

# Health Reform and Workforce: The North Carolina Connection

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**T**he health reform legislation passed in March of this year, the Patient Protection and Affordable Care Act (P.L. 111-148), was the focus of intense debate largely because of provisions that changed the way we provide health insurance coverage and regulate the insurance industry. Some provisions received very little attention both because they were less controversial and also because they were simply not of a scope that would draw the attention of the media or of most interest groups. One of the issues that “flew under the radar” is health workforce—the policies that guide the training and deployment of health care professionals.

North Carolina is often thought of as the “cradle” for innovative workforce programs. The state has been and continues to be a pioneer in the Area Health Education Centers (AHEC) movement; North Carolina was the location of the first nurse practitioner program to graduate students at the University of North Carolina (UNC) at Chapel Hill; the physician assistant profession was created at Duke University; and the East Carolina University Brody School of Medicine became one of the first primary care-focused medical schools developed in the expansion of medical education in the 1970s. North Carolina has also been a leader in the development of allied health training networks, the mobilization of its community college system for health professions training, and the development of a strong primary care-focused system in its Medicaid program. Almost every one of the workforce provisions in the reform bill will have very strong effects in the state, and the federal government and other states will look to North Carolina for guidance on how to make the promise of the health reform legislation come into being.

Health workforce legislation has a history even older than Medicare and Medicaid. Congress passed legislation

to support the training of nurses in the 1950s, then followed with a series of funded programs that supported medical and other health professions training. In 1970, the National Health Service Corps (NHSC) was created, setting a pattern of support not only for training but also for deploying of primary care physicians and other primary care professionals to underserved areas. Congress, in a series of health workforce

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programs passed into law in the 1970s, recognized that not enough generalist physicians were being trained in the United States and that they were not practicing in the places they were needed. With the 1976 passage of the Health Professions Educational Assistance Act (P.L. 94-484), Congress has recognized that we have an ongoing problem with the geographic and specialty distribution of physicians.

The need for federal support for nurse training was recognized as early as 1964 with the Nurse Training Act (P.L. 88-581), which established Title VIII of the Public Health Service Act. Subsequent programs supporting nurses fall under that section of the Public Health Service Act.

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# The National Health Service Corps – A Critical Component of Provider Recruitment in North Carolina’s Rural and Underserved Communities

*John Price, MPA*

Since the mid-1970s, the National Health Service Corps (NHSC) has been an invaluable resource for recruiting primary care providers in North Carolina. NHSC scholars have served in various practice settings across the state including free-standing sites, community health centers, or as private practice option providers. All of these are located in places where there are fewer practitioners and severe barriers to access to primary care, areas designated as Health Professional Shortage Areas (HPSAs) by the federal government. The program offers scholarships to students to attend medical school as well as guaranteed repayment of loans. The scholarship program reached its height in the late 1970s and early 1980s in North Carolina and the nation due in part to a spirit of Peace Corps volunteerism.

In the mid-1980s, the NHSC shifted its primary focus as a scholarship program for medical students to offering fewer scholarships and expanding the programs for loan repayment for medical providers who had completed training. This transition allowed the NHSC to contract for obligated service at a point when providers were more focused on personal and professional needs than when they accepted scholarship funding early in their medical school training. NHSC loan repayment offered another recruitment approach to attract primary care providers to rural and underserved communities where income, lifestyle, and other factors made recruitment more difficult.

Over the years, the NHSC loan repayment program has faced several challenges. Funding has been a major determinant for site eligibility. HPSA designation scores, based on the level of shortage, were used to allocate scarce resources and many providers from areas with low HPSA scores were unable to receive loan repayment due to the funding limitations. In addition, NHSC loan repayment required full-time practice, thus eliminating some candidates who were unable to make a full-time commitment. Finally, the NHSC would not consider

loan repayment until a candidate was already in practice. These factors restricted the potential placements through the program.

The American Recovery and Reinvestment Act of 2009 (ARRA) provided the NHSC with an additional \$300 million in funding over a two-year period. The NHSC has used this funding to increase the number of loan repayment contracts available to providers. The NHSC’s stated goal was to double their field strength through this initiative. The HPSA designation scores, full-time practice status, and the requirement that the candidate already be on-site are no longer required for NHSC loan repayment. These changes have already had a tremendous positive effect on recruitment efforts in North Carolina.

