# Health Innovation Summit

UTAH SOLUTIONS FOR A HEALTHY ECONOMY AND COMMUNITY

## What Are Utah's Health Workforce Needs for the Future?

Moderator: David Squire, Executive Director, Utah Medical Education Council
Session Manager: Marc Babitz, MD, Division Director, Family and Health and Preparedness, UDOH

## Summary

The work panel session "What Are Utah's Health Care Workforce Needs for the Future?" is focused on developing innovative solutions to preparing tomorrow's health workforce. The panel is comprised of twenty one members representing various aspects of healthcare workforce development, the moderator and the session manager. A list of the panel members is provided in **Appendix A: Taskforce Panel Members**. Panelists were provided with a white paper broadly addressing the factors influencing workforce development and a list of articles to explore prior to the session. (See **Appendix B: White Paper & Articles to Explore**)

The session is structured to encourage open discussion on healthcare workforce needs of the future and included a networking break. Some of the major concepts that evolved during this discussion were clinical training opportunities, barriers, and alternatives for professionals; patient centered health care teams – training development and barriers; promoting healthcare as a career option and developing a workforce pipeline; primary care workforce development and incentives for the same; focus on preventive care and public health; workforce assessment; and workforce diversity.

Participants were requested to identify two or more workforce development related issues/ideas that are important to them based on the discussion. These issues/ideas were then prioritized based on frequency and will be used to guide the panel in developing actionable strategies. Issues/ideas listed by three or more participants are **workforce needs assessment, healthcare teams, reimbursement and incentive issues, primary and preventive care focus, cost of training and funding for the same, and regulatory barriers** impacting the development of workforce in Utah. A complete list of issues identified is included in **Appendix C: Panelist Issues and Ideas**.

### Workforce Needs Assessment

The primary issue that was brought up by the most panelists was workforce assessment, specifically data accuracy and sharing. Accurate data, in this context, include data that are current and reflect reality. It is important to know who is actually providing care in the state, who is retiring, working part-time, or coming in temporarily from out-of-state, etc. Changing demographics need to be tracked in order to predict the workforce needs. While the Utah Medical Education Council (UMEC) has information for professionally licensed individuals, it is limited to health care professions that require a graduate level education. The Department of Workforce Services (DWS) also collects regional data about the healthcare industry, but they are restricted to using a federal structure, which may not serve the need to project our workforce requirements accurately. The Division of Occupational and Professional Licensure (DOPL) on the other hand collects licensure data that does not reflect the reality of practicing professionals accurately (e.g.

lacks specialty information, practice characteristics etc.). Most importantly, data sharing among various organizations that collect different aspects of health care workforce information is vital to improve efficiencies of our existing information infrastructure.

**Health Care Teams**

Interdisciplinary training models need to be incorporated into our healthcare education system, and should not be pursued only after all formal training of our professionals is completed. Accreditation and program models need to change, which is often difficult. Technological advances like simulation techniques should be employed efficiently in our training modules, followed by training in clinical settings. Team based training will also avoid turf wars, and competition for clinical rotation opportunities.

In addition, it is important to help the various health professionals (physician assistants, nurses etc.) practice to the full extent of their training and scope. Suggestions that were made to encourage utilization of all the professionals are 1) reminding them that they are interdependent; 2) avoiding turf battles; and 3) removing barriers for professionals so they can provide care to the full extent of their scope.

**Reimbursement & Incentives**

Payment models are a barrier to developing an effective workforce. Many providers will not provide services to the underserved because they have no financial incentive to do so. Even technological advances like tele-health are underutilized primarily because of reimbursement restrictions despite the cost saving that could be realized.

**Primary & Preventive Care Focus**

Access to primary care has been proven to be a cost-effective approach to health care. To realize these advantages, Utah should expand its primary care workforce. While expanding training programs and residencies is a likely way to strengthen our primary care workforce, many students opt for specialties other than primary care in their career choices. The incentives/motivations for going into primary care need to be considered and addressed. Primarily, reimbursement for primary care providers must be strengthened and a "pay for value" approach should be encouraged.

