

Workforce Strategic Planning

Informal Survey Results

As a starting point for workforce strategic planning, an informal survey was conducted in early May 2011, via e-mail to 21 stakeholders in primary care. The following is a list of those asked to participate. A total of 15 responses were received.

Informal Survey Invited Participants

<u>ID</u>	<u>Name</u>	<u>Organization Affiliation</u>
1.	Susan Hanrahan*	ASU Jonesboro – Department of Nursing and Health Professions
2.	Ed Franklin*	Arkansas Association of Two Year Colleges
3.	Omar Atiq*	Arkansas Medical Society
4.	Ann Bynum*	UAMS Regional Programs
5.	Bob Mason*	Arkansas State Dental Association
6.	Mark Mengel*	UAMS Regional Programs
7.	Mike Smets*	Arkansas Pharmacists Association
8.	Artee Williams*	Arkansas Department of Workforce Services
9.	Jean Zehler*	Arkansas Nurses Association
10.	Eddie Maples	AHEC - Pine Bluff
11.	Don Heard	AHEC - Ft. Smith
12.	Robert Gullett	AHEC - Northwest
13.	Dennis Moore	AHEC - North Central
14.	Michael Fitts	AHEC - South
15.	Pat Evans	AHEC - Southwest
16.	Ronnie Cole	AHEC - Northeast
17.	Becky Hall	AHEC - Delta
18.	Sip Mouden	Community Health Centers of Arkansas
19.	Joe Elser	Arkansas Children's Hospital – General Pediatrics
20.	Jennifer Dillaha	Arkansas Department of Health
21.	Elizabeth Burak	Arkansas Advocates for Children and Families
22.	Linda Mcghee	Arkansas Nurses Association

**Member of Workforce Taskforce Group*

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.



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Response Synopsis

Question #1: What do you consider to be the most pressing problems/issues with the health and health care delivery system in Arkansas?

Access: Limited number of providers, geographic maldistribution, cultural and linguistic issues. Large numbers of the population ages 19 to 64 lack health insurance. Many people do not know how to navigate the health care system.

Cost: Uninsured and underinsured populations, high cost insurance premiums and increasing cost of pharmaceutical products. Inadequate fiscal resources to develop new infrastructures.

Quality: Payment to providers should be based on outcomes or some other basis and not on a fee for service basis. There should be no inducement to provide extra services that do not have significantly better outcomes for the patient, but provide significantly higher reimbursement for the facility or provider. Lack of coordination of care/fragmentation – care transition and referrals across disciplines. Low health literacy

Increasing burden of chronic disease, obesity, cardiovascular disease, stroke, diabetes, arthritis.

Aging population.

Individuals not assuming responsibility for risk behavior including smoking, nutritional deficiencies, lack of physical activity.

Health Disparities, both geographic and based on race/ethnicity, impact of socioeconomic factors and relationship to mortality.

Rural physicians are ill-equipped to convert to an EMR, meet meaningful use, meet 5010 standards or participate in PQRI or change his/her model of care to a PCMH.

Inadequate reimbursement for primary care.

The development of risk-share arrangements among providers and other newer models of care demand cooperation, not competition, which will be a big change in Arkansas.

Low numbers of behavioral health providers resulting in inadequate access to mental health and substance abuse treatment.

Low performing public school system – inadequate preparation for health care careers.

Provider variation in accepting/capping/closing Medicaid and Medicare patients within practices.

Current and projected Medicaid Fiscal Status.

Lack of a state dental school, only one medical school.

Lack of “practice control” with not enough evidence-based medicine being practiced and no control over utilization (especially true in government run systems).

No serious consideration of tort reform.

Question #2: What are the most significant workforce challenges that your organization (or Arkansas) will face in the coming years, especially as provisions of the new health legislation are implemented?

On the east side of the state, the addition of 200,000+ enrollees added through Medicaid expansion. Since we are already MUA and HPSA, this poses a tremendous burden on existing providers.

We have primary care needs but also diagnostic (lab/imaging) and rehab needs.

Challenges in recruitment and retention of primary care providers in rural areas related to low compensation, rising malpractice premiums, professional isolation, limited time off and scarcity of jobs for spouses. Aging workforce and pending retirement.

Workforce is challenged by geographic realities; lack of care coordination and system inadequacies for proper utilization of all available resources.

Expanded scope of practice for PAs and NPs will be necessary to respond to increased demand for primary care services.

Loss of populations (emigration) including population loss in south eastern part of the state.

The number of physicians, dentists, mid-levels, nurses, and behavior health specialists who are culturally and literacy sensitive as well as bilingual and who would be willing to serve in underserved and rural communities.

Ability to recruit clinicians, especially from the ever enlarging pool of FMGs and J1 visa docs doing family medicine residencies in the AHEC system .

Access to specialty care within the underserved and rural communities.

Inadequate training in care coordination and case management .

Workforce solutions must include transportation options to bring patients to treatment rather than force providers to underserved areas.

Workforce must operate as a team and not in separate silos.

Question #3: Of these issues, which do you think can be addressed through health care workforce and how (current programs, new ideas, suggestions, etc.)?

Inform workforce needs by quantifying

- licensed provider groups in terms of number, practice location.
- number of graduates by school/applicant pool numbers/geographic location.
- entering workforce/yr, estimating retirements by year and overlaying the expected growth necessary to meet need.

