Welcome to the 11th Annual Public-Private Collaborations in Rural Health Meeting

October 26-27, 2023 | Washington, DC

Wifi Network: MarriottBonvoy_Conference
Access code: NRHA2023

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
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Federal Office of Rural Health Policy

Welcome And Introductory Remarks

Tom Morris
Associate Administrator
Federal Office of Rural Health Policy
Health Resources and Services Administration

Diane Hall
Senior Health Scientist and CDC Lead for Rural Health
Office of the Associate Director for Policy and Strategy
Centers for Disease Control and Prevention

Carrie Cochran-McClain
Chief Policy Officer
National Rural Health Association

The Rural Health Workforce: Challenges and Opportunities for Philanthropies

Cara James
President and *Chief Executive Officer*
Grantmakers In Health

Davis Patterson
Director
WWAMI Rural Health Research Center

CAPT Paul Jung, USPHS
Director, Division of Medicine and Dentistry
Health Resources and Services Administration (HRSA)

The Rural Health Workforce: Challenges and Opportunities for Philanthropies

Davis Patterson, PhD
Director, WWAMI Rural Health Research Center
Deputy Director, Health Equity, UW Center for Health Workforce Studies
Research Associate Professor
University of Washington School of Medicine

Public-Private Collaborations in Rural Health
Annual Meeting of the Rural Health Philanthropy Partnership
Washington, DC
Thursday, October 26, 2023

WWAMI • ruralhealth researchcenter
UNIVERSITY of WASHINGTON
Celebrating 35 Years

WWAMI Rural Health Research Center

- Mission: Improve and sustain rural health through research that engages policymakers, planners, and practitioners advancing equity in rural access to care.
- Funded since 1988 by Federal Office of Rural Health Policy, Health Resources & Services Administration (HRSA)

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Rural PREP:
The Collaborative for Rural Primary care Research, Education, and Practice

- Funded by HRSA 2016-2022 to conduct, promote, and disseminate research on rural primary care health professions education to build a community of practice

Rural PREP
Preparing for rural practice

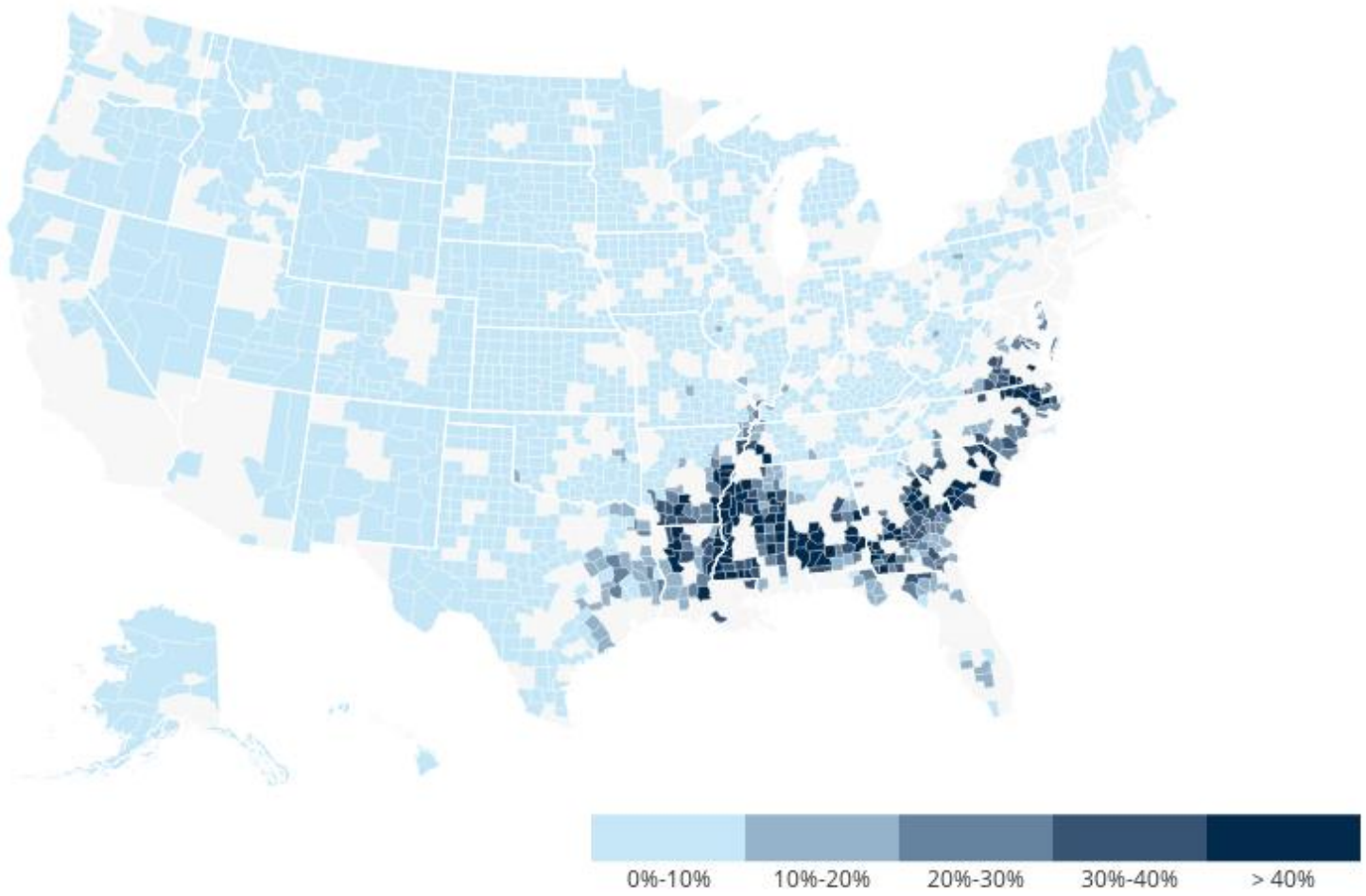
UW Center for Health Workforce Studies

- Conducts policy-relevant research since 1998 on the health workforce, with a focus on allied health and health equity.
- Funded by the National Center for Health Workforce Analysis, HRSA

Acknowledgments and Disclaimer

This research was supported by the Bureau of Health Workforce (BHW), the Federal Office of Rural Health Policy (FORHP), and the National Center for Health Workforce Analysis (NCHWA), Health Resources & Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreements #UH1HP29966, #U1CRH03712, and U81HP27844. The information, conclusions and opinions expressed in this presentation are those of the authors and no endorsement by BHW, FORHP, NCHWA, HRSA, or HHS is intended or should be inferred.

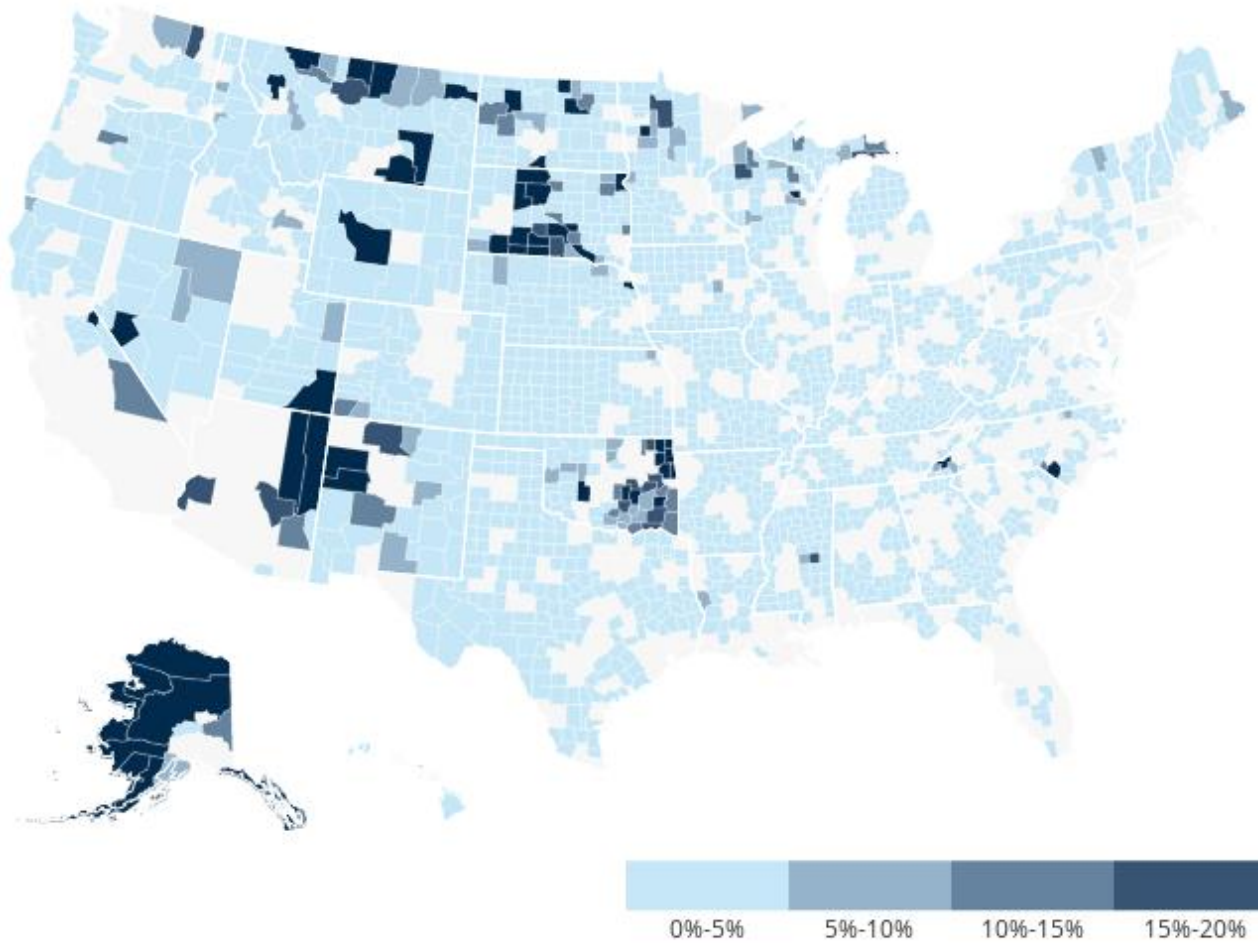
Black Population, 2021 - Nonmetropolitan



RHIhub
Rural Health Information Hub

Note: May include people of Hispanic origin.
Source: U.S. Census ACS, 2011, 2016, and 2021 5-year estimates.

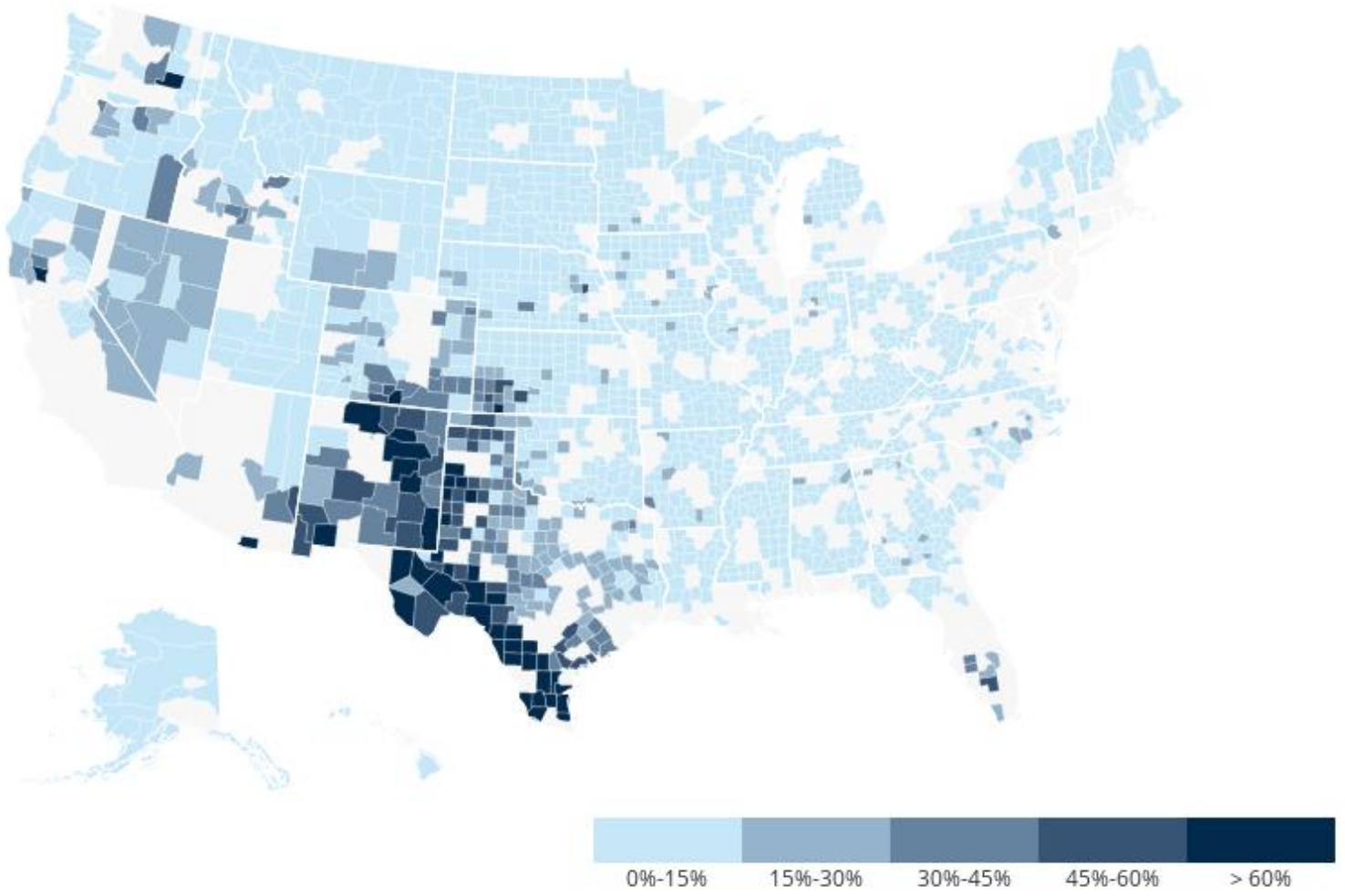
American Indian/Alaska Native Population, 2021 - Nonmetropolitan



RHI hub
Rural Health Information Hub

Note: May include people of Hispanic origin.
Source: U.S. Census ACS, 2011, 2016, and 2021 5-year estimates.

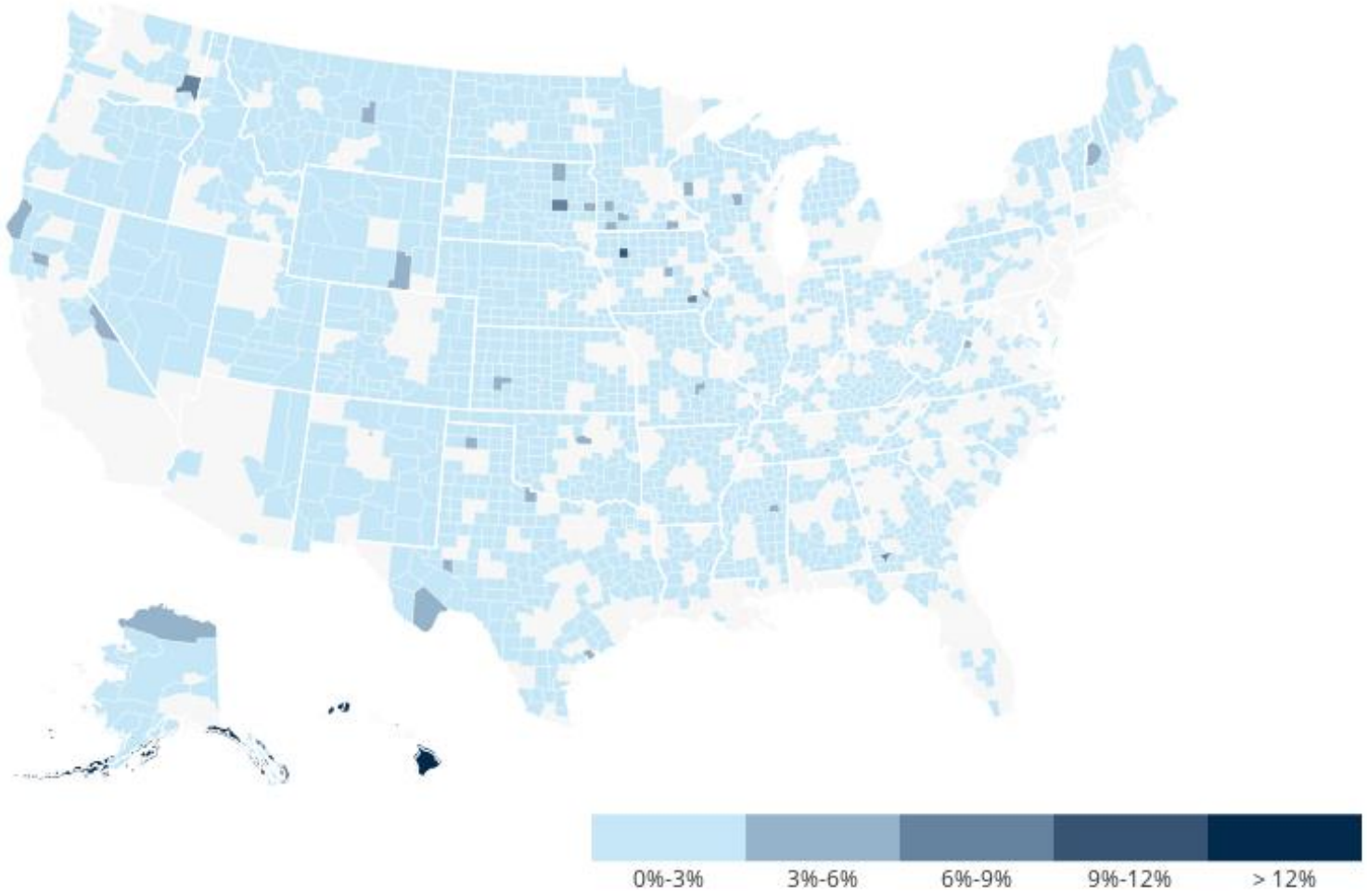
Hispanic Population, 2021 - Nonmetropolitan



RHIhub
Rural Health Information Hub

Source: U.S. Census ACS, 2011, 2016, and 2021 5-year estimates.

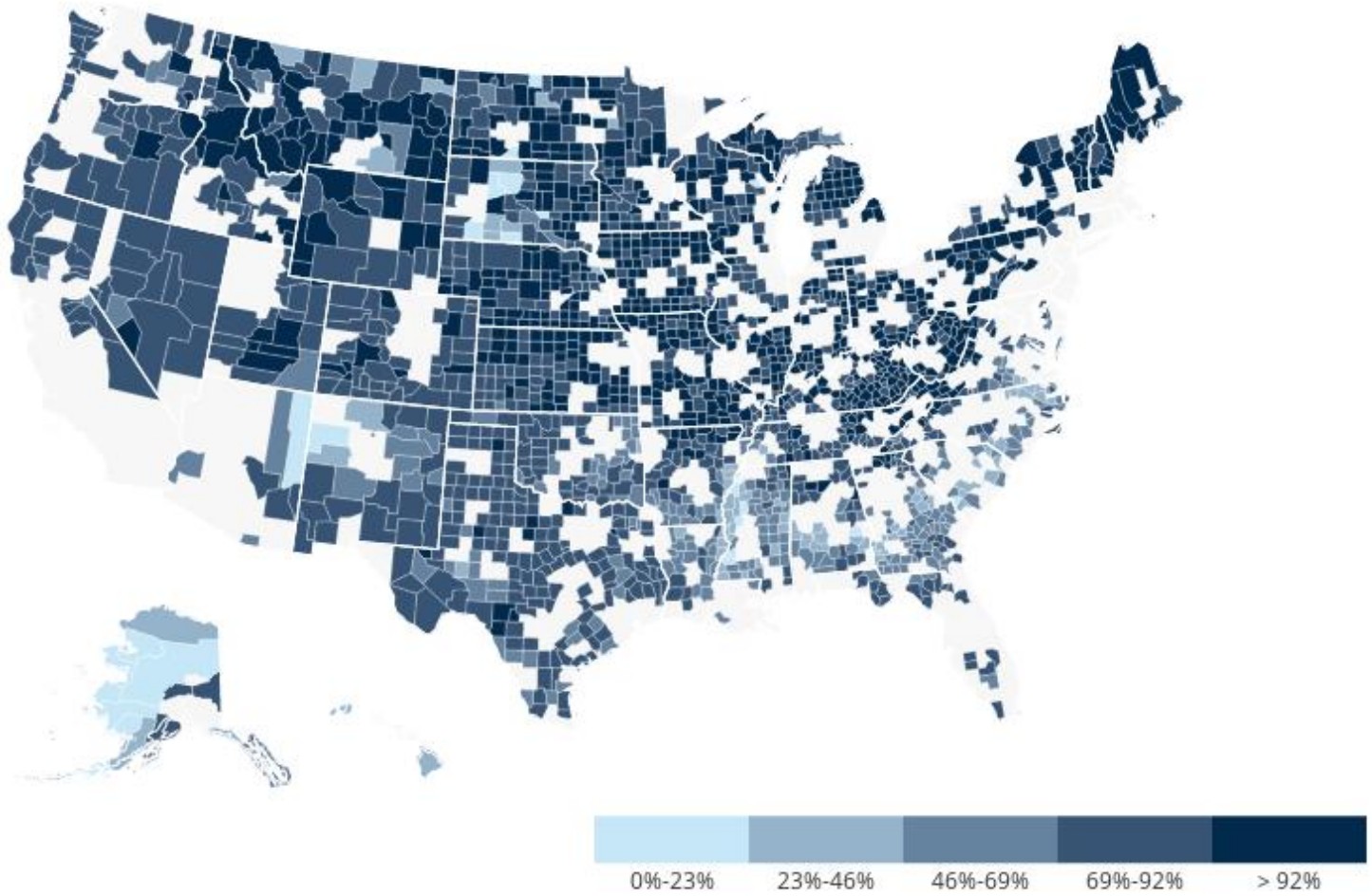
Asian Population, 2021 - Nonmetropolitan



RHIhub
Rural Health Information Hub

Note: May include people of Hispanic origin.
Source: U.S. Census ACS, 2011, 2016, and 2021 5-year estimates.

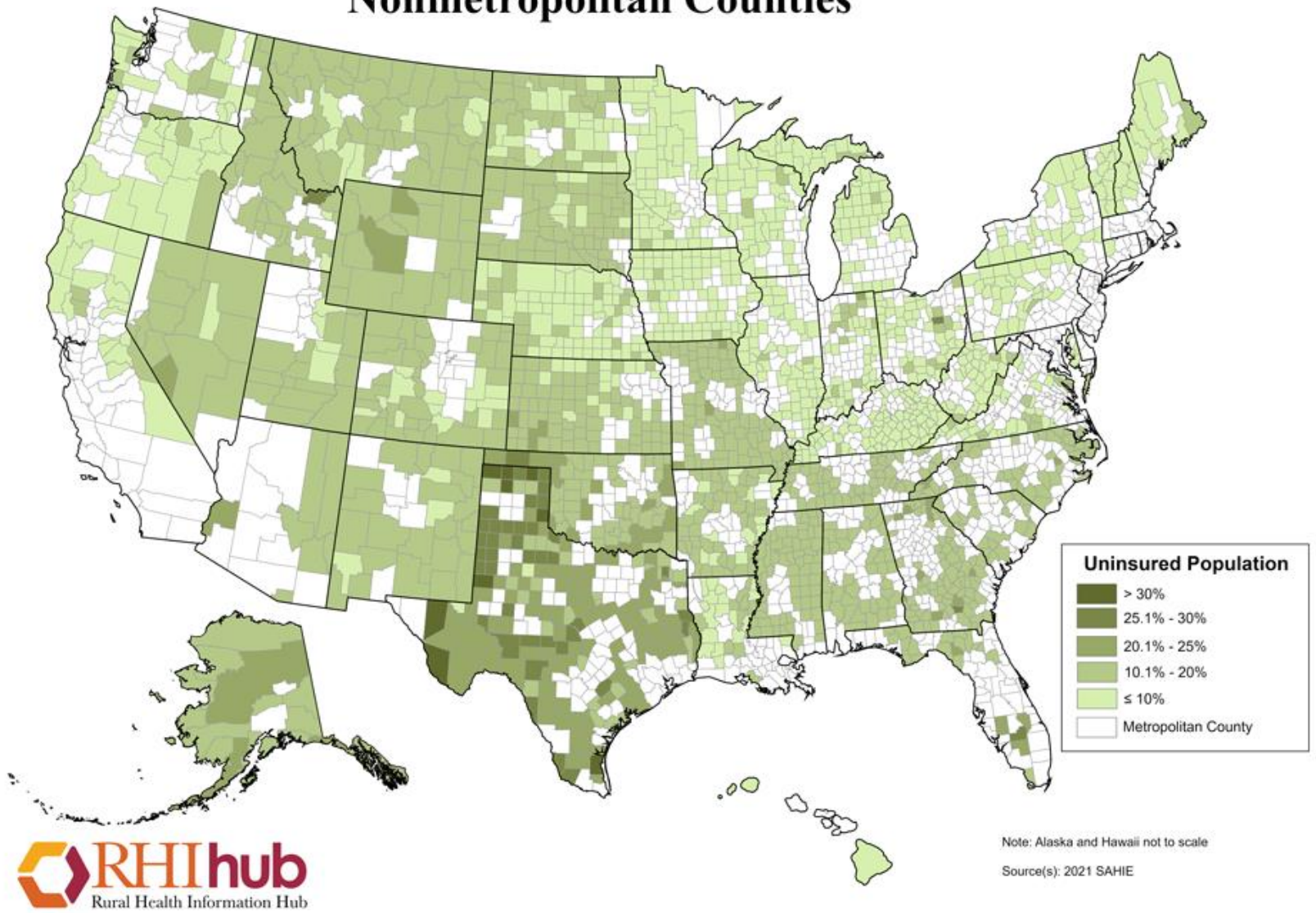
White Population, 2021 - Nonmetropolitan



RHI hub
Rural Health Information Hub

Note: May include people of Hispanic origin.
Source: U.S. Census ACS, 2011, 2016, and 2021 5-year estimates.

Uninsured Population in Nonmetropolitan Counties



RHIhub
Rural Health Information Hub

Yes, there are rural health workforce shortages

The Rural Nursing Shortage

The pandemic has worsened a long-standing national shortage of nurses. Rural communities face the greatest challenges.

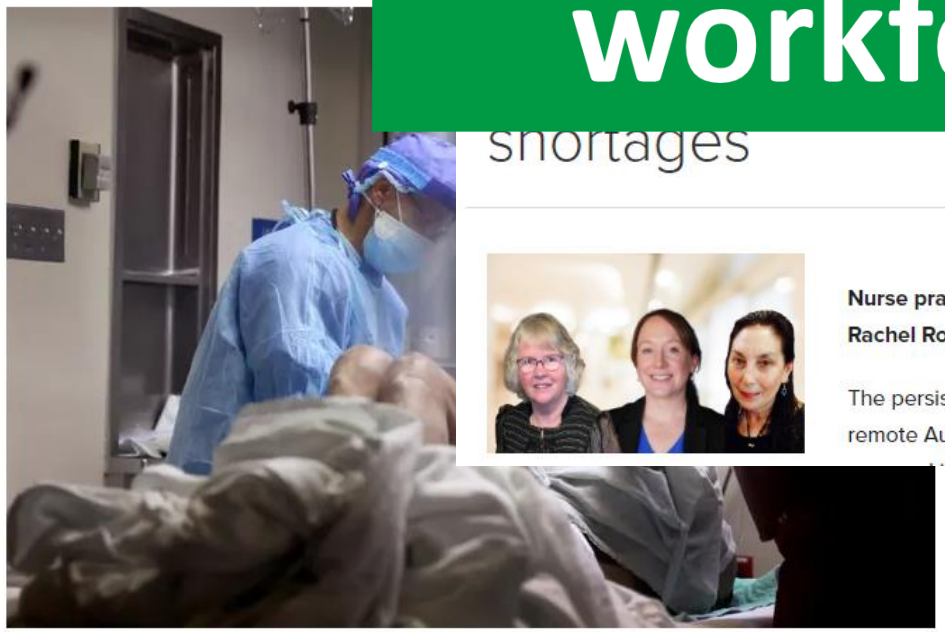
By Tim Sablik

NEWS

Workforce sho… hospitals harde…

Tammie Sloup FarmWeek

Published 5:03 a.m. CT Aug. 12, 2022 | Updated…



Health field experts predict a growing shortage of workers and smaller hospitals are already expanding their recruiting efforts. *Scott Olson/Getty Images*

…g demands more need as rural …ce mental health provider

THE MAINE MONITOR

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InSight+ Empowered by AMPCo

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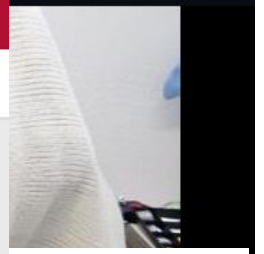


…kforce shortages

Nurse practitioners could play an integral part in addressing the rural health workforce shortage, write Rachel Rossiter, Katie Prior and Rosemary Phillips.

The persistent challenges arising from nationwide shortages of general practitioners in regional, rural and remote Australia are well known. Recent calls for new approaches incorporating effective team-based…

…cing | Health equity | He…

…utions

Rural hospitals struggle with staffing shortage, and not just doctors

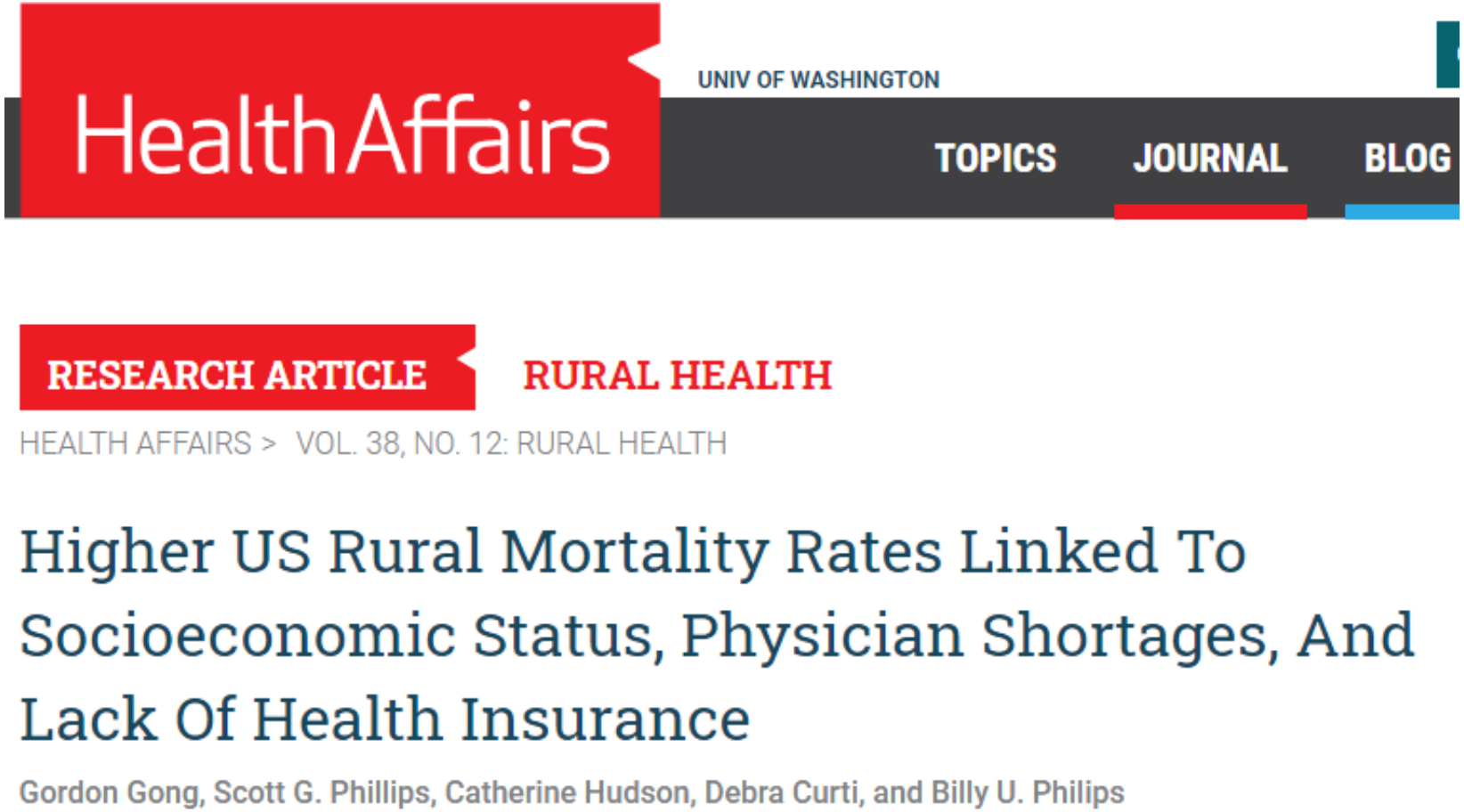
May 23, 2023

Ron Southwick

Workforce shortages and other barriers to care lead to higher rural mortality

“Rural residence in and of itself does not appear to negatively affect mortality.”

“States play an important role in determining the conditions closely associated with mortality.”

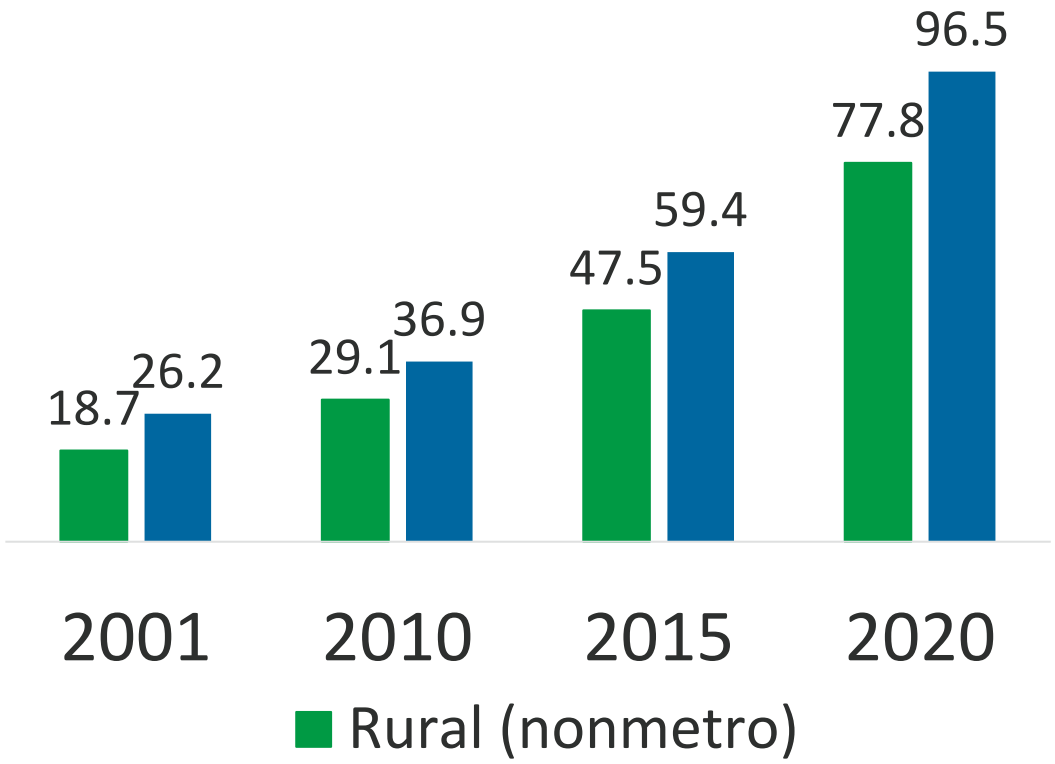


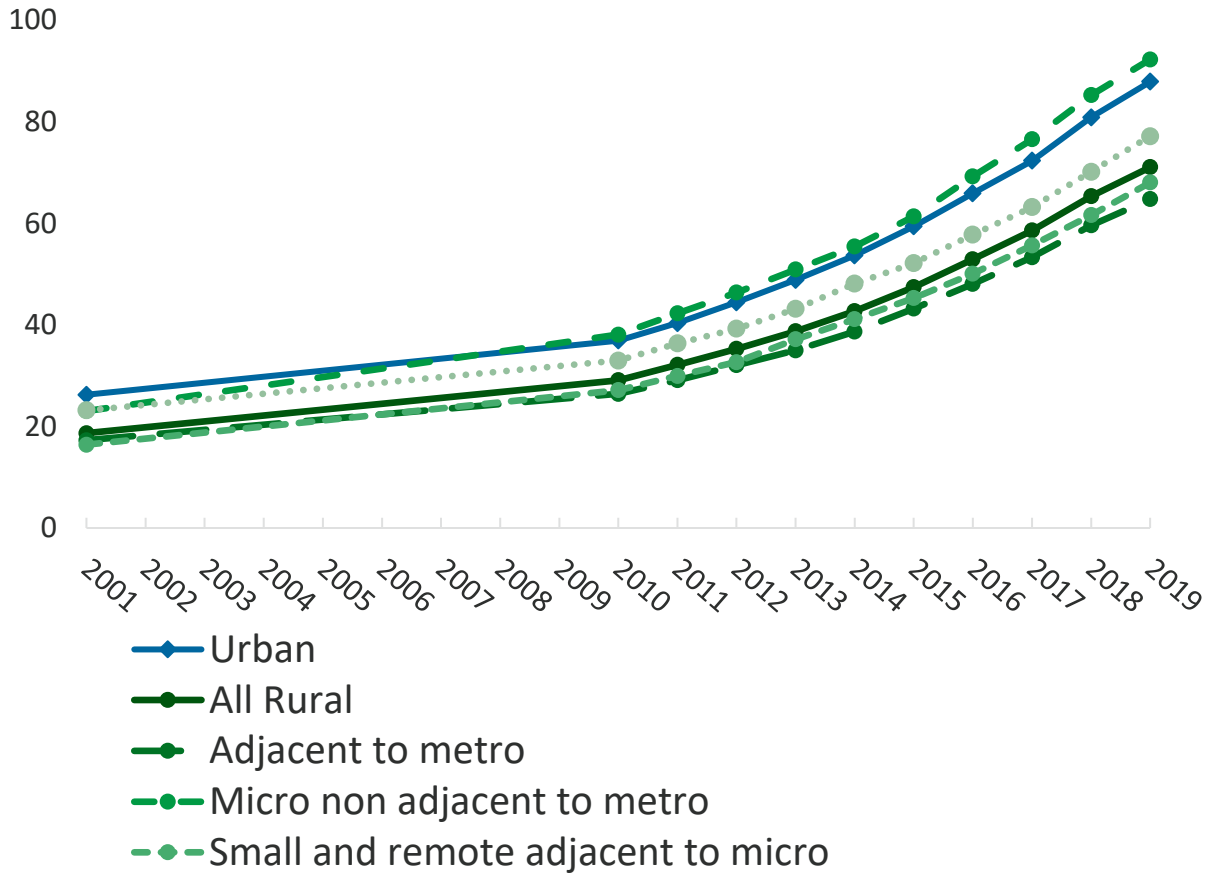
https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00722

Primary care workforce

Nurse practitioner supply is growing rapidly…

NPs per 100,000 Population in Rural and Urban U.S. Counties, 2001-2019

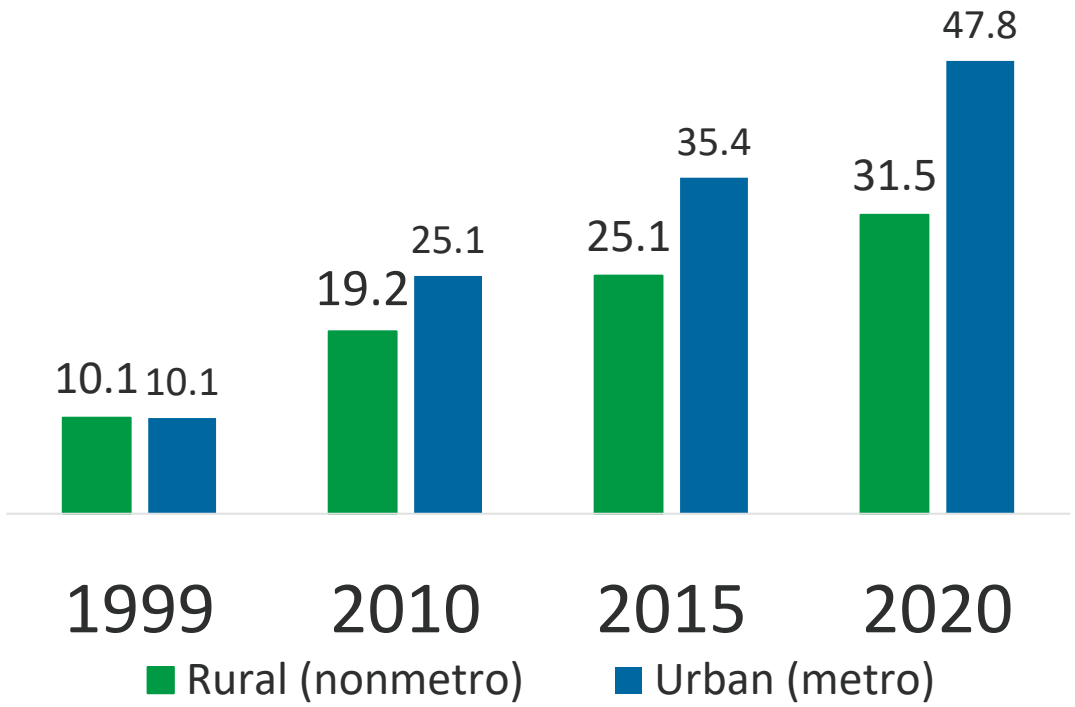


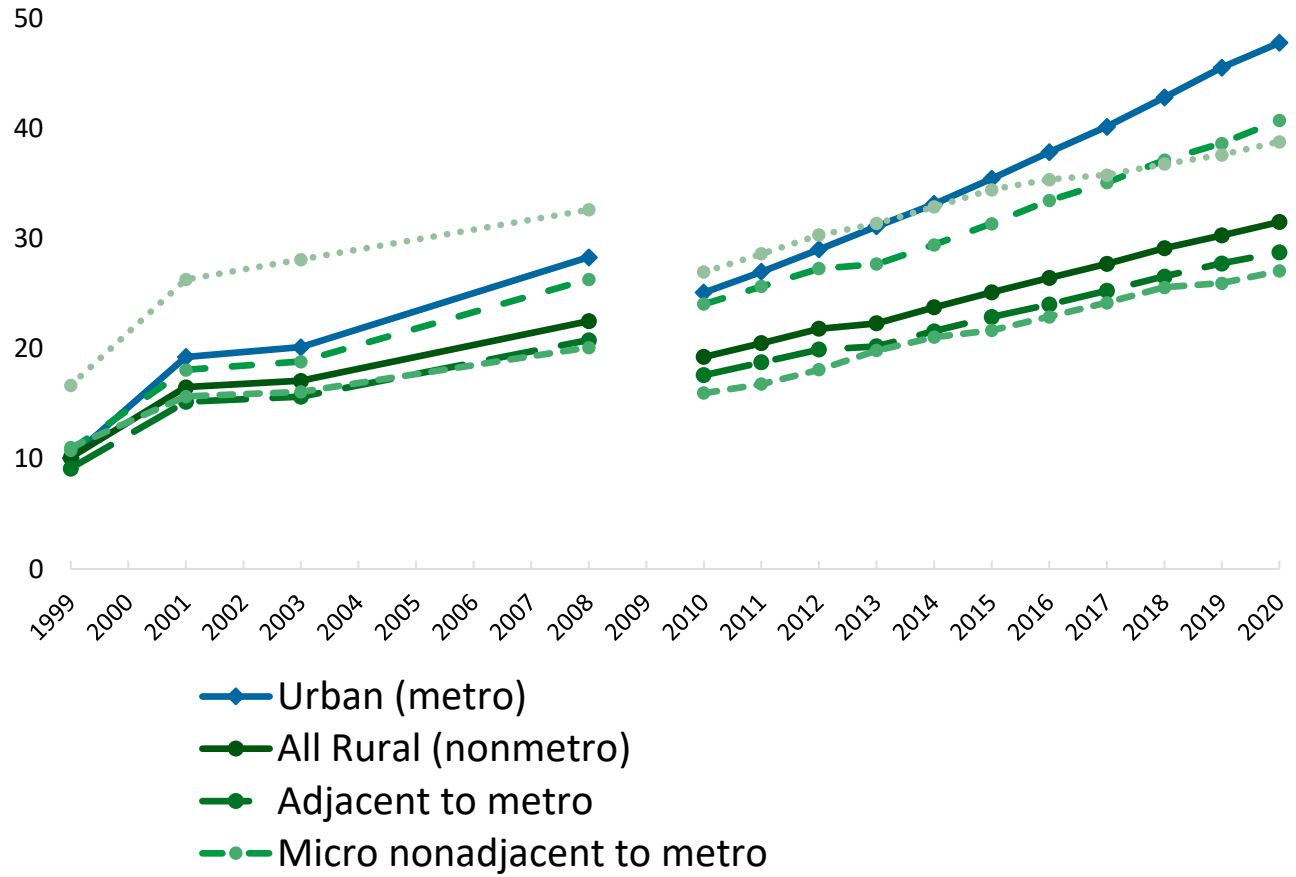


Data source: Area Health Resource Files (AHRF), 2009, 2019-2021. *AHRF 2001 data obtained from American Association of Nurse Practitioners (AANP) Survey. 2010-2020 data report NPs with a National Provider Identifier from the Centers for Medicare & Medicaid Services.

...as is physician assistant supply!

PAs per 100,000 Population in Rural and Urban U.S. Counties, 1999-2020





Data source: Area Health Resources Files (AHRF), 2009, 2014, 2020-2021. AHRF 1999-2008 data are projections from the American Association of Physician Associates (AAPA) Census; AHRF 2010-2020 data report PAs with a National Provider Identifier from the Centers for Medicare & Medicaid Services.

The #PowerofRural (rural place, that is) in rural health professional education

- Evidence from rural medical school education https://onlinelibrary.wiley.com/doi/10.1111/jrh.12542
- PA education programs that succeed at producing **rural** PAs require **rural** training and **rural** family medicine rotations. https://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2018/06/RHRC_PB164_Larson.pdf

(Data largely unavailable on characteristics of nurse practitioner and other programs that lead to rural practice.)

National Rural Health Day
Celebrating the Power of Rural!

November 16, 2023

The value of rural residency training for family physicians

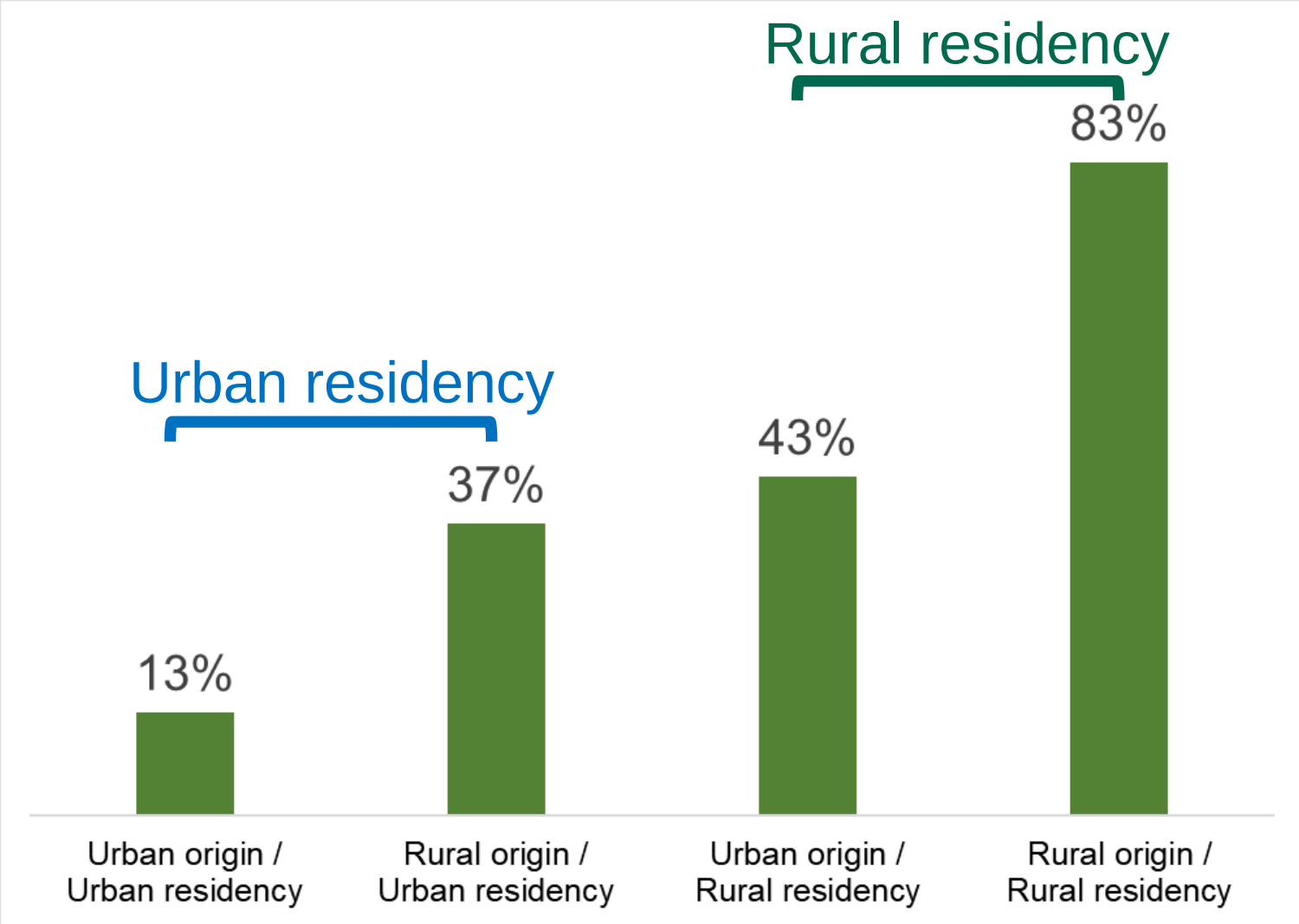
- Graduates from **rural** residency programs are **5 times** as likely as urban program graduates to be in rural practice.
- Family physicians trained in **rural** residencies provide more **rural** workforce years over their careers than urban-trained.

Russell DJ, Wilkinson E, Petterson S, Chen C, Bazemore A. Family Medicine Residencies: How Rural Training Exposure in GME Is Associated With Subsequent Rural Practice. J Grad Med Educ. 2022 Aug;14(4):441-450. doi: 10.4300/JGME-D-21-01143.1. PMID: 35991106; PMCID: PMC9380633.

Meyers P, Wilkinson E, Petterson S, Patterson DG, Longenecker R, Schmitz D, Bazemore A. Rural Workforce Years: Quantifying the Rural Workforce Contribution of Family Medicine Residency Graduates. J Grad Med Educ. 2020 Dec;12(6):717-726. doi: 10.4300/JGME-D-20-00122.1. Epub 2020 Dec 4. PMID: 33391596; PMCID: PMC7771603.

Rural residency training is stronger than rural background in predicting rural practice among family physicians

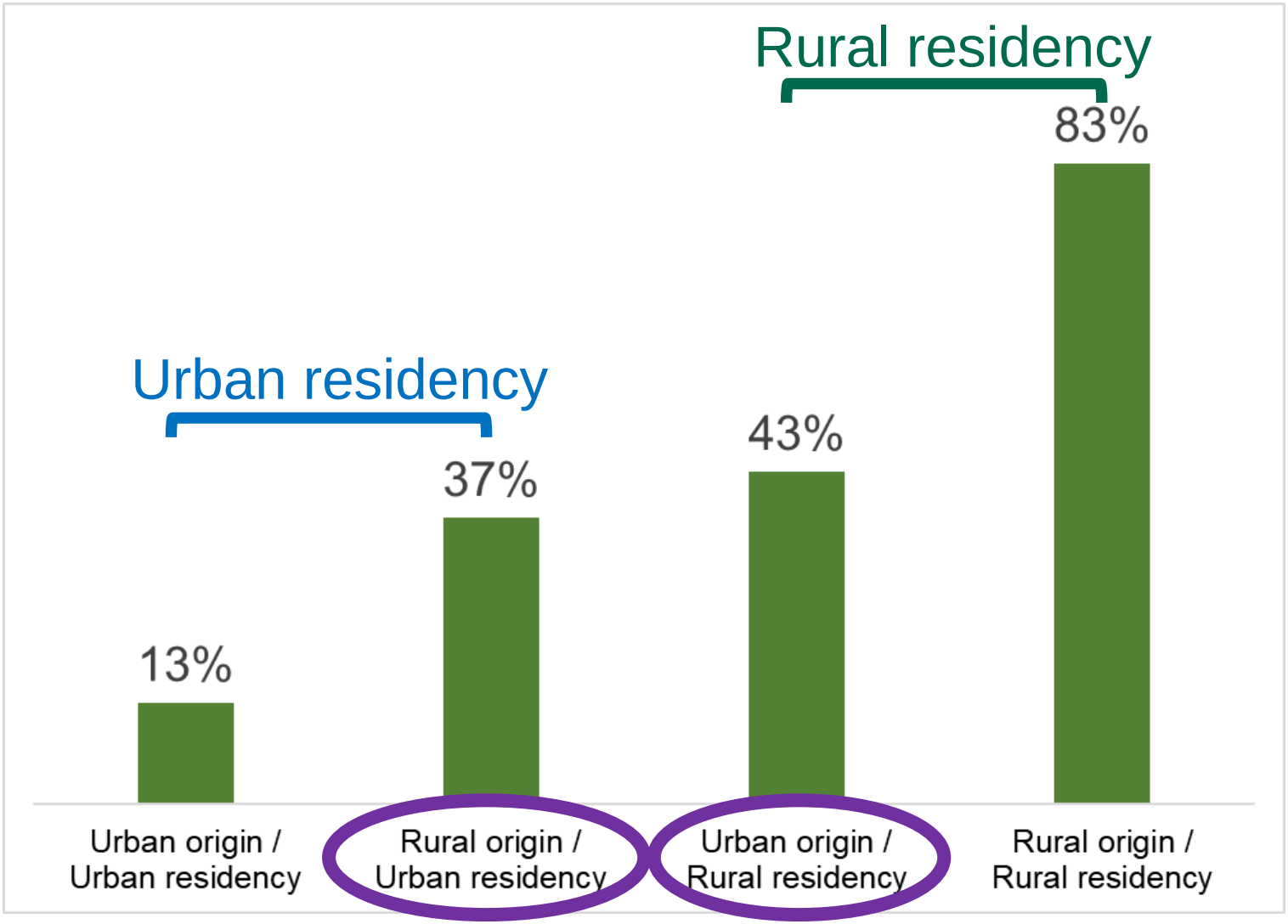
% in rural practice post-residency



Patterson DG, Shipman SA, Pollack SW, Andrilla CHA, Schmitz D, Evans DV, Peterson LE, Longenecker R. Growing a rural family physician workforce: The contributions of rural background and rural place of residency training. Health Serv Res. 2023 May 9. doi: 10.1111/1475-6773.14168. Epub ahead of print. PMID: 37161614.

