turner, Integrated Healthcare, CMC
Lindy Keller, Bureau of Drug and Alcohol Services
Eve Klotz, NH Northern Human Services
Natalie Rickman, Bi-State Primary Care

**Meeting Discussion:**

2:00 - 2:15 **Welcome and Introductions/Read EM #12 Checklist and Take Roll Call –** Mary Bidgood-Wilson, ARNP – Chair

2:15 – 3:10 **DSRIP Behavioral Health Workforce IDN Work –** Hope Worden Kenefick, Consultant for the Endowment for Health

Refer to the recorded presentation, https://youtu.be/WW_X2AqU3PI, and attached presentation slides, "IDN Behavioral Health Workforce Capacity Development."

3:10 – 3:50 **Health Professions Data Center Update –** Danielle Weiss, MPH, Health Professions Data Center Manager

Refer to the attached presentation, "2018 PA Workforce Report Overview."

3:50 - 4:00 **Updates & Adjourn**

**Next meeting: Thursday January 28, 2:00-4:00pm**

# Integrated Delivery Networks Behavioral Health Workforce Capacity Development

## An ASC ALL Summary

Prepared by Hope Worden Kenefick, MSW, PhD

Consultant to the Endowment for Health

October 2020

# Project overview:

Conducted 7 online focus groups with 38 individuals, including members of 6 of the 7 IDNs* and DHHS staff to summarize the…

