Competing for Quality Care

Blue Ribbon Task Force on Health Care
Workforce Shortage's

FINDINGS AND PROPOSALS FOR MONTANA'S HEALTH CARE WORKFORCE

Prepared for

Governor Judy Martz

September 26, 2002

Governor's Blue Ribbon Task Force on Health Care Workforce Shortage

September 26, 2002

Honorable Judy Martz, Governor
State of Montana
State Capitol
Helena MT 59620

Dear Governor Martz:

On behalf of the Governor's Blue Ribbon Task Force on Health Care Workforce Shortage, I am pleased to present you with Findings and Proposals to improve recruitment and retention of a quality health care and related human services workforce for Montana.

As you know, the growing shortage of qualified workers in critical health care/human services occupations is a nationwide problem and threatens to severely compromise access to quality health care. This problem is especially acute in a frontier state like Montana with a growing population of elderly citizens.

Governor, as the Task Force deliberated, the "elephant in the room" (as several members called it) was funding. We believe that we simply cannot ignore this "elephant" even in light of the current state fiscal crisis. You and the legislature will be making tough choices in the coming year. As you make those choices, we ask that you make this issue - resolving the health care workforce shortage - a priority.

The Task Force strongly believes that it is important for government programs (whether Medicaid or Medicare) to pay the cost of providing services to their beneficiaries. Continued Medicare/Medicaid cuts threaten our hospitals, home health agencies, nursing homes, mental health and developmental disability community based programs and facilities. We urge you to make adequate funding for health services paid for by the state of Montana a high priority. We also urge you and the legislature to work with our congressional delegation to actively seek their support of proposals in Congress to increase the federal Medicaid matching percentage. Even a small increase (1-2%) will help ease the state's Medicaid burden.

Certainly money is not the only way to address this crisis, as our report details. Nevertheless, some initial investments would have dramatic payoffs in the near future.

General funding is not the only funding source appropriate for addressing this issue, but other funds also have competing priorities and, again, we ask this issue to be given weight. Likewise, the private sector has much to gain by investing in solutions, but businesses need encouragement, reassurance and leadership to make such commitments.

The shortage of health care workers in our state has forced some providers to hire workers from other countries (e.g., the Philippines). Health care jobs offer real living wages, good benefits, opportunity for advancement, and, often most importantly, an opportunity to live and work in virtually any community in Montana. This is an important economic development opportunity, identified in your *Montana Framework for Economic Development*. We ask you to engage your Office of Economic Opportunity to ensure that progress is made and the recommendations in our report are promoted.

When you appointed the Task Force in October 2001, members undertook this monumental project relying heavily on the resources, experience and expertise of the members. Task Force members devoted significant time and energy to gather and analyze data, explore successful strategies in other jurisdictions, consult with affected Montanans, and work cooperatively to develop workable short and long term proposals for Montana.

I am proud of the work of the Task Force and of the personal dedication of the individual members. I believe you will find a blueprint for action in our Findings and Proposals. The Task Force members and I look forward to discussing our proposals with you.

Sincerely,

Loren Soft
Chairman

GOVERNOR'S BLUE RIBBON TASK FORCE ON HEALTH CARE WORKFORCE SHORTAGE

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TABLE OF CONTENTS

EXECUTIVE SUMMARY **2**

PART 1: THE PROBLEM
There *Is* A Shortage
Who is the "Health Care Workforce"? **7**
Where is the Health Care Workforce Employed? 12
Why Should Public and Policy Makers Be Concerned? 13
What is Causing the Workforce Shortage? 15
Increasing Demand for Services 15
Decreasing Supply of Workers 16

PART 2: **PROPOSALS**
Health Care Climate Proposals 19
Education Proposals 22
Work Environment and Regulation Proposals 28
Reimbursement and Compensation Proposals 36
Data Collection and Analysis Proposals 39

PART 3: WORKFORCE DATA 43
List of Figures
Figure 1. Nurses/Nurse Aides in Hospitals, Home Health, Nursing Homes, 1999 8
Figure 2. Health Services Workforce by Place of Employment 12
Figure 3. Age Distribution According to the 2000 Census 15
Figure 4. Acute Care Vacancy by Region and Critical Access Hospital 47
Figure 5. Acute Care Turnover by Region and Critical Access Hospital 48
Figure 6. Long Term Care Facilities Total Positions to be Filled 1999-2001 51
Figure 7. Long Term Care Facilities Positions to be Filled per Facility 51
Figure 8. Physicians in Active Practice by County 55

List of Tables
Table 1. Montana Health Care Professions 8
Table 2. WICHE/WWAMI/Minnesota Dental Programs 26
Table 3. Health Professions Degree Completions/Ten Year Trend for Montana 45
Table 4. Montana Rural Physician Incentive Program (MRPIP) Summary 46
Table 5. MRPIP Communities Served 46
Table 6. Nursing Degrees/Certificates in Montana 1991-2001 49
Table 7. Nursing Licenses in Montana 1995-2000 50
Table 8. Montana Dental School Graduates 52
Table 9. Pharmacy Degrees in Montana 1991-2000 53
Table 10. Results of Montana Clinical Laboratory Management Assoc. Survey 54
Table 11. WICHE/WWAMI/MN DENTAL: Medical/Dental Degrees 1996-2001 56
Table 12. Respiratory Degrees 57
Table 13. Direct Care Wage Study Comparison for the Year 2000 59

PART 4: BIBLIOGRAPHY **60**

EXECUTIVE SUMMARY

In October 2001, Montana Governor Judy Martz appointed a Blue Ribbon Task Force on Health Care Workforce Shortage:

> ***To accurately assess the shortage of health care workers in Montana, and to develop recommendations and strategies to effectively address the issue.***

Governor Martz was responding to the many health care and human services providers, workers and consumers who have shared with her serious concerns about the future of health care quality for Montana's citizens in light of an acute shortage of health care workers. The Governor appointed Task Force members representing health care/human services providers and professionals, Indian Health Service, education, consumers, the Legislature, and state government. The Task Force recognized in its deliberations the wide diversity in geography, citizens, cultures, health resources, educational facilities, and local and tribal governments in Montana. Members contributed immeasurable experience and expertise in assessing the health care and related human services workforce in Montana. The Task Force is sincerely grateful to the many organizations and individuals who contributed information, personal experiences, comments and testimony to the Task Force. This Report describes the findings and recommendations of the Task Force and is organized into a discussion of the Problem, a series of Proposals with action steps, an appendix of Workforce Data, and a Bibliography.

The Task Force concluded early on that this work is critical and timely for several reasons:

- **Health care represents Montana's largest overall service sector economy Gross State Product.**
- **Even though Montana's health care wages lag those in other states, health care wages in Montana average 21% higher than the overall Montana wage average.**
- **Montana is experiencing an unacceptable shortage of qualified health care workers.**
- **Significant barriers exist to alleviating this shortage.**
- **This shortage will increase without policy leadership and action.**

National Problem

The Task Force recognizes that the shortage of health care and related human services professionals is a national problem. Media reports, studies, and surveys abound throughout the country, struggling to address the crippling shortage of these workers. In Montana, the small population, vast geography and low wages exacerbate the problem. Of Montana's 56 counties, 50 have been designated in whole or in part as Health Professional Shortage Areas by the federal government.

Scope of Health Care Workforce Addressed

In its work on health care workforce shortage, the Task Force also included those human services professions that are essential to the health care system by providing care,

treatment and support services to children, families and individuals with disabilities and special needs. This includes services to those with developmental disabilities, emotional disturbances, mental illness and chemical dependency who may be served in community-based or in residential programs.

Why Should Public and Policy Makers Care About the Workforce Shortage?

State policy makers and the general public need to understand Montana's health care/human services workforce shortage and address it. Without proactive measures, serious consequences will result for Montanans in the quality of health care, the cost of health care, and access to any care at all. More than 35,000 people work in health care in Montana for a payroll of more than $1 billion. Even though Montana's health care wages lag those in other states, health care wages in Montana average 21% higher than the overall Montana wage average. Yet health care/human services jobs are going unfilled or filled with temporary and imported workers. This represents a very serious opportunity for economic development and for career opportunities for Montana workers.

Why is There a Shortage of Health Care and Human Services Workers?

The reasons for the shortage of health care/human services workers nationally and in Montana are many and are complex. Demand for health care services is increasing. The population nationwide (and world wide) is aging. An aging population uses more medical services. The average age of Montana's population is increasing even faster than the national average. Other circumstances also contribute to the demand for health care workers, for example, advances in medical science, new care alternatives, and increased regulatory and record keeping complexity.

At the same time demand is increasing, too few people are entering or remaining in the health care professions. The number of people in health care/human services professions is subject to much flux and, in many cases, decline. This is true in virtually every health care occupation. As with the general population, health care/human services professionals are aging, with fewer young workers entering these fields to replace retiring workers. Health care is not viewed as a desirable career choice as in previous generations. Working conditions are stressful. Pay is not always competitive with other professional choices. Montana pay is not competitive with other states. Montana's mega-rural nature can seem professionally isolated and undesirable, and makes access to education and training difficult.

Issues and Proposals

Five major issues were addressed by the Task Force and are listed below with the specific proposals for each issue. The Report also includes a number of specific action steps for accomplishing each proposal.

ISSUE 1: MONTANA'S HEALTH CARE CLIMATE

- **Proposal 1:** Lawmakers should establish in Montana statutes a statement of policy/philosophy for health care in Montana.
- **Proposal 2:** All Montanans can reduce the demand for health care services by promoting healthy behaviors and accident/illness prevention.
- **Proposal 3:** The Governor should direct the Departments of Health & Human Services and Labor & Industry, in consultation with the Higher Education and

professional associations, to educate the general public, potential workforce candidates and policy makers about the need for healthcare workers, about the diverse opportunities available in the health care field, and about the value and importance of health care workers to the Montana economy and citizens.

ISSUE 2: EDUCATIONAL OPPORTUNITIES

- **Proposal 4:** The education community should introduce health care occupations and integrate the skills necessary to attain them in K – 12 curricula.
- **Proposal 5:** The Commissioner of Higher Education should establish an integrated, "single point of contact" Distance Learning and Continuing Education Program for health professionals.
- **Proposal 6:** Policy makers should sustain health professions training programs through adequate funding.
- **Proposal 7:** The Governor, through the Office of Economic Opportunity and in accordance with SB469, should ensure that Montana's existing state and federally funded career development and employment training programs place a high priority on training, preparing and supporting workers for potential careers in health care and human services.

ISSUE 3: THE HEALTH CARE WORK ENVIRONMENT

- **Proposal 8:** The Task Force encourages Montana health care employers to improve the workplace partnership by creating a culture in which health care staff – including clinical, support, and managerial staff – are valued, have a sustained voice in shaping institutional policies, and receive appropriate rewards and recognition for their efforts.
- **Proposal 9:** The Governor should direct the Departments of Public Health & Human Services and Labor & Industry, in collaboration with professional associations and the health care community, to identify and take action to reduce those regulations which are excessive, overly complex, and duplicative.
- **Proposal 10:** The Governor should a form a study group to review existing state statutes related to health care and human service liability insurance, to review liability insurance rates in other states, and to compare Montana's laws with those other states that have lower liability insurance rates.

ISSUE 4: REIMBURSEMENT & COMPENSATION

- **Proposal 11:** Policy makers should ensure that public health and health-related human services funding sources pay the ***full*** cost of providing services, including the cost of staffing and training and of adequate wages and benefits paid to the workers providing the care.
- **Proposal 12:** The Governor should ensure that Montana pursues, and when possible takes advantage of, all public and private sources of additional funding or resources to help attract, train and retain health care and human services workers.

ISSUE 5: HEALTH CARE WORKFORCE DATA COLLECTION AND ANALYSIS

- **Proposal 13:** To enable government, employers, trainers and educators to plan for workforce supply and demand, the Governor should direct the Department of Labor and Industry to work with its federal counterparts to provide reliable,

timely, consistent information that is regularly evaluated and updated.

- **Proposal 14:** The Governor should direct the Department of Labor and Industry to take the lead as a high priority to improve the condition of data resources across the professions in view of the interest in workforce and economic development issues.
- **Proposal 15:** The Office of the Commissioner of Higher Education (OCHE), in collaboration with health care program providers, should assess and report on the program capacity of Montana's higher education system to meet health care workforce needs.

The Task Force strongly believes that, if enacted, these proposals will contribute significantly to alleviating the current shortage of skilled health care workers, to improving Montana's health care economy, and to averting a dangerous future for quality care for Montana citizens.

HEALTH CARE WORKFORCE SHORTAGE

PART 1
THE PROBLEM

THERE *IS* A SHORTAGE OF HEALTH CARE WORKERS

Health care/human services workers are in short supply throughout the country. This situation truly threatens the health and well being of us all. Moreover, this shortage is expected to worsen. Time Magazine, in a May 6, 2002, article "The Coming Job Boom" lists 16 Hot Jobs for the coming decade. Included: Registered Nurses, Health Therapists, and Social Workers. The article presents a guide to the best job opportunities now and in the foreseeable future. At the top of the list is health care. That's good news for those seeking jobs. However, since health care is only as good as the people providing it, that is bad news for our health. Lack of qualified workers equals compromised care.

Numerous national studies, special commissions, and other state governments are addressing this issue and what to do about it. What they are discovering is a complex and disjointed array of facts and figures that, nevertheless, all confirm a growing shortfall in essential health care workers. The reasons for the shortfall are numerous, the result of a unique convergence of economic, demographic, and very human circumstances. In this environment, competition for workers is keen. Montana's health care system must be able to compete. This critical and growing shortage of qualified workers has been a major subject of concern for some time for Montana's health care/human services industry.

In response to these concerns, and recognizing that Montana is a frontier state with unique strengths and challenges, Governor Martz appointed the Governor's Blue Ribbon Task Force on the Health Care Workforce Shortage in October 2001. She charged the Task Force with the following mission:

> **To accurately assess the shortage of health care workers in Montana, and to develop recommendations and strategies to effectively address the issue.**

The Governor appointed members representing health care/human services providers and professionals, Indian Health Service, education, consumers, the Legislature, and state government. Her expectation was that the Task Force examine this issue using Montana specific examples and statistics and develop workable recommendations. The Task Force benefited greatly from the expertise and contributions of the individual members. Members generously contributed resources, data, analytical skills and significant time to assess the nature of Montana's health care workforce shortage and to present useable recommendations.

WHO IS THE "HEALTH CARE WORKFORCE"?

OVER 50% OF MT HEALTH WORKERS ARE NURSES & NURSE AIDES

"Health care workforce" implies a whole host of occupations: from Home Health Aides, who enable the elderly and the disabled to live at home, to highly specialized health care providers performing state-of-the-art treatment procedures. As used in this Report, the health care workforce includes related human services professions that are essential to the health care system by providing care, treatment and support services to children, families and individuals with disabilities and special needs including development disabilities, child emotional disturbances, mental illness and chemical dependency. These services may be provided in community-based and in residential programs.

