



STRENGTHENING THE HEALTH CARE SAFETY NET WORKFORCE THROUGH INTERAGENCY COOPERATION, PLANNING AND POLICY

NATIONAL
CONFERENCE
of
STATE
LEGISLATURES

October 2009

“We need to do something now—right now—to have any hope of turning this around by the time the Baby Boomers hit the system in large numbers.”

--Marcia Brand, Deputy Administrator, HRSA, in Inside HRSA, January 2009

In July 2009, the National Conference of State Legislatures, the Association of State and Territorial Health Officials, the National Academy for State Health Policy, and the National Association of Community Health Centers brought together legislators, federal and state health officials, state rural health officials, primary care association representatives, state primary care offices, and workforce experts to share best practices and innovative ways to improve the primary care workforce pipeline and meet current and future demand for primary care services for the uninsured. This meeting was made possible by support from the Health Resources and Services Administration’s Bureau of Primary Health Care and Office of Rural Health Policy and Health and Human Services Office of Minority Health.

This summary and analysis identifies some of the major topics covered during the meeting, with an emphasis on strategies and solutions to address some of the complex challenges facing states. Federal and state health care reforms designed to improve access to primary care health services among the uninsured rely on an adequate supply of providers to deliver those services. This is not the reality in many states and localities. Without an adequate supply of health care providers in America’s safety net—community health centers, public hospitals, local health departments and other providers that deliver care to the medically underserved—many of the reforms may stumble. As a result, some states are considering or implementing programs to strengthen America’s safety net workforce.

This meeting brought together health leaders from Colorado, Idaho, Maine, Mississippi, Missouri and Ohio to form “state teams.” The teams’ objectives included learning about successful policy options to improve the workforce and to develop goals and strategies to improve the safety net workforce in their states. The collaborative meeting style allowed each team member to express priorities and concerns about workforce issues and to hear those of other attendees in an effort to bring consensus, understanding and motivation to move forward on state policy solutions. Participating teams returned to their states with a policy plan to improve the health care safety net workforce in their state. This summary highlights numerous policy options and strategies that were described at the meeting, but it is not a comprehensive summary of the meeting. (More detailed information on faculty presentations is available at <http://www.ncsl.org/?TabId=19332>.)

Strengthening the Safety Net Workforce Meeting Co-Sponsors

- Association of State and Territorial Health Officials
- National Academy for State Health Policy
- National Association of Community Health Centers
- National Conference of State Legislatures
- HRSA Bureau of Primary Health Care
- HRSA Office of Rural Health Policy
- HHS Office of Minority Health

Meeting Faculty

- Mirtha Beedle, MPA, Deputy Director, Office of Minority Health, Maryland
- Bruce Behringer, MPH, Assistant Vice President and Executive Director, Office of Rural and Community Health and Community Partnerships, Tennessee
- Marcia Brand, PhD, Deputy Administrator, Health Resources and Services Administration, Maryland
- Raul Burciaga, Assistant Director, Drafting Services, New Mexico Legislature
- Carrie Cochran, Deputy Associate Administrator, Office of Rural Health Policy, Maryland
- Diana Espinosa, Deputy Associate Administrator, Bureau of Health Professions, Maryland
- Hilda Heady, MSW, Associate Vice President, Rural Health Policy, West Virginia University
- James W. Hunt Jr., President and CEO, Massachusetts League of Community Health Centers
- Scott Leitz, MPA, Assistant Commissioner, Minnesota Department of Health
- Senita Robinson, Chief of Research, Policy and Planning Section, Health Workforce Development Division, California
- Rick Smith, MS, Associate Administrator, Bureau of Clinician Recruitment and Services, Maryland
- Donald Weaver, MD, Assistant Surgeon General, Deputy Associate Administrator, Bureau of Primary Health Care

Background: The Current State of the Health Care Safety Net Workforce

Health care workforce shortages are pervasive in rural and urban communities across the country. According to the U.S. Health Resources and Services Administration,¹ as of March 2009, there were:

- **6,080 Primary Care Health Professional Shortage Areas (HPSA)** with 65 million people living in them. It would take 16,585 practitioners to meet their need for primary care providers.
- **4,091 Dental HPSAs** with 49 million people living in them. It would take 9,579 practitioners to meet their need for dentists and other dental providers.
- **3,132 Mental Health HPSAs** with 80 million people living in them. It would take 5,352 practitioners to meet their need for mental health providers.

Addressing these shortages is a daunting challenge for states because expanding the number of health care professionals requires both time and a substantial investment of public and private resources. Workforce development typically focuses on three sets of problems: the overall supply of providers; their geographic and practice distribution (e.g., whether they practice in locations and settings—such as rural health clinics or health centers—that are in underserved communities); and other factors that relate to the workforce composition, such as cultural competency and diversity. Some recruitment and retention challenges for health centers—as well as for other safety net providers—are summarized in Table 1.

