

# **Recruitment and Retention of Primary Care Providers in Rural, Underserved Areas of Michigan**

(FY 2013 Appropriations Bill – Public Act 200 of 2012)

**September 30, 2013**

**Section 716:** (1) The department is encouraged to create and implement a pilot program limited to counties with a population of less than 100,000 to incentivize students attending medical schools in Michigan through a loan repayment program or other approaches for committing to provide medical services in rural counties with a medically underserved population. The program shall be limited to those students or individuals performing primary care or specialty services as identified by the department.

(2) By no later than September 30 of the current fiscal year, the department shall prepare a report and submit it to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director. The department shall evaluate the effectiveness of the pilot program, identify potential changes to improve the program, and make recommendations for statewide implementation in its report under this subsection.

*Michigan Department  
of Community Health*



**Rick Snyder, Governor  
James K. Haveman, Director**

## Section I- Purpose of the Report

This report is in response to Article IV, Section 716 of Public Act 200 of 2012, which requires the Michigan Department of Community Health (MDCH) to examine the issues facing the recruitment and retention of primary care physicians in Michigan.

Section 716:

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Under Section 716 (1) the department is encouraged to create a pilot program and in 716 (2) required to submit a report evaluating the effectiveness of the pilot program. In the absence of funding for the pilot program, MDCH focused on the programs already established in the state.

This report responds to the requirement by evaluating the current programs used in Michigan to achieve the goal stated in 716 (1) of recruiting and retaining primary care providers in rural and underserved areas of Michigan. The purpose of this report is to explore options for encouraging medical students to enter primary care and serve in underserved areas of Michigan. This report also examines social, cultural and financial aspects of physician recruitment and retention in underserved communities and explores the reasons why physicians do or do not locate in underserved areas.

## **Introduction**

The Institute of Medicine (IOM) defines Primary care as, "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

From the common cold to complex chronic conditions, the primary care system in the United States is the main source of medical care for the vast majority of the population. The U.S. primary care system serves as the first point of contact for prevention, diagnosis, treatment or management of all health concerns. This system is designed to provide long-term, person-centered care and also coordinates care from other facilities and specialty providers. Primary care practice is often located within the community, and a practitioner is able to manage the vast majority of chronic diseases that do not require exclusive care from a specialist. Having a primary care physician as a first point of contact decreases the likelihood of specialty care and increases the effectiveness and appropriateness of care. Primary Care practitioners are responsible for addressing a varied majority of personal health care needs, developing a long-term relationship with patients, and practicing in the context of family and community. Primary health care encompasses health promotion, illness prevention, treatment and rehabilitation. An extensive body of literature suggests that comprehensive primary health care may reduce mortality rates for conditions associated with population health disparities, such as heart disease and cancer.

Many Michiganders reside in medically underserved areas with a reduced access to primary care physicians. Some of these areas are located remotely whereas others do not have access to primary care physician in an urban or micropolitan area. The lack of accessible health services is particularly acute for poor and low-income people who do not have enough financial resources to travel to find health care. MDCH administers multiple programs that focus on improving access to primary care in Michigan so that all citizens may experience the benefits of primary care.

## **Factors that influence the primary care workforce in Michigan**

The primary care workforce includes physicians and non-physician health professionals such as physician assistants (PAs), nurse practitioners (NPs), nurses, and care coordinators. Evidence shows that nations with a strong network of primary care providers have lower health care cost and better population health<sup>1</sup>. Primary care workforce plays an important role in the general health of the communities, but there has been a decrease in the number of physicians interested in pursuing career in primary care fields, while the proportion of specialists continues to increase. Factors that contribute to this shortage are varied and complex.

Primary Care physicians are in high demand because of an increase in the aging population, chronic diseases and uninsured population. Older adults use more health care than the younger population. Medical and technological advances have also led to longer life spans, and the population of adults aged 85 is expected to increase between the years 2000 and 2030. This will lead to a potential dramatic increase in the demand for health care services in next 20 years.

It has also been reported that physician workforce is aging, average hours worked are falling compared to historical levels, and a large number of physicians are nearing retirement. The growth and aging of the United States population, as well as advances in technology with an accompanying growth in public expectations, has also contributed to a growing demand for primary care services.

