Twenty-Five Years of Serving the Health Care Needs of Rural North Carolina

Franklin Walker

The Community Practitioner Program seeks to improve access to quality health care for North Carolina's most vulnerable people by providing educational loan repayment grants to primary care physicians, physician assistants, and nurse practitioners in return for their service in rural and underserved communities.

The North Carolina Medical Society Foundation (NCMSF) started its Community Practitioner Program (CPP) with the foresight and passion of a dedicated handful of health care providers 25 years ago; since that time, CPP has become crucial to the overall health and well-being of our state's citizens—people who otherwise might have gone without necessary medical care. With the help of CPP, hundreds of physicians, physician assistants, and family nurse practitioners have had the opportunity to attend to the primary health care needs of patients in the underserved areas and remote back roads of North Carolina.

This corps of health care professionals provides more than 400,000 patient visits each year. The majority of these patients are uninsured, underinsured, or eligible for Medicaid or Medicare. Until the NCMSF placed a CPP participant in their area, many of these people did not have access to quality, continuous primary care from someone in their own community.

"Everyone needs access to health care, in my opinion," said Taineisha Bolden, MD. When she graduated from the School of Medicine of the University of North Carolina at Chapel Hill, Bolden knew that she wanted to serve in an underserved area, and she joined Roxboro Family Medicine and Immediate Care 3 years ago. "Coming out of school and training with lots and lots of debt, it can make it difficult to pursue the things your heart is telling you to do when the student loan people are telling you what you need to do." Thanks to CPP, she says, "I'm doing what I enjoy in a place [where] I feel like I can benefit the community."

Like the other providers who have participated in CPP over the last quarter century, Bolden completed her medical training saddled with significant educational loan debt. She knew she wanted to practice in a rural area, but it would have been financially impossible for her to do so without the help of a program like CPP. In exchange for committing to 5 years of practice in a rural or underserved area, CPP participants receive assistance with educational loan repayment. Over the life of the program, the average loan amount to participants has been $36,000, with a maximum allowed amount of $70,000. For the 38 current participants, the average loan amount is $46,000, reflecting the steep rise in the cost of medical school. In addition to loan repayment, CPP has also occasionally awarded funds for moving expenses, support for continued education training, or direct payment for a needed piece of major equipment.

Perhaps the most valuable benefit is the consulting services offered by the NCMSF practice improvement staff, who are on hand to help with the business side of running a medical practice, which is complex and often daunting. Over the 25 years of the program, this complexity has intensified with new financial and logistical challenges, such as the need to implement electronic health records, decreasing reimbursement rates, and both federal and local health reforms. Twice per year, CPP providers meet to share their experiences, learn from each other and the NCMSF staff and leadership, and bring new energy and ideas back to their communities.

The total amount of grant dollars benefitting the current group of community practitioners is estimated at $1.7 million. Additionally, the program typically provides approximately $50,000 per year of practice management and quality consulting to CPP practices.

History of CPP

In 1989 the Kate B. Reynolds Charitable Trust granted $4.5 million to the NCMSF to help attract and retain needed medical professionals in underserved communities throughout the state. The NCMSF was not the only or the first organization interested in achieving this goal. The generous grant, however, enabled the NCMSF to collaborate with other key stakeholders and bring everyone together on an advisory board. This advisory board included representatives of the family medicine department of each of North Carolina's 4 medical schools; the Area Health Education Centers; the

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North Carolina Office of Research, Demonstrations, and Rural Health Development; the North Carolina Hospital Association's Center for Rural Health Innovation and Performance; the North Carolina Department of Commerce; the Kate B. Reynolds Charitable Trust; the North Carolina Medical Society; and rural practitioners themselves. The close, synergistic relationships between all of these entities remain to this day.

