July 1, 2010

To: SustiNet Board of Directors
Human Services, Public Health and Appropriations Committees

From: Ellen Andrews, PhD
(203) 562-1636
andrews@cthealthpolicy.org

David Henderson, MD
(860) 679-4539
Henderson@uchc.edu

Re: SustiNet Healthcare Workforce Task Force Report

Pursuant to PA 09-148, An Act Concerning the Establishment of the SustiNet Plan, we are proud to submit the report of the SustiNet Healthcare Workforce Task Force. By this transmittal, we are fulfilling the requirement of the task force under Section 18 of that Act.

We want to thank all the members of the task force for their hard work in developing this report, the many generous experts who shared their wisdom with us, and to thank you for this opportunity. We also want to thank the able assistance of Anya Rader Wallack, Vicki Veltri, Michael Mitchell, Marilyn Rice, and Africka Hinds-Ayala without whose assistance this report would not have been possible.

We are available to answer questions or to re-convene the task force as needed to ensure Connecticut's health care workforce capacity.

Cc: House, Senate Clerks
CT Legislative Library
CT State Library

# SustiNet Healthcare Workforce Task Force
# Final Report

July 1, 2010

Respectfully submitted,
Ellen Andrews, PhD
David Henderson, MD
Co-Chairs

## Background

### Connecticut's Health Care Workforce Strengths

Connecticut has some of the best trained and most experienced health care workers in the world. Connecticut has two world-class schools of medicine and one of the most highly regarded dental schools in the country. Another medical school is planned to open in 2013 or 2014. Connecticut is home to nineteen schools of nursing[i] and hundreds of programs to train other professionals.[ii] Health care services employ one in eight Connecticut workers[iii].

Health care jobs are an important engine in Connecticut's economy. In the next few years, health care employment is expected to grow twice as fast as the rest of the economy.[iv] Traditionally, health care employment has been resistant to economic downturns as people are reluctant to skip health care services even in a recession.[v] In fact, the recent economic recession has provided some temporary relief in shortage areas. For example, nationally, last year some new nursing school graduates encountered difficulty finding jobs.[vi] The CT Hospital Association reports that nursing vacancy rates were down in 2009, but there were still 373 open positions at 27 Connecticut hospitals.[vii] Experts expect any relief from workforce shortages due to the economy to be temporary.[viii]

### Connecticut's Health Care Workforce Challenges

Between 1995 and 2015, Connecticut's total population is expected to grow by 464,000 people.[ix] Between 2010 and 2030, the percentage of Connecticut residents over age 65 is expected to grow by 40% and the ratio of Connecticut seniors to 100 workers (ages 20 to 64) is expected to grow from 23 to 40.[x] An aging population will place greater demands on the health care system at the same time that many health professionals will be retiring.[xi] National and state health reforms to cover the uninsured will add to the demand for providers. In 2006 when Massachusetts expanded coverage to almost all uninsured residents, wait times for physician visits increased significantly, to a year in some areas, and serious healthcare workforce shortages were reported across the state.[xii] There are concerns that expansions of insurance coverage due to national reform and SustiNet will cause similar shortages here in Connecticut.

Connecticut is already facing a shortage of many, even most, health care workforce categories. Shortages have been reported in nursing at multiple levels including nurse managers, pharmacists, respiratory therapists, physical therapists, physician assistants, and surgical technologists, among others[xiii]. The CT Dept. of Labor tracks occupations, annual wages, and projected openings. Growth is projected in every category except insurance clerks; in all but two other categories, double digit growth is projected (see Table 1). 25% of Connecticut family physicians and 22% of internists report considering a career change because of the state's practice environment. 26% of Connecticut family physicians and 28% of internists are not accepting new patients. On average, CT patients wait 18 days for a routine office visit.[xiv] 80% of CT physicians report difficulty recruiting new physicians to their practices in the state. Challenges cited by Connecticut physicians include liability issues, insurer administrative burdens, emergency room call, high risk patients, and challenges of technology integration.[xv]

