North Carolina Primary Care Payment Reform Task Force

Meeting 3: Workforce Adequacy

February 14, 2024

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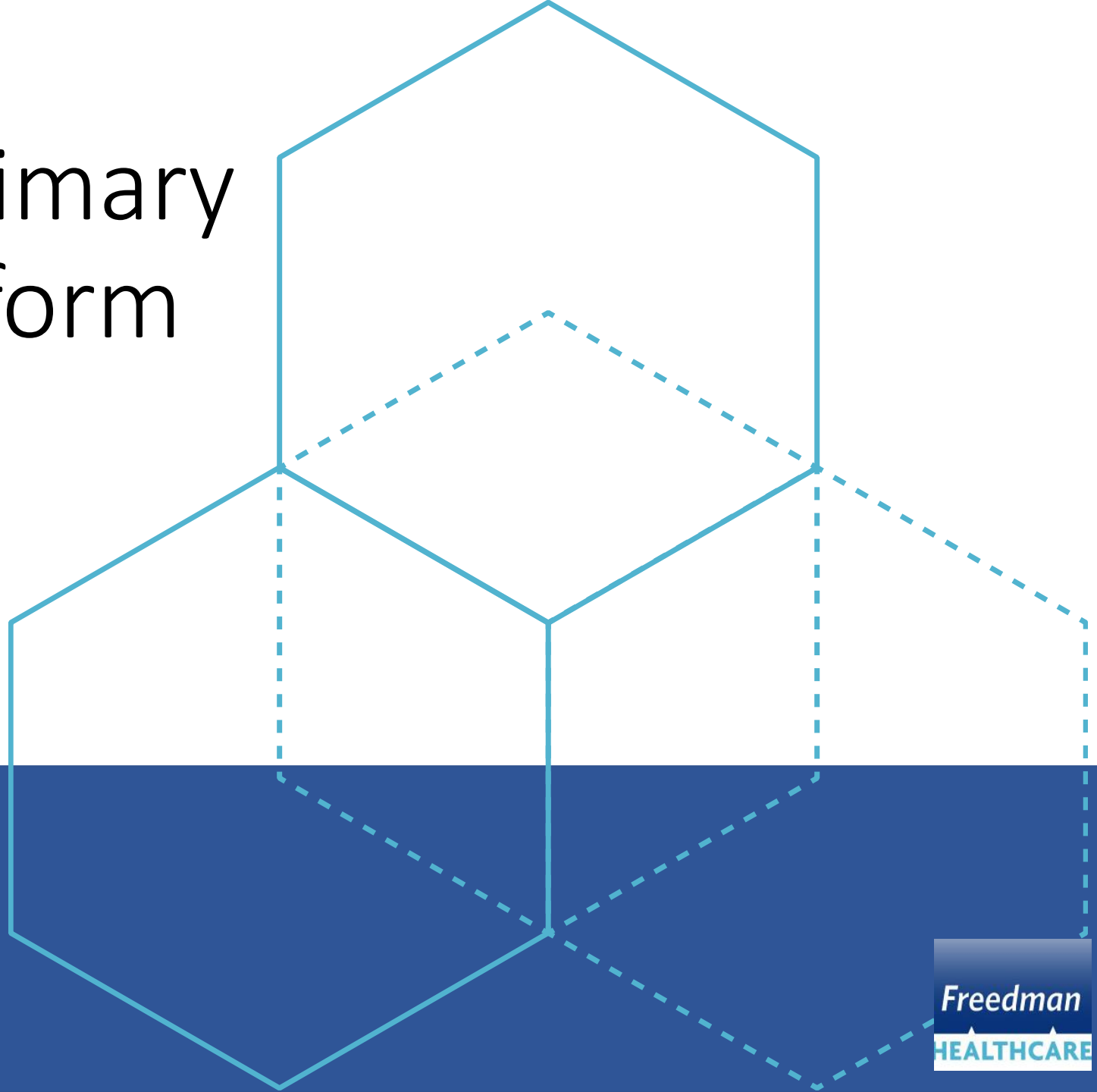

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Etiquette for Easy Collaboration

- Mute your microphone when you are not speaking to avoid background noises
- Use of your camera is encouraged
- Raise your hand to make a comment, provide feedback, or offer an idea
- Use the chat box, reactions, and emojis to contribute to the conversation
- Be present and practice active listening, we want to hear your insights
- Be respectful of differences in understanding and perspective
- Hold the tension of both/and thinking, rather than either/or thinking

Agenda

1.	Meeting 2 Review	8:00 AM
2.	Current State of the Primary Care Workforce	8:10 AM
3.	Ongoing Efforts to Address the Primary Care Workforce Adequacy	8:30 AM
4.	Approaches to Measuring the Primary Care Workforce	8:50 AM
5.	Wrap Up & Meeting 4 Preview	9:20 AM

Timeline

January 2024

- ***Meeting 1: National Overview & Definitions***
  - Friday, 1/19 from 2:00 – 3:00 PM
- ***Meeting 2: PC Measurement & Benchmarking***
  - Wednesday, 1/31 from 8:00 – 9:30 AM
- ***Data Review***
- ***Outline Report***

February 2024

- ***Meeting 3: Measurement & Workforce***
  - Wednesday, 2/14 from 8:00 – 9:30 AM
- ***Meeting 4: Recommendations***
  - Wednesday, 2/28 from 8:00 – 9:30 AM
- ***Draft Report***

March 2024

- ***Finalize Report***

April 2024

- **Report Delivered by April 1st**

Legislative Charge

Legislative Requirements (Senate Bill 595)

The Task Force must submit a report to the Joint Legislative Oversight Committees on Health & Human Services and Medicaid.

The Report is to include ***findings and recommendations*** that are specific, concrete, and actionable steps that the State and General Assembly can act on.

- Provide a **national overview** of primary care measurement and investment
- Recommend a working **definition of primary care**
- Set the stage for ongoing primary care **measurement and investment**
- Recommend primary care **investment targets**
- Recommend a **data collection strategy**
- Recommend policies for **future legislative opportunities**
- Recommend next steps for evaluating primary care **workforce adequacy**

Major Trends Impacting the National Primary Care Workforce

Across the national landscape, there is a gap between the number primary care providers needed and the number of primary care providers practicing. A 2021 consensus study report from the National Academies of Sciences, Engineering, and Medicine, identified four major trends strongly influencing the practice and expansion of interprofessional primary care teams in the United States. [1]

1. A **widening income gap** between primary care and medical subspecialties
2. Pressure to **increase efficiencies rather than effectiveness** of primary care
3. General **under-resourcing** of primary care teams
4. **Inconsistent scope of practices** due to differences in state licensure laws, specifically for NPs and PAs

The COVID-19 pandemic has led to a further depleted primary care workforce because of negative impacts on both the physical and mental health needs of healthcare workers.[2] Research has also found the COVID-19 pandemic heightened burnout and accelerated serious retirement considerations. [3]

1. National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press.
2. Khalil-Khan A, Khan MA. The Impact of COVID-19 on Primary Care: A Scoping Review. Cureus. 2023 Jan 2;15(1):e33241
3. Primary Care Collaborative & the Robert Graham Center, November 2023. Health is Primary: Charting a Path to Equity and Sustainability

Current State of the Primary Care Workforce

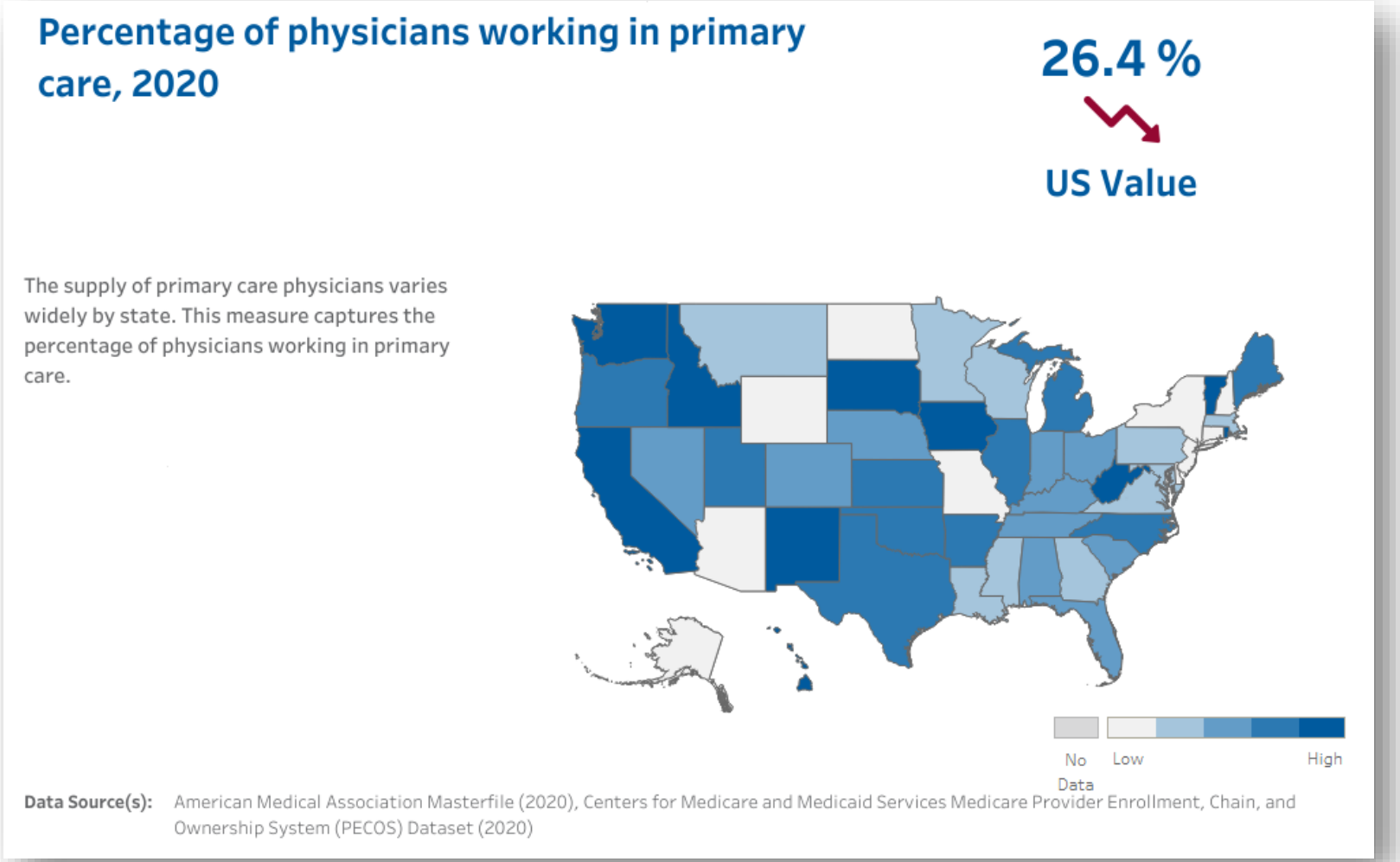
In the U.S. broadly and in North Carolina,

1. How many primary care providers are there now?
    a. How many primary care providers are needed in the future?
2. If there is a primary care workforce gap, what is the gap?
3. What are the major primary care workforce priorities for North Carolina?
    a. Are there differences in supply across different regions of the state?

National Primary Care Physician Shortages

Compared to the five-year average, there has been an **approx**. **9% decrease** in the percentage of physicians working in primary care.

This data also demonstrates a wide variation by state.



Jabbarpour Y., Petterson S., Jetty A., Byun H. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care, The Milbank Memorial Fund and The Physicians Foundation. February 22, 2023.

Projected National Shortage of Primary Care Physicians

By 2036, primary care physician specialties will only meet 81% of the need for both metro and nonmetro areas. In nonmetro areas, only 63% of the need will be met.

Projected Shortage of Primary Care Physicians by Specialty in 2036, Percent Adequacy*

Physician Specialty	Metro	Nonmetro
Family Medicine Physicians	79%	73%
Geriatricians	85%	44%
Internists	79%	44%
Pediatricians	98%	65%
Total	**83%**	**63%**

*Adequacy is defined as the number of practicing primary care providers compared to the demand for providers.