Are all these occupations experiencing current or imminent shortages? Unfortunately, the short answer is: Yes!

The following Table summarizes the Montana Health Care Workforce by occupation and projected increase in demand.

Table 1. Montana Health Care Professions

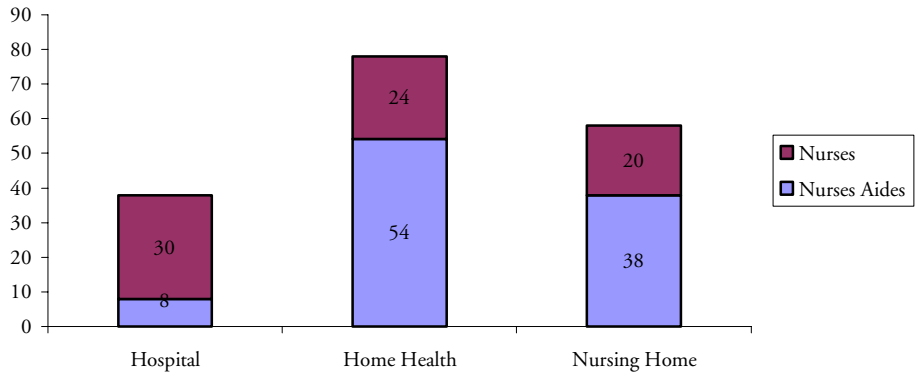
Profession	Total Employed	Percent of Total	Projected Increase 1998 to 2008
Physicians	1,838	6%	24%
Nursing (registered, advanced practice registered, licensed practical)	9,234	30%	17% to 19%
Dentistry (dentists, hygienists, assts)	2,399	8%	15% to 38%
Physician Assts	186	1%	49%
Other Clinicians (Chiropractors, Podiatrists, Optometrists, Opticians)	1,285	4%	11% to 24% (Opticians)
Pharmacy (pharmacists, techs, aides)	1,114	3%	4% to 15%
Mental Health (psychologists, social workers)	3,744	12%	16% to 45%
Allied Health Therapists (such as physical, occupational, speech & language therapists)	1,843	6%	11% to 54%
Allied Health Technicians & Technologists (such as emergency medical, radiology, laboratory)	2,409	8%	6% to 45%
Dieticians & Nutritionists	175	1%	13%
Auxiliary Health (Home Health Aides, nurse aides, orderlies, attendants)	6,871	22%	24% to 34%
TOTAL	**31,098**	**100%**	

Source: Research and Analysis Bureau, Workforce Services Division, Montana Department of Labor & Industry, *Job Projections for Montana's Industries and Occupations, 1998*-2008, March 2001.

Over 35,000 people, almost 10% of Montana's workforce, are employed in the health care industry when administrative and other support positions are added to the above. Statistical information can vary significantly by profession. Various state and federal agencies, institutes and professional associations collect occupation specific data, often for different time frames and for inconsistent data elements. Much data collected by the Task Force is compiled in Part 3 of this Report. Some extracts are provided below.

While demand in virtually every occupation is projected to grow significantly, the impact of Nursing and Auxiliary (Direct Care) professions is particularly compelling. These occupations represent a majority of home health (78%) and nursing home (58%) employees and over a third of hospital employees as shown in the figure below.

Figure 1. Nurses and Nurses Aides as a Percent of All Employees in Hospitals, Home Health and Nursing Homes, 1999



Source: GAO Analysis Bureau of Labor Statistics, 1999 Occupational Employment Statistics data. GAO-01-750T. May 17, 2001.

Nursing Professions

Several recent U.S. General Accounting Office reports to Congress[1] have addressed the emerging nursing shortage as a significant national problem. Registered Nurses are responsible for the largest portion of the nation's health care, and represent the largest group of health care providers. This is true for Montana, as well: nurses represent 30% of Montana's health care workforce. The GAO has found ample evidence of a current shortage and of a greater future shortage. As of June 2001, the GAO reported 15 states had legislation to address nursing shortages. The number of Registered Nurses per capita has declined in recent years.

Further, most Registered Nurses are nearing retirement age. In 2000, 70% were over 40 (average age is 45.5) while only 9.1% were under 30 years old.[2] Nationally, nursing shortages are especially acute in home care, nursing homes and hospitals – all facilities heavily dependent on nurses.

Unacceptable vacancy and turnover rates are certainly plaguing Montana health care employers. Surveys conducted in 2001 and 2002 by the Montana Hospital Association, the Montana Health Care Association, and the Indian Health Service all found shortages and difficulty recruiting and retaining nurses. Poor wages, difficult working conditions

[1] U.S General Accounting Office Reports: GAO-01-750T, GAO-01-912T, and GAO-01-944.
[2] Decker, Dollard, Kraditor, "Staffing of Nursing Services in Nursing Homes: Present Issues and Prospects for the Future," *Seniors Housing & Care Journal*, Volume 9, Number 1, 2001. Also, "Implications of an Aging Registered Nurse Workforce," *JAMA* Vo. 283, No 22, June 14, 2000.

and other career options are some of the reasons for these recruitment and retention problems.

According to the Montana Board of Nursing, the number of licensed nurses leaving Montana has grown from 91 in 1995 to 820 in 1999 and 738 in 2000. Among Montana students graduating as Registered Nurses, the Board has observed that many of these graduates do not plan to stay in Montana to practice, primarily because of wages. The number of nursing degrees conferred in Montana has remained relatively constant over the past decade.

Direct (Auxiliary) Care Professions

Direct care professions, such as nurse assistants, home health aides, habilitation aides, personal care assistants, make up 22% of Montana's health care workforce. These occupations are a critical component of the health care system, particularly for the elderly and disabled. For every 10 hours of paid long-term care, 8 hours is provided by direct care professions (home health aides, personal care assistants and certified nurse assistants).[3] In many ways, these professions provide the most personal relationships with patients in any residential care setting, since they assist with the most intimate care such as dressing, eating, toileting, and bathing. Yet these are difficult, low paying and high-risk jobs. Nurse aides have one of the highest rates of workplace injury of any occupation: 13 injuries per 100 people compared with 8 per 100 in the construction industry.[4]

For these reasons, turnover is very high. A 2001survey by the Montana Health Care Association found 93% of long-term care facilities reporting shortages of nurse assistants. Demand is growing for these positions as an aging population seeks assistants to remain independent.

Mental Health Professions

Montana has far fewer psychiatrists per capita than the national average (6.5 per 100,000 vs. 11.1 per 100,000).[5] Of Montana's 56 counties, 50 have been designated in whole or part by the federal government as Health Professional Shortage Areas for mental health. Significant, high profile changes in Montana's mental health delivery system have been underway for several years. Emphases have been placed on parity of treatment with physical illness, on elimination of mental illness stigma, and on community-based treatment. These changes have increased need for:

- Auxiliary Services, such as home health and personal care assistants.
- Psychologists, Psychiatrists, Social Workers, Licensed Therapists, and psychiatric/mental health Advanced Practice Registered Nurses.
- Pharmacy and medication management services, including visiting nurses.
- Services to rural areas.

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[3] Dawson & Surkin, *Direct Care Health Workers: The Unnecessary Crisis in Long Term Care*, Paraprofessional Health care Institute, January 2001.

[4] U.S. General Accounting Office Report GAO-01-750T, May 17, 2001.

[5] *HRSA State Health Workforce Profiles: Montana*. 2000.

Allied Health Professions
Explosive technological advances in health care have significantly increased the need for specialized therapists and technicians. As medical technology continues a steady pace of breakthroughs, inventions, and discoveries, the need for these occupations will continue rapid growth. MHA's 2001 survey of hospitals found high turnover in radiology technicians and respiratory therapists. According to the Montana Speech and Hearing Association, all areas of the state are now beginning to experience difficulty in recruiting speech pathologists and audiologists, especially in rural and eastern Montana schools. To be licensed in Montana, an individual must hold a master's degree. Since the University of Montana discontinued the masters program in the mid-1980s, Montana employers must compete for out-of-state applicants.

Physicians
Montana has fewer physicians per capita than the national average. Nine counties have no resident physician at all and another five counties have only one physician.[6] The average age of physicians in Montana is 49, higher than the national average.[7] Currently, 43 of 56 Montana counties have at least part of the county designated as a federal primary care health professional shortage area.

Dentistry
In 2000 the Montana Dental Association and the Montana Department of Public Health and Human Services surveyed Montana dentists. The response rate was 87% and confirmed data about the potential for an imminent shortage of dentists. Over 70% of Montana's dentists are 45 or older. Nationally the number of dental school graduates has been steadily declining, while the educational debt load and capital investment costs for practice continue to increase. Of Montana's 56 counties, the federal government has designated 35 as dental health professional shortage areas.

Pharmacy
Pharmaceutical costs are the fastest growing expenditure in health care today. An explosion of new "miracle drugs," as well as direct marketing to consumers, has dramatically increased demand. This will increase the demand for pharmacists and pharmacy technicians. Montana ranked 50th in the nation in ratio of pharmacy technicians to pharmacists.

Laboratory
According to the Montana Clinical Laboratory Management Association (CLMA), Montana averages 92 laboratory professionals per 100,000 population which is well behind the national average of 105 per 100,000 population. In January of 2002 the CLMA conducted a survey of 72 laboratories in Montana. There were 28 vacancies and

[6] Source: Montana Medical Association.
[7] *HRSA State Health Workforce Profiles: Montana*. 2000.

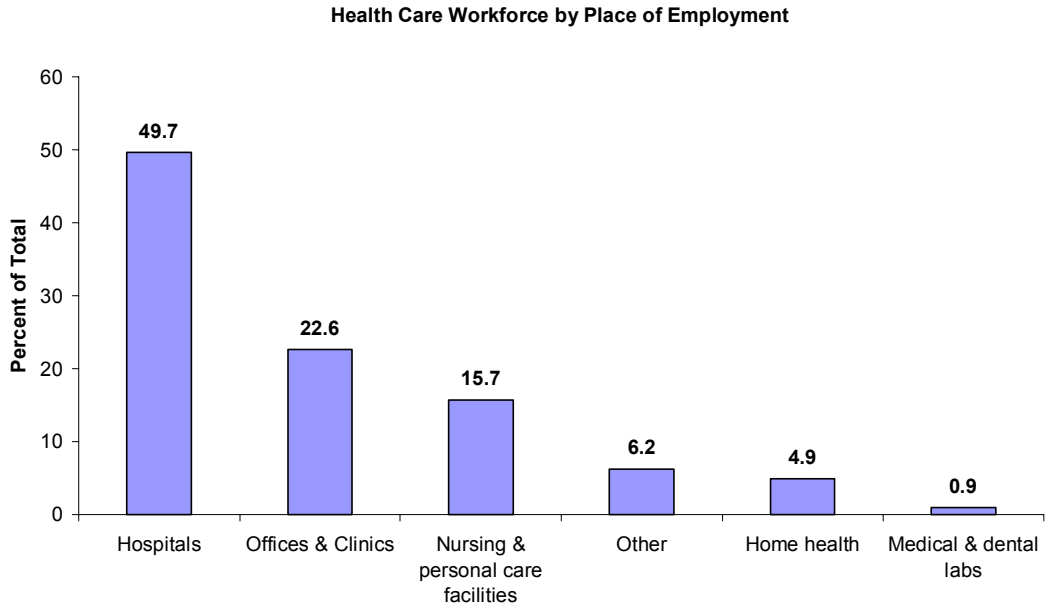
the average age of the Medical Technologist was found to be 45 years old. The above information, combined with the fact that 85% of a patient's medical record contains laboratory information, is cause for major concern with laboratory testing in Montana in the future without an adequate number laboratory professionals.

WHERE IS THE HEALTH CARE WORKFORCE EMPLOYED?

50% OF MT HEALTH WORKERS WORK IN HOSPITALS

Health care services tend to be clustered around population centers, and some counties have almost no health care workers. Montana ranks 48th among states for population: 6.2 people per square mile compared to the U.S. average of 79.6.[8] This creates health care delivery challenges since vast areas of Montana have few people, let alone hospitals and clinics. MHA's survey of Montana hospitals identified rural nurses[9] and found that turnover and vacancy rates were more acute for rural nurses in almost all cases. Many areas of Montana qualify for U.S. Department of Health and Human Services designation as Health Professional Shortage Areas (HPSA). This is defined, among other criteria, as having a ratio of: 3,500 or more population to a single primary health care physician; 5000 population to 1 dentist; 30,000 population to 1 psychiatrist. In 2002, Montana had 43 counties in which at least part of the county had been designated as a primary care HPSA, 24 counties (plus an additional 11 applications approved) as dental HPSAs, and 50 counties as mental health HPSAs.[10]

Figure 2 illustrates health services employment by place of work.[11]



[8] Montana Department of Public Health & Human Services, *State of Aging in Montana 2001.*
[9] Rural Nursing is defined by MHA as: The delivery of professional nursing care to a population of people residing in an area of diminished occupation.
[10] *Federal Register,* February 20, 2002.
[11] *HRSA State Workforce Profiles: Montana*. 2000.

WHY SHOULD PUBLIC AND POLICY MAKERS BE CONCERNED?

State policy makers play an important role in creating an environment to:

- **Foster good health care**, or discourage it. Montana statutes govern the licensing and certification criteria and requirements for health care professionals. State laws and rules regulate the Montana health insurance industry. Montana's education system establishes school curricula requirements and college degree offerings. The Montana Legislature sets funding levels for education, and reimbursement rates for Medicaid providers. Changing (or not changing) current policies can have major impact on the health care received by the Montana public.
- **Promote economic development**, or impede it. The services sector is producing jobs faster than any other sector of Montana's economy. The total health care revenue is estimated at $2.3 - $2.5 billion and is the largest overall service sector Gross State Product (39%). More than 35,000 Montanans are employed in the health services sector (nearly 10% of the workforce). In 2000, the payroll for these jobs was more than $1 billion, 12% of total payroll. The average wage of health care workers in Montana is 21% higher than the overall average wage.[12] Yet, these jobs are going unfilled or are filled with imported and temporary workers because no Montana workers are available.

Montana citizens are deeply and personally affected by the adequacy of the health care/human services workforce. For example:

- **Quality of Care**. With a primary portion of residential care provided by nurses and direct care workers, a high vacancy rate means either less care or care by tired and stressed workers required to put in overtime to accommodate vacancies. Appropriate staffing levels equals quality care. A HRSA study found a direct relationship between higher Registered Nurse staff levels and lower negative outcomes such as urinary tract infections and pneumonia in hospitals. A HCFA study found a direct correlation between minimum staffing levels in nursing homes and quality of care.[13] An AFT Healthcare survey of radiology technologists, respiratory therapists and certified nursing assistants identified quality of care, specifically not enough time to spend with patients, as a top problem for all three groups.[14]

  The horrendous turnover rates in the direct care professions mean that those patients most dependent on intimate personal care (toileting, dressing, etc.) may have a strange new caregiver several times in a single year. Over half of the 12 million people receiving long-term care nationally are elderly (6.4million). Non-

[12] Office of the Governor, *Montana Framework for Economic Development;* Dept of Labor & Industry, Research and Analysis; Morgan Quinto Press report, *Montana Health Care 2002* (per Sharon Kott).
[13] HRSA and HCFA studies cited in GAO report GAO-01-750T, page 5.
[14] April 11, 2002 press release on AFT website, www.aft.org.

elderly adults represent 5.3 million and children represent 400,000[15] in long-term care.

