Legislative Commission on the Interdisciplinary Primary Care Workforce

February 18, 2021 2:00-4:00pm – Zoom Conference

Call in information:

Join Zoom Meeting
https://nh-dhhs.zoom.us/j/99882497050?pwd=S25rWEVCdktNbnZOZ0tXVFRkclgyQT09

Meeting ID: 998 8249 7050
Passcode: 651907

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

Agenda

2:00 - 2:20  Read Emergency Order #12 Checklist and Take Roll Call
Attendance, Introduce Rep. Mark Warden

and Health Workforce Data Collection – Alisa Druzb &
Danielle Weiss, Rural Health & Primary Care, DHHS

3:15 - 3:45  Legislative Agenda – Group discussion

3:45 - 4:00  Updates & Adjourn

Next meeting: Thursday March 25, 2:00-4:00pm
STATE OF NEW HAMPSHIRE
COMMISSION ON THE INTERDISCIPLINARY PRIMARY CARE WORKFORCE

DATE: February 18, 2021
TIME: 2:00 – 4:00pm
LOCATION: Zoom Conferencing

Meeting Notes

TO: Members of the Commission and Guests
FROM: Danielle Hernandez
MEETING DATE: February 18, 2021

Members of the Commission:
Mark Warden, NH House of Representatives
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
Mike Ferrara, Dean, UNH College of Health and Human Services
Bill Gunn, NH Mental Health Coalition
Tom Manion, CEO, New London Hospital
Dianne Castrucci, NH Alcohol and Drug Abuse Counselors Association
Laurie Harding, Upper Valley Community Nursing Project
Kimberly Bean, NH Society of Physician Assistants
Trini Tellez, Healthcare Consultant

Guests:
Danielle Hernandez, Program Manager, Rural Health and Primary Care
Paula Smith, SNH AHEC
April Mottram, Executive Director, NNH AHEC
Geoff Vercauteren, Director of Workforce Development, Catholic Medical Center
Peter Mason, Geisel School of Medicine, IDN region 1
Ann Turner, Integrated Healthcare, CMC
Natalie Rickman, Bi-State Primary Care
Eve Klotz, Clinical Director, Northern Human Services

Meeting Discussion:

2:00 - 2:20 Welcome and Introductions/Read EM #12 Checklist and Take Roll Call, Introduce Rep. Mark Warden – Mary Bidgood-Wilson, ARNP – Chair

2:20 – 3:15 2020 Annual Report on the Health Status of Rural Residents and Health Workforce Data Collection – Alisa Druzba & Danielle Weiss, Rural Health & Primary Care, DHHS

Refer to the attached presentation, “Health Status of Rural NH & Health Professions Data Center - Legislative Report.”
3:15 - 3:45 Legislative Agenda – Group Discussion

- The State Loan Repayment Program (SLRP) received $1.2m from the Joint Underwriting Association (JUA) spread out to $410k per year to support continuing contracts
  o The SLRP account has two separate lines for JUA funds and general funds, allowing the JUA funds to sit in treasury (escrow) in an investment account so the program can draw off dividends
  o If there’s a reduction of general funding, the JUA funds act as a fallback to honor loan repayment commitments

- SLRP Expansion
  o Rural Health and Primary Care plans to expand the program by providers or site types
    ▪ Dependent on funding stability and consistency
  o $4m was taken from SLRP for the pandemic
    ▪ SLRP participants had to recommit to the program with the understanding the funding could end
    ▪ JUA funding was utilized

- SLRP funds allocated to the pandemic have not been transferred back to the budget line
  o Funding lapses after this State Fiscal Year (6/30)
    ▪ The funds won’t appear in the 2022 budget unless there’s legislative action to do so

- SLRP participation
  o ~78 on contacts right now
  o Service ends at various quarters throughout the year; some contracts just started and others have extensions

3:45 - 4:00 Updates & Adjourn

Next meeting: Thursday March 25, 2:00-4:00pm
Health Status of Rural Residents and Health Workforce Data Collection

