SB 139

<target><bill>SB 139</bill><subject>SB 139</subject><comm>HFIN26</comm></target>

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON

ALASKA
STATE CAPITOL
ROOM 508
JUNEAU, ALASKA 99801-1182

(907) 465-3707
FAX (907) 465-4821

Sponsor Statement
SB 139 – Incentives for Certain Medical Providers

Alaska is facing a serious shortage of healthcare practitioners, especially in the rural areas of our state, and it is projected to worsen significantly in the next few decades. Senate Bill 139 is intended to address this issue by establishing a program to immediately begin filling the vacant healthcare practitioner positions throughout the state.

This legislation will establish an incentive program in the Department of Health and Social Services. The program is designed to attract healthcare practitioners to Alaska. Currently, the WWAMI program serves a similar purpose by giving WWAMI medical students the option of paying off a portion of their loans by staying in Alaska to practice for a specified number of years. Recently, the number of WWAMI seats was increased from 10 to 20, and legislation such as SB 18 aims to raise that number. However, expanding the WWAMI program only ensures that we have more healthcare practitioners in future years, as WWAMI participants must complete their education before they can begin their service. Therefore, it is not the immediate solution that we need. SB 139 would be an effective way to fill this gap in the very near future, and would attract healthcare practitioners from all areas of country, rather than just from the WWAMI participating states.

Senate Bill 139 will provide incentives for up to 90 applicants per year in 10 different health care occupations. Thirty of the slots will be reserved for "very-hard-to-fill" positions, which can be located only in areas that are designated by the Commissioner of Health and Social Services. Priority will be given to sites that treat patients who are uninsured and who have medical assistance or Medicare coverage. The amount of monetary incentive will vary with each slot, according to location and the category of healthcare provided. Prioritized tier I slots are designated according to the relative need in the state, and will include physicians, pharmacists and dentists. A slot in this tier has incentives of up to $35,000 per year for three years at a regular site, and up to $47,000 per year for three years at a very-hard-to-fill site. Tier II slots are also designated according to the relative need in the state, and will include dental hygienists, registered nurses, certified nurse practitioners, physician assistants, physical therapists, clinical psychologists, and clinical social workers holding at least a master's degree in social work. A slot in this tier has incentives of up to $20,000 per year for three years at a regular site, and up to $27,000 per year for three years at a very-hard-to-fill site.

It is critical that we promptly address Alaska's healthcare shortages in order to ensure that all Alaskans have adequate access to medical care. SB 139 helps us to save and improve the lives of our constituents by allowing us to provide for those who cannot wait until tomorrow to get the care that they need today.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: CSSB 139(FIN)
(S) Publish Date: 4/11/10

Identifier (file name): SB139CS(FIN)-04-10-10
Dept. Affected: Health & Social Services

Title: Incentives for certain Medical Providers
RDU: Health Care Services
Component: Medical Assistance Administration

Sponsor: Olson

Requester: Senate Finance
Component Number: 242

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	89.3		89.3	89.3	89.3	89.3	89.3
Travel	6.0		6.0	6.0	6.0	6.0	6.0
Contractual	2,742.4		2,742.4	2,742.4	2,742.4	2,742.4	2,742.4
Supplies	2.0		2.0	2.0	2.0	2.0	2.0
Equipment	7.6						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**2,847.3**	**0.0**	**2,839.7**	**2,839.7**	**2,839.7**	**2,839.7**	**2,839.7**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match	2,036.3		2,036.3	2,036.2	2,036.2	2,036.2	2,036.2
1004 GF	132.3		124.7	124.7	124.7	124.7	124.7
1005 GF/Program Receipts	678.7		678.7	678.8	678.8	678.8	678.8
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**2,847.3**	**0.0**	**2,839.7**	**2,839.7**	**2,839.7**	**2,839.7**	**2,839.7**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time	**1.0**		**1.0**	**1.0**	**1.0**	**1.0**	**1.0**
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

CS for SB 139(FIN) creates a cash incentive program for eligible health professionals engaged in qualified employment. The intent of the legislation is to "address the worsening shortage of certain health care professionals in the state by increasing the number and
improving the distribution of health care professionals who provide direct patient care."

Division of Health Care Services estimates that it will need a total of 1 FTE to fully administer the employment incentive programs.

(continued on next page)

Prepared by: William J. Streur, Deputy Commissioner
Division: DHSS Health Care Services
Phone (907) 269-7827
Date/Time 4/10/10 1:00 PM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date 4/10/2010

STATE OF ALASKA **BILL NO.** CSSB 139(FIN)

2010 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Health Care Professions Incentive Program

The Division assumes it will need $2,715.0 for practitioner incentive payments in FY2011. Maximum payments established for cash incentive are: $35.0 annually for tier I health care professionals employed in "regular" positions; $47.0 annually for tier I health care professionals employed in "very hard-to-fill" positions; $20.0 annually for tier II health care professionals employed in "regular" positions; and $27.0 annually for tier II health care professionals employed in "very hard-to-fill" positions. The need for $2,715.0 in FY2011 assumes the following:

Tier I	27 Practitioners	$1,161.0	(assumes 9 participants from each of 3 types comprising tier I at $387.0 for each type)
Tier II	63 Practitioners	$1,554.0	(assumes 9 participants from each of 7 types comprising tier II at $222.0 for each type)
Total	90 Practitioners	$2,715.0	

The Division assumes the employing entities will provide 25% of the $2,715.0 as contributing match as specified in HB392. Therefore, the expected GF match is $2,036.3 The match for the employing entities is $678.7.

Incentive payments are available to professionals for up to 3 years of qualified employment with a lifetime maximum participation of six years in the direct incentives program by a tier I or tier II health care professional. The total number of participants in the program may not exceed 90 participants annually, regardless of whether the participant is a new or continuing participant.

On the fiscal note, the payments for practitioners will be paid from the contractual line:

Item	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016
Practitioner Payments	$2,715.0	$2,715.0	$2,715.0	$2,715.0	$2,715.0	$2,715.0
Evaluation Contract	$ 18.0	$ 18.0	$ 18.0	$ 18.0	$ 18.0	$ 18.0
Staff Contractual Costs	$ 9.4	$ 9.4	$ 9.4	$ 9.4	$ 9.4	$ 9.4
Total:	$2,742.4	$2,742.4	$2,742.4	$2,742.4	$2,742.4	$2,742.4

Administrative Costs

1 Health Program Manager II, $89.3 (includes fringe benefits). Assumes $9.4 per FTE annually for office space, phones, and other contractual costs; $2.6 one time costs per FTE for computers and software; $5.0 one time costs per FTE for office equipment; $2.0 per FTE annually for supplies; $6.0 per year for travel; $18.0 each year for a program evaluation contract.

Health Program Manager II.

This position will serve as lead program manager for the employment incentive program and will: establish procedures for the commissioner's designation and prioritization of sites eligible for participation in the program, develop the application process for participation in the program for sites and professionals, develop and disseminate public information and notices pertinent to the program, lead the development of the methodology and procedures for classifying each eligible site as having either regular or very hard-to-fill positions, prepare annual reports that document the successes and challenges of the program, facilitate the creation of and ongoing work of the advisory committee, and establish procedures and manage the employer contribution portion of the program.

Health Professional Shortage Area (HPSA) and Medically Underserved Areas and Populations (MUA/MUP) Listing 3/2009

(Listing does not include the automatic Primary Care HPSAs for Alaska Native Tribal Populations, which are available to meet designation requirements)

Census Area/Borough	Primary Care HPSA	Dental HPSA	Mental Health HPSA	MUA (Medically Underserved Area)	MUP (Medically Underserved Population per Governor's Request)
013 - Aleutians East Borough	yes	yes	yes	y	
016 - Aleutians West Census Area	yes	yes	yes	y	
020 - Anchorage Borough	CHC	CHC	CHC		y (North)
050 - Bethel Census Area	yes	CHC (applied for geographic DHPSA)	yes	y	
060 - Bristol Bay Borough	CHC	yes	applied/CHC	y	
068 - Denali Borough	yes	applied; CHC site	yes		y
070 - Dillingham Census Area	only AN; CHC shortly	yes	applied for geographic; CHC		y
090 - Fairbanks North Star Borough	Low income	CHC;applying for low income	CHC		y
100 - Haines Borough	CHC	--	yes		y
110 - Juneau Borough	--	--	--	--	--
122 - Kenai Peninsula Borough	CHC	CHC	CHC; Seward subarea is MHPSA		y
130 - Ketchikan Gateway Borough	--	--	--	--	--
150 - Kodiak Island Borough	CHC	CHC	CHC		y
164 - Lake and Peninsula Borough	yes	yes	yes	y	
170 - Matanuska-Susitna Borough	yes (north); 2 CHCs	yes (north); 2 CHCs	2 CHCs		y
180 - Nome Census Area	yes	yes	yes	y	
185 - North Slope Borough	yes	yes	yes	y	
188 - Northwest Arctic Borough	yes	yes	yes	y	
201 - Prince of Wales-Outer Ketchikan Census Area	CHC (lost geo)	CHC	CHC	y	
220 - Sitka Borough	--	--	--	--	--
232 - Skagway-Hoonah-Angoon Census Area	yes	yes	yes	y	
240 - Southeast Fairbanks Census Area	yes	--	--		y
261 - Valdez-Cordova Census Area	Cordova geo (and CHC); CHC Copper Valley	2 CHCs	2 CHCs	y part (Copper Valley)	y part (Cordova; Whittier)
270 - Wade Hampton Census Area	yes	yes	yes	y	
280 - Wrangell-Petersburg Census Area	CHC	CHC	yes		y
282 - Yakutat Borough	yes	yes	CHC	y	
290 - Yukon-Koyukuk Census Area	yes	yes	yes	y	

data from www.hrsa.gov March 3, 2009
http://www.hpsafind.hrsa.gov/HPSASearch.aspx

Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility).
Medically Underserved Areas/Populations are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population.

USDHHS HRSA: More about shortage areas

Alaska Primary Care Office information: http://www.hss.state.ak.us/dph/healthplanning/primarycare/PC_Home.htm

"Yes" in HPSA columns means there is a "geographic" HPSA designatuion approved by HRSA Office of Shortage Designation, for all or part of the census area or borough.
"CHC" indicates there is at least one Community Health Center with automatice HPSA designation. Where geographic HPSAs exist, the geographic area score is generally higher than the CHC score. Most of the areas with geographic designations also have CHCs in one or more sites within the census area or borough.

Prepared by Health Planning and Systems Development Section, Health Care Services, Alaska Department of Health and Social Services 3/19/2009

Health Care Professions Loan Repayment Program

Concept Proposal

Submitted by
Pat Carr, Chief
Health Planning & Systems Development
Department of Health & Human Services
State of Alaska

on
September 11th, 2007

via
PCC Workforce Subcommittee

to
Alaska Primary Care Council

Health Care Professions Loan Repayment Program

Summary

Problem

Alaska is competing with other states and nations for the finite pool of available healthcare professionals. This competition will only intensify since the growth of supply is continuing to fall behind that of demand.

A common state-level response to these pressures is the use of financial inducements, collectively known as support-for-service programs (SFSP's). Good outcomes have been achieved with these. There are five types: scholarships, service-option loans, loan repayment, direct financial incentives, and residency support programs. All SFSP's have the same public goal: To improve healthcare staffing in shortage areas. National studies have determined loan repayment programs to be one of the most effective of the several support-for-service strategies - in terms of both recruitment and retention (see: *HCPLRP: Issue Paper*, 2007)

A key problem is that Alaska does not have a robust support-for-service program while most other states do, many have several, and further, some of those are growing. In sum, Alaska is at a substantive disadvantage as it necessarily competes in the national healthcare labor market.

Discussion

Alaskan health care provider agencies use many approaches to recruit and retain staff. This has proved difficult, however, and particularly so where (1) federal loan repayment programs do not apply, or, (2) there is insufficient resource available to meet need. More tools are needed to confront the problem of steadily growing vacancies in the Alaskan healthcare workforce.

Most all other states have state-sponsored programs that influence health professionals' geographic and specialty distributions. Programs that integrate a number of strategies for attracting and retaining health professionals have had a greater likelihood of success than have programs which rely on a single strategy. Substantial evidence indicates that state-level support-for-service programs typically are a fundamental part of those strategies.

Support-for-Service Programs

It is well-established that many healthcare professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away. For instance, in 2004, young physicians' educational debt averages stood at over $109,000 and this cost was increasing at the rate of more than $4,000 per annum.

There are several types of support-for-service programs. One of the two most common types of such programs is the service-requiring scholarship program. These pay tuition and other costs for healthcare students while obligating them to a period of service that begins when they complete residency (or similar post-graduate training) years later. The other common program type is loan repayment. Loan repayment programs recruit healthcare practitioners as they complete their training and are ready to begin service in exchange for paying off the traditional education loans

they acquired years earlier. Programs of both types typically require one year of service for each year of training cost support they provide.

Considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of healthcare personnel. Overall, 81 state-level programs were identified. There were 44 states with at least one program (88% of states). Fully 21 states had two or more programs (47%), with highs found in New Mexico (at 5) and Minnesota (at 7). On average, the 44 states had nearly two programs (1.8) each.

Loan Repayment Programs

In national studies, loan repayment has been found to be a successful strategy to recruit and retain health care professionals. Twenty-five years of program evaluations have clarified many of the outcomes possible from healthcare training support-for-service programs. Furthermore, studies have demonstrated that loan repayment programs, as a whole, have better outcomes than scholarship programs. Studies have shown that there are several benefits which can accrue from loan repayment programs. Selected examples include: (a) high position-fill rates, (b) high service-completion rates, and (c) high retention rates.

These programs are successful because the benefit of loan repayment is clear to potential applicants, and programs typically only provide payments to participants after they complete each 3 or 6 months of work; therefore, if a participant leaves or otherwise fails to work in the agreed upon area or practice, payments simply stop and there is no need to enforce penalties.

In 2006, the Alaska Physician Supply Task Force recommended a number of specific strategies and action steps to assuring an adequate supply of physicians to meet Alaska's need. One of the PSTF findings was that loan repayment is a proven strategy for recruiting physicians, and the federal loan repayment programs currently available to Alaska physicians need to be stabilized financially and supplemented with Alaska-based programs.

Conclusion

Reported increasing vacancy rates, increasing costs of recruitment [SORRAS report], and comparisons with national norms [PSTF report] suggest that Alaska currently experiences a shortage of healthcare professionals, and, that shortages exist in several key occupational categories. Loan repayment programs have demonstrated substantial and longstanding success as a public strategy which has helped to rectify such shortages.

Recommendation

It is recommended that Alaska create a "Health Care Professions Loan Repayment Program".

To do this, a planning process should be established. This process should define and prepare for adoption at least the following program elements: (a.) organizational support, (b.) oversight, (c.) fiduciary agent, (d.) practitioner eligibility, (e.) site eligibility, (f) repayment details, (g.) program design & management, and (g) program evaluation.

Resource

Health Care Professions Loan Repayment Program: Issue Paper (2007). Health Planning & Systems Development, Alaska Department of Health & Social Services.

Health Care Professions Loan Repayment Program
Issue Paper

Abstract

This paper: (1.) illustrates the current and expected healthcare workforce needs of Alaska; (2.) indicates the widespread use elsewhere of support-for-service programs, and in particular loan repayment; and (3.) recommends that Alaskans should now explore creation of a Health Care Professions Loan Repayment Program (HCPLRP).

Main Issue

Alaska is increasingly vulnerable to the competitive challenges posed by other states and nations for the finite pool of available healthcare graduates. This vulnerability will increase during coming years because of two factors. (1.) The need for health care professionals in Alaska is steadily rising, and, shortages are now evident in some categories. (2.) Further, these trends are national. These workers are part of, and often respond to, nationwide labor markets. Further, these trends are expected to accelerate. This is particularly true in those states that do not produce adequate numbers of their own health workers in the given disciplines. This puts such states at a marked disadvantage. Financial incentive programs are particularly important for those states, and Alaska is one of these. As a result, several other states have become robust competitors in recruitment of the healthcare workforce, and some are planning new and expanded loan repayment programs (Pathman, 2007).

A fundamental, and common, state-level response to these pressures is the use of financial inducements, these collectively known as support-for-service programs (SFSP's). Excellent outcomes are readily achievable from these efforts. There are five types: scholarships, service-option loans, loan repayment, direct financial incentives, and resident support programs. All support-for-service programs have the same key public goal: To improve healthcare staffing in shortage area communities.

National studies have determined loan repayment programs to be one of the most effective of the several support-for-service strategies - in terms of both recruitment and retention. As compared to the other SFSP options, here loan repayment participants sign support-for-service contracts after they complete their training, when they are older and better informed as to their career options. These professionals make commitments at the time they are ready to begin their service-obligations. They are more likely to know their own needs and those of their families at this later juncture. They know where they will serve and have a sense as to how well their chosen worksites will "fit" their needs.

Problem

This section presents evidence which indicates that:

- A healthcare workforce shortage currently exists in several occupations.
- Under current conditions these shortages will continue into the foreseeable future.
- In several occupations, these shortages will escalate.

Trends in National Workforce

Numerous, prominent sources indicate that there is a growing national shortage in the rural health care workforce. Two examples follow.

GAO Position (2001): In 2001, the General Accounting Office's (GAO's) director of health care-public health issues testified before Congress regarding growing concerns about the adequacy of the health care work force and lessons learned from the experience of the National Health Service Corps (NHSC) in addressing the maldistribution of health care professionals (Heinrich, 2001). Selected key points were:

- Recruitment and retention of adequate numbers of qualified health care workers are major concerns for many health care providers today.
- Available evidence suggests emerging shortages in some fields (e.g. nurses).
- Vacancy rates for HC workers in rural areas and inner cities are especially high.
- Although demand for most health workers will continue to grow, the increasing age of Americans, and their workforce may limit supply.
- The National Health Services Corp (NHSC) illustrates the challenges in addressing shortages of health professionals in certain locations.
- Better placement coordination with waivers for J-1 visa physicians is needed.
- Loan repayment is a better approach than service-requiring scholarships, to which individuals commit when they are still students.

NOSORH Position (2006): A representative and recent understanding can be gained from the National Organization of State Offices of Rural Health (NOSORH). In September 2006 NOSORH issued a Statement of National Priorities. Presented below are selected summaries of that document, without further comment. Interested readers should see: http://www.nosorh.org/pdf/Rural_Impact_Study_States_IT.pdf

- While most rural communities in the U.S. already experience health care workforce shortages, the demand for health care workers nationwide is projected to grow faster than the supply. This shortage of health care workers can impact health care in a variety of ways, including: decreasing quality of care, decreasing access to care, increasing stress in the workplace, increasing medical errors, increasing workforce turnover/decreasing retention rates, and increasing health care costs.

- Most rural areas ... are classified by the federal government as Health Professional Shortage Areas (HPSAs) for primary medical care. A HPSA designation is made using a formula that includes a ratio of physician to population that is greater than 1:3,500. A population is considered "adequately served" when the ratio is 1:2,000. In 1997, more than 2,200 additional physicians would have been needed in non-metropolitan areas to eliminate HPSA designations. SORH directors consider the workforce shortage to be one of the greatest issues facing rural health, in particular shortages related to physicians and nurses.

- Certain national health workforce trends that will have a profound impact on rural populations and exacerbate the current rural health workforce shortages. Examples follow:

    - If health care consumption patterns and physician productivity remain constant over time, the aging population will increase the demand for physicians per thousand population from 2.8 in 2000 to 3.1 in 2020. Demand for fulltime-equivalent RNs per thousand population would increase from 7 to 7.5 during this same period.

    - Minority and female physicians have a greater propensity than do non-minority and male physicians to practice in urban communities. Meanwhile the percentage of physicians that are minorities and women is increasing.

    - The Bureau of Health Professions projects that there will be a 33-44% increase in demand for physicians, 41 percent for RNs, and 46 percent for LPNs from 2000 to 2020.

    - According to the Bureau of Health Professions, there is an acute shortage of pharmacists in the U.S. In February 1998, there were 2,670 unfilled full and part-time positions in the U.S. as compared to 6,920 in February 2000. Adding to this, enrollment rates in U.S. schools of pharmacy declined during this period.

    - In 1970, women accounted for 13 percent of the nation's pharmacists as compared to 2000 when they were 46 percent of the nation's pharmacists. Women tend to elect part-time work as pharmacists.

    - From 1990 to 1999, there was a 46 percent increase in the number of prescriptions dispensed from hospitals.

- *NOSORH concluded the following in its 2006 statement of national priorities:* ...SORH directors around the U.S. determined that they are most concerned with issues related to rural health workforce, health care services, and the needs of special populations. Research suggests that this concern is warranted as: demand for health care workers is increasing while the supply is decreasing; rural health care facilities continue to be fragile, there are gaps in these services, and all of these rural health services are critical to the health and well-being of the U.S.; and the needs of rural populations are changing, however, the programs serving them are unable to meet their needs. While SORHs respond to a variety of rural health needs and issues, new health care policies and additional rural health programs and funding will be needed if states are to address these increasingly important rural health issues and concerns.

Growth in Alaskan Jobs

Healthcare Workforce Overall: In 2004 there were 301,300 jobs in Alaska, with 32,700 (10.9 percent) of these in health care and social assistance (HCSA). By 2014, the overall job count is projected to be 349,550, with the HCSA workforce at 43,650 (12.5 percent). Thus by 2014, the number of HCSA jobs is projected to grow by 10,950 (34 percent), accounting for 22.7 percent of overall statewide job growth for the period. By 2014, health care and social assistance is projected to be the largest single industry workforce category in Alaska with 43,650 workers. (AHCDB, 2007, Table 3.300).

Social Service Occupations: For 2004, employment in community & social service (CSS) occupations was estimated to be 6,025 jobs. By 2014, this category of jobs is forecasted to be at 7,487, a rise of 1,462 (24 percent). The highest projected growth rates from 2000-2014 are projected to include mental health & substance abuse social workers (36.2 percent), social & human service assistants (34.6 percent) and mental health counselors (32 percent). (AHCDB, 2007, Table 3.310).

Selected Occupations: Review of 42 particular healthcare occupations indicates that these held 14,083 jobs in 2000, and that these are forecasted to reach 25,009 by 2010, an overall rise of 10,026 jobs (78 percent). Registered nursing positions are expected to grow the most, from 4,439 in 2000 to 8,556 in 2010, a gain of 4,117 jobs or (93 percent). All but one of the examined occupations is expected to have more jobs available by 2010. Further, of the 42 occupations presented, employment in 8 of these will more than double (e.g. AHCDB, 2007, Table 3.330).

Shortage in Alaskan Workforce

Health Professional Shortage Areas: Alaska has a large number of federally designated "Health Professional Shortage Areas" (HPSAs), the point of these designations being to aid in health care planning and finance. Typically these are determined by the existence of: (1.) a relative lack of desired personnel, and (2.) the existence of particular socio-economic conditions. A second route to HPSA designation, which is automatic, is via the existence of a federally funded community health center (CHC). HPSAs are of three types. Statewide in 2007 the following HPSAs existed: 28 in Primary Care (with 16 scored, and 12 via CHCs), 27 in Mental Health (with 14 scored, and 13 via CHCs), and 24 in Dental Health (with 7 scored, & 17 via CHCs). (Alaska Health Care Databook, 2007, Table 3.360). However, an important caveat is that many observers feel that the federal HPSA designation process underestimates the extant need for more healthcare professionals (e.g. US GAO, 1995). Thus, these designations should be considered as a conservative method for establishing need for the healthcare workforce.