Results of Shortages

- Access issues result in patients delaying care.
- Lower use of preventive care.
- Use of higher cost care in emergency rooms and specialty care.

Source: Bruce Behringer's presentation, NCSL Safety Net Workforce Meeting, July 2009.

Other challenges related to the workforce composition, include lack of diversity among incoming and future health providers. Workforce shortages result in several negative cost and health care quality issues, listed at right. As a result, policymakers are adopting and investigating a wide range of strategies, discussed below, to address these problems.

Recruitment Challenges	Retention Challenges
<ul style="list-style-type: none"> • Limited number of students entering medical school and choosing primary care. • Medical students and residents unfamiliar with health centers. • Salary for primary care is lower than that of specialists. • Recruitment resources are very limited. • Cost of living. • Geographic issues such as isolation rural areas. • “Recruitment Competition” from hospitals and private practices. 	<ul style="list-style-type: none"> • Salary. • Lack of opportunity for career development (in research, teaching and administrative roles) in many rural and underserved locations. • Outdated or inefficient operational systems. • Competition from hospitals and private practices.

Workforce Solutions

As one presenter said, “the solution has to match the problem.” Therefore, states are using a wide range of tools and strategies to solve their workforce problems. This section summarizes some strategies that were highlighted at the meeting.

- Training a primary care workforce;
- Reforming payment to provide more support to primary care providers;
- Providing loan repayment and financial incentives;
- Using workforce data to drive policy and planning; and
- Improving workforce diversity.

Training a Primary Care Workforce

Training a primary care workforce is a long-term process, beginning with students in the K-12 system and continuing through college, health professions training (e.g., medical school, nursing, pharmacy, dentistry, etc.) and into community practice. States are adopting varied approaches to ensure an adequate primary care workforce. According to Hilda Heady, Associate Vice President, Rural Health Policy, West Virginia University, experience and evidence indicate that a number of these programs are working.

Improving graduation rates and academic readiness among young students is a key focus for many states. Underrepresented young people are not prepared to enter health professions training—either because they lack the required math, science and study skills or because they did not graduate from high school. Underrepresented students include minority students and those who live

What’s Working?

- Rural training tracks for professional students and graduate residents
- Training in rural communities
- Financial incentives in training with or without service obligations
- Pipeline programs with rural focus and content
- Strategic admissions strategies (e.g., rural preferences, reserved spots)
- Community-led initiatives
- Financial incentives from and to communities
- Focus on health status of communities
- Community economic development

Source: Hilda Heady’s presentation, July 2009.

in underserved areas. Research shows that under-represented students who receive support are more likely to deliver care in underserved communities. Bruce Behringer, assistant vice president of the Office of Rural and Community Health and Community Partnerships at Tennessee State University, suggested that policymakers think of efforts to recruit and retain primary care providers as a highway system—with many off and on ramps—rather than as a pipeline.

The consensus of the presenters was that the absence of experience in working in underserved areas and an absence of exposure to primary care during medical school and residency programs is a principal barrier to recruitment. As a result, policymakers are exploring multi-pronged strategies that create many “on-ramps” to help health professionals become interested in primary care and serving in underserved areas throughout their education and careers. These “ramps” include grow-your-own programs, loan repayment programs, career ladders and nontraditional residency programs. Mr. Behringer reminded meeting participants that, “Life happens. You might recruit a promising student from a small rural community in hopes that he or she will return as the primary care physician, but then they become interested in research and stay in the university setting. Alternatively, a young medical student might never consider practicing primary care in an underserved area until he or she participates in a rotation at a community health center.” Medical students and health professionals must have exposure to the safety net to become interested in providing care in that setting.

New Mexico's Pathways to Health Careers program exposes young people to health careers and provides enrichment opportunities to prepare them for health professions training. According to Raul Burciaga, assistant director of drafting services for the New Mexico Legislature, early strategies are critical in a state where fewer than one in five eighth graders is considered proficient in math and science. As a result, the Legislature allocated resources to address this problem through a range of strategies, including academic enrichment for middle and high school students, as well as a residential summer program that provides academic enrichment and health careers training for incoming college freshmen.

In addition, the eight-year combined BA/MD program—with four years in college and four years in medical school—was developed by the New Mexico School of Medicine and funded by the Legislature. The program accepts high-performing high school seniors with a demonstrated commitment to community service; most are from rural areas. The program offers personalized academic advising, individual tutoring and group supplemental instruction, scholarships and financial aid, a preparatory course for medical school examinations, faculty mentors, learning projects in rural communities, guaranteed placement in medical school.

