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89th Legislative Session
THE LEGISLATIVE HEALTH
CARE WORKFORCE
COMMISSION

2015
Update and Recommendations on
Strengthening Minnesota's Health Care Workforce

December, 2015

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I. Commission Charge, Background and 2015 Work Plan

"Many policy levers that affect the supply, distribution and skill mix of the health workforce are state-based, including licensure and scope of practice regulations, state loan repayment programs, and Medicaid reimbursement rates. State-level decisions about whether to enact or change policies directed at training, recruiting, and retaining health professionals affect a wide range of stakeholders...."

-Dr. Erin Fraher, Director of the North Carolina Health Professions Data System

The 2014 Legislature created the Legislative Health Care Workforce Commission to study and make recommendations to the legislature on how to achieve the goal of strengthening the workforce in health care and gave it the following charge:

- Identify current and anticipated health care workforce shortages, by both provider type and geography.
- Evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce.
- Study alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce.
- Identify current causes and potential solutions to barriers related to the primary care workforce, including, but not limited to:
 - training and residency shortages;
 - disparities in income between primary care and other providers; and
 - negative perceptions of primary care among students.

The Commission legislation directed it to provide a preliminary report making recommendations to the legislature by December 31, 2014, and a final report by December 31, 2016.

The Commission held seven meeting meetings in 2014 during which it heard testimony from a wide variety of stakeholders. Much of 2014 was dedicated to in-depth background work (identifying and describing issues facing the health care workforce in Minnesota specifically). Issues the Commission examined included:

- Projected needs
- Demand and supply
- Pipeline issues

II. 2014 Commission Report and Recommendations

The Commission issued a preliminary report to the Legislature in December, 2014. The report¹ includes an overview of Minnesota's health care workforce and recommendations to the 2015 Legislature.

In its 2014 report, the Commission made the following findings:

1. Health workforce shortages are found in a variety of professions. Physician shortage projections were among those presented to the Commission, and, although estimates of the extent vary, analysts agree there are shortages significant enough to cause concern. The Commission also documented extensive long term care workforce shortages. Shortages are exacerbated by distribution problems in rural and other underserved areas, with vacant positions in those areas more difficult to fill.
2. The health care workforce is not as diverse as the general population and is not diversifying as fast as the general population.
3. There are disparities in income between primary care physicians and other specialties, with primary care paying less. There are also fewer primary care providers available in rural areas; 10 to 11 percent live in small and isolated rural areas, though 17 percent of the state's population is located there.
4. The long-term care sector has unique and significant issues. The long-term care sector typically includes workers with lower education levels than required for other health care professions and is more diverse than rest of health care sectors.
5. State government invests significant resources in health care workforce education, training and development. The Commission's preliminary review documented \$494 million in 2014 state appropriations.
6. Scope of practice law and regulation affects the contribution health professions make to meeting workforce needs. Minnesota has been a leader in implementing new types of health care professionals.

¹ http://www.lcc.leg.mn/lhcwc/legislative_healthcare_workforce_commission_report.pdf

III. 2015 Legislative Session: Health Care Workforce Recap

A number of the Commission's recommendations were considered in legislation introduced in the 2015 Legislature, and a number of those became law. In addition, other health workforce provisions were enacted by the 2015 Legislature.

Commission – related. Successful legislation directly related to Commission recommendations included:

- Loan forgiveness program expanded
- Primary care residency expansion grant program created
- International Medical Graduates Assistance program created
- Mental Health Workforce Summit recommendations partially enacted
- Telemedicine expanded and interstate physician licensure compact passed
- Medicaid long term care reform enacted, with significant workforce implications
- PIPELINE project for health care apprenticeship programs enacted
- \$15 million appropriated for University of Minnesota Medical School, in part dedicated to physician workforce programs

Other 2015 legislative action on health care workforce issues included:

- MERC appropriation increased \$1 million
- Emeritus Licenses for social workers
- Home and community based services/long term care scholarship program established
- Community Emergency Medical Technician established as a profession

A complete session recap is included in the report appendix

IV. 2015 Commission Meetings and Issues Identified

MEETINGS

The Commission held six meeting meetings in 2015 during which it heard testimony and discussed issues remaining from its work in 2014 and additional issues identified by members over the course of its 2015 meetings. The Commission's work plan and schedule is included in the Appendix. Issues the Commission spent significant time on are discussed below.

V. 2015 Issues and Themes Identified

HEALTH WORKFORCE PLANNING AND COORDINATION

In its 2014 report, the Commission recommended that the legislature create a state health professions council that includes representatives from health professions schools, clinical training sites, students, employers and other relevant stakeholders. Legislation to enact this recommendation was introduced but did not become law in the 2015 session.

During its September 2015 meeting, the Commission received testimony that the need for such a workforce planning and coordinating body remains. Despite periodic activity to bring together key stakeholders such as legislators, state agencies, higher-education partners, third-party payers, and professional associations, stakeholders have tended to pursue goals independently. Minnesota continues to lack a sustained, central, statewide workforce planning structure, and more consistent agency coordination with stakeholders is needed to meet health workforce requirements.

The Commission heard from the Minnesota Department of Health that a recently completed National Governors Association Health Workforce Policy Academy also recognized the creation of a workforce planning and coordinating body as a priority need and made progress identifying potential components of such a model for Minnesota. The Minnesota Medical Association also testified that a state-level, multi-sector workforce commission would be beneficial to coordinate efforts and ensuring effective assessment of supply and demand, education options available and addressing the state's health care needs.

Model Options – Health Care Workforce Governance Entity
From 2014 stakeholder meeting, National Governors Association Minnesota
Health Workforce Policy Academy

Responsibilities	Structure	Outputs	Funding
<ul style="list-style-type: none"> • Coordinate analysis of workforce data • Monitor future workforce trends • Link workforce to population health outcomes • Convene public/private stakeholders • Create policy recommendations • Develop shared policy/legislative agenda • Evaluate current initiatives and efforts • Monitor other states' efforts 	<ul style="list-style-type: none"> • Independent entity • Requires admin support • Housed in department of health • Representative stakeholders • Housed in state government • Governor appointed council or commission 	<ul style="list-style-type: none"> • Annual health workforce needs report, with prospective analysis and trends • Annual population health care needs report • Annual conference/summit • Provide accountability coordination of higher education • Provide training and technical assistance • Develop benchmarks and common methods • Annual report on health care workforce investment • Host local/regional forums • Advise governor/providers on changes needed to training and licensure (quarterly, annually) • Communications structure 	<ul style="list-style-type: none"> • Blended • Public existing • Private: Grants • Private: Fee for service • Public: New • Fees paid by health providers • Volunteer • Employed director + admin support

