### Workforce Work Group Priority Recommendations

**Governor’s Health Care Reform Taskforce**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Actions/Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Adopt the Advanced Practice Registered Nursing (APRN) Consensus Model and</td>
<td>Legislation</td>
</tr>
<tr>
<td>enact the APRN Model Act and Rules</td>
<td></td>
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<tr>
<td>2  Consider the impact of MN joining the Interstate Nurse Licensure Compact,</td>
<td>Budget request and related legislation</td>
</tr>
<tr>
<td>through establishing a stakeholder work group and conducting a study of</td>
<td></td>
</tr>
<tr>
<td>relevant issues.</td>
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</tr>
<tr>
<td>3  Restore the 2011 cuts in funding to the Medical Education and Research Costs</td>
<td>Legislation</td>
</tr>
<tr>
<td>(MERC) program, and invest additional funds in MERC targeted to new</td>
<td>Budget request</td>
</tr>
<tr>
<td>primary care training sites for primary care physicians, advanced practice</td>
<td></td>
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<tr>
<td>registered nurses, physician assistants and pharmacists to meet the health</td>
<td></td>
</tr>
<tr>
<td>workforce needs of the state.</td>
<td></td>
</tr>
<tr>
<td>4  Restore and increase the state’s Health Professional Loan Forgiveness</td>
<td>Legislation</td>
</tr>
<tr>
<td>Program beyond its pre-cut 2011 budget</td>
<td>Budget request</td>
</tr>
<tr>
<td>5  Investments in the Mental Health Substance Abuse Workforce</td>
<td>Public – private partnership</td>
</tr>
<tr>
<td>6  Improve employment opportunities for dental therapists and advanced dental</td>
<td>Budget request</td>
</tr>
<tr>
<td>therapists by supporting start-up changes and practice redesign changes</td>
<td></td>
</tr>
<tr>
<td>by prospective employers.</td>
<td></td>
</tr>
<tr>
<td>7  Increase wages and benefits of workers in the long-term care sector</td>
<td>Legislation</td>
</tr>
<tr>
<td>employed in nursing homes, in-home care, etc.</td>
<td>Budget request</td>
</tr>
<tr>
<td>8  Expand the Minnesota FasTRAC (Training, Resources, and Credentialing)</td>
<td>Budget request</td>
</tr>
<tr>
<td>program</td>
<td></td>
</tr>
<tr>
<td>9  Support and Expand Telehealth and related technology to improve quality and</td>
<td>Legislation and possible budget request</td>
</tr>
<tr>
<td>access and extend workforce capacity.</td>
<td>Coordination with Governors’ Broadband Task Force</td>
</tr>
<tr>
<td>10 Increase the number of foreign-certified physicians obtaining Minnesota</td>
<td>Budget request</td>
</tr>
<tr>
<td>licensure; Invest in recruiting diverse medical school candidates</td>
<td></td>
</tr>
</tbody>
</table>
Workforce Work Group Priority Recommendations

Recommendation 1: Adopt the Advanced Practice Registered Nursing (APRN) Consensus Model and enact the APRN Model Act and Rules

Sector: Transform Primary Care

Explanation: This strategy removes scope of practice barriers to APRN practice such as the statutory requirement for collaborative management and prescriptive agreements with physicians. It enables APRNs to practice to the full extent of their education and training. There are 5,532 APRNs in Minnesota and four 4 APRN certification categories: Nurse Practitioner (CNP); Registered Nurse Anesthetist (CRNA); Clinical Nurse Specialist (CNS); Nurse Midwife (CNM). APRNs hold graduate/post-graduate degrees from accredited institutions. National certification assures the public that every APRN has achieved education preparing them for the advanced role and passed a psychometrically sound examination that measures competency. APRNs meet the HRSA definition of “mental health professional” and enhancing their role would help address the severe shortage of psychiatrists in Minnesota, especially in non-metro areas.

Statement of Problem Addressed by Recommendation; Rationale and Data to Explain why Recommendation is a Priority:
Abundant research evidence demonstrates the critical role advanced practice registered nurses (APRNs) play in increasing the primary care workforce; providing safe, effective, quality care and effective chronic disease management; and in transforming our health care system to optimize health promotion and prevention. Currently, APRNs are not allowed to practice to the fullest extent of their education and training because of statutory barriers in Minnesota’s Nurse Practice Act. Minnesota’s Nurse Practice Act mandates APRN practice must occur in settings that provide for a collaborative arrangement between an APRN and a physician in order to care for and manage patients, and limits prescriptive authority to those APRNs who maintain a signed written prescriptive agreement with a physician. In contrast, 17 states and the District of Columbia (AL, AZ, CO, DC, HI, IA, ID, MT, ND, NH, NM, OR, RI, UT, VT, WA, and WY) allow APRNs to diagnose, treat and manage patients and prescribe medications and devices without requirements for physician collaboration or supervision. Examples of how statutory barriers limit consumer access to care include:
- APRNs cannot establish and operate nurse-managed health clinics in Minnesota because of the requirement to employ one or more physicians. Evidence from such clinics in other states demonstrates increased access to care and improved healthcare outcomes to vulnerable populations including those who are uninsured or under-insured.
- Psychiatric-mental health CNSs or NPs effectively counsel and provide medication management for people experiencing mental health problems; however, many have had difficulty partnering with a physician willing to sign their prescriptive agreements, especially in rural areas. PMH-CNSs and NPs have provided competent and much needed mental health services for over 30 years. When the physician with whom an APRN has had a prescribing agreement leaves the area, the APRN is unable to continue to provide care to patients.
- APRNs living in rural areas with inadequate physician coverage are unable to open primary care practices to serve the population unless they can find a physician willing to enter into some type of collaborative practice arrangement and sign the APRNs’ prescriptive agreements.
The current statutory restrictions applied to APRNs pose barriers to Minnesota citizens’ access to safe, affordable health care. Moreover, these restrictions limit cost-savings that could be realized by increasing APRNs’ capacity to provide care.

