House Resolution 230 and Senate Resolution 191 Combined Study Group Report

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Enhancing Health Care Access in Health Professional Shortage Areas

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LOUISIANA DEPARTMENT OF HEALTH

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Preface

During the 2016 Regular Legislative Session, two bills were enacted to examine possibility to further improve the quality of health care services in certain areas of Louisiana. A workgroup of select workforce development stakeholders was formed to investigate and make legislative recommendations to both the Louisiana Senate and House of Representatives on ways and means in which to enhance access to health services in health professional shortage areas.

Senate Resolution 191 was developed by Senator Regina Barrow to urge and request the Louisiana Department of Health to study ways to enhance access to health care services in health professional shortage areas.

House Resolution 230 was developed by Representative Willmott to urge and request the Department of Health to coordinate a study effort with select healthcare workforce development stakeholders to identify means by which to enhance access to needed health services in health professional shortage areas.

Workgroup Participants

The workgroup met for the first time October 2016 and again February 2017. Representatives from the following organizations were invited to attend the meeting:

- American Association of Retired Persons, Denise Bottcher
- Central Louisiana Area Health Education Center, Sharon Womack
- Louisiana Academy of Family Physicians, Richard Bridges, M.D and Ragan LeBlanc
- Louisiana Association of Nurse Practitioners
- Louisiana Board of Medical Examiners, Eric D. Torres
- Louisiana Department of Health Medicaid, Piia Hanson
- Louisiana Department of Health Office of Public Health, Avis Richard-Griffin, Kimberly B. Jones, Dorie Tschudy, Gina LaGarde, M.D. and Dr. Sundee Winder
- Louisiana Hospital Association, Paul A. Salles
- Louisiana Nursing Home Association,
- Louisiana Primary Care Association, Gerrelda Davis
- Louisiana Public Health Institute, Clayton Williams
- Louisiana Rural Health Association, Stacey Fontenot
- Louisiana State Board of Nursing, Karen Lyons
- Louisiana State Medical Society, Jeff Williams
- Louisiana State University Health Sciences Center at New Orleans, Larry H Hollier, M.D.
- Louisiana State University Health Sciences Center at Shreveport, G.E. Ghali, DDS, M.D.
- Louisiana Workforce Commission,
- Richland Parish Hospital, Joinger Greer
- Rural Hospital Coalition, Charles Castille
- Southeast Louisiana Area Health Education Center, Brian Jakes
- Southern University School of Nursing, Dr. Sandra Brown
- Southwest Louisiana Area Health Education Center, Bootsie Durand
- The Community Provider Association, Laura Brackin

Introduction

Primary and preventive health care services are necessary to maintain and improve health. Having an insurance card enables individuals to enter the health care system, but it does not guarantee access to timely and appropriate health care services.

There is a wealth of literature to describe the "lopsidedness" of health care delivery. Inadequate numbers of facility locations and medical personnel shortages are common areas of interests to policymakers and researchers. These works also include "factors that influence the decision or choice of health workers to relocate to, stay in or leave (rural and remote areas)."

Methods

The LDH Office of Public Health conducted a review of the literature that explored evaluations, interventions, and state and federal policy to enhance access to care in HPSAs. Electronic searches were conducted in August and September 2016 in the Journal of the American Medical Association, National Health Service Corp, Louisiana Department of Health, and the 3RNet database. Other primary sources of information were gathered from experts in the fields of medicine, policy research, Google searches, and websites from other government agencies and health departments in other states. Articles and bodies of research included were published between 2006 and 2016 and reported on primary care assessments, datasets, rural health information hub, and evaluation strategies to attract and retain health workers in rural areas. Documents used were from state, national, and international resources covering various levels of health workers practicing in urban, rural, and HPSA areas. Documents reviewed, but excluded from the report were those describing issues for recruitment and medical professional shortages that did not define a method nor presented information with specific recommendations and interventions. News articles, briefs and other related material that did not report on an identified evaluation were also excluded.

Recommendations

The Louisiana Department of Health Office of Public Health convened a workgroup of subject matter experts that included physicians, rural hospital administrators, policymakers, representatives from state boards and professional associations (representing the elderly, nurses, physicians, and rural community providers i.e., hospitals, clinics, health centers). The recommendations were developed after an extensive review of literature i.e., recruitment and retention, health work force shortages, with input from policy makers, practicing medical providers, health personnel. Supporting materials are references are included as an annexes to this report.

The short range and long range recommendations presented in this report builds on practical work experiences by stakeholders representing various levels of practice and geographic locations. They are also based on the assumption that ultimate outcome of enhancing access to care in HPSAs

depends on changing policy that affects regulatory, finance, education, and personal and professional support interventions.

Short-range recommendations by the workgroup include the following:

Regulatory

A. Support regulations that encourage out-of-state medical and dental students that are willing to select clinical rotations in Louisiana high need HPSAs.

