

# Primary Care Task Force Oversight Committee Meeting Summary September 30, 2015

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## **Committee Members Present:**

Robert Allison, MD  
Sen. Corey Brown

Mary Nettleman, MD  
Dr. Mike Rush

Sen. Billie Sutton

## **Workgroup Members Absent:**

Kim Malsam-Rysdon

Sandy Diegel

Gale Walker

## **Staff Present:**

Halley Lee  
Tom Martinec

Josie Petersen  
Susan Sporrer

## **Welcome and Introduction**

Tom Martinec, Deputy Secretary of Health, welcomed Oversight Committee members in Secretary Malsam-Rysdon's absence. Dr. Mike Rush, Executive Director for the Board of Regents was welcomed to the Committee.

## **Updates**

Halley Lee provided an update on the potential of increasing the size of the community eligible for the Rural Healthcare Facility Recruitment Assistance Program (RHFRAP) from the current 10,000 population to 15,000. This would add Huron, Pierre, Spearfish, Vermillion, and Yankton to the list of eligible facilities. After looking at the numbers it was determined that it was not economically feasible to add additional communities. The Department of Health will be moving forward to add Masters of Social Work and speech-language pathologists to the list of professions eligible to participate as well as adding ambulance services to the list of eligible facilities. These changes will be accomplished through administrative rule.

Tom Martinec reported that the DOH FY 2017 budget request included \$518,600 for the Recruitment Assistance Program and \$277,500 for the RHFRAP program in the base budget. It is unknown if the request will be included in the Governor's recommended budget or if the appropriations for RHFRAP will come through special appropriation bills as they have been previously.

## **Residency Program**

Oversight Committee members reviewed information regarding start-up and continuation costs for a Rural Residency Track. The DOH has requested \$205,000 in its FY17 budget request for one-time start-up funds for a rural residency track. Proposed ongoing funding would come from a variety of sources – resident generated income, general and federal funds, and hospital contributions.

Winner was not a feasible rural residency track site because it did not have sufficient patient volume to support residency training.

Dr. Kurt Stone with the Rapid City Family Residency program provided an update on Spearfish as a possible rural residency track site. Dr. Stone did not believe the community was able to support a rural track. Rapid City Regional is not willing to provide any additional support for a rural residency track in Spearfish so any expansion would need to be entirely funded by the state. Dr. Stone met with medical and administrative staff in Spearfish and there is not united support for a rural

residency track. There are also concerns about the availability of physician staff in Spearfish as the inpatient adult medicine is currently staffed by locum tenens physicians and are not permanent staff. Dr. Stone discussed an alternative to a rural residency track site which would be an alternate family medicine residency site that would allow family medicine clinics to be provided in a site 60 miles from the Rapid City program. The required rotations would be done at the main residency site and then family medicine clinics could be conducted in the alternate site. The main drawback is the medical residents would not be living in the community like they would in a rural residency track. Dr. Stone said Sturgis would be the likely alternate site for the Rapid City Program.

Dr. Mark Huntington with the Sioux Falls Center for Family Medicine and Dr. Rob Allison gave an update on their meetings with Pierre as a potential rural residency track site. Pierre meets most of the teaching requirements but would need to recruit a family medicine physician who would deliver babies. Pierre has committed to making that a recruiting priority. The pediatric intensive care requirements would likely have to be met at another location. Dr. Huntington was very encouraged by the meetings with Pierre physicians and all specialties were excited about possibility of a rural residency track site. The hospital's administration expressed support for developing a rural residency track in Pierre.

The Oversight Committee discussed the timeline for getting a rural residency track up and operational. Dr. Huntington said that once funding is available the best case scenario would be about one year to get a rural residency track accredited. The program would not be able to recruit residents to the program until accreditation was achieved. First year residents accepted into a rural residency track program would complete their first year at the main residency site and would not move to the rural site until years 2 and 3. Based on when the residency match occurs (each March), the earliest residents would enter the program would be June 2017. There was discussion that if the rural residency program missed the March match deadline, it could potentially be eligible to participate in a supplemental match process for those students who didn't match to a residency the first time.

Sen. Brown said that the focus of the Task Force and Oversight Committee has been on rural South Dakota and making sure we have providers. The Medical School has been expanded and the resident licensure issue was corrected and now the timing appears to be right to move forward with proposing a rural residency track. Based on the receptiveness of Pierre and some of the challenges facing Spearfish, the Oversight Committee supported moving forward with Pierre as the potential rural residency track site.