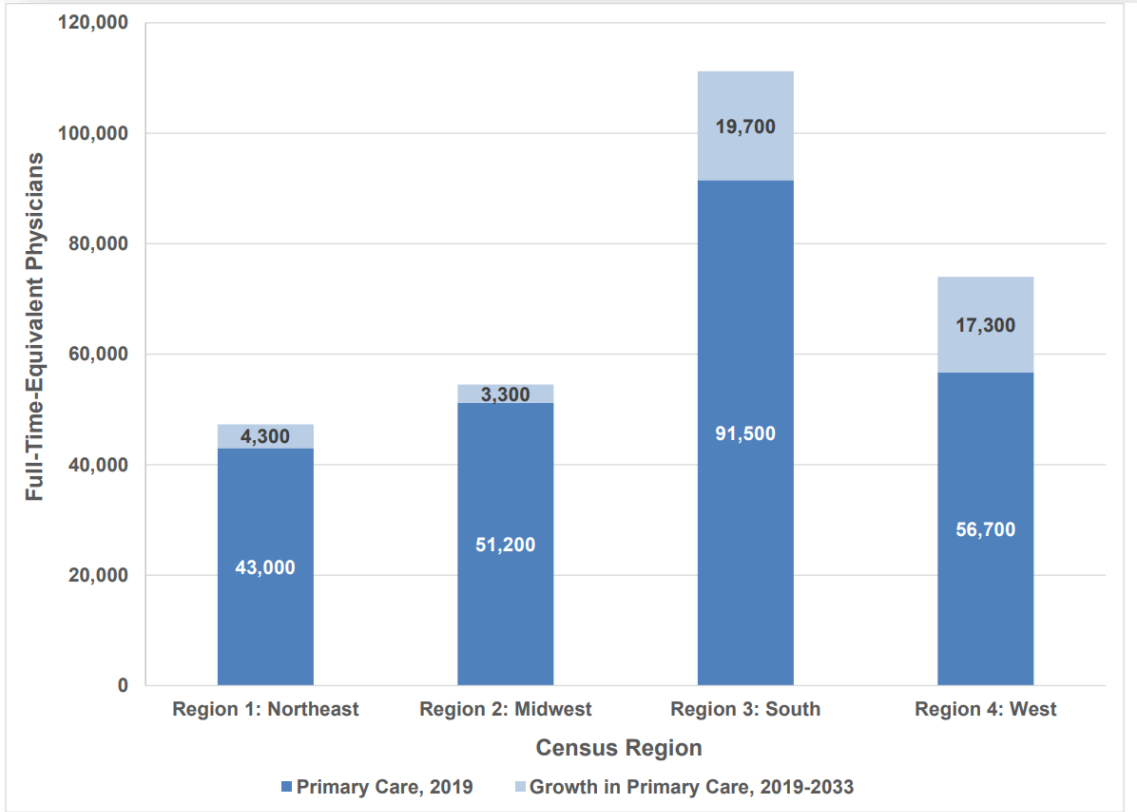
Adapted from the National Center for Health Workforce Analysis. November 2023. State of the Primary Care Workforce, 2023.

Primary Care Physician Workforce by U.S. Region

A June 2021 report from the Association of American Medical Colleges estimated a nearly 21% increase by 2023 in the demand for primary care providers in the South.

The greatest increase in provider demand is in the South.

Physician Primary Care Demand and Demand Growth by Census Region, 2019-2034

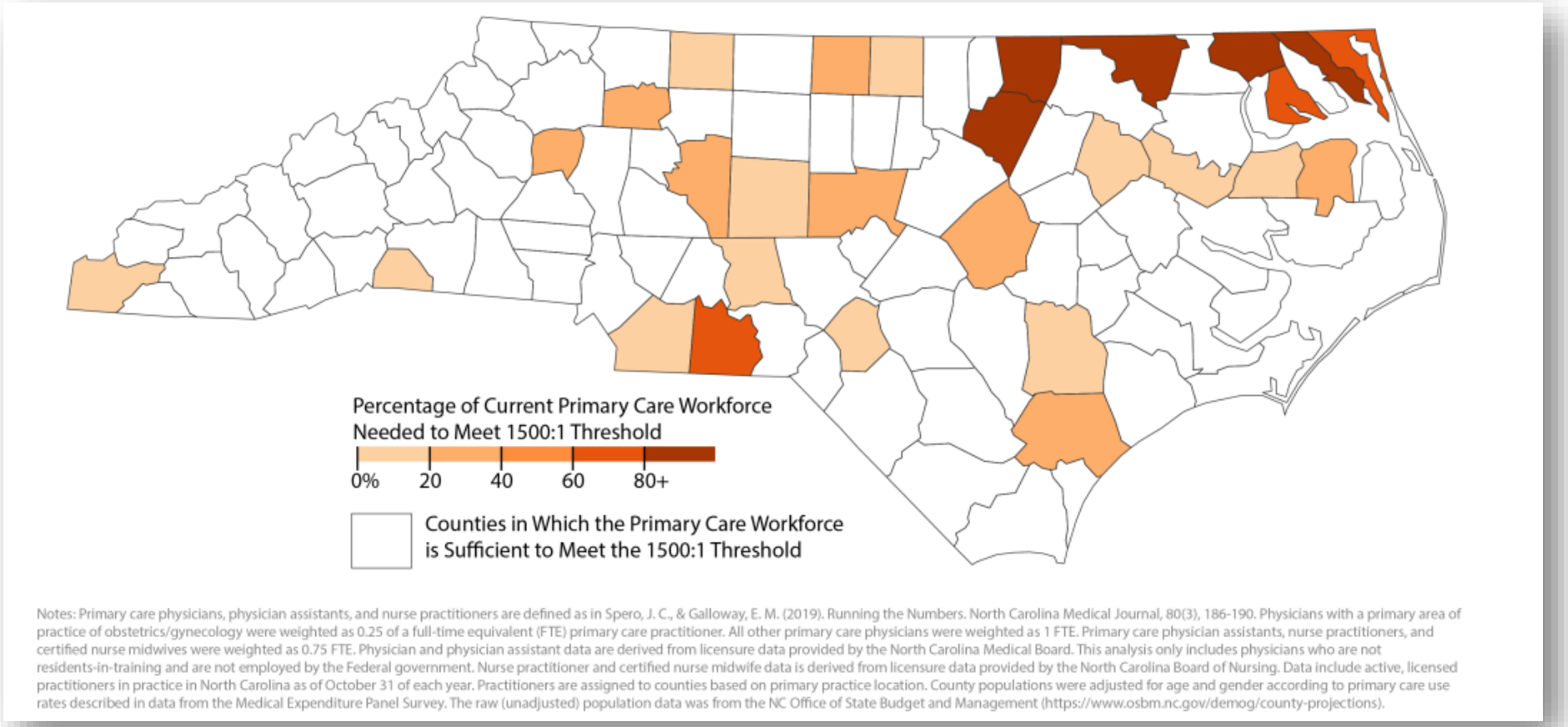


Note: Demand is defined as the number of FTE physicians required to provide a national-average level of care given the demographics, prevalence of disease and health risk factors, insurance coverage, household income levels, and health care use patterns of the population residing in each region.

IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Washington, DC: Association of American Medical Colleges; 2021.

One View of NC's Healthcare Workforce

Percentage of Current Primary Care Workforce Needed to Meet 1500:1 Population to Clinician Threshold, 2017-2021 Average, North Carolina

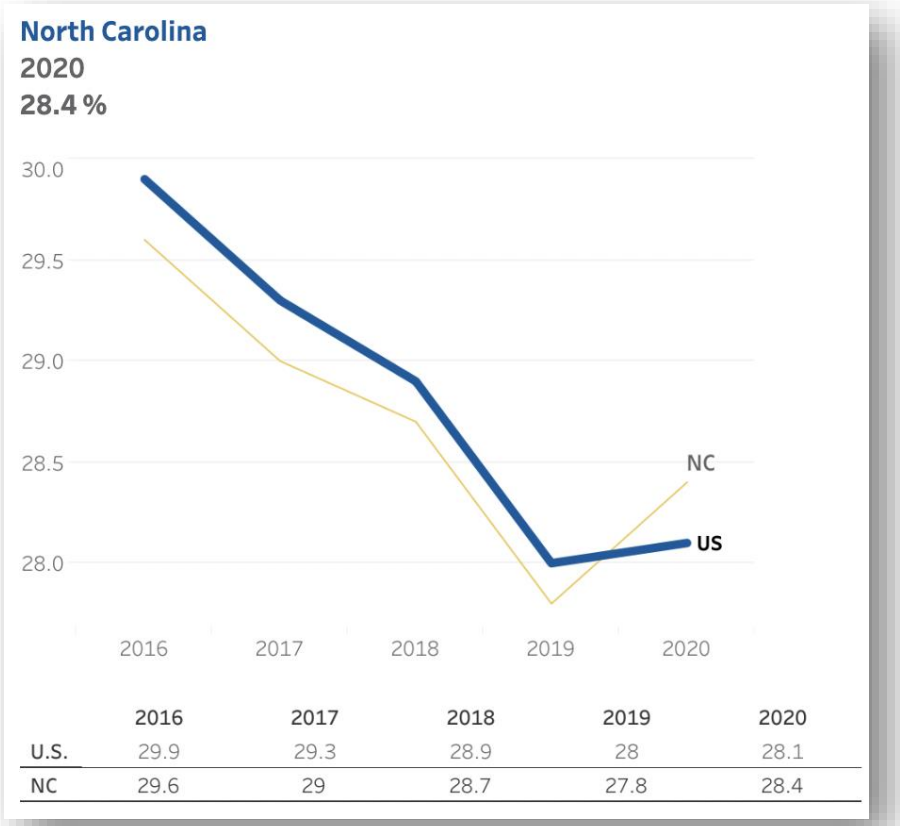


Notes: Primary care physicians, physician assistants, and nurse practitioners are defined as in Spero, J. C., & Galloway, E. M. (2019). Running the Numbers. North Carolina Medical Journal, 80(3), 186-190. Physicians with a primary area of practice of obstetrics/gynecology were weighted as 0.25 of a full-time equivalent (FTE) primary care practitioner. All other primary care physicians were weighted as 1 FTE. Primary care physician assistants, nurse practitioners, and certified nurse midwives were weighted as 0.75 FTE. Physician and physician assistant data are derived from licensure data provided by the North Carolina Medical Board. This analysis only includes physicians who are not residents-in-training and are not employed by the Federal government. Nurse practitioner and certified nurse midwife data is derived from licensure data provided by the North Carolina Board of Nursing. Data include active, licensed practitioners in practice in North Carolina as of October 31 of each year. Practitioners are assigned to counties based on primary practice location. County populations were adjusted for age and gender according to primary care use rates described in data from the Medical Expenditure Panel Survey. The raw (unadjusted) population data was from the NC Office of State Budget and Management (https://www.osbm.nc.gov/demog/county-projections).

The Cecil G. Sheps Center for Health Services. April 25, 2023. Transforming Data into Action to Drive Workforce Policy and Planning in North Carolina.

Percent of NC Physicians, Physician Assistants, and Nurse Practitioners Working in Primary Care

Percentage of PCPs, PAs and NPs Combined Working in Primary Care



	2016	2017	2018	2019	2020
U.S.	29.9	29.3	28.9	28	28.1
NC	29.6	29	28.7	27.8	28.4

Percent of Physicians, Physician Assistants, and Nurse Practitioners Working in Primary Care

	Physicians	Physicians Assistants	Nurse Practitioners
2018	28.4%	26.7%	31.6%
2019	27.1%	25.9%	31.8%
2020	**27.3%**	**27.8%**	**32.2%**

Jabbarpour Y., Petterson S., Jetty A., Byun H.The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care, The Milbank Memorial Fund and The Physicians Foundation. February 22, 2023.