The **West Virginia** Legislature in 1991 passed the Rural Health Initiative Act that addressed several challenges, including the serious need for primary care providers and improving access to adequate health care. Among other things, the legislation established a Rural Health Advisory Panel, comprised of rural health providers and representatives from participating academic institutions. The Legislature charged the panel with overseeing and evaluating the state's rural health initiatives and specified how the panel would work with the vice chancellor of health sciences to establish and operate primary care training sites—health centers, clinics, pharmacies and the like—where students, interns and residents receive educational and clinical experience. The law allocates funds for training and specifies that state efforts be implemented through strategic partnerships between local communities and higher education.

The Quillen College of Medicine at East **Tennessee** State University (ETSU) relies on community partnerships and a strong rural focus to achieve its goals, according to Bruce Behringer, assistant vice president of the Office of Rural and Community Health. This focus is articulated in the school's mission, which is “... to educate future physicians, especially those with an interest in primary care, to practice in underserved rural communities.” Behringer said that ETSU implements a “continuum of actions” that include recruitment and admissions policies, and curricula that include community-based learning. Applying a rural health mission produces positive results, including a large percentage of medical students who practice primary care (60 percent) in rural or underserved areas.

Reforming Payment to Support Primary Care Providers

In Minnesota, and other states across the country, the cost of private health insurance has risen more quickly than wages, inflation and per capita income. According to Scott Leitz, assistant commissioner at the Minnesota Department of Health, the cost of private health insurance per person has nearly doubled since 2000, while the state economy has grown by 50 percent, per capita income and wages by 30 percent to 40 percent, and total inflation by about 25 percent. Heavy spending, however, does not result in higher quality care in Minnesota or nationally; the U.S. consistently ranks below other countries for a number of indicators, such as the percentage of adults and children who receive recommended care for their conditions.

According to Leitz, the current payment system has several shortfalls, including payment incentives that discourage providers from delivering preventive care and consumers from shopping for high-performing providers and actively managing their health. The current system leads to overspending on expensive, high-profit margin services (such as imaging and outpatient services) and too little spending on less expensive, low-profit margin services (such as preventive health services and mental health services). In short, the current fee-for-service payment system does not encourage quality and value.

Reforming the payment system has the potential to align payment incentives with state goals to improve quality and control health costs. According to Leitz, a redesigned payment system contains the following characteristics:

- Provider incentives would change from “rewards for higher volume” to “rewards for better care management and outcomes.”
- The new system would include incentives to redesign care delivery systems to support teaching patient self-management skills, preventive services or nutrition education services.
- New payment models would support providers by sharing any savings. In the current system, providers stand to lose money when they provide more effective and efficient care.
- The new system would provide opportunities for providers to redesign care by holding them accountable for results but also giving them flexibility and opportunities to innovate.

Minnesota’s 2008 health reform legislation addressed payment reform, among a wide range of other issues, such as health care coverage and affordability, chronic care management, and health care cost measurement. Some key characteristics of Minnesota’s payment reforms are summarized below.

Payment and Price/Quality Transparency Measures in Minnesota’s 2008 Health Reform

- Develop quality measures and a statewide system of quality-based incentive payments for use by public and private purchasers.
- Develop transparent public ranking of providers on relative cost, quality and resource use. Private and public purchasers will use this information to develop products to encourage the use of low-cost, high-quality providers.
- Promote transparency and accountability by establishing “baskets” of health care services for conditions such as preventive care for children and adults, asthma, diabetes and obstetric care.
- Provide payment for primary care providers who function as medical homes (by partnering with patients and families to provide coordination of care).

Providing Loan Repayment and Financial Incentives

Most states face serious shortages of primary care physicians in rural and urban underserved communities. Loan repayment, loan forgiveness and other financial incentive programs may help to reverse this trend by providing a financial offset to some of the challenges of a primary care practice, among them lower salary, isolation, and fewer professional development and career advancement opportunities.

State Loan Repayment and Financial Incentives to Promote Workforce Goals

Massachusetts' sweeping health care reforms in 2006 significantly affected the health care system, according to James Hunt, president and CEO of the Massachusetts League of Community Health Centers. As the number of newly insured grew, so did the demand for primary care. According to Hunt, "recruitment and retention of primary care providers has never been more important." In response, Massachusetts developed the Primary Care Workforce Initiative to promote primary care as the foundation of health care delivery. With funding from public and private partners—the Commonwealth, Bank of America, the Neighborhood Health Plan and the Blue Cross Blue Shield Foundation—Massachusetts developed a loan repayment program that offers compelling financial incentives for medical students, residents, physicians and nurse practitioners. The program has increased the workforce supply by nearly 100 physicians and nurse practitioners in health centers, and an estimated increase in access for 144,000 medically underserved and newly uninsured people.

