

## **Legislative Commission on Primary Care Workforce Issues**

**October 25, 2018 2:00-4:00pm at the NH Medical Society Conference Room, Concord**

**Call in information:**

866-939-8416

Participant Code: 1075916

### Agenda

- |                    |  |
|--------------------|--|
| <b>2:00 - 2:10</b> | <b>Welcome and Introductions</b>                                   |
| <b>2:10 – 2:30</b> | <b>Senator Sharon Carson</b>                                       |
| <b>2:30 – 2:55</b> | <b>Provider Survey Implementation Update – Danielle</b>            |
| <b>2:55 – 3:20</b> | <b>J1 Visa Physicians/Diversity Discussion – Trini &amp; Alisa</b> |
| <b>3:20 – 3:50</b> | <b>ECHO Update - Jeanne</b>  |
| <b>3:50 - 4:00</b> | <b>Updates and Next Steps</b>                                      |

**Next meeting: Thursday November 29, 2:00-4:00pm**

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

DATE: October 25, 2018

TIME: 2:00 – 4:00pm

LOCATION: New Hampshire Medical Society

**Meeting Minutes**

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

**FROM:** Danielle Weiss

**MEETING DATE:** October 25, 2018

---

**Members of the Commission:**

Laurie Harding – Chair

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

Mary Bidgood-Wilson, ARNP, NH Nurse Practitioner Association

Kristina Fjeld-Sparks, Director, NH AHEC

Jeanne Ryer, NH Citizens Initiative

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

Trinidad Tellez, MD, Office of Health Equity

Scott Shipman, MD, Director, Primary Care Affairs and Workforce Analysis, AAMC

Bill Gunn, NH Mental Health Coalition

Pamela Dinapoli, NH Nurses Association

**Guests:**

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

Paula Smith, SNH AHEC

Paula Minnehan, NH Hospital Association

Nancy Frank, Executive Director, NNH AHEC

Peter Mason, Geisel School of Medicine, IDN region 1

Guy Defeo, MD, Associate Dean for Clinical Education, UNE

Barbara Mahar, New London Hospital

Don Kolisch, White River VA Hospital

Thomas Wold, Portsmouth Regional Hospital

Mandi Gingras, Bi-State Primary Care Association

Marcy Doyle, Director, Institute for Health Policy and Practice

Jim Kelly, retired primary care physician

**Meeting Discussion:**

2:00 - 2:10      **Introductions & Minutes**

2:10 – 2:30      **Workforce Legislation – Sen. Sharon Carson**

- If the Graduate Physician bill is filed again, it should go to House ED&A
  - o Carson will go with Paula Minnehan, if necessary, to ensure this is the case
- The dilemma is how to fast-track physicians when you need the residency component
  - o Eliminating residency would not be beneficial
  - o The legislation would put these providers in rural practices without requiring onsite supervision
  - o We're already having trouble getting residency seats and supervision for residents in these areas
    - There's a shortage of mentors to do this

- What's the evidence say about GPs?
  - o MO is only state to implement this program and there aren't any results to determine quality or access (insurance) issues
  - o Anecdotally, the physicians want help accessing a NH residency program, not to skip the residency

2:30 – 2:55                    **Provider Survey Implementation Update** – Danielle Weiss, Health Professions Data Center Manager

- Refer to the handout “**2018 Physician Survey Implementation Results**”

2:55 – 3:20                    **J1 Visa Physicians/Diversity Discussion** – Trini Tellez & Alisa Druzba

- Refer to the handouts “Culturally Effective Organization Framework,” “Diversifying the Health Care Workforce,” and “J1 Visa Waiver Program.”
- Is there something we can do better in regard to the Conrad 30 Program?
  - o Improve communications
    - Employers not open to the idea of foreign trained physician because they don't believe they can retain them
      - Quality measure of being culturally competent
  - o Target audience would be anyone who has or would use program
    - Not just Health Centers
    - Any health care employer
  - o Do we know which communities and employers have high retention rates?
    - No because we can't track them
      - Once we certify them through the Primary Care Office, the application is sent to the federal government and we lose contact
      - When we used to ask health centers, those who answered said retention was 71%
- Diversity in NH
  - o Topic at Dartmouth-Hitchcock hitting higher level because constantly gets dinged for lack of diversity in faculty
  - o There are more people who hear the message and can speak about how this can make an impact to their system
  - o When NHHA updates training schedules, will try to incorporate

3:20 – 4:00                    **ECHO Update** – Jeanne Ryer

- Refer to the PowerPoint “**Project ECHO Update.**”

