

Current Health Workforce Research at the WWAMI Rural Health Research Center

NOSORH Region E Meeting
Juneau, AK
July 28, 2011

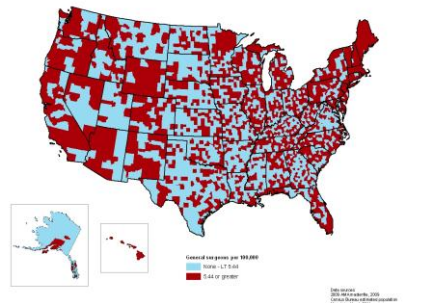
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Variability in surgical practice and patient characteristics in rural and urban US hospital settings

- WWAMI RHRC Team: Mark Doescher, Beth Jackson, Sue Skillman, Meredith Fordyce, Dana Lynge
- Goals: to help inform rural general surgery policy, the study examined rural and urban differences in:
 - inpatient general surgery scope of practice
 - surgical patient characteristics

General Surgery "Deserts" Exist in Many Rural Areas



Key Findings: Rural General Surgery Workforce Needs

- Rural hospitals concentrate on relatively narrow set of low complexity inpatient procedures performed on relatively low-risk patients.
- These results support the concept of rural training tracks that produce general surgeons with competence in:
 - "Traditional" general surgical procedures
 - A selected subset of ob-gyn and orthopedics procedures

The Contributions of Community Colleges to the Education of Allied Health Professionals in Rural Areas

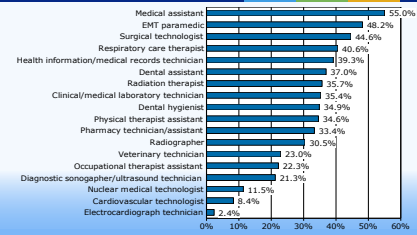
- WWAMI RHRC Team: Sue Skillman, Gina Keppel, Davis Patterson, Mark Doescher
- Goals: to describe and quantify --
 - why community colleges are important to the allied health workforce and to rural communities,
 - which allied health occupations are most relevant to rural areas and can be educated in community colleges,
 - how many/where allied health programs are (and are not) located within commuting distance of rural populations,
 - how many/where small rural hospitals are located near allied health education programs

The Rural Allied Health Workforce and Community Colleges: Background

- Recruiting and retaining the necessary allied health professionals in rural communities is a problem
(National Rural Health Association Policy Position: Allied Health (2008))
- Community colleges are important to rural economic development and in many rural communities they are the only higher education institutions accessible to their populations
- Many allied health occupations can be educated and job-ready after completing community college programs
- Adds up to: **Community colleges are important for rural communities and allied health workforce development**
- The study provides information for education program planning and improves policymakers' awareness of the need to support distance education and other methods to bridge rural workforce gaps

By Allied Health Occupation

Rural Populations within a 60-Minute Drive of a RRCDAH* Program



*Rural-relevant community college allied health

Critical Access Hospitals within a 60-Minute Drive of Specific AH Programs

(partial list)	CAHs U.S.	CAHs West	CAHs Midwest	CAHs South	CAHs Northeast
Surgical Tech	33%	11%	36%	49%	20%
Health Info/Med Records Tech.	30%	12%	33%	39%	28%
Respiratory Care Therapist	28%	8%	29%	43%	26%
Clin/Med Lab Tech	28%	3%	30%	45%	28%
Pharm Tech Asst	25%	15%	25%	35%	9%
Phys Ther Asst	24%	7%	25%	34%	37%
Radiation Therapist	23%	10%	21%	37%	37%
Diag Sonography/ Ultrasound	15%	4%	16%	22%	17%

The Current Contribution of Physicians, Advanced Practice Nurses, and Physician Assistants to the Rural Primary Care Workforce

- WWAMI RHRC Team: Mark Doescher, Sue Skillman, Holly Andrilla
- Goals:
 - To examine (via survey) the primary care visit productivity and scope of practice of rural physicians, nurse practitioners (NPs), and physician assistants (PAs)
 - To examine the primary care contributions of physicians, NPs, and PAs by degree of practice rurality, practice characteristics, and primary care HPSA

Rural Primary Care Survey

- Rural providers selected from licensing records in 13 states
 - AZ, GA, ID, IA, KY, ME, MN, OH, OK, OR, TX, VT, VA
 - 4,000 physicians; 3,000 PAs, 3,000 NPs
- Web-based or paper questionnaire response options
- Survey in field now – results expected Spring, 2012

