Fitzhugh Mullan Institute for Health Workforce Equity

THE GEORGE WASHINGTON UNIVERSITY

Policies to Strengthen Health Workforce Equity

In Primary Care

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Health Workforce Equity: A Vision of…

A diverse health workforce that has the competencies, opportunities & courage to ensure everyone has a fair opportunity to attain their full health potential.

Interrelated Health Workforce Equity Domains

1. Who **ENTERS** the health workforce
   Does the health workforce and its leadership reflect the diversity of the communities they serve?
2. How they are **EDUCATED** & **TRAINED**
   To what extent do health professions' education institutions exercise social mission ?
3. **WHERE** & **WHAT** they practice
   Are clinicians distributed across geographic regions and specialty areas in accordance with the needs of all population groups?
4. Whom they **SERVE**
   Do they serve high need patients, i.e., Medicaid beneficiaries, the uninsured, and those with complex comorbidities?
5. How they **PRACTICE**
   Do they practice in ways that help address the root causes of health disparities?
6. Under what **WORK CONDITIONS**
   Do all health workers have safe, fair and supportive work environments?

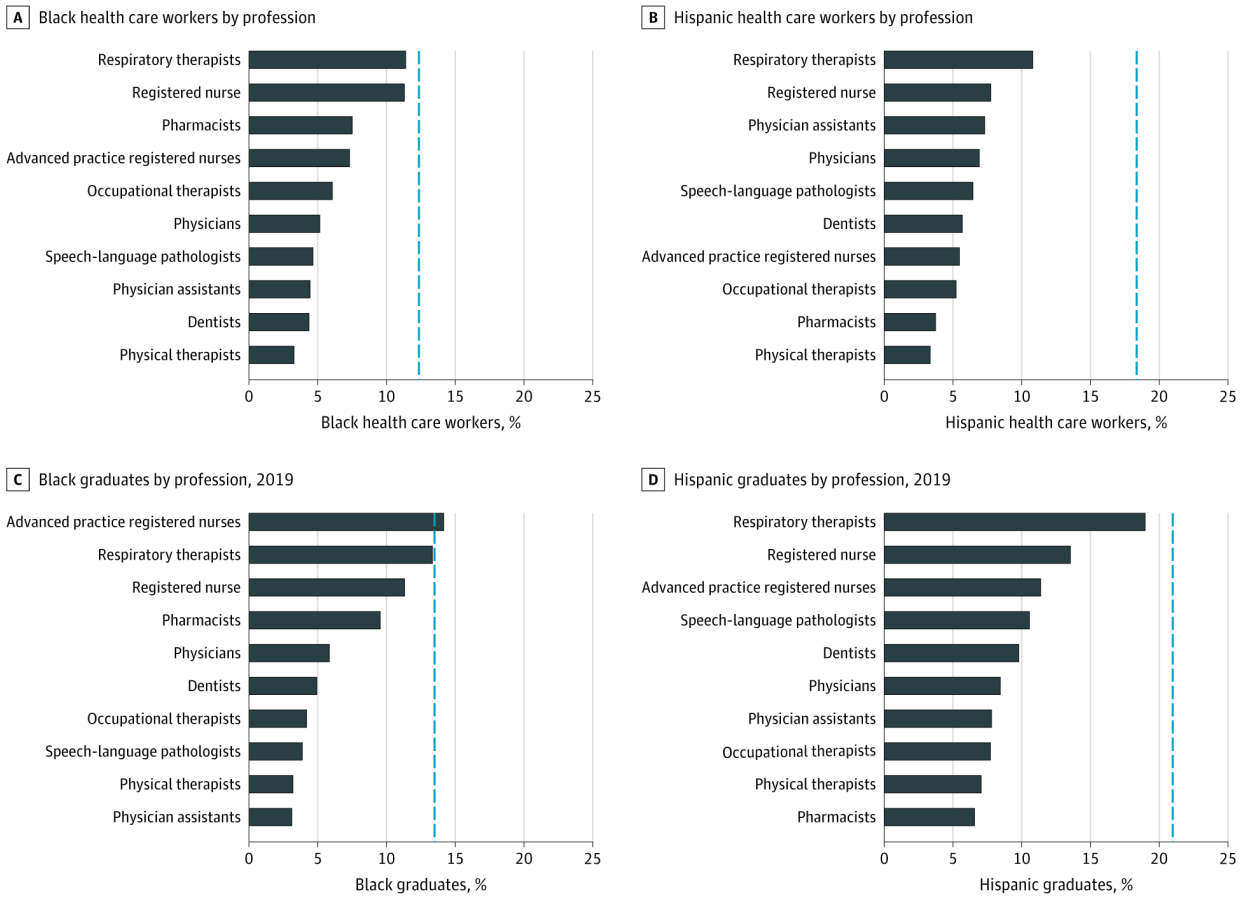
PRIORS

PROBLEM	ACTIONS
The US has no national health workforce policy function, leaving most of this to states and creating a patchwork quilt of regulations and policy, driven largely by vested interests, rather than evidence.	Fund the Health Workforce Commission & include policy experts that are NOT workforce experts.
There is no central registry of health professionals that can be used for research and disaster planning.	Modernize the National Provider Identifier (NPI) Registry, include race/ethnicity, and explore implication of adding non-billing licensed professionals.