B. Encourage licensure updates that supports health providers to practice at the top of their clinical training, such as the nurse practitioner collaboration agreement.

C. Support statewide collection of provider and patient demographic data through licensure and health plans to support workforce capacity assessments.

D. Increase the number of clinical delivery points in high need, health professional shortage areas creating patient access where residents work and live. This would include expansion of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), partner contracts, and telemedicine sites.

E. Streamline standard formulary. All state Medicaid plans are not equal in services provided and patients and providers are not always aware of the difference in what a plan provides until a service is denied. For example, providers should have consolidated access to their Healthy Louisiana Plan patient panel data (enrollment, gaps in care and cost information) so they can better manage their patients' costs and outcomes. Currently, providers are forced to access multiple plan-specific portals which all present information in different ways and is very cumbersome and inefficient.

Finance

1. Provide state general funds to begin a statewide recruitment service with concentration on high-need HPSAs recruits and with these services to become sustainable in five years.

2. Allow Medicaid providers to collect reimbursement for the provision of medical and mental health services provided on the same day. Provide reimbursement for patient management that includes education, outreach, and assistance with obtaining prescriptions. The shift to patient-centered medical home models supports this transition. The emerging roll of the community health work adds value to this model but not reimbursed in Louisiana.

3. Provide reimbursement for telemedicine sites for both the transmitting facility and provider.

4. Create payment incentives for providers to practice in high need HPSAs.

Education

1. Increase enrollment of minority and rural students in medical training programs.

2. Support the practice of training health care students in rural and medically underserved facilities throughout the state.

Personal and Professional Support

1. Increase access to patient data that contain key indicators for improving health outcomes through health information exchange and robust analytic tools.

2. Leverage workforce capacity with the use of technology to provide telemedicine which has been shown to increase access to primary care and specialty physicians, dentists, and behavioral health professionals.

3. Protect clinical health care training school budgets that expand training experiences in rural and underserved areas in exchange for service in HPSAs.

4. Increase incentives to attract the healthcare workforce into HPSAs by increasing tax incentives to include all health professionals.

Long-Range Recommendations include the following:

1. Support health care workforce pipeline development of "growing your own" through programs that support student exposure to medical career choices. With limited funding, the Area Health Education Centers do an excellent job of exposing students to medical careers, i.e. career days in elementary, middle and high schools.