Approaches

Strengths

Challenges

Accomplishments

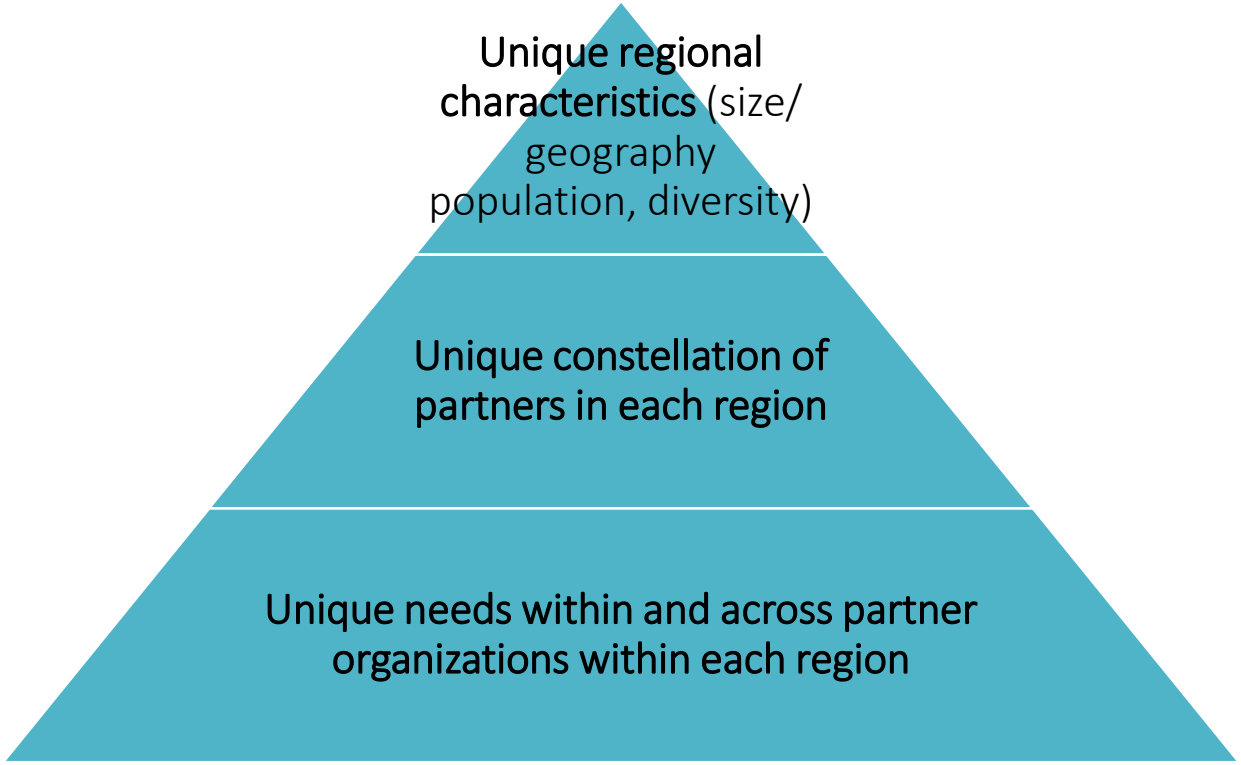
Left to Do

Lessons learned

Related to A1/Behavioral Health Workforce Capacity Development that occurred across New Hampshire under the DSRIP waiver.

**Region 2 IDN was unable to participate*

*"You know what they say, 'If you have seen one IDN, you've seen one IDN.'"*




Sought to summarize commonalities across IDNs while asking about unique features (e.g., approach, partnerships, accomplishments, challenges); "Unique features" are based on available data

# Estimated funding for A1 Activities

Estimated total for A1 among the 6 IDNs: $11.4m

Average: $1.9m

Range: $840k and $3.2m

Money spent on other categories also supported workforce capacity development

Acknowledgment that all categories touched on workforce in some way

# Approach/structure

Common elements of all or most IDNs:

- Assessment of partner needs related to workforce development informed regional work
- Regions informed state-level efforts through participation in statewide taskforce and sub-committees
- Governance/steering committee structures made decisions about approach
- Workforce broadly defined/very inclusive
- Lots activity/partnership re: recruitment, retention, and advancement; less on pipeline
- Strategies included an array of activities (e.g., training and professional development, bonuses/pay increases, recruiting and moving costs, loan repayment)*
- While attending to regional/common needs, built in flexibility/latitude so partners could address their institution-specific workforce needs
- Dissemination of funds to partners via RFAs/mini-grants

**not all IDNs used all of these strategies*

# Approach/structure, cont'd

Unique features:

One IDN became an LLC, sharing decision-making and fiduciary responsibilities across partners and setting them up differently for sustainability

Knowledge Exchange – process for sharing about new approaches/experiences across partner organizations

Corrections and courts among partners who were engaged

Tiered incentive payments to keep partners engaged in the IDN which allowed for flexible spending

Matching funds for SLRP/bumped applicants up on priority list

Focus on sustainability – to be funded, partner efforts must not rely on IDN funds for long-term sustainability

Diversity efforts (cultural effectiveness trainer; recruitment from/professional development for workers from racially/ethnically/linguistically diverse communities)

# Strengths

The **workforce** was/is flexible, creative, responsive, dedicated, passionate

The **waiver**:

Supported the infrastructure critical to convening multiple partners (including competitors) and forging new/strengthening existing relationships

Supported  training and hiring efforts and positions; led to some improvements in integration, access to BH/SUD services, and diversity of the workforce

Created mechanism for challenges at local/regional level to make their way to the state level (and for some change to occur) and for work at state-level to be communicated back to regions

# Challenges – IDNs struggled with…

Medicaid rates – lower than in neighboring states

Critical positions not billable (CHWs, peer recovery workers)

Steep increase in demand for BH services

Despite increased knowledge/demand for BH, difficultly recruiting (and, for some, in sustaining) workers; Competition for workers (within a region, across regions, with neighboring states)

A flood of SDOH needs detected through screening

Licensing – although some improvement made, challenges remain – slow, burdensome, rigid processes that interfere with hiring and advancement

Data/reporting requirements (i.e., volume, schedule, reporting on sub-set of patients) were cumbersome; hard to measure impact

Pandemic changed how we work; diverted resources and attention; increased demand and needs, especially among most vulnerable

Cuts to SLRP funding

# Challenges, cont'd

Some or most IDNs also found that:

CMHCs are training ground/generally lose workers after licensure; need to incentivize other organizations to do training