Health Information Technology (HIT) Workforce Needs of Rural Primary Care Practices

- WWAMI RHRC Team: Sue Skillman, Holly Andrilla Davis Patterson, Mark Doescher
- (Proposed for 2011-12)
 - Will survey rural primary care practices assess current and projected demand for workers with EHR/HIT skills
- Findings will improve our understanding of the specific HIT workforce needs and constraints facing primary care practices
- NOSORH and SORHs in selected states will be asked to help refine survey tool and with identification of practices

The Pre-hospital Emergency Medical Services Workforce in Rural and Urban Areas

- WWAMI RHRC Team: Davis Patterson, Meredith Fordyce, Gina Keppel, Sue Skillman, Mark Doescher
- (Proposed for 2011-12)
 - Will analyze and compare rural and urban EMS agency staffing and vacancy data from a 2008 survey of all EMS agencies in 9 states (AR, FL, MA, KS, MT, NM, OR, SC, WI)
 - Will look at workforce issues by size of service area, patient volumes, funding basis, and organizational type
- Findings will inform policy options to ensure an adequate supply of EMS personnel in rural areas.

The Influence of State Policies and Practices on J-I Visa Waiver Physicians' Service* in Rural Areas

* through the Conrad State 30 Program

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 - Mary Amundson, Center for Rural Health, University of North Dakota School of Medicine and Health Sciences

Outline

- Conrad State 30 program background
- Study questions and methods
- Trends in the use of Conrad 30 J-I visa waivers
 - Specialty (primary care v. specialists)
 - Geography (rural v. urban)
- Conrad 30 program recruitment and retention strategies
- More questions

Conrad State 30 Program Background

Conrad State 30 “Conrad 30” Program

- Federal legislation authorizes each state to recruit up to 30 non-US citizen international medical graduates (IMGs) per year to serve in shortage areas (HPSAs, MUAs).
- Up to 10 of the 30 slots can be outside of shortage areas but serving populations from those shortage areas (“flex” slots).

The Basics

1. An IMG physician gets a J-1 (“Exchange Visitor”) visa for U.S. residency training and must return home for 2 years upon completion, UNLESS...
2. The J-1 physician finds an offer of full-time employment for at least 3 years to provide care to the underserved.
3. The state DOH recommends to the US Dept. of State that the physician receive a waiver of the J-1 visa requirement to return home.
4. The physician converts to an H-1B visa, with option to pursue permanent residency after successful completion of obligated service.

How does Conrad 30 work in practice?

- Federally legislated but no dedicated funding*
- Little or no federal guidance or technical assistance beyond basic legislative requirements
- Each state must, if they choose,
 - devote resources
 - set goals and priorities
 - decide additional requirements (if any)
 - administer the program

* Can use State Primary Care Office funding for recruitment and retention activities

Study Questions and Methods

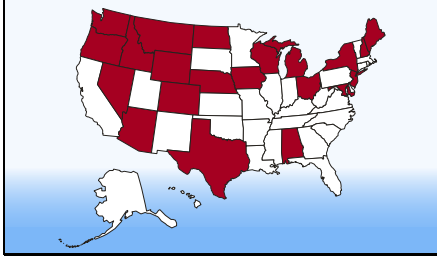
Key study questions

- How do states' Conrad 30 program policies vary?
 - Emphasis on primary care v. specialists?
 - Emphasis on rural v. urban underserved?
- What do we know about physician retention after obligated service? What factors contribute to retention?
- What are promising practices for states to best use the Conrad 30 program to ensure healthcare for rural and underserved populations?

Methods

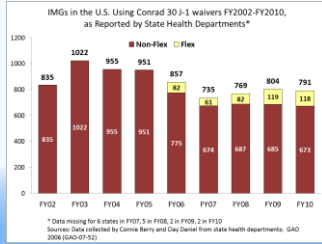
- Review of all states' Web sites
- Document review
- Review of legal Web sites aimed at J-1 physicians
- In-depth interviews (1:00-1:45) with Conrad 30 Program personnel with additional follow-up, querying all 50 states – in progress