### **Workforce Issues and Trends**

Robin Arends, Executive Director of the Nurse Practitioner Association of South Dakota (NPASD) talked to the Oversight Committee about NP supply and demand in the state, barriers to practice and key issues/trends affecting the profession. There are currently 690 NPs in the state with jobs expected to grow by over 22% by 2022. South Dakota's NPs tend to come from rural practice and return to these communities to practice primary care. Workforce supply is affected by decreased numbers of physicians entering primary care who are able to serve as collaborating physicians and the limited number of preceptors able and willing to precept. If a NP loses their collaborating physician, they are not able to practice until they have a new collaborative agreement in place which in turn impacts access to health care services.

According to the American Association of Nurse Practitioners website, as of May 12, 2015, 22 states permit full practice for NPs while 17 states have reduced practice (required collaborative agreement with physician) and 12 states have restricted practice (required supervision, delegation

or team-management by physician). Robin indicated that NPs are moving to surrounding states which allow them to practice without a collaborative agreement. NPASD will be bringing legislation in 2016 to remove the collaborative agreement requirement and allow independent practice by NPs in South Dakota.

Justin Thurman with the South Dakota Academy of Physician Assistants shared that there are between 300-350 PAs in South Dakota. PAs face the same challenge in that if they lose their supervising physician, they are unable to practice until a new supervisory agreement is in place. The ratio of 4 FTE to 1 supervising physician can also be a challenge. Justin shared that Nebraska has the same 4:1 ratio as South Dakota, Wyoming has a 3:1 ratio, while both Iowa and Minnesota have a 5:1 ratio. North Dakota and Montana have no established ratios. Justin wondered if there was perhaps a need to look at an exception to the supervisory agreement requirement to allow the PA to continue to practice until a new agreement was in place.

Gloria Damgaard, Executive Director for the South Dakota Board of Nursing shared information from the recent Joint Board of Nursing (BON) and Medical and Osteopathic Examiners (BMOE). The Primary Care Oversight Committee asked the BON and BMOE to look at potential barriers in statute, administrative rule or board interpretation that would prohibit telehealth being used to its fullest potential to help assure accessibility to health care services. The original request was specific to the definition of “direct supervision” of medical assistants to allow for supervision by means of telehealth technology. The Joint Boards approved a change in the definition of “direct supervision” for medical assistants to allow the physician, PA, NP, or nurse midwife to provide direct supervision by means of electronic communication. The Joint Board also approved moving forward with changes to administrative rules for nurse practitioners to allow the “direct personal contact” requirement to be permitted by means of electronic communication. The expectation is that the administrative rules for PAs regarding direct supervision will also be updated to be consistent with the changes for medical assistants and NPs. It is believed this change has the potential to make physicians more willing to participate in collaborative or supervisory agreements with NPs and PAs by eliminating the requirement for the physician to be onsite every 90 days.

The Oversight Committee was interested in looking at a “grace period” to allow the NPs and PAs to find a new collaborating/supervising physician while maintaining their ability to work. The DOH will work with the BON and BMOE to look at potential options and whether the change could be done via administrative rule or if legislation would be needed. The BON and BMOE will also look at the 4:1 ratio that is currently required as well.

Susan Sporrer provided an update on a survey conducted by the DOH of nursing facilities and hospitals regarding nursing workforce needs and challenges. The survey was the result of a concern raised to the DOH that the movement from two-year Associate degree RN programs to four-year Bachelor degree RN programs was having a detrimental effect on the ability of health care facilities to recruit nurses. When asked about preference for nursing degree type, the majority of respondents indicated they didn’t have a preference. Hospitals were more likely to give preference to BSN as were communities of 15,000 or more. Facilities were asked to rank barriers to filling nursing positions in facility. Lack of available nursing workforce in the community and lack of nursing staff to work all shifts was the biggest barrier across all facility types and community size. Communities with a population of 5,000-15,000 said lack of a 2-year Associate degree RN program was a barrier. Facilities were also asked about strategies used on a regular basis to recruit nurses. Flexible work schedules was the most cited recruitment strategy. Hospitals were most likely to utilize flexible work strategies while nursing facilities were most likely to use the state Facility

Recruitment Assistance Program. While it wasn't a focus of the survey, the DOH continued to hear about the need for certified nurse aides.

**Wrap-up**

Halley said that staff are currently working to get all the data pulled together for the 2015 annual report. Susan will draft the report and provide a copy to the Oversight Committee for their review and comment before it is finalized and submitted.

Focus areas for next year were discussed by committee members including: (1) potential alternate family medicine residency sites; (2) provider retention, particularly in rural areas; and (3) physician assistant/nurse practitioner issues if they aren't addressed during 2016 session.