SUMMARY OF HEALTH CARE WORKFORCE DEVELOPMENT IN SELECTED U.S. STATES

To help inform health care workforce development planning in New Hampshire, the Endowment for Health supported a review of the workforce development plans of other states with large rural areas to understand their structure, components (i.e., areas of focus and strategies), and implementation plans. Ten states were identified for inclusion from among those involved in the National Governors Association Health Workforce Policy Academy and based on recommendations from New Hampshire's Office of Rural Health and Primary Care. A consultant reviewed and summarized relevant documents available for nine states (Alaska, Colorado, Kentucky, Minnesota, Montana, Oklahoma, North Carolina, South Carolina, and Wisconsin) and interviewed representatives from a sub-set of the states. Information for Indiana was not available.

Approaches:

Four of the included states had workforce development strategic plans or action agendas: Alaska Health Workforce Coalition Action Agenda (2017 – 2021); Colorado Health Workforce Development Strategy (2014); Montana Healthcare Workforce Statewide Strategic Plan (2016); and Oklahoma Health Improvement Action Plan (2014 – 2016). For three states, reports (e.g., on progress, shortages, barriers) were reviewed, including the HealthForce Minnesota Snapshot (2017 – 2018); Kentucky's "Development of the Healthcare Workforce" (2015); and Wisconsin's Health Care Workforce Report (2019). In the Carolinas, the consultant reviewed information on the work of dedicated research centers: The Program on Health Workforce Research and Policy, Sheps Center, University of North Carolina at Chapel Hill and the South Carolina Office for Healthcare Workforce. Information on HealthForce, a Center of Excellence (CoE) focused on Minnesota's health workforce, was also reviewed; HealthForce is one of six CoEs collectively focused on the state's workforce more broadly.

Workforce Plan/Action Agenda Elements:

The four workforce plans/agendas from Alaska, Colorado, Oklahoma, and Montana shared four common elements:

1. Data on workforce trends, projections on supply and need, and mapping
2. Context (e.g., relevant information on health reform and progress and barriers related to previous or current workforce development efforts
3. The specifying of strategic areas, goals, objectives, strategies, and action steps
4. A very inclusive definition of workforce involving multiple health care professionals and para-professionals.

The plans were organized around necessary systems change and capacity building initiatives (i.e., workforce data collection and analysis; coordination of workforce efforts; policy, advocacy, and infrastructure; and pipeline, recruitment, and retention); more detail on these initiatives is provided below.

Workforce Data Collection and Analysis:

Across the nine states, most track the practice location, FTEs, specialty, age, and education for licensed professionals and the number and location of educational programs and residencies and clinical placements. They use these data

to identify workforce shortages, track progress in building the workforce, inform and advocate for policy change and/or funding, determine the return on investment in various workforce initiatives, help communities engage partners in understanding and addressing local workforce needs, and to develop and identify best practices (e.g., how to retain staff or reduce clinic closures).

Coordination of Workforce Efforts:

Numerous organizations engaged in planning and workforce development and the planning processes ranged from siloed (e.g., for a single profession) to highly collaborative and inclusive. A government agency (e.g., state health department) or academic institution usually coordinated the planning efforts. Two states have statutory requirements related to workforce development. Colorado's Office of Primary Care is required to do health workforce development. Oklahoma's Subcommittee of the Governor's Council on Workforce and Economic Development focuses on health workforce; the statute enables the group to designate a data clearinghouse for health workforce data. North Carolina has a federally-funded center that analyzes and supports development of 19 different health professions. Although the Center has a national focus, one branch focuses on North Carolina's health workforce.

Policy, Advocacy, and Infrastructure:

The policy priorities of the states typically included improvements in: reimbursement for primary care providers, and for telehealth and the broadband necessary to support it; funding for health professions education and tuition and loan programs; support for residencies/clinical placements and the platforms for facilitating them (i.e. web-based infrastructure for identifying, matching, and coordinating placements and managing paperwork) and capacity for data collection and analysis. The priorities also called for measures to enable Nurse Practitioners and Physician Assistants to practice at the top of licensure and for the easing of licensing barriers for new and out-of-state practitioners. Alaska's plan was unique in its inclusion of grant writing and coordination of submissions as part of capacity building. Kentucky included malpractice caps in its work.

Pipeline, Recruitment, and Retention:

The states were involved in a range of activities to cultivate, expand, and retain the workforce. Typical initiatives included education and camp programs to introduce youth to health/STEM careers and give them hands-on experiences, particularly in rural/underserved areas (RUAs); improving post-secondary educational and professional development opportunities across professions, including distance education for RUAs; and providing support (e.g., tuition/loan programs, stipends) for students in health professions education and to attract students from RUAs. The initiatives also included the creation of in-state residencies and rotations, especially in RUAs and for physicians, nurses, and other high priority health professions; cultivating and supporting mentors and preceptors in RUAs; succession planning for critical staff positions; and increased opportunities for professionals in RUAs to network with peers and participate in research.

Implementation:

The type of entity responsible for implementing health workforce initiatives in the various states differs. In Colorado, the state's Office of Primary Care is responsible. In Montana, the Montana Office of Rural Health and the Area Health Education Center (AHEC) share responsibility. In Oklahoma, the responsible party is the Health Workforce Subcommittee to the Governor's Council on Workforce and Economic Development while in Minnesota, it's the Health Workforce Director at HealthForce Center of Excellence within the Minnesota State University system. In Alaska, no single entity is named; rather, responsibility is shared. The Alaska plan names responsible parties (i.e., public sector and non-governmental partners) and champions for each strategy in the plan.

Recommendations:

Several recommendations were derived from the plans and interviews with state representatives.

To guard against planning fatigue and skepticism, it is advisable to identify "seed" money for implementation so there is a guarantee that something from the plan will come to fruition soon after planning ends. Having good data about the workforce is essential to planning, engaging legislators, and attracting funding. Thus, it is important to work with state licensing boards and professional associations to get such data on health professions and any gaps that exist. Those states that mandate the provision of data as part of the licensing process have a fuller picture of the status of licensed health professions. It is advantageous to participate in compacts that allow physicians and nurses licensed in one state to practice elsewhere. It is advisable to explore telehealth to learn who is using it and which entities are paying for it, understand its availability and utilization, and identify where gaps may exist. It is worthwhile to invest in efforts that enable nurse practitioners and physician assistants to practice at the top of their licenses to increase clinical workforce capacity. The AHECs are important partners for pipeline efforts in particular and should be engaged in planning and implementation. Inclusive planning and implementation can be slow and hard to manage because of the number of organizations involved and multiple competing priorities. While inclusive planning is preferable, it may be more fruitful to ensure critical access to care statewide exists in primary care (i.e., physicians, physician assistants, nurse practitioners, medical assistants, coders and billers, and health information technology staff), behavioral health (i.e., social workers, mental health counselors, psychologists, psychiatrists, peers/substance use disorder counselors), general surgeons, and maternity care (i.e., nurse practitioners, midwives, and obstetricians) and work from there to bring in other representatives of other professions and specialties.