



Final Recommendations from the Colorado Health Professions Workforce Policy Collaborative

**ADDRESSING
COLORADO'S
PRIMARY CARE
PROVIDER
SHORTAGE**



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Funding and Support for the Collaborative

The Colorado Trust, a grantmaking foundation dedicated to achieving access to health for all Coloradans by 2018, provided a three-year grant (2008-2011) to the Colorado Rural Health Center (CRHC) to manage and support the efforts of the Colorado Health Professions Workforce Policy Collaborative to build and strengthen the state's health care workforce through public policy. As well, Engaged Public (formerly TAG Strategies) provides facilitation and assistance with policy analysis and development for the Collaborative; the Center for Research Strategies conducts assessments and monitors the impact of the Collaborative; and the Colorado Health Institute provides associated health professions data and analysis. The Colorado Health Professions Workforce Policy Collaborative is a multidisciplinary group of more than 30 organizations that is committed to ensuring a highly qualified health care workforce to provide all Coloradans with access to quality health care. The Collaborative's unique contribution to this vision is to research and develop possible public policy solutions that it recommends by consensus.

The Colorado Health Professions Workforce Policy Collaborative was created in 2008 to better understand the complex nature of health care workforce policy and to develop and support effective changes. The organizations participating in the Collaborative represent sectors responsible for – and affected by – health workforce issues, including health care facilities, government agencies, research and policy organizations, statewide advocacy organizations, and educational institutions.

The Collaborative’s work includes research, outreach to stakeholders undertaking a shared learning agenda and identification of policy priorities to assist the state to address health professions workforce issues. The Collaborative focuses its work on state-level policy change and recommends policy interventions that are: evidence-based, actionable, able to address root causes, able to positively impact the general population over time, and able to demonstrate measureable outcomes.

VISION: Colorado will have a competent, diverse health care workforce sufficient to ensure that all residents have access to health care that is effective, efficient, safe, equitable, timely and patient-centered.

MISSION: The Colorado Health Professions Workforce Collaborative will study, develop and advocate for public policy to accomplish the vision of a competent, diverse health care workforce sufficient to ensure that all residents have access to health care that is effective, efficient, safe, equitable, timely and patient-centered.

Participating Organizations

- Adams County Education Consortium
- Centers for Medicare & Medicaid Services
- Center for Research Strategies
- ClinicNET
- Colorado Academy of Family Physicians
- Colorado Area Health Education Centers
- Colorado Behavioral Health Network
- Colorado Center for Nursing Excellence
- Colorado Coalition for the Medically Underserved
- Colorado Commission on Family Medicine
- Colorado Community College System
- Colorado Community Health Network
- Colorado Dental Association
- Colorado Department of Labor and Employment
- Colorado Department of Public Health and Environment
- Colorado Health Foundation
- Colorado Health Institute
- Colorado Medical Society
- Colorado Nurses Association
- Colorado Rural Health Center
- Colorado Society of Osteopathic Medicine
- Mental Health America of Colorado
- Regis University Loretto Heights School of Nursing
- Regis University School of Physical Therapy
- San Luis Valley Regional Medical Center
- The Colorado Trust
- University of Colorado College of Liberal Arts & Sciences
- University of Colorado College of Nursing

INTRODUCTION

In 2010 the Colorado Health Professions Workforce Policy Collaborative released a series of public policy recommendations intended to ensure the availability of a highly qualified health care workforce to meet the needs of Coloradans. Since then, much has happened in health care policy – and much has stayed the same. At the federal level, landmark health care reform legislation passed, which will provide coverage for more than 33 million Americans by 2014. In anticipation of the increased demand, the act also provides substantial resources to increase the number of health care professionals providing primary care services. In Colorado, the overarching policy issue has been, and remains, the constrained state budget, which makes it difficult or impossible to undertake new or expanded programs – including implementing most of the recommendations made by the Collaborative.

The Collaborative’s 2011 policy framework largely mirrors the previous year’s, but has been updated based on policy changes over the last year, newly available data and policy analysis, and the ongoing inter-professional dialogue among members and participants in the Collaborative. While many organizations and professional groups work on health care workforce policy, the Collaborative is unique because it is multidisciplinary and open to any person or organization that agrees to support its vision and mission. This breadth of perspective allows the Collaborative to take a comprehensive view and to identify policy recommendations across the professions. The history of health care workforce policy has often included professions working at cross-purposes with each other. The Collaborative seeks to bring together leaders from all professions to make wise policy recommendations to benefit the people of Colorado, not just a single profession.

COLORADO’S SHORTAGE OF PRIMARY CARE PROVIDERS AND REGISTERED NURSES

Health care workforce policy is a complex field and even the best data and analysis do not always accurately predict future needs. The Collaborative is supported by the Colorado Health Institute and the Center for Research Strategies to ensure that the best available data are used and interpreted with integrity. Indeed, the first recommendation of the Collaborative is to work with the Colorado Department of Regulatory Affairs to get more accurate, granular and comprehensive raw data. Furthermore, the Collaborative is working in partnership with the State Office of Primary Care on a federal grant that would fund additional data and policy analysis to support detailed policy recommendations in the future.

