

MEMORANDUM

To: Joint Legislative Commission on Health Care Reform
House Committee on Health Care
Senate Committee on Health and Welfare

CC: Robert D. Hofmann, Secretary, Agency of Human Services

From: Susan Besio, Commissioner, Department of Vermont Health Access

Date: November 15, 2010

Re: Interim Study of Vermont's Primary Care Workforce Development

As required in Section 31 of Act 128 of the 2010 legislative session, please find attached the Interim Study of Vermont's Primary Care Workforce Development.

This report summarizes the current climate, recent efforts and options for the future to ensure that Vermont meets its increasing primary care work force needs. Successful health care reform relies on primary care and more practitioners across many disciplines will be needed, both in the short term and over time.

Primary care is fast losing ground as the preferred field of practice. Lower payments and the fee-for-service payment system have reduced time spent with patients and made the practice of primary care both more difficult and less rewarding. An aging population with increasing health needs calls for investing in a new generation of primary caregivers through increased resources for training, new and higher incentives to practitioners, and support for caregivers who choose to enter primary care in underserved areas. The need is to educate, employ and retain primary care providers in all areas of the state.

The Department of Vermont Health Access (DVHA) and Vermont Department of Health (VDH) will build on the report and continue to address the many issues raised about Vermont's primary care workforce. This will be made easier by the recent award of a federal (ACA) health care workforce planning grant of \$132,000 to the Vermont Area Health Education Center – AHEC, and the availability of future workforce implementation grants.



Future efforts will include:

- Continuing to engage with the workforce work group convened by Act 128,
- Developing specific estimates of the additional capacity needed geographically and in each of the many parts of Vermont's primary care delivery system, and
- Developing and implementing a detailed workforce development plan, including targets and resources needed to achieve them.

Primary Care Workforce Report and Five-Year Plan



A Report to the Joint Legislative Commission on Health Care Reform, House Committee on Health Care, and Senate Committee on Health and Welfare

November 15, 2010

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Primary Care Workforce Report and Five-Year Plan

1. Executive Summary

This report summarizes the current climate, recent efforts and options for the future to ensure that Vermont meets its increasing primary care work force needs. Successful health care reform relies on primary care, and so to achieve broad health reform goals, more practitioners across many disciplines will be needed, both in the short term and over time.

Primary care is fast losing ground as the preferred field of practice. Lower payments and the fee-for-service payment mechanisms have reduced time spent with patients and made the practice of primary care both more difficult and less rewarding. An aging population with increasing health needs calls for investing in a new generation of primary caregivers through increased resources for training, new and higher incentives to practitioners, and support for caregivers who choose to enter primary care in underserved areas. The need is to educate, employ and retain primary care providers in all areas of the state.

A five-year plan to ensure sufficient capacity in the primary care workforce and access to the healthcare delivery system for all Vermonters must include:

1. Improve data collection and analysis to monitor the status of Vermont's primary care workforce and inform planning.
2. Increase capacity for primary care provider education and training
3. Support primary care provider recruitment and retention
4. Pursue Affordable Care Act – Title V opportunities
5. Review and transform Vermont's practice environment and reduce administrative burdens
6. Evaluate and reform reimbursement for healthcare
7. Update Benchmarks for Provider/Patient Ratios informed by the Vermont Blueprint for Health
8. Identify a lead state organization to coordinate primary care workforce development activities.

The Department of Vermont Health Access (DVHA) and Vermont Department of Health (VDH) will build on this report and continue to address the many issues raised about Vermont's primary care workforce. This will be made easier by the recent award of a federal (Affordable Care Act) health care workforce planning grant of \$132,000 to the Vermont Area Health Education Center – AHEC, and the availability of future workforce implementation grants. VDH and DVHA's future efforts will include:

- Continuing to engage with the workforce work group convened by Act 128,
- Developing specific estimates of the additional capacity needed geographically and in each of the many parts of Vermont's primary care delivery system, and
- Developing and implementing a detailed workforce development plan, including targets and resources needed to achieve them.

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2. Introduction

The Vermont Legislature, through Act 128, Section 31, directed the Department of Vermont Health Access (DVHA), the University of Vermont Area Health Education Centers (AHEC) and the Vermont Department of Health (VDH) to convene a committee to assess Vermont's primary care workforce and make recommendations for maintaining an adequate workforce throughout the implementation of recent healthcare reform initiatives. This report summarizes the current climate, recent efforts and recommendations to ensure that Vermont has an adequate primary care workforce to meet the healthcare requirements for a population with increased insurance coverage and medical management needs. Workforce is the foundation of the health care system and core to ensuring access for all Vermonters.

