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86TH LEGISLATIVE SESSION

THE LEGISLATIVE COMMISSION ON HEALTH CARE ACCESS

Workforce Shortage Working Group
Incentive Ideas and Recommendations

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Fairview - Human Services: Laura Beeth

Protect and increase current state and federal Graduate Medical Education funds to ensure support for training of future physicians. In particular, protect MERC to ensure continued federal matching funds.

Support innovations in education to promote interdisciplinary training of medical professions. “Team” is the future of care delivery; new care structures require a variety of medical professionals—doctors, nurses and much more—to work together in new ways.

Support and contribute to the development and spread of Minnesota’s Student Max Clinical Rotation Program, currently coordinated and funded by HealthForce Minnesota.

Health Policy, Sanford Health: Meghan Goldammer

In Minnesota, Sanford operates 13 hospitals, of which, 12 are critical access hospitals.

Geographically, the majority of the population's that Sanford serves is in a health professional

shortage area (HPSA) or medically underserved area (MUA). Therefore, Sanford's experience in

Minnesota is that of providing rural health care.

Incentives

Monetary:

- Loan repayment
- No string sign-on bonus
- Improved income guarantee
- Resettlement expenses
- Lifestyle incentives

Non-monetary:

- No/limited on-call schedule
- Lifestyle/Community attractions

Issues to Consider

- Lifestyle in a small community
- Two-professional families/finding a job for the other professional spouse
- "Growing your own" health professionals
- Appropriate staffing
- Telehealth options

Greater Minnesota Family Services- Jon Marchand

[A]

Unlike a thought, feeling or perception, a skill is observable by others. It is an activity that must be practiced in order to be mastered and maintained. There are right ways and wrong ways to perform the skill. Typically, a skill is performed for a reason and a skill can be generalized and adapted to many different situations. CTSS (Children's Therapeutic Services and Supports) Skills training is designed to help the client develop psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory that has been disrupted by a psychiatric illness. Skills training may also be delivered to help the youth to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired during the course of a psychiatric illness. The term "skills" refers to the billable services of the mental health practitioner as a necessary and effective adjunct service to psychotherapy. Mental health practitioners providing services for the treatment of mental illness, who are not eligible for enrollment, must be under clinical supervision of a mental health professional and must be qualified in at least one of the following ways

- Bachelor's degree in a behavioral science/related field, from accredited college/university and:
- Completed 2000 hours of supervised clinical experience delivering clinical services to treat mental illness or children with emotional disturbances

or

- Bachelor's degree in a behavioral science/related field, from accredited college/university and:
- Fluent in the dominant, non-English language of at least 50% of clients
- Complete 40 hours of training & delivering services to clients with mental illness or children with emotional disturbances
- Minimum of once-a-week clinical supervision to achieve the 2000 hours of supervised experience
- Completed 6000 hours of supervised clinical services experience delivering mental illness treatment
- Enrolled graduate student in behavioral science/related field formally assigned to the center for clinical training by accredited college/university
- Obtained a Master's degree/doctorate in a behavioral science/related field from accredited college/university

These MHCP practitioner level requirements apply to all mental health services.
The burden placed on rural mental health centers and clinics in finding practitioner applicants who meet all requirements and conditions results in fewer clinical staff, longer wait times for consumers, and increased caseloads for existing practitioners. One consideration to take when discussing broadening the scope and practice of mental health practitioners is to loosen the basic requirement of 2000 hours of clinical experience to a standard more reflective of the general population of rural Minnesota. Many people from related child centered professions (education or pediatric nursing for example) have significant experience working with children such that, with appropriate supervision, they would make excellent mental health practitioners. These professionals have direct experience and understanding of the interrelationships of children and their families, and with the appropriate amount of clinical supervision they could deliver CTSS mental health services with acuity and professionalism. In addition to the direct benefit to consumers, local economies can benefit from the increased pool of potential employees at mental health centers and clinics; more jobs in the mental health sector means more people employed. In an economy where employment in many child related fields is uncertain, an increased accessibility to the mental health field seems a win/win situation from all perspectives.