**Next meeting: Thursday November 29, 2:00-4:00pm**

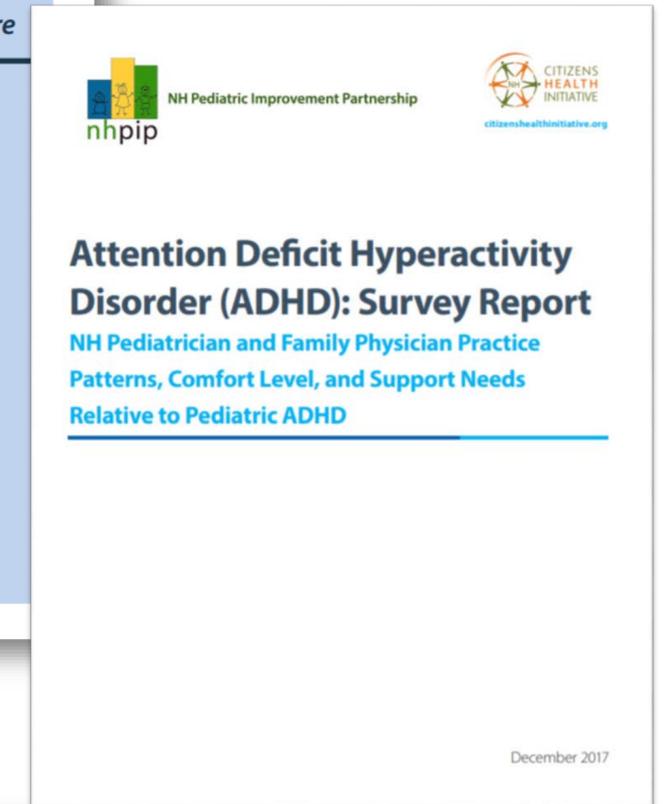
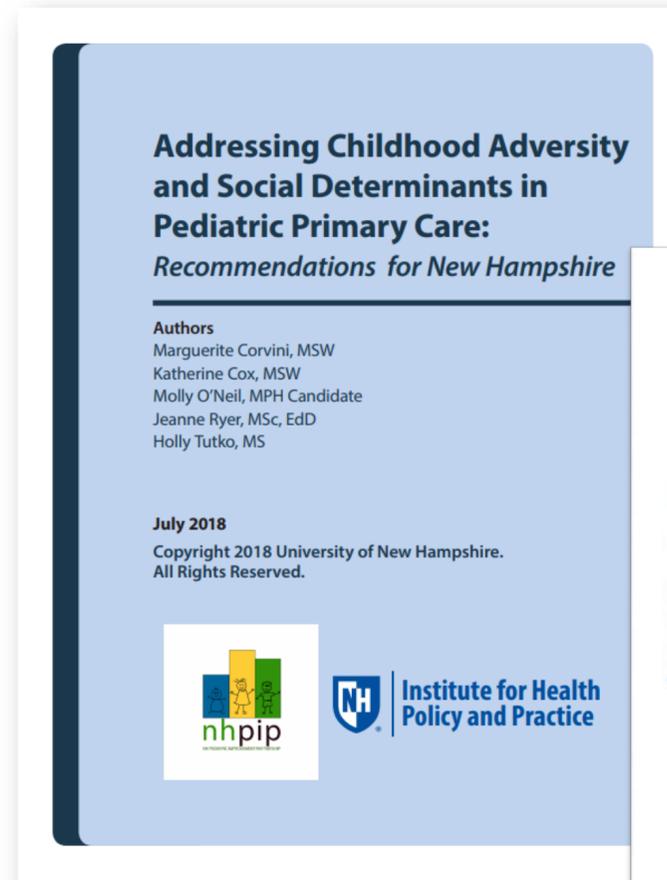
# UPDATE: PROJECT ECHO® IN NEW HAMPSHIRE

Jeanne Ryer, MSc, EdD



# WHO ARE WE?

The NH Citizens Health Initiative tackles critical gaps in the coordination and delivery of health care in New Hampshire. We catalyze high-value shared learning, putting proven, innovative practices into action for better care at lower cost.