The process for preparing this report included three meetings of the full workforce report committee and numerous additional sub-group meetings and calls. (Committee members are acknowledged in Section 7.) Data, comments and suggestions were invited throughout the process. DVHA served as the designated repository for this information. DVHA compiled information and lead the drafting of this report. A first draft was shared with the committee; however, the comment period was short in order to meet the legislated report deadline.

This document is the second draft of the report and includes feedback from the committee. It is important to note this report is not an end but a starting point for development of a more detailed workforce development plan.

Finally, it should be noted – as is apparent in the Act 128 committee requirements – that there are many workforce collaborators and stakeholders. This report does not necessarily represent a consensus by all participating members/organizations, but it represents a good faith effort to provide a balanced report and summarize the data provided and concepts presented that had the strongest support.

3. Background and Trends To-Date

At both the state and national levels the health care delivery system is dependent on an appropriate and adequate health care workforce. More importantly, recruiting and retaining the primary care workforce is essential to maintain the health of Vermont's population.

In Vermont, primary medical care is provided by a system of approximately 800 individual primary care practitioners – 545 physicians; 239 advanced practice registered nurses (APRNs), certified nurse midwives (CNMs), and certified physician assistants (PA-Cs), and 20 naturopathic physicians. (AHEC, 2009; VANP, 2010) The primary care physicians (PCPs) in this count include Family Medicine, General Internal Medicine, Obstetrics/Gynecology and General Pediatrics.

In order to assess the adequacy of Vermont's primary care network, this committee examined data and reports generated by VDH and AHEC. Both organizations used generally accepted methods for collecting and analyzing this data and both used the Graduate Medical Education National Advisory Committee Report (GMENAC) benchmarks for patient to provider ratios. Despite the different methodologies, the conclusions are similar; Vermont's primary care network is understaffed in several geographic areas of the state.

The Vermont Department of Health has been collecting information on health care practitioners since 1994. Physicians (MD's and DOs), Dentists and Physician Assistants are surveyed every two years at the time of their relicensing. The surveys are intended to include all practitioners who provide direct patient care in Vermont, acting as a census rather than a sample survey. Survey forms are included with the relicensing renewal form and respondents are compared with lists of those who renewed their license. Follow-up mailings and phone calls are made to those practitioners residing in Vermont or a neighboring state, who did not return the survey. Physicians participating in residency programs are not required to maintain a Vermont license, although some choose to do so. For consistency, all residents, clinical fellows and research fellows are excluded from the reports.

The data collected includes specialty, practice setting, town(s) of practice and the number of hours per week in clinical practice. This allows the calculation of full-time equivalency (FTE's) by specialty and by geographic region. Information on whether practitioners are accepting new patients, and new Medicaid patients, is also collected.

According to VDH data, there is a shortage of 16 overall physician FTEs in primary care. This data includes physician counts for family medicine, internal medicine, obstetrics/gynecology and pediatrics. (VDH Physician Summary, 2009) The data suggest that this shortage is concentrated in a shortage of internal medicine physicians. As the table below shows, there are abundant providers in the specialties of family medicine, obstetrics/gynecology and pediatrics. Unfortunately, we are facing a shortage of 54

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internal medicine physicians. It is possible that some of the need for internal medicine specialists can be met by the abundance of family practice physicians.

Shortage or abundance of providers by specialty, according to VDH Data	
PC Specialty	Provider count above or below GMENAC Benchmark
Family Medicine	14
Internal Medicine	-54
Obstetrics/Gynecology	4
Pediatrics	19
Total	-16

AHEC conducted its own research on this subject by surveying all of the practice sites in Vermont. Their conclusions were similar to the VDH results. AHEC's provider snapshot describes an overall shortage of 27 primary care providers. Again, this shortage breaks down into an abundance of family medicine, obstetrics/gynecology and pediatrics physicians and a shortage of 57 internal medicine providers.

Shortage or abundance of providers by specialty, according to AHEC Data	
PC Specialty	Provider count above or below GMENAC Benchmark
Family Medicine	2
Internal Medicine	-57
Obstetrics/Gynecology	7
Pediatrics	21
Total	-27

The differences between VDH and AHEC data are explained through their different methodologies and the difference in time between the studies. The important factor is that both studies independently concluded that there is a shortage of providers in certain areas of Vermont and these shortages are focused on the internal medicine specialty. This is a very brief summary of two complete reports (the VDH and AHEC reports are referenced at the end of this report). Summary data can sometimes be misleading, so we recommend that readers of this summary examine the complete VDH and AHEC reports for additional information.