Access issues are most acute for Connecticut residents covered by public programs; barely half of Connecticut physicians accept Medicaid, HUSKY or SAGA patients.[xvi]

| Table 1- Connecticut Health Care Occupations in Demand | | | | | |
|---|---|---|---|---|---|
| **Occupational Title** | Employment | | Change | | Annual Openings |
| | 2006 | 2016 | Net | Percent | |
| **Rehabilitation Counselors** | 4,370 | 5,220 | 850 | 19.4% | 172 |
| **Child, Family, and School Social Workers** | 5,200 | 5,700 | 504 | 9.7% | 160 |
| **Mental Health/Substance Abuse Social Workers** | 2,640 | 3,280 | 642 | 24.4% | 120 |
| **Social and Community Service Managers** | 2,780 | 3,340 | 560 | 20.1% | 109 |
| **Medical and Health Services Managers** | 3,690 | 4,070 | 379 | 10.3% | 107 |
| **Pharmacists** | 2,760 | 3,280 | 520 | 18.8% | 100 |
| **Mental Health Counselors** | 2,010 | 2,600 | 584 | 29.0% | 98 |
| **Physical Therapists** | 3,200 | 3,780 | 585 | 18.3% | 98 |
| **Medical and Public Health Social Workers** | 2,220 | 2,680 | 461 | 20.8% | 93 |
| **Medical Scientists, Except Epidemiologists** | 1,750 | 2,060 | 312 | 17.9% | 85 |
| **Health Specialties Teachers, PS** | 2,490 | 2,890 | 403 | 16.2% | 82 |
| **Clinical, Counseling, and School Psychologists** | 2,950 | 3,270 | 326 | 11.1% | 78 |
| **Substance Abuse/Behavioral Disorder Counselors** | 1,210 | 1,640 | 430 | 35.5% | 67 |
| **Chemists** | 1,820 | 1,950 | 136 | 7.5% | 62 |
| **Family and General Practitioners** | 2,070 | 2,280 | 216 | 10.4% | 59 |
| **Medical and Clinical Laboratory Technologists** | 2,150 | 2,390 | 238 | 11.1% | 57 |
| **Biological Technicians** | 990 | 1,180 | 189 | 19.1% | 54 |
| **Internists, General** | 1,750 | 1,930 | 186 | 10.6% | 51 |
| **Registered Nurses** | 32,840 | 38,560 | 5,722 | 17.4% | 1,114 |
| **Nursing Aides, Orderlies, and Attendants** | 24,660 | 27,590 | 2,924 | 11.9% | 513 |
| **Licensed Practical and Licensed Vocational Nurses** | 8,020 | 9,070 | 1,050 | 13.1% | 324 |
| **Fitness Trainers and Aerobics Instructors** | 3,970 | 4,620 | 658 | 16.6% | 140 |
| **Dental Hygienists** | 3,160 | 3,790 | 625 | 19.8% | 123 |
| **Radiologic Technologists and Technicians** | 2,970 | 3,410 | 437 | 14.7% | 84 |
| **Emergency Medical Technicians and Paramedics** | 2,800 | 3,150 | 346 | 12.3% | 67 |
| **Medical Records and Health Information Technicians** | 1,570 | 1,760 | 192 | 12.3% | 61 |
| **Surgical Technologists** | 1,060 | 1,250 | 184 | 17.3% | 50 |
| **Social and Human Service Assistants** | 8,350 | 9,670 | 1,322 | 15.8% | 229 |
| **Medical Assistants** | 4,990 | 6,520 | 1,529 | 30.7% | 215 |
| **Pharmacy Technicians** | 2,880 | 3,710 | 826 | 28.7% | 171 |
| **Medical Secretaries** | 5,690 | 6,440 | 753 | 13.2% | 166 |
| **Dental Assistants** | 3,390 | 4,060 | 671 | 19.8% | 126 |
| **Insurance Claims and Policy Processing Clerks** | 6,150 | 5,820 | -332 | -5.4% | 74 |
| **Home Health Aides** | 10,590 | 13,280 | 2,694 | 25.4% | 364 |
| **Personal and Home Care Aides** | 6,340 | 8,450 | 2,109 | 33.2% | 319 |

Source: CT Dept. of Labor data reported in T. Court, Policy Brief: Connecticut's Health Care Workforce Under Construction, The Business Council of Fairfield County, May 2010.