DOMAIN 1: Diversity

From: **Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce**

Salsberg et al. JAMA Netw Open. 2021;4(3):e213789. doi:10.1001/jamanetworkopen.2021.3789



PROBLEM	ACTIONS
• Diversity index is below 1 for current workforce in all 10 professions, & especially low for Hispanic professionals. • Slight improvements among new grads, esp NPs, and for Hispanic grads.	• Fund accountable pipeline programs • Fund accountable partnership with community colleges to create stackable degrees. • Employer funding

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JAMA Network™

Domain 2: Social Mission of HP Education

PROBLEM	ACTIONS
HP schools do not value HRSA training grants	• Increase 8% cap on training grant indirects
NIH funds $40 B in specialty research (AHRQ and HRSA PC research tiny)	• More research funding for PC
Medical schools educate for specialty GME match (drop in US seniors' interest in PC)	• Increase PC training grants, including NP/PA and expanded teams • Link federal funding to accountability for outcomes with better measures, e.g., *Social Mission Metrics* & workforce outcomes
GME allocative system leads to hyper specialization and geographic maldistribution	• Targeted geographic expansion of PC slots with FM, Peds and geriatrics
Insufficient community-based training opportunities for PCPs (126.5M vs 15B)	• Permanent increase in THC funding • Increase NP PC residency funding • Blend some parts of NP and physician residency training

Domain 3: Distribution by Pop Need

PROBLEM	ACTIONS
Restricted SOP and restricted use of NPs, PAs, pharmacists, PTs & behavioral health providers reduces access to PC	• Make temporary State SOP waivers permanent for NPs, PAs, pharmacists and PTs. • Make Medicare waivers permanent
HPSA designations have become ubiquitous, reducing allocative efficiency of many programs intended to improve access	• Adopt prior advisory committees proposed improvements, including consideration of NPs and PAs, and Medicaid acceptance.
NHSC restricted to pre-existing sites and job offers, which reduced potential impact on access	• Expand NHSC to target PC deserts (using new criteria) and new jobs

Domain 4: Serving High Need Patients

PROBLEM (preliminary analysis of 2016 T-MSIS Mullan Inst.)	ACTIONS
• PCPs w/no Medicaid participation ranged from 12 % IA- 30% HI • % w/ > 100 patients VA 22 – NM, VT 56% • Density of Medicaid PCPs >11 patients ranged from 35 in CA – 146 in NB • PC specialty varies w/Peds highest and PAs lowest.	• CMS should track as state Medicaid policy outcome • States should hold MCOs accountable for gap between network credentialing and claims • Enhance Medicaid payments and reduce administrative burdens

Domain 5: Practice Patterns

PROBLEM	ACTIONS
VBP inducing consolidation with some negative effects on low value care, prices and possible access	• VBP should anticipate and address problems • Funding for rural health centers and CHCs more important than ever
Use of NP & PA in teams and home visits constrained by 85% Medicare, and in some states 75% Medicaid billing	• Remaining states should go to 100% Medicaid • Medicare should increase payment to 100%
Despite evidence on CHWs and other peer workers contributions to team outcomes, uptake is still slow	• Remove requirement for Medicaid State Plan Amendments for preventive services. • Extend types of services CHWs can bill Medicaid for to community health promotion
Use of RNs in PC still rare, and largely restricted to rural areas and certain HRSA programs	• Consider RN billing waivers, similar to Medicaid unlicensed personnel waiver
Home care workforce do not interact with PC teams	• Create programs that train and reward PCPs to partner with home care agencies to help integrate DCWs into teams, as HRSA has done with behavioral and dental health workforces.

Domain 6: Fair and Safe Working Conditions

PROBLEM	ACTIONS
Direct care and medical assistance workforces below living wage creating high turnover for employers, and poor health outcomes for them	• Increase payment and link to increased worker compensation for home care, eg make ARPA programs permanent. • Cancel student debt for MAs
Burnout and moral injury pervasive	• Make COVID era reduction in administrative burden permanent • Assess impact & feasibility of national scale up of TX gold card legislation, and other efforts to reduce pre-authorization burden