**Who would implement the recommended strategy:** MN Board of Nursing

**Implementation Resources Needed:** legislation to amend the Nurse Practice Act

**Intended Outcomes, if implemented** (on health care, health status, access and/or cost, including return on investment, if available): Alleviation of shortages and increased access, especially to primary care and mental health services. Fuller utilization of APRN resources, and consequently increased efficiency and cost effectiveness. Comparable results in areas of health status, satisfaction, and use of specialists.

**Anticipated Implementation Challenges:** Scope of practice proposals can be controversial

**Sources:**
AARP & RWJF Center to Champion Nursing in America (2011). *Practice and access to care.*


Primary Care Workforce Steering Committee of the Governor’s Workforce Development Council (2011). *Minnesota’s primary care provider shortage: Strategies to grow the primary care workforce.*
Recommendation 2: Consider the impact of MN joining the Interstate Nurse Licensure Compact, through establishing a stakeholder work group and conducting a study of relevant issues.

Sector: Transform Primary Care

Explanation: The Nurse Licensure Compact (NLC) is an agreement between states to mutually recognize the license of a nurse as authority to practice in other states that are party to the agreement. The basic concept of the mutual recognition model of nurse licensure is to issue a nurse one license by state of residence, and allow the nurse to practice in other states subject to each state’s practice regulations.

Statement of Problem Addressed by Recommendation: An impact evaluation of the NLC is needed to inform Minnesota policymakers. The scope of the evaluation may include impact of the NLC on access to care, quality and patient safety; numbers of nurses expected to arrive in or leave Minnesota and net effects, to the extent this can be determined; effects on collective bargaining and labor relations; effects on regulation, discipline and the Board of Nursing; effects on employers and health systems; and issues related to telehealth and interstate practice.

Rationale and Data to Explain why Recommendation is a Priority: Nursing is by far the largest sector of Minnesota’s licensed health care workforce, and nurses play critical roles in all health care settings. Nurses’ roles are also central to a reformed health care system. Understanding the licensing, supply/demand, working conditions and other issues possibly related to implementation of the Nurse Licensure Compact is important to workforce and health reform planning.

Implementation Resources Needed: Funding ($120,000) is needed for a study and stakeholder workgroup process.

Intended Outcomes, if implemented (on health care, health status, access and/or cost, including return on investment, if available): To be identified by study and workgroup.

Anticipated Implementation Challenges: None, once consensus reached on study scope.
Recommendation 3: Restore the 2011 cuts in funding to the Medical Education and Research Costs (MERC) program, and invest additional funds in MERC targeted to new primary care training sites for primary care physicians, advanced practice registered nurses, physician assistants and pharmacists to meet the health workforce needs of the state

Sector: Transform Primary Care

Statement of Problem Addressed by Recommendation: The MERC budget was halved in 2011 and will be only partially restored in 2012. The pool of MERC funds must support both primary care and specialty training. In addition, current federal Medicaid restrictions require funds be distributed entirely on the basis of each training site’s Medicaid revenue, regardless of the number of trainees, site training costs or any consideration of state priorities. This makes it impossible to target MERC to primary care sites.

Communities depend on sufficient numbers of physicians to provide care for their populations in both primary care and specialty practices. While many factors affect population health, the presence of sufficient numbers of physicians is a key ingredient of the care system.

Rationale and Data to Explain why Recommendation is a Priority: Workforce needs tie directly to the health care delivery system, and MERC is the state’s foundation investment in Minnesota’s system of clinical training. Restoring MERC will greatly stabilize health professions training in Minnesota, and investing new resources specifically in new primary care training capacity will support the redesign of practice to the team-based, primary-care centered approach needed to achieve health reform goals and transform primary care.


Medical Education and Research Cost (MERC) 2011 Report to the Legislature. MDH, St. Paul

Who would implement the recommended strategy (state agency, health plans, etc.)