Connecticut's shortages, like other states, are most severe in primary care. Connecticut has only 240 primary care physician training program positions.[xvii] Nationally there has been a trend of moving hospital primary care training slots to specialty care training.[xviii] The difference in long term compensation in medicine between primary care and specialists is estimated at $3.5 million.[xix] A 2008 analysis of primary care capacity in Connecticut for the Primary Care Authority found that shortages are concentrated in rural areas and for inner city populations that rely on safety net providers. The report did find that suburban areas of the state may be in better shape than the rest of the country to respond to increasing demand. The report found that numbers of licensed physicians likely overstate the true capacity and there is very little data on how many providers are in active practice.[xx] Causes of the primary care capacity shortages vary. Primary care practices are extremely busy. Payment rates are below those for specialty care. Business costs are increasing, and practices rely on an antiquated payment system that requires labor intensive, inefficient face-to-face patient encounters to generate revenue.[xxi]

Forty Connecticut communities have been designated primary care shortage areas by the US Dept. of Health and Human Services; 19 and 39 have been designated mental health and dental workforce shortage areas, respectively. Seventeen areas of the state have been designated Medically Underserved Areas and twelve populations have been designated as Medically Underserved Populations. Designation allows these areas to attract new graduates through the National Health Service Corp and providers delivering care in these regions receive 10% higher Medicare rates. Most of the state has not been assessed for shortage area designation; it is possible that these benefits could be extended to more eligible communities in Connecticut struggling with limited capacity.[xxii]

Connecticut's enduring nursing shortage is not due to lack of interest among students but to a lack of training slots. Nurses are the largest job classification among Connecticut health care providers. In 2006 over 1,200 qualified nursing applicants were denied entrance into Connecticut nursing programs due to lack of space.[xxiii] Connecticut ranks 49th among states in producing nurses.[xxiv] 23% of Connecticut's nursing faculty expects to retire in the next five years; the average age of the state's nursing faculty is 52 years.[xxv] Nursing faculty earn significantly less than their colleagues in active practice or other health care roles including administrative, pharmaceutical and health information technology sectors[xxvi]. Even for students who are lucky enough to enroll in a nursing program, clinical training slots are scarce[xxvii].

Mounting debt is a serious challenge for new health care graduates in Connecticut. Students leaving nursing school this year average between $10,000 and $30,000 in debt, some with debt loads up to $130,000.[xxviii] There is good evidence that rising debt levels of graduating physicians is a significant driver of the move to specialty care over primary care.

Despite growing public health threats, Connecticut's public health workforce per capita dropped by 16% from 2001 to 2006.[xxix] This growing shortage mirrors national trends that have caused reductions and in some instances the elimination of vital local public health programs.[xxx]

Nonprofessional, informal caregivers constitute a large and important part of the health care workforce. Unfortunately they are largely unrecognized, their needs and capacity are not measured. Across the US it is estimated that 34 million family caregivers, mainly women, provide 75 to 80% of long term care services in the community. Estimates of the value of that unpaid care reach $375 billion per year, more than US total spending on Medicaid[xxxi]. As the long term care system grows more complex and polices focus on transitioning patients to community settings, reliance on informal caregivers will grow.[xxxii] Nationally caregivers are more likely to be low income and working at other jobs. Seventeen percent report that caregiving has compromised their own health and 31% are highly stressed by their responsibilities.[xxxiii] In Connecticut, it is estimated that 380,000 informal caregivers provide 410 million hours of care valued at $4.8 billion.[xxxiv] Several studies have quantified significant savings to the system from the contributions of informal caregivers, including delays and reductions in expensive institutional care[xxxv]. It is critical that Connecticut monitor this essential but invisible sector of our health care workforce, determine the system's capacity, identify needs, and design supports and programs to ensure that they can provide care to loved ones. Suggested supports include information resources, emergency response devices, transportation assistance, and respite services.[xxxvi]

**The work of the Task Force**

The SustiNet Health Care Workforce was convened in August 2009 and held its first meeting October 15th. The charge to the task force, created by PA 09-148, An Act Concerning the Establishment of the SustiNet Plan, is to "develop a comprehensive plan for preventing and remedying state-wide, regional and local shortage of necessary medical personnel, including, physicians, nurses and allied health professionals."

Throughout the rest of 2009 and into 2010, the task force held five meetings at the Legislative Office Building and four meetings by webinar. A recommended reading list was provided to task force members and was publicly available. The task force heard presentations on Connecticut's workforce by

- Marcia Proto, CT League for Nursing
- Matthew Katz, CT State Medical Society
- Scott Selig, CT Community Health Center Association
- Jon Davis, CT State Dental Society
- Alice Pritchard, Allied Health Workforce Policy Board
- Tanya Court, The Business Council of Fairfield County
- Kristin Sullivan, DPH
- Johanna Davis, DPH
- Jennifer Fillipone, DPH
- Cindy Lord, PA, American Academy of Physician Assistants

The CT League for Nursing generously offered to field a survey drafted by the task force of 475 new graduates of Connecticut nursing programs. Responses to the survey were analyzed by the

CT Health Policy Project and helped inform our recommendations. All task force meetings, minutes, agendas, reports, documents and webinars were publicly available; all activities were transparent.

