It seems a recipe for health care disaster: Combine population growth with an aging population, add expanded health insurance coverage, and … hope for the best? The growing need for health care workers of all disciplines is well recognized. Midwestern states have already moved to address the growing crisis with recruitment and retention strategies, as well as by redefining professionals’ scopes of work and expanding the use of new applications of technology such as telehealth.

The baseline problem is daunting. In its July/August 2016 edition of Capitol Ideas, The Council of State Governments’ bimonthly national magazine noted that Georgetown University’s Center on Education and the Workforce predicts that “demand for health care services will grow twice as fast as the national economy over the next decade.”

The Association of American Medical Colleges (3) forecasts a national primary care physician shortage of between 15,000 and 35,000 by 2025. And while there seems to be some good news regarding the number of nurses — the U.S. Health Resources and Services Administration (4) projects strong growth in the supply of nurse practitioners through 2020 — the American Nurses Association (5) says a combination of demographic factors and expanded access to health care “will create a renewed critical shortage for nurses.”

This workforce problem is most acute in many of the Midwest’s rural areas. In a 2012 policy paper, the Kansas-based National Rural Health Association (6) forecast prolonged rural shortages of full-time physicians, registered nurses, mental health professionals, pharmacists and dentists.

“The shortage does go all the way across [the spectrum of health care professions],” says Dr. Raymond Christensen, associate dean for rural health and associate director of the Rural Physician Associate Program (7) at the University of Minnesota Duluth.

In Minnesota, for example, the final report (8) of the Legislative Health Care Workforce Commission, released in December 2016, noted that while the statewide percentage of all occupations currently open is 3.6 percent, the rates are much higher in health care fields — 6 percent for physical therapists and nurse practitioners, 14 percent for internists and general physicians, and 18 percent for psychiatrists.

In a recent ongoing series of stories, the (Madison) Wisconsin State Journal (9) cited data from the state Department of Workforce Development showing that by 2024, “analysts expect there will be nearly 52,000 more job openings than in 2014 in the health care and social assistance fields — more than twice as many as the next-largest sector.”

The biggest need will be for registered nurses (more than 5,000), physical therapists (616) and doctors (376), the newspaper reported. The State Journal also cited state and federal data showing “a need for other health care workers, including more than 4,600 certified nursing assistants and more than 2,000 home health aides. Those are 13 percent and 28 percent increases from 2014, compared with a 10 percent increase for nurses.”

And as South Dakota Sen. Deb Soholt noted (10) in the May edition of Stateline Midwest, 43 percent of residents in her state live in a designated primary care shortage area; her state needs to increase its primary care workforce 27 percent by 2030 to meet projected demand, while 45 percent of current-day practicing physicians are older than 50.

The recruit-and-retain strategy
Perhaps the most widespread recruitment/retention program is loan repayment, under which medical students who agree to provide services in a designated “health professional shortage area” (usually rural) qualify for funds to help pay down their student debt. All Midwest states have at least one such program; Minnesota has nine.

The Kansas State Loan Repayment Program offers up to $25,000 for physicians and dentists ($20,000 for other providers) in exchange for at least two years’ work at a site in a federally designated Health Professional Shortage Area, while the Kansas Bridging Plan offers up to $26,000 for physicians in Kansas residency programs who agree to practice full-time in a rural community for three continuous years upon completion of their residencies.

Likewise, Nebraska’s Rural Health Student Loan Program awards medical, dental or psychology students up to $30,000 for up to four years (or $15,000 for two years to master’s level mental health students); students must agree to practice full-time in state-designated shortage areas for one year for each year the loan was awarded. They also must accept Medicaid patients.

Additionally, the National Health Service Corps operates a Student Loan Repayment Program with participating states (which are required to provide matching funds). All Midwestern states except Indiana and South Dakota are participants. While loan forgiveness programs are “reasonably effective,” Dr. Christensen says, the cap on medical residencies funded by Medicare — established by the U.S. Congress in 1997 — is a bottleneck in the current system. Generally, the federal government funds residencies for direct costs such as salaries, benefits and teaching, as well as indirect costs associated with the assumed greater inefficiency of trainees. (Indirect cost coverage is determined by a formula set by U.S. Congress and the U.S. Centers for Medicare & Medicaid Services. States can add funding, too.)

Wisconsin’s newly approved budget includes two measures advanced by the Wisconsin Rural Initiative, a group of state legislators promoting rural development, to improve access to care in underserved areas. One of the measures establishes a grant program for hospitals, health systems or schools that create education and training programs for individuals seeking careers as therapists, medical technicians or other “allied health professionals.” The second grant is for hospitals and health clinics that provide more training opportunities in advanced-practice nursing.

