

HB

78

<TARGET><BILL>HB 78</BILL><SUBJECT>HB
78</SUBJECT><COMM>HHSS27</COMM></TARGET>

27-LS0147\X
Mischel
3/17/11

CS FOR HOUSE BILL NO. 78()

IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES HERRON, Edgmon, Feige

A BILL

FOR AN ACT ENTITLED

1 **"An Act establishing a loan repayment program and employment incentive program for**
2 **certain health care professionals employed in the state; and providing for an effective**
3 **date."**

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 *** Section 1.** AS 18 is amended by adding a new chapter to read:

6 **Chapter 29. Health Care Professions Loan Repayment and Incentive Program.**

7 **Sec. 18.29.010. Legislative intent.** The loan repayments and direct incentive
8 payments provided under this chapter are intended to ensure that residents throughout
9 the state, including recipients of medical assistance and Medicare, have access to
10 health care and that residents of rural areas of the state, in particular, experience
11 improved access to health care services.

12 **Sec. 18.29.015. Health care professions loan repayment and incentive**
13 **program; purpose; advisory body.** (a) The health care professions loan repayment
14 and incentive program is established in the department for the purpose of addressing

1 the worsening shortage of certain health care professionals in the state by increasing
2 the number and improving the distribution of health care professionals who provide
3 direct patient care.

4 (b) The program established under this section must include

- 5 (1) direct incentives paid under AS 18.29.020;
6 (2) loan repayments made under AS 18.29.025;
7 (3) procedures for the commissioner's designation and prioritization of
8 sites eligible for participation in the program;
9 (4) an application process for participation in the program as
10 (A) an eligible site; or
11 (B) a tier I or tier II health care professional;
12 (5) the dissemination of public information and notices pertinent to the
13 program;
14 (6) classification by the commissioner of each eligible site as having
15 either regular or very hard-to-fill positions, or both;
16 (7) matching payments, as provided under (d) of this section;
17 (8) a lifetime maximum period of 12 years for participation in the
18 program by a tier I or tier II health care professional, as described in (f) of this section;
19 (9) procedures for allowable leaves of absence; and
20 (10) annual program evaluations and reports.

21 (c) The program shall be administered by the commissioner in consultation
22 with an advisory body appointed by the commissioner. The advisory body is made up
23 of members with health care expertise, including expertise in economic issues
24 affecting the hiring and retention of health care professionals in the state. Members of
25 the advisory body serve at the pleasure of the commissioner to provide
26 recommendations for and oversight and evaluation of all aspects of the program. The
27 commissioner shall accept a recommendation of the advisory body on a matter
28 pertaining to the identification and monitoring of areas of shortages, eligible sites,
29 payment priorities, or evaluation of the program, unless the commissioner finds, in
30 writing, that the recommendation cannot be financially or otherwise supported by the
31 department.

1 (d) An employer or other entity approved for participation in the program may
2 make nonrefundable quarterly matching payments to the department for deposit in the
3 general fund. The payments must be in an amount that is

4 (1) a portion of the combined annual incentive payment and the loan
5 repayment amounts paid under the program for the benefit of the employee, as
6 determined by the commissioner; and

7 (2) adjusted by the employer's or other entity's ability to pay, as
8 determined by the commissioner, in consultation with the program advisory body.

9 (e) A matching loan repayment or direct incentive payment made under (d) of
10 this section shall be paid as a combined amount to the professional by the department
11 from money appropriated for the purpose.

12 (f) The department may approve loan repayment and direct incentive
13 payments for a qualified applicant under the program for three-year periods, as
14 follows:

15 (1) an initial period of three years;

16 (2) a renewal period of three years if the applicant

17 (A) requests loan repayments and has a continuing loan
18 obligation on the same loan that was subject to repayment under the program
19 during the initial three-year period and is otherwise eligible under the program;

20 (B) continues to qualify for direct incentive payments under the
21 program; or

22 (C) is eligible under both (A) and (B) of this paragraph;

23 (3) a reapplication period of six years that is equivalent to (1) and (2)
24 of this subsection if the applicant is engaged in qualified employment and the
25 applicant

26 (A) requests additional loan repayments under the program and
27 has incurred additional loans that qualify for repayment under the program
28 during or after the first six years of the applicant's participation in the program;

29 (B) requests additional direct incentive payments under the
30 program; or

31 (C) is eligible under both (A) and (B) under this paragraph.

1 (g) The department shall prorate loan repayments and direct incentive
2 payments under the program based on the number of hours of qualified employment
3 worked in a calendar quarter. However, the department may not make a loan
4 repayment or direct incentive payment before the completion of a calendar quarter for
5 which the loan repayment or incentive payment is made.

6 (h) The department shall adopt regulations necessary to implement the
7 program.

8 (i) Direct incentive payments, loan repayments, and matching payments shall
9 be made with funds appropriated by the legislature for that purpose.

10 **Sec. 18.29.020. Direct incentives.** (a) The department shall provide direct
11 incentives in the form of quarterly cash payments to eligible tier I and tier II health
12 care professionals engaged in qualified employment.

13 (b) Payments made under this section, when combined with a matching
14 payment and a loan repayment amount paid under AS 18.29.025, if any, may not
15 exceed

16 (1) \$35,000 annually for a tier I health care professional employed in a
17 regular position;

18 (2) \$47,000 annually for a tier I health care professional employed in a
19 very hard-to-fill position;

20 (3) \$20,000 annually for a tier II health care professional employed in
21 a regular position; or

22 (4) \$27,000 annually for a tier II health care professional employed in
23 a very hard-to-fill position.

24 (c) The commissioner shall calculate the annual incentive payment amount by
25 multiplying the annual maximum payment under (b) of this section by the percentage
26 of full time equivalent employment for each of not more than three years of qualified
27 employment less a matching payment amount as determined under AS 18.29.015(d) of
28 this section and loan repayment amount, if any, under AS 18.29.025.

29 **Sec. 18.29.025. Loan repayment.** (a) The commissioner shall repay a portion
30 of eligible education loans described in this section that are held by or made to eligible
31 tier I and tier II health care professionals under the program according to the loan

1 repayment procedures established in this section.

2 (b) A loan is eligible for repayment under the program if the loan was issued
3 by a government or commercial entity for the payment of actual costs of tuition and
4 other reasonable educational and living expenses related to the undergraduate or
5 graduate education of a participant who is eligible under AS 18.29.035 and that
6 resulted in a degree required for employment as a tier I or tier II health care
7 professional under the program.

8 (c) A loan repayment under this section when combined with a matching
9 payment shall be in an amount not to exceed 33.3 percent of the unpaid loan balance
10 existing in the first year of program participation, multiplied by the percentage of full
11 time equivalent employment for each of up to three years of qualified employment less
12 a matching loan repayment or incentive amount from an employer or other entity as
13 determined under AS 18.29.015(d).

14 (d) The commissioner shall make a loan repayment under this section in
15 quarterly installments payable to the lending institution or to the eligible health care
16 professional.

17 (e) A loan or interest on a loan is not eligible for repayment under this section
18 if the loan or interest is

19 (1) to be repaid by another source, including another loan repayment or
20 forgiveness program or an employer-sponsored repayment program;

21 (2) consolidated with a loan that is not eligible for repayment; or

22 (3) refinanced.

23 **Sec. 18.29.030. Number of participants.** (a) The number of participants to
24 whom the commissioner may provide a direct incentive payment, loan repayment, or
25 both under the program established under AS 18.29.015 may not exceed 90
26 participants annually as described in (b) of this section, regardless of whether the
27 participants are new participants, continuing participants, or both.

28 (b) The commissioner shall reserve sufficient funding for not fewer than three
29 positions in each of the 10 tier I and tier II health care professions in very hard-to-fill
30 positions at eligible sites.

31 (c) If insufficient funds are appropriated in a fiscal year, the department shall

1 prorate payments based on the number of approved participants in the program.

2 **Sec. 18.29.035. Eligibility and priority.** (a) To be eligible for a direct
3 incentive payment under AS 18.29.020, an individual shall

4 (1) submit an application that is approved by the commissioner;

5 (2) be engaged in qualified employment at an eligible site with a
6 participating employer or entity;

7 (3) be licensed or exempt from licensure as a tier I or tier II health care
8 professional in the state;

9 (4) meet a priority for payment established under (c) of this section;
10 and

11 (5) meet other criteria established by the commissioner.

12 (b) To be eligible for loan repayment under AS 18.29.025, an individual shall

13 (1) meet eligibility and priority criteria established under (a) of this
14 section; and

15 (2) have an unpaid balance on one or more eligible education loans
16 described under AS 18.29.025 and verified by the Alaska Commission on
17 Postsecondary Education.

18 (c) The commissioner shall establish priorities for payment of incentives and
19 loan repayments under the program based on the recommendations of the program
20 advisory body and the availability of funding. The commissioner shall prioritize
21 eligible sites based on the needs assessment for the site, remoteness of the site, the
22 percentage of underserved patients treated at the site, or a combination of these
23 elements; in this subsection, an underserved patient

24 (1) is uninsured;

25 (2) receives or is eligible to receive medical assistance or Medicare
26 coverage; or

27 (3) receives or is eligible to receive other federal health program
28 benefits.

29 **Sec. 18.29.099. Definitions.** In AS 18.29.010 - 18.29.099,

30 (1) "commissioner" means the commissioner of health and social
31 services;

1 (2) "department" means the Department of Health and Social Services;

2 (3) "eligible site" means a service area or health care facility that the
3 commissioner has designated as located in a health care services shortage area based
4 on a needs assessment score and employment statistics for qualified tier I or tier II
5 health care professionals;

6 (4) "program" means the health care professions loan repayment and
7 incentive program;

8 (5) "qualified employment" means employment of a tier I or tier II
9 health care professional at an eligible site at which the health care professional is hired
10 and paid to work

11 (A) in a full-time or not less than half-time position;

12 (B) for a contract term that is not less than three years; and

13 (C) not less than 50 percent time on direct patient health care
14 services;

15 (6) "tier I health care professional" means a person licensed or exempt
16 from licensure in the state as a dentist, pharmacist, or physician;

17 (7) "tier II health care professional" means a person licensed or exempt
18 from licensure in the state as a dental hygienist, registered nurse, certified nurse
19 practitioner, physician assistant, physical therapist, clinical psychologist, or clinical
20 social worker holding at least a master's degree in social work.

21 * **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to
22 read:

23 HEALTH CARE INCENTIVE PROGRAM REPORT. On or before January 1, 2019,
24 the Department of Health and Social Services shall prepare and submit a report to the
25 legislature that describes the participation rates, costs, and effect on health care profession
26 shortage areas, as designated by the commissioner of health and social services, of the health
27 care profession incentive program established under AS 18.29.015.

28 * **Sec. 3.** AS 18.29.010, 18.29.015, 18.29.020, 18.29.025, 18.29.030, 18.29.035, and
29 18.29.099 are repealed June 30, 2019.

30 * **Sec. 4.** This Act takes effect immediately under AS 01.10.070(c).

CS HB 78 () "Incentives for Certain Medical Providers"
Sponsor: Representative Herron

"An Act establishing a loan repayment program and employment incentive program for certain health care professionals employed in the state; and providing for an effective date."

Changes from 27-LS0147\D to ""\X

All changes proposed in amendment D.1, offered by Representative Keller on 3/17/2011, are incorporated:

- Addition at \X page3 line2 - "for deposit in the general fund";
- Addition at \X Page3 line11 - "from money appropriated for the purpose"
- Addition of new subsection (i) at \X page4 line8 - "(i) Direct Incentive payments, loan repayments, and matching payments shall be made with funds appropriated by the legislature for that purpose."
- Addition of new subsection (c) at \X page5 line31 - "If insufficient funds are appropriated in a fiscal year, the department shall prorate payments based on the number of approved participants in the program."

At \X page3 line4, "not more than half" is replaced with "a portion". This gives the Commissioner, in consultation with the program's advisory body, to determine matching payments ranging from zero-100% for each individual site, depending on the site's ability to pay.

On \X page5, loans eligible for repayment by the state under the Health Care Professions Loan Repayment and Incentive Program are defined.

- **At page5 line2, new subsection (b):** "A loan is eligible for repayment under the program if the loan was issued by a government or commercial entity for the payment of the actual costs of tuition and other reasonable educational and living expenses related to the undergraduate or graduate education of a participant who is eligible under AS 18.29.035 and that resulted in a degree required for employment as a tier I or tier II health care professional under the program."
- **At page5 line17, new subsection (e):** "A loan or interest on a loan is not eligible for repayment under this section if the loan or interest is
 - (1) to be repaid by another source, including another loan repayment or forgiveness program or an employer-sponsored repayment program;
 - (2) consolidated with a loan that is not eligible for repayment; or
 - (3) refinanced.

On \X pages 6 and 7, eligible site determination and prioritization is clarified:

- **Eligible site determination.** At \X page7 line4, the word "score" is added. This directs DHSS, in the needs assessment process, to assign each site a score indicating its level of need. This score, as well as employment statistics, will be factors in site eligibility determination.
- **Prioritization of eligible sites.** At \X page6 line21, the words "the needs assessment for the site" are added to allow DHSS to prioritize eligible sites based on the site's needs assessment score, remoteness, the percentage of patients treated at the site who are underserved, or a combination of these three factors.

3/17/2011 11:34:29 AM

Representative Bob Herron

Rep.Bob.Herron@legis.state.ak.us

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House District 38
Kuskokwim & Johnson Rivers
Kuskokwim Bay & Nelson Island

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Akiak
Atmautluak
Bethel
Chefornak
Eek
Goodnews Bay
Kasigluk
Kipnuk
Kongiganak
Kwethluk
Kwigillingok
Lower Kalskag
Mekoryuk
Mertarvik
Napakiak
Napaskiak
Newtok
Nightmute
Nunapitchuk
Oscarville
Platinum
Quinhagak
Toksook Bay
Tuluksak
Tununak
Tuntutuliak
Upper Kalskag

February 16, 2011

Representative Wes Keller, Chair
House Health and Social Services Committee
State Capitol Room 432
Juneau, AK 99801

Representative Keller,

I respectfully request a hearing of HB 78, "Incentives for Certain Medical Providers," in the House Health and Social Services Committee.

A bill packet is attached, ordered as specified in the committee's hearing request memo dated January 20, 2011.

A list of expected testifiers, and any special accommodations they may require, will be provided once the bill is scheduled, to allow my staff to confirm availability.

Thank you for your consideration. Please feel free to contact me, or aide Liz Clement (x6576 direct), with any questions.

A handwritten signature in black ink, appearing to read "Bob Herron".

Representative Bob Herron

ALASKA STATE LEGISLATURE

Representative Bob Herron

Official Business



State Capitol
Juneau, Alaska
99801-1182

House Bill 78 – Incentives for Certain Medical Providers

Version 27-LS0147\B

Staff Contact: Liz Clement 465-6576

SPONSOR STATEMENT

Alaska communities, both urban and rural, face a serious shortage of health care providers that, if not immediately addressed, will rapidly worsen. In response to this challenge, HB 78 proposes to create a *Health Care Professions Loan Repayment & Incentive Program (HCPLRIP)* - a loan repayment and direct monetary incentive program in the Department of Health and Social Services (DHSS), which will quickly reduce the shortage by filling vacant health care provider positions throughout the state with both new and experienced health care professionals.

HCPLRIP will support up to 90 participants each year, spread across 10 different essential health care occupation shortage areas¹. 30 of these slots will be reserved for the most underserved areas of the state, designated by the DHSS Commissioner as having the greatest need². Benefit will not be limited to rural Alaska, however; urban health centers are also encouraged to participate.

Other health workforce supports exist but, on their own, they are not enough³. HCPLRIP is an effective and efficient step to fill the gaps left open by these programs. When implemented, Alaska's HCPLRIP will be one of very few in the United States offering incentives to mid-career professionals who may have already exhausted other loan repayment options, or who no longer carry educational loan debt. This feature will put Alaska on the cutting edge with a powerful recruitment tool, and will bring with it the benefit of experience only seasoned professionals can provide. New graduate or mid-career, HB 78 is designed to bring them here - and keep them here for the long term.

It is critical that we promptly address Alaska's healthcare workforce shortage, in order to ensure that all Alaskans have meaningful access to the basic health care they need and deserve.

Please join me in supporting HB 78.

¹ Three positions will be reserved for practitioners in each of the following participating professional groups: dentist, pharmacist, physician, dental hygienist, registered nurse, certified nurse practitioner, physician assistant, physical therapist, clinical psychologist, and Master's level or higher clinical social worker.

² Based upon ongoing needs assessments, employment statistics.

³ The valuable WWAMI program, which I fully support, is on its own not enough to meet Alaska's complex health care needs. Students who eventually practice in Alaska can only do so once their education is complete. In addition, the program only supplies physicians, while Alaska demands a variety of health care professionals.

LEGAL SERVICES

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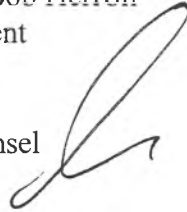
MEMORANDUM

January 17, 2011

SUBJECT: Sectional Summary (HB 78; Work Order No. 27-LS0147\B)

TO: Representative Bob Herron
Attn: Liz Clement

FROM: Jean M. Mischel
Legislative Counsel



You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Requires the Alaska Commission on Postsecondary Education to repay education loans made to health care professionals, as defined, under eligibility criteria established in sec. 2. Specifies that the loan repayment obligation is not a financial obligation of the corporation. Provides for quarterly payments based on the fulfillment of qualified employment at eligible sites located in the state.

Section 2. Establishes the health care professions loan repayment and incentive program in the Department of Health and Social Services for the purpose of addressing a shortage of certain health care professionals in the state and for improving the distribution of those professionals. Requires the commissioner of health and social services to administer the program, to designate and prioritize eligible employment sites, and to monitor the program in consultation with an advisory body established under this section. Provides for maximum combined loan repayment and employment incentives based on the type of employment.

Section 3. Requires the Department of Health and Social Services to prepare and submit a report in 2019 pertaining to the health care professions incentive program established in the bill.

Section 4. Repeals all provisions in the bill that establish the health care professions incentive program on June 30, 2019.

Section 5. Provides for an immediate effective date for the bill.

JMM:ljw
11-022.ljw

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 10,926 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.

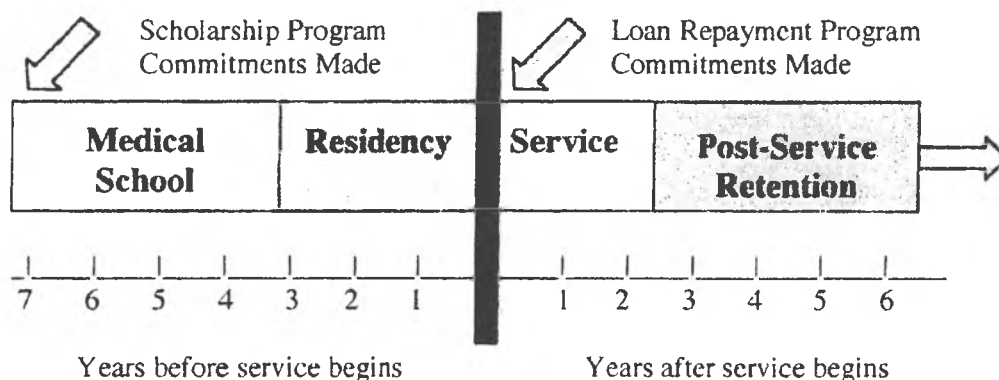
Medical Training Debt & Service Commitments: Pathman, et al (2000) assessed how student loan debt and scholarships, loan repayment and related programs with service requirements influence the incomes young physicians seek and attain, influence whether they choose to work in rural practice settings and 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"

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

Table 1: "State Program" (continued)

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

State-Level Offices: Service-for-Support Programs

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

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

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

(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 underserved 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 underserved 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
- Indicators 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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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.

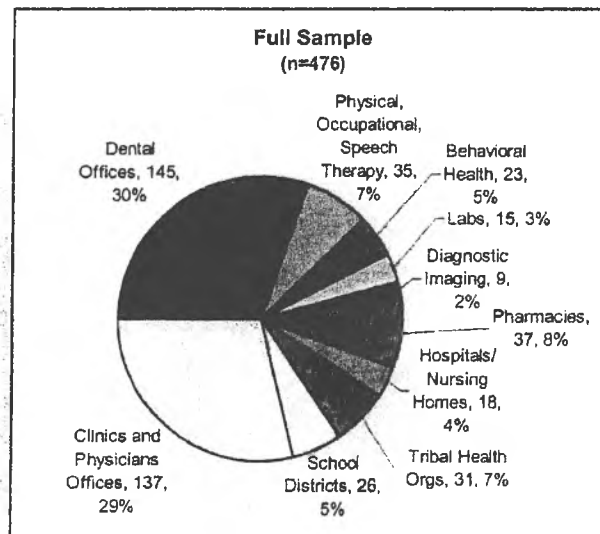


Figure 1

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).

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 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%

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.

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%	7.3%	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	359	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

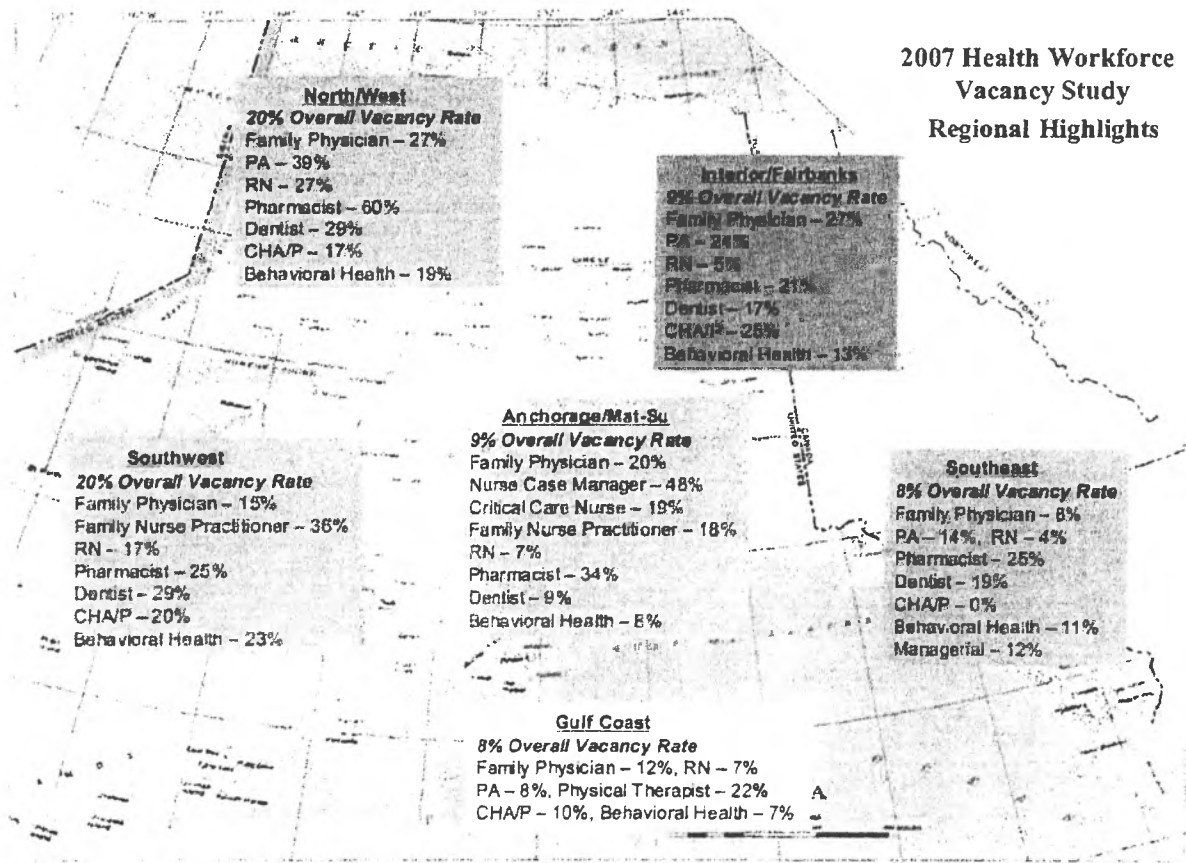
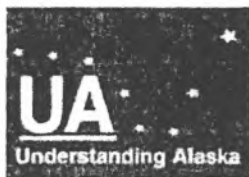


Figure 2. Regional Highlights



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.

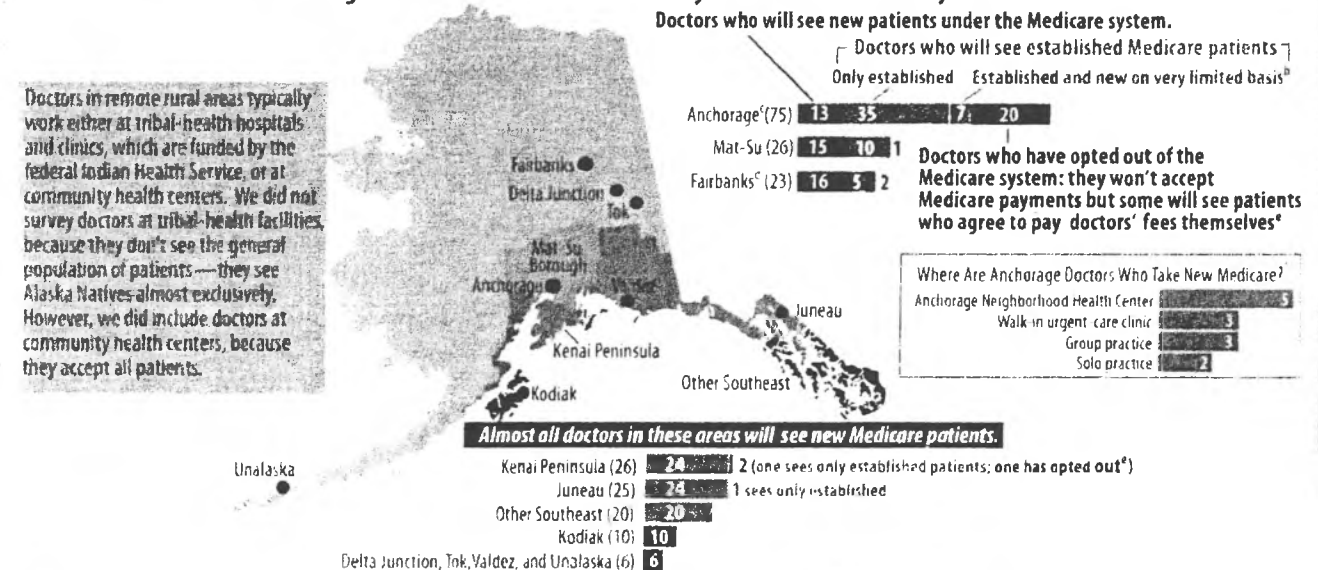
- Almost all doctors in smaller communities take new Medicare patients. Rural places have few doctors—so doctors probably feel more of an obligation to see all patients. For patients (Medicare or otherwise) in rural Alaska, the challenge is more likely to be recruiting and keeping doctors.

- 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



^aIn 2008 we surveyed 229 doctors; 15 weren't taking any new patients at all; 2 had no Medicare patients. In 2009 we re-surveyed doctors who didn't take new Medicare patients in 2008. ^bTen 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. Includes Eagle River (Chugiak). Includes North Pole. See Figure 4. See page 4.

*Suppose 21% of non-poor families 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.

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.

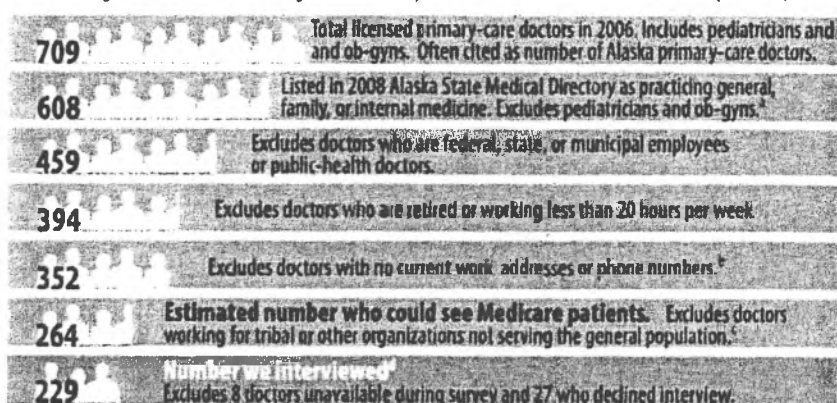
The CMS formula actually includes three geographic differentials: one for "physician work" itself, one for doctors' costs of operating practices, and one for doctors' costs of carrying liability insurance.

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).

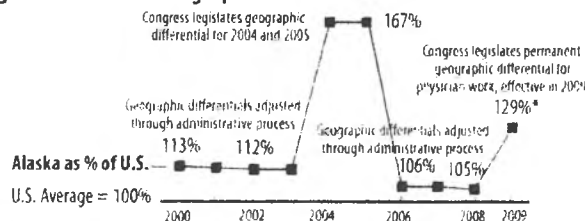
Figure 2. How Many Primary-Care Doctors Are Available to See Medicare Patients?
(Among Alaska Doctors Practicing General, Family, or Internal Medicine at Least 20 Hours per Week)



^aWe excluded pediatricians and obstetrician-gynecologists, who are often included in definitions of primary-care doctors, because they don't routinely see older patients. ^bAbout 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. ^cWe 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. ^dWe interviewed either doctors or members of their staffs.

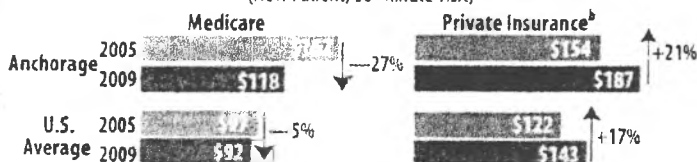
- After that legislation expired, the Medicare differential dropped sharply, to about 5% above the U.S. average from 2006 to 2008.
- In 2009, the cost differential for Alaska doctors climbed to 29% above the U.S. average, due to new federal legislation—as we just discussed. But Medicare still pays doctors 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. If 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* to Primary-Care Doctors, Anchorage and U.S. Average, 2005 and 2009
(New Patient, 30-Minute Visit)



*Figures include the amount Medicare or private insurance pays and the amount the patient pays. [†]Median payments. Source: Inquris 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.

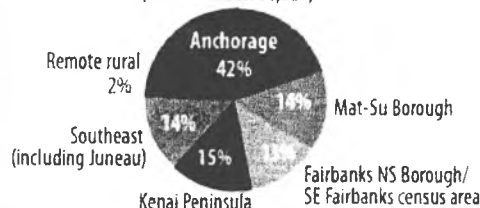
• Anchorage's Medicare patients don't seem to be turning more to emergency rooms. Data from Providence Hospital's emergency room show that visits by older patients have stayed mostly steady, with seasonal variations, since 2004 (Figure 7). But some health-care providers think that Medicare patients may 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.

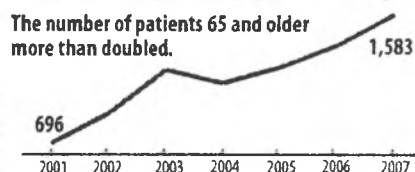
Figure 5. Where Do Non-Native Alaskans Over 65 Live?
(2006 Estimate: 38,227)



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

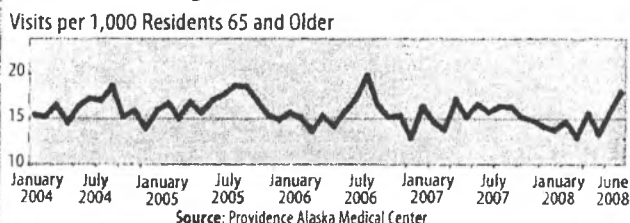
Figure 6. Growth in Number of Patients 65 and Older at Anchorage Neighborhood Health Center, 2001-2007

Patients over 65 jumped from 6% to nearly 14% of all patients who came to the clinic.



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

Visit Type	Location	Medicare Payment	Patient Payment	Total Payment
30-minute visit	Doctor	\$94.90	\$23.72*	\$118.62
	ANHC	\$119.28	\$39.60*	\$158.88
1-hour visit	Doctor	\$189.56	\$47.39*	\$236.95
	ANHC	\$119.28	\$76.20*	\$195.48

*Patient co-pay; 20% of total payment. **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.

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.

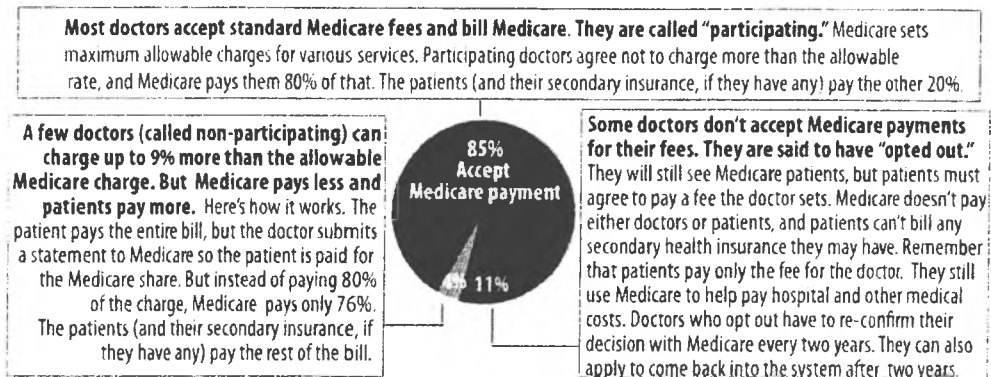
As more Alaskans turn 65, the access problem will get worse, unless something changes. Growing numbers of Medicare patients around the country are also reporting access problems. And the American College of Physicians has reported that a nationwide shortage of primary-care doctors is looming—which would 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 9. How Do Alaska Primary-Care Doctors Who See Medicare Patients Deal with the System?
(Among 211 Surveyed Who See New or Established Patients)



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

^aPatients can bill secondary insurance to help pay their share. ^bPatients can't bill secondary insurance to pay any amount.

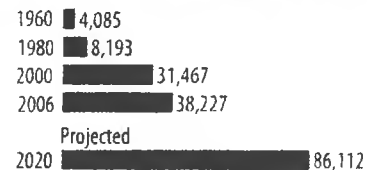
Sources: American Academy of Family Physicians; Government Accountability Office

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.

This research is part of ISER's Understanding Alaska Choices research initiative, funded by the University of Alaska Foundation. Karen Perdue, associate vice president for health programs, University of Alaska, provided additional funds.

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

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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 opinion¹

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,

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ISSN: 0025-7079/04/4206-0560

DOI: 10.1097/01.MLR.0000128003.81622.ef

and resident support⁵—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 residents⁶ 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 1996⁵ 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 non-normally 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' buy-out 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%).

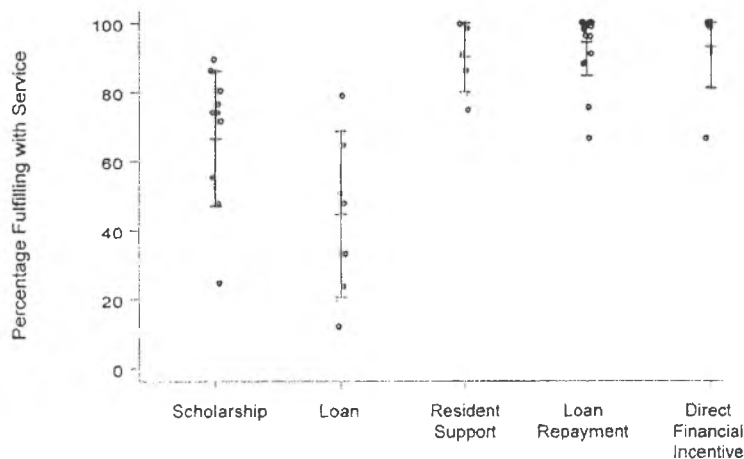


FIGURE 1. Percentage of recent physicians in each program (°) who fulfilled their obligations with service, grouped by program type.

Bars denote group means +/- standard deviations

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

	(n Physicians/ Programs)	Community and Patient Characteristics				
		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.

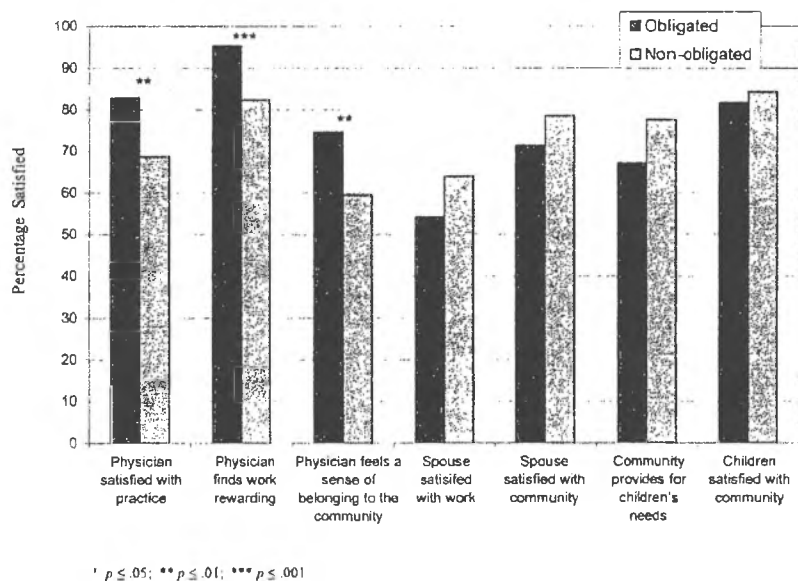


FIGURE 2. Satisfaction and needs fulfillment of physicians and their families serving in all state programs combined (n = 330) compared with nonobligated physicians (n = 368)

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 willing-

ness 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 benev-

olence of individuals who commit to and then fulfill service requirements predisposes them to find particular satisfaction from work that they believe in.^{25,26}

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.

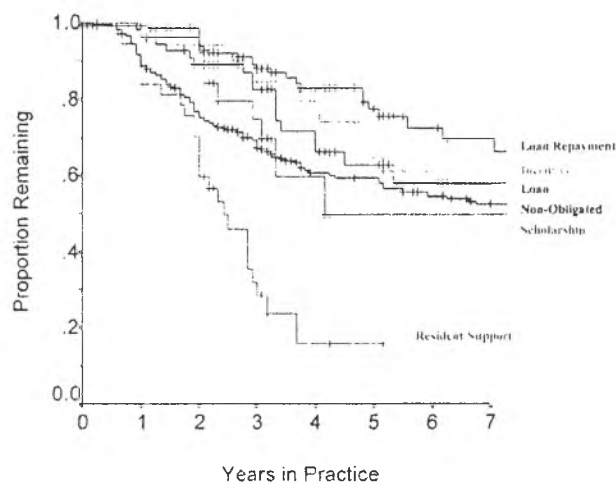


FIGURE 3. Retention of obligated physicians within their service practices: Kaplan-Meier estimations by type of program and compared with nonobligated physicians

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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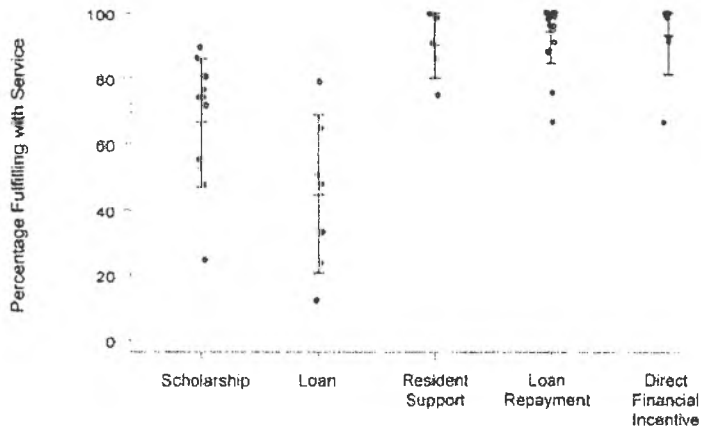


FIGURE 1. Percentage of recent physicians in each program (*) who fulfilled their obligations with service, grouped by program type.

Bars denote group means +/- standard deviations

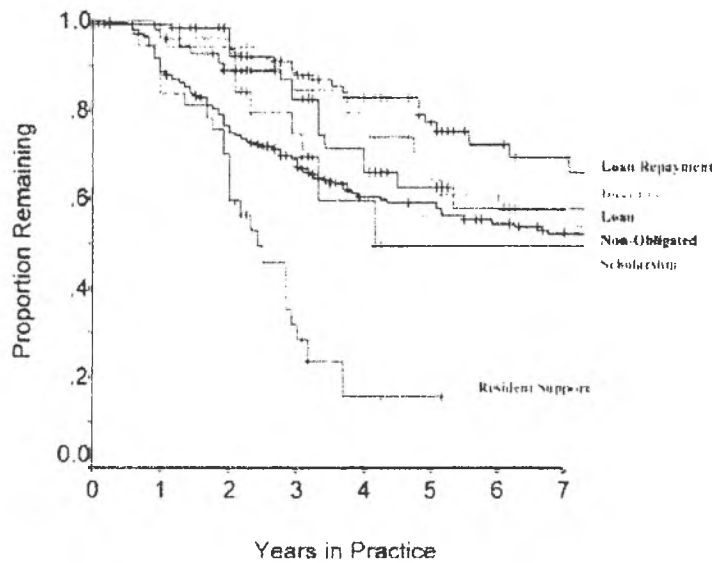


FIGURE 3. Retention of obligated physicians within their service practices: Kaplan-Meier estimations by type of program and compared with nonobligated physicians



RESOLUTION 2011-02 Health Care Professionals Incentive Program

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 nationally for the finite pool of available health care professionals; and Alaska is suffering from labor shortages in most health care occupations,¹ demonstrated by the fact that most of the state is designated either a Health Professional Shortage Area or a Medically Underserved Area,² and these shortages are particularly acute for primary care "safety net" agencies; and

WHEREAS a common state-level response to these pressures is the use and state funding of financial inducements, collectively known as support-for-service programs (SFSPs), and good outcomes have been achieved with these,³ and national studies have determined loan repayment programs and incentive programs to be two of the most effective of the several SFSP strategies in terms of both recruitment and retention of new providers and experienced providers respectively;⁴ and

WHEREAS Alaska does not have a robust SFSP while most other states do, many have several, and some of those are growing, and these SFSP assist with the geographic and specialty distributions of providers in these states;⁵ and

WHEREAS it is well-established that many health professionals carry a heavy debt-burden from the date of graduation and are attracted to locations where a share of that burden can be relieved; and

WHEREAS for areas in the state where providers are required to work in professional isolation due to remote settings, direct incentives are needed to attract more experienced health care providers who do not carry debt and are considered desirable placements, and direct incentives can also be used to recruit and retain recent graduates who can use the incentives to pay student loans; and

WHEREAS the State of Alaska is making positive and important strides to reduce the health care workforce shortage administering a small, newly created federally and AMHTA and CHC funded program called SHARP (Supporting Health-care Access through loan Repayment), Alaska also needs a state-designed and state-controlled program to allow us to address our unique needs and help us be more competitive with other states in drawing candidates: ensuring an adequate number of provider slots, providing for certain health care professional categories not included in SHARP that are in shortage, allowing for greater flexibility in placements, and offering incentives to experienced providers without student loans as well as recent graduates with student loans; and

WHEREAS in 2006, the Alaska Physician Supply Task Force recommended specific strategies and action steps to assure an adequate supply of physicians to meet Alaska's need, including creation of a SFSP, and the 2007 Alaska Workforce Vacancy Study and the 2005-2006 Status of Recruitment Resources and Strategies (SRRAS II) point to the need for a state loan repayment and incentive program; and



WHEREAS a proposal submitted to the Alaska Primary Care Council by DHSS Health Planning and Systems Development recommends that "Alaska create a 'Health Care Professions Loan Repayment Program'"⁶ based on the following logic;

Reported increasing vacancy rates, increasing costs of recruitment [SORRAS report,] and comparisons with national norms [PSTF report] suggest that Alaska (per DHHS March 2009 data 7,) 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;⁸

WHEREAS, the Alaska Health Care Commission, in its 2009 Report / 2010-2014 Strategic Plan entitled "Transforming Health Care in Alaska," recommends as a goal to the Governor and Legislature the following: "Develop the health care workforce.....[by] increas[ing] the supply of primary care physicians by supporting educational loan repayment and financial incentives for recruitment" and later explained in its report:

[O]ther strategies to improve recruitment and retention of physicians from outside Alaska must be considered. Support-for-Service programs offer an important recruitment and retention tool for states. These programs provide current or future health practitioners with educational scholarships, educational loans, repayment of educational loans, or direct monetary incentives in return for a contractual obligation with the practitioner to serve a period of service in a needy area.

Loan repayment and financial incentive programs are the most popular form of support-for-service programs, as studies document service obligations established at the beginning of a practitioner's educational process (through a scholarship or loan) are less effective in terms of achieving the desired recruitment outcome as are loan repayment and financial incentive programs. Another benefit of loan repayment and financial incentive programs is that the return is immediate.

WHEREAS Having experienced providers on staff helps overall retention and recruitment, and many providers are reaching retirement age with no current incentives in place to keep these providers in the workforce beyond retirement age; and

WHEREAS federal health reform law permits state funding used for loan repayment to be tax exempt;

THEREFORE BE IT RESOLVED that the Alaska Primary Care Association supports the creation of a state-sponsored "Health Care Professionals Incentive Program," and recommends that the program include a provision that will allow incentives used for loan repayment to be tax exempt, and will advocate for the necessary authorizing and fiduciary legislation.

DONE AND DATED THE 16th DAY OF September IN THE YEAR 2010

SIGNED BY

Sonia Handforth-Kome

Board President, Alaska Primary Care Association



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.

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
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February 9, 2011

Representative Bob Herron
Alaska Capitol, Room 411
Juneau, AK 99801-1182

Subject: Support for HB 78, Incentives for Certain Medical Providers

Dear Representative Herron:

The Alaska Commission on Aging (ACoA) supports for HB 78, a bill to establish a loan repayment program to build Alaska's health care workforce by increasing the recruitment and retention of targeted health care professionals in urban and rural, underserved communities. This bill is authored by you and co-sponsored by Representative Edgmon.

Alaska, as with the rest of the nation, is experiencing a shortage of health care workers as fewer students are entering the health care profession and many of those already working in health care are preparing for retirement. Alaska is one of five states that does not offer a state-sponsored loan repayment program for health care professions. As a result, our hospitals, clinics, and communities lose potential health care workers to other states that incentivize their workforce with loan repayment programs.

Access to quality health care is a priority for all Alaskans and a critical need for people age 65 years and older. Older Alaskans benefit from regular health care services which enhance their overall health and decrease the need for more expensive, intensive treatment and emergency visits.

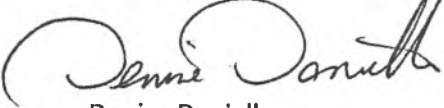
Alaska continues to lead all states with the fastest growing senior population currently comprising about 12 percent of our state's population and is projected to increase by five to six percent each year until 2020. The graying of Alaska's population is creating substantial shifts for workforce, particularly in the health care and long-term support service sectors, as demand increases and providers are reaching retirement age. If older Alaskans are unable to find a health care provider, they may be forced to leave the state in search of access to health care professionals. As a result, Alaska could suffer from a loss of retirees, who contribute more than \$1.7 billion to the state's economy in addition to their significant volunteer service, caregiving activities, and community leadership.

ACoA supports HB 78 and believes that the proposed legislation will help to build a qualified health care workforce who will be available to meet the health care needs of older Alaskans. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information about our position. Thank you.

Sincerely,

Sincerely,


Sharon Howerton-Clark
Chair, Alaska Commission on Aging


Denise Daniello
ACoA Executive Director



Alaska Pharmacists Association

February 1, 2011

Representative Bob Herron
Alaska State House State Capitol Room 411
Juneau, AK 99801

RE: Support for HB 78
Alaska Health Care Professions Loan Repayment & Incentive Program

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 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, 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: akphrmcv@alaska.net



HAKAŁOKKZ

Iliuliuk Family and Health Services, Inc.

P.O. Box 144
Unalaska, Alaska 99685

Phone: (907) 581-1202
Fax: (907) 581-2331

Re: Support for HB 78 Incentives for Certain Medical Providers

February 9, 2011

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 HB 78 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 a handful of 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 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.

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 – until July of 2009, we had two open RN positions for over two years, and currently have one RN position that has been open for over four years. We fill this position with locums RNs, but far prefer a full-time staff RN for consistency of care to our patients. A state-sponsored support-for-service program would help make our recruitment package more appealing and more competitive.

The Professions Loan Repayment & Incentive Program proposed in HB 78 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

"Serving Unalaska, the Aleutian Islands and the Bering Sea"

incentives have been shown to effectively help alleviate shortage problems in other states. HB 78 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

IFHS supports HB 78 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,

A handwritten signature in cursive script that reads "Sonia Handforth-Kome". The signature is written in black ink and is positioned above the printed name.

Sonia Handforth-Kome
Executive Director

☐ SUNSHINE CLINIC HC 89 Box 8190 Mile 4.4 Talkeetna Spur Road, Talkeetna, AK 99676 Ph: (907) 733-2273 Fax: (907) 733-1735

Delivery Address: 34300 South Talkeetna Spur Road

☐ WILLOW CLINIC P.O. Box 1049 - Mile 67 Park Hwy - Willow, AK 99688 Ph: (907) 495-4100 Fax: (907) 495-4106

Delivery Address: 11203 N. Nancy Lakes Parkway

February 9, 2011

Representative Robert Herron
State Capitol
Juneau, AK

Dear Representative Herron,

I am writing you regarding HB 78

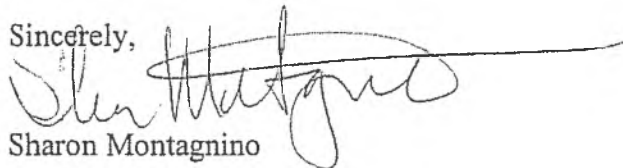
As executive director for the Sunshine Community Health Center, I cannot tell you how valuable a loan repayment and incentive program is to recruiting potential medical and dental providers.

It took Sunshine 20 months (December 2008 – August 2010) to hire a new dentist and while there were other obstacles (i.e. licensing for one) which hampered our efforts, loan repayment was the number one question asked by candidates. In March of 2009, we began a search for a medical provider, which last 6 months, 70% of the candidates interviewed said loan repayment was critical in their choice of employment. During those six months, we were forced to employ a locum rather than reduce clinic days or hours, which would have been a hardship to the rural and remote patients we see. The cost in hiring a locum is 35% more than hiring a permanent provider.

While Alaska certainly has a lot of offer we cannot compete with clinics and centers in the lower 48 if the playing field is not level. One-way to even the playing field is to approve and fund a loan and incentive program in Alaska.

I urge you to support this bill because without and even playing field we place clinics in a position of having to scale back hours as they search for months for new providers. At a time when clinics in Alaska are seeing a shift in patient needs seeing more uninsured, Medicare and Medicaid patients we cannot afford to close or reduce hours at the expense of good patient care.

Sincerely,



Sharon Montagnino
Executive Director

cc: Regan Mattingly, AKPCA

Liz Clement

From: Mary Sullivan [msullivan@akeela.org]
Sent: Monday, March 07, 2011 3:43 PM
To: Rep. Bob Herron
Cc: Shelley Hughes
Subject: HB 78

Re: Support for HB 78 Incentives for Certain Medical Providers

March, 07, 2011

Dear Representative Herron:

Thank you for your tireless work on behalf of Alaskans and their best interests. My name is Mary Sullivan and I'm the program manager of the Seniors Behavioral Health Coalition, facilitated by Akeela Inc. The SBHC is made up of senior service providers, senior citizens, private business and state and tribal entities and is dedicated to prevent older adult behavioral health problems, as well as to ensure the full continuum of care for this population. Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Senior Behavioral Health Coalition strongly supports HB 78 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 members of the SBHC feel that ensuring health care access especially to seniors is a key protective factor against the development of behavioral health problems in later life. HB 78 would help to recruit qualified providers both in primary care, and in the ancillary services (such as social work) that are often needed with the medically fragile and those experiencing chronic conditions, such as those that many older adults experience. Access early and often to these ancillary and primary care services means that the development of more costly diseases and behavioral problems are more likely to be prevented. However, with the workforce shortage, access to much needed services is extremely impeded and in some cases impossible. Older adults already face challenges with access to primary care due to the reimbursement rates of Medicare, and the workforce shortage makes it doubly difficult for our elders, who worked very hard all their lives, to get the health care they need and have earned the right to deserve. Therefore, the SBHC feels that HB 78 is a wise choice for Alaska with its aging population, and is also a fiscally responsible role for government to fill in helping make Alaska a desirable place of work for these hard to fill health care positions.

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 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 clinical 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. HB 78 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

The Senior Behavioral Health Coalition supports HB 78 and feels it is an important and needed piece of legislation. Your work on behalf of Alaska's seniors is very appreciated.

Respectfully,

Mary Sullivan
Program Manager
Seniors Behavioral Health Coalition
Akeela Inc
msullivan@akeela.org
907-565-1214 (office)



POSITION PAPER

CONTACT: Valerie Davidson, Senior Director
 Legal and Intergovernmental Affairs
 Through Pat Jackson, State Liaison for Alaska Native Health
 523-0363 – pajackson@anthc.org

DATE: March 7, 2011

RE: HB-78 – Incentives for Certain Medical Providers

POSITION: Support

ANTHC is a tribally controlled, non-profit, statewide tribal health organization formed pursuant to federal law to provide medical and community health services for more than 130,000 Alaska Natives. ANTHC is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 229 federally recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. ANMC hospital and SCF clinic facilities together employ 161 physicians, 37 dentists and 509 nurses, along with many more employees working in health-related professions. We face the same workforce challenges as our partner health organizations, competing with employers in the Lower 48 to recruit and retain a quality workforce.

Current reports prepared by the Indian Health Service on physician positions within the tribal system and by Alaska tribal facilities on nursing positions provide a good snapshot of workforce challenges. These challenges are even greater for rural sites that also experience higher turnover rates. One significant issue not included in the reports is the aging population of our current providers.

<i>Profession</i>	<i>Positions Authorized</i>	<i>Vacancies</i>	<i>Percentage</i>
Physicians – statewide	305	59	19%
Physicians – ANTHC/SCF	168	17	10%
RN – statewide	900	133	15%
LPN – statewide	107	25	23%
APN – statewide	137	38	28%

Ideally we would grow our own health professionals in numbers that would meet our workforce needs, and we have made progress over the years. The tribal health system offers internships and scholarships that bring some of our best and brightest to the medical field. More Alaska Natives are choosing Medical and Dental careers; a University of Alaska Anchorage program, Recruitment and Retention of Alaska Natives into Nursing, is graduating Alaska Native nurses; many of our Community Health Aides have built on their basic training opportunities to prepare for advancing careers; and the Dental Health Aide Program is graduating students who fill a need for dental health services and patient education. We are inching forward, but more work needs to be done. Experienced providers are needed now to meet the needs of our patient/owners while we work to grow our own. They are also needed as preceptors and role models to students.

HB 78 is a strategy to attract skilled health professional to Alaska jobs. It would work in tandem with other efforts as Alaska’s health provider community work to provide quality care to our residents. ANTHC urges your favorable consideration and passage of HB 78 to help us turn the corner on Alaska’s health care workforce.



Ethel Lund Medical Center
3245 Hospital Drive, Juneau, AK 99801
907.463.4040 · www.searhc.org

Re: Support for HB 78 Incentives for Certain Medical Providers

March 4, 2011

Dear Representative Herron 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 SEARHC Ethel Lund Medical Center strongly supports HB 78 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 6,000 active patients). We have found recruitment of healthcare providers to be extremely challenging, including physicians, physician assistants, pharmacists, physical therapists, optometrists, and other healthcare professionals. Almost all potential applicants request loan repayment.

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 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 clinical 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. HB 78 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 HB 78 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
Clinic Administrator/Medical Director

Liz Clement

From: Gretchen Clarke [gretchensclarke@gmail.com]
Sent: Monday, March 07, 2011 10:10 AM
To: Rep. Bob Herron
Cc: Liz Clement
Subject: HB 78 Incentives for health workforce providers

Dear Representative Herron,

I am writing in support of HB 78 Incentives for Health Workforce Providers.

As you know, Alaska is 1 of 5 states without a state-sponsored program and communities, clinics, and hospitals in Alaska lose candidates daily to other states because we don't have a program. For every dollar spent, there is a 100% return on state investment: every penny spent will mean a practitioner was filling a vacancy in Alaska. Unlike other loan programs and scholarship proposals which target students in training, HB 78 targets professionals who are ready to work immediately – and targets seasoned professionals (incentive portion of program) so greatly increases size of candidate pool; will make Alaska highly competitive (traditional loan repayment programs target only recent graduates with student debt – a smaller pool)

Without action, Alaska will face ongoing recruitment costs and high locum tenens costs due to high turnover, and the length of vacancies will continue to increase health care costs in Alaska. Without action, Alaska will continue to trend toward a public health crisis in pockets of the state; and without action, Alaska can expect increased ER use, increased Medivac use, increased Medicaid travel costs, and increased costs associated with chronic disease.

Thank you for your continued support of HB 78.

Sincerely,
Gretchen Clarke
Sitka, AK

--

Gretchen S. Clarke, MPH
gretchensclarke@gmail.com

Summary: HB 78 Incentives for Certain Medical Providers

Sponsored by Representative Bob Herron

Health Care Professions Loan Repayment & Incentive Program

The following organizations support the loan repayment and incentive solution as outlined in HB 78 Incentives for Certain Medical Providers:

Alaska State Medical Association
• Alaska Dental Society •
Alaska Primary Care Association •
Alaska Osteopathic Medical Association • Alaska State Hospital and Nursing Home Association • Alaska Mental Health Trust Authority • Alaska Native Health Board • Alaska Pharmacists Association • Alaska Physical Therapy Association • AARP-Alaska • Advisory Board on Alcoholism and Drug Abuse • Alaska Behavioral Health Association • Alaska Mental Health Board • Alaska Public Health Association • Alaska Dental Hygienists Association • Commonwealth North • Iliuliuk Family and Health Services, Inc. • Maniilaq Association • Municipality of Anchorage Senior Citizens Advisory Board • Mary Willard, DDS, Clinical Site Director, Alaska Native Tribal Health Consortium • Alaska Chapter National Association of Social Workers • Nome Eskimo Community • SEARHC • School of Social Work- UA • Dental Hygiene Program- UA • Sunshine Community Health Center

Problem:

Having a sustainable and competent practitioner workforce is vital to the health of Alaskans. However, Alaska is at a serious disadvantage as it competes in the national health care labor market. In other states, “support-for-service programs” (SFSPs) have shown substantial and long-standing success as a cost-effective strategy to address shortages (e.g., loan repayment and direct incentive). A key problem is that Alaska does not have a robust SFSP while 46 other states have one or more SFSPs.

Solution:

The Health Care Professions Loan Repayment and Incentive Program, as outlined in Representative Herron’s HB 78 will make Alaskan health care employment more competitive and attractive enough for practitioners to want to work in Alaska, particularly in hard-to-fill localities. State funds will be used to ensure that Alaskans with the greatest difficulty in obtaining care due to limited financial resources, cultural barriers, and geography will have access to professional health care services.

Program Description:

1) Practitioner Eligibility

- DHSS Commissioner will annually prioritize the 10 eligible practitioner types:
 - Tier-1: Dentists, Pharmacists, Physicians (MD and DO)
 - Tier-2: Dental Hygienists, Nurse Practitioners, Nurses (RN), Physical Therapists, Physician Assistants, Psychologists, Social Workers (LCSW)
- A practitioner’s clinical duties must constitute at least 50% of duties to be eligible.
- A part-time practitioner may participate and be eligible for pro-rated payments.
- Preference may be given to current Alaskan residents.

2) Payment Detail

- Placement Type

	Regular	Hard-to-Fill
○ Tier 1:	up to \$35,000/year	up to \$47,000/year
○ Tier 2:	up to \$20,000/year	up to \$27,000/year

- Duration of award is for a 3-year period of service.
- Payments will be made every quarter following a completed full quarter of service.

3) Site Eligibility

- DHSS Commissioner will rank eligibility of sites annually and determine any area and/or population in Alaska as a “shortage priority.” These may include, but are not limited to, federally defined Health Professional Shortage Areas.
- Preference will be given to sites that provide care to individuals regardless of insurance status, including persons who are uninsured or have Medicare and/or Medicaid.

4) **Oversight Entity**

- Department of Health & Social Services will serve as the Oversight Entity.
- DHSS Commissioner will appoint an advisory body to make recommendations regarding program administration including the identification of shortages, eligible sites, payment priorities and program evaluation.

5) **Program Evaluation**

- By January 1, 2019, DHSS will submit a report to the Legislature on the program: the participation rates, costs, and the effect on the health care profession shortage areas.

6) **Fiscal Agent**

- DHSS will serve as Fiscal Agent. DHSS will make loan repayments to the lending institution or eligible practitioners and will make incentive payments to eligible practitioners.

7) **Funding**

- An in-cash “employer match” is required and is paid on a quarterly basis by eligible sites to DHSS. The level of required match will be adjusted according to the ability of the eligible site to contribute and may be set between 0% and 50%.
- Program funds will not be used to offset current or expected provider supports.
- The DHSS Commissioner will reserve funding for not fewer than three very-hard-to fill positions in each of the tier 1 and tier 2 categories.
- The fiscal note has not yet been released but the expected funding for FY12 is \$2.7 million to fund 90 participants for year 1 of their 3 years of service; that is, approximately 9 practitioners in each of 10 occupational categories.

Our view: Competing for docs**Reality check: Alaska needs to put money into recruitment**

(12/14/08 21:20:44)

A group of health care professionals, working over the past several months, has taken a big step to overcome a critical shortage of health care workers in Alaska: They've come up with a plan to lure such workers north. Forty-four of the 50 states already offer doctors, nurses or other health workers financial incentives, such as student loan repayment, to come practice in their states.

We don't.

"In this state, so far all we do is give them a brochure with a nice glacier on it," says Robert Sewell, a health planner for the state who has researched loan repayments and other incentives.

"We're losing the battle with other states," says Shelley Hughes of the Alaska Primary Care Association.

A group co-chaired by Hughes and Rod Betit of the Alaska State Hospital and Nursing Home Association says the state can fix that by offering to pay back student loans, or even give straight monetary incentives, to as many as 90 health care and social work professionals a year.

The 90 would be promised a total of three years worth of incentives, as long as they stayed on the job. The cost: \$7.1 million.

If those 90 slots don't fill the shortages, the state can seek more money to continue offering the incentives.

Betit's group will propose to the Legislature that the state pay for most of it, with matching contributions from organizations that benefit and can afford to help.

A program like this is sorely needed in Alaska. Shortages of primary care doctors, dentists in rural Alaska and nurses have been well documented.

The shortage of doctors is one reason that many senior citizens on Medicare -- a government insurance program that doesn't pay very well -- can't find primary care providers. If there were more doctors to take Medicare patients, caring for them would not put such a financial strain on any one doctor's practice.

As envisioned, health care providers would have to agree to take a share of Medicare and Medicaid patients and treat people without insurance to be eligible for the financial incentives. Doctors and nurses recruited for the Anchorage Neighborhood Health Center, for example, would qualify.

The state health commissioner would identify the jobs and places with the greatest need and set priorities for distributing the limited number of incentive payments.

Professionals who took very-hard-to-fill jobs -- like dentists willing to relocate to Bethel -- would

get more than those who worked in the cities.

The incentives would be substantial: Doctors, dentists and pharmacists in the cities would get \$35,000 per year for three years. Those in places where the jobs are harder to fill would get \$47,000 each year for three years. Social workers, nurses and some other health workers in hard-to-fill jobs could get smaller incentives.

For those paying off loans, the money could go to that. For established doctors or nurses, the same amount of money would be available as straight incentives.

This plan is thorough and well-thought-out.

The state has already taken some steps to ease shortages, such as doubling the number of state-subsidized medical school spots in the WWAMI program and expanding the UAA nursing school.

But those measures will take several years to produce more health care workers here in Alaska.

This plan for financial incentives would make Alaska more competitive for health care workers right now. The Legislature and governor should get behind it.

BOTTOM LINE: Here's a good way for the state to attract doctors and nurses where they're needed in Alaska.

Our view: Medicare woes
State should look for ways it can help, but how exactly?*(01/11/09 21:40:24)*

Health care professionals with solid credentials and decades of experience in Alaska spoke Friday at a forum on answers to Medicare problems in Alaska. The problem? Too many Alaska senior citizens can't find a doctor. That's mainly because doctors are refusing to see any more Medicare patients. And that's mainly because doctors say they're not reimbursed enough to cover the costs of seeing any more Medicare patients.

If nothing changes, the problem will only get worse as more Alaskans join the ranks of senior citizens 65 and older. There are about 45,000 now.

The experts have solutions for Anchorage and Alaska:

- Expanding the Anchorage Neighborhood Health Center. Because it's a federally qualified clinic, it pays a higher reimbursement rate for Medicare services, so it welcomes Medicare patients.
- A separate Medicare clinic. A private group of doctors is exploring such a clinic. Joan Fisher, head of the Anchorage neighborhood center, and Rep. Les Gara both supported using public funds for a larger clinic to serve older Alaskans.
- Higher reimbursement rates for primary care doctors. Alaska's congressional delegation won a 35 percent increase in reimbursement rates for the state in 2009, but many primary care doctors say Medicare rates are still way too low.
- Allow doctors to fill the gap between their fee and Medicare's payments by turning to other sources, such as the patient's private insurance coverage or by allowing the state to contribute supplemental payments. Federal law prohibits this now.
- • Use financial incentives to increase the number of doctors, dentists, pharmacists, nurses, therapists, physician's assistants and other health care workers in Alaska. Shelly Wright of the University of Alaska Anchorage argued for a proposal we've backed here before: Help pay back student loans for health professionals who come to work in Alaska. A bigger pool of health care providers will be able to cover more seniors and other Alaskans.
- • And we could further help seniors by offering larger student loans to doctors and nurses who see more Medicare patients.
- • Those financial incentives would help Alaska recruit more doctors in a fiercely competitive market. Dr. Tom Nighswander, who helped moderate the Friday discussion, pointed out that Alaska is competing for doctors with every other state west of the Mississippi, all of which have their own shortages of medical professionals.
- Get around federal restrictions on supplemental Medicare payments by offering a state bonus to those doctors who see a certain number of Medicare patients every year. Rep. Gara is working on

this idea; he doesn't know if the feds will allow it.

Discussion Friday was lively, but there was much preaching to the choir. As both Reps. Gara and Mike Doogan pointed out, the people with purse strings in the Legislature were noticeably absent. Rep. Doogan said more money wouldn't likely be forthcoming from the Republican House majority, and only a few senators had aides at the meeting.

➔ Drawing more health care professionals is a big part of the long-term solution. Loan payments, state support for an expanded family practice residency program at Providence Alaska Medical Center and expanding the Anchorage Neighborhood Health Center make sense, given demand and demographics.

But what about the older Alaskan on Medicare scrambling as of yesterday to find a primary care doctor who will see her? That's a short-term problem, and that older Alaskan doesn't live in the long term, she lives day-to-day, just like the rest of us.

The best suggestions for immediate action at Friday's forum? Allow the state, individuals or insurance coverage to supplement Medicare's meager reimbursement rates. But that would require a change in federal law. Older Alaskans may not have that much time.

Maybe Rep. Gara's state bonus plan for primary care doctors to open their doors to more seniors is the way to go.

Lawmakers should take a close look this session.

BOTTOM LINE: Medicare in Alaska is such a mess, the state can't wait for the feds to fix it.

Drug Topics

July 1, 2009

Alaska RPh shortage worsens

By Fred Gebhart, Contributing Editor

If pharmacy jobs look tight, think of Alaska. Nearly a quarter of the pharmacist positions in the state are open and pharmacy employers report that the typical RPh vacancy takes 15 months to fill. Physicians, nurses, dentists, and other healthcare professionals are in equally short supply.

"I believe the pharmacist shortage in Alaska is getting worse, not better," said Robert Sewell, health program manager for the state Department of Health and Social Services. "The sky isn't falling, but the shortage is developing into a severe situation."

Alaska has about 400 licensed pharmacists and close to 100 open pharmacist positions, according to a 2007 state healthcare-provider vacancy survey. A new vacancy survey to be released in the fall is expected to show an even larger shortfall.

The pharmacist shortage is most severe in small towns and rural areas, but even urban settings such as Anchorage are perennially short of pharmacists. Other largely rural states such as Wisconsin, Idaho, and Montana have similar RPh shortages, said Amber Biggs, president of the Alaska Pharmacists Association, but Alaska has a unique set of problems. Recruiting pharmacists to Alaska is tough; retaining them is even tougher.

Alaska is a three-day drive or a long plane flight from the rest of the continental United States, which Alaskans call the Lower 48. And while Alaska is twice the size of Texas, it has only about 665,000 residents.

"You are somewhat isolated in Alaska," said pharmacist and Anchorage resident David Campana, the state's Medicaid pharmacy program manager. "Families can find that they are a long way from relatives. We also have some distinct advantages, like mouth-dropping scenery in every direction and long summer days. On the other hand, winter nights get to be pretty long."

According to Biggs, Alaska's physical and psychological isolation repels as many people as it attracts. Pharmacist employers face even more barriers, starting with education. Alaska residents who want to study pharmacy must go out of state. Few return.

"We are the only state in the country that doesn't have a pharmacy school," Biggs said. "And we're almost the only state that doesn't have a loan-repayment program or some other kind of financial assistance for pharmacists. When you look at the debt burden that most new pharmacists carry, that puts us at a distinct disadvantage."

For a recent pharmacy grad, choosing Alaska over almost any other state is a real financial sacrifice."

The demographics are also working against Alaska. In 2005, 31 percent of state pharmacists were already over 55 years of age. Four years later, Sewell said, older pharmacists are starting to retire. Now pharmacists are leaving the workforce as the state's overall population is aging and the need for pharmacy services is growing.

7/22/2009

Drug Topics: Alaska RPh shortage wor...

Healthcare reform is likely to make things worse in the short term. If the Obama administration is successful in expanding access to healthcare for America's uninsured population, the demand for pharmacy services will skyrocket nationwide.

"Improved access would mean greater availability of care, but not necessarily any more providers to serve that new population," Sewell said. "Creating greater access to care nationally will only exacerbate our provider-supply problems."

Technology can only stretch pharmacy services so far, he continued. Telepharmacy is widely used, but there are not enough telepharmacists to meet current demand.

The long-term RPh supply could be increased by opening a pharmacy school, said Nancy Davis, executive director of the Alaska Pharmacists Association (AkPhA). AkPhA and pharmacy employers are urging the state university to create a pharmacy-education program, but the first graduating class would be at least a decade away.

Addressing the financial disparities that discourage new pharmacists from coming to Alaska could improve the supply more quickly.

Federal loan-repayment programs help physicians and other providers, but not pharmacists. That leaves it up to employers and the state of Alaska to devise attractive incentives.

AkPhA has joined medical, dental, nursing, and other healthcare-provider associations to push for state investment. A provider coalition is sponsoring SB 139, which would provide up to \$47,000 in loan repayment or other incentives to bring new providers to Alaska, including pharmacists.

The proposal enjoys strong support in the legislature, Davis said, but Governor Sarah Palin has not taken a position. Davis is hopeful that the governor will support the bill.

"Healthcare is not one of Governor Palin's strengths, but she is coming up to speed quickly," Davis said.



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American
Dental
Hygienists'
Association

Re: Support for HB 78—Incentives for Certain Medical Providers

March 7, 2011

Dear Representative Herron and Members of the Alaska State Legislature:

The Alaska State Dental Hygienists' Association (ASDHA) supports House Bill 78 to establish a loan repayment and incentive program. This legislation addresses the shortage of certain health care professionals in the state and will increase the number and improve 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.

House Bill 78 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 HB 78 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 HB 78 would provide an additional incentive for them to stay.

The ASDHA supports HB 78 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, RDH, BSDH
Alaska State Dental Hygienists' Association

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



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-taskforce-on-forming-a-health-and-social-service-board&catid=29:health-and-human-services-board&Itemid=20147#.

ⁱⁱ U.S. Department of Human Services, Health Resources and Service Administration. Health Professional Shortage Area. <http://datawarehouse.hrsa.gov/GeoAdvisor/shortagedesignationadvisor.aspx>.

ⁱⁱⁱ Matanuska-Susitna Borough. Alaska Department of Labor, Division of Research & Analysis.

<http://laborstats.alaska.gov/cgi/databrowsing/localAreaProfileOSResults.asp?geogArea=0204000170&population+census+data=Population&BI=View+Report>.

^{iv} Alaska State Plan for Senior Services FY2008-FY2011. Alaska Commission on Aging. June 2007.

http://www.hss.state.ak.us/acoa/documents/statePlanFinalFY08_FY11.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.hss.state.ak.us/healthcommission/200905/iser_doctors.pdf

^{vi} 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>.