Colorado’s population over age 65 will increase by nearly 500,000 and the state’s total population will increase by 1 million over the coming decade, while at the same time 20,000 (32%) of Colorado’s registered nurses will retire.

While more data and additional analysis are always desirable and well-meaning experts may disagree on their meaning, one judgment is clear: a significant gap exists between the health care workforce Colorado needs in the future and the workforce it will have without public and private interventions. It is clear that the combined forces of health care reform, an aging population needing more care and the impending retirement of many health care providers will create an extremely challenging health care workforce shortage. Veterans of the health care workforce participating in the Collaborative cautioned against waiting for yet another study or additional data before taking action because data alone cannot anticipate the subtleties and unknowns of future needs. Instead, the Collaborative has worked with data and policy experts to craft recommendations that would move the state in the right direction.

DEFINING THE GAP

Projections based upon current delivery models and the best available data analyzed by the Colorado Health Institute show that if current trends continue, Colorado will have a significant health care workforce shortage in the future. Indeed, in many parts of the state – including rural, frontier and inner city areas – that shortage already exists. The magnitude of the current and projected shortage is such that it is beyond the capacity of most local communities, health care and educational institutions, foundations and other entities to solve. Their contributions are critical, but significant action is needed by the state and federal governments to have a lasting and sustainable impact.

Of particular concern are the shortages projected for Colorado’s primary care and professional nursing workforce. Based on current practice models, assumptions and the best data available, the Colorado Health Institute (CHI) has analyzed supply and demand for primary health care professionals. CHI projects that, by 2025 Colorado will need an additional 2,200 primary care providers beyond the anticipated supply.¹ (This estimate is referred to as “the shortage” throughout this document.) This shortage of primary care providers includes more than 1,000 physicians, 480 physician assistants and 660 advanced practice nurses practicing in primary care. This could have a negative effect on thousands of Coloradans’ ability to access primary care services, resulting in longer waits, less provider choice and a number of other access restrictions.

"Colorado's economy and quality of life is powerfully affected by the availability, quantity and quality of its health care workforce. As of June 2009, the health care and social assistance sector employed one in nine Colorado employees, and provided \$11 billion in annual wages. With 253,000 employees, health care and social services is a major contributor to the state's economy, with average wages that are 60 percent greater than the retail sector. *The health care and social assistance sectors are projected to grow by an additional 56,000 employees by 2018, in addition to the roughly 50,000 individuals needed to replace retirees.*"

Colorado Center for Nursing Excellence, *The Nursing and Health Care Workforce in Colorado: Driver of Prosperity or an Economic Roadblock?* March 2010

Colorado’s current registered nurse shortage of 11% is predicted to triple by 2020.² While the number of professional nurses declines, job opportunities are expected to increase by 46% between 2008 through 2018.³ Projections from the Colorado Center for Nursing Excellence suggest that, by 2018, Colorado will need an additional 6,300 registered nurses.⁴ This number is likely a conservative projection, given the impact of state and federal health reform. Like much of the nation, Colorado is experiencing an increasingly mature workforce approaching retirement in the coming decade. Combined with current pipeline limitations for training and graduating adequate numbers of nursing students, these factors demonstrate that unless deliberate action is taken, demand for nursing services will soon outpace supply.

While the supply of dental providers in the western region of the United States is expected to continue to grow,⁵ the composition and distribution of dental providers will continue to pose challenges for Colorado unless deliberate actions are taken to address the factors contributing to these imbalances. Currently, there are nine of Colorado’s 64 counties without a dentist⁶ and an estimated 12 counties without a dental hygienist.⁷

Colorado also faces a serious gap in the supply of behavioral health providers. According to 2010 data, there were 582 psychiatrists, 1,633 psychologists and 3,488 licensed clinical social workers in Colorado,⁸ which is equal to approximately 12 psychiatrists, 33 psychologists, and 70 social workers for every 100,000 people. While these data generally reveal behavioral health workforce shortages in Colorado, the disparity is even more pronounced outside of the Front Range area.

SUMMARY OF RECOMMENDATIONS

1. *Collect key data elements through the state's professional licensure and certification processes*
2. *Enact policies to support adequate reimbursement and control practice costs*
3. *Increase public funding for health professions education programs*
4. *Protect current funding allocated to loan repayment and optimize effectiveness of loan programs*
5. *Support policies to increase number of clinical experiences and residencies*

The Collaborative's policy recommendations specifically target those health care professionals who provide primary care. While this term is commonly used, it can be subject to varying interpretations. The professionals that the Collaborative's recommendations are intended to address, are those who provide health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.

POLICY RECOMMENDATIONS

The five policies presented in this framework are the Collaborative's priorities for action at the state level during Colorado's 2011 legislative session. These recommendations follow the same framework as the previous year's and are updated based on changes to state and federal policy. They also have been broadened to include other elements of primary care – behavioral and oral health – as well as nursing. The following policies will help lay the groundwork for further interventions and continue the work necessary to develop the high quality workforce necessary to ensure access to health for all Colorado residents.

