GOVERNOR'S PRIMARY CARE TASK FORCE
MEETING SUMMARY
August 30, 2012

Members Present

Deb Bowman
Mary Nettleman, MD
Julia Abraham, PA
Rob Allison, MD
Susan Anderson, MD
Sen. Corey Brown
Larry Gabriel
Dixie Gaikowski
Doneen Hollingsworth
David Kapaska, DO
Dean Krogman
Dr. Michael Lawler
Rep. Melissa Magstadt
Kimberlee McKay, MD
Dr. Roberta Olson
Seth Parsons
Dr. Robin Peterson-Lund, CNP
Mark Schmidt
Kurt Stone, MD
Sen. Billie Sutton
Bruce Vogt, MD
Michael Wilde, MD

Members Absent:

Cecelia Fire Thunder
Rep. Spencer Hawley
David Whitney, MD

Staff Present:

Liza Clark
Sandi Durick
Halley Lee
Tom Martinec
Susan Sporrer

Welcome

Dr. Mary Nettleman opened the meeting of the Governor's Primary Care Task Force. Twenty-two members were present.

Dr Nettleman reminded members of the Governor's charge to the Task Force – to consider and make recommendations to ensure accessibility to primary care for all South Dakotans – with a particular emphasis on rural areas. In particular, the Task Force needs to look at capacity of education programs and how to provide meaningful rural education opportunities for students to encourage practice in rural communities, distribution of providers, innovative primary care delivery models to enhance support mechanisms for rural practitioners, and establishment of accountability/outcome measures to make sure the state is getting a return for any investments made.

Deb Bowman added that the agenda has been designed to look at "best practices" in several different areas – capacity, distribution of providers, and innovative primary care models. The task force needs to look at whether or not the necessary components are in place for quality rural experiences for healthcare students and what can be done to enhance or modify existing programs in South Dakota. The task force will also be hearing from a panel of rural providers who will talk about why they chose a rural practice and administrators who are going to talk about the challenges they have in recruiting and retaining providers and what opportunities they see for the state to address the challenges. One of the biggest concerns she sees for State policy makers is the lack of good, consistent data on students, graduates, residents, etc. as far as where they are practicing. Deb also suggested that the task force needs to look at a coordinated system to recruit primary care students back to South Dakota once they have completed their residencies and fellowships.

Follow-Up from First Meeting

- *Recruitment Incentive Programs* – In follow-up to question from the first task force meeting, Tom Martinec provided data on the outcomes of tuition reimbursement programs. The Department of Health (DOH) currently manages recruitment assistance programs for physicians,

dentists, physician assistants, and nurse practitioners. Since the original physician tuition reimbursement program was put in place in 1997, 22 physicians have completed their commitment and 13 (59%) of those are still practicing in the original community. Seven dentists have complete their commitment under the dental tuition reimbursement program and all are still currently in the original community while the four physician assistants/nurse practitioners who have completed their commitment are still in their original community. The DOH also manages a program to provide assistance to a variety of health professionals (i.e., nurses, dietitians, physical/occupational therapists, etc.) practicing within health facilities. That program has a 58% retention rate.

There were questions regarding why recruitment assistance programs are limited to communities of 10,000 or less. Tom responded that the programs are designed to help small, rural communities who do not have as many resources as larger communities.

- *Data Request Review* – Tom Martinec shared that the DOH had been working with the School of Medicine, PA program, NP program, and residency programs to try to collect comparable data that can be used by the Task Force in their discussions at this meeting. However, there is still work that needs to be done to pull that information together so it will be provided prior to the final task force meeting in October.

- *Healthcare Workforce Pipeline* – Halley Lee with the DOH Office of Rural Health provided an overview of the various healthcare workforce pipeline activities managed by the DOH to encourage middle and high school students to consider careers in healthcare such as Health Occupations for Today and Tomorrow (HOTT), Scrubs Camps, Camp Meds, and Community Healthcare-workforce Allies through Mentoring, Partnership, and Solutions (CHAMPS). There are also a variety of other pipeline activities being coordinated by other entities.

