

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

(FY 2014 Appropriations Bill – Public Act 59 of 2013)

September 30, 2014

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
Nick Lyon, Director**

Section I- Purpose of the Report

This report is in response to Article IV, Section 716 of Public Act 59 of 2013, which requires the Michigan Department of Community Health (MDCH) to examine the issues facing the recruitment and retention of primary care physicians in 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.

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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.

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. This report will identify the areas of Michigan that are experiencing a shortage of primary care resources and provide an over view of several programs administered by the Michigan Department of Community Health that focus on improving access to primary care in Michigan so that all citizens may experience the benefits of primary care.

Health Care Workforce Shortage Areas in Michigan

Shortage of health professionals is not solely a problem of rural areas; it has widely been documented in urban areas as well. In order to systematically 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.

Health Professional Shortage Areas

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. 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. 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

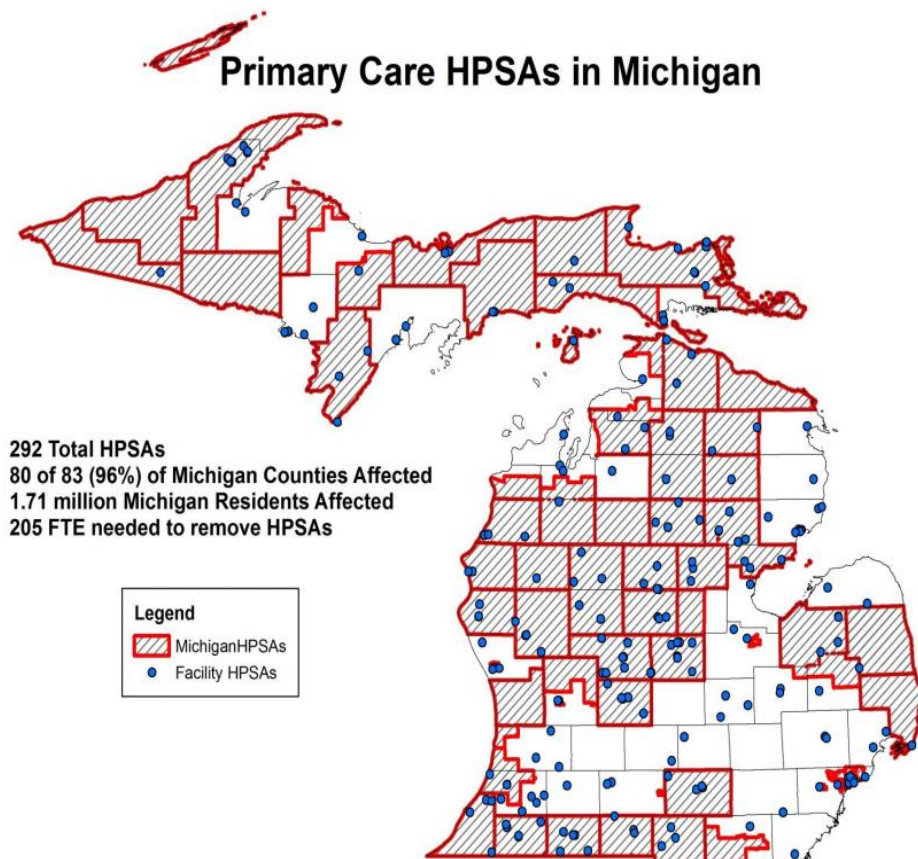
capacity to meet the needs of that area or population. These facilities include community health centers, rural health clinics, federal correctional facilities, and state hospital. Each HPSA is given a score by the Health Resources and Services administration (HRSA) within HHS based on certain specific criteria for each type of HPSA. This score indicates the degree of shortage. HPSA designations are updated every 3-4 years. There are three kinds of HPSAs; Primary Care, Dental Care or Mental Health. Each category has a different set of qualifying criteria and takes different data into account. For example, a primary care HPSA designation will demonstrate the population-to-provider ratio, the number of individuals below 100% of the federal poverty level, the infant health index and average travel time or distance to the nearest source of accessible care.