Medically Underserved Areas: Alaska also has numerous federally designated "Medically Underserved Areas" (MUA) and "Medically Underserved Populations" (MUP). These designations identify shortages of primary medical care, dental health or mental health providers. Designations may be either geographic (MUA, i.e. a county or service area), or demographic (MUP, i.e. low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services). Each designation is assigned an Index of Medical Underservice (IMU) score, which is used to determine the eligibility of an area or population for MUA/MUP status. For 2007, there were 17 area designations and 11 population designations. (Alaska Health Care Databook, 2007, Table 3.350).

Resident Workers with Age: Two aspects of worker demographics further suggest the likelihood of a workforce shortage in the health care and social assistance (HCSA). The first of these regards "resident workers with age". In 2005 total employment in all HCSA occupations stood at 28,356. Of resident workers in all HCSA occupations statewide, 40 percent were age 45 and older; 27 percent were age 50 and older. Of resident workers who were in health care practitioner occupations per se, 47 percent were age 45 and older; and 31 percent were age 50 and older. Therefore, succession planning will be of concern over the next two decades as today's mature health care professionals retire (Alaska Health Care Databook, 2007, Table 3.320).

Non-Resident Workers: A second workforce demographic issue regards the sizeable number of "non-resident" workers. Overall, 10 percent of the workforce was non-residents in 2005, with a

high of (13 percent) among non-resident health care practitioner and technologist occupations. Expect additional pressure to build on the health care system if non-resident (itinerate) workers are not available to fill Alaska health care workforce gaps (e.g. AHCDB, 2007, Table 3.320).

Selected Occupations: Physicians

Physician Shortage – 1997: A decade ago Johnson and Norris (1997) conducted a comprehensive study to describe Alaska's geographic distribution of generalist physicians relative to population. These investigators queried all 443 generalist care physicians (family, general, general internal medicine, and pediatric) or their offices as to their specialties, employers, populations served, hours spent per week offering direct patient care, and locations. The results indicated a 30% overall shortage of generalist physicians for the state, representing roughly 141 full-time-equivalent generalists relative to national practice patterns and trends of health maintenance organizations. Of 17 primary health care areas, including the Anchorage area, 15 showed a need for additional generalist physicians. Most areas had a 20 to 40% shortage.

Physician Shortage – 2004: In 2004, a survey by the American Medical Association showed that, nationally, there were 2.38 practicing physicians per 1,000 people. Alaska's rate of practicing physicians was 2.05 per 1,000 people. Based on Alaska's 2004 population estimate of 656,834 and the national average of 2.38 physicians per 1,000 people, Alaska should have had 1,565 practicing physicians to be on par with national averages. The actual number of physicians practicing in Alaska was 1,347, indicating a shortage of 14 percent or 218 physicians. In areas outside of Anchorage, the rate of physician deficiency was 16 percent. (Alaska Health Care Databook, 2007, Table 3.370).

Physician Shortage – 2006: In 2006, the AK DHSS and the University of Alaska jointly assembled the "Alaska Physician Supply Task Force" (PSTF). This group then conducted a large inter-agency study, issuing the authoritative report, "*Securing an Adequate Number of Physicians for Alaska's Needs*". It found that Alaska had a shortage of physicians. Although not at crisis levels, the shortage was affecting access to care throughout the state, and, increasing cost to hospitals and other health care organizations. Up to 16% of rural physician positions in Alaska were vacant in 2004. Patients with Medicare were having difficulty finding a primary care physician. Several important specialties were in serious shortage in Alaska. It concluded that:

- The shortage is very likely to worsen over the next 20 years as the state's population increases and ages. Physician supply nationwide is entering a period of shortage, according to the best current predictions. Physicians in Alaska are aging and one-third may be retiring in the next 10-15 years. The new generation of physicians wants a more balanced life, meaning fewer hours on duty and more predictable schedules. These trends mean that more physicians will be required to serve the same population. Technology and scientific advances have increased the amount of medical care available, also adding to the need for physicians, as the patients expect more care than previously.

- As the supply of physicians shrinks, recruitment will become more competitive. Alaska's traditional system of recruiting physicians from federal assignment in the military and Indian Health Service is much less effective with changes in these systems. Alaska is far behind the other states in production capacity. (1-2) Long-range planning, even if it includes a four-year medical school in Alaska, will not address current physician needs in a timely fashion, so interim measures are needed. (59)

Selected Occupations: Nurses

Nursing Shortage – 2003: The nursing shortage is particularly acute, both in Alaska and nationwide. It is estimated that during this decade the need for RN's will increase by 4,117 (in 2000: 4,439; in 2010: 8,556) (Fried, N. & Keith, B. (2003). National shortages will make recruitment yet more difficult. As a result, Alaska will have a great need to recruit and retain registered nurses. Addressing the need of rural and remote areas will be yet more difficult and expensive than to do so for urban areas.

Impact on CHC's

Rosenblatt, et al. (2006) examined the status of provider workforce shortages such as these may limit CHC expansion. They noted that the federal government has continued to expand the capacity of community health centers (CHCs) to provide care to underserved populations. The researchers therefore conducted a survey of all 846 federally funded US CHCs that directly provide clinical services and are within the 50 states and the District of Columbia (May-Sept, 2004). Questionnaires were completed by the chief executive officer of each grantee. Overall response rate was 79.3%. Information was supplemented by data from the 2003 Bureau of Primary Health Care Uniform Data System and weighted to be nationally representative.

Rosenblatt, et al (2006) found that primary care physicians made up 89.4% of physicians working in the CHCs, the majority of whom are family physicians. In rural CHCs, 46% of the direct clinical providers of care were non-physician clinicians compared with 38.9% in urban CHCs. There were 428 vacant funded full-time equivalents (FTEs) for family physicians and 376 vacant FTEs for registered nurses. There were vacancies for 13.3% of family physician positions, 20.8% of obstetrician/gynecologist positions, and 22.6% of psychiatrist positions. Rural CHCs had a higher proportion of vacancies and longer-term vacancies and reported greater difficulty filling positions compared with urban CHCs. Physician recruitment in CHCs was heavily dependent on National Health Service Corps scholarships, loan repayment programs, and international medical graduates with J-1 visa waivers. The study concluded that CHCs face substantial challenges in recruitment of clinical staff, particularly in rural areas. The largest numbers of unfilled positions were for family physicians at a time of declining interest in family medicine among graduating US medical students. They stated that success of the current US national policy to expand CHCs may be challenged by these workforce issues.

Strategy

It is essential to enhance the capacity of Alaskan health care provider agencies to recruit and retain staff where: (1.) federal loan repayment programs either do not apply, or, (2.) there are insufficient resources available to meet need. More tools are needed to confront the problem of steadily growing vacancies in the Alaskan healthcare workforce.

Most other states have programs that influence health professionals' geographic and specialty distributions. Programs that integrate a number of strategies for attracting and retaining health professionals have a greater likelihood of success than do programs which rely on a single strategy. Substantial evidence indicates that state-level support-for-service programs should be, and typically are, a fundamental part of those strategies.

Debt from Health Care Training

What follows are brief summaries of recent, representative studies which suggest that:

- Health care student debt affects subsequent practitioner career choices;
- Loan repayment options support recruitment goals; and
- These programs directly help to correct practitioner maldistributions.

Factors in Recruitment & Retention: Daniels, et al. (2007) sought to identify factors associated with rural recruitment and retention of graduates from a variety of health professional programs in the southwestern United States. They conducted a longitudinal study by mailing a survey to graduates from 12 health professional programs in New Mexico. The main outcomes examined were: (1.) first rural employment, and, (2.) aspects of any rural employment, since graduation. Daniels, et al. (2007) concluded that rural background and preference for smaller sized communities are associated with both recruitment and retention. In addition, however, they stated that loan forgiveness and rural training programs appear to support recruitment. Retention efforts must focus on financial incentives, professional opportunity, and desirability of rural locations

Medical Student Debt & Career Choice: Rosenblatt & Andrilla (2005) examined the notion that medical students' rising total educational debt is one of the factors that explains the recent decline in students' interest in family medicine and primary care. They analyzed the results from questions on the Association of American Medical Colleges' 2002 Medical School Graduation Questionnaire that focused on students' debt and career choices. Students reported that higher levels of debt influenced their future career choices. An inverse relationship was observed between the level of total educational debt and the intention to enter primary care, with the most marked effect noted for students owing more than $150,000 at graduation.

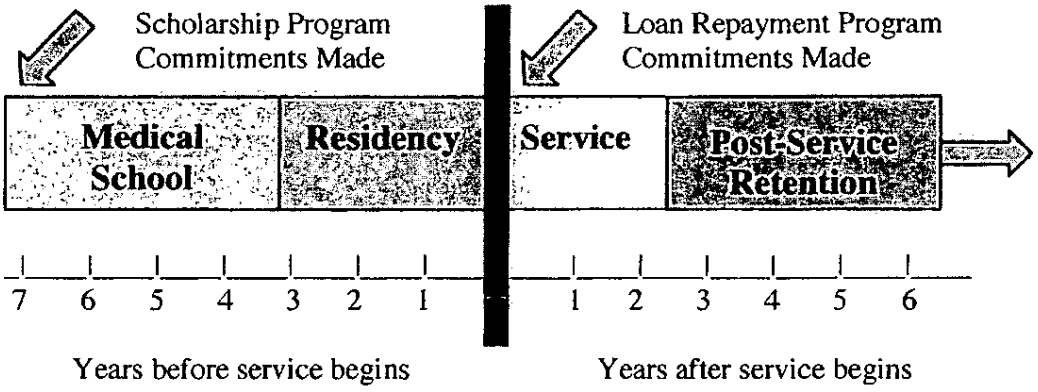
Medical Training Debt & Service Commitments: Pathman, et al (2000) assessed how student loan debt and scholarships, loan repayment and related programs with service requirements influence the incomes young physicians seek and attain, influence whether they choose to work in rural practice settings and affect the number of Medicaid-covered and uninsured patients they see. Data are from a 1999 mail survey of a national probability sample of 468 practicing family physicians, general internists and pediatricians who graduated from U.S. medical schools in 1988 and 1992. A majority of these generalist physicians recalled "moderate" or "great" concern for their financial situations before, during and after their training. Eighty percent financed all or part of their training with loans, and one-quarter received support from federal, state or community-sponsored scholarship, loan repayment and similar programs with service obligations. In their first job after residency, family physicians and pediatricians with greater debt reported caring for more patients insured under Medicaid and uninsured than did those with less debt. For no "specialty" was debt associated with physicians' income or likelihood of working in a rural area. Physicians serving commitments in exchange for training cost support, compared to those without obligations, were more likely to work in rural areas (33 vs. 7 percent, respectively, $p < 0.001$) and to provide care to more Medicaid-covered and uninsured patients (53 vs. 29 percent, $p < 0.001$), but did not differ in their incomes ($99,600 vs. $93,800, $p = 0.11$). Thus, among physicians who train as generalists, the high costs of medical education appear to promote, not harm, national physician work force goals by prompting participation in service-requiring financial support programs and perhaps through increasing student borrowing.

Support-for-Service Programs

It is well-established that a sizeable number of healthcare professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away. For instance, training to become a physician is expensive, as 80 percent of medical students who graduate in debt will attest (e.g. Jolly, 2005). In 2004, young physicians' educational debt averages stood at over $109,000 and was this cost was increasing at the rate of more than $4,000 per annum (e.g. AAMC, 2004). Nonetheless, educational costs and students' fears of acquiring six-figure debts have created a market for government programs that link support for healthcare training costs to a period of obligated clinical work in shortage areas.

There are several types of financial "support-for-service programs" (SFSP's). These include: scholarships, service-option loans, loan repayment, direct financial incentives, and resident support programs. One of the two most common types of such programs is the service-requiring scholarship program. These pay tuition and other costs for healthcare students while obligating them to a period of service that begins when they complete residency (or similar post-graduate training) years later. The other common program type is loan repayment. Loan repayment programs recruit healthcare practitioners as they complete their training and are ready to begin service in exchange for paying off the traditional education loans they acquired years earlier. Programs of both types typically require one year of service for each year of training cost support they provide.

Figure 1 - Timeline of physicians' training years, signing of commitments with service-requiring scholarship and loan repayment programs, service periods (typically two-to-four years) and post service retention.



(After: Pathman, D.E. (2006). What Outcomes Should We Expect From Programs That Pay Physicians' Training Expenses in Exchange For Service? NCMEDJ, 67(1), pg. 77)

Support-for-service programs appear to be a natural solution to both the students' and the public's needs. They have grown in popularity over the past 25 years in tandem with rising tuition costs, with both federal and state agencies using them. In one well-known federal example, in 2005 the Bureau of Health Professions reported that the National Health Service Corps (NHSC) was providing an obligated physician workforce of about 1,700 scholars and loan re-payers. As a result of NHSC shifting most of its funding to loan repayment, more workers were immediately brought into the fold, and that census has now roughly doubled. In addition, most states also

sponsor their own support-for-service programs. In 1996 there were a total of 69 state programs with an estimated workforce of 1,300 practicing physicians. These state programs doubled in number from 1990 to 1996 and very likely have grown further since (Pathman, et al. 2000).

State Scholarship, Loan Forgiveness, and Related Programs: Pathman, Taylor, et al (2000) noted that in the mid-1980s, states expanded their initiatives of scholarships, loan repayment programs, and similar incentives to recruit primary care practitioners into underserved areas. These programs have since grown substantially during the ensuing two decades. The authors thus sought to identify and describe state programs that provide financial support to physicians and midlevel practitioners in exchange for a period of service in underserved areas, and to begin to assess the magnitude of the contributions of these programs to the US health care safety net. This cross-sectional, descriptive study established the number and types of state support-for-service programs in 1996; trends in program types and numbers since 1990; distribution of programs across states; numbers of participating physicians and other practitioners in 1996; numbers in state programs relative to federal programs; and basic features of the state programs.

The study found that in 1996 there were 82 eligible programs operating in 41 states, including 29 loan repayment programs, 29 scholarship programs, 11 loan programs, 8 direct financial incentive programs, and 5 resident support programs. Programs more than doubled in number between 1990 (n = 39) and 1996 (n = 82). In 1996, an estimated 1306 physicians and 370 midlevel practitioners were serving obligations to these state programs, a number comparable with those in federal programs. Common features of state programs were a mission to influence the distribution of the health care workforce within their states' borders, an emphasis on primary care, and reliance on annual state appropriations and other public funding mechanisms.

The authors concluded that as of 1996 the several states had fielded an obligated primary care workforce comparable in size to the better-known federal programs. Thus, these state programs constitute a major portion of the US health care safety net. The study emphasized that such state programs should be considered in plans to further improve health care access.

Experience of Other States

State-Level Support-for-Service Programs (2007): Considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of healthcare personnel. Tables 1, 2 & 3 here-present listings of those state-level support-for-service programs that were web-posted by the Association of American Medical Colleges (as of 8/10/07). These provide a selective look at state and federal loan repayment, forgiveness and scholarship programs available to allopathic medicine and other health professions students. This compilation is not exhaustive, and at present, our office is not aware of one that is. The here-derived tables shows that, overall, there were 81 programs. There were 44 listed states with at least one program (88% of US states). Fully, 21 of these states had two or more programs (47% of listing), with highs found in New Mexico (at 5) and Minnesota (at 7). On average, the 44 listed states had nearly 2 programs (1.8) each. Table 1 presents 43 listings that were designated as "state programs". Table 2 presents another 20 listings that were designated as "federal/state programs". Finally, Table 3 presents another 18 programs were not otherwise classified, though quick inspection of titles suggests that many can be readily classified. Those programs that were categorized as (strictly) "federal" (e.g. NIH, military) are not further considered. Click on any program title for more programmatic detail.

State-Level Offices: Service-for-Support Programs

Table 1: Designation as: "State Program"

State	Program
Arizona	Arizona Medical Student Loan Program
Arkansas	Community Match Physician Recruitment Program
Arkansas	Physician Grant Recruitment and Retention Program
Colorado	Colorado Health Professions Loan Repayment Program
Georgia	State Medical Education Board of Georgia Scholarship Program
Indiana	Indiana Primary Care Scholarship Program (IPCSP)
Iowa	Osteopathic Physician Recruitment Program (O.P.R.P.)
Kansas	Kansas Bridging Plan
Maine (2)	Maine Health Professions Loan Program
Maryland	Loan Assistance Repayment Program for Primary Care Physicians
Minnesota	Minnesota Dentist Loan Forgiveness Program
Minnesota	Minnesota Nurse Loan Forgiveness Program
Minnesota	Minnesota Rural Mid-level Practitioner Loan Forgiveness Program
Minnesota	Minnesota Rural Physician Loan Forgiveness Program
Minnesota	Urban Physician Loan Forgiveness Program
Mississippi (2)	Family Medical Education Loan/Scholarship Program
Mississippi	State Medical Education Loan/Scholarship Program
Missouri	Primary Care Resource Initiative for Missouri (PRIMO)
Montana (3)	Montana Rural Physician Incentive Program (MRPIP)
Montana	WICHE Professional Student Exchange Program
Montana	WWAMI Medical Exchange Program
Nebraska	Nebraska Student Loan Program
Nevada	Nevada Health Service Corps
New Mexico (5)	Allied Health Loan-for-Service Program
New Mexico	New Mexico Health Professions Student Loan-for-Service Program
New Mexico	Nursing Loan-for-Service Program
New Mexico	Osteopathic Medical Student Loan for Service Program
New York	Regents Physician Loan Forgiveness Award Program
North Carolina (4)	Community Practitioner Program
North Carolina	NC Student Loan Program for Health, Science and Mathematics
North Carolina	North Carolina State Loan Repayment Program
Ohio	Ohio Physician Loan Repayment Program

Table 1: "State Program" (continued)

Oklahoma (3)	Family Practice Resident Rural Scholarship Loan Program
Oklahoma	Oklahoma Rural Medical Education Scholarship Loan Program
Oklahoma	Oklahoma State Loan Repayment Program
Oregon	Oregon Rural Health Services (RHS) Loan Repayment Program
South Dakota	South Dakota Midlevel Tuition Reimbursement Program
Tennessee (2)	Health Access Incentive Program: Incentive Grant: Mid-Levels
Tennessee	Health Access Incentive Program: Incentive Grant: Physicians
Virginia	Virginia Loan Repayment Program
Washington (2)	WA State Health Professional Loan Repayment Program
West Virginia	Medical Student Loan Program
Wyoming	Wyoming WWAMI Medical Education Program

State-Level Offices: Service-for-Support Programs

Table 2: Designations as: "Federal/State Program"

Connecticut	Connecticut State Loan Repayment Program
Delaware	Delaware State Loan Repayment Program
Illinois	Illinois/National Health Service Corps Loan Repayment Program
Iowa (2)	Iowa PRIMECARRE Loan Repayment Program
Louisiana	Louisiana State Loan Repayment Program
Maine	Maine State Loan Repayment Program
Massachusetts	Massachusetts State Loan Repayment Program
Minnesota	Minnesota State Loan Repayment Program
Missouri (2)	Physician Loan Repayment
New Hampshire	NH Primary Loan Care Repayment Provider Plans
New Jersey	Primary Care Loan Redemption Program of New Jersey
New Mexico	Health Professional Loan Repayment Program (HPLPP)
Ohio	NHSC / BHPr Ohio Loan Repayment Program
Pennsylvania	Pennsylvania's Primary Health Care Practitioners Loan Repayment Program
Texas	Physician Education Loan Repayment Program of Texas
Utah	Utah Health Care Workforce Financial Assistance Program
Virginia (2)	National Health Service Corp-VA Loan Repayment Program
Washington	WA State Health Professional Scholarship Program
Wisconsin (2)	Wisconsin Health Professions Loan Assistance Program
Wisconsin	Wisconsin Physician Loan Assistance Program

(number in parentheses indicates total state-office programs for that state that are not "federal" per se)

State-Level Offices: Service-for-Support Programs

Table 3: Programs – "Not Otherwise Designated"

Arizona (3)	Arizona Loan Repayment Program
Arizona	NHSC/Arizona Department of Health Services
Arkansas (3)	Arkansas Rural Medical Practice Student Loan/Scholarship Program (ARMPSLSP)
California (2)	Dr. James L. Hutchinson & Evelyn Ribbs Hutchinson Medical School Scholarship
California	NHSC/CA State Loan Repayment Program
Georgia (2)	Georgia Physician Loan Repayment Program
Kentucky	Rural Kentucky Medical Scholarship Fund (RKMSF) Grant Program
Michigan	Michigan Essential Health Provider Program/SLRP
Minnesota (7)	Federal National Health Service Corps (NHSC) Loan Repayment Program
Nebraska (2)	Nebraska Loan Repayment Program
North Carolina	Loan Repayment Program
North Dakota (2)	The Medical Personnel Loan Repayment Program
North Dakota	The State Community Matching Physician Loan Repayment Program
Rhode Island	Rhode Island Health Professional Loan Repayment Program
South Dakota (3)	NHSC/Loan Repayment and Scholarship Program
South Dakota	South Dakota Physician Tuition Reimbursement Program
Vermont (2)	Freeman Educational Loan Repayment for Physicians Program
Vermont	Vermont State Loan Repayment Program

(number in parentheses indicates total state-office programs for that state that are not "federal" per se)

Loan Repayment Programs

In national studies, loan repayment has been found to be a successful strategy to recruit and retain physicians and nurses. Twenty-five years of program evaluations have clarified many of the outcomes possible from healthcare training support-for-service programs. Furthermore, studies have demonstrated that loan repayment programs, as a whole, have better outcomes than scholarship programs. Results of these comparisons have proved compelling. For example, studies demonstrating the strengths of loan repayment programs prompted Congress recently to allow the NHSC to make more loan repayment and fewer scholarship awards (e.g. Bureau of Health Professions, 2005) and led some states to expand their loan repayment programs (Pathman, et al. 2000).

Studies have shown that there are several benefits which can accrue from loan repayment programs. Selected examples follow:

> *High Position Fill-Rates:* Some programs, including the NHSC, have many more applicants than their funds can support and regularly fill all funded positions; other programs have many unfilled positions for lack of applicants.
>
> *High Service Completion Rates*: Very few loan repayment programs, accordingly, have found a need to set any buy-out penalties; as a group, their service completion rates average 93% without them (Pathman, et al, 2004). It is the physician-program-community fit and the financial attractiveness of the program that prompts physicians to complete their obligations with service (the "carrot"), not financial and legal threats (the "stick").
>
> *High Retention Rates:* Beyond merely completing obligations with service, there has long been the hope that obligated physicians will remain in their service communities for years afterwards ... In fact, data show that physicians participating in state-run support-for-service programs remain in their service sites as long on average as other young physicians remain in practices of all types nationwide. Physicians obligated to state-run loan repayment programs remain substantially *longer* than other young physicians (e.g. Pathman, 2004).

Effectiveness of Support-for-Service: Sempowski, I.P. (2004) attempted to evaluate the effectiveness of programs that provide financial incentives to physicians in exchange for a rural or underserviced area return-of-service (ROS) commitment. This was done via a systematic literature review using Medline and Ovid HealthSTAR databases were searched from 1966 to 2002. The initial search yielded 516 results. Bibliography review yielded additional references. Ten publications were selected as the highest level of evidence available. The main outcome measures were: (a.) initial recruitment of physicians, (b.) buyout rates, and (c.) long-term retention.