Rural residency training is a stronger predictor than rural background of rural practice among family physicians

% in rural practice post-residency



Patterson DG, Shipman SA, Pollack SW, Andrilla CHA, Schmitz D, Evans DV, Peterson LE, Longenecker R. Growing a rural family physician workforce: The contributions of rural background and rural place of residency training. Health Serv Res. 2023 May 9. doi: 10.1111/1475-6773.14168. Epub ahead of print. PMID: 37161614.

How available is rural training?

169 rural residency programs (family medicine, internal medicine, pediatrics, psychiatry, surgery) **– and growing, through the Rural Residency Planning and Development Program**

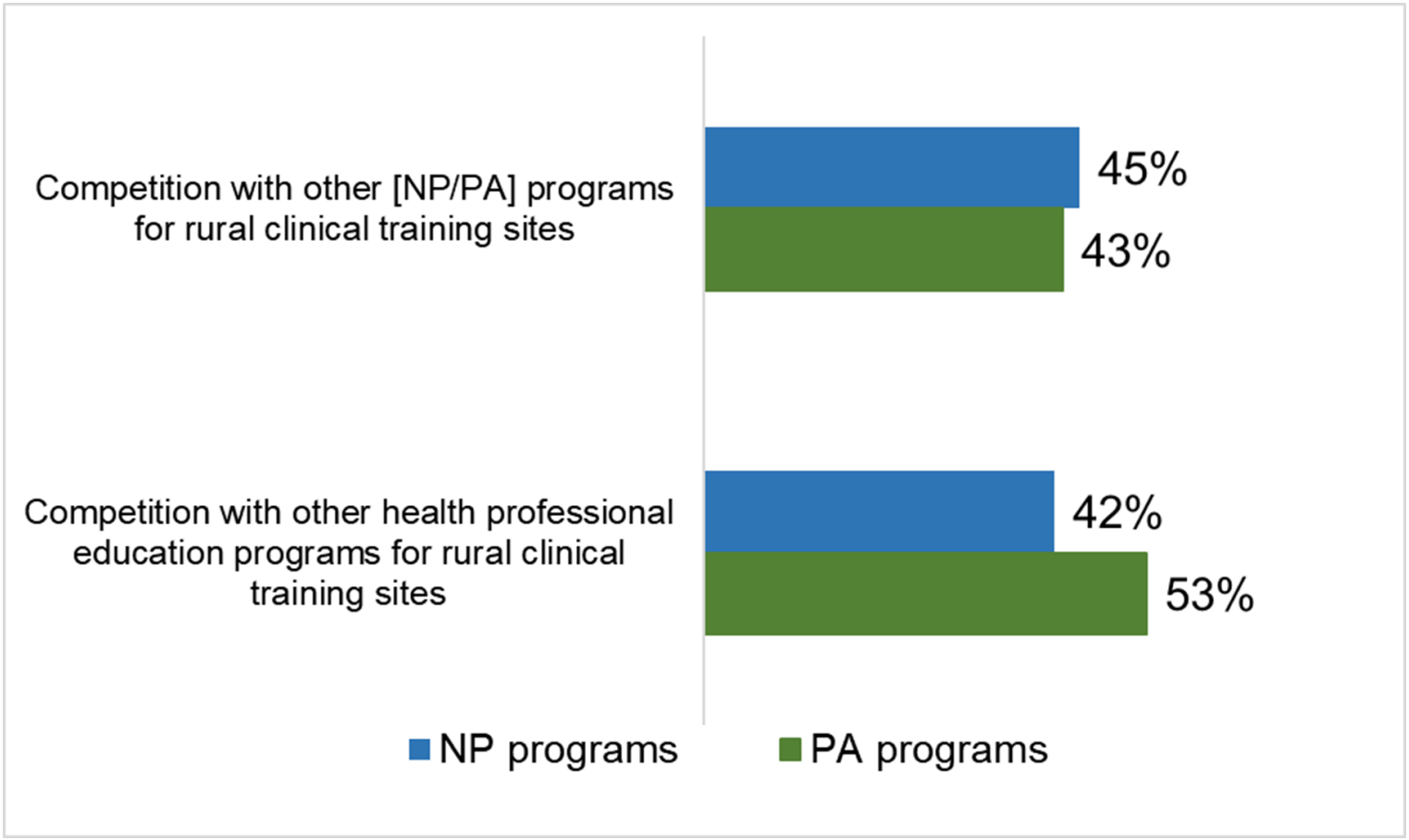
Still – very *little* rural training is happening

- Only 3.5% - 4% of family medicine residents do a rural residency (>50% time in rural).
- Fewer than 10% of family medicine residents do ANY rural training.

Russell DJ, Wilkinson E, Petterson S, Chen C, Bazemore A. Family Medicine Residencies: How Rural Training Exposure in GME Is Associated With Subsequent Rural Practice. J Grad Med Educ. 2022 Aug;14(4):441-450. doi: 10.4300/JGME-D-21-01143.1. PMID: 35991106; PMCID: PMC9380633.

Patterson DG, Shipman SA, Pollack SW, Andrilla CHA, Schmitz D, Evans DV, Peterson LE, Longenecker R. Growing a rural family physician workforce: The contributions of rural background and rural place of residency training. Health Serv Res. 2023 May 9. doi: 10.1111/1475-6773.14168. Epub ahead of print. PMID: 37161614.

Competition for rural clinical placements is the top barrier for NP and PA programs

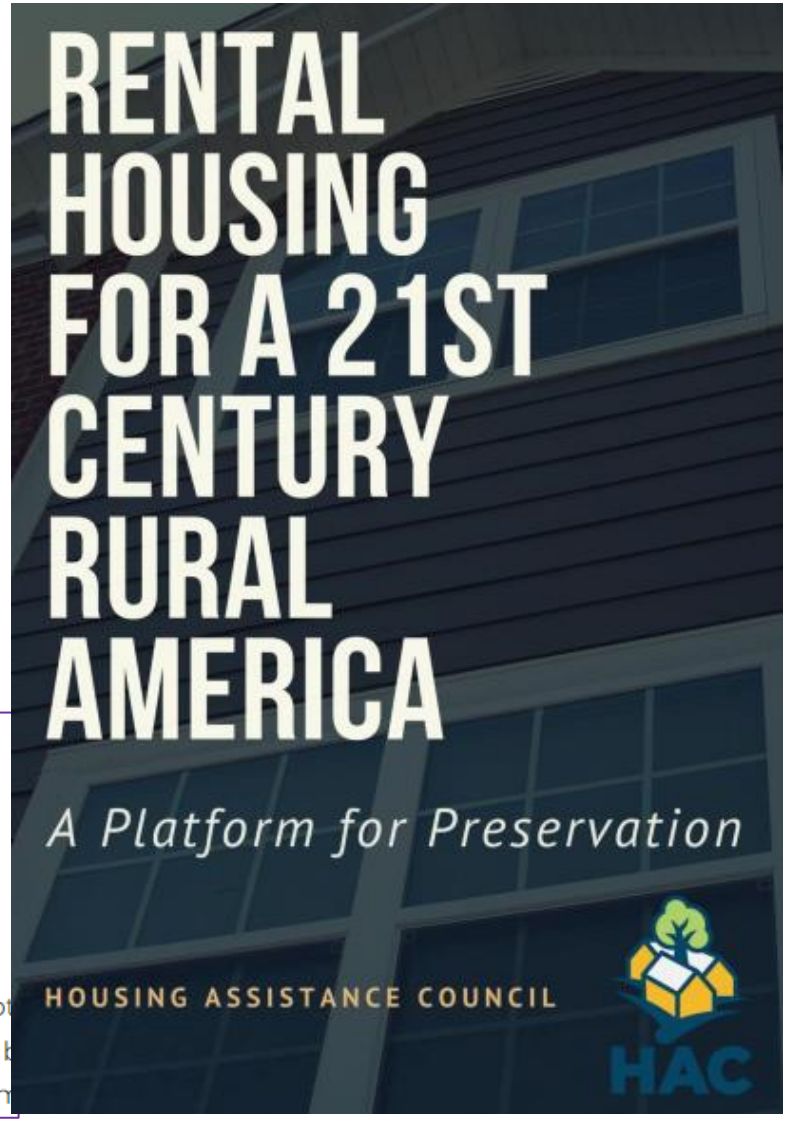


Kaplan L, Pollack S, Skillman S, Patterson DG. NP programs' efforts to promote transition to primary care rural practice. The Nurse Practitioner. 2020;45(10):48-55.

Larson EH, Oster NV, Jopson AD, Andrilla CHA, Pollack SW, Patterson DG. Routes to Rural Readiness: Enhancing Clinical Training Experiences for Physician Assistants. J Physician Assist Educ. 2023 Sep 1;34(3):178-187.

Other barriers to rural training:

- Student living costs and travel time/expense
- Lack of available preceptors (how is health system consolidation affecting this?)



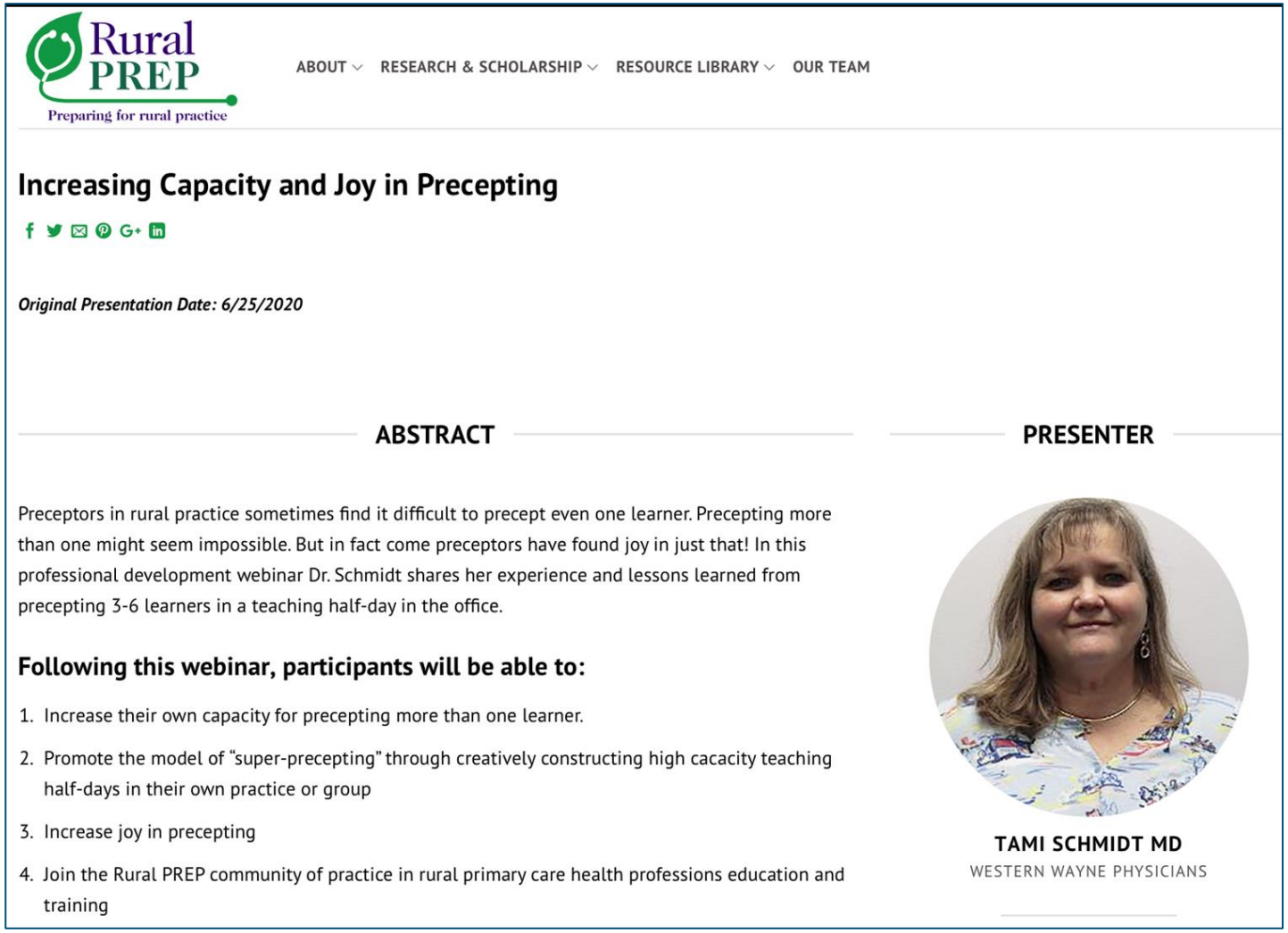
Rural America is Losing its Affordable Rural Rental Housing

A LOOMING CRISIS

A Crisis: The increasing lack of affordable housing is not just an urban problem. Rental housing opt
declining. An important source of housing in many rural communities are rental homes financed b
there are over 13,000 USDA rental properties providing more than 415,000 affordable homes to fam

https://ruralhome.org/rural-america-is-losing-its-affordable-rental-housing/

Collaborative, interprofessional educational models can maximize rural placements.



Rural PREP
Preparing for rural practice

ABOUT RESEARCH & SCHOLARSHIP RESOURCE LIBRARY OUR TEAM

Increasing Capacity and Joy in Precepting

Original Presentation Date: 6/25/2020

ABSTRACT

Preceptors in rural practice sometimes find it difficult to precept even one learner. Precepting more than one might seem impossible. But in fact come preceptors have found joy in just that! In this professional development webinar Dr. Schmidt shares her experience and lessons learned from precepting 3-6 learners in a teaching half-day in the office.

Following this webinar, participants will be able to:

1. Increase their own capacity for precepting more than one learner.
2. Promote the model of "super-precepting" through creatively constructing high cacacity teaching half-days in their own practice or group
3. Increase joy in precepting
4. Join the Rural PREP community of practice in rural primary care health professions education and training

PRESENTER

TAMI SCHMIDT MD
WESTERN WAYNE PHYSICIANS

https://ruralprep.org/research-scholarship/webinar/

Welcome all learners in rural sites

Students from racial and ethnic minority backgrounds report experiencing discrimination from preceptors, patients, and community members.

"I think it would also be helpful to have…an outright conversation of…the racism, sexism, and the many –isms you're going to experience in the clinical environment and more likely outside of the clinical environment—especially if you're not from these communities."

DOI: 10.1111/jrh.12745

THE JOURNAL OF RURAL HEALTH

BRIEF REPORT

Positive yet problematic: Lived experiences of racial and ethnic minority medical students during rural and urban underserved clinical rotations

Brian Cedeño BA[1] | Genya Shimkin MPH[2] | Alexa Lawson MA[3] | Bopha Cheng M.Ed.[3] | Davis G. Patterson PhD[4] | Toby Keys MPH[3]

[1]Medical Student, University of Washington School of Medicine, Seattle, Washington, USA

[2]Department of Family Medicine, University of Washington School of Medicine, Seattle, Washington, USA

[3]Office of Rural Programs, University of Washington School of Medicine, Seattle, Washington, USA

[4]WWAMI Rural Health Research Center, University of Washington School of Medicine, Seattle, Washington, USA

Abstract

Purpose of Study: Medical students who identify as Black, Indigenous, and People of Color (BIPOC) regularly experience mistreatment and discrimination. This study sought to understand these student experiences during rotations in rural and urban underserved community teaching sites.

Methods: Self-identified BIPOC medical students who completed the University of Washington School of Medicine's Rural Underserved Opportunities Program from 2019 through 2021 were invited to participate in a 60- to 90-minute focus group dis-

https://doi.org/10.1111/jrh.12745

Rural PREP
Preparing for rural practice

ABOUT | RESEARCH & SCHOLARSHIP | RESOURCE LIBRARY | OUR TEAM

Welcoming Diverse Clinical Learners into Diverse Rural Communities

Original Presentation Date: 5/23/2019

Overview

All communities of medical practice benefit from having learners join the healthcare team. Successful integration and support of learners into a rural community health care setting can invigorate a practice, help trainees understand the unique needs of rural communities, lead to lifelong relationships, and can create a pipeline for communities to recruit future health care providers. These first contacts can be formative for trainees who may be considering a career in rural medicine. This webinar briefly reviews the staffing needs of rural communities and the experiential opportunities for trainees there, and discusses methods to support learners from diverse backgrounds in these settings.

Following this webinar, participants will be able to:

1. Articulate the healthcare staffing needs of rural communities
2. Describe the ways in which trainees can be integrated into healthcare in rural settings
3. Name the challenges and opportunities of having diverse trainees in rural settings

PRESENTER

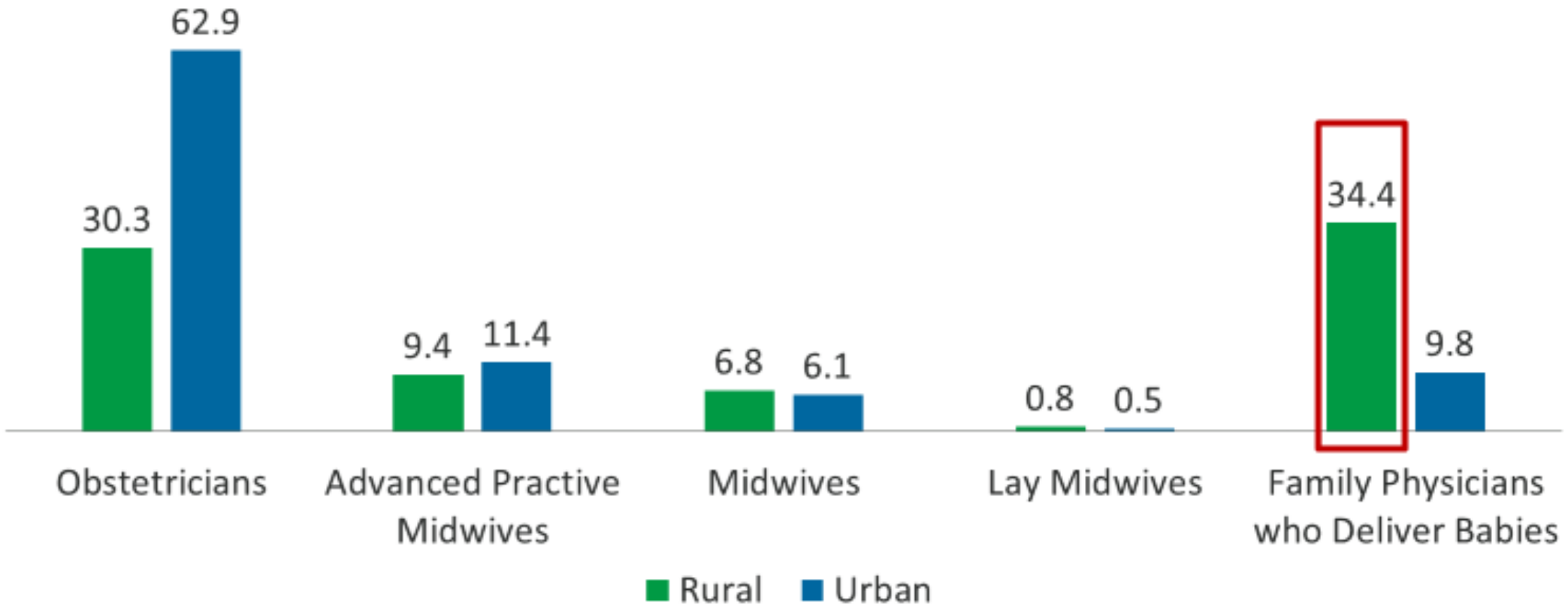
MICAELA GODZICH, MD
ASSISTANT CLINICAL PROFESSOR
DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE, UNIVERSITY OF CALIFORNIA, DAVIS

https://ruralprep.org/webinar-welcoming-diverse-clinical-learners-into-diverse-rural-communities/

Obstetrics workforce

Family physicians deliver babies more often than other OB providers in rural places

Obstetric providers per 100,000 women of childbearing age* in rural and urban counties



*Women ages 15-49

Data Sources: Area Health Resource Files (AHRF), 2020-2021 for obstetricians and advanced practice midwives; National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI), 2021 for midwives and lay midwives; American Board of Family Medicine Certification Examination Registration Questionnaire (2014-2018) for family physicians who deliver babies.

https://familymedicine.uw.edu/rhrc/studies/the-supply-and-rural-urban-distribution-of-the-obstetrical-care-workforce-in-the-u-s/

But fewer and fewer family physicians are delivering babies

23% in 2000

7% in 2016

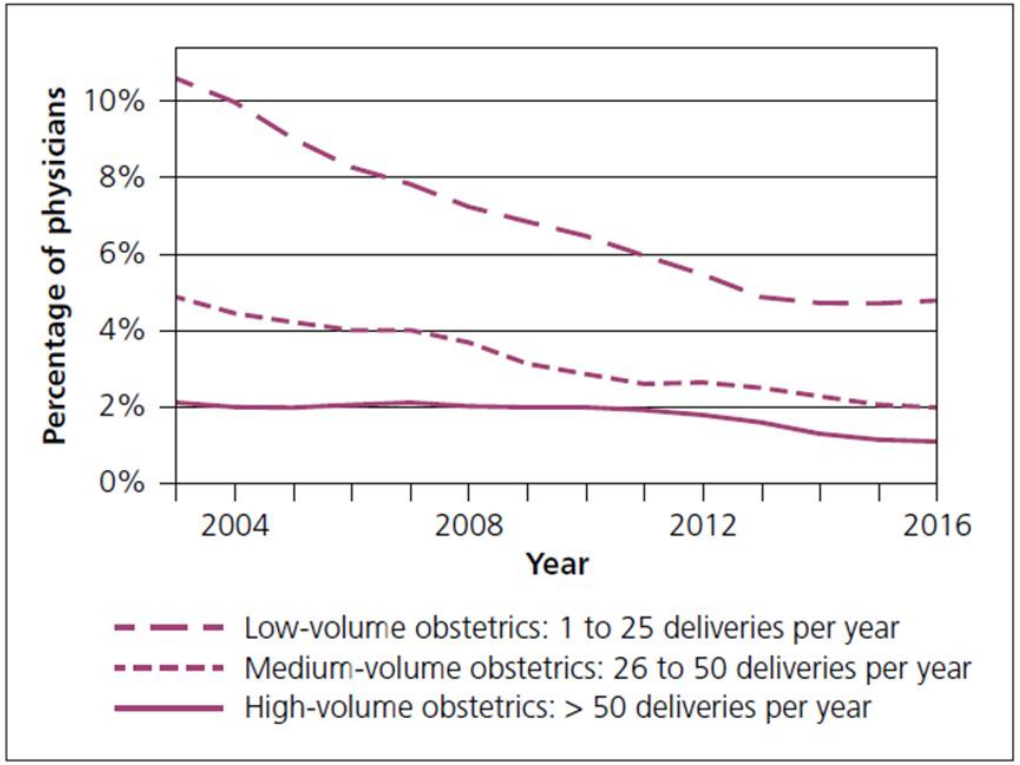


Figure 1. Estimated percentage of deliveries performed by family physicians who practice obstetrics, 2003 to 2016. Data from the American Board of Family Medicine's certification examination registration questionnaire (n = 95,750).

Barreto T, Peterson LE, Petterson S, Bazemore AW. Family physicians practicing high volume obstetric care has recently dropped by half. *American Family Physician*. 2017;95(12):762.

Opportunities to support the rural OB workforce

- Federal efforts (e.g., Rural Maternity and Obstetrics Management Strategies Program – RMOMS)
- Public health/maternal health nursing workforce development
- Increase collaboration of perinatal teams
  - Expansion of midwifery and doula care
- More robust rural family medicine OB training in residencies and fellowships
  - 21 rurally oriented family medicine OB fellowships

Kozhimannil KB, Hardeman RR, Attanasio LB, Blauer-Peterson C, O'Brien M. Doula care, birth outcomes, and costs among Medicaid beneficiaries. Am J Public Health. 2013 Apr;103(4):e113-21.

Woolcock S, Fredrickson E, Evans DV, Andrilla CHA, Garberson LA, Patterson DG. Understanding and Overcoming Barriers to Rural Training in Family Medicine Obstetrics Fellowships. WWAMI Rural Health Research Center, University of Washington, Jun 2023.

Behavioral health workforce

Collaborative care model: tele-consultation in primary care for common mental health conditions to build rural workforce capacity

Telepsychiatric Consultation as a Training and Workforce Development Strategy for Rural Primary Care

Morhaf Al Achkar, MD, PhD[1]
Ian M. Bennett, MD, PhD[1,2]
Lydia Chwastiak, MD, MPH[2]
Theresa Hoeft, PhD[2]
Tre Normoyle, PhD[3]
Melinda Vredevoogd, MS[2]
Davis G. Patterson, PhD[1]

[1]Department of Family Medicine, University of Washington, Seattle, Washington

[2]Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington

[3]Valley View Health Center, Chehalis, Washington

ABSTRACT

PURPOSE There is a shortage of rural primary care personnel with expertise in team care for patients with common mental disorders. Building the workforce for this population is a national priority. We investigated the feasibility of regular systematic case reviews through telepsychiatric consultation, within collaborative care for depression, as a continuous training and workforce development strategy in rural clinics.

METHODS We developed and pilot-tested a qualitative interview guide based on a conceptual model of training and learning. We conducted individual semi-structured interviews in 2018 with diverse clinical and nonclinical staff at 3 rural primary care sites in Washington state that used ongoing collaborative care and telepsychiatric consultation. Two qualitative researchers independently analyzed transcripts with iterative input from other research team members.

RESULTS A total of 17 clinical, support, and administrative staff completed interviews. Participants' feedback supported the view that telepsychiatric case review-based consultation enhanced skills of diverse clinical team members over time,

Al Achkar M, Bennett IM, Chwastiak L, Hoeft T, Normoyle T, Vredevoogd M, Patterson DG. Telepsychiatric consultation as a training and workforce development strategy for rural primary care. Ann Fam Med. 2020;18(5):438-445.

Mentoring, specialty consultation also help rural clinicians overcome barriers to caring for patients with opioid use disorder

THE JOURNAL OF RURAL HEALTH

ORIGINAL ARTICLE

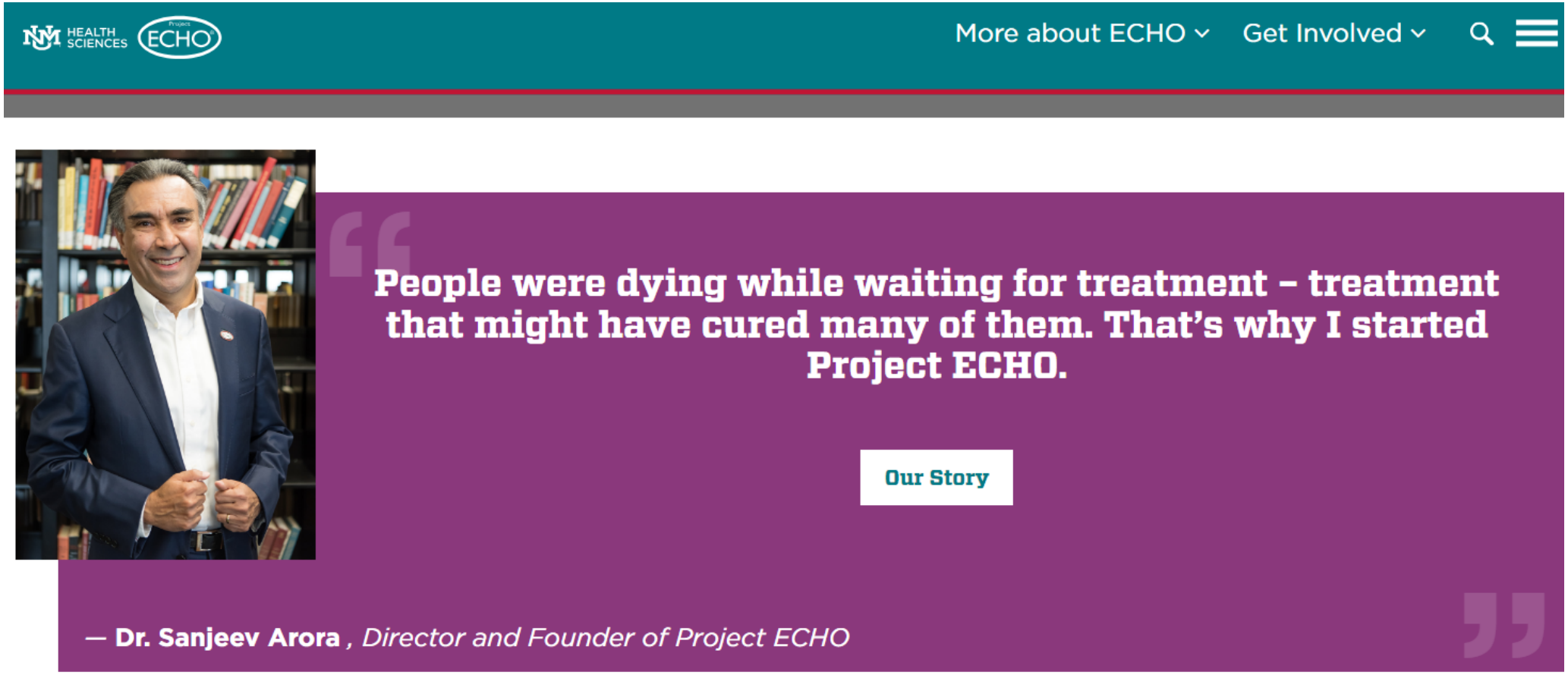
Overcoming Barriers to Prescribing Buprenorphine for the Treatment of Opioid Use Disorder: Recommendations from Rural Physicians

C. Holly A. Andrilla, MS; Tessa E. Moore, BS; & Davis G. Patterson, PhD

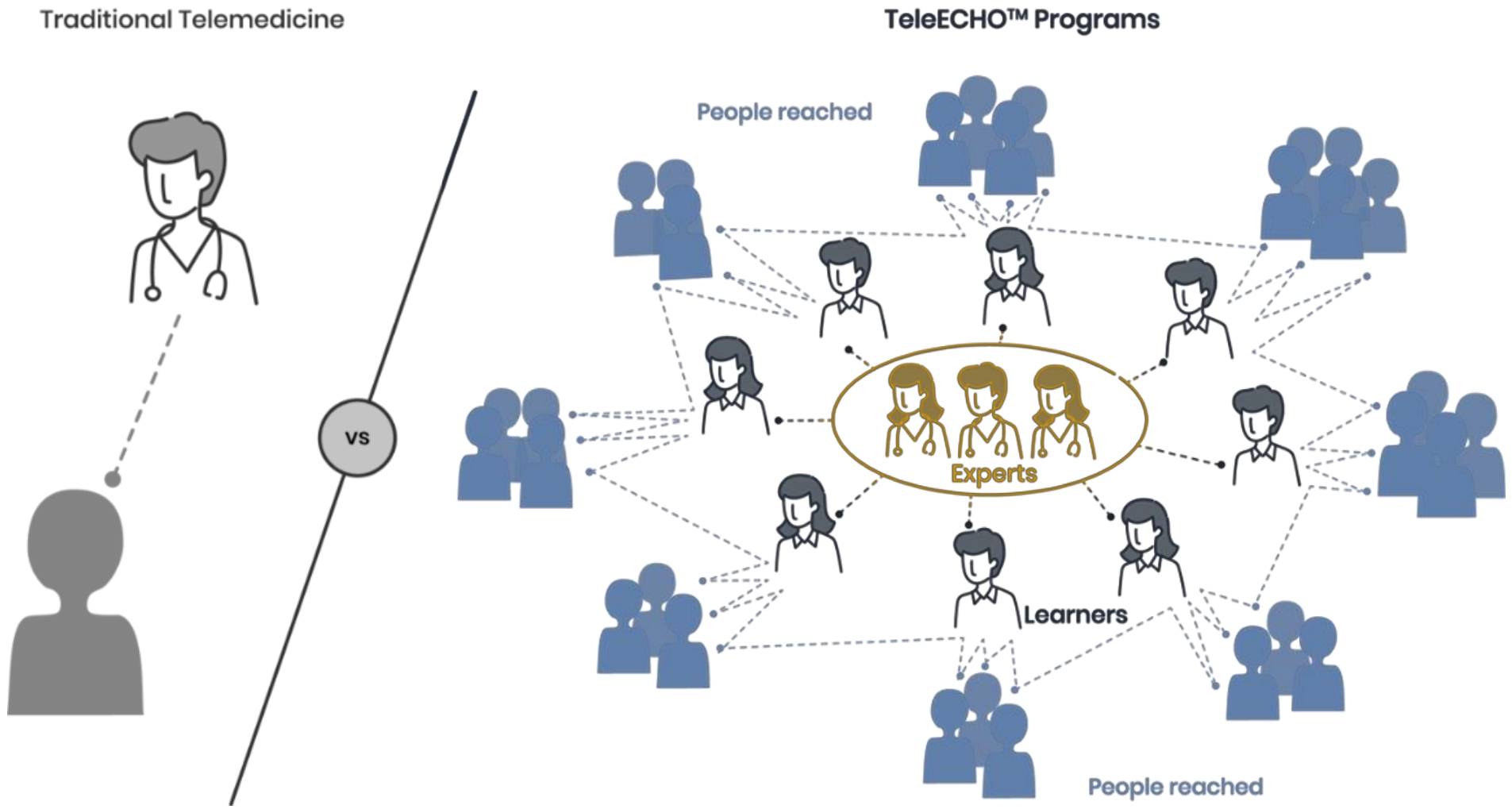
WWAMI Rural Health Research Center, Department of Family Medicine, University of Washington School of Medicine, Seattle, Washington

Andrilla CHA, Moore TE, Patterson DG. Overcoming Barriers to Prescribing Buprenorphine for the Treatment of Opioid Use Disorder: Recommendations from Rural Physicians. J Rural Health. 2019 Jan;35(1):113-121.

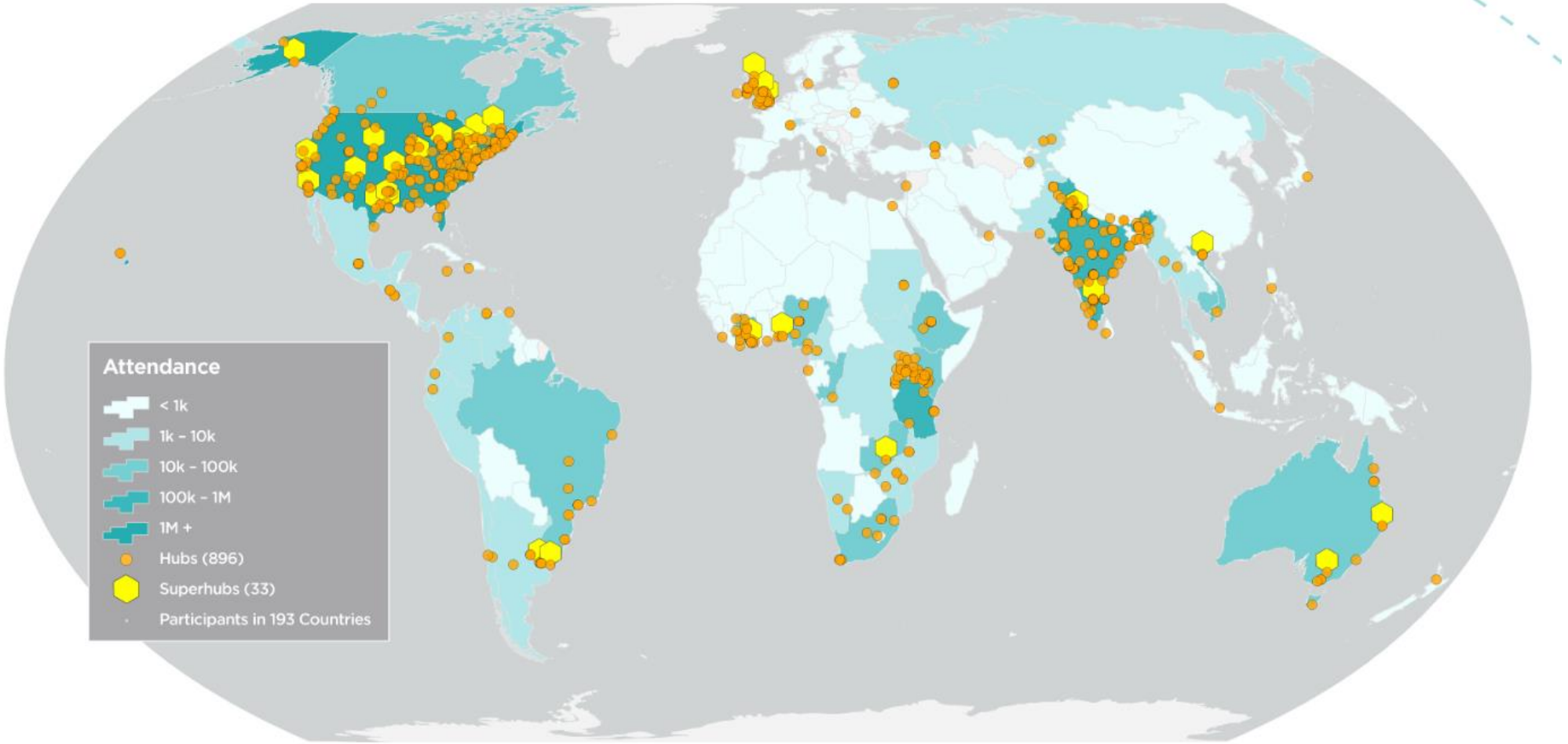
Tele-consultation: Project ECHO



Telehealth vs. ECHO



ECHO AROUND THE WORLD



https://hsc.unm.edu/echo/

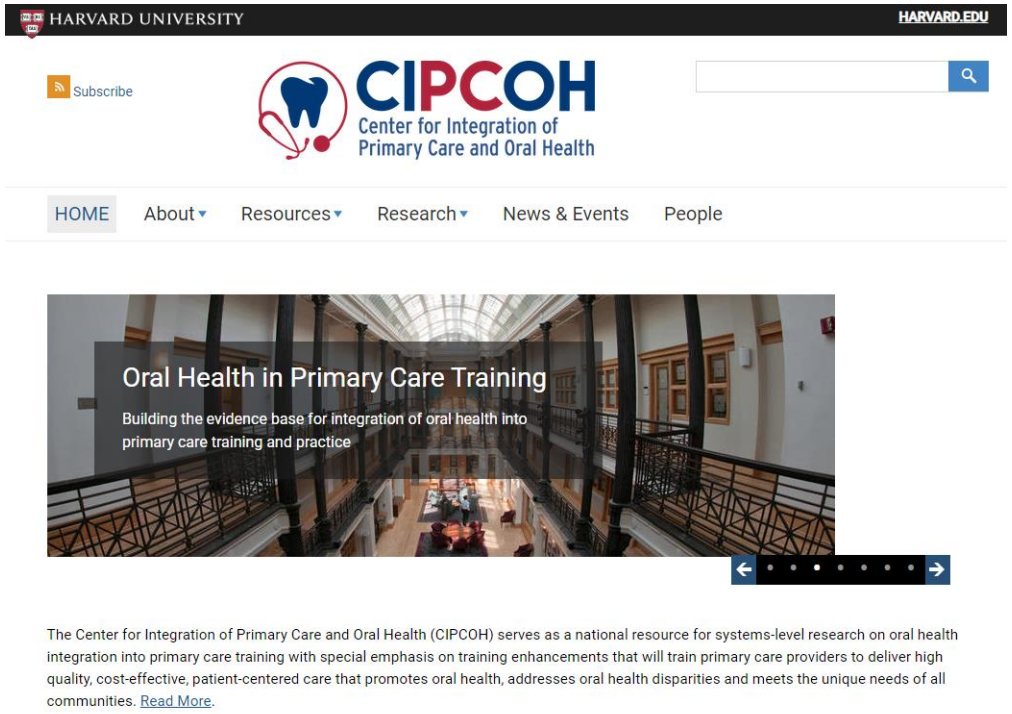
Partial list of ECHO initiatives

- Antimicrobial Stewardship
- Behavioral Health and Addiction
- Bone Health
- Climate Change and Human Health
- COVID-19 Response
- Dermatology
- Endocrinology
- First Responder Resiliency
- Hepatitis C Programs
- HIV and HIV Prevention
- Miners' Wellness
- Medicaid Quality Improvement and Hospitalization Avoidance
- Medication Treatment (Opioid Use Disorder)
- Improving Perinatal Health
- Reproductive Health
- Rheumatology
- Tuberculosis/Tuberculosis Infection
- Community Health Worker/Peer Support Worker

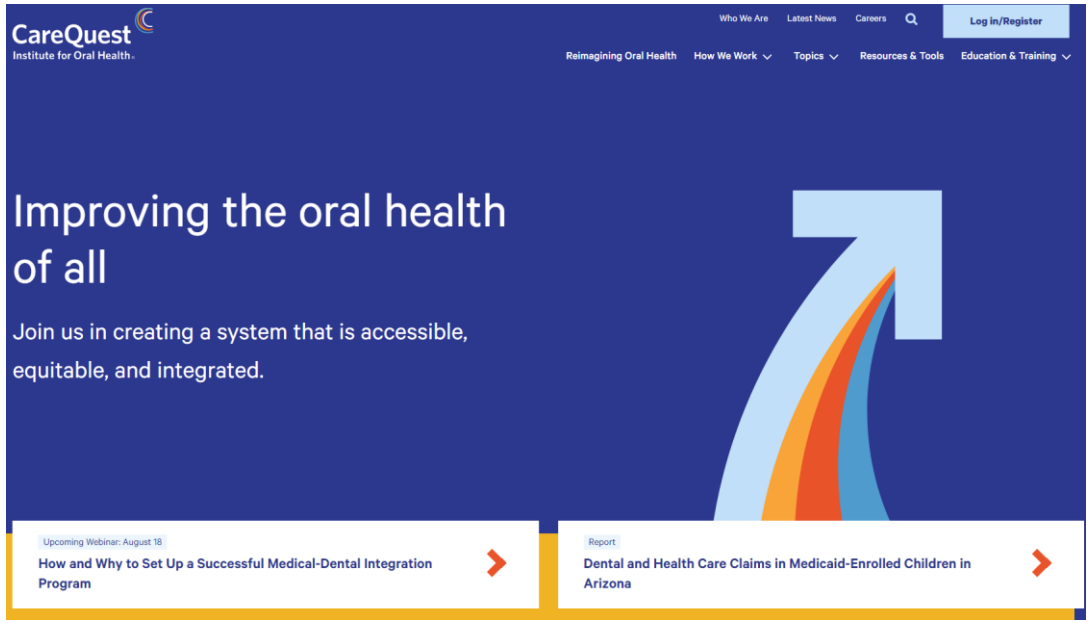
Oral health workforce

Oral Health/Primary Care Integration

Center for Integration of Oral Health and Primary Care: https://cipcoh.hsdm.harvard.edu/



CareQuest Institute for Oral Health: https://www.carequest.org/



Dental Therapy

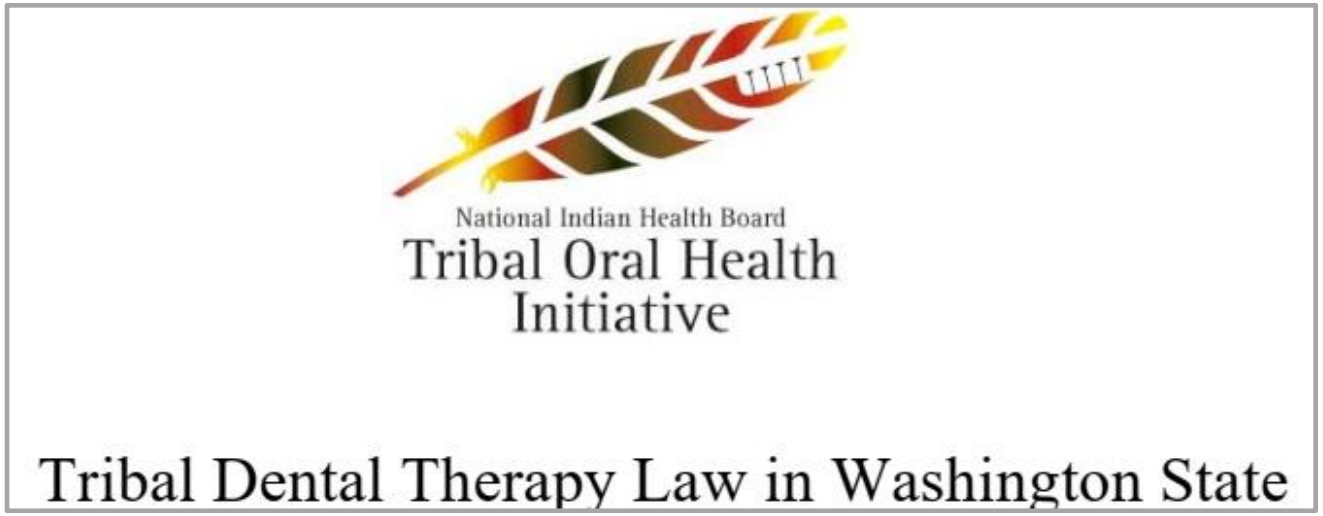
Enabling Dental Therapy Practice to Improve Access to Oral Health Services

Simona Surdu, MD, PhD
Margaret Langelier, MSHSA
Elizabeth Mertz, PhD

https://www.healthworkforceta.org/media-library/enabling-dental-therapy-practice-to-improve-access-to-oral-health-services/

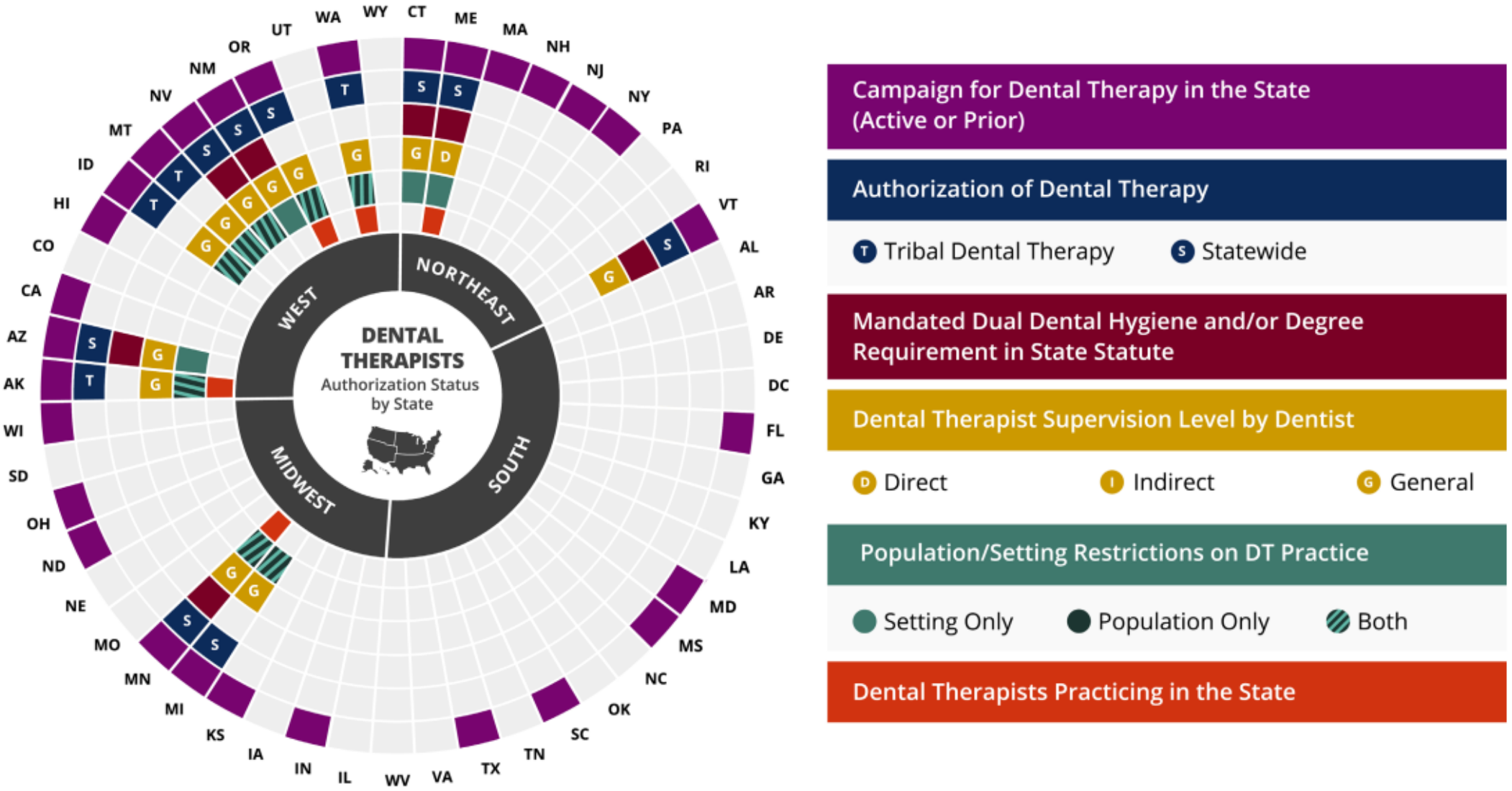
Dental Therapy

- Over 50 countries, in the U.S. since 2005
- Evidence-based
- Preventive (health education, prophylaxis, x-rays) and restorative care (fillings, temporary crowns, tooth extractions)
- Enhances capacity and productivity of oral health teams
- Improves remote/underserved patient access to care



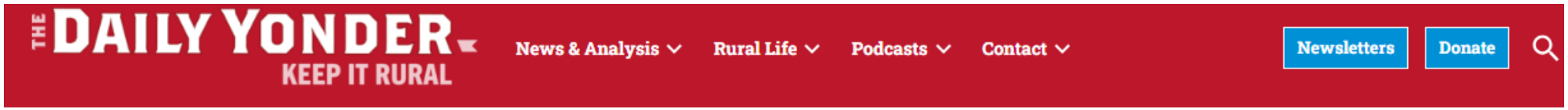
https://www.healthworkforceta.org/media-library/enabling-dental-therapy-practice-to-improve-access-to-oral-health-services/

Dental therapy authorization and advocacy (as of late 2020)



https://oralhealthworkforce.org/authorization-status-of-dental-therapists-by-state/


Emergency medical services



HEALTH

Rural Residents Five Times More Likely to Live Far from Ambulance Stations

A first-of-its-kind study found that about half of all residents who live more than 25 minutes from an ambulance station are in rural areas.

Jonk, Y., Milkowski, C., Croll, Z., & Pearson, K. (2023). Ambulance Deserts: Geographic Disparities in the Provision of Ambulance Services [Chartbook]. University of Southern Maine, Muskie School, Maine Rural Health Research Center.

Rural EMS professionals need specific skills and system supports

- Rural EMTs are more likely than urban to perform skills above their recommended scope.
- Patients in smaller, more remote rural areas are less likely to receive evidence-based emergency care for seizure, stroke, hypoglycemia, and trauma.

➢ Enhanced training and medical direction needed for evidence-based care in rural and low-resource contexts

➢ Rural areas need to be specifically considered for development of systems of care including stroke, trauma, STEMI, and others

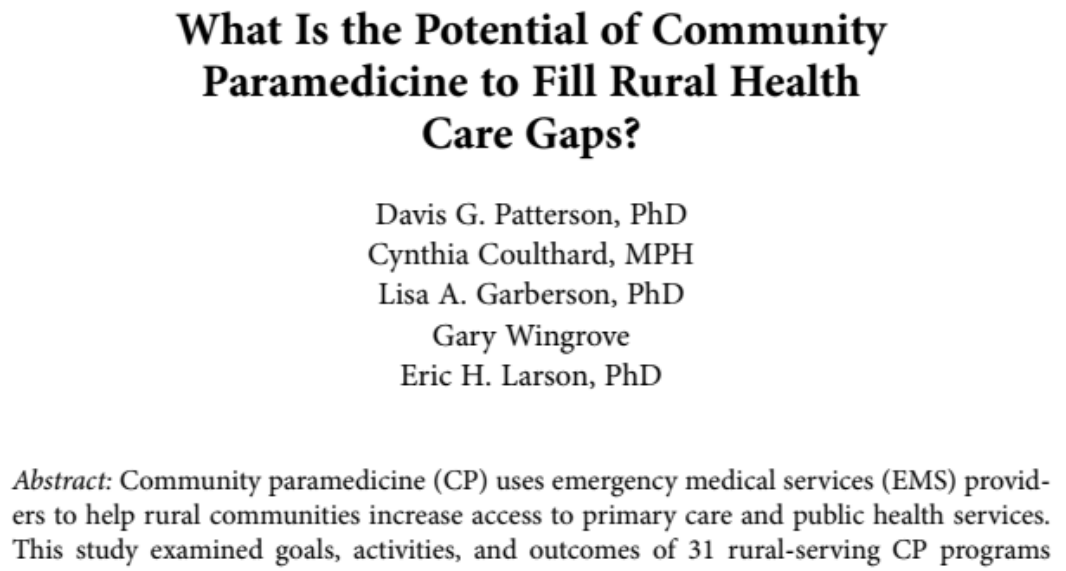
Patterson DG, Nudell N, Garberson LA, Andrilla CHA. Prehospital Emergency Medical Services Personnel: Comparing Rural and Urban Professional Experience and Provision of Evidence-Based Care. WWAMI Rural Health Research Center, University of Washington, May 2022.

Patterson DG, Stubbs BA, Nudell NG. How Actual Practice of Emergency Medical Services Personnel Aligns with the Recommended National Scope of Practice in Rural Versus Urban Areas of the U.S.. Center for Health Workforce Studies, University of Washington, Feb 2022.

Community paramedicine deploys EMTs and paramedics to connect patients to care and community resources

Rural community paramedics work to

- improve disease management
- reduce EMS/healthcare use and costs (e.g., ED visits, hospital (re)admissions)
- improve patient satisfaction



What Is the Potential of Community Paramedicine to Fill Rural Health Care Gaps?

