

Office of Health Transformation Coordinate Health Sector Workforce Programs

Background:

Ohio's 540,000 health care practitioners directly influence the cost and quality of health care through their diagnoses, orders, prescriptions, and treatments.¹ These medical, mental health, dental and other health care providers labor every day to take care of their patients, but experts say there are too few of some types of health care professionals and some are not located where they are needed. Rural Ohioans and those living in other underserved areas across the state are especially vulnerable to health sector workforce shortages.

Ohio trains more physicians than it retains. The state's six public medical schools² enroll over 3,700 medical students, which ranks Ohio 5th among states in terms of the number of public medical school enrollees per capita.³ However, only 44 percent of physicians who graduated from public medical school in Ohio stay in Ohio. As a result, Ohio ranks 16th in terms of active physicians per capita and 24th in terms of active primary care physicians per capita.⁴ According to federal Health Professional Shortage Area designations, more than 1.1 million Ohioans reside in an area that is underserved for primary care, 1.4 million reside in an area that is underserved for dental care, and 2.7 million reside in an area that is underserved for mental health care. An additional 282 physicians, 283 dentists, and 194 psychiatrists are needed in these areas.⁵ The individuals who live in these underserved areas are disproportionately from minority and low-income populations within rural and urban areas throughout the state.

In February 2012, Governor Kasich created the Office of Workforce Transformation (OWT) to coordinate and align workforce policies, programs and resources across the state. OWT has authority to coordinate workforce activities across all state agencies, but relies on a core team that includes the Ohio Board of Regents, Ohio Development Services Agency, and Ohio Department of Job and Family Services. The goal is to create a unified workforce system that supports business in meeting its workforce needs. The Governor's Office of Health Transformation (OHT) also is involved to assist OWT by coordinating health sector workforce activities across Ohio's health and human services agencies.

¹ US Bureau of Labor Statistics, [Ohio Occupational Employment and Wage Estimates](#) (May 2011), including health care practitioners and technical occupations, and health care support occupations.

² The Ohio State University, the University of Cincinnati, Wright State University, The University of Toledo, Northeast Ohio Medical University, and Ohio University.

³ Association of American Medical Colleges, [2011 State Physician Workforce Data Book](#) (2011) page 24: students enrolled in public medical or osteopathic schools for the 2010-2011 academic year

⁴ Ibid. pages 8 and 12

⁵ Health Resources and Services Administration, Designated Health Professional Shortage Area Statistics (2012). The estimate of additional health professionals required to adequately serve currently underserved areas is based on population-to-provider ratios of 2,000:1 for physicians, 3,000:1 for dentists, and 10,000:1 for psychiatrists.

Executive Budget Proposal and Impact:

The Executive Budget includes several initiatives to coordinate health sector workforce programs. These initiatives support OWT and OHT activities already underway. Working together, OWT and OHT are coordinating 16 state agencies to identify health sector workforce needs, align existing workforce programs, reform higher education training programs, and change payments for health services to support workforce priorities.

IDENTIFY NEEDS

- ***Provide comprehensive health sector workforce data.*** OWT has made it a priority to forecast in-demand jobs using existing workforce data and, when data does not exist, by creating new forecasting tools. Individuals interested in health care careers and health professions training programs do not have a consistent way to identify current and future health sector job and skill needs. Assessing health workforce needs is difficult because there are many variables that determine its adequacy and no single entity in the United States is in charge of workforce planning. The state currently relies on local partners to survey providers to obtain data needed to identify health professional shortage areas. The Ohio Department of Health (ODH) is leading an initiative to obtain comprehensive state-level health sector workforce data. Working in collaboration with OWT and OHT, ODH will: (1) use the Department of Administrative Services e-licensure system to collect the nationally recognized Minimum Data Set (MDS) for all primary care disciplines, (2) add data elements to Ohio's MDS that are required for designation of federal Health Professional Shortage Areas, and (3) develop an advanced primary care workforce forecasting model to assist in planning for health professions education programs and recruitment and retention strategies. OHT is providing Health Transformation Funds to support these activities (there is no additional budget request).
- ***Prioritize advanced primary care.*** Various trends are projected to impact demand for the primary care workforce statewide. An aging population and expansion of health insurance coverage will impact a system that is already experiencing provider shortages and maldistribution. New models of advanced primary care will also bring about changes in the way care is delivered, calling for increased use of interdisciplinary care teams.⁶ Ohio is working to expand the patient-centered medical home (PCMH) model of care across the state. The PCMH model of care improves health outcomes, enhances the patient experience of care, and reduces expensive, unnecessary inpatient hospital admissions and emergency department visits.⁷ A strong primary care workforce is a critical element of the PCMH model and, given the current shortage, it is imperative to educate and retain a workforce to provide advanced primary health care services.

⁶ "Advanced primary health services" are health services related to family medicine, general internal medicine, general pediatrics, obstetrics/gynecology, geriatrics, mental health, oral health and clinical pharmacy provided by a patient-centered interdisciplinary team of health care professionals.