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<sup>1</sup> <http://www.jhsph.edu/news/news-releases/2002/primary-care.html>

Addressing health workforce shortages in the U.S. and Michigan requires considerable insight into the causes and development of strategies that are as varied as the contributing factors.

Many factors, including lifestyle concerns, lower income as compared to specialties and reimbursement concerns impact recruitment and retention of healthcare professionals in underserved areas. Concerns about the work/life balance due to high patient loads can also push physicians and other health care professionals away from looking at rural and underserved communities as a viable practice area. As a result more doctors choose to practice in specialty medicine. This trend has resulted in fragmented care, inappropriate use of specialists, and less emphasis on prevention. Of particular concern, research shows that a primary care workforce shortage negatively impacts most vulnerable populations such as elderly and those dependent on community clinics<sup>2</sup>.

One interesting factor to consider is familiarity with rural life. Research indicates that rural upbringing is one of the most important indicators for providers locating in rural areas. Rural background prepares them well for unique challenges of a rural practice. The role of a healthcare provider in such communities is different from urban environments.

In 2012, the Michigan Department of Community Health conducted the eighth annual survey of fully licensed physicians. Of the providers surveyed 71 percent were active in Michigan and 29 percent were not currently active in Michigan. About one-third of active physicians who took this survey (35 percent) were primary care physicians and the remainders were specialists in an area other than primary care. In this survey, about 51 percent of active Michigan-licensed physicians grew up in Michigan, and 28 percent grew up in another U.S. state. About 46 percent of active physicians grew up in a suburban area, 29 percent in an urban area, and 25 percent in a rural area/small town.

Survey results also show that about 42 percent of active physicians attended a medical school in Michigan, 34 percent attended a medical school in another state, and about 24 percent attended a medical school outside of the United States. About 60 percent of active physicians surveyed completed a residency in Michigan and about 15 percent did a fellowship in Michigan. About 5 percent of fully licensed physicians are currently enrolled in a graduate medical training program in Michigan.

These characteristics of Michigan's provider population suggest that practicing in Michigan is connected with having lived previously in Michigan or attending medical school in Michigan.

## **Section II- Health Care Workforce Shortage Areas in Michigan**

In order to identify areas facing a critical shortage, the U.S. Department of Health and Human Services (HHS) developed Health Professional Shortage Area (HPSA) designation and Medically Underserved Area and Medically Underserved Population (MUA and MUP) systems.

A HPSA is a geographic area, population group, public or nonprofit private medical facility or other public facility determined to have a shortage of primary health care professionals. Information considered when designating a HPSA includes health provider to population ratios, rates of poverty, and access to available health care services. A HPSA designation can demonstrate a service area or population that has a critical shortage of primary care, dental or mental health providers.

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<sup>2</sup> Kuehn BM. Reports Warn of Primary Care Shortages. JAMA.2008;300:1872–1875. doi: 10.1001/jama.300.16.1872.

Health Professional Shortage Area (HPSA) Definition:

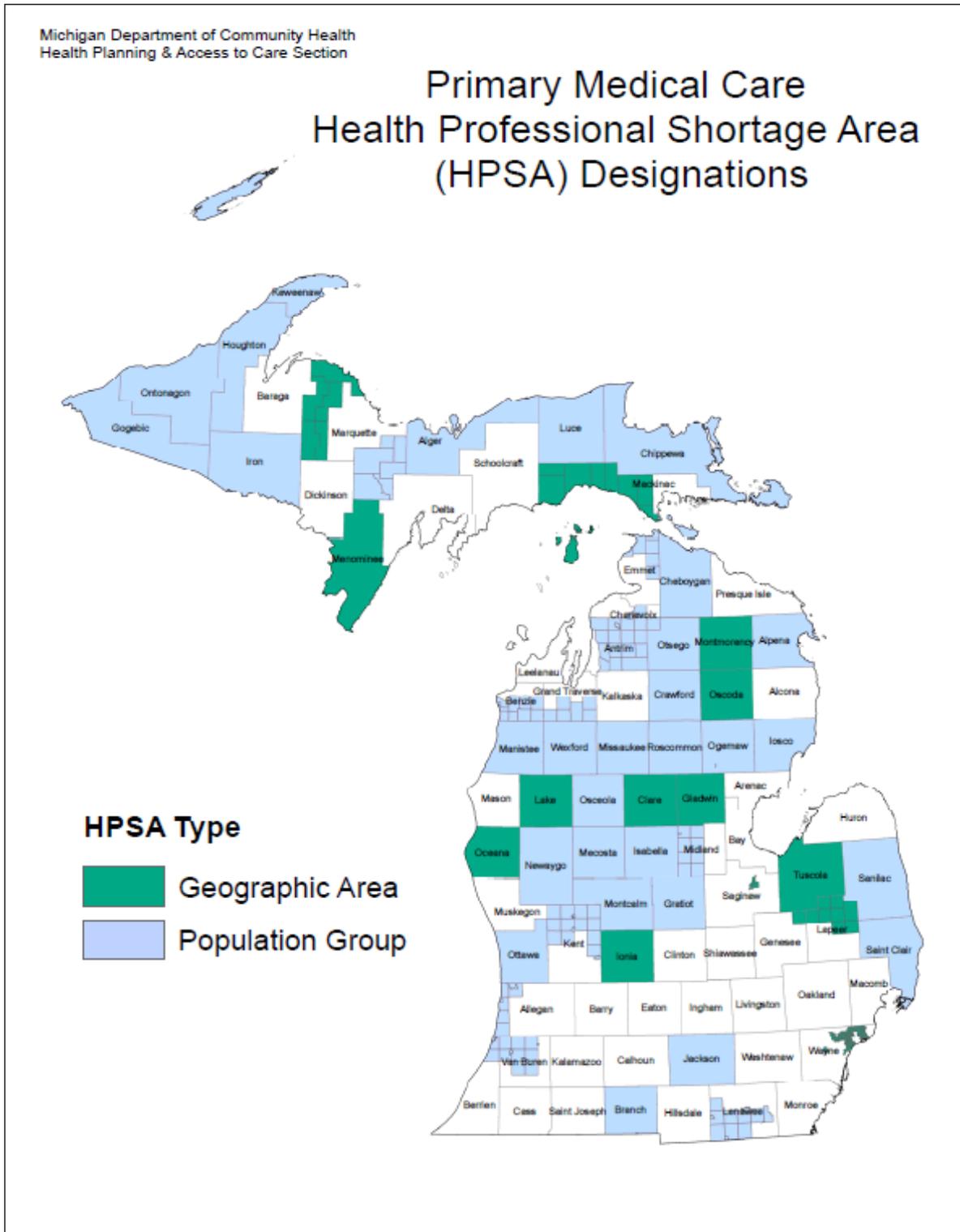
1. The area must be a contiguous county or community.
2. The community must have population-physician ratio of 3,500:1, or have an unusually high need for primary care services.
3. Existing primary care professionals must be over-utilized, excessively distant, or inaccessible to the population.

All Health Professional Shortage Areas must be sub- categorized into one of the following categories; geographic, population or facility. A geographic designation is granted when there is a shortage for the total population in a rational service area. A population designation indicates that a subpopulation of individuals living in the area of designation has insufficient access to care. Population groups include those below 200% of federal poverty level, groups on Medicaid, migrant farm workers, tribal or homeless populations, among others. A facility designation is only for public and non-profit medical facilities that provide primary care services to an area or population group designated as HPSA and has insufficient capacity to meet the needs of that area or population. These facilities include community health centers, rural health clinics, federal correctional facilities, and state hospitals.

All HPSAs are evaluated and re-evaluated on a regular schedule to monitor for changes in the general population and number of providers in the area. Though the final determinations are made by the U.S. HHS, the Michigan Department of Community Health provides data and recommendations to the federal agency.