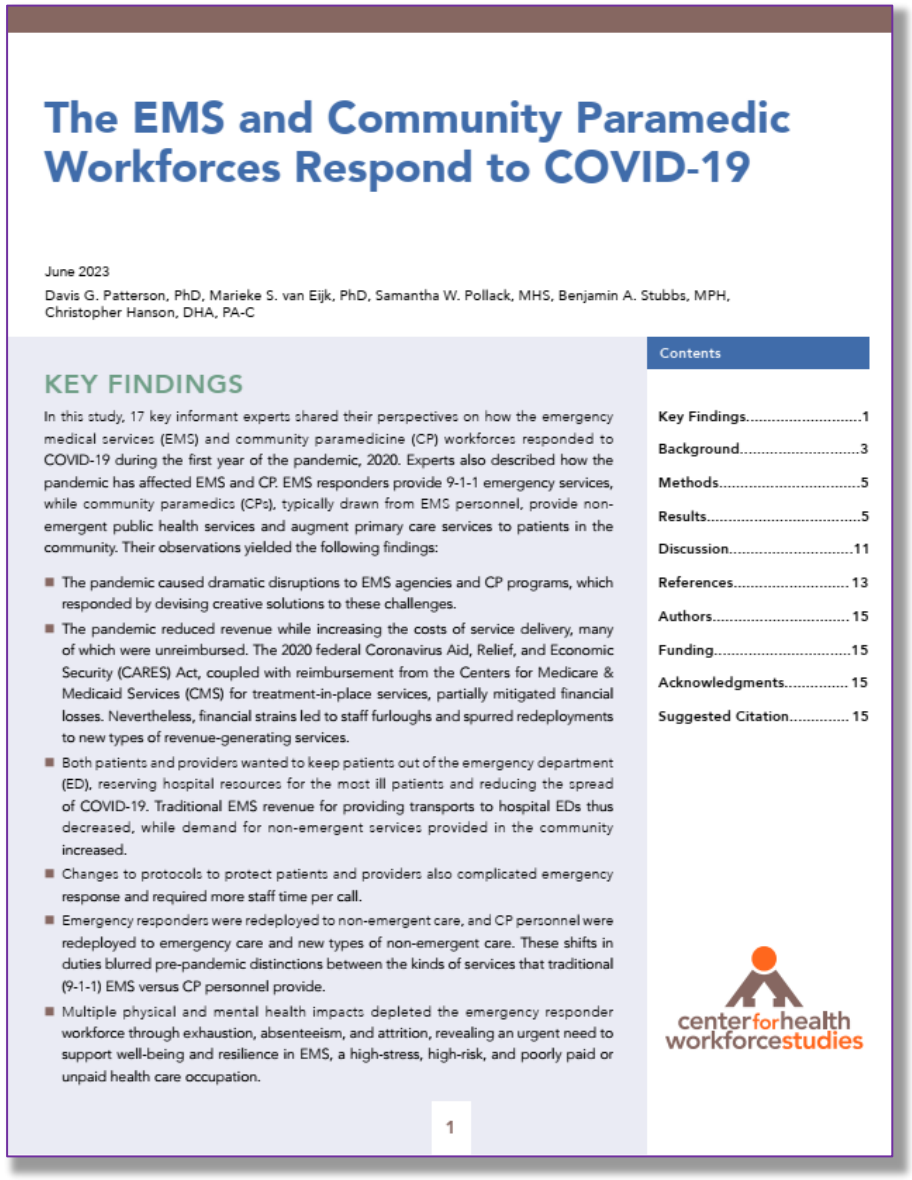
Davis G. Patterson, PhD
Cynthia Coulthard, MPH
Lisa A. Garberson, PhD
Gary Wingrove
Eric H. Larson, PhD

Abstract: Community paramedicine (CP) uses emergency medical services (EMS) providers to help rural communities increase access to primary care and public health services. This study examined goals, activities, and outcomes of 31 rural-serving CP programs

Patterson DG, Coulthard C, Garberson, LA, Wingrove G, Larson EH. What is the potential of community paramedicine to fill rural health care gaps? J Health Care Poor Underserved. 2016;27(4A):144-158.

"EMS providers are masters of the workaround."

"Mobile integrated health has taught me that EMS is at the center of public health. We should be at the forefront because a lot of communities have disdain for health care, government, but they will always let us in…For the record, the genie does not fit back in the bottle!"



The EMS and Community Paramedic Workforces Respond to COVID-19

June 2023

Davis G. Patterson, PhD, Marieke S. van Eijk, PhD, Samantha W. Pollack, MHS, Benjamin A. Stubbs, MPH, Christopher Hanson, DHA, PA-C

KEY FINDINGS

In this study, 17 key informant experts shared their perspectives on how the emergency medical services (EMS) and community paramedicine (CP) workforces responded to COVID-19 during the first year of the pandemic, 2020. Experts also described how the pandemic has affected EMS and CP. EMS responders provide 9-1-1 emergency services, while community paramedics (CPs), typically drawn from EMS personnel, provide non-emergent public health services and augment primary care services to patients in the community. Their observations yielded the following findings:

- The pandemic caused dramatic disruptions to EMS agencies and CP programs, which responded by devising creative solutions to these challenges.
- The pandemic reduced revenue while increasing the costs of service delivery, many of which were unreimbursed. The 2020 federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, coupled with reimbursement from the Centers for Medicare & Medicaid Services (CMS) for treatment-in-place services, partially mitigated financial losses. Nevertheless, financial strains led to staff furloughs and spurred redeployments to new types of revenue-generating services.
- Both patients and providers wanted to keep patients out of the emergency department (ED), reserving hospital resources for the most ill patients and reducing the spread of COVID-19. Traditional EMS revenue for providing transports to hospital EDs thus decreased, while demand for non-emergent services provided in the community increased.
- Changes to protocols to protect patients and providers also complicated emergency response and required more staff time per call.
- Emergency responders were redeployed to non-emergent care, and CP personnel were redeployed to emergency care and new types of non-emergent care. These shifts in duties blurred pre-pandemic distinctions between the kinds of services that traditional (9-1-1) EMS versus CP personnel provide.
- Multiple physical and mental health impacts depleted the emergency responder workforce through exhaustion, absenteeism, and attrition, revealing an urgent need to support well-being and resilience in EMS, a high-stress, high-risk, and poorly paid or unpaid health care occupation.

Contents

centerforhealth workforcestudies

1

https://familymedicine.uw.edu/chws/publications/the-ems-and-community-paramedic-workforces-respond-to-covid-19/

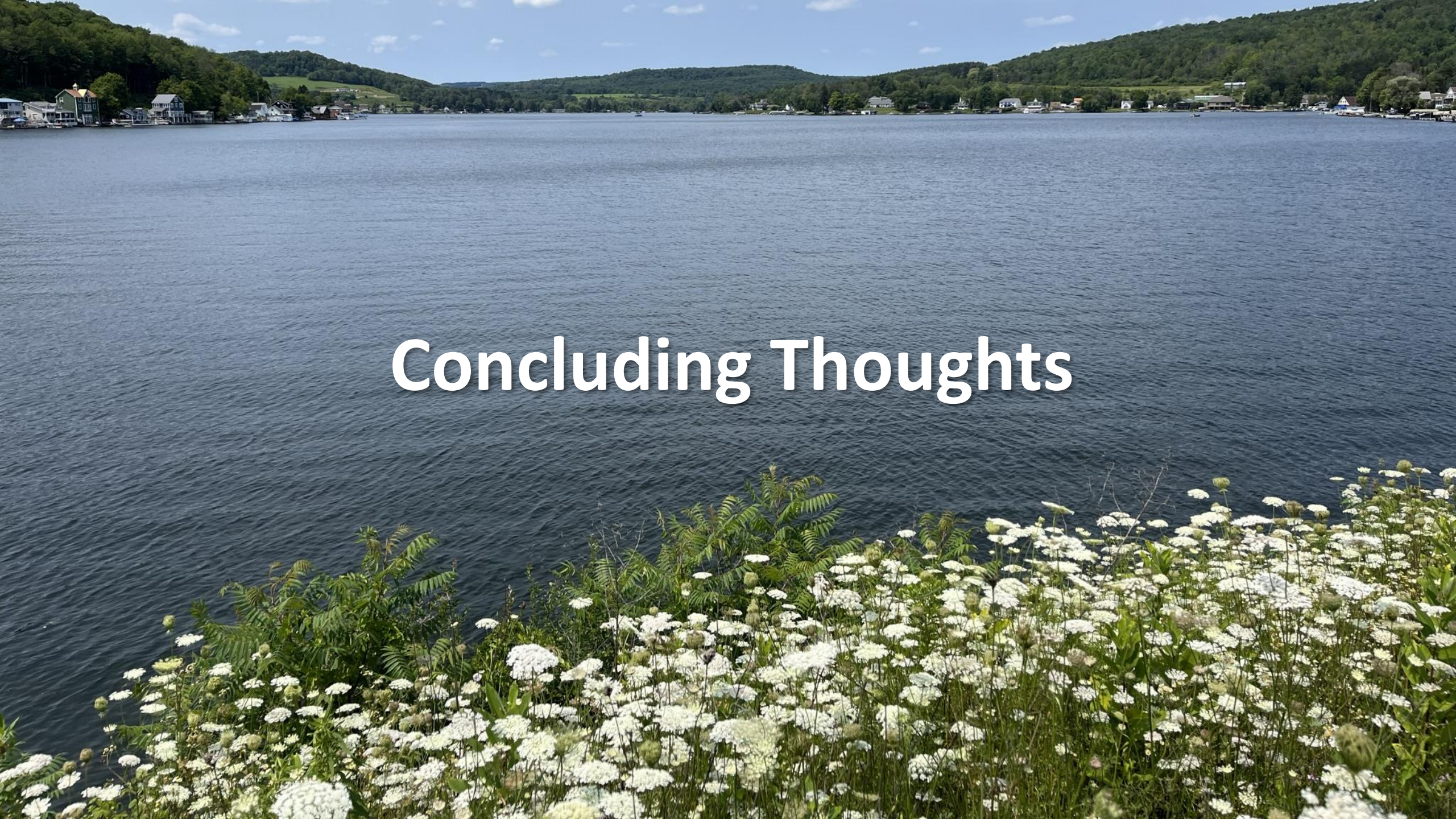

Public health workforce

Rural public health workforce stresses and strengths

Compared to urban staff, rural staff reported

- **lower intent to leave their jobs** despite higher odds of reporting **stress, bullying**, and certain **PTSD symptoms**
- greater proficiency in **community engagement, cross-sectoral partnerships, and systems and strategic thinking**

Kett PM, Bekemeier B, Patterson DG, Schaffer K. Competencies, Training Needs, and Turnover Among Rural Compared With Urban Local Public Health Practitioners: 2021 Public Health Workforce Interests and Needs Survey. Am J Public Health. 2023 Jun;113(6):689-699. doi: 10.2105/AJPH.2023.307273. PMID: 37196230; PMCID: PMC10186819.



Concluding Thoughts

Things That Keep Me Awake at Night

(a short list, in no particular order)

- Moral injury, burnout, trauma
- Effects of health system consolidation
- End of affirmative action
- Breakdown in social cohesion, hostility to our public/health workforce
- Chronic underinvestment in public health and primary care
- Entrenched positions that limit workforce innovations (e.g., payment, scope of practice)
- Inactive National Health Workforce Commission – no designated focal point for national health workforce planning
- Flat funding for health workforce and rural health research

Rural-centric policies and practices

- Promoting well-being requires attending to intersectionality:
  - Rural + ethnicity, race, gender identity, region, sexual orientation, age, ability, religion, education, language, income…
  - Include these voices in decision-making processes about allocating resources.
- Use right-sized and “rural-proofed” – as opposed to “top-down” – approaches.

Rural-centric policies and practices

WORKFORCE DEVELOPMENT FOR RURAL RECRUITMENT, RETENTION, AND EFFECTIVE PRACTICE

- Include cultural humility and culturally responsive care front and center in all health professional education.
- Invest in K-16 rural students.
- Invest in rural place-based health professional education (stop thinking that simply producing more graduates will end shortages!).
- Use collaborative, interprofessional educational models.
- Equip the teams we have with resources (e.g., remote consultation) to expand their capacity.
- Remember retention! (“recruitention” – Tim Skinner, formerly of 3RNet).

Rural-centric policies and practices

- Promote scopes of practice that use the workforce we have to maximum capability.
- Fully realize the potential of proven workforce solutions (e.g., ECHO, dental therapy, midwifery, etc.)
- Continue development of newer roles and types of health professionals (e.g., community health workers, community paramedics, peer specialists).

Requests

Incorporate **place** and geographic context of learner education in required documentation (e.g., administrative and research databases) to enable **research** and **social accountability**.

Research team members

University of Washington
Holly Andrilla
David Evans
Lisa Garberson
Andrew Jopson
Beverly Marshall
Natalia Oster
Davis Patterson
Samantha Pollack
Benjamin Stubbs
Sara Woolcock

Washington State University
Louise Kaplan

American Board of Family Medicine
Zachary Morgan
Lars Peterson

Association of American Medical Colleges
Scott Shipman

Ohio University Heritage College of Osteopathic Medicine
Randall Longenecker

University of North Dakota School of Medicine & Health Sciences
David Schmitz

Paramedic Foundation
Nikiah Nudell

For more than 30 years, the Rural Health Research Centers have been conducting policy-relevant research on healthcare in rural areas and *providing a voice for rural communities in the policy process.*

Rural Health Research Gateway

The Rural Health Research Gateway ensures this research lands in the hands of our rural leaders.

ruralhealthresearch.org

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facebook.com/RHRGateway

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Funded by the Federal Office of Rural Health Policy, Health Resources & Services Administration

Contact

Davis Patterson: davisp@uw.edu

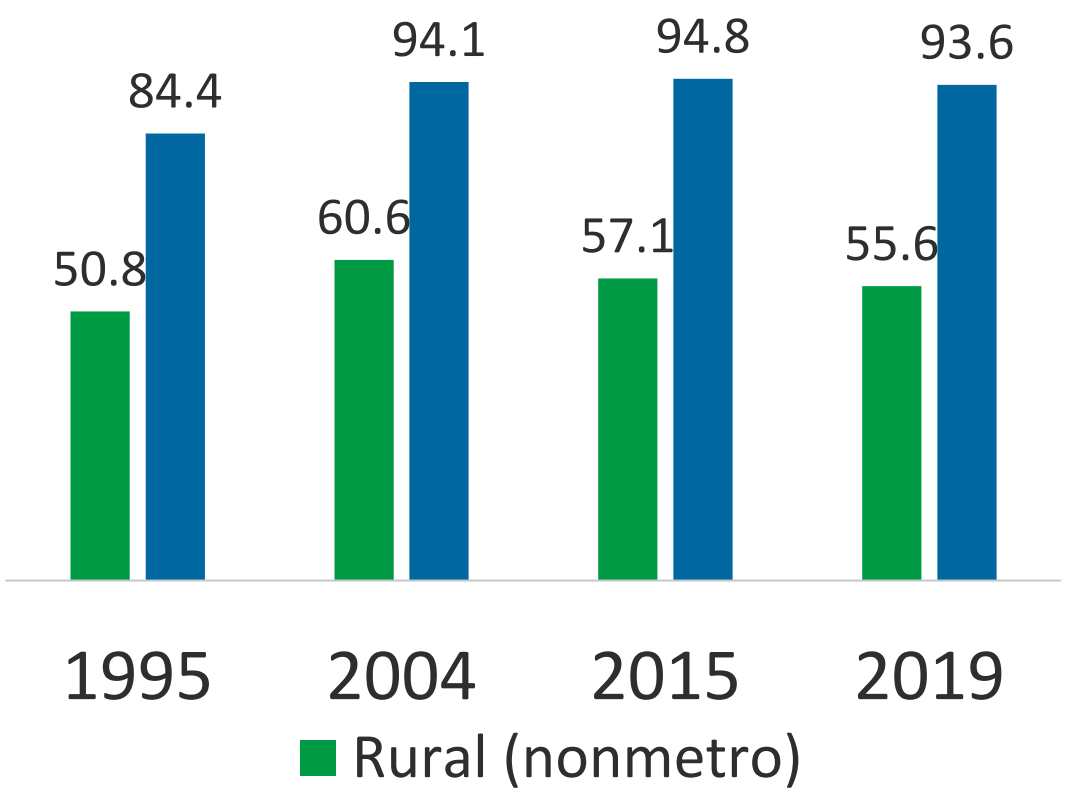
WWAMI Rural Health Research Center
http://depts.washington.edu/uwrhrc @wwamirhrc

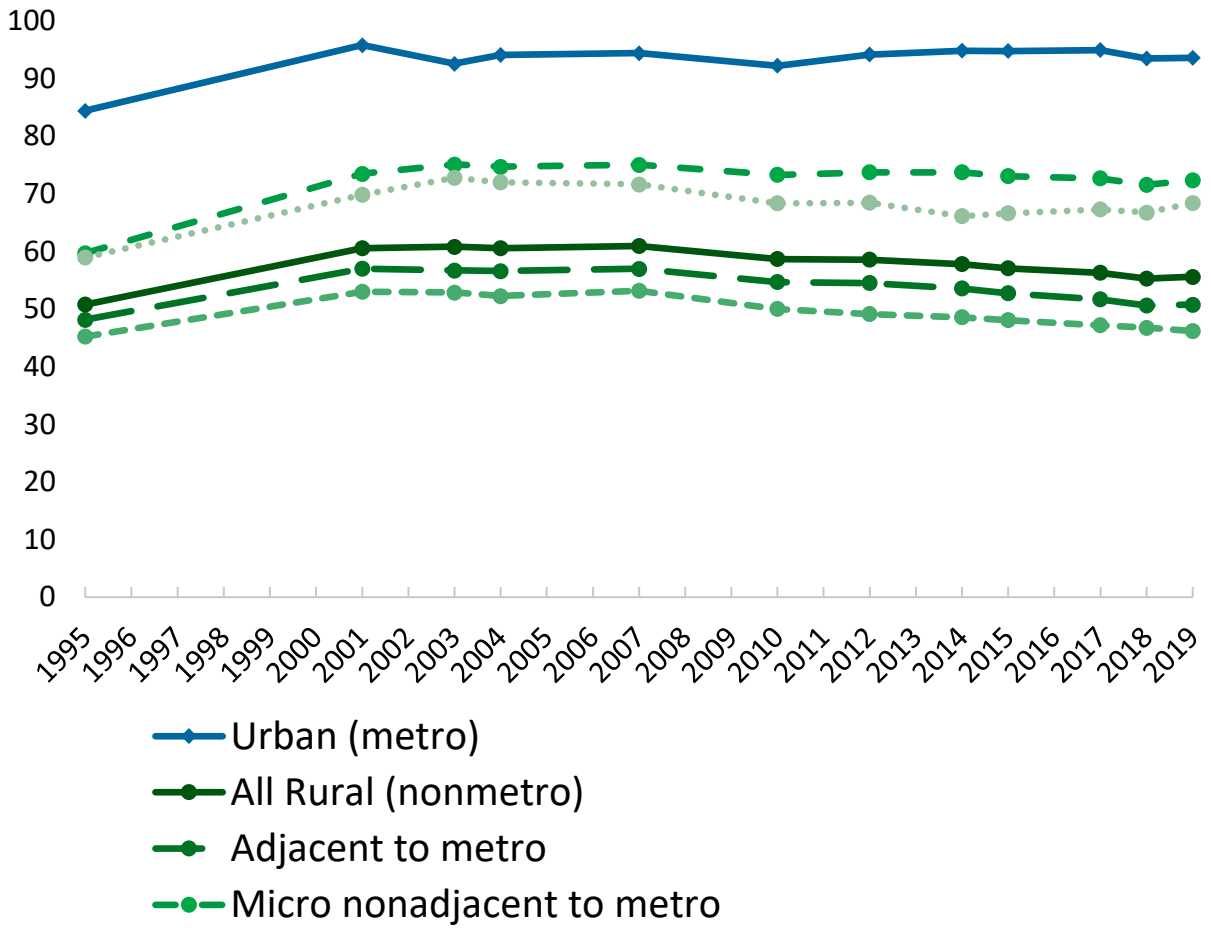
Rural PREP
https://ruralprep.org/ @ruralprep

UW Center for Health Workforce Studies
https://familymedicine.uw.edu/chws/ @uwchws

Bonus slides

Supply of primary care physicians per 100,000 population in rural and urban U.S. counties, 1995-2019

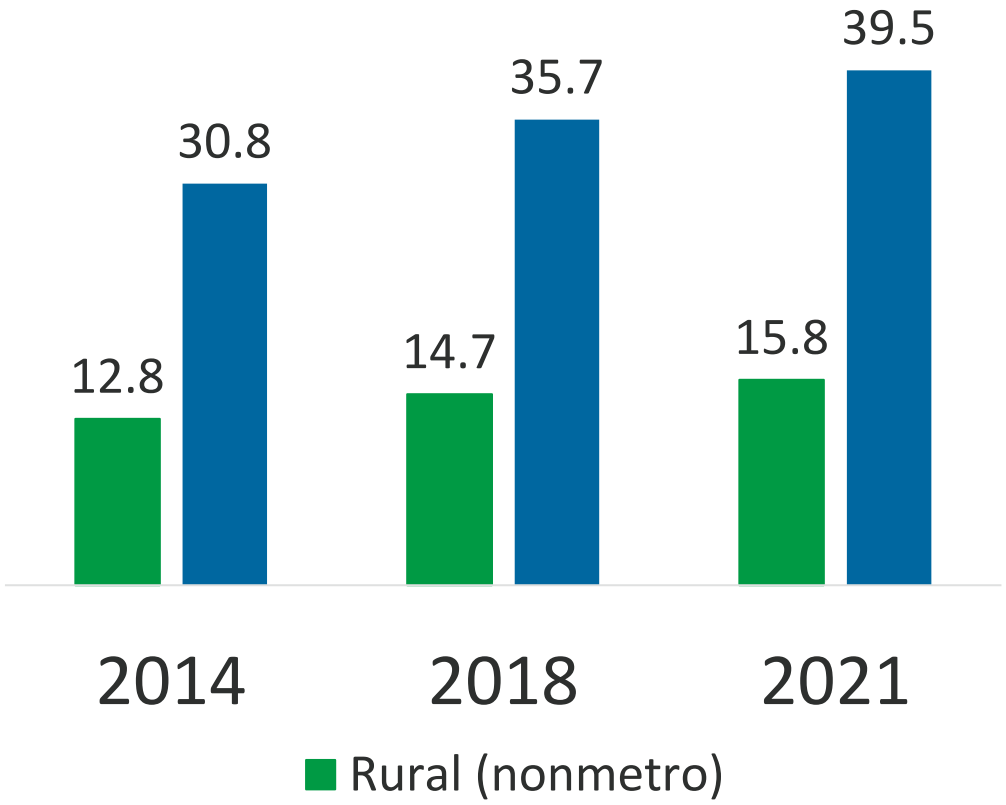


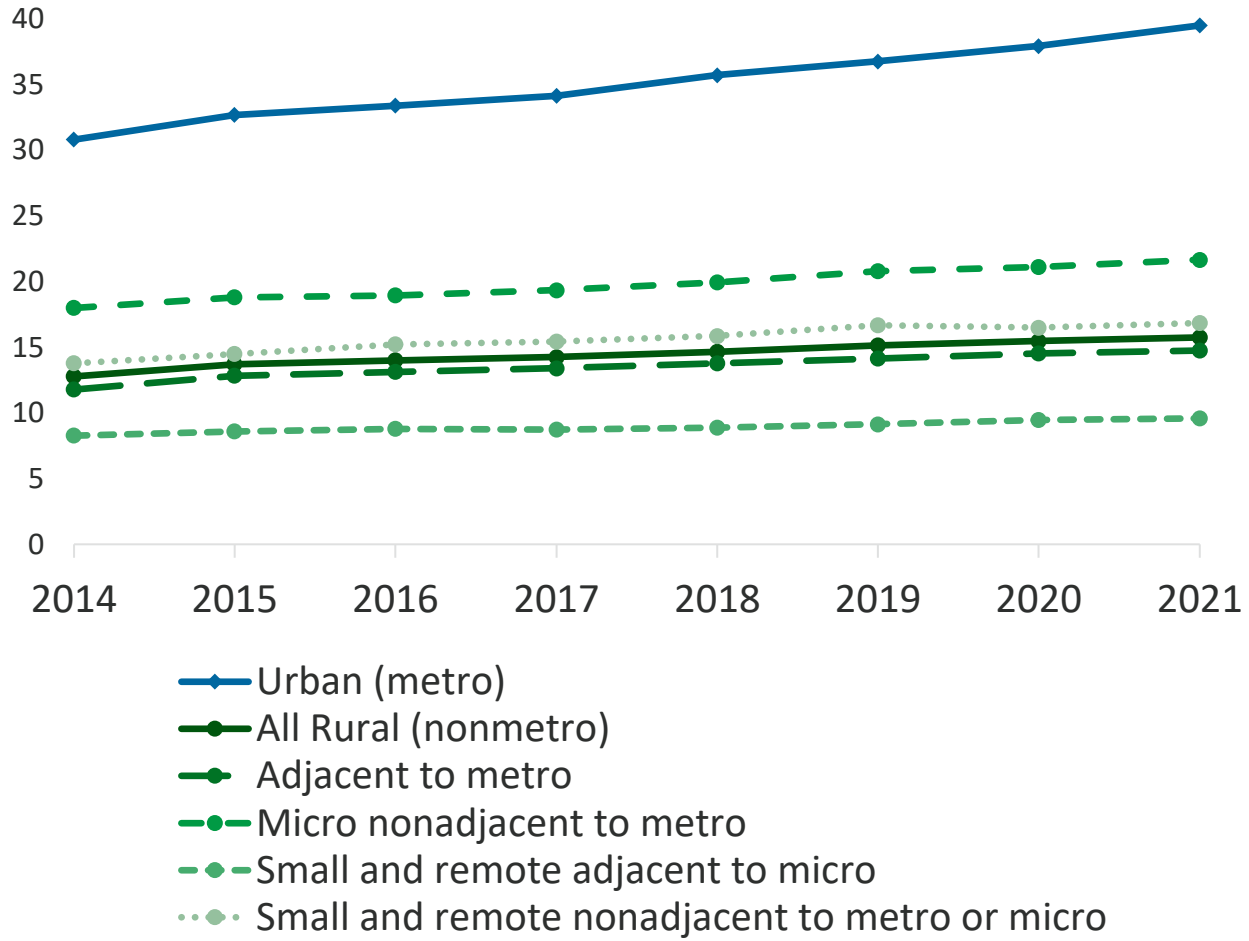


Data source: Area Health Resource Files (AHRF), 2003, 2006-2007, 2009, 2019-2021.

Psychologist supply increasing, but more in urban

per 100,000 population in rural and urban U.S. counties, 2014-2021

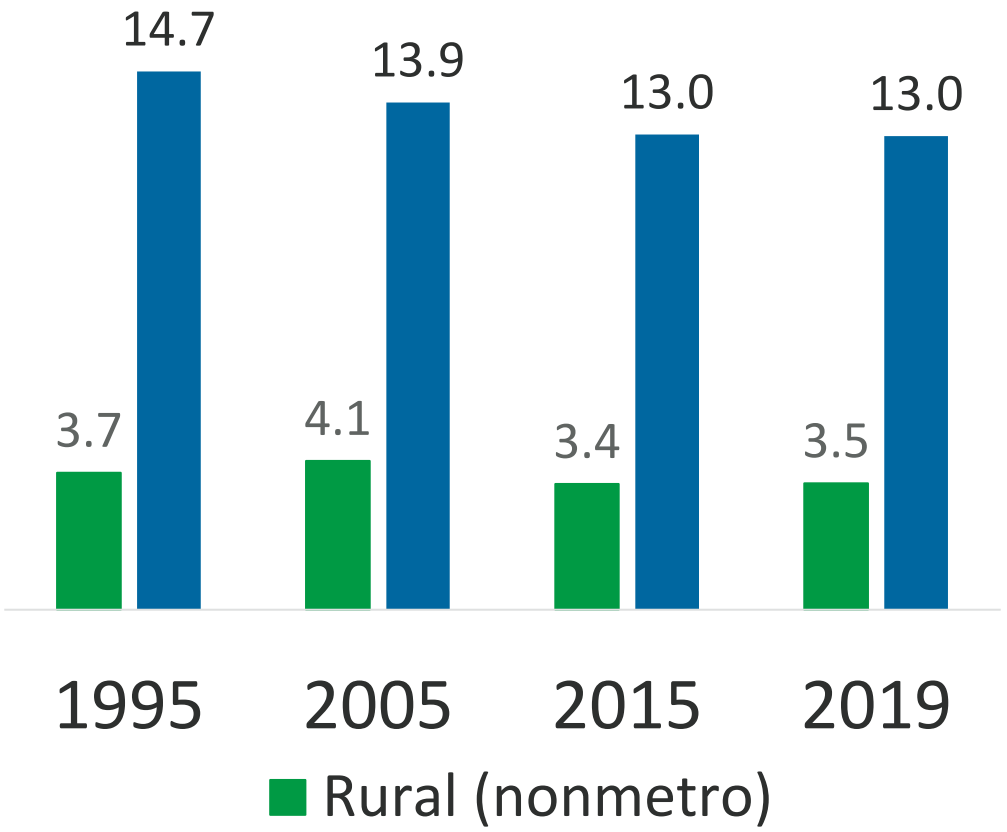


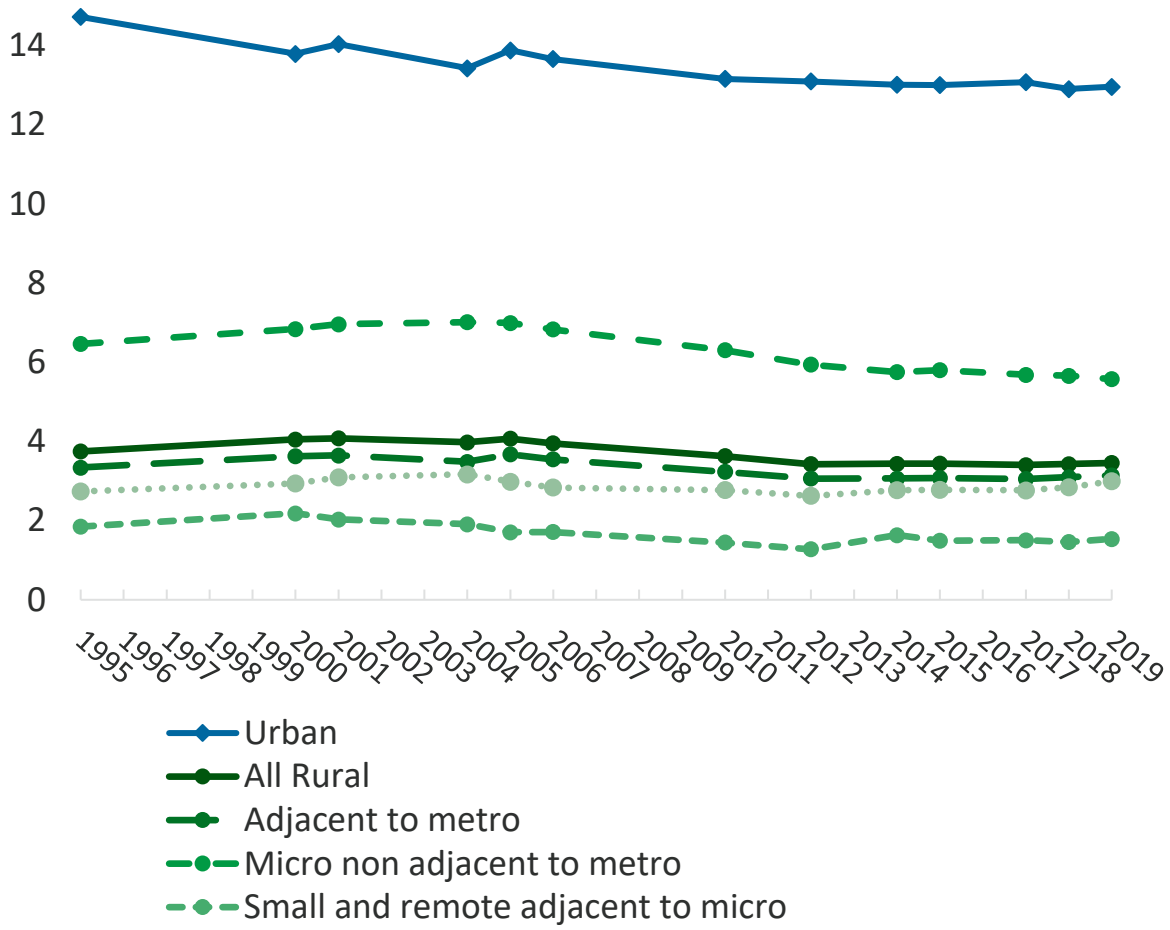


Data Source: National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI), 2021.

Psychiatrist supply is *decreasing*

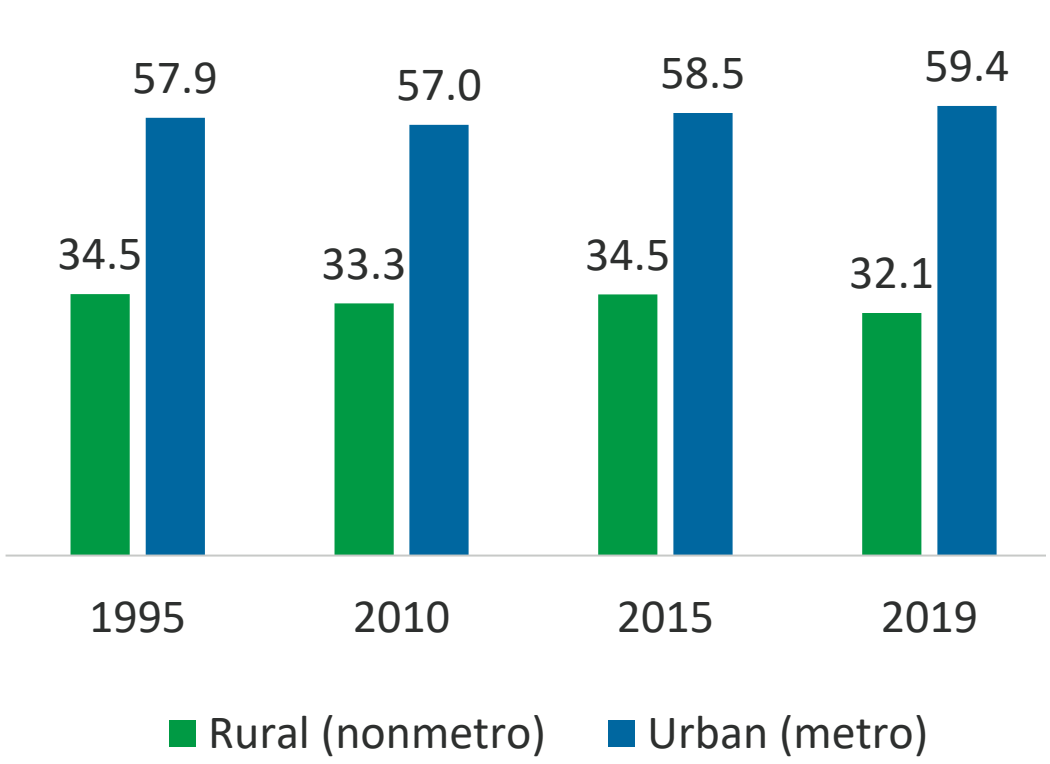
per 100,000 Population in Rural and Urban U.S. Counties, 1995-2019

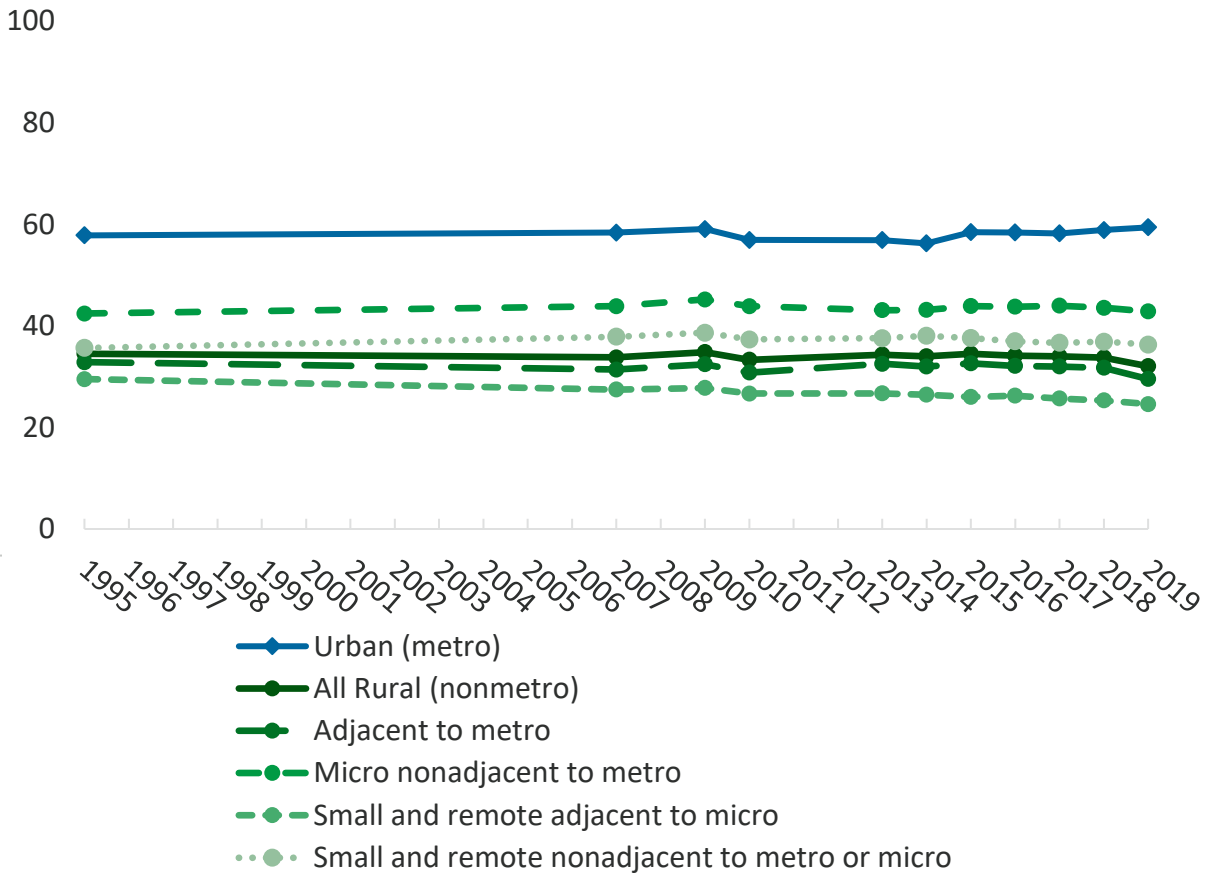




Data Source: Area Health Resource Files (AHRF), 2019.

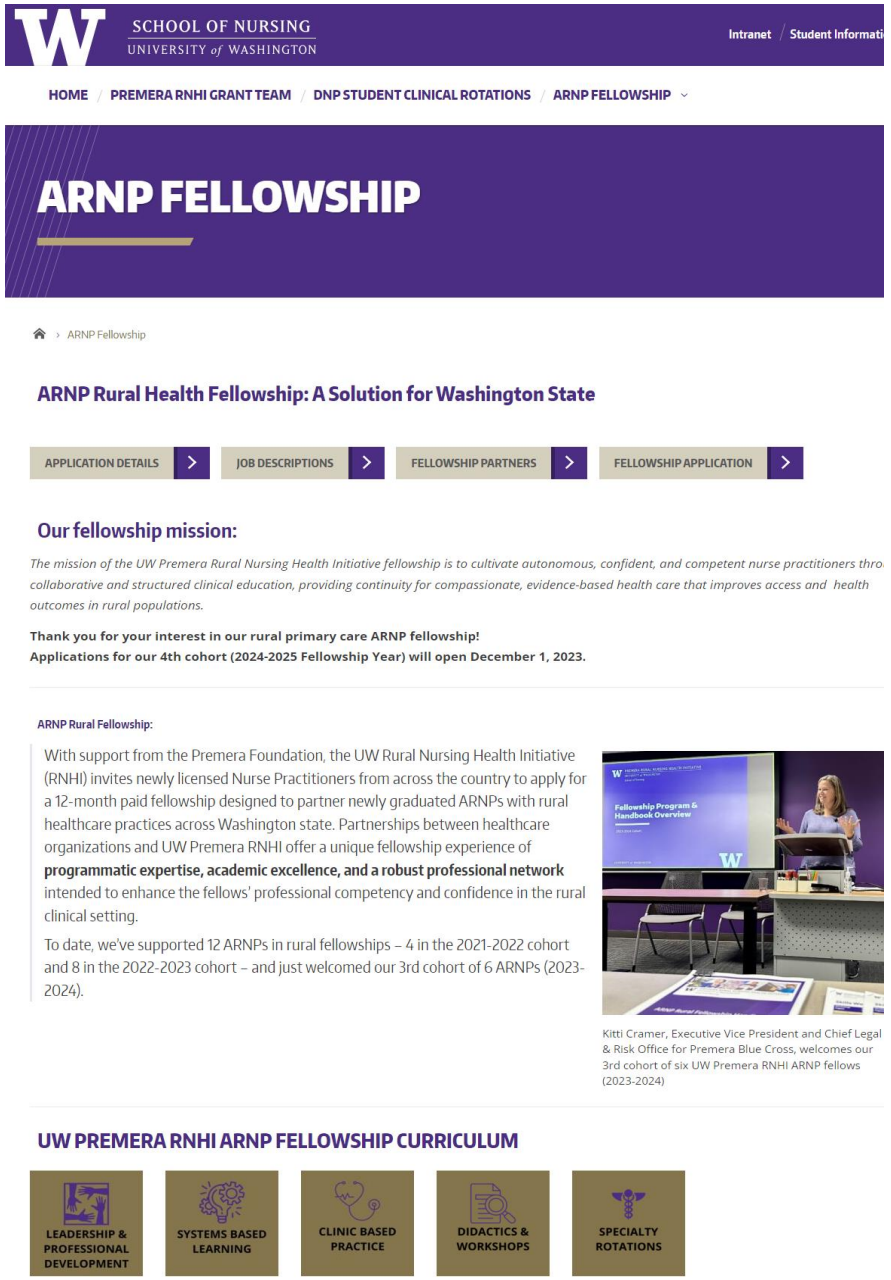
Trends in the Supply of Dentists per 100,000 Population in Rural and Urban U.S. Counties, 1995-2019





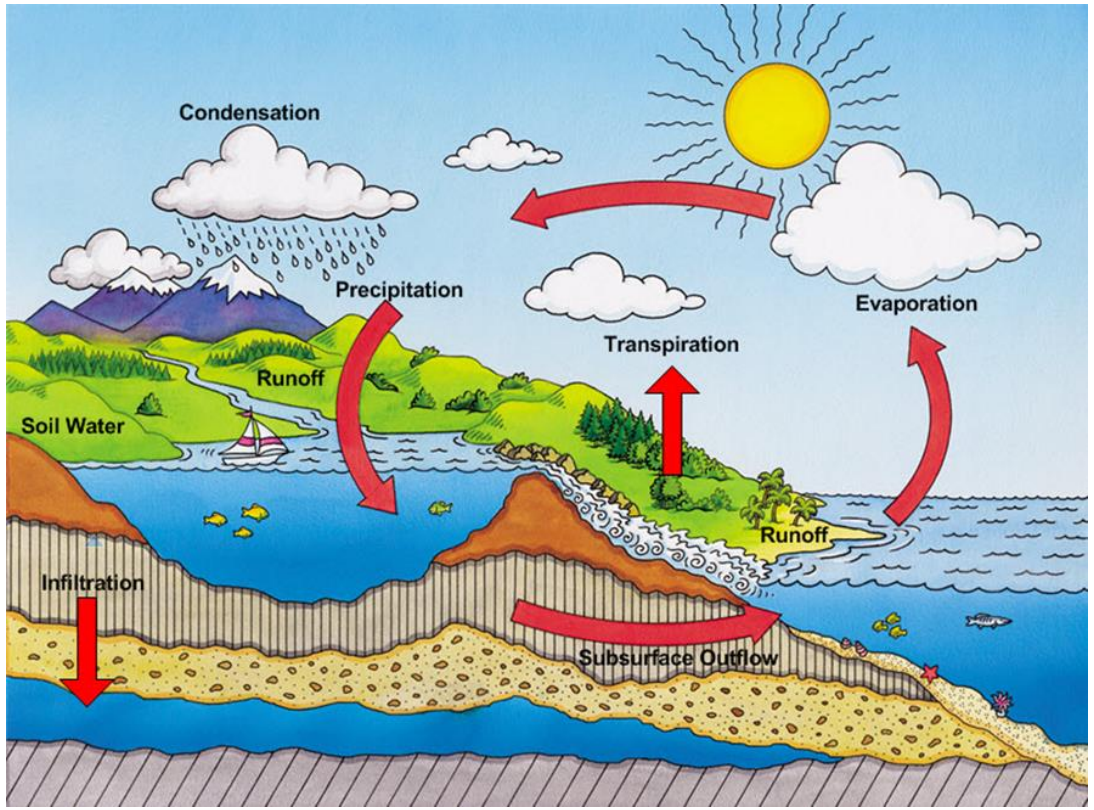
Data Sources: Area Health Resource Files (AHRF), 2003, 2006-2007, 2009, 2019-2021.

20 rural or rural-serving NP residencies/fellowships in 2020 – and growing.



Kaplan L, Pollack SW, Skillman SM, Patterson DG. Is being there enough? Postgraduate nurse practitioner residencies in rural primary care. J Rural Health. 2023 Jun;39(3):529-534. doi: 10.1111/jrh.12729. Epub 2022 Nov 28. PMID: 36443985.

Ecosystem



Pathway

Conceptual Framework: Building a Health Workforce to Achieve Health Equity*

Diverse, Prepared, Dedicated, Resilient Workforce Deployed to Achieve Health Equity*

Pre-college and college institutions and programs

- Educational equity
- Community engagement and service
- Finances
- Health professions pathway programs
  - Academic enhancement
  - College/health professions admissions preparation
  - Motivation/awareness
  - Resilience
  - Career counseling
  - Mentorship
  - Research apprenticeship
  - Health professions schools/K-16 academic partnerships

Health professions educational institutions and programs

- Socially accountable mission
- Leadership commitment to social accountability
- Equitable admissions policies
- Finances
- Supportive environment
  - Anti-bias initiatives
  - Resilience
- Diverse faculty
- Pathway programs
- Curriculum/skills development
  - Social drivers of health
  - Population health
  - Cultural humility
  - Advocacy
- Place-based education – in and with under-resourced communities
- Interprofessional education for team-based care

Health professional recruitment into practice

- System/practice socially accountable mission
- Community-based "grow your own" strategies
- Effective recruitment practices
- Incentive programs
- Healthy environment
  - Anti-bias initiatives
  - Equitable compensation/benefits
  - Safety
  - Resilience
- Population health approach
- Team-based care

Health professional retention and effective practice

- System/practice socially accountable mission
- Learning health system
- Incentive programs
- Healthy environment
  - Anti-bias initiatives
  - Equitable compensation/benefits
  - Safety
  - Resilience
- Population health approach
- Team-based care
- Provider/patient/community fit
  - Racial/ethnic/cultural concordance
  - Cultural humility
- Advocacy
- Career advancement
- Continuing education

Foundation: federal, state, private sector, and local community contexts
(e.g., laws, regulations, policies, funding, professional association human resources)

*For groups that have been historically marginalized or under-resourced based on race, ethnicity, income, geography, disability, gender, sexual orientation, religion, migration status, language, age, criminal justice involvement, or other identities, beliefs, behaviors, or circumstances

HRSA
Health Resources & Services Administration

Growing the Rural Health Workforce

Rural Health Philanthropy Partnership Meeting

October 26, 2023

CAPT Paul Jung, USPHS
Director, Division of Medicine and Dentistry
Bureau of Health Workforce
Health Resources and Services Administration (HRSA)

Vision: Healthy Communities, Healthy People

Agenda

1. Workforce Challenges
2. BHW's Aims
3. Program Development
4. Workforce Resources

HRSA Health Workforce

The Health Workforce Challenge

STAT

FIRST OPINION

Policymakers must take action on the physician shortage

By Tochi Iroku-Malize, Sandy Chung, Verda Hicks, Omar T. Atiq, Ira P. Monka and Petros Levounis
Sept. 25, 2023

The pressures of the last three and a half years have affected every corner of the health care landscape, but nowhere is the effect more evident than the country's physician workforce. Burnout, staffing shortages, financial challenges, administrative burden, and two U.S. Supreme Court decisions that stand to stifle diversity and representation in medicine have hamstrung physicians across specialties and settings — in rural and urban communities, in hospitals, clinics, and independent practices.

These workforce challenges are compounded by the fact that America — both physicians and our patient population — is also aging, and the number of available doctors is shrinking. Nearly 334,000 health care professionals left the workforce in 2021. Further, the Health Resources and Services Administration estimates that by 2025, there will be a shortage of more than 250,000 mental health professionals, including psychiatrists.

CNN health

Concern grows around US health-care workforce shortage: 'We don't have enough doctors'

By Jacqueline Howard, CNN
Published 11:00 AM EDT, Tue May 16, 2023

(CNN) — There is mounting concern among some US lawmakers about the nation's ongoing shortage of health-care workers, and the leaders of historically Black medical schools are calling for more funding to train a more diverse workforce.

As of Monday, in areas where a health workforce shortage has been identified, the United States needs more than 17,000 additional primary care practitioners, 12,000 dental health practitioners and 8,200 mental health

The Washington Post

Primary care saves lives. Here's why it's failing Americans.

By Frances Stead Sellers
October 17, 2023 at 6:00 a.m. EDT

abc NEWS

Less staff, longer delays and fewer options: Rural America confronts a health care crisis

Young medical professionals confront a looming rural health care crisis.

By Peter Charalambous
March 18, 2023, 8:06 AM

More than 40,000 graduating medical students learned Friday where they will spend the next three to seven years of their medical training.

With the United States grappling with a simultaneous shortage of primary care physicians and a rural health care crisis, many of the graduating students are set to enter the front lines of the country's health care shortage.

At least 136 rural hospitals and health systems closed between 2010 and 2021, and over 40% of rural hospitals operate with negative profit margins. Despite billions of dollars in investment in health care, hospitals throughout the United States face the possibility of shutting down.

TIME

IDEAS • HEALTH

American Health Care Faces a Staffing Crisis And It's Affecting Care

IDEAS BY ROBERT GLATTER, PETER PAPADAKOS, AND YASH SHAH JUNE 30, 2023 8:43 AM EDT

Hospitals, urgent care facilities, clinics, and imaging centers throughout the United States are experiencing staffing issues. Since the COVID-19 pandemic, costs have reached new highs as institutions are forced to staff their facilities with temporary health professionals due to rising turnover

HRSA Health Workforce

The Pandemic's Impact on the Health Workforce

mid-pandemic

79%

of workforce impacted by staff shortages[1]

49.9%

overall burnout rate[2]

28.7%

intent to leave job[2]

impact of work overload

⬆2.9x

risk of burnout[2]

⬆2.1x

risk of leaving[2]

[1]Galvin, G. Nearly 1 in 5 Health Care Workers Have Quit Their Jobs During the Pandemic. *Morning Consult.* (Oct 4, 2021).

[2]Rotenstein, *et al.* The Association of Work Overload with Burnout and Intent to Leave the Job Across the Healthcare Workforce During COVID-19. *Journal of General Internal Medicine* (2023).