1. Collect key data elements through the state's professional licensure and certification processes

OVERVIEW

Efforts to address Colorado's health care workforce shortage are hindered by a lack of reliable and available data. While the Colorado Department of Regulatory Agencies (DORA) collects much important information as part of the licensing process, it does not capture all the data necessary for painting a comprehensive picture of Colorado's health care workforce (i.e., demographic characteristics, practice location, whether a provider is actively practicing full-time or part-time, etc.). This is because such data are germane to determining whether an individual is qualified to be licensed as a health care professional. Accordingly, efforts to capture more detailed information rely on voluntary surveys of the health care workforce in Colorado. As a result, the state is missing an important opportunity to leverage existing resources and processes to better inform public policy by tracking health professions workforce needs and projections over time.

By far the most efficient and effective way to get timely health care workforce data that can be trended over time would be to use the licensure renewal process. DORA, as the entity responsible for regulating health care professionals, reviews provider license and certification applications, keeps records of individual professionals practicing in the state, and issues renewals of provider licenses and certifications. To fulfill these responsibilities, DORA maintains contact with regulated health professionals in Colorado – all of whom must renew certifications and licenses on a continuing and frequent basis.

The Michael Skolnik Transparency Acts of 2008 and 2010 expanded the amount and type of data that DORA collects on health care professionals – establishing a precedent for the agency to collect data

that are not required for licensure but serves other public policy purposes. That development, combined with the fact that DORA is in the process of building a new licensing database, makes the present an opportune time to refine the type of data that are collected through the licensure process.

POLICY RECOMMENDATION ON HEALTH PROFESSIONS DATA

1.A Require collection of additional workforce data for all regulated health care professions as part of the health care professional licensing process in Colorado, and work with DORA to make such collected data available for research and analysis while taking health care professionals' privacy and confidentiality into consideration.

DISCUSSION

In order to understand the nature and location of the gaps in Colorado's current health care workforce, we need robust and timely data on geographic distribution, percentage of actively practicing providers, the type of work in which licensees are engaged, specialty/population focus, and related information. The Collaborative will work with DORA to determine the best vehicle for collecting such information and ensuring that it is readily searchable and appropriately accessible.

2. Enact policies to support adequate reimbursement and control practice costs

OVERVIEW

Reimbursement issues related to primary care providers are currently problematic – especially in light of the impact of federal health care reform. In tough economic times, cutting provider fees may appear to policymakers to be the easiest among difficult policy options to balance the state budget. However, adequately funding primary care is one of the wisest investments the state can make in ensuring the health of the population.

In the case of physicians, primary care specialties earn a fraction of other physician specialties. A study published in 2008 in the *Journal of the American Medical Association* found that as few as 2% of medical graduates choose to pursue general internal medicine.⁹ Reimbursement levels must be maintained – indeed, increased – to maintain the viability of primary care practices and to attract new physicians to primary care. Federal health care reform legislation will improve Medicare reimbursement levels for primary care physicians, but the increase in payments is only a temporary patch to a larger problem.

Physician assistants (PAs) and advance practice nurses (APNs) are integral to the provision of quality primary care services and they are essential to providing adequate and affordable access to health care. The benefits provided by such providers have been well documented, yet many are not being utilized to their fullest potential in many settings in Colorado. This not only affects these professionals but also has a negative impact on health care quality, cost and access for all Coloradans.¹⁰ In recent years, Colorado policymakers have begun to address the issue through a thorough scope of practice review of APNs. Resulting scope-of-practice clarifications have benefitted APNs in the state, but there are a number of outstanding issues and barriers that still impede their ability to participate as primary care providers in Colorado who practice at the top of their scope as defined by their professional licenses.

Increased costs to primary care practices also threaten their viability. Implementation of electronic health records, filling out required paperwork for multiple payers, and medical liability insurance, both for physicians and APNs, are all significant costs. If, for example, caps on damages in malpractice cases were increased, the cost of insurance would also, placing additional financial burdens on providers.¹¹

POLICY RECOMMENDATIONS ON ADEQUATE REIMBURSEMENT AND CONTROLLING PRACTICE COSTS

- 2.A *Make reimbursement to primary care providers a top priority in the state budgeting process, avoid additional cuts, and restore the cuts to previous levels. Reimbursement levels for primary care providers are currently at such low levels that they already threaten access to care for the publicly insured and the viability of many practice settings.*
- 2.B *Ensure that the implementation of HB 10-1330, the All-Payer Claims Database, includes disclosure and reporting of reimbursement policies to ensure they are based on fair and reasonable criteria for all providers. One opportunity to accomplish this recommendation is to work with the Advisory Committee established by the Act.*
- 2.C *Maintain or improve the current tort environment so that liability insurance costs to providers are contained.*
- 2.D *Mitigate the additional practice costs associated with payer requirements, quality improvement and patient safety programs.*
- 2.E *Support development of new payment models that encourage greater access, reduce waste, and recognize the value of primary care services across provider types, and help implement coordinated and integrated care.*

DISCUSSION

Reimbursement for primary care providers – whether physicians, APNs, PAs, dentists, dental hygienists or behavioral health providers – is currently very low; further cuts could be harmful not only to efforts to sustain and build a quality workforce, but also to the public’s ability to seek and receive the health care it needs. While the Collaborative recognizes the severe state budget crisis, it urges the General Assembly and Governor to refrain from further cutting reimbursement rates to primary care providers. Further cuts could have the foreseeable effect of reducing the number of primary care providers and exacerbating the problem of attracting new professionals to primary care.