The task force membership found many engaged stakeholders making progress on expanding Connecticut's health care workforce capacity. There was a great deal of informal communication and collaboration across stakeholder groups. The task force wishes to thank those stakeholders for their generosity in sharing their resources and wisdom with us. It is important that Connecticut policymakers respect and support this uniquely collaborative environment and the potential of this network to develop effective and feasible solutions to this important challenge.

**Contributing issues and trends impacting Connecticut's health care workforce**

It is important to recognize important trends that are not part of the task force's charge but have profound impact on our work. These include patient-centered medical homes, racial and ethnic health disparities, and payment reform trends.

*Patient Centered Medical Homes*
Proponents of patient-centered medical homes argue that medical homes can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities. Medical homes have become an important theme of health reform discussions at both the state and federal level and there is a great deal of momentum to transform and expand primary care practices in Connecticut.

Patient centered medical homes have important differences from traditional medical practices that will impact the health care workforce. New skills will be required included working in teams, care coordination, health information technology interaction, risk assessment and care planning, medication management, patient self-management education and support, and cultural competence. Patient centered medical homes will require expanded hours for practices and new connections to community resources, both medical and non-medical. In a patient centered medical home, care is provided by teams of providers, with every team member working at the top of their license; providers will have to become comfortable delegating care to appropriate colleagues and trusting their abilities. Patient centered medical homes treat patients as whole people, understanding the entire context of their lives. This is a significant departure from traditional roles for many providers and will require training for new graduates and retraining of the existing workforce. The challenges of transformation to a patient centered medical home model should not be under-estimated, even for willing and enthusiastic providers. Research identifying those challenges and finding solutions that work is ongoing. SustiNet would be well served by closely following those developments and working to help all Connecticut's health care workforce respond.

*Health care disparities*
Connecticut, like most states, is becoming more diverse. Unfortunately, our state is not exempt from the gap in health care access and outcomes between genders, races and ethnic groups. These disparities have complex causes[xxxvii], some attributable to provider behavior that must be addressed by training and expanding the diversity of Connecticut's health care workforce. Solutions that impact providers include cross-cultural competence training curricula both for new providers and continuing education for established practitioners, integration and financial support of translation services into care and patient education, collection and monitoring of data on disparities, and evaluation of intervention efforts[xxxviii]. Perhaps the most important change for Connecticut's workforce is a greater attention and sensitivity to disparities and its causes among providers, recognizing any issues in their practices and institutions their patients rely on, and engaging in solving the problem.

*Payment reform and quality-based purchasing*
There is a growing recognition that the current, fee-for-service system of paying for health care is fueling rising costs of care. Most payers are moving to a system of linking payment rates to the quality of care and realigning provider incentives from promoting utilization and toward efficiency.

This is a significant transformation in the way providers and health systems are paid and will require new skills and tools to navigate. Efficiencies will encourage providers to substitute more efficient care such as phone, email, interactive websites, and group visits, when appropriate, for face to face encounters. Providers will be expected to share risk and savings, with payers and with each other, under various payment reform scenarios. Connecticut's provider environment may move from predominantly independent, small practices to larger, integrated systems of care such as Accountable Care Organizations, either co-located or in virtual networks. Providers will be expected to follow evidence-based guidelines and will be measured and held accountable for the quality of the care they provide in new ways. Under payment reform, providers may find that their compensation is tied not only to their own performance, but the quality of care delivered by other providers and institutions. Providers may also find that they are held responsible for patient behavior, including adherence. Rates paid to providers will become far more complex including risk adjustment for patient complexity and history of resource use.

**What we learned**

*Faculty, clinical training slots*
Through presentations and discussions among the task force members, concerns were raised about the capacity of Connecticut's educational system to meet our state's health care workforce needs, current and future. Concerns were raised that compensation for faculty members and quality of life issues are not competitive with other employment options for qualified teachers. There are concerns that students entering health care training programs are not adequately prepared; employers need to provide extensive on-site training to new employees in some cases. It takes at least nine months to get approval for a new training

program – in many cases, this delay is purely administrative and does not reflect a thoughtful process to ensure that the program is meeting a demonstrated need. There is no coordinated system to identify and share clinical training slot openings. Understandably, schools tend to jealously guard their training relationships, however it is not clear that all slots are being filled efficiently or in the best interests of Connecticut's workforce capacity. Institutions and busy providers who train students are not compensated adequately for that time and work, creating a serious disincentive to offering training.

