WHITE PAPER #6: FRONTIER HEALTHCARE WORKFORCE

The recruitment and retention of a qualified health care workforce has long been a challenge in rural areas and even more so in frontier communities. As a result, the ability to recruit and retain physicians, nurses, physician assistants and a range of allied health practitioners will play a critical role in the long-term success of any of FCHIP systems. While the authorizing statute of the FCHIP demonstration allows for a waiver of Medicare and Medicaid regulations, it does not include authority to waive requirements for HHS' health workforce programs. Consequently, while this paper notes a number of long-term health workforce policy issues facing frontier communities, it includes only recommendations related to potential Medicare changes that could help address some specific workforce concerns.

The Frontier Community Health Integration Demonstration is authorized under Section330A of the Public Health Service Act and is also guided by authorization of Section 123 of P.L. 110-275, the Medicare Improvements to Patients and Provider's Act of 2008 (MIPPA). The purpose of the Frontier Community Health Integration Demonstration is to develop and test new models for the delivery of health care services in frontier areas through improving access to, and better integration of, the delivery of health care to Medicare beneficiaries. The authorizing legislation defines a frontier Critical Access Hospital (CAH) as a CAH located in a county with a population of 6 people or fewer per square mile and a daily acute-care census of 5 patients or less. The legislation also identifies four "frontier-eligible" states: Alaska, Montana, North Dakota and Wyoming.

In response to the MIPPA legislation and subsequent funding by Congress, the Health Resources and Service Administration/Office of Rural Health Policy (HRSA/ORHP) awarded an 18-month cooperative agreement to the Montana Health Research and Education Foundation (MHREF) to inform the development of a new frontier health care service delivery model. Actual design and implementation of the demonstration are the responsibility of the Center for Medicare and Medicaid Services (CMS).

To better identify and communicate the challenges and solutions for health care delivery in frontier communities, a Framework Document and subsequent topical white papers are being developed by MHREF and shared with the CMS. This is White paper #6 in this series.

I. CURRENT LEGISLATION AND REGULATIONS:

The following are relevant regulatory policies and programs administered by the U.S. Department of Health and Human Services (HHS), Center for Medicare and Medicaid Services (CMS) (Health Resources and Services Administration) impacting healthcare providers in rural and frontier communities:

Alternative Coverage Waiver— In Montana, there are three very isolated frontier Critical Access Hospitals (CAHs)[1] that are unable to recruit more than one physician assistant or nurse practitioner experienced in emergency medicine to their frontier communities. 42 CFR 485.618(d)(2) allows an alternative coverage waiver process with CMS that allows "a registered nurse with training and experience in emergency care" to give the only medical provider in these

[1] Dahl Memorial Healthcare in Ekalaka, MT; Garfield County Health Center in Jordan, MT, and McCone County Health Center in Circle, MT

isolated frontier communities short periods of time off by conducting medical screening examinations within their scope of RN practice. However, the alternative coverage waiver process currently is limited to CAHs with "no greater than 10 beds." (see 42 CFR 485.618(d)(3)(i)).

Rural Health Clinic (RHC) Productivity Screens— RHC-503.40.3-Screening Guidelines for RHC/FQHC Health Care Staff Productivity (Rev. 1, 10-01-03) requires "at least 4,200 visits per year per full time equivalent physician" and "at least 2,100 visits per year per full time equivalent physician assistant or nurse practitioner" employed by the clinic. These screening guidelines are used to determine the payment rate for services provided in the RHC.

A. Other Current Regulations or Legislation:

The demonstration authorized under section 123 of MIPPA provides the Secretary of HHS with broad authority to waive titles XVIII and XIX of the Social Security Act as may be necessary and appropriate for the purpose of carrying out the Frontier Community Health Integration Demonstration. Although the following programs, and the recommendations on these programs detailed below, do not fall under that authority, they are important workforce programs for frontier communities that the group would like to highlight.