Policy intervention 2.B seeks to address a concern articulated in the Governor’s Collaborative Scopes of Care Advisory Committee, as a result of a comprehensive study completed in December 2008. Colorado statute indicates that an insurance company shall not be precluded from setting different fee schedules for different services performed by different health professionals, but that the same fee schedule shall be used for those health services that are substantially identical although performed by different professionals.¹² The State of Colorado reimburses all licensed health care providers at the same rate for the same services provided under the Medicaid program. However, based on anecdotal information collected from private payers by the Collaborative Scopes of Care Advisory Committee, the requirement for equal payment does not appear to be uniformly practiced among all private payers.

On May 26, 2010, Governor Bill Ritter signed into law HB10-1330, which provides for the development of the All-Payer Claims Database, administered by the Colorado Department of Health Care Policy and Financing (HCPF). An advisory committee was appointed to develop recommendations, including suggestions for addressing reimbursement rate disclosure by insurers. The creation of the database is contingent on securing private funds.

The All-Payer Claims Database could be used by stakeholders to achieve transparent public reporting of health care information, including services billed by a physician and incident to a physician. The All-Payer Claims Database also provides an opportunity to capture more providers through claims data.

The Collaborative would like to see the database collect information from health care providers billing for services under the physician or “incident to a physician.” Currently services provided by providers other than physicians are not captured separately because they fall under the physician billing. The Collaborative will monitor the progress of and offer input to HCPF and the appointed advisory committee to ensure the disclosure of reimbursement policies and other relevant issues are adequately addressed.

Enacting policy interventions 2.A and 2.B would contribute to the overall goal of alleviating the shortage of primary care providers in Colorado by 2025 by addressing reimbursement issues for primary care providers. Protecting reimbursement levels from further cuts will help ensure that these health care providers can continue to serve health care consumers. Requiring health plans and other payers to report their reimbursement policies and practices through the All-Payer Claims Database would assist the state in ensuring these providers are adequately and equitably reimbursed according to current state law and allow the state to take action against insurers that are not in compliance.

Recommendation 2.C seeks to contain the cost of liability insurance, which represents a major expense for primary care providers. While Colorado is considered to have one of the more stable tort environments among the states, there are frequent attempts by certain advocacy groups to raise the damage caps through the Legislature, which would increase costs. Over the long-term the state should substantially reform its system to better serve consumers and providers, but in the meantime stability in the current system should be maintained.

Along with cost containment related to liability insurance, primary care providers struggle with additional practice costs related to payer requirements, quality improvement and patient safety programs. Payers have different types of billing and coding requirements that often demand costly education, training and billing systems. As practices move to electronic health records, the upfront capital investment, ongoing maintenance and short-term productivity loss all result in large initial costs to practices.¹³ It is hoped that implementation of HB10-1332, the Medical Clean Claims Act, will address some of these coding and billing concerns.

Many of the costs related to billing and coding requirements are directly mandated and others, such as electronic health records, are required for practice maintenance and patient safety measures. The Colorado Regional Health Information Organization (CORHIO), a nonprofit for improving health care in Colorado through health information exchange (HIE), and the Center for Improving Value in Health Care (CIVHC) may be helpful partners for mitigating some of these challenging practice costs. However, the Collaborative requests the Legislature’s consideration of these challenges as policies related to coding, billing, quality improvement and patient safety are developed.

Reimbursement policies are only part of a larger systemic set of issues in health care delivery and financing that must be addressed as the number of people with health insurance increases. Health care costs in the United States are driven, in part, by the predominate fee-for-service reimbursement system. When a provider is reimbursed per service provided, the economic incentive is to provide more services. As new payment systems are implemented, there will be impacts on workforce that should be carefully evaluated.

A large portion of the care provided by primary care clinicians involves care coordination between multiple providers and organizations. The need for care coordination will continue to grow with the aging of the population and the increasing prevalence of chronic disease. Yet, in most cases, care coordination services are not consistently or reasonably reimbursed.

New models of payment – including bundled payments, global payments to Accountable Care Organizations, enhanced reimbursement to medical homes, care management payments and payment in recognition of quality and patient centeredness – hold the promise of providing incentives for better, more cost-effective care.

If policy goals are to include realizing the most health per health care dollar spent, then attention must be paid to aligning the incentives of all participants in the health care enterprise. The Collaborative is working in tandem with the CIVHC, which was created to identify and advance initiatives across the state that enhance consumers' health care experiences, contain costs and improve the health of Coloradans by creating an efficient, high-quality and transparent health care system.