- **Access to Care**. Fewer health care/human services professionals means more difficulty finding care, especially in rural areas. Many rural Montanans are already traveling great distances to access physicians and other primary care providers, dentists, and residential treatment facilities. Nursing homes that drop below certain staffing levels cannot accept new patients until those levels are attained, which can create waiting lists. Medicaid's low reimbursement levels and paperwork complexity discourage many health care providers from serving Montana's poor. Health care providers can only accommodate a certain number of patients. As demand increases/supply decreases, waiting lists result. The 20% of the population with no health care insurance at all may have particular difficulty finding health providers willing to risk lack of payment. Since hospitals cannot legally deny services to anyone, those unable to access service elsewhere present at hospitals. This increases the burden on the already over taxed and short staffed Montana hospitals.
- **Cost of Care.** Vacancies and shortages might imply lower costs as a result of unpaid salaries. In fact, these vacancies and shortages must be staffed in order for facilities to maintain licensure. Consequently, facilities must mandate overtime from existing staff to cover the shortage, and pay overtime wages. If overtime is not an option, facilities hire temporary staff at premium wages (often including travel, room and board costs). Most Montana Hospitals (73%) are using overtime to address shortages. Other strategies include Traveling Nurses (used by 41% of Montana hospitals) and On-Call (45.5%).[16] In addition to the added costs of overtime and temporary staffing services, employers have the costs of recruiting, selecting and training staff, which run from 35% to 70% of a position's annual cost.[17] *All these costs are passed on to consumers.*
- **Employment Opportunity.** For Montanans who are unemployed or employed in low wage jobs or who have children in these situations, this worker shortage equals opportunity. The public interest is surely served by understanding where these jobs are and how to obtain them.

[15] Dawson & Surkin, *Direct Care Health Workers,* Paraprofessional Health Care Institute, Page 1.
[16] MHA, *Montana's Workforce Shortage.* PowerPoint Presentation to Governor's Blue Ribbon Task Force on Health Care Workforce Shortage, Spring 2002.
[17] Montana State Personnel Division.

WHAT IS CAUSING THE WORK FORCE SHORTAGE?

The workforce shortage is the result of two converging trends:

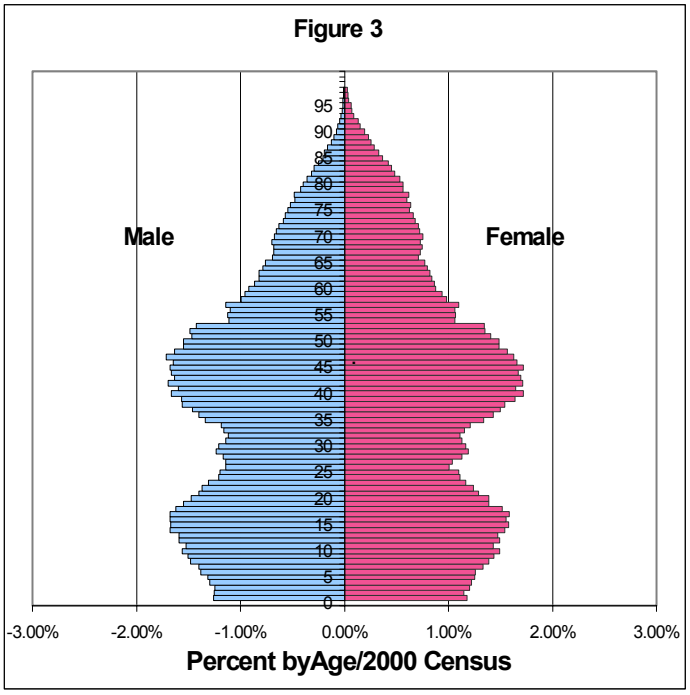
1. **DEMAND FOR HEALTH CARE SERVICES IS INCREASING.**

2. **TOO FEW PEOPLE ARE ENTERING OR REMAINING IN THE HEALTH CARE AND HUMAN SERVICES PROFESSIONS.**

1. DEMAND FOR SERVICES IS INCREASING.

The population is aging. An Associated Press article in the April 7, 2002, Helena Independent Record entitled "U.N. to Tackle Population Boom of World's Elderly" made clear that longevity is a global phenomenon. According to the article, in 50 years the number of people aged 60 and older will triple to 2 billion and will outnumber the world's youth. The ratio of working people to retirees, currently at 9:1 will decrease to 4:1 by 2050. Montana is actually aging faster. While in 2000 Montana ranked 44th among states for total population, we ranked 14th for percent age 65 or older (13.4%). By 2025, we are projected to continue to rank 44th in total population and in the top 15 for age 65 or older, with an increased proportion for the over-65 age group (21%).[18] While this extended life expectancy is good news, it signifies major consequences for the health care delivery system, as an aging population uses more services. Figure 3 illustrates Montana's disproportionate age distribution according to the 2000 census.

Figure 3



[18]Derived from projections from MPA Data Services, Inc., by the Research and Analysis Bureau, Workforce Services Division, Montana Department of Labor & Industry.

Source: Dept. of Public Health & Humans Services, State of Aging in Montana 2001.

Medical Advances are Proliferating. People now survive conditions that were once fatal. Heart disease, organ failure, premature birth, traumatic injury, cancer, even AIDS are all examples of conditions dramatically altered in survival outlook by the advances of medical science. The impact on the health care system is obvious: aggressive new treatment, increased rehabilitation, and on-going follow up care mean more qualified professionals are needed to deliver these new products and procedures.

Residential Facilities are Increasingly Regulated. State and Federal governments have established licensing and certification requirements, inspections and surveys of residential facilities designed to promote quality and guard public safety. These measures are labor intensive and affect staff needs of the facilities. Regulatory agencies also compete with the facilities for similarly skilled professionals such as Registered Nurses.

Desirable Alternatives to Nursing Homes are Multiplying. Home health, personal care, assisted living centers, adult day care are all services designed to assist the elderly and disabled to live as independently as possible for as long as possible. There is great and growing demand for these services. As an example, personal care services are now provided to approximately 3000 elderly and disabled Montanans under the Montana Medicaid program.

Patients in Residential Facilities are More Seriously Ill. People living in nursing homes now days are very medically complex, not only physically but mentally as well (Alzheimer's, for example). Nursing homes are no longer "rest homes" but are intense and demanding medical treatment centers with acutely ill patients, often with very difficult and challenging behaviors. The training and skill levels needed for staff are more complex than ever before.

Funding is Complicated and Time Consuming. The health insurance industry has changed dramatically, awkwardly, and very publicly in the past dozen years with the growth of HMOs, PPOs, POSs, and a whole alphabet soup of acronyms all resulting in more oversight (and paperwork) for health providers by cost conscious insurers. Government programs such as Medicaid, Medicare, Workers Compensation and the Children's Health Insurance Program (CHIP) have special funding rules and regulations. These provisions take more professional health staff both at the provider level and at government agencies and insurance companies.

2. TOO FEW PEOPLE ARE ENTERING OR REMAINING IN THE HEALTH CARE AND HUMAN SERVICES PROFESSIONS.

Fewer People are Choosing Health Care/Human Services Careers. A major finding of the American Hospital Association report, *In Our Hands*, was the lessening interest in health care careers. Among the reasons:

- in today's information age, health care is viewed as low tech;

- once viewed as safe, prestigious and stable, health care is now considered chaotic and unpredictable;
- health care was once one of few professional career opportunities easily accessible to women. Women now have options. Decreasing interest in nursing careers, especially by women, is considered one factor in the aging of nursing professionals;[19]
- in a short-stay hospital system, emphasis is changed from patient relationships to regulations, protocols and documentation; and
- with the work place and hours flexibility offered by information age employers, the rigid 24/7 demands of much health care employment are seen as unacceptable.

Salaries and Benefits are not Competitive. Direct care occupations, such as home health aides, habilitation aides and certified nurse assistants, are particularly low paid, in the same range as entry-level fast food jobs at $6.00 to $9.00 per hour. A recent survey by the Montana Department of Public Health & Human Services found average direct care workers' wages at $7.00 and $8.00, depending on occupation. Nurse aides are twice as likely to qualify for Medicaid and Food Stamps as other workers and are uninsured at a rate of 24% compared with 16% nationally for all workers. (30% of home health aides are uninsured.)[20] A recent survey by the Dental Hygiene Association found that most dental hygienists in Montana are employed only part time, with no benefits.

The 2000 HRSA State Health Workforce Profile for Montana shows Montana salaries lagging the national averages in almost every health care occupation. While this is not dissimilar from other occupations in Montana, where average income ranks near the bottom among states, this is an especially crucial component of Montana's ability to recruit qualified workers in the midst of a national workforce shortage for health care.

The Working Conditions are Challenging. Health care is heavily regulated and paperwork intensive. This, combined with the "zero-error" nature of the work, makes for stressful work environments. Shortages and turnover cause overwhelming workloads. Health care is a 24-hour/seven days a week delivery system, requiring significant shift work. Health care/human services workers are faced with growing personal safety concerns such as needlesticks, violent patient behavior, and physical demands of caring for severely ill patients. Nurse aides have one of the highest rates of workplace injury of any occupation: 13 injuries per 100 people compared with 8 per 100 in the construction industry.[21]

In addition, studies and surveys show increasing dissatisfaction among health care workers who do not feel their work is valued, do not feel adequately trained, do not have career ladders, and do not feel able to provide the kind of compassionate care that attracted them to health care in the first place.[22] According to AFT Healthcare Chair Candice Owley, "Healthcare in America is getting to be like assembly-line work with a conveyor belt speeding out of control."

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[19] Decker, et at, *Senior Housing & Care Journal*, page 6.
[20] U.S. General Accounting Office Report GAO-01-750T.
[21] U.S. General Accounting Office Report GAO-01-750T
[22] American Hospital Association, *In Our Hands,* 2002. AFT Healthcare.

The Health Care/Human Services Workforce is Aging. In an interesting twist of fate, many professional health and human services care givers are aging right out of the workforce just at the same time an aging general population will need more services. The average age of registered nurses is 45.5. In 2000, 70% were over 40 while only 9.1% were under 30. The average age of doctors in Montana is 49. Over 70% of Montana dentists are 45 years or older.[23] Who will replace these retiring professionals?

Health Care is Viewed as a Paperwork and Litigation Nightmare. Health insurance requirements and complexities, government reimbursement programs, and liability costs are among the major deterrents to many considering opening health care clinics and practices. Most Montana doctors and dentists operate in small private business practices. Major changes in the way medicine is now funded are complicated and costly for these small businesses, which must comply also with all regular business and employment laws and regulations.

Education is Often Inaccessible: Prohibitive Cost/No Available Programs. All higher education is costly. Most students end their college careers with significant debt. Education costs for doctors of medicine and dentistry are especially staggering. Without help, few Montanans could shoulder these costs.

While Montana has many health care degree programs available, few are offered at remote locations or in nontraditional formats. This means that rural Montanans, where health care professionals are especially sparse, must choose between leaving their home communities (and perhaps also their current health care employment) or abandon any professional ambitions.

The Task Force heard examples of the obstacles and hardships experienced by rural Montanans. One example was provided by a Sidney resident, a Registered Nurse with an associate degree participating in a B.S. completion program in Bismarck, North Dakota. Although Bismarck was closest geographically to her, obstacles and frustrations were caused for her by attending an out of state school. Fulfilling required clinical rotations is especially difficult for rural Montanans.

These kinds of barriers make health care career education difficult for many rural Montanans.

Rural Locations are Often Viewed as Undesirable/Isolated Places to Practice. Health care professionals are attracted to employment opportunities that allow for continuing professional growth, with access to emerging technology and association with professional colleagues. Montana can only support this kind of environment in a few population centers. Telecommunication advances improve, somewhat, this situation, but cannot totally overcome the isolation of much of Montana. An example is the chronic nursing shortage at the Eastern Montana Veterans Home in Glendive. The Veteran Home has been unable to recruit staff or access appropriate local education solutions. As a result, the facility has recruited nurses from the Philippines.

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[23] HRSA *State Workforce Profiles. Montana.* MHA Presentation. Decker, et al, *Seniors Housing & Care Journal 2001.*

PART 2
PROPOSALS

ISSUE 1: MONTANA'S HEALTH CARE CLIMATE

The Task Force took up the charge of addressing the health care workforce shortage in a climate of near crisis for health care in general. For over a decade, the federal government and most states including Montana have attempted to address soaring health care costs and increasing numbers of uninsured Americans. Costs continue to rise. The number of uninsured Montanans continues to grow. Demand for services, such as pharmaceuticals, continues to soar. Every state is currently contending with explosive and crippling growth in state Medicaid costs.

In Montana, a number of efforts have been undertaken to address costs of and access to health care. A Health Care Authority was created by the Legislature in the early 1990s. The Authority dissolved and was succeeded by the Health Care Advisory Council. The Health Care Advisory Council was dissolved. Currently, the Legislature is studying health care issues through a Legislative Interim Committee created by Senate Joint Resolution 22. The Department of Public Health and Human Services is seeking federal grant funds for another Health Care Advisory Council, and Governor Martz recently convened a Health Care Summit to address the chronic health care cost and access issues facing Montanans.

The Task Force recognizes that health care issues are frighteningly complex and fast changing. The Task Force applauds and supports the ongoing efforts of policy makers to tackle these difficult issues for the benefit of the public. To this end, the Task Force proposes the following to contribute to improving the health care climate in Montana.

Proposal #1: Lawmakers should establish in Montana statutes a statement of policy/philosophy for health care in Montana.

> **Recommended Action: The Task Force strongly urges the Governor to direct the Department of Public Health and Human Service, working with the Legislative Interim Committee and others, to review the Montana Constitution and current state laws on health care and develop a "comprehensive health policy" for the state of Montana that will improve and protect the health and safety of all its people.**

Discussion: The health of Montana communities is a shared responsibility of many entities, as well as a personal responsibility of each community member. Addressing the health issues of the 21st Century is a tremendous challenge. A comprehensive leadership plan can best be achieved by continuing the private/public partnership and working with state executive agencies, legislators, community partners, business and economic development partners, state and local health professionals, citizens at large and others to envision and secure collective responsibility for the public's health.