Given that 44% of all physicians (VDH Physician Summary, 2009) only work part-time, the actual number of additional providers needed is actually higher. It is also important to note that an unpredictable number of providers retire or move out of Vermont each year, so recruitment efforts also must keep up with attrition. 27% of all physicians working in Vermont have been practicing here for at least 20 years (VDH, 2009). Statewide, 19% physicians are over age 60 (VDH Physician Summary, 2009) which means many may be considering retirement. 25% of all PAs in Vermont are considering retirement in the next 5 years (VDH PA Summary, 2009)

Advanced practice registered nurses (APRN) include licensed nurse practitioners, and certified nurse midwives who provide primary care. Data analysis from the past five years indicates that the mean age of these providers has increased slightly over the past 6

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years to a mean of 51 years old. There has been a 226% increase in the number of applicants to the University of Vermont graduate program in nursing from 2000 to 2009 due to the addition of a master's entry option. The number of graduates has remained fairly constant due to the lack of clinical placement sites and faculty resources. The Vermont Educational Loan Repayment Program for Primary Care Practitioners has been helpful in attracting nurse practitioner to underserved areas. (AHEC, 2010)

This is a snapshot of our primary care workforce shortage today, before the implementation of many healthcare reform changes that will increase the need for primary care.

Vermont Statutes (8 V.S.A. 4080f) define "Primary care" as "health services provided by health care professionals specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and shall include prenatal care and the treatment of mental illness". The consensus of the workgroup is that any discussion of healthcare providers in Vermont must acknowledge the important role of oral health providers (general dentistry) in patient health. Additionally, the ongoing need to integrate physical and mental health services is a consideration. To narrow scope, this discussion is focused only on providers licensed by the State of Vermont.

The number of Vermonters over age 65 continues to grow and the incidence of chronic disease is on the rise. Approximately 34% of Vermont primary care providers have closed their practice to new patients or have restricted the number of new patients they will serve. (AHEC, 2009) As Vermont's population ages, so does its workforce. These factors combine to increase the demand on our healthcare delivery system. (Healthcare Workforce Partnership, 2005) Healthcare consumers are more knowledgeable and demand higher levels of service. Medical conditions and the technologies to treat these conditions continue to grow in complexity and cost. These factors add to the training requirements, financial obligations and workload of healthcare professionals. (Direct Care Workforce Study Advisory Group Report, 2007)

Provider recruitment and retention activities in Vermont have been innovative and fairly successful. These activities center on educational debt reduction, educational programs designed to introduce students to health careers, marketing by way of printed and web-based recruitment resources, and direct outreach to providers considering a medical career in Vermont.

Approximately 54% of all primary care providers in Vermont have had their educational debt reduced in exchange for a service commitment through efforts of the Vermont Area Health Education Center (AHEC) Program which administers the Vermont Educational Loan Repayment Program for Primary Care Practitioners and the UVM College of Medicine Freeman Medical Scholars Program. (AHEC, 2009) These specific educational debt repayment programs are very effective recruitment and retention tools. Vermont was an early adopter of this recruitment/retention strategy. In the past, these programs were rare, which gave Vermont a distinct edge in the drive to recruit/retain providers. Today,

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educational debt reduction programs are common in many states and are often expected by providers looking for a practice location. Vermont is forced to compete for primary care practitioners with other states with larger loan repayment programs. The state-based programs supplement the federally-funded National Health Service Corps (NHSC) program targeted at Federally Qualified Health Centers (FQHCs) and awarded using national workforce data rather than customized to individual state needs.

First with American Recovery and Reinvestment Act of 2009 (ARRA) funding and now with federal health care reform, there has been a surge in funding for Federally Qualified Health Centers. This includes expansion grants and workforce programs like the National Health Service Corps. Vermont has strong Congressional representation in these areas and has a history of leveraging these federal programs and funds.

The AHEC Freeman Physician Placement Specialist staff focuses on facilitating a pipeline of UVM College of Medicine (UVM COM) trainees (both during their student years and during their residency programs throughout the country) and Fletcher Allen Health Care (FAHC) medical residents into the Vermont physician workforce, including rural and underserved areas of the state. Approximately 35% of Vermont's physician workforce trained at UVM COM and/or FAHC. (VDH Physician Summary, 2009) Between 1996 and 2008, Vermont gained 100 more primary care physicians (an increase of 60 FTEs). This growth trend flattened in 2006, but the overall percentage of UVM COM/FAHC-trained physicians remained constant throughout the growth.