Minnesota this year considered establishing tax credits for medical preceptors (doctors who volunteer to train or supervise medical students), an idea that came from Tennessee. That idea didn’t advance this year, says Sen. Greg Clauson, who sat on the state’s Legislative Health Care Workforce Commission.

In its final report, that panel recommended expanding residency slots in rural areas, especially for mental health, geriatric care and psychiatry, along with expanding the use of telehealth, identifying underserved regions and increasing funding to the University of Minnesota Medical School, in part for physician workforce programs.

“We’re continuing to monitor those things to see how it’s going,” Clauson says.

Kansas this year approved SB 32, which added general and child psychiatry to the list of residencies covered by the state’s Medical Student Loan Act and eligible for the Kansas Medical Residency Bridging Program. As important as passage, the bill was also funded, says Rep. Susan Concannon, who serves as co-chair of the Midwestern Legislative Conference’s Health and Human Services Committee.

Kansas legislators are also working on a measure to allow nurse practitioners to have practices independent of supervision by physicians, but the votes aren’t there yet, Concannon adds. That step already was taken in Nebraska in 2015, when LB 107 was signed into law. It allows licensed nurse practitioners to practice fully, without a written agreement with a doctor. Similar legislation was signed into law this year in South Dakota.

“It really helps to deal with the primary care practitioner shortage,” since 44 percent of LNPs practice in rural areas, says Sen. Sue Crawford, who is vice chair of the MLC’s Health and Human Services Committee.

Nebraska’s unicameral Legislature in 2009 created the Behavioral Health Education Center of Nebraska (part of the University of Nebraska Medical Center) to recruit and retain students and professionals to address behavioral health shortages in rural counties, as part of its broad strategy to address rural health needs.

Now, however, Crawford says, “Our primary strategy is passing laws to improve the integration of care.” That includes the improvement and expansion of telehealth — the use of electronic information technology to support
long-distance health care, patient/provider interaction and health administration.

“You’re maximizing what your current health professionals can do with technology,” Crawford adds.

Minnesota is at the cutting edge of telehealth legislation, according to the Advisory Board, a Washington, D.C.-based medical consultancy firm. In a blog post published in January identifying major legislative trends, the firm noted that Minnesota had

- passed parity laws requiring Medicaid and private insurers to pay the same for telehealth services as for in-person services,
- entered into the Interstate Medical Licensure Compact,
- added homes or schools as allowable “originating” sites (meaning a patient’s location during telehealth sessions), and
- expanded to 18 its list of providers authorized to use telehealth.

Wages low, needs high in home health

While most of these efforts focus on building up the supply of direct health care providers, jobs in service/support positions like home health workers go unfilled mainly because of low pay, says Paul Osterman, a professor at the Sloan School at the Massachusetts Institute of Technology, whose latest book, “Who Will Care for Us? Long-Term Care and the Long-Term Workforce,” addresses this topic.

“Loan forgiveness programs aren’t really relevant to a lot of these folks because the amount of training they get is negligible,” Osterman says, adding that with compensation generally around $10 an hour, “they might as well go to work in a department store. It’s an easier job.”

Normally, the market would correct that and wages would rise, but home health aides are reimbursed by Medicaid, and state legislatures control that, he says. There is room to raise workers’ pay — as states such as Illinois and Wisconsin have done in their new budgets — but not by just spending more money, Osterman says.

The key, he says, is to make workers more productive by increasing their training and the scope of work they’re allowed to do; that will lower overall costs by reducing the need for higher-priced specialists. Some of those savings can then be used for raises.

In 2016, New York legislators created the new job category of “advanced home health care aide”; the state’s Department of Health is now in the process of drafting regulations for it. These aides will work under a licensed registered nurse’s supervision to perform tasks such as “administering routine or pre-filled medications that are easy to give ... as well as other tasks to be defined in regulations.”

According to PHI PolicyWorks, the new law will make jobs in home health care more attractive by filling two caregiving gaps — first, by giving home health aides a new opportunity for advancement; and second, by allowing them to perform tasks that currently only be done by licensed personnel, family members or individuals in Medicaid’s Consumer Directed Personal Assistance Services program.

Osterman says the issues of home health workers’ pay and professional development don’t get much traction.

One reason: It’s often assumed that as a fallback provision, family members will care for patients. “With baby boomers retiring, the ‘muddling through’ option is becoming less and less attractive,” Osterman adds. “We were told to prepare for the ‘silver tsunami’ but, human nature being what it is, we put it off and put it off and put it off.”
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Links
[12] http://dhhs.ne.gov/publichealth/RuralHealth/Pages/StudentLoanProgram.aspx
[20] https://www.unmc.edu/bhec n/
[23] https://phinational.org/