# INITIATIVE'S KEY PROJECTS



**Practice Transformation**



**NH Behavioral Health Integration  
Learning Collaborative**

**NH Pediatric Improvement  
Partnership**



**Project ECHO®:**  
Northern NE ECHO® Network  
UNH ECHO® Hub

# PROJECT ECHO®

**ECHO: Extension for Community Healthcare Outcomes**

Case-Based Distance Learning

Knowledge Exchange

Professional Learning Community

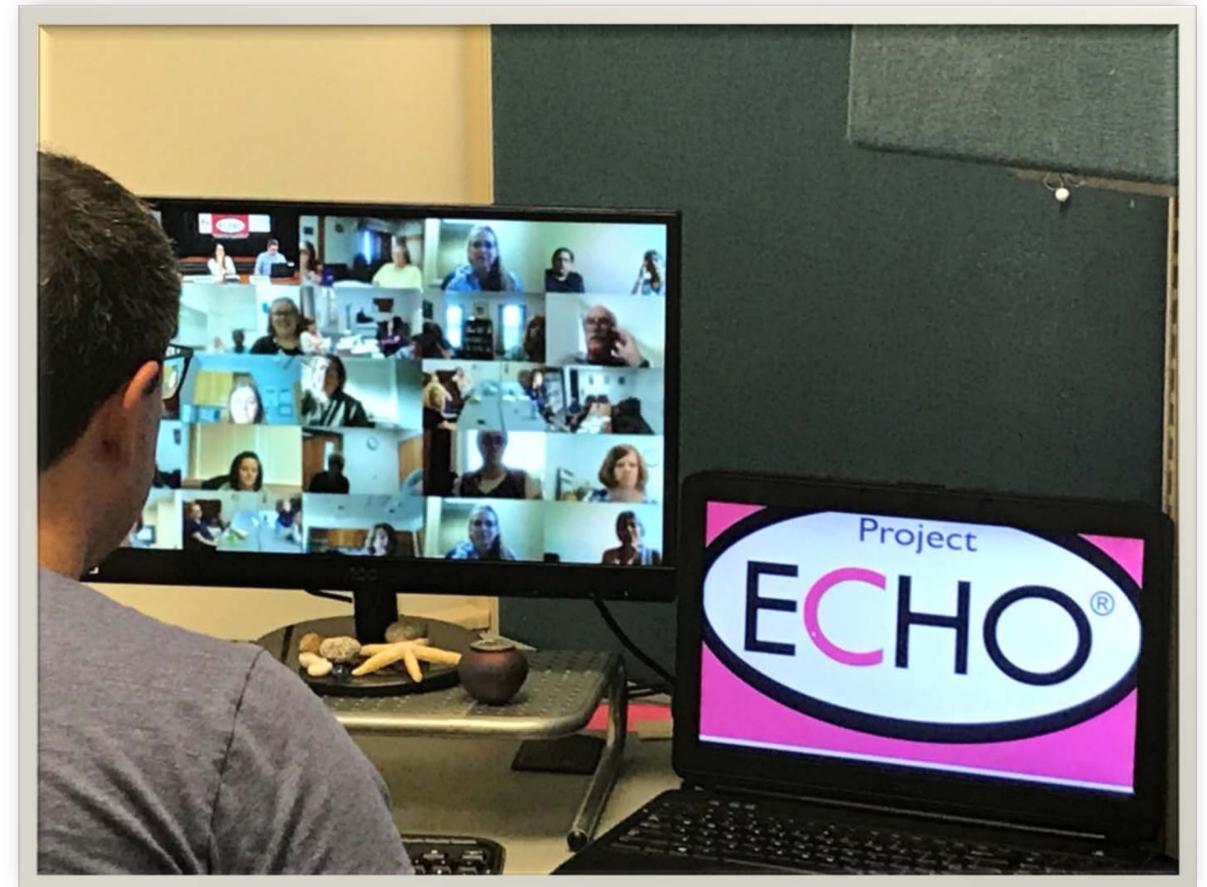
Supports Community-Based Providers

[Project ECHO](#)

# PROJECT ECHO® MODEL

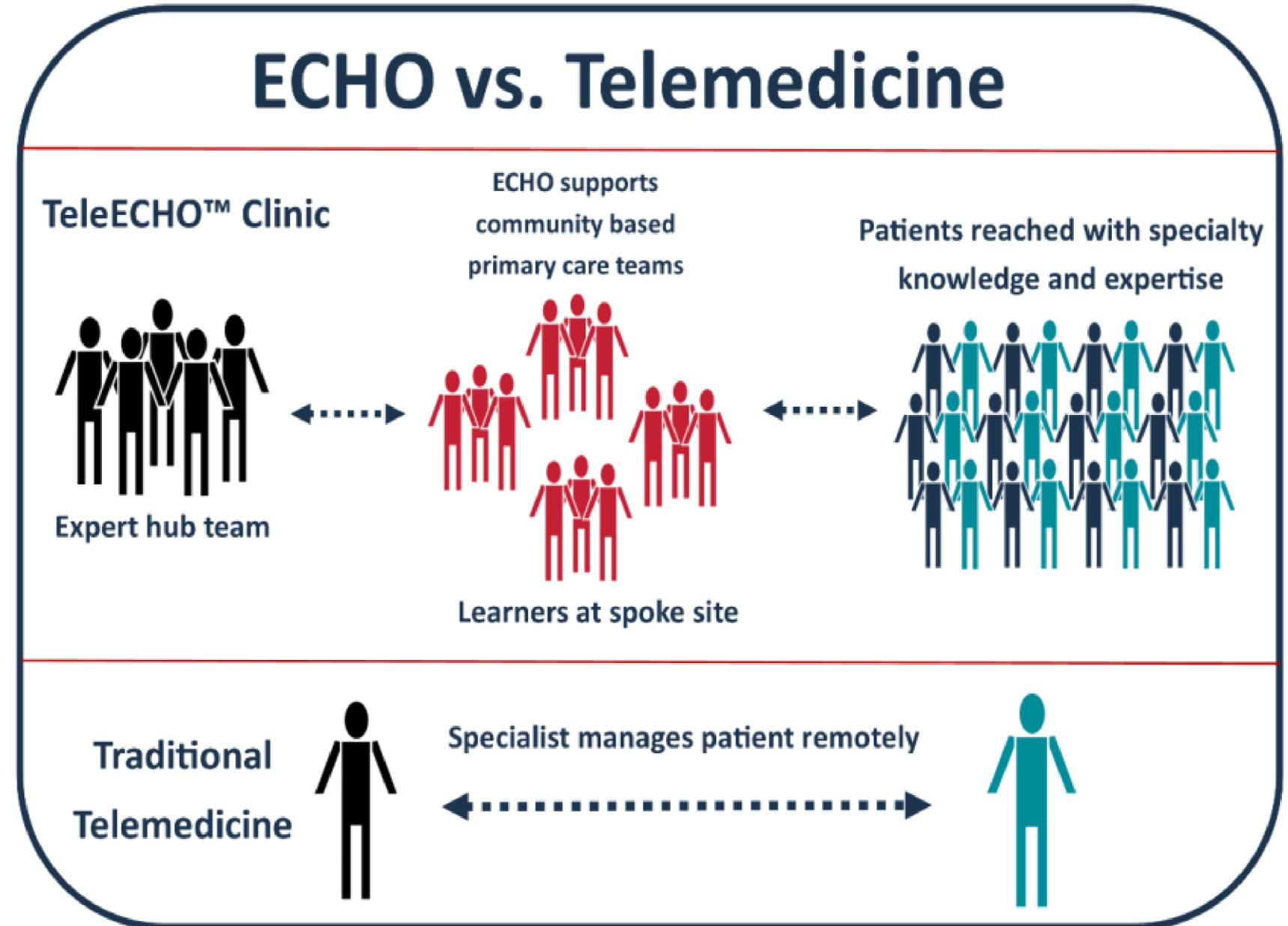
- Evidence-based method
- Links teams of interdisciplinary specialists with primary care clinicians
- Developed by researchers at the University of New Mexico