The National Health Service Corps (NHSC) Loan Repayment Program – This program offers loan repayment assistance to primary care providers in exchange for working in Health Professional Shortage Areas (HPSAs). Eligible disciplines include Medicine (MD and DO in Primary Care practice areas), Physician Assistant, Nursing, Dentistry and Dental Hygiene, and Mental and Behavioral Health. The NHSC Scholarship Program offers funding to students in primary care education programs, in exchange for service upon graduation and licensure. Scholars also work in the NHSC approved sites, with the requirement of one year of service per scholarship year. NHSC sites are typically outpatient facilities, such as Federally Qualified Health Centers (FQHC) or RHCs. Recently, CAHs have been added as NHSC sites with flexibility for loan repayors to split practice time between inpatient and outpatient settings. As of February 2012, Montana had 357 approved NHSC sites (does not include CAHs) with 138.5 loan repayors in practice and 12 scholars.[2]

Teaching Health Center Graduate Medical Education Program – This program is a $230 million, five-year initiative which began in 2011 to support an increased number of primary care residents and dentists trained in community-based ambulatory patient care settings. Currently, the Montana Family Medicine Residency, based at Riverstone Clinic in Billings, MT is one of just 11 such programs in the nation. The goal of these community based programs is to increase the number of Primary Care residents and Dentists in underserved areas. Physicians trained in health centers are more than 3 times as likely to work in a health center and more than twice as likely to work in an underserved area than those not trained at health centers.[3]

[2] http://www.dphhs.mt.gov/publichealth/primarycare/documents/newsletter/PCONewsMarch2012.pdf
[3] http://bhpr.hrsa.gov/grants/teachinghealthcenters/index.html

II. EXPLANATION OF THE PROBLEM:

Montana is a very large and extremely rural state: Just one of the 56 counties in Montana is considered urban with more than 50 persons per square mile while ten counties are classified as rural (from seven to 50 persons per square mile).[4] The remaining 45 counties are considered frontier with six or fewer persons per square mile.[5] Although there are 48 CAHs in Montana (in addition to the 9 larger health systems), seven counties still do not have a hospital.[6]

The national shortage of Primary Care Physicians is well documented. Montana ranks 39th in the nation for Primary Care Physicians per100,000 population with 100.1/100,000. Wyoming ranks 43rd with 93.7/100,000 population, while Alaska ranks 28th (111.5/100,000) and North Dakota ranks 14th (126.9/100,000). The national average is 121.0/100,000.[7] Only four counties in Montana are not classified as Primary Care HPSAs.[8]

Nationally, nearly 20 percent of the total population resides in rural/frontier areas, but only 11.4 percent of physicians practice in rural areas.[9] Montana, likewise, suffers from significant maldistribution of the healthcare workforce. It is consistently difficult to recruit health care professionals – particularly those who are newly trained and face significant educational loans – to very small rural communities. In fact, nearly 39 percent of the primary care physicians in the state practice in just three cities.[10] Another striking example of workforce maldistribution can be seen in the Pharmacy workforce: six Montana counties have 51 or more pharmacists, while another six counties have zero pharmacists. Most counties have 10 or fewer.[11]

Provider maldistribution is a concern within the behavioral health workforce as well. Ninety percent of psychologists and psychiatrists and 80% of masters-level social workers work in metropolitan areas[12], but 85% of Mental Health HPSAs are in rural locations.[13] Likewise, psychologists in Montana

---

[4] See Table #2: Montana's 56 Urban, Rural & Frontier Counties—With Population Density on p. 3, *Montana's Rural Health Plan, July 2011*, Department of Public Health & Human Services (DPHHS). www.dphhs.mt.gov/qad/montanaruralhealthplan.pdf

[5] *Ibid.*

[6] p. 10, *Montana's Rural Health Plan, July 2011*; *op.cit.*

[7] *America's Health Rankings, United Health Foundation, state specific rankings. http://www.americashealthrankings.org/*

[8] Montana Department of Health and Human Services, Primary Care Office. http://www.dphhs.mt.gov/publichealth/primarycare/documents/MontanaPrimaryCareHPSAMap.pdf

[9] "The Future of Family Medicine and Implications for Rural Primary Care Physician Supply," Rosenblatt, Chen, Lishner and Doescher, WWAMI Rural Health Research Center, University of Washington—School of Medicine.

[10] "Montana Physicians in Active Practice, Number and Distribution of Physicians by Community and County," Newman. http://healthinfo.montana.edu/Montana%20Physicians.html

[11] Montana Office of Rural Health/AHEC website. http://healthinfo.montana.edu/MTHWAC/2010%20Pharmacists.jpg

[12] "Reducing Behavioral Health Disparities—Policy Platform," National Organization of State Office of Rural Health, http://www.nosorh.org/policy/platform.php

[13] "Rural Workforce Issues," The Annapolis Coalition on the Behavioral Health Workforce. http://www.annapoliscoalition.org/Rural_Workforce.aspx

are narrowly distributed: five counties have 16 or more psychologists, while 34 counties do not have any psychologist.[14]

The Allied Health workforce is critical to provision of quality care in frontier areas, but professional supply is limited. Post-secondary educational opportunities are very limited in frontier areas—coursework is most often via distance learning opportunities. For some allied health professions, Physical Therapy (PT) Assistant, for example, there are no training programs in the state—those wishing to pursue a PT Assistant career must attend a university outside of Montana.