[B]

The variation in benefit sets of commercial insurance plans and policies is vast. One plan may cover 90% of psychotherapy services while another may not cover them at all. The Mental Health Parity and Addiction Equity Act of 2008 does NOT apply to small group health plans or health

insurance coverage in the individual (non-employment based) market, although state law requires mental health parity in such other cases. MHPAEA applies to most group health plans with more than 50 workers. Mental health services have been a mandated benefit in Minnesota since 1986, although the copay or deductible rate is not specified. Between 1995 and 2000, the Minnesota Legislature expanded plans to include HMOs, with equal copays and coinsurance. Parity does not equal comprehensive coverage or reduced consumer responsibilities to pay, however. The primary instrument of in-home mental health services is CTSS Skills, and these are not covered by commercial plans.

The Mental Health Parity Act of 1996 (MHPA) states that a group health plan may not impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical surgical benefits. The MHPAEA preserves the MHPA protections, and adds significant new protections. Although the law requires "parity", or equivalence, with regard to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does NOT require large group health plans and their health insurance issuers to include mental health or substance abuse benefits in their benefits package. The law's requirements apply only to large group health plans and their health insurance issuers that already include such benefits in their benefit packages. The broadening of commercial plans to include skills training (as well as improved and increased therapy code reimbursements) would allow mental health practitioners to access commercial insurance for what is now a MA/PMAP only service. This would ease the burden on state covered plans, as well as place the onus for implementing the potential expanded benefits as set forth by the MHPAEA on the shoulders of commercial plans.

Metro Minnesota Council on Graduate Medical Education:

Troy Taubenheim

The MMCGME represents physician training programs for all of Minnesota with the exception of the Mayo organization, and the MMCGME agrees with the multitude of studies that indicate a severe overall shortage of physicians in years to come. In addition, they agree and have some first hand facts on the shortage of primary care in certain geographic areas. The total number of residents in training in the Minnesota metro area has not changed over the years, but has seen a shift away from primary care.

State and Federal funding currently is effective to develop, attract and retain the overall number of physicians being trained. The incentives to shift the training to primary care is minimal and ineffective.

Fear of losing existing funding incentives to train physicians is a concern at both the Federal and State level. The number of physicians trained in Minnesota would be decreased if the MERC funding were reduced or eliminated. That would obviously magnify the projected physician shortage.

The greater level of training funds for physicians comes from CMS, but is capped at an historic level that is not indicative of the needs of today. This cap must be increased or eliminated or alternative funding received in order for the hospitals and physicians to be able to afford to train more physicians in the state.

General Medicine: Dr. Baird, Dr. Kibort, Dr. Rice, and Dr. Lohr

Loan Forgiveness

In the context of an ever smaller proportion of medical student graduates entering primary care fields, and recognizing the financial incentives to enter other fields of medicine which have higher compensation, Minnesota could devote a portion of revenue collected from the provider tax to help with medical student loan repayment. Specifically:

- Medical student loan repayment would be offered to physicians completing residency in Family Medicine, Pediatrics, and Internal Medicine who agree to work as primary care physicians in recognized underserved areas of Minnesota
- $10,000/year of service up to 10 years would be available
- The state (through the provider tax) would support 50% of this commitment, and local communities and/or hospitals would support the balance
- We would need some financial modeling to determine the funds needed from the state
- Metrics of success would be # of applicants, # of applicants staying >5 years, overall primary care physician workforce growth
- We would need agreement that the provider tax could be used in this fashion, however it has already been used to build roads…

Interdisciplinary Team Support

It is clearly important to expand the use of interdisciplinary teams who are already a required component of health care homes as defined by the State of Minnesota. To reinforce those teams and encourage their development, we can redirect MERCC funds to clinics as they become certified health care homes. Last year MERCC funds were transferred from clinics to hospitals to support the hospitals losses due to indigent care.

Primary Care Physician: Randy Rice

From a primary care physician standpoint, working to remove distractions/obstacle to patient care is important. Reducing administrative hassles, prior approval issues, and other tasks that unnecessarily take up our time away from direct care of the patient will both improve physician satisfaction, making it hopefully easier to attract and retain physicians, as well as free up more time to actually take care of patients.