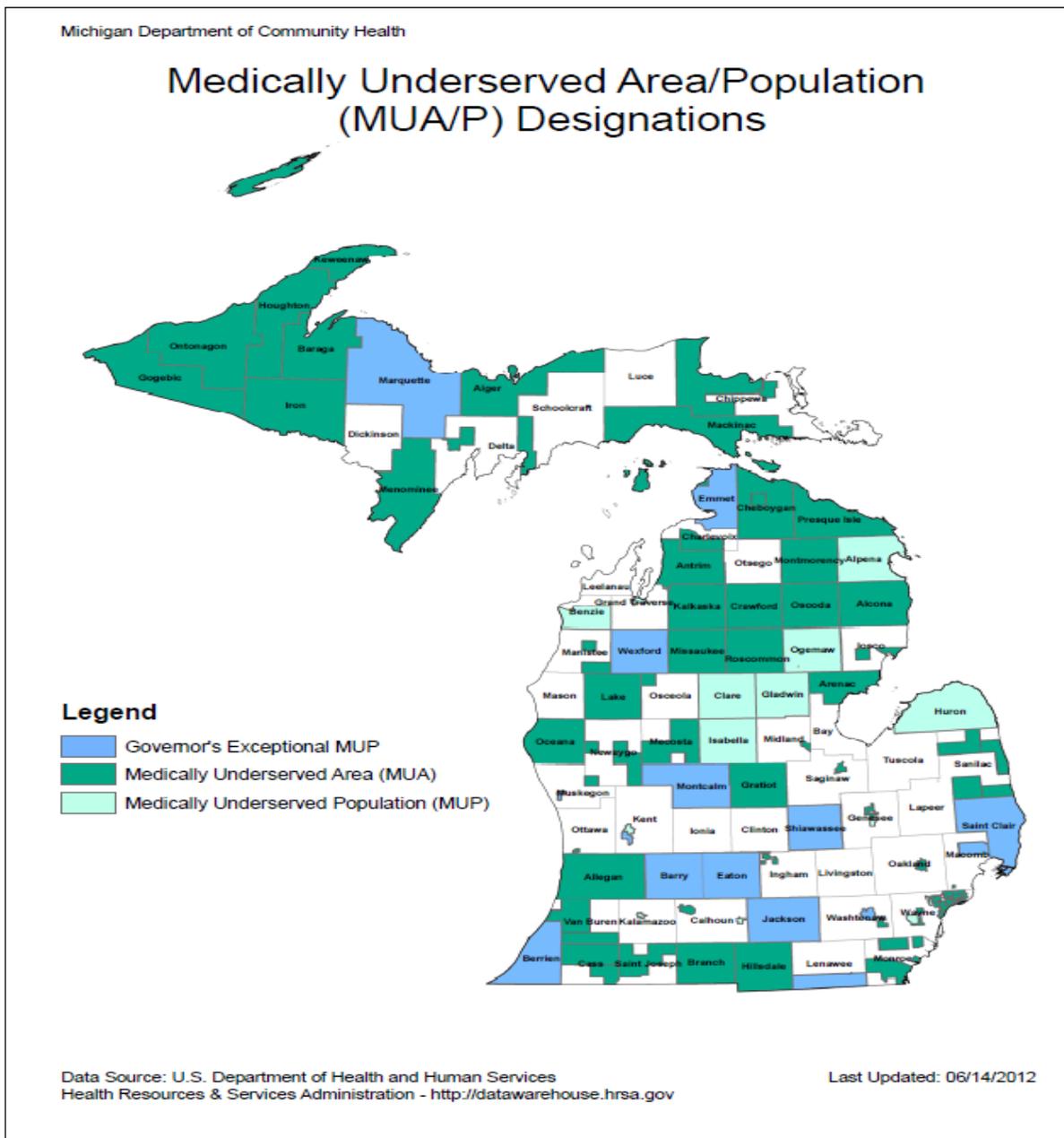
See the map on the next page for a listing of current HPSA designations in Michigan.

**Graphic Data: Primary Care Health Professional Shortage Area (HPSA) Designations**



A Medically Underserved Area (MUA) is a rational service area with a demonstrable shortage of primary healthcare resources relative to the needs of the entire population within the service area. A Medically Underserved Population (MUP) is a group of persons within a rational service area facing barriers to healthcare access and having a demonstrable shortage of primary healthcare resources relative to the needs of that specific population group. MUPs may include those groups of people who face economic, cultural or linguistic barriers to healthcare.