With healthcare workforce shortages in frontier communities, professionals who are already overburdened by their workloads may be hesitant to offer their time and expertise as mentors and preceptors. Limited rural practicum opportunities do not allow for students to get a feel for rural practice. Professionals may be hesitant to practice in frontier communities where mentors are not on-site. Research tells us that rural practicum is a positive indicator of willingness to practice in rural communities. With few practicum sites, those opportunities are lost.

It is no surprise that frontier communities face challenges when recruiting health care providers. The most frequently cited professional concerns include: low salaries, cultural isolation, poor-quality schools and housing, and lack of spousal job opportunities.[15] Research shows that the most effective Primary Care recruitment strategies include: targeting students with rural background, exposing students to rural areas and issues during medical school and offering financial incentives to practice and remain in rural areas.[16] National Health Service Corps opportunities are perceived to be effective recruitment tools.

III. PROPOSED CHANGES:

While many of the policies and programs providing incentives for health care professionals to practice in rural areas do not fall under the purview of CMS for purposes of a demonstration project, there are three specific regulatory areas where certain changes could have significant impacts on proposed Frontier Health System entities participating in a demonstration project:

Alternative Coverage Waiver— Change 42 CFR 485.618(d)(3)(i) to allow the alternative coverage waiver process in Frontier Health System (proposed model for the Frontier Community Health Integration Demonstration) facilities with "no greater than 25 beds (or 35 beds if the proposed Frontier Health System recommendations are adopted)."

[14] Montana Office of Rural Health/AHEC website, http://healthinfo.montana.edu/MTHWAC/2010%20Psychologists%20by%20county.jpg
[15] Informing Rural Primary Care Workforce Policy: What does the Evidence Tell Us? McEllistrem-Evenson, Alex. April 2011. ruralhealthresearch.org
[16] Ibid

RHC Productivity Screens— Add "Physicians, physician assistants and nurse practitioners employed at Rural Health Clinics owned or operated by a CAH [or Frontier Health System] are exempt from the 4,200 visits per year per full time equivalent physician and 2,100 visits per year per full time equivalent physician assistant and nurse practitioner requirements."

Telehealth and Telemedicine Regulations – The expansion of the use of telehealth in frontier communities offers several workforce benefits to frontier CAHs. Non-physician providers could practice in more areas of the state while being advised by off-site specialists. Telemedicine also serves to support newly recruited graduates by increasing the availability of specialists. Patient transfers out of small rural centers may be avoided by accessing specialists via telemedicine.[17] In order to benefit from telehealth expansion however, the overriding issues of reimbursement and licensure must be clarified and resolved positively for rural practitioners. Current barriers and recommended proposals that would positively impact frontier CAHs are detailed in a separate white paper titled: "Case Study on Frontier Telehealth."

A. Other Recommended Program and Policy Changes:

A demonstration project providing revised regulatory and payment procedures for frontier health care facilities can do a lot to structurally enable frontier facilities to integrate and stabilize services in order to improve access to health care for Medicare beneficiaries and other community members. However, none of the structural changes will make a difference if these entities cannot assemble the medical staff necessary to provide critical health services in these very small communities. Although the following recommended policy changes are not within the scope of the Frontier Community Health Integration Demonstration, they are important policy issues for frontier communities that should be highlighted for future consideration.

Currently, there are a number of federal and state initiatives aimed at recruiting and retaining primary care providers, particularly in rural areas. In particular, the Patient Protection and Affordable Care Act (ACA), enacted in 2010, offers many provisions focusing on expanding the primary care workforce through three main focus areas:

a. increasing the number of trainees who are likely to pursue careers in primary care,
b. encouraging graduates to practice primary care, particularly in underserved geographic areas, and
c. adding to the skills of practitioners already working in primary care.

Frontier and rural health care entities need to utilize these opportunities to the maximum extent possible to insure the availability of necessary health care providers in their communities. If federal funding is unavailable, state funding should be sought. Some potential program or policy changes to address rural health care needs are outlined below:

[17] Health Care Workforce Distribution and Shortage Issues in Rural America. January 2012. Position paper from National Rural Health Association.