Our healthcare system must be patient centered and focus on prevention and wellness. The patient is central to a better health care system – both in treatment options and costs of treatment. More tests and expensive treatments are not necessarily better. Public health needs to be incorporated as a focal point in our educational and training programs. We do not need providers to perform more surgeries; we need to keep people from needing surgery.

**Funding/ Cost of Training/ Loan Reimbursement**

The high costs and lack of funding for educational programs have a strong impact on the practice choices of providers – both in terms of practice specialties and geographic distribution. Strategies like loan reimbursement or increased funding for training opportunities need to be explored.

**Regulatory Barriers**

Inter-agency, intra-agency, and government enforced rules and regulations prevent change from the status quo. Accreditation requirements limit clinical training and team-based education opportunities in health care, while practice rules and codes limit providers from practicing to the full extent of their scope.

Panelists suggested that maintaining a robust group of primary care clinicians, providing financial incentives to help motivate students to choose primary care, team-based care, and efficient and effective use of technological advancements were some of the strategies proposed to maintain health care quality while reducing the associated costs.

Panelists also agreed that targeting K-12 students is vital to develop a health care workforce pipeline for our state. This is an opportunity to not only ensure a future workforce, but also to increase diversity of the workforce to meet the needs of the changing demographics of our state.

Some of the major concepts developed in this session (workforce assessment, pipeline development, educational capacity development, faculty development, recruitment and retention incentives, and reimbursement reform) were outlined in the Health Workforce Issues White Paper developed by the Utah Department of Health's (UDOH) Healthcare Workforce Group (See **Appendix D: UDOH Health Workforce Issues White Paper**) suggesting that Utah is on the right track when it comes to healthcare workforce development. The discussion in this workforce needs session adds to the list already identified by the UDOH.

The condensed list of issues (Appendix C: Panelist Issues and Ideas) and the UDOH's white paper (Appendix D: UDOH Health Workforce Issues White Paper) could be used as tools to take this session's discussions to the next level – actionable strategies to address the health workforce needs of Utah for the future.

## Appendix A: Taskforce Panel Members

- David Squire – Utah Medical Education Council, Moderator
- Marc Babitz – Utah Department of Health, Session Manager
- Bob Bunnell – Utah Academy of Physician Assistants
- Bob Jex (for Peter Taillac) – Utah Department of Health
- Carrie Mayne – Department of Workforce Services
- David Tiejen – Argosy University
- Dennis Moser – Utah Center for Rural Health
- Dirk Anjeneiden – Utah Health Care Association
- Doug Thomas – Division of Substance Abuse and Mental Health
- Jennifer Lloyd – Association of Utah Community Health
- John Nelson – Leavitt Partners
- Linda Leckman – Intermountain Healthcare
- Loredine Harper – Salt Lake Community College
- Luz Robles – State Representative
- Marilyn Mariani – Lakeview Hospital, Utah Organization of Nurse Leaders
- Mark Munger – University of Utah, School of Pharmacy
- Mark Stoddard – Central Valley Medical Center, Board of Regents
- Maureen Keefe – University of Utah College of Nursing, Utah Action Coalition for Health
- Michael Benson – Utah System of Higher Education
- Renee Coffman – Roseman University of Health Sciences, Dental School
- Rhonda Menlove – State Representative
- Scott Theurer – General Practice Dentist, Utah Dental Association
- Wayne Samuelson – University of Utah

