

Facing the future of health care

A report detailing conversations with twelve Greater Minnesota communities

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In the fall of 2004, the University of Minnesota Academic Health Center (AHC) convened meetings in twelve greater Minnesota communities to discuss the health professions workforce, issues in the educational pipeline, and their relationship to the future of health care and economic vitality. As a land grant, research-based institution, the University of Minnesota prepares the next generation of dentists, nurses, pharmacists, physicians, public health professionals, and veterinarians, as well as health professions faculty, for the state and region. This broad cross-disciplinary leadership and research expertise uniquely positioned the AHC to convene these important meetings. Our intent was to learn more about how the University of Minnesota can meet the educational needs of the future health professions workforce by partnering with the communities it serves.

These informal, wide-ranging conversations brought together community leaders and citizens with faculty and staff of the AHC. Barbara Brandt, Ph.D., assistant vice president for education, Academic Health Center, facilitated all twelve meetings and encouraged participants to openly and candidly share ideas and voice concerns. What we learned has informed AHC educational programs and continued to shape Minnesota Area Health Education Center (AHEC), a University-community partnership that serves as a platform for addressing regional workforce shortages and community health needs. (For more information on AHEC, visit www.mnahec.umn.edu.)

Participating Communities*

Bemidji
Brainerd
Crookston
Detroit Lakes
Fergus Falls
Grand Marais
Grand Rapids
Hibbing
Marshall
Montevideo
Paynesville
Willmar

Three major themes emerged from these conversations: changing demographics, workforce development, and financing and economic development. In this document, we explore each of these themes.

For more detailed information about these issues, visit our *Sustaining A Vital Health Professions Workforce* web log at <http://blog.lib.umn.edu/brandt/HPWorkforce>

Highlights from the 12 community visits

- 12 rural Minnesota communities hosted community conversations
- 225 community members participated, including nine elected officials, 20 educators, and more than 30 business representatives
- 38 AHC faculty participated, traveling nearly 4,000 miles
- AHC faculty toured 8 new or remodeled health care facilities

*Additional visits in St. Cloud, Moose Lake, Princeton and Fond du Lac will be scheduled for spring 2005.

Changing demographics

Aging population

Minnesota's population is both growing and aging. By 2010, the state's population is expected to increase by 12 percent, with the largest population increase expected in the 65- to 84-year-old age range. We heard stories about retirees moving to smaller, rural communities, where health professionals already are in short supply. Some rural communities are facing a double burden of preparing for an increasingly aging population and a smaller than average increase in young adults moving to or staying in their communities. Communities are considering how to align the needs of their aging population with the availability of health care services. We observed a varying level of preparedness for increased need for chronic care, long-term care and end-of-life services across the communities.

Aging workforce

As the state's population ages, so does the health professions workforce. For example, in northwest Minnesota, more than 30 percent of the current health professions workforce is 50 years of age or older¹. Local health care systems face new challenges with this aging workforce, such as reduced hours and increased disability among workers. In one community, we heard about older health professionals who winter in warmer climates, but are recruited for seasonal employment in their home communities to meet the demands of the summer vacation population. Some health care administrators reported one to two year vacancies for certain types of health professionals, such as pharmacists and mental health providers. One recent study indicates that by 2020 Minnesota will need 1,359 *additional* physicians to keep health care access at its 2000 level².

Workforce retention

Health professionals new to rural communities often struggle to make personal connections within the community that extend beyond their professional colleagues. This lack of integration can lead to a "revolving door" of professionals, an expensive and time-intensive retention challenge for communities and health systems. Factors such as flexibility of call schedules, opportunities for spousal employment, and affordable housing also play important roles in how new health professionals become integrated into the fabric of communities.

Intergenerational changes

Participants—young and more senior—informed us that new generations of health professionals are placing greater value on developing a work/life balance. Health professionals in their 20s and 30s have different expectations than their parents and grandparents, seeking flexible work weeks and schedules that accommodate families and recreation. An increasing number of health professionals are women, many of whom work fewer hours while they balance work with young families.

Diversity

Minnesota is becoming an increasingly diverse state, and that diversity has an impact on health care delivery. Statewide, Somali, Hmong, Sudanese, and Hispanic populations are growing rapidly. (Minnesota's Hispanic population grew 166 percent during the 1990s.) There are increased pressures on public and private resources in response to the changing needs of communities. Sixty different languages

¹ The Northwest Minnesota Health Professions Study: An Analysis. June 2003. HealthScience Concepts., Inc.

² Sally T. Buck, M.S., Vicki Trauba, and Raymond G. Christensen, M.D. Minnesota Workforce Analysis: Rural Supply and Demand. Minnesota Medicine. September 2004. Vol 87

are spoken in some rural school districts. Health professionals are seeking new and different resources, such as health interpreters, to support the care of these new community members. Many communities identify community-University partnerships as a solution to emerging needs.

Workforce development

Dental access

Eleven of twelve communities identified access to dental care as one of their top health care issues. The nature of the issue is twofold: a low dentist-to-patient ratio and low reimbursement for medical assistance patients. One community reported that an alarming lack of access prompted them to send thousands of youth outside their home region for dental care. Physicians reported to us that in greater Minnesota, an increasing number of people with dental emergencies are going to hospital emergency rooms for pain therapy because no dental treatment options are available.