Some ideas as to how this could be improved:

1. Have a common drug formulary. I, and I think most of my colleagues, do not so much have a problem with the concept of a formulary or guidelines as to prescribing with drugs with the highest value (not always cheapest) first, but rather in the disjointed and illogical way it is done. With multiple plans each having their own formularies, and changing sometimes more often than yearly, it is very hard to figure what can be prescribed for a patient or determine really what is best. Most formularies are much more about backroom deals between insurers and drug companies than about what is really best medicine or best true cost. A lot of time is wasted for the physician, the pharmacy, the patient and even the insurer trying to figure what will get covered. This would be similar to some to the initiatives by ICSI trying to develop common practice guidelines and getting insurers to agree to those common guidelines, rather than make their own.

2. Consider having some type of physician compliance measure (rating of how well a physician follow a formulary) and allow a "pass" for those physicians meeting reasonable targets, such that if over a recent period, that physician meets targets, his formulary exceptions are automatically accepted. I've found, as have many of my colleagues who try to practice cost effectively, that the majority of time I am requesting an exemption, there is good reason and in those cases it almost always eventually gets approved. Streamlining the process for those who meet guidelines would save a lot of frustration and time (and expense).

Physician Assistant: Heather Bidinger

Listed below are three components that contribute to work force shortage issues as it relates to the physician assistant profession, along with suggestions as to potential incentives.

1. **Problem: A larger pool of interested and qualified applicants to Physician Assistant programs exist than can be accommodated in Minnesota's current Physician Assistant Program**.

    a. There is currently only one PA Program based in Minnesota and a second affiliated with MN through the Mayo clinic system.

    *HRSA announced a new funding opportunity for Physician Assistant Programs as of June 17, 2010: the Affordable Care Act Expansion of Physician Assistant Training Program (EPAT). This is available only to established programs that are accredited and does not provide support to programs in development. It is my understanding that the short time between announcement and application due date, along with criteria for proving eligibility for this grant, made it time and resource prohibitive.

    *When another PA Program, such as being proposed by St. Catherine University, gains approval from institution, Office of Higher Education and the PA accreditation body, this will help increase PA education opportunities to qualified applicants.

    b. It is difficult to recruit and retain qualified faculty for PA programs.

    *This was the first year PA faculty were eligible for faculty loan repayment grants through HRSA. This changes was important in providing an access, however, with only 23 grants provided nationally to over 400 applicants, competing with other allied health faculty, the incentive is not as great as it could be.

    *State funded student loan repayment for faculty in healthcare programs.

    c. Limited quantity of clinical sites for PA student training. If site availability for training increases, so could the number of students and thus graduates.

    *Incentives to healthcare organizations who allow for physicians to teach or incentives within healthcare systems that allow for FTE release or an RVU exchange for physicians, PAs and NPs and others who serve as clinical instructors.
    *Address CMS rules for students and residents, which is prohibitive to physicians and organizations for taking on clinical education.

2. **Similarly to physicians, more PAs are choosing specialty fields of practice in lieu of primary care.**

    a. Keeping primary care attractive

    *Improve loan repayment options for PAs who are willing to practice in medically underserved regions. Currently, this amount is nominal and allied health providers

are combined together in a large pool of applicants for few slots. Even when PAs have been in underserved, designated/qualified loan repayment sites, the funding is not always there or they are not chosen to receive reimbursement.
*Address Medicare reimbursement rates, which allow for greater physician reimbursement for services provided in medically underserved areas, but for which, physician assistants are not eligible.

3. **Rural areas tend to be less attractive for physician assistant employment.**
    a. Practice style
    b. Lack of Benefits

    *Consider locum tenens staff available through the state to cover when providers in an underserved area want to take vacation or CME time.
    *Consider a pool of some sort that providers in small practices could join to become eligible for group health insurance and other such benefits.

***Components of PA practice to consider as PA workforce are not independent of physician workforce.**

c. Physician availability for participation in supervisory agreements may not support PA employment in some areas.

d. Increases in specialty practice by physicians, drives increases in physician assistant job availability in these specialties.

e. Physician Assistant utilization, and thus the workforce needs to which they contribute, vary between clinic systems, specialties and settings.

Advanced Practice Nurses: Mary Chesney, Ann Olson

On October 5, 2010 the Institute of Medicine and the Robert Wood Johnson Foundation released their report *The Future of Nursing: Leading Change, Advancing Health* (http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx). This landmark, evidence-based report makes a number of recommendations that are critical to enacting health reform and advancing the health of the nation. Two of these recommendations in particular are relevant to the discussion of providing incentives for APRNS to practice in Minnesota.