HRSA Health Workforce

Projected Shortages through 2035

Nationwide Shortages 2035

PRIMARY CARE	BEHAVIORAL HEALTH	ORAL HEALTH	MATERNAL HEALTH	LP NURSES
35,260	15,180	1,310	5,790	141,580

NonMetro Areas / Projected Adequacy 2035 (Selected Examples)

49%	29%	57%	54%	N/A
General Internal Medicine	Adult Psychiatrists	Oral Surgeons	OB/GYN Physicians	

*Reflects data from early in the COVID-19 pandemic.
https://data.hrsa.gov/topics/health-workforce/workforce-projections
https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand

HRSA Health Workforce

HRSA Workforce Aims

Increase Supply

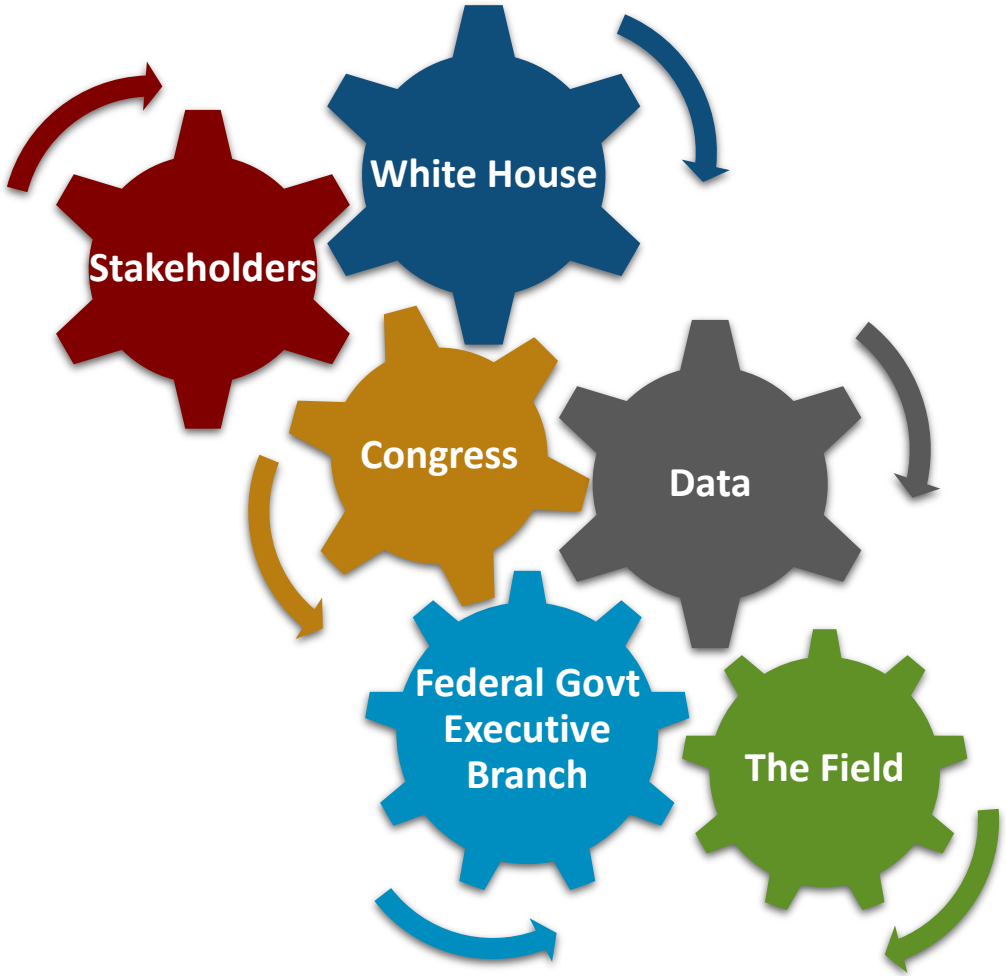
Advance Health Equity

Improve Distribution

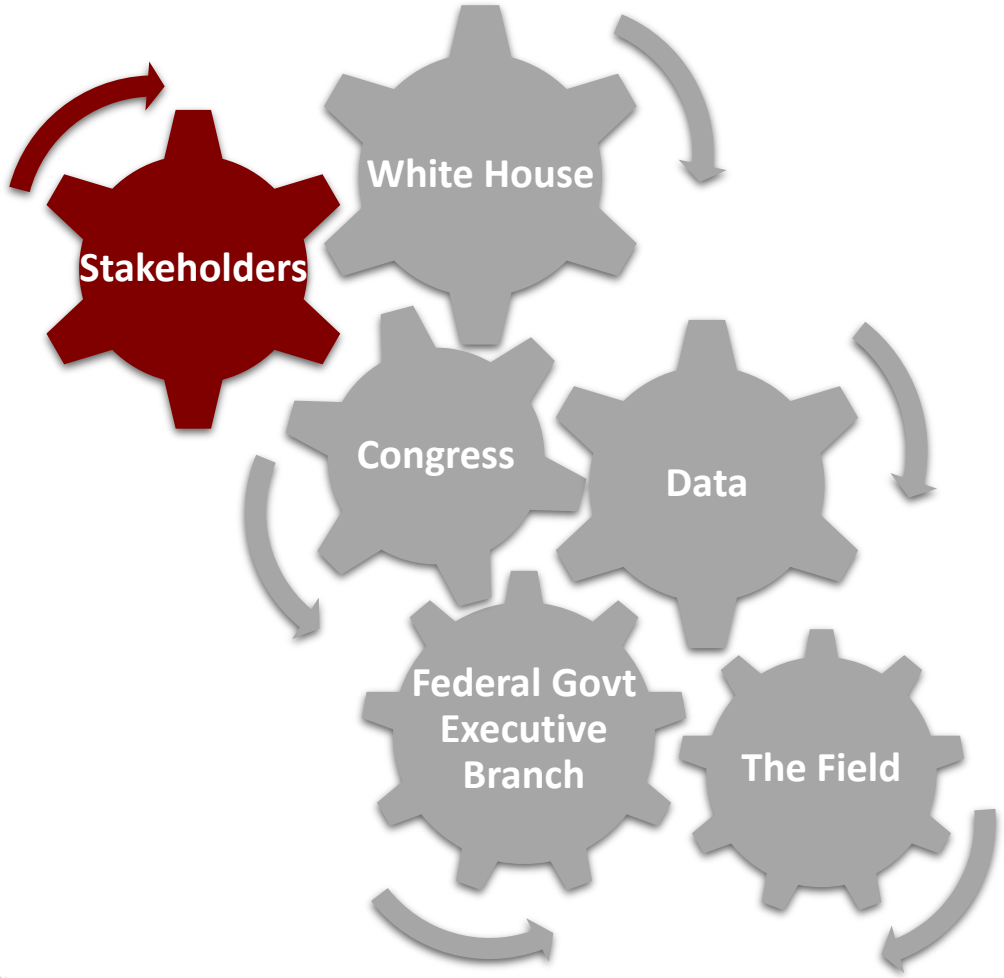
Promote Resilience

Amplify HRSA Impact

How Health Workforce Programs Come To Be



The Role of Stakeholders



GROUPS

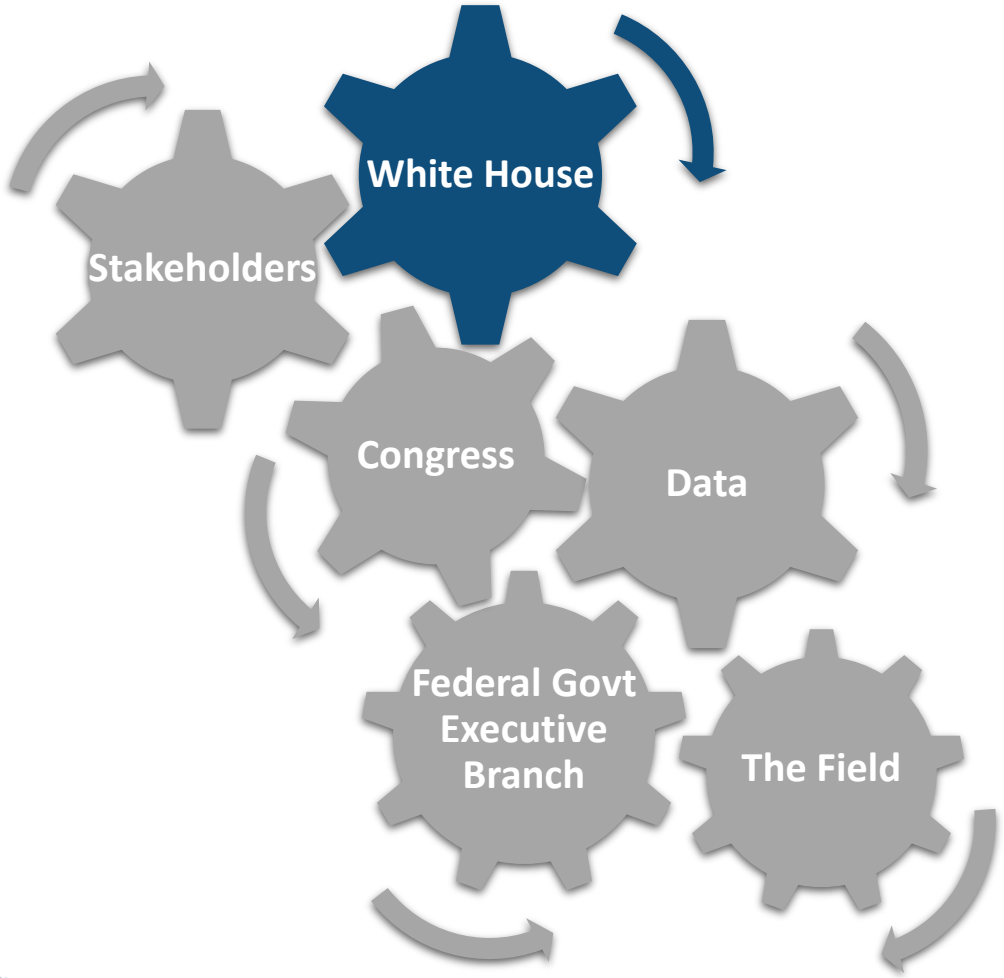
- Membership organizations / associations
- Special interest groups
- Lobbyists

INDIVIDUALS

Direct communication with:

- White House
- Congressional representatives
- HHS, HRSA, and/or BHW

The Role of the White House



PRESIDENT'S BUDGET

- Lays out program priorities
- Signals policy direction

REQUEST FOR BHW (FY 2024) = $2.71 B

$1.75 B → +$357.1 M (+FY 2023)

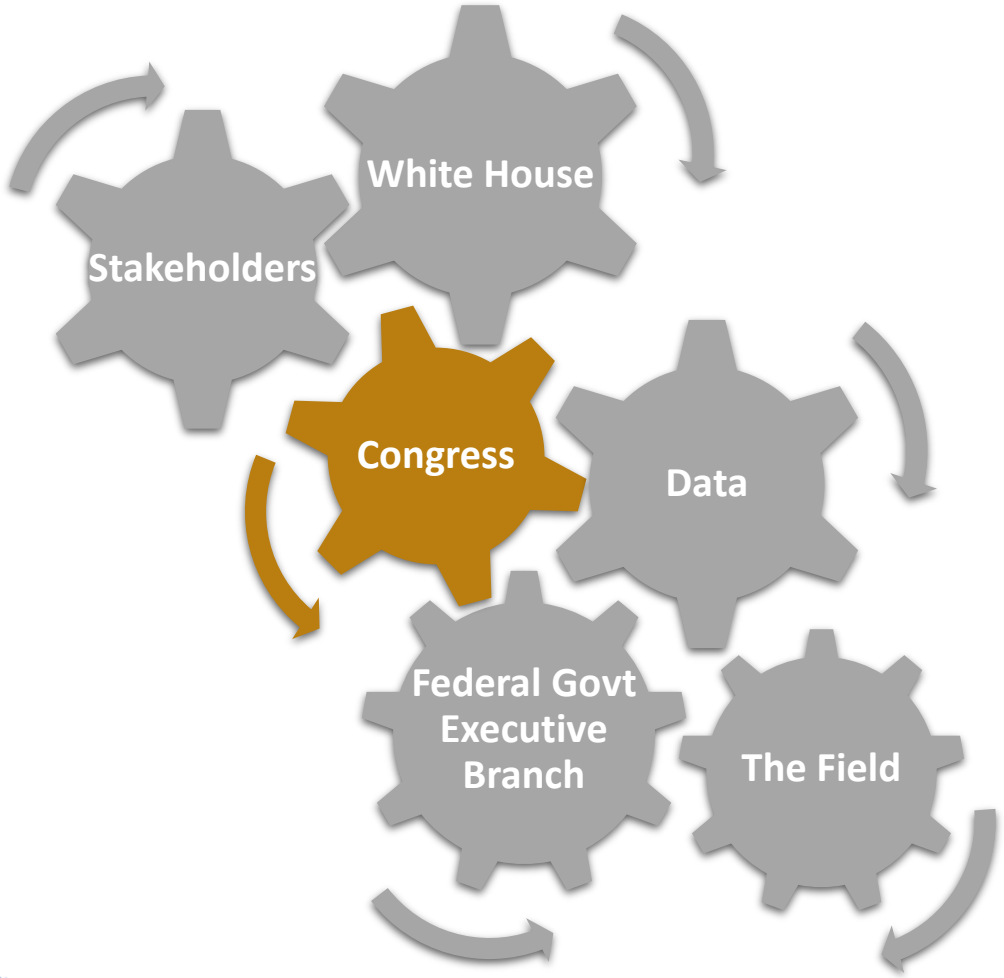
$947 M → +$535.4 M

$18.8 M → +$0

Discretionary | Mandatory | User Fees

HRSA Health Workforce

The Role of Congress



AUTHORIZING LEGISLATION

- Public Health Service Act (42 U.S.C.)
- Amended by
  - Health Care Safety Net Act
  - Patient Protection and Affordable Care Act
  - CARES Act
  - And many others

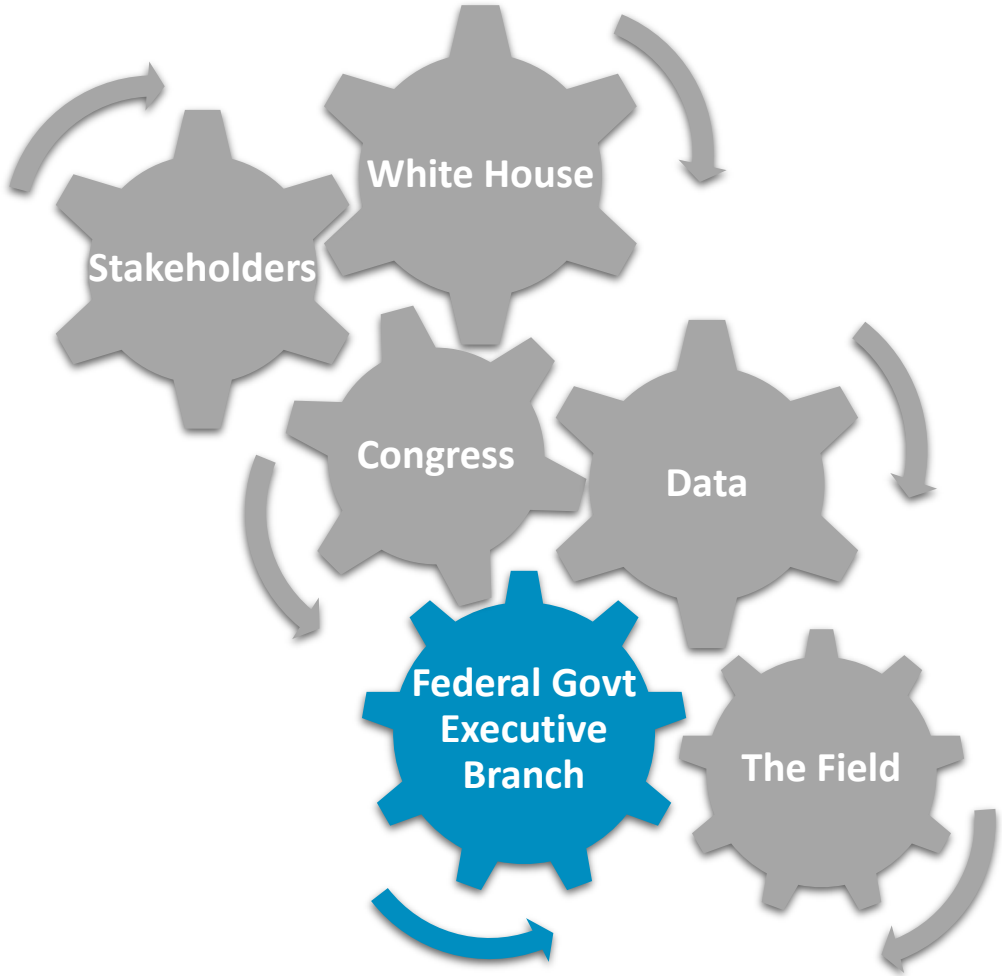
…depending on the program

FUNDING

- Annual appropriations bills
- Continuing resolution(s)

REPORTING REQUIREMENTS

The Role of Agencies in the Executive Branch



HRSA'S PROGRAMMATIC WORK

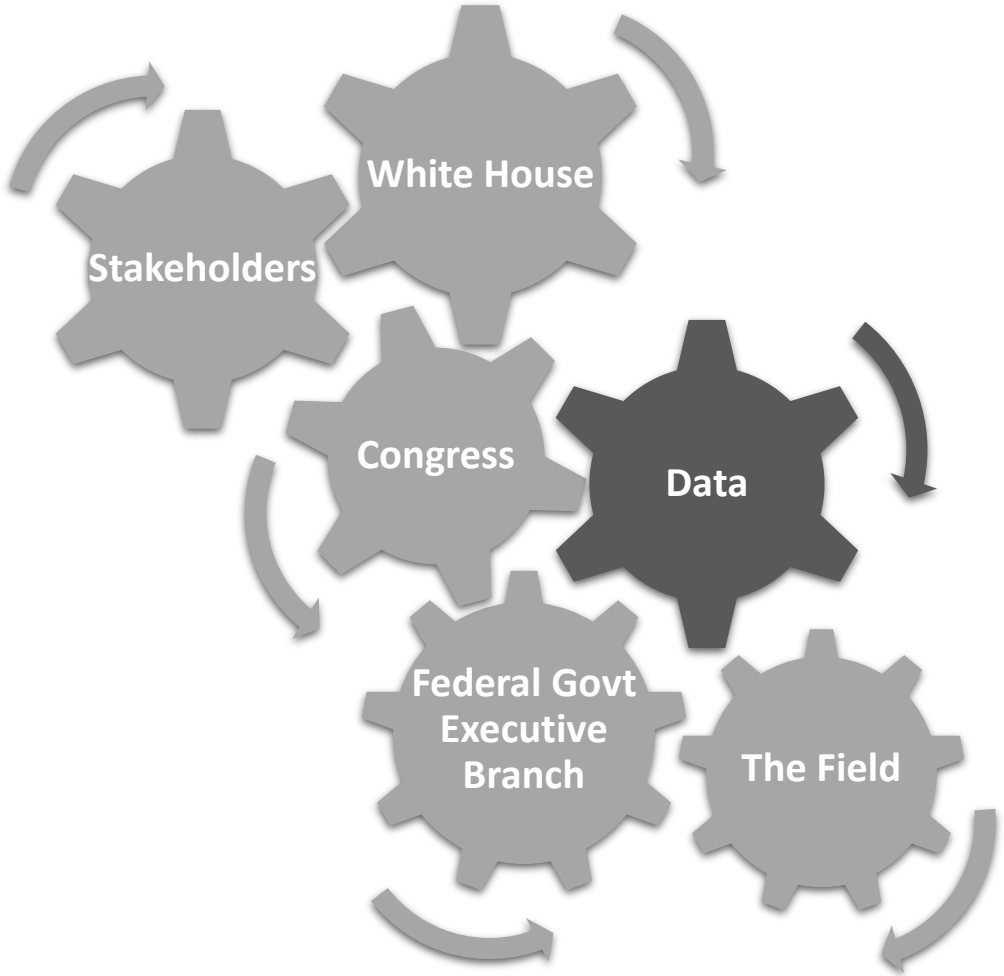
- Implement legislation from Congress
- Offer competitive funding opportunities
- Provide technical assistance to grantees

SUPPORT FOR APPROPRIATIONS & THE LEGISLATIVE PROCESS

- Budget priorities and formulation
- Legislative inquiries
- Legislation proposals
- Feedback on draft legislation

HRSA Health Workforce

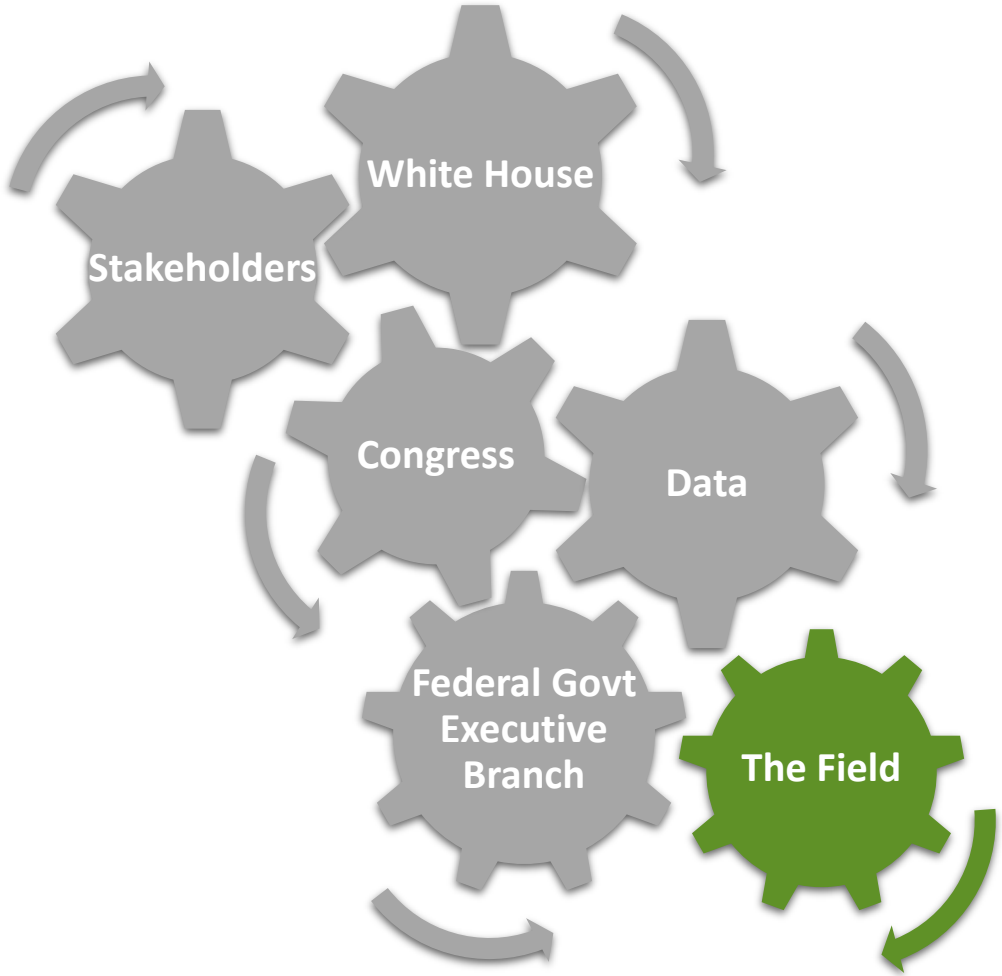
The Role of Data



EVIDENCE-BASED DEVELOPMENT

- Literature reviews
- Current and projected data
- Grantee input and results
- Stakeholder perspectives
- Sister agencies' activities and outcomes

The Role of Those in the Field



COMPOSITION

- The health workforce
- Academic organizations that train them
- Clinical partners

COMMUNICATION

- Regular stakeholder meetings
- Quarterly calls with grantees
- Listening sessions
- Stakeholders reach in

HRSA Health Workforce

Improving Equity via BHW Grants

STREAMLINED FUNDING ANNOUNCEMENTS

- Shorter
- Easier to read
- Reduced burden

DATA AND IMPACT

- Reach to underrepresented minorities
- Strategies to address health and learning disparities

Workforce Resources

LEARN MORE

- bhw.hrsa.gov
- nhsc.hrsa.gov
- data.hrsa.gov
- grants.gov

GET HELP

- FAQs
- Webinars
- Regional offices
- Project officers

STAY INFORMED

- Subscribe to email updates

HRSA Health Workforce

Celebrating Rural Health Day

Nov 15
6-9pm

HRSA Virtual Job Fair

Promoting job vacancies for rural health care facilities only

REGISTER: bhw.hrsa.gov/job-search

HRSA Health Workforce

Ongoing Engagement

Contact Us

CAPT Paul Jung, USPHS

Director, Division of Medicine and Dentistry

Bureau of Health Workforce (BHW)

Health Resources and Services Administration (HRSA)

Email: pjung@hrsa.gov

Website: www.bhw.hrsa.gov

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Questions

The Rural Health Workforce: Challenges and Opportunities for Philanthropies

Q&A Session

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

11th Annual Public-Private Collaborations in Rural Health Meeting

Break

Wifi Network: MarriottBonvoy_Conference
Access code: NRHA2023

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Supporting the Rural Primary Care and Nursing Workforces

Morgan McDonald
National Director for Population Health and Health Equity Leadership
Milbank Memorial Fund

Carolyn Montoya
Interim Dean
College of Nursing, University of New Mexico

The Health of US Primary Care Provider Workforce

Morgan McDonald, MD FACP FAAP

October 2023

Milbank Memorial Fund

Using evidence to improve population health.

Roadmap to Achieve Vision of 2021NASEM Report "Implementing High Quality Primary Care"

Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care

A Tool to Help Implement High-Quality Primary Care for All

- Intended to both ***measure the health of primary care*** in the US and ***progress in the five goal areas*** identified by NASEM: payment/financing; access, *workforce,* HIT and research/accountability
- **2023 Topline Message:** The first national primary care scorecard finds a chronic lack of adequate support for the implementation of high-quality primary care in the United States across all measures, although performance varies across states.

Findings from research and analysis conducted by the Yalda Jabbarpour, MD, and colleagues at the Robert Graham Center

Online Dashboard with State Trend Data by Indicator

Select an indicator to view state and/or national data

NASEM Recommendation:
Pay for primary care teams to care for people, not doctors to deliver services

Primary care spending as a share of total health care spending in commercial health insurance

- Broad Definition of Primary Care Providers
- Narrow Definition of Primary Care Providers

Primary care spending as a share of total health care spending in Medicare

- Broad Definition of Primary Care Providers
- Narrow Definition of Primary Care Providers

Primary care spending as a share of total health care spending in Medicaid

- Broad Definition of Primary Care Providers
- Narrow Definition of Primary Care Providers

Percentage of primary care patient care revenue from capitation

NASEM Recommendation:
Ensure that high-quality primary care is available to every individual and family in every community

NASEM Recommendation:
Train primary care teams where people live and work

Percentage of physicians trained in rural areas or medically underserved areas

Percentage of physicians, nurses, and physician assistants (PAs) working in primary care

- All
- Physicians
- Nurse Practitioners
- Physician Assistants

Percentage of new physicians entering primary care workforce each year

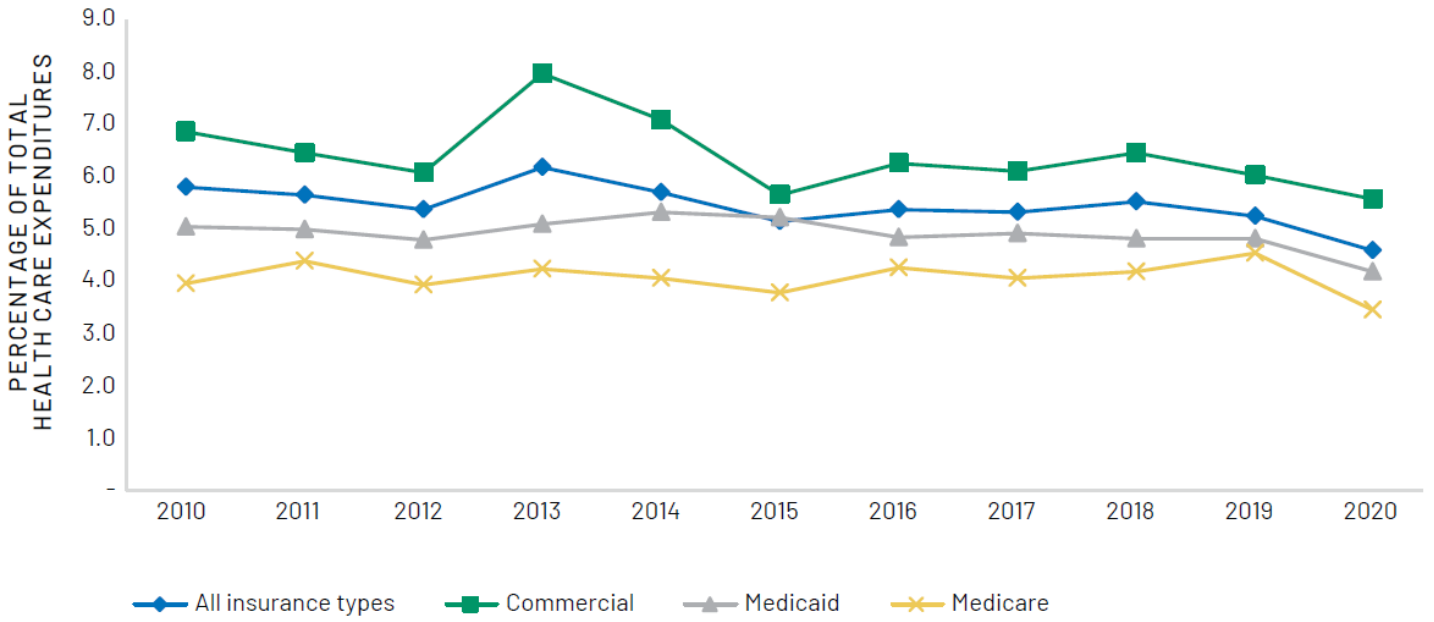
Medical residents per 100,000 population

NASEM Recommendation:
Design information technology that serves the patient, family, and interprofessional care team

There are no current data for this category

Financing: The US is underinvesting in primary care across all payer types

Figure 1: Primary Care Spending (Narrow Definition) from 2010 to 2020



Data Source: Analyses of Medical Expenditure Panel Survey (MEPS), 2010-2020. MEPS was redesigned in 2018. Data on ambulatory care expenditures derived from the consolidated, office-based, and outpatient event files. See Appendix B for details.

Notes: The primary care narrow definition is restricted to primary care physicians only. The primary care specialties included family medicine, general practice, internal medicine, pediatrics, geriatrics, and osteopaths.

Financing: Fee for service dominates

(NASEM suggested a hybrid payment model (FFS/capitation mix); current available measure is full capitation

Table 1. Percentage of Fully Capitated Physician Visits

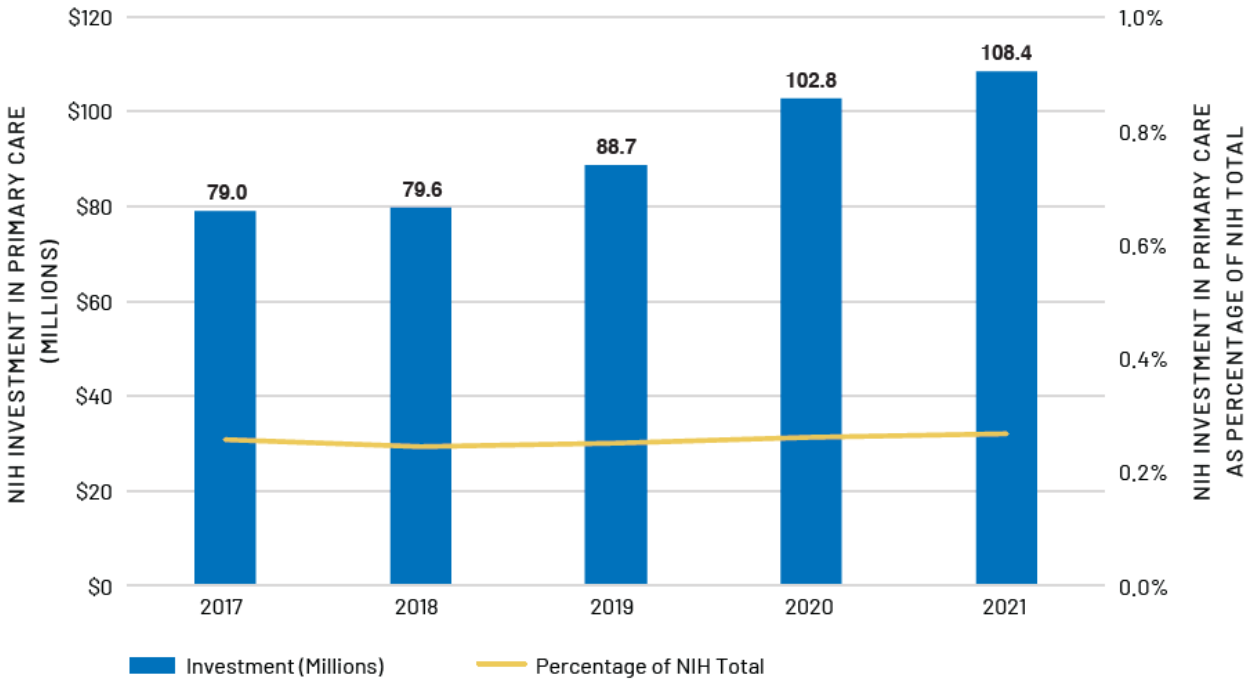
Year	All Physician Visits	Non-PCP Visits	PCP Visits
2010	6.4	4.4	8.7
2011	7.0	4.6	9.9
2012	5.5	3.5	8.1
2013	5.5	4.0	7.7
2014	5.1	3.5	7.4
2015	7.1	5.0	8.9
2016	6.8	4.7	8.6
2017	6.7	4.9	9.3
2018	6.5	4.4	9.6
2019*	5.7	4.4	7.7
2020*	6.2	5.3	7.6

Data Source: Analyses of Medical Expenditure Panel Survey (MEPS), 2010-2020. MEPS was redesigned in 2018. Data on ambulatory care expenditures derived from the consolidated, office-based, and outpatient event files. See Appendix B for details.

Notes: The primary care physicians included family medicine, general practice, internal medicine, pediatrics, geriatrics, and osteopaths. All other subspecialists were non-primary care physicians.

Research: Almost no federal funding for primary care research

Figure 8: NIH Investment in Primary Care in Millions of Dollars and as a Percentage of Total Funding



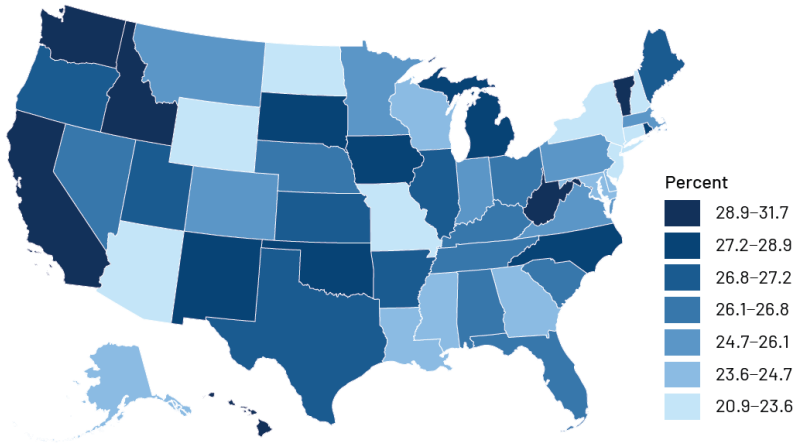
Data Source: NIH RePORTER, 2017-2021.
Notes: Family medicine as proxy for primary care, unadjusted dollars.

The primary care workforce is shrinking

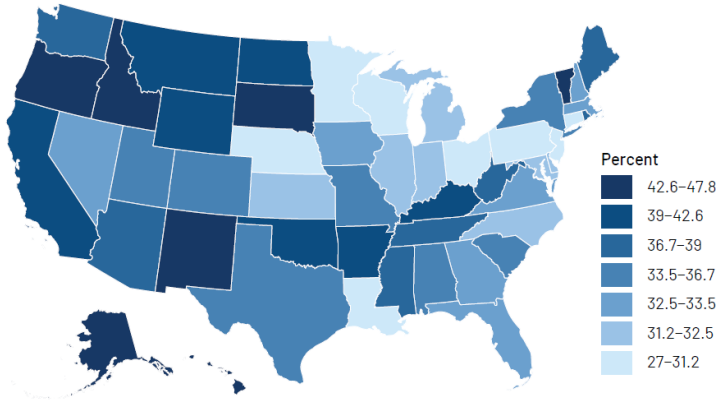
- About **1 in 3** physicians specialized in primary care in 2010
- In 2020,**1 in 5** physicians entered the primary care workforce
- Among all provider types in 2022, primary care physicians had the highest turnover (8.4%)
- Multidisciplinary approach is critical component to high-functioning PC teams
- NP programs are growing more quickly, are more likely to train in rural areas and primary care
- We must address drivers of burn out and incentivize quality team based care, pipeline recruitment, cost of training and training locations

Workforce: There is wide state variation in the proportion of clinicians in primary care

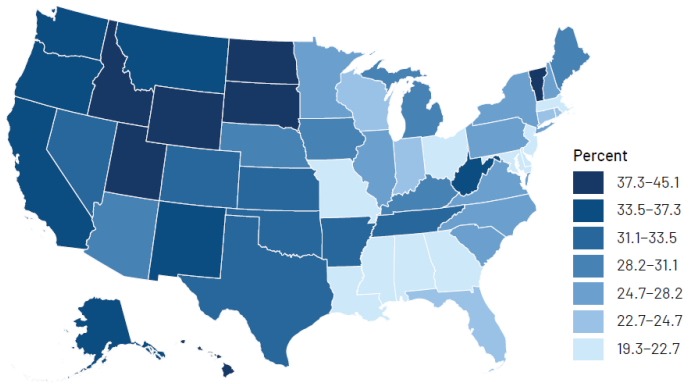
Physicians



Nurse Practitioners



Physician Assistants

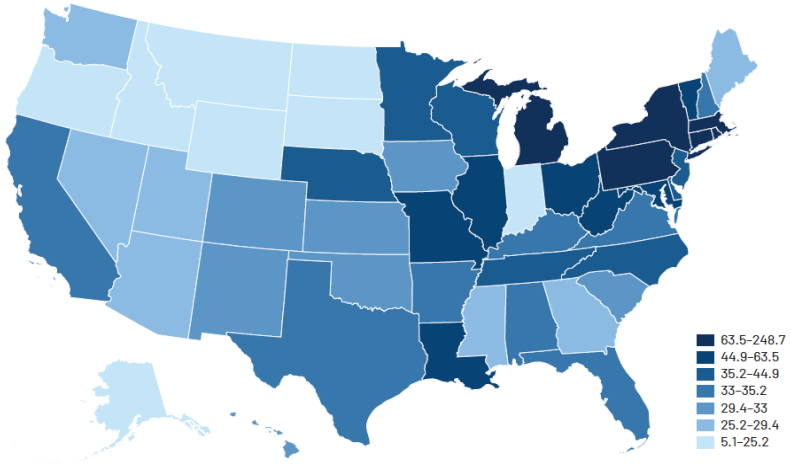


Data Source: Analyses of American Medical Association Masterfile (2020), Centers for Medicare and Medicaid Services Medicare Provider Enrollment, Chain, and Ownership System (PECOS) data (2020), and Centers for Medicare and Medicaid Services Physicians and Other Suppliers data (2020).

Notes: Primary care specialty included family medicine, general practice, internal medicine, and pediatrics.

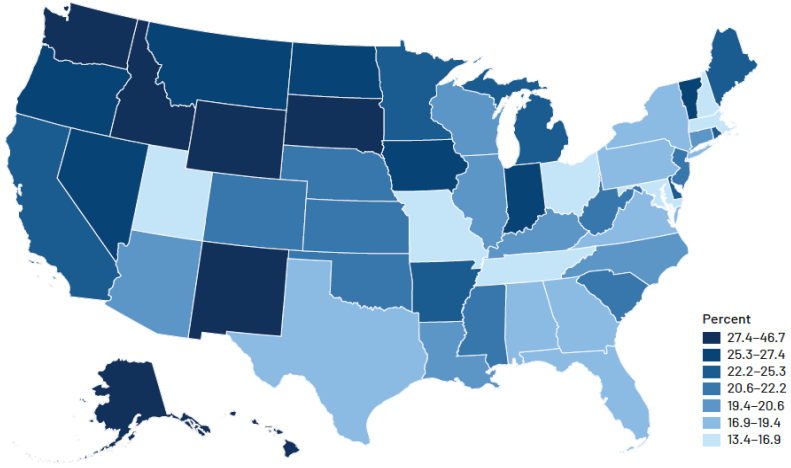
Training: There are significant geographic discrepancies between where physicians train and where people live and work

Figure 6. Medical Residents per 100,000 People by State in 2020



Data Source: Analyses of Accredited Council for Graduate Medical Education program-level data to get counts for medical residents and Area Health Resource File for the population data (2017–2020, 2022).

Figure 2. Percentage of Physicians Entering Primary Care by State in 2020

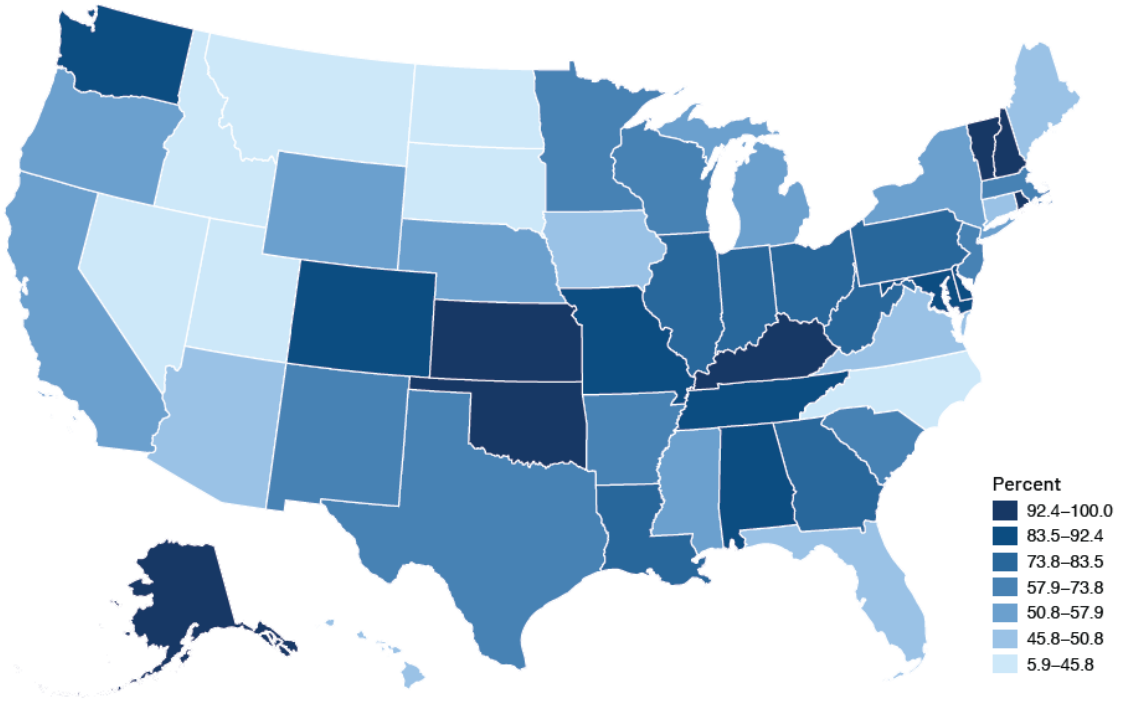


Data Source: Analyses of Accredited Council of Graduate Medical Education data in American Medical Association Masterfile, 2020.

Notes: Primary care specialties included family medicine, general practice, internal medicine, and pediatrics.

Training: In some states, only 6% of resident physicians train in MUAs or rural counties,

Figure 7: Percentage of Physician Residents Trained in a Medically Underserved Area or Rural County by State in 2020



Data Source: Analyses of site-level information from publicly available Accredited Council for Graduate Medical Education data, MUA HRSA Data Warehouse, Medically Underserved Area Dataset (2020), and United States Department of Agriculture Rural-Urban Continuum Codes.

What works in workforce development?

J Gen Intern Med. 2018 Feb; 33(2): 191–199. PMCID: PMC5789104
Published online 2017 Nov 27. doi: 10.1007/s11606-017-4210-z PMID: 29181791

Recruiting Rural Healthcare Providers Today: a Systematic Review of Training Program Success and Determinants of Geographic Choices

Ian T. MacQueen, MD,[1,2] Melinda Maggard-Gibbons, MD, MSHS,[1,2,3] Gina Capra, MPA,[4]

Systematic Review of over 7000 references examining rural health care provider choices

31 studies exploring reasons for geographic choices and 24 studies documenting the impact of training programs

LOW EVIDENCE	MODERATE EVIDENCE	STRONG EVIDENCE
• Loan Repayment • Family Ties • International Medical Graduate • Osteopathic Medicine • Salary • Scope of Practice • Recreation	• Rural Rotations in Training • Primary Care Focus of Training Programs	• Rural Background

Opportunities for State Action on Primary Care

- New CMMI models:
  - AHEAD
  - Making Care Primary (MN, WA, CO,NC, NY, MA, NJ, NM)
- Medicaid waivers in OR and MA: paying more for primary care, paying differently
- State level workforce training and financing legislation and maximization of federal (HHS, education, labor) and private funding
- Get Organized: Primary Care Investment Network- 20 states convened by Milbank, Commonwealth Fund and Primary Care Development Corp to measure and increase primary care spend in Medicaid and Commercial

Current Opportunities for Federal Action

Executive Branch

- HHS plan and dashboard; NASEM advisory panel
- CMMI Payment Models
- HRSA Programs
- Medicare Physician Fee Schedule Modifications
- Medicaid Access Regulations
- MSSP Modifications

Legislative:

- HRSA reauthorizations:

  Health Centers, National Health Service Corps, Teaching Health Centers
- Payment. Medicare payment reforms:

  site neutral payments, Medicare Advantage, MedPAC agenda

https://www.commonwealthfund.org/blog/2023/how-congress-can-strengthen-primary-care-through-medicare-payment-reform

Opportunities for Private Investment in Rural Primary Care Workforce

- Apprenticeship funding and infrastructure
- Wrap around assistance for rural students (housing, childcare, books, uniforms) increase recruitment and double retention
- Rural high school career exposure
- Community health worker sustainability
- Funding and support for rural community college, rural university and graduate programs, rotations in rural practices and facilities
- Advocacy for state and federal funding and policy/payment changes to support primary care workforce

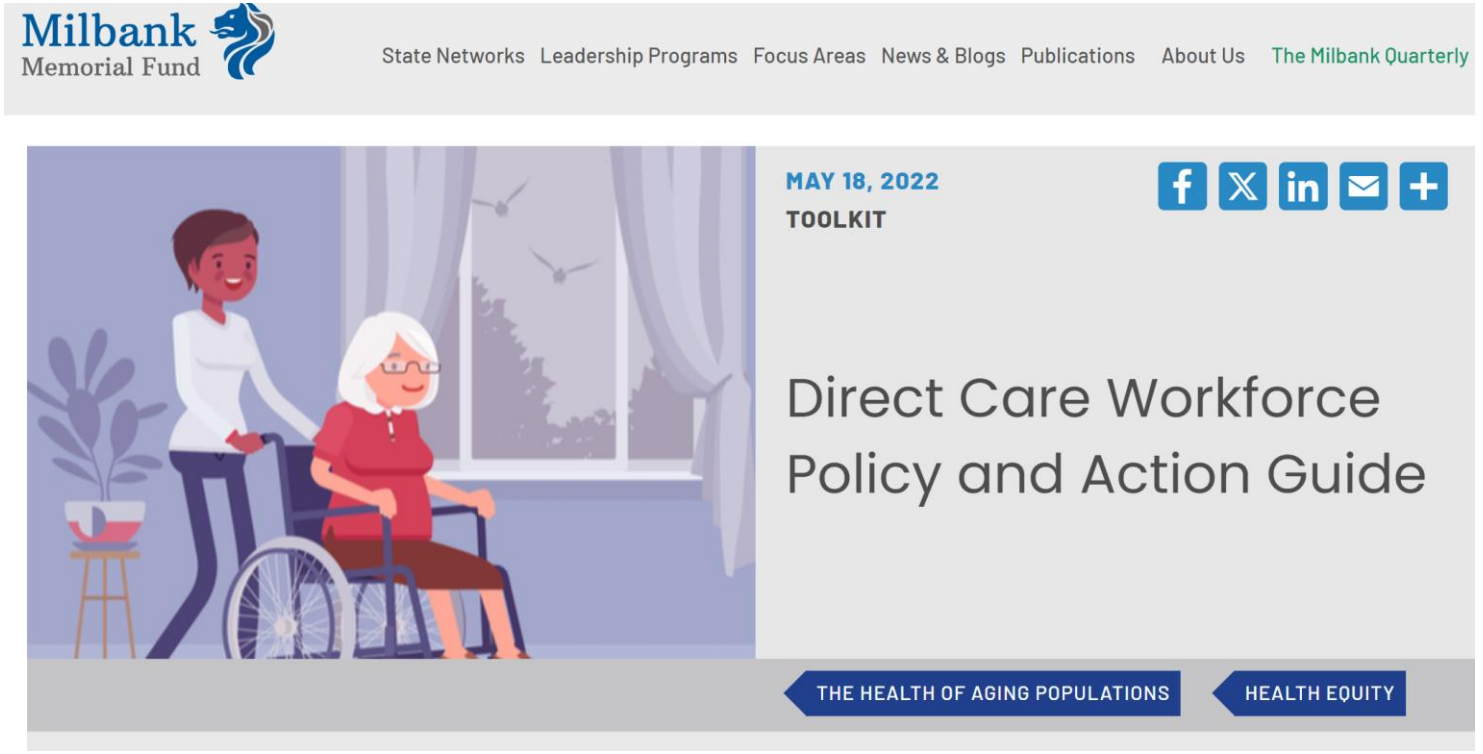
Other Milbank Resources on Primary Care

- Medicaid payments by state (forthcoming)
- Multi-state collaboratives to improve access to primary care
- Examples of state primary care investment at work
  - How MA Medicaid is Paying for Primary Care Teams to Take Care of People, Not Doctors to Deliver Services
  - Colorado Multi-Payer Collaborative: Lessons Learned in Primary Care Improvement
  - Assessing the Efficacy of Policies to Improve Access to Primary Care ofr Underserved Populations (WV)

https://www.milbank.org/focus-area/primary-care-transformation/

It Takes a Team and a System

….Other Opportunities to Promote Access and Quality



https://www.milbank.org/publications/direct-care-workforce-policy-and-action-guide/

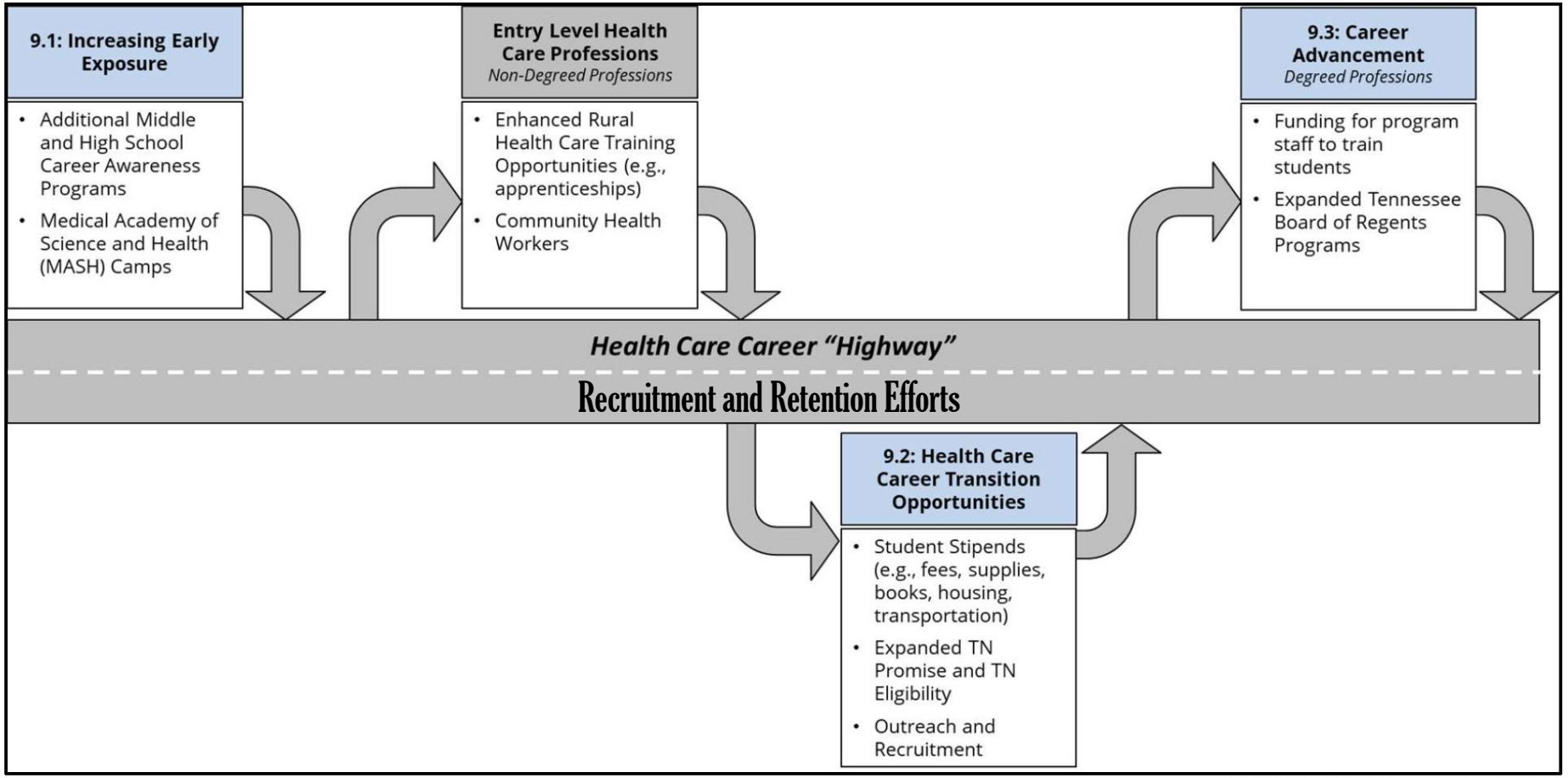
ACTION STEP: Higher wages/benefits and non-wage benefits/supports for DCWs

	Sample Strategies	Implemented in
Stakeholder buy-in	Statewide coalition with stakeholder engagement across all sectors; include legislators	NM, NJ, PA
State-level leadership	Establish legislative care caucus	MI
	Legislation that supports DCWs	CO, IA, IN, MN, NJ, NV, WA
County/city/local-level leadership Many of these examples come from localized strategies for addressing the workforce crisis.	Millage bonds to pay for senior services	OH
	High-level and entry-level training	NY
	Establish a network of DCW centers	PA through Transitional Paths to Independent Living (PHI)
	Enforce labor laws	NYC Council passed law creating Labor Policy and Standards, a city office charged with enforcing local labor laws, and established Paid Care Division, a public advocate for home care workers

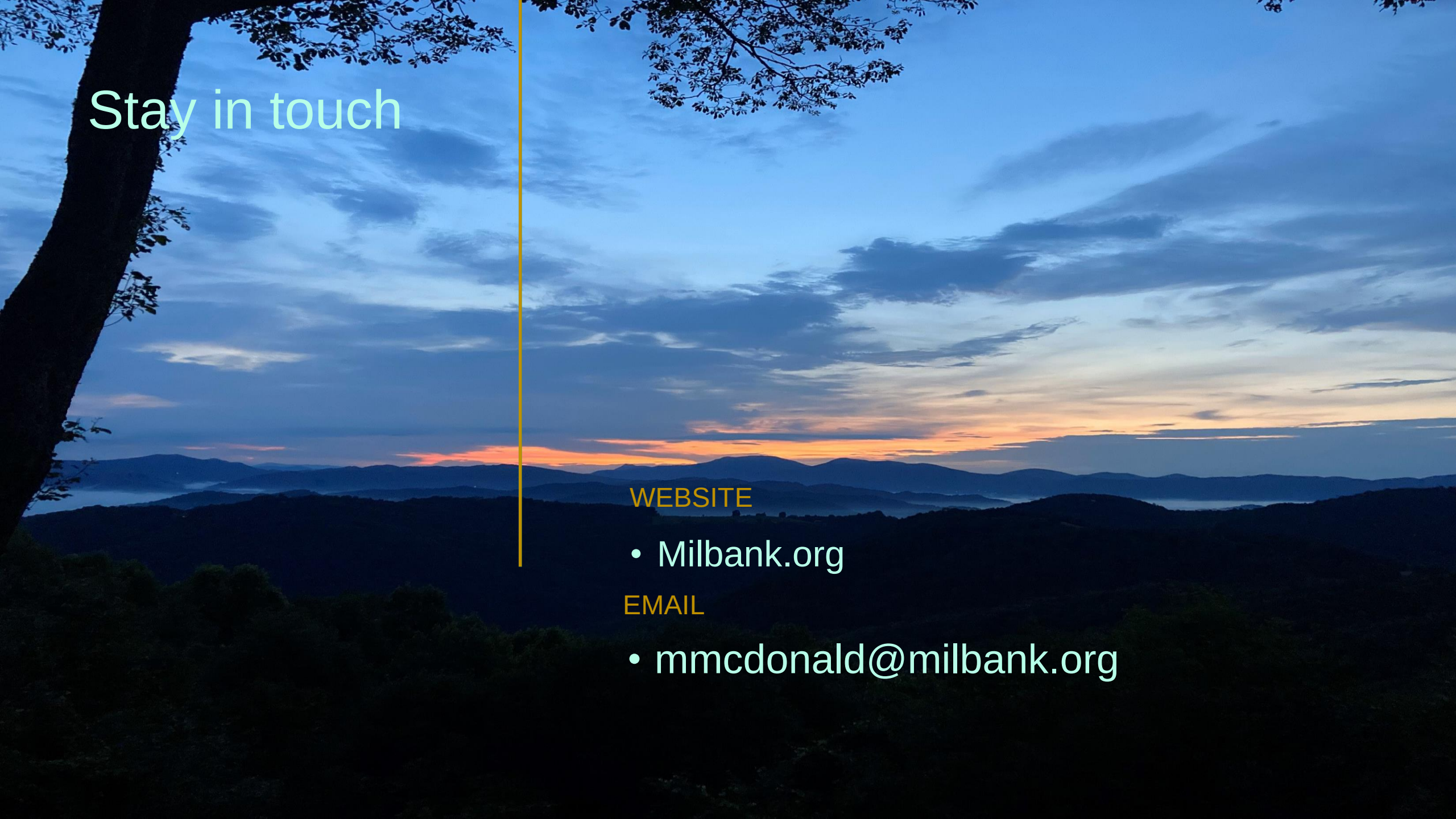
Action Step: Professionalization of the Workforce