The majority of studies reported effective recruitment despite high buyout rates in some US-based programs. The one prospective cohort study on retention showed that physicians who chose voluntarily to go to a rural area were far more likely to stay long term than those who located there as an ROS commitment. Multidimensional programs appeared to be more successful than those relying on financial incentives alone. Sempowski, I.P. (2004) concluded that ROS programs to rural and underserviced areas have achieved their primary goal of short-term recruitment but have had less success with long-term retention. However, this study combined different types of support-for-service programs within its analysis thus somewhat preventing conclusions as to loan repayment programs, per se.

Loan Repayment vs. Payback Programs: Miller & Crittenden (2001) sought to determine and contrast the possible impact that two different types of support-for-service programs might have on medical school choice, and, students' intentions to return to their home states. The authors examined difference in preferences for: (a.) payback programs regarding state-subsidized medical education which are designed to increase the rate of graduates returning to those states to practice; and (b.) loan repayment programs that are designed to entice medical school graduates from rural states to return to their home states.

Miller & Crittenden (2001) surveyed 229 medical students (response rate 80 percent). The questionnaire collected background information on the students and addressed the possible

impact of payback and loan repayment policy proposals on student plans. Forty-seven percent of students reported that they would attend a different medical school if a required payback program were in place. Students who were more competitive at the time of admission to medical school were significantly more likely to say they would attend another medical school than were less competitive students. In contrast, 48 percent of students reported that they would be more likely to return to their home states if expanded loan repayment programs were available for service in areas of need. The findings suggest that payback programs may dissuade more competitive students from entering medical schools with such requirements, compromising the pool of students most likely to return to rural areas. Conversely, medical students appear willing to consider loan repayment programs upon completion of their training.

Why Do Loan Repayment Programs Work? Expert opinion was sought for insights into why loan repayment programs work. Donald Pathman, MD, MPH, (Univ. of North Carolina) was queried as to his view. Dr. Pathman stated:

> "As a whole, state-run (loan repayment) programs are successful but not because they are run well---- most are under-funded, under-staffed and can't offer individualized assistance to the health care practitioners they support. They are successful because the benefit of loan repayment is clear to potential applicants and programs typically only provide payments to participants after they complete each 3 or 6 months of work; therefore, if a participant leaves or otherwise fails to work in the agreed upon area or practice, payments simply stop and there is no need to enforce penalties." (Pathman, 2007)

Does a Loan Repayment Program Make Sense for Alaska? Expert opinion was sought for perceptions as to whether a loan repayment program makes sense for Alaska. Again, Donald Pathman, MD, MPH, (Univ. of North Carolina) was queried as to his view. Dr. Pathman stated:

> "I am glad to hear that Alaska is thinking of expanding loan repayment opportunities. I visited Alaska for the first time this past spring for the National Rural Health Association meeting, in Anchorage, with a side trip to Minto and Fairbanks. What an amazing place! I spoke with several folks working with the Native American health corporation in the state, and realize the physician shortages for the populations they serve. I was impressed that they knew little about how to attract and keep a physician. Lots of opportunities there for improvement in programs." (Pathman, personal communication, 2007)

Position of the Alaska Physician Supply Task Force (2006): The PSRF recommended a number of specific strategies and action steps to achieve four main goals related to assuring an adequate supply of physicians to meet Alaska's need. One of the PSRF findings was that Alaska's clinics and hospitals receive inquiries from physicians about the availability of loan forgiveness often. Loan repayment is a proven strategy for recruiting physicians, and the federal loan repayment programs currently available to Alaska physicians need to be stabilized financially and supplemented with Alaska-based programs. For detail, see: *"Securing an Adequate Number of Physicians for Alaska's Need"* (2006).

Precedents in Alaska: There are, and have been, other circumspect loan repayment programs for health professionals here in Alaska. These have typically been via categorical federal funding. Examples include Indian Health Service supports, and use of the National Health Service Corp. There have also been selected opportunities via the regional health corporations, and certain hospitals. Further, the Alaska Mental Health Trust has recently considered some loan repayment supports in the behavioral health field. While promising, these will collectively still fall far short of garnering the needed workforce to face projected need.

Recommendation

Recommended: Alaska should establish a Health Care Professionals Loan Repayment Program (HCPLRP). Decisions as to particular program elements must await further public process. Questions should be addressed regarding at least the following program elements:

- *Organizational Support*: What are the best ways to build legislative and public understanding and support on this issue? For instance, members of the Alaska Physician Supply Task Force supported a loan payback provision for physicians.

- Oversight: What is that governance entity most suited to provide leadership and oversight of this program? Similarly, which entity is most suited to administer the program? There is evidence that no single entity has the expertise to properly oversee and administer such a program. This might argue for a blended or interagency oversight structure. One agency might provide programmatic administration, while the other might serve as fiduciary agent.

- *Fiduciary Agent*: It may prove both workable and preferred that fiduciary mechanics and other administrative aspects be organizationally separated. If so, which agency is most to assume this fiduciary role? One approach might be to have the program work in tandem with the Alaska Commission on Postsecondary Education (ACPE). It is possible that the functions of the Alaska Commission on Postsecondary Education could be amended as these relate to repayment provisions healthcare degree program participants. It appears likely that no substantive change would be necessary for ACPE to act strictly as fiscal agent for participant payments. Further, this would not be a recommendation to change the scope of the ACPE mission to include direct workforce development. This later function would likely be accomplished by another state agency via interagency partnership.

- *Provider Eligibility*: Which healthcare occupations are to be deemed as eligible for the HCPLRP? Are all eligible occupations to benefit equally from the HCPLRP, or, will the occupations differ in terms of: (a.) maximum financial benefit, (b.) length of service required, (c.) specificity of service location, and, (d.) penalty for early-quit? There is evidence that for a loan repayment program, marked penalties are not needed, and, are actually likely harm outcomes.

- *Repayment Details*: Several policy and procedural decisions must be concluded. Examples follow. What is an adequate period of service-payback? What is the proportionality of payback when scheduled over years? What are the most useful policies with which to govern service payoff?

- *Work Processes*: Several work-process details will need to be established as regards management client relationships. Programmatically, what ways do we want to work, one-on-one, with program applicants to help them find suitable communities/positions? What types of assistance do we most want to provide to applicants, practices and communities?

- *Program Evaluation*: An ongoing evaluation should be installed and maintained as an expected part of any proposed support-for-service program (e.g. Henderson & Fox-Grage, 1997). It is in everyone's interest, and particularly in those of Alaska's medically underserved communities, that such programs: (a.) have explicit outcome objectives, (b.)

are regularly monitor as to those outcomes, (c.) openly acknowledge weaknesses, and (d.) embrace change as needed. Many different types of outcomes might be monitored. Reasonable measures might include:

- Practice in specific needy communities (e.g. HPSAs)
- Serve high-priority patient groups (e.g. Medicaid)
- Service completion of participants
- Retention rate of participants
- Satisfaction of participants
- Indictors as to the content of practice/work of program participants (e.g., proportion that provide inpatient care, that provide obstetrical care, or whatever specific services are deemed to have critical workforce shortages)

Other Support-For-Service Options to Consider:

As robust as a state-level loan repayment is likely to prove, there are other programmatic strategies. At least two other strategies should also be thoroughly examined: (a.) service-option loans, and (b.) direct incentives.

- *Strategy: Service-Option Loan Programs*

  Consider provision of educational loans to all citizens of Alaska who undertake health professions training, where the loans will be forgiven if they work within Alaska after graduation. This would provide added incentive for health care students who were raised in Alaska to return to Alaska to practice, rather than being wooed away by the states/communities where they receive their training. There is evidence that these have worked well elsewhere, given attention to key programmatic details. For Alaska, a service-option loan program should nicely complement a loan repayment program; because the former would address only Alaska residents and the latter would primarily attract those health practitioners coming from out-of-state.

- *Strategy: Direct Incentive Programs*

  Consider provision of direct incentive programs. In these, funding is provided to practitioners who agree to work in needy settings whether or not they have educational loans to be repaid. There is no reason to believe that only young practitioners-with-debt are suited to work in rural areas and/or with underserved populations.

  Loan repayment programs only target recent graduates who have weighty educational debts. For instance, as regards physicians, many recent graduates carry minimal debt (perhaps 40%). Further, a large portion of those physicians who are potentially recruit-able to Alaska are 10 or 20 years out of training and have no educational debts. It is possible, even likely, that "an Alaskan adventure" would appeal to some number of mid and late-career physicians. It may prove informative to assess the State's medical licensure files to learn the average/median/quartiles of age of physicians as to when they gain their first Alaska license. If, indeed, many are older, then this is a group that should be targeted. Direct incentive programs target those practitioners without loans, and, older practitioners.

Finally, support-for-service programs (of all types) constitute only one way to help bolster recruitment and retention of health care professionals. Alaska must develop a multi-pronged approach to confronting our growing healthcare workforce shortage.

Conclusion

Substantial evidence shows that Alaska currently experiences a shortage of healthcare professionals, and, that this shortage exists in several key occupational categories.

There are several types of support-for-service programs, and the national experience has proven loan repayment programs to be robust. These have demonstrated substantial and longstanding success as a public strategy which has helped to rectify such shortages. To quote from Pathman, et al. (2004),

> "As a whole, states' support-for-service programs bring physicians to needy communities where they find satisfying work caring for at-risk patient populations and remain for many years. Of all program types, the loan repayment and direct financial incentive forms, which target physicians after training, show the broadest successes. The successes of these state programs warrant their continued support and perhaps expansion to remedy the continuing maldistribution of physicians." (pg. 567).

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How Hard Is It for Alaska's Medicare Patients to Find Family Doctors?

By Rosyland Frazier and Mark Foster

UA Research Summary No. 14 • March 2009
Institute of Social and Economic Research • University of Alaska Anchorage

In the past few years, Alaskans have been hearing reports that some primary-care doctors won't see new Medicare patients. Medicare pays these doctors only about two-thirds of what private insurance pays—and that's after a sizable increase in 2009. But most Americans 65 or older have to use Medicare as their main insurance, even if they also have private insurance. Just how widespread is the problem of Alaska's primary-care doctors turning away Medicare patients? ISER surveyed hundreds of doctors to find out—and learned that so far there's a major problem in Anchorage, a noticeable problem in the Mat-Su Borough and Fairbanks, and almost no problem in other areas.

Medicare is the federal health insurance program for older Americans and for some younger people with disabilities. At issue is what Medicare pays primary-care doctors for their services—not what it pays for other medical costs. Alaska's 50,000 Medicare enrollees are almost all in the "fee for service" plan, which pays doctors standard fees for their services.*

Why is it so worrisome if primary-care doctors won't see Medicare patients? These are the doctors who provide broad care, track patients' overall health, and coordinate care with specialists. That's very important for older people, who often have various medical problems and chronic conditions. And the number of Alaskans over 65 is growing fast—it's expected to double in the next 15 years.

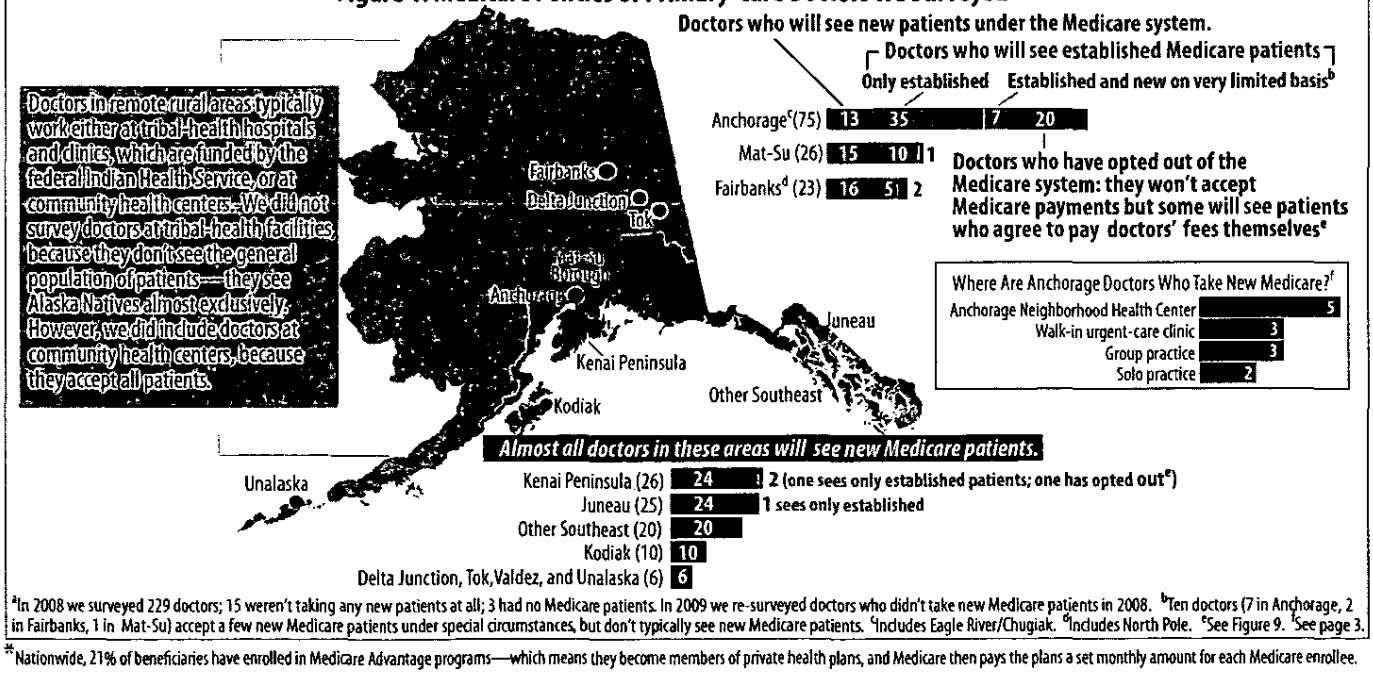
To learn how hard it is for older Alaskans to find primary-care doctors, in 2008 we tried to survey all those who could see the general population of Medicare patients. We were able to interview 229 doctors or their staffs—about 85% of those we tried to reach.

But Medicare payments for Alaska doctors increased in 2009, thanks to efforts of Alaska's U.S. senators. So we recently called back the doctors who had told us they weren't taking new Medicare patients. None of them had opened their doors to significant numbers of new Medicare patients. Four said they now see a very limited number of new Medicare patients, under special circumstances. Two doctors in a joint practice who still didn't see new Medicare patients had hired a nurse practitioner who did.

It's certainly also possible that without the 2009 increase, even more doctors would have decided not to see Medicare patients. Figure 1 shows what our 2008 and 2009 surveys found.

- *It's mainly doctors in Alaska's larger urban areas who are declining to see new Medicare patients.* But that's where the majority of older Alaskans live. Most doctors (even in Anchorage) will still see established patients—that is, patients they've seen in the past.
- *Almost all doctors in smaller communities take new Medicare patients.* Rural places have few doctors—so doctors probably feel more of an obligation to see all patients. For patients (Medicare or otherwise) in rural Alaska, the challenge is more likely to be recruiting and keeping doctors.
- *One in ten doctors we surveyed has opted out of the Medicare system.* Most are in Anchorage. They will not accept Medicare payments, but some will see patients who agree to pay the entire doctor's bill themselves.
- *The Anchorage Neighborhood Health Center,* which accepts all patients, saw twice as many Medicare patients in 2007 as in 2001. It has become the only choice for many of Anchorage's Medicare patients.
- *Medicare patients are not relying more on emergency rooms,* if figures for Providence Hospital's emergency room in Anchorage are typical. Numbers of Medicare patients there haven't changed much in the past several years.

Figure 1. Medicare Policies of Primary-Care Doctors We Surveyed[a]



[a]In 2008 we surveyed 229 doctors; 15 weren't taking any new patients at all; 3 had no Medicare patients. In 2009 we re-surveyed doctors who didn't take new Medicare patients in 2008. [b]Ten doctors (7 in Anchorage, 2 in Fairbanks, 1 in Mat-Su) accept a few new Medicare patients under special circumstances, but don't typically see new Medicare patients. [c]Includes Eagle River/Chugiak. [d]Includes North Pole. [e]See Figure 9. [f]See page 3.

*Nationwide, 21% of beneficiaries have enrolled in Medicare Advantage programs—which means they become members of private health plans, and Medicare then pays the plans a set monthly amount for each Medicare enrollee.

Survey of Primary-Care Doctors

We surveyed only primary-care doctors. So far there hasn't been any sign that specialists are declining to see Alaska's Medicare patients—not surprising, since Medicare tends to pay them closer to private-insurance rates.

We first had to determine how many doctors fit our survey criteria: those who currently practice general, family, or internal medicine at least 20 hours a week and who could see the average Medicare patient, if they chose to.

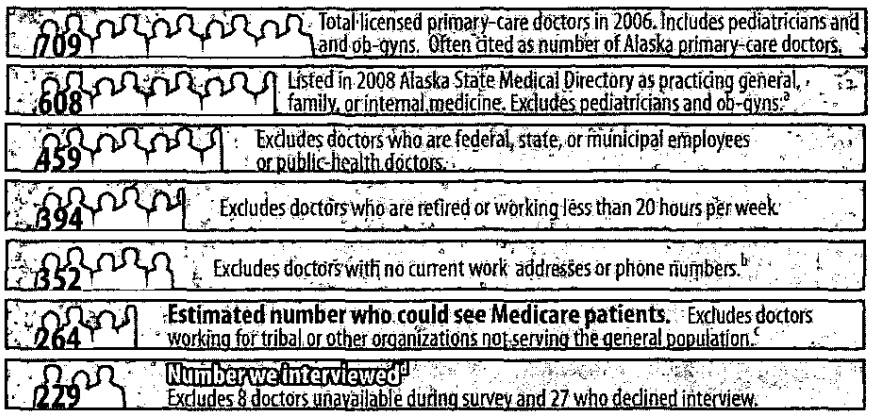
About 700 primary-care doctors are licensed in Alaska, but most aren't available to see the general population of Medicare patients. Hundreds work for government agencies, are in public health, or see only specific groups (Figure 2).

Among those who didn't fit our criteria are doctors working for tribal-health facilities that provide Indian Health Service programs for Alaska Natives. These doctors do see Alaska Native Medicare patients.

We estimated that 264 doctors were left, after we took out those who didn't fit our criteria. In 2008 we tried to reach all 264. We were able to talk with about 85%—229 doctors or their staffs. We asked them to tell us their policies for seeing Medicare patients and to rank reasons why they might be limiting or turning them away. The top reason they cited was "inadequate reimbursement"—that is, Medicare payments aren't enough to cover the costs of seeing patients.

We also followed up, in 2009, with doctors who had told us in 2008 that they weren't taking new Medicare patients. We reached all but two.

Figure 2. How Many Primary-Care Doctors Are Available to See Medicare Patients?
(Among Alaska Doctors Practicing General, Family, or Internal Medicine at Least 20 Hours per Week)



[a]We excluded pediatricians and obstetrician-gynecologists, who are often included in definitions of primary-care doctors, because they don't routinely see older patients. [b]About 42 doctors were not at the addresses and phone numbers in the medical directory. We tried but weren't able to find them, and we assume they have left the state or are not practicing [c]We excluded doctors working for tribal-health organizations, the military, the Veterans' Administration, and Planned Parenthood, because they don't see the general population of Medicare patients. Doctors who work for tribal-health facilities do see Alaska Native Medicare patients. [d]We interviewed either doctors or members of their staffs.

Medicare Versus Private Insurance

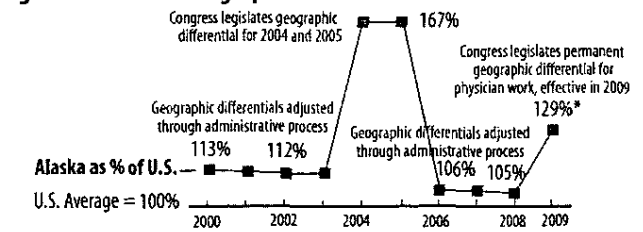
The federal Center for Medicare and Medicaid Services (CMS) calculates Medicare payments for doctors under a complex formula that takes into account geographic differences in costs around the country. Alaska's doctors have historically been paid more than the U.S. average for seeing Medicare patients.

The CMS formula actually includes three geographic differentials: one for "physician work" itself, one for doctors' costs of operating practices, and one for doctors' costs of carrying liability insurance.

In 2008, Congress set the Alaska geographic differential for "physician work" at 50% above the U.S. average, effective in 2009. Alaska's U.S. senators Lisa Murkowski and Ted Stevens were instrumental in gaining that increase for Alaska doctors. But combined with the other differentials—set by CMS—the overall Medicare geographic differential for Alaska doctors in 2009 is 29% above the U.S. average. Figure 3 shows the differential since 2000.

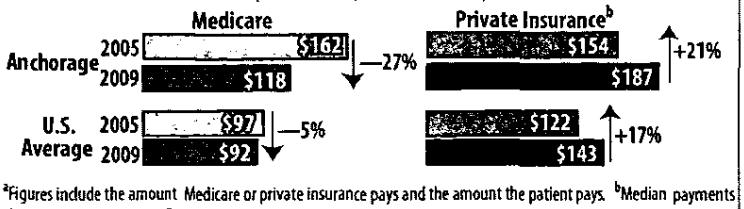
- *From 2000 to 2003, the geographic differential for Alaska doctors was about 12% above the U.S. average.* That differential was set entirely under CMS's administrative process.
- *In 2004 and 2005, the differential for Alaska doctors jumped to 67% above the U.S. average.* Ted Stevens, at that time Alaska's senior U.S. senator, spearheaded the legislation that led to the substantial but temporary increase. In those two years, Medicare paid Alaska doctors as much as private health insurance (Figure 4).
- *After that legislation expired, the Medicare differential dropped sharply,* to about 5% above the U.S. average from 2006 to 2008.
- *In 2009, the cost differential for Alaska doctors climbed to 29% above the U.S. average,* due to new federal legislation—as we just discussed. But Medicare still pays doctors less now than it did in 2005 (Figure 4).
- *Medicare pays about two-thirds of what private insurance pays, in Alaska and on average nationwide.* (But in the adjacent markets of Washington state, Medicare pays 68% to 75% of what private insurance pays.)
- *That nationwide gap helps explain why more Medicare patients are having trouble finding doctors.* Recent national surveys sponsored by the Medicare Payment Advisory Commission found that 17% of Medicare patients in the U.S. had "a big problem" finding family doctors in 2007, up from 13% in 2005. Alaska may be the harbinger of a national trend.

Figure 3. Medicare Geographic Cost Differential* for Alaska Doctors



*This is a weighted average of three geographic cost differentials the Center for Medicare and Medicaid Services uses in a complex formula that determines what doctors are paid. One of those is the differential for "physician work," and Congress set that at 150% of the U.S. average for Alaska doctors, effective in 2009. But the other differentials—for physicians' costs of operating their practices and for carrying liability insurance—are set by CMS and can vary from year to year.
Source: Center for Medicare and Medicaid Services; Medicare Payment Advisory Committee

Figure 4. Medicare and Private Insurance Payments[a] To Primary-Care Doctors, Anchorage and U.S. Average, 2005 and 2009
(New Patient, 30-Minute Visit)



[a]Figures include the amount Medicare or private insurance pays and the amount the patient pays. [b]Median payments
Source: Ingenix National Fee Analyzer

Where Are the Medicare Patients?

• *Nearly 70% of non-Natives over 65 live in Anchorage, the Mat-Su Borough, and the Fairbanks area.* Figure 5 shows only where older non-Natives live, because older Alaska Native patients have access to doctors through tribal-health care facilities. For them, the issue is not that doctors won't see them but that there may not be enough doctors, especially in rural areas.

Who Accepts Medicare Patients?