Data show that private funding (a gift to the UVM COM from the Freeman Foundation) for medical student scholarships along with physician loan repayments administered by AHEC (with support from the Vermont Department of Health) played a significant role in recruitment and retention successes. (AHEC, 2009) After 12 years, the private funding is ending.

In an effort to encourage youth to consider health care careers, AHEC provides health career awareness and exploration programs. These programs include school-based presentations as well as other learning experiences such as "job shadowing" a healthcare professional, health career conferences, and an intensive hands-on MedQuest summer camp.

The Bi-State Primary Care Association manages a Vermont Recruitment Center designed to assist practices with recruitment. As a non-profit organization, the Bi-State Primary Care Association is able to provide recruitment services at a cost which is much lower than fees charged by for-profit recruitment organizations. The Vermont Recruitment Center conducts national outreach activities to find and recruit providers to Vermont. The Vermont Recruitment Center and AHEC coordinate and target different provider populations; the work is complementary and not redundant. Much of this work is done in conjunction with VDH through programmatic and funding support. There is a national shortage of primary care providers which makes competition for these providers significant. These coordinated recruitment activities allow Vermont to maximize the impact of our recruitment resources.

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According to the Bi-State Primary Care Association and AHEC, the barriers to provider recruitment include

- availability of employment for the primary care provider's spouse or partner. Many providers are hesitant to move to Vermont unless all adult household members have suitable employment prospects
- availability and level of educational debt reduction programs
- length of time needed to obtain a license to practice medicine in Vermont
- reimbursement rates and salaries
- administrative burdens associated with practicing medicine in Vermont.
- licensure of nurse practitioners is dependent on a collaborating physician and can be difficult if a collaborating physician retires or there are none available in a rural service area.

Despite these barriers, Vermont has many positive qualities to help our recruitment efforts. Vermont has a reputation for collegiality among healthcare providers and the quality of our healthcare and public health systems consistently ranks high in national surveys. Our healthcare reform activities make Vermont a model for other states eager to expand and improve access to healthcare. These factors are appealing to many providers who are searching for a place to practice.

Much of the AHEC and Bi-State workforce development efforts to-date have been done in collaboration with the VDH Office of Rural Health and Primary Care. VDH and Bi-State work together on primary care and federal designations for medically underserved areas (MUAs) and health professions shortage areas (HPSAs). The federal designation and outreach processes are instrumental to implementing Federally Qualified Health Centers (FQHCs) sites in Vermont and enabling provider eligibility for the National Health Service Corps (NHSC). The executive director of Bi-State has been appointed to the national review committee to determine an updated methodology for HPSA determinations; ensuring the Vermont voice in the national discussion.

4. The Next Five Years: Federal and State Changes

Vermont's healthcare delivery and payment systems will change more over the next five years than they have in several decades. Myriad state and federal healthcare reform activities are already underway and work continues about how best to address additional issues related to healthcare access, healthcare costs, workforce supply and healthcare quality. In short, the healthcare environment – which has historically been considered dynamic – will only be more dynamic in the years ahead.

Over the next five years, our primary care workforce will be affected by the following changes:

- It is likely that Vermont will have 47,000 newly insured citizens by 2014.
- Vermont's Blueprint for Health initiatives are investing in primary care. The Blueprint represents an innovative alternative to the traditional system of healthcare delivery, including payment mechanisms, interdisciplinary team approach to health care services, and a stronger bridge between public health, prevention, and the primary healthcare system. The Blueprint will present increasing opportunities for communication, collaboration, coordination and cooperation among health care professionals that should lead to improved care for patients. The Blueprint's Medical Home Program and Community Health Teams may have a profound impact on the makeup and needs of our future healthcare workforce. Whether these reforms will be sufficient to attract the needed primary care practitioners is an open question. It is critical that the Blueprint inform Vermont's workforce development system and that workforce considerations are included in the Blueprint's framework.
- The Patient Protection and Affordable Care Act – Title V will offer opportunities and funding to improve our primary care workforce development system. This is discussed in more detail later in the report.
- The use of technology such as electronic medical records and data exchange will increase significantly to improve administrative efficiencies patient care. Elements of these technologies and data repositories may also inform workforce research, planning, and development. Initially, however, incorporating electronic tools, such as EHRs or E-prescribing into practices may create financial and administrative burdens for primary care practices.
- Based on current trends and without significant changes to the medical education system, the United States will face a significant shortage of physicians over the next 10 years (Association of American Medical Colleges, 2008)
- The predicted shortage of physicians will put pressure on existing physicians, advance practice nurses, physician assistances, certified nurse mid-wives, and other health professionals to support primary care delivery.