*Primary Care Shortage*

The physician primary care workforce in Connecticut is limited in number as well as diversity. The physician licensure data base maintained by the Connecticut Department of Public Health (DPH), the *Physician Characteristics and Distribution in the US, 2005,* and a 2004 database from the American Medical Association's Physicians' Professional Data, were used to arrive at estimates of the supply of primary care physicians in Connecticut. The DPH physician licensure data provide little in the way of practice information other than primary specialty. Subspecialties of internal medicine and pediatrics are not listed. Only a portion of physicians listed by self-designated specialty actually provide primary care. Based on these data the primary care physician to population ratio was estimated to be 72.2 per 100,000 (based on total population of 2,536). This ratio falls in the middle of the supply of generalist physicians recommended by the federal Council on Graduate Medical Education, 60-80 per 100,000 population. With a physician to population ratio well within the recommended range, one might suspect that the state should have a paucity of physician shortage areas. However, given the skewed distribution of physicians, Connecticut unfortunately has a wealth of physician shortage areas.

The American Medical Association's *Physician Characteristics and Distribution in the US, 2005*, provides demographic information on the supply of physicians in the U. S. Limiting the 2004 AMA database to those physicians who are licensed in Connecticut, who are age 70 years or less, and who are involved in direct patient care, indicates that only 2.2 percent of physicians are African-American and 2.4 percent are Hispanic.

*Informal caregivers*

There is a network of programs providing assistance to family caregivers in Connecticut, but they meet only a small part of the need. Reportedly, the most pressing need for Connecticut's informal caregivers is respite services.[xxxix] Programs have limited resources, for example only $500 per family every other year, and long waiting lists. Private insurance benefits for respite and home care are often inadequate. Other suggested supports include information resources, emergency response devices, and transportation assistance.[xl] There is a well-organized network of consumers and advocates representing Connecticut caregivers and their patients. The state needs to recognize these informal workers as an important part of Connecticut's health care workforce and the value of their services, with monitoring and providing the support they need.

*Scope of practice*
The patient-centered medical home model is based on every team member practicing at the top of their license. It has been suggested that removing barriers to practice for a variety of provider groups would help ease Connecticut's workforce shortages, particularly in primary care. Connecticut does not have a system to monitor and impartially evaluate scope of practice laws outside the legislature. Debate over scope of practice bills are time consuming and often contentious. The General Assembly's Program Review and Investigations Committee completed a study of the legislative process to define and modify scope of practice laws for the health care professions in December 2009. The report recognizes that as skills needed within health care professions become more sophisticated, modifications in scope of practice laws are needed. The report makes several recommendations to improve legislative processes including a timeline for requests and responses to change scope of practice laws, analysis by the Department of Public Health, and development of an independent review committee for each request.[xli]

## Proposed recommendations

### Strategic plan
Connecticut needs an in-depth analysis of current and future workforce capacity, future and current needs and a plan to address the gaps with specific annual targets and numbers of graduates each year by occupation.

It is critical to consider not just licensed providers, but to count those in active practice. Capacity must be assessed by practice area such as primary care, behavioral health, oral health, care management, by geographic area and populations served such as state employees, Medicaid, Medicare, employer coverage, state exchange coverage (individual and small group), SustiNet, undocumented immigrants, and any remaining uninsured in Connecticut after national reforms are implemented. The plan needs to consider non-traditional sectors of the health care workforce such as family caregivers and must include the public health workforce. The assessment must consider the health system from prevention, to diagnosis, to treatment, and to end of life care.

The plan must consider appropriate levels of training needed to fill gaps and develop a realistic strategy to provide that training, with discrete goals and timelines. It is critical to assess economic and other incentives driving practitioners to more highly specialized levels of training and whether that correlates with better health outcomes; to assess the Return on Investment for those providers and the public's investment of limited resources compared to continuing education. The plan should consider barriers to retention, both in school and in practice, and develop a plan to address those barriers. The plan must assess continuing education needs and employer-based training capacity.

The plan should assess each recommendation individually for the following and indicate priority goals.