Wages	Increase minimum wage	AZ
	Wage pass-throughs	Multiple states
	Increase wages — premium/hazard pay	MI, AK
	Set wage requirements for publicly funded LTSS programs or designate funding for DCW wages	CO, NYC region, MA, MN, NJ
	Set a sector-specific minimum wage	NY, ME
	Tie reimbursement rates to quality standards — rewards high-road employers and allocates funds in an evidence-based manner	RI, TN, WY
	Offer one time recruitment/retention bonuses	WI
Training	Provide training	NJ, CA, ME, DE, CO
	Offer free training tuition or substantial training fund	NY
	Offer talent development grants to pay for training such as Advanced Home Care Aide Registered Apprenticeships	MI, WA
Competency and credentials	Set DCW competency and training standards	IA, AZ, WA, CA

Opportunities for Health Workforce Investment
Tennessee Rural Health Care Task Force Example



https://www.tn.gov/health/news/2023/6/30/--tennessee-rural-health-care-task-force-releases-recommendations.html



Stay in touch

WEBSITE

- Milbank.org

EMAIL

- mmcdonald@milbank.org

Supporting the Rural Primary Care and Nursing Workforces

Q&A Session

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Early Childhood Workforce

Jocelyn Richgels
Director of National Policy Programs
Rural Policy Research Institute

Hannah Burnett
Director, Campaign Giving and Business Engagement
Let's Grow Kids, Vermont

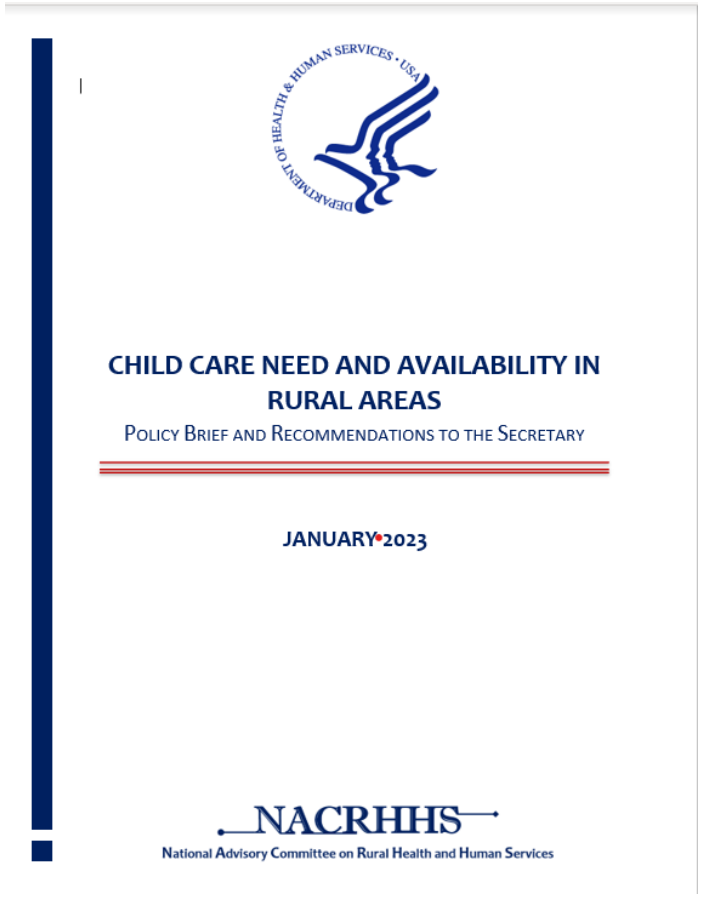
Early Childhood Workforce Policy Options

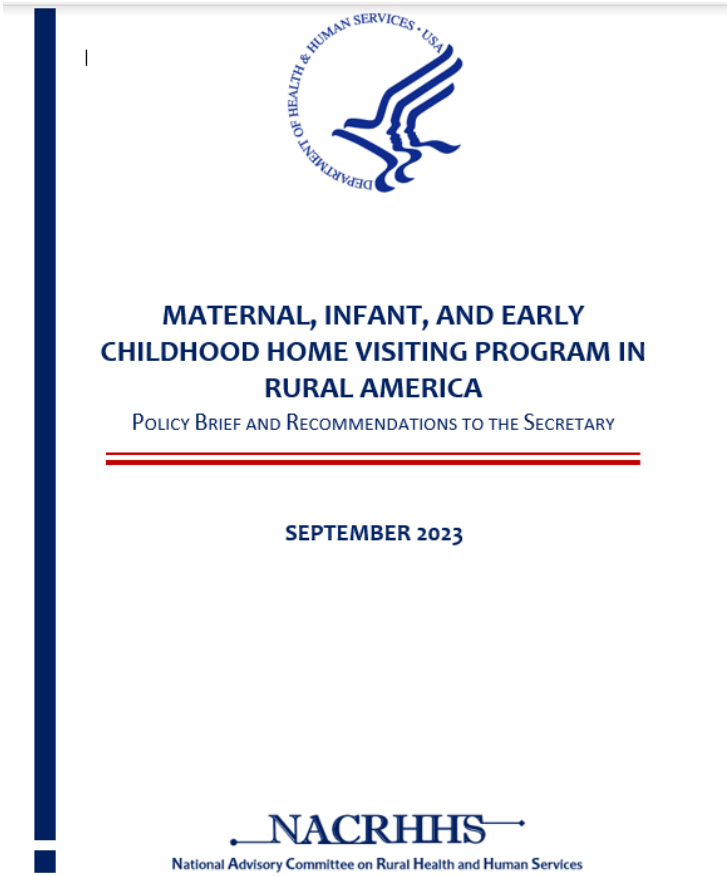
Jocelyn Richgels

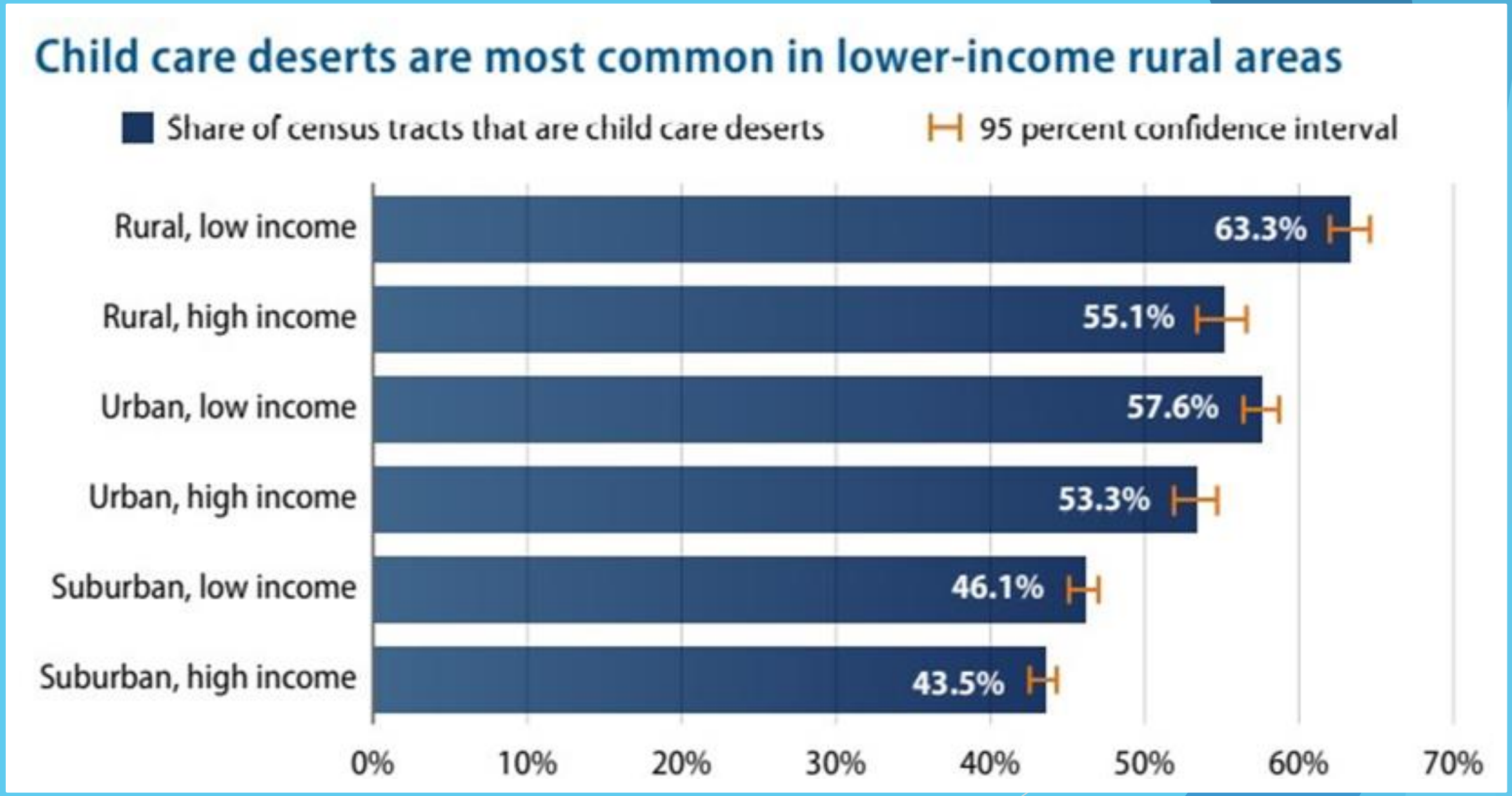
Rural Policy Research Institute

October 26, 2023

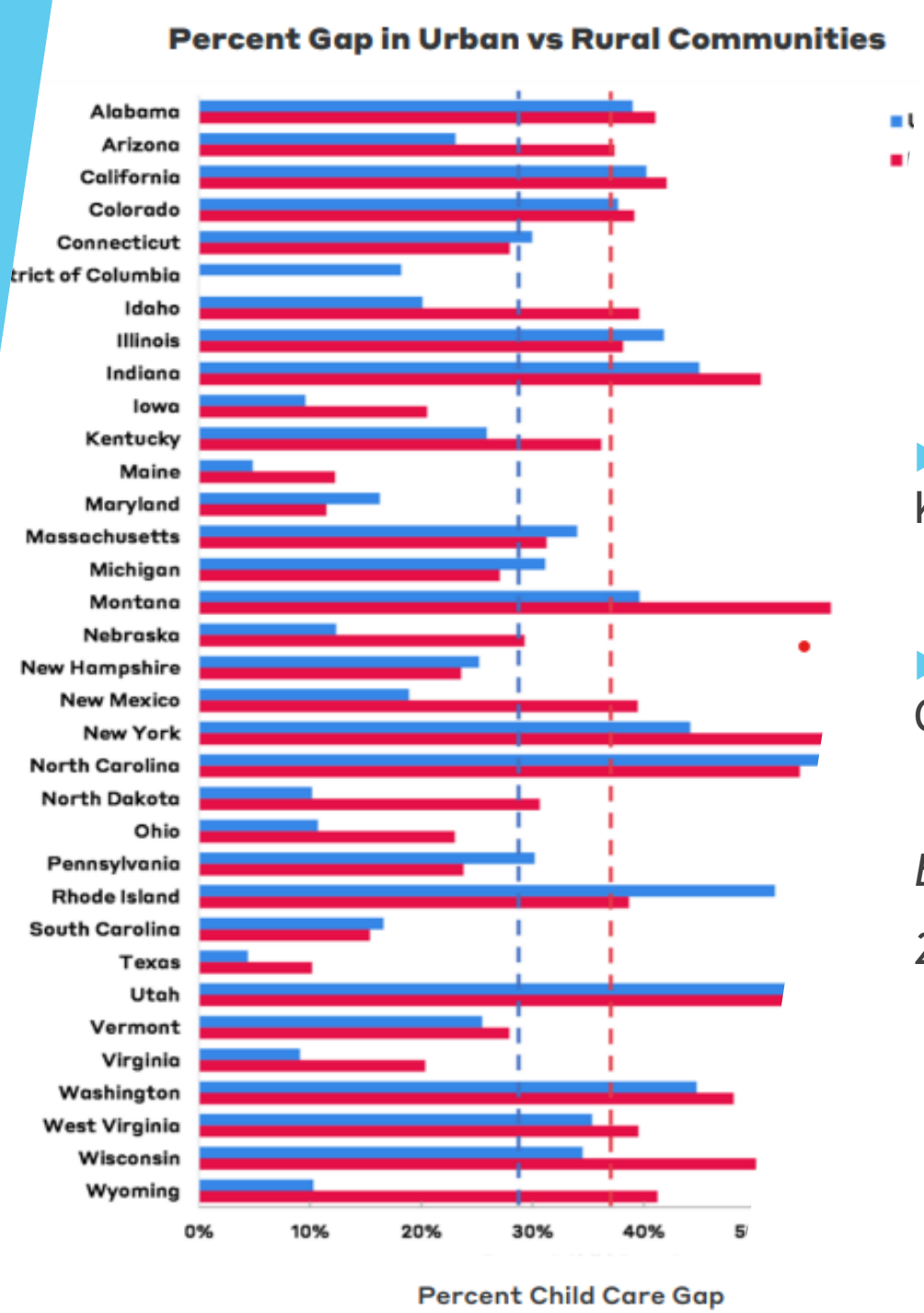
National Advisory Committee on Rural Health & Human Services







Center for American Progress



- Child Care in 35 States: What We Know & Don't Know.

- Child Care Need in Urban vs. Rural Communities

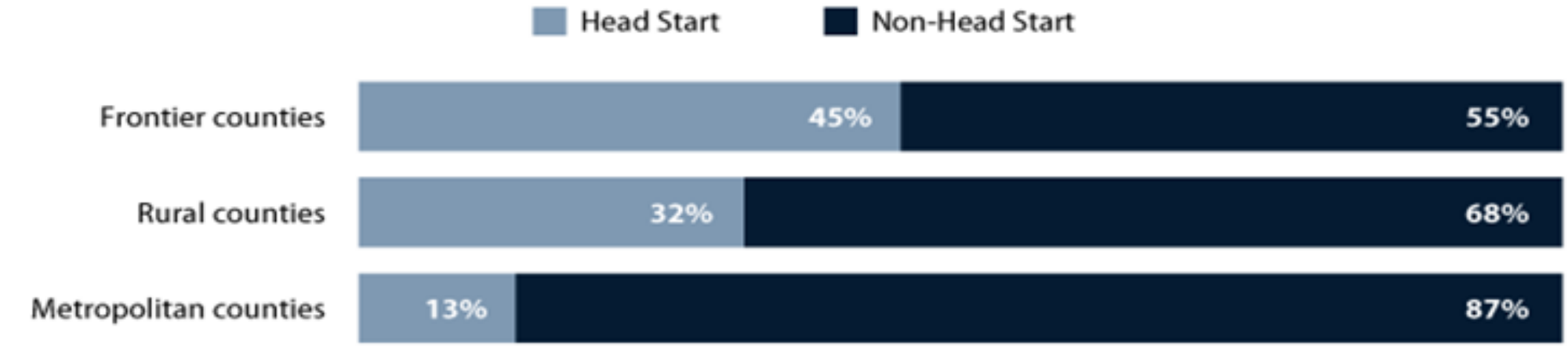
Bipartisan Policy Center

2021

FIGURE 4

Head Start fills a child care gap in rural and frontier counties

Share of the child care centers that are Head Start grantees, by type of county



Note: Metropolitan counties have a rural-urban continuum code of 1 through 4; rural counties are coded as 5, 6, or 7; frontier counties are coded as an 8 or 9.

Source: Authors' analysis; see Methodology.

CAP

NACRHHS Policy Recommendations

Child Care

- The Committee recommends the Secretary consider creating a Child Care Shortage Area (CCSA) designation similar to the Health Professions Shortage Area designation (HPSA) to inform future policymaking about child care supply, access and affordability.
- The Committee recommends the Secretary support organizations that serve minority and rural populations, such as Historically Black Colleges and University (HBCUs) tribal colleges, community colleges, Community Health Workers (CHWs), Colonias community leaders, and tribal leaders.

NACRHHS Policy Recommendations

Child Care

- The Committee recommends that whenever possible, the Secretary allow for expansion of Head Start program capacity in communities with newly created or expanded Early Head Start programs to allow for continuity of education from Early Head Start through entry into kindergarten.
- The Committee recommends the Secretary extend the Qualification Waiver for Head Start Preschool Teachers to Early Head Start programs who face similar difficulties with recruiting qualified teachers as it applies to waiving the CDA requirement. Extending this waiver would allow Early Head Start programs to immediately enroll infant and toddler teachers in a CDG program and provide initial training prior to entering the classroom.

NACRHHS Policy Recommendations

Child Care

- The Committee recommends the Secretary ensure both ACF's Office of Head Start and Office of Child Care provide the necessary flexibility and support for rural providers that allow them to develop programs to train parents and community members and provide support to obtain required child care licenses and degrees.
- The Committee recommends the Secretary work with USDA, the Commerce Department, and the Federal Communications Commission to help rural home-based child care providers gain access to high-speed, low-cost broadband services for training and education.

NACRHHS Policy Recommendations

Maternal, Infant, & Early Childhood Home Visiting

- HHS should provide rural-specific workforce training support to home visiting programs by adding a rural track within the Institute for Home Visiting Workforce Development and the Jackie Walorski Center for Evidence-Based Case Management.

Jocelyn Richgels
jrichgels@rupri.org
www.rupri.org

National Advisory Committee Reports:

https://www.hrsa.gov/advisory-committees/rural-health/publications

Vermont's Child Care Campaign: Investing in the Workforce Behind the Workforce

Rural Health Philanthropy Partnership Meeting
October 26-27, 2023

Hannah Burnett
Director of Campaign Giving & Employer Engagement
Let's Grow Kids
hannahb@letsgrowkids.org

LET'S GROW KIDS
CHILD CARE IS ESSENTIAL

The State of Child Care in Vermont

3 out of 5 Vermont children lack access to child care

Families pay too much

Early childhood educators make too little

Let’s Grow Kids is a catalyst for child care

The Vision of Vermont's Child Care Campaign

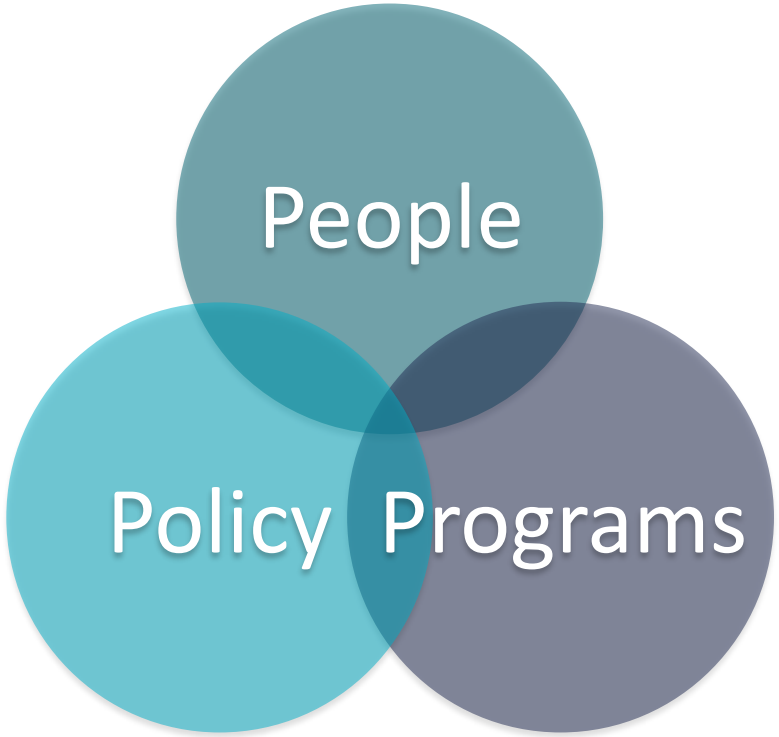
Access

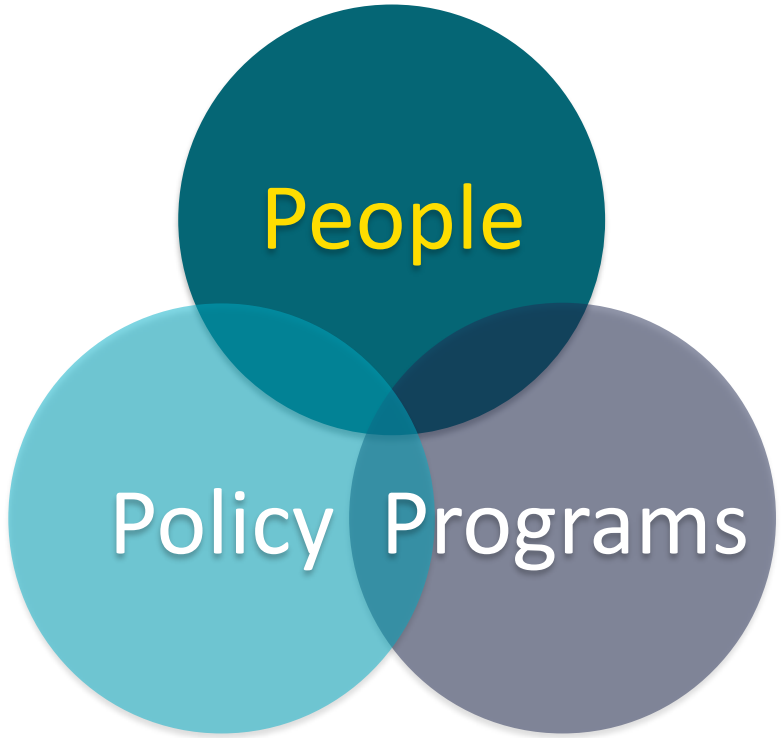
Affordability

Quality


Act 76
makes
Vermont's
child care
system
one of the


CHILD CARE IS
ESSENTIAL


People
Policy
Programs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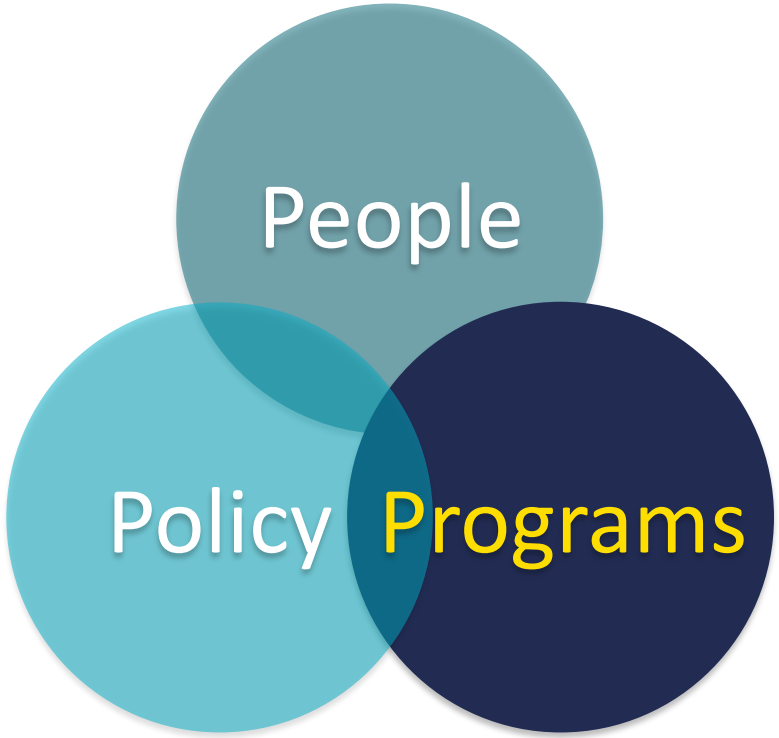
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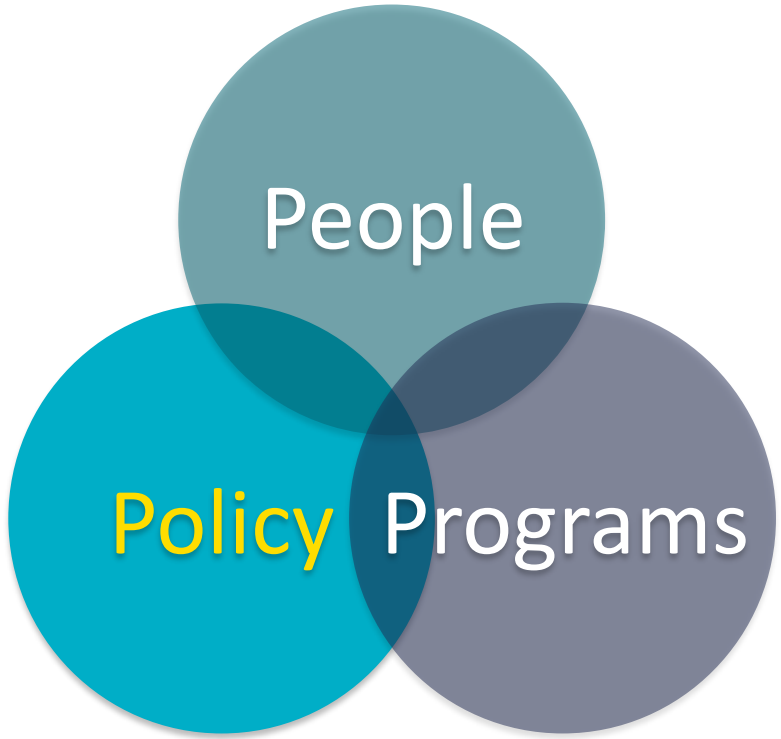
People
Policy
Programs

Key Takeaways

Elevate the voices of early childhood educators

Engage the business community

Don’t be afraid of politics!

Prepare the child care system for public investment

Mixed delivery systems are essential for success

Build sustainable infrastructure through partnerships & collaboration

Our Work is Not Done Until…

Access

Affordability

Quality

Thank You!

Hannah Burnett
Director of Campaign Giving & Employer Engagement
Let's Grow Kids
hannahb@letsgrowkids.org

Visit www.letsgrowkids.org for more information

Early Childhood Workforce

Q&A Session

National Rural Health Association

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U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

11th Annual Public-Private Collaborations in Rural Health Meeting

Lunch

Wifi Network: MarriottBonvoy_Conference
Access code: NRHA2023

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U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Sustaining the Community and Public Health Workforce

Diane Hall
Senior Health Scientist and CDC Lead for Rural Health
Office of the Associate Director for Policy and Strategy
Centers for Disease Control and Prevention

Kim Tieman
Vice President and Program Director
Benedum Foundation

A.J. Pearlman
Director
Public Health Americorp

Sustaining the Community and Public Health Workforce in Rural Areas

Diane Hall, PhD, MSEd – Moderator

Director, Office of Rural Health, CDC

Kim Tieman

Vice President and Program Director, Benedum Foundation

A.J. Pearlman, JD

Director, Public Health AmeriCorps

Borrowing an Analogy: *The Jar of Life*

Sustaining the Community and Public Health Workforce

Q&A Session

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

11th Annual Public-Private Collaborations in Rural Health Meeting

Break

Wifi Network: MarriottBonvoy_Conference
Access code: NRHA2023

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Oral Health Workforce

Marcia Brand
Former Deputy Administrator
Health Resources and Services Administration

Amy Martin
Professor
Medical University of South Carolina

Stacy Warren
Associate Director, Health Care
The Duke Endowment

National Rural Health Association

The Rural Oral Health Workforce: Challenges and Opportunities

Rural Health Philanthropy Partnership Meeting
October 26, 2023

Marcia K. Brand, Ph.D.

Co-Chair, NRHA Rural Health Leadership and Education Foundation

Co-Chair, Appalachian Funders Network, Health Workgroup

National Rural Health Association

The Presentation

Why oral health and the oral health workforce are important

Overview of the nation's **current rural oral health status**

Overview of the **rural oral health workforce**

Opportunities for foundations, rural stakeholders and rural advocates **to promote the rural oral health workforce**

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The Effect of Oral Health on the Community, Overall Well-being and the Economy

- Oral health plays a vital role in the **physical, mental, social and economic well-being** of individuals and populations.

- The oral cavity and surrounding structures are essential parts of the human body, integral to daily functioning and contributing substantially to the **overall well-being of individuals.**

- **Oral health is integral to overall health**.

Oral Health in America: Advances and Challenges, National Institute of Dental and Craniofacial Research, December 2021.

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Oral Health Is the Sector Where the US Has the Largest Disparities in Access to Care

- As a result, **inequities in oral health status and outcomes** are pronounced.
- In addition to its impacts on physical health and economic and social engagement, **poor oral health makes conditions like diabetes and heart disease worse.**
  - Growing body of research that demonstrates the **impact of poor oral health on overall health.**
- Dental pain or infections are a leading cause of **Hospital Emergency Department visits**; treatment generally providing temporary relief, and frequently causing financial losses for the patient and the facility.

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Challenges in Providing Oral Health Care in Rural America

- **Geographic** isolation
- Lack of adequate **transportation**
- Higher rates of **poverty** compared to metro areas
- Large **elderly population** (with limited insurance coverage of oral health services); nearly one in four rural residents is at least 65 years old
- Acute **provider shortages**
- State-by-state-variability in **scope of practice**
- Difficulty finding providers willing to treat **Medicaid** patients
- Lack of **fluoridated community water**
- Poor oral health **education**

HRSA, Improving Oral Health Care Services in Rural America, December 2018 Policy Brief

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Rural Oral Health Status

- Rural adults are **more likely to have untreated dental disease, be missing some or all of their teeth**, and are more likely than their non-rural peers to have received no recent dental care. (Braswell&Johnson, 2013; Fish-Parcham et al., 2019)
- **Lower rates of dental care utilization**
- **Higher rates of dental caries**
- **Lower rates of insurance**
- **Less water fluoridation**

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The Rural Oral Health Workforce

- **Who is the "oral health workforce"**? Dentists, dental hygienists, dental therapists, public health dental hygienists, dental assistants, community dental health coordinators, community health workers…
- In 2015, urban areas had 30 practicing dentists per 100,000 people; **rural areas only had 22 dentists per 100,000 people**.
- In 2020 HRSA reported that **68.7% of dental health professional shortage areas were in rural or partially rural locations**, affecting 31 million people.
  - In March 2022, 4,633 of the nation's 6,927 Dental HPSAs were in rural or partially rural areas.
- Around 5,500 dental practitioners are needed to remove these designations.
- What contributes to these distribution challenges? **Reimbursement rates, stressful caseloads, isolation, student debt, an aging workforce**.

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Opportunities to Promote Rural Oral Health Through Workforce Investments

- Supporting projects that **expand the "oral health workforce"** to include "non-dental providers"
  - Promoting **interprofessional health education** that includes oral health.
    - Supporting educational programs that focus on **promoting an interprofessional oral health curriculum**, like Teaching Oral-Systemic Health (TOSH)
    - Using Smiles for Life, a free, on-line oral health curriculum endorsed by 22 health professions organizations and has had more than 3 million site visits to **skill up "non-dental providers"** about oral health – think pharmacists!
  - Promoting **interprofessional practice** - **team-based care -** in health centers and other efforts that encourage integrating oral health into primary medical care.
    - Encouraging the application of silver diamine fluoride, billing under the SDF code.

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Opportunities (cont.)

- **Strategies that help to recruit and retain families** – expanding childcare, reauthorizing and increasing funding for rural development, providing housing vouchers or assistance to families moving to rural, underserved areas to practice dentistry. Partner's job?
- **Grow your own and pipeline programs** – supporting the NHSC and other workforce programs, creating programs that target middle and high school students for dental careers
- Provide **financial incentives** for dental providers to serve rural communities
  - Student loan forgiveness
  - Grants and loans for purchasing dental equipment
  - Assistance in establishing clinical facilities

Opportunities (continued) – A little less “direct” but could promote the rural oral health workforce

- Provide **funding for demonstrations and evaluations of innovative state and local efforts** to expand access to oral health services for rural populations, and disseminate information about effective programs.
  - **Supporting veterans’ oral health** – ¼ living in rural areas, less likely to visit the dentist and more likely to have lost all their natural teeth compared to non-rural vets. Create programs that provide care for rural vets?
  - **Long-term care** – getting dental providers into these facilities, “skilling” up the existing workforce about oral health care?
  - Supporting **mobile dental clinics**
  - Employability – poor oral health impacts an individual’s ability to find and keep a job. Work with **state and local employment agencies** and the dental workforce to create programs that make persons “employable”?
- **Data** – we always need more data about what works to recruit and retain dental providers! See the Center for Health Workforce Studies, Oral Health Workforce Research Center, School of Public Health, SUNY Albany as an example.
- **Workforce demonstration programs** – maximizing the oral health workforce – practicing at the top of their licensure? Safety?

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Gamechangers for Oral Health That Will Impact the Rural Oral Health Workforce?

- **Teledentistry** – close the gaps for Americans in dental HPSAs? Oral health education and self-care?
- **"Preventistry"** – focus on caries and periodontal disease management and minimally invasive procedures
- New insurance **coverage approaches**
- Keep an eye on:
  - **NRHA's Rural Oral Health Initiative** – compendium of best practices
  - **Association of State and Territorial Dental Directors** – directory of state oral health programs (https://www.astdd.org/stateprograms/)
  - **National Organization of State Offices of Rural Health**
  - **OPEN** (Oral Health Progress and Equity Network) – Rural Network Response Team
  - **American Network of Oral Health Coalitions (ANOHC)**
  - **National Network for Oral Health Access (NNOHA)**

Oral Health Workforce Issues:
Public-Private Partnership Opportunities

October 26, 2023

Amy Martin, MUSC
Stacy Warren, The Duke Endowment

Overview

- Brief History of Oral Health Public-Private Partnerships in the Carolinas
- Rural Oral Health Workforce Issues
- SC Oral Health Workforce Summit – Snapshot of What Is & What Is To Come
- Opportunities for Public-Private Partnerships
- Questions & Feedback

THE DUKE ENDOWMENT

MUSC Medical University of South Carolina | James B. Edwards College of Dental Medicine

Brief History – A 10-year journey

How this initiative has impacted PPP in the Carolinas

2012
SC OHNA
- SDH gaps closing
- Rural inequities persist

→

2013
Public-Private Partnership Initiative launched

→

2014
USDHHS Frameworks
- HRSA Integration Report
- HHS Strategic Framework

2015
HRSA Grant Awards
- ROADS
- ROADTRIP

→

2016
HRSA/FORHP Public Private Partnership
- The Duke Endowment Portfolio

→

2017
The Duke Endowment with BCBS NC funds first round of school-based oral health programs & integrated care concept

2018
National Advisory Council for Rural Health & Human Services

Site visit with TDE

→

2019
SC Medicaid supports oral health policy analyses

BCBS SC joins as collaborative funder

→

2023
School-based program initiative into 5th year

Preparing for institutionalization

MUSC Medical University of South Carolina | James B. Edwards College of Dental Medicine

Rural Oral Health Workforce Issues

Impact of COVID on the workforce

- Disruptions & instability in utilization
- Workforce disruptions
- Impetus for needed legislative changes

What's in Senate Bill 146, the Dental Legislation Recently Signed Into North Carolina Law?

By NC Oral Health Collaborative August 11, 2021

A landmark piece of dentistry legislation became law in North Carolina on Friday, July 23, 2021. Senate Bill 146, sponsored by Senator Jim Perry, with a House counterpart sponsored by Representative Donny Lambeth, is a broad-reaching piece of oral health legislation that will allow North Carolina to take several steps toward a more accessible, equitable oral health care future.

There are four main parts of the legislation:

1. It codifies teledentistry in North Carolina law.
2. It allows dental hygienists with proper training and qualifications to administer local anesthesia.
3. It further aligns two existing regulatory provisions that allow dental hygienists to more efficiently work in community-based settings.
4. For the first time, it formally recognizes Federally Qualified Health Centers (FQHCs) in North Carolina statute.

ORIGINAL REPORT

Impact of COVID-19 on Dental Care Utilization and Oral Health Conditions in the United States

S.E. Choi[1], E. Mo[2], C. Sima[3], H. Wu[2], M. Thakkar-Samtani[4], E.P. Tranby[4], J. Frantsve-Hawley[4], and J.R. Barrow[2]

Abstract: ***Purpose:*** *We aim to understand the impact of the COVID-19 on health care utilization and oral health conditions of patients at federally qualified health centers (FQHCs), where patients are disproportionately low income, publicly insured, or uninsured.*

Methods: *Using deidentified electronic health records of patients at FQHCs in the United States from*

preventive services were observed in 2020. As compared to 2019, patients experienced more psychological stress–related dental conditions with odds ratios of 1.52 (95% confidence interval [CI], 1.31–1.76) for uninsured, 1.48 (95% CI, 1.07–2.02) for Medicaid enrollees, and 2.38 (95% CI, 1.68–3.40) for private insurance beneficiaries.

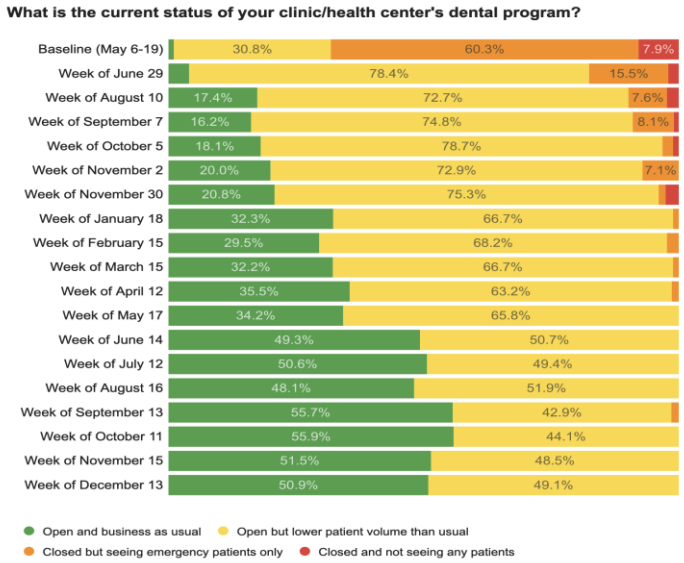
Conclusion: *As a result of COVID-*

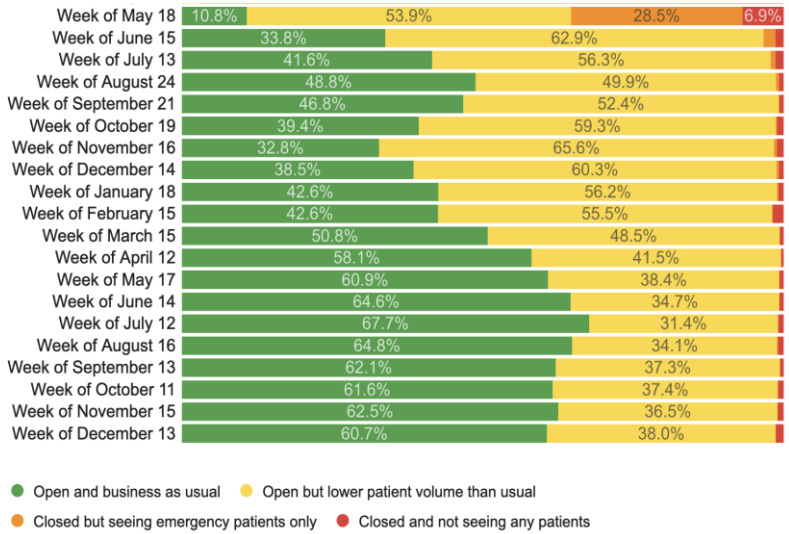
results of this retrospective cohort study can be used by clinicians and policymakers on understanding the clinical needs of the vulnerable populations after the pandemic. It highlights the need for continued support to expand access to oral health care and oral health promotion to these populations.

Keywords: access to care, [illegible] populations, health [illegible]

Are the Objects in the Mirror Closer than They Appear?
FQHC vs. Private Practice 2020 – 2021 Capacity

Source: ADA Health Policy Institute, https://www.ada.org/resources/research/health-policy-institute/impact-of-covid-19/private-practice-results





FQHC Dental Clinics vs. Private Practices

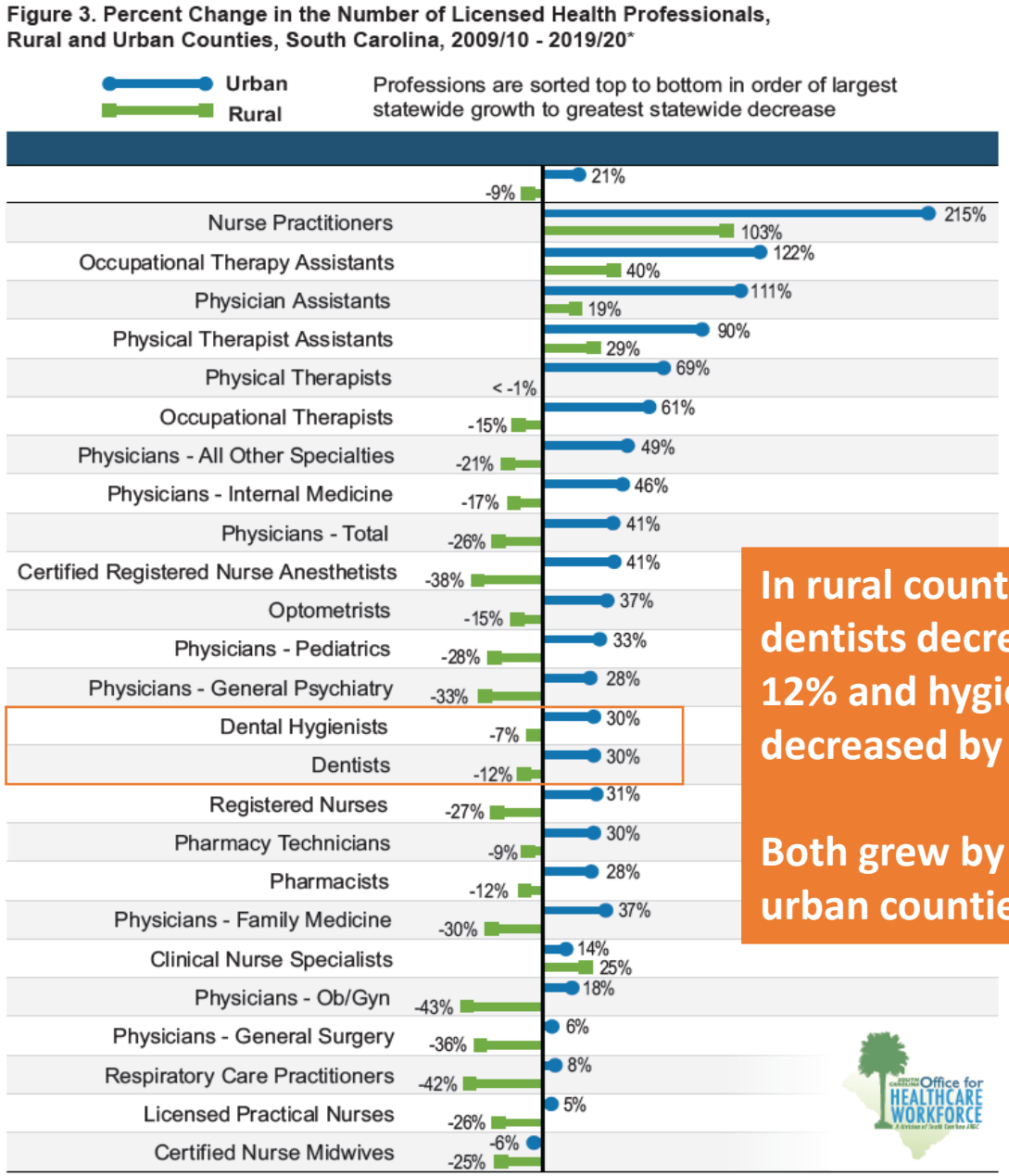
Where's the Workforce?

Deeper Dive into SC Dental Workforce Data

Is the hygiene and dental assistant workforce shortages real or perceived?

- Findings from the State's Dental Staff Workforce Summit
- Clues from state licensure data, HRSA, and SC Medicaid

Most health professions are losing numbers in rural areas, while most are gaining in urban

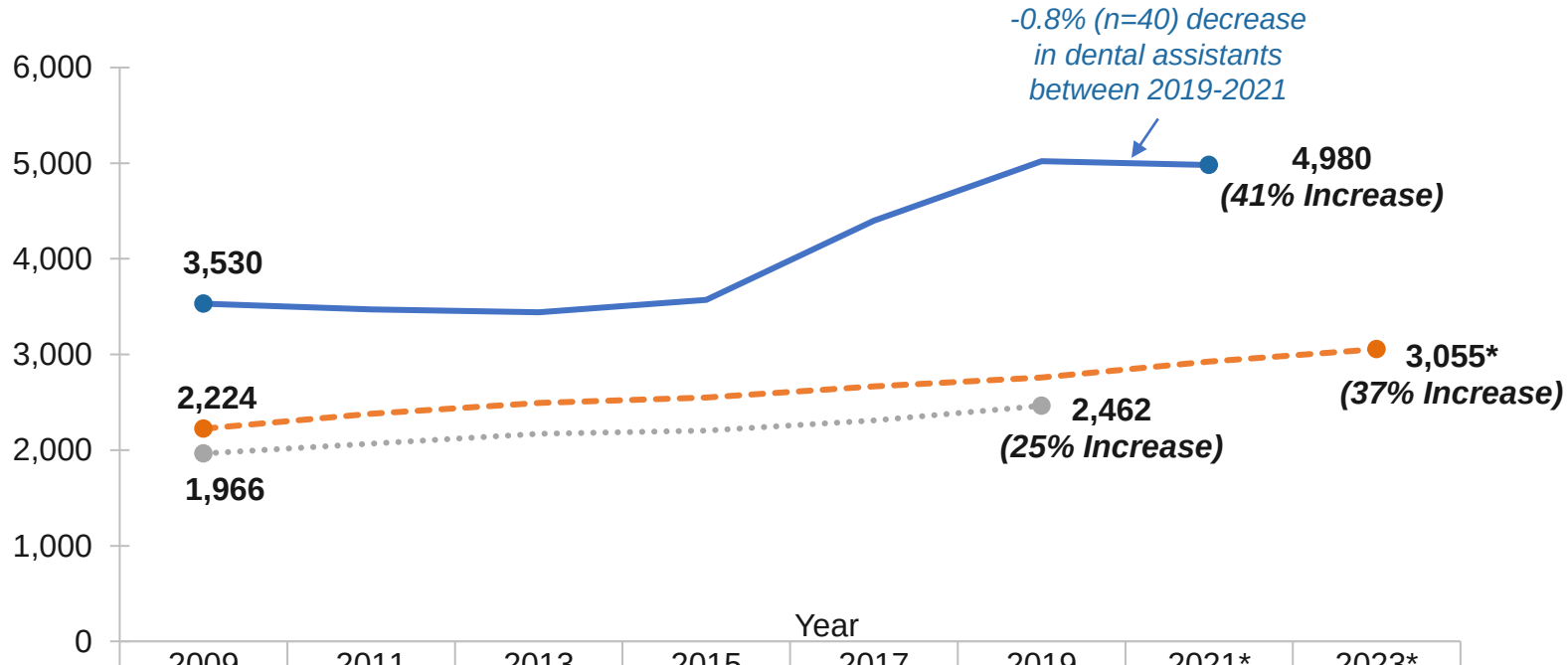


In rural counties dentists decreased by 12% and hygienists decreased by 7%

Both grew by 30% in urban counties

https://www.scahec.net/scohw/reports/137

Dental Assistants, Dental Hygienists and Dentists Actively Practicing Within South Carolina, 2009-2023*

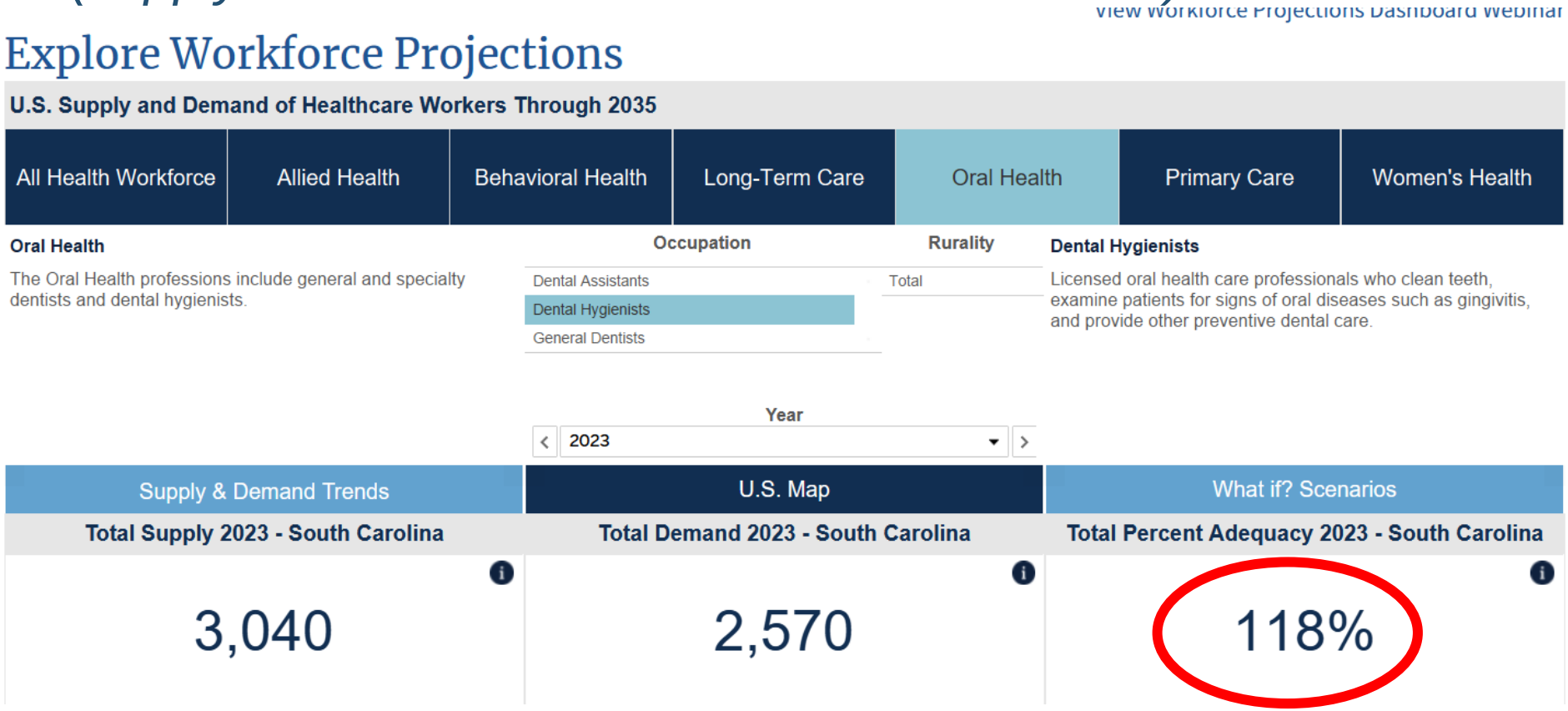


	2009	2011	2013	2015	2017	2019	2021*	2023*
Dental Hygienists	2,224	2,381	2,492	2,551	2,665	2,760	2,926	3,055
Dentists	1,966	2,069	2,170	2,205	2,312	2,462		
Dental Assistants	3,530	3,470	3,440	3,570	4,400	5,020	4,980	

Source: SC Office for Healthcare Workforce, SC AHEC, with data collected from LLR and obtained from RFA; dental assistant data from the US Bureau of Labor Statistics, https://www.bls.gov/oes/tables.htm, retrieved 4/24/2023.
*Hygienist data for 2021 and 2023 are preliminary and may change after further cleaning and processing.