## Appendix B: White Paper & Articles to Explore

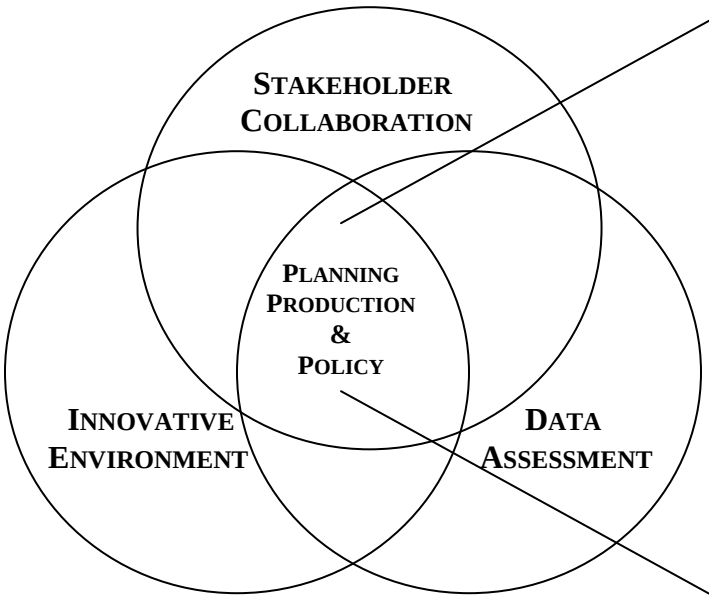
### What Are Utah's Health Workforce Needs for the Future?

Moderator/White Paper Author: David Squire, Executive Director, Utah Medical Education Council
Session Manager: Marc Babitz, MD, Division Director, Family and Health and Preparedness, UDOH

Across the United States, including the state of Utah, there is a shortage of healthcare professionals in acute care, primary care, long-term care, and public health care. Further complicating the shortage is an inequitable geographic distribution of healthcare workers. There are not enough healthcare professionals to provide every citizen access to affordable adequate quality healthcare.

Access to healthcare services is a function of availability of healthcare professionals, i.e. supply and demand. Several key factors affect access to healthcare professionals. Population growth overall is inevitable and will continue to exacerbate the healthcare shortage problem. However, the rapid growth in both elderly and minority populations are of particular concern, both nationally and locally. Other factors will continue to influence the level of healthcare access.

Technology development will continue to increase demand for healthcare but might also change the site in which healthcare is received. Costs associated with healthcare will continue to be a major factor influencing demand and location of services. Governmental policies, at all levels (federal, state, and local), will continue to play a larger role in healthcare workforce production as supply and demand varies over time.




Workforce production policies must include the following key factors:

1. Assessment
    a. Demand
    b. Supply
2. Production
    a. Students
    b. Faculty
    c. Institutional Accreditation
    d. Infrastructure
        i. Educational
        ii. Clinical
3. Financing
    a. Payer's (individuals or third party)
    b. Trainees
    c. Educators
    d. Providers
        i. Clinicians
        ii. Facilities
            1. Hospitals
            2. Clinics

In order to develop a rational healthcare workforce production policy plan, there needs to be an environment in which healthcare workforce assessment, collaboration, and innovation can thrive.

## What is Utah's Health Workforce Need/Demand for the Future?

**I. Assessment**

How many health care providers are enough for Utah's population? How do we obtain good information to make decisions? It is difficult to make any workforce decisions if we do not know the current capacity, including both healthcare delivery and education. There is some collaboration between organizations concerning health workforce data, but it rarely crosses public-private boundaries.

Primary question: Does Utah have an appropriate/ adequate health care workforce now?

Issues to consider:

A. Availability of information and data
B. Data sharing (e.g., All-Payer Database, UMEC)

**II. Demand**

Utah has always had a healthy population compared to the rest of the nation (Utah's Health: An Annual Review 2010), but we need to invest resources to maintain and improve the health workforce. Utah has had one of the fastest growing populations in the U.S. for many years, and it is also aging. While the State's residents are healthier than the nation in some respects, there are still areas of concern (e.g. diabetes, long-term/hospice care, cardio-thoracic surgery, etc.). In relation to an aging population, many of the current health care workers will retire in the near future. In addition, changes in the economy have a direct influence on the demand for health care services.

Utah tends to have fewer health care professionals for its population than the national average. This could be both positive and negative. It is possible that Utah has a healthy population and the healthcare delivery methods utilized in the State are more efficient than in other areas of the country. However, it is also possible that some portion of the population is not receiving health care according to their needs.

Primary question: What is need and how do you define it?