- Likelihood to solve the stated problem
- Where else it has been tried – in Connecticut and elsewhere
- Timeline for implementation, current benchmarks
- Who will be ultimately responsible for implementation – which entity is accountable for each step
- Return on investment, available funding sources and other resources, i.e. federal and foundation funding opportunities
- Stakeholders that must be involved for success and the role of each
- Realistic feasibility of each recommendation, compared to competing initiatives
- What is the expected outcome, how and when will progress be evaluated

The plan must develop clear career maps for each shortage profession and track not only the numbers of primary care providers, but also measures of access to care, prevention and screening targets, by population served. The plan must assess barriers to moving up the career ladder building on the important work of the Allied Health Policy Workforce Board.

The plan should emphasize regional partnerships for implementation. The plan must consider Connecticut's health care workforce context including the impact of the proposed new medical school at Quinnipiac and expansions at the UConn Health Center.

The planning entity should be an on-going permanent planning group, possibly a Healthcare Workforce Data Center, including experts, representatives from health care professional organizations and schools, practicing providers, regulators, legislative representatives, and consumers (especially those with chronic conditions, elderly, children with special health care needs and from underserved populations and areas of the state). The group will require on-going resources, and should be coordinated through the Department of Public Health. The state should work to maximize available federal and private funding to support planning.

While developing the comprehensive strategic plan, the Department of Public Health should prominently post an annual health care workforce report card using the most recent Department of Labor occupation forecasts and Department of Higher Education enrollment, certificates and degrees awarded, as well as an assessment of actively practicing professionals in each category from Department of Public Health information.

**Debt relief for students**

The state must provide relief for rising tuition costs and debt levels of students considering the health professions. The state should prioritize scholarships over loan forgiveness; the costs of both programs are similar but upfront scholarships, resulting in no or less debt, are more salient to potential students than future promises to assist with debt. Assistance must require active practice in Connecticut shortage areas and/or care for underserved populations. Assistance should be targeted to minority students, particularly those who represent

underserved populations. The state could also consider medical malpractice assistance, limits on liability to encourage practice in shortage professions and areas.

**Scope of practice**

The Task Force supports the findings of the Program Review and Investigations Committee report to the legislature to foster a more thoughtful process to revise scope of practice laws. The Task Force recommends regular review of practice standards and real-world practices, i.e. are providers routinely practicing at their top skill level.

**Address primary care shortages**

Connecticut must address the predicted shortage of primary care providers. Training and support for providers practicing in patient-centered medical homes is critical. SustiNet must increase primary care reimbursement rates, particularly for underserved populations such as Medicaid patients, and increase primary care clinical training slots by linking state and federal assistance to institutions to training slots and providing training stipends to institutions to compensate for the time involved in clinical training. The state should encourage institutions to ease quality of life barriers to employment for primary care providers, i.e. on call, part time practice. The state should assess and minimize insurance and administrative barriers, include online data submission. To encourage students to enter primary care professions, the state should develop an educational campaign to encourage students to pursue primary care, support innovative programs, i.e. internships, rotations, students shadowing primary care providers for a day or a week. The state should consider medical malpractice assistance or limits on liability for primary care providers and expand and support current successful programs i.e. SEARCH program by community health centers.

**Maximize federal resources**

Recent federal legislation creates numerous opportunities to support building Connecticut's primary care capacity. The state must apply for all appropriate federal opportunities – ARRA, national reform, Graduate Medical Education, and others as they arise. The Department of Public Health should be directed to expand analysis for health shortage area designation to entire state, potentially increasing funding to many Connecticut primary care practices. Federal funding opportunities to develop the health information technology structure within the state must be fully exploited. The state should assist Connecticut provider institutions and schools in applying for all appropriate opportunities and maintain regular communications with Connecticut's Congressional delegation about health care workforce capacity and opportunities.

**Nursing shortage**

Anticipating future shortages, the state needs to expand nursing education opportunities and foster retention of the current nursing workforce. The state should expand opportunities and provide financial assistance for continuing education, particularly training in team skills, health information technology, and care management. Financial assistance and scheduling assistance to encourage continuing education and moving up the career ladder are important to current nurses. A system to match training and employment opportunities to employment sites,

reducing travel time, would ensure slots are filled efficiently. The state needs to consider reducing paperwork and administrative burdens on nurses in every regulation and promote workplace supports for older workers to lengthen tenure. The state should support flexible scheduling, reasonable work hours and staffing levels that foster delivery of high quality care.

The state should support ongoing initiatives such as the joint application to the Robert Wood Johnson Foundation by the CT League for Nursing, Gateway Community College, Annie E. Casey Foundation, the Workforce Alliance and the New Haven Public Schools. This project will develop systems to "fast track" nurses to the next educational level, creating seamless pathways from LPN to RN and RN to MSN to train more nursing faculty.[xlii] The state should convene hospitals and other institutions regularly to share best practices, through a neutral convener such as SustiNet.