PRECEPTOR AND CLINICAL TRAINING CHALLENGES AND STRATEGIES

Background

As the Commission discussed in its 2014 report, training at clinical sites is required in health professions education, in addition to classroom education. Again in 2015, all higher education, employer and clinical training sites that communicated with the Commission identified the availability, sustainability, and access to clinical training sites for students as their greatest challenge, with the exception of the aging services sector, which identified recruitment and retention as its greatest challenge. The cost and availability of clinical sites was identified as a major bottleneck to producing more providers to meet state workforce needs. Although many colleges and universities arrange clinical training experiences for students, and although there are state requirements for many institutions to arrange placements (discussed below) some require students to find their own clinical placements. Students in these programs face increasing difficulty as competition for clinical spots increases.¹

Minnesota teaching hospitals and other clinical training sites reported total 2012 costs of about \$350 million to the MERC program. Medicare Graduate Medical Education funding to Minnesota totals \$180 - \$200 million per year, and state MERC funding is currently \$57 million per year. Medicare funding for residency training has been capped at the number of slots that existed in 1997, and funding by Medicare is less than costs to provide care, according to the Metro Minnesota Council on Graduate Medical Education. Medical school graduates are increasing, but the number of residency slots is staying the same. (Primary care residency expansion grants enacted by the 2015 legislature will increase these numbers some.) Forty percent of Minnesota programs that train physicians are primary care-focused. The VA Medical Center in Minneapolis is a significant Graduate Medical Education site outside the Medicare support system, and federal funding for residency slots at Minnesota's children's hospital is provided by the U.S Health Resources and Services Administration.

The Commission received testimony from the Minnesota Medical Association on its preceptor initiative with the University of Minnesota medical School. Through interviews across the state it has become apparent to the Association that it is becoming more difficult to find and retain preceptors, there is a need for more preceptors and additional training for preceptors. The Association cited several challenges to securing sufficient preceptors including:

- The majority of physicians do not receive training to serve as preceptors
- Practicing physicians lack time available to teach
- There is a lack of incentives for physicians to serve as preceptors
- There is frequently a lack of organizational support from the organizations where physicians work for precepting.

The University of Minnesota — Duluth Medical Program also reported it has difficulty finding sufficient preceptors for its students. Furthermore, since any payments for precepting work are typically made to the preceptor's organization, this type of payment incentive is not effective in encouraging individuals to precept, because the benefit does not reach the individual preceptor. Specifically in the rural setting, housing for students and medical residents can also be troublesome.

Similar challenges are experienced securing sufficient preceptors in advanced practice nursing and physician assistant education, according to testimony provided by The Clinical Coordination Partnership, the Minnesota Private College Council and the University of St. Catherine.

Physician Assistant clinicals typically involve 11 separate experiences in different healthcare specialties, and Nurse Practitioner clinical typically require 1,000 – 1,200 clinical hours within different settings. Additionally some specialties (i.e., nurse anesthetists) will require additional hours. Current challenges of advanced practice nursing providers include:

- The significant time training requires
- Challenges inherent in navigating large systems
- Revenue models for providers that, although changing, remain driven by moving patients in and out quickly, limiting time available for precepting
- Rapidly changing demographics
- Availability of clinical education

Areas of opportunity include:

- Better facilitation of the on-boarding and orientation processes at clinical sites in order to reduce time and repetition
- Better methods of assigning preceptors (relationship based vs. availability)
- Greater recognition of regional disparities
- Exploring options for compensation of preceptors (MERC and otherwise) that will not result in passing the cost onto students

Higher education testifiers reported it is becoming more common for training sites to require payments from schools for placement. The University of St. Catherine indicated that training site charges range from \$500 to \$1,200 depending on the system. In addition, the University of St. Catherine indicated that this payment did not go directly to the provider in most circumstances.

Anecdotally, the number of preceptors varies greatly per semester and year. Clinical sites report that the staff who they draw from for preceptors may volunteer to be a preceptor only once per year, may take a year off and/or may decide not to precept again. Oftentimes the driver of an individual's decision to precept is based on what their last preceptor experience

was like – this means the number of preceptors in the state is a moving target/number. Therefore, determining the number of available preceptors for a semester or year is very difficult.

The Commission heard testimony of employer preceptor issues from Fairview Health System. Fairview views itself as a supporter of education, and in its system in 2014, 6,400 students required 11,000 preceptors to complete the necessary hours. Fairview recognizes that providing preceptors is the right thing to do. However; Fairview faces financial challenges to its commitment to education. Most of its MERC funding typically goes to salaries for residents and other trainees but does not cover cost of training. Furthermore, there are barriers to scheduling and securing placements — both of these require resources from the system and the provider, which can be demanding. Fairview believes that the most effective strategy is to ensure adequate funding for the institutions providing training, and believes it's important to keep the funding at a system level to maximize systems ability to use funds effectively.

The Metro Minnesota Council on Graduate Medical Education (MMCGME) presented testimony that physicians are struggling with how to apply limited resources to meet workforce needs and coordinating efforts to analyze workforce data. Currently, medical school program slots are driven by the number of applicants rather than workforce needs, which is leading to an imbalance. In response to a question about specialties in which Minnesota is over-producing physicians, Dr. John Andrews indicated that there is no data for Minnesota that can answer that question; however, looking at where health systems have difficulty recruiting can answer the inverse of the question to a certain extent. He indicated that radiology slots are becoming harder to fill because this service is changing. He also stated that residency slots in this type of situation are not shifted to a different specialty because the size of programs is generally dictated by their historical size and the medical services the training site needs to supply to patients.

Dr. Andrews indicated that this is a looming need to develop geriatricians, and training in geriatrics requires additional training after residency. However, geriatric positions do not pay as well as other specialties. Current programs are generally small but the growing demand is a valid reason to expand them. Dr. Andrews indicated that filling additional geriatric training slots would be particularly tricky because most people enter this type of specialty due to a personal connection, and the pay is typically not commensurate with the additional training necessary. It was noted that the residency expansion grant program passed in the 2015 legislative session included two slots for geriatric medicine.