Besides the doctors who will see new or established patients, some doctors have made another choice: they've opted out of the Medicare system. They don't accept any Medicare payments (see Figure 9), but some will see Medicare patients who agree to pay the doctor's fee themselves. Patients who can do that have more choices. But for those who need Medicare to help pay the bill, the access problem is the worst in Anchorage.

• *We found only 13 primary-care doctors seeing the general population of new Medicare patients in Anchorage.* Of those, 3 were at walk-in, urgent-care clinics, which mostly just treat minor injuries and illnesses (Figure 1).

• *Five of the 13 Anchorage doctors seeing new Medicare patients in 2008 were at the Anchorage Neighborhood Health Center.* That's one of dozens of federally funded community health centers in Alaska. There are hundreds more across the U.S. These centers are open to everyone, but they are mainly for medically "under-served" groups of people—poor and uninsured, for instance—or areas of the country without adequate local medical care, like many of Alaska's rural communities.

• *The Anchorage Neighborhood Health Center is the main choice for growing numbers of Medicare patients.* Both the number of Medicare patients coming to the clinic and the percentage they make up of all patients doubled between 2001 and 2007 (Figure 6). That growth did flatten out in 2004 and 2005, when Medicare paid doctors at a level comparable to private insurance. But after that, the numbers climbed. (In Fairbanks, the community health center saw a similar percentage increase. In the Mat-Su Borough, a health center just opened in 2005, so data are limited.)

• *Until recently there was another choice for Anchorage's Medicare patients—the Alaska Family Medicine Residency Program*, where some family doctors get their final phase of training. These resident doctors see patients, and they had been accepting growing numbers of Medicare patients. But to make sure the residents see a variety of patients, the program has now capped the number of Medicare patients it accepts.

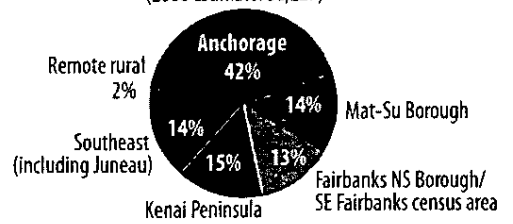
• *Anchorage's Medicare patients don't seem to be turning more to emergency rooms.* Data from Providence Hospital's emergency room show that visits by older patients have stayed mostly steady, with seasonal variations, since 2004 (Figure 7). But some health-care providers think that Medicare patients may be postponing care they need and coming in only when medical problems get much worse.

Medicare Payments to Doctors and to Health Centers

• *Medicare pays doctors and community health centers differently.* Some people believe that Medicare uniformly pays health centers more than it pays private doctors, making it more feasible for health centers to see Medicare patients. But the reality is more complex.

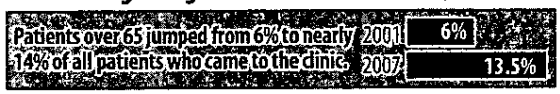
• *Medicare pays health centers the same fee for seeing Medicare patients for any visit, but private doctors more for longer, more complex visits.* Figure 8 compares payments for 30- and 60-minute visits with new patients, at doctors' offices and the Anchorage Neighborhood Health Center (ANHC). For a 30-minute visit, Medicare pays ANHC $119 and doctors about $95. But for a 60-minute visit, it still pays ANHC $119, but the doctors $189.

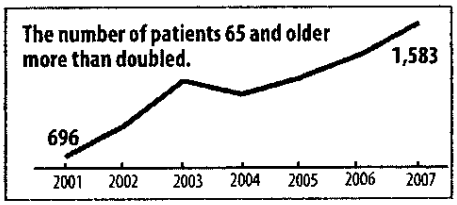
Figure 5. Where Do Non-Native Alaskans Over 65 Live?
(2006 Estimate: 38,227)



Source: Alaska Department of Labor, Research and Analysis section, 2006 bridge estimates

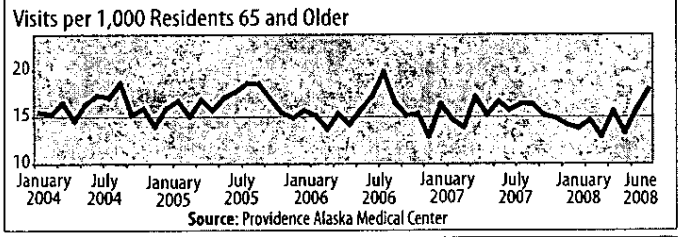
Figure 6. Growth in Number of Patients 65 and Older at Anchorage Neighborhood Health Center, 2001-2007





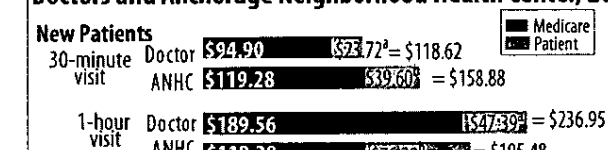
Source: Uniform Data System Reports, U.S. Department of Health and Human Services, Health Resources and Services Administration

Figure 7. Visits to Providence Hospital's Emergency Room in Anchorage, Patients 65 and Older, 2004 to 2008



Source: Providence Alaska Medical Center

Figure 8. Medicare and Patient Payments to Private Doctors and Anchorage Neighborhood Health Center, 2009



[a]Patient co-pay; 20% of total payment. [b]Facility fee charged to patient, but many are not able to pay full charge. Patients with incomes up to 200% of federal poverty line pay on a sliding fee scale.

Sources: Anchorage Neighborhood Health Center; Ingenix National Fee Analyzer

• *What Medicare patients pay at health centers and at doctors' offices is also determined in different ways.* Essentially, Medicare allows the health centers to take their own fees into account when determining what patients are charged. But Medicare doesn't allow doctors to use their own fees; instead, Medicare sets a maximum allowable charge for specific kinds of visits, and patients pay a portion of that (see Figure 9).

• *Neither ANHC nor the doctors' offices necessarily collect the amounts shown in Figure 8 as payments from patients.* At ANHC, patients with incomes up to 200% of the federal poverty line are charged on a sliding fee scale. Likewise, private doctors may not always be able to collect the patient's share. And both private doctors and ANHC report losing money when they see Medicare patients.

Doctors and the System

Primary-care doctors who see Medicare patients have three choices for getting paid. Figure 9 describes those choices among doctors we surveyed.

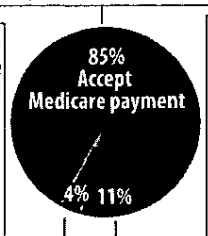
About 85% choose the standard Medicare process ("participating"). Another 4% still work with the Medicare system but charge patients somewhat more ("non-participating"). The final 11% have opted out of the Medicare system, but will still see patients who agree to foot the bill.

Patients also pay different amounts, depending on their doctors' policies. For a service with an allowable Medicare fee of $100, patients seeing doctors who accept that fee would pay $20—but only after Medicare paid the other $80. Patients seeing "non-participating" doctors would pay the doctors $109.25; Medicare would later reimburse the patients $76, so their final cost would be $33.25. Patients seeing doctors who have opted out of the Medicare system would pay a fee determined by the doctor—perhaps a negotiated fee, but still typically more than Medicare pays.

Figure 9. How Do Alaska Primary-Care Doctors Who See Medicare Patients Deal with the System?
(Among 211 Surveyed Who See New or Established Patients)

Most doctors accept standard Medicare fees and bill Medicare. They are called "participating." Medicare sets maximum allowable charges for various services. Participating doctors agree not to charge more than the allowable rate, and Medicare pays them 80% of that. The patients (and their secondary insurance, if they have any) pay the other 20%.

A few doctors (called non-participating) can charge up to 9% more than the allowable Medicare charge. But Medicare pays less and patients pay more. Here's how it works. The patient pays the entire bill, but the doctor submits a statement to Medicare so the patient is paid for the Medicare share. But instead of paying 80% of the charge, Medicare pays only 76%. The patients (and their secondary insurance, if they have any) pay the rest of the bill.



Some doctors don't accept Medicare payments for their fees. They are said to have "opted out." They will still see Medicare patients, but patients must agree to pay a fee the doctor sets. Medicare doesn't pay either doctors or patients, and patients can't bill any secondary health insurance they may have. Remember that patients pay only the fee for the doctor. They still use Medicare to help pay hospital and other medical costs. Doctors who opt out have to re-confirm their decision with Medicare every two years. They can also apply to come back into the system after two years.

Example: How Much Would Patients Pay for a Service with an Allowable Medicare Charge of $100?

	Participating Doctors Charge $100	Non-Participating Doctors Can Charge $109.25	Doctors Who Have Opted Out Can Set Their Own Fees
Medicare pays	$80	$76	$0
Patient pays	$20[a]	$33.25[a]	Entire doctor's fee[b]

[a]Patients can bill secondary insurance to help pay their share. [b]Patients can't bill secondary insurance to pay any amount.

Sources: American Academy of Family Physicians; Government Accountability Office

Conclusion

With few exceptions, Americans 65 or older who are retired have to use Medicare as their primary insurance—even if they also carry private health insurance or have retirement benefits that include health-care coverage. Any other insurance they have can *only* be used to help pay *their share of the allowable Medicare charge*. They can't use private insurance to pay doctors more than Medicare allows.

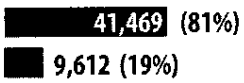
As more Alaskans turn 65, the access problem will get worse, unless something changes. Growing numbers of Medicare patients around the country are also reporting access problems. And the American College of Physicians has reported that a nationwide shortage of primary-care doctors is looming—which would make the problem even worse.

This summary talks about just a very narrow slice of the multitude of issues facing Medicare. It's one of the largest and fastest-growing federal programs, and President Obama has said reforming it will be part of his plan to improve the U.S. health-care system. How potential reforms might affect Medicare patients' access to family doctors isn't clear today.

Because Medicare is a federal program, the state's options for helping improve access are limited. But Alaskans are talking about various possibilities—like recruiting more doctors and offering them bonuses to see Medicare patients, and either establishing an Anchorage clinic for Medicare patients or expanding the Anchorage Neighborhood Health Center.

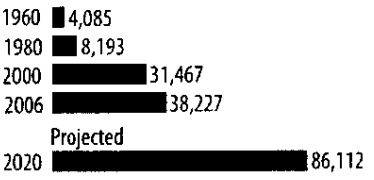
In a publication later this year, we'll look at the implications of various ways of trying to improve access for Medicare patients. We'll also report what family doctors themselves told us—how they make decisions about seeing Medicare patients and what might make them willing to see more.

Figure 10. Alaska Medicare Enrollment, 2005



Source: Alaska Department of Health and Social Services, Alaska Health Care Data Book 2007

Figure 11. Non-Native Alaskans 65 and Older



Sources: U.S. Bureau of the Census; ISER estimates based on census data; Alaska Department of Labor, Research Analysis, 2006 estimates and mid-range 2020 projections

Back-up materials for figures in this summary are available from ISER. Call the authors at 907-786-7710 with questions. We've also developed a basic model that doctors—or anyone else—can use to estimate how changing the balance between patients paying with Medicare and with private insurance could affect doctors' revenues. To try that model, go to ISER's Web site:

www.iser.uaa.alaska.edu

The authors thank the doctors and others in health care who took the time to help us. We especially thank doctors Leslie Bryant, Richard Neubauer, and Thomas Nighswander; Joan Fisher of the Anchorage Neighborhood Health Center; James Jordan of the Alaska State Medical Association; and Providence Alaska Medical Center, Providence Health and Services - Alaska.

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Editor: Linda Leask Graphics: Clemencia Merrill

Alaska Center for Rural Health – Alaska's AHEC
UNIVERSITY of ALASKA ANCHORAGE
August 2007

2007 Alaska Health Workforce Vacancy Study Research Summary

Key Findings: *Alaska is confronted by severe shortages of professional health workers, primarily in high-level primary care occupations that include* ***Family Physician, General Internist, Critical Care Nurse, Nurse Case Manager, Family Nurse Practitioner, Physician Assistant, Pharmacist, Dentist, Physical/Occupational/Speech Therapist,*** *and* ***Behavioral Health*** *occupations. Shortages in* ***RNs*** *and* ***Allied Health*** *are much less acute. Most affected are rural areas and Tribal Health Organizations, though growth-driven high vacancy rates affect the Anchorage-Matsu region as well.*

BACKGROUND

Alaska is confronted by a "perfect storm" of health professional shortages. The state has long suffered from a deficient "supply side" characterized by insufficient numbers of key health workers whose recruitment, retention and training have been impeded by Alaska's remoteness, harsh climate, rural isolation, low population density and scarce training resources. Now exacerbating this already difficult situation is a burgeoning "demand side" for increased health services for a steadily growing and aging population. The health services industry is the fastest growing sector of Alaska's economy, employing over 7% of the state workforce.

METHODOLOGIES

The key questions this study sought to answer were: What health occupations were at this time most critically affected by shortages? Exactly how many budgeted positions existed and how many of these currently remained unfilled? Where were these vacancies regionally and in what types of organizations? What did employers perceive to be the major underlying causes of their vacancies? How many new trainees/graduates could the job market actually absorb annually and how many organizations could absorb them?

Four hundred seventy-six (476) purposively sampled Alaska health service organizations of all types responded to the study survey (Figure 1). Survey data was used to generate estimates of positions and vacancies for the entire state of Alaska.

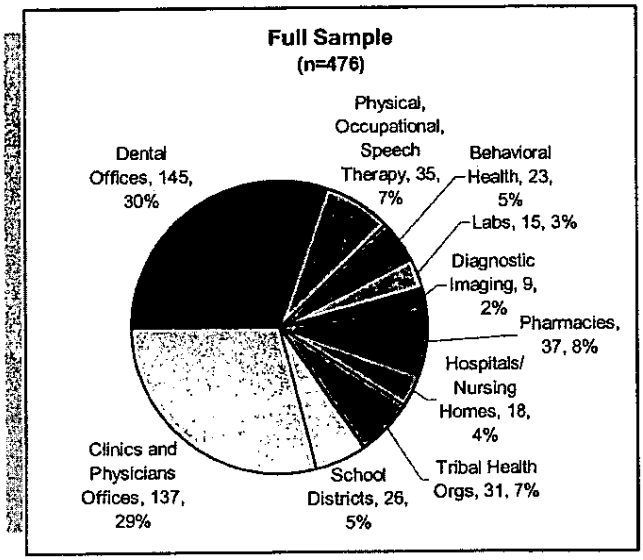

Figure 1

KEY FINDINGS

The findings confirm and quantify the trends cited in recent studies and accumulating anecdotal evidence: despite the recent progress in training and deploying health personnel, such as **Registered Nurses**, critical shortages persist (Tables 1,2).

The situation for key primary care occupations – **Family Physician, General Internist, Nurse Practitioner, and Physician Assistant** – was troubling, particularly in the rural areas, with numerous estimated vacancies and high estimated state vacancy rates between 15% and 20%.

Though vacancies for **Psychiatrists** were not numerous, they were particularly in demand (19.0% estimated vacancy rate) and difficult to recruit (mean vacancy length of 34.5 months).

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The national **Pharmacist** shortage has hit Alaska hard and affects every region, with high estimated vacancy numbers (98), and an estimated vacancy rate of 23.7%.

Therapists of all kinds – **Physical, Occupational, Speech, and Speech-Language Pathologists** – were in short supply, with estimated vacancy rates ranging from 15.6% to 29.3%. No part of the state escaped the shortages; vacancy rates were most acute in rural areas, but numerically high in the Anchorage Mat-Su region.

High numbers of vacancies and high vacancy rates were reported for key specialized nursing occupations, particularly for **Nurse Case Manager, Family Nurse Practitioner,** and **Critical Care Nurse.** These appeared to be the current areas of most critical shortage in nursing.

The estimated **Registered Nurse** vacancy rate was moderate (8.0%), but this masked 10% rates in hospitals and tribal health organizations, and an estimated rural rate of 16.1%.

While the estimated vacancy rate for **Dentist** was 10.3%, this masked a 15.3% estimated rural rate and a very high 42.0% rate for tribal health organizations, which had 39% of estimated **Dentist** vacancies.

Table 1. Occupational Groups

Occupational Groups	Study Sample (n=476)			State Estimate		
	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
All Occupations	18158	1866	10.3%	34738	3529	10.2%
Physicians	730	109	14.9%	1931	226	11.7%
Professional Nurses	4202	462	11.0%	7139	696	9.8%
Other Nursing Staff	1769	135	7.6%	1762	111	6.3%
Professions/ Therapists	1240	217	17.5%	2281	404	17.7%
Behavioral Health	2938	327	11.1%	7450	1033	13.9%
Allied Health	3209	291	9.1%	5523	434	7.9%
Public Health/ Nutrition	154	18	11.7%	189	ND	ND
Other Primary Care (PA & CHAP)	759	132	17.4%	1067	198	18.5%
Managers	1337	69	5.2%	2947	160	5.4%
Health Information/ Reimbursement	1816	106	5.8%	4451	253	5.7%

In the **Behavioral Health** occupational group, the most acute shortages – with both extremely high vacancy numbers and high vacancy rates – appeared to be among **Human Services Workers.** In addition, overall estimated **Behavioral Health** occupation vacancies were extremely numerous (1033), around 29% of all estimated vacancies – more than any other occupational group.

Among **Allied Health** occupations, high vacancy rates were affecting employers of **Physical Therapy Assistants** and **Respiratory Therapists. Sonographer** vacancies were difficult to fill, and **Surgical Technician** vacancies, though not numerous, were averaging 3 to 4 years in length.

One hundred (100) vacancies and a vacancy rate of 18.1% were reported for **Community Health Aide/Practitioners (CHA/Ps).**

Among "front office" and "back office" occupations, **Coding Specialist** and **Certified Coder** had 11% estimated vacancy rates and very long mean vacancy lengths.

The managerial occupations for which high vacancy rates were reported were healthcare related: **Behavioral Health Supervisor, Clinical Department Manager, Health Information Manager, Medical Director, Nurse Manager, and Practice Manager.** Behavioral health organizations had the most estimated managerial vacancies.

Table 2. Key occupations

Key Occupations (high numbers of vacancies, high vacancy rates)	Study Sample (n=476)			State Estimate		
	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
Family Physician	252	48	18.3%	675	107	15.8%
General Internist	71	15	21.1%	200	40	20.0%
Psychiatrist	36	10	27.8%	93	18	19.0%
Registered Nurse	3109	299	9.6%	5489	439	8.0%
Critical Care Nurse	497	43	8.7%	629	60	9.5%
Nurse Case Manager	136	42	30.9%	209	49	23.4%
Family Nurse Practitioner	155	36	23.2%	364	71	19.5%
Physician Assistant	207	32	15.5%	515	98	19.0%
Pharmacist	302	73	24.2%	413	98	23.7%
Physical Therapist	271	29	10.7%	510	84	16.5%
Dentist	319	47	14.7%	692	71	10.3%
Human Services Worker	1568	170	10.8%	4800	697	14.5%
Behavioral Health Clinician	297	35	11.8%	555	71	12.8%
Case Manager/Care Coordinator	505	52	10.3%	1163	164	14.1%
Physical Therapy Assistant	35	11	31.4%	62	18	28.6%
Medical Assistant	367	38	10.4%	1092	102	9.3%
CHA/P	552	100	18.1%	552	100	18.1%
Certified Coder	85	6	7.1%	209	22	10.6%
Medical Director	49	6	12.2%	120	18	14.8%
Behavioral Health Supervisor	82	13	15.9%	176	22	12.5%

Looking at respondent types, tribal health organizations reported the highest overall vacancy rate (16.5%). These organizations reported 87 **CHA/P** vacancies; approximately half of all estimated vacancies for **Nurse Case Manager, Pharmacist, Chemical Dependency Counselor, Dentist, Medical Lab Tech, Medical Technologist,** and **Health Educator**; and all the estimated vacancies for **Coding Specialist.** But every respondent type was a locus for acute shortages in key occupations, such as clinics/offices of physicians for **PAs**, hospitals/nursing homes for **RNs**, pharmacies for **Pharmacists**, behavioral health organizations for **Human Services Workers**, and school districts for **Speech-Language Pathologists**.

Higher vacancy rates were generally found in the rural respondents, particularly in the North/West and Southwest regions, which reported double digit vacancy rates for nearly all occupational groups, and overall vacancy rates of around 20% (Table 3, Figure 2). Occupations with much higher rural estimated vacancy rates included **RN** (6.9% urban, 16.1% rural), **Behavioral Health Clinician** (9.3% urban, 22.9% rural), **Dentist** (7.2% urban, 15.3% rural), **Physical Therapist** (13.5 urban, 31.6% rural), and **PA** (14.7% urban, 26.8% rural) (Table 4).

DISCUSSION

The "supply side" shortages apparently persist. "Inadequate Pool of Qualified Workers" was the top reason given for vacancies, cited by 54% of respondents, followed by "Transience/Moving Away" (28%), "Insufficient Compensation" (18%), and "Rural Isolation" (16%). Many tribal health organizations also reported "Insufficient/Expensive Housing" as a top reason for unfilled vacancies. The data also indicated a burgeoning "demand side," where shortages were exacerbated by population growth and an increased need and demand for health services, particularly in the high-growth Anchorage Mat-Su region.

Table 3. Regional vacancy rates

Occupational Group	Regions (Study Sample n=476)						
	North/West (n=10)	Southwest (n=17)	Interior (n=72)	Anchorage Mat-Su (n=232)	Gulf Coast (n=69)	Southeast (n=70)	Statewide/ Multiregional (n=6)
Physicians	26.7%	21.2%	21.6%	12.6%	10.4%	6.8%	30.3%
Professional Nurses	26.0%	21.6%	5.9%	11.1%	8.0%	5.9%	12.1%
Other Nursing Staff	18.6%	18.8%	5.8%	6.2%	4.6%	2.3%	8.8%
Dentists/Pharmacists/Therapists	32.4%	32.4%	20.7%	15.9%	16.5%	16.3%	12.4%
Behavioral Health	19.0%	22.7%	13.1%	8.3%	7.1%	11.1%	11.6%
Allied Health	17.0%	24.6%	5.3%	6.5%	8.4%	7.7%	8.6%
Public Health/ Nutrition	30.0%	6.3%	0.0%	4.0%	18.9%	0.0%	10.5%
Other Primary Care (PA & CHA/P)	19.7%	18.6%	24.5%	9.0%	9.1%	4.0%	0.0%
Managers	13.8%	2.4%	3.5%	3.2%	6.4%	11.7%	4.0%
Health Information/ Reimbursement	15.9%	16.9%	2.0%	5.3%	6.6%	2.8%	7.2%
All Occupations	20.1%	20.3%	9.0%	8.6%	8.1%	7.7%	10.2%

Table 4. Urban vs. Rural vacancies and vacancy rates

Occupation	Urban		Rural	
	Estimated Vacancies	Estimated Vacancy Rate	Estimated Vacancies	Estimated Vacancy Rate
Family Physician	68	14.9%	38	17.6%
General Internist	27	18.8%	13	23.1%
RN	339	6.9%	94	16.1%
Family Nurse Practitioner	36	13.3%	34	36.4%
Pharmacist	68	22.7%	30	25.9%
Behavioral Health Clinician	36	9.3%	34	22.9%
Human Services Worker	158	8.5%	209	10.1%
Dentist	32	7.2%	38	15.3%
Dental Hygienist	14	3.6%	17	10.0%
Dental Assistant	27	4.4%	64	14.9%
Physical Therapist	59	13.5%	26	31.6%
PA	50	14.7%	47	26.8%
All Occupations	1998	8.1%	1162	13.3%

Many respondents provided commentary with their surveys and noted positions that are particularly difficult to fill:

- *"We have been hiring travelers for Physical Therapy positions at $67/hr – we can't find therapists to employ. We have been looking for 2 years."* (Urban Medical Clinic)
- *"Without a state Physical Therapy program it is very difficult to get PT staff. Usually this area is staffed by PTs that leave competing PT clinics."* (Urban Physical Therapy Office)
- *"We really need a pharmacy school in Alaska. It took two years to fill our last pharmacist position."* (Urban Pharmacy)
- *"Pharmacists are always the most difficult position to fill."* (Rural Pharmacy)

The availability of military spouses has apparently alleviated some of the workforce pressure, but has exacerbated the "transience" problem. Also affecting the shortages was the absence of local training resources (such as medical, dental, pharmacy, and therapy schools) to provide a local workforce pipeline. In the qualitative data, common refrains were, "we need a pharmacy school," "we need a dental school," "we need a physical therapy school."