**Nursing faculty and education**

Connecticut must address a growing shortage of nursing faculty and educational capacity. Connecticut needs to expand the capacity of current programs. It is critical to equalize nursing faculty pay with active practice and other faculties. Scholarships and loan forgiveness for faculty training are critical, dependent on work in training in shortage professions in Connecticut. It is critical to expand faculty slots in diverse settings including home care, long term care, sub-acute and acute care and to ease administrative burdens on faculty. The state should review faculty qualifications, specific to each training position, and encourage outside resources, speakers and other opportunities to enrich the educational experience. The state should widely publicize faculty openings with specific information on positions including full or part time, benefits, and salary range.

To encourage students to pursue nursing, the state should create apprenticeship programs, targeting shortage areas and populations, tied to future practice in Connecticut. The state should create a coordinated statewide outreach campaign with input from all stakeholders to encourage students to pursue shortage professions targeting minority students, with detailed information on shortage professions, resources, career counseling for parents and students, location and qualifications for shortage professions. The state should pilot a six week high school summer health career awareness camp targeting shortage professions and minority students and create a health tutorial website. Connecticut should create a nurse residency program to help train and retain new graduates and maintain and expand current state support for paid health care internships. The state should continue current incumbent worker training support through the Dept. of Labor and the Workforce Investment Boards.

**Public health workforce**

Facing growing public health challenges, Connecticut must expand the state's public health workforce. Public health workforce capacity must be included in state health care workforce assessment and strategic planning. The plan should clearly define and enumerate the public health workforce, and establish career ladders and a pipeline strategy. Connecticut should create a public education plan to raise the visibility of the public health workforce and functions, including educating students, teachers, and guidance counselors at middle and high

school levels and providing opportunities to experience the public health workplace. The state must support continuing education, training and mentoring programs for current public health workers.

**Educational supports and support for career ladder**

Connecticut must address support needs that cross health care professions including new learning modes such as online learning and simulator training. Mentoring and tutoring programs, remedial education, and academic counseling services are critical for appropriate students. Lifestyle supports, such as child care, transportation and supplements for living expenses, are important to ensuring students are successful and finish their course of study. The state should authorize the use of state financial aid for students pursuing non-credit certificate programs. Many students need further training after graduation; the state must support employer-based training at health care institutions and practices. The state needs to access and support foreign trained, immigrant providers to become licensed and practice in Connecticut, particularly those who are from under-served racial and ethnic groups.

**Expand appropriate access to clinical training slots**

Clinical training is critical to ensuring Connecticut's health care workforce capacity. The state should both provide training stipends to institutions and providers that train students, but also link state and federal assistance to creation of training slots. The state can reduce administrative burdens on primary care sites that expand training slots and the providers who serve as trainers, i.e. longer period between licensure renewals; the state could consider medical malpractice assistance or limits on liability for training sites. Connecticut should create an online statewide centralized clinical placement scheduling system and require all institutions that get state or federal assistance to participate and list their capacity.

**Support family caregivers**

Connecticut's family caregivers provide an essential support to very fragile patients; without their assistance, many patients would be institutionalized at the state's expense. It is critical that Connecticut expand respite programs, provide administrative supports, and provide flexible financial assistance for family and patient-directed programs. Connecticut should consider tax benefits for caregivers and provide health coverage options such as reductions in cost sharing/premiums for SustiNet coverage to family caregivers. At a minimum, the state should create and support family caregiver support groups and networks to share resources and best practices.

---

[i] The Guide: Nursing Education in CT 2010-2012, CT League for Nursing, http://www.ctleaguefornursing.org/guide/clnnursingguide.pdf

[ii] Allied Health Workforce Policy Board, SustiNet Healthcare Workforce Task Force Briefing Paper, Dept. of Public Health, CT Community Colleges.