- *Health Occupations Students of America (HOSA)* – Brock Rops provided information on HOSA which is a student-led organization aimed at nurturing healthcare career interests of students through projects, healthcare procedures, and skill development. HOSA events cover such areas as health professions, health science, emergency preparedness, leadership, teamwork, and recognition. There are currently seven HOSA pilot sites in South Dakota, mostly in more populated areas in order to get a critical mass to start the program. Plans are to expand to 15 schools by the 2013-2014 school year.

Primary Care Issues on South Dakota Reservations

Dixie Gaikowski provided an overview of recruitment and retention challenges of primary care providers on South Dakota reservations. Aberdeen Area Indian Health Services (IHS) encompasses South Dakota, North Dakota, and Nebraska. Recruitment isn't as difficult in North Dakota and Nebraska as it is in South Dakota – mainly because of the location of facilities. Housing and schools are a problems South Dakota reservations face when recruiting healthcare providers. Many providers don't want to come to South Dakota because the service areas do not provide a full-service of health care services and providers don't want to lose competencies (i.e., surgery, etc.). Also, hospitals may not be well equipped for OB services and there are no trauma teams in emergency rooms so providers are in the ER alone. Aberdeen IHS is working to build up providers through contracts. However, 75% of primary health care is provided by contract providers and that makes continuity of care very difficult. IHS is restructuring its retention program and is looking at tuition reimbursement programs. They also recognize as they recruit physicians, they also need to be recruiting nurses. Tribal communities must engage in the recruitment/retention process as well.

Short and Long Term Expectations
Liza Clark with the Bureau of Finance and Management (BFM) provided a timeline of the budget process. After receiving agency budget requests, BFM spends September and October meeting with agencies and analyzing budget requests. BFM looks at requests for additional money to determine how the increase will benefit South Dakota. BFM presents the budget recommendations to the Governor in early November.

Deb Bowman explained that the Governor receives the budget requests from all state agencies, Constitutional offices, Unified Judicial System, and Board of Regents. Before any decisions are made on budget, the funding requirements for Education and Medicaid have to be met. When funding Medicaid, every percentage point increase in the state match requires approximately $7 million dollar in state general funds to fund the state share. Then the Governor begins to make decisions on the remainder of the budget. Deb said that the explanation that "it's done because we always have", is not good enough anymore. The Governor then presents his final recommended budget to the Legislature in December.

Senators Corey Brown and Billie Sutton talked about the legislative budget process. The Senate and House Appropriations Committees meet jointly nearly every morning during session to make decisions on the state's $4 billion budget. Sen. Brown said that appropriators want to know how progress is being measured (i.e., how do you link an increase in the slots in the Medical School to increased number of providers in rural South Dakota). Sen. Sutton said that while legislators may disagree on how much or where money goes, they all agree that there needs to be accountability for money that is spent.

Rural Experiences for Health Profession Students (REHPS)
Sandi Viau Williams with the Yankton Rural Area Health Education Center (AHEC) provided an overview of the REHPS program. REHPS provides first and second year medical, physician assistant, nurse practitioner, and pharmacy students with experience in a rural setting with the ultimate goal of increasing the number of medical professionals who practice in rural and frontier communities in South Dakota. Two healthcare students (one pharmacy and one physician/PA/NP student) are paired together in a community for a four-week rotation. The students cannot leave the community during the time unless they have permission. The students receive a $4,000 stipend while in the community. REHPS is starting its third year and has seen a 250% increase in applicants to the program since it started because students see a value to the program. REHPS currently has sites in Wessington Springs, Redfield, Parkston, Winner, Wagner, and Philip. Plans are to invite three more communities to join for a maximum of 18 communities with 36 students. Sandy indicated that she is currently looking at options for sustainability once federal grant funding ends. The total cost of the program is about $6-7,000 per student. One of the options being looked at is requiring some financial buy-in by the community.

Interprofessional Education/Rural Medical Education Track
Dr. Gwen Wagstrom Halaas, Senior Associate Dean with the University of North Dakota School of Medicine and Health Science presented information on interprofessional education and rural medical education tracks.