In general, a HPSA designation must meet these three criteria:

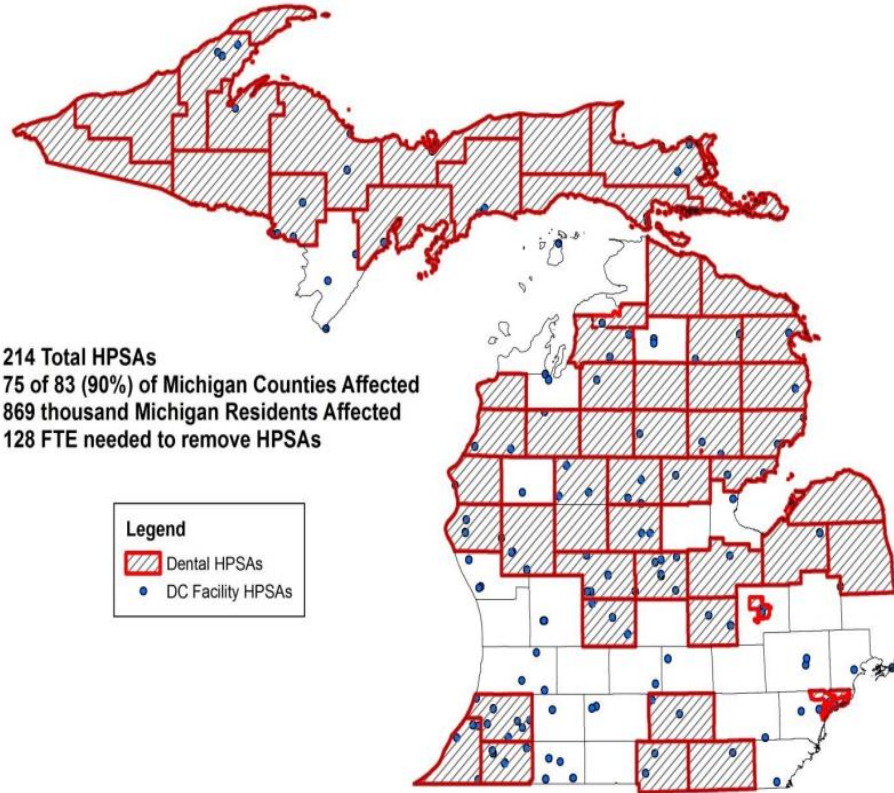
1. The area must be a county, rational service area or a defined community.
2. The community must demonstrate specific population-physician ratio requirements or have an unusually high need for primary care services.
3. Existing primary care professionals must be over-utilized, excessively distant, or inaccessible to the population

There are currently approximately 6,100 designated Primary Care HPSAs, 4,900 Dental HPSAs and 4000 mental HPSAs in the United States. There are currently 702 HPSAs in Michigan out of which 292 are Primary Care HPSAs, 214 are Dental Care HPSAs and 196 are Mental Health HPSAs. Below you will find maps of the current HPSA designations in Michigan by type.