1) Nurses should practice to the full extent of their education and training.
2) Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States (IOM-RWJF, 2010).

The report goes onto recommend removal of legislative and regulatory barriers that limit APRNs from practicing the full breadth of their education and training.

Incentive
Based on our experience in APRN practice, education, and in working collectively with APRN colleagues to remove significant barriers that prevent APRNS from practicing to the full extent of their education and training, we believe the most important incentive the State of Minnesota could provide for APRNs practicing in our state is to grant APRNs licensed independent practitioner (LIP) status and place the regulation of APRNs under the sole jurisdiction of the Minnesota Board of Nursing.

In 2008, the APRN Consensus Group (46 national APRN organizations) and the National Council of State Boards of Nursing APRN Advisory Council released the *Consensus Model of APRN Regulation* (http://www.aacn.nche.edu/Education/pdf/APRNReport.pdf), a model of APRN regulation based on standardized licensure, accreditation of APRN educational programs, certification of APRNs, and educational requirements. The goal of the model is to standardized APRN regulation across states. The key points of the document are:

- APRN categories include certified nurse-midwife (CNM), certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA), and clinical nurse specialist (CNS);

- APRNs should be licensed "as independent practitioners (LIPs) with no regulatory requirements for collaboration, direction, or supervision" (p. 14);

- APRNs should be licensed for practice as one of the four recognized APRN roles (e.g. CNM, CNP, CRNA, CNS) in one of six identified foci (family/across lifespan, adult/gero, neonatal, pediatrics, women's health/gender related, and psychiatric MH);

Nurse Practitioner, Rural Coverage: Ann Olson

Incentives:

A. <u>Establish a Minnesota State Center of Excellence in Primary Care</u>

1. Multi-disciplinary Advocacy: Prevention, Early Detection and Intervention
    a) Health Care Home Model
2. Promotion of rural Minnesota
3. Liaison for economic support
4. Membership category qualifications (partial list)
    a) Mentorship
    b) Consultation
    c) Research
    d) Clinical sites for Students

B. <u>Legislation: Scope of Practice as defined and recommended in all reports above</u>

C. <u>Promote regional relationships between academic health centers and primary care sites, with an emphasis on rural Minnesota (Refers to A.2.)</u>

1. Create and sustain clinical experiences in community primary care settings
    a) Incentives for students and partnering institutions (both clinical site and academic center)
2. Partnering within the MN State Center of Excellence in Primary Care
    a) Pilot projects re: use of "Tele-Medicine" linking primary care providers with specialists at point-of-care (e.g. bringing the specialty care focus into the exam room within the primary care setting)

MNA Recommendations: Linda Slattengren, RN

The nursing shortage is well-documented, despite the current recession which has brought more nurses in the labor market, and ironically, is resulting in nurse layoffs and new graduates are having trouble finding jobs. The estimate for the shortage by 2020 is anticipated to be between a half-million. The shortage is evidenced by a number of factors including:

- Increasing opportunities for women outside of nursing;
- Stagnant wages and onerous working conditions; and
- Declining perception of the attractiveness of the profession.[1]

Given the legislative task force's charge of creating incentives to address the workforce shortage, and the committee's desire to focus on changes as they relate to health care delivery reform through Accountable Care Organizations (ACO's) and Health Care Homes, MNA has prioritized the following key issues with our suggested idea to consider:

Utilize RNs Appropriately in Health Care Home to Reward Nursing Work & Improve Patient Outcomes Nurses are a vital link between patients and high quality health care. Much of what nurses do is consistent with overall health care reform efforts to focus on health promotion, patient education and health counseling, preventative services, care coordination, and aggressive, and effective chronic disease management. But as new roles for health care workers emerge (surgical technicians, medical assistants, community paramedic, community health workers), there is a concern that the care of individuals will become highly fragmented which is inconsistent with overall health care reform efforts to promote care coordination and holistic care.

In Minnesota we are moving down that path with the development of **Health Care Homes** and the use of interdisciplinary teams to deliver care. This model will begin to pay for the services not currently reimbursed which supports much of what nursing does. We support this work, but because care coordination roles are often invisible we are concerned that nurses may be replaced by non-nursing personnel that may be less expensive, but do not often have the appropriate skill level to meet the patient health care needs. The model must support a team approach that utilizes the professional skill and knowledge of RNs as Care Coordinators or Case Managers and their ability to appropriately supervise unlicensed health care workers.