MDH, DHS

- Restore MERC formula grants to 2011 levels, with the existing formula. Cost: $14.4 million/year.
- Encourage CMS to allow formula revisions to re-associate some portion of MERC funding with training costs and activity.
- Fund a new state only MERC pool for primary care training of 150 physicians, advanced practice nurses, physician assistants and pharmacists. Costs to subsidize 50% of the costs of new slots for students/residents in these areas are approximately $7.1 million/year, including 1 FTE for administration and for workforce analysis/planning. Expansion funds could be targeted to teaching programs that implement standards/competencies/outcomes for residents and students such as care coordination, team-based care, shared decision-making, etc. Higher subsidy could be provided for new slots in underserved or shortage areas.

Intended Outcomes, if implemented: (on health care, health status, access and/or cost, including return on investment, if available)
Health professions clinical training provides significant benefits to patients' health, to care systems, and to communities. Residents and other students provide service while learning, and may care for low income patients, provide emergency care and cover after-hours care.

In addition to the public benefit derived from supplying competent health providers, teaching hospitals and academic medical centers help maintain the health care safety net by serving as the providers of care for much of the safety net population. The medical innovation and scientific/technological advancement occurring in GME settings are another critical public good accruing to all society. GME programs also have a positive effect on the quality of care. Findings of available studies also document better quality of care in teaching hospitals. In Minnesota, most students trained here remain to practice here.

**Anticipated Implementation Challenges:** None known
**Recommendation 4:** Restore and increase the state’s **Health Professional Loan Forgiveness Program** beyond its pre-cut 2011 budget by adding 100 new participants annually for four years. Add psychologists, social workers, Licensed Alcohol and Drug Counselors, dental therapists and advanced dental therapists, dental hygienists occupation therapists and physical therapists as eligible participants.

**Sector:** Transform Primary Care

**Statement of Problem Addressed by Recommendation, Rationale and Data to Explain why Recommendation is a Priority:**
In addition to producing adequate numbers of new health professionals, including those from diverse racial and ethnic backgrounds, influencing where those providers choose to work is key to achieving Minnesota’s health reform and workforce goals. Loan forgiveness is a proven strategy to induce health professionals to practice where they’re most needed. Research also confirms that providers who are incented to practice in underserved areas stay there, making a long term contribution in response to a relatively modest upfront investment in loan forgiveness. The state’s loan forgiveness program does not have sufficient funds to respond to these needs, especially following a budget reduction in 2011. The program can fund fewer than 30% of the applications received. In addition, several professions important to transforming care delivery are not included in the program.

Physicians who agree to practice in rural and underserved areas, advanced practice nurses, physician assistants and pharmacists who agree to serve in rural areas, dentists who agree to serve significant numbers of public program and sliding fee patients, registered nurses who agree to work in nursing homes and nursing/allied health faculty are now included in the program.

**Bringing Health Care to the Heartland: An Evaluation of Minnesota’s Loan Forgiveness Programs for Select Health Care Occupations** MDH April 2007

**An Evaluation of Minnesota’s Loan Forgiveness Programs for Select Health Care Occupations** MDH August 1999


**Implementation Resources Needed:**
- a. Legislation: Current statute would be amended to add new professions
- b. Funding: Budget request (add 100 slots. Approx. $2,200,000 in year 1, rises to $8,200,000 in year 4.)

**Who would implement the recommended strategy?** MDH

**Intended Outcomes, if implemented** (on health care, health status, access and/or cost, including return on investment, if available): Access outcomes will be improved provider availability in underserved communities. As a strategy that affects provider distribution at the end of training, outcomes occur relatively quickly, and the cost of loan forgiveness incentives is less than that of the preceding educational investment.

**Anticipated challenges with implementation?** None
Recommendation 5: Academic programs, both graduate and undergraduate, and community-based behavioral health programs need to actively prepare and maintain workers for employment in the current and future health care environment.

Sector: Investments in the Mental Health and Substance Abuse Workforces

Statement of Problem Addressed by Recommendation: State and national trends suggest that the emerging medical and behavioral workforces are not prepared to deliver services in the current healthcare environment. This is due, in part, to dramatic changes in the behavioral healthcare field and the difficulty of academic training programs to keep pace with these changes. There is a gap between what is actually being taught in those programs and the knowledge and skills that are necessary to work effectively in the increasingly integrated primary care and behavioral health settings that are emerging in the context of health reform. In particular, little training is provided for Primary Care clinicians in screening for, identifying, assessing or treating Substance Use Disorder or Mental Illness. Both Mental Health and Substance Use Disorder training programs could be improved with expanded cross-training of professionals in the areas of co-occurring disorders and longitudinal health care for sustained long-term recovery. There is also a need for many workers currently employed in behavioral health provider organizations to develop basic competencies in the assessment and treatment of both mental health and substance abuse disorders. Finally, there are similar needs among the long-term care workforce to ensure that these workers receive substantive orientation or training about behavioral health problems and their treatment.