The **New Mexico** Legislature enacted several laws to establish and fund programs that provide financial incentives—such as tax credits, stipends and loan repayment—for rural providers.

- The New Mexico Health Service Corps Act offers commitment stipends of \$30,000 for health professional students and licensed health professionals who serve in an eligible community for at least two years.
- The Rural Health Practitioner Tax Credit Act provides up to \$5,000 per year in a personal income tax credit for rural physicians and other providers serving in rural, underserved areas. The credits are available to full- and part-time providers.

Using Workforce Data to Drive Policy and Planning

Policymakers use data and information about the current and future health care workforce to drive policy and planning. Some states, for example, establish workforce centers to monitor the supply and demand for specific health care providers and evaluate the effectiveness of educational and workforce strategies. In 2007, the **California** Legislature established a health care workforce clearinghouse to collect data on supply and demand, diversity, geographic distribution and other factors. Among its many activities, the clearinghouse is charged with conducting a needs assessment to determine workforce and educational needs and identify a user-friendly, comprehensive data infrastructure. According to Senita Robinson, chief of research, policy and planning in the California's Office of Statewide Health Planning and Development, data benefits everyone by informing solutions that close gaps and address specific shortage areas, improving access to comprehensive data, and improving worker and student recruitment and retention.

Improving Workforce Diversity

According to Mirtha Beadle, deputy director of the U.S. Office of Minority Health, workforce diversity is a key element of health care access. The current health care workforce does not reflect the population at large, and this affects quality and access to care. "Clearly, minority professionals work in underserved areas disproportionately, minority patients tend to receive better interpersonal care from minority professionals, and non-English speaking

patients experience better interpersonal care and medical comprehension when they have a provider who speaks their language.”

An underlying problem is the low graduation rate among students of color. According to Beadle, approximately 88 percent of all high school students graduate, but the rate drops to 65 percent among Blacks and Hispanics. Beadle suggested that solutions aimed at improving minority participation in the health care workforce should address the problem of low graduation rates among students of color. For example, California’s Health Careers Training Program’s “mini-grants” encourage underrepresented students to explore health careers through academic support, internships, career fairs and Saturday academies.

Federal Resources and Programs

State workforce strategies often benefit from partnerships with federal programs, such as the Bureau of Health Professions and the Office of Rural Health Policy in the U.S. Health Resources and Services Administration (HRSA). According to HRSA, the American Recovery and Reinvestment Act includes \$500 million for health workforce programs, including \$200 million for scholarships, loans and loan repayment programs, and \$300 million to double the field strength of the National Health Service Corps by 2010.² Some examples of federal resources include:

- The National Health Service Corps recruits and retains physicians and other providers to rural and urban health professional shortage areas. The program repays participant loans in exchange for service in a needy area. Since its inception, the program has placed more than 30,000 primary care clinicians nationwide.
- HRSA funds the Health Workforce Information Center (<http://www.healthworkforceinfo.org>) to provide comprehensive information about funding sources, workforce data and policy, educational opportunities and models, and state-specific data.
- HRSA administers “Centers of Excellence” grants to support medical schools and other health professions schools in their efforts to create a more diverse health care workforce. The federal grants support strategies to develop a competitive applicant pool, recruit and retain underrepresented faculty, provide community-based clinical training, and provide stipends to students.

Conclusion

State and federal health care reforms depend on an adequate supply of primary care providers to deliver cost-effective health care. Developing an adequate health care workforce requires commitment and collaboration among various public and private sectors to achieve results. According to Heady, state experiences have demonstrated several important lessons:

- State policymakers, educational institutions and community leaders working as a partnership team can make a difference.
- There is no single solution; therefore, strategies appropriate for states and regions must be blended into a full complement of programs.
- Outcomes should be directly linked to health status, program elements and best practices.

Notes

1. HRSA, "Shortage Designation: HPSAs, MUAs, and MUPs," (Rockville, Md.: HRSA, April 2009); <http://bhpr.hrsa.gov/shortage/>.
2. HRSA Health Professions website, <http://bhpr.hrsa.gov/grants/diversity.htm>.



NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

National Conference of State Legislatures

William T. Pound, Executive Director

7700 East First Place
Denver, Colorado 80230
(303) 364-7700

444 North Capitol Street, N.W., #515
Washington, D.C. 20001
(202) 624-5400

www.ncsl.org

© 2010 by the National Conference of State Legislatures. All rights reserved.

ISBN 978-1-58024-____-