Expand the primary care pipeline by developing physician expander training sites in the AHEC's.

AHEC programs are strategically located to serve as regional hubs for the development of a network of rural satellite clinics. These clinics could be linked to their regional hub for all their EMR needs, management resources, etc. This would be like a state supported rural clinic program where the physician is an employee and the network and management are state resources managed by UAMS/Regional Programs/AHEC's. FQHC certification would need to be pursued in order for this type of plan to have sufficient revenue to survive.

Care coordination can be improved by sharing of appropriate patient information throughout the state via an interoperable and interconnected efficient EHR system linking all physicians and hospitals, etc.

Separation of preventive and curative health care in a carefully crafted tiered system with fail safe mechanisms and credible physician supervision.

Establish new family medicine residency program through AHEC at hospitals without a cap. Two communities are very interested—Hot Springs and Searcy.

Develop a new PA program at UAMS and expand NP training at UAMS, ASU, and UA-F.

Recruitment – encourage 1st generation health care providers.

Facilitate access with community-based health navigators and community health workers.

Community dental rotations.

Subsidize medical training; establish and expand more federal and state funded health workforce scholarships and loan repayment programs.

Establish a Center for Health Literacy in the Center for Rural Health for statewide outreach to both patients and providers.

Ascertain “new” costs to work the plan.

Question #4: What are the most significant workforce opportunities/solutions/innovations that Arkansas should consider as it plans and develops workforce to meet patient and community needs?

Satellite operations for existing/proposed programs to areas that have workforce need.

In primary care, consider FNPs and PAs in addition to primary care MDs.

Understand that as larger numbers of individuals turn 65 and a larger number of those live beyond 85, almost every individual will have an orthopedic or neurologic event—the need for rehab providers (PT, OT and speech) will be very important.

Provide more inter-professional team training to support some of the varying medical home model concepts.

Provide teaching to more locations in the state on the Geriatric Home Caregiver Program (Elder Pal, Alzheimer's and Dementia Training, Personal Care Assistant, and Home Care Assistant). All four of these levels of training and skill competency equal 115 clock hours. Individual is then qualified to take the AR CNA exam administered by the Office of Long Term Care.

Provide more training statewide of the Chronic Disease Self Management Program (this will allow lay public to complete more self care of long term disease).

Promotion of health and wellness programs.

Promotion of health literacy.

Better incentive to pay providers to practice in rural setting (specific locations) – economically depressed parts of the state, not the rural retirement communities.

Develop healthcare interest groups in high schools and colleges (modeled after FM Interest Group at UAMS and expand “Hands-on Health Care” to HS and college students – one-day intensive “MASH” where students experience many of the engaging parts of the MASH experience.

Give 4-yr universities incentives to partner with UAMS – universities do not have an incentive to direct students to UAMS and complete a health care degree.

Working to change or create new policy/legislation which supports “workforce development” in Arkansas.

Total state financing of under-graduate and professional education for qualified students at in-state educational facilities without repayment if the clinician agrees to practice in-state in an

underserved area for an extended period of time, i.e., a minimum of one year for every year of state paid education plus two years with a minimum of 4 years.

All pharmaceutical companies doing business with the state would be required to contribute a % of the amount paid by the state for the company's products to pharmacy school scholarships at in-state pharmacy programs.

Provide state incentives to providers if they are located in MUA's. These incentives could be in the form of reduced taxes, subsidized office rent, purchases of supplies and equipment at state contract prices or other incentives.

There are 73 Community Health Center locations in Arkansas. Clinical rotations of MDs DOs APNs, PAs, DDS, DMD, RDH could be a possibility

Advocate for increased support of residency programs through Medicare. Increase the capped number of resident physicians teaching hospitals can claim under Medicare reimbursement. Increase use of bio-monitoring technologies and payment mechanisms to encourage group visits.

Retail clinics: Expanded roles for pharmacists and expand primary care to include dental and vision care.

On-site primary care in the workplace.

Team-based care management models with specialists collaborating with the medical home concept in shared risk arrangements.

Medical School curricular innovations that align with technology enabled care management, team-based care models lifelong learning that is measurable.

Partner with the respective health licensing boards to develop a required contribution fee to support program awards and operations. This support will build long-term sustainable funding.

Consider practice act changes to allow some of the current unmet need to be provided by those who are educated to perform screening OR build new skill sets into existing educational curriculum so that a scope of practice expansion will meet the cost, access and quality components.

Question #5: What resources are you able to share that might help the Health Care Workforce Workgroup with their work (data, surveys, results)?

- AHEC patient data base
- AMS input
- Results of the 2011 Health Care Workforce Vacancy study
- Progress on development of the PCMH at UAMS
- Arkansas Department of Workforce Development:
 - Referrals to job openings
 - Referrals to education and training
 - Labor Market Information
 - DWS Training Trust Fund where appropriate
- CHC Statewide Strategic Growth (SGS) Report (when complete). This report will provide information about the expected number of providers / staff Community Health Centers will need to meet planned growth over the next 4 years (*pending funding availability*)
- CHC access for All Arkansans Plan-data reflecting provider needs
- CHC Data
- Information about NHSC
- Information from state Primary Care Associations as to how they are addressing the Workforce Issues within their respective states
- AACF coalition support
- AHEC - Arkansas statewide workforce vacancy data
- Pharmacy data