CMHCs and FQHCs can't compete with salaries of larger organizations

Focus on productivity hinders professional development, engagement in related/important/macro efforts, contribute to burnout, and disadvantage workers that cover/travel large territories

Recruiting to fill some positions, especially those requiring advanced degrees, was exceedingly difficult

Efforts to serve a diverse community hampered by costs of education involved in building/ advancing a diverse workforce

Competing organizational priorities affected both who and how engaged partners were IDN work

Some partners found systems-change related to one payer difficult

# Accomplishments

Changes in awareness, service delivery, and culture of care

Challenges (e.g., licensing, need for telehealth) and value of non-billable services now better understood at state-level

Improved relationships and inter-organizational communications, cooperation, collaboration, and coordination

- Brought multiple sectors together
- Grown and maintained partnerships

Increased screening for & decreased redundancy when addressing SDOH; Some relief of “choke points” in the system

Capacity increases via skill/knowledge-enhancement, advancement/“grow your own” efforts, and hiring of new staff

- Several waiver-funded positions will be sustained
- Trainings/tools created that will be available ongoing
- Technology and systems for communicating and working together & with patients exist (direct care messaging; telehealth)

# Left to do

Demonstrate collective impact of workforce to support continued engagement and ward off burnout

Sustain partnerships/collaboration without resources for convener role

Continue “boundary spanning” – working across two or more organizations freely

Cultivate the pipeline (introducing students - high school or younger - to BH careers)

Move into ED and inpatient settings

Continue building connection between health care and those addressing SDOH in community

Figure out how to maximize existing billing codes to support/sustain the work

Increase support (funding and models) for those who want to get education in BH to do schooling; ensure higher education understands and produces workers that meet the BH needs/requirements

Increase focus on children’s BH needs

Figure out how to sustain training and capacity building into the future

# Lessons learned

**State-level/policy:**

Payment reform is critical (to cover critical positions, pay competitive wages, and improve integration)

Telehealth is essential (and successful) in expanding access to services

Licensure processes and requirements must support hiring and advancement efforts

Ensure state-level work is partner-owned/driven; two-way communication exists; regional needs drive state-level efforts (there is no one-size-fits-all approach)

Ensure data/reporting is standardized, based on consensus, and feasible to ensure understanding of need and impact

# Lessons learned

**Regional approach/structure:**

The role of convener and neutral facilitator is critical; resource it appropriately

Regional governance should focus on simplifying processes/decision-making

Planning for sustainability should happen from the outset

Build flexibility into funding so organizations can use funds to address specific workforce needs

# Lessons learned

**Partners:**

Outreach/securing the right people and partners takes time

Cast a large net for partners; lots of orgs have a role/stake

- Given credential-heavy nature of field, engage higher ed in workforce planning
- Ensure community/SDOH partners are at the table

Identify/engage internal champions to drive organizational change (cannot drive change from outside)

Give partners equal voice/leave egos at the door

# Lessons learned

**Strategies:**

Given competition for workers, grow your own/re-purposing of workforce will likely be critical to filling positions

Valuing employees is critical to keeping them (pay, advancement opportunities, appreciation and acknowledgement of impact, supervision)

- Beware of impact on existing workers when using money to increase pay of new workers

Invest in training: Make it free, readily available, easy to access

- Support priority skill/knowledge-development AND interests, cross-institutional understanding, licensure, supervision, and leadership

Focus early on effective screening, registry, and RISK (vs. cost) stratification to identify those most in need and who is involved in their care

Locate services where patients are; make screening and referral as seamless as possible for staff, providers, and patients

Thank you to all who participated in the focus groups!