5. Recommendations for the Next Five Years (2011-2015)

A. Improve data collection and analysis to monitor the status of Vermont's primary care workforce and inform planning.

Vermont has several good sources for assessing the status of its primary care workforce. These sources include:

- Provider surveys and analyses completed during licensing and biennial license renewal by the VDH and the Office of Professional Regulation
- Surveys coordinated by AHEC, the Vermont Medical Society and VDH
- Banking, Insurance, Securities and Health Care Administration (BISHCA) data
- Claims data from Medicaid/DVHA, Medicare and other payers including data collected by BISHCA's multi-payer claims database: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Recommendations for Data Collection:

- Support the expansion of electronic surveys for all licensed healthcare providers. Current surveys require significant staff time in order to achieve high rates of provider participation. The provider survey data compiled annually by the Vermont Department of Health requires significant staff time in order to achieve high levels of participation by providers. A mandatory web-based survey system completed in conjunction with licensing should be explored. This will increase the administrative burden slightly for some providers during licensure, but the data will be extremely valuable to providers and policy-makers. Data should be pre-populated during renewal process to reduce time to complete but still allow for data review, changes, and corrections.
- The data collected in provider surveys should be consistent and comparable over time in order to identify trends. Survey questions should be similar enough to allow for comparisons across provider types (i.e., a common minimum data set). Careful attention needs to be given to the development of the common minimum data set.
- The design and implementation of a comprehensive consumer survey conducted regularly (appropriate intervals require further discussion) to assess primary care issues from the perspective of citizens. The majority of available workforce data is from the provider community perspective. The VDH Behavioral Risk Factor Survey is an excellent source for some of this information, but it was not designed to serve as a comprehensive survey of the general public's perspective on the primary care delivery system and access to care. We recommend further exploration to determine the feasibility of a survey of citizens which will address issues related to:
 - difficulties/barriers to accessing healthcare,
 - wait times for appointments,
 - perceptions of healthcare quality, and

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- the types of providers used or preferred for primary care, utilization of and preferred therapies (e.g., traditional medicine, alternative, complementary and alternative/integrative medicine), and other related questions.
- Data should be collected to assess scope of practice and roles of Naturopathic Physicians (NDs), Physician Assistants (PAs), Advance Practice Registered Nurses (APRNs), and other licensed providers. Over the next five years, we will need to increase the number of these providers to meet the primary care needs of all Vermonters.

Recommendations for Data Storage, Distribution and Analysis:

- A centralized data repository should be created to store, analyze and share data related to healthcare professionals. The Vermont Department of Health maintains a robust range of data and reports spanning many primary care workforce topics over many years. The impact of this data has significantly improved our ability to monitor and react to trends in our primary care workforce. This and other data could further enhance our work if it were shared through a central repository. This repository could allow for more sophisticated analyses to inform workforce planning, policies and programs. This concept should be pursued in conjunction with the Affordable Care Act State Health Workforce Development Planning Grant recently awarded to UVM and align with planning and development initiatives and other electronic data exchange systems underway with UVM, BISHCA, VITL, DVHA and others.
- The Vermont Departments of Economic Development and Labor should develop web-based tools which can be utilized to assist with spousal/partner employment. These tools can be used beyond health care recruitment and are key to attracting needed providers to Vermont.
- Employment data collected by the Vermont Department of Labor should differentiate the levels of nurse employment (i.e. licensed practical nurse, registered nurse, advanced practice registered nurse)

B. Increase capacity for primary care provider education and training

Education programs create new providers and support the improvement of existing providers. The Association of American Medical Colleges anticipates major physician shortages over the next decade unless education systems are expanded. Current national projections indicate a shortage of 125,000 physicians by 2025 (this does not account for increased access under new reform law, which will exacerbate the shortage). Vermont's nursing schools must train enough nurses to meet the increased demand, including advanced degrees for APRNs. Similarly, opportunities for educating PAs and other licensed providers should be assessed.