February 18, 2021
Today’s Purpose

- Health Status of Rural Residents
  - Statutory requirements
  - Rural definition
  - Measures used
  - Overview of health outcomes in rural in NH
  - Comments on data request and analysis
  - Future plans
RSA 126-A:5, XVIII-a(e) requires that the State Office of Rural Health (SORH) submit a report on or before December 1, 2019, and annually thereafter to the speaker of the house of representatives, the senate president, the governor, the oversight committee on health and human services established under RSA 126-A:13, the chairs of the house and senate executive departments and administration committees, the chairs of the house and senate policy committee having jurisdiction over health and human services, and the commission on primary care workforce issues established by RSA 126-T:1, on the health status of rural residents, incorporating current data from the Bureau of Health Statistics and Data Management.

In 2019, RSA 126-A:5, XVIII-a was amended to include that the SORH shall receive and collect data regarding surveys completed by participating licensees pursuant to RSA 317-A:12-a, RSA 318:5-b, RSA 326-B:9-a, RSA 328-D:10-a, RSA 328-F:11-a, RSA 329:9-f, RSA 329-B:10-a, RSA 330-A:10-a, and RSA 330-C:9-a. Annual reports submitted by the SORH shall incorporate aggregate data and information on current and projected primary workforce needs and the participation rate on surveys completed by clinicians.
DHHS Definition of Rural

Rural and Non-Rural New Hampshire Regional Public Health Networks 2017/2018

- Rural
- Non-Rural
Primary Care Focus

- Primary care = medical, oral and behavioral health

- The Rand Health Insurance Study demonstrated the benefit of access to primary care services, in particular for the poor, that resulted in improved vision, more complete immunization, better blood pressure control, enhanced dental status, and reduction in estimated mortality in comparison to low-income individuals and their children who had financial barriers to access.

- Patients receiving primary care had significantly higher-value care on average and better health care access and experiences than those without primary care.

- This is why most of our workforce programs also focus on primary care providers.

- 2020 Primary Care Office Needs Assessment Report - no national standardized measures or consensus as to which health behaviors and outcomes best predict primary care access and utilization, the indicators contained in the report were selected from the NH State Health Improvement Plan Priority Areas as the most likely to be impacted by primary care and most indicative of the population’s health status. Demographic data highlights population risk factors associated with access to and utilization of primary care.
Selected indicators were classified under the following categories (for a full list of analyzed health indicators, see Appendix A in the report):

- Demographics
- Barriers to Care
- *Workforce Supply
- Substance Use and Mental Health
- Maternal Health
- Preventive Care
- Health Outcomes

* Not included in this report; data analysis still underway, refer to the Health Professions Data Center figures on distribution.
We did multi-year aggregates (details at the bottom of the graphics) to get around low numbers for many of the indicators.

Data statistics (rates and accompanying intervals at the 95% confidence level) were compiled by the Bureau of Public Health Statistics and Informatics at the NH Department of Health and Human Services and by Community Health Institute, John Snow Inc.

Apart from the All-Payer Claims Database (APCD) statistics, which do not contain confidence intervals, the visualizations contained in this report represent indicators found to be statistically different - according to confidence intervals (CI) - in rural and non-rural areas of the state. Indicators with slightly overlapping CIs for estimated rates were also included, as these relationships warrant further investigation.
Demographics

Sources:

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Census American Community Survey 2014-2019</th>
<th>Percent</th>
<th>Crude</th>
</tr>
</thead>
<tbody>
<tr>
<td>65+</td>
<td></td>
<td>15.4%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Disabled 18-64</td>
<td></td>
<td>9.3%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Low Income</td>
<td></td>
<td>7.2%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Not Fluent in English</td>
<td></td>
<td>0.4%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Uninsured</td>
<td></td>
<td>6.9%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Veteran</td>
<td></td>
<td>8.6%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>
Barriers to Care

Sources:

<table>
<thead>
<tr>
<th>Primary Care Visits</th>
<th>NH All Payer Claims (CHIS)</th>
<th>2019</th>
<th>Mean Minutes to Visit</th>
<th>PC Visits per Member Year</th>
<th>Percent of PC Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Crude</td>
<td>Crude</td>
</tr>
</tbody>
</table>