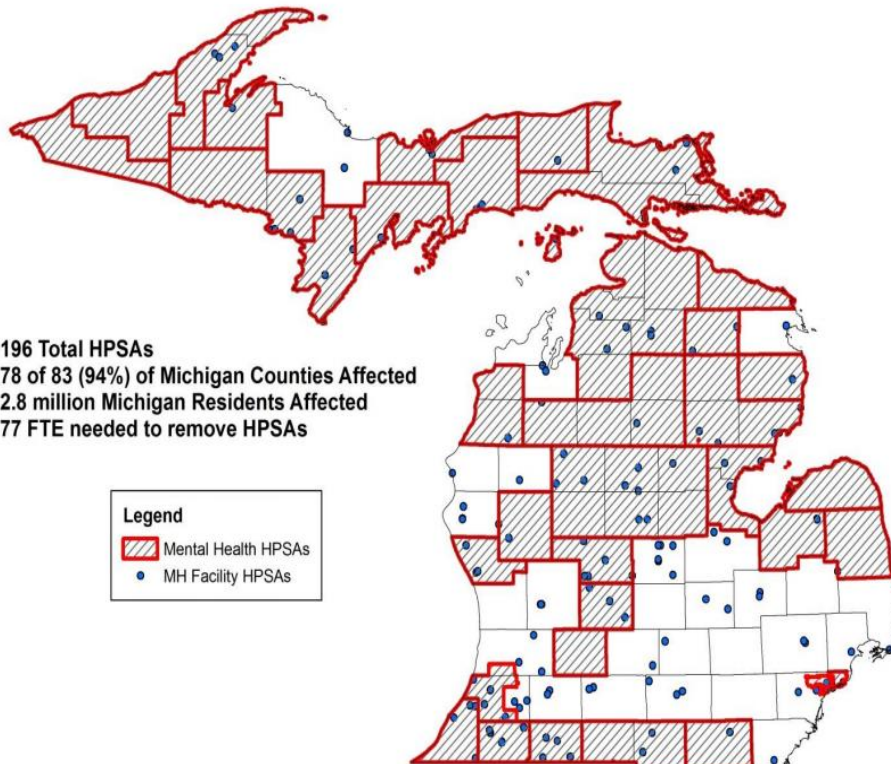
Current HPSA Maps by Type



Dental Care HPSAs in Michigan



Mental Health HPSAs in Michigan



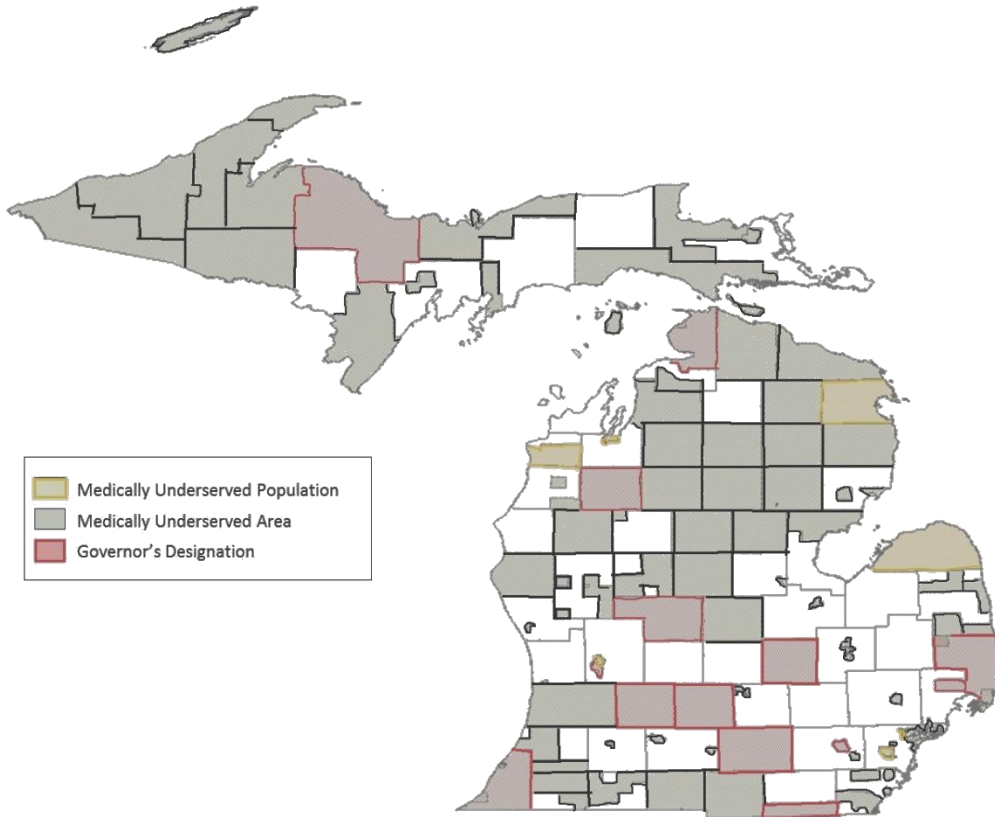
Medically Underserved Areas or Populations

Another kind of shortage area designation is a Medically Underserved Area or Population (MUA/P). An MUA/P designation identifies areas or populations with a shortage of health care services. These areas are only applicable for primary health care services and unlike a HPSA this type of designation does not expire under current federal guidance. An MUA/P designation is based on the explanation as to why the area in question is a defined community or county and the documentation of four factors; health care provider-to-population ratio, infant mortality rate, percentage of population below 100% of the federal poverty level, and the percentage of population aged 65 and over.