In ECHO® session, experts mentor and share their expertise across a virtual network via case-based learning, enabling primary care practice teams to treat patients with complex conditions in their own communities.



# PROJECT ECHO® IS NOT...

- Telemedicine
- Direct patient care
- eConsult model



# PROJECT ECHO® EVIDENCE: A SAMPLE

## Treatment Outcomes

### Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers

(Arora, S. et al. NEJM, 2011).

Outcome	ECHO	UNMH	P-value
	N=261	N=146	
Minority	68%	49%	P<0.01
SVR* (Cure) Genotype 1	50%	46%	NS
SVR* (Cure) Genotype 2/3	70%	71%	NS

\*SVR=sustained viral response

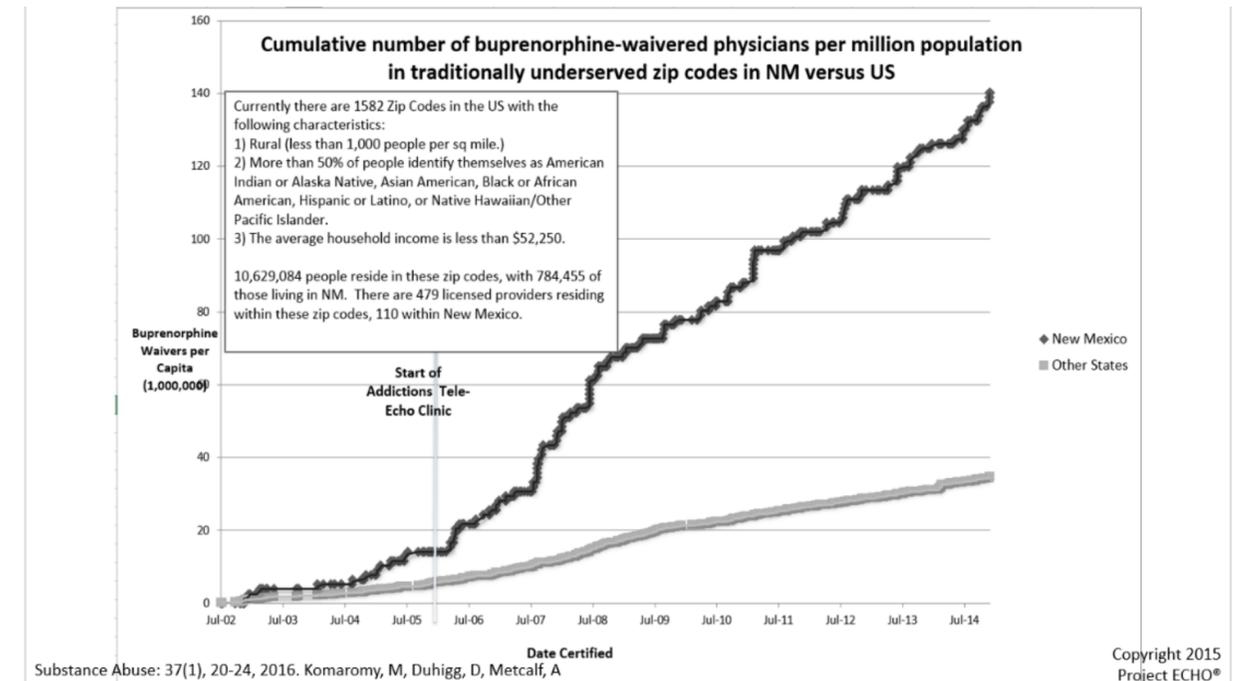
NEJM : 364: 23, June 9-2011, Arora S, Thornton K, Murata G



Copyright 2015 Project ECHO®

### New Model for Educating Primary Care Providers About Treatment Of Substance Use Disorders

(Komaromy M. et al., 2016. Substance Abuse 37(1):20-4.