Questions?

an official NEW HAMPSHIRE government website

dhhs New Hampshire Department of HEALTH AND HUMAN SERVICES

# 2018 PA Workforce Report

NH State Office of Rural Health

Rural Health and Primary Care

Division of Public Health Services, DHHS

NH Health Professions Data Center

NH DHHS, DIVISION OF PUBLIC HEALTH SERVICES

# Background

- Data was collected from PAs renewing in 2018
  - The only provider type to renew annually
- While 2017 legislation required survey/opt-out completion, it was not a condition of license renewal
  - HB322 (Laws of 2017, Chapter 131; RSA 126-A:5, XVIII(c))

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# Analysis Considerations/Limitations

- Data was summarized by provider count for PA characteristics and by site count for practice setting elements
  - FTE/Primary care FTE was used to estimate true capacity in specialty analyses
  - Data summarized by sites take the total number of NH practice locations at which PAs practiced on a regularly scheduled basis
    - Not distinct, the total number represents all sites entered (up to 6 for each respondent) by PAs, allowing for duplication
- Results reflect practice characteristics at the site level as reported by providers
- Results may not be representative of the PA workforce as a whole due to the possibility of response bias

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# Definitions

- Clinical Practice includes direct patient care, as well as any administrative activities related to charting, billing for services, and participation in clinical team activities.
- Sites entered by respondents were locations at which PAs practiced on a regularly scheduled basis in NH
  - 2+ hours/week
- Sliding Fee Scale Policy – not simply discounts provided by practice; we are using the federal definition that's used for shortage designation purposes

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# Survey Participation/Practice Status

- 63% of renewing PAs completed the workforce survey
  - Only 11 completed the opt out
- 95% of PAs indicated FT/PT practice status in NH

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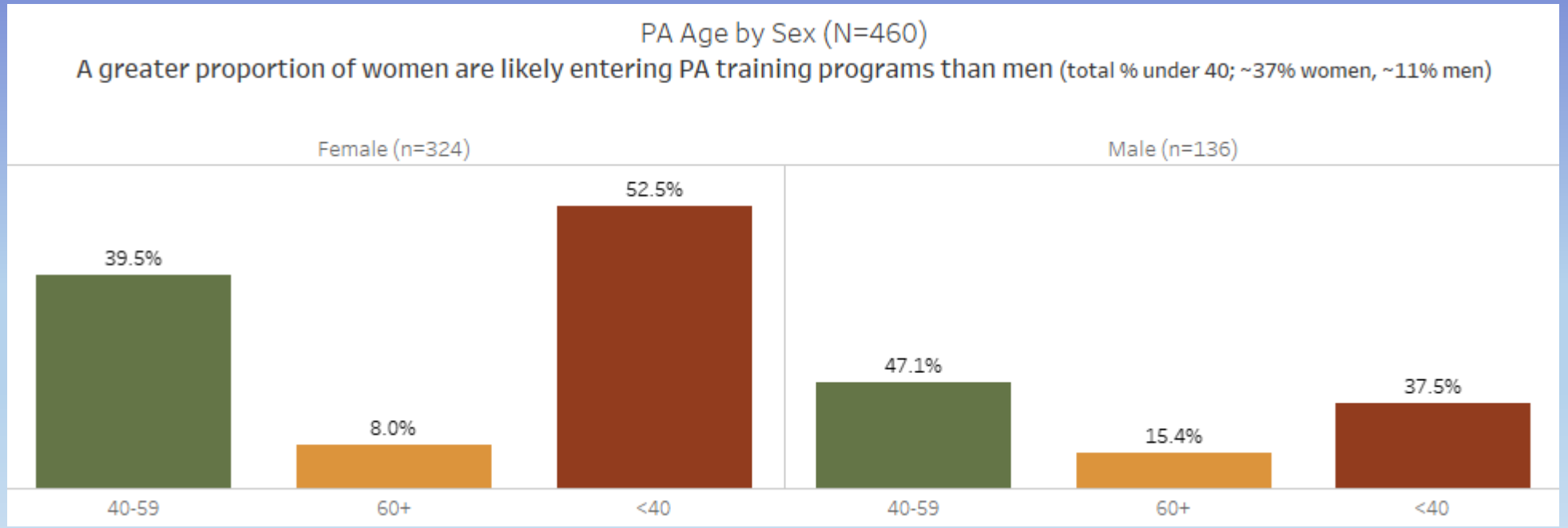
# Demographics