Role of State Government in Ensuring Availability of Clinical Training

The Commission heard testimony that some colleges and universities require students to secure their own placements, sometimes delaying students' ability to graduate. In response, the Commission received information from the Office of Higher Education and the Minnesota Department of health on existing state authority intended to ensure higher education programs provide required placements for students. Two state laws require private and out-of-state public postsecondary educational institutions to meet state standards to operate legally in Minnesota. These laws generally apply to online programs or programs and institutions that are on-ground in Minnesota and are administered by the Minnesota Office of Higher Education.

Which Institutions Must Be Licensed?

Private Career School Licensure is required for most private schools and training firms that offer occupational programs below the associate level in Minnesota.

Which Institutions Must Register?

Degree-Granting Institutional Registration is required for most postsecondary institutions that are:

- private institutions; or
- out-of-state public institutions; or
- grant degrees exclusively at the associate level or above; or
- use the terms "academy," "college," "institute," or "university" in their names.
- Some online and other distance education programs are exempt.
 - A school, including a school using an online platform service, offering training, courses, or programs is exempt to the extent it offers tuition-free courses to students in Minnesota.
 - Religious institutions that are substantially supported or maintained by a church and offer degree programs that prepare students to enter into becoming a minister (or equivalent vocation) or conduct their lives in consonance with a particular faith.
 - An out-of-state institution that has been approved to participate in the National Council for State Authorization Reciprocity Agreement.
 - Educational programs sponsored by employers for their employees at no cost to the employee.
 - Educational programs sponsored by a nonprofit trade, labor, business, professional, or trade organization where the programs are for the sole benefit of the members of that organization and not available to the public.
 - Out-of-state Institutions that are sending students to Minnesota for clinical placements or internships, but the student's academic program does not include didactic courses in Minnesota.
- The University of Minnesota and MNSCU programs do not need to register.

Degree Standards

Degree Standards have been established for both associate degrees and baccalaureate degrees offered by private and out-of-state public institutions in Minnesota. OHE has been using informal degree standards for graduate and professional degrees.

Student Academic Records - Licensed and registered institutions must make arrangements to preserve student academic records for 50 years after the student has attended.

Complaints - The Office of Higher Education addresses complaints that registered and licensed institutions have not met legal requirements.

Accreditation requirements- Degree-granting institutions that are located in Minnesota must receive accreditation by an accreditor recognized by the U.S. Department of Education within five years of their initial registration approval. An out-of-state institution that is seeking approval to offer distance education programs to Minnesota residents must already have accreditation through an accreditor recognized by the U.S. Department of Education. Accreditation is not required to receive a licensure of a non-degree granting institution. If the employability of students in any program is contingent on receiving specialized accreditation or approval, our office will authorize the program contingent on approval by accreditation.

Requirement that programs arrange clinical experience for students in health care programs – OHE requires any institution that is registered or licensed approved by OHE to be responsible for ensuring students, including students in health fields, graduate, and professional students, receive a clinical experience required for graduation.

It is the responsibility of the institution to arrange clinical experiences within a reasonable amount of time and within a reasonable distance from their institution or home. OHE does allow institutions to expect students to assist in the arranging of a clinical placement, but if a student is struggling, the institution is expected to intervene. This policy is found in Administrative Rule 4880.1800 Subp. 3 for licensed schools, but degree-granting institutions are notified of this requirement in their approval letter. Failure to ensure students are placed into their clinical experience for students will be a violation of their state authorization and can result in remedial action, revocation of the approval of a program, and/or compensation for students. Compensation for students includes refunds of tuition and fees and funding for continuing education experiences to refresh skills. OHE does provide flexibility to institutions on the requirement to place students if the student has been unable to be successfully placed due to issues outside of the institution's control, including failure to successfully interview for a clinical experience or a student being removed from a clinical experience by an employer.

Reciprocity – Minnesota joined the Midwestern State Authorization Reciprocity Agreement in 2015. This provides a streamlined process of regulating online education. This makes distance education courses more accessible to students across state lines. Any law in Minnesota that

applies to higher education programs including quality or consumer protections will not apply to out-of-state institutions that participate in the state authorization reciprocity agreement.

Strategies to Improve Recruitment and Retention of Preceptors

In 2014 the Commission recommended that the 2015 legislature consider tax credits and similar incentives to retain and attract primary care preceptors for medical, advanced practice nursing and physician assistant students. In 2015 the Commission again discussed potential incentives, and heard background presentations from House Research on approaches to tax benefits and from MDH on health provider tax credits in other states.

House Research reviewed the distinctions between tax deductions and tax credits and the characteristics of each. Each has different effects on the taxpayer depending on their income marginal tax rates and other factors. A tax deduction is a subtraction from taxable income and reduces the amount of income subject to tax. Nonrefundable tax credits offset liability, but not to less than zero. Refundable credits offset liability, with any excess paid as a refund.

Examples of Minnesota tax deductions are K-12 education expenses, which cost the state \$18.6 million in FY 15 and had 216,000 filers and organ donation expenses and disposition of farm property by insolvent taxpayers, costing less than \$50,000 each in FY 15 with an unknown number of filers. Among Minnesota tax credits there are 5 nonrefundable credits, 9 refundable, 3 targeted to lower-income filers, 5 targeted to business/economic development and 1 for military service in combat zones. Examples include the working family credit, costing \$245.5 million in FY 15 with 324,600 filers and the Greater MN internship credit, with about 10 returns in TY 2014.

Comparing tax expenditures and direct spending, tax expenditures don't have to be reauthorized and, according to House Research, are not always transparent (i.e. a \$10,000 deduction isn't "worth" \$10,000) and are offset by federal tax increase for itemizers (smaller state income tax deduction). They can have an administrative efficiency if a large share of taxpayers is eligible. Direct spending has to be reauthorized each budget cycle, is transparent (a \$10,000 grant is "worth" \$10,000) and is subject to tax. Direct expenditures can be more effective for delivering \$ to a small number of eligible claimants.

House Research shared considerations for policymakers contemplating tax incentives and discussed a recent example, the volunteer retention stipend aid pilot, passed by the 2014 Legislature as a three-year pilot program to provide an annual \$500 stipend payment to volunteer or paid on-call firefighters, ambulance attendants, and emergency medical responders who have provided service for fire departments or EMS organizations within a 14-county pilot area and meet the program qualifications. A report on that pilot is due in 2018; program sunsets in 2018.

The Minnesota Department of Health presented information collected on health provider tax credits in other states. Georgia has a preceptor tax deduction in place. Rural Provider Tax Credits exist in Oregon, New Mexico and Louisiana.

Georgia offers a Preceptor Tax Deduction that provides a Tax deduction of \$1,000 for every 160 hours of training provided for Physicians who teach MD, DO, NP and PA students who are NOT compensated through any other source are eligible.