2. Increase enrollment of minority and rural students in medical training programs.

3. Streamline managed plan services to lessen confusion for patients and providers.

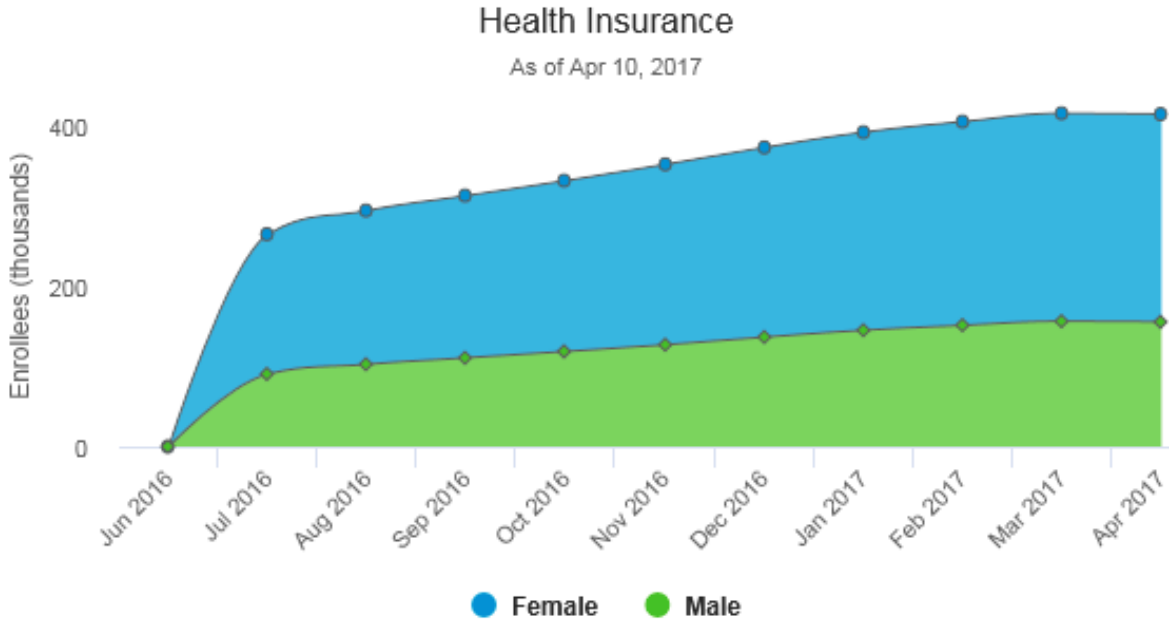
Overview of Louisiana's Population

According to the 2015 U.S. Census, the total estimated population for the state of Louisiana was 4,670,724. The majority of the population was Caucasian at 63.2 percent. African-Americans were the largest racial minority group at 32.5 percent, considerably larger than their representation in the nation (13 percent). Hispanics make up about five percent of the state's population, which is considerably lower than their representation in the nation (17 percent). Hispanics are the largest racial or ethnic minority group in the nation. (Krogstag & Lopez, 2015). Asian/Americans, Native Americans, and residents who identified as "Other" or with "Two or More Races" were approximately 1.6 percent of the Louisiana's total population.

The age and gender distributions for the state of Louisiana resemble that of the nation with the majority of the population (62.1 percent), being between 18 and 64 years of age 23.9 percent under the age of 18, and 14 percent 65 years of age and older. Similarly, male's makeup 48.9 percent of Louisiana's population and 51.1 percent of the population is female.

The 2015 census indicates that one in five Louisiana residents live in poverty, unchanged from the 2014 U.S. Census. Louisiana had the third-highest rate of poverty in the country for 2014, at 19.8 percent, falling behind New Mexico and Mississippi.

In January 2016, Louisiana's Governor signed an executive order to begin expanding Medicaid in Louisiana. On June 1, 2016, Louisiana residents with incomes up to 138 percent of the federal poverty level became eligible to start enrolling in the state's expanded Medicaid program, with coverage effective July 1, 2016. As of April 2017 enrollment has exceeded 415,000 individuals who did not quality for full Medicaid coverage and could not afford to buy private insurance. The table below shows the enrollment trend since the beginning of Medicaid expansion.



Addressing Health Disparities

Many factors influence health. "Poor health status, disease risk factors, and limited access to health care are often interrelated and have been reported among persons with social, economic, and environmental disadvantages." Where individuals live (primarily) and work help to explain why some populations are healthier while others are not healthy. According to the World Health Organizations, "Social determinants of health are mostly responsible for health inequalities … (including) race, ethnicity, sex, sexual orientation, age, and disability (which) all influence health." Identification and awareness of the differences among populations regarding health outcomes and health determinants are essential steps towards reducing disparities in communities at greatest risk. (Meyer PhD, 2013)

Health disparities are important to public health. "The burden of illness, premature death, and disability disproportionately affects certain populations." (Meyer PhD, 2013) Chronic disease,

premature death, and illness excessively impacts certain groups of individuals. For instance, rates of premature death from stroke and coronary heart disease were higher among non-Hispanic blacks than among whites; motor vehicle-related death rate for men is almost 2.5 times that for women; suicide rates were higher for non-Hispanic whites and the rates for American Indian/Alaska Natives is two to five times those of other races and ethnicities and asthma attacks were reported more frequently for children than adults. (CDC, 2013)

"Despite persistent racial, ethnic, and socioeconomic gaps in health care and health status, awareness of such disparities remains low among the general public. Much can be accomplished within the health and public health arena; however, the multiple and complex causes of health disparities can only be addressed with the involvement of partners in fields that influence health such as housing, transportation, education and business. Identifying disparities and monitoring them over time is a necessary first step toward the development and evaluation of evidence-based interventions that can reduce disparities." (Benz, 2011)

Statewide Overview of Primary Care, Dental, and Mental Health Workforce

This section focuses on one method of assessing the availability of primary care, dental, and mental health workforce to the population through the designation of parishes and census tracts as federal health professional shortage areas (HPSAs). HPSAs include the assessment of available providers to population ratios. These ratios include populations within an area, usually a parish, as reported by the U.S. Census Bureau regardless of age, gender, or financial status.

Section 332 of the Public Health Service Act, 42 U.S.C. 254e, provides that the Secretary of the U.S. Department of Health and Human Services (DHHS) shall designate health provider shortage areas based on criteria established regulation. HPSAs are defined in Section 332 to include (1) urban and rural geographic areas with shortages of health professionals, (2) population groups with shortages, and (3) facilities with such shortages. DHHS Health Resources and Services Administration (HRSA), Office of Shortage Designation (OSD), a Division of Policy and Shortage Designation, Bureau of Health Workforce (BHW) has the responsibility for designating and updating HPSAs with provider data provided by the State's Primary Care Office (PCO). Section 332 further requires that the U.S. DHHS Secretary annually publish a list of the designated geographic areas, population groups, and facilities. The designated HPSAs are to be reviewed at least annually and revised as necessary.