- 70% female
- ~90% under 60yo
- 92% non-Hispanic White
- <4% speak a language other than English in clinical practice

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# Education/Training

- ~50% of the PA workforce graduated within the last 10 years
- 68% graduated from NE schools for all years
  - 37% in NH – but not even indicated until ’99-’08 graduation bracket
- Very few PAs attended a residency/fellowship
- MCPHS-Manchester has been the most attended PA school for the last 20 years

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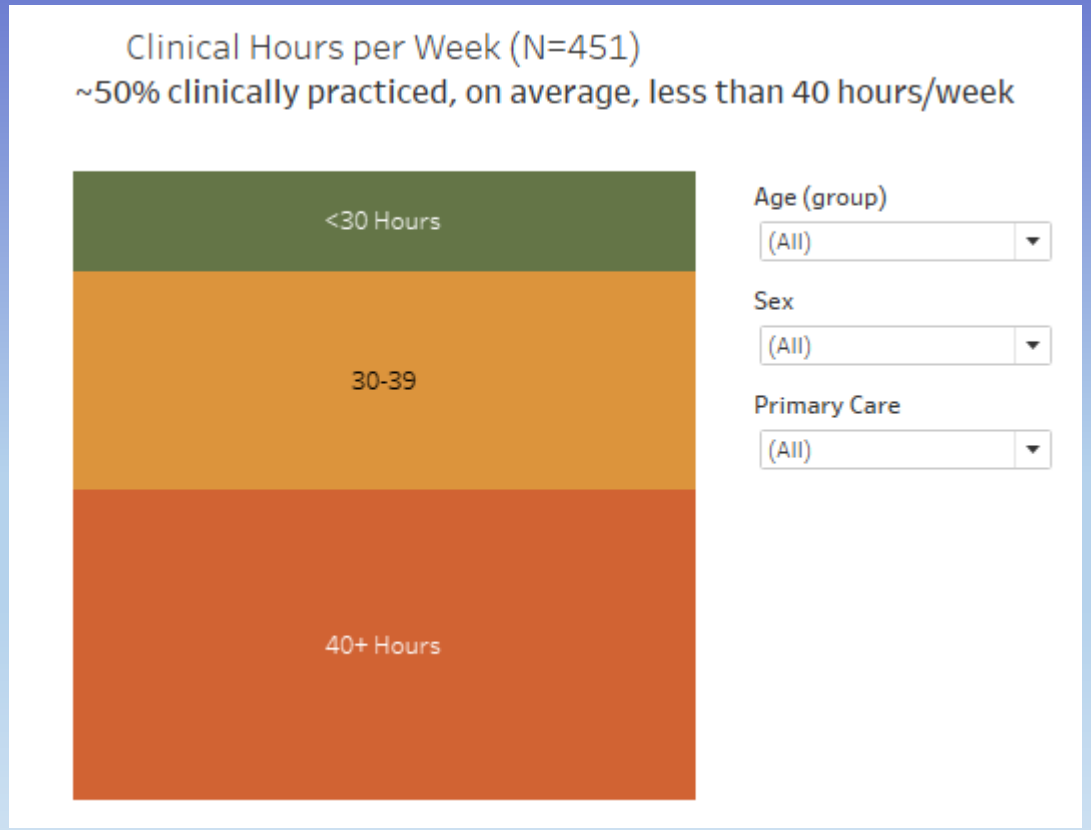
# Sites/Hours

- ~20% work at 2+ sites
- ~50% practiced < 40 hours/week, PT work increased with age

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# Specialty

- The 4 most practiced specialties by FTE made up >50% total FTE
  - Family Medicine/General Practice
  - Orthopedic Surgery
  - Emergency Medicine
  - Internal Medicine
- >25% of total FTE was in primary care practice
  - Majority (90%) comes from family medicine/general practice & internal medicine