Developing a "comprehensive health policy" for the state can assist:

- the people of Montana to learn about leading health problems, risk factors and causes of death and to live more active and healthy lifestyles;
- the policy makers to know more about health care problems, challenges and issues, resulting in better planning and future policies for the state to accomplish key health priorities for Montana;
- the providers of health care and related human services to become more effective and expand their role in prevention and early intervention; and
- the economic health of our communities and the state of Montana.

Such a statement of policy would serve as a guide for various agencies and groups addressing health care issues in Montana. Oregon and Washington are examples of states that have attempted to define public policy parameters for health care. The Task Force envisions flexible language that does not guarantee service or funding but does provide direction for the state in addressing health care issues and the ebb and flow of resources.

Proposal #2: All Montanans can reduce the demand for health care services by promoting healthy behaviors and accident/illness prevention.

> **Recommended Action: Governor Martz should direct key state agencies to coordinate program efforts directed at promoting fitness and encouraging healthy choices and to partner with private sector entities to develop plans to communicate the importance of taking steps to improve one's own personal health and fitness.**
>
> **Recommended Action: Governor Martz should direct key state agencies to assess the cost savings potential of effective federal/state/local/private sector partnerships to prevent the occurrence of costly diseases and dysfunction, assess the current strength of Montana's infrastructure to secure such savings, and formulate a plan that will achieve a sufficient level of public and private sector commitment within the next decade.**

Discussion: Effective measures can be taken today to prevent or delay much of the burden resulting from chronic disease. Individuals at any age can improve their quality of life by being more physically active and making healthier choices. In addition, a limited investment of public and private sector dollars in targeted education and mentoring programs can greatly limit the occurrence of disease and dysfunction which are far more costly to the taxpayers, and far more painful for families to bear. Such programs include nutrition, parenting skills, in-school services, accident and injury prevention, and many others. Ironically, those professions that provide expertise for these programs are also found high on the shortage list, for example nursing and nutritionist.

Proposal #3: The Governor should direct the Departments of Health & Human Services and Labor & Industry, in consultation with Higher Education and professional associations, to educate the general public, potential workforce candidates and policy makers about the need for healthcare workers, about the diverse opportunities available in the health care field and about the value and importance of health care workers to the Montana economy and citizens.

> **Recommended Action: Develop a media campaign to increase public and legislative awareness of the need for health care professionals, the education programs currently available, and the need for public support of such programs.**
>
> **Recommended Action: Develop public service announcements to: 1) encourage careers in health care, targeting the most serious shortage areas, and 2) portray the importance and value of health care workers.**

Discussion: There is clearly a need to educate the public about the health care worker shortage, about available and diverse careers in health care, and about the importance of working in health care. Many people exploring careers are simply unaware of the diversity of health education and employment options available in Montana. This needs to change. The general feeling that health care industry jobs are not desirable needs to be countered. These jobs need to be valued and viewed as a "career" choice that involves upward mobility. Society must place a visible, high value on the work performed by health care workers at all levels. This includes public recognition and appreciation.

Montana offers unique and desirable lifestyle opportunities to advertise to potential health care providers. In the Montana Survey of Dentists, 62% of survey respondents reported being very satisfied with their professional dental life. When describing the most important factor in choosing to practice in Montana, quality of lifestyle was cited most often.

Private grants should be sought for marketing and promotion activities. Federal appropriations should be sought for promotional activities. Enhancing the image of the profession will go a long way toward enticing future workers and retaining current workers. Promoting the advantages of a Montana quality of life can help counter concerns about living in rural locations.

ISSUE 2: EDUCATIONAL OPPORTUNITIES

A recurring theme in the health care/human services workforce discussion is education. Health care/human services occupations require skilled training at a minimum and considerable higher education in most cases. This is not a one-time shot of education and training. More than most industries, health care is subject to rapid, constant change and innovation. Ongoing education and training are crucial to successful delivery of the most up-to-date medical treatment.

Montana does offer many very excellent degree programs. (See Table 3.) Unfortunately, as demand is increasing for many occupations, the number of degrees conferred is not increasing and in some cases even decreasing. This is a national trend. (For example, note in Table 6 that the number of Bachelor of Science degrees for Registered Nurses has not shown significant increase in a dozen years.)

Montana is one of only seven states with no medical school and has no dental school. Montana has out-sourced professional healthcare education for physicians, dentists, and others through several regional agreements: WICHE, WWAMI and the Minnesota Dental program. The out-sourcing program is administered by Office of the Commissioner of Higher Education (OCHE), and the state funds a number of slots through different institutions.

The Task Force recommends the following proposals to strengthen Montana's educational system capacity to address the health care/human services workforce needs of Montanans.

Proposal #4: The education community should introduce health care occupations and integrate the skills necessary to attain them in K – 12 curricula.

Recommended Action: The Governor should work with the Superintendent of Public Instruction to design and implement a statewide system of health occupations education through the Office of Public Instruction.

Recommended Action: The Governor should work with the Superintendent of Public Instruction to establish a Health Occupations Education Specialist in the Office of Public Instruction.

Recommended Action: To assure implementation of the two previous recommended actions, the Governor and the Superintendent of Public Instruction should consider all appropriate funding sources including the state general fund, interest from the tobacco trust fund, health care stakeholders, foundations, corporations, and federal Workforce Investment Act (WIA) funds.

Discussion: Development of a skilled workforce to meet Montana's health care workforce shortage must begin with K-12 education. Primary and secondary schools provide students with skills and attitudes necessary to hold jobs, pursue advanced education, and develop careers. While some of these skills and attitudes (such as language, mathematics, communication, respect, cleanliness) are timeless, others (such as technology, procedures, best practices) are constantly changing and evolving. Today's health occupation options are vastly different from those of 10 or even five years ago. They change as a result of various influences including technology, demographics, labor force, and markets. A health occupations program will introduce students to the wide range of health career options and provide instruction in basic skills that enable students to work in health care even while they pursue higher education. K-12 also can prepare students for entry level employment, licensing, and/or apprenticeship in health care careers such as Certified Nursing Assistant (CNA), Home Health Aide, Dental Assistant, Veterinary Assistant, Medical Receptionist, Emergency Medical Technicians, Dental Laboratory Assistant and others that do not require higher education.

Centralizing a statewide system at the Office of Public Instruction will provide the catalyst and the structure to infuse health care occupation curricula into Montana's K – 12 education. At the end of one year, significant programs will result:

- A certification process for Health Occupations instructors will be in place so that students can receive vocational education credits for health occupations courses.
- A general health occupations curriculum guide will be developed in consultation with teachers and the health industry.
- At least 20 schools will commit to implement health occupations programs.
- At least five rural and/or reservation schools will participate in piloting rural health occupations models.
- Montana will be affiliated with the Health Occupations Students of America.
- Montana industry representatives, health occupations instructors, students, parents, and local administrators will have identified replicable "best practice" programs in at least three other states.
- At least 2,000 students will have been introduced to health occupations opportunities in Montana.
- Evaluation baselines and data collection and analysis techniques and tools will be in place, and funds will be secured to continue the program for at least two more years.

Proposal #5: The Commissioner of Higher Education should establish an integrated, "single point of contact" Distance Learning and Continuing Education Program for health professionals.

Recommended Action: The Commissioner of Higher Education should establish, within the next 2-4 years, a formal Consortium that includes existing Distance Learning programs and affected health care providers and professional organizations, to identify gaps, expand offerings and establish formal relationships/contracts with other states' programs where appropriate.

Recommended Action: The Distance Learning Consortium is expected to explore new and innovative distance learning techniques such as video-conferencing, on-line courses, self-paced study modules, awarding credit for specific competencies. The Consortium is expected to work with others, such as hospitals and the Montana Health Care Telecommunication Alliance. Other states' programs can serve as models.

Discussion: Montana needs to expand access to professional development and health/human services professions education, including continuing education and career ladder education.

Education for health/human services professionals does not end with a college degree. Ongoing education is essential in this rapidly changing field. This is as true for rural practitioners, far from institutions of higher learning, as for any other. In Montana, where distances are great and population is sparse, the challenge is to bring credentialing, licensing and career ladder opportunities to rural professionals with the least disruption possible to their rural practices. In addition to providing educational opportunities, successful distance learning programs can help reduce feelings of professional isolation for rural health professionals and demonstrate commitment to and valuing of Montana health care workers.

The Task Force envisions a formal Consortium of Montana's existing Distance Learning programs developing an integrated, single point of entry program which will be designed and marketed to meet the needs of rural Montana health/human services professionals seeking to improve skills, develop new skills, or advance up a health care career ladder (i.e., move from CNA to Associate Degree Registered Nurse to Bachelor of Science Nurse to masters level nurse or nurse practitioner). The program design should provide flexibility for those people who wish to remain at home and support their families while continuing to perform their current full-time health professions jobs. This benefits the health care facility as well as the student.

A vibrant and innovative Distance Learning Program is necessary to insure an adequate number of health/human services professionals for Montana. The Consortium should be encouraged to innovate. Video-conferencing, on-line courses and self-paced study modules are examples. On-campus skills laboratories or clinical training can be structured to occur at satellite locations or on campus during concentrated time frames. The Consortium should recommend a system for awarding educational credit for specific competencies and experiences that are demonstrated or gained while working in an existing health care job. Options to maximize clinical learning sites need to be explored, expanded, and streamlined in terms of approval processes.

Montana's graduate nursing degree program at Montana State University-Bozeman is an instate model for a distance delivery program. Distance learning RN to Baccalaureate programs have been in existence at Salish Kootenai College since 1998 and MSU-Northern since 1997. The MSU-Northern program has been offered statewide online since fall of 2000. Existing programs in other states can also serve as models.

Recommended Action: Expand Nursing Refresher/Reentry Courses to be accessible across the state.

Discussion: According to U.S. Health Resources and Services Administration, 762 Registered Nurses in Montana were inactive during 2001. Effort should be made to attract these educated health professionals who, for one reason or another, have been out of the active work force for a period of time and may desire to return. The Task Force envisions that the Consortium, recommended above, will be responsible for the program and also envisions that the courses will be self-sustaining through tuition fees within the next two years. Several models exist. For example, the University of North Carolina-Chapel Hill (UNC) has developed a nursing refresher course designed to be self-paced with both didactic and clinical components. (In the UNC model, the course must be completed within 5 months of the nurse returning to practice or it must be repeated from the beginning.) MSU-Northern has developed RN Refresher courses beginning May 21, 2002 for licensed registered nurses. These courses are offered on the Havre, Great Falls and Lewistown campuses and will assist in providing an appropriately prepared return-to-nursing workforce.

Proposal #6: Policy makers should sustain health professions training programs through adequate funding.

> **Recommended Action: The Office of the Commissioner of Higher Education (OCHE) and the Governor's Office of Economic Opportunity are urged to explore means by which the State may effectively retain, for practice in Montana, graduates of its programs who will be in high demand in the national labor market. Strategies should be in place in the next four years. Examples include: funding a tax-free educational loan-reduction program on the model of Montana Rural Physicians Incentive Program, conditional scholarships, tax credits, education debt relief, childcare.**

Discussion: The Task Force recognizes a need for the State to find ways to sustain education/training programs offered in Montana for health and related human services professions, including addressing the shortage of health professions educators. The Tobacco Settlement Fund is one appropriate source of state funding. It is not possible for all health professions' training programs to operate solely on grant and foundation money ("soft" money). For example, the Dental Hygiene Program, which is accepting its first class of students the fall of 2002, is critical to improving access to good dental care for Montanans. While this program will result in access and economic benefits for the state, the program will need support initially.

In the interest of efficiency, existing health professions training programs should work together as much as possible, including clinical rotations and apprenticeships.

The program to purchase medical training from other states (WICHE, WWAMI, and Minnesota Dental Program) is administered by the Commissioner of Higher Education. One of the benefits of this program is that it affords some flexibility so that the investment of State resources can be adjusted on the margin to respond to shortages in some fields when demand is more moderate in others. Table 2 below details the allocation of these slots and the funding for each in FY 02.

Any expansion of education supports should be coupled with incentives for graduates to return to Montana to practice, to insure that Montana's health care system benefits. Incentives are especially essential to attract health professionals to return to rural and underserved areas to practice where compensation may not be sufficient to enable graduates to accommodate the enormous debt often associated with health care education. Montana currently graduates professionals in pharmacy and nursing, for example, who may end school with debt burdens that drive them to higher paying positions in other states. The Task Force believes that incentive programs should be implemented for all levels of health professionals within the next four years. Such incentive programs would not necessarily all have to be at the State level. Counties, communities and health care organizations should participate in incentives (i.e., scholarships, loans in exchange for time commitment).

Table 2: WICHE/WWAMI/Minnesota Dental Programs

Program	FY 2001 ACTUAL Number of Students Supported	FY 2002 ACTUAL Number of Students Supported	FY 2003 BUDGETED Number of Students Supported
WICHE:			
Medicine	25	26 @ $22,800	24
Osteopathic Medicine	1	3 @ $14,600	4
Dentistry	7	6 @ 15,300	7
Veterinary Medicine	32	33 @ $21,700	35
Podiatry	0	1 @ $10,200	1
Optometry	7	6 @ $9,900	5
Occupational Therapy	3	1 @ $13,500 + 1@ $8,100	2
Public Health	1	1 @ $5,600 + 1 @ $3,734	2
Total WICHE	**76**	**79**	**80**
WWAMI Medicine	**80**	**60 @ $45, 958 for 3 years**	**80**
Minnesota Dental	**7**	**8 @ $ 15,300**	**8**

Proposal #7: The Governor, through the Office of Economic Opportunity and in accordance with SB469, should ensure that Montana's existing state and federally funded career development and employment training programs place a high priority on training, preparing and supporting workers for potential careers in health care and human services.

Recommended Action: The Governor, through the Office of Economic Opportunity, should identify, develop and promote programs to retrain displaced workers, displaced homemakers and non-traditional students to become health care professionals.

Recommended Action: The Governor should instruct the Departments of Labor & Industry and Public Health & Human Services to establish, as high

priority, careers in health care for all new and existing publicly funded employment and training programs.

Recommended Action: The Governor should require the Departments of Labor & Industry and Public Health & Human Services to prepare written analyses describing their successes and strategies for increasing the number of program recipients trained for, and subsequently working in, health care. The Departments should be required to provide periodic updates regarding the status of their efforts to prepare Montanans for careers in health care.

Discussion: Many Montanans are currently unemployed and a significant number are underemployed. Although the state provides a variety of state and federally funded career development and training programs and services to its citizens, there continues to be a shortage of health care and human services workers.

Many Montanans have found themselves unemployed as the traditional economy has been transformed: mines closing, lumber mills shutting down, ranchers and farmers going out of business. Often, people have strong ties to the communities where they have lived and worked. At the same time, these communities may well have critical needs for health and related human services professionals. This combination may provide excellent retraining and employment opportunities for individuals and communities alike. Such occupations often include benefits such as health insurance and retirement benefits, and allow people to stay in rural communities performing much needed services.