# NNE PROJECT ECHO® NETWORK

## THREE ECHO SESSIONS

- **Perinatal SUD Continuum of Care**  
Just ended  
21 Participants sites; 62 Team members, 10 Faculty
- **Medications for Addiction Treatment**  
In progress  
27 Participant sites; 100 Provider team members, 11 Faculty
- **Care for Older Adults**  
Starting soon

## HRSA Funded Partners

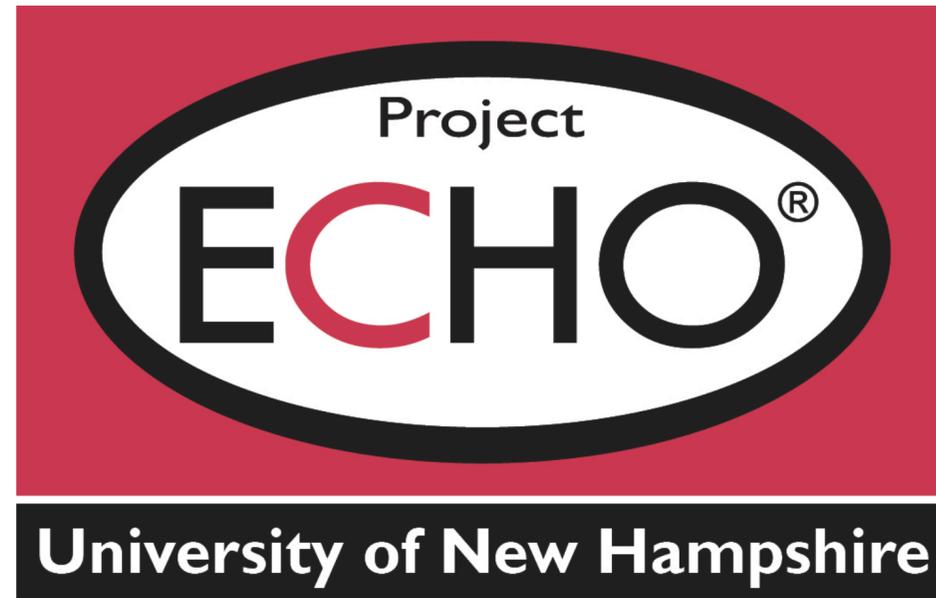
- Maine Quality Counts
- NH Citizens Health Initiative/UNH IHPP
- Vermont Program for Quality in Health Care
- ME, NH, and VT AHECs



# NEW! UNH ECHO® HUB

Concord & Durham ECHO®  
Sites

UNH TelePractice Center



## Partnership for Academic-Clinical Telepractice (PACT)

***First Session: Medications for Assistance Treatment (MAT) – SAMHSA Funded***

- Integrates MAT waiver training into Nurse Practitioner graduate school curriculum
- ECHO® supports clinical MAT curriculum for NP waiver students and community practice provider sites
- Case-based, distance learning to support best practice treatment for Opiate Use Disorder
- Future ECHO®-related projects in planning: Using claims data for ECHO® feasibility, pedi behavioral health, BH integration

# REFERENCES

Arora S, Thornton K, Murata G, et al. Outcomes of treatment for hepatitis C virus infection by primary care providers. *N Engl J Med*. 2011;364(23):2199–2207.

Komaromy M, Duhigg D, Metcalf A, et al. Project ECHO (Extension for Community Healthcare Outcomes): A new model for educating primary care providers about treatment of substance use disorders. *Subst Abuse*. 2016;37(1):20–24.

Extensive Project ECHO Bibliography at: <https://echo.unm.edu/about-echo/research/>

# QUESTIONS?





# CONTACT US



## **VISIT US**

[www.citizenshealthinitiative.org](http://www.citizenshealthinitiative.org)