Oregon's Rural Practitioner Tax Credit is available to Physicians, podiatrists, physician assistants, advanced practice registered nurses who work in a rural clinic or hospital, providing patient care at least 20 hours/week and providers are eligible for up to \$5,000 per year. It was claimed by approximately 1,600 health professionals, and administrators and the Oregon Department of Revenue reports it "appears to have achieved its purpose by attracting new practitioners to rural communities and retaining existing practitioners." New Mexico's Rural Health Care Practitioner Tax Credit is available to physicians, dentists, psychologists, podiatrists, optometrists, who can receive up to a \$5,000 annual tax credit. Louisiana's Tax Credit for Physicians and Dentists provides \$5,000 per tax year up to a maximum of 5 years.

The full House Research and MDH presentations are available on the Commission's website.

As noted above, the Commission also received testimony on the non-financial barriers to serving as a preceptor, such as approval by employers, accrediting standards that requires programs to document satisfactory progress of their students toward graduation, housing for students in small communities, etc. Commission members discussed the importance of addressing these barriers.

LONG TERM CARE WORKFORCE ISSUES

According to estimates, Minnesota's long term care sector employs 129,000 workers. It's predicted that the demand for older adult services will increase between 45 – 65 percent. One national study projects there will be a 71 percent growth in home/community based health services nationally, and that by 2020, it will be the largest job category nationally. An increasing competition for future workers, combined with the growth in demand for long term care services, shrinking long term care labor force and competitive challenges for workers, portend a growing workforce recruitment and retention challenge for the long term care sector.

According to the Long Term Care Imperative, Minnesota's long term care sector currently has over 1,800 positions open in its top four job categories in nursing homes across Minnesota: registered nurses, LPNs, nursing assistants and dietary aides. According to the January 2014 edition of Minnesota Employment Review, 51 percent of graduating nurses were hired by older adult service providers in Minnesota. Long term care industry representatives point to

challenges paying wages competitive with other job opportunities and note that state policy governs most revenue available to long term care facilities. After 18 months, 76 percent of new graduate hires had left and taken jobs elsewhere, primarily with hospitals, a result of the large salary gap between hospitals and older adult services. An RN in a hospital makes \$17.26/hour more than in a nursing home, adding up to a \$35,888 difference in pay per year. Nursing assistants make \$12,000/year more in a hospital than in a nursing home. Retention in nursing homes today is about 65%. Turnover in housing with services, primarily in assisted living, is at 44%. Fourteen percent of Minnesota nursing homes last year reported they were forced to suspend admitting new residents because they didn't have the needed care givers to provide services, despite having facilities available.

In 2015 the Commission continued its review of workforce issues in the long term care sector. It reviewed updates from the Department of Human Services and the Department of Health on nursing home and home/community based services workforce scholarship grants established or expanded by the 2015 Legislature, and heard testimony from stakeholders in the nursing home, home and community based services and pediatric home care nursing fields.

The Commission also received testimony from nursing home administrators that the Legislature's 2015 increases to scholarships and loan forgiveness programs have been a key component of attracting people to careers in long term care. Nursing home administrators report these programs are important to retain their existing talent and recruit nurses into long term care. The programs also help offer career ladder programs that increase opportunities to retain employees.

Early effects of 2015 Nursing Home Reform legislation

Several Nursing home administrators reported that in anticipation of increased state funding that will begin in January, 2016, they have begun to increase hourly wages where they have had urgent vacancies and provide across the board wage increases to bring entry level workers up to a more livable wage and to make pay for nurses more competitive with what hospitals pay.

One administrator shared plans to use at least 59% of new funds dollars for wage increases, health insurance benefits, pension and other incentives to induce the population at large to work in its nursing facilities. That nursing home has lowered the number of hours worked for employees to be considered full time, increased its contribution to employee insurance and added a pension benefit, all intended to improve recruiting and retention of employees. Other administrators made similar reports.

Administrators also made the point that these improvements take place in an extremely competitive employment market and that it will take time for pay levels to become competitive and benefit programs to improve.

Home and Community Based Services Workforce Issues

Stakeholders in the Home and Community Based Services sector presented information to the Commission on the characteristics of the workforce in that sector and the challenges e and Community Based Services face securing sufficient staff. The sector includes disability waiver services, Day Training and Habilitation, services in ICF/DD facilities, Elderly Waiver and Alternative Care services and personal care attendant services. There are 91,000 people receiving Home and Community Based Services, with most receiving services require 24 hour staffing, and the sector employs 90,000 workers.

Average caregiver/direct support professional wages are \$11.41/hour. Caregivers typically work long hours in two to three jobs to support their families. As the economy improves caregivers increasingly opt for better paying jobs in other industries. Turnover rates vary among the services; 40% to 50% is typical. 78% of rate revenue goes to employee compensation. A variety of factors impact employers' ability to compensate their workforce. Testifiers spoke in support of 5% increase in rates to help with the sector's staffing needs.

Home Nursing Services Issues

The Commission heard testimony and discussed home care nursing for critically ill and medically fragile children. Such children often require 24 hour nursing services at home or in the hospital to survive from moment to moment and day to day, and the Commission heard testimony from the parents of one such child. The family testifying described the arrangements for their child as a "mini-ICU" at home.

Pediatric Home Service, an employer of home care nurses, reported that the nurses in its employ must provide the same level of care and skills as nurses in a hospital intensive care unit because they are solely responsible for their patient in the home. The supply of home nurses does not meet the demand of at home intensive child health care, and Pediatric Home Service's turnover has been 74%. Pediatric Home Service attributes this to salary disparities and to the stress of its highly demanding positions and the isolation nurses face working alone in a client's home. The company is not accepting new patients because of nurse shortages.

The Commission discussed the cost effectiveness of additional investments in home care nursing compared to hospital care for fragile children, many of whom are enrolled in state public programs. The Commission heard an overview of a study commencing on "Causes and Impacts from Delayed Hospital Discharges of Children with Medical Complexity on Pediatric Hospital Days and Expenditures," being conducted by researchers from four hospitals and the University of Minnesota School of Public Health. The study will be completed in approximately twelve months, and the Commission recommends the legislature review the findings of the study to determine if there may be documentable savings from providing additional state support to home nursing services for medically fragile children.

The Commission expressed an interest in obtaining data regarding hospital cost v. home care cost and potential saving that may be available to state government from increased use of home care nursing and on the training costs and economic of home care nursing.

