Maryland Loan Assistance Repayment Program (MLARP) for Physicians and Physician Assistants

Data and Its Use Subgroup

Virtual Meeting
June 2, 2021, 1:00 p.m. – 2:00 p.m.

Attendees
Matthew Dudzic, Board of Physicians
Elizabeth Vaidya, Primary Care Office
Jane Krienke, Maryland Hospital Association
Jennifer Witten, Maryland Hospital Association
Karin Weaver, MedStar Good Samaritan Hospital
Kelly Kyser, MedStar Health
Shamonda Braithwaite, Mid-Atlantic Association of Community Health Clinics
Rick Rohrs, Maryland Academy of Physician Assistants
Sara Seitz, Maryland Department of Health
Sadé Diggs, Maryland Department of Health

Approved Notes

I. Welcome/Introduction

Attendance was taken, and subgroup lead provided agenda to use for meeting discussion

II. Administrative

a. Approval of minutes from most recent meeting, May 6, 2021
b. Timeline
    i. July 2021 - Subgroup Recaps & Initial Recommendations
    ii. September 2021 - Report Draft Review, Recommendations Review & Revisions
    iii. November 2021 - Submission of Report to MDH
    iv. December 1, 2021- Final Report to Legislature Due

III. Discussion

Workforce Data

a. MHA Research: MLARP Data & its use subgroup
    i. Health professional shortage area designations: HRSA uses state-submitted health workforce data to designate health professional

shortage areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps)

ii. Making sure that we have the right healthcare providers in the right locations (most in need of providers) is the goal. If we are not as a state providing the best matches, we could be placing providers in places that may not be the neediest.

b. Potential draft recommendations
    i. Require providers to complete survey with all license-certification renewals, beyond current questions and beyond physicians or physician assistants (PAs). Start with physicians and PAs.
        1. Note: Interstate Medical Licensure Compact can interfere with ability to survey providers
    ii. Establish a central workforce data collection unit for the State
    iii. Expand healthcare workforce planning beyond physicians and PAs
    iv. Establish State-defined parameters for population to provider ratios to determine where state resources should go for recruitment of providers
c. Data collection
    i. See these recommendations as longer-term goals and how we as a state are looking at healthcare goals more broadly. Some states do this voluntarily, some require it for incentive programs, but other states have mandated that approach. It is harder to make it voluntary.
        1. Put first level of recommendations on LARP and then think about the longer-term goals.
    ii. Legislation could be written to state that providers must fill out this survey. If legislatively mandated, then by default resources for personnel to manage data could be possible.
    iii. National Commission on Certification of Physician Assistants (NCCPA) asks a lot of demographic questions about specialties and practice sites in its survey to providers
        1. High response rate gained by survey.
        2. Workgroup could make a request for Maryland for data on PAs to gather state specific data and the survey includes lots of information that we are looking for.
        3. May take 2 years to get any kind of data to do analysis based on Maryland PA licensure cycle
    iv. Maryland could partner with Practice Sights's Retention Collaborative & Data Management System to get assistance on data analysis and comparisons

1. Collaboration between North Carolina and other partners (state and primary care) do the work to send out surveys to participants in loan repayment programs and do the data collection and analysis.
2. Cost is $2000, price went up since inception back in about 2012.
3. Project allows Practice Sights and participating states to see what is working and what is trending across states.
4. The majority of the states that are getting that $ 1 million SLRP recipients are participants in this program (Alaska and CA).
5. As there are restrictions of how we can use the funds that we receive, this may be something to add to the conversation for sustainable funding.
6. We would need to make sure if we go this route that we have access to the full data collected and not just the analysis.
7. Practice Sights has expressed interest to present if we would like to learn more about what they offer.

IV. Program Data

a. As a state, want to find out what is working and what is not working.
b. Colorado Model – This state has a very robust program overall including data collection. The program builds data collection requirements for sites and awardees into participant contracts, including:
    i. Semiannual report- report required at 6-month intervals and when completing the program (A lot of this data can be used for the overall workforce data needed from the state)
    ii. Exit survey – upon completion of the program, discusses things that worked and did not work from a provider perspective
    iii. Site visits-30 minute in person site visit in the first year of program, and phone visit during the third year. All information shared from the site visit is anonymous and is used for recruitment and retention evaluation efforts

V. Open Discussion

a. A way to emphasis that we are looking at this data to ensure diversity and start matching providers to the population that they served. Ensuring a health equity approach may resonate a bit more with legislation next year.

b. When the Primary Care Office (PCO) recommends designations, the office looks at participant demographics, which can be reviewed against provide placements/ practice sites
c. MDH - CDC grant received (2-year funding cycle) to conduct health equity work.
    i. Activities to include examining the profile of the Maryland healthcare workforce and to what extent it matches the diversity of the Maryland population and healthcare needs
    ii. This is time to determine healthcare workforce data collection structures and make connections to collect data on a regular basis, building in sustainability
d. With healthcare workforce data in-hand, MDH program data can be compared to that broader workforce to see who is being successfully awarded and if the awards are successfully moving the state toward the goal of serving the underserved and aiding shortage areas appropriately
e. If the program can show successful results by having healthcare workforce data plus program data, it can be used to drive funding structure/ opportunities
f. The Workgroup is looking to provide recommendations for near-term legislation, but also long term and ongoing project

VI. Next Meeting
a. Next meeting date: Plan to have roughly 2 weeks from today. Meet mid to late June and send Doodle to see what works for everyone
b. Goals/Assignments
    i. Everyone will send subgroup lead, Matthew Dudzic, any additions to recommendations and he will collate thoughts for next meeting and prior to July main group meeting