Idea: Ensure appropriate utilization of RNs and sufficient oversight of unlicensed health workers to ensure cost-effective quality care. Additionally, ensure appropriate funding for the RN Care Coordinator Role in ACOs and Health Care Homes.

Create Regulatory Framework to Retain APRNs in the State of MN and Utilize in Health Care Homes

In Minnesota, Advanced Practice Registered Nurses (APRNs) have the legal authority to practice as independent licensed practitioners (MN Statute 147.285). APRN is an umbrella term for registered nurses with advanced education and include (Nurse Practitioners, Certified Nurse Anesthetist, Certified Nurse Midwives and Certified Nurse Specialists). These highly trained nurses are able to do 60-80 percent of the primary and preventative care traditionally done by physicians. Numerous studies show that APRNs provide high quality care that is cost-effective and many APRNs have been willing to locate in communities where there are other provider shortages and often serve vulnerable populations in both rural and urban areas alike.[2] However,

[1] BHPR, "What Is Behind HRSA's Projected Supply, Demand and Shortage of Registered Nurses?" 2004 and P.I. Buerhause et.al, The Future of the Nursing Workforce in the United States; Dates, Trends and Implications 2009

[2] Brown, S.A. & Grimes, D. E. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. Nursing Research, 44 (6), 332-339

APRNs continue to face significant barriers presented by the health care delivery system including restrictive reimbursement policies, some of which limit prescriptive authority, requirements for collaboration with another health care provider, limitations on institutional privileges and/or difficulty in obtaining liability insurance.

Idea # 1: Reduce regulatory barriers by eliminating the written prescriptive agreement in statutes, and clarifying the law so that collaborative management is not misinterpreted to be the management of the advanced practice nurse, but rather the collaborative management of patient care.

Retain Experienced and New Direct Care RNs Utilizing New Federal Payment Reform

As of October 2008, CMS (Centers for Medicaid and Medicare) is not reimbursing for the costs of 8 hospital-acquired conditions/adverse events. The state of Minnesota applied these same non-payment rules to Medicaid. Many of these events are nurse sensitive and can be prevented by the appropriate number and skill mix of the nursing staffing. In addition, the recently passed federal health care reform law will no longer pay for preventable 30 day hospital readmissions, another key indicator of nursing care. All of these changes should be an opportunity for Hospitals to see the economic value of nursing on hospital and patient safety.

Numerous studies show that an increased number of nurses is correlated with decreased patient complications and improved patient outcomes.[3] A major new study provides compelling new evidence that an RN-to-patient staffing law reduces patient mortality and substantially promotes retention of experienced nurses. [4]

Idea #1: Address onerous working conditions and ensure patient safety by legislating minimum staffing levels that are adjusted based on patient acuity, nursing intensity and skill mix.

Idea #2: Require Data Collection on information regarding Nurse Sensitive patient outcomes to better ascertain the economic value of nursing on preventing adverse events. The state of Maine collects information on nurse sensitive patient outcomes (pressure ulcers, and falls) along with the skill mix and the number of nursing hours per patient day at the time of an event, along with reasons why nurses are leaving the profession.

Retain Experienced and New RNS Through New Payment Ideas

Under our current payment system nursing care in the hospital is a flat per diem rate in the room and board revenue code. The lack of nursing data in the billing code makes nursing "invisible at the policy and financing levels. This payment system does not adequately reflect the differences in levels of nursing intensity (nursing care and nursing costs) across patients or diagnoses.

Research suggests that implementing nursing intensity into the payment system may create incentives for hospitals to optimize nursing resources and thereby improving the workload of nurses, increasing quality of care, decreasing complications and excess morbidity and may eventually decrease hospitals costs.[5]

Idea #1: Consider Applying for a Medical Assistance Waiver to pay for nursing intensity. The State of New York applied for this waiver, garnering one hospital an additional $4 million in revenue when Medical Assistance began paying for nursing care.