Rationale and Data to Explain why Recommendation is a Priority: Many of the recommendations set forth elsewhere in this document will help to address long-standing workforce needs in both the mental health and substance abuse treatment fields. Enhancing the capacity of APRNS; loan forgiveness and tuition reimbursement for mental health and addictions counselors, including programs that incent workers to practice in rural areas; increase acceptance of and use of telemedicine and enabling billing for this service and steps to increase an ethnically diverse workforce are needs within the behavioral health field. However, the move towards new models of integrated care and financial incentives to achieve better outcomes and improved wellness for the patient being treated in any health care setting requires that new professionals and paraprofessionals entering these fields have the broadest training possible to enhance their value in these new models of care. Increased training for primary care providers to assist in identifying mental illness or drug and alcohol misuse/dependency (in addition to serious psychiatric issues and severe long-term substance use disorders that are often easier to identify) are important in bridging the gaps in behavioral health workforce needs. For pediatricians, being able to identify developmental delays and mental health symptoms at the earliest time – including infant and toddler check-ups – and being comfortable discussing findings and behavioral health treatment options, is also needed. Enhancing basic primary care knowledge among behavioral health workers and long-term care workers is also necessary to identify and address preventative and treatable medical conditions such as diabetes, hypertension, obesity and asthma. Although the Patient Protection and Affordable Care Act created a federal grant program, it was never funded and it remains unclear if Congress will appropriate funds for it. The State could create its own state grant to invest in an educated and interdisciplinary work force.

Implementation Resources Needed:
• a. Legislation: Create and Fund **MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS** modeled after the Section 756 of the Affordable Care Act and award grants to eligible institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in—

  o (1) baccalaureate, master's, and doctoral degree programs of social work, as well as the development of faculty in social work;
  
  o (2) accredited master's, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services;
  
  o (3) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling; and
  
  o (4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for pre-service or in-service training of paraprofessional child and adolescent mental health workers.

b. Funding: State Appropriation needed if federal grant program is not funded.

c. **Public-private partnership** - Regardless of whether state creates this grant fund, there is still a need for change within educational systems by working with the oversight organizations that accredit, certify, and license training programs, service programs, and individual practitioners

**Intended Outcomes, if implemented** (on health care, health status, access and/or cost, including return on investment, if available): **Interdisciplinary education resulting in increased access and coordination of care.** All health professionals would be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice and with competencies in the assessment and treatment of both substance use disorders and co-occurring mental and addictive disorders, and long-term care workers would have training on core issues relating to behavioral health symptoms and appropriate responses and referrals.

**Recommendation 6:** Improve employment opportunities for dental therapists and advanced dental therapists by supporting start-up changes and practice redesign changes by prospective employers

**Sector: Investments in the Oral Health Workforce**

**Background:** Dental therapists (DTs) and advanced dental therapists (ADTs) are new midlevel dental providers, and Minnesota became the first state to license these providers in 2009. DTs/ADTs work under the supervision of a Minnesota-licensed dentist through a collaborative management agreement; practice in settings that serve low-income, uninsured, and underserved patients or are located in dental health professional shortage areas; and provide oral health care services, including preventive, evaluation and assessment, palliative, therapeutic, and restorative services. As of April 2012, there are twelve licensed DTs, who comprised the initial 2011 graduating cohort. The second class, of about the same size, graduates in 2012
Statement of Problem Addressed by Recommendation: Dental employers have been slow to hire and integrate these providers as members of their staff because it requires rethinking and redesigning the roles of dental providers such as dentists, hygienists and dental assistants. Anecdotal reports also suggest that many dentists do not know how make this delivery model financially sustainable. Other barriers to integrating DTs/ADTs into the current dental clinic model include accommodations for operatory space and equipment, schedule coordination with other dental staff, and integration of the DT/ADT into the work flow process. In addition, many supervising dentists have limited experience with collaborative management agreements, and need information pertinent to the cost-effectiveness or potential benefits of adding a DT/ADT to the dental staff.

Rationale and Data to Explain why Recommendation is a Priority: DTs/ADTs are trained and charged to meet the oral health needs of the uninsured and underserved. To achieve this, practice barriers will need to be mitigated to fully leverage the potential DTs/ADTs have to offer, and to realize a return on investment made in this provider type.

Implementation Resources Needed: A multi-pronged approach is needed to support the entry and integration of DTs/ADTs into existing oral health care teams.  

1. Provide state funding to develop model practice types, template CMAs and liability coverage terms for DTs/ADTs and to increase awareness among the existing oral health providers and the public about the new profession (Approximately $500,000, one-time)
2. Provide state grants to support start-up costs of dental therapist employers. (Approximately 30 grants @ $50000 = $1.5 million)

Intended Outcomes, if implemented (on health care, health status, access and/or cost, including return on investment, if available): The addition of this new provider will expand the reach and capacity of oral health care practitioners to meet oral health care needs of the underserved and uninsured. Improved access to dental care will prevent more complex dental issues for individuals, and therefore, prevent potential emergency room visits due to non-traumatic dental emergencies. The reduction in emergency room visits due to dental emergencies will result in a reduction in costs to the public health system.

Anticipated Implementation Challenges: These efforts require coordination among multiple entities. Modifications to existing practices and changes in traditional provider roles will likely be controversial in the beginning. However, model practices that demonstrate financial feasibility with the inclusion of the DT/ADT will counter such controversies.

Additional Oral Health Issue: Authority for dental hygienists to conduct and be reimbursed for oral assessments provided as part of Child and Teen Check-ups.