Workforce Shortages as Identified by HPSAs

Louisiana's PCO collects and analyzes primary care, dental, and mental health provider data for HPSA determination. Once the area or facility criteria is met, the PCO submits an application to the Office of Shortage Designation (OSD) for federal designation as a HPSA. OSD reviews the data to verify that it meets the Federal Shortage Designation criteria for HPSA designation. There are three HPSA designation types including:

- **Geographic area designation** – includes the entire population of the requested area (parish) to all available primary care physicians full-time equivalent (FTE). Primary care includes family medicine, general practice, general internal medicine, pediatrics, and obstetrics/gynecology.

- **Population group designation -** are special groups. The most common of population groups are low-income and Medicaid eligible designations. Low income designations use a ratio built upon the low-income population of the area and the physicians providing services to this population. Medicaid eligible designations are based on the number of Medicaid eligible people and the physicians that accept Medicaid. Louisiana uses the low-income population methodology.
- **Facility designation –** incorporates a facility's outpatient census, wait times, patients' residences, and in-house faculty to evaluate a facility's designation eligibility. This method is used only for the purpose of qualifying for educational loan repayment or scholarship programs offered by the National Health Service Corp, NURSE Corp and Louisiana State Loan Repayment Program.

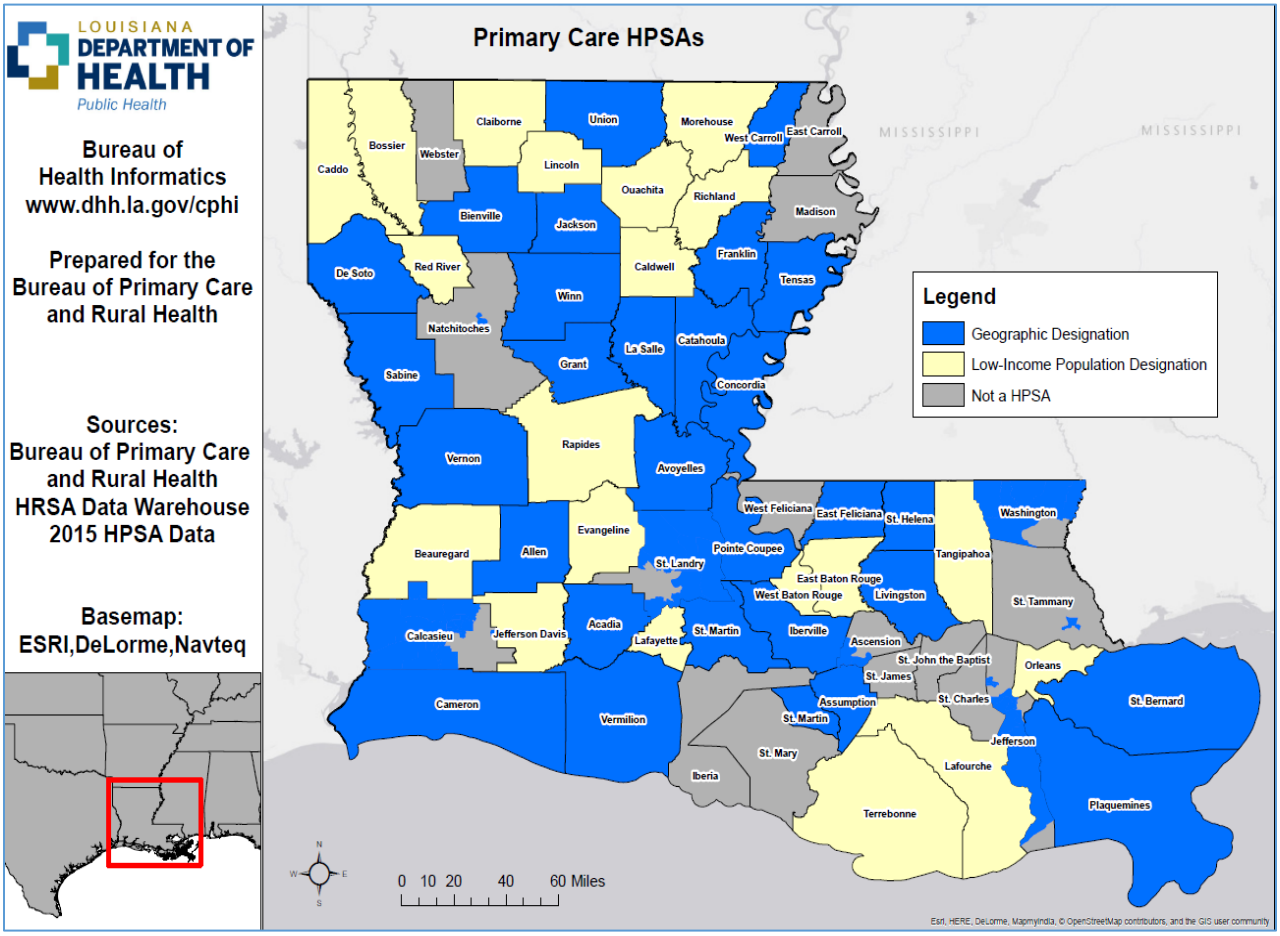
HPSAs are assigned scores for use by the National Health Service Corp (NHSC) and HRSA to prioritize the need of practitioners in designated areas. Scores range from one to 25 for primary care and mental health, one to 26 for dental and mental health. ***The higher the score, the higher the need.*** Scores increase an area's priority for placement of new practitioners (eligibility for acquiring NHSC recruits is typically a score of 14 or higher). Several factors go into determining a score, such as providers-to-population ratios, population poverty levels, and the incidences of infant mortality or low-birth weights. The chart below illustrates Louisiana designations within the three HPSA types.