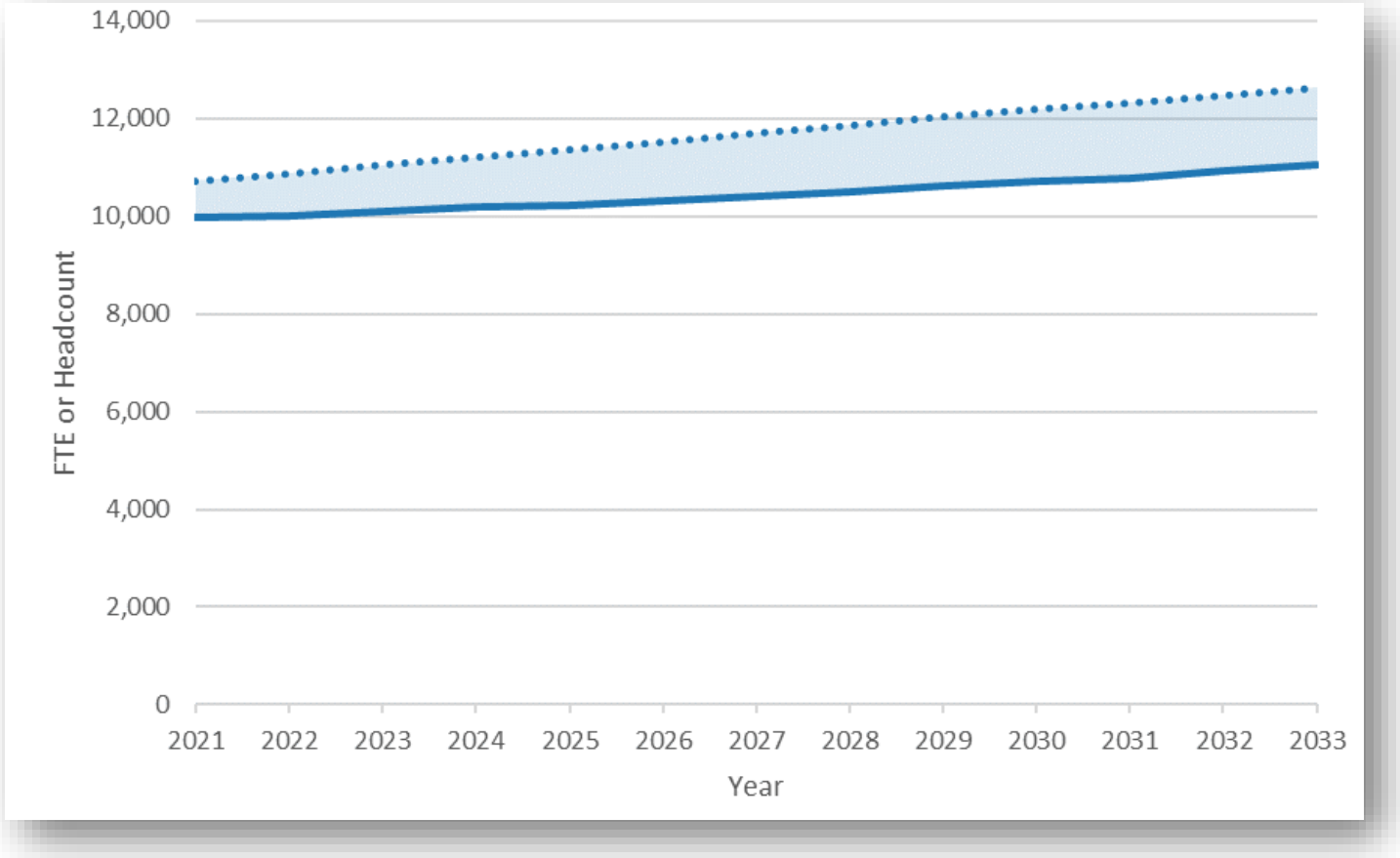
Future Needs of NC's Healthcare Workforce

There is currently a deficit in supply of primary care providers, with 92% of demand met.

This is projected to shrink to 88% by 2033.

	Supply	Demand	Difference	Adequacy
2024	10,180	11,040	-860	92%
2033	11,070	12,640	-1,570	88%

Physician Assistants, Pediatrician, Internal Medicine, Family Medicine Supply and Demand



Adapted from Workforce Projections, National Center for Health Workforce Analysis retrieved February 1, 2024.

Ongoing Efforts to Address Primary Care Workforce Adequacy

For North Carolina,

1. What are existing efforts to support primary care workforce evaluation across the state?
2. What is going on to build a sustainable and attractive pipeline for the primary care workforce?

Strategic Investments in Workforce Strategies

Primary care physicians earn 30% less than other physicians, on average, and they have among the highest rates of physician burnout. [1]

In what ways can defining primary care and setting investment benchmarks help create change to better support health care workers?

- Address staffing levels and administrative functions to prevent burnout
- Allow providers to practice at the top of their license to lower barriers to entry
- Improve data collection to help states make informed decisions
- Promote pathway programs that offer supports and mentorship

National Academy for State Health Policy. 2022. State Strategies to Support the Future of the Primary Care Physician and Nursing Workforce.
1. California Health Care Foundation, 2022. The Case for Investing in Primary Care.

Workforce Adequacy Example 1 - NC Center on the Workforce for Health

A statewide center focused on the collaborative and comprehensive development of NC's workforce with goals to:

- Ensure sustained efforts to address health workforce issues to ultimately better align the supply of health workers with the demand for those workers.
- Convene employers, educators, workers, regulators, and others to develop, deploy, monitor, and assess efforts to address health workforce issues.
- Gather and make available relevant data and policy information to make it actionable and provide technical assistance and guidance to interested parties when acting to address health workforce issues.
- Provide a forum for interested parties to share best practices and lessons learned.

Partner Organizations

NORTH CAROLINA AHEC

North Carolina Area Health Education Centers Program

NCIOM

North Carolina Institute of Medicine

UNC | THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

Cecil G. Sheps Center for Health Services Research

Workforce Adequacy Example 2 - UNC School of Medicine's FIRST Program

The Fully Integrated Readiness for Service Training (FIRST) program consists of three parts:

1. A three-year accelerated and enhanced medical school curriculum
2. Directed pathway into an affiliated residency program
3. Three years of service in a rural/underserved community in North Carolina with ongoing support in practice.

Upon meeting the academic and professional standards for graduation from medical school, participants will be ranked favorably to match into the NC Residency Program through the National Resident Matching Program (NRMP).

UNC Family Medicine will provide ongoing support, mentoring, and opportunities for continuing medical education throughout the three years of service after residency.

"If we are successful in training young doctors to practice in rural North Carolina, it really improves access to the community and region."[1]

- Dr. Joe Pino, associate dean and campus director of the UNC School of Medicine's Wilmington campus

As of March 2020, the program had successfully recruited 5 classes of medical students, and 3 of those classes had matched into residency. [2]

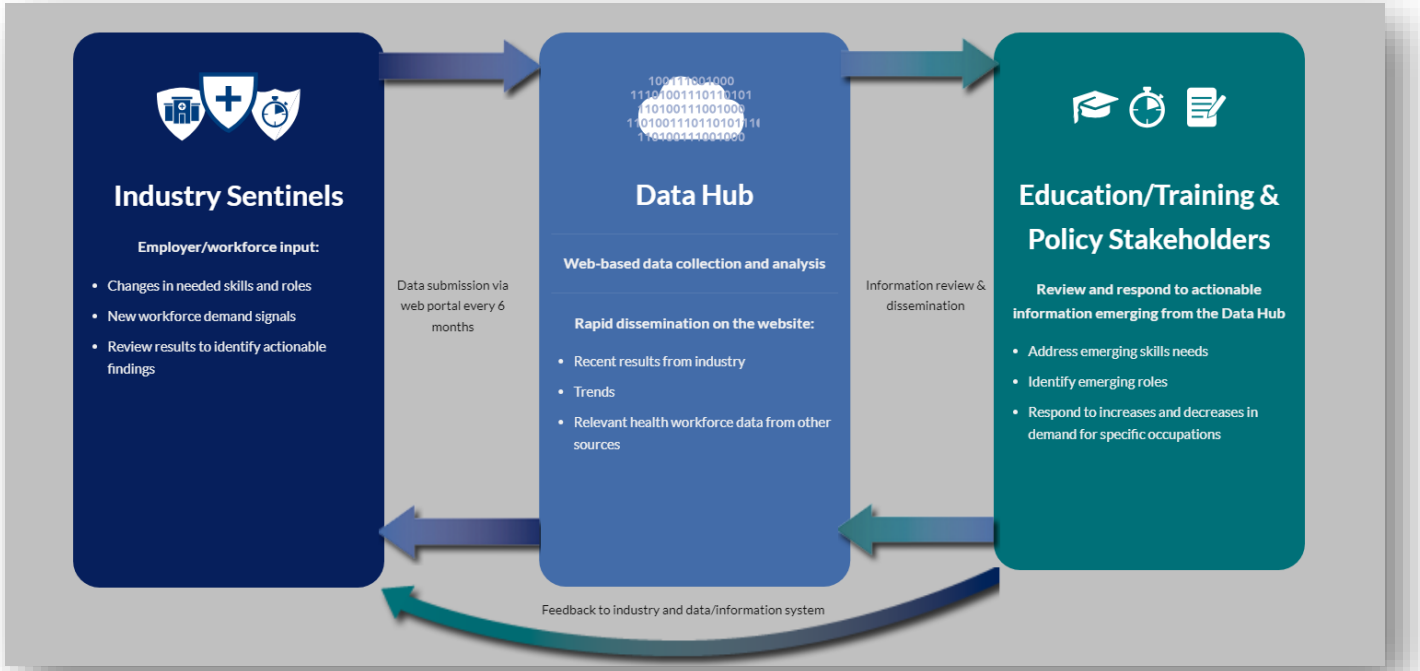
NC Chamber Foundation. Institute for Workforce Competitiveness.

1. Frevert, P. Novant Health, July 2021. How One Program Helps Young Doctors Serve Rural N.C.
2. Coe CL, Baker HM, Byerley JS, Page CP. Fully Integrated Readiness for Service Training (FIRST): An Accelerated Medical Training Program for Rural and Underserved North Carolina. Acad Med. 2021 Oct 1;96(10):1436-1440.

Addressing Burnout and Burden - Health Workforce Sentinel Network North Carolina

In North Carolina, the NC Health Workforce Sentinel Network was launched in 2021, with funding and direction from the North Carolina Area Health Education Centers (NC AHEC) Program and participation by partners around the state.

Links the healthcare sector with policymakers, workforce planners and educators to identify and respond to changing demand for healthcare workers, with a focus on identifying newly emerging skills and roles required by employers.



Approaches to Measuring Primary Care Workforce Adequacy

In the U.S. broadly and in North Carolina,

1. What data currently exists?
2. Are there any existing recommendations for collection?
    a. What would be required to implement these solutions?

Workforce Data Availability

	Potential Current Data Sources		Potential Future Data Source
	National Data Sources (Publicly Available Data)	**State Data Sources** (Publicly Available Data)	**State Database**
Data Types	• NPPES, MEPS, HRSA Workforce data	• Existing claims and encounter data from State sources • Voluntary data submission via questionnaire or accreditation organizations (ex. NC Commerce, HPDS, Sentinel)	• Develop survey collection tools that can be used in conjunction with existing data sources • Formal health data collection ecosystem (APCD or otherwise)
Considerations	• Allows for national comparisons • Requires time to collect and resources to analyze	• More accurate than national sources • Requires data aggregator Requires time to collect and analyze	• Build on HIE investments • Potential long-term solution • Shows the services providers perform, where, and for which patients

Establishing Principles to Track Workforce Adequacy

Literature suggest starting with implementing solutions to track primary care workforce. These data can inform policy solutions over time.

- ***Apply a common definition of primary care based on taxonomy***
  - Track provider demographics
- ***Track workforce changes over time using available data***
  - Seek to identify variation across professions and geographies
  - Measure workforce pipeline changes over time
- ***Apply more sophisticated measurement tools over time***
  - Continue to invest in the N.C. Health Information Exchange Authority
  - Build more robust data collection strategies through, plan or provider reporting requirements, an APCD or other mechanisms over time

Potential Reporting Solutions

Data Source	Considerations
HRSA Workforce Projections	• Nationally developed data analyses that provide information based on vetted data systems • Projections and estimates are made on supply and demand according to national standards, allowing for easy comparisons • Statistical tools are used to allocate providers by region, though adjusted to reflect differences in populations and regions, data may by less accurate than other sources • May not fully align with the Task Force's working definition of primary care • Data may be less flexible than other sources
North Carolina Health Professions Data System	• State level data set supported by researchers and professional affiliate organizations • May not fully align with the Task Force's working definition of primary care • Data may be less flexible than other sources