## **SEND US A NOTE**

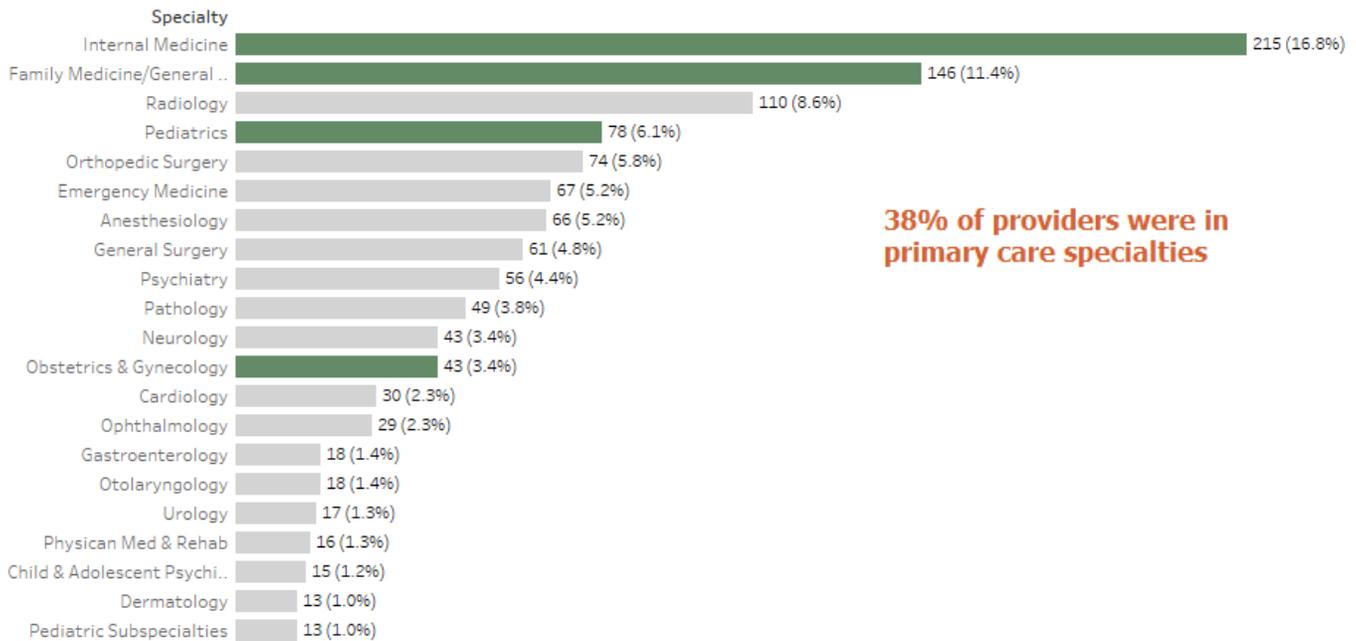
[Jeanne.Ryer@UNH.edu](mailto:Jeanne.Ryer@UNH.edu)

# 2018 Physician Survey Implementation Results

## 59% Survey Response Rate (2,961 physicians renewed)

- 1,280 physicians did not complete the survey, 46 (3%) opted out on paper or by phone
- In 2017, without legislation, the response rate was ~48%

### Nonrespondents (N=1,280)



38% of providers were in primary care specialties

## Cause of Low Response Rate

- Inconsistency among administrator guidance to communicate survey completion as a requirement
  - Sampling bias results in inability assume a representative sample and extrapolate data
- Lack of physician survey notification on renewal materials

## Result of Low Response Rate and Incompletion of Opt-Out Form

- Inability to determine the following workforce indices:
  - Practice status (active/inactive)
  - Practice location (region/2+ locations)
  - Practice hours (infrequent/PT/FT)
- Inability of the PCO to validate provider data for shortage designation purposes

## Data Improvement Opportunities

- Online renewals
- Practice status question on Board of Medicine renewal form
- OPLC leadership prioritizing consistent survey communication
- Increase in physician survey notification through reminder postcards and online renewal page
- Provider association/CEO involvement
- Legislation to require completion of either the opt-out form or survey?



## **J1 Visa Waiver Program (Conrad 30)**

### Program Process

The federal J-1 Visa Program allows an international medical graduate to come to the United States (US) under an educational exchange program for up to seven (7) years.

When the Visa expires, the physician must return to his/her native country for at least two (2) years before applying for a permanent Visa in the US. The J-1 Visa Waiver Program will eliminate the two-year requirement, providing the sponsoring state approves the waiver, if the waiver recipient agrees to practice medicine full-time in a designated health care facility for a minimum of three-years and begin employment within 90 days of receiving of the waiver.

The J-1 Visa Waiver Program allows each state to sponsor 30 waiver applications per federal fiscal year, October 1st through September 30th for primary care providers and sub-specialists who support primary care efforts.

Federal law allows for up to ten (10) waiver applications from facilities outside designated underserved areas if the J-1 physician's service site(s) can document that they serve patients from medically underserved areas and serve as a safety net to the indigent and medically underserved population.

Each application will be reviewed to determine whether the application is complete and meets the requirements of the federal and state policies and guidelines. In reviewing waiver requests, RHPC will ensure the packet is complete with the information and documentation requested. RHPC will determine how the J-1 physician and service site(s) will improve access to care in the MUA or non-designated area to ensure that the proposed placement will not adversely affect or compromise the delivery of health care in the underserved areas in the State. The USDOS reviews and considers state recommendations with other policy considerations. The USDOS certifies the state recommendation and forwards it to the US Citizenship and Immigration Services (USCIS). The USCIS makes a final recommendation to approve or disapprove the J-1 waiver. The USCIS will send a letter to the health care facility and/or immigration attorney with their decision

### NH Program Details

NH has a preference for outpatient primary care physicians but will consider specialists in the service area if the facility can demonstrate that a shortage of that specialty exists in that service area and that the J-1 physician and service site(s) are willing to charge for services at the usual and customary rates prevailing in the service area. In addition, the service site(s) shall have a policy providing the patients unable to pay the usual and customary rate a reduced rate according to the service site's sliding-fee-schedule or not at all, based on poverty level. The site(s) agrees not to discriminate on the patient's ability to pay for care or the payment source, including Medicare and Medicaid. Providers in federal designation areas will have priority over non-designated waiver requests.