3. Increase public funding for health professions education programs

OVERVIEW

To alleviate the shortage of primary care providers and nurses, Colorado will need to recruit or educate a significant number of health professionals *in addition* to its baseline of projected graduates and the current number of providers practicing in the state. One of the most effective means of increasing the number of health care providers in Colorado is to “grow our own,” meaning Colorado could educate more health professionals in-state to increase the likelihood that they will remain after graduation.¹⁴ Colorado also should focus on educating more state residents, particularly those from rural areas, because they would be more likely to stay in Colorado and practice primary care.¹⁵ Faculty limitations and shortages in the state's health professions education programs must be addressed in order to accomplish this goal.

Unfortunately, the current economic downturn has aggravated the state's already severe higher education funding shortage. Instead of expanding or offering more incentives, schools have been forced to raise tuition and consider limiting capacity, cutting financial aid or taking other measures to meet financial needs. While Collaborative members understand that it would be unlikely that funding for health professions education programs could be increased in 2011, they raise this as a priority issue because education funding is fundamentally important to training the professionals necessary to alleviate an impending shortage.

POLICY RECOMMENDATIONS ON FUNDING FOR HEALTH PROFESSIONS EDUCATION

- 3.A *The Legislature should look for new sources of revenue for health professions education funding separate from general higher education funding. The current level of funding, and the process by which higher education funds are allocated for health professions, is not adequate to meet current or future workforce needs.*
- 3.B *Create a legislative interim task force, consisting of members of the Colorado State Senate and House of Representatives, and charge its members to work with relevant state departments, institutions of higher education and other key stakeholders to examine the issue of health professions education program funding within the state budget appropriations for secondary and higher education.*

Among the funding issues this task force could examine and consider expanding are:

- *programs that encourage Colorado students from middle school through twelfth grade to consider the possibilities offered by a career in the health professions by exposing them to the field and preparing them to be successful in math, science and technology curricula;*
- *programs offering post-secondary certificates and associate degrees in the health professions;*

- *higher education programs offering four-year degrees in the health professions;*
- *programs to diversify the health care professions workforce, especially regarding race and ethnicity;*
- *graduate and professional school programs in the health care fields;*
- *clinical placements, preceptors and other training programs for health professions students;*
- *loan repayment and scholarship programs for health professions students serving in priority areas;*
- *residencies and other post-graduate training programs for advanced health professionals; and*
- *loan repayment and other financial incentives for health professions faculty, clinical placement instructors, preceptors and other clinical providers who are responsible for educating Colorado's health professions workforce; and*
- *behavioral health education mandates to require education and training settings for primary care providers.*

This task force should issue a report of its findings and make recommendations and/or draft legislation as appropriate to ensure that health professions education programs are adequately funded to meet current and future demands on Colorado's health professions workforce.

The legislative interim task force also should share its findings with the Governor's Office and the Colorado Department of Higher Education as the department completes and implements its statewide strategic planning effort to determine the future direction of the state higher education system.

3.C Increase salaries for health professions faculty at public schools to alleviate large gaps between what a provider could make as a clinician compared with earning power as a teacher.

DISCUSSION

Because budget challenges are anticipated to severely affect policymakers' ability to increase or even preserve higher education funding levels in the 2011 legislative session, the Collaborative recommends that the Legislature commit to studying these issues and crafting strategies to address funding levels. Although Collaborative members stress the importance of increasing funding for health professions education programs and understand that this is the single most effective intervention in ensuring an adequate number of health professionals in the future, they understand current constraints and recommend that policymakers, at the least, undertake a thorough examination of this issue and its implications and begin planning for potential solutions and future interventions. This will raise awareness about the importance of the state's health professions education programs and educate policymakers and the broader public about the projected needs and the best strategies to meet them.

Policy recommendation 3.C is based, in part, on recommendations from the Governor's Nurse Workforce and Patient Care Task Force, which released its full report in December 2007.¹⁶ Attracting and retaining high quality nursing faculty is essential to the state's future ability to prepare talented and dedicated nurses and who will provide access to health for all Coloradans. The task force found that nursing educators in Colorado are affected by two wage gaps – the difference between academic and clinical salaries, and also the gap between academic salaries in Colorado and nationally. A Colorado Center for Nursing Excellence study showed that in Colorado, faculty compensation ranges from one-third to two times lower than clinical salaries.¹⁷ Further, at the time of the study Colorado ranked 26th in the nation for salaries for nurses with PhD degrees and 25th in the nation for non-doctoral nurse faculty salaries at four-year schools.¹⁸ Faculty salaries at community colleges are even more challenging.