Data Collection Options

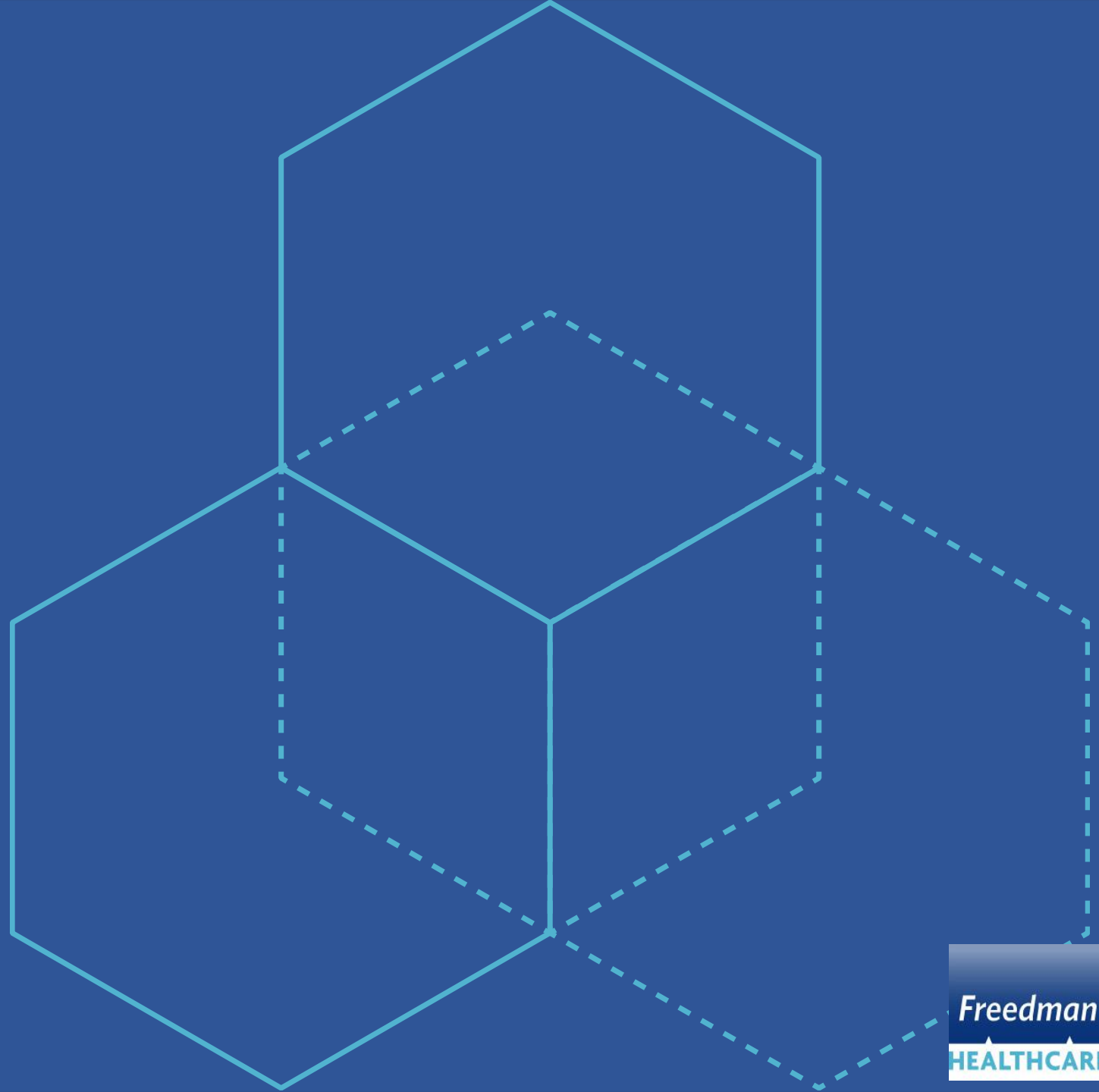
Current workforce and broader data limitations:

- May be hard to track workforce trends and devise policy recommendations
- Publicly available analyses may not provide information we need, e.g., may be hard to determine workforce adequacy drivers
- Does not tell us who physicians are treating or where they are treating them
- May be difficult customize reports that meet specific needs
- May be less complete than more robust data collection solutions e.g., focus of current practice

Why states are building their own healthcare data ecosystems:

- Flexibility to measure and report on a wide array of issues
- Ability to report on health care spending, utilization and performance
- Enhance state policy and regulatory analysis
- Provides a reliable source for health care research and evaluation

Next Steps



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Upcoming Activities

Task Force asks

- Review materials and meeting notes

Freedman Healthcare

- Draft report
  - Update based on Task Force meetings
- Data analysis and collection
  - Release data collection request
  - Host review and technical assistance sessions

Task Force Meeting Dates and Times

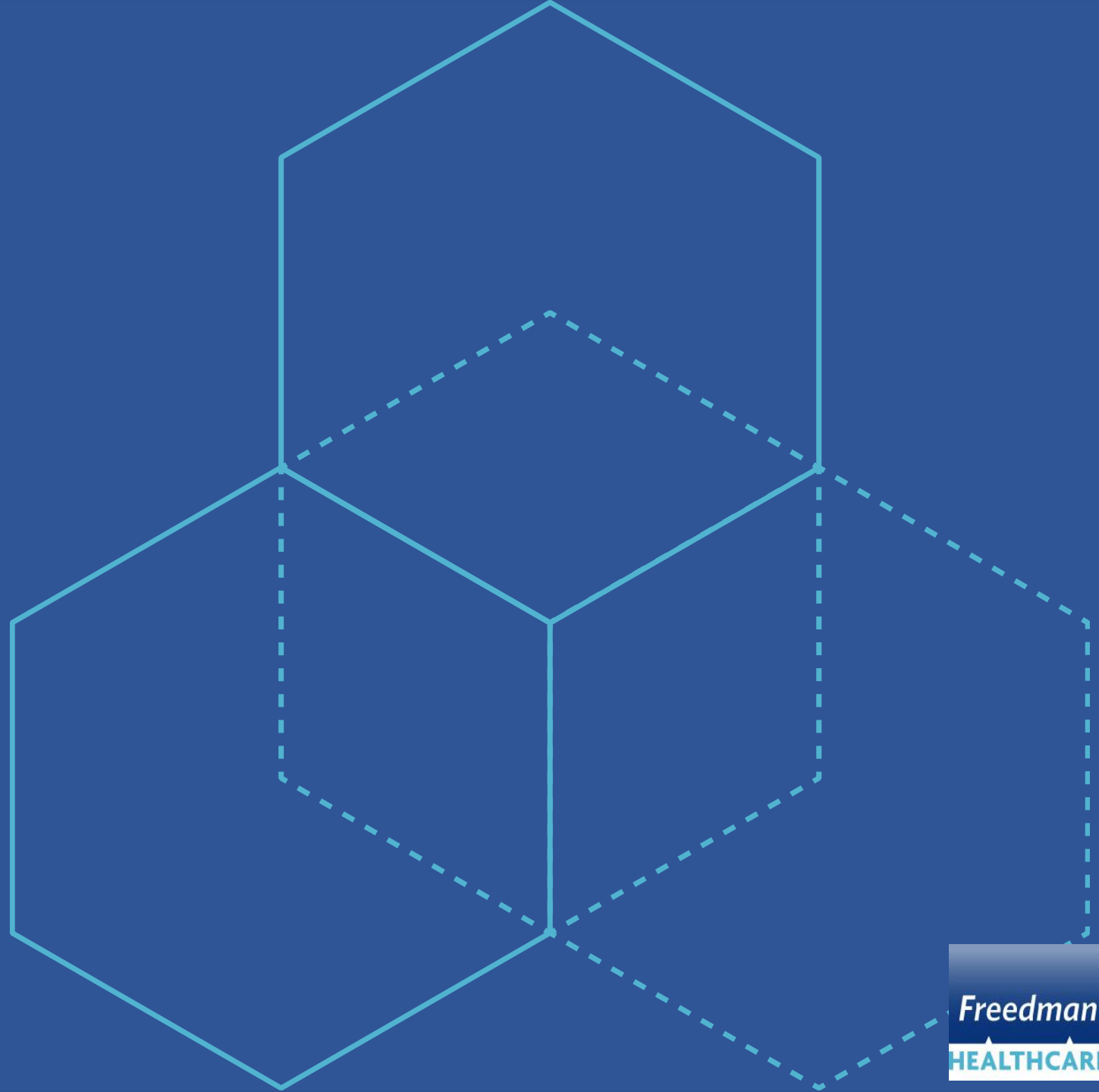
Meeting	Date	Time
✓ 1	Friday, 1/19	2:00 – 3:30 PM
✓ 2	Wednesday, 1/31	8:00 – 9:30 AM
3	Wednesday, 2/14	8:00 – 9:30 AM
4	Wednesday, 2/28	8:00 – 9:30 AM

Meeting 4:

Working agenda –

- Meeting Review
  - Definition of Primary Care
  - Investment Proposal
  - Workforce Recommendations
- Report Overview
- Timeline and Data Collection
- Final Comments

Appendix



Payers in North Carolina Are Working to Ensure Adequate Primary Care Access

Adult Access to Care Distance Standards for Primary Care Physicians

BlueCross NC (On the Exchange)	NC Medicaid Pre-Paid Health Plan

• Large Metro County-
  ○ 10 minutes / 5 miles
• Metro County-
  ○ 15 minutes / 10 miles
• Micro County-
  ○ 30 minutes / 20 miles
• Rural County-
  ○ 40 minutes / 30 miles
• Counites with Extreme Access Considerations (CEAC)-
  ○ 70 minutes / 60 miles
	• Urban-
	  ○ ≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members
	• Rural-
	  ○ ≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members

BlueCross BlueShield of North Carolina, January 2023. Access to Care Standards for On-Exchange Members in All Products in All Lines of Business- Driving Distance to Providers.	NC DHHS, 2019. Revised and Restated RFP 30-190029-DHB Prepaid Health Plan Services.

Payers in North Carolina Are Working to Ensure Adequate Primary Care Access

Adult Access to Care Maximum Wait Time Standards for Primary Care Physicians

BlueCross NC	NC Medicaid Pre-Paid Health Plan

• Urgent, not life threatening (care needed within 24 hours)
  ○ Within 48 hours
• Symptomatic, non-urgent (cold, no fever)-
  ○ Within 30 days
• Follow-up of urgent care-
  ○ Within 7 days
• Chronic care follow-up (blood pressure checks, diabetes checks)-
  ○ Within 14 days
	• Urgent Care Service, non-emergent illness or injury that require immediate care
	  ○ Within 24 hours
	• After-Hours Access (Emergent and Urgent)
	  ○ Immediately (24 hours/day, 365 days/year)
	• Routine/Check-up without Symptoms
	  ○ Within 30 days
	• Preventive Care Services
	  ○ Within 30 days

BlueCross BlueShield of North Carolina, January 2023. Access to Care Standards for All Products in All Lines of Business- Primary Care.	NC DHHS, 2019. Revised and Restated RFP 30-190029-DHB Prepaid Health Plan Services.

Workforce Pipeline Example – State Partnerships

NC's Institute for Workforce Competitiveness	NC Center on the Workforce for Health

• Launched by the NC Chamber Foundation in 2022 to increase the labor force participation rate in the state by:
  ○ Removing barriers to entry through policy innovation solutions.
  ○ Closing the job supply-and-demand gap by scaling and aligning proven employer, community, and industry-based efforts.
  ○ Addressing acute worker shortages by elevating proven employer and community-based efforts.
• Expanded the U.S. Chamber of Commerce Foundation's Talent Pipeline Management (TPM) program within the state.
	• A statewide center focused on the collaborative development of NC's workforce with goals to:
	  ○ Ensure sustained efforts to address health workforce issues to ultimately better align supply with the demand for those workers.
	  ○ Convene employers, educators, workers, regulators, and others to develop, deploy, monitor, and assess efforts to address health workforce issues.
	  ○ Make available actionable data and policy information and provide technical assistance.
	  ○ Provide a forum to share best practices and lessons learned.

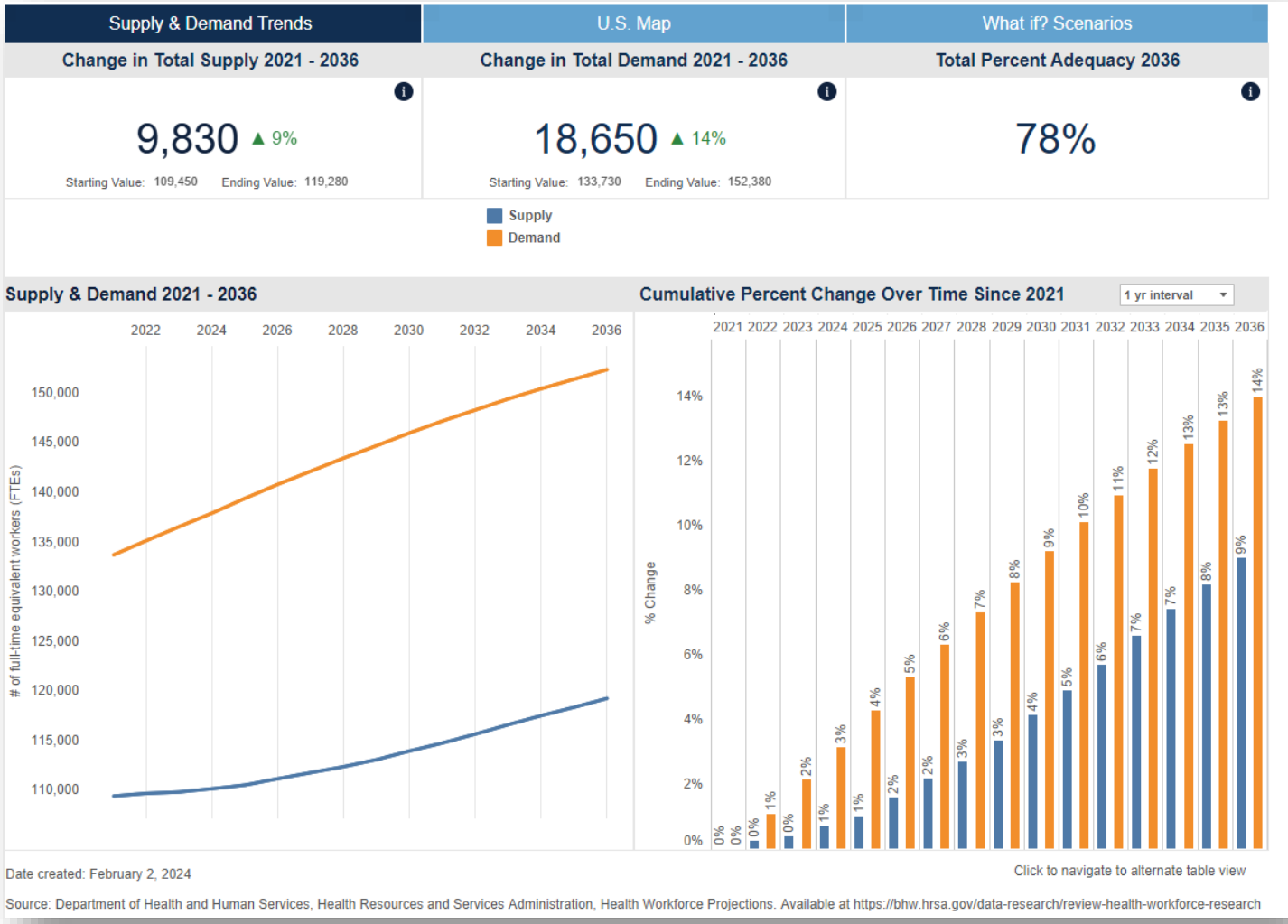
NC Chamber Foundation. Institute for Workforce Competitiveness.	North Carolina Institute of Medicine. NC Center on the Workforce for Health.