Applicants must:

- Have a contract for full-time employment from an eligible service site(s).
- Work a minimum of 40 hours per week (for at least 45 weeks per service year) in an outpatient, clinical setting. At least 32 hours, of the required 40 hours per week, must be spent providing direct patient care in the outpatient ambulatory care setting at the approved service site.
- Up to 7 weeks (35 work days) of leave is allowed from the service site per service year (vacation, holidays, professional education, illness, etc.).
- Have completed an approved and accredited postgraduate training program in the US or Canada in primary care or a specialty that supports primary care.
- Have a NH Medical License.
- Include either a “No Objection” letter from the home country, or a statement that the physician is not contractually obligated to return to the home country.

Flex (non-designated) slots:

We require that the employer or immigration attorney (the use of an immigration attorney is strongly suggested) provide early justification for the need of a J-1 physician in a non-designated service area.

This allows the State an opportunity to evaluate the need of the community and the appropriateness of approving the J-1 physician to serve in the specified service area. Rural Health and Primary Care will e-mail the employer’s contact representative the decision. If the non-designated service area is approved, a flex-spot will be held for the facility and the completed waiver application must be received by the State for final review within 3 months.

In all cases, federal designated waivers will have priority over non-designated slots. Also, keeping all medically underserved areas of New Hampshire in mind, the State will impose a limit of 3 flex slots per facility from October 1 to March 1 after which time the slots will be opened to any eligible facility regardless of how many they’ve requested (up to 10).

More information, complete guidelines and application package instructions can be found at:

<https://www.dhhs.nh.gov/dphs/bchs/rhpc/visa.htm>

# Culturally Effective Healthcare Organizations

## A Framework for Success

April 2015

### Executive Summary

Healthcare organizations across the United States are implementing a range of practices to keep pace with a diversifying patient population and workforce. These practices have the potential to improve quality of care, enhance patient safety and satisfaction, and reduce health disparities. Culturally effective organizations also gain a competitive edge in the marketplace because these practices enable them to meet legal, regulatory, and accreditation mandates, and cultivate a stable and engaged workforce. This document summarizes seven key elements that constitute a framework for healthcare institutions seeking to become culturally effective organizations. These elements are drawn from a cross-walk of the recommendations established by various healthcare industry accrediting and standard-setting organizations, as well as subject matter experts and the National CLAS Standards. For more information, see *Culturally Effective Healthcare Organizations: A Framework for Success* <http://iasp.brandeis.edu/pdfs/2015/CE.pdf>.

### Framework for a Culturally Effective Organization



- 1. Leadership** – Executive leadership and boards of directors formally model the organization’s commitment by including consideration of cultural effectiveness in the strategic planning process and overall organizational expectations and practices. Leadership is responsible for guiding the organization to address biases and overcome resistance to change.
- 2. Institutional Policies and Procedures** – Healthcare organizations take a systematic approach to formalizing their commitment to cultural effectiveness by articulating their vision through written policies, procedures, goals, and practices.

3. **Data Collection and Analysis** – Data related to cultural effectiveness and workforce diversity informs strategic planning and aids in tailoring service delivery to meet community needs. Data is also used to identify treatment variation and differences in patient outcomes and satisfaction across groups, and to monitor the impact of cultural effectiveness-related policies and activities on health equity and outcomes.
4. **Community Engagement** – Organizations are more effective when they engage the community in a two-way process to learn, communicate, and share knowledge. This requires establishing relationships that position the community as an active partner in organizational decision-making, such as participation in the development and interpretation of community health needs assessments, serving on Boards, or advising the development of strategic plans.
5. **Language and Communication Access** – Effective communication is essential to the provision of quality, culturally competent care. Several federal civil rights laws require communication assistance: Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and Section 504 of the Rehabilitation Act of 1973. In response, organizations are establishing policies and systems to identify and track patients' communication access needs, including preferred language, and to provide appropriate interpretation, translation, and communication assistance services.
6. **Staff Cultural Competence** – Healthcare organizations implement a range of practices to ensure that patients from all racial and ethnic backgrounds receive optimal patient care. To meet accreditation standards, healthcare organizations are integrating patients' cultural preferences into care delivery and supporting these changes with organizational policies and procedures which enable staff members to fulfill these expectations. The cultural competence of all staff requires continuous learning and professional development.
7. **Workforce Diversity and Inclusion** – The nation is becoming more diverse, and this diversity is reflected in the patient population and the workforce. However, racial and ethnic minority groups are underrepresented in health occupations and workplace settings that pay better and offer opportunities for advancement. Meanwhile, nursing and residential care facilities and home healthcare agencies are increasingly recruiting and employing professionals from diverse backgrounds and seeking ways to nurture increased multiculturalism among patients and staff. Healthcare organizations can address underrepresentation by diversifying their workforce and introducing practices to ensure that employees from all backgrounds have the opportunity to contribute meaningfully to the workplace.