HPSA	Number of Parishes with a HPSA	Percentage of Parishes with a HPSA	Number of HPSAs	Number of Parishes with a HPSA Score of 14 or Higher
Primary Care	55	86	120	24
Dental	54	84	179	34
Mental Health	59	92	65	45

Source: HRSA Data Warehouse, 2015
http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspxThe following three maps illustrate each of the three HPSA shortage designation types.

(See Figure 1) Primary care designations (shown in blue and yellow) pertain to an area's access to physicians that practice principally in one of the following: family practice, general practice, internal medicine, pediatrics, and obstetrics/gynecology. A ratio is used to measure the level of primary care access. To be considered underserved, a ratio of ≥ 3,500 possible patients to one primary care physician full-time equivalent (FTE) is required. The ratio of 3,000:1 qualifies as a high need area. To be considered a high need area, 20 percent or more of the area population must be over 200 percent of the federal poverty level. Provider FTEs are determined by taking the number of hours per week the physician spends in providing direct primary care services, either in-office or on-rounds at the hospital, divided by 40 hours. The total of these FTEs is divided by the total resident/civilian population of the area.

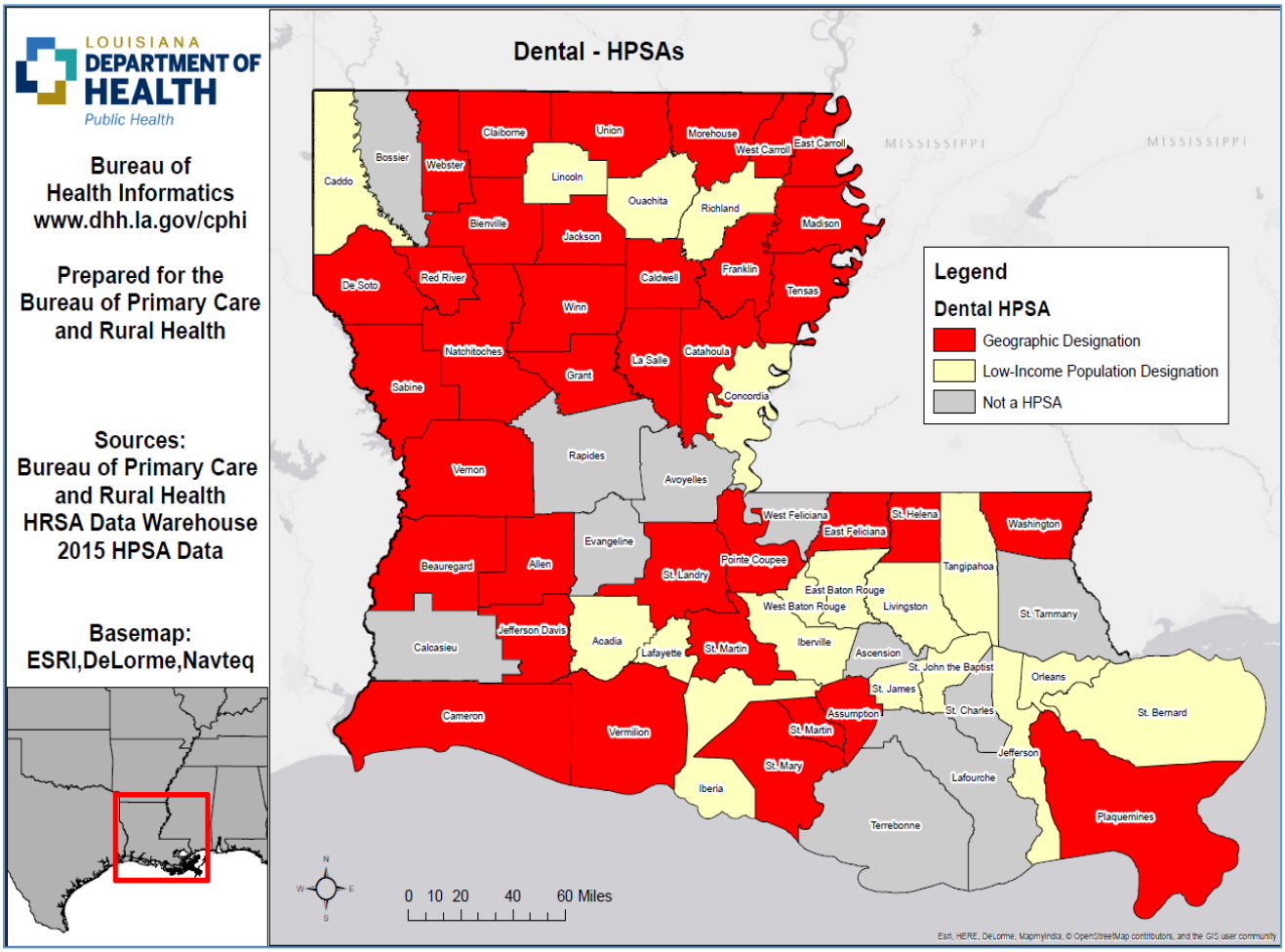
Figure 1 Primary Care HPSAs



Source: HRSA Data Warehouse

(See Figure 2) Dental designations are shown in yellow for designations that are low-income and red for geographic. Dental FTEs are calculated by starting with the number of direct patient hours worked per week provided by the dentist. The FTE is then weighted according to the dentist's age and number of in-house assistants the dentist employs. A ratio of ≥5,000 possible patients to one dentist FTE is required or 4,000:1 for high needs areas.