In 2009-2010, the Colorado Health Institute, in collaboration with the Colorado Center for Nursing Excellence, conducted a survey to collect data on Colorado's nurse faculty workforce. Survey findings show that 23% of respondents intend to retire their faculty positions by 2015 and an additional 24% intend to retire their faculty positions by 2020.¹⁹ Of those planning to retire in the next 1-2 years, more than 72% said an increased salary would be the best strategy to defer retirement.²⁰ The top two reasons nursing faculty reported dissatisfaction with their faculty positions were salary and benefits, respectively; improvements in salaries and benefits, along with financial support, loan forgiveness and tuition assistance were the top suggestions for addressing recruitment and retention of nurse faculty.

Physician's Assistant (PA) programs also face extreme difficulty in recruiting faculty due to the salary discrepancy between clinical and academic positions (\$20,000-\$50,000 per year), as well as the overall shortage of PA faculty nationwide. PA program expansion has increased significantly in the last 10 years, which has led to a significant shortage in available PA faculty. The PA profession is noted by the Bureau of Labor Statistics as one of the fastest growing health professions in the country²¹; therefore, the increased demand and shortage of faculty is not likely to change in the near future.

The Collaborative understands the current budget challenges facing the state and urges policymakers to address this critical funding issue as soon as possible.

4. Protect current funding allocated to loan repayment and optimize effectiveness of loan programs

OVERVIEW

Health professions students are increasingly reluctant to enter into primary care practice, and many attribute this trend to the confluence of high levels of educational debt and relatively low earning potential in primary care practice. The reluctance of health professions students to enter into this field has contributed to the statewide shortage of primary care providers that is particularly stark in rural and underserved communities which must overcome unique challenges in providing access to health care services.

Providing incentives to primary care professionals in the form of loan repayment and special tax credits has been shown to encourage service in rural and underserved areas. Programs such as the National Health Service Corps recruit recent graduates to primary care settings and underserved areas through a promise of educational loan repayment in return for two or more years of dedicated service. Similarly, The Colorado Health Service Corps, administered by the Primary Care Office at the Colorado Department of Public Health and Environment (CDPHE), also forgives student loans of providers practicing in an urban or rural Health Professional Shortage Area in exchange for two or three years of service. In addition, there is a State Dental Loan Repayment Program, administered by the Oral Health Unit at CDPHE, directing loan repayment to encourage service to publicly insured and uninsured populations. Finally, The Colorado Rural Health Center administers the Colorado Rural Outreach Program (CROP), for all health professionals in the rural areas of the state, with a specific focus on loan repayment and other incentives for retention of health care providers.

Just as there are barriers to recruiting health professions students into primary care practice, barriers are also present in the recruitment and retention of primary care and nursing faculty due to high levels of educational debt and low earnings potential, when compared to clinical practice. Both clinical professionals and faculty are needed in the pipeline to provide the workforce necessary to serve Colorado, and adequately funded loan repayment programs for both clinical practitioners and faculty are valuable tools to address the shortages.

POLICY RECOMMENDATION ON LOAN PROGRAMS

4.A *Increase state funding for loan repayment programs.*

Background

Passed in the 2010 legislative session, HB 1138 rebranded the State Health Care Professional Loan Repayment Program as the Colorado Health Service Corps, exempted the program from certain State procurement rules, and allowed for regular reporting to the Governor and Legislature about the effectiveness of provider incentive programs. The Colorado Health Service Corps Advisory Council, the entity determining loan repayment award decisions for the program, was expanded by five seats to allow for representation of mental and oral health professions, advance practice nursing, a philanthropic organization interested in the needs of medically underserved populations, and an economic development organization. Additionally, dentists and dental hygienists are now eligible to apply for loan repayment through the program. Federal health care reform also served to strengthen the Colorado Health Service Corps through a provision in the Patient Protection and Affordable Care Act which stated that all state administered loan repayment programs of this type are tax exempt. As a result, the funds in Colorado's program are far less constrained by the stringent eligibility criteria that was previously required with the use of federal dollars. Consequently, the Colorado Health Service Corps is more attractive to private foundations that now may wish to channel their existing loan repayment dollars through the program for a tax-free benefit for their recipients.

The Colorado Loan Incentive for Teachers of Nursing (LIFT Nursing) program eligibility was expanded through HB 10-058 to allow half time faculty to apply, in addition to full-time faculty. Eligible applicants may now apply four years after completion of an advanced nursing degree. Both clinical and classroom instructors are eligible. These state level policy changes were developed and implemented with the strong support of the Collaborative.

DISCUSSION

As mentioned previously, financial disincentives prevent a number of health care professionals and health professions students from entering into the primary care and nursing fields, which has contributed significantly to the statewide shortage of primary care and nursing providers. Loan repayment programs can counteract those disincentives and encourage professionals to serve where they are most needed. For example, a strong state loan repayment program can be used to incentivize providers to practice in desired settings, such as integrated care settings that provide both primary care and behavioral health care.

Every increased investment in state loan forgiveness programs has the direct effect of increasing the number of health care professionals placed in rural and underserved areas for a minimum of two years. Based on the average award granted through one such program in 2008, every \$30,000 of additional investment provides an additional health care provider in an underserved area of Colorado. This ratio could be more impactful for non-physician providers, because they tend to have less educational debt and therefore require less investment to repay outstanding loans.