The cost and commitment required to complete these educational programs is substantial and growing. Financial and programmatic support may be available to Vermont institutions through the Affordable Care Act (ACA), via the Health Resource Services Administration (HRSA) and its competitive grant programs. We recommend that the

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University of Vermont, the Academic Medical Center, and other academic institutions and organization continue to submit grant proposals for recruitment and retention programs described in the Affordable Care Act. Substantial resources will be made available through the ACA including: expansion of training programs for primary care, continuing education support, and support for new educational models and programs.

Recommendations for increasing training capacity:

- Increase state support for the University of Vermont and public colleges that offer education and training for health professionals. Support should also be given to “transition to practice” programs, particularly programs in nursing, allied health, and the College of Medicine.
- Study Vermont’s educational capacity. Most healthcare training programs rely heavily on community-based faculty (preceptors) for student clinical experiences or rotations. Most preceptors are “volunteer” teachers. Teaching in the clinic takes provider time and may limit patient visits or billable services. Vermont is a small state with approximately 220 primary care sites. (AHEC 2009) The limited number of sites and providers able to teach and supervise students affects educational capacity. The availability of practice sites and preceptors is a concern in many states. In Vermont, in-state as well as out-of-state programs are competing for a fixed number of primary care preceptors and practice sites. Some out-of-state programs offer significant stipends to preceptors to compensate them for their time which may put Vermont programs at a disadvantage. Before we can recommend program growth or adding new programs we must conduct a thorough assessment of preceptor capacity.
- Further study should be conducted to determine the feasibility of using technology to improve preceptor/site coordination between training programs and institutions to maximize in-state clinical rotations without detriment to the care delivery system.
- Work with Congressional delegates and federal agencies to change legislation and regulations that are counter to Vermont’s workforce efforts (e.g., the National Health Service Corps Scholars Program—currently Vermont does not benefit from this program.)
- Assisting employers on innovations such as re-tooling job descriptions may be necessary to accommodate the needs of the mature worker. The concept of “encore careers” and retraining employees to transition into other needed jobs requires further exploration. The Vermont Department of Labor and the Department of Aging and Independent Living have resources to assist with these recommendations..
- Continue to support continuing medical education and quality improvement programs for existing providers. These offerings should be based on demonstrated need and ensure the provider community voice. Providing access to educational resources is a strong retention tool.
- Support programs designed to encourage youth to pursue healthcare careers. These activities serve as the pipeline to nursing, allied health, medical, and dental programs.

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C. Support primary care provider recruitment and retention

Recommendations:

- We recommend increased support for recruitment and retention programs already in place through AHEC and the Bi-State Primary Care Association and the Vermont Dental Society. These recruitment and retention programs are well established, currently accessed by our provider network and they have made much-needed progress toward organizing and coordinating our recruitment and retention activities.
- Support and expand the existing VDH student incentive scholarship program (for dental students, dental hygiene student, and nursing students) administered by Vermont Student Assistance Corporation (VSAC). Expand to include funding for medical students.
- The Committee recommends increasing funds to the Vermont Educational Loan Repayment program, if fiscally feasible. Currently, significant unmet need exists within this program. For 12 years, private funding to the UVM College of Medicine supplemented Vermont's loan repayment program to recruit and retain physician but this funding will not continue. Loan repayment for nurse educators is a critical recruitment tool for the state of Vermont and this funding must be sustained in order to recruit educators qualified to teach nurses at the graduate level.
- Work with Congressional delegates and federal agencies to change legislation and regulations to support Vermont's workforce efforts
- Public and private health care organizations in Vermont should work together to influence Federal policy that impacts patient access to health care professionals. For example:
 - Congress should lift the cap on Medicare-supported residency positions
 - Remove financial barriers that discourage hospital-based residency programs from providing clinical experiences in collaboration with community hospitals and practices
 - Congress should repeal the sustainable growth rate Medicare physician pay formula. Absent congressional action, in December the Medicare physician payment cut will be 23% and the payment cut will increase to nearly 30% in January 2011. Reimbursement cut of this magnitude will threaten physicians' ability to treat Medicare beneficiaries.
- Support of the J-1 Visa Waiver program and outreach lead by VDH and Bi-State.
- Support recruitment and marketing activities that highlight Vermont as an attractive, innovative health care practice environment.

D. Pursue Affordable Care Act – Title V opportunities

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The ACA – Title V may provide substantial financial and programmatic resources to help Vermont meet its primary care workforce goals over the next five years. The ACA has sections specifically designed to support almost every recommendation contained in this report.