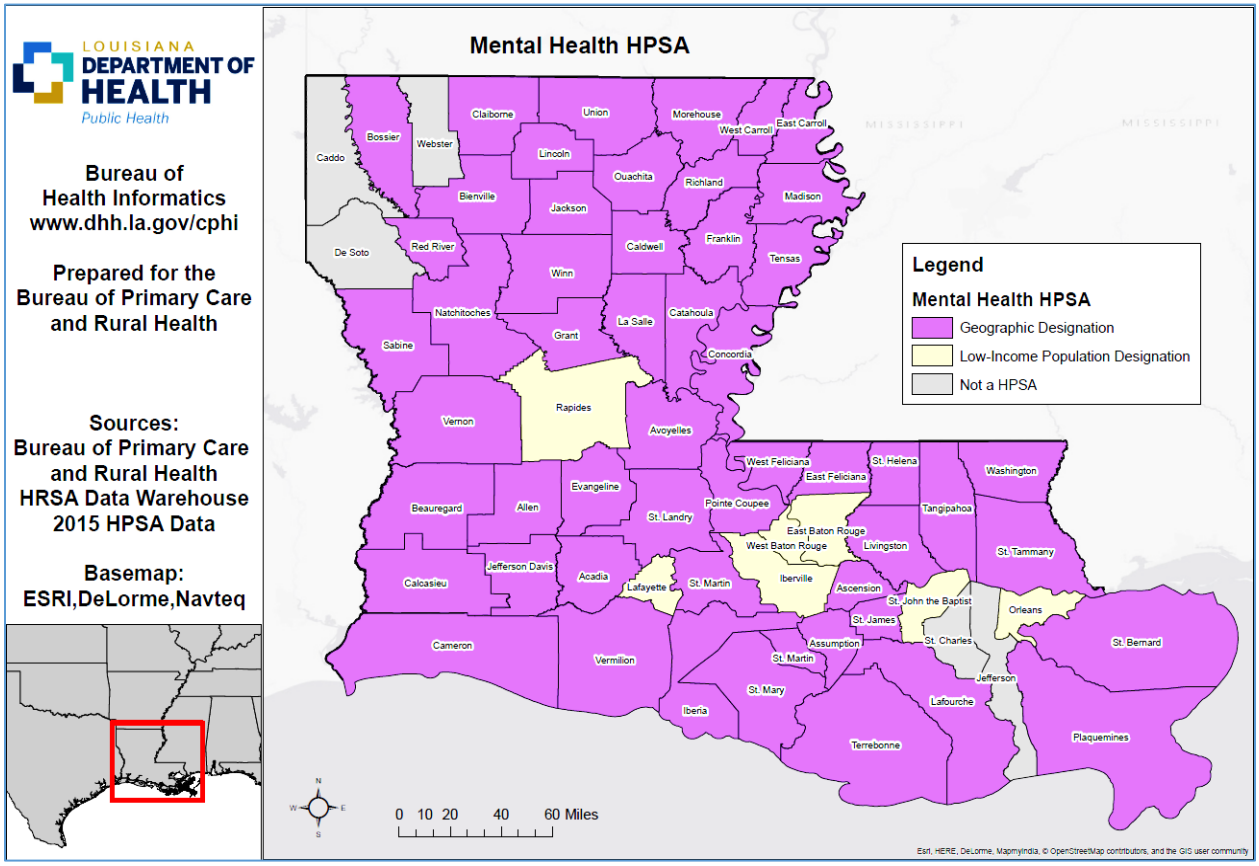
Figure 2 Dental HPSAs



Source: HRSA Data Warehouse

(See Figure 3) Mental health HPSAs (shown in purple for geographic and yellow for low income designations) are based on a psychiatrist to population ratio of 30,000:1. The ratio for high needs area is 20,000:1. In other words, when there are 30,000 or more people per psychiatrist, an area is eligible to be designated as a mental health HPSA. Regulations allow mental health HPSA designations to be based either on psychiatrist to population ratio or core mental health provider to population ratio. Louisiana applies the psychiatrist to population ratios.

Figure 3 Mental Health HPSAs



Source: HRSA Data Warehouse

HPSA Designations that Impact Health Workforce

Several workforce incentive programs use HPSA designations as a requirement when approving grants and other funding. These programs include: Conrad State 30/J-1 Visa Waivers, National Health Service Corps Scholar and Loan Repayment Programs, Louisiana's State Loan Repayment Program, the 10 percent Medicare Bonus Incentive Program, rural health clinic designations, and several health care access grants including training programs.

A 10 percent Medicare bonus payment is available to qualifying physicians through the Centers for Medicare and Medicare Services (CMS) Primary Care Incentive Payment Program. To qualify providers must provide services in a geographic, primary care HPSA. The key to eligibility is

where the service to the Medicare patient is actually provided. If a service is delivered within the HPSA, the physician receives the bonus. Eligible providers include primary care physicians, specialists, Surgeons, doctors of podiatric medicine, licensed chiropractors, and optometrists. In addition, psychiatrists furnishing services in a geographic mental health HPSA are also eligible to receive a bonus payment. This bonus incentivizes physicians to live and work in Louisiana's more limited service areas and offer services to the patients in the areas. In 2012, CMS reported bonus payments in the amount of $8,253,841 to qualifying Louisiana providers. Medicare bonus payment is based on qualifying provider services being delivered in a zip code located within a geographic primary care or mental health HPSA. Annually, CMS publishes a list of qualifying zip codes. In 2016, the Louisiana list included 236 primary care and 439 mental health zip codes.

Louisiana Statewide Resources to Improve Patient Access in Designated HPSAs