The advisory board and the program's first director, E. Harvey Estes, MD, emeritus professor of community and family medicine at Duke University, decided that CPP's primary means of assistance should be educational loan repayment. The 3 primary goals of the program have remained constant over the years: First, CPP aims to improve access to health care for uninsured and underinsured populations in rural, economically distressed, and medically underserved communities across North Carolina, and it prioritizes federally designated Tier I, II, and III counties and whole or partial health professional shortage areas (HPSAs; See Figure 1). Second, the program seeks to provide cost-effective quality health care to underserved communities by helping the assisted CPP providers to succeed, remain in their communities, and operate financially viable practices despite low Medicaid and Medicare reimbursement rates, a high number of uninsured patients, and often less sophisticated business operations. Third, CPP aims to develop and support a fellowship of primary care providers skilled in treating low-income, uninsured, and underinsured populations.

The Office of Rural Health and Community Care works with state and federal governments and local communities to identify the needs of the community and to determine whether the community meets federal HPSA guidelines. This program also offers loan repayment, but because CPP is a private program that is funded through private donations and grants, it is able to be more flexible than government programs. Furthermore, public programs have seen dwindling funding allocations, making programs like CPP even more important.

Because CPP has more flexibility and can thoroughly vet those providers who are willing and eager to work in rural, economically distressed communities, retention in the program has been excellent. To date, 73% of CPP participants continue to practice in rural or economically distressed communities, and 85% remain in North Carolina. Also, CPP collaborates with state-run programs, the North Carolina Hospital Association's Center for Rural Health Innovation and Performance, and the state's medical schools, so eligible providers are often referred to CPP; thus the program has no recruiting expenses.

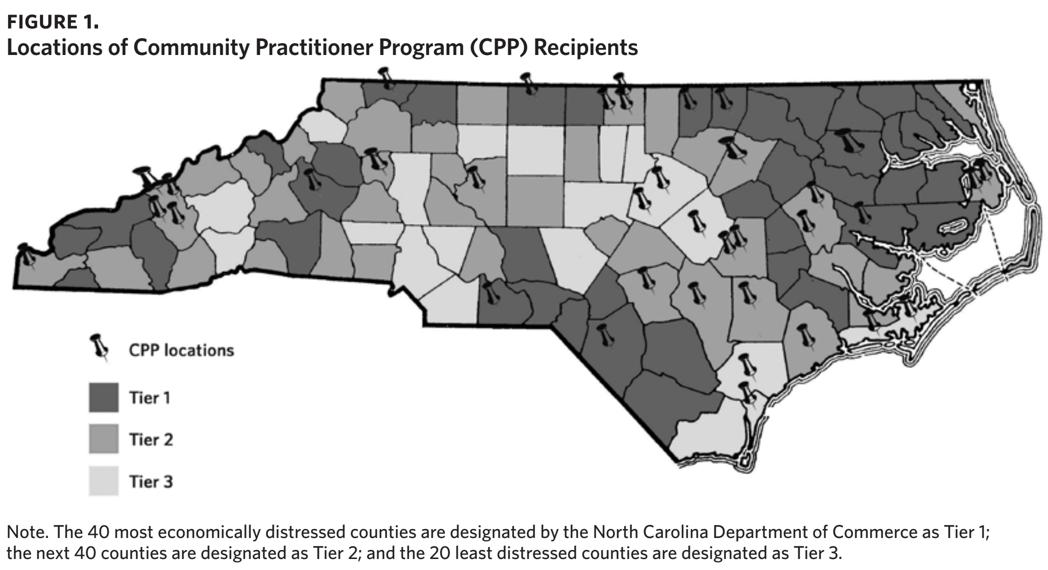
"When I saw what a grateful community this was when I started working here, it made doing that so much easier and more rewarding," said Liz Riley Buno, PA-C, of Roxboro Family Medicine and Immediate Care, who has remained active with CPP and helped bring Bolden, her partner, into the program. "The community is so thankful to have people here that care about them and want to see them healthy."

Assessing the Need

In the program's first 8 years (1990–1997), 33 individuals received educational loan repayment grants. As the program became more established, that number rapidly accelerated, and 89 repayment grants were made during the 6-year period from 2002–2007. In just the past 7 years, CPP participants totaled 104, bringing the total number of participants for the last 25 years to 391.