An MUA may apply to whole counties, a group of counties or civil divisions, or a group of urban census tracts. The MUP includes groups of persons who face documented economic, cultural or linguistic barriers to health care. A Governor’s Designation area is an area that does not meet the established criteria but has unusual local conditions which are a barrier to access or to the availability of personal health services. There are currently 112 total designated areas in Michigan.

MUA	87
MUP	11
Governor’s Designation	14
Total	112

Map of Designated MUA/P in Michigan



Healthcare Workforce Recruitment & Retention Programs in Michigan

MDCH currently administers three programs that actively address primary health care workforce shortages in HPSAs: Michigan State Loan Repayment Program; National Health Service Corps; and the Conrad 30 J-1 visa waiver program. Additionally, to specifically target shortages in rural areas, MDCH collaborates with Michigan Center for Rural Health to achieve the goals of the State Office of Rural Health program.

Michigan State Loan Repayment Program

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 make loan repayment programs very successful in easing the burden for primary care providers that opt to work in underserved areas.

In Michigan, providers can utilize 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 Hospitals and Certified Rural Health Clinics 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. In 2014, the Michigan Legislature enacted a bill that allows for MSLRP policy changes that will be beneficial to participants, their employers, and to the underserved communities in which they practice. Providers will now be able to participate for up to eight years and receive up to \$200,000 in loan repayment assistance where previously providers were only able to participate for four years with a total of \$120,000 in assistance. The changes to the MSLRP statute greatly modernize the program and reflect the trend of increasing amounts of medical education debt.

As an example of the range of medical education debt among MSLRP participants in 2014, primary care physicians had an average educational debt of \$190,800 in 2014 with a range of \$15,945 to \$482,642. By comparison, the average educational debt in 2014 for awarded mid-level providers, including nurse practitioners, physician assistants, Masters of Social Work, and a psychologist was \$61,109 in 2014 with a range of \$33,479 to \$137,958.

The table below depicts the providers participating in the MSLRP program in 2014. Of the 30 providers awarded, 14 were physicians. Eight were Medical Doctors (MD) and six were Doctors of Osteopathic Medicine (DO). Five providers were Masters of Social Work, three were nurse practitioners, four were physician assistants, two were dentists, and two were Certified Nurse Midwives.

FY 2014 MSLRP Providers	
<i>Provider Type</i>	<i>Number</i>
Primary Care Provider – MD	8
Primary Care Provider – DO	6
Masters of Social Work	5
Nurse Practitioners	3
Physicians Assistants	4
Dentists	2
Certified Nurse Midwife	2
Total	30

Of the 30 providers awarded loan repayment agreements, 17 were working at rural practice sites and 13 were working at urban practice sites. For FY 2014, the program obligated a total of \$1,594,430. This included a \$569,400 federal program award, \$666,250 in state general funds and \$358,780 in employer contributions. Provider agreements were funded by 40 percent federal, 40 percent state, and 20 percent employer contributions.

National Health Services Corps

MDCH partners with the U.S. Health Resources and Services Administration to manage another medical educational debt relief program called the National Health Service Corps (NHSC) loan repayment program. MDCH plays an important role in the development and review of site applications. 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 HPSAs with a very high degree of demonstrated need.

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. In 2013, nearly 8,900 NHSC clinicians were providing care to more than 9.3 million people who live in rural, urban, and frontier communities at more than 5,100 NHSC-approved sites. There are currently 471 NHSC approved sites in Michigan.

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 HPSAs and 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 full-time in a HPSA or MUA/P for the required three year obligation period. Priority is given 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 underserved 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 410 providers between 2001 and 2014. In 2014, 16 healthcare providers were serving in rural communities and 12 were primary care providers.

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 scholarship program at Michigan State University for medical students that have expressed a desire to practice primary care medicine in rural Michigan.

Conclusion

This report highlighted some of 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.