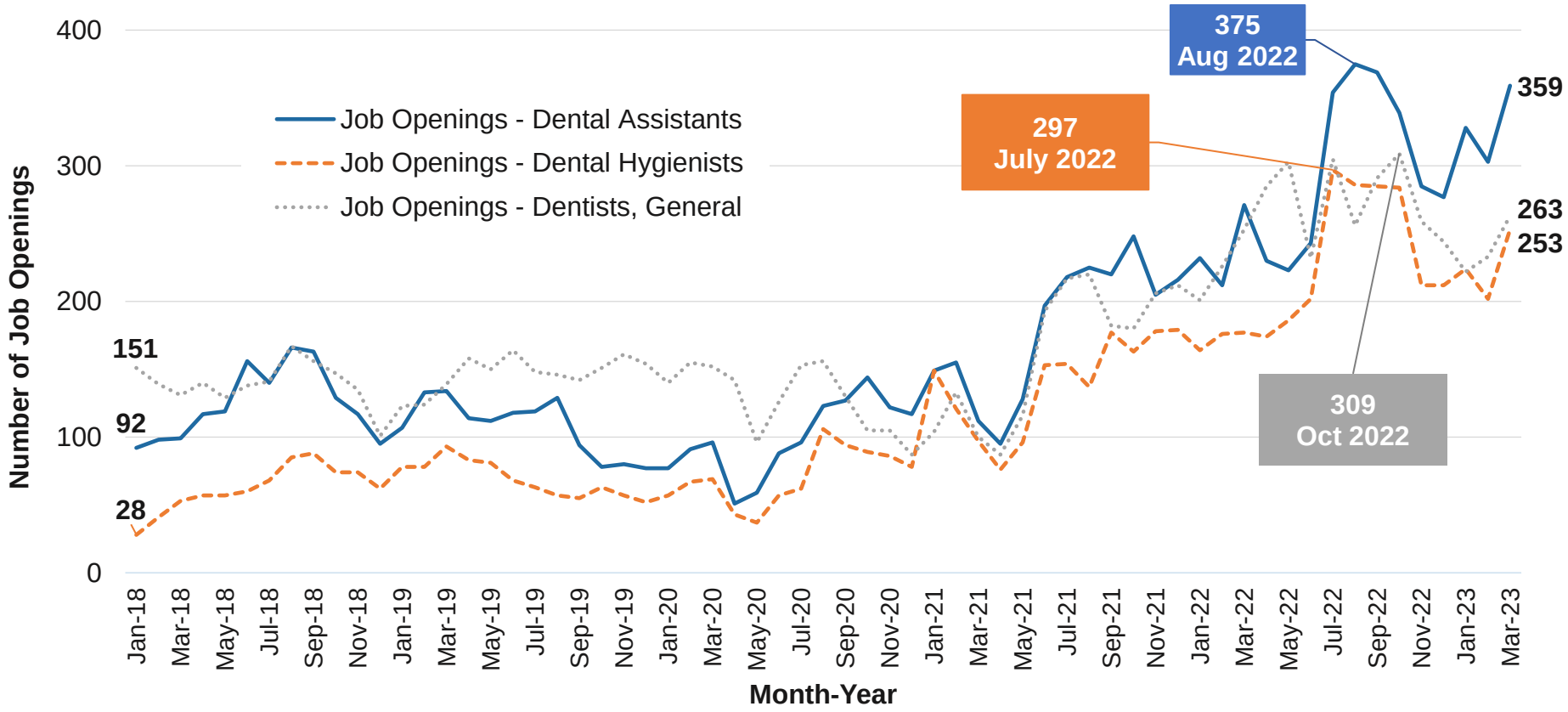
HRSA projects a surplus of dental hygienists in South Carolina

(supply data not available for dental assistants)



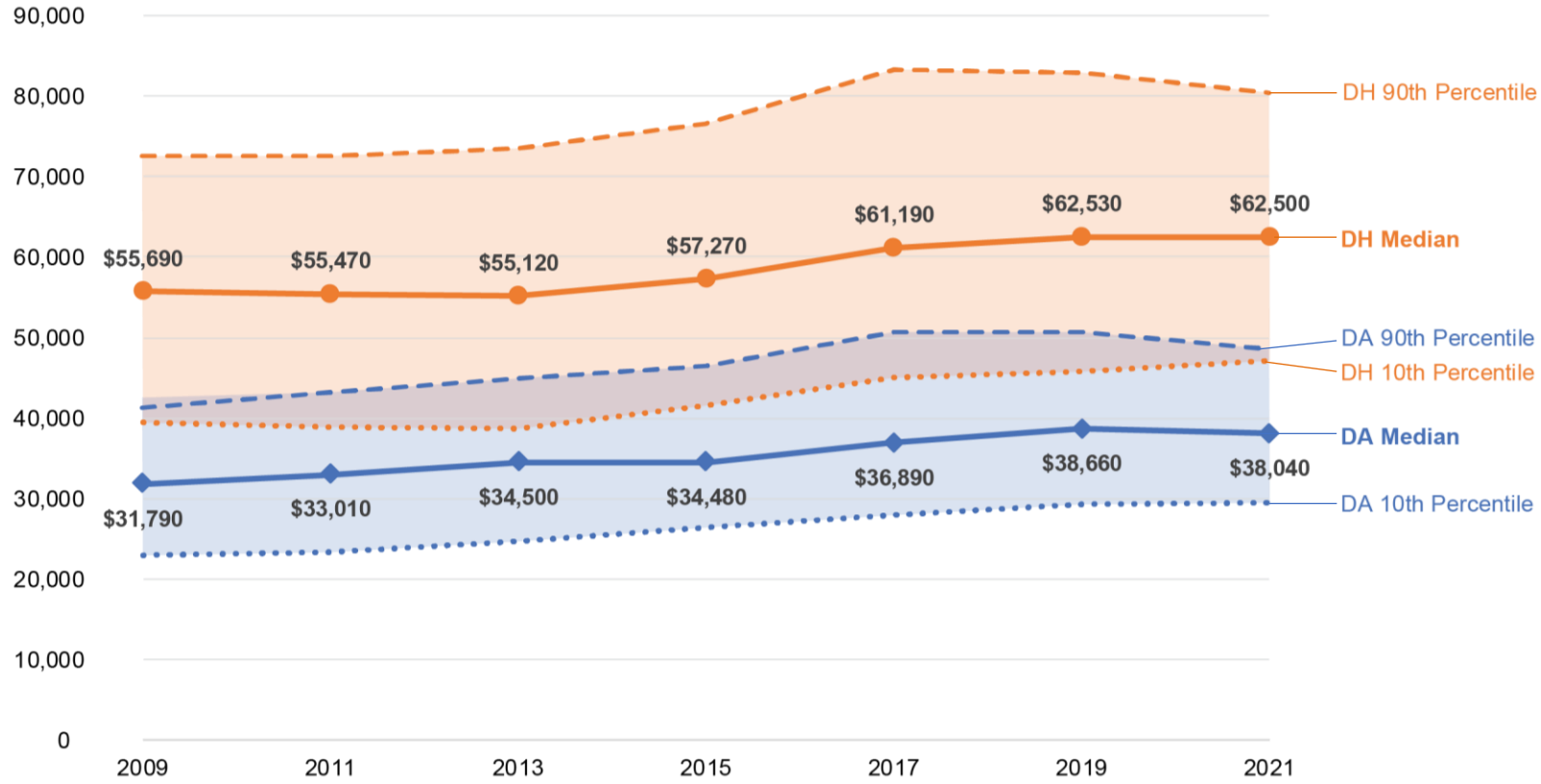
https://data.hrsa.gov/topics/health-orkforce/workforce-projections, retrieved 4/24/2023

Demand: Number of Job Openings for Dental Assistants, Dental Hygienists and General Dentists, South Carolina, January 2018 - March 2023



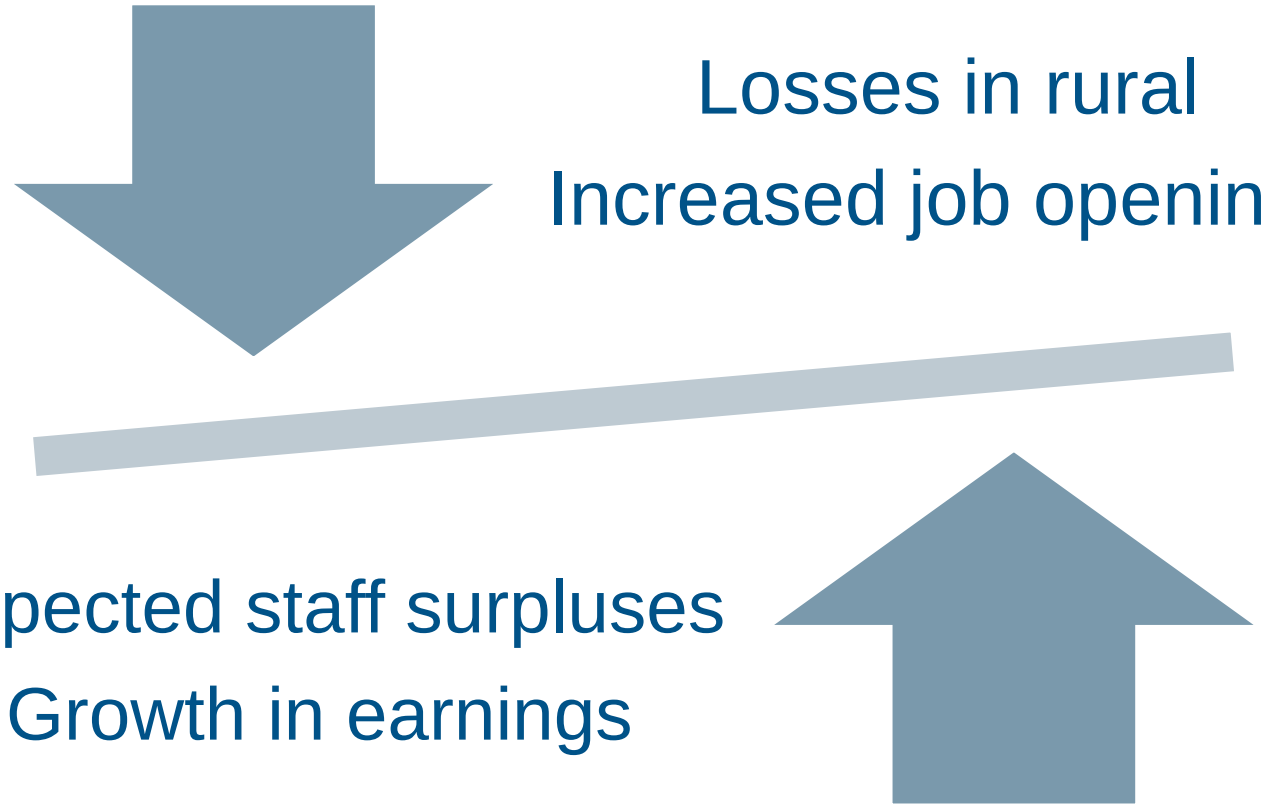
Source: Job Openings by Occupation Trends, SC Works Online Services, South Carolina Department of Employment and Workforce, https://jobs.scworks.org/, retrieved 4/24/2023.

Dental Assistant (DA) and Dental Hygienist (DH) Wages, South Carolina, 2009-2021: 10th Percentile, Median, 90th Percentile



Source: Bureau of Labor Statistics, State Occupational Employment and Wage Estimates, https://www.bls.gov/oes/current/oes_sc.htm, retrieved 4/24/2023.

What does this tell us?
How can contradicting indicators be true?



Losses in rural

Increased job openings

Expected staff surpluses

Growth in earnings

Workforce Summit Themes

Recruitment/Pipeline

- Faculty Shortages
- Infrastructure
- COVID & application/tuition impacts
- Competing professions

Retention

- Dental leadership
- DSOs
- Compensation model changes
- Rise in contracted work

PPP Oral Health Workforce Opportunities

1. Existing HRSA Resources

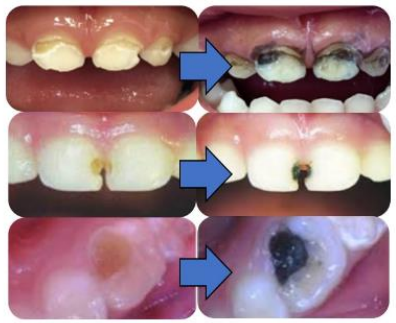
- HRSA Residencies
- HRSA State Oral Health Workforce grants

2. School-based programs

- Grant portfolio package

3. Integrated care models

- SDF in primary care



Before and After SDF Application

New CPT Code Empowers Medical Professionals to Apply Silver Diamine Fluoride (SDF) to Treat Cavities

This is a major milestone in advancing an integrated approach to oral health equity and expanding access to person-centered care.

October 17, 2022 12:12 PM Eastern Daylight Time

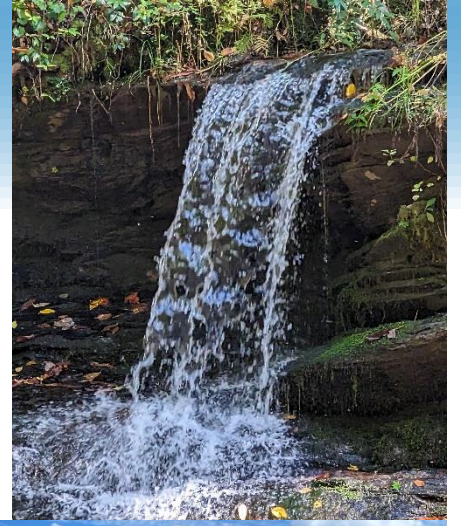
Oral Health Equity – National Call to Action

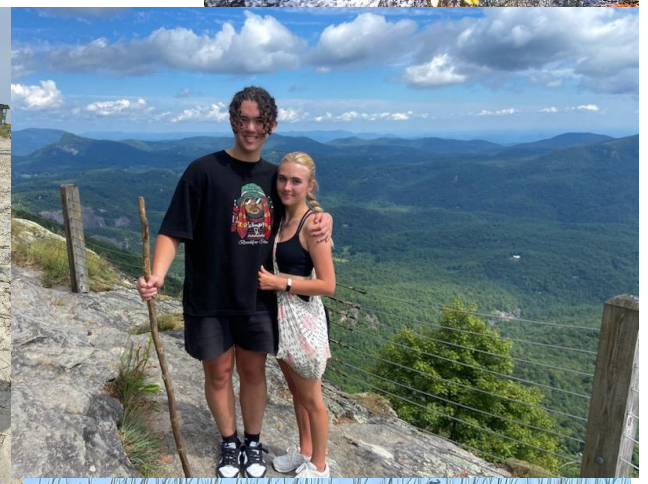
1. Improved availability of care & proven public health interventions, e.g. community water fluoridation
2. Care integration
3. New Training Initiatives
4. Implement teledentistry
5. Expand access to dental insurance
6. Offer school-based oral health services
7. *Create new categories of dental practitioners
8. Encourage dentists to locate in rural areas

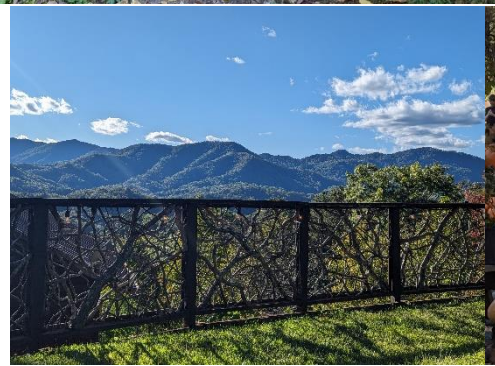
*Alternatives exist to this approach as it is not feasible in all states. Examples in other states include alternative hygiene supervision approaches (e.g. SC, PA, NV)

Thank you!

Bringing smiles from the mountains to the sea!







Oral Health Workforce

Q&A Session

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
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Elder Care Workforce

Alana Knudson
Director
NORC Walsh Center for Rural Health Analysis

Rani Snyder
Vice President of Programs
The John A. Hartford Foundation

Phil Lewis
Senior Program Officer
Healthy Aging Michigan Health Endowment Fund

Rural Elder Workforce

Rural Health Philanthropy Partnership

October 26, 2023

Alana Knudson, PhD

NORC Walsh Center FOR RURAL HEALTH ANALYSIS

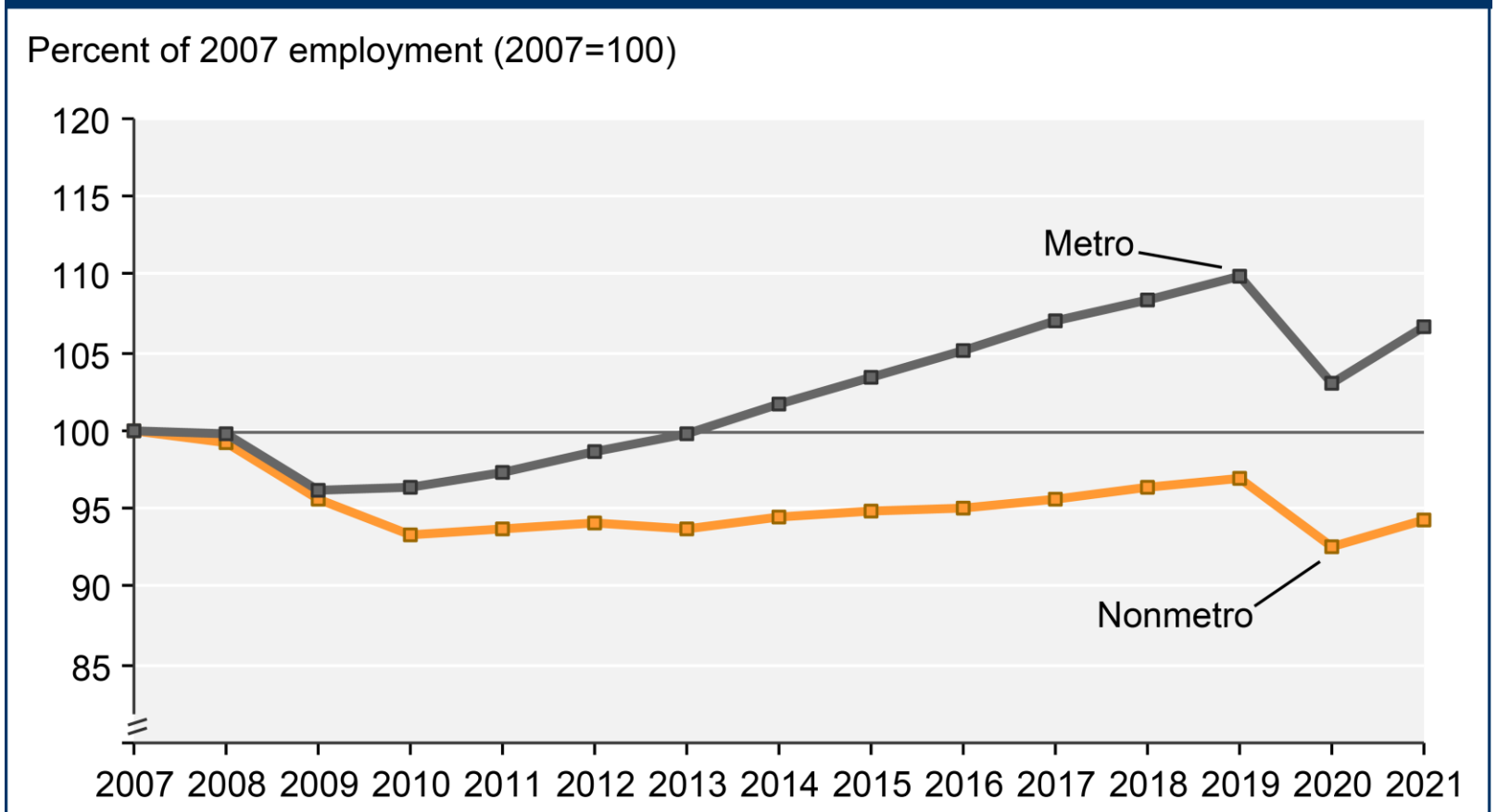
RURAL HEALTH EQUITY RESEARCH CENTER

WHY SHOULD RURAL AREAS MATTER TO YOU?

Rural areas are not only the source of much of our food, drinking water, energy production, and outdoor recreation, one in five Americans—including a disproportionate number of veterans and active-duty service members—live there, making the study of the health needs and challenges of rural Americans essential to us all.

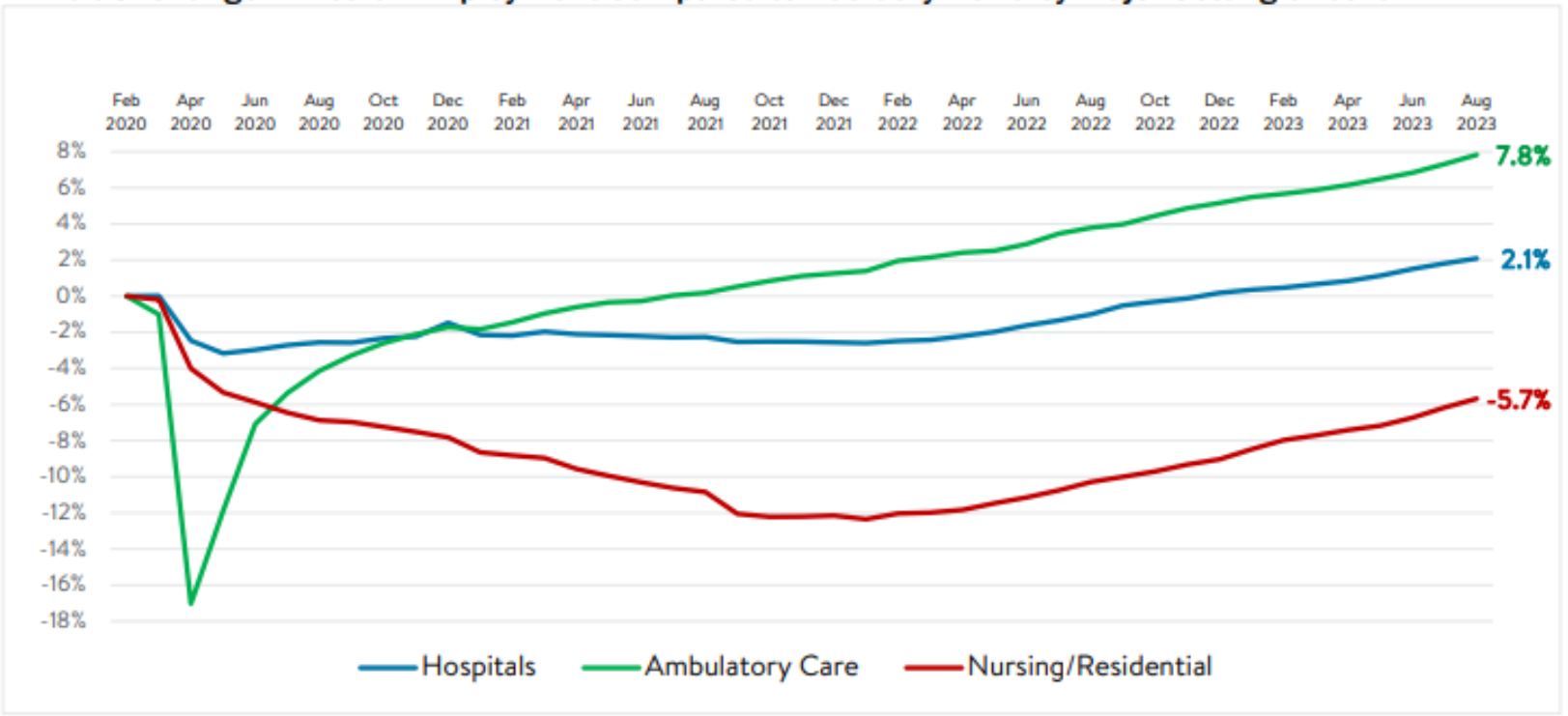
NORC Walsh Center for Rural Health Analysis

U.S. employment in metro and nonmetro areas, 2007–21



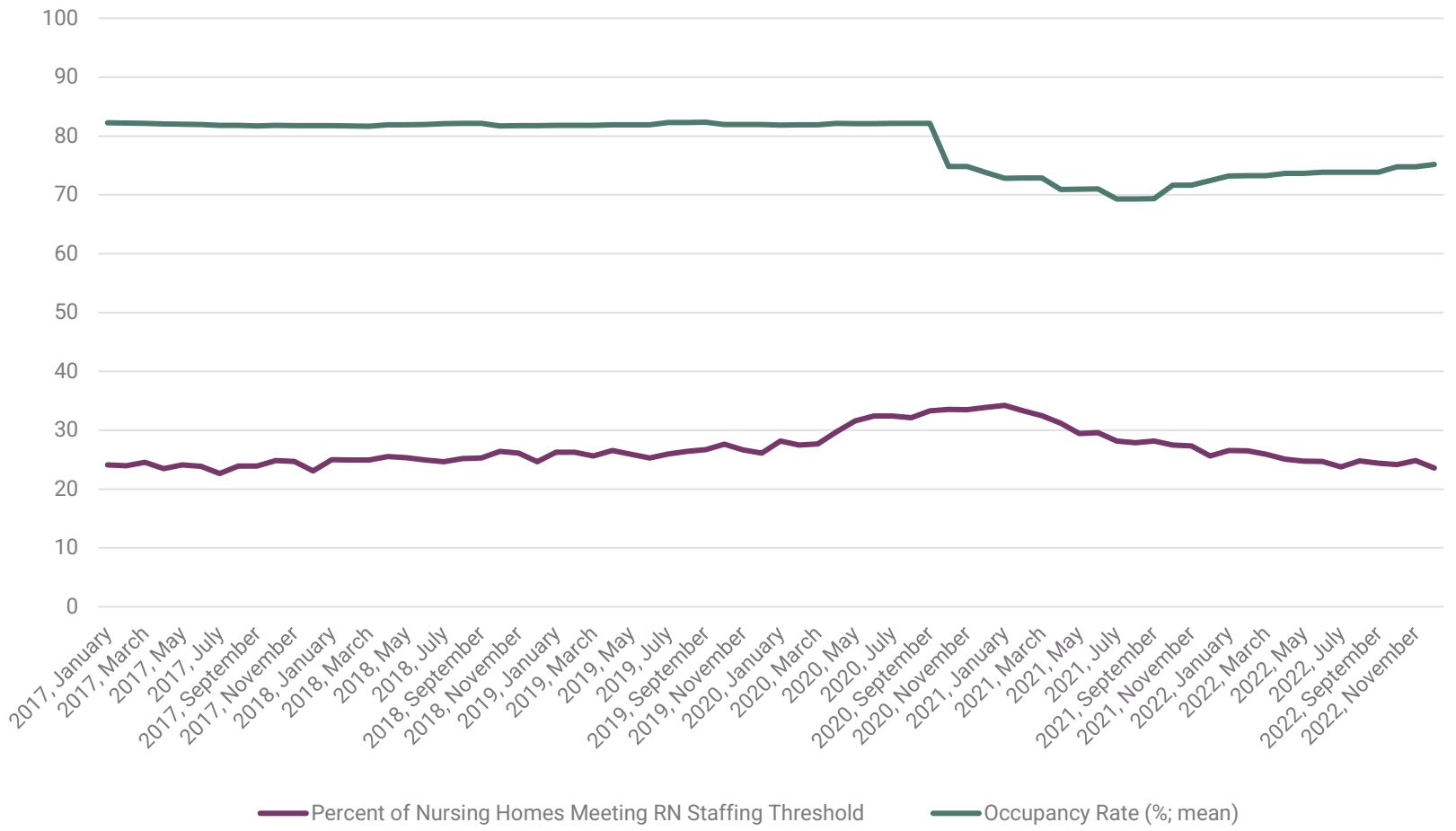
Note: Annual average total employment estimates for 2021 are calculated using preliminary December 2021 data. Metro and nonmetro designations are based on the 2013 definition of metropolitan counties, as determined by the U.S. Office of Management and Budget.
Source: USDA, Economic Research Service using data from the U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics program (March 2, 2022 release).

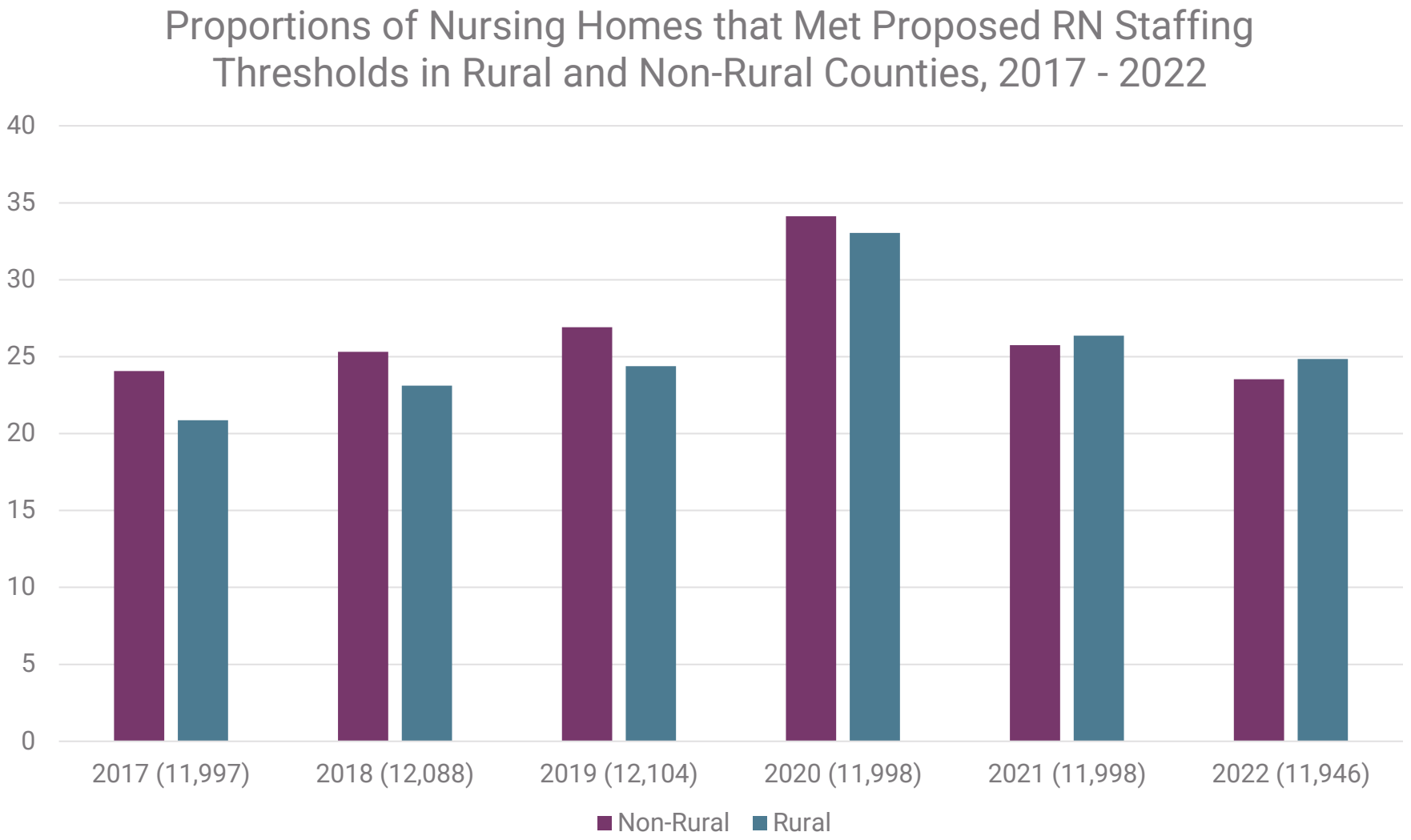
Exhibit 3. Change in Health Employment Compared to February 2020 by Major Setting of Care



Source: Altarum analysis of monthly BLS Current Employment Statistics data.

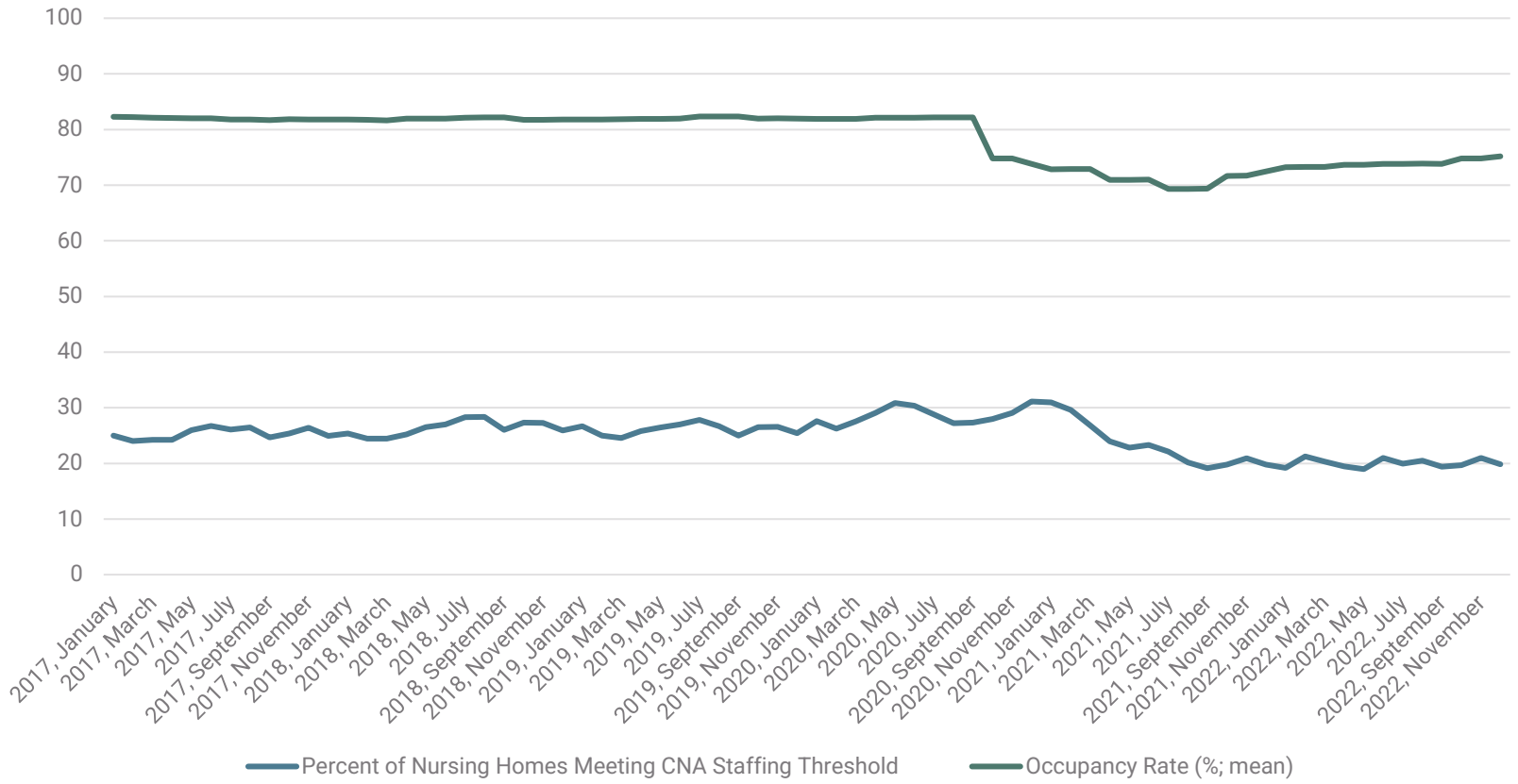
Percent of Nursing Homes Meeting Proposed RN Threshold with Occupancy Rate, 2017-2022

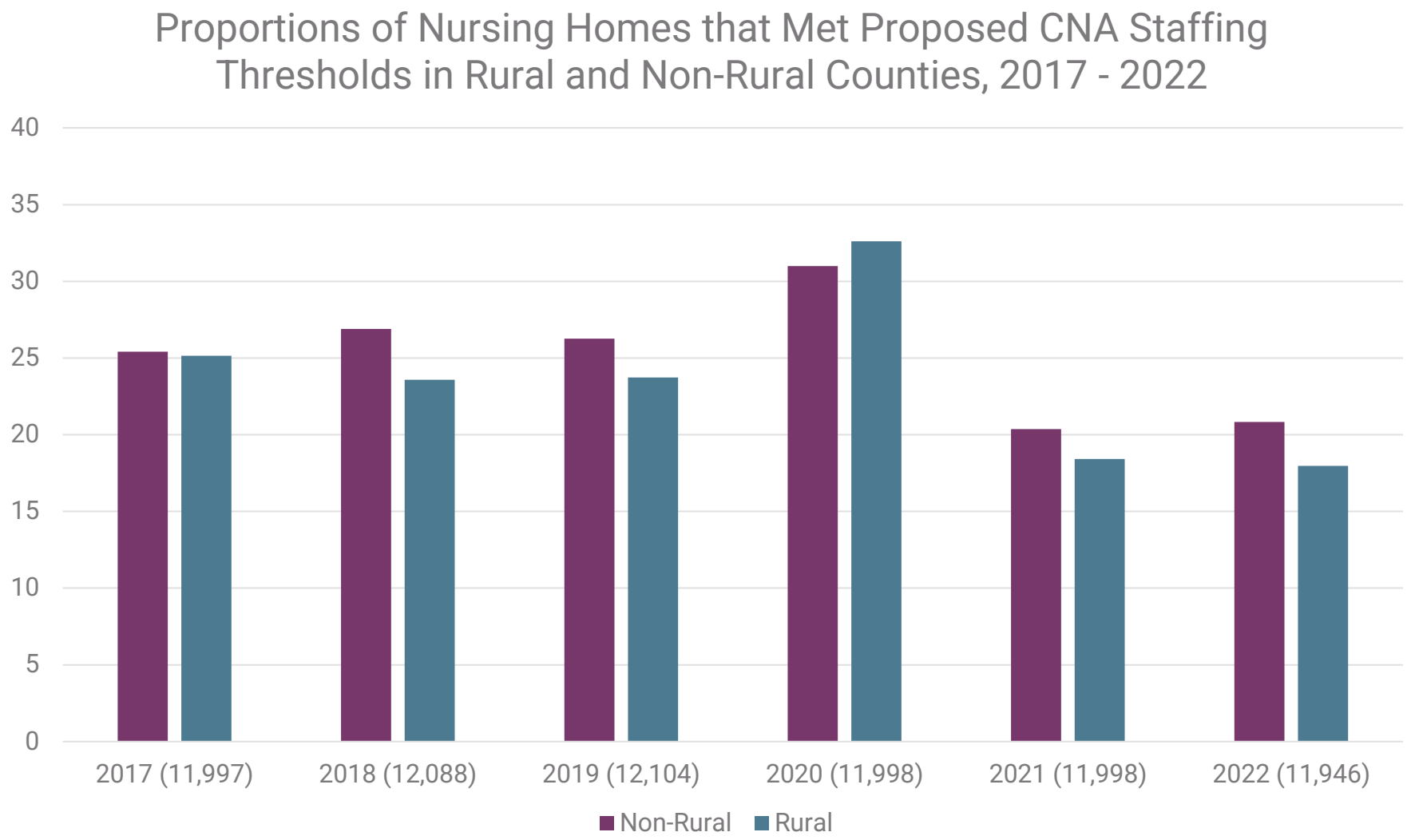




Data source: Payroll Based Journal (PBJ) nurse staffing files, data.cms.gov

Percent of Nursing Homes Meeting Proposed CNA Threshold with Occupancy Rate, 2017-2022

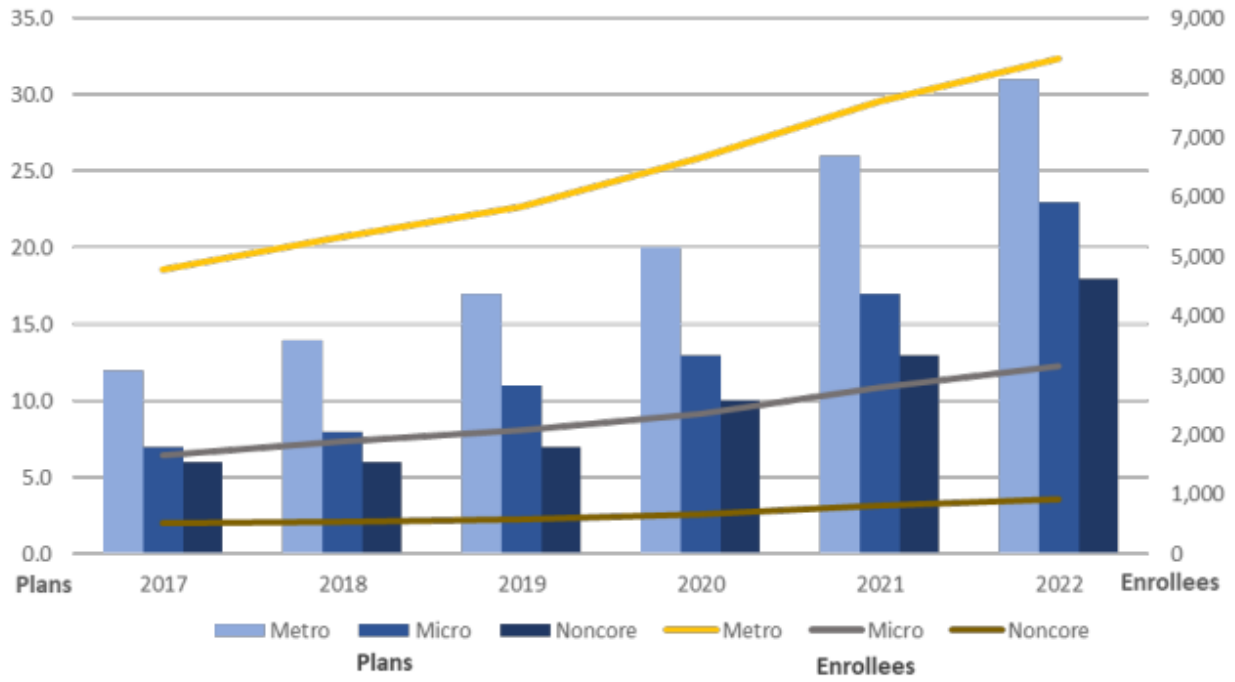




Data source: Payroll Based Journal (PBJ) nurse staffing files, data.cms.gov

Medicare Advantage Penetration by Rural/Urban 2017-2022

Figure 1. Median Number of MA Plans and Enrollees by County, 2017-2022



Note: bars correspond to plans; lines correspond to enrollment

Source: RUPRI Center for Rural Health Policy Analysis, https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Distribution_analysis_of_MA_Enrollment.pdf

What are we hearing…

- **Turnover at all levels**
  - Recruitment and retention
    - Wages and compensation
  - Leadership training needed
    - Create a culture of caring
- **Quality concerns**
- **Older adult needs**
  - Behavioral health
  - Higher levels of acuity, increasing medical complexity managed at home
  - Housing
  - Telehealth literacy and support
    - Remote patient monitoring


Resources

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IN THIS TOOLKIT

Modules

1: Introduction
2: Program Models
3: Program Clearinghouse
4: Implementation
5: Evaluation
6: Funding & Sustainability
7: Dissemination
About This Toolkit

For More Information

Community Supports for Rural Aging in Place and Independent Living
This topic guide offers the

Rural Health > Tools for Success > Evidence-based Toolkits

Rural Aging in Place Toolkit

Welcome to the Rural Aging in Place Toolkit. The toolkit compiles evidence-based and promising models and resources to support organizations implementing aging in place in rural communities across the United States.

The modules in the toolkit contain resources and information focused on developing, implementing, evaluating, and sustaining rural aging in place programs. There are more resources on general community health strategies available in the Rural Community Health Toolkit.

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IN THIS TOOLKIT

Modules

1: Introduction

2: Program Models

3: Program Clearinghouse

4: Implementation

5: Evaluation

6: Sustainability

7: Dissemination

About This Toolkit

- Housing
- Legal Assistance
- Telehealth/Home Health
- Caregivers and Caregiver Well-Being
- Transportation Programs
- Community Integration
- Community Supports
- Designing Age-Friendly Communities

Rural Community Health Toolkit

Start here for a guide to building rural community health programs to address any type of health issue. Learn how to identify community needs, find evidence-based models, plan and implement your program, evaluate results, and much more.

Aging in Place Toolkit

Explore program models and approaches to support rural aging in place.

Care Coordination Toolkit

Find models and program examples for delivering high-quality care across different rural healthcare settings.

Chronic Obstructive Pulmonary Disease Toolkit

Learn how to develop programs to address COPD in rural communities.

Community Health Workers Toolkit

Learn about roles community health workers (CHWs) fill, as well as CHW training approaches.

Community Paramedicine Toolkit

Discover models and resources for developing community paramedicine programs in rural areas.

Diabetes Prevention and Management Toolkit

Find resources and best practices to develop diabetes prevention and management programs in rural areas.

Early Childhood Health Promotion Toolkit

Learn how to develop early childhood health promotion programs in rural communities.

Emergency Preparedness and Response Toolkit

NEW

Discover strategies, resources, and case studies to support rural emergency planning, response, and recovery.

Health Equity Toolkit

Explore evidence-based frameworks and promising strategies to advance health equity in rural communities.

Health Literacy Toolkit

Discover resources and model programs for improving personal and organizational health literacy in rural communities.

Health Networks and Coalitions Toolkit

Find resources and strategies to help create or expand a rural health network or coalition.

Health Promotion and Disease Prevention Toolkit

Learn about strategies and models for rural health promotion and disease prevention in the community, clinic, and workplace.

HIV/AIDS Prevention and Treatment Toolkit

Explore models and resources for implementing HIV/AIDS prevention and treatment programs in rural communities.

Maternal Health Toolkit

Find resources and models for developing programs to address rural maternal health issues.

Mental Health Toolkit

Discover resources and models to develop rural mental health programs, with a primary focus on adult mental health.

Medication for Opioid Use Disorder Toolkit

Learn about models and resources for implementing medication for opioid use disorder programs in rural communities.

Obesity Prevention Toolkit

Find out how rural communities, schools, and healthcare providers can develop programs to help address obesity.

Oral Health Toolkit

Discover rural oral health approaches that focus on workforce, access, outreach, schools, and more.

Philanthropy Toolkit

Find emerging practices and resources for building successful relationships with philanthropies.

Prevention and Treatment of Substance Use Disorders Toolkit

Learn about models and resources for developing substance use disorder prevention and treatment programs in rural communities.

Services Integration Toolkit

Learn how rural communities can integrate health and human services to increase care coordination, improve health outcomes, and reduce healthcare costs.

Social Determinants of Health Toolkit

Discover evidence-based models and resources to address social determinants of health in rural communities.

Suicide Prevention Toolkit

Find evidence-based models and resources for implementing a suicide prevention program in rural areas.

Telehealth Toolkit

Discover program examples and resources for developing a telehealth program to address access issues in rural America.

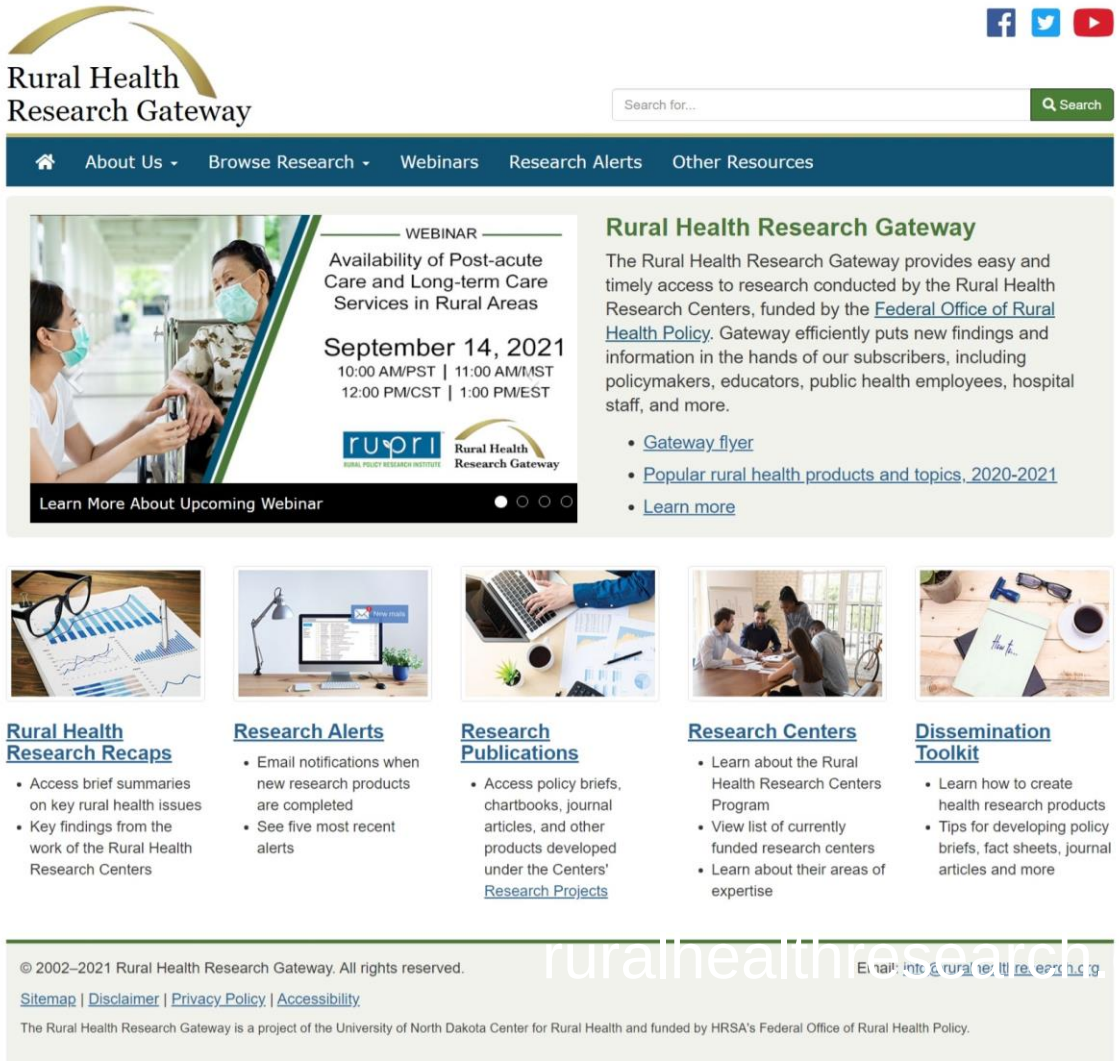
Tobacco Control and Prevention Toolkit

Explore program examples and resources for implementing tobacco control and prevention programs in rural areas.

Transportation Toolkit

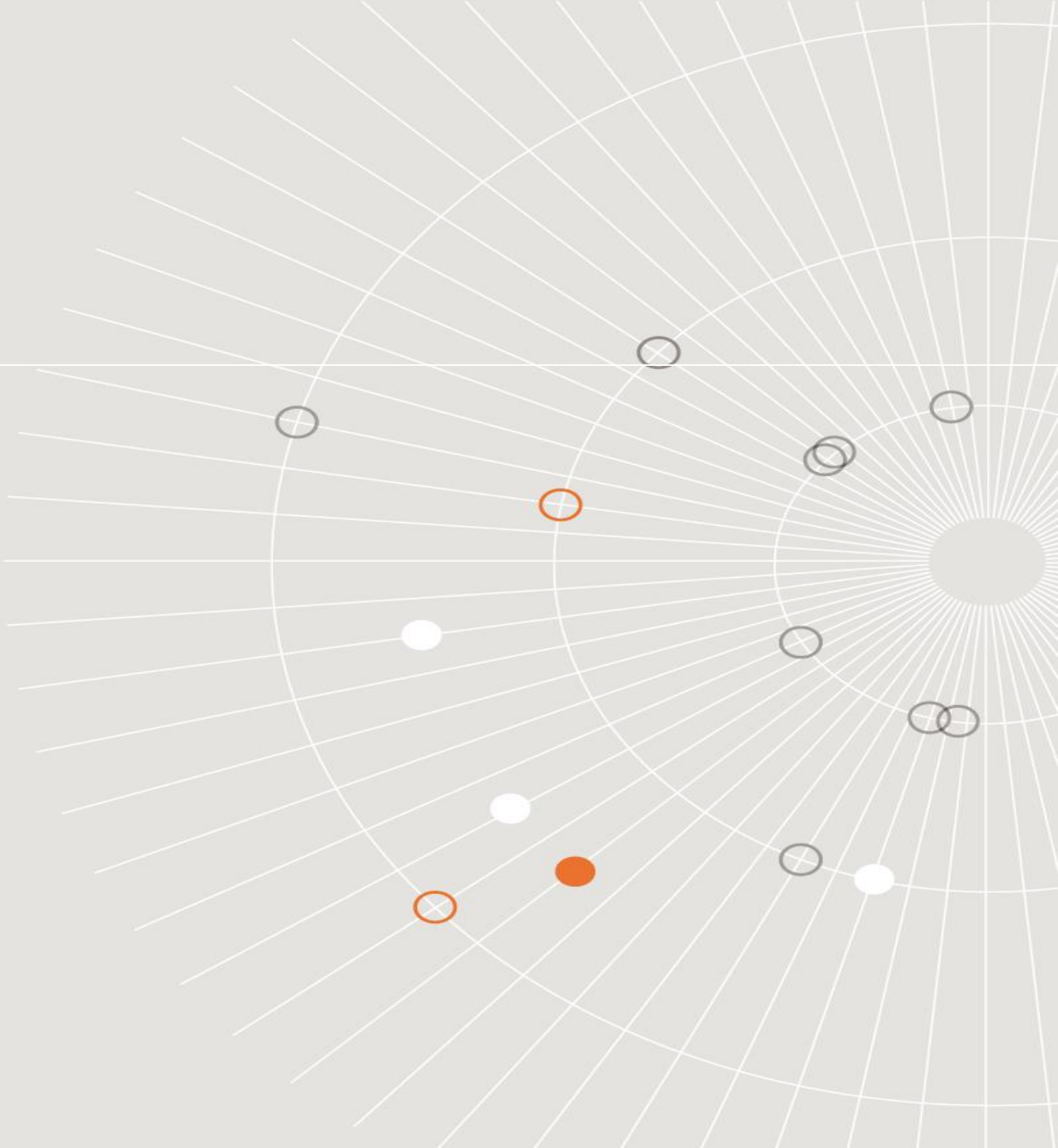
Explore how communities can provide transportation services to help rural residents maintain their health and well-being.

nosorh.org/rural-health-capital-resources-council-project/



RURAL HEALTH EQUITY RESEARCH CENTER

Questions?



Thank you!