In addition to providing educational loan repayment programs, the National Health Service Corps also provides a scholarship program for students in training to become primary care physicians, dentists, dental hygienists, nurse practitioners, certified nurse-midwives or physician assistants in exchange for service in areas of need. The Colorado Health Service Corps could be expanded to include scholarships in a similar fashion to the National Health Service Corps. This could be impactful for Colorado communities "growing our own" health care professionals.

Just as strong educational loan repayment programs are useful tools to encourage providers to serve where they are needed, such programs may also provide needed incentives to support the recruitment and retention of faculty to educate future providers. The difficulties surrounding the recruitment and retention of nursing and PA faculty, referenced in policy recommendation 3.C, could be alleviated in part by addressing loan repayment for faculty. For example, loan repayment for PA faculty might increase the ability to recruit and retain clinical teachers for students in the clinical setting if the eligibility included potential for a half time commitment, similar to the Colorado LIFT program for nurse faculty.

5. Support policies to increase number of clinical experiences and residencies

OVERVIEW

Research studies indicate that physicians are more likely than not to practice in the state in which they complete their residency training or fellowship, with generalist physicians being even more likely than specialists to remain.²² The likelihood that physicians remain in the state of their training programs is also strongest in those states that train smaller numbers of physicians compared to their populations and in contrast with other states with more robust medical education systems. For example, data collected by the Colorado Commission on Family Medicine show that while 85% to 90% of the 198 residents annually training in Colorado's Family Medicine residencies are graduates of medical schools outside of the state, usually at least 65% practice in Colorado after graduation, with at least 30% of these opting for a rural or underserved urban community in Colorado. These factors help to build a case for increased investment in Colorado's ability to train more primary care physicians and nurses, as well as other health care professionals, since they will be likely to settle in Colorado to practice once their education is complete.

POLICY RECOMMENDATIONS ON RESIDENCIES AND CLINICAL TRAINING

- 5.A *The Governor and members of the state General Assembly should encourage Colorado's congressional delegation to support measures that will increase the state's ability to train more primary care physicians through increased funding and more flexible parameters.*
- 5.B *Support funding and programs that encourage health care providers to offer experiential/clinical learning opportunities for all health disciplines, and support electronic platforms and clearinghouses that ease the burdens of health care providers and educational facilities for securing opportunities for clinical education.*

DISCUSSION

Not all components of health care workforce education can be taught from a book or through distance learning. Clinical experiences are essential to preparing future health care providers, and all types of provider facilitates should offer their patient setting to help prepare the next generation of health care providers.

The federal government funds a significant portion of physician residency training expenses through Graduate Medical Education (GME) payments from Medicare.²³ No other disciplines have residencies supported by the federal government, except for pastoral care residencies. The other major contributors to physician residencies are the hospitals sponsoring the residencies. The Balanced Budget Act of 1997 capped the number of resident slots funded through Medicare. Furthermore, Federal statutes require that payments be made to the hospitals operating residency training. Although there are some measures of flexibility, especially for rural areas and primary care specialties, these exceptions fall short of meeting the current and increasing demand for primary care physicians. The recently enacted *Patient Protection and Affordable Care Act* provides additional funding for primary

care residency training but is time-limited, in the form of grants, and is not adequate to fund this training. Federal reform did not expand Medicare-funded positions for GME, however it did direct 65% of unused slots to be redistributed mainly to primary care and general surgery programs. While it is hoped that Colorado will benefit from this redistribution, such rearrangement is not likely to satisfy the need for increased flexibility and funding to appropriately adapt to changes in the local workforce.

The Collaborative supports national and state organizations in calling for increased financial support for training primary care physicians, advanced practice nurses, physician assistants, oral health, and behavioral health professionals. Such support could come through an expansion of GME payments and other targeted educational funding that would help increase the number of primary care providers in training.

Because advocating for increased state funding for primary care clinical training opportunities would be extremely difficult in the midst of a budget crisis, the Collaborative instead recommends that the Governor and Legislature encourage their federal counterparts to address funding issues related to GME and consider expanding Colorado's ability to train more primary care providers in-state through other federally funded programs, with the expectation that many of those providers will elect to practice in the state.

Clinical education is an important part of a health care worker's educational program. From nursing to occupational therapy, pharmacy or any other professional providing health care services, experiential clinical learning provides future professionals with hands-on experience and opportunities for critical analysis of care delivery issues. Experiential education gives greater meaning to the didactic curriculum and helps develop well-rounded health care professionals. Furthermore, clinical education experiences provide opportunities for health professionals to gain greater insight into the health care system and provide a practical framework for developing professional responsibility.

ADDITIONAL PRIORITY ISSUES

In addition to the issues above for which the Collaborative crafted recommendations, it also reviewed and discussed other issues that have a profound impact on whether Colorado will have the health care workforce it needs. The most critical are ensuring the availability of clinical training opportunities and larger system reforms, including delivery system and payment reforms.