National Tools - HRSA Workforce Data

National Center for Health Workforce Analysis (NCHWA) under HRSA

This is an integrated microsimulation model that estimates the current and future supply of and demand for health care workers by occupation, geographic area, and year. It incorporates factors like:

- Changing population size
- Demographics
- Distribution of the U.S. population
- New entrants and exiting providers in various occupations
- Differing levels of access to care

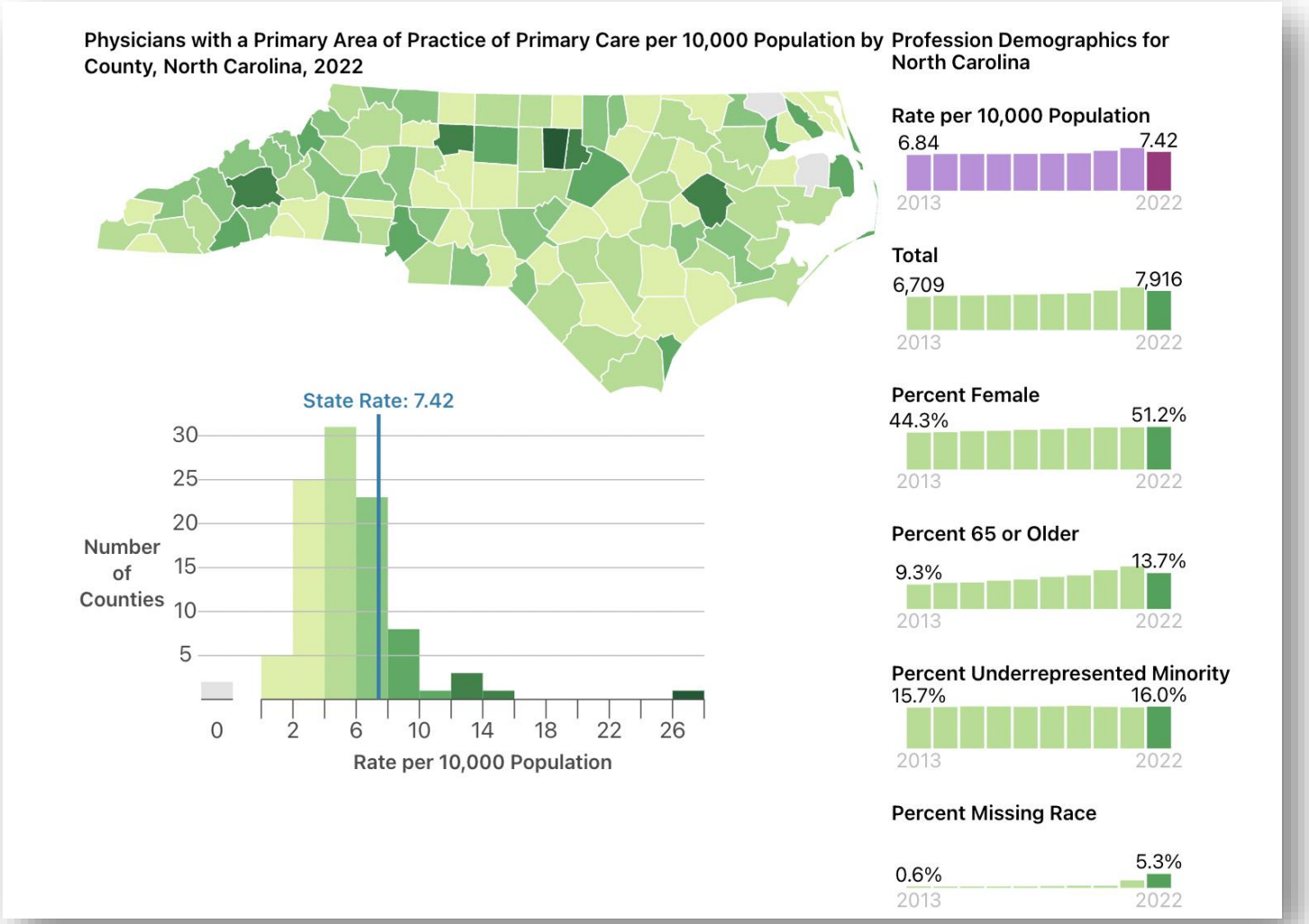


Workforce Projections, National Center for Health Workforce Analysis retrieved February 2, 2024.

State Level Tools – North Carolina Health Professional Data System

Cecil G. Sheps Center for Health Services Research, UNC

- Provides timely, objective data and analysis to inform health workforce policy in NC and across the U.S.
- Manages the North Carolina Health Professions Data System (HPDS)- collecting and disseminating descriptive data on selected licensed health professionals in NC
- Have annual files dating back to 1979

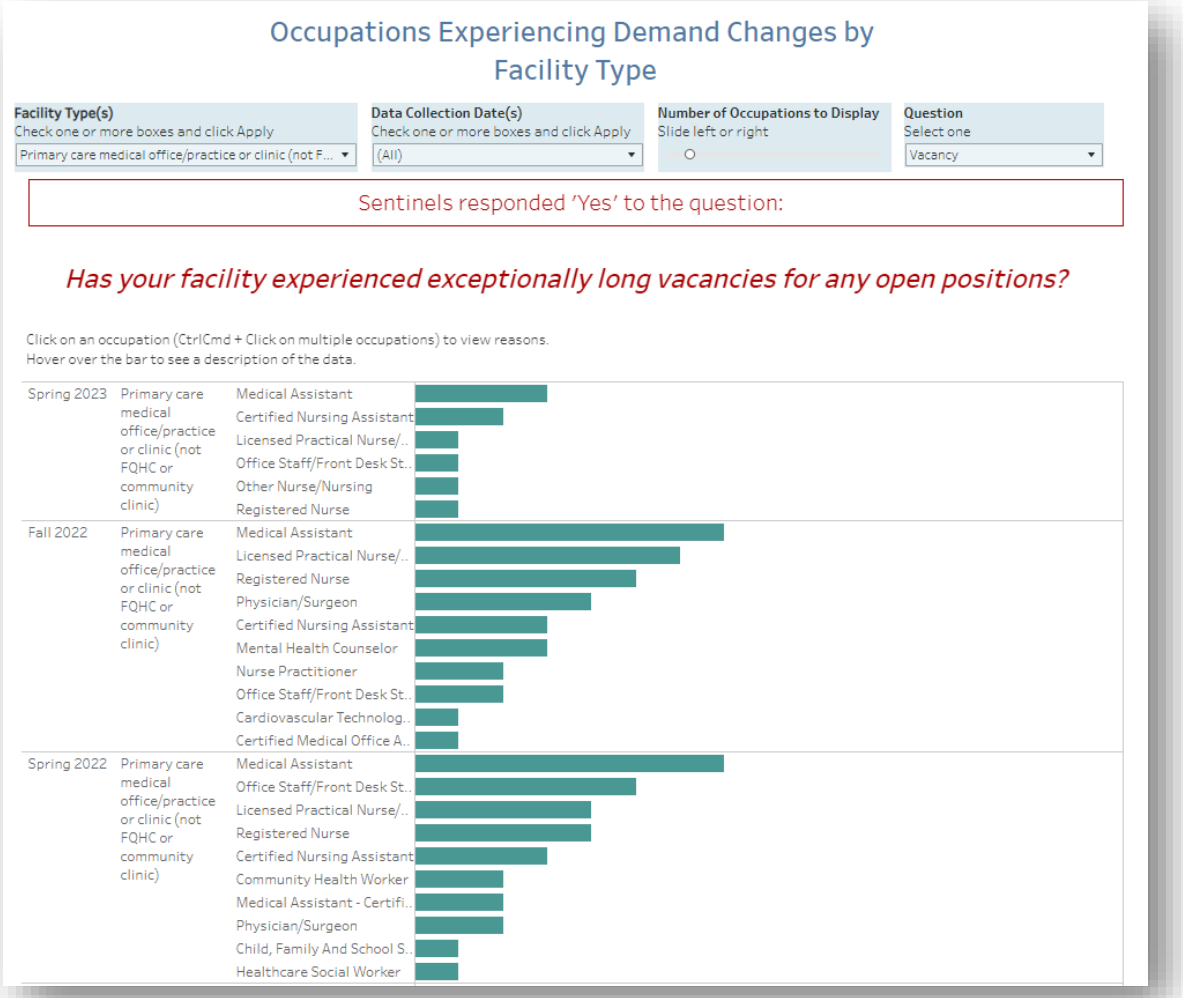


Publicly Available Workforce Data

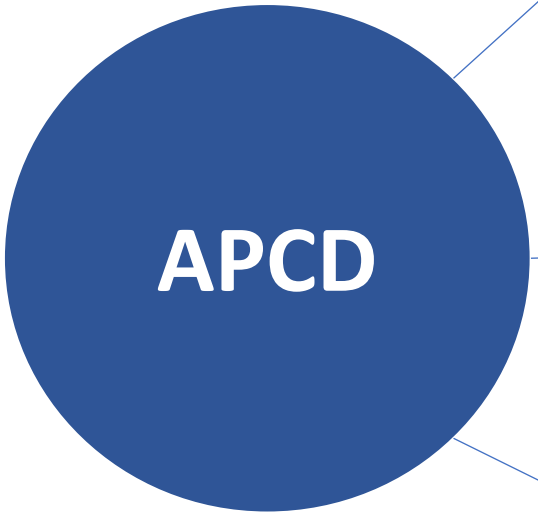
Health Workforce Sentinel Network North Carolina

The Health Workforce Sentinel Network links the healthcare sector with policymakers, workforce planners and educators to identify and respond to changing demand for healthcare workers, with a focus on identifying newly emerging skills and roles required by employers.

The Health Workforce Sentinel Network was originally developed collaboratively by Washington's Workforce Board and the University of Washington's Center for Health Workforce Studies.



APCD Overview



Large Scale Database

Systematically collects healthcare claims and sometimes non-claims data from **multiple payer sources**

Provides comprehensive data

Helps understand variation in **cost, utilization, access, and quality**

Data Sources

- Commercial Health Plans
- Medicaid
- Medicare (FFS and MA)

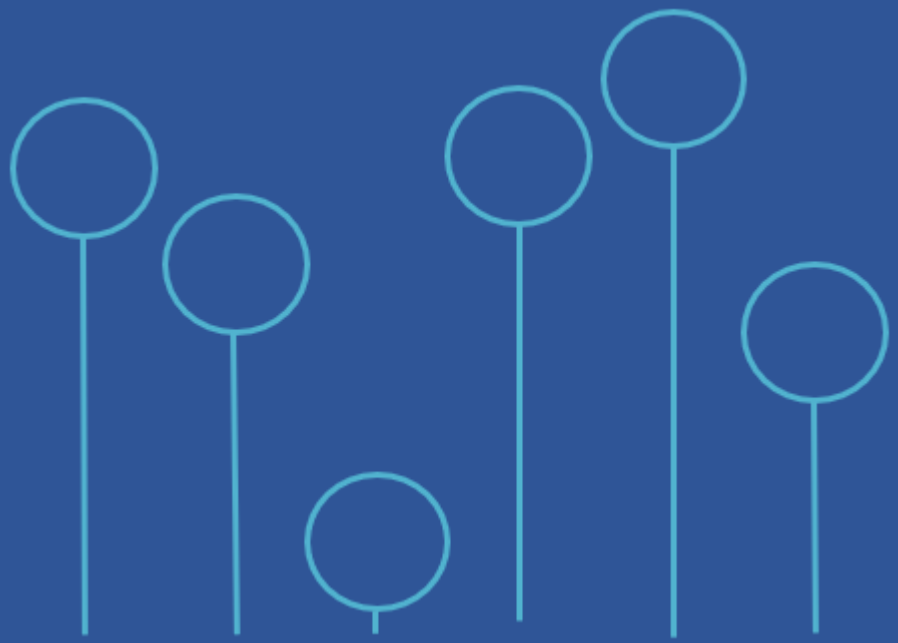
Identify opportunities to:

- improve care
- reduce costs
- improve population health
- increase high value spending e.g., primary care

Potential Longer-term Solutions cont.