NHSC loan repayment and scholarship programs have recently been opened up to CAHs as a demonstration project (October 2011)— a very positive step in recruiting physicians, and other Primary Care Providers, to rural hospitals. The flexibility for loan repayors to divide service time between inpatient and outpatient care is expected to be attractive to program applicants. Most states, however, do not offer any loan repayment options for allied health professionals. There is more flexibility within the State Loan Repayment Program (SLRP) operated by HRSA. The program provides funds to States for loan repayment and recently added pharmacists as eligible providers and also allows States to include CAHs as eligible participants. States, however, must match every dollar under this program. Currently, Montana takes part in the SLRP program while Alaska, Wyoming and North Dakota do not. HRSA also administers programs that provide scholarships and loan repayment for nurses, dentists, pharmacists and optometrists. Unfortunately, the FCHIP authorization does not include authority for waiving any provisions of the NHSC or current HRSA scholarship and loan programs.

Establishment of **Residency programs in community health centers** is viewed as a positive retention strategy for rural communities— residents trained in community health centers would likely continue to serve at those sites as physicians. It has been well documented that students trained in rural areas are more likely to remain in rural areas upon completion of residency.

Reimbursement and Payment Policy Reform must level the playing field for frontier healthcare professionals. The reforms enacted through the ACA should increase the quantity of primary care services and make rural practice a more lucrative opportunity for primary care practitioners.

Team-Based care (Patient-Centered Medical Home) models of care offer significant benefit for patients and may offer opportunities to increase access to care for rural/frontier communities. The team can potentially deliver more care to a greater number of patients than just a single physician working alone. These new models typically emphasize quality of care and patient satisfaction. Although the physician patient-panel size may decrease, thereby decreasing the number of Primary Care physicians, other practitioners i.e. Community Health Workers or Care Coordinators, need to be identified and trained for new opportunities.[18] An additional benefit of team based care has been the integration of behavioral health services into the primary care setting.

IV. DISCUSSION:

[18] The Montana Health Research and Education Foundation (MHREF) is pilot testing a 3-year Care Coordination Network project in the original Frontier Workgroup communities, utilizing local Community Health Workers and a centralized, clinically trained Care Transitions Coordinator to build a system of consistent care and interventions for Medicare beneficiaries with multiple chronic conditions The goal of the project is to improve transitions of care for frontier residents and management of chronic health conditions that that often lead to avoidable hospitalizations and preventable readmissions. Outcomes will be tracked and evaluated in order to assess potential cost savings through reducing unnecessary hospitalizations, lowering readmission rates and improving overall health status. HRSA H2GRH23239 (2011-2014).

This discussion section focuses on the two regulatory areas administered by CMS that could be modified for a demonstration project. As noted earlier, the proposed modifications allowing for an expanded use of telehealth in frontier communities are addressed in a separate white paper.

A. Alternative Coverage Waiver:

For an effective frontier health care system to work – one that provides critical health care for rural residents close to home and at lower costs than what would be incurred traveling to tertiary care centers – there needs to be incentives that enable frontier entities to attract and retain a qualified health care workforce. In communities that only have one mid-level practitioner such as a Nurse Practitioner or Physician Assistant, that individual cannot be expected to be available 365 days a year, 24 hours a day. The alternative coverage waiver process set forth in 42 CFR 485.618(d)(2) and (3) is an essential tool for the retention of sole practitioners in some isolated frontier CAHs and communities because it allows appropriately trained registered nurses to provide temporary coverage when the practitioner is unavailable . However, as currently applied, the alternative coverage waiver 10-bed limit prevents CAHs from converting nursing home beds to swing beds and therefore more fully integrating and efficiently managing healthcare services for Medicare and Medicaid beneficiaries in these isolated frontier locations. Rule exceptions that were originally intended to enhance access to care for Medicare beneficiaries in frontier areas, now actually prevent the smallest of these facilities from providing the full range of health care necessary to meet community needs. With aging populations in rural communities, the provision of extended and post-acute care is a critical, essential service and it is important for frontier CAHs to be able to utilize swing beds for these purposes. At the same time, the waiver would afford vital relief for sole practitioners who could rely on experienced nurses to provide temporary coverage, thus avoiding burn-out or relocation to areas where they would not be the sole practitioner on site. Allowing the use of alternative coverage waiver for frontier facilities up to 25 beds (or potentially 35 beds as proposed in the "Frontier Health System" model) participating in a frontier demonstration project would provide more flexibility to truly provide the range of essential health care services and access to these services in a cost effective manner for Medicare beneficiaries while retaining practitioners who are willing to serve in some of the smallest rural communities.