The Montana Departments of Labor & Industry and Public Health & Human Services currently spend state and federal funds to train and prepare unemployed and underemployed people for a variety of careers in our state. These programs should periodically report on activities to promote health care/human services occupations. The publicly funded employment training services offered by these departments are excellent resources. Directing these resources toward existing workforce shortages in careers with livable wages and benefits is a win-win opportunity.

Distance learning options, as part of the Distance Learning Consortium described above, should be offered to enable people to receive their didactic training while at home and reduce the cost of their education. Mechanisms of delivery such as video-conferencing, on-line courses and self-paced study modules are ways didactic education can take place while people are able to remain at home with their families, performing the tasks of their current employment, yet upgrading themselves professionally. On-campus skills laboratories or clinical training can take place as determined by the administering program. These methods could also improve partnerships between communities and the university system**.** For example, health/human services training programs could work with the Cooperative Extension Service in each county/community to implement retraining programs. These programs could be held at the local high school, hospital, or Senior Center.

ISSUE 3: THE HEALTH CARE WORK ENVIRONMENT

A second major theme in the many studies of the health care/human services workforce shortage is the workplace environment. The Task Force explored a wide range of topics, including:

- lack of career development;
- inherent health risks;
- the "hassle factor" of regulatory and payment systems;
- increasing liability;
- inadequate staffing;
- loss of efficiencies of scale;
- increased work load;
- nature and rigidity of work schedules (staffing health care facilities 24-7, holidays, weekends);
- lack of infrastructure and expectations in rural settings;
- difficult patient behaviors and expectations;
- mental health and other disabilities;
- more medically complex patients; and
- inter-professional relationships.

The Task Force sought to "boil down" the problem to several points for action. In this process many smaller, but no less significant, issues can fall by the way side. The Task Force has attempted in this report to shed some light on all the issues discussed, even though not all will be addressed with specific action items.

A health care/human services worker's environment is often one of high stress and long hours where too few people share the work. Both workers and finances are stretched thin. The workers face difficult working conditions, such as inadequate staff/patient ratios, overtime in response to understaffing, continued use of latex in health care facilities despite increasing numbers of persons with sensitivity and allergies, needle sticks, back injuries, infectious diseases, workplace violence and disruptive professional conduct. Professionals fear liability in this arena where perfection is expected and lawsuits are common. Continuing education and staff development does not occur to the extent required for workers to adapt to their ever-changing environment. Excessive government regulations and paperwork often become the straw that broke the camel's back. The picture the Committee examined is one of a work force in crisis.

Even the patients are changing. As our population ages and technology advances, we are encountering new and more medically complex patients. Difficult patient behaviors are common. Expectations are also at a high point due, in part, to increased health care options, including community-based and individualized services, and a more informed consumer. All of this adds to the stress and strain on health care workers.

The general public may not realize or understand the extent of the problem. Few people are informed about or interested in careers in health care. Those in health care careers no longer feel highly valued by the public. But those who do choose to work in health care are very special people indeed. All of us have a vested interest in reinforcing health care

professions as prestigious and rewarding career choices. ***The quality of the care the public receives is directly attributable to the quality of the individual professionals providing the care.***

What can we do? Funding is critical, but is not the only proposed remedy. Funding recommendations are addressed in more detail in a separate Issue 4. Along with funding, the Task Force recommends the following proposals as a beginning to redress the current unacceptable work environment for health care workers.

Proposal #8: The Task Force encourages Montana health care/human services employers to improve the workplace partnership by creating a culture in which health care/human services staff – including clinical, support, and managerial staff – are valued, have a sustained voice in shaping institutional policies, and receive appropriate rewards and recognition for their efforts.

Recommended Action: Health care/human services employers are encouraged to review their current practices to insure that practices promote retention and job satisfaction among workers, including the development and implementation of a zero-tolerance policy for disruptive behaviors among professionals.

Recommended Action: Montana's health care/human services organizations should provide continuing education and career development opportunities for health care/human services managers that focuses on executive leadership development, quality work environment, and participatory management. Private/federal/state funding for the development of a Health Care Management Institute should be sought.

Recommended Action: The Task Force encourages Montana providers to provide continuing education and career development opportunities and incentives for their current health care/human services professionals.

Recommended Actions: Policy makers should increase state/federal/private funding for health care services to enable facilities to hire sufficient staff and do adequate training, as described in Proposal #11.

Discussion: The American Hospital Association's Commission of Workforce for Hospitals and Health Systems issued its findings and proposals in a report published April 2002 and entitled *In Our Hands.* The AHA found that ***employee dissatisfaction*** was a major contributor to high turnover and retention problems in general. Further, AHA found that significantly higher percentages of the employees of health care employers reported their expectations not being met than for employees of employers in general. AHA measured the areas of work-life harmony, growth in the job, affiliation or being a "part of the team,"

compensation and benefits, and safety and security.[24] Percentages of health care employees with unmet expectations ranged from a low of 30% to 56%, well above employees in general. Surveys by AFT and other organizations[25] have also found worker dissatisfaction problematic among health care workers. An Urban Institute report also addresses working conditions, management styles and alternative models for nursing homes.[26]

The findings of a survey conducted by Dr. Alan H. Rosenstein of VHA West Coast suggest, "…the quality of nurse-physician relationships must be addressed as facilities seek to improve nurse recruitment and retention." Respondents reported nurses revised schedules, changed shifts or departments, or left the facility permanently due to disruptive physician behaviors. The tolerance of ***disruptive behaviors*** by healthcare facilities is also a concern of nurses. A study published in a 2002 *New England Journal of Medicine* issue, concluded fewer incidents of infections, bleeding, pneumonia, blood clots, shock and cardiac arrests correlated with greater hours of care per day provided by registered nurses. According to *U.S. News & World Report*, June17, 2002, hospitals that have instituted zero abuse tolerance policies have witnessed a decrease in nurse turnover rates. Institutions must also address removing barriers to reporting disruptive professional behaviors and providing feedback on the outcomes of such reporting in order to facilitate the retention of nurses.

A frequent reason cited in studies and surveys for health care workers leaving the profession or moving from direct care to more autonomous situations is ***dissatisfaction with management***. Whether or not management is unsupportive and unresponsive, this perception of many workers contributes significantly to decisions to leave the profession. The health care/human services industry is not unique among industries in frequently selecting managers from its best practitioners. And like other industries, the best practitioner or clinician is not necessary equipped for managing other people. Managing people and resources require specific, often different, skills.

Health care/human services managers are under tremendous stress themselves to meet staffing, regulatory and financial demands. In addition, turnover rates for health care administrators and discipline-specific managers are often high. Management pressures and turnover can leave little opportunity for developing ***meaningful communication with workers***. But, as all successful businesses understand, lack of effective communication leads to misunderstandings, rumors, resentments – and turnover. Workers are in the best position to provide management with beneficial suggestions that help patients, lessen the burden of staff, and save money. Workers in every discipline resent not being consulted.

The Task Force assumes that Montana is reflective of the findings of the AHA and others and that there is an ongoing need for ***executive leadership development*** for health care managers. A Health Care Management Institute is envisioned similar to the Public Health Institute that the Department of Public Health and Human Services is coordinating, using grant funds, for local public health officials. Many examples of leadership

[24] AHA, *In Our Hands,* April 2002, page 28.
[25] See also: American Association of Colleges of Nursing, *Hallmarks of the Professional Nursing Practice Environment,* January 2002.
[26] Stone & Weiner, *Who Will Care for Us? Addressing the Long Term Care Workforce Crisis,* Urban Institute.

development institutes exist. A good list of "Key Middle Management Competencies" is provided in the AHA report. [27]

Lack of ***sufficient training and career development*** opportunities in the work place clearly contributes to the negative work environment, including burn out and injuries. However, facilitating training brings on problems of its own as well. Employees need time to train, something in short supply. While some staff is being trained, others need to carry an even larger workload. In some parts of the state access to continuing education classes is also a problem. Unfortunately, those who hold the purse strings in work places often don't see the benefit of work force investment because the benefits are intangible, and compete for limited funds with other more tangible necessities. A major barrier is the fact that employers place insufficient value on career development, therefore making it a lower priority. Again, there is the need to have enough personnel to fill-in while others are being trained. The training/education needs to be affordable, accessible, and ongoing to continually update technical skills.

Quality of care is directly related to adequate, well-trained staff. The current dilemma of too little staff to enable adequate training simply exacerbates both situations. Overworked, under trained employees will leave. The work place will have fewer, even more overworked employees remaining who may then also seek to leave. It is most certainly in the public interest to seek an end to this downward spiral since it is the quality of care that suffers. In addition to providing better-trained employees, professional development has been shown to reduce turnover. Healthcare facilities that promote professional development through nursing involvement in institutional decision-making have significantly less turnover rates of registered nurses.[28] Opportunities to maximize federal funds should be explored. Refresher courses and on-site learning opportunities should be developed. Funds for retraining dislocated workers should be directed toward these occupations. Adequate staff and staff training will decrease turnover and decrease vacancies, and increase staff competency resulting in better quality patient care and job satisfaction, decreased workplace injuries, increased staff retention, and enhanced recruitment potential.

Proposal #9: The Governor should direct the Departments of Public Health & Human Services and Labor & Industry, in collaboration with professional associations and the health care community, to identify and take action to reduce those regulations which are excessive, overly complex, and duplicative.

> **Recommended Action: Develop legislation (state and federal) to provide for "deemed status" whenever appropriate, between licensing and accrediting bodies for facilities. (This allows for credentialing by one agency to be transferable to another.)**

[27] AHA, *In Our Hands*, April 2002, pages 34-35.
[28] The Montana Nurses' Association has reported this finding.

Recommended Action: A Regulatory Commission should be appointed by the Governor to review regulations and identify excessive, overly complex, duplicative or unnecessary regulations that add time and cost without adding to the quality of health care, and to make recommendations for changes for both state and federal government. In addition, the Commission should examine the efficacy of boards and explore opportunities to model innovative, new programs.

Recommended Action: A Professional & Occupational Licensing Commission should be appointed by the Governor to review and streamline health care licensing requirements, assessing and removing unnecessary barriers to an adequate health care workforce in Montana. Areas to review include reciprocity, scope of practice, and approval of educational programs.

Discussion: Excessive, overly complex and duplicative regulations (state and federal) create unnecessary paperwork, add to the cost of health care, and diminish direct patient contact, causing some workers and providers to leave the health care profession. To guard against fraud and abuse and assure quality health care, the state and federal governments (as well as third party payers) have enacted extensive, and often complex, regulations for licensing both facilities and professionals. Many of these regulations are necessary and appropriate and do, in fact, meet their goal of promoting quality and discouraging fraud and abuse. However, some are excessive, overly complex, and duplicative – failing to hit the target.

An example of excessive and duplicative licensing/accreditation regulations can be found in the experience of a private, not-for-profit residential treatment center for children and adolescents located in Montana. The agency provides a full continuum of treatment services from in-home prevention through inpatient residential treatment. Approximately 450 children and families are served daily through twelve different programs in seven communities throughout Montana. The agency is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and is also accredited by the Council on Accreditation (COA), the two largest national accrediting organizations in the U.S. Additionally, the State of Montana licenses the agency through eleven separate licensing reviews including: Residential Treatment Facility, Mental Health Center, Therapeutic Youth Group Homes (6), Child and Adolescent Day Treatment, Adolescent Intensive Case Management, and Child Placing Agency. The educational program is accredited by both the Montana Office of Public Instruction (K-8) and the Northwest Association of Schools and Colleges.

In January 2002, the agency was notified by a representative of the Montana Board of Visitors that, by Montana Statute (Title 53, Chapter 21, MCA), the Board needed to complete a site review because the agency is licensed as a mental health center. The Board of Visitors was sent approximately 65 lbs of documentation that had been developed for the accreditation review by the Council on Accreditation. This did not suffice so a site review was scheduled which involved a team of six individuals for two days. And finally, as a result of recently passed federal regulations regarding restraint and time-out/seclusion procedures, any agency that utilizes these procedures (which are all carefully reviewed by

JCAHO and COA) must report any and all incidents, in which the client was bruised in any fashion during the procedure, to the Montana Advocacy Program.

Excessive regulations aimed at health care facilities and organizations mean bureaucratic red tape, excessive paper work and stress at the worker level when unreasonable expectations cannot be met. Regulations and paperwork take time and energy away from the very people health care workers serve – the patients. Excessive paper work, procedural steps and approvals aimed at health care professionals mean delays, frustrations and potential barriers to adding to the pool of needed health care workers. It is important that regulations and their attendant paperwork be reasonable and necessary.

In addition to state issues, the Task Force believes that state policy makers should play a strong role in the development of federal legislation and regulations, dealing with health care, especially since so much is at stake. Additionally, policy makers should work to determine better ways to deliver services with integration of public and private health systems. Improved regulations that are reasonable and not overly complex, and reduced duplication of licensing/accrediting requirements and oversight, will allow health care/human services workers and providers to devote more time to innovative, quality patient care and services, while still assuring a quality health care system.

Proposal #10: The Governor should form a study group to review existing state statutes related to health care and human services provider liability, to review liability insurance rates in other states, and to compare Montana's laws with those other states that have lower liability rates.

Recommended Action: The study group should determine the necessity of and, where necessary, recommend the substance of legislation that will: (a) affect stabilization or a downward impact (smaller rate of increase) on the cost of professional liability insurance; (b) tend to reduce the number and severity of adverse incidents, whether by negligence or otherwise, in the health care setting; (c) strongly consider and focus in those geographic areas and specialties or types of care in Montana where the availability of professional care is limited or likely to be further limited because of economics and liability issues; (d) provide for and take into account the benefits of such legislation to medical consumers, in a manner cognizant of their health care needs and the cost of their care, as well as to the Constitutional protections available to them under Montana's Constitution.

Discussion: Since the mid-1970s, Montana has enacted a series of tort reform measures, designed to improve the circumstances in Montana for the availability of business liability insurance, including professional liability insurance or "malpractice" insurance, at an affordable cost, after considering the impact on Montana citizens - both in terms of the cost and availability of goods and services - if such legislation was not enacted. These legislative efforts came in the mid- to late 1970s and again in the mid-to late 1980s.

Those legislative measures - many of which extended to all forms of court cases and types of litigants and not just health care providers - include the topics of statutes of limitations, "screening panels" for medical liability claims, damages in contract cases, punitive damages, wrongful termination of employment, joint & several liability, ceilings

on non-economic damages, elimination of duplicate payment of damages, periodic payment of future damages, and so on.

Provisions of this legislation and other separate legislation was directed at the necessary trade-offs in terms of benefits to and protection of Montana citizens from legislative efforts that might otherwise have just focused on the needs of health care providers or other businesses. In the medical liability area, changes were made in the reporting of data on claims, required reporting of medical malpractice incidents, non-binding resolution of medical malpractice claims at no cost to the patients to obtain all medical records and have their claim heard by panels of attorneys and health care providers, and so on.