The passage of the Patient Protection and Affordable Care Act (HR 3590), the health care reform legislation of 2010, appropriated \$1.5 billion to the NHSC through 2015 (Section 10503 (b)(2)). Section 5207 authorized over \$4 billion through 2015. Given this significant investment, the NHSC has been charged with bolstering the nation’s recruitment efforts in light of the estimated 32 million individuals who will be insured under the law. Until supply can meet demand, competition among communities will grow. With expanded NHSC loan repayment and the potential for additional scholars, rural and underserved HPSA communities will have a recruitment tool that will allow them to compete in an environment where salary and lifestyle opportunities may be limiting. This is very good news for rural and underserved communities in North Carolina as the nation moves toward the implementation of health care reform.

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In 1972, the AHEC program was created as one mechanism to coordinate the many emerging federal and state programs related to health workforce development. By the 1980s these were bundled under the rubric of Title VII (referring to a subsection of the Public Health Service Act) for physicians, dentists, and other non-nursing health professions. The recent health reform legislation has amended, extended, or enlarged many programs under Titles VII and VIII and has created some new programs that are classified under those sections. Other components of the overall bill touch on or will have important effects on the workforce, but this commentary will focus mainly on the elements under those two parts of the Public Health Service Act.

One of the recognized problems in health workforce policy has been the lack of coordination across programs. In the discussions leading up to the passage of health reform there were several proposals to create some form of coordinating mechanism. In the end, the legislation establishes a National Health Workforce Commission charged with reviewing health workforce supply and demand, evaluating existing programs, and making recommendations on policies and priorities. That commission will consist of 15 members drawn from a range of stakeholder groups, but with health professionals mentioned as only one of the eight groups. The commission is to provide recommendations to Congress and the Administration on national health workforce priorities,

goals, and policies via annual reports. The prescribed structure and powers of the Commission is weaker and more limited than other proposals, but it is the first federally mandated body that is to address all health professions policy at the national level. As of June 2010, Congress has not voted any appropriations to support the Commission but the Administration is moving ahead with the appointment process.

There are many specific programs that are created or modified under the bill that will have direct relevance to North Carolina—almost all of the provisions directly related to Title VII and VII programs will touch the state as multiple programs and institutions in North Carolina are recipients of funds or are guided by federal rules and policy. Two completely new programs created by the law will likely be implemented in the state given our track record of leadership in health workforce.

First, the law creates “teaching health centers” under Title VII to train primary care medical and dental residents in community health centers, with funding authorized for grants to develop these centers and to support the costs of training residents. This is a very important departure from how physicians and dentists have previously been paid for their graduate training. The Medicare Graduation Medical Education (GME) system has focused almost entirely on the in-hospital experience and this has tended to create a cadre of physicians who are oriented to specialty-focused hospital care and inpatient conditions. The teaching health centers will try to balance the current hospital-focused GME training of physicians with the realities of ambulatory care by giving them more exposure to patients in outpatient settings and to systems that are trying to provide more continuity of care as well as a primary care emphasis. North Carolina has a very active network of community health centers that will be eligible for this program, and most are already working closely with health professions schools across the state in training physicians, nurses, pharmacists, dentists, and allied health professionals. The North Carolina AHEC system will likely play a key role in helping develop these programs, as they are a specifically mentioned “eligible entity” for grants under the legislation (§749A(f)), but it will also require the full involvement of the academic schools and departments, particularly in family medicine. The eventual structure of these programs will require substantial negotiation and inter-organizational coordination to meet all of the specific requirements of the bill. The long history of collaboration among academic programs and the primary care community will serve us well in responding to this new opportunity.

Another innovation is the primary care extension program (§5405 of the bill adding §399w to Part P of Title III of the Public Health Service Act). Interestingly, this is being established under the Agency for Healthcare Research and Quality (AHRQ) to “...provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management,

mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors....” The legislation calls for the creation of “state hubs” that include the state health department and Medicaid agency and at least one health professions training program department as well as other stakeholders. Again, the law only authorizes funds for this program and it will not be established without follow-on appropriations. The program is also given a six-year development timeline after which states are to support these activities. For North Carolina, the AHEC system functions in much the same way as the proposed extension program.

North Carolina has been very active in overall workforce development and in coordinating programs at community colleges with the needs of health care delivery systems and health related industries. The state has a network of workforce development boards established under the Workforce Investment Act (P.L. 105-220). Section 5102 of the health reform bill provides grants for planning and implementation to help integrate health care more closely with those boards. Again, North Carolina enjoys a role as a leader in cooperation and coordination in health workforce development and can build on an existing network of stakeholders across the state and among agencies and institutions.

While we have mentioned the AHEC program many times, we cannot forget that the Area Health Education Centers legislation is subject to regular reauthorization by Congress. Section 5403 of the new law extends the authorization for AHECs through 2014. Further, the bill states for the first time that it is the intent of Congress that every state have an AHEC. The bill authorizes grants for extending and improving the work of the AHECs and provides much greater specificity to guide the programs in their work. North Carolina is seen as the national leader and model for a state AHEC system and will provide examples as well as technical assistance to other states. Within our own program, the specific language that calls for innovative primary care training programs and community-based participatory research provides opportunities for the many creative thinkers in health care and medical education in the state to try out groundbreaking strategies.