Interprofessional practice is important because many medical errors occur because of a lack of communication. One way to get past the barriers of hierarchy is to start early with interprofessional education to allow students from two or more professions to learn from and with each other to begin building effective communication. Interprofessional collaborative practice, particularly in rural areas, can provide a support system for healthcare providers and foster cooperation and coordination between professions to deliver the highest quality of care for patients. Dr. Nettleman noted as the School of Medicine is revising its curriculum, one of the areas being addressed as part of professionalism is how to work as a team. Dr. Halaas said while there are barriers to interprofessional education (i.e., initial expense of new program, matching academic schedules/student skill sets, turf-guarding, etc.), evidence shows that

interprofessional education enables collaborative practice which in turn optimizes health services, strengthens health systems, and improves health outcomes.

Dr. Halaas said that while 20% of the population lives in rural communities, only 9% of physicians practice in rural areas and only 3% of current medical students plan rural practice. When entering medical school, three factors play a significant role in determining if a physician will eventually choose a rural practice location – growing up in a rural area, planning to practice in a rural area, and planning to practice family medicine. Opportunities need to be provided to medical students to experience rural medical practice with the ultimate goal of increasing the number of primary care physicians in rural areas. The University of Minnesota Medical School's Rural Physician Associate Program (RPAP) has been in place since 1971 with 1,055 physicians now in practice. Of those, 76% are in primary care, 65% are in family medicine, 64% practice in Minnesota, and of those 61% are in rural practice. RPAP places 40 third year students in 110 communities during the year. The students spend 9 months in a rural community (1,000-30,000 population) with a primary preceptor. The success of the program has led other medical schools to develop similar programs. Success factors for rural medical education include integrated clerkships (continuity of care), rural physician mentors (lifestyle and leadership), interprofessional education, and community engagement.

Frontier and Rural Medicine Program (FARM)
Dr. Susan Anderson provided an overview of the FARM program which is designed to increase the number of primary care physicians practicing in rural South Dakota. FARM offers third-year medical students the opportunity to spend nine months of their clinical training in a rural community (< 10,000 population). Beginning in 2014, up to six students will be selected to participate in the program in one of the five FARM locations of Milbank, Mobridge, Parkston, Platte, or Winner. To be eligible as a FARM site, the community had to have at least 2 primary care physicians, inpatient/ambulatory/long-term care, surgery presence, outreach specialty clinics, and an opportunity for prenatal/postpartum care. Students will participate in the full spectrum of the practice of rural medicine and will follow patients over time in the clinic/hospital setting. Through the training, students will gain an understanding of the rewards and challenges of rural practice while living in the community.

Overcoming Recruitment and Retention Challenges
A panel of rural providers discussed the challenges of recruiting and retaining primary care practitioners in rural areas as well as what drew them to practice in a rural community. Panel members included Mark Burket, CEO of Platte Health Care Center, Travis Henderson, MD from Mobridge Regional Hospital and Clinic, Christopher Boschee, DO from Avera St. Benedict Health Center in Parkston, Julia Abraham, PA from Oahe Valley Community Health Center in Pierre, and Dr. Robin Peterson-Lund, CNP from Philip Health Services. The panel said that what typically draws people to a rural community is that is where they were born and raised and they see the value in what a rural community can offer such as ability to spend more time with family. Providers like that they have the opportunity to provide a continuum of care and like the broad spectrum of services primary care provides. The more exposure you can provide to students to the rural health care experience, the more confident they are in their abilities to practice in that setting. In recruiting providers, it was noted that many times you spend more time recruiting the spouse. While salary is a factor, many times the more important considerations is how much call there will be and what support system is in place for rural practitioners to make rural practice more appealing. A question was asked whether there is an inventory of telehealth capabilities of South Dakota hospitals. There was also a question regarding the collaborative and supervisory requirements for nurse practitioners and physician assistants.

Task Force Discussion
Dr. Robert Allison distributed a copy of a paper that was by the SD State Medical Association in consultation with the SD Academy of Physician Assistants, and Nurse Practitioner Association of SD.

The paper includes potential recommendations for strengthening primary care access in South Dakota that could be considered by the Task Force in its deliberations. It was suggested that the Task Force establish subcommittees to help come up with proposed recommendations for discussion at the final Task Force meeting. Task Force members will be given the opportunity to volunteer to serve on the subcommittee which will meet the afternoon of October 10th. Recommendations need to look at partnerships (i.e., private, state, and community).

Next Meeting
The next meeting will be Thursday, October 11th in Sioux Falls.