Recommendations:

- DVHA shall work with stakeholders to conduct a careful review of the provisions of ACA – Title V and corresponding program guidance (i.e., the details) issued by federal agencies to ensure that Vermont takes advantage of any available resources for the support of our primary care workforce. These opportunities will typically take the form of competitive grant proposals. Requests for proposals should be communicated to providers, state entities and educational institutions. UVM has already taken an important first step in the implementation of workforce development activities. They were recently awarded a \$131,786 planning grant through the Health Resources and Services Administration. This workforce report will inform that project. After completing the one-year planning process, Vermont will be better positioned to compete for a workforce development implementation grant.
- Continue to apply for federal planning and job training grants that will be available for workforce planning and expansion of the state apprenticeship program and other training programs for many health care occupations, including direct care.

E. Review and transform Vermont's practice environment and reduce administrative burdens

Vermont generally offers a good environment for medical practitioners, but there is room for improvement. It is important for us to maximize the appeal of our practice environment in order to attract and retain excellent medical providers.

Recommendations:

- Review Vermont's licensing requirements for medical professionals. Wherever possible, we should streamline this process without compromising the quality of the process. This will help us reveal potential efficiencies that could be realized and help us ensure that adequate resources are available to meet the educational/mentoring requirements some professionals face during initial licensing.
- Review of the administrative burdens associated with submitting medical claims for payment. This analysis is needed to assess if claim submission systems work efficiently and determine if there are opportunities to standardize forms between payers. Similarly, obtaining prior authorization for drugs, imaging, hospital admission and other services could be reviewed. Public and private insurance plans all have different drug formularies, prior authorization processes, and

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- quality assurance standards and programs, which create duplicative administrative burdens for health care professionals.
- Increase the use of technology for health information data exchange to improve efficiency and patient care.
 - Review the barriers to Vermont nurse practitioner licensure, particularly related to the lack of collaborating physicians in underserved areas.

The Vermont Medical Society has documented the impact these administrative requirements have had on provider satisfaction. Clearly, there will always be a need for administrative functions related to healthcare delivery and payment, but Vermont should be cognizant of the cumulative effects and “paper work burden” produced by all of these requirements.

F. Evaluate and reform reimbursement for healthcare

In this era of healthcare reform, we will be challenged to control the growing costs of healthcare while ensuring that the system is adequately funded. Healthcare costs continue to rise at a rate that is not sustainable for providers or insurers. The ACA provides incentives and support for innovations in health care delivery and reimbursement based on outcomes, rather than a traditional “fee-for-service” model. We are hopeful that these new models for healthcare delivery and payment will improve outcomes, control costs and adequately reimburse healthcare providers. Currently public payers do not reimburse the cost of care, creating a cost shift. V.S.A. Title 32 section 307(d)(6) calls for the governor’s proposed financial plan for the Medicaid budget to include “recommendations for funding provider reimbursement at the levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement.”

Recommendations:

- Carefully consider the healthcare delivery models developed by the Blueprint for Health. These must be factored into workforce development planning.
- Renew our commitment to funding reimbursement at levels sufficient to ensure reasonable access to care.

G. Update Benchmarks for Provider/Patient Ratios informed by the Vermont Blueprint for Health

In 1981, the Graduate Medical Education National Advisory Committee (GMENAC) report established benchmarks for assessing the adequacy of provider/patient ratios. These are commonly referred to as the GMENAC benchmarks, and they are generally accepted benchmarks for evaluating the number of providers needed for a given population. Unfortunately, these benchmarks do not take into consideration the age of a population and they assume a model of medical care that was common in 1981. It is reasonable to suggest that these benchmarks may not be accurate 30 years after the

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benchmarks were developed. . We recognize that the GMENAC standard is imperfect in today's practice environment but that it should be used until an updated, evidence-based standard can be developed.

Recommendations:

- We propose the development of new standards for the evaluation of provider to patient ratios. A new system should take into account the expanded roll of primary care providers since 1980 and our population demographics have changed. This will not be an easy task to complete as it will require in-depth analysis of the time various providers spend with a wide sample of patient types. Our recommendation is that the Vermont Department of Health, UVM and the Department of Vermont Health Access (Blueprint for Health) explore this issue further. Learning from the Blueprint for Health, Patient-Centered Medical Home, and Community Health Team pilots currently underway is crucial to inform the ideal make up of the care delivery team and project future workforce needs based on this information.
- We recommend that the Vermont Blueprint for Health more closely align with health care workforce research, planning and development and that workforce impact be integrated into the Blueprint as a foundational or core element. It would be premature to develop a new standard until after we have data from the Blueprint to inform the process.