**Graphic Data: Medically Underserved Area/Population (MUA/P) Designations**



## **Section III- Healthcare Workforce Recruitment & Retention Programs in Michigan**

Several programs have been designed to address health professional shortage and to attract quality health care professionals in Michigan. There are currently three programs administered by MDCH that actively address primary health care workforce shortages in HPSAs. These programs include the Michigan State Loan Repayment Program (MSLRP), the National Health Service Corps (NHSC), and the Conrad 30 J-1 visa waiver program. Further, MDCH collaborates with Michigan Center for Rural Health to address shortage of health professionals in rural areas. MDCH also partners with Michigan Health Council to examine healthcare workforce problems and to develop creative solutions statewide.

### **1. Michigan State Loan Repayment Program (MSLRP)**

Medical education debt is at an all-time high and often burdens providers that are entering the health care system after completing their education requirements. The crippling amount of medical education debt is a factor that pushes new graduates to higher paying specialties. This unfortunate circumstance does serve to makes loan repayment programs very successful in easing the burden for primary care providers that opt to work in underserved areas.

In Michigan, providers can turn to the Michigan State Loan Repayment Program (MSLRP) to provide primary care in an underserved area while receiving relief from medical education debt. The MSLRP program was established in 1990 as a federal, state and local partnership that is administered by MDCH. Funding from state, federal and local sources is combined to provide loan-assistance up to four years to primary care providers. MSLRP requires participants to work in a HPSA and an eligible practice site that provides primary care.

The MSLRP selection criteria give preference for some providers and practice site types. For Example, obstetric providers including certified nurse-midwives, family physicians, nurse practitioners, and physician assistants providing obstetric services are on the top of priority list in the current application period. Practice sites receiving preference in the selection process include local health departments, state-funded institutions, Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes, Critical Access Hospital (CAH) and Certified Rural Health Clinics (RHCs) that have been designated as facility HPSAs. Initial MSLRP loan repayment agreements must be for two years, those awarded initial two-year agreements may reapply for an additional two years. For mid-level providers, such as physician assistants and nurse practitioners, agreement amounts may range from \$15,000 up to a maximum of \$35,000 per year. For primary providers, such as physicians and dentists, annual agreement amounts may range from \$25,000 up to a maximum of \$35,000 per year.

Throughout the program's history a greater proportion of providers have practiced in rural areas compared to urban. However, in recent years, the proportion of urban providers has increased. The number of providers supported by the program has grown significantly because the amount of medical education debt is increasing. For example, average allopathic medical graduate debt has increased from \$86,000 at public schools and \$120,000 at private schools in 2001, to \$120,000 and \$160,000 respectively in 2006.

Since 1991, 620 providers have utilized MSLRP and about two dozen of medical, dental or mental health professionals each year utilize the program.<sup>3</sup> In FY2013, 32 providers participated in this program and 14 out of those are serving in rural areas.

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<sup>3</sup> Source: Michigan Department of Community Health, 2013.

## **2. National Health Services Corps (NHSC)**

MDCH partners with federal government in the administration of another medical educational debt relief program called the National Health Service Corps (NHSC) loan repayment program (LRP). MDCH plays an important role in development and review of site applications. The department also recommends NHSC site applications and provides technical assistance to sites and providers. This program offers primary care medical, dental and behavioral health providers the opportunity to have their student loans repaid in exchange for providing health care in communities located in selected Health Professional Shortage Areas (HPSAs). In addition to loan repayment, these professionals also earn a competitive salary.

This loan repayment program provides an initial, tax-free award of up to \$60,000 for two years of full-time service in an underserved community. A participant may be eligible to continue loan repayment beyond the initial contract up to \$140,000 for a total of 5 years of service. This program also provides scholarships and stipends to students as they complete their professional education. Nationwide, there are currently more than 10,000 NHSC members and over 17,000 NHSC-approved rural and urban sites. There are currently 489 NHSC approved sites in Michigan.

## **3. Conrad J-1 Visa Waiver program**

MDCH administers the State Conrad 30/J-1 Visa Waiver Program in an effort to improve access to health care services, and to address health disparities, within federally designated health professional shortage areas (HPSAs) and medically underserved areas/populations (MUAs/MUPs). This federal program allows each state to recommend 30 physicians to receive a waiver of J-1 educational visa requirements in exchange for practicing in a medically underserved community for three years. This program places both primary care and specialist physicians in underserved communities. A physician must practice in a HPSA or MUA/P for the required three (3) year obligation period in which the provider works full-time. This program gives priority to safety net provider sites that include: county health departments, federally qualified health centers (and look-alikes), community mental health centers, free clinics, public and critical access hospitals and associated clinics; state correction and psychiatric facilities; and certified rural health clinics.