Issues to consider:

A. Should the State assure a minimum level of care?
    1. Should workforce be based on ability to pay?
    2. Should access be based on urgency or preventative basis? Balance?
B. Do longer wait times improve/diminish efficiencies?
C. Number/mix of different professionals

**III. Supply**

Many sources are predicting an overall physician shortage with recommendations to increase both medical school slots and residencies. But, physician supply is just one component. Health care delivery is changing. It is increasingly a team environment, with advanced practice nurses and physician assistants taking on physician responsibilities. In addition, the role of pharmacists, podiatrists, dentists, and other professionals is expanding.

While each profession may have their own agendas, the reality is that health care is a complex system that involves many people and organizations, including hospitals, clinics, practices, educational institutions, insurance companies, etc. While physicians tend to be the main focus, providing the population with an adequate health workforce requires much more planning that simply training/recruiting more physicians.

It begins with education, where it may be important to look at what influences students to choose health care degree programs and explore whether they are prepared to successfully complete those programs. Perhaps most critical to workforce planning is the issue of financing the training. Students, educators, universities/colleges, health care providers, insurance companies, and the population all share the costs of training.

Primary question: What are the challenges of producing an adequate health workforce?

Issues to consider:

A. Education
   1. Are the current training models best?
   2. Does faculty have the time to teach students?
   3. Institutional accreditation (public and private schools)
   4. Educational and clinical infrastructure

B. Who will/ should pay for the training?

**IV.Distribution**

After training, health care providers do not all practice in the same location or treat the same type of patients. Utah has a significant rural population that often has limited access to primary care. But, there are many factors that go into where a health care provider practices, including their training, specialty, family needs, income, and personal preferences. In addition, there are urban areas whose residents may find it difficult to receive even basic health care.

Primary question: Do people have access to health care or not?

Issues to consider:

A. Should rural areas try to "grow their own" health care providers?
B. What influences students to choose a particular profession/ specialty?
C. How can we encourage providers to accept Medicaid patients?

## Articles to Explore


1. Association of Academic Health Centers. 2008. Out of Order, Out of Time: The State of the Nation's Health Workforce. http://www.aahcdc.org/policy/AAHC_OutofTime_4WEB.pdf

2. Alliance for Health Reform. 2011. Health Care Workforce: Future Supply vs. Demand. http://www.allhealth.org/publications/Medicare/Health_Care_Workforce_104.pdf

3. Hegmann, Theresa. 2006. The Shortage of Physicians and the Implications for PAs. Journal of the AmericanAcademy of Physician Assistants. 19(5):16-17. http://media.haymarketmedia.com/documents/8/guestedit0506_1765.pdf

4. Love, Denise, W. Custer, and P. Miller. 2010. All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency. Commonwealth Fund. 1439(99). http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Sep/1439_Love_allpayer_claims_databases_ib_v2.pdf

5. New YorkCenter for Health Workforce Studies. 2006. The United States Health Workforce Profile. http://www.uiowa.edu/~ibl/documents/The_U.S._Health_Workforce_Profile.pdf

6. Blumenthal, David. 2004. New Steam from an Old Cauldron -- The Physician-Supply Debate. New England Journal of Medicine. 350(17):1780-1787.

7. Utah's Health: An Annual Review. 2010. UH Review 2010. The University of Utah. http://www.matheson.utah.edu/Annual_Review/UHReview/journal2010.pdf

8. Utah Medical Education Council workforce repots. http://utahmec.org/publications.php

## Appendix C: Panelist Issues and Ideas

| ISSUE | TOTAL |
|---|---|
| Workforce needs assessment/identify barriers/data sharing/accuracy of data/maldistribution focus | 7 |
| Team approach/educate in teams/patient centered care | 5 |
| Reimbursement issues/Type of incentives/Restrictions on tele-health reimbursement | 4 |
| Primary care focus/financial incentives | 4 |
| Prevention specialists/Public health focus/Wellness/Not the focus of workforce training | 4 |
| Funding/Cost of training/Loan reimbursement | 4 |
| Internal and external regulation | 3 |
| Medical school class expansion and finance residency | 2 |
| Target training early/K-12 awareness and training | 2 |
| Clinical training sites/accreditation barriers | 2 |
| Rural Access/Workforce | 2 |
| Faculty shortages | 2 |
| Rural training site underutilization/lack of students willing to go | 1 |
| Effective utilization of technology in training | 1 |
| Low pay for entry level professionals resulting in high turnover | 1 |
| Current training models lack flexibility | 1 |
| Under education of RN workforce | 1 |
| Identify other professionals (Chiropractors etc.) | 1 |
| Role of USHE - what can we do better? | 1 |

**Note:** 21 participants returned their cards, each listed 1 or more issues; the highest number of issues listed was 4. There were a total of 48 issues which could be grouped into the above listed 19 categories.