Recruiting and retention challenges hiring associate degree registered nurses

The Commission heard testimony from nursing home administrators on their difficulty recruiting and retaining registered nurses who graduated from two year nursing programs. Nursing homes report two year nurses are important to nursing home operations for a number of reasons, according to employers. Two year RNs have worked in long term care for over 40 years and have served the senior population well. The two-year RN is frequently someone who began as a nursing assistant and then obtained a two year degree, bringing nursing home experience. In contrast, new graduates from four year programs may not have nursing work experience. The two-year degree is a quicker route to graduating RNs, and thus two-year RNs are more quickly available as employees in response to nursing shortages. These factors make two year nurses important to both assuring quality care and meeting workforce needs.

In addition, two year programs offer more flexibility with career ladder opportunities for current employees, i.e., moving from a nursing assistant to become a two year nurse. The state's nursing loan forgiveness program provides incentives for such career ladder nurses to remain in long term care. Two year programs may also better meet the needs for non-traditional students (encore careers, single parents, new Americans) than four year degrees, and two year programs are more affordable for such students. Nursing homes report that the two year nurse is more likely to stay in long term care, because four year nurses are heavily recruited by hospitals, where they are in demand and receive significantly higher pay. Nursing homes report they are at a wage disadvantage that contributes to four year nurses leaving to work in hospitals.

The Commission also heard from nursing educators, who point out that although more baccalaureate prepared nurses will be needed in Minnesota, this does not eliminate the need for associate prepared nurses. The Minnesota Alliance for Nursing Education reported that Minnesota has 24 Associate Degree programs and 19 Baccalaureate Nursing programs. In 2014 Minnesota graduated 1981 Associate and 1084 Bachelors level nurses. (The Minnesota Alliance for Nursing Education was created by seven community and Metropolitan State University to support one application and one curriculum leading to both Associate of Science and Bachelor of Science in nursing degrees.)

The Minnesota Alliance for Nursing Education testified that there is a rise in acuity and complexity of patient care needs, creating an increased need for BSN prepared nurses, and that hiring practices are shifting to BSN only in hospitals in many areas of the state. This rise in acuity and consequently in staff levels is taking place not only in hospitals but in home care,

non-traditional care (telehealth and other) environments and in long term care transitional care units. This has required a review of the mix of nurses required to provide care, and nursing education programs are not being eliminated or phased out, but adapting to meet demands for the immediate and long-term future. One driver of nursing education trends is a 2010 report. The Future of Nursing, by the Institute of Medicine. The report recommended increasing the number of baccalaureate prepared nurses to 80% by 2020 to meet the needs of the population and health care environments.

Recruiting and retention challenges in the Certified Nursing Assistant (CNA) Workforce

The commission discussed recruiting and retention challenges finding and keeping an adequate number of Certified Nursing Assistants (CNAs).

Opportunities for Larger Contribution by Adult Basic Education Programs

Adult Basic Education (ABE) programs serve students ages 16 and over who are not enrolled in school and who want to improve their basic skills in reading, writing, math, listening, and speaking. Adult Basic Education in some locations is paired with training for participants to become Certified Nursing Assistants (CNAs). The Commission received testimony from Southwest Adult Basic Education in Marshall, Minnesota, which provides training to Adult Basic Education participants to prepare them for the CNA state certification test, customer service and communication skills training, basic computer skills training, assistance with health career exploration and job seeking skills.

Southwest Adult Basic Education recommended creation of online content to raise literacy focused on CNA and healthcare development and increase the pool of qualified CNAs.

Role of CNA Certification in Nursing Education

One aspect of the shortage of CNAs is that students in nursing programs are no longer required to become certified as a CNA. Such a requirement for students is up to each nursing education program. In recent years, nursing education programs have responded to expectations of their accrediting body that programs be no longer and include no more credits than necessary. (A CNA certificate program can be a 3 - 4 credit course). According to reports, this has driven the elimination of the requirement that nursing students become CNAs. A potential unintended consequence of elimination of this CNA education requirement is decreased enrollment in nursing assistant programs and a decreased pool of employees.

With recent changes in accreditation, some programs may be considering adding the CNA certification requirement back. Some believe CNA certification leads to more successful nursing students, and report the previous requirement contributed to a larger pool of CNAs. Others are concerned about the tuition cost to students, and believe it forces people to become certified

who have no interest in being a CNA, creating a “revolving door” among CNAs who leave CNA jobs quickly upon graduation as a nurse. HealthForce Minnesota is surveying the status of this requirement on MNSCU campuses, and will have results in late 2015 or early 2016.

CHALLENGES TO VOLUNTEERING AND PROVIDING CHARITY CARE

The health workforce, including the physician workforce, could be extended through greater use of volunteers. Then Commission discussed the potential for greater use of volunteer health care providers and the challenges limiting the use of volunteers. Challenges include:

- Liability concerns;
- Absence of incentives, such as tax credits, to recognize and reward volunteers; and
- Operational barriers for facilities, including the efficiency of volunteer providers, availability of volunteers for scheduling, training on Electronic Health Record systems and continuity of care for patient.

SCOPE OF PRACTICE

Continuing its 2014 discussion on the role of scope of practice law and regulation in meeting the state’s health workforce needs, the Commission received an overview on scope of practice from the regulatory perspective from Shirley Brekken, Executive Director, Minnesota Board of Nursing. State law defines scope of practice, most commonly in state practice acts enacted by the legislature. The stated purpose of health professional licensure is to protect the public. Components of scope of practice include the education and training of health professionals, the authority and regulation conducted by states, and the extent to which institutions and employers allow professionals to practice. Ms. Brekken shared that states should allow for professionals to practice to the full extent of their demonstrated knowledge and competence and allow for the ongoing evolution of roles and overlapping scopes of practice.

Ms. Brekken presented an excerpt from Changes in Healthcare Professions Scope of Practice: Legislative Considerations, a national consensus document produced by six national associations of state health licensing boards. Consensus principles from that report include:

- The purpose of regulation – public protection – should have top priority in scope of practice decisions, rather than professional self-interest;
- Changes in scope of practice are inherent in our current healthcare system;
- Collaboration between health care providers should be the professional norm;
- Overlap among professions is necessary; and
- Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service.

The Commission also reviewed these principles in 2014 and reported in 2014 that the principles can be guides for scope of practice decisions by future legislatures.

Factors to consider in proposals to change scopes of practice include a basis in evidence, appropriate and accredited training and assessment, potential to promote access to care, and involvement of the relevant regulatory boards.