APCDs support state understanding of:

- Cost
- Health System Performance
- Use of Low-Value Care/ Services
- Utilization
- Care Patterns
- Medicaid Program Evaluation
- Quality
- Geographic Differences
- Insurance Coverage
- Efficiency
- Variation by Provider/ Facility
- Access to Care & Population Health

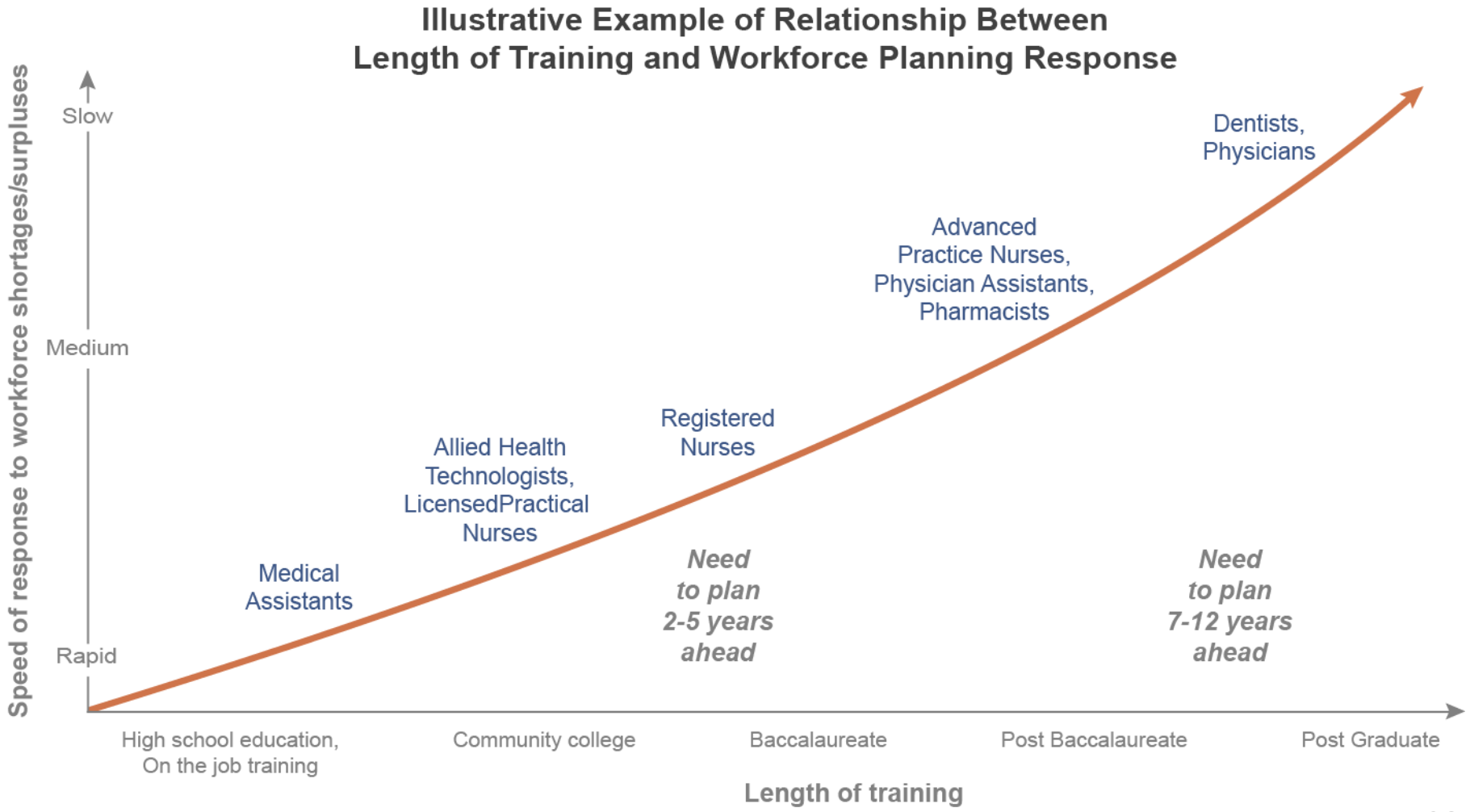


Healthcare Workforce Slides provided by

NC Area Health Education Center (AHEC)

North Carolina Center on the Workforce for Health

It takes a long time to train many health professions, so we need to proactively plan for future workforce needs



Why we are establishing the Center

- There are a lot of hard working, well-intentioned people in North Carolina training the health workforce in North Carolina – this work is too often siloed and driven by anecdote/resources not data/a plan
- We are unaware of any organization in North Carolina that convenes and supports stakeholders to align the supply and demand of health professionals and other personnel
- With such an organization, we can:
  - Facilitate sharing and supporting immediate actions – spreading what works and learning from what doesn't
  - Plan and help inform decisions to allocate resources, adopt policies, act, etc. intentionally to meet aligned, data-driven, defined goals reflecting the ecosystem – at the state and local levels
  - Persist in the work
- NOTE: This will inform decisions and maintain focus – it wouldn't stop anyone from doing anything

Why we are establishing the Center

- The place to go for information about and to address health workforce challenges

- Supporting collaboration to take on urgent and long-standing and multi-factorial challenges