A key value of the program is that it helps practices to implement an electronic health record (EHR) system and, over a period of 3 years, to meet the meaningful use requirements established by the Centers for Medicare & Medicaid Services (CMS). This has not only resulted in added incentive money, but it has also kept these practices from incurring CMS penalties for noncompliance. The practices further

FIGURE 1.
Locations of Community Practitioner Program (CPP) Recipients



Note. The 40 most economically distressed counties are designated by the North Carolina Department of Commerce as Tier 1; the next 40 counties are designated as Tier 2; and the 20 least distressed counties are designated as Tier 3.

benefit by using their meaningful use data to obtain patient-centered medical home (PCMH) recognition. By meeting meaningful use criteria, these practices have avoided the 1% Medicare penalty imposed in 2014 on practices that have not adopted EHR technology and met meaningful use criteria.

The ability to adapt to changes in technology has also allowed for improved patient care through the state's PCMH initiatives. Of the current CPP practices, over half have already been recognized as a PCMH by the National Committee for Quality Assurance, and the rest are in the process of completing the recognition process. This designation provides for better patient care and follow-up. Also, through Blue Cross and Blue Shield of North Carolina (BCBSNC), these practices are able to earn Blue Quality Physician Program (BQPP) recognition, which allows for increased payments from BCBSNC. For some practices, this can mean as much as a 25% increase. In small, rural practices, this allows them to stay independent within their community.

CPP's success is also evident in the growth and expansion of several practices over the years. Roxboro Family Medicine and Immediate Care went from a tiny office building to more spacious quarters, allowing the group to increase the number of providers it employs and offering much needed care in the rural area north of the Triangle. Likewise, Robeson Pediatrics also expanded into a larger facility, and Surf Pediatrics and Medicine in Nags Head added offices in Kill Devil Hills and Kitty Hawk and moved from being a pediatrics-only practice to also covering family medicine.

CPP Will Leverage Technology

Beginning in July 2011, the NCMSF was part of a collaborative team that developed an open-source software tool to predict physician surpluses and shortages. The FutureDocs Forecasting Tool identifies areas of the state where a CPP provider might be most needed and best utilized [1]. The tool estimates the current supply of physicians, the use of health care services, and the capacity of physician supply to meet the health care needs throughout the US population. It is designed to engage a wide range of stakeholders—including physicians, physician organizations, policy makers, health system executives, and other interested parties—in developing workable and practical solutions to address imbalances in the supply and distribution of physicians.

The tool is an important and innovative step forward for health care workforce modeling because it is interactive, web-based, and user-friendly. The FutureDocs Forecasting Tool gives users the ability to display different estimates of supply for various specialties, health care services use, and shortages or surpluses for many types of services at different geographic locations between the years 2011 and 2030. The software accommodates different scenarios, such as the impact of the insurance marketplaces established by the Patient Protection and Affordable Care Act of 2010, Medicaid expansion, retirement rates and work effort by physicians, and the possibility of physicians working more closely with nurse practitioners and physician assistants to meet future demand for health care services.

The Future of CPP

As CPP looks to the future, our efforts will focus on areas of North Carolina that persistently lag behind in social determinants of health. CPP was fortunate to participate in the North Carolina Institute of Medicine's Task Force on Rural Health, and we will use the report's 6 priority recommendations to help guide our work [2].

CPP views medical practices as small businesses that are vital to a strong rural economy, and we will work to ensure that CPP participants remain financially sound as payment models evolve and change. Care delivery is also changing, and CPP will help participants to focus on patient-centered care and to think strategically about ways they can be a resource to the community and more effectively use the communities' assets to improve patient health. We will continue our strong public-private partnership with the Office of Rural Health and Community Care and will make private financial resources available for medical education loan repayment so that it can be used as a recruitment tool. With 25 years of progressive improvement and success, a strong framework, and innovative tools to navigate and embrace the rapidly changing health care environment, CPP looks forward to a robust and healthy future. NCMJ

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