At previous legislative sessions, representations were made as to the impact of the solutions on the cost and affordability of business liability insurance - including professional liability insurance - or other benefits from the legislation. Some of those legislative measures have received judicial attention and have accordingly been modified or not modified, depending upon the court case.

Major Questions posed as to Previous and Possible Future Legislative Measures or Changes to Existing Legislation in Montana

Have those legislative solutions fully or partially resolved the question of the cost and availability of business liability insurance and eliminated concerns about adverse impacts on consumers? What has been - since those measures were enacted - the response of insurance carriers to that legislation, in terms of the costs of insurance and its availability? What does the future hold? By *comparison*, in those states that didn't enact such legislation or enacted different and more legislation, what has been the experience in those states, both in terms of the cost and the availability of medical liability insurance? What additional or different legislation in Montana - affecting either the litigation system or the insurance system - would either ameliorate current circumstances or avoid the impact of probable adverse future consequences from not addressing the issues? What scientific studies have determined the type and nature of legislation that effectively addresses the problems posed? Are there modifications to existing legislation that would and could meet the recommended action? What are the consequences of doing nothing? Is a restriction in the availability of access to appropriate health care and the cost of that care a current or looming issue in Montana vis-à-vis the cost and availability of professional liability insurance?

The Emergence of Problems in Other States

Of late, there are strong indications of a major crisis in many states in the area of the cost and availability of professional liability insurance and the impact on medical consumers as to the cost and availability of medical services.

There are reports that medical liability insurance rates are rising rapidly in certain parts of the country. The increase has had its greatest impact on the physicians practicing in West Virginia and Pennsylvania. For example, physicians in West Virginia have reported a 150% increase in their rates over the past year and a half. Insurance companies have requested huge increases in premium rates, in some states as great as 70 percent.

In June 2002 the American Medical Association released a 50 state analysis that expressed the view that the medical liability issue has reached "crisis" proportions in 12 states, with more than 30 other states seeing problem signs. The 12 states were: Florida,

Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia.

One response in many of those states has been the limitation of medical practices and early retirement, causing a reduction in the availability of health care to the citizens of those states, especially in rural areas. The problem is real in terms of its impact on the people in those states, leaving the questions that remain for Montana.

The closest example to home involving a different response took place in July 2002. The University of Nevada Medical Center closed its trauma center in Las Vegas for ten days - on the basis that liability insurance premiums had increased sharply, some as much as from $40,000 to $200,000 - only re-opening when surgeons became county employees for a time.

The reaction of the special legislative session in August 2002 was to cap on damages for pain and suffering at $350,000, with some exceptions. To get very specific, is this at all comparable to Montana's circumstance, either now or on the horizon? Montana has a cap on non-economic damages like pain and suffering. Has it worked? Have the insurance carriers built the known probable impacts from the legislation into their rates, and if not, why not, and given that piece of legislation and other legislation on the books, how does Montana compare to the states that are listed above?

Major Questions Posed as to the Specific Montana Facts

Without engaging in a blame game or unproductive finger-pointing exercise, what are the *comparative facts* where there is an apparent crisis involving the cost and availability of medical malpractice insurance, with those facts concerning:

- The historical & projected cost of professional liability insurance on a statewide, urban-rural, & type of practice basis?
- The historical and projected number and rate (number per 100 health care providers) of medical malpractice claims, both in terms of resolution with and without a lawsuit?
- The concentration or non-concentration of those claims by geographic area, medical specialty, or a specific limited number of health care providers that skew the result?
- The results of those claims, either by way of settlement or the dropping of those claims prior to or at the Montana Medical Legal Panel - through which most claims progress - and thereafter by settlement or the dropping of claims or a verdict or decision in court?
- The payouts from professional liability insurance carriers & the size and range of settlements and jury verdicts?
- As to Montana specifically, what are:
    - The limits, if any, on the availability of professional liability insurance?
    - The specific historical, current and projected cost of professional liability insurance, by carrier and type of health care provider?
    - The current reserving policies, and current and historical investment returns & costs of professional liability carriers?

While many of the above matters seem formidable, there is a wealth of available data and information from previous interim legislative committee work that is in need of update, which can be provided by those interested in or disinterested in legislative change, avoiding the re-invention of the wheel.

ISSUE 4: REIMBURSEMENT & COMPENSATION

The ability to attract and retain a qualified health care/human services workforce in both the public and private sector in Montana is directly related to the wages and benefits paid to these individuals. The ability to pay adequate wages and benefits is directly related to the reimbursement health care/human services providers receive from public and private funding sources for providing care. While private funding sources (health insurance) have become increasingly cost conscious, these payers generally cover the cost of care. Public programs (Medicaid, Medicare) generally do not. When government programs do not pay the full cost of health care, providers must shift the losses onto other private payers. With the advent of managed care, this is more difficult to do. For some providers, there simply is no private payer to pick up the shortfall.

Private practitioners may have flexibility to apportion a fixed percent of their business to Medicaid or Medicare in order to sustain their businesses. This, in effect, restricts access to services for those people covered by these programs. Other providers, such as hospitals, must serve everyone. Public funding sources account for only about 10% of hospital revenue. Nursing homes, however, are dependent on public funds, Medicaid (for 60% of days of care) and Medicare.[29] Hence, nursing homes and similar services, especially direct care services, are particularly sensitive to the adequacy of reimbursement provided through the Medicare and Medicaid programs.

Proposal #11: Policy makers should ensure that public health and health-related human services funding sources pay the *full* cost of providing services, including the cost of staffing and training and of adequate wages and benefits paid to the workers providing the care.

Recommended Action: The Governor should designate, as a high priority, funding the full cost of providing publicly funded health and human services, including the cost of an equitable and adequate wage and benefit package for public and private sector workers, when developing Executive Budget proposals for presentation to the 2003 and future legislatures.

Recommended Action: The Task Force will write a letter to President Bush and the members of Montana's Congressional delegation encouraging them to take action to ensure that federal health and human services programs fund the full cost of providing care, including an adequate wage and benefits package for direct care workers.

Recommended Action: The Governor should require the Department of Public Health & Human Services to prepare and publish a periodic analysis of the state's health and human services provider reimbursement systems. The purpose of this

[29] Source: Montana Department of Public Health & Human Services, Senior & Long Term Care Division.

analysis is to clarify for policy makers and the public the direct relationship between reimbursement systems and provider viability, including staffing patterns. The analysis should identify the following information for each major service:

- **the cost of providing the service;**
- **the percent of the cost that is reimbursed by the department;**
- **the average wage and benefits paid to workers providing direct care;**
- **the percentage of the service that is paid for by each different source of payment; and**
- **a measure of the difficulty of recruiting and retaining workers to provide the service.**

Discussion: The failure of Medicare and Medicaid to pay the full cost of providing care, then, is a direct cause of a number of negative outcomes, including: a shift of those costs to private purchasers of services, where they exist; a reduction in the number of organizations or individuals providing services; the loss of access to care for vulnerable recipients; and an overall deterioration of the quality of care.

Publicly funded health care/human services programs have a responsibility to Montana's fragile health care system to provide reimbursement that reflects the full cost of delivering the services, including the cost of the wages and benefits necessary to attract and retain a high quality workforce. Montana does not have adequate capacity to absorb the shortfall in the system created by these programs. The alternative is an end to the services in Montana.

Proposal #12: The Governor should ensure that Montana pursues, and when possible takes advantage of, all public and private sources of additional funding or resources to help attract, train and retain health care and human services workers.

Recommended Action: The Governor, working with the private sector, should create or designate a single private foundation/organization to act as catalyst to secure any available public or private grants or other sources of funding which will aide the state in addressing the health care/human services workforce shortage, and, with her cabinet, provide strong and active support for such efforts.

Recommended Action: The Governor should require the Department of Public Health & Human Services to prepare a written analysis of creative funding mechanisms, such as Medicaid Intergovernmental Transfers or service provider utilization fees, and make recommendations regarding their potential for use as a source of additional funding to address the health care/human services workforce shortage.

Recommended Action: The Governor should direct the Department of Public Health & Human Services to explore all avenues to increase funding for health care, including: maximize use of federal matching funds; assure Medicaid provider rates are sufficient to meet standards and regulations; develop state and community tax-free loan forgiveness programs for instate service; access private grants; seek private funds for internships, regulatory issues and pilots; seek greater federal appropriations.

Recommended Action: The Governor should direct the Department of Public Health & Human Services to develop a formal mechanism to process J-1 Visa Waivers.

Discussion: Lack of resources hinders Montana's ability to attract, train and retain sufficient numbers of high quality health care workers. Hiring sufficient staff to avoid burnout means spending more money. Better compensation for health care workers costs money. Providing more training and staff development also has a cost. Training and equipment to safeguard against work place injuries and illnesses add to cost. Each component of the problem has a financial cost. While this Report has sought and suggested other measures besides funding to end the dearth of health care/human services workers, the fact remains that under-funding health care/human services contributes to the problem. Adequate funding will enable solutions. Any discussion of money also needs to include the realization that the Medicare and Medicaid programs have traditionally under-funded provider rates.

A workplace environment that results in better staff retention, provider retention and quality patient care is unlikely in many residential facilities and community-based programs without additional resources.

For this reason all possible sources of private and public funding should be explored. Additional funding for health care/human services for public education, worker education and training, and increased worker wages and benefits would be of great value to our state. Obviously the intense competition for existing state funds makes additional state resources difficult at best, if not altogether unlikely. As other states, private industry and the federal government grapple with these same workforce issues, more sources of private and public funding, or creative ways to use existing funding mechanisms, may well develop. It is crucial that Montana be aware of new funding sources and methods and aggressively pursue them when appropriate.

Montana state agencies and private individuals have shown much ingenuity over the years in accessing and maximizing funding opportunities. However, active support and encouragement is necessary to foster an environment of innovation.

In addition, support is needed to implement a program to assist with the state's recruitment efforts for those underserved areas in our state that are not successful in recruiting a U.S. born physician. In past years, Montana has relied on the U.S. Department of Agriculture (USDA) program for requesting J-1 Visa Waivers for International Medical Graduates. The USDA no longer participates in the waiver program, leaving states with the responsibility to step into the role formerly filled by the USDA.

ISSUE 5: HEALTH CARE WORKFORCE DATA COLLECTION AND ANALYSIS

Several issues emerged as the Task Force went about its inquiry. Most relate to the inadequacy of the data, the data sources, or the processes for gathering data. No single comprehensive source exists for health care/human services workforce data collection. Various professional organizations and state agencies gather information and survey members capturing different data elements for differing time periods. The most comprehensive workforce information, the statewide *Job Projections for Montana's Industries and Occupations, 1998-2008,* published in March 2001, lags the current market by a considerable amount of time. Data published about nursing professions, for example, did not seem to capture what is really going on in the workplace today.

Proposal #13: To enable government, employers, trainers and educators to plan for workforce supply and demand, the Governor should direct the Department of Labor & Industry to work with its federal counterparts to provide reliable, timely, consistent information that is regularly evaluated and updated.

> **Recommended Action: The Department of Labor & Industry (DLI) is commended for the comprehensive nature of the *Job Projections for Montana Industries and Occupations 1998-2008* and urged to expedite publication of subsequent reports with posting on the Web immediately and hard-copy publication as feasible.**
>
> **Recommended Action: Given the changeability of health care/human services supply and demand cycles presently, the Department of Labor & Industry should organize special research studies focused on areas of greatest need in health care and related human services over the next few years.**

Discussion: Task Force members inquiring about the status of *Job Projections* learned that it is funded from the U.S. Department of Labor and is renewed and republished biennially. According to the Department of Labor & Industry, publication of the 1998-2008 information was significantly delayed by the federal government, and work on an update is now underway. This update is slated for completion by the end of 2002, at which time another publication covering the period 2000-2010 will be released.

Proposal #14: The Governor should direct the Department of Labor & Industry to take the lead as a high priority to improve the condition of data resources across the professions in view of the interest in workforce and economic development issues.

Recommended Action: The Department of Labor & Industry should convene representatives of all State offices charged with licensure or certification of health care professionals to:

1) **develop recommendations for a common set of data elements to be collected regularly from all applicants and practitioners in all health care/human services fields; and**
2) **recommend items for a standard survey and standard definitions to be used by all licensure offices to collect workforce planning and employment information on a regular basis, and a cycle for administration of said survey.**

Recommended Action: The Department of Labor & Industry is urged to set a *regular* cycle for administration of surveys to update workforce information in the various health care/human services fields; assign an analyst to design the surveys and oversee administration of the first few; and task the analyst to design the database, oversee data entry, and organize information into a report on changing supply-demand and other workforce conditions in each field.

Recommended Action: To aid DLI and professional organizations in workforce planning, the Task Force suggests that the Office of the Commissioner of Higher Education (OCHE) publish annually the degree completions for the health care/human services professions and those programs contracted with out-of-state institutions.

Discussion: In addition to the biennial updates of *Job Projections,* DLI will pursue another research study funded by the U.S. Department of Labor in the off years. This study will focus on designated Metropolitan Statistical Areas and give county labor market conditions in Yellowstone, Missoula and Cascade counties. Here again, timely and statewide dissemination of information for planners and others will be essential.

The Task Force is grateful to the professional associations and others who provided data and information for its work. These studies included membership surveys ranging from informal to scientific, so the Task Force cannot "certify" results uniformly. However, this does point to another problem in data collection—that data quality and consistency are widely variable across the professions. In the case of speech pathology and audiology, members were advised that the state licensing office did not collect licensees' ages. This is a critical piece of information for workforce planning.

From these Report recommendations, DLI could establish a single database model and survey format to be adopted by all offices licensing health care practitioners. This would permit these offices to maintain and update fundamental demographic information about practitioners that is essential in workforce projections and planning as well as in oversight functions.

Such reports would serve as "official" information for state planning and avoid the methodological problems inherent in non-standard approaches. The updates should be posted on the DLI Web site and disseminated statewide. The health care fields for which the Task Force could not find data would be an excellent starting point for survey

administration under the model suggested and a good way to test the validity of the data selection and survey design.

For comprehensive workforce planning, it is necessary that planners be informed about program productivity at all levels of higher education in the state and in the contracted programs for the preparation of health care professionals through WICHE, WWAMI and University of Minnesota.

Proposal #15: The Office of the Commissioner of Higher Education (OCHE), in collaboration with health care program providers, should assess and report on the program capacity of Montana's higher education system to meet health care/human services workforce needs.

Recommended Action: The Task Force recommends that OCHE conduct an assessment of capacity for all relevant health care programs (Table 3 + physicians assistant) offered in the state and to report this information to the Department of Labor & Industry or such other entities as will be charged with guiding state initiatives augmenting the state health care/human services workforce.

Recommended Action: In addition to the above, the Task Force recommends that OCHE investigate whether the current capacity of high-demand programs offered in Montana could be increased through alternate scheduling, distance delivery, emphasis on non-traditional students, or other non-traditional means. A report on possibilities available should be made available to state planners and DLI.