- Staying focused over time

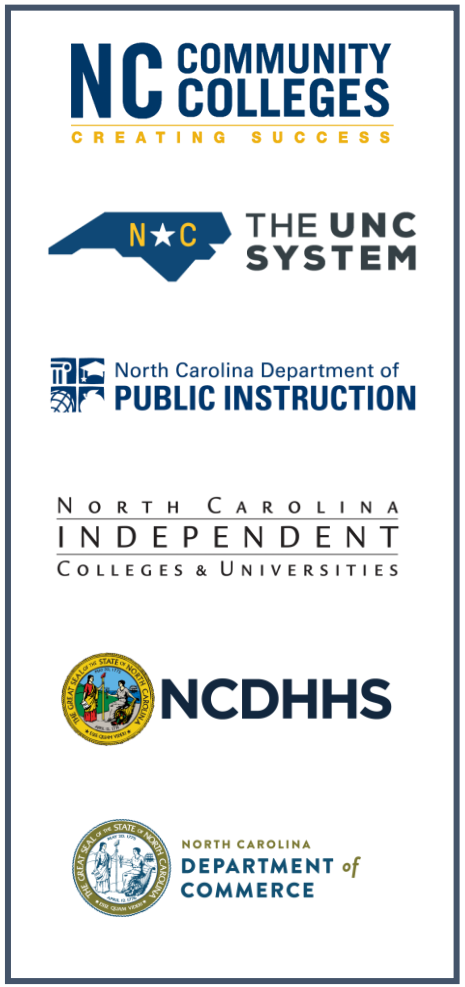
NC Health Talent Alliance

NC Center on the Workforce for Health

NC Chamber Foundation

Partners

Education & Public Sector Partners

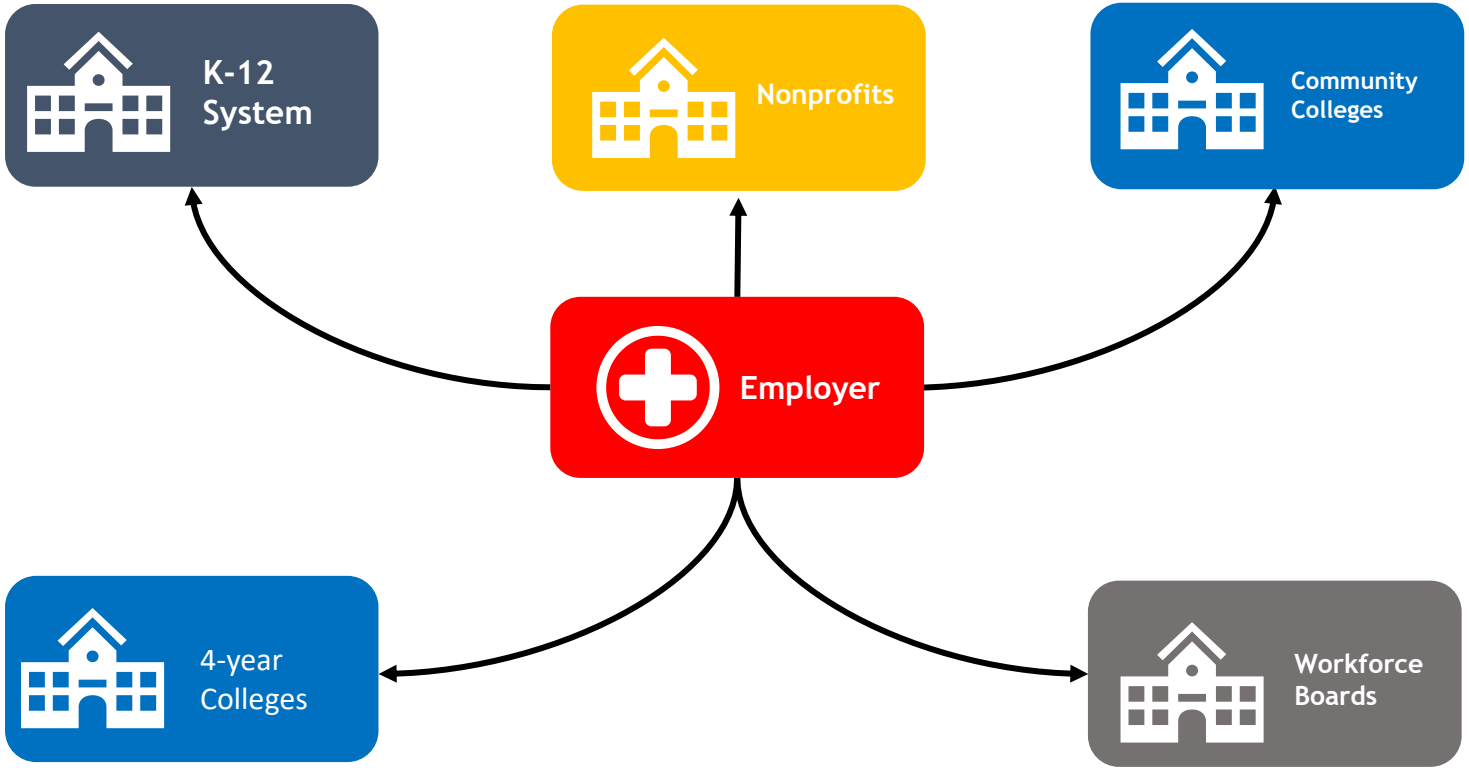


Organizations staffing NC Health Talent Alliance

Association Partners

Current Environment

BUSINESS & EDUCATION RELATIONSHIPS ARE CHALLENGING TO MANAGE & MAINTAIN

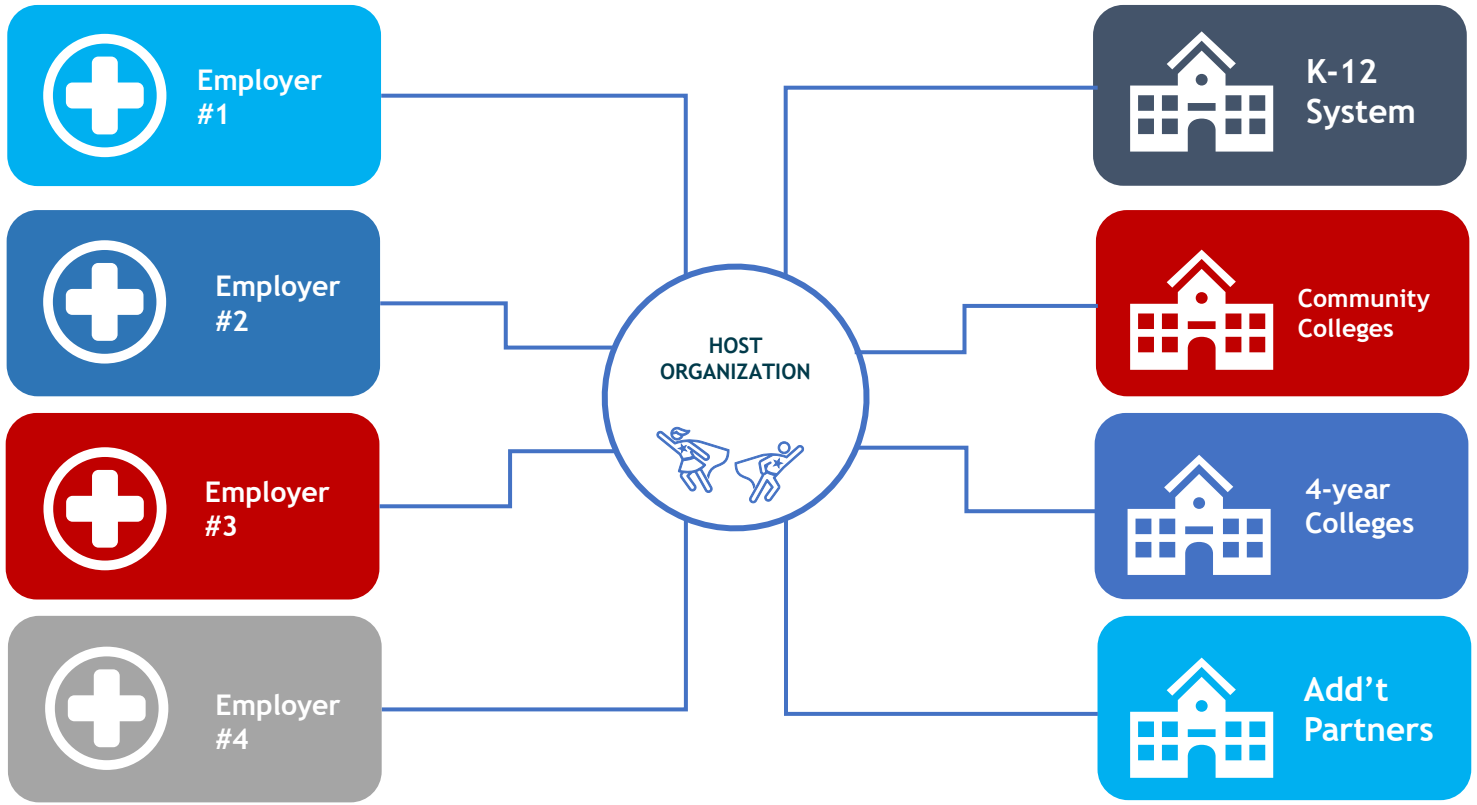


CHALLENGES

- Inefficient communication across sectors hampers strong ROI-focused partnerships
- Most employers are not well-positioned to partner with all talent providers, and vice versa
- Few incentives exist for employers to work together when partnering with talent providers
- Anecdote and individual communications drives investment, not data and coordinated action

TPM® Structure: Employer-Led Collaborative & Host Organization

EMPLOYERS FORM COLLABORATIVE, HOST ORGANIZATION COLLECTS & MANAGES KEY WORKFORCE DATA FROM ALL RELEVANT STAKEHOLDERS



BENEFITS

- Cross-sector communication & coordination is ROI-focused
- Positioned to engage entire ecosystem of health employers & talent providers
- Investments based on data-driven health care needs
- Facilitates and persists local & regional solutions in coordination with statewide approaches

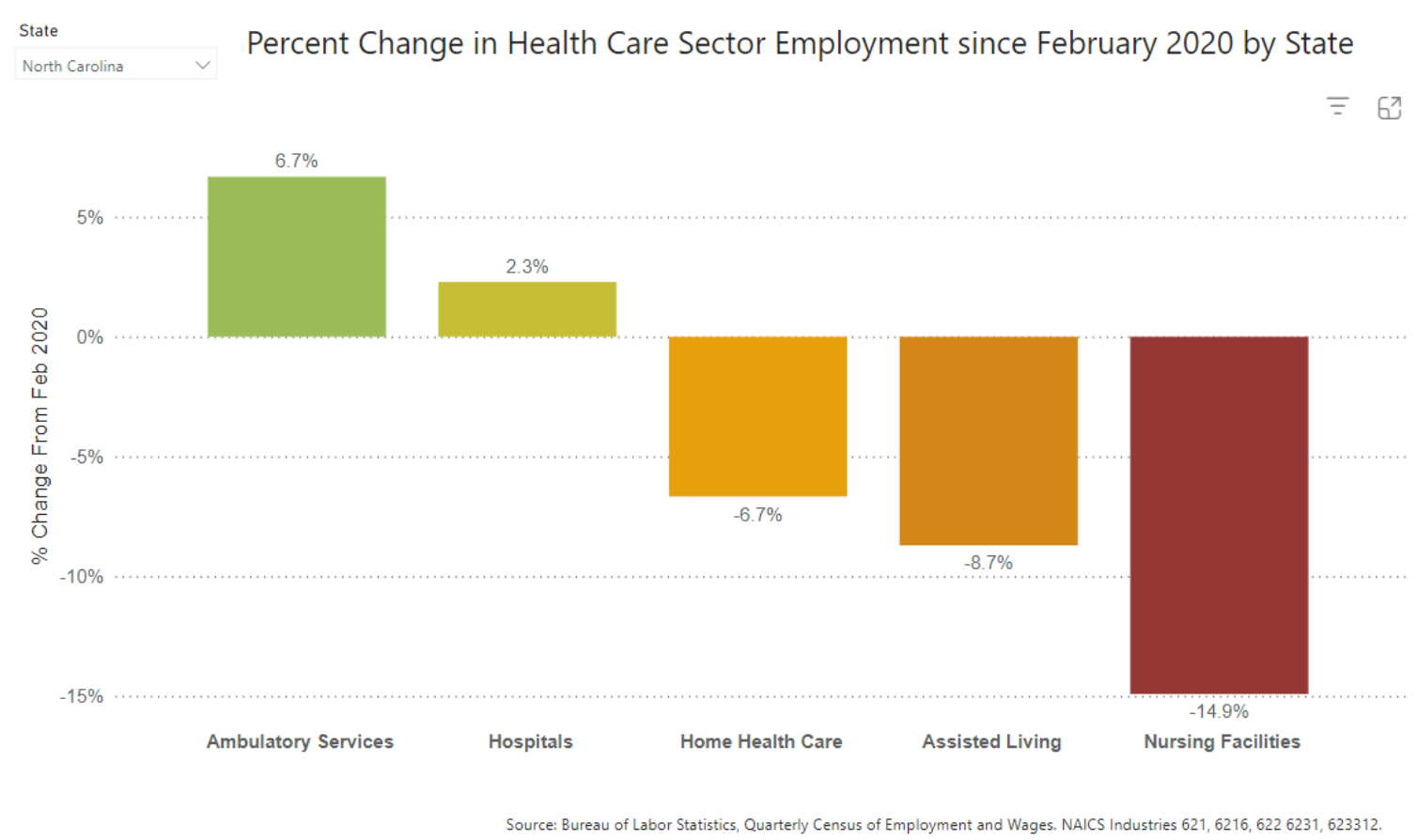
Framework

- Recruit more people into health careers (pipeline/pathway)
- Train people efficiently and effectively
- Retain people in the workplace and in their profession
- Innovate

Boiling it down

- The TPM process in a nutshell:
  - Collect data from employers & educators
  - Share, analyze, identify priorities with data
  - Partner regularly with employers & educators to respond to priorities and deploy solutions
  - Monitor progress with collaborative and adjust where needed – at state (Center) and local levels
  - Repeat
- Without a clear plan, these challenges are daunting
- TPM is the plan—It focuses the approach for everyone and cuts through the noise

It’s an ecosystem



Source: Bureau of Labor Statistics, Quarterly Census of Employment and Wages. NAICS Industries 621, 6216, 622 6231, 623312.

DATA SHOW THE FOLLOWING CURRENT TOP STATEWIDE WORKFORCE AREAS OF NEED

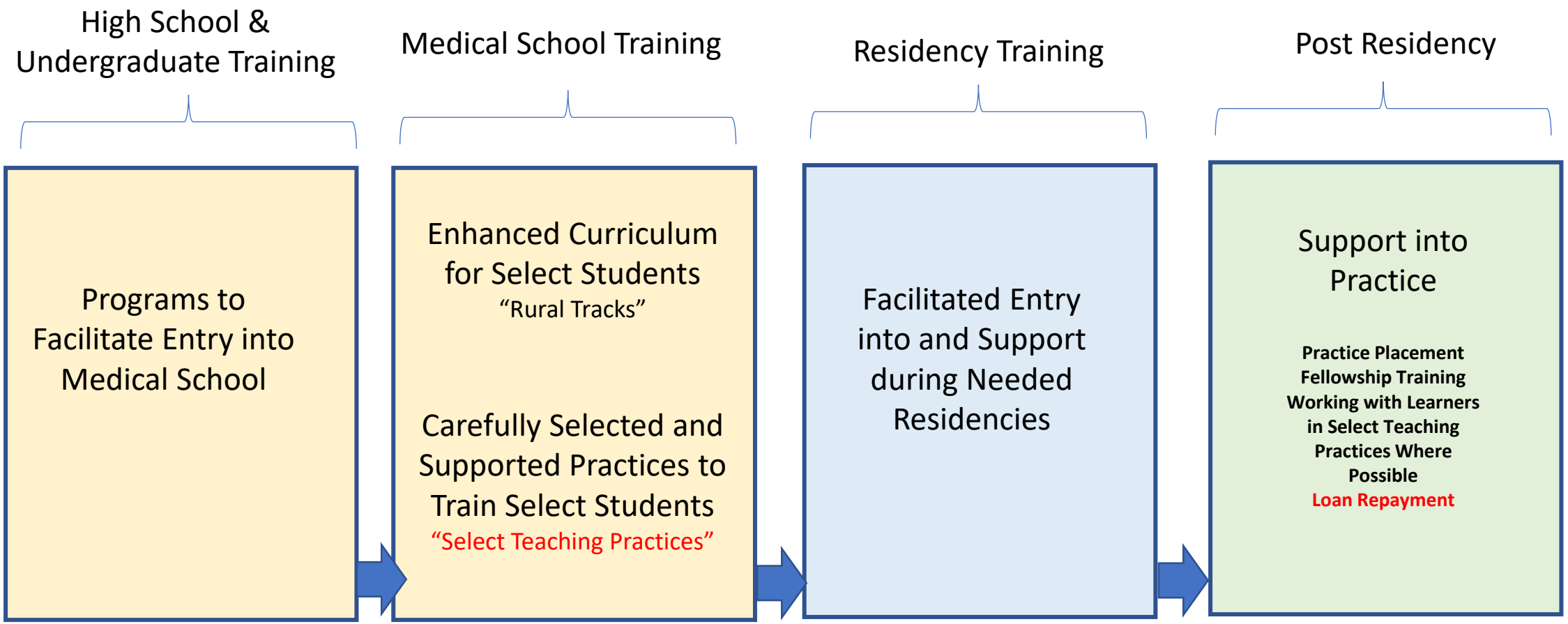
			Top Workforce Areas of Need			
Category	**Analysis**	**Source**	**Nursing**	**Direct Care Workers**	**Behavioral Health**	**Other**
A. Overall Need: Supply and Demand	1. By NC Supply/Demand Need, 2023-35	HRSA	✓	N/A	✓	✓ Primary Care Physicians
	2. By NC Job Opening Projections, 2018-28	NC Commerce LEAD	✓	✓		✓ Med. Assistant
	3. By Longest Vacancies per Employers, 7/2022	UNC Sheps	✓	✓		✓ Med. Assistant
	4. By Coverage Rate per 10k Decline, 2001-21	UNC Sheps, PHI (2016-21)	✓	✓	✓	
	5. By Pct. Profession Age 65+, 2021	UNC Sheps, PHI			✓	
B. By Geographic Distribution	1. By Counties without Health Workforce, 2021	UNC Sheps		N/A	✓	✓ Women's Health
C. By Demo-graphics	1. By alignment with population demographics, 2018	UNC Sheps	✓	✓ Beyond Black	✓	✓ Many

While significant needs exist across many workforces, the preliminary analysis based on available data suggests highest repeated needs shown in:
Nursing, Direct Care, Behavioral Health