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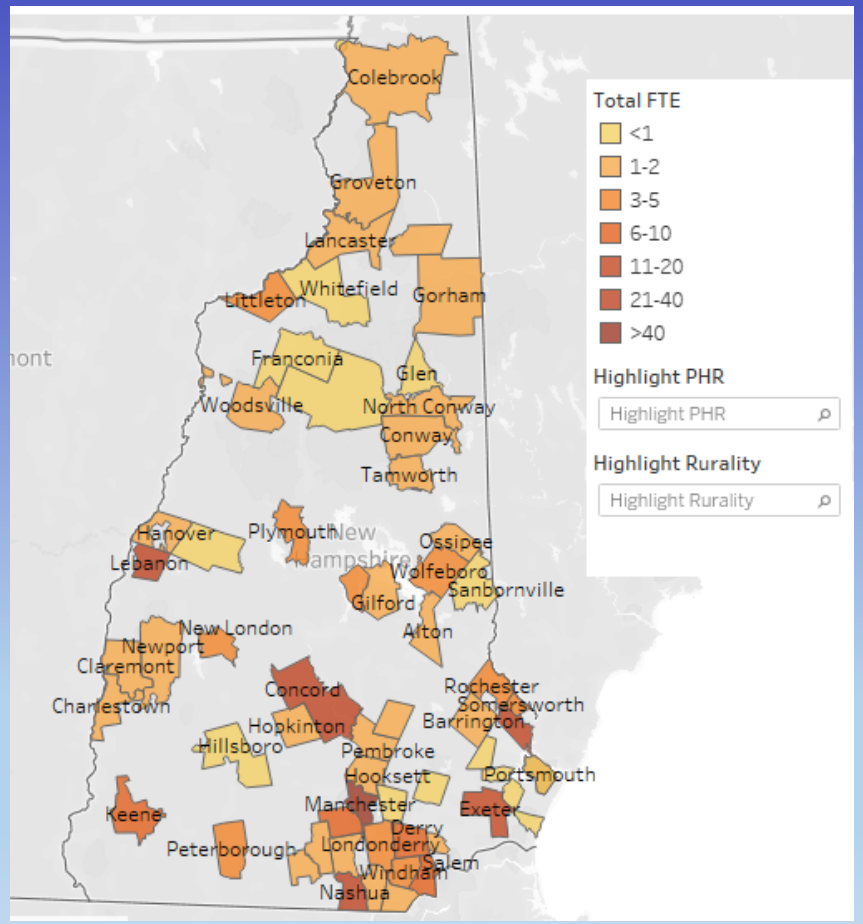
# Distribution




| Rurality | PHR | |
|---|---|---|
| Non-Rural PHRs | Greater Manchester | 20.69% |
| | Greater Nashua | 13.46% |
| | Seacoast | 12.89% |
| | Capital Area | 12.52% |
| | Strafford | 8.62% |
| | South Central | 7.23% |
| | Total | 75.41% |
| Rural PHRs | Upper Valley | 9.02% |
| | North Country | 3.82% |
| | Greater Monadnock | 3.58% |
| | Carroll | 2.87% |
| | Greater Sullivan | 2.44% |
| | Winnipesaukee | 1.70% |
| | Central NH | 1.17% |
| | Total | 24.59% |