Diagram showing:
- % Visits > 30 Min - All: 15.3% and 27.5%
- Mean Travel Time - All: 17.4 and 21.5
- Visits Per Year - All: 2.3 and 2.5
## Substance Use & Mental Health

### Substance Use and Mental Health

<table>
<thead>
<tr>
<th>Alcohol Drug</th>
<th>Substance Use - ED Visits</th>
<th>Substance Use - Inpatient</th>
<th>Mortality</th>
<th>Suicides</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Drug</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mortality</td>
<td></td>
</tr>
<tr>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Rural</th>
<th>Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Drug</td>
<td>119.4</td>
<td>148.1</td>
</tr>
<tr>
<td>Substance Use - ED Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use - Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>15.4</td>
<td>18.0</td>
</tr>
<tr>
<td>Suicides</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Sources:

- Alcohol Drug & Self-Harm: NH DHHS BPHSI
- Mortality: NH DHHS Vital Records

### Notes:

- 2018: Rate Per 100K
- 2010-2019: Deaths per 100,000
- Age Adjusted
Maternal Health

Sources:

Maternal Health | NH DHHS Vital Records | 2015-2018 | Percent of Births | Crude
--- | --- | --- | --- | ---
Delivery at 42+ weeks | 0.7% 1.0% | |
No or late prenatal care | 3.4% 4.0% | |
Smoked during pregnancy | 9.0% | 16.6% |
## Preventive Care

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Rural</th>
<th>Non-Rural</th>
<th>2016</th>
<th>Percent</th>
<th>Crude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had colonoscopy in past 10 years (ages 50 to 75)</td>
<td></td>
<td></td>
<td></td>
<td>68.9%</td>
<td>74.6%</td>
</tr>
<tr>
<td>Had mammogram past two years (women 50-74)</td>
<td></td>
<td></td>
<td></td>
<td>76.6%</td>
<td>85.0%</td>
</tr>
<tr>
<td>No dental visit within past year</td>
<td></td>
<td></td>
<td></td>
<td>25.9%</td>
<td>32.7%</td>
</tr>
</tbody>
</table>

**Sources:**
- Preventive Care: Behavioral Risk Factor Surveillance System (BRFSS)
- 2016
- Percent
- Crude
Inpatient Prevention Quality

Sources:
Prevention Quality Indicators | NH Uniform Healthcare Facility Discharge Dataset (UHDDS) | 2019 | Admissions per 100,000 pop | Age Adj
Health Outcomes - Cancer

Health Outcomes - Cancer

<table>
<thead>
<tr>
<th>Health Outcomes - Cancer</th>
<th>Rural</th>
<th>Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast (Female) - Late Stage Diagnosis Rate</td>
<td>42.0</td>
<td>48.3</td>
</tr>
<tr>
<td>Breast (Female) - Proportional Rate</td>
<td>28.6%</td>
<td>34.6%</td>
</tr>
</tbody>
</table>

Sources:

<table>
<thead>
<tr>
<th>Health Outcomes - Cancer</th>
<th>NH DHHS</th>
<th>2013-2017</th>
<th>Rate per 100k population</th>
<th>Age Adj</th>
</tr>
</thead>
</table>
Data Request and Analysis
Lessons Learned
Future Plans

- Once the new WISDOM data system is available, where possible, all data will be able to be viewed as rural versus non-rural according to the definition by Public Health Region.
- The RHPC will then create a Rural Health dashboard in Tableau that will link to the WISDOM system but contain rural relevant indicators for: basic demographics, health status, morbidity rates, mortality rates, health care access, social determinants, and environmental determinants. The link for the rural dashboard will be on our section website and also used for future annual reports. This data will be updated annually at a minimum but as often as the datasets change.
Today’s Purpose