**Appendix D: UDOH Health Workforce Issues White Paper**

# Utah Department of Health

# Health Workforce Issues White Paper

**By the**

# UDOH Healthcare Workforce Workgroup

**Prepared By**

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## UDOH Healthcare Workforce Workgroup
## Issues White Paper – Executive Summary

Across the United States, including in the state of Utah, there is a shortage of healthcare professionals in acute care, long-term care, public health, and primary care as well as in specific sub specialties of medicine. Population growth overall is inevitable and the aging and minority populations are particularly increasing quickly. There are not enough healthcare professionals to provide adequate and quality care. Due to the impact these shortages have on the quality, access and cost of healthcare in Utah, Dr. Sundwall, the Executive Director of the Utah Department of Health, convened a Healthcare Workforce Workgroup to address problems and possible solutions to grasp the broad base of the shortage issue.

The Healthcare Workforce Workgroup identified six major issues: 1). Health Professions Workforce Assessment/Projections, 2). Health Professions Workforce Pipeline, 3). Health Professions Educational Capacity, 4). Faculty Development for Health Professions Education Programs, 5). Incentives (recruitment and retention) for Health Professionals, and 6). Reimbursement Reform for Health Professionals. Within each of these six areas, the Healthcare Workforce Workgroup has outlined problems and has made recommendations accordingly. Although funding is often a solution, the committee focused their efforts not on funding increases; rather they emphasized the need to prioritize current funding as well as creating programs or policies that cost little to nothing but make an impact. The following white paper addressed these six issues with their respective problems and solutions in more detail.

## Issues White Paper

### Issue #1 Health Professions Workforce Assessment/Projections

| Problems | Solutions |
|---|---|
| Healthcare Professional Shortages nationally in all areas (acute care, long term care, public health and primary care) that directly impact Utah. | Accurate Data for Utah is required.<br>Important role of Utah Medical Education Council (UMEC) to identify needs, identify production. |
| Increasing population overall, with particular growth for the elderly and minority groups. | Accurate data on population growth is needed, along with accurate data on specific types of professionals needed to address these changes (specialty, ethnicity, etc.). UMEC role. |
| No increase (nationally) in 18 – 24 year olds entering the health professions workforce (or overall workforce). | Identify potential sources of needed health professionals from diverse backgrounds so that they can be mentored towards health careers. Area Health Education Centers (AHEC) role and others. Need to be a collaboration. |
| No data modeling to accurately predict future workforce shortages by discipline, especially given "team" (e.g. Medical Doctor + Physician Assistant, or Medical Doctor + Nurse Practitioner) practices. | Database to reflect models; someone to know the workforce data (UMEC and Association of Utah Community Health [AUCH]). Need to identify optimal ranges for MA/CAN/DA, PA/NP/MD/DO, etc. (see glossary) |