Source: HHS HRSA "Projecting Health Workforce Supply and Demand" Nov 2022, NC Dpt. Commerce LEAD Employment Projections 2018-28, UNC Sheps Center "Health Professional Supply Data", UNC Sheps Center "Health Workforce Sentinel Network NC", UNC Sheps Center "Using Data to Shape the Physician Workforce We Need" Oct 2022

DISCUSSION DRAFT

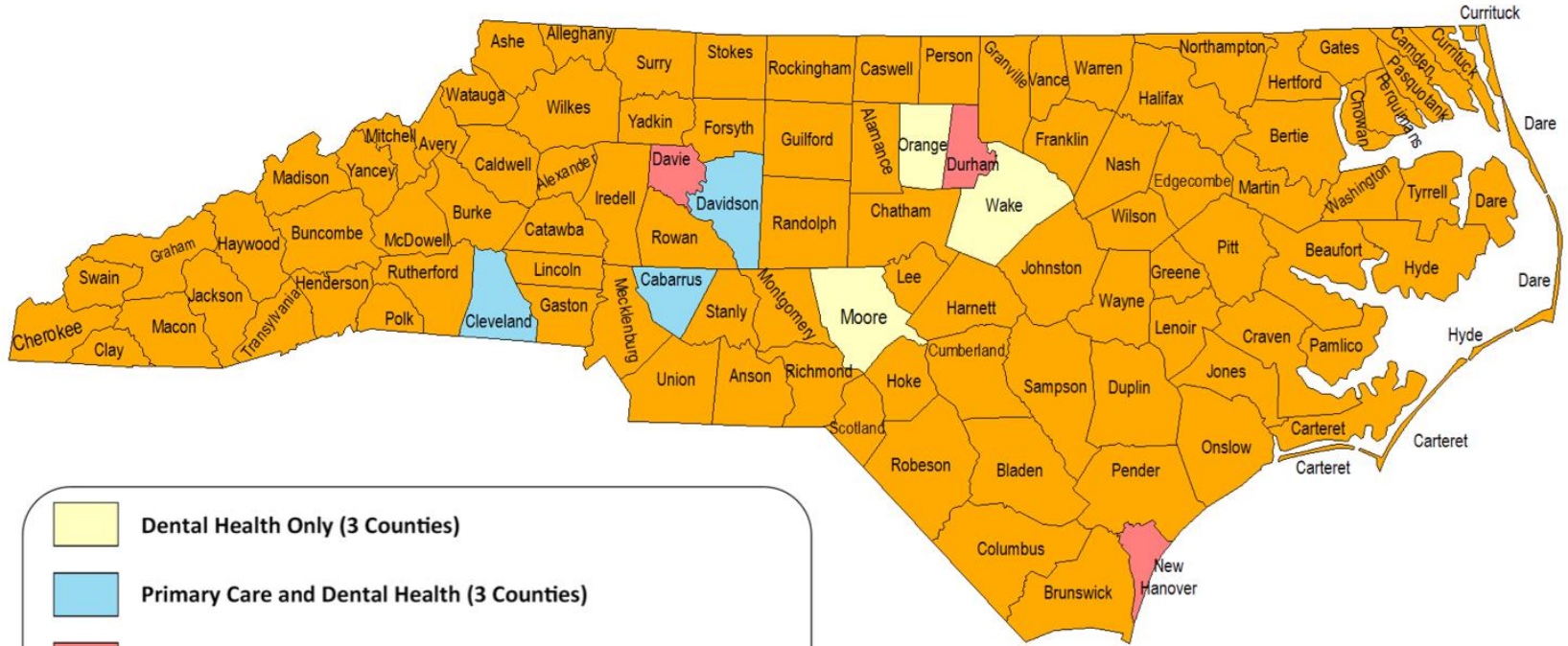
Pathway to Primary Care



Support Across the Educational Continuum: Curricular, Mentorship, Financial

Policy Interventions to Encourage a Career in Primary Care

North Carolina Office of Rural Health
Counties Designated Health Professional Shortage Areas



- Dental Health Only (3 Counties)
- Primary Care and Dental Health (3 Counties)
- Dental Health and Mental/Behavioral Health (3 Counties)
- Primary Care, Dental and Mental/Behavioral Health (91 Counties)

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Rural Health

-Shortage area may be a whole county, population or geographic area within a county.

Data as of March 18, 2022

Area: Asheville Region | See Map | Occupational Group: 6-digit Detailed Occupations | Annual Wage: No Minimum – No Maximum

Education: All Education Levels | Work Experience: Any Experience | Job Training: Any Training

Search | Start Over

Excel | CSV | Search Occupation:

Occupation		Employment		Total Openings				% Growth	Wage	Education, Experience and Training		
SOC	Occupation Title	2021	2030	Net Growth	Exit	Transfer	Total	Annualized	2022 Median	Education	Work Exp.	Job Training
27-3042	Technical Writers	31	31	0	8	17	25	0.0%	*	Bachelor's degree	Less than 5 years	Short-term on-the-job training
27-3092	Court Reporters and Simultaneous Captioners	*	*	*	*	*	2	0.0%	*	Postsecondary nondegree award	None	Short-term on-the-job training
27-4031	Camera Operators, Television, Video, and Film	*	*	*	*	*	3	0.0%	*	Bachelor's degree	None	None
27-4032	Film and Video Editors	*	*	*	*	*	2	0.0%	*	Bachelor's degree	None	None
29-1081	Podiatrists	*	*	*	*	*	0	0.0%	*	Doctoral or professional degree	None	Internship/residency
29-1124	Radiation Therapists	*	*	*	*	*	2	0.0%	*	Associate's degree	None	None
29-1211	Anesthesiologists	5	5	0	1	0	1	0.0%	*	Doctoral or professional degree	None	Internship/residency
29-1212	Cardiologists	10	10	0	2	1	3	0.0%	*	Doctoral or professional degree	None	Internship/residency
29-1216	General Internal Medicine Physicians	*	*	*	*	*	1	0.0%	*	Doctoral or professional degree	None	Internship/residency
29-1224	Radiologists	*	*	*	*	*	0	0.0%	*	Doctoral or professional degree	None	Internship/residency
29-1241	Ophthalmologists, Except Pediatric	*	*	*	*	*	0	0.0%	*	Doctoral or professional degree	None	Internship/residency
29-1242	Orthopedic Surgeons, Except Pediatric	*	*	*	*	*	0	0.0%	*	Doctoral or professional degree	None	Internship/residency
29-1249	Surgeons, All Other	*	*	*	*	*	0	0.0%	*	Doctoral or professional degree	None	Internship/residency
29-1299	Healthcare Diagnosing or Treating Practitioners, All Other	*	*	*	*	*	3	0.0%	*	Master's degree	None	None
29-2036	Medical Dosimetrists	*	*	*	*	*	0	0.0%	*	Bachelor's degree	None	None
29-2051	Dietetic Technicians	*	*	*	*	*	2	0.0%	*	Associate's degree	None	None
29-9092	Genetic Counselors	*	*	*	*	*	2	0.0%	*	Master's degree	None	None
31-1132	Orderlies	*	*	*	*	*	11	0.0%	*	High school diploma or equivalent	None	Short-term on-the-job training
31-2012	Occupational Therapy Aides	*	*	*	*	*	4	0.0%	*	High school diploma or equivalent	None	Short-term on-the-job training
31-9094	Medical Transcriptionists	*	*	*	*	*	5	0.0%	*	Postsecondary nondegree award	None	None
31-9095	Pharmacy Aides	7	7	0	4	7	11	0.0%	*	High school diploma or equivalent	None	Short-term on-the-job training
33-3031	Fish and Game Wardens	*	*	*	*	*	4	0.0%	*	Bachelor's degree	None	Moderate-term on-the-job training
33-3052	Transit and Railroad Police	*	*	*	*	*	0	0.0%	*	High school diploma or equivalent	None	Moderate-term on-the-job training
33-9093	Transportation Security Screeners	*	*	*	*	*	4	0.0%	*	High school diploma or equivalent	None	Short-term on-the-job training
35-2013	Cooks, Private Household	*	*	*	*	*	24	0.0%	*	Postsecondary nondegree award	Less than 5 years	None

Showing 126 to 150 of 717 entries (filtered from 13,149 total entries)

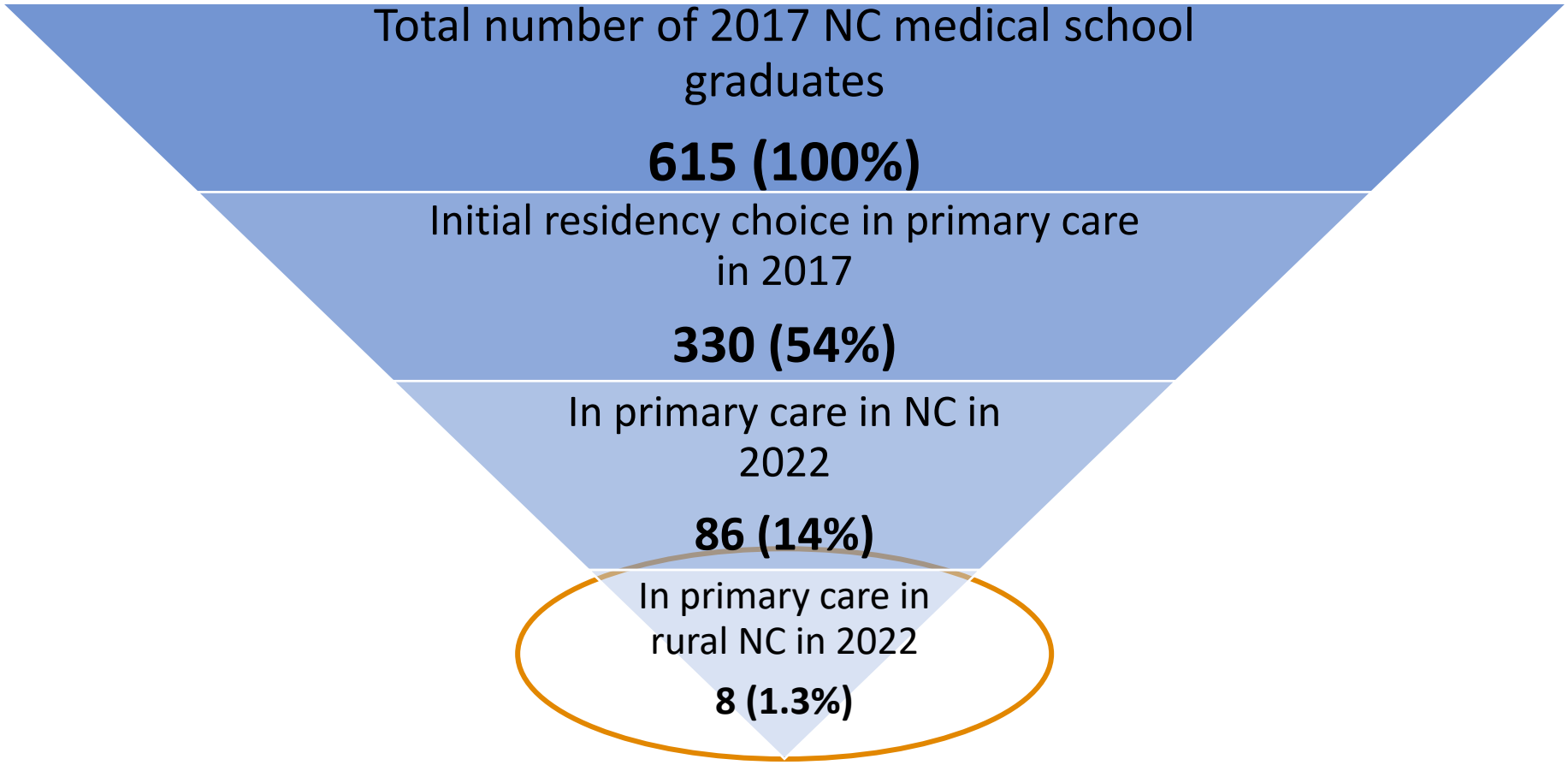
Previous | 1 | ... | 5 | 6 | 7 | ... | 29 | Next

Show 25 entries

* Data not shown due to suppression.

NC DEPARTMENT of COMMERCE
LABOR & ECONOMIC ANALYSIS

Why the shortages? 5 years after graduation, only 1.3% of medical students practice in rural, primary care in NC



Rural source: US Census Bureau and Office of Management and Budget, July 2017. "Core Based Statistical Area" (CBSA) is the OMB's collective term for Metropolitan and Micropolitan Statistical areas. Here, nonmetropolitan counties include micropolitan and counties outside of CBSAs.

Summary

- It’s an ecosystem
- We need to focus – leverage data to prioritize, plan, deploy solutions and monitor progress
- Planning for and training primary care providers requires a longer horizon – programs and investments are already being developed and deployed
- State policies can create and are needed for an environment that is more conducive to selecting a career in primary care