The Workforce Work Group believes resolution of federal prohibitions on reimbursing dental hygienists to conduct and be reimbursed for oral assessments provided as part of Child and Teen Check-ups could have significant impact on children’s oral health. On June 13, staff learned that CMS has approved this change. DHS is responsible for next steps in Minnesota. It’s not clear if action is still needed on this issue.
Recommendation: Increase wages of Long-term Care (LTC) workers employed in nursing facilities, LTC waiver programs and in-home care, as compared to counterparts working hospitals, ability to do some targeted career advancement

Sector: Make Critical Investments in the Long-term Care Workforce

Explanation: This recommendation will provide increased funding to nursing facilities and other LTC providers to increase wages of direct care workers. The funds made available would be sufficient to enable providers to narrow or close the gap between their current wage levels and the wage levels of hospitals in their area. The cost of this proposal is a function of the target wage level to be achieved.

Target wage levels can be determined in one of two ways:

- Assign a target wage level at a specified percentage of average hospital wages, within a region, for each direct care discipline (RN, LPN, CNA, TMA). While arbitrary, using this method will allow the establishment of a target wage level commensurate with funding that can be made available for this purpose,
- Evaluate samples of hospital and nursing facility job descriptions and rate them using well established methodologies to assign fair and reasonable relative wage levels. Use regional hospital wage levels and these relative values to compute target wage levels for each direct care discipline. This second, more empirical method, could be made responsive to concerns about affordability by either closing only a portion of the gap or by phasing in the adjustments over a few years.

Changes in wage levels over time may threaten to erase any gains achieved through these investments, unless the data is tracked continuously and rates and wage levels are adjusted accordingly. It is recommended that wage levels of direct care disciplines in hospitals be tracked annually and to LTC wage levels be adjusted in order to retain the established differences.

The goal of this proposal is to narrow or close the gap between wage levels in hospitals and nursing facilities. While this goal could be addressed more simply using statewide data, the use of regional data would allow for achieving this goal more efficiently. Given the enormous cost associated with this goal, more efficient strategies will enable better accomplishment of the goal.

This proposal addresses wages only, rather than wages and benefits because of uncertainty at this time about the effects that the Affordable Care Act will have on LTC providers. For example, LTC employers with 50 or fewer employees, and their employees, will be eligible to participate in any health insurance exchange. The implications are not yet well understood.

This proposal also is to enhance the Nursing Facility Scholarship Program (NF-SP) and to restore and reform the Home and Community-based Services Scholarship Program (HCBS-SP). The NF-SP would be enhanced by allowing new courses of study to be eligible for funding, focusing this expansion on areas of health care workforce concern. The HCBS-SP expired one year ago. It should be restored with a new, ongoing appropriation, and may need to be re-conceptualized to enable broader participation by providers.

Statement of Problem Addressed by Recommendation: Direct care worker wages are a problem for several reasons:

- LTC providers are having difficulty today in recruiting and retaining sufficient staff to meet the demand for services. Predicted increases in need for direct care services and staff as the baby boomers age will be impossible to meet without enabling providers to be more competitive in the labor market.
- Low wage levels contribute to high employee turnover/low employee retention.
Low wage levels result in difficulty in recruiting new workers and particularly in recruiting and retaining high quality workers.

Nursing facilities and other LTC providers currently report needing to restrict admissions due to staff shortages. Access to LTC services will be enhanced by higher wages for LTC workers.

Low wage levels fail to acknowledge the importance and difficulty of the work done by direct care workers.

**Rationale and Data to Explain why Recommendation is a Priority:**

Direct care workers in LTC are paid substantially less than their peers who work in hospitals:

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<th>Hospital</th>
<th>NF</th>
<th>WAGE INCREASE NEEDED TO ACHIEVE EQUITY</th>
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<tbody>
<tr>
<td>RN</td>
<td>$41.97</td>
<td>$26.87</td>
<td>56%</td>
</tr>
<tr>
<td>LPN</td>
<td>$20.79</td>
<td>$19.65</td>
<td>6%</td>
</tr>
<tr>
<td>CNA</td>
<td>$17.16</td>
<td>$13.00</td>
<td>32%</td>
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Direct care workers in nursing facilities have a current retention rate of 73.75%, ranging from 27.9% to 97.6%. Between 2003 and 2008 the average direct care retention rate stayed between 71.7% and 72.2%, and then rose a slightly with the economic downturn. Unfortunately, the Department of Employment and Economic Development cannot provide data showing hospital and nursing facility wage levels of direct care workers, by discipline, on a regional basis. However, MDH collects data that can be used to derive the hospital information and DHS collects comparable information for nursing facilities. These analyses will enable accurate comparisons needed to more fully develop and implement this proposal.