Recommended Action: The Task Force recommends that OCHE investigate the cost and feasibility of each option above and to prepare recommendations to the appropriate state offices about how Montana can meet its short-term workforce needs.

Recommended Action: For projected high-demand fields where the state now has *no* programs or agreements to ensure a continuing supply of practitioners, the Task Force recommends that OCHE and the appropriate state agencies and legislative committees work together to cost options and make recommendations to the 2003 Legislature about ways to forestall a crisis in these fields.

Recommended Action: The Commissioner of Higher Education, in coordination with health care professionals and employers, should evaluate the efficacy of existing funding resources, including Western Undergraduate Exchange (WUE), and seek additional WWAMI, WICHE and Minnesota dental slots for Montana residents.

Discussion: The Subcommittee's investigations revealed several health care/human services fields where there are projected to be large increases in demand for qualified professionals. There are different circumstances surrounding clusters of professions. The recommended actions are designed to address the circumstances generally rather than specific programs.

First, data suggest sufficient capacity in some existing programs offered by Montana institutions even though the current programs are not producing as many graduates as needed.

Second, it is already clear that some strategies or programs now in place will not yield sufficient numbers of qualified professionals to meet State needs in the next decade: for example, dentistry. There are several strategies that could be invoked to recruit and retain more dentists in the State:

- increase the number of slots and funding allotted to dentistry in the WICHE and the Minnesota programs;
- explore the creation of other, similar contract arrangements with other dental schools;
- identify a source of funding that would permit creation of an educational loan-reduction program on the model of MRPIP for dentistry; and
- identify other effective strategies for recruiting and retaining in Montana more health care professionals in high-need fields of practice.

Third, there are health care fields where Montana is likely to experience an increasingly severe workforce shortage, but there are no in-state programs or out-of-state access agreements for training in the field: for example, speech pathology and audiology. Here, it is important for the state to take measures now, either to establish programs at Montana institutions or to enable Montanans to acquire the training that would enable them to take up positions across the state in schools, hospitals and other facilities needing this expertise. In speech pathology and audiology, for example, there are more than 200 practitioners employed in public schools across the state, many of whom are reaching retirement age with no clear strategy for their replacement.

CONCLUSION: The Task Force believes that opportunity exists for Montana to successfully address the health care/human services workforce shortage. Montana has unique attributes and strengths, including:

- strong education system;
- excellent foundation of health care providers;
- responsive government leaders;
- underlying commitment to quality health care for citizens;
- educated, productive workforce;
- active citizen participation in decision-making; and
- quality lifestyle and unsurpassed scenery.

The proposals in this report are intended to put these qualities to work for the benefit of Montana's health care/human services system.

PART 3
WORKFORCE DATA

The Data Subcommittee of the Governor's Task Force on Health Care Workforce Shortages worked to identify suitable data sources, analyses and projections for health care professions in the state and to use this data to set a framework for workforce and educational planning. The Subcommittee contacted professional associations, licensing boards, accrediting agencies, state agencies, and the Department of Labor and Industry to solicit information. State publications'[30] projections, in members' judgment, lag the current market too much to comport with actual conditions in some sectors of the state's health care industry—hospitals, long-term care facilities, Indian Health Service. The Subcommittee sought other data sources such as surveys and/or national reports whose findings could be applied to Montana.

One important source of information is the Western Interstate Commission for Higher Education (WICHE) *Workforce Brief* for Montana. Published in November 2001, the *Brief* identifies 30 fastest growing professional fields expected in the period 1998-2008. Among these are four health-related occupations: occupational therapists, physical therapists, medical scientists, and health diagnostics instructors.

MONTANA DEMOGRAPHICS

For the foreseeable future, Montana's health care workforce needs will be shaped by the state's atypical demographics. The state's population will grow slowly in the next 25 years, but the proportion of individuals over 65 will grow more quickly and continue to exceed the national average. This segment is expected to double from 121,000 (13.4%) in 2000 to about 241,000 (21%) of state population by 2025. An increasingly aging population in a largely rural setting will pose many complex challenges to health care providers.

Combined with the factors of an aging population and rural environment, other factors come into play and shape workforce projections. As the population ages, the expected life span increases. Further, the decade 1998-2008 marks the entry of Baby Boomers into middle age and retirement. As a result, some health professions are projected to grow substantially in both Montana and the country.

	MT	US
Registered Nurses	+19%	+22%
Physical Therapists	+26%	+34%
Physician Assistants	+50%	+48%
Physicians	+24%	+21%
Occupational Therapists	+23%	+34%

[30] Montana Department of Labor and Industry, *Job Projections for Montana's Industries and Occupations, 1998-2008,* March 2001.

Montana Department of Labor and Industry, *Montana Informational Wage Rates by Occupation for 1999,* June 2001.

EDUCATIONAL OUTCOMES

To meet the state's health care workforce needs, higher education offers many programs of study ranging from certificates through doctorates. "The Health Professions and Related Clinical Sciences Degree Completions 10-Year Trend for the State of Montana" (Table 3) documents degrees awarded in these fields by all Montana post-secondary institutions over the past decade. The data suggest that there is presently a margin of unused capacity across institutions and programs, a resource to be tapped in responding to particular health care workforce needs.

Table 3: Health Professions and Related Clinical Sciences Degree Completions
10 Year Trend for the State of Montana

CIP	Field of Study	Degree	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	Total
DOCTORATE DEGREES													
42.0101	Psychology	PhD	7	5	10	7	4	7	10	10	4	7	71
51.2003	Medical Pharmacology & Pharmaceutical Sci	PhD	0	0	0	0	0	0	0	2	1	2	5
MASTERS DEGREES													
13.1314	Health & Human Perf. (Health Promotion)	MS	13	15	16	6	5	10	9	9	13	5	101
19.0101	Health & Human Dev. (Health/Exercise/Wellness)	MS	9	9	6	5	19	21	11	13	22	20	135
42.0101	Psychology	MA	9	6	35	18	7	11	9	13	9	7	124
51.0701	Health Administration	MHA	0	0	0	0	0	0	0	0	18	20	38
51.1601	Nursing (RN)	MS/MSN	0	6	9	5	14	14	6	5	12	10	81
51.2001	Pharmacy	PharmD	1	2	1	3	2	0	3	4	2	1	19
51.2206	Industrial Hygiene	MN	0	0	0	8	6	11	8	5	8	9	55
51.2308	Physical Therapy	MS	0	0	0	0	0	0	0	0	26	30	56
51.2399	Rehabilitation & Related Services	MSRC	0	0	0	0	0	0	0	0	5	7	12
BACHELOR DEGREES													
13.1314	Health & Human Perf. (Health Studies + others)	BSHHP	104	101	130	98	72	99	82	101	77	85	949
19.0101	Health & Human Dev. (Pre-physical Therapy)	BS	3	1	1	1	48	51	60	54	119	115	453
26.0501	Microbiology (Medical Lab Science + others)	BS	29	31	29	23	33	54	50	54	54	44	401
42.0101	Psychology	BA	129	146	313	148	175	227	188	175	182	188	1871
44.0701	Social Work	BA	56	62	74	68	62	80	55	48	58	42	605
51.0701	Health Administration	BS	0	6	4	3	3	9	1	0	4	3	33
51.1005	Medical Technology	BA	22	18	25	23	14	7	11	6	6	12	144
51.1199	Preprofessional Health Sciences	BS	0	0	11	16	0	0	0	0	0	0	27
51.1601	Nursing (RN)	BA/BSN	154	119	165	159	141	130	129	141	156	142	1436
51.2001	Pharmacy	Bpharm	39	44	48	52	52	56	24	30	30	33	408
51.2206	Industrial Hygiene	BS	0	0	0	0	29	22	34	20	32	21	158
51.2308	Physical Therapy	BS	18	20	21	19	19	26	24	7	1	0	155
51.2399	Rehabilitation & Related Services	BSRRS	11	0	0	0	0	0	0	0	4	1	16
ASSOCIATE DEGREES													
42.0101	Psychology	AAS	2	1	3	5	6	8	0	0	0	0	25
44.0701	Social Work	AAS	19	22	47	15	29	24	32	26	31	20	265
51.0707	Health & Information Technology	AAS	0	0	2	3	4	18	18	9	11	13	78
51.0601	Dental Assistant	AAS	4	1	2	3	5	3	3	4	1	2	28
51.0801	Medical Assistant	AAS	1	4	9	9	6	11	10	15	7	15	87
51.0805	Pharmacy Technology	AAS	0	0	0	0	0	0	0	1	0	0	1
51.0806	Physical Therapist Assistant	AAS	0	0	0	0	0	0	17	11	13	6	47
51.0904	Emergency Medical Tech-Paramedic	AAS	0	0	0	0	0	0	0	1	3	6	10
51.0908	Respiratory Care	AAS	13	15	13	10	11	9	13	9	11	21	125
51.1199	Preprofessional Health Sciences	AAS	0	0	0	0	0	2	10	8	7	10	37
51.1501	Chemical Dependency Counseling	AAS	15	8	12	9	16	12	19	19	17	7	134
51.1601	Nursing (RN)	AS/AAS	102	104	114	122	94	99	94	86	89	121	1025
51.1613	Nursing (LPN)	AAS	0	0	0	0	0	0	0	18	48	62	128
52.0101	Medical Administrative Assistant	AAS	26	27	37	27	34	40	27	23	41	25	307
52.0401	Office Technology (Med Office Specialist)	AAS	68	44	32	29	25	28	26	29	62	43	386
52.0404	Medical Office Tech (Medical Office Spec.)	AAS	63	46	62	62	26	38	62	36	46	28	469
51.1004	Medical Laboratory Technology	AS	0	0	0	0	0	0	7	6	10	6	29
CERTIFICATES													
51.0601	Dental Assistant	C	24	18	25	26	29	29	24	8	19	15	217
51.0908	Respiratory Care	C	22	23	21	12	12	11	22	10	12	0	145
51.0909	Surgical Technology	C	11	13	12	10	0	0	15	12	12	13	98
51.1613	Nursing (LPN)	C	204	150	145	144	87	108	151	59	67	42	1157
51.1614	Nurse Assistant (CNA)	C	57	45	19	34	1	2	1	1	0	1	161
51.0805	Pharmacy Technology	C	0	0	0	0	0	0	7	7	8	7	29
52.0404	Medical Reception/Receptionist	C	13	8	5	2	12	7	6	3	2	4	62
51.0904	Emergency Medical Tech-Paramedic	C	55	0	15	21	20	0	0	0	11	6	128

New programs not reported on are BS in Health Care Informatics, AAS in Dental Hygiene, AAS Dental Receptionist, AAS in Health Administration, and AAS in Surgical Technology.

To attract and retain physicians in rural Montana, the Montana Legislature approved in 1991 a special strategy--the Montana Rural Physician Incentive Program (MRPIP)--which is intended to encourage primary care physicians to practice in medically underserved areas of rural Montana. Participation in the program requires a joint application from an individual physician and the community health care organization(s) that want to retain/recruit professionals. MRPIP awards up to $45,000 in medical education loan repayments for the physician at six-month intervals over a one-to five-year period of service.

Since the inception of the program in 1993, 61 applications have been submitted of which 49 have been approved, and 4 are currently pending review/approval. The table below illustrates the status of all applications.

Table 4: MRPIP Allocation Summary

Status	No. of Physicians
Currently In Loan Repayment	19
Completed Loan Repayment	15
MRPIP Approved—All Debt Repaid Under Federal Loan Repayment Program	5
Pending Federal Loan Repayment Participation	1
Received Partial Loan Repayment/Withdrew	6
Withdrew	3
Pending Review/Approval	4
Denied	8
TOTAL	**61**

Current data reflect an 85% retention rate of the physicians who have completed loan repayment under the MRPIP. Overall, 41 of the 49 approved physicians are currently practicing in Montana, or 84%. This model may serve to recruit and retain specialists in other health care professions according to state needs. The communities served by MRPIP physicians are identified below:

Table 5: MRPIP Communities Served

CITY/TOWN	COUNTY	CITY/TOWN	COUNTY
Anaconda	Deer Lodge County	Harlowton	Wheatland County
Big Timber	Sweet Grass County	Havre	Hill County
Chester	Liberty County	Lewistown	Fergus County
Chinook	Blaine County	Livingston	Park County
Columbus	Stillwater County	Miles City	Custer County
Culbertson	Roosevelt County	Plains	Sanders County
Deer Lodge	Powell County	Plentywood	Sheridan County
Dillon	Beaverhead County	Polson	Lake County
Ennis	Madison County	Scobey	Daniels County
Forsyth	Rosebud County	Shelby	Toole County
Glasgow	Valley County	Sidney	Richland County
Glendive	Dawson County	Superior	Mineral County
Hamilton	Ravalli County	Stevensville	Ravalli County

HEALTH CARE PROFESSIONS OVERVIEW

Nursing

Registered Nurses: With 9,811 active Registered Nurses (RNs) in 2001, Montana's ratio of 812 RNs per 100,000, population is slightly better than the national average of 782 per 100,000 (2000). Nevertheless, several factors combine to suggest that the state faces difficulties in RN staffing:

- an aging RN population with 40% of RNs reaching age 50 in the next 10 years;
- a relatively non-competitive wage;
- growing RN vacancy and turnover rates, especially in rural settings; and
- the increasing number of RNs seeking employment outside of the state.

Hospitals report a 16.9% turnover rate for RN's and a 2.4% vacancy rate. Further, the vacancy rate for all nursing staff is 8.8% with a 20.9% turnover rate, but the vacancy rate for rural nurses is 16.9%. Long-term care facilities saw an increase in recruiting between 1999 and 2001. RN vacancies increased from 82 to 122. The Indian Health Services reported different vacancy rates from the beginning to the end of 2001 from 9% in January to 16% in December, with affiliated hospitals reporting 7% vacancy in January and 18% in December. Similar increases in RN vacancy rates occurred in ambulatory care and administrative/education.