Safety-net medical facilities are sites recognized as providing health care services to Louisiana's medically underserved populations. Many state and federal programs require HPSA designation as a qualifying factor for participation. Patients benefit by having local health care access regardless of geographic or financial considerations. Safety-net medical facilities accept Medicare and Medicaid patients and often offer a sliding fee scale or discount policy to uninsured and underinsured patients.

Medical facility types include:

- **Federally Qualified Health Centers** (FQHCs) are safety net providers that primarily engage in providing services typically furnished in an outpatient clinic. In Louisiana, there are over 200 FQHCs service delivery sites. These sites include community health centers, migrant health centers, health care for the homeless centers, public housing primary care centers, and outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization. The main purpose of the FQHC program is to enhance the provision of primary care services in medically-underserved urban and rural communities.
- **Rural Health Clinics** (RHCs) are designated through the Rural Health Clinics Act of 1977. The federal government developed RHCs to encourage and stabilize the provision of outpatient primary care in rural areas through cost-based reimbursement provided by physicians, nurse practitioners, physician assistants and certified nurse midwives. RHC regulations distinguish between two types of RHCs: independent and provider-based. The independent RHC is a freestanding practice that is not part of a hospital, skilled nursing facility, or home health agency. The provider-based RHC is an integral and subordinate part of a hospital, skilled nursing facility, or home health agency. Louisiana has a total of 129 RHCs.
- **School Based Health Centers** (SBHCs) were authorized in 1991 under Governor Buddy Roemer. The 63 SBHCs provide convenient access to comprehensive, primary and preventive physical and mental health services for public school students at school sites.
- **Parish Health Units** (PHUs) under the supervision of the Office of Public Health offer preventative services to all regardless of their ability to pay. Services include immunizations, Tuberculosis treatment, Women, Infants and Children (WIC) services, Reproductive Health Services which includes Sexually Transmitted Disease (STD)

screening and treatments, HIV testing, Children with Special Health Needs Clinics and Vital Records.