Alana Knudson, PhD
Knudson-Alana@norc.org
(301)-908-0835

Research You Can Trust™

RURAL HEALTH EQUITY RESEARCH CENTER

NORC Walsh Center FOR RURAL HEALTH ANALYSIS

The John A. Hartford Foundation

Public-Private Collaborations in Rural Health
Annual Meeting of the Rural Health Philanthropy Partnership:
Eldercare Workforce

Thursday, October 26, 2023

Rani E. Snyder, MPA

Vice President, Program

The John A. Hartford Foundation

The John A. Hartford Foundation

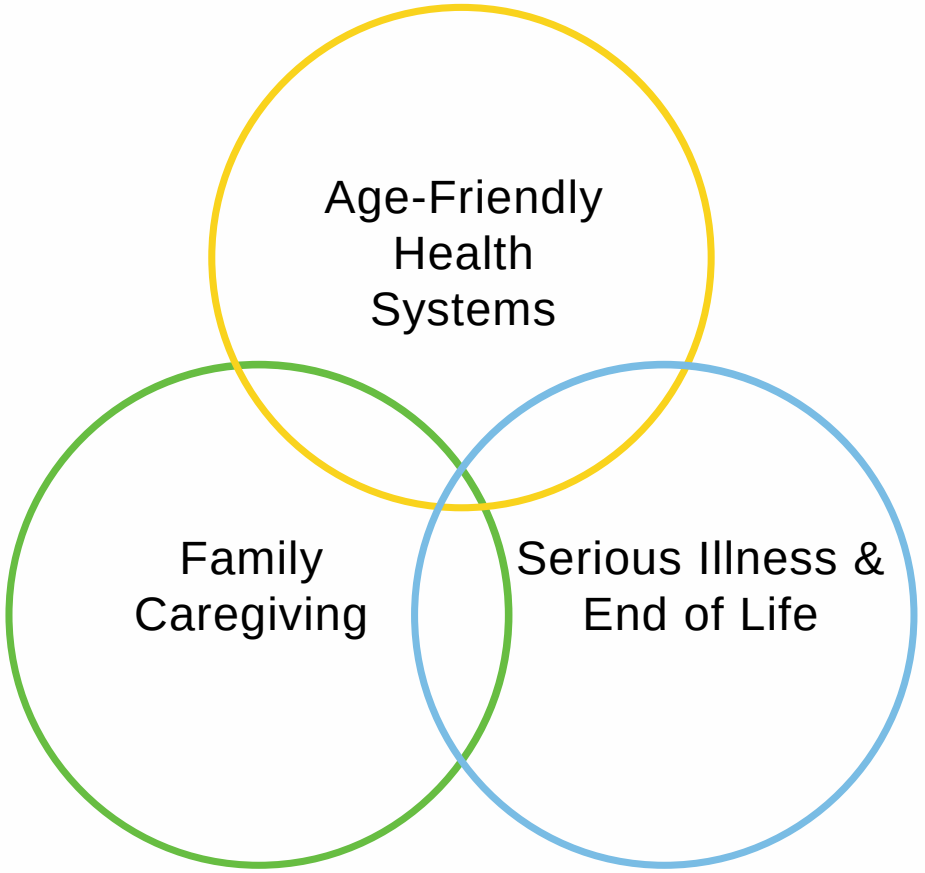
A private philanthropy based in New York City, established by family owners of the A&P grocery chain in 1929

DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

Mission

DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

PRIORITY AREAS

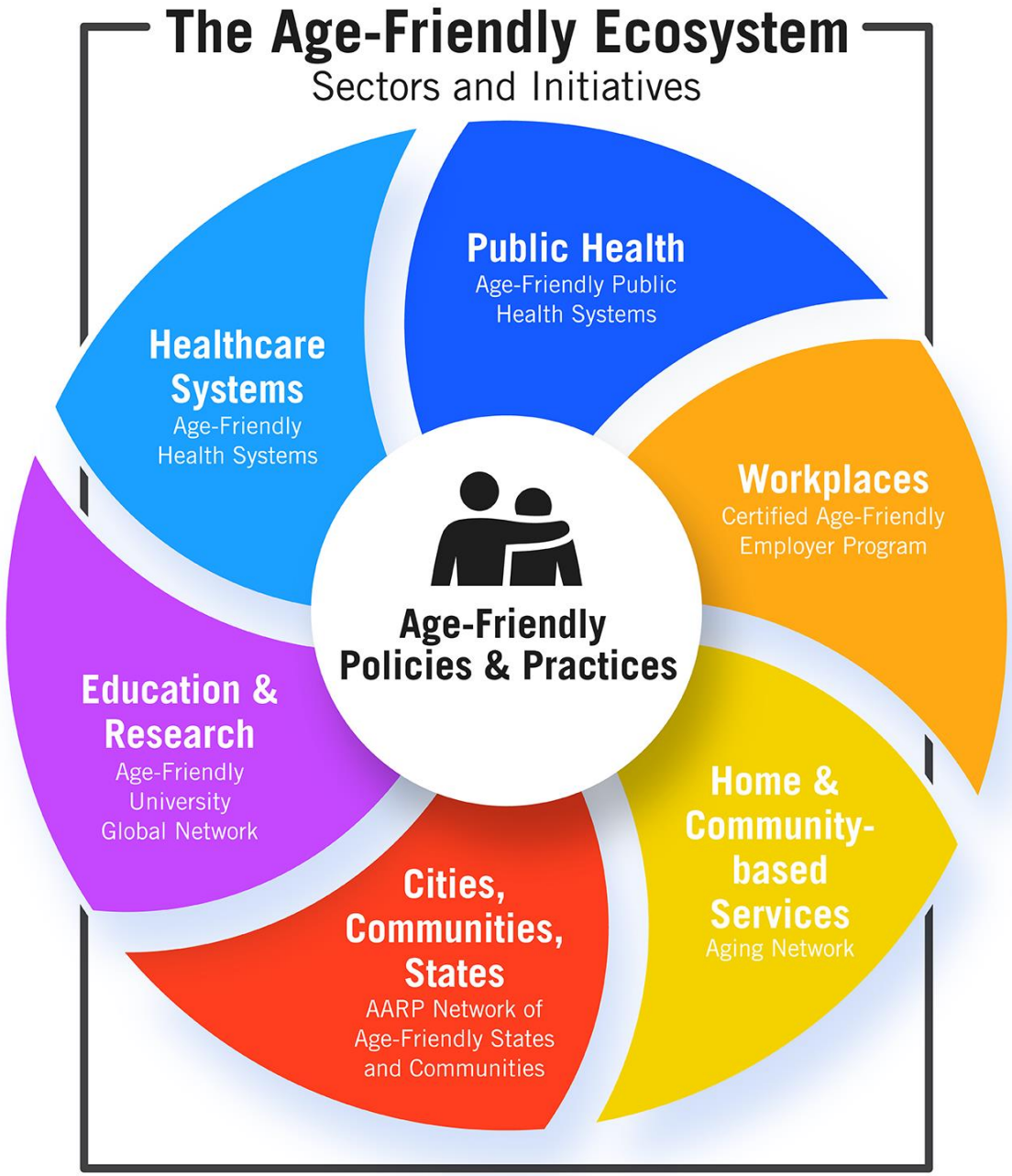


Objectives

- Share a brief overview of the Age-Friendly Health Systems movement
- Experience of rural Age-Friendly Health Systems
- Examples of social determinants that affect rural older adults
- Key takeaways for health systems across the Age-Friendly Ecosystem

We All Need an Age-Friendly Society

- Longevity is greatest success story of last century
- As we age, we can make vital contributions and power up communities – with support
- A just society requires us to make all sectors **age-friendly**



Age-Friendly Health Systems

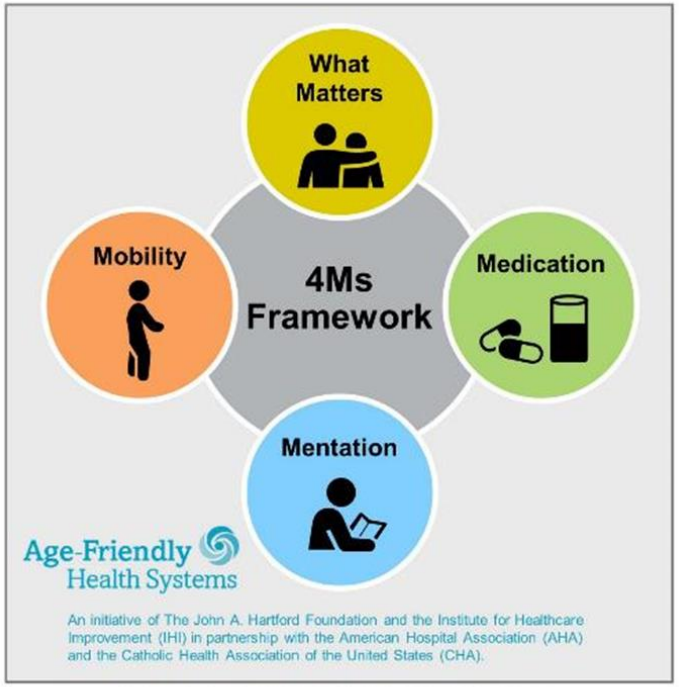
Build a movement so **all care** with older adults is **age-friendly care**:

- Guided by an essential set of evidence-based practices (4Ms)
- Causes no harms
- Is consistent with What Matters to the older adult and their family

The 4Ms of Age-Friendly Care

The John A. Hartford Foundation

- Represents core health issues for older adults
- Builds on strong evidence base
- Simplifies implementation and measurement, increase effect
- Components are synergistic and reinforcing



What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

IHI.org/agefriendly

Two Levels of Recognition from IHI

3,402

Hospitals, practices, convenient care clinics and nursing homes have described how they are putting the 4Ms into practices

2,000*

Hospitals, practices, convenient care clinics, and nursing homes have shared the count of older adults reached with 4Ms care for at least three months

**Age-Friendly Health System-Participants* count is inclusive of hospitals and practices that went on to be recognized as *Age-Friendly Health Systems-Committed to Care Excellence*

The John A. Hartford Foundation

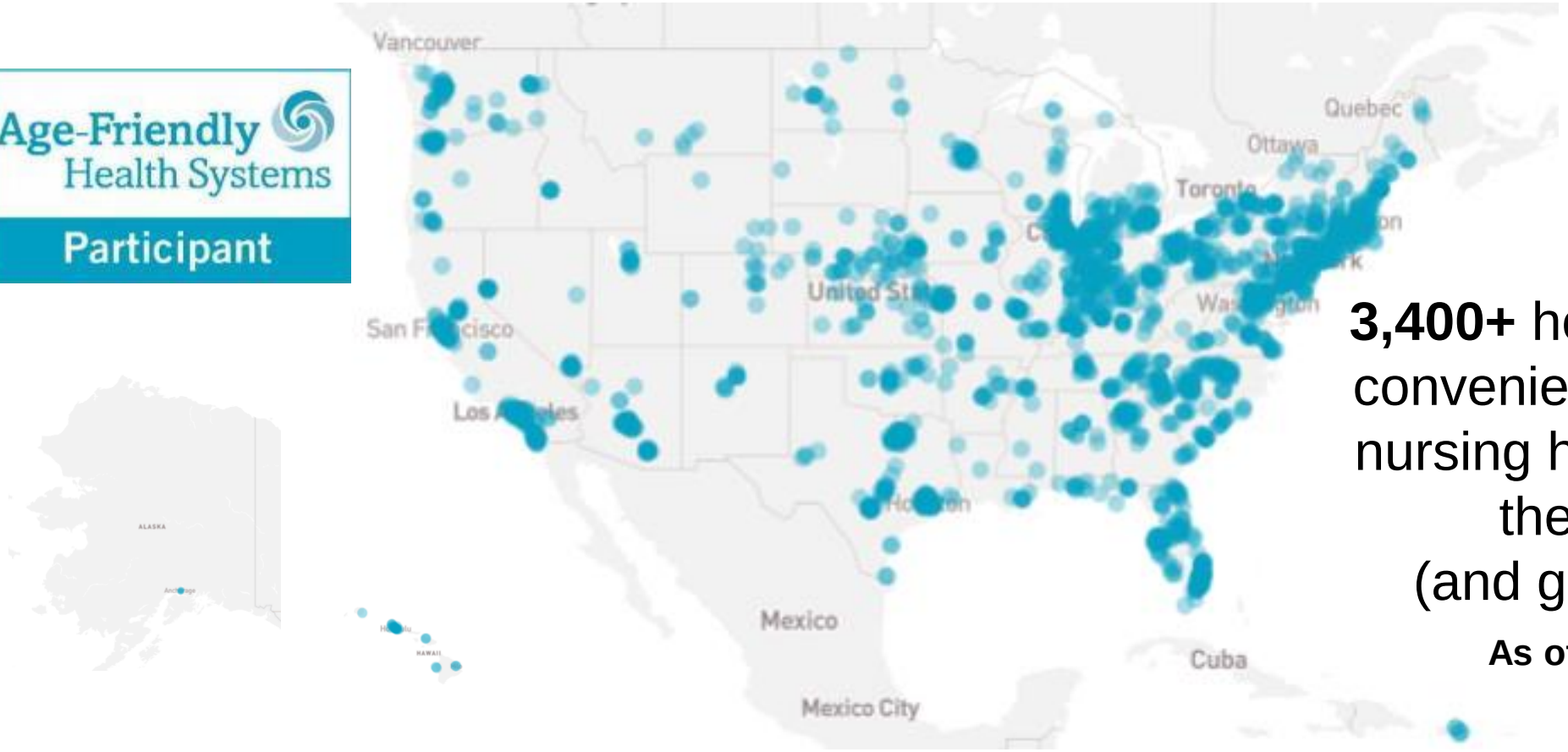
More than 2,710,000 older adults have been reached with 4Ms care.

As of September 2023

A Growing Movement!

The John A. Hartford Foundation

Age-Friendly Health Systems
Participant

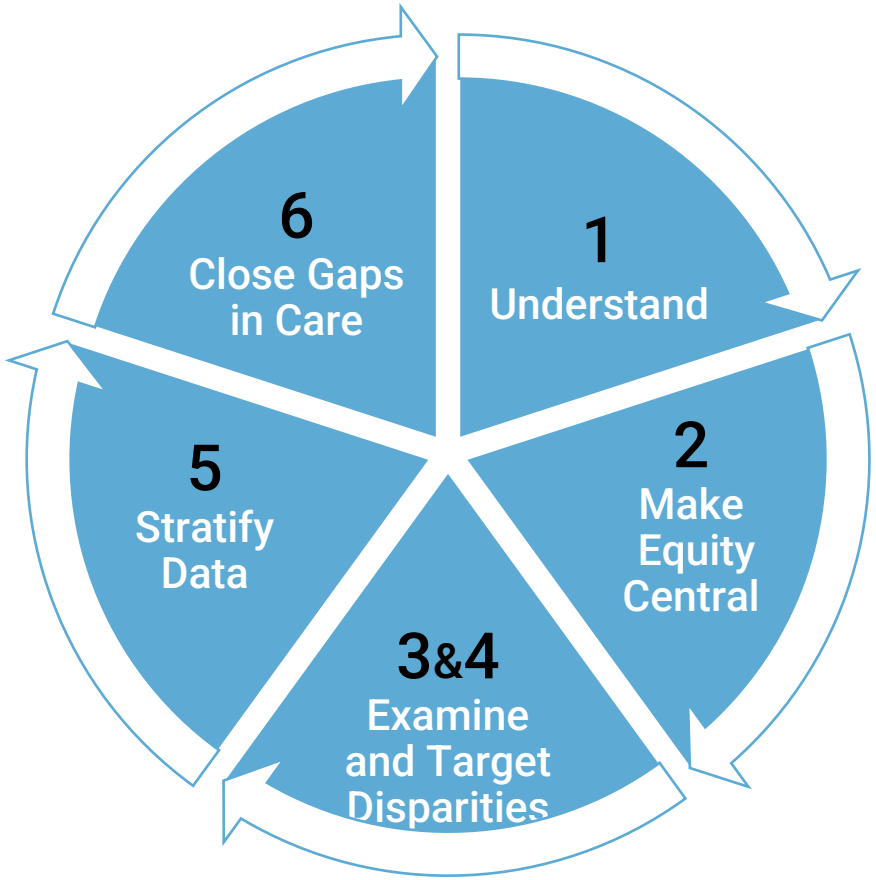


3,400+ hospitals, practices, convenient care clinics and nursing homes have joined the movement!
(and growing globally)

As of September 2023

http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/Background.aspx

Movement is Focused on Health Equity



Read: Ensuring Equitable Age-Friendly Care; Incorporating Health Equity Into An Initiative to Transform Care for Older Adults; Health Equity in an Age-Friendly Health System: Identifying Potential Care Gaps

Step 1: Understand

Understand current work underway in your system regarding equity and how older adults are represented in that work.

Step 2: Make Equity Central

Ensure equity is a central to your AFHS journey, specifically in your aim and 4Ms Care Description.

Steps 3&4: Examine and Target Disparities

Examine workflows and test change ideas that address known disparities in care and align with the diverse cultures.

Step 5: Stratify Data

Stratify your Age-Friendly Health Systems measures to understand any disparities in process or outcome measures.

Step 6: Close Gaps in Care

Eliminate disparities while sustaining care consistent with the 4Ms.

The John A. Hartford Foundation

Experience of Rural Age-Friendly Health Systems

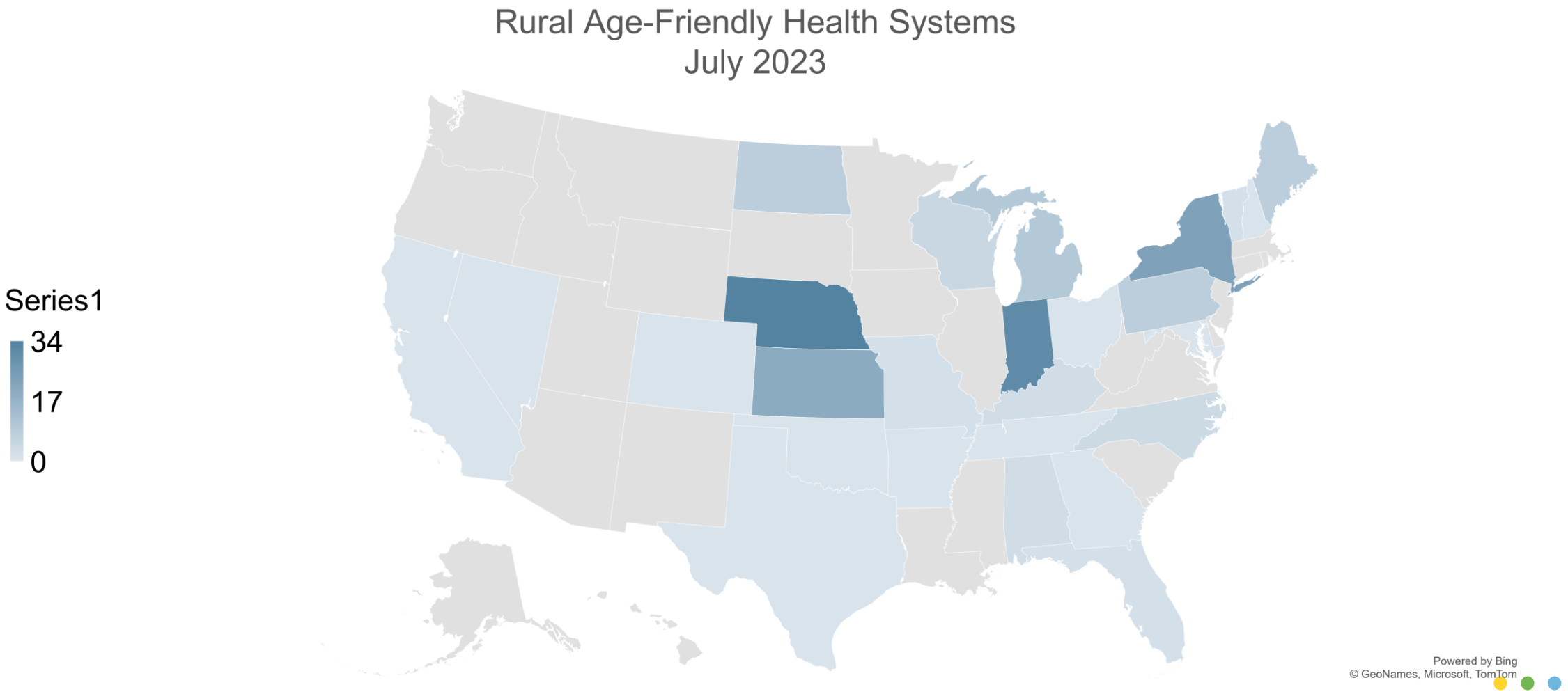
Number of Rural Sites

The John A. Hartford Foundation

- **179 total**
- **70** Inpatient
- **43** Nursing Homes
- **54** Outpatient
- **1** Convenient Care Clinic

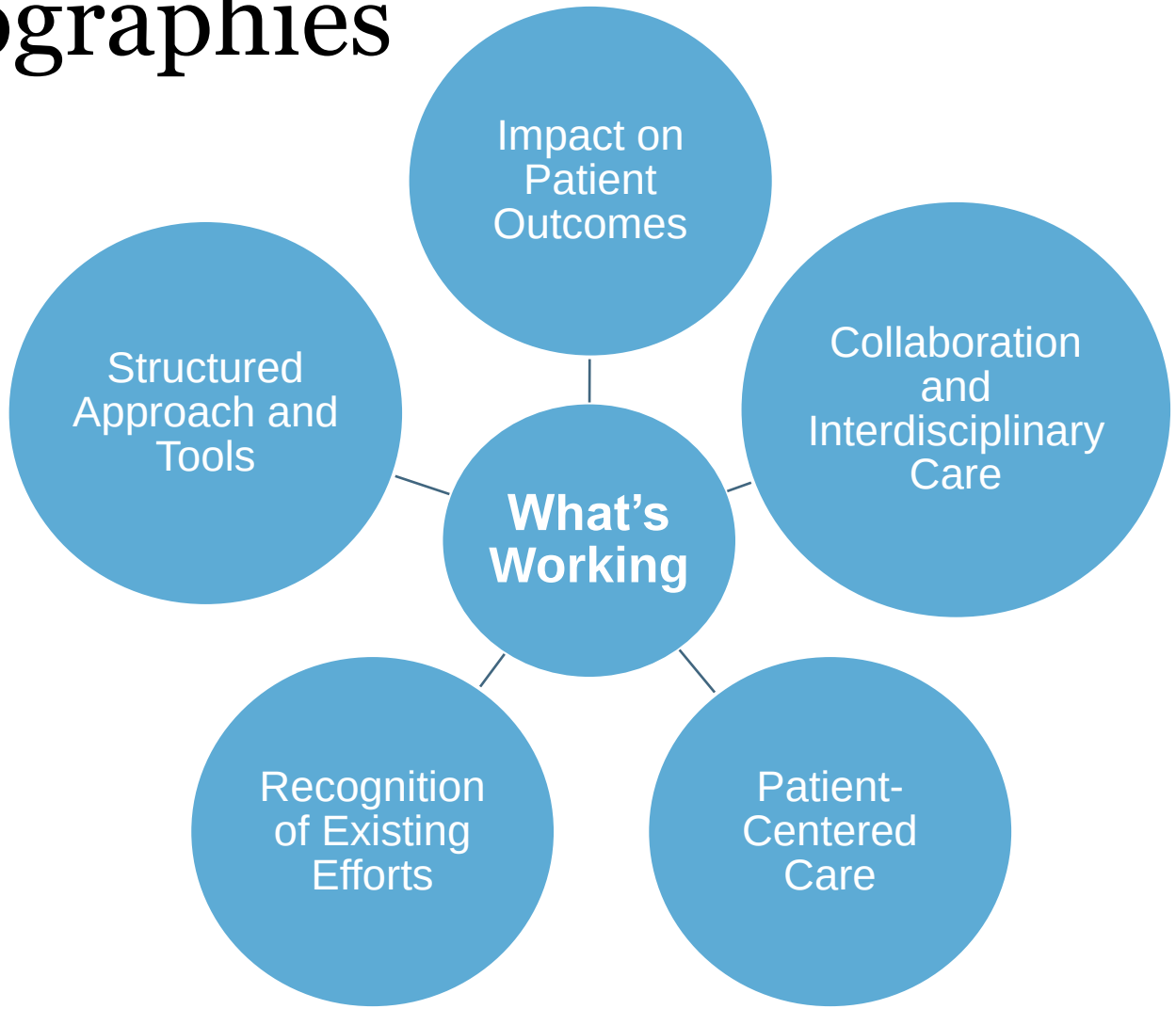
Where They Are

The John A. Hartford Foundation



Key Themes for Health Systems in Rural Geographies

The John A. Hartford Foundation



Source: Data from 185 health systems between January 2020 – September 2023

Key Themes for Health Systems in Rural Geographies

The John A. Hartford Foundation

Source: Data from 185 health systems between January 2020 – September 2023

Bassett Health, New York

Bassett Healthcare Network

The John A. Hartford Foundation

Recognized as an Age-Friendly Health System Participant in 2022

Positive Impacts:

- De-siloed work, increased collaboration
- Active Age-Friendly Core Team for communicating with staff
- Easier to implement in a culture where “It feels like family: family caring for family; neighbors caring for neighbors”
- PFAC includes older adults with lived experience

Challenges & Areas for Improvement:

- Resources: Financially, staff
- Impact of travel nurses
- Messaging and communicating with staff
- Community partnerships
- Impact of the geography

Supported by the Healthcare Association of New York State (HANYS)

Community Hospital, Nebraska

Recognized as Committed to Care Excellence in October 2022

Positive Impacts:

- Collaboration across the interdisciplinary team
- Innovation and proactive in their approach

Challenges & Areas for Improvement:

- Interdisciplinary collaboration can be challenging
- Meeting the standards of Age-Friendly Health Systems

Supported by the Nebraska Hospital Association (NHA) and national Action Communities

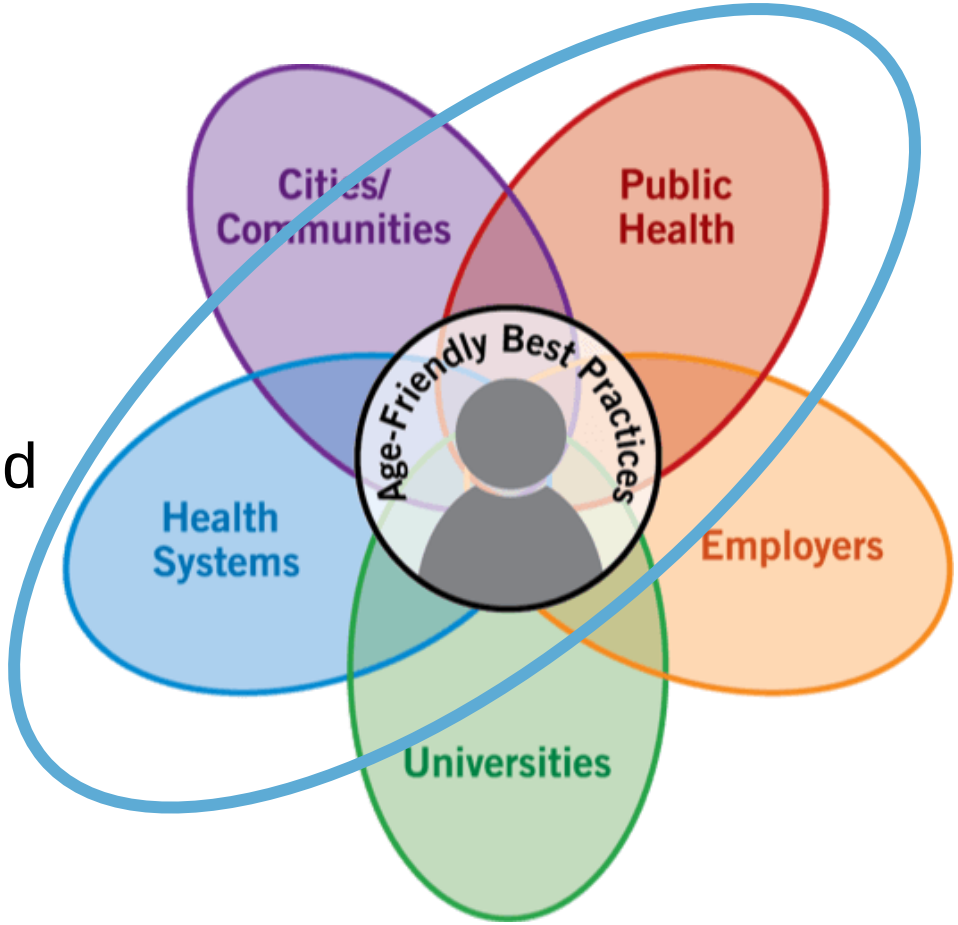
The John A. Hartford Foundation

Examples of social determinants that affect rural older adults

Three Keys to Cross-Sector Age-Friendly Care

The John A. Hartford Foundation

- Published March 2023
- Developed by Trust for America's Health, Institute for Healthcare Improvement & Michigan Health Association
- Funded by Michigan Health Endowment Fund



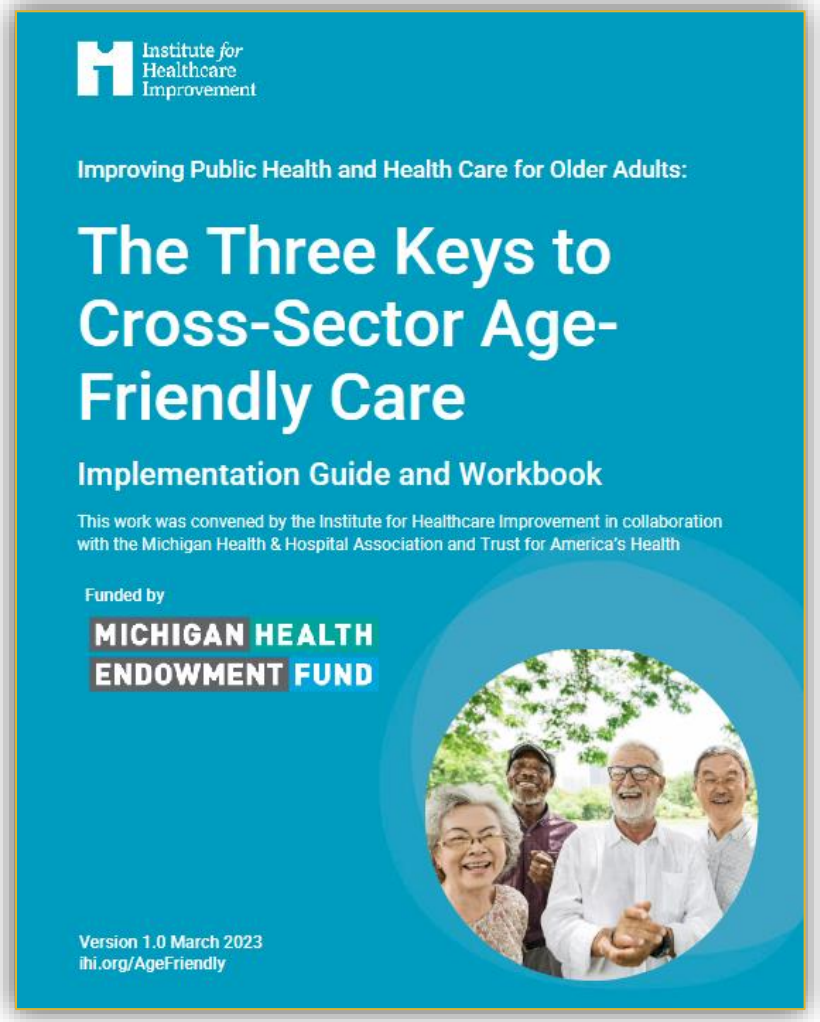
Age-Friendly Health Systems

Age-Friendly PUBLIC HEALTH SYSTEMS

Implementation Guide

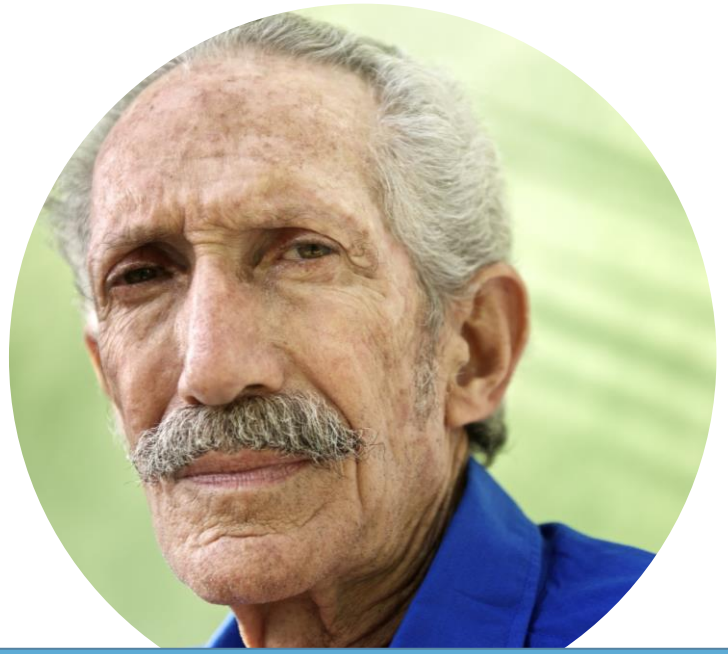
Three Keys:

1. What Matters
2. Supportive System Structures
3. Financial Structures & Policy Landscape



Example: Care Journey Map Set 1

"I live in a **rural community**, identify as **Latinx or Hispanic**, I have **diabetes** and **other chronic health conditions**, and I am **75** years old. **What Matters to me** is to live in my home with my family and caregivers nearby."



"I want my dad to be heard and seen by the health care system for his whole self."

- Older adult's caregiver

The John A. Hartford Foundation

Key Takeaways for Health Systems across the Ecosystem

Challenges

- Older adults lack access and affordability to **technology**
- **Public health professionals** – don't see themselves in this space and understand their roles
- **Housing** – high costs and lack of housing are an issue for workforce too because you cannot recruit if people are unable to find housing
- Lack of **providers and workforce**
- Lack of **support for caregivers**, which impacts care coordination for older adults
- Many rural communities do not have **palliative care**

Solutions

Fund Existing Programs, e.g.:

Statis Health

- Rural initiative that uses community-based approach to start or strengthen palliative care programs
- Started in Minnesota – only palliative care facility in the state
- Rural Community-Based Palliative Care Service Development Framework and toolkit developed

USAging

- Programs are emerging from across rural communities
- Trust is key and we must take advantage of existing relationships

Solutions

JAHF's Age-Friendly Community Health Worker Program under development with National Rural Health Association:

- Developing an age-friendly CHW training curriculum
- Facilitating evidence-based modules for rural communities
- Developing implementation plan for intervention pilot project
- Beginning in Texas rural communities


The John A. Hartford Foundation
Thank You!
Rani.Snyder@johnahartford.org
WWW.JOHNAHARTFORD.ORG
Access free resources and Action Communities for any health care setting
ihi.org/agefriendly
Subscribe for more resources on age-friendly care, family caregiving & serious illness care
johnahartford.org/stay-connected
CMS Thank you slide.png

MICHIGAN HEALTH ENDOWMENT FUND

ABOUT THE HEALTH FUND

MISSION

To improve the health of Michigan residents, with special emphasis on the health and wellness of children and seniors, while reducing the cost of health care.

ESTABLISHED	2013, Public Act 4
ANNUAL GIVING	Over $35 million
BEYOND GRANTMAKING	Partnership and collaboration Capacity building for health nonprofits Engaging and informing leaders

MICHIGAN HEALTH ENDOWMENT FUND

OUR FIVE-YEAR GOALS

1. Increase access to services
2. Bridge health equity gaps
3. Advance integrated care
4. Expand role as a thought leader
5. Increase efficacy and cost-effectiveness
6. Strengthen health workforce and nonprofit community

MICHIGAN HEALTH ENDOWMENT FUND

GRANTMAKING OVERVIEW

	GRANT RANGE	CYCLE OPENS	AWARDS
BEHAVIORAL HEALTH	Up to $500,000	Winter	August
NUTRITION & HEALTHY LIFESTYLES	Up to $500,000	Winter	August
HEALTHY AGING	Up to $500,000	Summer	November
COMMUNITY HEALTH IMPACT	Up to $150,000	Rolling	May, November
CAPACITY BUILDING	Up to $150,000	Rolling	May, November
SPECIAL PROJECTS & EMERGING IDEAS	Up to $500,000	Summer, by invitation	November

MICHIGAN HEALTH ENDOWMENT FUND

HEALTHY AGING

PROGRAM PRIORITIES

- Improving the quality of life for older adults with Alzheimer's and related dementias
- Supporting a strong direct care workforce in Michigan
- Improving the health and quality of life for older adults who are victims of abuse, neglect, exploitation, or discrimination
- Increasing respite opportunities for caregivers
- Addressing social determinants of health for older adults
- Improve the health and quality of life for older adults and caregivers living in rural areas across Michigan

MICHIGAN HEALTH ENDOWMENT FUND

HEALTHY AGING

GRANT RANGE Up to $500,000

APPLICATIONS OPEN Summer

Improving the quality and coordination of care and supporting caregivers to improve the health and well-being of older adults.

MICHIGAN HEALTH ENDOWMENT FUND

CROSS-PROGRAM FOCUS AREAS

WORKFORCE

Develop innovative methods, new financing models or policies to improve the quality of care, increase job satisfaction, or reduce turnover rates

- 100+ grants since 2019
- Training, innovative care delivery models, use of technology to improve access, retention, etc.

RURAL HEALTH

Increasing understanding or the unique challenges faced by older adults and caregivers living in rural settings across Michigan

- 90+ grants since 2019
- Telehealth, Transportation (NEMT), Care Transitions, Food Access, Substance Use Disorder Recovery, Hospice Care

ENVIRONMENT IN MICHIGAN

BEHAVIORAL HEALTH WORKFORCE

Widespread Labor Shortages and Pipeline Concerns in Michigan:

- Approximately 40 percent of Michigan is classified as a mental health professional shortage area
- At present, 27 counties in Michigan have no psychiatrists or addiction medicine physicians

Source: MDHHS Workforce Report 2023

MICHIGAN HEALTH ENDOWMENT FUND

ENVIRONMENT IN MICHIGAN

DIRECT CARE WORKFORCE

The direct care workforce is failing to keep pace with the trends of increased compensation across the country and rising inflation rates.

- Michigan turnover rates : 68 percent for CNAs, 89 percent for personal care aides, and 89 percent for home health aides.
- Closely tied to burnout, declining workplace morale commonly contributes to turnover

Source: MDHHS Workforce Report 2023

MICHIGAN HEALTH ENDOWMENT FUND

BUILDING WORKFORCE CAPACITY

MICHIGAN SOLUTIONS COLLABORATIVE

Partnership with the Michigan Health Council in 2022.

- Statewide workforce plan using data to coordinate activity across key partners and provide leadership across all activities in state, public and private (e.g., Michigan Center for Rural Health).
- Centered on data, inventory of initiatives, planning and creating briefings identifying gaps and solutions.

MICHIGAN HEALTH ENDOWMENT FUND

KEY TAKEAWAYS

COLLABORATION IS KEY

Redoubling our efforts to help set the table has delivered results

- Workforce discussions, convenings (tentative 2024)
- Multi-sector collaborations, key in rural settings
- Proof of concept/demonstration projects to inform policy change

EMERGING FOCUS AREAS: AGING, RURAL HEALTH, WORKFORCE

- Mobility
  - Non-emergency medical transportation, care transitions
- Accessibility
  - Physical, social environment, health care, housing stability
- Connectivity
  - Telehealth, broadband access
- Workforce
  - Training, pipelines

MICHIGAN HEALTH ENDOWMENT FUND

FIND US mihealthfund.org

MICHIGAN HEALTH ENDOWMENT FUND

QUESTIONS & ANSWERS

MICHIGAN HEALTH ENDOWMENT FUND

Elder Care Workforce

Q&A Session

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Day 1 Wrap-UP

Carrie Cochran-McClain
Chief Policy Officer
National Rural Health Association

11th Annual Public-Private Collaborations in Rural Health Meeting

Day 2 Sessions Begin at 9am

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Welcome to the 11th Annual Public-Private Collaborations in Rural Health Meeting

October 26-27, 2023 | Washington, DC

Wifi Network: MarriottBonvoy_Conference
Access code: NRHA2023

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Welcome Back and Context Setting

Tom Morris
Associate Administrator
Federal Office of Rural Health Policy
Health Resources and Services Administration

Engagement in Rural Health with Federal Partners

***Two 30-minute sessions: Federal representative will be the same for each session

Centers for Disease Control and Prevention
Department of Agriculture
Department of Education
Department of Transportation
Environmental Protection Agency
Health Policy and Finance Table (ASPE and FORHP)
Housing and Urban Development
Indian Health Service
National Institutes of Health
3RNET
Appalachian Regional Commission (ARC)

11th Annual Public-Private Collaborations in Rural Health Meeting

Break

Wifi Network: MarriottBonvoy_Conference
Access code: NRHA2023

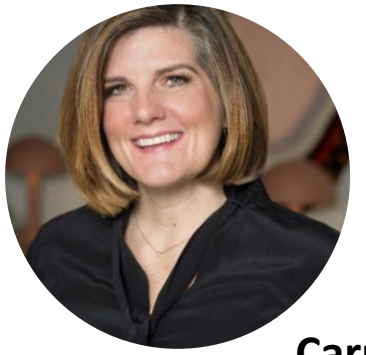
National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Behavioral Health Workforce: New Opportunities

Karen Scott
President
Foundation for Opioid Response Efforts (FORE)



Carrie Cochran-McClain
Chief Policy Officer
National Rural Health Association

Megan Meacham
Director, Rural Strategic Initiatives Division
Federal Office of Rural Health Policy

Foundation *for* Opioid Response Efforts

10/27/23

Strengthening the Opioid Use Disorder Workforce

Findings from a Groundbreaking Multi-State Survey of Peer Recovery Coaches

Introduction

Karen A. Scott, MD, MPH
President
Foundation for Opioid Response Efforts

Findings from the study can be found:
https://www.ForeFdn.org

About FORE

Founded in 2018, the **Foundation for Opioid Response Efforts (FORE)** is a 501(c)(3) private, national, grantmaking foundation focused on one urgent public health emergency – **the opioid crisis**.

Vision

To inspire and accelerate action to end the opioid crisis

Mission

To convene and support partners advancing patient-centered, **evidence-based solutions** addressing the opioid crisis

Focus

With **patients at the center**, our focus includes:

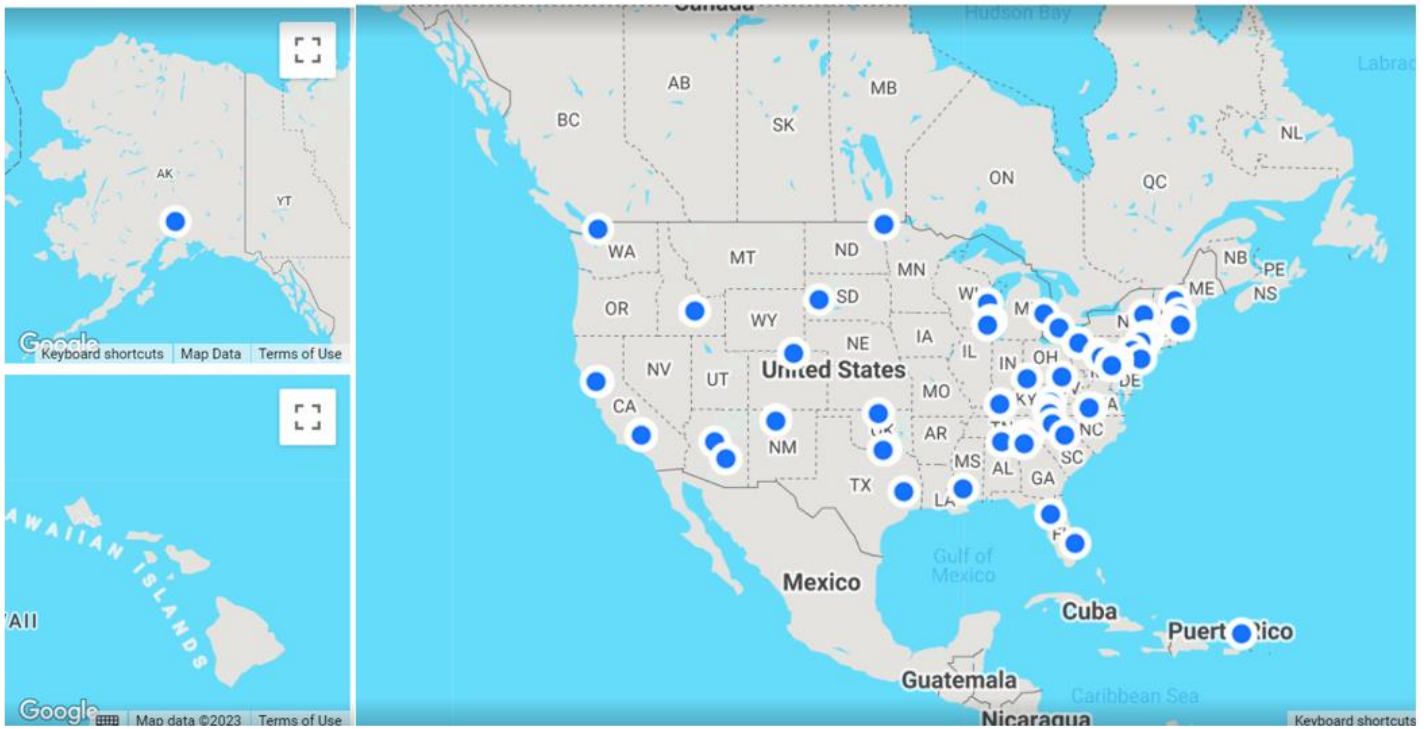
- Professional education
- Payer & Provider strategies
- Policy initiatives
- Public awareness

FORE

FORE Grantee Portfolio

Grants to date: **100**

Amount awarded: **$39.2M**



See all FORE Grantees on our website:
https://www.ForeFdn.org/Our-Grantees/

FORE

FORE's Grantmaking Programs

FORE grantmaking programs to date have focused on:

- **Access to treatment** for vulnerable populations
- Responding to the **COVID-19 pandemic** through recovery services and evaluation of regulatory policies
- **Innovation** challenge to tackle some of the opioid crisis' most intractable problems (such as stigma, as well as generating more timely and actionable data)
- **Family- & community-based prevention** for children and families at high risk
- Supporting **Community-Based Organizations** responding to the overdose crisis

FORE Resources

Through issue and policy briefs, webinars, and articles, we are contributing current vital information to inform communities, providers, and policymakers on best practices and solutions.

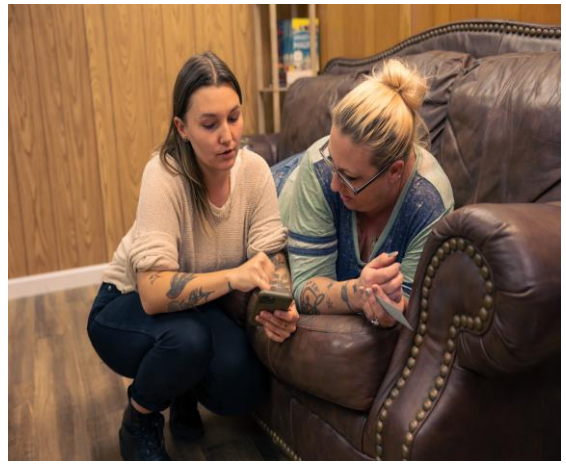
See all FORE Grantees on our website:
https://www.ForeFdn.org/Our-Grantees/

FORE

Why focus on Peer Workforce?

Bobby Bazell, PRC and trainer, South Carolina

- Gaps between receipt of OUD treatment and those who could benefit remains very large –
  - SAMHSA NSDUH Data 2021 estimates 6.3% received treatment in past year;
  - Racial/ethnic disparities significant
  - Access/provider capacity limitations in rural areas
  - stigma



E. Ripley, Peer, Western North Carolina

- Key component of linkages to treatment for many FORE projects:
  - Emergency departments
  - Outreach/engagement of Black/Hispanic populations
  - Rural communities
  - Pregnant/post-partum
  - Justice involved/re-entry

FORE

Methodology – Overview

- With this survey, FORE hoped to better understand the experiences, needs, and challenges faced by certified Peer Recovery Coaches across the country.
  - Informed by qualitative research conducted in 2021 and in collaboration with the FORE Team and FORE's Advisory Group
- **Key Challenge** - Developing a Representative Sample
- In lieu of a national sample source, SSRS collaborated with the FORE team to gain support from individual states/certification boards
  - DE, PA, RI, VA – International Credentialing and Reciprocity Consortium (IC&RC)
  - Oregon - Mental Health & Addiction Certification Board of Oregon (MHACBO).
  - Maine - Portland Recovery Community Center (PRCC)
  - Nevada - Center for the Application of Substance Use Technologies (CASAT)
  - New York – Office of Addiction Services and Supports (OASA)
  - Arkansas – Department of Human Services
  - Ohio and Idaho – publicly available data

Methodology – Key Components

Worked closely with an Institutional Review Board (IRB) to ensure the proper protection of the rights and welfare of the peers we interviewed, particularly given the sensitive nature of the survey

Survey instrument informed by qualitative research, with input from FORE and Advisory Group. Conducted five cognitive pretest interviews with peers from FORE's network ahead of the field period to test the survey instrument

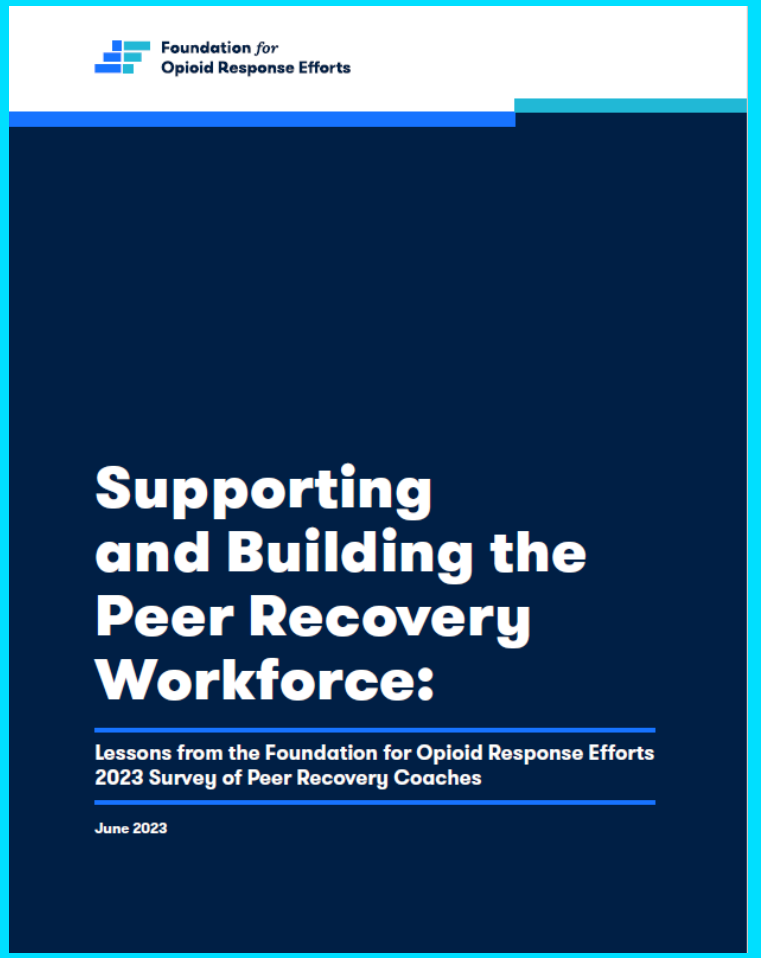
Tailored outreach to PRCs in 11 states, including invitation and reminder emails To increase cooperation, a $25 virtual gift card was offered to all respondents upon completion of the survey.

Self-administered web survey, conducted October 25, 2022-January 19, 2023.

Note: Please see full methodology report for details on how this survey was conducted.

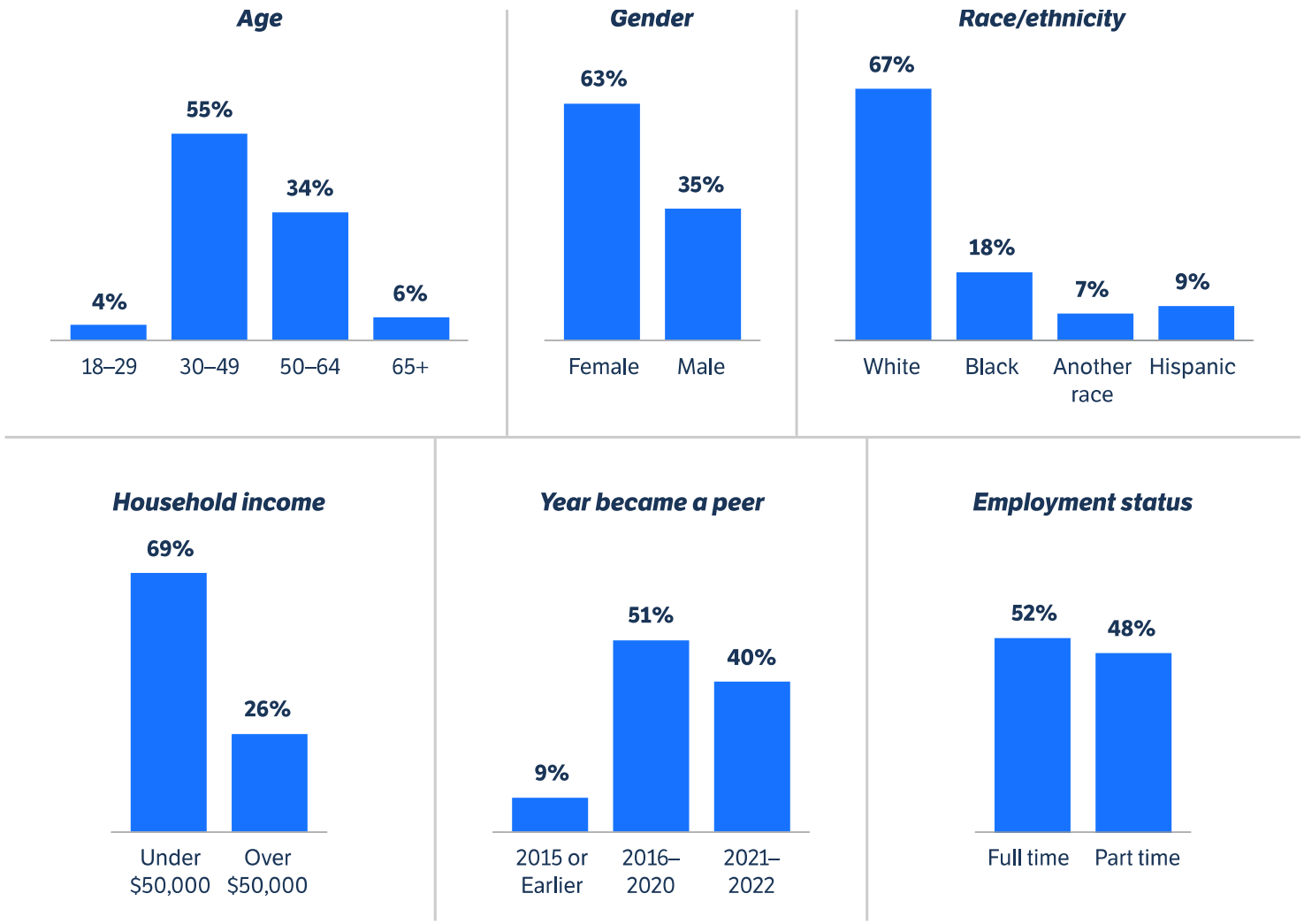
State	Available Sample	Total Invited	Total Completed Interviews	Response Rates
Delaware	150	150	73	50%
Pennsylvania	1565	398	154	46%
Rhode Island	173	173	76	47%
Virginia	927	456	171	42%
Oregon	1565	250	85	37%
Maine	104	104	57	69%
Nevada	228	228	84	53%
New York	3053	339	207	NA
Arkansas	166	166	43	34%
Ohio	834	834	198	26%
Idaho	653	653	26	11%
TOTAL	9,418	3,751	**1,174**	

National Peer Survey Results



See Reports on: www.ForeFdn.org

Demographics of PRC Survey Respondents



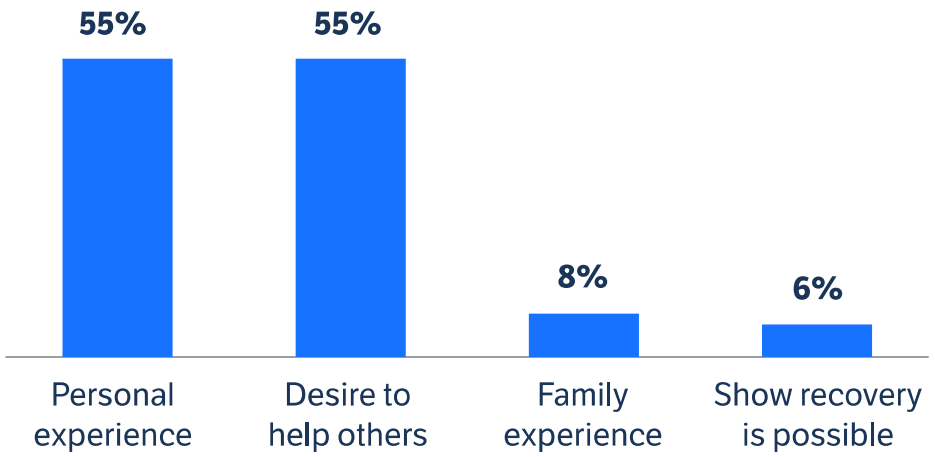
Foundation for Opioid Response Efforts 2023 Survey of Peer Recovery Coaches

FORE

Survey Respondents reported being highly motivated and mission driven to support people in recovery – but concerned about ability to stay in the field.