Interviews complete in 21 states



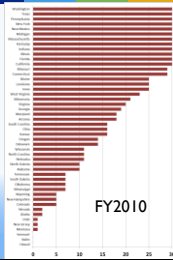
Trends in the Use of Conrad 30 Waivers

Total Conrad 30 waivers (50 states), FY2002-10

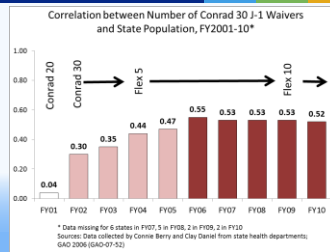


Distribution of waivers

- States have used 55-68% of available waivers from FY2002 to FY2010.
- In FY2010:
 - 12 states used 30 waivers.
 - 15 states used fewer than 10.
 - Mean per state: 16.5 total waivers, 2.5 "flex"



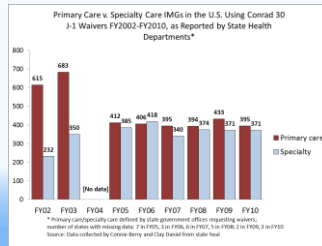
Bigger States Gain Increasing Share



**Preliminary findings:
Primary care v. specialists**

- **Primary care:** At least 39 states explicitly state a preference (includes psychiatry in at least 30 states).
- **Specialists:** At least 39 states allow most or all types of specialists, sometimes with restrictions:
 - waiting period before considering applications from specialists (if any open slots left)
 - quotas reserved for primary care
 - facility must demonstrate need for specialists

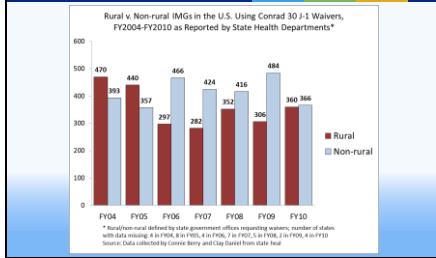
**Conrad 30 waivers FY02-10:
Primary care v. specialists**



**Preliminary findings:
Rural v. urban underserved**

- **Rural:** 5 states explicitly state a clear rural preference:
 - AZ, FL, IA, IL (psych), TN
- Many other states prioritize specific facility types, often rural, or informally prioritize rural placements.

Conrad 30 waivers FY04-10: Rural v. non-rural placements



Competition for J-1 physicians

- Competition for J-1 physicians on many levels:
 - between states
 - between urban and rural ("flex" slots a factor?)
 - between primary and specialist care ("flex" slots may play a role here)
- Competition will likely intensify:
 - As US medical graduates increase, residency slots for IMGs could largely disappear by 2020.
 - Some states have lost other tools due to budget constraints (e.g., state loan repayment programs).

Conrad 30 Program Recruitment and Retention Strategies

Approaches cited to improve recruitment/retention at each stage of process

- Pre-service:
 - **Market** to employers, recruiters, law firms
 - **Lower barriers to entry** (e.g., program/application requirements)
 - **Encourage a good match** between employers/communities and physicians (e.g., accommodating special needs of physicians)
 - **Get community letters of support** (e.g., civic, health department, and school district leaders)

Improving long-term retention

- Pre-service:
 - **Ensure clear understandings** of rights and responsibilities between employers and physicians
 - **Require employers to provide a long-term retention plan** with application
 - **Make the program user-friendly** for employers, physicians, and intermediaries

Improving long-term retention

- During service:
 - **Monitor program compliance and employer-physician relations:** calls, visits, questionnaires
 - **Build relationships** with physicians
 - **Provide technical assistance to employers** about foreign physician needs

Improving long-term retention

- Post-service:
 - Disallow non-compete, non-solicitation clauses
 - Provide letters of support for National Interest Waiver leading to permanent immigration
 - Additional 2 years of obligated service
 - Require a longer obligation period (e.g., 4 years)

More Questions

How do we gauge success?

- Given that states have wide latitude in designing, funding, staffing, and carrying out the Conrad 30 program:
 - What are appropriate and desirable roles for states to play—beyond the basics?
 - How much federal involvement is desirable?
 - What should the Conrad 30 program's success benchmarks be—both during obligated service and afterward?

Retention: how long is reasonable?

- “The fact that obligated physicians may move after 3 or 4 years may reflect broader societal trends of mobility—it’s a more migratory workforce than in prior decades. I was talking with an employer who said 3 years was a long time for physicians to be on staff, especially if they’re just out of training—that’s better than the average for physicians as a whole.”

Ethical questions

- “Not everyone is an advocate of the Conrad 30 program. Not everyone believes they should stay on...It’s not in the [federal] government’s best interest to have a policy about how to recruit an IMG. Some say those physicians are needed in their home countries and they should fulfill the conditions under which they came here” [to return home on completion of training].

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