Who would implement the recommended strategy:

MN Department of Human Services

**Implementation Resources Needed:**

a. Legislation would be needed to authorize the provision of rate adjustments and for the methodologies recommended to ensure the desired use of the funds.

b. Funding would need to be appropriated. We estimate that a 1% wage increase for all LTC direct care workers would have an annual state cost of $10.3 million. The annual state share cost of fully closing the gap would be about $320 million. The cost of the first year of a three year phase-in, with an October 1 effective date, at the 85% parity level, would be about $24.6 million.

c. Administrative action to implement would be different between nursing facilities and the waiver and in-home care programs, though in both areas methods that have been used previously would be suitable. For nursing facilities, the rate increases would be implemented upon completion of a timely application and approval process that would ensure that the funds made available are, in fact, used to cover the costs of the wage increases and associated costs such as FICA. For waiver and in-home care providers, the increase would be incorporated into the waiver rate setting methodology and implemented using a “Letter of Assurance” methodology.

**Intended Outcomes, if implemented:**

(On health care, health status, access and/or cost, including return on investment, if available)

More competitive wage levels will enable providers to be more competitive in the overall labor market, contributing to a higher quality and more stable LTC workforce, which will, in turn, contribute to improved quality and greater efficiency of services. In addition, with the aging of Minnesota’s population, it is essential to move forward with strategies that will support the needed growth in the LTC workforce.

**Anticipated Implementation Challenges:**
Given the history of nursing facility rebasing, with a back-end loaded, eight year phase-in that ultimately was cancelled, it would be advisable to phase-in increases with straight-line or front-end loaded investments.

**Recommendation:**
We recommend:
- A three year phase-in of rate and wage increases, using a target wage level based on 85% of hospital wage levels in the first year, beginning October 1, 2013,
- A study of the relative value of direct care positions in hospitals and nursing facilities to be conducted by March 31, 2014,
- Target wage levels in years two and three of the phase-in, based on the relative value study,
- Target wage levels be determined based on MSAs,
- Workers be held harmless where this recommendation would result in wage reductions for them,
- For nursing facilities, rate adjustments are provided based on an application process similar to what was used in 2008,
- For waiver and in-home care providers use the “Letter of Assurance” methodology that was used in 2008, in combination with the Waiver rate setting methodology,
- Changes in wage levels in hospitals that occur be reflected in LTC provider wage levels, subject to the application or assurance process, and
- The NF-SP and HCBS-SP be enhanced or restored and reformed as noted above.
**Recommendation 8:** Expand the Minnesota FastTRAC (Training, Resources, and Credentialing) Adult Career Pathway program

**Sector:** Investments in the Long-term Care Workforce

**Explanation:** Minnesota FastTRAC is an innovative career pathways strategy that rapidly prepares educationally underprepared adults for entry level jobs in health care and other industries. The program integrates basic academic skills, career-specific training and general workplace readiness for adults. FastTRAC simultaneously teaches Adult Basic Education (ABE), English as a Second Language (ESL), and career and technical instructors are placed, and adults benefit from intensive career and academic advising, and other support services such as child care and transportation.

FastTRAC is a collaboration between MnSCU, the Minnesota Department of Education (MDE), the Department of Employment and Economic Development (DEED), local workforce development partners, human services, and community-based organizations.

Programs similar to FastTRAC are in place in seven other states.

**Statement of Problem Addressed by Recommendation:** Minnesota is facing an unprecedented age wave in the coming years, and as a result there will a high corresponding demand for caregivers working in long-term care settings, including nursing homes, housing with services, and in-home care. Minnesota is currently unprepared to meet this demand, with high vacancy rates, high turnover and difficulty recruiting for these positions.

Many adults who could be suitable for these positions need help with basic academic skills and career-specific training. Traditional educational programs assume a certain level of academic readiness, and offer these services separately and sequentially. FastTRAC integrates these trainings, offers support services and allows nontraditional learners to reskill themselves quickly in a cost-effective approach tailored to worker and employer needs.

**Rationale and Data to Explain why Recommendation is a Priority:** The 2008 Institute of Medicine (IOM) report on *Retooling for an Aging America: Building the Health Care Workforce* notes the need for enhancing geriatrics competence especially among certified nursing assistants (CNAs) and direct care workers (including nurse aides, home health aides, personal care aides) who are the primary care providers for older adults. The IOM report also highlights the importance of supporting training, recruitment and retention of long term care workers. Minnesota’s FastTRAC Adult Career Pathway programs are designed to boost both the competence and readiness to respond to the aging population and the size/capacity of the long term care workforce.

807 adults have enrolled in FastTRAC ABE bridge courses. Of these, 540 have successfully moved into integrated MnSCU/ABE courses – a success rate of 67%.

Models similar to the Minnesota FastTRAC are underway in six other states that include Illinois, Michigan, Ohio, Wisconsin, Washington, and Oregon. Similar models have been endorsed by some national organizations such as the National Governors Association, the Joyce and Lumina Foundations, the National Fund for Workforce Solutions, and the U.S. Departments of Labor and Education.