The acuity of workforce shortages was also reflected by the high percentage of estimated vacancies the responding employers would consider filling with new grads (Table 5). Respondents indicated that they had the capacity to hire sizeable graduating cohorts of Family Physicians, PAs, Occupational and Physical Therapists, Pharmacists, and Dentists. These may be the occupations likely to yield optimal responses to substantial investments in preparation and training programs and/or targeted recruitment and retention campaigns.

Copies of the full study can be downloaded from the ACRH website at:

http://nursing.uaa.alaska.edu/acrh/

Table 5. New Grad Vacancies

Occupation	Study Sample (n=476)	Statewide Estimate
Human Services Worker – HS diploma	68	266
Registered Nurse	93	226
Human Services Worker – AA degree	47	195
Case Manager/Care Coordinator	37	120
Family Physician	25	89
CHA/P	88	88
Pharmacist	46	84
Medical Assistant	21	84
Physician Assistant	23	80
Occupational Therapist	21	75
Dental Assistant	26	75
Dentist	27	67
Physical Therapist	23	62
Speech Language Pathologist	28	53
Behavioral Health Clinician	19	53

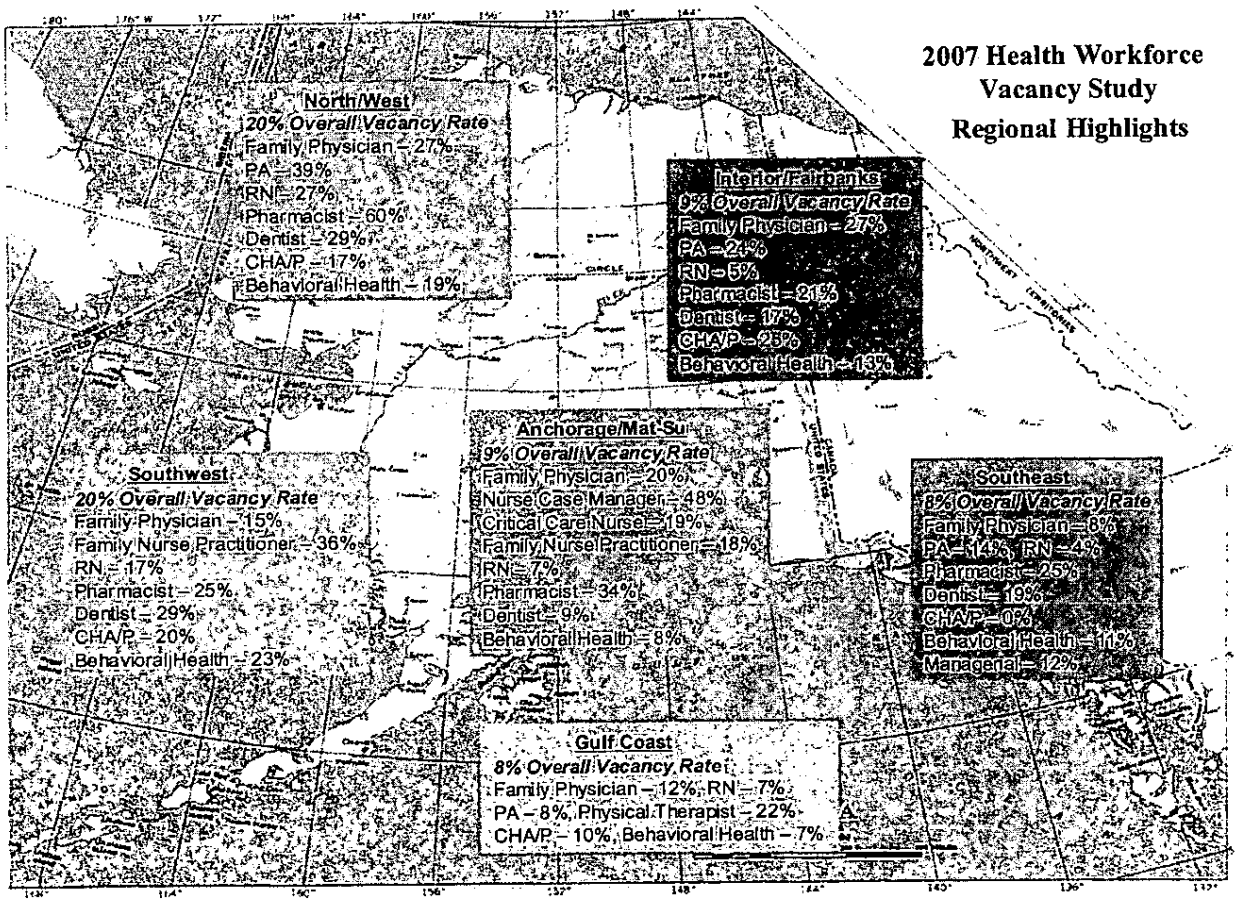

Figure 2. Regional Highlights

Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians

Donald E. Pathman, MD, MPH,† Thomas R. Konrad, PhD,* Tonya S. King, PhD,‡ Donald H. Taylor, Jr., PhD,§ and Gary G. Koch, PhD‖*

Context: Many states attempt to entice young generalist physicians into rural and medically underserved areas with financial support-for-service programs—scholarships, service-option loans, loan repayment, direct financial incentives, and resident support programs—with little documentation of their effectiveness.

Objective: The objective of this study was to assess outcomes of states' support-for-service programs as a group and to compare outcomes of the 5 program types.

Design: We conducted a cross-sectional, primarily descriptive study.

Participants: We studied all 69 state programs operating in 1996 that provided financial support to medical students, residents, and practicing physicians in exchange for a period of service in underserved areas; federally funded initiatives were excluded. We also surveyed 434 generalist physicians who served in 29 of these state programs and a matched comparison group of 723 nonobligated young generalist physicians.

Data Collection: Information on eligible programs was collected by telephone, mail questionnaires, and from secondary sources. Obligated and nonobligated physicians were surveyed, with 80.3% and 72.8% response rates, respectively.

Main Outcome Measures: Levels of socioeconomic need of communities and patients served by physicians, programs' participant service completion and retention rates, and physicians' satisfaction levels.

Results: Compared with young nonobligated generalists, physicians serving obligations to state programs practiced in demonstrably needier areas and cared for more patients insured under Medicaid and uninsured (48.5% vs. 28.5%, $P < 0.001$). Service completion rates were uniformly high for loan repayment, direct incentive, and resident-support programs (93% combined) but lower for student-targeting service-option loan (mean, 44.7%) and scholarship (mean, 66.5%) programs. State-obligated physicians were more satisfied than nonobligated physicians, and 9 of 10 indicated that they would enroll in their programs again. Obligated physicians also remained longer in their practices than nonobligated physicians ($P = 0.03$), with respective group retention rates of 71% versus 61% at 4 years and 55% versus 52% at 8 years. Retention rates were highest for loan repayment, direct incentive, and loan programs.

Conclusions: States' support-for-service programs bring physicians to needy communities where a strong majority work happily and with at-risk patient populations; half stay over 8 years. Loan repayment and direct financial incentive programs demonstrate the broadest successes.

Key Words: physicians, health services access, rural health, primary care, student loans and scholarships, loan repayment, state health policy

(*Med Care* 2004;42: 560–568)

■ *It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.—"Louis Brandeis*
Supreme Court of the United States
New State Ice Co. v. Liebmann, *1932; dissenting opinion*[1]

States and federal agencies frequently use service-requiring scholarships, loans, loan repayment, and related incentives to entice physicians into medically underserved settings.[2–4] As of 1996, 40 states offered 69 such physician-obligating programs, the federal National Health Service Corps (NHSC) and Indian Health Service (IHS)-sponsored scholarship and loan repayment initiatives,[5] and the NHSC and states jointly sponsored an additional 29 loan repayment programs. Service-requiring programs collectively wield a sizable workforce, estimated at 2900 physicians in 1996, half each under state and federal auspices.[5]

The 5 recognized program types—scholarships, service-option loans, loan repayment, direct financial incentives,

From the *Cecil G. Sheps Center for Health Services Research, and the †Department of Family Medicine, UNC-Chapel Hill, Chapel Hill, North Carolina; the ‡Department of Health Evaluation Sciences, Pennsylvania State University, Philadelphia, Pennsylvania; the §Terry Sanford Institute of Public Policy Studies, Duke University, Durham, North Carolina; and the ‖Department of Biostatistics, UNC-Chapel Hill, Chapel Hill, North Carolina.

Reprints: Donald E. Pathman, MD, MPH, Cecil G. Sheps Center for Health Services Research, UNC CB# 7590, Chapel Hill, NC 27599. E-mail: don_pathman@unc.edu.

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and resident support[5]—share fundamental goals and an approach that links financial support to periods of service; however, these program variations differ in important ways. *Scholarship programs* obligate medical students early in their training and many years before they are to serve their obligations. Participants in scholarship programs are firmly expected to provide service, and hefty penalties are used to discourage participants from buying out their obligations should their career interests change. *Service-option loan programs* also target medical students but offer participants a choice of performing service or repaying program funds at standard interest rates.

Loan repayment and *direct financial incentive programs* commit physicians much later, near the completion of residency training when their service is to begin. They typically levy no or minimal penalties on physicians who fail to complete a period of service. With loan repayment programs, physicians receive assistance repaying traditional education loans they acquired years earlier as students, whereas financial incentive programs provide unrestricted funds.

The newest programs, the *resident support* type, respond to the growing financial pressures on residents[6] with assistance in the form of scholarships, loan repayment, and direct financial incentives. Service is required and begins 1 to 2 years after a commitment is signed, at the end of residency.

Over the decades much has been said, with little supporting evidence, about the outcomes of these programs as a group and the relative strengths of the individual program types. It is generally believed, for example, that physicians in support-for-service programs are less satisfied and remain in their practices briefer than physicians without obligations. Many observers believe that stiff penalties are required to curtail otherwise high buyout rates, especially in programs that obligate individuals years in advance of service.[7] Others worry, however, that high penalties trap some participants in ill-suited commitments who are then unhappy as they serve and unlikely to be retained.[8–10] Proponents of loan repayment and direct incentive programs believe satisfaction and retention are better when physicians sign commitments after their training when they know their career interests, job options, and families' needs.[11] Scholarship defenders counter that only captive scholarship recipients can be drawn to the most desperately underserved communities because they are so unattractive.[12]

Few studies have assessed the outcomes of support-for-service programs, like the rates at which their practitioners complete their obligations with service and their practitioners' satisfaction and retention. Programs do not often undertake self-evaluations and those that do seldom have comparative data on other programs.[2,13] States and federal agencies regularly add, drop, and modify their programs without firm evidence of their effectiveness.[14–17]

This study has 2 primary goals: 1) to assess outcomes of states' support-for-service programs as a group, and 2) to compare outcomes for the 5 program types. We assess program outcomes we believe are important to underserved communities, physicians, and policymakers: the levels of socioeconomic need of communities and patients served by participating physicians, participant service completion and retention rates, and satisfaction levels of participants and their families. We also test the assumptions that 1) higher buyout penalties increase the proportion of physicians who fulfill their obligations with service but at a cost of lower physician satisfaction and poorer retention, and 2) scholarship programs bring physicians into the neediest communities.

METHODS

Identifying Eligible State Programs

We identified all state support-for-service physician programs nationally as of 1996[5] by supplementing previous lists of relevant programs[3,18,19] with information from telephone calls to key contacts in every state and from available online sources and printed materials. Eligibility criteria for programs were that they 1) provided financial support to students, residents, and/or practicing physicians in 1996; 2) had a service requirement or option in defined medically needy settings located across a given state; and 3) received no direct federal support. Of the 69 identified eligible programs, 20 offered scholarships, 24 provided loan repayment incentives, 12 offered loans with service options, 7 offered direct financial incentives, and 6 offered support to residents.

Program Data

We obtained basic descriptive information for all programs through initial and follow-up telephone contacts with program directors and from programs' web sites, brochures, reports, and copies of their enacting legislation. This information was verified and supplemented through an 8-page mailed questionnaire completed by 45 programs (65%). Forty-eight (86%) of the 56 programs old enough to have had more than 20 physicians eligible for placement in service sites provided estimates of the service completion rate for their obligated physicians over the previous 3 years. Programs were approached for survey and other data in no particular order other than we started with the few directors we knew and tended to recruit all programs within a particular state at the same time.

Identifying State-Obligated and Comparison Group Physicians

Programs were asked to provide names and basic information on each physician who signed a first contract with them and/or had been placed in a first-service site in 1991 and 1996. These 2 years were selected because individuals who

committed to student programs in 1991 and loan repayment and direct incentive programs in 1996 would have begun serving their obligations in approximately 1996. Programs created after 1991 provided names of individuals contracted in their first year of operation; very large programs provided only a randomly selected subsample of names from 1991 and 1996, and smaller programs supplemented their samples with names of physicians obligated in proximate years (eg, 1992 and 1995). We elected not to request physician names from the last 12 eligible programs as a result of project time requirements. Of the 48 programs from which we requested physician data, 29 (60%) provided all data we needed to survey their obligated physicians. Programs from which we requested and received physician-specific information, programs from which we requested but did not receive this information, and programs from which this information was not requested were similar in size, physicians' contract terms, the types of geographic locations where their obligated practitioners served, and reported service completion rates.

We surveyed all 434 family physician, general internist, and general pediatrician participants (allopaths and osteopaths) identified by programs as then serving or having served their obligations. We excluded nongeneralists and physicians who defaulted or bought out their obligations without ever serving a day of their obligations. Programs reported no international medical graduates.

We constructed a comparison group of nonobligated generalists from the American Medical Association Physician Masterfile. A sampling frame of eligible subjects was constructed of all 8742 graduates of U.S. allopathic and osteopathic medical schools in 1988 and 1992 who 4 years after graduation were in clinical practice in the United States in family practice, general internal medicine, and general pediatrics. A stratified random sample of 723 of these physicians was selected, with oversampling of strata to match the state-obligated cohort in specialty distribution and geography, and to ensure diverse racial and ethnic representation.

Physician Surveys

In 1998 and early 1999, we sent up to 4 questionnaire mailings to the state-obligated and comparison group physicians. Of the 434 obligated physicians surveyed, 23 proved to be ineligible or were never located, and there were 330 eligible respondents (80.3%). Response rates for obligated physicians were comparable across service program types, physician specialties, and racial–ethnic groups.

In the comparison sample of 723 physicians, 56 subjects proved ineligible or were never located and 468 eligible physicians responded (72.8%). Response rates for the comparison sample did not vary by subjects' rural/urban location, gender, or specialty; rates were somewhat lower for blacks (52.4%). We excluded 100 physicians from the comparison group who indicated that they had or were serving a state or federal obligation.

In the physician questionnaires, participants of state programs reported details of the first practice in which they served their obligations. On parallel questionnaire items, comparison group physicians described the first practice after residency in which they worked 9 months or longer. Both groups reported their incomes, satisfaction, their families' experiences, and their patients' insurance types. Nearly all questionnaire items had been used in earlier studies[9,20,21] and were pilot-tested again for applicability to this study with 30 obligated and nonobligated physicians in North Carolina.

We appended 1990 U.S. Census data characterizing the towns and cities where physicians worked.[22] County data on local physician-to-population numbers were appended for 1994 from the Area Resource File.[23]

Analyses

We compared obligated and nonobligated physicians on a variety of outcomes, including satisfaction and retention rates. We also compared programs of each of the 5 types individually and with the other 4 program types as a group. We used chi-squared tests, independent sample 2-tailed t tests, and 1-way analysis of variance (ANOVA) to compare groups on normally distributed variables. The Kruskal-Wallis test was used to compare groups on 4 nonnormally distributed variables: physician income, town population, town per capita income, and county primary care physician-to-population ratios. Bivariate comparisons were followed with linear and logistic regression models (with log transformations of nonnormally distributed variables) to adjust for key potentially confounding or explanatory variables. Life tables were used to describe proportions of physician groups remaining in their practices for specified numbers of years. Kaplan-Meier plots and Cox proportional hazards models were used to compare estimates of retention for various physician groups over time.

We also assessed relationships between programs' buyout costs and the various program outcomes with chi-squared and 2-tailed t tests. We further used multiple and logistic regression to test the relationships between buyout costs and the various outcomes for confounding by varying service obligation terms across programs and/or respondents' actual obligation periods. No confounding was found and we do not report these models.

Comparisons of obligated and nonobligated physicians were weighted to adjust for strata sampling fractions and response rates and run on the SUDAAN statistical software program (Research Triangle Institute, Research Triangle Park, NC). Analyses involving only obligated physicians were run on the SPSS statistical program (release 11.5.0; SPSS Inc., Chicago, IL) and not weighted. A level of statistical significance of $P \leq 0.05$ was used throughout.

RESULTS

State Programs

In 1996, the 69 eligible programs were relatively new and small, with a median age of just 6 years and median workforce of 11 physicians. Sixty-four programs were funded with state revenues, 2 had only private support, and 3 were self-supporting using buyout funds from earlier participants; 9 programs also used community matching funds. Forty-seven programs were based in state offices of rural health or other state agencies, 18 within individual medical schools, and 4 within private organizations.

Programs supported physicians with an average of $14,000 for each year of obligated service with no significant differences across the 5 types of programs ($P = 0.55$). Average minimum service obligation terms did vary across program types, from 12 months in resident support programs, 18 months in scholarship programs, 19 months in service-option loan programs, 29 months in loan repayment programs, and 36 months in direct financial incentive programs ($P = 0.003$).

Physicians and Their Practices

Physicians obligated to state programs, compared with physicians without obligations, were more often male (63% vs. 53%, $P < 0.05$), more often married (84% vs. 75%, $P < 0.05$), slightly older (33 vs. 32 years on average, $P < 0.001$), but no more or less likely to be black or Hispanic (8.5% vs. 6.2%, $P = 0.10$). Obligated physicians were much more likely than nonobligated generalist physicians to be family physicians (72% vs. 38%, $P < 0.001$) and more often owned the practices where they worked (36% vs. 27%, $P < 0.05$), but earned comparable salaries (median, $89,735 vs. $89,622, $P = 0.2$).

Comparing physicians obligated to the 5 types of programs, we found no differences in gender, marital status, ethnicity, or income. Loan program participants, however, were less likely to be family physicians than participants of other programs (54% vs. 75%, $P = 0.02$), and physicians in incentive programs more often owned their practices (49% vs. 16%, $P = 0.01$).

Although minimum service obligation durations varied across programs of the 5 types, the average number of years this study's respondents were actually obligated to their programs did not differ for those in 4 of the types (range, 3.13–3.48 years, $P = 0.31$) but was shorter for participants of resident-support programs (2.72 years, $P = 0.02$).

Service Completion Rates

The 5 types of programs differed greatly in how often their physicians completed their obligations with service rather than buying out or defaulting ($P < 0.001$) (Fig. 1). Service-option loan programs reported the lowest average service completion rates (44.7%) followed by scholarship programs (66.5%). The 30 programs of the remaining 3 types, programs that committed physicians after training or as residents, reported uniformly high service rates (entire group mean, 93%; 92% after omitting the 5 of these 30 programs without a minimum service period).

Program directors reported obligation default rates, the proportion of obligated physicians who failed to provide either service or repay program funds, of 5.2% on average for all programs combined with no significant differences across program types ($P = 0.78$). In contrast, the percentage of physicians who bought out-of-service commitments differed greatly across the 5 program types, greatest in service-option loan programs (49.2%) and scholarship programs (27.2%).

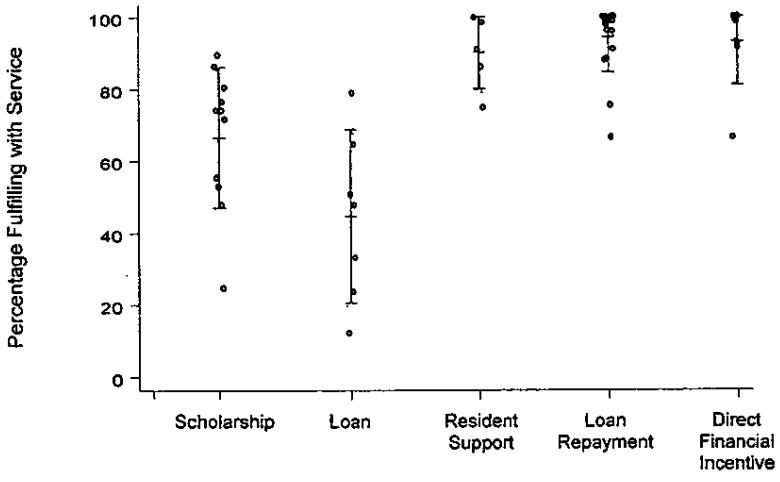


FIGURE 1. Percentage of recent physicians in each program (°) who fulfilled their obligations with service, grouped by program type.

Programs of the remaining 3 types reported comparable low buyout rates (2.3% combined). Thus, the high buyout rates of student programs account for their low service completion rates.

The costs that loan repayment, direct incentive, and resident support programs levy on physicians who buyout of obligations had no relationship with programs' service completion rates. Only among student programs, scholarships and service-option loans, were penalties and service completion rates related; specifically, rates averaged 80.3% for the 4 student programs that charged penalties of 3 times the amount of support provided compared with 48.6% for the 12 programs that charged less ($P = 0.02$).

Communities and Patients Served by Physicians

Physicians serving in state programs of all types combined, compared with the nonobligated physicians, worked in counties that were far more often rural and had lower primary care physician-to-population ratios, in cities and towns that were much smaller and poorer, and they reported more of their patients were uninsured or covered under Medicaid (Table 1). Even in analyses run separately for rural and urban-situated physicians and in multivariate models adjusting for physicians' rural versus urban location, specialty, and demographics, obligated physicians were still found to work in needier communities and with needier patients by all measures.

We explored whether county physician-to-population ratios were lower for obligated physicians simply because states with a greater need for physicians (and thus lower ratios) more often sponsored support-for-service programs.[24] We confirmed that, indeed, obligated physicians worked in counties with primary care physician-to-population ratios lower than their state's median county ratios more often than nonobligated physicians (37% vs. 11%, $P < 0.001$).

Among obligated physicians and weighing findings on all 5 measures of community need (Table 1), those serving in direct financial incentive programs worked in the neediest settings. Contrary to popular belief, the towns and counties where scholarship participants worked demonstrated no greater need than where participants of other programs worked.