### Issues #2: Health Professions Workforce Pipeline

| Problems | Solutions |
|---|---|
| Pipeline programs and initiatives are not fully known. | Identify existing programs and initiatives within the state. |
| Lack of positive reputation and/or exposure to the full variety of healthcare professions that are needed (particularly beyond physicians, dentists and nurses). | Positive media campaigns that include cultural, racial/ethnic, geographical and linguistic diversity.<br>Support pipeline (career development) programs for youth (AHEC role) that includes mentoring programs for those youth from medically underserved communities. |
| Difficulty having formal and effective tracking of students in pipeline programs to assess impact/outcome.<br>Students from minority, economically disadvantaged and rural backgrounds have less interest in health professions careers. | Support AHEC, career counseling, and training program efforts in identifying and tracking students (e.g., a statewide database).<br>Support programs such as AHEC and Health Careers Opportunity Programs (HCOP).<br>Encourage sponsoring institutions to prioritize grant applications to support these programs. |
| There is a lack of academic preparation in rural underserved areas and/or under-resourced urban schools that would facilitate the ability of students to work in health professions in those underserved communities. | Create academic preparation programs (e.g., AHEC summer camps, SAT prep classes), career mentoring and counseling programs (e.g., AHEC support for career counselors), and health professions mentoring (shadowing) programs to get high school students trained to be CNAs, Dental Assistants, Pharmacy Assistants, PT Aides, etc. |

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|---|---|
| No Health Occupation Students of America (HOSA) or Utah State Office of Education (USOE) career pathway programs for rural students. | Support the development of local, school-based, career pathway programs (such as HOSA). Encourage institutions to identify qualified and dedicated faculty advisors for such programs. |
| Mobility issues limit health professions workforce development (i.e., there are many access barriers to entering training programs, particularly for "non-traditional" students, including distance and cost). | Develop training alternatives for non-traditional students (e.g., distance learning, local clinical experiences).<br>Provide incentives (e.g. scholarships) for new students and current healthcare professionals who wish to pursue a terminal degree. |
| Existing programs need to be evaluated to assure that they are doing what they should be doing. | Develop evaluation criteria that include recognition of three types of potential students: 1st: those who already know and are on track, 2nd: those who need a little more guidance, and 3rd: minority and underserved students requiring encouragement and more guidance. |
| Health care is an important factor in Economic Development for the state. Health care is Utah's largest employer and provides critical benefits for its corporate employees. | Office of Economic Development and business leaders need to be recruited to assist in pipeline efforts. |

**Issues #3: Health Professions Education Capacity**

| Problems | Solutions |
|---|---|
| There is a lack of clarity and data about the complex funding of existing education and training programs. | Create a clear, data driven plan for agencies that fund educational capacity (e.g., the legislature, the federal government) that focuses on training programs' needs (growth , facilities, faculty development, faculty salaries, etc.). |
| Most training programs operate independently and have clinical training sites that serve just one program. There is also a lack of coordination among programs that use clinical training sites. | Better coordination of training programs and clinical training sites to increase capacity. |
| There is currently a lack of capacity in existing education and training programs to meet current and future needs. | Prioritize funding to expand capacity with an emphasis on innovative programs, e.g. distance learning, night and weekend programs, virtual universities, more web-based trainings, allowance for part-time enrollment (to allow concurrent employment). Innovative programs require evaluation to determine effectiveness. |
| Financing is a barrier to both training programs and individuals. | In addition to items mentioned above, consider expanded scholarship and loan repayment programs for needed professions. |
| The enrollment in some health care professions training programs is not at capacity. | Support pipeline initiatives as noted above. |

**Issues #4: Faculty Development for Health Professions Education Programs**

| Problems | Solutions |
|---|---|
| Many practicing health professionals lack terminal degrees that would qualify them for | Provide career development, mentoring, and training of young professionals in education. |

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|---|---|
| faculty positions. | Expand loan repayment programs in exchange for obligation to teach. |
| Many health professionals do not want to teach, whether as full-time or part-time faculty, or as a preceptor or mentor. (Many reasons – no interest, do not know how/where to begin, feel that they don't have enough training, financial concerns [loss of productivity or time away from practice]). | Support funding for health professions education and training programs to offer faculty development training (e.g. Saturday or evening workshops, use of mentors). Consider scholarship and/or loan repayment programs for those moving into full-time teaching. |
| Faculty salaries are usually lower than private sector pay for a given profession. | Develop incentives for faculty (e.g. better pay, loan repayment, scholarships, housing stipends, paid time for faculty development training, continuing education credits, recognition systems). |
| Accreditation standards for faculty lines are set high, e.g., only MS and PhD can teach in nursing. | Work with accrediting bodies and Nursing Association to encourage more flexibility so that those with BSN and other appropriate training can teach. Use of mentoring and junior faculty to pursue teaching careers. |