B. Rural Health Clinic Productivity Screens:

The Rural Health Clinic Services Act of 1977[19] was enacted to address an inadequate supply of physicians servicing Medicare beneficiaries in rural areas and to increase the utilization of non-physician practitioners such as nurse practitioners (NP) and physician assistants (PA) in rural areas. There are approximately 3,800 RHCs nationwide that provide access to primary care services in rural communities.[20]

[19] Public Law 95-210
[20] US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Learning Network ICN 006398, October 2011

Productivity standards for RHCs were developed for evaluating the reasonableness of a clinic's productivity, to justify the need for a cost-based payment system, and to ultimately determine payment rates based on number of visits. Physicians, physician assistants and nurse practitioners at some RHCs in frontier communities have difficulty meeting these productivity standards because of very low service area populations. The patient population in these frontier communities is simply too sparse to support the kind of productivity envisioned for the majority of RHCs. Not meeting productivity standards causes reduced Medicare per visit payments for frontier RHCs and hampers the ability of frontier communities to be able to recruit and financially retain additional physicians, physician assistants or nurse practitioners. This cycle threatens the loss of access to a medical provider for frontier beneficiaries because of the inability to recover costs, posing significant barriers to assembling the medical staff necessary to meet the community's health care needs.

Eliminating productivity standards (or significantly modifying to be realistic for frontier RHCs) would eliminate these barriers while insuring the provision of timely and cost-effective health care services for Medicare beneficiaries in frontier areas.

V. CONCLUSION:

In order to positively impact the rural/frontier healthcare workforce, policies must address exposure to rural areas and issues during medical school and must offer financial incentives to practice and remain in rural areas. Additionally, provision of health care cannot be just doctor-driven but must include allied health professionals to achieve optimal outcomes. Some policy changes may show limited impact in the short run. However, improving the rural workforce must be considered a long-term challenge. When transitions are enacted in a thoughtful and data-driven manner, the benefits for rural and frontier communities will be many.

Appendix A:

Table 1
Summary of Health Reform Provisions to Increase Primary Care Capacity

Policy	Description	Potential Impact
Payment Reform	Designated primary care practitioners receive a 10 percent Medicare bonus payment (effective 2011-15); Medicaid payment rates for specific primary care services provided by primary care physicians increased to at least equal Medicare levels (effective 2013-14).	Some modeling suggests higher payment rates can increase the quantity of primary care services provided; however, a temporary increase may have less impact.
Care Delivery Reforms and Pilot Programs	Medicare Shared Savings/accountable care organizations (ACO) Program; community health teams to support patient-centered medical homes.	Health care organizations, such as ACOs, may encourage development of team-based primary care practices to increase capacity and improve efficiency.
Support Primary Care Training in Academic Settings	Awards grants to plan, develop and operate training programs in primary care; provides financial assistance to trainees and faculty; enhances faculty development in primary care and physician assistant programs.	Students recruited through targeted training programs are more likely to enter primary care in underserved areas. However, such programs may require large investment with a relatively small yield. Also, if residency slots are fixed, increases in U.S. graduates may merely displace international graduates, resulting in minimal impact on the net primary care workforce.
Creating New Primary Care Residency Programs	Redistributes residency positions in case of vacancies, and mandates 75 percent of new Medicare-supported residencies be in primary care, including internal medicine; academic medical centers or teaching hospitals may obtain grants for primary care residency programs.	Focusing on residency programs historically has a higher yield than creating academic training programs. Residents can also provide patient care and generate revenue for hospitals during their training.

Scholarships for Students Planning to Practice Primary Care	Grants to medical schools to recruit students likely to practice in rural areas; grants to train residents in preventive medicine specialties.	Students who are more likely to practice primary care, particularly in underserved areas, are also likely to face financial barriers to obtaining medical training; scholarships can address this barrier.
Loan Forgiveness and Direct Financial Incentives for Primary Care Practitioners	Increases annual and aggregate maximum on loans for nurses; increase in National Health Service Corps scholarships and loan forgiveness funding for primary care practitioners that practice in shortage areas.	Relative to scholarships, loan forgiveness has much lower dropout rates, higher retention and satisfaction.
Source: Authors' analysis of the 2010 Patient Protection and Affordable Care Act		

*Table from the National Institute for Health Care Reform, Policy Analysis, December 2011.Matching Supply to Demand: Addressing the US Primary Care Workforce Shortage. Carrier, Emily; Yee, Tracy; Stark, Lucy.