Physician and Family Satisfaction

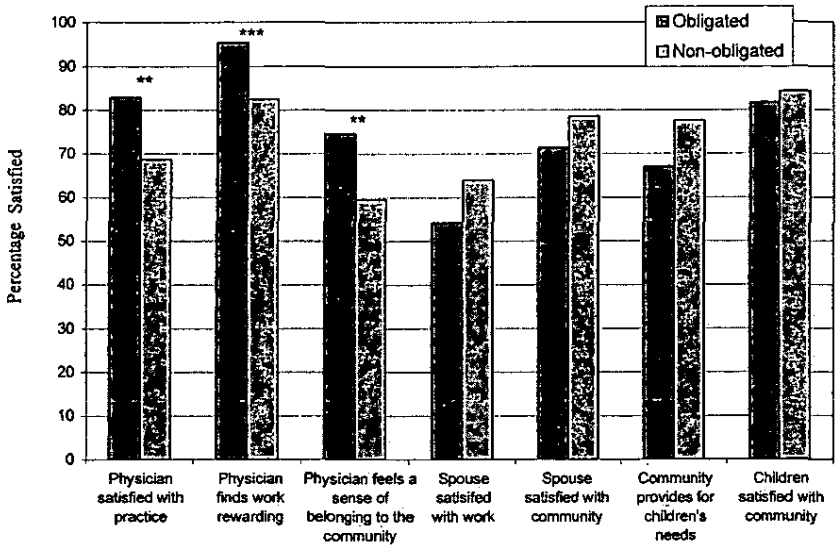
Physicians serving state obligations were more often satisfied with their work and practices and more often felt a sense of belonging to their communities than nonobligated physicians (Fig. 2). Obligated and nonobligated physicians gave comparable estimations of the satisfaction and needs-fulfillment of their spouses and children.

In virtually all ways tested, satisfaction was comparable for physicians and families participating in the 5 types of programs, the only exception being that scholarship program participants more often than others felt restricted by the practice sites available to them (36.6% vs. 19.3%; $P < 0.01$).

TABLE 1. Comparison of Community and Patient Characteristics of State-Obligated and Nonobligated Physicians; Physicians Serving in the 5 Types of Service Programs; and Physicians Obligated to Programs Using Different Types of Site-Eligibility Criteria

		Community and Patient Characteristics				
	(n Physicians/ Programs)	Rural (Nonmetropolitan) County (%)	Median Town/City Population	Median Town/City per Capita Income ($)	Median County Primary Care Physician-to-Population Ratio	Mean Patients Covered by Medicaid or Uninsured (%)
Obligated vs. nonobligated						
Obligated, all types	(330/29)	68.4‡	5094‡	10,813‡	78.5‡	48.5‡
Nonobligated	(368/NA)	11.6	56,129	14,090	118.1	28.5
Comparisons of 5 program types						
Scholarship	(30/5)	86.2*	3541	10,302	82	40.5
Service-option loan	(56/3)	50.0‡	7284	12,082‡	76	43.3
Resident support	(38/3)	51.4*	4062†	10,958	57‡	50.8
Loan repayment	(138/14)	73.3	5422*	10,681	91†	48.0
Direct financial incentive	(68/4)	75.4	4410	9911‡	64	55.5†

*$P \leq 0.05$;
†$P \leq 0.01$;
‡$P \leq 0.001$; 2-tailed t-test, chi-square, and Kruskal-Wallis comparisons of nonobligated versus obligated physicians, and comparisons of physicians in each program type versus obligated physicians in all four other types of programs.



* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

FIGURE 2. Satisfaction and needs fulfillment of physicians and their families serving in all state programs combined (n = 330) compared with nonobligated physicians (n = 368)

A remarkable 90.2% of obligated physicians indicated that they likely would enroll in their program if they had it to do all over again, including 64.2% who indicated that they definitely would do so. Differences across programs were found only for physicians in scholarship compared with loan repayment programs in which 47% versus 71% of physicians indicated that they would definitely sign up again ($P = 0.01$).

We explored the relationships between the buyout costs that programs levied and physicians' satisfaction, again finding associations only for medical student-targeted programs. When service-option loan and scholarship programs charged more than simple principal plus interest to buyout, most measures of physician satisfaction were lower, including fewer participants reporting, in retrospect, a definite willingness to commit to their programs again (36% vs. 65%, $P = 0.04$).

Retention

Obligated physicians remained longer in their service practices than nonobligated physicians remained in their first jobs after training (hazard ratio [HR] for leaving, 0.70; 95% confidence interval [CI], 0.51–0.96; $P = 0.029$) (Table 2). Respective group retention rates from life tables at 2 years were 92% versus 77%, at 4 years 71% versus 61%, at 6 years 59% versus 55%, and at 8 years 55% versus 52%. Retention tended to be better for obligated physicians than nonobligated physicians even after adjusting for group differences in physicians' specialties and demographics, although the differ-

TABLE 2. Comparison of the Retention of State-Obligated versus Nonobligated Physicians

	Hazard Ratio	*P* Value	95% Confidence Interval
Model 1 (unadjusted)			
Obligated vs. nonobligated	0.70	0.029	(0.51–0.96)
Model 2 (adjusted)			
Obligated vs. nonobligated	0.75	0.080	(0.53–1.03)
Family physician vs. internist	0.91	0.688	(0.58–1.43)
Pediatrician vs. internist	0.80	0.533	(0.40–1.61)
Male vs. female	0.76	0.190	(0.50–1.15)
Married vs. unmarried	0.75	0.270	(0.46–1.25)
Age when physicians began serving obligations	1.01	0.675	(0.95–1.08)

ence fell under the threshold of statistical significance (P = 0.08).

Among the 5 types of service-requiring programs, the longest group retention was seen for loan repayment recipients, 66% of whom remained in their service sites 8 years after starting work there, with a hazard ratio of departure compared with all other programs = 0.46 (95% CI, 0.30–0.70; P <0.001) (Fig. 3). Retention was shortest for resident support programs (HR, 6.72; 95% CI, 4.05–11.12; P <0.002). Scholarship participants demonstrated the second shortest retention (HR relative to service-option loan, loan repayment and direct incentive programs, 1.96; 95% CI, 0.97–3.97; P = 0.061).

Programs' buyout penalties were associated with retention, but once again only in scholarship and service-option loan programs, wherein penalties above simple principal plus interest were associated with lower odds of retention at 4 years (odds ratio, 12.4; P = 0.012).

DISCUSSION

Outcomes for states' support-for-service programs as a group were generally quite positive. Programs as a whole placed physicians in small and needy rural towns and counties, where physicians estimated that almost half of their patients were covered by Medicaid or were without health insurance. Physicians who served in these state programs were generally more satisfied with their work and communities and remained in their service sites longer than nonobligated "mainstream" generalists. We do not believe that the jobs and communities where these physicians served were inherently more pleasing; rather, we suspect that the benevolence of individuals who commit to and then fulfill service requirements predisposes them to find particular satisfaction from work that they believe in.[25,26]

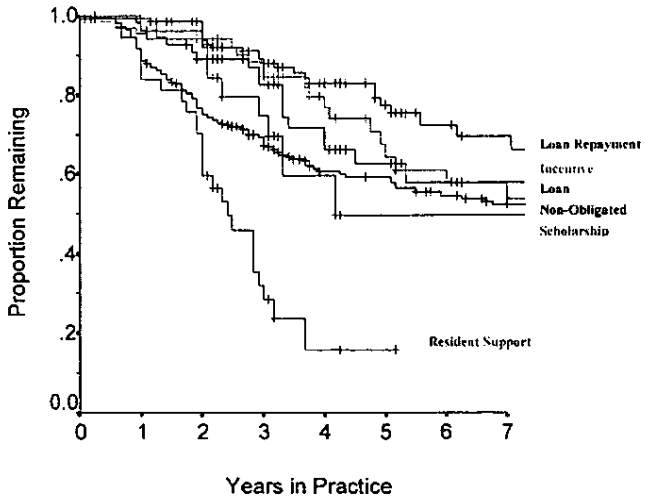


FIGURE 3. Retention of obligated physicians within their service practices: Kaplan-Meier estimations by type of program and compared with nonobligated physicians

Loan repayment and direct financial incentive programs enjoyed the greatest successes among the various program types, confirming the wisdom of recruiting physicians at the end of their training.[11] Financial buyout penalties were generally not used or needed in these programs, because their service completion rates were excellent without financial threats. Several program directors spoke of how much easier loan repayment and financial incentive programs are to administer than student-targeted programs, in which program staff must monitor participants during their training and deal with the many who buy out.[10,27] Direct financial incentive programs demonstrated an interesting niche among the program types, supporting physicians who often owned their practices, often in particularly needy settings.

Despite positive outcomes for programs overall, this study confirmed some commonly held concerns about scholarship programs. Very high penalties do seem to cut buyout rates by one third,[7] but penalties of any amount were associated with lower physician satisfaction and shorter retention. Contrary to claims,[12] state scholarship program participants did not work in demonstrably needier settings than participants of other programs. Studies of the NHSC Scholarship Program have similarly found that its participants do not serve in needier settings than those in the NHSC Loan Repayment Program.[11,27] The Congressional Government Accounting Office (GAO) and NHSC further similarly concluded that the NHSC Loan Repayment Program achieved better outcomes—higher service-completion rates, greater satisfaction, and longer retention—than the NHSC Scholarship Program, and also at a lower cost.[11,15,28]

The affordable buyout terms of student service-option loan programs allowed half of their participants to opt out of service, but the half who did serve were satisfied and long retained. Service-option loans could play an important complementary role to programs that target graduates, appealing to aspiring medical students who might otherwise choose not to pursue a medical career rather than assume the typical $100,000+ debt in traditional education loans. To embrace loan programs with service options, states must accept that it is not fatally undesirable for some participants to satisfy their loan contracts financially rather than with service. Indeed, most medical students fund their education with traditional loans, like the Health Education Assistance Loans (HEAL), where there is no option or enticement for service.[6] Concerns that too many physicians buyout of loan-for-service programs leaving too few available for shortage communities can be addressed quite readily by making more awards up front, costing programs nothing more because nearly all who opt not to serve repay their loans with interest.

Limitations and Unanswered Questions

Some of this study's data were self-reported and thus vulnerable to reporting inaccuracies. Directors provided figures on their programs' default and buyout rates and likely used a variety of methods to determine these rates. We are unaware, however, of any systematic inaccuracies likely to have biased our principal findings.

Some directors of scholarship and service-option loan programs who otherwise cooperated with our study would not provide the physician-specific information we needed to survey their participants, citing federal confidentiality protections of administrative data collected on students.[29] Given the demonstrated similarities between participating and nonparticipating programs, most importantly in the service completion rates of their participants, we do not suspect that the lower participation rates of student programs biased our outcomes. However, if less successful student programs withheld participants' names to hide their weaknesses, then loan repayment and direct incentive programs could actually be relatively even *more* successful than we judged (ie, bias, if present, was toward the null).

We had wanted to assess program costs and cost-effectiveness but program directors could not provide complete or comparable cost data. We also did not assess the experiences of physicians who signed up with these programs but chose not to serve.

We had no validated criteria on which to judge how often state-obligated physicians work in the very neediest settings, because states have not substantiated their site eligibility criteria and current federal criteria are inadequate.[30,31] Nonetheless, because some state programs use very broad site eligibility criteria, it is very likely that some obligated physicians do not work in the neediest areas.[5,32]

CONCLUSIONS AND RECOMMENDATIONS

As a whole, states' support-for-service programs bring physicians to needy communities where they find satisfying work caring for at-risk patient populations and remain for many years. Of all program types, the loan repayment and direct financial incentive forms, which target physicians after training, show the broadest successes. The successes of these state programs warrant their continued support and perhaps expansion to remedy the continuing maldistribution of physicians.

ACKNOWLEDGMENTS

The authors are grateful to the many state program directors, program staff, and participating physicians who provided data for this study. The authors thank the indispensable contributions of Kathleen Crook, MPA, to the data management aspects of this study, and the contributions of Tim Henderson, MSPH, of the National Conference of State Legislatures and James Bernstein, MHA, and Thomas Tucker of the NC Office of Rural Health and Resources Development to our understanding of these state programs and interpretation of the data. The authors also thank the fellows of UNC's National Research Service Award Primary Care Research Fellowship for their thoughtful suggestions on various drafts of this paper. This study was funded by grant R01-HS09165 from the Agency for Healthcare Research and Quality.

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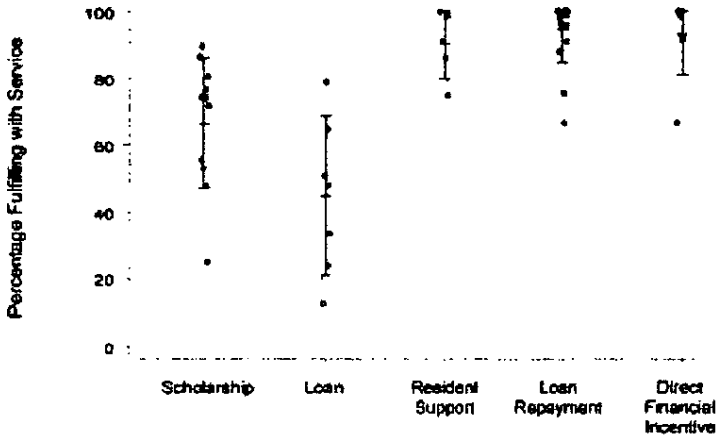
From: Pathman DE, Konrad TR, King TS, Taylor DH, Koch GG. Outcomes of states' scholarship, loan repayment, and related programs for physicians. *Medical Care*. 2004;42:560-568.

FIGURE 1. Percentage of recent physicians in each program (°) who fulfilled their obligations with service, grouped by program type.



Bars denote group means +/- standard deviations

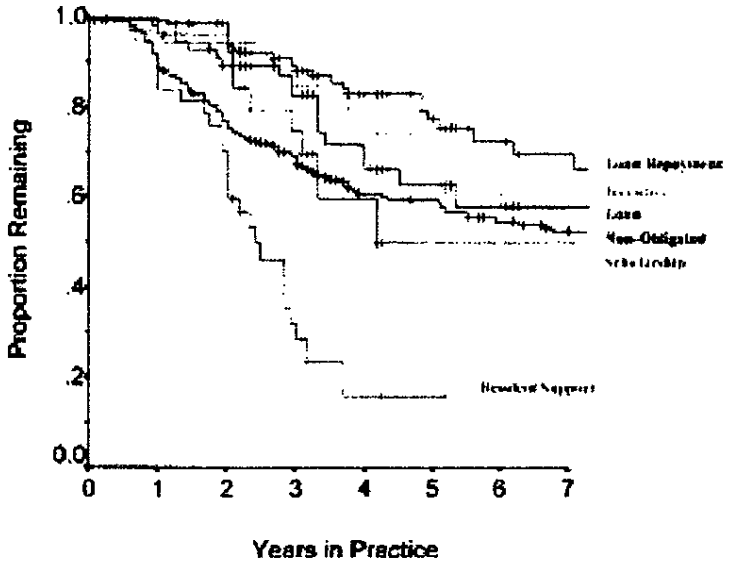


FIGURE 3. Retention of obligated physicians within their service practices: Kaplan-Meier estimations by type of program and compared with nonobligated physicians

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Anchorage Daily News

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Money seen as cure for shortage of doctors in Alaska

PRIMARY CARE: State considers help for more medical students; paying physicians to move north.

By ROSEMARY SHINOHARA
rshinohara@adn.com
(12/16/09 16:10:18)

Citing a continuing shortage of primary care doctors in Alaska, a state commission recommends the state spend considerably more money to train new doctors and lure more already-qualified doctors to the state.

Exactly how many primary care physicians Alaska needs isn't clear, but it's certain we need more, said Dr. Ward Hurlburt, chief medical officer for the Alaska Department of Health and Social Services and chair of the Alaska Health Care Commission, which made the recommendations.

Getting more primary care doctors will help deal with the crisis in care for senior citizens on Medicare, too, the commission believes. Doctors say reimbursement rates for Medicare are too low, and many primary care physicians won't take new Medicare patients.

If there were more doctors available, though, they could spread the Medicare population around.

The proposals include:

• Adding four students annually to the WWAMI medical school jointly operated by University of Alaska Anchorage and the University of Washington, taking each class up from 20 to 24 students. The state pays about $50,000 per student to UW for each of the second, third and fourth years of their schooling. The first year is spent at UAA.

• Starting up three new residency programs to turn medical school graduates into fully qualified psychiatrists, pediatricians and primary care internists. The cost is unknown, but the state pays $2 million per year to support Alaska's only full-fledged residency program: Alaska Family Medicine Residency.

• Paying primary care doctors to get them to move to and practice in Alaska.

The health care commission, comprised of seven people most of whom work in health care, was appointed by then-Gov. Sarah Palin in January. The report completed so far is a draft. The group's final report is to be delivered to the governor and the Legislature by Jan. 15.

A spokesman for Gov. Sean Parnell said it's too early for him to comment.

The commission suggested other ways to improve health care in Alaska beyond increasing the supply of doctors, but put some issues -- such as expanding health insurance, and improving water and sanitation systems around Alaska -- aside for later.

ALASKANS IN MEDICAL SCHOOL

The commission recommends that the state's financial resources target increasing the supply of primary care providers, including doctors, physician assistants and nurse practitioners.

In one case, at least, this single-minded focus is controversial: their approach to the WWAMI program, in which Alaska medical school students do part of their studies at the UAA and the rest at the University of Washington.

The state subsidizes each Alaskan in WWAMI. The commission proposes the students be required to pay the state subsidy back in full if they don't practice as primary care physicians in Alaska for five years. Currently, there's a requirement that Alaska students pay back half the state contribution if they don't practice in Alaska for five years.

Dennis Valenzeno, director of the Alaska WWAMI program, said in an interview that he's afraid the 100 percent payback provision could actually discourage med school graduates from going into primary care.

They come out of medical school with about $100,000 in other debt anyway, he said. If they also have to repay some $150,000 plus interest to the state, the medical school graduates might think they can't afford to go into primary care -- a career that pays half or a third as much as some other specialities, said Valenzeno.

"My fear is this is going to be another disincentive," he said.

WWAMI does have the space to add four more students as recommended, said Valenzeno, but the earliest it could do so would be the fall of 2011.

PAY AND THEY WILL COME The quickest way to get more doctors to Alaska, without doubt, is to pay doctors who have already finished their training to come here.

Research shows that's also the most cost effective way to get primary care doctors, said Hurlbert. "It's convincing."

A bill pending in the Legislature, SB 139, calls for paying doctors, nurses or specified other health workers incentives to take certain Alaska jobs -- from $35,000 to $47,000 for doctor positions, depending on how hard they are to fill.

The commission also suggests the state should figure out how to deliver primary care to Alaskans more efficiently, and how to make better use of "physician extenders" like advanced nurse practitioners, who do some of the same work as a doctor.

The Alaska Health Care Commission's proposals include three new residency programs to turn med school graduates into fully qualified psychiatrists, pediatricians and primary care internal medicine.

Two of those programs are already more than just a dream: Residency programs for psychiatrists and pediatricians are in the planning stages for Alaska, said Dr. Harold Johnston, director of the Alaska Family Medicine Residency.

Both of the new programs would be partnerships with University of Washington. Multiagency steering committees are putting together the pediatric and psychiatric residency proposals.

"We think it's very realistic, very doable. It will require some funding. We don't know how much," Johnston said.

Both Johnston and Susan Humphrey-Barnett, area operations administrator for Providence Health

and Services Alaska, say Alaska's most critical shortage appears to be in psychiatrists.

The need for more pediatricians doesn't seem to be as urgent, said Dr. Richard Mandsager, chief executive of Providence Alaska Medical Center, but there is an opportunity available -- Seattle Children's Hospital and UW are interested in starting a pediatrics residency in Alaska, he said.

An internal medicine residency for primary care doctors -- arguably the one that would help older Alaskans the most -- doesn't appear to be off the ground yet.

Find Rosemary Shinohara online at adn.com/contact/rshinohara or call her at 257-4340.

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Comments Regarding Senate Bill 139

These comments are unsolicited support for Senate Bill 139.

My name is David Head, M.D. I have practiced medicine in Nome, Alaska at Norton Sound Health Corporation nearly 21 years, 20 of those years as Chief of Staff. I have also served on the Alaska State Medical Board for the last 7 years, 4 of those years as the Chairman for the Board. In addition I have served on multiple State and National committees and advisory groups regarding Physician Shortage and recruitment and retention strategies.

It is these experiences that cause me to be such a strong supporter for **Senate Bill 139**.

At this time Alaska is entering a crisis situation when it comes to adequate medical providers. For the first 15 years that I was in Nome, if we had a vacancy open up we were able to pick and choose between several qualified, experienced and well educated physicians to fill that slot. We had no difficulty maintaining a full staff. During the last 5 years this has changed dramatically. The national shortage of primary care physicians, along with the dramatic increase in the cost of living in Bush Alaska has led us into operating in crisis mode. We have slowly gone from a full time staff of 8 physicians to now 3. We scramble to maintain adequate coverage with temporary "traveling doctors", often going through 20-30 different physicians per year to provide basic care. This makes it near impossible to maintain the high quality level of care that the people of this area have become accustomed to, as well as burning out our regular doctors. We have hired recruitment firms that over the last 3 years have only been able to find 2 doctors that would even come for interview. Although I do not see Senate Bill 139 as the "cure all", I do believe it offers immediate aid and will greatly help give us additional chips to play in this game of attracting the professionals that we so greatly need until other more long term answers can be found.

Thank you for your time and dedicated service.

David Head, M.D
Chief of Staff
Norton Sound Health Corporation
Nome, Alaska

Christina Apathy

From: Coady [coady@alaska.net]
Sent: Tuesday, January 26, 2010 3:03 PM
To: Sen. Donny Olson
Subject: SB 139

Dear Senator Olson...Donny:

...a voice from the past, in Nome. It's hard to believe that our family moved from Nome back to Fairbanks 18 years ago. We still have the same C-180 as we did in Nome, and I'm doing some flight instruction to keep my hand in the flying business.

Carol and I noted your Bill SB139, and it made us think of a situation with one of our daughters: Erica will complete a 2 year post-doctoral fellowship in neuropsychology at UCLA this summer. Her work has focused on neurocognitive testing of patients with brain tumors, memory issues, aphasias, movement disorders, HIV, brain injuries, as well as other neurological problems associated with both clinical and forensic cases. She would love to return to Alaska (I'm told there is only one board-certified neuropsychologist in Alaska), but with $100,000 in student loans to pay off she has no choice but to remain in California or other South 48 location where salaries are high enough to make reasonable progress in paying down her education debt. A cash incentive or loan forgivineness program that would include her profession would be a major step in bring her skills and training back home to Alaska.

We trust all is well with you and your family. Please contact us on your next trip to Fairbanks (cell 907-750-5083). It would be great to get together for a visit. Best regards for now.

John Coady

From: Barbara Hale [mailto:bfhale1@msn.com]
Sent: Sunday, April 05, 2009 3:44 PM
To: Sen. Bettye Davis; Sen. Joe Paskvan; Sen. Johnny Ellis; Sen. Joe Thomas; Sen. Fred Dyson
Cc: Sen. Donny Olson; Sen. Bill Wielechowski; Sen. Kevin Meyer; Natalie Hale
Subject: The Alaska Health Care Professions Loan Repayment & Incentive Program
Importance: High

Dear Senators Davis, Paskvan, Ellis, Thomas and Dyson,

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. Competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska. The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. This proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. Loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. This proposal is more cost-efficient and results-producing than other methods.

My daughter, Natalie Hale, will be entering her first year of medical school in August at the University of Washington WWAMI program in Anchorage. With more than $50,000 in student loan debt from her undergraduate studies at Yale already, the Alaska Health Care Professions Loan Repayment and Incentive Program will offer an incentive and encouragement for her to be able to pursue her first love, public health policy and primary care, here in Alaska. Thank you all for your consideration of this important policy under SB 139 to help alleviate health care shortages that Alaska is experiencing and to help retain providers who begin their studies here.