- 75% of the total FTE is in non-rural NH

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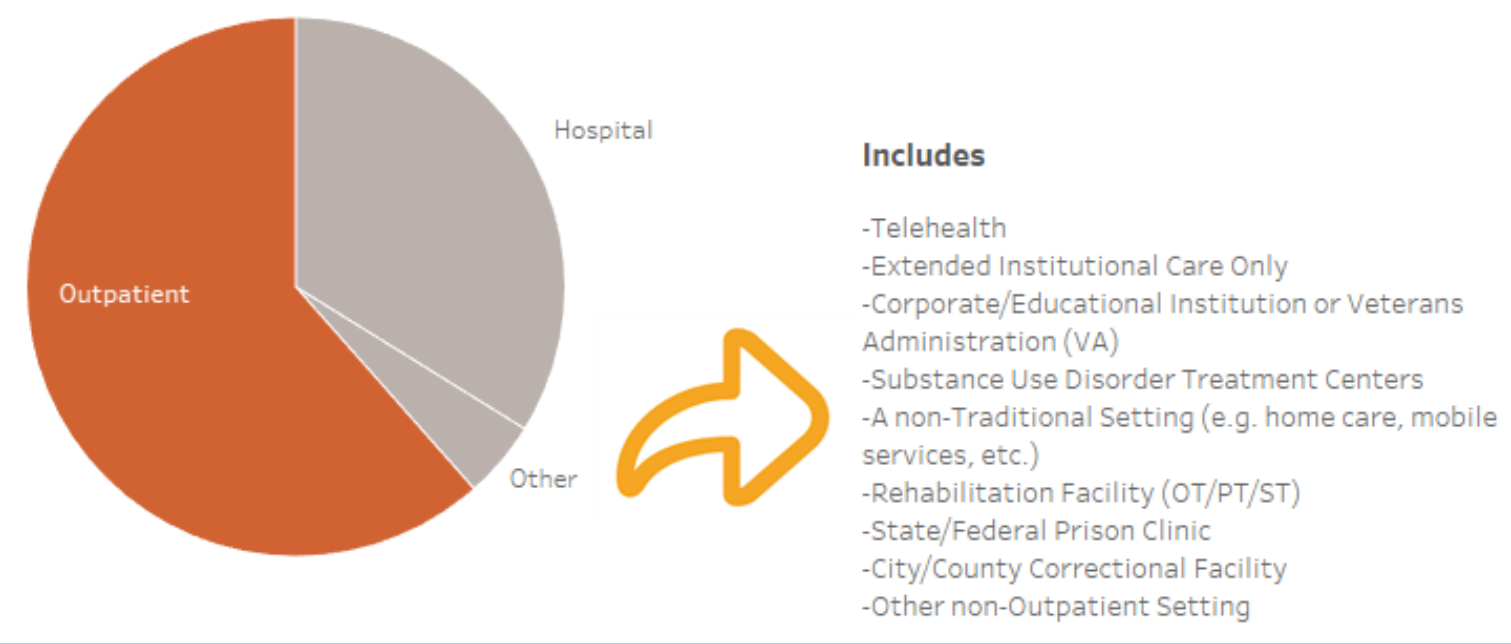
# Practice Setting