We heard about innovative community-based models of care under development. In some communities, hospitals are collaborating with the dental community to support dental practices within the health campus and are exploring tax-free financing of new dental practices. We had the opportunity to discuss with communities that Minnesota leads the nation in its negative decline in dentist-to-population ratio³. As a regional dental school, the University of Minnesota's School of Dentistry is committed to working on innovative models to encourage dental graduates to stay in the state and consider rural practice. For example, the University of Minnesota Hibbing Community College Dental Clinic, established in 2002, sees about 90 patients weekly - 65 percent public program patients and 20 percent uninsured who otherwise could not access care.

Allied health

During our visits, communities had many questions about reports of University discussions regarding its allied health programs. Several communities expressed concern about the growing shortage of clinical laboratory scientists, particularly as the University of Minnesota Medical Technology program is the primary supplier of new graduates to the state. This concern was fueled by recent dialogue among the University and interested stakeholders about exploration of new partnerships to sustain this program in the future. Some communities voiced concern about the future of the Occupational Therapy program. The University has suspended future enrollment in the program as it struggles with budget constraints and mounting pressure to focus financial resources to train future physicians, dentists, pharmacists and nursing faculty for the state. We had the opportunity to discuss the allied health educational models task force, recently convened by Dr. Frank Cerra, senior vice president for health sciences, University of Minnesota to look at alternative models for educational delivery.

Supply and demand

While most communities face health professions workforce shortages, we heard of an oversupply of certain health professionals. This overproduction, specifically of LPN nurses, has led to underemployment of trained health care workers in some rural communities. Some shared stories about the realities of pursuing additional degrees. Our observation is that this imbalance in the supply and demand equation for certain health professionals points to the need for a comprehensive planning strategy to ensure that future supply meets demand.

³ ADA, Distribution of Dentists; and US Department of Commerce, Bureau of the Census, 1990 and 2000 Census.

K-12 health careers exploration

In some communities, local health systems are collaborating with elementary and high schools to support health careers exploration. These efforts provide students with a competitive edge when pursuing professional health career options. Other communities are beginning to explore how partnerships between the school districts and health care facilities could benefit career exploration among youth. Our meetings in the latter communities served as a catalyst for discussion between public education, the health systems, and business representatives.

Financing and economic development

Reimbursement rates

Examples of the fragility and interconnectedness of rural health care systems was described in many of the communities. The value of the team approach to care, involving professionals across disciplines and facilities, was apparent as one discipline often advocated for the needs of another. For example, in some communities, physicians discussed their concerns about reimbursement of pharmacists and mental health providers. We received requests for the University to take leadership in advocating at a regional, state, and national level to identify long-term solutions to critical reimbursement constraints.

Health care facility redesign

We visited some exciting new and renovated health care facilities that are designed with a focus on patient-centered care. Health administrators and professionals discussed the importance of responding to the Institute of Medicine's *Crossing the Quality Chasm*⁴ report as a driver. We believe there is tremendous health care innovation in greater Minnesota, and that our health professions students would benefit from learning in these team environments.

Financing options

Many communities are thinking in new ways about both the impact and future of health care in their communities. Economic development, local banks and other business and industry leaders are engaging in discussions about how to support the local health care system in the future, highlighting the link between a healthy business environment and health care access. Some communities have developed creative financing packages that allow new dentists to buy existing practices, upgrade outdated equipment, or purchase a first home. Others have offered low-interest loans, loan forgiveness, or tax-free financing.

The link between health care and economic development

The breadth of participants' interests and backgrounds greatly enriched these conversations. Business leaders were interested in discussions of student debt loads, workforce shortages, the realities of health professions education, and the University's interest in innovations. After several meetings, we received calls from economic development directors or chambers of commerce representatives seeking additional information. Their response showcases the important link between the future of health care and the vitality of their communities.

⁴ Crossing the Quality Chasm: A New Health System for the 21st Century. Committee of Health Care Quality in America. Institute of Medicine. National Academy Press. Washington D.C. 2001.

What happens next?

The community visits have led to a number of AHC initiatives. We are working on:

- inviting community leaders from across Minnesota to *Leading Change: Strategies for a Vital Health Professions Workforce* on April 14-15, 2005. At this conference, they will join with other leaders from government, higher education, foundations, and business to discuss how to connect economic development strategies with plans for regional health professions workforce development;
- informing University faculty and administrators about health workforce and health-system issues in greater Minnesota communities, so they may adapt their educational programs as well as delivery of education to rural areas;
- raising awareness of these health workforce and health-system issues among a wider public in local communities, at the state level, and regionally;
- establishing a web log, *Sustaining a Vital Health Professions Workforce*, at <http://blog.lib.umn.edu/brandt/HPWorkforce> to collect and share information on these issues;
- strengthening community outreach efforts through Academic Health Center schools; and
- developing a process to promote and build regional development in partnership with the University of Minnesota and other higher education institutions.