Best Regards,
Barbara Hale
P.O. Box 240211
Douglas, AK 99824-0211
907-586-6590

Christina Apathy

From: Julie Lynch McDonald [julie.cpfi@gmail.com]
Sent: Wednesday, March 03, 2010 8:47 AM
To: Sen. Donny Olson
Cc: Denise Liccioli
Subject: SB 139 Support by Pharmacist Interested in Working in Alaska
Attachments: SB139_Julie_McDonald_3-2-10.pdf

Dear Senator Olson,

I am a pharmacist in south Florida who previously interned in Alaska. I would like to share my story and subsequent support for SB 139 *Incentives for Certain Medical Providers* due to my desire to return and work in Alaska. Please include my attached letter as written testimony for the SB 139 hearing.

After putting myself through college to earn a bachelors degree in environmental science, I decided to move back into my parent's home in order to save for a place of my own and to begin aggressively repaying my nearly twenty thousand in student loans. After a year of working as a field biologist and living on a restricted budget, I was very excited to purchase a garden apartment. However, during this year had been very involved with a children's hospital and nursing home. This volunteer work inspired me to return to college in order to pursue a career that offered the daily opportunity to help alleviate suffering and improve the health of those in my community. I decided the best career would be the profession of pharmacy. As a result, I spent the following year continuing my same employment as a field biologist, completing prerequisite courses in the evening, volunteering on the weekends, living with my parents, and renting my apartment. I was accepted into two private colleges of pharmacy and one out of state college. I knew any choice would result in massive student loans accrued during the four years required for a Doctor of Pharmacy degree (tuition alone exceeded eighty thousand). Therefore, I choose a local college of pharmacy that allowed me to continue living with my parents throughout pharmacy school and rented my apartment that I sold a few years later without having the pleasure of ever living in it.

The summer after my first year in pharmacy school, I was thrilled to have the opportunity to spend a month working at the Prescription Center Pharmacy in Fairbanks and volunteering with the Fairbanks Native Bible Church. I anticipated enjoying the beauty of the Alaskan outdoors, but did not expect to fall in love with the people and culture of Alaska. One small example is the quick bond I developed with those who simply rode the same bus route. One day a co-worker generously offered to pick me up for work. I can still recall on the following morning how those on the bus shared they had been truly concerned since I had not been on the bus the previous day. My time in Alaska made a marked impression. Therefore, I was saddened to leave when the month was over and have hoped to return to Alaska ever since.

After graduation from pharmacy school, I felt a great responsibility to begin immediately paying down my student loans. As a result, I did not choose to defer my loans in order to complete a residency and subsequently enter into a more sought-after field of pharmacy. Rather, I entered the very demanding field of retail pharmacy. I have spent nearly two years working fulltime at an independent retail pharmacy and as a relief pharmacist at another independent pharmacy. I have come to value and respect the vital role a local retail pharmacist has in counseling and advising patients, collaborating with practitioners on patients' medication therapy, seeking innovative ways to meet individual patient's needs (i.e. compounding medications), and often serving as a listening friend. It is a physically demanding and emotionally draining, but richly rewarding by the relationships built with your patients.

Currently my husband, who has a bachelors in business, and I are considering moving to Craig. We would be working at an independent retail pharmacy and are enthused to become a part of the Prince of Wales

community. Additionally, I serve on the board of directors for a pharmacy organization where I oversee seventy-six student chapters nationwide and internationally. Part of my work in Craig would be encouraging pharmacy students from numerous states to come to Alaska for a summer position or complete a rotation during their final year of pharmacy school. My husband and I are confident the culture and spirit of Alaska would be of great benefit for us and we would continually seek to benefit the community through our combined diverse background in medicine, environmental science, business, accounting, and construction. However, my monthly student loan payment is significantly greater than our mortgage payment. My husband and I would like to relocate to Craig, but my more than two hundred thousand in student loans causes us to be very cautious with our choices.

From my perspective, SB139 would be a powerful incentive to draw pharmacists to the great state of Alaska. I have witnessed much legislation that is well intentioned, but often a significant portion ends up benefiting or rewarding those who have not necessarily made the hard choices. In contrast, I personally found SB139 to be distinctive and very encouraging. The reason for this is twofold. First, SB139 will attract medical professionals to Alaska and rural areas in particular, thus benefitting those who live in those areas and are often underserved. Second, SB139 will actually assist those who have made the continuous rigorous sacrifices of time, energy, and finances to enter the medical profession in an effort to give of themselves in the service of others.

Thank you for your time and consideration!

Sincerely,

Julie McDonald
Julie.CPH@gmail.com
561.222.3330

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."

The Honorable Senator Olson
Alaska State Senate
State Capitol, Room 514
Juneau, Alaska 99801-1182

Re: Support for Incentives for Certain Medical Providers – SB 139

March 18, 2008

Dear Senator Olson,

The Alaska Primary Care Association (APCA) represents 26 health care organizations and 141 Community Health Centers (CHCs), as well as other safety net providers throughout Alaska. The APCA knows firsthand that workforce shortages can affect access to health care services in Alaska's Community Health Centers. In 2007, our sites provided primary health care services to over 80,000 patients despite suffering a severe 35% shortage of primary care physicians and a 22% shortage of midlevel providers at Community Health Centers.[1] In fact, Alaska's CHCs have current vacancies for an estimated 22 physicians, 20 physician assistants, 26 nurse practitioners, 6 dentists, and 10 licensed certified social workers – to name a few.

Alaska is suffering from labor shortages in most professional health care occupations[2], while most of the State of Alaska has been designated either as a Health Professional Shortage Area or a Medically Underserved Area[3]. All but six states have addressed similar professional health provider shortages by implementing support-for-service programs which have helped to attract and retain health care providers[4].

The Alaska Primary Care Association supports SB 139 and the creation of a state-sponsored "Health Care Professions Loan Repayment and Incentive Program" to help fill vacancies and help health care facilities recruit and retain health care professionals.

We appreciate your hard work and service to Alaskans and support your efforts to expand access to health care for all Alaskans.

Respectfully,

Regan Mattingly
State Affairs Coordinator

Shelley S. Hughes
Government Affairs Director

[1] Bureau of Primary Health Care. "Alaska Section 330 Grantees Uniform Data System (Provider Utilization)."
2 Alaska Health Workforce Vacancy Study Research Summary. University of Alaska. August 2007. http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce-summary_final.pdf.
3 US Department of Human Services, Health Resources and Service Administration. Health Professional Shortage
4 Health Care Professions Loan Repayment Program Concept Proposal. Pat Carr, Chief Health Planning & Systems Development, Alaska

Alaska Primary Care Association
903 W Northern Lights Blvd, Suite 200
Anchorage, AK 99503

ph. 907-929-2722
fx. 907-929-2734
www.alaskapca.org

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."

Alaska Primary Care Association
Board of Directors

RESOLUTION 2009-02

Health Care Professions Loan Repayment and Incentive Program for Alaska

WHEREAS the Alaska Primary Care Association strives toward the goal of a healthy population, it recognizes that a robust health care workforce is necessary to provide adequate health care access for all Alaskans and is a key ingredient in improving the public health of all Alaskans; and

WHEREAS Alaska is competing with other states and nations for the finite pool of available health care professionals; and

WHEREAS Alaska is suffering from labor shortages in most professional health care occupations[1], and these shortages are hitting primary care "safety net" agencies particularly hard; and

WHEREAS most of the State of Alaska has been designated either a Health Professional Shortage Area or a Medically Underserved Area;[2] and

WHEREAS a common state-level response to these pressures is the use of financial inducements, collectively known as support-for-service programs (SFSPs), and good outcomes have been achieved with these;[3] and

WHEREAS national studies have determined loan repayment and incentive programs to be two of the most effective of the several SFSP strategies in terms of both recruitment and retention;[4] and

WHEREAS a key problem is that Alaska does not have a robust SFSP while most other states do, many have several, and further, some of those are growing;[5] and

WHEREAS most all other states have state-sponsored SFSPs that influence health professionals' geographic and specialty distributions;[6] and

WHEREAS it is well-established that many health care professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away; and

Phone 907-929-2722 • Fax 907-929-2734 • www.alaskapca.org • alaskapca@alaskapca.org
903 West Northern Lights Blvd., Suite 200 • Anchorage, AK 99503-2400

DONE AND DATED THE 21st DAY OF January IN THE YEAR 2009

SIGNED BY _____

Sonia Handforth-Kome, APCA Board President

[1] Alaska Health Workforce Vacancy Study Research Summary. University of Alaska. August 2007. http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce-summary_final.pdf.

[2] US Department of Human Services, Health Resources and Service Administration. Health Professional Shortage Area. http://hpsafind.hrsa.gov/.

[3] Health Care Professions Loan Repayment Program Concept Proposal. Pat Carr, Chief Health Planning & Systems Development, Alaska DHSS. September 11, 2007. http://www.hss.state.ak.us/primarycare/assets/loan-proposal.pdf.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Health Planning & Systems Development, Alaska Department of Health & Social Services. *Health Care Professions Loan Repayment Program Concept Proposal*, September 11, 2007.

[8] Ibid.

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 17, 2009

Honorable Donald Olson
Alaska State Senate
Capitol, Room 514
Juneau, Alaska

RE: SB 139 – Recruitment Increments for Certain Health Care Professionals

Dear Senator Olson:

As you know, Dr. Olson, the Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

On behalf of all ASMA members, I thank-you for introducing SB 139. ASMA participated as one of the stake holders who came together to develop the concept for the loan repayment and direct incentive program embodied in SB 139. ASMA strongly supports SB 139 as an effective recruitment tool for physicians as well as the other health care professionals covered by the program.

Alaska competes with all other states in the recruitment of an ever shrinking pool of physicians practicing general internal medicine or family medicine. Currently only 2% of medical school graduates are choosing general internal medicine or family medicine residencies. 44 of those states already have a loan repayment or direct incentive program.

SB 139 will help to provide an important part in solving Alaska's chronic and acute (in certain practice specialties) physician workforce shortages. All of the health care system reforms aimed at providing some form of universal insurance coverage provides an empty promise so long as sufficient numbers of appropriately trained physicians (and other health care professionals) do not exist.

ASMA supports SB 139 and urges passage of this important legislation.

Again, ASMA, thanks you in your leadership and efforts to introduce and secure passage of the Alaska Health Care Professions Loan Repayment and Incentive Program.

Sincerely,

Thomas J Vasileff

By: Thomas Vasileff, MD, President
For: The Alaska State Medical Association

Re: Support for SB 139 Incentives for Certain Medical Providers

March, 19, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, I strongly support SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

In my roll as clinical site director for the U.W. DENTEX Training Center, I have had the opportunity to hear about the difficulties health care facilities in Alaska have in recruiting and retaining providers.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

There is already a crisis of dental care access in rural Alaska. We have large numbers of our Alaska Native population who cannot access even the basic services needed, such as a yearly exam or treatment for urgent dental needs. The caries rate is 2 ½ times the national rate in our rural communities. Headstart programs struggle to find local providers to perform the mandatory evaluations for their students, many programs resort to bringing in outside providers at great expense. Teeth are left untreated until it is too late to restore them, because there are not appointments available for routine care. Our communities should not have to suffer with the pain and cost of untreated disease.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

I support SB 139 and urge passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Mary E. Williard, DDS
Clinical Site Director
ANTHC Division of Community Health Services
U.W. DENTEX Training Center
4200 Lake Otis Parkway, Suite 204
Anchorage, AK 99508

Alaska Native Health Board

1840 Bragaw Street, Suite 220
Anchorage, Alaska 99508

Phone: (907) 562-6006
Fax: (907) 563-2001

January 25, 2010

Senator Donny Olson
State Capital Building, Room 514
Juneau, Alaska 99801-1182

Dear Senator Olson,

We write to express the Alaska Native Health Board's support for SB 139, establishing a health professions loan repayment and employment incentive program. Alaska is one of only six states without a state-sponsored health professions support-for-service program.

Overall, Alaska health workforce vacancy rates are now over 10% and growing, particularly for hard-to-fill positions in rural locations where most providers are "safety net" providers who deliver care to primarily to Medicaid and Medicare beneficiaries and the uninsured.

Among tribal providers, who are the only provider of health services in many areas of the state, health professional vacancy rates exceed the statewide rates across the board by 150-200%.

The challenges are daunting: The average time it takes for a tribal provider to fill a physician vacancy is over a year, while the average time to fill a mid-level vacancy is six months. **As of November 2009, within the Alaska tribal health system alone, there were over 80 physician vacancies.** These severe workforce shortages compound the challenge of providing good access to quality healthcare for all Alaskans, particularly in the rural areas.

SB 139, The Alaska Health Care Professions Loan Repayment & Incentive Program, is an important part of the solution to Alaska's health workforce shortage. It was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska.

More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively alleviate shortage problems in other states, and we are certain that SB 139 will work because it has been thoroughly reviewed and customized for Alaska.

Sincerely,

Evangelyn "Angel" Dotomain
President/CEO

P.O. Box 240247 " Anchorage, AK 99524 " www.asdha.com

Re: Support for SB 139--Incentives for Certain Medical Providers

March 23, 2009

Dear Senate and House Members of the Alaska State Legislature:

The Alaska State Dental Hygienists' Association (ASDHA) supports Senate Bill 139 to establish a loan repayment and incentive program. This legislation addresses the shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals that provide direct patient care.

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. This legislation would allow Alaska to compete with other states in the recruitment of numerous providers and help fill the alarming number of vacancies that exist.

Senate Bill 139 provides incentives for dental professionals, including dentists and dental hygienists. While current practice act limitations exist for direct patient care by dental hygienists, we are hopeful SB 139 will attract more dentists and dental hygienists to our state and to rural communities. With up to eighteen dental hygiene students graduating from Alaska universities yearly, we believe SB 139 would provide an additional incentive for them to stay.

The ASDHA supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Gail Walden

Gail Walden, RDH
Alaska State Dental Hygienists' Association

Alaska Osteopathic Medical Association

142 East Ontario Street | Chicago, IL 60611
Phone 800.621.1773, ext. 8128 | Fax 312.202.8428 | Email: AKOMA@osteopathic.org

December 3, 2008

Dear Governor and Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Alaska Osteopathic Medical Association (AKOMA) strongly supports the concept of a state-sponsored loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

The mission of the AKOMA is to promote public health through providing quality, relevant and professional CME that enhances the body of knowledge and skills of those in attendance. Emphasis will be placed upon Osteopathic Practice and Principles to enable attending physicians to better serve the needs of their patients.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Health Care Professions Loan Repayment & Incentive Program proposal brings to the table an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. The proposed program designed for Alaska will provide much needed relief for our state.

AKOMA recommends the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program and requests that you actively take steps to create and fund the program.

Respectfully,

T. Capistrant

Todd Capistrant, DO
President

Alaska Pharmacists Association

RE: Support for SB 139
Alaska Health Care Professions Loan Repayment & Incentive Program

March 24, 2009

Dear Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, putting Alaskans in jeopardy, the Alaska Pharmacists Association strongly supports the concept of a state-sponsored loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a limited and shrinking national pool.

"The Mission of the Alaska Pharmacists Association is to preserve, promote and lead the profession of pharmacy in Alaska."

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, LCSWs (licensed, clinical social workers), and physical therapists are all in short supply in Alaska.

Based on statistics provided by Laura Miller, PhD, Senior Economist with the National Association of Chain Drug Stores, the national average of community pharmacists per 10,000 people is 5.36. For Alaska, the figure is 3.35. To get to the national average, Alaska would need an additional 137 pharmacists. The average number of people per community retail pharmacy is about 5,300 nationally, and in Alaska it is 8,900. Even if you add in the 15 Indian Health Service (IHS) pharmacies, Alaska's pharmacies average about 7,500 people, much higher than the national average.

The Health Care Professions Loan Repayment & Incentive Program proposal brings to the table an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. The proposed program designed for Alaska will provide much needed relief for our state.

Respectfully,

Nancy O. Davis
Executive Director

E-mail: akphrmcy @ alaska.net

203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880

Alaska Pharmacists Association

Alaska Pharmacists Association
Board of Directors

RESOLUTION 2009-01

Health Care Professions Loan Repayment and Incentive Program for Alaska

WHEREAS Alaska is competing with other states and nations for the finite pool of available healthcare professionals; and

WHEREAS Alaska is suffering labor shortages in most professional healthcare occupations, and that these shortages are hitting primary care "safety net" agencies particularly hard; and

WHEREAS the harsh conditions of Alaska and the fiscal limitations of safety net clinics makes it difficult for Alaska to compete in the hiring market; and

WHEREAS the entire State of Alaska has been designated either a Health Professional Shortage Area or a Medically Underserved Area; and

WHEREAS a common state-level response to these pressures is the use of financial inducements, collectively known as support-for-service programs (SFSP's), and that good outcomes have been achieved with these; and

WHEREAS national studies have determined loan repayment programs to be one of the most effective of the several SFSP strategies in terms of both recruitment and retention; and

WHEREAS a key problem is that Alaska does not have a robust support-for-service program while most other states do, many have several, and further, some of those are growing; and

WHEREAS most all other states have state-sponsored SFSP programs that influence health professionals' geographic and specialty distributions; and

WHEREAS it is well-established that many healthcare professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away; and

WHEREAS considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of healthcare personnel; and

E-mail: akphrmcy@alaska.net

203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880

WHEREAS in 2006, the Alaska Physician Supply Task Force recommended a number of specific strategies and action steps to assuring an adequate supply of physicians to meet Alaska's need, including creation of a loan repayment program; and

WHEREAS AkPhA serves as a voice on behalf of Pharmacists to preserve, promote and lead the profession of pharmacy n Alaska;

THEREFORE BE IT RESOLVED that the Alaska Pharmacists Association (AkPhA) supports the creation of a state-sponsored "Health Care Professions Loan Repayment and Incentive Program" and will advocate for the necessary authorizing and fiduciary legislation.

SUBMITTED BY:
Melanie Gibson, AkPhA President
Nancy Davis, Executive Director

DONE AND DATED THE 25th DAY OF AUGUST IN THE YEAR 2008

SIGNED BY

_____

Melanie Gibson, AkPhA Board President

[1] Alaska Center for Rural Health. *2007 Alaska Health Workforce Vacancy Study*. July 2007, http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce_7-24-07_body_final.pdf.

E-mail: akphrmcy@alaska.net

203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880

ALASKA PHYSICAL THERAPY ASSOCIATION, INC.

A CHAPTER OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION
PO BOX 140351 ANCHORAGE, AK 99514-0351
PHONE (907) 566-3749

Re: Support for Alaska Health Care Professions Loan Repayment & Incentive Program

November, 26, 2008

Dear Governor and Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Alaska Physical Therapy Association strongly supports the concept of a state-sponsored loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

The Alaska Physical Therapy Associations mission is that it's a member driven organization (290 members) is to represent and advocate for the profession of physical therapy and promote excellent, ethical, and autonomous practice, which serves the culturally diverse population of Alaska.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

At any given time you can contact most remote hospitals and clinics and find at least 1-2 vacancies, or openings for physical therapists. Even urban clinics are constantly recruiting for providers due to turnover, retirement, or keeping up with population growth in their respective communities. There are companies that provide temporary travelling Physical Therapists for 13-16 week assignments which can be extremely expensive for coverage, and again the turn over rate creates changes for patients and can also cause breaks in care or shortage of man power coverage.

The Health Care Professions Loan Repayment & Incentive Program proposal brings to the table an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. The proposed program designed for Alaska will provide much needed relief for our state.

APTA
American Physical Therapy Association

The Alaska Physical Therapy Association highly recommends and advocates for the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program and requests that you actively take steps to create and fund the program for health related assistance to our states residents.

Respectfully,

Sundi M Hondl, PT, OCS

Sundi M Hondl, PT, OCS
Alaska Physical Therapy Association President

ALASKA PUBLIC HEALTH ASSOCIATION

Committed To Advancing Alaska's Public Health Since 1978

ALPHA

March 20, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Alaska Public Health Association (ALPHA) strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

ALPHA supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Jayne Andreen

President
ALPHA Board of Directors

P.O. Box 9-1825 Anchorage, AK 99509 907/332-1030 *e-mail:* publichealth@alaska.net
www.alaskapublichealth.org

3766

Ilaqalaqkz
Iliuliuk Family and Health Services, Inc.
P.O. Box 144
Unalaska, Alaska 99685
Phone: (907) 581-1202
Fax: (907) 581-2331

Re: Support for SB 139 Incentives for Certain Medical Providers

March 17, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, Iliuliuk Family and Health Services, Inc. (IFHS) strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

Our organization, IFHS, is the only comprehensive service provider for medical, dental and behavioral health services within 800 air miles of Unalaska. We are remote, and we frequently find that we are unable to compete with "lower 48" medical practices for providers, since we also cannot compete effectively with salaries. State loan repayment options for our providers would help us offer a competitive package.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

It takes IFHS over a year to recruit a single doctor; six months to recruit a behavioral health specialist, and the last time we recruited a dentist, it took us four years to do so. We cannot recruit RNs – we have had two open RN positions for over two years. A state-sponsored support-for-service program would help make our recruitment package more appealing and more competitive.

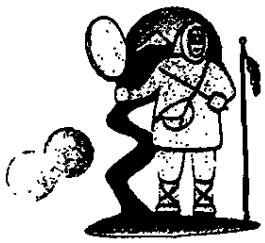
The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB

139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

IFHS supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Sonia Handforth-Kome
Executive Director



Maniilaq Association

Maniilaq Health Center

Administration

Phyllis Boskofsky RN
Hospital Administrator
P.O. Box 43, 436 5th & Stevens Way
Kotzebue, AK 99752
Phone (907) 442-7319
FAX (907) 442-7250

Re: Support for SB 139 Incentives for Certain Medical Providers

March 20, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, especially in remote regions such as ours, the Maniilaq Health Center (MHC) strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

In order for the Maniilaq Health Center to meet its Mission Statement:
"The Maniilaq Health Center provides comprehensive health care to all the people in our service area while promoting prevention, fitness, wellness, holistic strategies, and incorporating local traditional core values and beliefs", its Vision Statement: ***"All customers of Maniilaq health services, including its employees, are empowered, and involved partners in its high quality services and healing atmosphere"***, and its Purpose statement: ***"We are a family of care, helping every person live a healthier life"***, we must have a trained healthcare workforce.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult, and becomes even more difficult as you leave urban area facilities for remote facilities such as MHC. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

Maniilaq Health Centers Professional Vacancy Rates

MD/DO Vacancies	3 vacancies out of 9 positions = 30% vacancy rate
Dentist Vacancies	3 vacancies out of 5 positions= 60% vacancy rate
Pharmacist Vacancies	3 vacancies out of 4 positions= 75% vacancy rate
Registered Nurse Vacancies	12 vacancies out of 24 positions = 50% vacancy rate
Physical Therapist	1 vacancy for > 2 years= 100% vacancy rate

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

The Maniilaq Health Center supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Phyllis A. Boskofsky
Hospital Administrator

Member Villages

Ivissaappaat, Nunatchiaq, Ipnatchiaq, Katyaak, Kivaliniq, Laugviik, Qikiqtagruk, Naitaaq, Nuurvik, Tikigaq, Akuligaq, Isinnaq,
Ambler, Buckland, Deering, Kiana, Kivalina, Kobuk, Kotzebue, Noatak, Noorvik, Point Hope, Selawik, Shungnak

Mat-Su Health Foundation Resolution to Support Health Care Professions Loan Repayment & Incentive Program for Alaska

WHEREAS the Mat-Su Health Foundation's mission is to enhance the health of Alaskans living in Mat-Su, where health is in part determined by access to primary, behavioral, and dental care and preventive services;

WHEREAS an adequate healthcare workforce is necessary to provide this access, and according to the *2005-2015 Mat-Su Borough Health Plan*, Mat-Su has an "inadequate number of providers to meet the demands of a growing population" in both the core area and the outlying rural areas of the borough;[i]

WHEREAS Mat-Su is designated a Medically-Underserved Area/Population by the U.S. Health Resources and Services Administration and has sub-regions designated Primary Care Health Professional Shortage Area, Mental Health Professional Shortage Area, and Dental Care Health Professional Shortage Area;[ii]

WHEREAS the Mat-Su Borough is the fastest growing area of Alaska, growing from 5,188 in 1960 to 82,515 in 2008 due to both positive birth and in-migration rates; and the AK Department of Labor projects that all Mat-Su age groups will continue to grow through 2020;[iii]

WHEREAS the Mat-Su Borough is experiencing one of the highest rates of population growth in the state among senior citizens, who use the healthcare system disproportionately more than any other age group; and the Alaska Commission on Aging reports Mat-Su's senior growth rate at 11.6%, which includes a net gain from a senior in-migration rate that is almost double its senior out-migration rate;[iv]

WHEREAS the Alaska Health Care Commission has designated Medicare-access as one of its six focus areas; and the University of Alaska Anchorage Institute of Social and Economic Research has reported that access to primary care for Medicare beneficiaries is problematic in Mat-Su, where data reveals that only 57.7% of Mat-Su primary care physicians will see new Medicare patients;[v]

WHEREAS the Mat-Su Health Foundation believes that an investment in the education of Mat-Su residents will help to build the healthcare workforce of the future and an engaged citizenship with a higher capacity to address the health-related challenges impacting Mat-Su and Alaska; and to this end has offered scholarships to help defray the cost of higher education and encourage Mat-Su residents to complete a degree or certificate program that emphasizes health and/or wellness; but also recognizes that more needs to be done to bolster the healthcare workforce in Mat-Su and Alaska;

WHEREAS Mat-Su Regional Medical Center has spent $6,238,438 on contract labor over the last five years on temporary health professionals from outside the state to fill current needs;

WHEREAS Alaska is competing with other states for the finite pool of available health care professionals; and over 40 states currently offer Support-for-Service Programs (SFSPs) that have influenced health professionals' geographic and specialty distributions;

WHEREAS national studies have determined loan repayment and incentive programs to be two of the most effective strategies in terms of both recruitment and retention;[vi]

WHEREAS without this incentive, it will be challenging for Alaska to compete for medical and health professionals, especially to work in rural areas;

BE IT THEREFORE RESOLVED that the Mat-Su Health Foundation promotes and advocates for the establishment of the Health Care Professions Loan Repayment & Employment Incentive Program to bring more qualified medical professionals to Alaska and will advocate for the necessary authorizing and fiduciary legislation.

***Approved by the Mat-Su Health Foundation Board of Directors on* January 18, 2010.**

Deborah Prator, President

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[i] 2005-2015 Mat-Su Borough Health Plan. Information Insights. January 2006.
http://www.matsugov.us/planning/index.php?option=com_content&view=article&id=69:mayors-blue-ribbon-task-force-on-borough-health-and-social-service-board&catid=20:health-and-human-services-board&Itemid=[illegible]

[ii] U.S. Department of Human Services. Health Resources and Service Administration. Health Professional Shortage Area.
http://hpsafwarehouse.hrsa.gov/GeoAdvisor/shortageDesignate.aspx?type=[illegible]

[iii] Matanuska-Susitna Borough. Alaska Department of Labor. Division of Research & Analysis.
http://laborstats.alaska.gov/pop/projections/pub/MatSu.pdf

[iv] Alaska State Plan for Senior Services FY2008-FY2011. Alaska Commission on Aging. June 2007.
http://www.gov.state.ak.us/aging/boards/council/pdf/2008-2011_State_Plan.pdf

[v] How Hard Is It for Alaska's Medicare Patients to Find Family Doctors? University of Alaska Anchorage Institute of Social and Economic Research. UA Research Summary No. 14. March 2009.
http://www.iser.uaa.alaska.edu/Publications/2009_03-Medicare_Access.pdf

[vi] Health Care Professions Loan Repayment Program Concept Proposal. Pat Carr, Chief Health Planning & Systems Development, Alaska DHSS. September 11, 2007. http://[illegible]

March 20, 2009

Re: Support for SB 139 Incentives for Certain Medical Providers

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Alaska Behavioral Health Association strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

One of our primary goals deals with Workforce Development and this bill fits well within the goal to assure that a well trained adequate workforce is available to behavioral health providers.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants, behavioral health clinicians, addiction professionals, and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

The Alaska Behavioral Health Association supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

In Health,

Steve Horn
Executive Director

2009 abha Membership

Organization	Community
Akeela	Anchorage
Alaska Children's Services	Anchorage
Alaska Family Services	Palmer
Alaska Island Community Services	Wrangell
Alaska Youth & Family Network	Anchorage
Anchorage Community Mental Health Services (Southcentral Counseling)	Anchorage
Arc of Anchorage	Anchorage
Assets, Inc.	Anchorage
Mat-Su Health Services	Wasilla
Bristol Bay Counseling Center (BBAHC)	Dillingham
Boys and Girls Home of Alaska	Fairbanks
Catholic Community Service	Juneau
The Center	Homer
Community Connections, Inc.	Ketchikan
Denali Family Services	Anchorage
Edgar Nollner Health Center	Galena
Fairbanks Community Behavioral Health Center, Inc.	Fairbanks
Fairbanks Native Association	Fairbanks
Family Centered Services of Alaska	Fairbanks

Organization	Community
Frontier Community Services	Soldotna
Gateway Center for Human Services	Ketchikan
Impact Counseling	Haines
Juneau Alliance for Mental Health, Inc.	Juneau
Juneau Youth Services	Juneau
Kenai Peninsula Care Center	Kenai
Lynn Canal Counseling	Haines
Maniilaq Association	Kotzebue
North Star Behavioral Health System	Anchorage
Peninsula Community Health Services	Soldotna
Petersburg Mental Health Services, Inc.	Petersburg
Railbelt MH and Addictions	Nenana
SEARHC - Behavioral Health Service Division	Sitka
SeaView Community Services	Seward
Sitka Counseling and Prevention Services	Sitka
Southcentral Foundation Behavioral Health Services	Anchorage
Volunteers of America of AK	Anchorage
Yukon-Kuskokwim Health Corporation	Bethel

Advisory Board on Alcoholism and Drug Abuse

abada amhb

Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

March 25, 2009

Senator Donald Olson
Alaska State Capitol, Room 514
Juneau, Alaska 99801

Re: SB139 – Loan Repayment and Employment Incentive Program

Dear Senator Olson,

The Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board appreciate your support for Alaska's health care workforce. The Boards support the intent of SB 139, and look forward to continued dialogue about how best to support our health care professionals and encourage more Alaskans to enter the field.

As you know, the health care industry has been one of our fastest growing employment sectors. Despite that, health care providers — including mental health and substance abuse providers — report an inability to maintain a workforce that meets the demand for services. The Alaska Department of Labor and Workforce Development reported that growth in health care jobs has slowed since 2006 (reporting growth of only 1% in Anchorage in 2008) and forecasts only modest growth in 2009. In this environment, we need measures to sustain the workforce we have and to encourage more Alaskans to enter the health care fields.

Loan repayment programs prove to be very effective ways to encourage health care professionals to serve rural and underserved populations, and often result in longer terms of service in these communities. Offering this much needed support to our current health care workforce will help promote stability for our providers and encourage more people to pursue health care careers.

We recognize the immense amount of effort that has gone into SB 139, and applaud the fact that it involved a cooperative effort by a coalition of stakeholders. We also recognize the concerns about the potential cost of the program and the infrastructure necessary to implement the program. We are hopeful that as SB 139 progresses through committee, there will be greater understanding about these issues.

Thank you for your work this session, and always, on behalf of Alaska.

Sincerely,

L S Walters

Lonnie Walters, Chair
ABADA

Debi Keith, Chair
AMHB

The TRUST

The Alaska Mental Health Trust Authority

November 10, 2008

Re: Support for Alaska Health Care Professions Loan Repayment & Incentive Program

Dear Governor and Members of the Alaska State Legislature:

The Alaska Mental Health Trust Authority (The Trust) strongly supports the concept of a state-sponsored health professional loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a limited and shrinking national pool.

The Trust has invested in workforce development around providers serving our beneficiaries for many years, often partnering with both state and non-state entities. The Trust will be investing over $3,300,000 in FY 10 in our Workforce Development Focus Area and partners such as the University of Alaska will invest much more in this important area. Currently The Trust's Workforce Development Focus Area is investing $200,000 in a loan repayment strategy for behavioral health professionals in underserved areas and another $200,000 in cash incentives because research indicated this is an effective strategy for recruitment and retention. The Trust believes that in order to continue to address health professional recruitment and retention we will have to be innovative and aggressive, and with many other states and the federal government using loan repayment as a key strategy, we must also have a program that is available to our health professional organizations serving Alaska's residents.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. The Department of Labor and Workforce Development's labor data tell us that health and social services jobs are and will be some of the top growth job opportunities in Alaska for the next 10 years. Strategies such as loan repayment are critical to meeting the demand in this high job growth area and Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists, psychiatrists, physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, LCSWs (licensed, certified social workers), and physical therapists are all in short demand in Alaska.
The Trust invests in a semi-annual vacancy rate study conducted by the Alaska Center for Rural Health which shows that behavioral health vacancy rates are some of the highest of all health professionals. Psychiatrist's in all of our public mental health systems have become a critical problem with a mean vacancy length of 34.5 months.

The TRUST

The Alaska Mental Health Trust Authority

The Health Care Professions Loan Repayment & Incentive Program proposal brings to the table an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. The proposed program designed for Alaska will provide much needed relief for our state.

The Trust recommends the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program and requests that you actively take steps to create and fund the program.

Respectfully,

Delisa Culpepper

Delisa Culpepper
Chief Operating Officer

Tel Fax

Christina Apathy

From: RIPLEY, ELIZABETH [E.Ripley@MSrmc.com]
Sent: Monday, January 25, 2010 11:40 AM
To: Sen. Donny Olson
Subject: Mat-Su Health Foundation Resolution to Support Health Care Professions Loan Repayment & Incentive Program for Alaska
Attachments: MSHF Resolution in Support of Loan Repayment & Incentive Program 10.pdf

Sen. Olson, In reference to your sponsorship of SB 139, please consider the attached **Mat-Su Health Foundation Resolution to Support Health Care Professions Loan Repayment & Incentive Program for Alaska** in support of your efforts. Many thanks!

Elizabeth Ripley

Elizabeth Ripley | Executive Director | Mat-Su Health Foundation | 950 E. Bogard Road | Wasilla, AK 99654 | Direct: 907-352-2896 | Main Office: 907-352-2863 | Fax: 907-352-2865 | e.ripley@msrmc.com | http://www.matsuhealthfoundation.org

Christina Apathy

From: Nancy St.John-Smith [nsjsmith@pchsak.org]
Sent: Tuesday, February 09, 2010 5:01 PM
To: Sen. Donny Olson
Subject: Capitol Hill Visit

Dear Senator Olson and staff,

Thank you for your hospitality during our capitol hill visit on February 2 and 3, 2010. It was my first visit to Juneau and you all made us feel right at home. We know that we can count you as a friend to community health centers across the state and we appreciate the time and attention you were able to give to our cause.

An amazing fact that you can share with others who need to know about the importance of community health centers in our great state is that Peninsula Community Health Services provided either medical, dental, or behavioral health care to about 25% of the central peninsula's population last year. The demands on community health centers continue to grow as there are more and more uninsured and underinsured consumers in our state. As always, we treat all comers and do not turn consumers away based on their ability to pay. Due to the high quality of care received at our facilities, people from all walks of life access their health care through us. Unfortunately, we are not able to keep up with the rising costs of providing care and recruiting providers.

As members of the Alaska Primary Care Association, we are in support of SB 139, which provides loan repayment and incentives for health care providers to work and live in the state of Alaska. We have asked for $ 400,282.00 in funding for senior access. Alaska's community health centers are asking for $2 million for operating funds to cover the rising costs of doing business, such as insurance premiums. We support increasing the Denali Kid Care eligibility limit to 200% of the federal poverty level.

We look to you and our other legislators to provide the leadership and support to accessing funding from the state of Alaska for community health centers in Alaska. We are one of only 5 states which do not routinely fund their community health centers.

Sincerely,
Nancy

Nancy St.John-Smith
Manager of Dental Support Services
Aspen Dental Center, a clinic of
Peninsula Community Health Services
395 Main Street Loop
Kenai, Alaska 99611
907.283.7759

SEARHC
SouthEast Alaska Regional Health Consortium
3245 Hospital Drive, Juneau, AK 99801
907 463-4000 • www.searhc.org

Re: Support for SB 139 Incentives for Certain Medical Providers

March 20, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the SEARHC Ethel Lund Medical Center strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

The SEARHC Ethel Lund Medical Center provides comprehensive outpatient care to Alaska Native/Native American patients in the Juneau area (over 7,000 active patients). We have found recruitment of health providers to be extremely challenging, including physicians, physician assistants, pharmacists, physical therapists, optometrists, and other health care professionals. Almost all potential applicants request loan repayment. Juneau does not qualify for any loan-repayment program, and this puts us at a significant disadvantage in recruiting health care providers.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage that we here at SEARHC Juneau, and that the rest of Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

The SEARHC Ethel Lund Medical Center supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Janice Sheufelt, MD

Janice Sheufelt, MD
Medical Director
SEARHC Ethel Lund Medical Center
Juneau, Alaska

P.O. Box 787 (Mile 4.4 Talkeetna Spur Road) Talkeetna, AK 99676 (Ph) (907) 733-2273 (Fax) (907) 733-1735 schc@sunshineclinic.org

RE: Support for SB 139 Incentives Alaska Health Care Professions Loan Repayment & Incentive Program

March 25, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, Sunshine Community Health Center (SCHC) strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

SCHC's mission is to assist people in the upper Susitna Valley to meet their health care responsibilities by providing affordable, accessible, quality health care, including preventive aspects, to all people regardless of their ability to pay for services. We are a safety-net provider, with our primary focus on patients who are uninsured and unable to pay for basic medical care. We operate two clinics, one in Talkeetna that is open 6 days a week and one in Willow that is open 5 days a week.

The biggest obstacle to accomplishing our mission is our inability to fully staff the organization with the number of medical, dental, and mental health providers we need. As of this writing, SCHC has been recruiting unsuccessfully for a medical provider to staff our Willow clinic for 3 years. We have been recruiting for a full-time mental health professional for 2 years, a nurse for 1 year, and a dentist for 6 months. Two years ago, unsuccessful recruiting and unexpected vacancies shrank our staff of five medical providers (not including dental and mental health) to just two medical providers covering both clinics, and since then we have never been fully staffed.

Our efforts at recruitment during this period have attracted a high level of interest from providers interested in relocating to our community because of the attractive quality of life we offer. Unfortunately, once excitement gives way to realism, the following factors dissuade them from actually accepting a position and moving here:

- the high cost of student loans; medical and dental graduates average over $100,000 of student debt;
- moving expenses;
- high cost of living in Alaska;
- the escalating cost of health insurance.

SCHC's experience is not unusual. With alarming and rising vacancy rates, Alaska is poised for a crisis unless there is some new intervention. Alaska is one of only six states without a state-sponsored incentive program such as a loan repayment program. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

Sunshine Community Health Center supports SB 139 and urges passage of this important legislation. Your support and action on this matter are greatly appreciated.

Respectfully,

Mary Loeb, MD
Medical Director of Sunshine Community Health Center

AaNA Alaska Nurses Association
3701 E Tudor Road Suite 208
Anchorage, Alaska 99507

March 9, 2010

To Senator Olson

Re: SB 139

The Alaska Nurses Association supports SB 139 Education Reinvestment Act that will provide loan repayment and incentives to health professionals who commit to continued professional practice in Alaska. The elements of SB 139 that provide incentives to health professionals who have completed their education and are ready to provide critical health services are excellent recruitment and retention strategies for those professionals in short supply.

SB 139 provides a fast start to making a difference in our health professional shortages. Incentives and loan repayment are key concerns for recruitment and the mechanism for staging the incentive payments on a quarterly basis increase the likelihood that it will also serve as an excellent retention tool.

Alaska faces an uphill struggle to attract qualified health professionals to work here. A number of other states have enacted incentives and loan repayment programs that stiffen the competition for our state. Although our state has many unparalleled opportunities, the economic burdens for health professionals to move to Alaska, get set up in a practice, and repay enormous loans for education, make it impossible for many to even consider working in our state. SB 139 not only helps level that economic field, but it speaks volumes to Alaska's commitment to solving our health professional shortages

The Alaska Nurses Association with a membership of over 1100 Registered Nurses in Alaska appreciates your sponsoring SB 139 and looks forward to working with you in support of this important legislation. Alaskans deserve our best efforts to protect and promote their health. A qualified workforce of health professionals is essential to that goal.

Sincerely,

Nancy C. Davis, RN MS

Nancy C. Davis, RN, MS
AaNA President
907-274-0827 Office

Debbie Thompson

Debbie Thompson, BSN, RN, CNOR
AaNA Executive/Labor Program Director
907-274-0827 Office

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 25, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 139 (Olson)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 139, authored by Senator Donald Olson and co-sponsored by Senators Bill Wielechowski, Kevin Meyer and you.

As you know, Alaska has a chronic shortage of health professionals. We compete with the other states who all have their own shortages. SB 139 follows a proven tradition of recruitment incentives by providing loan forgiveness and economic incentives to encourage health professionals to practice in our state. We understand that there is a cost to recruitment and retention. We also understand that there is a greater cost when our citizens are unable to secure the services of health professionals.

AARP requests an "AYE" vote on SB 139.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Donald Olson

COMMONWEALTH
NORTH

Resolution 2009-2
In support of Incentives for Certain Medical Providers as proposed in Senate Bill 139
April 14, 2009

This resolution is based on the 2005 Commonwealth North study entitled "Alaska Primary Health Care: Opportunities and Challenges."

Commonwealth North:

Encourages and promotes the establishment of incentives to bring more qualified Medical professionals to Alaska.

Requests all state legislators to approve authorizing legislation in Senate Bill 139; and

Forwards this resolution to all members of the Alaska State Legislature, Governor Sarah Palin, and Alaska's congressional delegation.

Resolved for the following reasons:

1. There are critical health manpower shortages in both our urban and rural areas
2. The State of Alaska is in competition with over forty states who already offer similar programs
3. Without this incentive, it will be difficult for Alaska to compete for medical and health professionals
4. Multiple millions of dollars are being spent annually in Alaska to have temporary health professionals from Outside fill our current needs
5. Current and potential future shortages can be identified in specific specialties including family practice physicians, internists, nurse practitioners, physician's assistants, nurses and clinical support health manpower areas such as physical therapist, x-ray and laboratory technicians

Approved by the Commonwealth North Board of Directors
April 14, 2009

David Wight

David Wight, President

Nome Eskimo Community
Box 1090
Nome, Alaska 99762
Phone (907) 443-2246
Fax (907) 443-3539

March 23, 2009

RE: Support for SB 139 Incentives for Health Care Professions

Dear Senate and House Members of the Alaska State Legislature:

The Nome Eskimo Community strongly supports SB 139 that would establish a loan repayment and incentive program for health care professions in Alaska. The on-going healthcare workforce shortage in Alaska significantly impacts access to and continuity of health care for our residents and the creation of such a program could be a solution to address a critical shortage in our state.

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program. The competition for recruitment of providers is very difficult and the establishment of this program would allow Alaska to compete with the lower 48 for the recruitment of much needed medical providers. Alaska is experiencing a crisis: we have more than 90 pharmacist vacancies in Alaska; many communities have inadequate, if any, access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit, and nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply statewide.

Loan repayment and incentive programs have been proven to effectively alleviate workforce shortage problems in other states and the Alaska Health Care Professions Loan Repayment & Incentive Program could be part of the solution to address this issue in Alaska. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention, and with input from stakeholders statewide that includes consideration of factors that are unique to Alaska; SB 139 will establish a program customized for Alaska.

The Nome Eskimo Community fully supports and encourages the passage of SB 139. Your support to assure the establishment of the Alaska Health Care Professions and Loan Repayment & Incentive program is greatly appreciated.

Respectfully,

NOME ESKIMO COMMUNITY

Denise Barengo, Executive Director

Christina Apathy

From: Pamela J Embler [afpje@uaa.alaska.edu]
Sent: Wednesday, February 03, 2010 7:23 AM
To: Sen. Donny Olson
Subject: SB139

Senator Olsen -

Thank you for sponsoring such an important piece of legislation which has the potential to positively impact the residents of our great state. I would like to ask that you consider adding nurse educators to the list of qualified applicants. I am a faculty member at the University of Alaska Anchorage, School of Nursing. I recently received my masters in nurse education, that is my specialty area of nursing practice. Nurse educator certification has been recognized by the National League of Nursing as an advance practice specialty. I have been accepted to the University of Tennessee's nurse PhD program, an online/onsight program. The PhD is the expected terminal degree for nurse educators.
Alaska, the University of Alaska needs nurse educators to prepare the nurses of tomorrow, nurses for tomorrow that can meet the needs of the residents of Alaska. Many students are traveling outside to obtain a their nurse edcuation, many who leave may not return. If we want the students to stay in Alaska after obtaining their education we need to be able to educate them here, to that end we need more nurse educators.

Thank you for your time and your consideration.

Respectfully,
Pam Embler

Pam Embler, MSN, RN
Assistant Professor
University of Alaska Anchorage
3211 Providence Drive
PSB 110A
Anchorage, AK 99645
afepje@uaa.alaska.edu
(907)786-4509 Office
(907)786-4559 Fax
(907)775-3428 Cell

UAA UNIVERSITY of ALASKA ANCHORAGE
Dental Clinic

Re: Support for SB 139 Incentives for Certain Medical Providers

March 15 2009

Dear Senate and House Members of the Alaska State Legislature:
Senator Bettye Davis, Chair, and Members of the Senate HSS Committee

The University of Alaska Anchorage Dental Hygiene Program has produced successful candidates for over thirty years, our graduates placing second nationally in two of the last three years. Our goal is to prepare professionals who are familiar with the most advanced technology and evidenced-based practice and proficient in providing a wide range of dental services to diverse populations in a caring manner. It is a well known fact that we face an increasing demand for dental care with the burgeoning senior population, in addition to the many citizens who lack access to care. Poor dental health directly compromises systemic health, and contributes to a myriad of complications when not addressed. Our rural population suffers the most. Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the University of Alaska Anchorage Dental Hygiene Program strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program. The competition for recruitment of providers is very difficult. Due to alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist vacancies exist in Alaska; many communities have inadequate access to dentists or hygienists; physician assistants and nurse practitioners are increasingly difficult to recruit. Dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces by providing more support to those willing to serve at risk populations. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. Loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states, proving less costly and more effective than other methods. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

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The University of Alaska Anchorage Dental Hygiene Program supports SB 139 and strongly recommends passage of this important legislation.

Respectfully,

Elizabeth Barnett, Clinic Director
UAA Dental Hygiene Program
3211 Providence Drive
Allied Health Science Bldg #121
Anchorage, Alaska 99508
barnett@uaa.alaska.edu
907.786.6926