North Carolina has also been a leader in rural-focused training with East Carolina University ranked in the top five nationally for rural medical education. Section 10501 (subpart I) creates a special grant program for medical schools to “establish, improve, or expand rural focused education and training” and support the recruitment of rural residents into medicine.

A new United States “public health sciences” track for medical, dental, nursing, public health, and behavioral and mental health professional students is authorized to support programs that “grant advanced degrees (in public health)

in a manner that uniquely emphasizes team-based service, public health, epidemiology, and emergency preparedness and response," (§5315 of the bill). This offers opportunities for the UNC Gillings School of Global Public Health and the public health programs at East Carolina University, UNC Greensboro, and Wake Forest University to extend the programs. The tradition of engaged public health training in the state will make North Carolina institutions likely recipients of these program funds. The bill also provides authority to expand Centers for Disease Control and Prevention fellowship programs in epidemiology, lab science, public health informatics, and the epidemiologic intelligence service; again, the existing graduate programs at those institutions will be well-positioned to take part in this program.

The reform bill includes very substantial landmark legislation expanding nurse training and the legislation recognizes expanded roles for nurses. An amendment to Medicare laws provides for a demonstration project under which hospitals may receive payment to cover costs of providing training to advanced practice nurses. This is an innovative approach to supporting the costs of training of nurses and builds on the example of Medicare GME. When Medicare was passed in 1965 there was a concern that there wouldn't be enough doctors to treat the newly insured population; thus, in follow-up legislation, Medicare GME was set up to support the training of physicians via add-on to payments for teaching hospitals. This nurse GME program builds on that experience but without a direct link to the Medicare reimbursement system. This program will be limited to five eligible hospitals across the nation and a report on its progress will be due in October 2017. The training programs are directed to conduct at least half of the training in community-based setting unless the institution is in a rural or underserved area and that requirement is not feasible.

The bill also includes additional extensions or expansion of Title VII support to nursing including a three-year demonstration program that trains family nurse practitioners in federally qualified health centers (FQHCs) or nurse managed health centers. A separate section funds grants to nurse managed clinics (§5208), providing an opportunity for a new and innovative approach to primary care training. North Carolina has long been supportive of independent nurse practitioner practice and, combined with its strong nurse training programs, will be a likely place for these programs to emerge.

Other provisions in the law create opportunities for expanding primary care dentistry training, extending and expanding existing Title VII programs (§5303), and creating a grant program to support training or employment of "alternative dental providers in rural underserved areas." This may affect North Carolina in areas where we continue

to struggle to expand access to dental care and where there are plans for community-based dentist training.

Although certain workforce programs have had funding appropriated in the health reform legislation, most of the workforce provisions will need separate appropriations action in Congress. Health workforce programs with funding already appropriated include:

- A series of provisions on loan repayments and scholarships intended to promote health workforce diversity.
- Demonstration projects to provide health profession and home care aide training to people with low incomes.
- The graduate nurse education demonstration project described above.

The law creates a community health center fund to be administered by the US Secretary of the Department of Health and Human Services to provide for expanded and sustained national investment in community health centers. This fund will indirectly affect the health workforce because it will provide many more opportunities for community-based, team-oriented primary care practice in more than 8,000 sites across the nation. This section of the bill includes greatly expanded support for the NHSC that has the potential to double its field strength. This will benefit the recruitment programs of the state's Office of Rural Health and Community Care and other programs and institutions that seek to bring health care professionals into their communities. Revisions to the laws covering the NHSC will also allow for part-time service over an extended period, providing greater flexibility for loan repayment.

Primary care training grants under Title VII are modified and expanded and include grants for demonstration projects providing training to physicians and physician assistants in new competencies, such as providing care in a patient-centered medical home setting. North Carolina has the programs in place that can make immediate use of these funds. The law calls for priority in awarding grants to programs that have formal relationships with FQHCs, AHECs, and rural health clinics. The state has networks and programs like the Care Share Alliance that can serve as immediately available structures to facilitate new and expanded programming.

The health reform bill includes many provisions that require action at the state level, including reauthorization of state and regional workforce centers to collect and analyze data; grants for states to assess and expand their health care labor markets; and grants for primary care extension program "state hubs" to coordinate outreach efforts to primary care providers. North Carolina is well-positioned to take advantage of the opportunities as well as lead the way in making many of these proposed programs a reality. **NCMJ**