Scope of practice changes by themselves often do not lead directly to changes in the real-world responsibilities of practitioners, their distribution or employment prospects, the roles of providers on a care team in a clinic or hospital, or have a quantifiable impact on access. The Commission explored an example of barriers that can remain following such changes from leaders in the doula field. Although Minnesota maintains a voluntary registry for doulas and Medicaid payment for doula services in 2014, issues inhibiting doulas' ability to provide services to their clients are the challenges in obtaining National Provider ID (NPI) numbers or collaborating providers under whose NPI they can bill, challenges and delays becoming credentialed by payers and reimbursement rates the field believes are too low to cover costs.

The Commission received an overview of a one year National Governors Association scope of practice technical assistance project scheduled to begin in fall, 2015 with the goal of addressing some of the issues presented to the Commission. The project will:

1. Analyze and support the scope of practice changes recently enacted in Minnesota – convene state government and other leaders to review and digest these and similar changes from recent years and develop plans to better assure these changes will succeed in addressing state health policy goals.
2. Develop a common framework for evaluating scope of practice proposals. Initiate a community discussion that works toward a consensus framework for legislative and executive branch leaders. The core team, with stakeholder input, will develop a consensus framework or guiding principles to inform policy discussions around these issues, and
3. Review/identify needs and opportunities for additional scope of practice changes. Convene licensing boards, subject matter experts, associations, researchers, practitioners and policy makers to identify changes and updates to specific practice scopes with an aim to enhance access to care and meet workforce needs.

The Commission Co-chairs are members of the core team for this NGA project, along with two other legislators, state licensing board and health staff and higher education representatives.

VI. State Spending on Health Professions Education and Workforce Development – 2015 Update

The Commission continued its exploration of state government spending on health professions education and workforce development, begun in 2014.

As in 2014, according to the House Fiscal Analysis department, the Higher Education committees spend the most on health-related higher education, but do not focus greatly on details of the need for health professionals and strategies to meet the need through the higher education pipeline. The Health & Human Services Committees are more focused on workforce needs and gaps in the workforce. The Health & Human Services Committees spend less on health-related higher education and workforce development than the Higher Education Committees. The two committees do not regularly communicate in an organized way to address pipeline and workforce needs. There are also several related programs under the jurisdiction of the Jobs and Economic Development Committees.

In 2015, the Commission reviewed the inventory of state programs directed at each section of the workforce development pipeline and updated it based on additional information and 2015 session changes.

Direct state government total for spending on health professions educations and workforce development is an estimated \$342 million per year. As part of its role the Commission conducted an initial tally of direct state spending on health professions education and workforce development in 2014, and that analysis has been updated with additional information and revised to reflect results of the 2015 legislative session. Commission members continue to believe Eighty-seven percent of the appropriations identified originate in the Higher Education divisions. The Commission noted that some state investments and activities not explicitly identified as workforce development spending have an indirect effect on health workforce dynamics. Examples include scope of practice regulation and state support of health care home and accountable care organization models. The Commission found this research complex, and recommends continued work to compile a complete picture of state investments in this area.

State Government Spending On Health Professions Education and Development - 2015 Medical Education and Research Costs Program (MERC). The Commission heard a presentation on the Medical Education and Research Costs Program (MERC) Program from MDHⁱⁱ. With \$58 million distributed to clinical training sites through a distribution formula, and additional funds allocated to dental education and Hennepin Country Medical Center, MERC is the largest health professions program in the Health and Human Services budget. The program is administered by MDH through a partnership with twenty sponsoring education and training institutions 248

teaching programs and 350 – 400 training sites. Commission members expressed interest in understanding the distribution of MERC funds between primary care and specialist trainees and in understanding how alternative distribution approaches would affect MERC's ability to better respond to changing workforce needs and health care delivery trends.

The Commission also heard presentations and testimony from employers, private colleges and others about their health workforce investments outside of state government. Presentation materials are posted on the Commission's website.

The Commission considered the current level of public and private investment in health professions education and workforce development, noted that this investment is not expected to fully overcome the dynamics that lead to health workforce shortages, and concluded some level of additional investment will be necessary of Minnesota is to meet its health workforce goals and continue to respond to citizens' need for health services.

**State Government Spending On Health Professions Education and Development –
2015 Update**

Higher Ed Division

Program Name	Agency or Institution	Division	Fund	Pipeline Segment	2016 Appropriation
1. HealthForce, includes Scrubs Camps	MNSCU	Higher Ed	GF	Prepare students	Incl in MNSCU
2. U of M Duluth Med School Campus- rural focus	U of M	Higher Ed	GF	Recruit students	4,510
3. Center of American Indian & Minority Health	U of M	Higher Ed	GF	Recruit students	391
4. Future Doctors Program	U of M			Recruit students	0
5. Academic Health Center	U of M	Higher Ed	Cig Tax	Recruit/educate	22,250
6. Primary Care Education Initiatives	U of M	Higher Ed	HCAF	Recruit/educate	2,157
7. Health Science “Specials”	U of M	Higher Ed	GF	Recruit/educate	8,858
8. United Family Medicine Residency	OHE	Higher Ed		Clinical Training	501
9. St. Cloud Hospital family practice residency program	MMB	Higher Ed	GF	Clinical Training	346
10. Mayo Clinic Medical School	Mayo	Higher Ed	GF	Clinical Training	665
11. HCMC graduate family medicine program	OHE	Higher Ed	GF	Clinical Training	645
12. New U of M Med School funding	U of M	Higher Ed	GF	Research	14,000
13. Foreign Born Nurses	MNSCU	Higher Ed	G	Recruit/educate	35
14. Dual training “PIPELINE” PROGRAM	DOLI/OHE	Higher Ed	GF	Recruit/retain	2,200
15. Veterinarian loan forgiveness	OHE/MDH	Higher Ed	GF – 1 time	Recruit/educate	250
16. Mayo Family Medicine & General Residency Programs	Mayo	Higher Ed	GF	Clinical Training	686
17. Rural Physician Associate Program (RPAP), Metro PAP, Duluth Future Scholars	U of MN	Higher Ed	GF	Clinical Training	1,693
18. MNSCU Health Professions Programs	MNSCU	Higher Ed	GF	Credit-based	60,360
19. Other state appropriations to U of M medical school and other health professions education programs	MN Legislature	Higher Ed	GF	Clinical Training	132,354
20. State financial aid to health professions students	OHE	Higher Ed	GF		16,000
TOTAL				TOTAL	267,901