The J-1 Visa Waiver program has been instrumental in maintaining access to healthcare in many rural communities when other recruitment efforts have failed. Michigan's program has been fortunate enough to use all available slots every year; this program has placed 350 providers between 2001 and 2012. In 2012, 18 healthcare providers were serving in rural communities and 12 were primary care providers. MDCH received 56 applications during the 2013 cycle, a historic number of applications for Michigan.

## **4. State office of Rural Health Programs**

In partnership with the U.S. Health Resources and Services Administration, MDCH works closely with the Michigan Center for Rural Health to address healthcare access issues in Michigan's rural communities. The Michigan Center for Rural Health is concerned about shortage of healthcare professionals in rural areas. The Center has collaborated with other organizations to address the shortage and has been instrumental in exposing medical students to various aspects of rural health care. The Michigan Center for Rural Health has taken a number of steps to address primary health care workforce shortage in rural areas.

Some of their most successful initiatives include creating a Clinician Retention Plan Toolkit that gives useful, proven strategies to rural clinics that are focused on retaining providers, a Rural Community Breakfast that pairs rural physicians with medical students to discuss benefits and challenges of primary care in rural areas, a Rural Community Road Trip provides exposure for medical students to promote rural primary care medicine as a career in Michigan, and the Gettel Scholars program at Michigan State University provides scholarships for medical students that have expressed a desire to practice primary care medicine in rural Michigan.

### **Other Successful Programs**

MDCH works with many other nationwide and community partners to address underserved areas in recruiting and retaining primary care providers. Several of the most successful programs are listed below.

#### Michigan State University – Marquette General Hospital Rural Health Program

In this program, students gain experience in a community-based setting in rural Michigan. This program requires students to complete a two-month family medicine clerkship at a small northern Michigan community for greater experience with rural primary care, including intensive one-on-one education with attending physician. It responds to some of the most important items keeping physicians away from primary care: education and experience. Providing education and mentoring in a rural setting, is a successful, evidence-based component to increasing rural physician recruitment and retention. Up to 16 Michigan State University College of Human Medicine students participate in the Rural Physician program at Marquette General Hospital.

#### Portage Community Hospital Recruitment Program

Portage Community Hospital, located in Houghton County, Michigan, addresses its recruiting difficulties by increasing clinical education rotations for medical, physician assistant, and nursing students, and by hiring a staff health care recruiter. By investing in additional student rotations and full-time staff to address its recruiting needs, the hospital has an 88% contract acceptance rate for providers and realizes a \$90,000 annual savings. Full-time recruiting staff also increases health care providers' access to programs like NHSC and MSLRP, further bolstering recruiting efforts.

#### Medical Opportunities in Michigan (MOM)

Medical Opportunities in Michigan, an online program of the Michigan Health Council, has been instrumental in changing the approach to provider recruitment in Michigan over the past 20 years. It is designed to directly connect providers with healthcare employers and minimizing the need for expensive search firms and third party recruiters. This program has registered over 440,000 candidate/opportunity matches resulting in thousands of jobs filled with qualified candidates, saving Michigan's healthcare employers millions of dollars in recruitment fees.

#### National Rural Recruitment and Retention Network

The National Rural Recruitment and Retention Network (3RNet), is a national resource to advertise provider positions in rural and medically underserved communities. The network also provides hospitals, clinics, and other care settings resources to improve retention of providers while bolstering patient care outcomes.

## **Conclusion**

This report highlighted the challenges of recruiting physicians to medically underserved areas in Michigan, and identified the programs in Michigan that are aimed at addressing that shortage.

MDCH is committed to working with national, statewide and local partners to continue to address the primary care needs of rural and underserved communities in the state. While the programs identified in this report are successful in recruiting and retaining primary care providers in targeted areas of the state, there are many others that are not included in this report that are operating on the local level to keeping valued providers in their hometown.

MDCH continues to work closely with partners to ensure that all programs aimed at recruiting and retaining primary care providers are addressing current needs and are creating the maximum benefit for all Michigan citizens.