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[3] Kane, Robert L., et al, 2007, AHRQ Publication, A Review of Nurse Staffing and Patient Care

[4] Aike, Lind H. et al, 2010, Health Services Research, Impli8cations of the California Nurse Staffing Mandate for Other States

[5] J. M. Welton et al., "Hospital Nursing Costs, Billing, and Reimbursement," Nursing Economics 24 no. 5 (2006): 239-245.

Review MDG's Nurse Faculty Loan Forgiveness Program and Career Ladder Programs (NA/LPN/RN)

Several years ago MNA worked with the legislators to create a nurse loan faculty program and career ladder programs to encourage nursing assistants and LPNs to become RNs. These programs were funded in part using surplus nurse licensure fees collected by the Minnesota Board of Nursing (MN Statute, section 144.1501). The purpose of the loan faculty program is to encourage nurses who may be considering leaving direct care nursing, or those who are working part-time, to consider teaching as an option; as well as encouraging those currently in nursing school to consider *nursing education* as a career *option*. We limited the requirement for teaching to 20 hours a week so that working nurses could keep working part time to pursue their Masters, while transitioning into teaching.

Idea #1: Ask MDH to present summary data on how well these loan forgiveness programs are working and consider other financing options in addition to nurse licensure fees.

Mental Health: Trish Stark

Workforce issues in mental health are complex. They are complicated by type of profession, subspecialty, and geography. Given the direction of health reform, incentives need to address new models of training and practice. Below are some suggestions for expanding and maximizing the use of mental health providers.

Licensed Prescribers

The greatest need in Minnesota is for licensed prescribers of psychotropic medication. Current efforts to increase the numbers of prescribers include:

- Increased rates of payment for critical access providers
- Efforts to increase the number of psychiatric residents.
- Use of physician extenders such as APRNs and Physician Assistants

Additional incentives for prescribers

- Alternative payment models for collocation of Physician Assistants and APRNs with psychiatric specialties in primary care settings. Bundled payments focused on time in the clinic rather than per patient contact reduces administrative costs, increases professional availability, improves quality, and furthers integrated care.
- Provide consultation to primary care by non-prescribing mental health professionals. For less severe cases, mental health professionals can assist primary care providers with accurate diagnoses and behavioral plans. Primary care providers can more confidently make medications choices. This would reduce costs and free up psychiatric time for the most complex cases. Might be funded as psychiatric consultation is currently.

Integrated Care

- Designate some of the state loan repayment monies for integrated care sites.
- Collocate mental health professionals in primary care to address health-interfering behaviors and bill per contact, or on a contract basis. Psychologists can use CPT Health and Behavior codes, which are reimbursed at a higher rate.
- Train mental health professionals how to work in an integrated fashion:
    - Funding ($100,000) is currently available but not accessed in Minnesota, for graduate psychology education for year-long Pre-doctoral internships. It requires "innovation." It is one year funding but can be repeated. Funding could be used to train professionals in primary care sites perhaps in conjunction with the Rural Physician Associate Program or other programs that focus on interdisciplinary integrated care.
    - Monitor funding that may be available through PPACA. Two grants, currently not funded, hold promise. They are available to psychology and social work programs with a focus on innovative integrated care and geriatrics.
        - The U of M Medical School has a health psychology internship and clinical site that could be expanded with integrated funding.
        - St. Thomas is starting a geriatrics program in its Interprofessional Center that provides training and interdisciplinary services to families in the fields of social work, psychology, and law. Services are free to the public.
- Consider using Licensed Marriage & Family Therapists and/or Licensed Professional Counselors with additional training as Care Coordinators in primary care. They can address team cohesiveness and functioning, as well as ensuring that patients' needs are addressed.

Mental Health/Behavioral Aids, Mental Health Rehabilitation Workers

These individuals work primarily with serious and persistently mentally ill individuals on basic skills, independent living, and mental health rehabilitation. The workforce issue is retention, as workers will leave due to low pay. Often there are no benefits. Efforts have been made to try to increase pay and offer healthcare coverage.

Behavioral Healthcare Homes

Create legislation authorizing a behavioral healthcare home for individuals who receive the majority of their care in a behavioral healthcare setting. Perhaps have a pilot project. Primary care could consult to the behavioral healthcare home. Such a service is a better fit for individuals with serious and persistent mental illness who frequent community mental health centers or other community service centers with which they have established relationships. This allows workforce to be used most efficaciously for this particular population.

Collaborative care models by psychologists

Prescription privileges for psychologists is a hot button issue. However, there may be some ways to use appropriately trained psychologists' skills to function as physician extenders and address the great shortage of mental health prescribers. Psychologists have the diagnostic and treatment planning skills. The legislature can dictate what the other requirements might be necessary for appropriately trained doctoral psychologists to practice safely. This might include:

- Licensing under the Board of Medical Practice
- Require to work under the supervision of a physician
- Require coursework similar to that of a Physician Assistant, including prerequisites
- Require a one-year full time internship with a psychiatrist including inpatient and outpatient training.

Mental Health Workforce Shortages

Center for American Progress; Lesley Russell, Visiting Fellow

Oct 2010

Outline of the issue and its impact

The current shortage of mental health professionals, particularly psychiatrists, makes it inevitable that a considerable amount of mental illness care is provided in the nonmental health care sector. Recent county-level estimates across the nation have identified widespread shortages of psychiatrists, and maldistribution of other mental health professionals, especially in rural areas.7 The authors of this study included the caveat that these estimates of need were extrapolated from current provider treatment
patterns rather than from a normative standard of how much care should be provided and by whom.

A 2007 study showed there were 353,398 clinically active providers in six mental health professions: advanced practice psychiatric nurses, licensed professional counselors, marriage and family therapists, psychiatrists, psychologists, and social workers.8 Provider-to-population ratios varied greatly across the nation, both within professions and overall. Social workers and licensed professional counselors were the largest groups; psychiatrists and advanced practice psychiatric nurses were the smallest. Professionals tended to be in urban, high-population, high-income counties. Marriage and family therapists were concentrated in California, and other mental health professionals were concentrated in the Northeast of the country.

Of these mental health professionals, only psychiatrists and advanced practice nurses can prescribe the medicines that are an important part of many patients' treatment regimes. Mental health prescribers are currently represented by an estimated 32,000 psychiatrists and 8,000 advanced practice nurses nationwide.9 Psychiatrists are older on average than other mental health providers. The proportion of psychiatrist providers will decline over the next decade, which will increase the demand for prescriptions from nurses and other medical professionals and

reopen issues about prescribing by psychologists. The importance of the number of mental health professionals is reflected in the fact that, on average, the higher the number of psychiatrists, psychologists, and
social workers per capita in a state, the lower the suicide rate10.

The shortage of mental health professionals is highlighted not just by current unmet needs but by the fact that for those patients who do get treatment, current service use is not overly generous: Adult patients with a serious mental illness such as psychosis typically spend 10.5 hours per year with nonprescriber mental health professionals and 4.4 hours per year with prescriber mental health professionals or primary care physicians in mental health visits; adults with a less serious mental illness such as depression or anxiety spend about 7.8 minutes with nonprescriber mental health professionals and 12.6 minutes with prescriber mental health professionals or primary care physicians in mental health visits per year11.

Suggested reforms

Better long-term planning for workforce needs

Future workforce planning must not ignore the needs of mental health services. It must acknowledge the current large level of unmet need, the importance of appropriately trained mental health professionals to deliver services to children, adolescents, and the elderly, and the need for cultural sensitivity. The primary care workforce is already acknowledged as being in short supply, and f primary care doctors are to do more in mental health, then this must be factored into the number of education and training places needed. Future analyses must recognize that the mental health workforce is characterized by a considerable overlap of roles and functions, with numerous types of professionals vying for patients, recognition, and financial resources. The ability for different types of mental health professionals to substitute for each other is
complicated because of variations in state scope of practice laws and insurance reimbursement rules. National workforce planning efforts would benefit from the central collection of standardized practice information from clinically active providers in all mental health professions.

More incentives to encourage people to enter the mental health workforce

The provision of academic assistance and financial incentives will help encourage students, especially those from disadvantaged backgrounds, to enter the mental health field.
Expanded academic training capacity for critical professions such as psychiatry, psychology, psychiatric nursing, and social work will also be required, along with opportunities for retraining and continuing professional education.

Incentives to address the maldistribution of the mental health workforce

The health care reform legislation recognizes that primary care clinicians can be encouraged to practice in areas of workforce shortage by the provision of additional Medicare payment incentives. Such incentives should be explored for a
range of mental health professionals, in particular for psychiatrists and clinical and child psychologists who practice in underserved areas.

Better use of telemedicine and IT

The use of telecommunications to provide mental health services has been in existence for more than 40 years. It has been used successfully as a tool for treatment and providing counseling services in rural areas, with high levels of patient and physician satisfaction.12 A number of payers and health services offer telemedicine

mental health services and benefits, including Medicare and Medicaid.
The American Telemedicine Association recently released evidence-based practice guidelines for the use of telemedicine and videoconferencing in the delivery of mental health services.13 These guidelines are designed to form the standard of care for such services and to be the basis for the development and practice of uniform, effective, safe, and sustainable telemedicine mental health practices.
Such services can also be used to increase access to training and educational programs for mental health professionals.

Recognition of the important role of pediatricians

Pediatricians play an important frontline role in assessing the mental health and behavioral problems of children. Pediatricians consistently report that pediatric residencies do not adequately prepare them to treat patients with learning disabilities, attention deficit disorders, mental retardation, substance abuse issues, or psychosocial and behavioral problems. This deficiency should be remedied through changes in training and requirements for continuing medical education.

Provisions in the ACA that will help deliver these reforms

While there are very few provisions in the ACA that specifically address shortage and maldistribution in the mental health workforce, there is a raft of provisions to tackle these issues generally and judicious implementation of these can increase the supply of the range of mental health professionals.

In particular, the establishment of a national commission tasked with reviewing health care workforce and projected workforce needs (Section 5101) will help with the alignment of federal health care workforce resources with national needs.
In Section 5602, the secretary of health and human services is directed to establish a comprehensive methodology and criteria for designating medically underserved populations and health professional shortage areas. This work must include a consideration of mental health needs.

It is important to ensure that current and new education and training programs and recruitment and retention programs have a mental health focus that reflects the current and projected needs. Progress toward the better integration of physical and mental health services means that all health professionals need to have adequate training in managing mental health issues. Section 5306 of the new law authorizes funds for mental and behavioral health education and training grants across a broad range of professions, and ensures that some of these grants go to historically black colleges or universities or other minority-serving institutions. For the fiscal years 2010 through 2013, this provision authorizes $8 million for training in social work; $12 million for training in graduate psychology, of which not less than $10 million is to be allocated for doctoral, postdoctoral, and internship-level training; $10 million for training in professional child and adolescent mental health; and $5 million for training in paraprofessional child and adolescent work. It will be critical that these funds are fully appropriated. Moreover, given the need, it would be disappointing if the only focus on mental health workforce was through the provisions of Section 5306.

Disability Services: Mary Alice Mowry

Since 2001, Pathways to Employment (PTE) a Medicaid Infrastructure Grant from the US Department of Health and Human Services' Centers for Medicare and Medicaid Services, has been working toward the mission to increase the competitive employment of people with disabilities and meet Minnesota's workforce needs. As the director of PTE and the Demonstration to Maintain Independence and Employment, I have overseen several initiatives that work on building the skills and access to jobs for people with disabilities in high-demand fields, including health care.

Part of the problem facing Minnesota and other states is the shortage of skilled workers. A recent report from the Governor's Workforce Development Council indicated that in seven years, 70% of Minnesota jobs will require education beyond high school yet only 40% of working-age adults in Minnesota have a postsecondary degree.1 As more and more workers retire as part of the baby boom generation, the demand for *all* workers to participate in the workforce will only increase. We need to be sure that training and credentialing in health care and other fields is accessible to all populations, including people with disabilities, for businesses to thrive and communities to proper.

Anecdotal evidence suggests that direct care workers are often people with disabilities themselves. A survey of enrollees in Minnesota's Demonstration to Maintain Independence and Employment (DMIE), a demonstration project focused on employed people with a potentially disabling condition, showed that over two-thirds of the Demonstration participants held service industry jobs. This segment includes home health service workers and janitorial/cleaning service workers. This group is likely to experience co-morbidities, one of which is often related to years of a physically demanding occupation.

1 Governor's Workforce Development Council. "Strengthening the Skills of Our Current Workforce: Recommendations for Increasing Credential Attainment Among Adults in Minnesota." September 2010. Online at: http://www.gwdc.org/adult_learners/GWDC_Strengthening_the_Skills_of_Our_Current_Workforce.pdf