Clinical Training Opportunities

The inter-professional members of the Collaborative have identified the availability of clinical training placement sites and preceptors (licensed health professionals who provide clinical education to students in their area of expertise) as a limiting factor to educating additional professionals. However, this is a complex issue and no single programmatic or public policy approach has arisen as a favored way forward. Moreover, some Collaborative members are uncertain if the challenges of clinical placements should be addressed through public policy or private approaches. Resolving these issues will be a priority for next year's work.

System Reforms Affect Provision of Primary Care

With the passage of federal health care reform in 2010, pilot and demonstration projects will be implemented to test new ways in which health care is delivered and reimbursed. Medicare payments to primary care physicians and those performing psychotherapy services were increased through federal reform, and new coverage requirements for preventive care are improved in Medicaid, Medicare and

private insurance. Beginning in 2010, health plans are now required to provide a minimum level of coverage without cost-sharing for preventive services such as immunizations, preventive care for infants, children and adolescents, and other preventive care and screenings for women.

While health care reform did not result in a complete systemic overhaul, the legislation did authorize some pilot changes to the current reimbursement system to move away from a fee-for-service model and toward paying for performance or reimbursing for whole episodes of care. Medicare is now authorized to contract with accountable care organizations (ACOs) to provide care for enrollees. Additionally, broader roles for community health clinics, coupled with increased funding for the National Health Service Corps, allow for an expansion of these services in underserved communities. The federal legislation also established several demonstration programs and a Medicaid state option to test patient-centered medical home models. More broadly, these experiments involving new delivery models such as medical homes will change reimbursement incentives to reorient primary care towards preventive services and chronic care management. Many involved in the health care delivery system continue to suggest that reforms around the role of primary care are central to broader efforts to expand access to health care and improve quality across the system.

While the Collaborative has not developed its own recommendations on delivery system or payment reforms, changes to these areas have a profound impact on health care workforce. The Collaborative has established communication with state entities – most notably CIVHC – to ensure that a strong workforce perspective is represented during these discussions

CONCLUSION

In recognition of the extraordinary economic strain on the state budget, Collaborative members have prioritized immediate policy interventions that require little or no state money. These can and should be implemented in 2011. However, when the state's economic conditions improve it will be necessary for the state to focus even more concretely on the needs of an aging health care workforce that is shrinking relative to the state's population. Today's state leaders must resist the temptation to delay action on this long-term problem – the brunt of which will fall on their successors if action is not taken now.

Ensuring that Colorado will have the health care workforce it needs requires solutions that are complex, expensive and long-term. The actions that are required span multiple state departments – including Public Health and Environment, Health Care Policy and Finance, Regulatory Affairs, Higher Education, Labor and Employment, and Education. Strong leadership is needed to coordinate solutions and ensure effective action. The Collaborative stands ready to support the state's public officials as they seek to secure the health and safety of our state by ensuring adequate access to quality health care for Colorado residents now and in the future.

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- ¹⁰ For more information on the quality of care provided by non-physician health care professionals and the barriers that currently restrict their ability to provide care, see the *Colorado Collaborative Scopes of Care Study*, commissioned through Executive Order by Governor Bill Ritter, Jr., and conducted by the Colorado Health Institute: <http://coloradohealthinstitute.org/resourceHotissues/hotissuesViewItemFull.aspx?theItemID=43>
- ¹¹ Colorado Strategies, *Primary Care in Colorado: A discussion of Major Trends and Issues*, July, 2010.
- ¹² Colorado Revised Statute 10-16-104. "(7) **Reimbursement of providers.** (a) **Sickness and accident insurance.** (I) (A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. Nothing in this part 1 or parts 2 or 5 of this article shall preclude an insurance company from setting different fee schedules in an insurance policy for different services performed by different professions, but the same fee schedule shall be used for those portions of health services that are substantially identical although performed by different professions."
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- ²² Overall, 51 percent of physicians are practicing in the state in which they obtained their graduate medical education. Generalist physicians are more likely than specialists to remain in their state of graduate medical education (odds ratio 1.36). Also, there is a negative association between the number of physicians in training per capita in a state and the likelihood of a physician remaining in the state to practice – in other words, states like Colorado that train a relatively small number of physicians in comparison with other states have a higher likelihood of retaining more of those physicians after their education is complete (ratio of 0.90 to 0.91, for an increment in resident supply of 10 per 100,000 population). Seifer, Sarena D., Karen Vranizan, MA, and Kevin Grumbach, MD. “Graduate Medical Education and Physician Practice Location: Implications for Physician Workforce Policy.” *Journal of the American Medical Association*. 274(9):685-691; 1995.
- ²³ In addition to Medicare GME payments, there are two other less-significant sources of funding for residency programs. First, individual states can elect to make a state appropriation for GME through their Medicaid programs, which can receive an enhanced match from the federal government. An additional but indirect source of funding for GME comes through federal government Disproportionate Share Hospital (DSH) payments. Because having residents on staff allows hospitals to serve more publicly insured and uninsured patients, hospitals may be able to increase their DSH reimbursement through this expanded service and therefore increase the facility’s bottom line and future ability to train more residents.