**Implementation Resources Needed:** MN FastTRAC is a public private partnership and has benefitted from the planning and implementation grants from the Joyce and Bremmer Foundations. However to sustain and expand the programs offered, a dedicated funding stream is critical. This proposal seeks a sustainable funding mechanism to scale up and institutionalize the adult career pathways throughout Minnesota.
By 2013, the goals of FastTRAC program are to serve 3,000 adults; establish 50 FastTRAC adult career pathways offered at MnSCU campuses through the integrated ABE and Career Technical Education courses, and 50 FastTRAC bridge courses offered through the ABE consortia. The program also aims to place 75 percent (2,250) of the participants in employment, and ensure that at least 50 percent (1,500) of enrolled FastTRAC participants will have earned industry-recognized credentials by 2013. At this rate, by starting now and in combination with complementary strategies, FastTRAC can get Minnesota much closer to meeting future workforce skill demands.

**Funds requested:** $2.65 million per FY

**Intended Outcomes, if implemented** (on health care, health status, access and/or cost, including return on investment, if available): Increasing the number of trained direct care long term care workers will help home, community-based and institutional aging services providers minimize unnecessary institutionalization and improve quality of life for older Minnesotans who are able to remain independent or receive high quality nursing facility care when needed, avoiding unnecessary medical and long term care costs.

**Anticipated Implementation Challenges:** Minnesota FastTRAC requires a new way of doing business by adult educators, postsecondary institutions and the workforce development system. The FastTRAC team has carefully built buy-in in each of these sectors; however, more and on-going data collection and evaluation regarding credential attainment and securing family-supporting wage jobs by FastTRAC participants is required to ensure full success of this model. With the collaborations in place, the program hopes to deepen its collaborations, design industry-recognized credential for program graduates; funds needed to adopt similar models that offer career/technical education and training in all MN state colleges.
Recommendation 9: Support and Expand Telehealth and related technology to improve quality and access and extend workforce capacity. Specifically, 1) broaden providers eligible for Medicaid telehealth reimbursement, 2) allow the nursing home 60 day required visit to be a telehealth visit, 3) develop demonstration projects and training for emerging telehealth models, and 4) support the efforts of the Governor’s Task Force on Broadband to close bandwidth gaps in rural MN.

**Sector:** Extend workforce capacity through Telehealth and related technology

**Explanation:** Workforce shortages exist in all of the core mental health professions and many medical disciplines in rural Minnesota. Lack of access to these professionals is a driving force for the use of telehealth. Telehealth technology helps to combat this shortage. The use of teleconfierencing is also effective in heightening collaboration among health care professionals. Telehealth services can bridge the health services gap for patients with limited access to mental health and other specialty services, in particular those in rural and frontier communities. Improved access, quality and cost demonstrate that telehealth is a timely and effective method these health needs in rural areas.

**Statement of Problem Addressed by Recommendation; Rationale and Data to Explain why Recommendation is a Priority:**

Telehealth has proven potential to extend the reach of health professional services, including mental health and substance abuse treatment services, and improve acute and chronic disease outcomes. However, regulatory, reimbursement and infrastructure barriers limit the potential of telehealth to meet these goals in Minnesota. Limited reimbursement, inconsistent reimbursement policies, infrastructure challenges, and credentialing concerns create significant barriers to expanding the use of telehealth. An additional barrier in some areas is the availability of a broadband connection and appropriate bandwidth. There is also a need to and broaden acceptance of telemedicine in emergency departments (especially in rural communities) and as a tool for consultations involving psychiatric and addiction and substance use disorders.


Regional Medicaid Reimbursement For Telehealth/Telemedicine Services Great Plains Telehealth Resource Center, University of Minnesota 2011

**Who would implement the strategy:**

Broaden providers eligible for Medicaid telehealth reimbursement – DHS

Develop telehealth demonstration projects and training resources – Initiated by MDH.

Broadband development and policy: Governor’s Broadband Task Force

**Implementation Resources Needed:**

Legislation and/or administrative action needed to revise Medicaid reimbursement and requirements. It is hard to predict whether forecast costs would be positive or negative.

Legislation may be sought by the Governor’s Broadband Task Force to implement its recommendations.

Funds will be needed to develop telehealth demonstration projects and training resources. Sources could be state, federal or private.
**Intended Outcomes, if implemented** (on health care, health status, access and/or cost, including return on investment, if available):

**Increased access to specialty and mental health services.** All mental health procedures that are delivered in person can be delivered remotely via telehealth, as can many medical specialty services.

**Earlier diagnosis and treatment will yield better outcomes.** Earlier intervention and easier access helps patients engage in their care and, ultimately, this will improve mental health outcomes and save health care costs.

**Cost-effective delivery of services.** More than 85 percent of patients seen via telemedicine remain in their local communities, resulting in lower costs of care and further enhancing the financial viability of the community hospital or clinic. Other potential cost savings come from reduced wait times and a reduction of no-show rates. Costs are reduced overall for patients, providers and health systems, even after including start-up costs for the necessary equipment and technology infrastructure.

**Enhanced coordination of care.** As the integration of primary care and mental health continues, more psychiatrists are providing peer consultation to family practice physicians, especially in rural Minnesota. Research shows that patients most often discuss their mental health concerns first with their primary care physician. Telemental health also creates an opportunity to engage additional mental health providers.