[iii] March 2010 data, *CT Economic Digest*, CT Dept. of Labor, May 2010, http://www.ctdol.state.ct.us/lmi/misc/cedmay10.pdf

[iv] Health care jobs are estimated to grow by 15% from 2006 to 2016 compared to only 8% across all employment, Connecticut Department of Labor, Connecticut Statewide Forecast by Industry, 2006-2016, http://www.ctdol.state.ct.us/lmi/misc/fc2016_industry.htm.
[v] Job numbers in Health Sector Defy Recession, More Growth Expected, Kaiser Health News, Jan. 11, 2010, Earnings of Healthcare Workers by Level of Duties and Responsibilities 2008, US Bureau of Labor Statistics, April 2010.
[vi] Nurses, Once in High Demand, Face Job Shortages, Kaiser Health News, Aug. 28, 2009.
[vii] Annual Legislative Report, Allied Health Workforce Policy Board, January 2010.
[viii] P. Buerhaus, et. al., The Recent Surge in Nurse Employment: Causes and Implications, Health Affairs 28:w657-668, June 12, 2009.
[ix] CT's population projections, US Census.
[x] CT State Data Center.
[xi] CT's Health Care Workforce: Under Construction, Briefing paper for the SustiNet Health Care Workforce Task Force, The Business Council of Fairfield County, Tanya Court, May 2010, B. Cleary, et. al., Expanding the Capacity of Nursing Education, Health Affairs 28:w634-w645, June 12, 2009.
[xii] http://www.npr.org/templates/story/story.php?storyId=97620520, 2007 Physician Workforce Study, MA Medical Society, July 2007.
[xiii] Averting Crisis: Ensuring Health Care for Future Generations in Connecticut, CT Hospital Association, April 2007.
[xiv] R. Aseltine, et. al., CT 2009 Primary Care Survey, CT Medicine 74:281-291, May 2010.
[xv] R. Aseltine, et. al., CT Physician Workforce Survey 2008, CT Medicine 72: 539-546, October 2008
[xvi] CT Health Policy Project, unpublished survey.
[xvii] CT Primary Care Authority.
[xviii] T. Bodenheimer, et. al., A lifeline for primary care, N Engl J Med 360:2693-2696, 2009.
[xix] R. Steinbrook, Easing the Shortage in Adult Primary Care – Is it all About Money? N Engl J Med 360:2696-2699, 2009.
[xx] Assessment of Primary Care Capacity in Connecticut, UConn Center for Public Health and Health Policy, December 2008.
[xxi] R. Baron, What's Keeping Us So Busy in Primary Care? A Snapshot from One Practice, N Engl J Med 362:1632-1636, 2010, L Sandy, et. al., The Political Economy of US Primary Care, Health Affairs 28:1136-1144, 2009, S. Spigel, Backgrounder: Recruiting and Retaining a Primary Healthcare Workforce, CT Office of Legislative Research, December 2008.
[xxii] Johanna Davis, DPH, presentation to task force, Feb. 25, 2010.
[xxiii] ibid
[xxiv] CT League for Nursing, presentation to CT SustiNet Health Care Workforce Task Force, 4/15/2010
[xxv] 2008 CT Nursing Study, CT League for Nursing, December 2008.
[xxvi] B. Cleary, 2009.
[xxvii] Clinical Placement Capacity Assessment Report, CT Hospital Association, September 2007.
[xxviii] Workforce Survey of 2010 CT Nursing School Graduates, CT Health Policy Project and CT League for Nursing, March 2010
[xxix] K. Sullivan, Connecticut's Public Health Workforce, presentation to task force Feb. 25, 2010.
[xxx] Local Health Department Job Losses and Program Cuts, National Association of County and City Health Officials, November 2009, D. Draper, et. al., Public Health Workforce Shortages Imperil Nation's Health, Center for Studying Health System Change Research Brief, April 2008.
[xxxi] Benefits and Cost Savings Due to Respite, National Respite Coalition Task Force.
[xxxii] C. Levine, et. al., Bridging Troubled Waters: Family Caregivers, Transitions, and Long-Term Care, Health Affairs 29:116-124, January 2010.
[xxxiii] Caregiving in the US, MetLife Foundation and AARP, December 2009.
[xxxiv] CT Fact Sheet, Family Caregiver Alliance.
[xxxv] Benefits and Cost Savings Due to Respite, National Respite Coalition Task Force.
[xxxvi] Caregiving in the US, MetLife Foundation and AARP, December 2009.
[xxxvii] *Addressing Racial and Ethnic Disparities in Health Care Fact Sheet*. AHRQ, February 2000.

[xxxviii] B. Smedley et. al., Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Institute of Medicine, 2003.
[xxxix] Joy Liebeskind, Coordinator, CT Lifespan Respite Coalition.
[xl] Caregiving in the US, MetLife Foundation and AARP, December 2009.
[xli] Scope of Practice Determination for Health Care Professionals, Program Review and Investigations Committee, CT General Assembly, December 2009.
[xlii] CT League for Nursing communication