HHS Division

Program Name	Agency or Institution	Division	Fund	Pipeline Segment	2016 Appropriation
1. MERC Clinical Training	Health	HHS	Various	Clinical Training	58,127
2. Summer Health Careers Intern	Health	HHS	HCAF	Prepare students	300
3. Nursing Facility Scholarship Program	DHS	HHS	GF	Recruit students	2,603
4. Primary Care Residency Expansion	Health	HHS	HCAF	Clinical Training	1,500
5. Home & Community Based Services Scholarships	Health	HHS	HCAF	Retention	1,000
6. Int'l Medical Graduates	Health	HHS	HCAF	Clinical Training	1,000
7. Clinical Dental Education Grants	Health	HHS	HCAF	Clinical Training	1,122
8. HCMC Clinical Medical Education	Health	HHS	GF	Clinical Training	1,035
9. Teaching hospital MA add on	DHS	HHS	GF	Clinical Training	tdb
10. MN Health Professional Loan Forgiveness Program	Health	HS	HCAF	Employment High Need Settings	3,371
11. National Health Service Corps – state match	Health	HHS	HCAF	Employment High Need Settings	100
12. Community EMT	DHS	HHS	GF – 1 time	Retention	32
13. Volunteer Ambulance Award Program (Cooper Sams)	EMSRB	HHS	GF	Retention	700
14. MA Primary Care Rate add-on	DHS	HHS	GF	Retention	expired 12/2014
15. Emerging professions support	MDH	Federal		Redesign	900
16. Telemedicine partity		HHS	GF	Improve access	170
TOTAL				TOTAL	71,960

Other Finance Divisions

Program Name	Agency or Institution	Division	Fund	Pipeline Segment	2016 Appropriation
1. Foreign-trained health worker test prep	DEED – 1 time funds	Jobs/Ec. Devel	WF Devel	Recruit students	200
2. FasTRAC	DEED	Jobs/Ec.Devel	WF Devel	Recruit students	1,500
TOTAL				TOTAL	1,700

Grand Total

GRAND TOTAL				GRAND TOTAL	341,561
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The University of Minnesota reported that it distributes the \$9.2 million in Health Science “Specials” in the table above as follows:

PROGRAM	SCHOOL	
Biomedical Engineering	MED	\$76,742
Rural Physicians Associate Program(RPAP)	MED	\$193,064
St Cloud Residency Program	MED	\$346,000
Hennepin County Pass Through	MED	\$0
Dental Care	DENT	\$100,000
Health Sciences Research	PUBHL	\$340,743
Health Sciences Research	AHCSH	\$2,124,211
Regenerative Medicine/Mayo	AHC Health Specials	\$4,350,000
Veterinary Diagnostic Lab	VETMD	\$1,673,240
Subtotal Health Sciences		\$9,204,000

Additional state spending affects health workforce education and promotion, and also affects the workforce needed to serve state residents, even though the workforce effects of this spending is not easily identifiable within specific appropriations. Examples include:

1. Team care approaches such as state-certified Health Care Homes
2. State quality reporting and Medicaid alternative payment demonstrations that provide indirect incentives to use non-physician staff for care coordination and patient follow-up
3. Visa Waivers for foreign medical grads ("J-1")
4. Medicaid reimbursement of services by emerging professions such as dental therapists, community paramedics, community health workers, doulas, peer mental health support workers, etc.
5. Scope of practice regulations and modifications administered by Health Licensing Boards
6. Portions of broadband grants that improve the capacity of health facilities and patients to participate in telehealth
7. Dept. of Education programs such as Career and Technical Education, Adult Basic education, etc.
8. DEED Workforce Development Programs

VII. Health Professions Education Enrollment and Graduation – 2015 Update

In 2014 the Commission studied health professions education in Minnesota, received background information from each of the state’s higher education sectors – the University of Minnesota, Minnesota State Colleges and Universities, private colleges, and career colleges, and reviewed data on the number of students graduating with health professions credentials. The Commission learned that 25,684 students received a health professions certificate or degree at some level from Minnesota higher education programs in the 2012 - 2013 academic year, according to the data from the Integrated Postsecondary Education Data System (IPEDS), provided by the Minnesota Office of Higher Education.

In the 2013 – 2014 academic year, 23,087 students received a health professions certificate or degree at some level from Minnesota higher education programs. 42,753 students were enrolled in health professions education programs in Minnesota in the 2013 – 2014 academic year. Because students at the beginning of their education may not have yet declared majors, this figure undercounts the number who will go on to graduate from health professions programs.

Students in the disciplines below received the largest number of awards during 2013 - 2014:

Registered Nursing/Registered Nurse	6586
Psychology (largely bachelors and masters)	5116
Licensed Practical/Vocational Nurse Training	2013
Nursing Assistant/Aide and Patient Care Assistant/Aide	1863
Health/Health Care Administration/Management	1071
Medical/Clinical Assistant	960
Mental Health Counseling/Counselor	900
Public Health, General	560
Dental Assisting/Assistant	392
Substance Abuse/Addiction Counseling	387
Massage Therapy/Therapeutic Massage	384

VII. Recommendations

During its 2015 deliberations, the Commission considered potential recommendations from among its 2014 recommendations not acted upon or partially acted upon during the 2015 session and potential recommendations that emerged from 2015 Commission discussion. The Commission ranked recommendations to establish priorities for short and long term action and agreed on the recommendations below.

PRIORITY RECOMMENDATIONS FOR ACTION BY THE 2016 LEGISLATURE:

- 1) The Legislature should address barriers to limit the availability of enough preceptors to meet the state's need for clinical training for health professions students:
 - a) Address non-financial barriers to serving as a preceptor, such as approval by employers, accrediting standards that requires programs to document satisfactory progress of their students toward graduation, housing for students in small communities, etc.
 - b) Consider preceptor incentives such as tax credits and other approaches that respond to challenges recruiting and retaining preceptors.
 - c) Continue to seek complete information on the number of health professions preceptors in Minnesota.
- 2) The legislature should identify and study expanding the scope of practice for health care professions, taking into account the plans and results of a National Governors' Association-sponsored project that is developing plans to support recently enacted scope of practice changes, developing a common framework for evaluating scope of practice proposals, and reviewing opportunities for additional scope of practice changes.
- 3) The legislature should review the effectiveness of the MERC program and consider alternate models Graduate Medical Education funding.
 - a) Assess the effectiveness of the current MERC distribution of funds in meeting high priority state workforce needs, supported by in depth data on the current distribution of MERC funds
 - b) Direct DHS to examine the feasibility of seeking a waiver from the Centers for Medicare & Medicaid Services (CMS) that would provide for state management of Graduate Medical Education distribution in Minnesota.
- 4) The legislature should address the multiple factors that create challenges recruiting and retaining the range of nursing education, skill and experience needed in long term care settings.
 - (a) Encourage or incentivize nursing education programs and higher education systems to maintain a balance between associate and baccalaureate

Registered Nurse degree programs so both levels of nursing graduate will remain available to meet workforce needs in long term care settings.