Creating Access Where Patients Live and Work

The study group identified that patient access can be limited by several community factors including transportation, employment, education, and culture. Barriers to healthcare identified by the study group include:

- When a patient is homebound, regardless of provider availability the patient does not have access to health care without home visits.
- Transportation issues prevent patients from keeping appointments and contributes to poor health outcomes and a waste of provider resources (lost reimbursement/available time slots due to no shows).
- Transportation limits access to specialty care, as most specialists are located in larger cities only.
- Access to specialty care appointments are limited for Medicaid patients.
- Low paying jobs often do not allow time off for family medical appointments. Extended hours are vital in creating patient access for this population. Low wage earners are also limited in time away from work in accessing appointments with specialists for themselves and children.
- Low literacy contributes to a patient's ability to engage in dialogue with the provider, understand diagnosis, treatments, or medication instructions. Additional communication time is required of the provider or extender, and reimbursement becomes an issue.
- The use of communication technology is important in creating opportunities to improve patient compliance with treatments, access to monitoring outcomes and specialty provider care. Reimbursement and regulations are sometime issues in implementing technology.
- Access to a culturally diverse health care workforce is limited. Communities need more providers that are from the high need communities and are willing to return to live and work; as is supported by the grow your own approach.

Study Group Conclusions

Types of patient access solutions identified by the workgroup include additional providers, financial incentives, and streamlining systems (enrollment).

1) **Facility-based solutions that increase access to care**
   - Clinics are increasing patient access by extending clinical hours in the evenings and on weekends.
   - The emerging urgent care clinic model gives patients treatment options other than the emergency room for afterhours care.
   - Providers willing to provide home care for elderly and disabled patient that do not have the ability to seek clinic-based care increases access.
   - Utilizing technology (telemedicine) to increase access to specialty care.

- Increase patient compliance through face-to-face education and through technology (tele-health).

2) Provider incentive programs that focus on rural and underserved areas

- State Loan Repayment Program (SLRP) - The purpose of the SLRP is to encourage primary health care services practitioners to serve in Louisiana's HPSAs. Eligible providers for this program include primary care physicians, psychiatry, and dentists. Other eligible health care professionals include primary care physician assistants and certified nurse practitioners, certified nurse midwives, registered clinical dental hygienists, licensed clinical or counseling psychologists, psychiatric nurse specialists, licensed professional counselors, marriage and family therapists, and licensed clinical social workers. The program funds loan repayment for approximately 49 providers per year which includes 8-12 renewals and/or new awards.
- Conrad State 30/J-1 Visa Program - This program supports the annual placement of up to 30 foreign medical graduate physicians who enter the United States to participate in residency training and are willing to serve 3 year service commitments in a HPSA. These are often the most difficult to fill positions. In 2015-16 a total of 49 physicians were serving three year commitments in medical clinics and hospitals.
- LSU School of Dentistry Rural Dental Scholars Program – This program will accept the first student in 2017-18 academic year. Included in the program is training assignments in rural and underserved clinics within the state.
- The Rural Scholars Track (RST) at LSUHSC School of Medicine—the New Orleans program was created to directly address a dire physician shortage. The RST is designed to recruit highly motivated students who are committed to practicing primary care medicine in rural areas of Louisiana.
- AHEC Career Development Programs
  - A Day with the Doctor is a one-day interactive program that offers high school students interested in becoming a physician, the opportunity to experience doctors' daily activities and life on LSU Health Shreveport and New Orleans campuses.
  - The A-HEC of a Summer program is an exciting opportunity for ninth, tenth, and eleventh grade students with at least a 2.0 GPA who are interested in pursuing a healthcare career
  - The Primary Care Elective (Pce-120) and Primary Care Rural Preceptorship Program are four-week elective courses offering medical students an opportunity to observe and experience community-based primary medical care. Primary care specialties include: Family Medicine, Internal Medicine, Pediatrics, and Obstetrics/Gynecology.

Barriers to Care

Several factors were identified by the study group that contribute to patient access issues. This includes workforce willing to work in areas where the population lives, whether in rural or urban communities. Providers willing to treat all patients regardless of their ability to pay for services. The study group identified the following barriers:

1) **Patients' perspective of access to health care barriers**
   - Transportation – This issue applies to patients without access to bus lines and personal transportation to access local care and often expected to travel hours in access to specialty care.
   - Education / literacy levels – Patients do not always understand a providers instructions and the importance of compliance.
   - Limited phone and internet connections – Rural areas may not have adequate internet to support patient education and follow-up.
   - Access to specialty care appointments – Many specialty physicians are in high demand. Appointments may take weeks and physicians are often located in larger cities.

2) **Health workforces' perspective of barriers to health care access**
   - Access to specialty referrals is an issue for Medicaid and the uninsured populations.
   - Attracting workforce to live and work in high-need areas is extremely difficult unless they have trained or lived in such an area.
   - Medicaid is complicated. Payments are slow with many denials. Credentialing with five plans is overwhelming and a lengthy process, often taking months.
   - Payment for community health workers and para-professional workforce extenders would improve patient compliance effecting access and health outcomes
   - Provider income potential in high need areas is often less than urban.
   - Obtaining real time provider practice data is difficult in assessing availability of appointments and referrals.

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