Motivation for Becoming a PRC

Q: Thinking back to before you started working as a peer, what was the main reason you wanted to support people experiencing OUD?



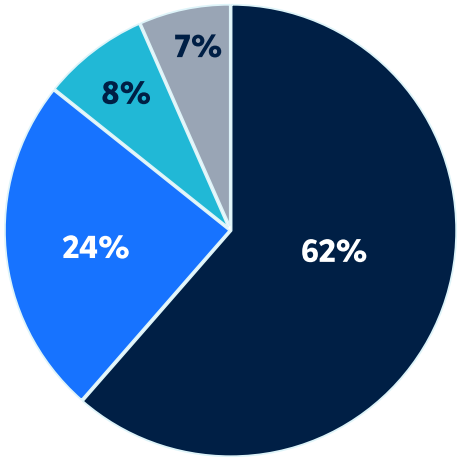
Note: Multiple responses were allowed

Foundation for Opioid Response Efforts 2023 Survey of Peer Recovery Coaches

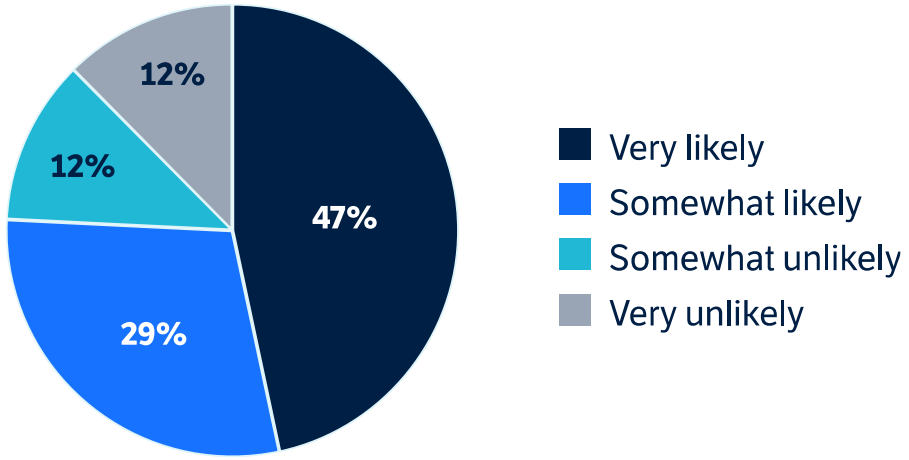
FORE

Likelihood of Remaining a PRC

Q: Thinking ahead two years, how likely is it that you will still be a PRC in 2024?

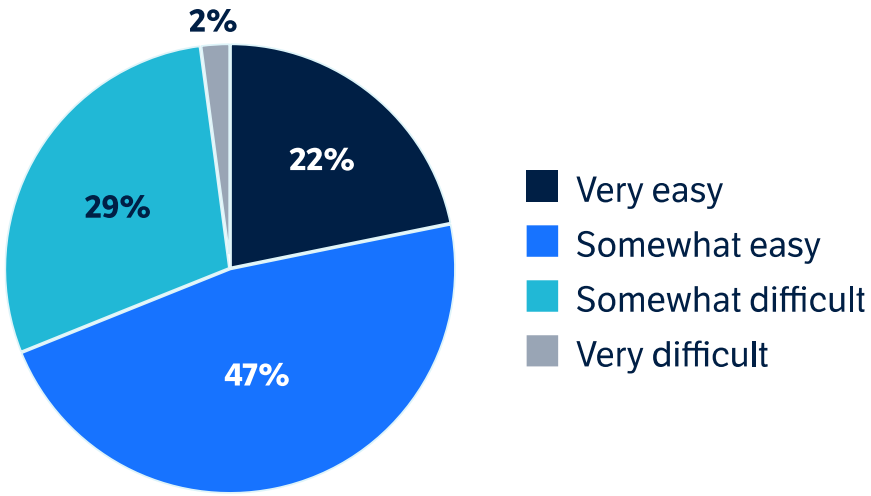


Q: Thinking ahead five years, how likely is it that you will still be a PRC in 2027?



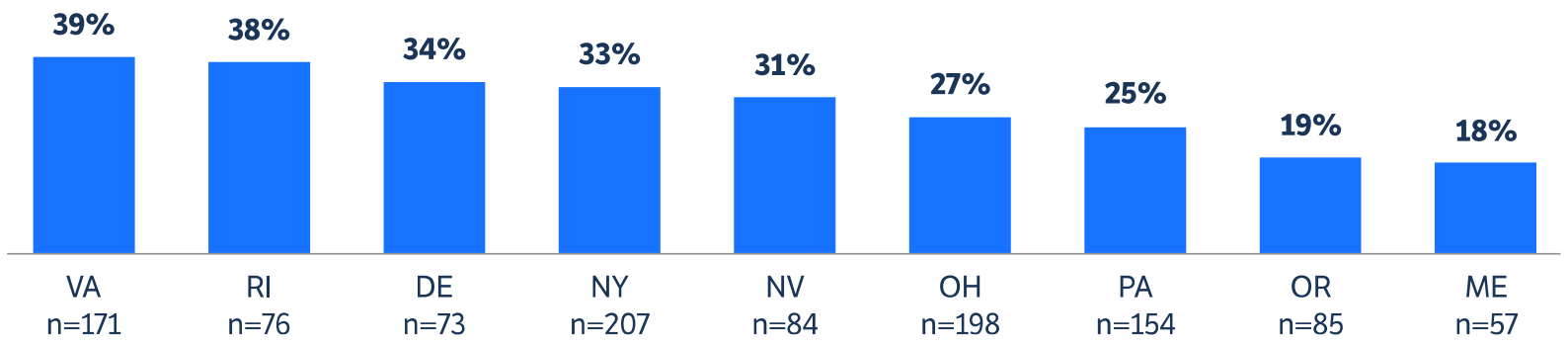
Certification Process

Q: Overall, how easy or difficult was the certification process?



Ease of Certification Process

% of PRC respondents who say the certification process was very or somewhat difficult



Note: Data shown for states where there were more than 50 responses

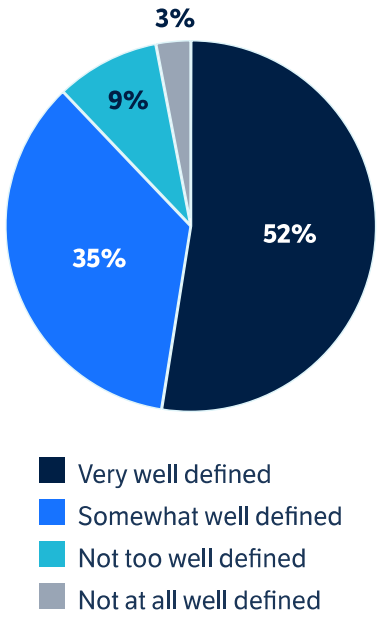
Foundation for Opioid Response Efforts 2023 Survey of Peer Recovery Coaches

FORE

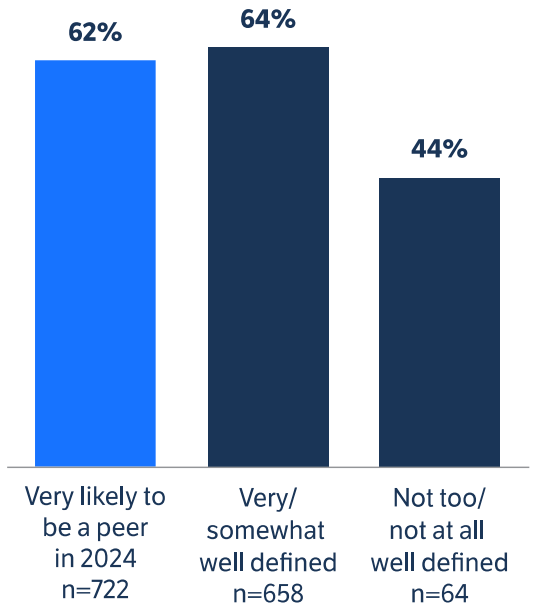
PRC respondents reported working in many different settings, with people from many backgrounds, and engaging in a wide range of activities.

Defining Responsibilities

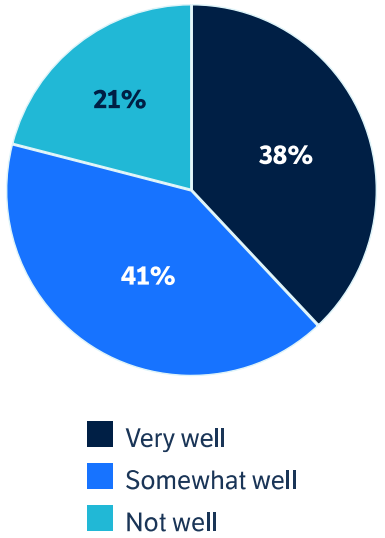
% of PRC respondents who say their role is...



% of PRC respondents who are very likely to still be a peer in 2024, by how well they feel their role is defined

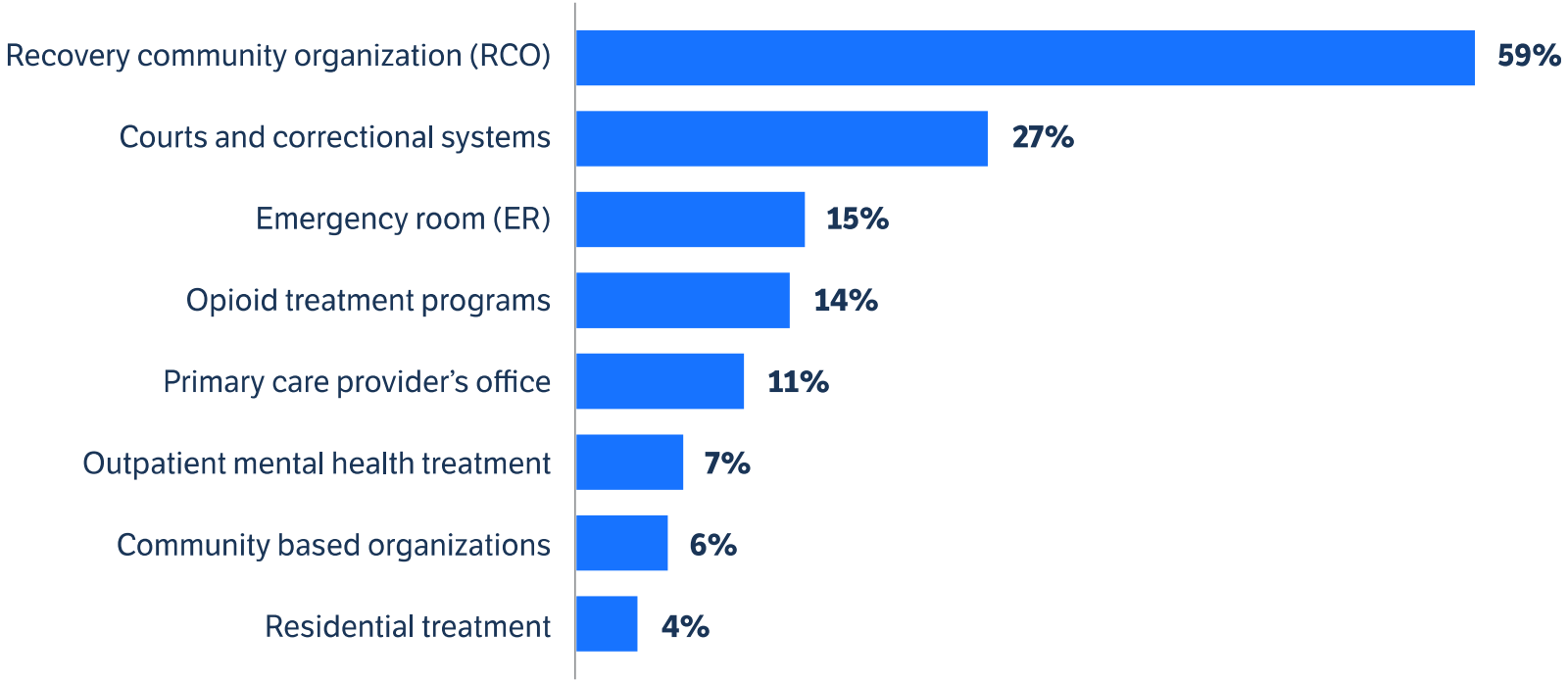


% of PRC respondents who say their coworkers understand their role as a PRC...



Work Settings

Q: In which of the following settings do you currently support clients?

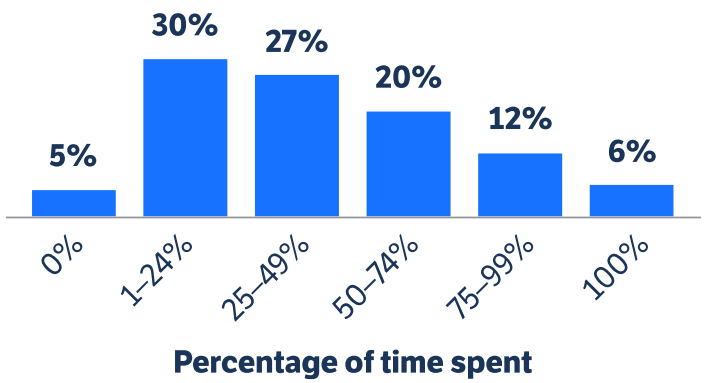


Time Spent Supporting Recoverees

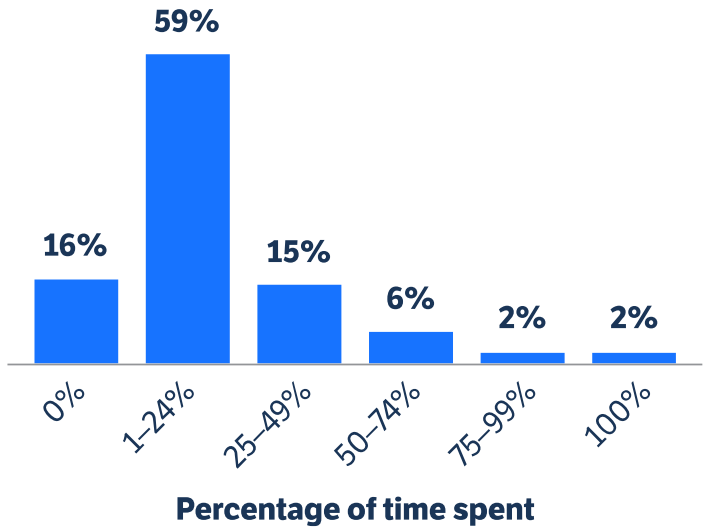
Q: What portion of your time, on average, is spent supporting recoverees in the following ways?

% of PRC respondents

Assisting with social needs such as housing, food, employment



Connecting with legal services/ assisting with legal issues

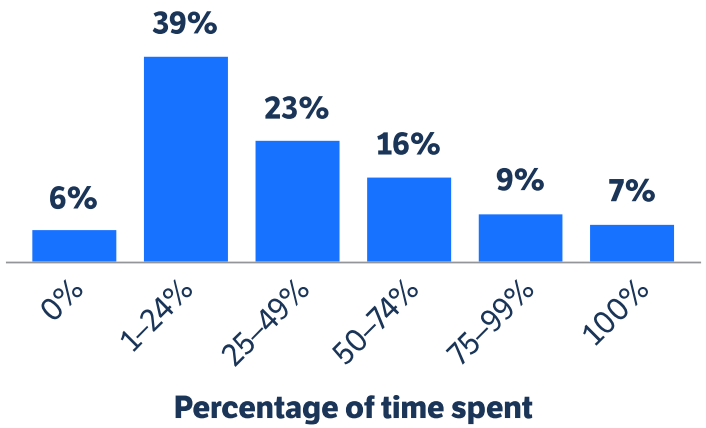


Time Spent Supporting Recoverees

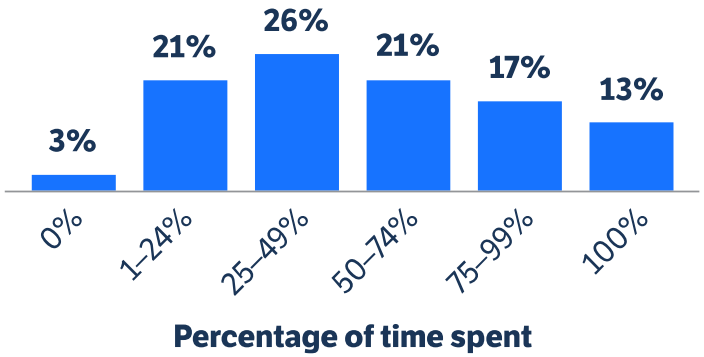
Q: What portion of your time, on average, is spent supporting recoverees in the following ways?

% of PRC respondents

Providing support to help recoveree stay on their medications/in treatment

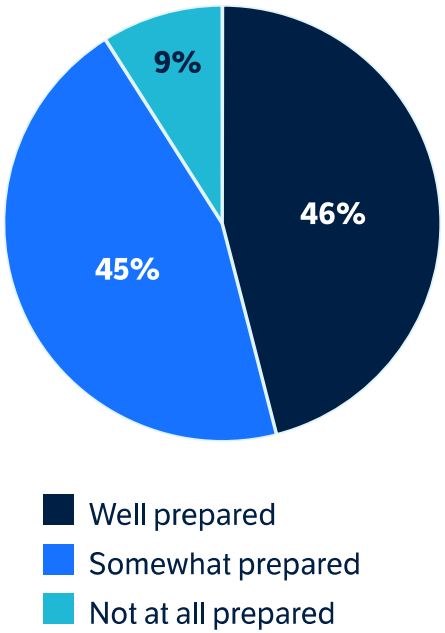


Providing specific counseling supports such as motivational interviewing

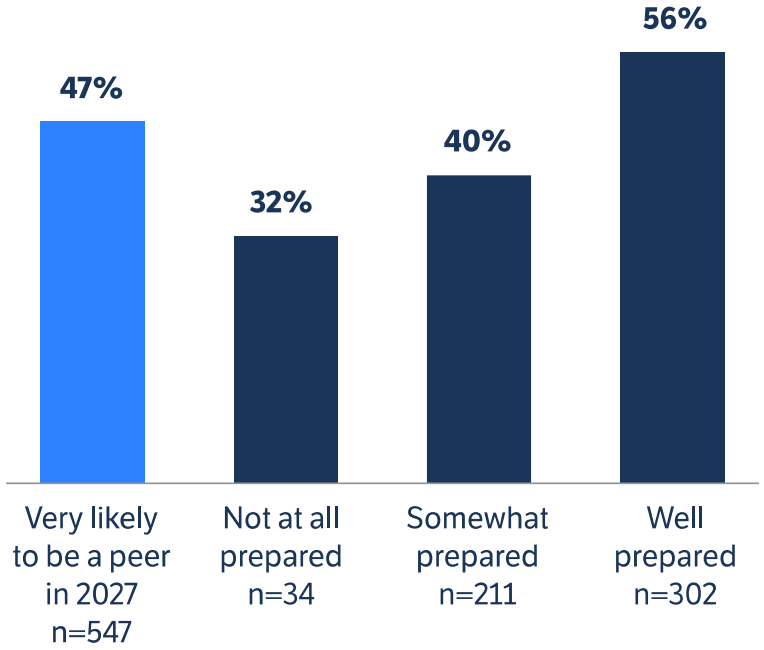


Preparation for the Role

Q: Upon entering the workforce, how prepared did you feel for your role as a PRC?

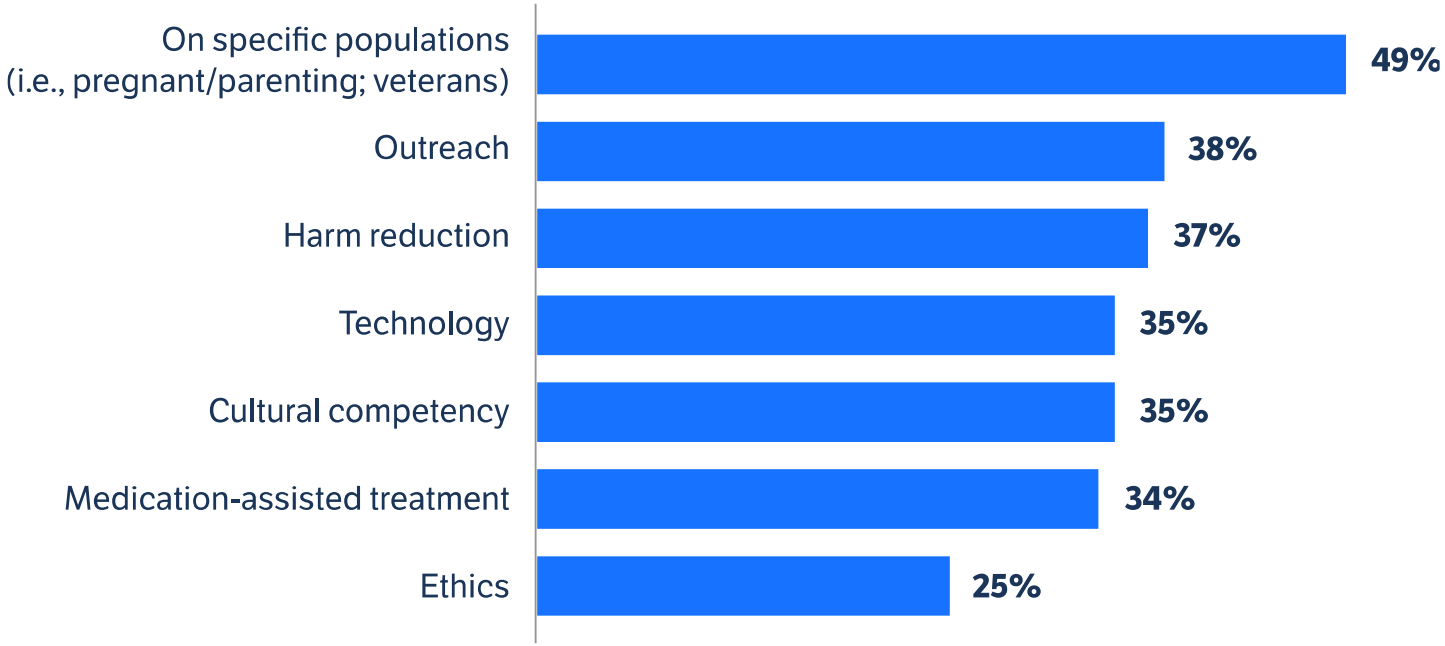


% of PRC respondents who are very likely to still be a peer in 2027, by how prepared they felt for their role



Training Needed

Q: In which of the following areas, if at all, do you feel you need (additional) training?

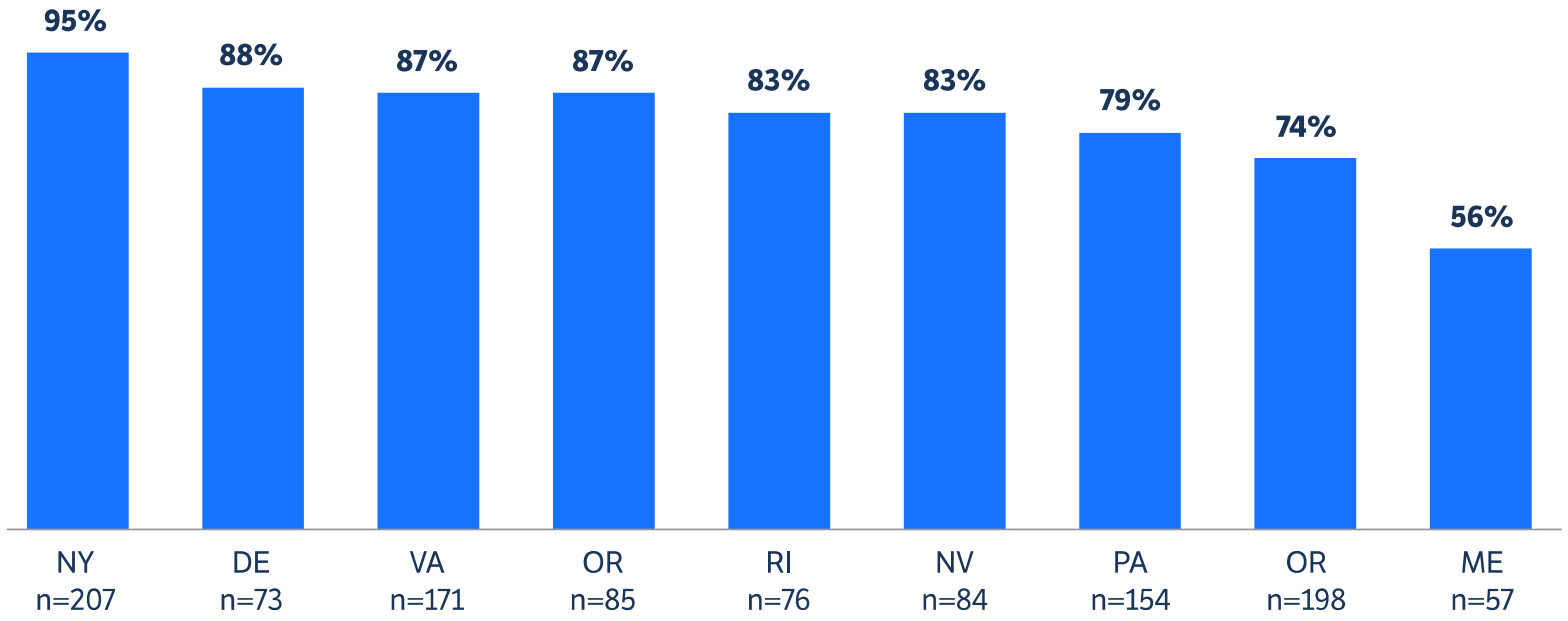


Foundation for Opioid Response Efforts 2023 Survey of Peer Recovery Coaches

PRC respondents reported concerns with financial compensation and stability, and levels of burnout and stress.

Financial Compensation

% of PRC respondents who receive financial compensation for the work they do as a PRC



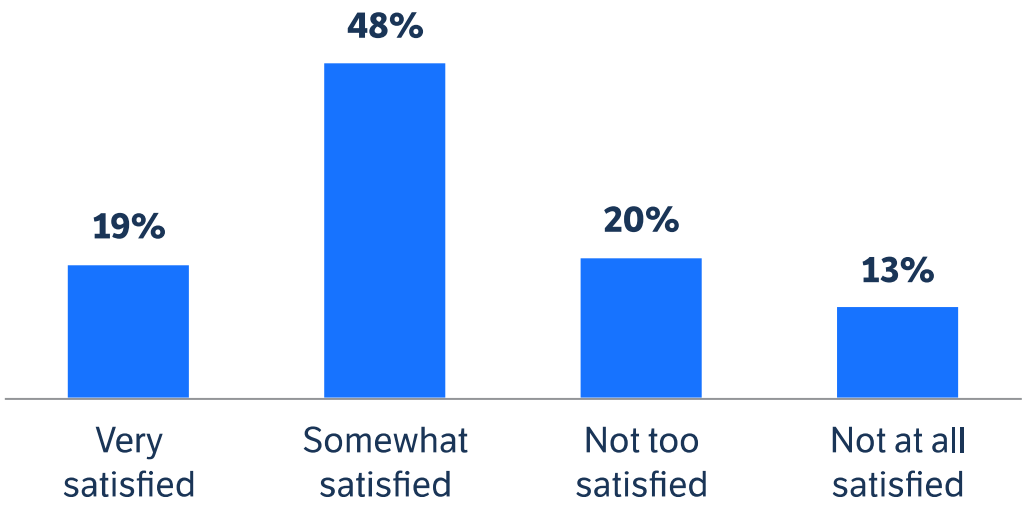
Note: Data shown for states where there were more than 50 responses

Foundation for Opioid Response Efforts 2023 Survey of Peer Recovery Coaches

FORE

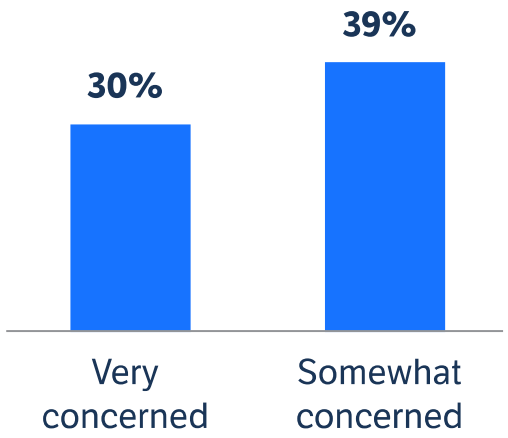
Financial Compensation

% of PRC respondents who are very/somewhat/not too/ not at all satisfied about their financial compensation (among PRCs who receive financial compensation, n=968)



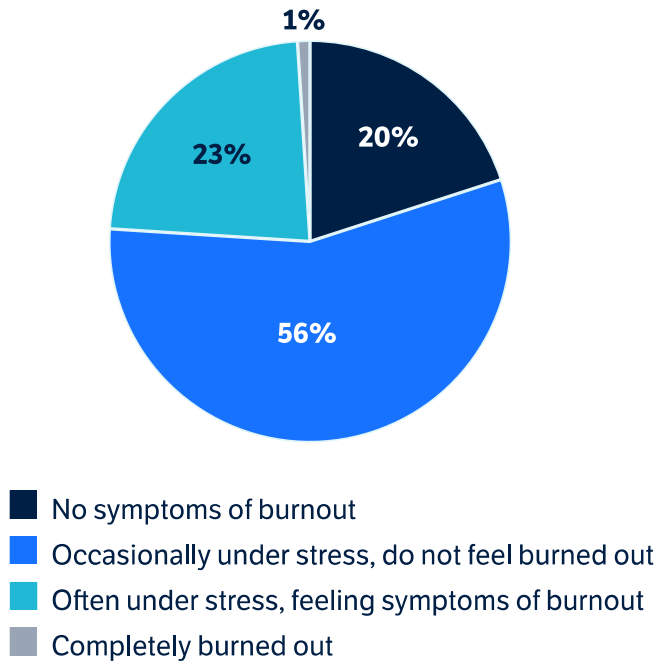
Financial Compensation

% of PRC respondents who are very/somewhat concerned about potential budget cuts/loss of funding to support the PRC position within the next two years

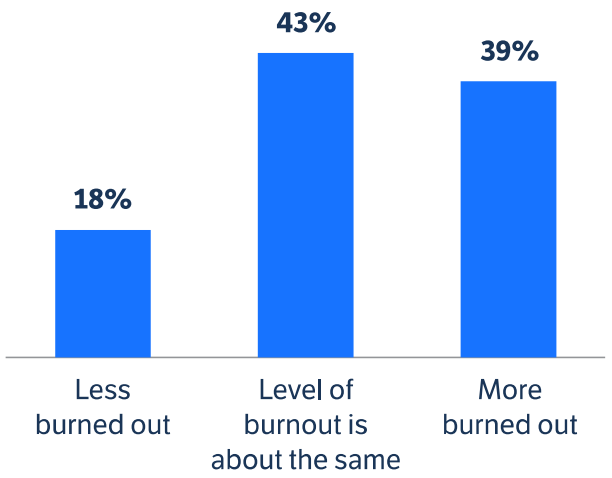


Battling Burnout

Level of burnout



% of PRC respondents who say they feel _____ compared with before the pandemic began in March 2020, n=412



FORE

Causes of Burnout

What's contributing to burnout? Based on those who feel some level of burnout, n=941

48%

Emotional strain of working with recoverees

26%

Do not feel supported at work

24%

Working too many hours

23%

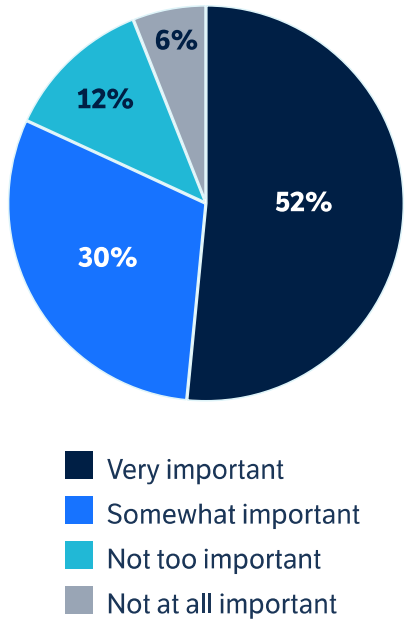
Caseload is too large

FORE

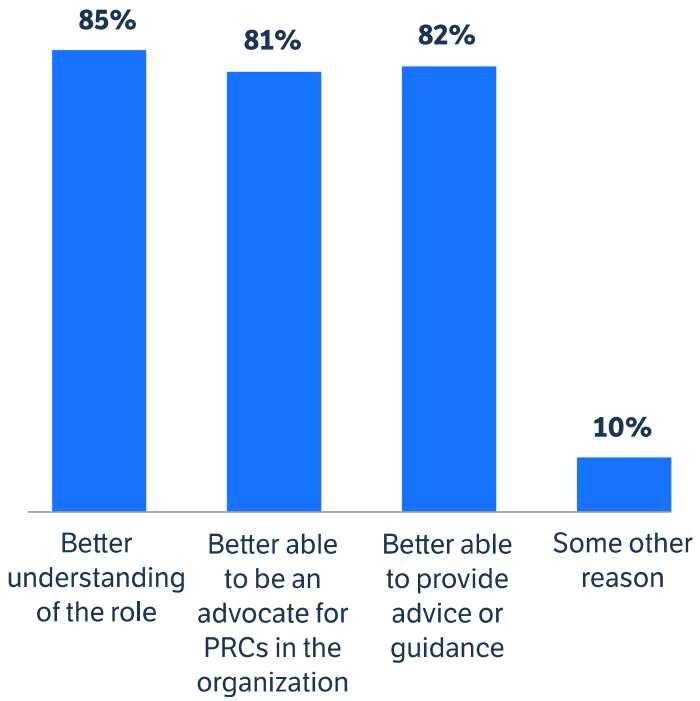
Experienced supervision, career advancement and financial supports can all contribute to strengthening this workforce.

Importance of Supervision

Q: How important, if at all, is it to have a supervisor that is a PRC themselves?



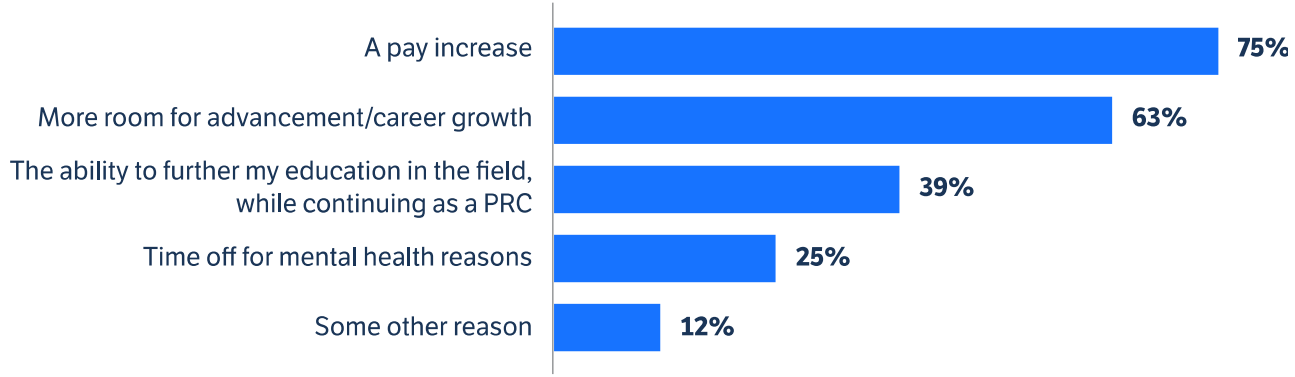
Q: Why is it important their supervisor is a PRC?



Career Goals

Q: What is the primary reason you are likely to find another career path?

Q: Which of the following factors, if any, would make you more likely to remain a PRC?



Conclusions

PRCs are mission-driven, but face many challenges.

- PRCs work in a relatively new and evolving field. While they feel passionate about their work, they face several challenges that could make it hard to sustain and grow this workforce.

PRCs need adequate compensation.

- Employers, state Medicaid programs, public or private funders, and others who help pay for the work of PRCs should assess what comprises an appropriate level of compensation, considering whether peers earn a livable wage and their employment benefits.

PRCs need recognition from coworkers and emotional support.

- Some PRCs said they often felt stressed or experienced symptoms of burnout due to the stress of working with people in recovery, because their caseloads were too large, and/or because they felt unsupported by their coworkers.

PRCs want opportunities to learn and build careers.

- Employers and others should ensure that certification and training opportunities are accessible to PRCs so they can pursue their mission and develop their skills.

As Funders, we can:

Analyze local/state reimbursement policies and opportunities to strengthen;

Support recovery community organizations and health care organizations in their efforts to recruit and train peers;

Partner with organizations employing peers to create supportive work environments, with a focus on retention;

Support development of training content and opportunities for on-going professional development

FORE

Acknowledgements

Advisory Group Members

Adrienne Brown, MSW, Board of Directors, Foundation for Opioid Response Efforts, Former Senior Administrator, Alcoholics Anonymous World Services

Dwayne Dean, RCPF, CPRS, RPS, Certified Peer Recovery Specialist, University of Maryland College Park

Julia W Felton, PhD, Assistant Scientist, Henry Ford Health System

Karen Fortuna, PhD, LISCW, Assistant Professor of Psychiatry, Geisel School of Medicine, Dartmouth University

Cortney Lovell, Director, Practice Improvement and Consulting, National Council for Mental Wellbeing

Jessica F. Magidson, PhD, Director, Center for Substance Use, Addiction, and Health Research, University of Maryland College Park

SSRS

Robyn Rapoport, MA, Executive Vice President, Health Care, Public Policy Research and Strategic Initiatives

Rob Manley, Research Director

Elizabeth Sciupac, Research Director

Hope Wilson, Associate Project Director

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General inquiries: info@ForeFdn.org

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National Rural Health Association

Behavioral Health Workforce: New Opportunities

Rural Health Philanthropy Partnership

Carrie Cochran-McClain, DrPH
Chief Policy Officer

October 27, 2023

National Rural Health Association

Why Focus on Behavioral Health Workforce in Rural Areas?

There is a current **workforce shortage** of behavioral health professionals in rural areas in comparison to their urban counterparts.

68% of mental health HPSAs are in rural areas[1].

Rural areas **lack behavioral healthcare infrastructure**, leading residents to travel longer distances for basic care, and even longer for specialist care

At least **30%** of hospitals in rural areas are, on average, at **risk for closure**[2].

Rural residents are at **higher risk for behavioral health issues**, with a higher percentage suffering from mental illness and substance use.

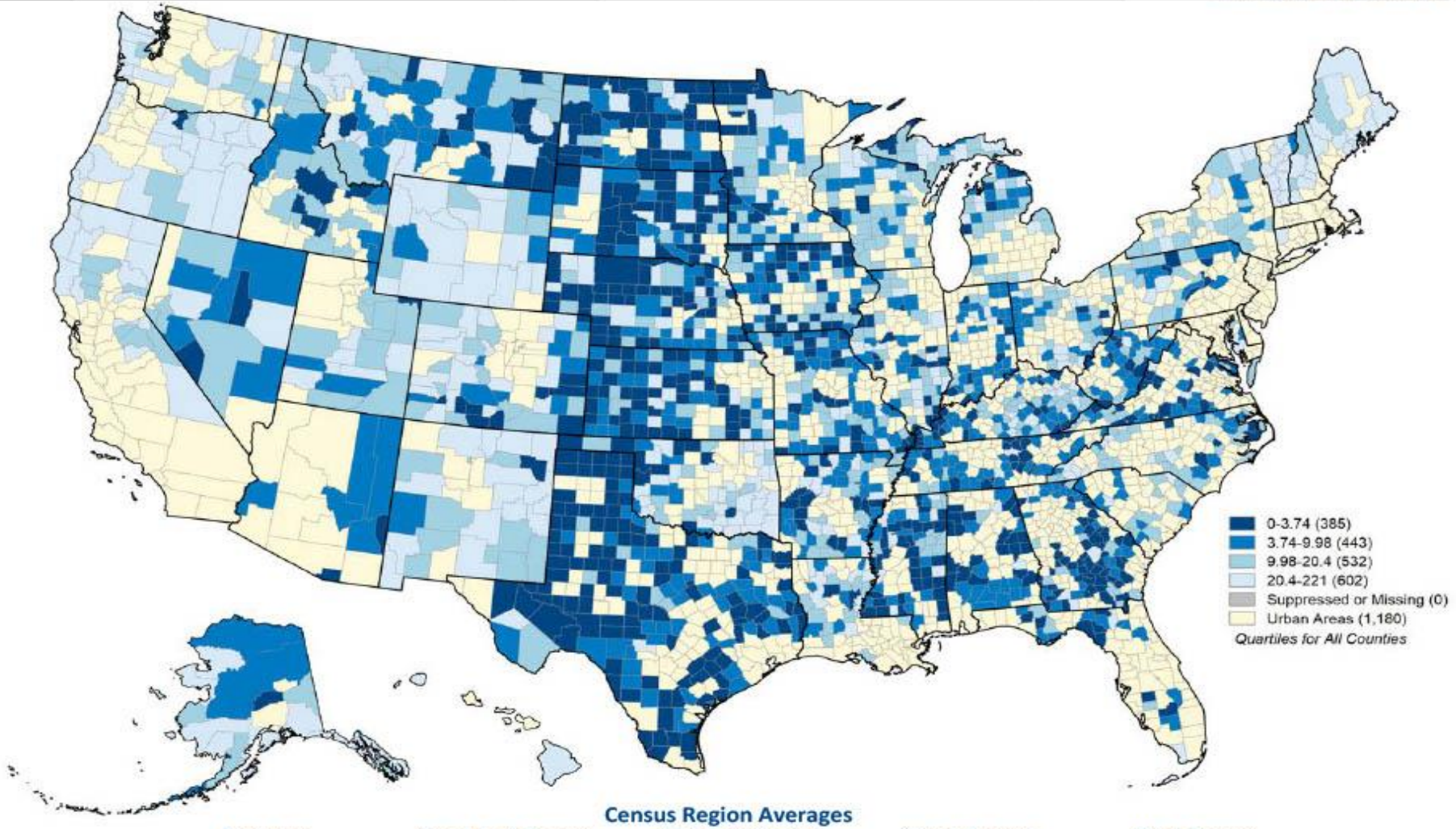
Almost a quarter of rural adults report having any mental illness (AMI)**.**[3]

Mental Health Care Provider Supply

Mental health care providers per 10,000 population (2016)

NC RHRP
NC Rural Health Research Program

Access to Care Domain



Census Region Averages

National		Northeast Region		Midwest Region		South Region		West Region	
Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
26	17	32	23	24	15	19	13	34	29

Challenges With Workforce Shortage

As of March 2023, **160 million** Americans live in an area with **mental health professional shortages**[3]

About an **additional 8,000 mental health professionals** would be needed to ensure an **adequate supply**[3]

There a **lack of diversity** among workforce, leading to **lack of culturally competent care** in rural areas[3]

Provider shortages lead to:

- **Longer waitlists** to seek necessary care[4]
- **60%** of mental health concerned visits are through primary care physicians instead of specialists[4]

- Many behavioral health specialists **lack incentive** to work in rural areas due to pay barriers, billing restrictions, and lack of reimbursement options for services[4]
- Rural hospitals have **lack of oversight** to enforce standards and protocol[3]

Behavioral Health and Outcomes in Rural Areas

Opioid & Substance Use

Rates of Opioid use and misuse in rural areas continues to grow over the years despite implementation of prevention programs and OUDs[2]

Rural communities struggle with implementation of prevention programs due to workforce concern, lack of community-provider collaborations, and lack of timely treatment and protocol adherence[2]

Mental Health

Adults in rural areas are less likely to seek a mental health specialist for depression due to lack of mental health practitioners[2]

Less than 20% of rural adults seek treatment from mental health professionals[2]

National Rural Health Association

Who is the Behavioral Health Workforce?

Licensed Providers

- Psychiatrists
- Family physicians
- Nurse practitioners
- Physician assistants
- Psychologists
- Marriage and family therapists
- Mental health counselors
- School counselors

Clinical Supporters

- Social workers
- Addiction counselors
- Certified peer specialists
- Recovery coaches
- Occupational therapists

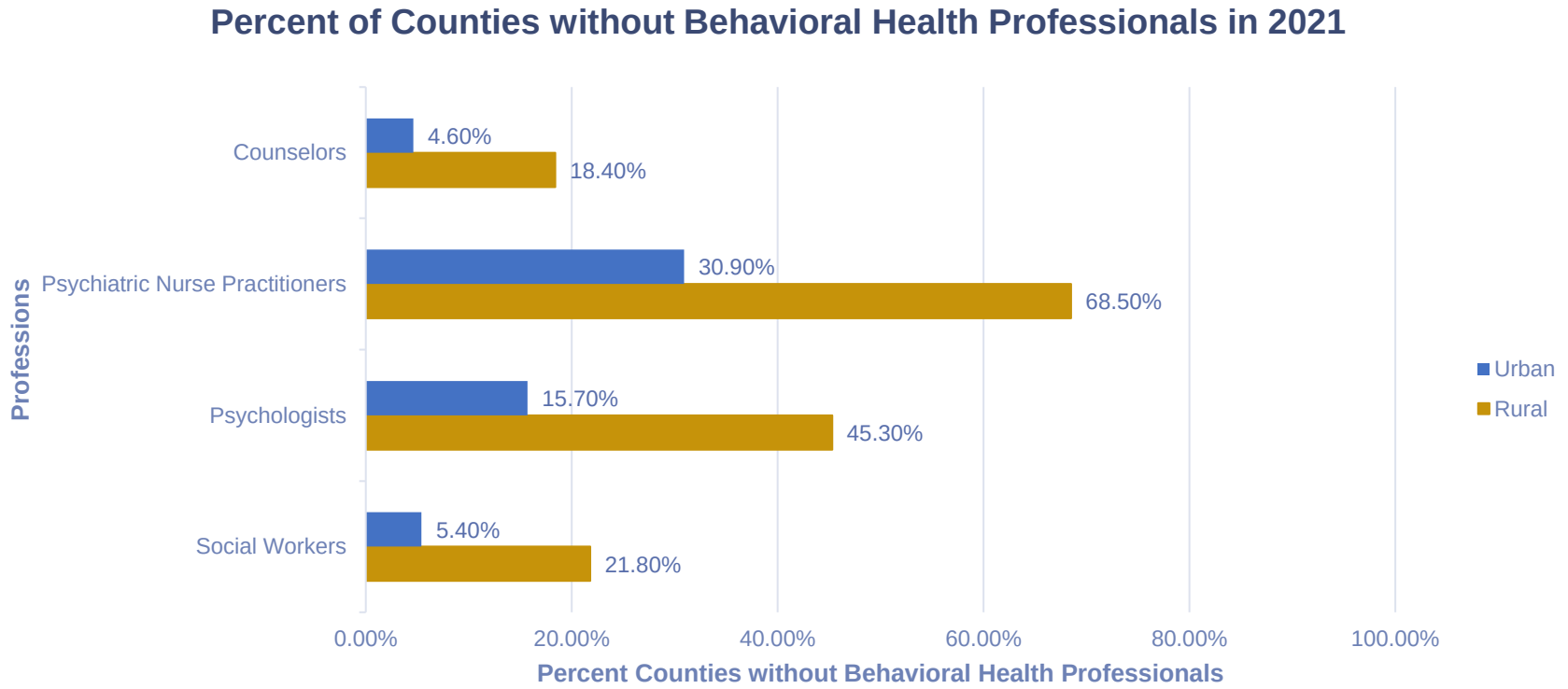
Community Care Workers

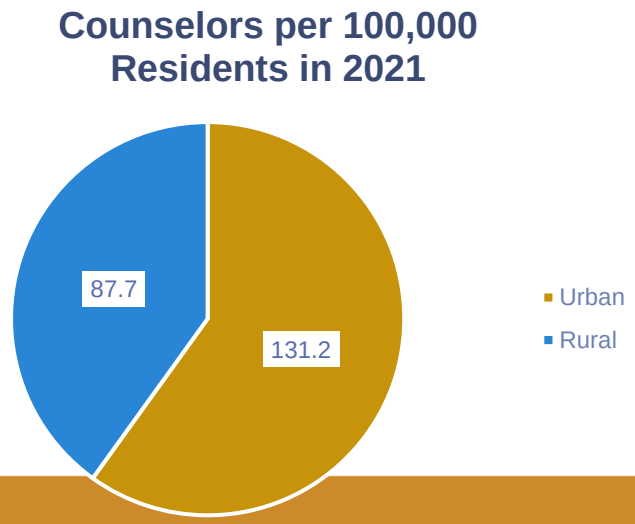
- Peer support specialists
- Community health workers
- Behavioral health volunteer

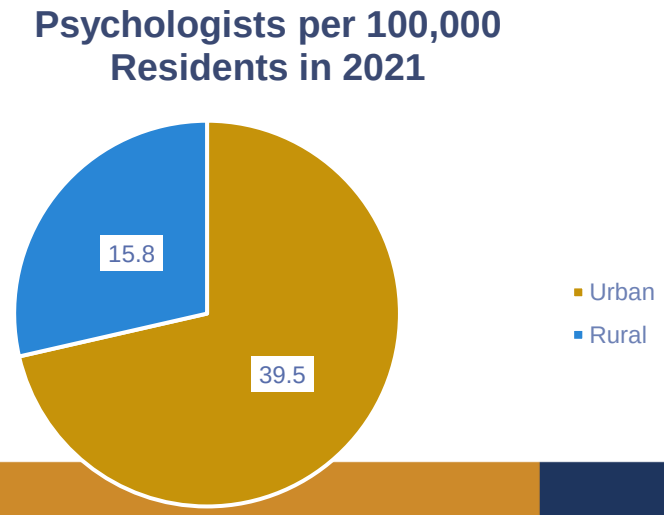
Frontline Workers

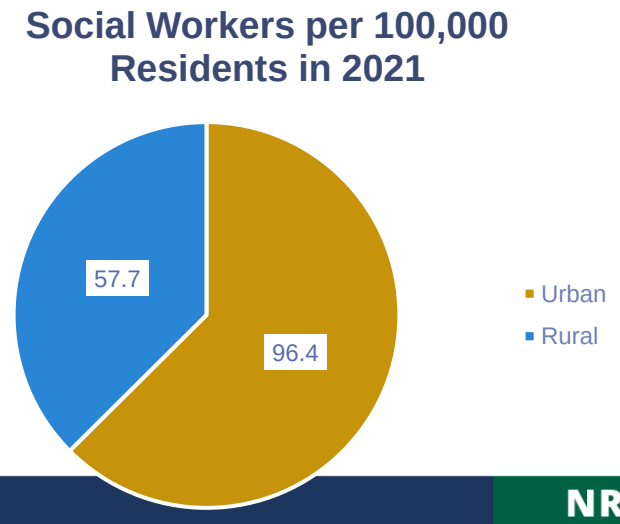
- Law enforcement
- Teachers/school employee
- Daycare providers
- Emergency medical staff
- Social service providers

Rural Behavioral Health Providers









National Rural Health Association

Funding for Behavioral Health Workforce

Licensed Providers

Services covered by Medicaid and Medicare

- Low reimbursed rates
- Challenges to find accepting providers

Expanding authorities for providers

- Services under “incident to” can be delivered under general supervision
- Proposal to allow MFT & MHC to bill Medicare
- Coverage of telehealth

Clinical Supporters

Limited/ low reimbursement

Expanding authorities for providers

- Proposal to allow addiction counselors enroll as MHC

Many services are grant-funded, resulting in limited access

Community Care Workers

Most services paid for by grants or uncompensated

- No/very limited insurance

Frontline Workers

No insurance reimbursement

Limited grant funded initiatives

Carrie Cochran-McClain
Chief Policy Officer
ccochran@ruralhealth.us

@NRHA_Advocacy

Behavioral Health Workforce: New Opportunities

Q&A Session

National Rural Health Association

GRANT MAKERS IN HEALTH

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Key Takeaways

Allen Smart
Founder
PhilanthopywoRx

Sheldon Weisgrau
Vice President of Health Policy
Missouri Foundation for Health

Brian Myers
Director of Community Engagement
Washington State University College of Medicine

Craig Glover
President and CEO
Family Care, WV

Continuing the Conversation

Tom Morris
Associate Administrator
Federal Office of Rural Health Policy
Health Resources and Services Administration

Carrie Cochran-McClain
Chief Policy Officer
National Rural Health Association

Cara James
President and *Chief Executive Officer*
Grantmakers In Health

11th Annual Public-Private Collaborations in Rural Health Meeting

Thank You for Joining Us!

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U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy