Minnesota Association of
COMMUNITY HEALTH CENTERS

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Representative Tom Huntley
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The purpose of the correspondence is to convey the Minnesota Association of Community Health Center's (MNACHC) comments on the Minnesota Legislative Health Care Workforce Commission's recommendations to strengthen the state's healthcare workforce. As safety net providers, we applaud your Commission's focus and effort on ensuring a robust workforce for Minnesota's future.

MNACHC is the state membership organization of 17 federally qualified health centers (FQHCs) throughout Minnesota. These FQHCs (hereinafter interchangeably referred to as "community health centers" or "health centers") provide comprehensive, preventive and primary medical, mental health and oral health services to roughly 178,000 low income Minnesotans.

Safety Net Perspective on Minnesota's Health Care Workforce

As community-based organizations (50 percent patient-community board membership), *health centers are in the unique position to view health through the lens of the uninsured, low income and medically underserved*. Nearly **94 percent of community health centers' patients have incomes below 200 percent** of the federal poverty level (UDS 2013). Not surprisingly, **37 percent** of health center patients are **uninsured, and an additional 41 percent are enrolled in a Minnesota Health Care Program, such as Medical Assistance or MinnesotaCare** (UDS 2013).

Community health centers serve a diverse population, with nearly **70 percent from Minnesota's ethnic and cultural communities** (UDS 2013). Moreover, community health centers are located in medically underserved areas (MUA) of Minnesota, where the communities are the poorest in Minnesota and experience the greatest number of health disparities.

Health Centers complement our core medical, mental health and dental services with "enabling services." Services such as patient education, transportation and language translation, assist (or "enable") our patients to overcome access barriers to primary health care services. In 2013, Health Centers collectively spent $18.5 million on these services.

MNACHC Recommendations

MNACHC supports the draft recommendations of the Commission and supporting comments from stakeholders including the Minnesota Medical Association, Leading Age MN, Minnesota Organization of Registered Nurses and the University of Minnesota.

To this support, we put a particular emphasis on the following recommendations:

Recommendation #4 – The legislature should support the continuation and growth where warranted, of proven programs with measure outcomes like loan forgiveness for physicians, advanced practice nurses, physician assistants, pharmacists, dentists and health faculty; Rural Physician Associate Program, etc. These programs greatly assist Health Centers' ability to recruit and retain providers. Without these programs, Health Centers would struggle to offer competitive salaries for providers.

Recommendation #9 – The legislature should target loan forgiveness and loan repayment to primary care and health care professionals willing to practice in underserved communities, and restore funding levels to those greater than 2008 levels.

Recommendation #12 – The legislature should support the recommendations of the Foreign Physicians Taskforce recommendations. More than 30 percent of health center patients prefer care delivered in languages other than English. In order to promote access and begin to address disparities in our communities of color, a health care workforce should be representative of the patients it serves.

Recommendation #16 – The legislature should support programs promoting early exposure (K-12) to health careers. MNACHC would enhance this recommendation by targeting these early exposure programs to Minnesota's cultural communities, ethnic communities and communities experiencing the highest rates of health disparities.

Recommendation #20 – evaluation of team-based models of care, Accountable Care Organizations, health care homes, etc. MNACHC stresses the need to recognize skill sets, expertise and costs these new care models demand, especially for safety net providers without significant financial reserves.

In order to participate in this evolving delivery reform, Health Centers must develop data analytics, IT, care coordination, EMR utilization, capacities. In our experience participating in MDH's Health Care Homes and the DHS Integrated Health Partnerships project, the costs of developing this new expertise in current staff, or bringing it on with new staff, is borne solely by Health Centers and their partners. In other words, there is no "up-front" investment from the State to safety net providers such as Health Centers to participate in the reformed system.

MNACHC advocates for a revamp in healthcare curriculum and clinical training programs to incorporate new team-based models of care and health promotion including inter-professional education, prevention/wellness and data analytics/informatics expertise. Additionally, MNACHC urges the state to take ownership and invest developing current workforce in these fields, in addition to training new workforce in them.

Recommendation #22 – increased funding to Family Medicine residencies and similar programs, particularly for providers serving underserved communities.

Recommendation #27 – study expanding the scope of practice for health care workforce professions. In particular, MNACHC advocates the state expand and support emerging professions with underserved communities and communities of color, including: community health workers, dental therapists, doulas, community paramedics, etc.

In addition to the individual draft recommendations, MNACHC urges the Commission to recognize and act on the following points to Charges #1 and #4:

Charge #1 – Of the current and anticipated workforce shortages, MNACHC advocates for the expansion of the dentistry training and psychiatry training and delivery programs.

Charge #4 – Identifying causes and potential solutions for disparities in income between primary care and other providers, MNACHC urges the Commission consider the challenge of serving a complex patient case mix (e.g., 95% below 200% of poverty, 40% uninsured, 30% served in a language other than English) that experiences greater health disparities with fewer resources health centers (safety net providers) have in offering competitive salaries.

Summary

Again, we thank you, members of the Commission and state agency staff to devoting considerable focus and effort on the state's health care workforce needs. Your Commission has outlined many of the changes in our state that our future workforce will need to address.

From a Health Center perspective, the challenges of recruiting and retaining a workforce is dependent upon three major factors: 1] the changing diversity of Minnesota's population from a cultural perspective; 2] the ability our non-profit Health Centers to offer all of our providers a competitive salary; and 3] "capitalizing" the evolving model of care that relies upon a team based approach to care and an emphasis on robust data analytic capacity.

Please feel free to contact me at 612.253-4715, ext. 16 or at jin.lee.johnson@mnachc.org if you have any questions regarding MNACHC's comments in this correspondence or Health Centers in general.

Respectfully submitted,

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cc. Mark Shoenbaum, MDH