**Issues #5: Incentives (recruitment and retention) for Health Professionals**

| Problems | Solutions |
|---|---|
| Lack of positive perception of some healthcare jobs. | Create positive media campaigns (general public, targeted to public school students, etc.) that include cultural, racial/ethnic, geographic and linguistic diversity and that highlight lesser known professions. |
| The majority of health professions students come from populations/communities that are different from those populations/communities that are most in need of their services. | Expose a maximum number of health professions students to practice opportunities through mentors and clinical training sites in underserved communities. Target recruitment of future health professional students from communities of need (e.g. rural, underserved). Change admissions policies for education and training programs to assure appropriate admission of individuals from undeserved communities. |
| Lack of clinical training sites in rural and urban, underserved areas. | Develop more externship/internship sites in underserved areas so students can get some experience in these areas. Provide housing or small stipend as incentives for students and residents to receive training in these areas. |
| Practice sites in underserved areas do not have recruitment/retention plans. | Provide technical assistance to underserved communities to develop comprehensive recruitment and retention plans. |
| Lack of career mobility for practicing health professions within their community. | Develop "career ladder" approaches to build upon current level of training. Offer advanced training opportunities locally. |

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|---|---|
| Lack of incentives to work in medically underserved areas. | Expand scholarships and loan repayment programs; explore models like Americorps and Peace Corps to support future training in return for service. |
| Lack of provider "ownership or buy-in" at their employment/practice site. | Educate practices in underserved areas on the importance of provider involvement as a retention tool. |
| "Lifestyle" factors influencing career choice and practice location. | Provide flexible work options to attract nontraditional healthcare professionals. |
| Provider isolation in underserved settings. | Partner with employers and training facilities to enhance professional contact, offer training opportunities, offer teaching opportunities, provide cultural competence training specific to provider's location. |
| There are foreign trained health professionals living/working in Utah who cannot practice their profession. | Training assistance to pass exams, update skills, and to be eligible for licensure. May need to include scholarship assistance or other incentives. |
| Leadership from Higher Education (e.g., a member of the Board of Regents) needs to be involved in addressing health professions workforce solutions. | Invite Higher Education leadership to participate in Workforce workgroup and follow up with them. |

**Issues #6: Reimbursement Reform for Health Professionals**

| Problems | Solutions |
|---|---|
| Low reimbursement rates by Medicaid and Medicare (particularly harmful to the most vulnerable populations). Significant impact on availability of dental care for underserved. | Work with government to ensure appropriate Medicaid/Medicare reimbursements, including alternative payment systems (care coordination, managed care, etc.). UDOH runs dental clinics that survive on Medicaid reimbursement and could offer "best practices" workshops to train private dentists, who want to serve the underserved, on how to efficiently care for Medicaid clients. Change the perception of dentists from "I lose money" to " I don't lose money." |
| High debt load of many graduates of health professions programs. | Expand loan repayment programs for "needed" health professions (need good supply and demand data in order to prioritize most needed professions). |
| Inadequate numbers and distribution of primary care providers. | Need to address payment inequalities (RVU system) that promote sub-specialty care over primary care (despite evidence regarding cost and quality). |
| Need to maintain an appropriate balance of primary care and sub-specialty care. | Initial efforts need to focus on primary care. |

## Glossary

AHEC: Area Health Education Center

AUCH: Association of Utah Community Health

CNA: Certified Nurse Assistant

DA: Dental Assistant

DH: Dental Hygienist

DO: Doctor of Osteopathic Medicine

HCOP: Health Careers Opportunity Programs

HOSA: Health Occupations Students of America

MA: Medical Assistant

MD: Doctor of Allopathic Medicine

NP: Nurse Practitioner

PA: Physician Assistant

PT: Physical Therapist

PT Aide: Physical Therapy Aide

RN: Registered Nurse

RVU: Relative Value Unit

UDOH: Utah Department of Health

UMEC: Utah Medical Education Council

USOE: Utah State Office of Education