**Anticipated Implementation Challenges:** No major challenges foreseen
Recommendation 10: Expand grants to prepare students for future health careers, and increase the diversity of the healthcare workforce.

Specifically, 1) initiate and fund programs that expose K-12 students to health careers and emphasize the development of science, technology, engineering and mathematics (STEM) competencies; 2) support ongoing programs such as Stepping Stones to Health Careers, Native Americans into Medicine (NAM) that mentor and train underrepresented students to pursue healthcare careers; expand programs such as Minnesota’s Future Doctors and Minnesota Refugee Physician Training Pathway that supports nontraditional, minority, rural or low-income students to pursue careers in medicine; 3) explore alternative roles/capacities for foreign trained physicians who are unable to practice as physicians in the US health care system.

Sector: Investments in the health care workforce education pipeline

Explanation: To prepare Minnesota’s future healthcare workforce, investments in the workforce “pipeline” beginning at the K-12 level through post-secondary and into the post-graduate level are critical. In the K-12 setting, students need opportunities to explore and be exposed to careers in health care, and need adequate science and math training to be academically prepared for post-secondary education. Programs that support traditionally underrepresented students with academic enrichment, mentorship, finances and training opportunities, need to be expanded to build a diverse workforce in response to the changing patient and population demographics.

The Workforce Development Pipeline

Prepare K-12 students in basic science; expose to health careers & role models
Recruit traditional & non-traditional students
Incent education & training programs in high need settings; encourage interprofessional practice
Encourage grads to seek employment in high need settings
Retain the health care workforce

Redesign health care delivery; realign reimbursement with quality

The Center for American Indian and Minority Health at the University of Minnesota Duluth through its programs—the Stepping Stones to Health Careers; the Native Americans into Medicine (NAM); and the Pre-Admission Workshop—supports the exploration and preparation for health careers for promising American Indian students in high school all the way to preparing students for medical school exams. The Minnesota’s Future Doctors program at the University of Minnesota Medical School targets and supports low-income, rural and minority college students through medical school matriculation. Financial support to expand the capacity of such initiatives is critical to building a diverse workforce. The Minnesota Refugee Physician Training Pathway, a collaboration between the University of Minnesota and the HealthEast care system, selects, updates and trains refugee physician skills for a successful clinical practice, and places them in communities of need for the duration of their residency in family medicine. Other foreign trained physicians that are unable to practice as physicians in the US for a variety of reasons (lack of medical language fluency; differences in understanding of patient-centered health care delivery model as practiced in US; foreign credentials with no US equivalents; too few residency slots) are yet another unharvested resource. Exploring other roles for foreign trained physicians such as the community paramedic, community health worker or physician assistant, that leverages their past medical training and experience, language fluency and community ties is another strategy to build a diverse and culturally competent healthcare workforce.

Statement of Problem Addressed by Recommendation: The pathway to a successful career in medicine is lengthy requiring students to make deliberate academic choices early on. Health career awareness programs that offer early exposure, support and mentorship to young students increases their understanding, awareness,
interest and the likelihood that they will pursue such careers. Concerted efforts are needed to recruit non-traditional students into healthcare careers to diversify the provider pool to reflect the changes in patient demographics. Communities need to “grow their own” healthcare workers who are responsive to local needs and challenges. Such initiatives are critical for Minnesota’s to respond to the increasing and changing demand for health care.

**Who Would Implement this Recommendation:** A public-private partnership needs to be fostered with schools, colleges and universities that train students in healthcare careers.

**Implementation Resources Needed:** Dedicated funds to support and expand these programs are needed. **Budget: $1.87 million**

- Funds to supplement the programming at the Center for American Indian and Minority Health are $100,000.

- The annual budget for Minnesota’s Future Doctors program is $375,000. The program supports 50 college freshmen at the cost of $6,500 per scholar. Historically the program has been funded by medical school Dean’s office, a private donor, and the private foundation. However this level of funding is no longer sustainable.

- The residency costs for the Minnesota Refugee Physician Training Pathway program is $1.4 million.

**Intended Outcomes, if implemented:** Increased program capacity to serve students interested in healthcare careers

**Anticipated Implementation Challenges:** None
BIBLIOGRAPHY


Minnesota Safety Net Dental Providers. Recommendations on how to support Dental Therapist and Advanced Dental Therapists. May 16, 2012 (available upon request)

ENDNOTES

1 Further discussion on the definition of ‘primary care’ medicine may be fruitful. The traditional definition of primary care medicine includes family medicine, general internal medicine and pediatrics, and sometimes obstetrics. The work group also discussed the centrality of general surgery.

2 Inclusion of dental therapists and advanced dental therapists in the state’s loan forgiveness program is part of recommendation 4.

3 FasTRAC programs that train the long term care workforce include *Southwest Minnesota Universal Health Care Worker* (trains certified nursing assistants, certified home health aides and trained medication administration workers); *Rochester Community & Technical College Mayo C.N.A. FastTRAC Program* (trains certified nursing assistant, hospital certified nursing assistant); *Anoka Healthcare/Nursing Pathways* (trains universal health care worker in older adult services certificate).