- >60% practiced in an outpatient setting

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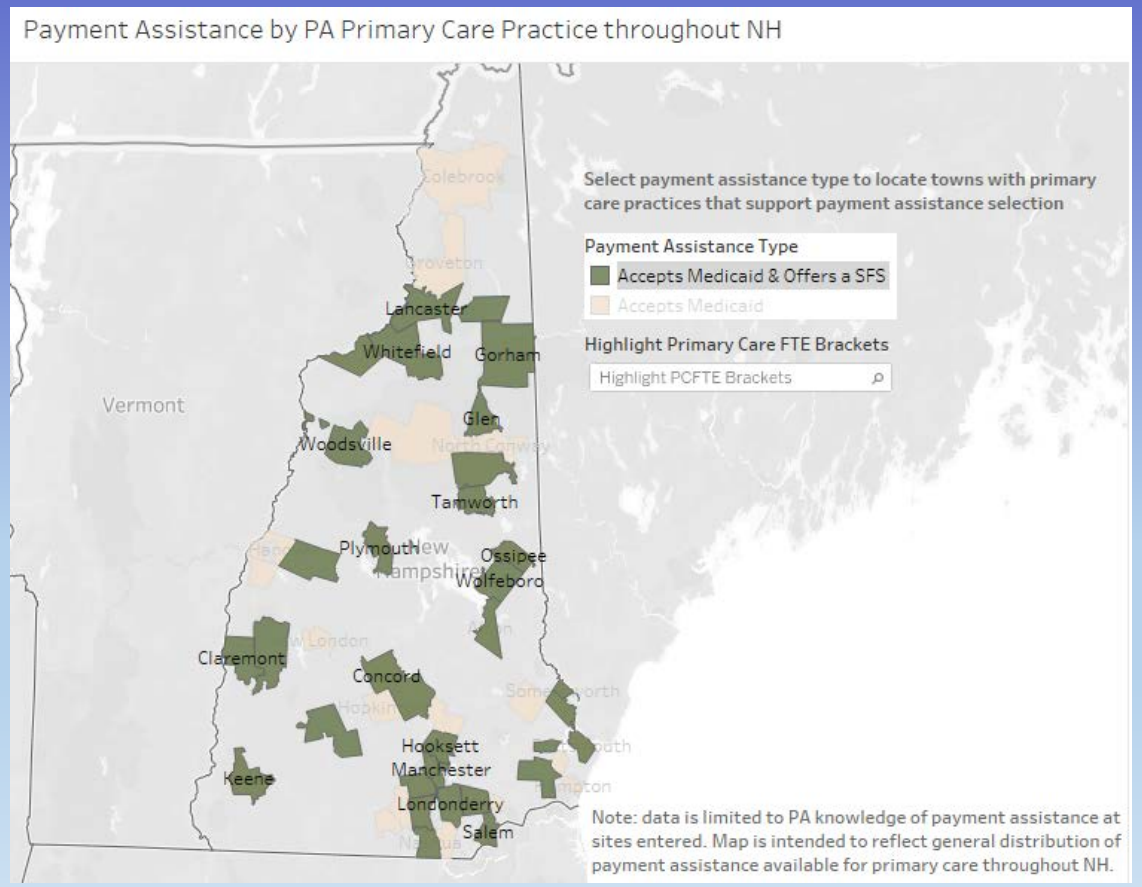
# Payment Assistance

- ~90% in outpatient settings accept Medicaid

Map illustrating availability of both types of payment assistance throughout NH for primary care

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# Wait Times

- ~80% of PAs in outpatient settings reported established patients, on average, are seen within 1 week
  - 65% reported the wait for new patients to be within 1 week
- ~85% of PAs in outpatient primary care practice reported to be accepting new patients

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# Retention

- >60% of PAs had NH ties (lived or worked in NH) prior to receiving their license
- 40% of PAs have been practicing in NH for < 5 years
- 19% of the available PA capacity (by FTE) is expected to decrease in 5 years
  - 10% from a reduction of hours
  - 7% from practice in another state
  - 2% from no longer practicing

  *These results do not reflect the anticipated PA workforce supply as a whole. NH licensing list figures suggest PAs are entering the NH workforce at a greater rate than they are leaving

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# Statistically Significant Rural Associations

- Retention
  - Rural practicing PAs were
    - 1.5x more likely to have graduated PA school in the last 5 years
    - 1.3x more likely to have been practicing for < 5 years
      - Those that practice for > 5 years in one location are more likely to stay
    - 1.5x more likely to anticipate a reduction in capacity
      - Likely attributed to moving to another state and possibly a reduction in hours instead of planning to no longer practice
    - 1.4x less likely to have NH ties
- Young, newly licensed, looking for experience but may be less likely to stay
  - Greater opportunities in rural (filling gaps, flexibility, other perks)? Encouraged through education?
  - Taking advantage of federal programs designed to attract workforce to rural areas?

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# Capacity/Access

- Specialty
  - Rural practicing PAs were
    - 1.6x more likely to practice primary care
- Payment Assistance & Wait Time
  - Rural Practicing PAs were
    - 1.5x more likely to work at outpatient sites that have a SFS policy
    - 1.75x and 1.5x more likely to work at outpatient sites that have wait times >1 week for established and new patients, respectively

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# What's to Come

- Complete provider data
- Reports with multiple provider types to better understand the full picture of primary care access and capacity in NH
  - Combined provider types
- Time trends to watch for shifts
- Faster releases with a HPDC analyst

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