The issue brief *Culturally Effective Healthcare Organizations: A Framework for Success* was produced in April 2015 as part of an ongoing series for the Healthcare Employer Research Initiative, a four-year partnership of the Institute on Assets and Social Policy at Brandeis University with the New Hampshire Office of Minority Health and Refugee Affairs. The goal of this initiative is to identify New Hampshire healthcare employer needs, challenges, and best practices for increasing diversity in the healthcare workforce. This brief responds to healthcare employer requests for information and strategies to advance this work. Authors: Melanie Doupé Gaiser, Laurie Nsiah Jefferson, Jessica Santos, Sandra Venner, Janet Boguslaw, and Trinidad Tellez, MD. Available at: <http://iasp.brandeis.edu/pdfs/2015/CE.pdf>. For more information, contact Sandra Venner at: [venner@brandeis.edu](mailto:venner@brandeis.edu).

The Institute on Assets and Social Policy, Brandeis University

415 South Street, MS 035

Waltham, MA 02454

(781) 736-8685

[www.iasp.brandeis.edu](http://www.iasp.brandeis.edu)

**IASP**



## Strategies for Diversifying Your Healthcare Workforce: A Tool for Healthcare Providers

New Hampshire's population is becoming more diverse and the state's healthcare workforce is not keeping pace with this trend. A workforce reflective of the patient population results in improved access to care, patient satisfaction, patient-provider communication, and health outcomes. **All providers and patients benefit from a culturally effective, diverse environment focused on delivering high quality care.** There are economic benefits as well; diversity improves business performance and competitiveness, reduces interpretation costs, decreases the cost of care, and stimulates medical and public health innovations. This locally developed tool based on national best practices is a resource for your organization to **increase the proportion of underrepresented racial, ethnic and linguistic minorities among health professionals** in your workforce and maximize the human capital our state has to offer.

Area	Strategy
1 <i>Know Your Community and Your Workforce</i>	1 Collect demographic information on your community 2 Collect Race, Ethnicity and Language (REaL) data on your patient population 3 Collect Race, Ethnicity and Language (REaL) data on your workforce 4 Translate brochures and informational materials
2 <i>Recruitment</i>	1 Support early intervention and pipeline programs 2 Implement targeted, innovative recruitment campaigns to increase visibility of job openings 3 Establish partnerships with health profession training programs 4 Create appropriate marketing materials 5 Make Equal Employment Opportunity (EEO) policies and commitment to diversity explicit 6 Consider adding alternative hiring criteria
3 <i>Retention</i>	1 Create flexible scheduling options 2 Offer training and professional development opportunities that foster self-efficacy 3 Encourage social support networks and mentoring 4 Offer culturally-appropriate supervision and mentorship
4 <i>Career Development and Advancement</i>	1 Establish articulation agreements and career ladders 2 Provide tuition reimbursement or opportunities for work-study to encourage advancement 3 Publicize your organization's workforce development strategy
5 <i>Create a Climate of Inclusion</i>	1 Offer diversity programming and cultural competency training 2 Identify and publicize the benefits of diversity for business 3 Offer professional development
6 <i>Policies and Procedures</i>	1 Conduct an assessment to analyze your institution's current policies and practices 2 Develop a Diversity Plan 3 Align diversity with organizational strategies 4 Seek and publicize commitment from senior management 5 Establish a diversity structure 6 Create a system for organizational accountability 7 Partner with other sectors



## The Culturally Effective Organizations Framework & Resources

In NH we value that everyone lives freely, but that means ensuring everyone has equal opportunity to thrive. We know that organizations strive to ensure this opportunity by providing high quality services that are accessible to all in NH – yet achieving this can be challenging. Many of us have simply not had access to training about an effective approach that would turn our goals into broader success.

The good news is that a roadmap exists; the **Culturally Effective Organizations (CEOrgs) Framework<sup>1</sup>** is the roadmap that enables, cultivates, and supports the delivery of high-quality services for all people.

### Framework for a Culturally Effective Organization



The **NH Health & Equity Partnership** ([www.equitynh.org](http://www.equitynh.org)) has a **Culturally Effective Organizations Work Group** focused on supporting organizations to learn about the essential pathways for success.

Check out the **Culturally Effective Organizations Framework Online Digital Toolkit<sup>2</sup>** and the toolkit **webinar** which provides an overview of the toolkit to assist on the journey to becoming a culturally effective organization and providing high quality services for all.

*For questions please contact the Office of Health Equity:  
[healthequity@dhhs.nh.gov](mailto:healthequity@dhhs.nh.gov) or (603) 271- 8557*

**Seeking for all a fair opportunity to live a long, healthy life.**

[www.equitynh.org](http://www.equitynh.org)

<sup>1</sup> The full issue brief can be accessed at <http://iasp.brandeis.edu/pdfs/2015/CE.pdf> ; the executive summary is at <https://iasp.brandeis.edu/pdfs/2015/CEO%20Ex%20Sum%20final%20-%20Print%20Version.pdf>

<sup>2</sup> The online toolkit can be accessed at <http://www.mchc-nh.org/center-of-excellence-for-culturally-effective-care/>