- (b) Encourage nursing education programs to consider reinstating the requirement that Licensed Practical Nurse/Registered Nurse students become certified as Certified Nursing Assistants.
- 5) The legislature should analyze and respond to any state barriers, such as regulatory or reimbursement issues, that may be slowing the growth of telehealth to meet workforce needs.
- 6) The legislature should strongly consider those recommendations of the Mental Health Workforce Summit that did not become law in the 2015 session.

RECOMMENDED GOALS AND PRINCIPLES TO GUIDE LEGISLATIVE ACTION

- 1) The legislature should support continuation of proven programs with measurable outcomes like loan forgiveness for physicians, advanced practice nurses, physician assistants, pharmacists, dentists and health faculty; Rural Physicians Associate Program, etc. and expand such programs where additional investment would likely have a direct effect on improving workforce supply and distribution.
- 2) The legislature should support programs that expose K - 12 students to health careers, such as the state Summer Health Care Intern Program, HealthForce Scrubs camps, summer enrichment programs, [STEM related programs such as Project Lead The Way] and other programs that prepare and recruit rural students and nontraditional students into medical school, nursing and other health careers.
- 3) The legislature should invest in strategies that will lead to a more diverse health care workforce.
- 4) The legislature should continue to support the PIPELINE/dual training grants to develop the Health Support Specialist occupation. The program received base funding from the 2015 Legislature.
- 5) The legislature should encourage nursing schools to consider prior health care experience, such as nursing home employment, in admissions.

RECOMMENDATIONS FOR ADDITIONAL AND FUTURE CONSIDERATION

Charge 1: Identify current and anticipated health care workforce shortages, by both provider type and geography

- 1) The legislature should create a state health professions council that includes representatives from health professions schools, clinical training sites, students, employers and other relevant stakeholders to coordinate efforts, enable better coordination among and of workforce training, pipeline strategies, investments and

policies and ensure that recommendations to address the state's health care workforce needs are developed with the expertise and involvement of all stakeholders.

- 2) Executive branch agencies, led by MDH, and other entities engaged in health workforce data collection, should establish a formal structure to coordinate and integrate the collection and analysis of health workforce data to provide the legislature and other policymakers integrated health workforce information and analysis.
 - a) MDH should explore measurement approaches to documenting workforce shortages that capture indicators such as wait times for appointments, Minnesota scope of practice variations and better reflect the full range of professions in Minnesota's health workforce, in addition to using federal Health Professional Shortage Area indicators.
- 3) The legislature should review the findings of the study commencing on "Causes and Impacts from Delayed Hospital Discharges of Children with Medical Complexity," conducted by researchers from four hospitals and the University of Minnesota School of Public Health, to determine if there may be documentable savings from providing additional state support to home nursing services for medically fragile children.

Charge 2: Evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce

Recommendations addressing this charge are included in the 2016 priority recommendations and Recommended Goals and Principles to Guide Legislative Action, above.

Charge 3: study alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce

- 4) The legislature should explore public/private partnership opportunities to develop, attract and retain a highly skilled health care workforce.
- 5) The legislature should encourage nursing schools to consider prior health care experience, such as nursing home employment, in admissions.
- 6) Health professions education programs in all higher education sectors should inventory their online Masters programs in health fields and create additional online Masters Programs to provide rural residents with career ladder and advancement additional opportunities they may cannot find within a reasonable distance of their communities
- 7) The legislature should consider a range of state responses to meeting the workforce needs of the long term care and home and community based services sectors. Recommendations not included above. For example:

- i) Support creation of online Adult Basic Education (ABE) content to raise literacy and prepare more for Certified Nursing Assistant and other healthcare jobs.
- 8) Address barriers to more widespread use of volunteer health care providers, such as a deduction for charity care, addressing liability issues, etc.
- 9) The legislature, MDH, DHS and other relevant state agencies should monitor and evaluate the effects of the growth of team models of care, Accountable Care Organizations, health care homes, and other new developments on the state's workforce supply and demand. Data is becoming available on the cost effects of these new models, but little analysis is yet being conducted on the workforce effects.
- 10) The legislature, MDH and DHS should evaluate how health care homes and Accountable Care Organizations are working in all areas of the state and identify whether there are particular problems in certain places.

Charge 4: Identify current causes and potential solutions to barriers related to the primary care workforce, including, but not limited to:

- i. Training and residency shortages;
 - ii. disparities in income between primary care and other providers and
 - iii. negative perceptions of primary care among students
- 11) The legislature should increase funding for Family Medicine residencies and similar programs, including both rural family medicine programs and those serving underserved urban communities. Funding should include support of APRN and physician assistant clinical placements in rural and underserved areas.
 - 12) The legislature should sustain beyond 2014 the ACA-required Medicaid payment bump for primary care, which increases primary care Medicaid rates to Medicare levels for 2013-2014
 - 13) The legislature, higher education institutions and health care employers should increase the number of available clinical training sites for medical students and advanced practice nursing, physician assistant and mental health students in Minnesota.
 - 14) The legislature should consider preceptor incentives such as tax credits and other approaches that respond to challenges recruiting and retaining preceptors.
 - 15) Continue to seek complete information on the number of health professions preceptors in Minnesota
 - 16) Examine the role of state law and regulation in assuring students obtain required clinical experiences and precepting; Strengthen and/or enforce education program responsibilities for placements
 - 17) Remove reimbursement and other barriers to more widespread use of doulas in Minnesota.

IX. Directions for 2016 Interim

The Commission's enabling legislation directs it to provide a final report to the legislature by December 31, 2016, addressing each aspect of its charge, after which the Commission expires. As it did in 2015, the Commission may want to develop a 2016 Interim work plan that includes the following:

- Review 2016 session results
- Pursue preliminary implementation information on Commission and other health workforce legislation enacted in 2015 and 2016
- Continue to examine outstanding priority issues
- Update health workforce background data and landscape description
- Produce final report and recommendations, including future directions for health workforce leadership and planning.