H. Considerations for the Future

As we enter a period of rapid changes in the healthcare delivery system, it will be more important than ever to continually monitor the adequacy of our provider network.

Recommendations:

- Designate a lead state agency to continue workforce development work through the next five years. The infrastructure for this work exists in Vermont, but coordination of these efforts will significantly improve our primary care workforce.

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7. Acknowledgements

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The Vermont Department of Health

The University of Vermont College of Medicine's Area Health Education Centers (AHEC) program and the Office of Primary Care

The Banking, Insurance, Securities and Health Care Administration, Division of Health Care Administration

The University of Vermont College of Nursing and Health Sciences

The Vermont Technical College nursing program

Norwich University's nursing program

The Vermont Association of Naturopathic Physicians

The Bi-State Primary Care Association

The Vermont Nurse Practitioners Association

The Physician Assistant Academy of Vermont

The Vermont Medical Society

The Vermont health care workforce development partners

The Vermont assembly of home health agencies

The Vermont Department of Labor

The Vermont Dental Society

8. Language from Act 128, Section 31

* * * HEALTH CARE WORKFORCE PROVISIONS * * *

Sec. 31. INTERIM STUDY OF VERMONT'S PRIMARY CARE WORKFORCE DEVELOPMENT

(a) Creation of committee. There is created a primary care workforce development committee to determine the additional capacity needed in the primary care delivery system if Vermont achieves the health care reform principles and purposes established in Secs. 1 and 2 of No. 191 of the Acts of the 2005 Adj. Sess. (2006) and to create a strategic plan for ensuring that the necessary workforce capacity is achieved in the primary care delivery system. The primary care workforce includes physicians, advanced practice nurses, and other health care professionals providing primary care as defined in 8 V.S.A. § 4080f.

(b) Membership. The primary care workforce development committee shall be composed of 18 members as follows:

- (1) the commissioner of Vermont health access;
- (2) the deputy commissioner of the division of health care administration or designee;
- (3) the director of the Blueprint for Health;
- (4) the commissioner of health or designee;
- (5) a representative of the University of Vermont College of Medicine's Area Health Education Centers (AHEC) program;

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(6) a representative of the University of Vermont College of Medicine's Office of Primary Care, a representative of the University of Vermont College of Nursing and Health Sciences, a representative of nursing programs at the Vermont State Colleges, and a representative from Norwich University's nursing programs;

(7) a representative of the Vermont Association of Naturopathic Physicians;

(8) a representative of Bi-State Primary Care Association;

(9) a representative of Vermont Nurse Practitioners Association;

(10) a representative of Physician Assistant Academy of Vermont;

(11) a representative of the Vermont Medical Society;

(12) a representative of the Vermont health care workforce development partners;

(13) a mental health or substance abuse treatment professional currently in practice, to be appointed by the commissioner of Vermont health access;

(14) a representative of the Vermont assembly of home health agencies;

and

(15) the commissioner of labor or designee.

(c) Powers and duties.

(1) The committee established in subsection (a) of this section shall study the primary care workforce development system in Vermont, including the following issues:

(A) the current capacity and capacity issues of the primary care

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workforce and delivery system in Vermont, including the number of primary care professionals, issues with geographic access to services, and unmet primary health care needs of Vermonters.

(B) the resources needed to ensure that the primary care workforce and the delivery system are able to provide sufficient access to services should all or most Vermonters become insured, to provide sufficient access to services given demographic factors in the population and in the workforce, and to participate fully in health care reform initiatives, including participation in the Blueprint for Health and transition to electronic medical records; and

(C) how state government, universities and colleges, and others may develop the resources in the primary care workforce and delivery system to achieve Vermont's health care reform principles and purposes.

(2) The committee shall create a detailed and targeted five-year strategic plan with specific action steps for attaining sufficient capacity in the primary care workforce and delivery system to achieve Vermont's health care reform principles and purposes. By November 15, 2010, the department of Vermont health access in collaboration with AHEC and the department of health shall report to the joint legislative commission on health care reform, the house committee on health care, and the senate committee on health and welfare its findings, the strategic plan, and any recommendations for legislative action.

(3) For purposes of its study of these issues, the committee shall have administrative support from the department of Vermont health access. The commissioner of Vermont health access shall call the first meeting of the committee and shall jointly operate with the representative from AHEC to cochair of the committee.

(d) Term of committee. The committee shall cease to exist on January 31, 2011.