⁷ Patient-Centered Primary Care Collaborative, [Benefits of Implementing the Primary Care PCMH](#) (2012)

- **Prioritize underrepresented minorities in health professions.** National research indicates that health care providers originating from population groups and communities that are historically underserved for health care are more likely to choose primary care practice and to work in underserved areas. Underrepresented minority health professionals, particularly physicians, disproportionately serve minority and other medically underserved populations.⁸ Data generally support the notion that minority patients receive better interpersonal care from practitioners of their own race or ethnicity, particularly in primary care and mental health settings. Patient-practitioner language concordance similarly is associated with better interpersonal care, greater medical comprehension, and greater likelihood of keeping follow-up appointments, particularly in mental health care. These findings indicate that greater health professions diversity will likely lead to improved public health by increasing access to care for underserved populations.⁹

ALIGN PROGRAMS

- **Target scholarship, training and loan repayment programs to support workforce priorities.** Factors such as large educational debt and lack of training in community-based primary care settings negatively influence health professions students, residents and providers who might otherwise choose to practice primary care in underserved areas. While Ohio currently has various programs in place to recruit and retain primary care providers for shortage areas, the programs are not adequate to meet the growing need for an interdisciplinary and diverse workforce. Working together to overcome the currently misaligned and fragmented system, OWT and OHT will: (1) coordinate priorities and resources across existing scholarship and training programs, including Choose Ohio First Scholarships for primary care, Medicaid Technical Assistance and Policy Program Healthcare Access Initiative, and combined Board of Regents line items for family medicine, geriatric medicine, primary care residencies, and the Area Health Education Center program; (2) seek matching funds for the State Loan Repayment Program grant from licensure boards that represent eligible disciplines, including physician assistants, nurse practitioners, certified nurse midwives, psychiatric nurse specialists, health service psychologists, licensed professional counselors, licensed clinical social workers, marriage and family therapists, registered dental hygienists and pharmacists; (3) revise loan repayment program application scoring criteria to increase opportunities for underrepresented minorities and to support advanced primary care practices; and (4) revise Ohio Physician and Dentist Loan Repayment programs to address large educational debt and the need for community-based training. These activities use existing funds (there is no additional budget request).

⁸ “Underrepresented minorities in health professions” include racial and ethnic populations whose representation in their profession is disproportionately less than their proportion in the general population. Persons from rural or socioeconomically disadvantaged backgrounds are also considered to be underrepresented groups in the health care workforce.

⁹ US Health Resources and Services Administration, [The Rationale for Diversity in the Health Professions](#) (2006)

- **Define core competencies in the direct care workforce.** Currently, no standardized certification program exists for direct care workers providing care in the homes and residences of consumers receiving home and community based services reimbursed by Medicaid. The Executive Budget establishes a process to define core competencies for direct care workers across all of Ohio's health and human services agencies. This is important to ensure that direct care workers in the homes and residences of consumers are trained, tested, and certified in the core competencies needed to provide these services. (See also "Prioritize home and community based services.")

REFORM TRAINING

- **Target direct medical education to support workforce priorities.** The federal government pays for teaching hospitals to train physicians in residency programs and for the higher costs associated with teaching. The Executive Budget does not change the current level of Medicaid direct graduate medical education funding – about \$200 million over the biennium – but it does propose to target those funds to support health sector workforce priorities. Beginning July 1, 2014, Medicaid direct medical education payments will be allocated based on rules that will be developed to support: a workforce trained in comprehensive primary care with a commitment to serve all Ohioans; dollars following residents into community practices; primary care placements in recognized patient-centered medical homes; a residency mix that recognizes and supports the needs of Ohio; and strategies that mitigate underserved areas in Ohio. While budget neutral, the opportunity to focus \$200 million over the biennium to achieve workforce priorities is significant. (See also, "Reform hospital payments.")
- **Support training in promising models of care.** The existing state-funded Patient-Centered Medical Home (PCMH) Education Pilot Project provides technical assistance to convert 50 primary care practices, some in underserved areas, to PCMH status and use those sites for training in advanced primary care. These 50 sites have already been selected and begun their transformation. A statewide PCMH Education Advisory Group (EAG), comprised of various stakeholders from government agencies, educational, medical, and nursing organizations, provides input and guidance for the implementation of the project. All sites selected in the pilot have an affiliation with a medical or nursing school and will be training medical and nursing students, interns and residents on a patient-centered model of care using a curriculum developed by the EAG. The budget authorizes ODH to adopt standards and procedures for certifying PCMH, eligibility requirements for providers, and uniform health care quality and performance measures.

ALIGN PAYMENT

- **Primary care rate increase.** The federal government requires states to raise Medicaid fees at least to Medicare levels for family physicians, internists and pediatricians for many primary care services. In Ohio, primary care physicians will see their Medicaid payments increase 82 percent on January 1, 2013, and receive an estimated \$700

million more in Medicaid payments over the two-year period ending December 31, 2014, all of which is federally funded. (See also “Reform other provider payments.”)

- **Home and community based services rate increase.** The Executive Budget holds the line on spending for institutional services, but increases payment for home and community based services. The budget increases aggregate spending for Medicaid aide and nursing services three percent, increases adult day service rates 20 percent in the Ohio Department of Aging’s PASSPORT and Choices programs, and increases assisted living rates three percent. These provisions cost \$30.8 million (\$11.4 million state share) over the biennium. (See also, “Prioritize home and community based services.”)
- **Support payment innovation.** More than 40 percent of a primary care physician’s day is spent in essential but non-reimbursed tasks such as care coordination¹⁰ and 27 percent of their revenue is spent on administrative activities such as insurance company and government compliance and regulations.¹¹ New payment methodologies need to be developed to reward prevention, coordination of care, and management of chronic diseases. In January 2013, Governor Kasich convened an Advisory Group on Health Care Payment Innovation to align public and private health care purchasing power to reward the value of services, not the volume. The Advisory Council is exploring innovative payment models, including paying for better coordinated care and improved outcomes through patient-centered medical homes and accountable care organizations, which treat patients for “episodes” of care rather than on a per visit basis, and coordinate care as patients are discharged from the hospitals to prevent re-hospitalization.

Updated January 31, 2013

¹⁰ New England Journal of Medicine, [What’s Keeping Us So Busy in Primary Care?](#) (April 2010)

¹¹ Health Affairs, [Peering Into the Black Box: Billing and Insurance Activities in a Medical Group](#) (January 2013)