- Health Workforce Data Collection
  - Timeline for workforce data reports
  - Response rate data
  - Noncompliance
  - Future plans
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Data Collected - <strong>Partial</strong></th>
<th>Data Collected - Full</th>
<th>Workforce Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistant (PA)</td>
<td>N/A</td>
<td>*2018, annually thereafter</td>
<td>2020</td>
</tr>
<tr>
<td>Physician</td>
<td>*2018</td>
<td>*2019</td>
<td>2020</td>
</tr>
<tr>
<td>Psychologist</td>
<td>*2019</td>
<td>2020</td>
<td>2021</td>
</tr>
<tr>
<td>Alcohol &amp; Drug Counselor (MLADC/LADC)</td>
<td>*2019</td>
<td>2020</td>
<td>2021</td>
</tr>
<tr>
<td>Advanced Practice Registered Nurse (APRN)</td>
<td>*2019</td>
<td>2020</td>
<td>2021</td>
</tr>
<tr>
<td>Mental Health Practitioner</td>
<td>*2019</td>
<td>2020</td>
<td>2021</td>
</tr>
<tr>
<td>- Independent Clinical Social Worker (LICSW)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Clinical Mental Health Counselor (LCMHC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Marriage and Family Therapist (MFT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pastoral Psychotherapist (PP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Dental Hygienist Dentist</td>
<td>N/A</td>
<td>2021</td>
<td>2023</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>2022</td>
<td>2024</td>
</tr>
</tbody>
</table>

Note: Timeline expected without data analyst position filled
* Data collection occurred prior to implementation of the 2019 legislative amendment, which requires survey/opt out as a condition of license renewal; as a result, survey/opt out responses are limited.
** Providers due to renew (about half of all licensees)
Table 2. Provider Response Rate Data for SFY2020

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Data Collection Period</th>
<th>Met Survey Requirement</th>
<th>*Opt Outs</th>
<th>**Total Renewals</th>
<th>Nonrenewals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistant (PA)</td>
<td>Oct-Dec 31, 2019</td>
<td>800 (95.1%)</td>
<td>12 (1.4%)</td>
<td>841 of 903</td>
<td>6.9%</td>
</tr>
<tr>
<td>Physician</td>
<td>Mar-Jun 30, 2020</td>
<td>2,989 (95.1%)</td>
<td>51 (1.7%)</td>
<td>3,144 of 3,678</td>
<td>14.5%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>Apr-Jun 30, 2020</td>
<td>173 (99.4%)</td>
<td>3 (1.7%)</td>
<td>174 of 233</td>
<td>25.3%</td>
</tr>
<tr>
<td>Alcohol &amp; Drug Counselor (MLADC/LADC)</td>
<td>Apr-Jun 30, 2020</td>
<td>242 (99.2%)</td>
<td>2 (0.8%)</td>
<td>244 of 279</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

* Of licensees who met the survey requirement
** Of those due to renew
<table>
<thead>
<tr>
<th>Provider</th>
<th>Noncompliance Rate Pre-Board Intervention (#)</th>
<th>Noncompliance Rate Post-Board Intervention (#)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists</td>
<td>11% (19)</td>
<td>~0% (1)</td>
<td>11%</td>
</tr>
<tr>
<td>LADCs/MLADCs</td>
<td>9% (22)</td>
<td>1% (3)</td>
<td>8%</td>
</tr>
<tr>
<td>*Physicians</td>
<td>5% (151)</td>
<td>5% (151)</td>
<td>0%</td>
</tr>
</tbody>
</table>

* The Board of Medicine did not conduct follow up on noncompliant providers
Future Plans

- **Compliance**
  - NHMS
  - OPLC Enforcement Division
  - Transition to rolling renewals

- **Staffing**
  - Data analyst

- **Data Use**
  - Comprehensive analyses of primary care
  - True anticipated supply
  - Grants/Publication
  - Full workforce data
2020 Report on the Health Status of Rural Residents and Health Workforce Data Collection

Alisa Druzba - Administrator
Danielle Weiss - Health Professions Data Center Manager
Jan Wainwright - Primary Care Workforce Program Specialist
Alia Hayes – Rural Health Manager
Marie Wawrzyniak - Rural Health Quality Improvement Coordinator
Vacant – Primary Care Workforce Data Analyst (New position)
Vacant – Health Data Analyst (New part-time position in BHPSI)