Figure 4

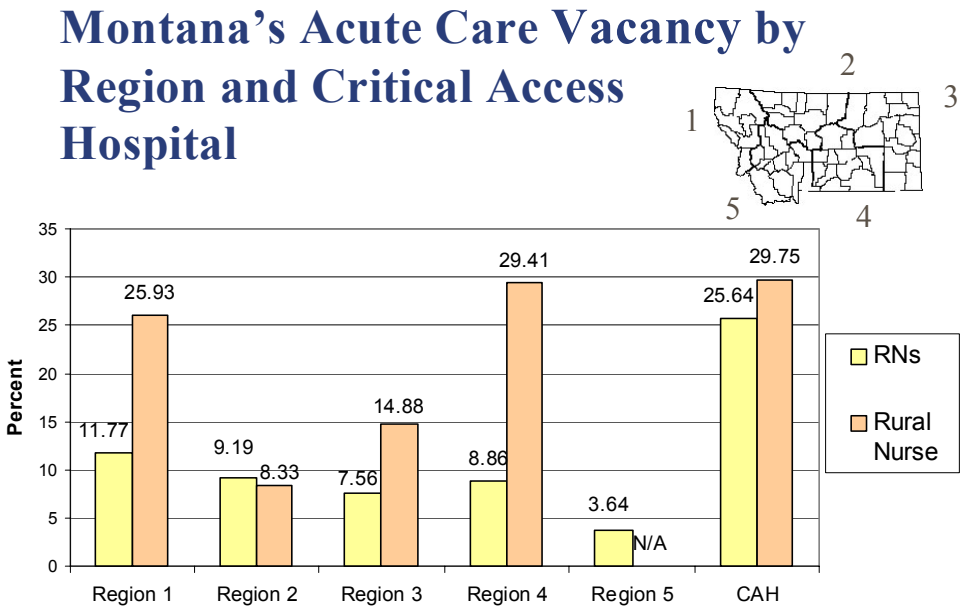
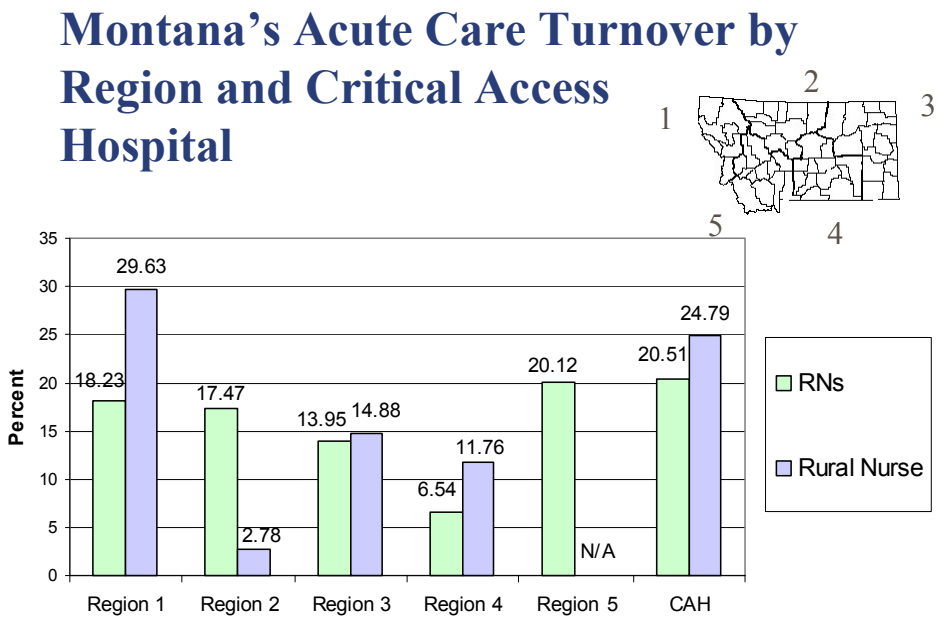


Figure 5



Hospitals and other employers use many strategies to secure RN services: traveling nurses (40.9%), overtime (72.7%), temporary agencies (34%), and on-call (45.5%). Employment projections (1998-2008) show RN positions increasing by 21.7% nationally and by 19% in Montana. All neighboring states expect RN positions to increase more than 15% over the decade, and several have identified RN's as top priority in occupational growth. To address the projected shortages, several strategies are now in place:

- Montana Initiative for Nursing Transformation aims to address educational mobility for nurses through articulating competencies to each level of education;
- Nurse Education Loan Repayment Program pays 60% of qualifying loans for 2 years (42 participants);
- online degree programs including a BSN completion program from MSU-Northern and MAPP (Mountain and Plains Project) for RN's in rural areas;
- Registered Nurse refresher course offered by MSU-Northern at Havre, Great Falls and Lewistown campuses; and
- MSU-Bozeman is offering junior and senior nursing courses in the Flathead Valley beginning January 2003 as an extension of their Missoula campus.

Licensed Practical Nurses: Apart from the Montana Health Care Association Staffing Survey and Department of Labor & Industry report, the Subcommittee did not locate data on Licensed Practical Nurse (LPN) needs. In long-term care facilities, 65% of institutions reported active recruiting for LPNs up from only 45% in 1999; vacancies increased from 83 to 114. According to the Labor and Industry projections, there will be a 17.3% growth in LPN positions between 1998 and 2008.

Advanced Practice Registered Nurse: Advanced Practice Registered Nurses (APRNs) are registered nurses with Masters preparation who are clinical nurse specialists (CNS), nurse anesthetists (CRNA), midwives (CNM) and nurse practitioners (NP). State regulations require APRNs to be nationally certified and recognized by the Montana State Board of Nursing.

As APRNs, they can receive third party reimbursement for covered services and apply for prescriptive authority. They provide care to Montanans in both rural and urban areas, in clinics and hospitals. APRNs provide mental health services in private and public practice, OB care for pregnant families, anesthesia services in rural and urban hospitals, primary health care for individuals and families in clinics, critical access facilities and tribal health services. In parts of Montana, APRNs provide the only health care services available, and without those services, some critical access hospitals, clinics, nursing homes and/or pharmacies would close. As we contemplate the projected shortage of primary care providers in Montana, these providers will assist in alleviating this shortage.

Montana State University-Bozeman is the only nursing graduate program in the state. It currently prepares family nurse practitioners (FNP) and is developing plans to prepare clinical nurse specialists in acute and chronic care of the ill adult and in community health.

The FNP program began in 1995 and has prepared 61 FNPs to provide primary health care with an emphasis on rural health care needs. More than 80% of those graduates practice in Montana. This program is a five semester in-state distance-learning program that uses interactive video technology, web-based technology and face-to-face learning. They have a capacity of 12 FNP students per year. Students are able to gain clinical experience in a community where the College of Nursing campuses are located or in communities near one of the campuses and the student's home.

Higher education production of nursing degrees and certificates for the last 10 years appears in Table 6:

Table 6: Nursing Degrees/Certificates in Montana 1991-2001

Field of Study	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	Total
MSN Nursing	0	6	9	5	14	14	6	5	12	10	81
BSN Nursing (RN)	154	119	165	159	141	130	129	141	156	142	1436
BS Nursing (Post-RN)	0	0	0	8	11	23	11	26	0	0	79
AS Nursing (RN)	102	104	114	122	94	99	94	86	81	*100	996
AAS Nursing (LPN)	0	0	0	0	0	0	0	18	48	62	128
Certificate Nursing (LPN)	204	150	145	144	87	108	151	59	67	42	1157
Certificate Nurse Assts (CNA)**	57	45	19	34	1	2	1	1	0	1	161

**17 ASN degrees at Montana Tech not reported in IPEDS 00-01.*

***Majority of CNAs are trained outside the Higher Education system, by nursing homes, high schools, and technical schools.*

The following summarizes the **Nursing Licenses** issued by the Montana Board of Nursing for the year 1995 through 2000.

Table 7. Nursing Licenses in Montana 1995-2000

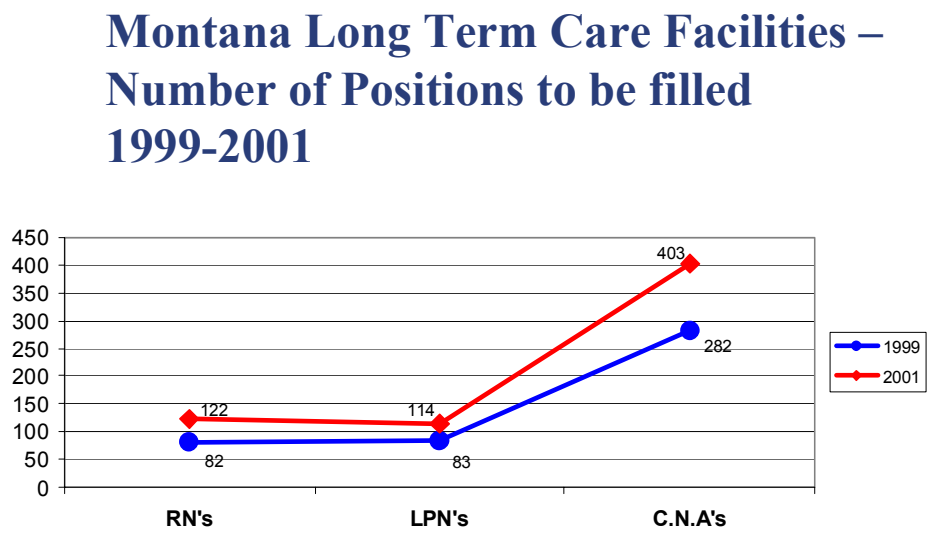
PROFESSION	1995	1996	1997	1998	1999	2000
REGISTERED NURSES						
Total Active Licenses	10026	10222	10300	10495	10215	10834
New Licenses by Endorsement	355	334	287	390	416	548
New Licenses by Examination	325	279	215	252	249	456
Residing Out of State					1677	1698
In State Unemployed & Not Employed in Nursing					4054	1394
LICENSED PRACTICAL NURSES						
Total Active Licenses	3464	3424	3438	3469	3223	3385
New Licenses by Endorsement	45	56	50	68	55	106
New Licenses by Examination	114	119	115	124	108	198
Residing Out of State					242	248
In State Unemployed & Not Employed in Nursing					541	493
ADVANCED PRACTICE REGISTERED NURSES						
Nurse Anesthetist	134	143	123	130	132	135
Nurse Midwife	26	26	27	31	33	38
Nurse Practitioner	203	212	240	256	273	313
Clinical Nurse Specialist	11	13	17	22	26	28
Prescriptive Authority	27%	37%	45%	46%	49%	55%
VERIFICATIONS						
Number of Verifications for Nurses Leaving Montana	91	100	479	517	820	731

Source: Montana Board of Nursing

In a survey of long term care facilities conducted in October 2001 by the Montana Health Care Association, responding facilities cited severe shortages in all nursing professions for:

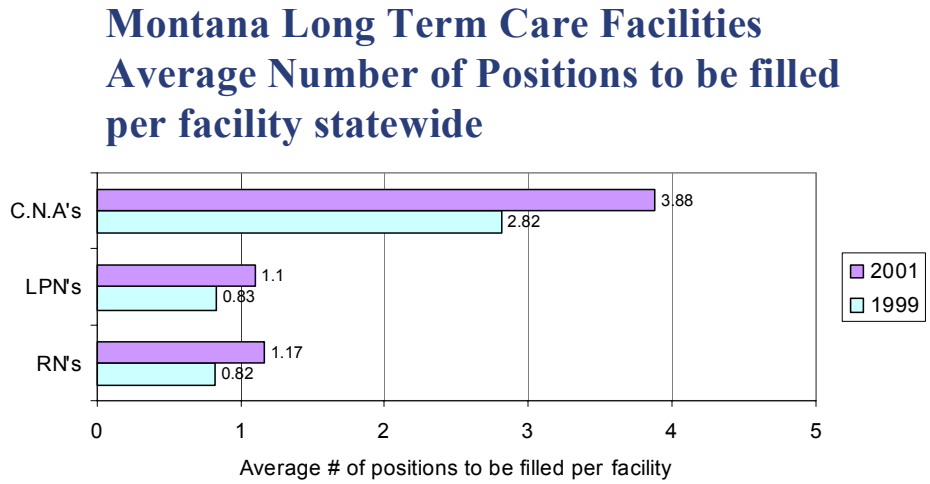
- Registered Nurses, 92% of facilities reported shortage or crisis in availability (52% report crisis);
- Licensed Practical Nurses, 90% of facilities reported shortage or crisis in availability (47% report crisis); and
- Certified Nurse Assistants, 93% of facilities reported shortage or crisis in availability (35% report crisis).

Figure 6



Source: Montana Health Care Association Staffing Survey, participating facilities, Oct. 2001.

Figure 7



Source: Montana Health Care Association Staffing Survey, participating facilities, Oct. 2001 & 1999.

Dentistry

The Montana Dental Association and the Department of Health and Human Services surveyed 482 dentists in 2000. With an 87% response rate, the survey found 477 practicing dentists of whom 26% are age 55 or older and 70% are age 45 or older. Montana's 52 dentists per 100,000 population compares to a national average of 55 per 100,000 and yields a ranking of 23rd nationally, up from 48th in 1998.

Occupational projections for dentists in Montana indicate a 15% increase from 1998 to 2008 against a national increase of only 5.9%. According to Labor and Industry data, annual openings in dentistry will reach 40 with about half attributable to growth. U.S. Department of Labor statistics show national median hourly wage at $64.04 and mean hourly wage at $54.24. The number of dental school graduates has declined sharply and their educational debt load upon graduation had increased to approximately $100,000[31] in 1998.

In view of the above information, it is probably worth repeating the information about the number of Montana students who are supported by state agreements with out-of-state educational providers. The table below shows the number of Montana students who graduated in the past five years under the WICHE and Minnesota contracts. Their numbers are clearly insufficient to meet the projected demand in Montana over the next decade.

Table 8. Montana Dental School Graduates

MT Dental Graduates	96-97	97-98	98-99	99-00	00-01
WICHE Dental	2	1	1	1	2
MN Dental	1	1	1	2	1
Total Dental	3	2	2	3	3

Dental Hygienists And Assistants

According to the Montana Dental Association and the Department of Health and Human Services 2000 survey, nearly 80% of Montana dentists employ dental hygienists as compared to 60% nationally. Some 54% of Montana's dentists perform work that could be done by a hygienist, and 30% of survey respondents indicated a need for more hygienist hours in their practice. State employment projections for dental hygienists show an increase of 38.4% between 1998-2008, second highest in the region after Idaho (56.1%) and slightly above national projections at 36.7%. Montana State University College of Technology at Great Falls has a new dental hygienist program and will graduate the first class in 2004.

With respect to wages, the workforce shortage in Montana may have had the benefit of driving up hourly rates. Montana's median hourly rate of $24.28 and mean hourly rate of $23.77 compare to national averages of $24.68 and $24.99 respectively and fall in the mid-range in the region.

Dental assistants positions are expected to increase by 37.2% between 1998-2008, which is consistent with national projections and second after Idaho (59.8%) in the region.

[31] Source: American Dental Association, HRSA *Workforce 2000.*

State projections indicate an average of 40 vacancies per year over the decade with some 75% occurring due to growth. Dental assistant wages in Montana are low. The median hourly wage of $10.48 and the mean wage of $10.79 fall below the national average of $12.49 and $12.86 respectively and place Montana and Wyoming second from the bottom among seven regional states.

Pharmacists

According to WICHE, the projections for growth in this field are moderate at 7% in the region. Montana Department of Labor and Industry projections for the period 1998 to 2008 show growth in Montana pharmacy occupations of 4% to 15%. Montana is fortunate to have a School of Pharmacy at the University of Montana. However, graduates are heavily recruited and many leave Montana to practice in other states. Degrees produced in the field over the decade appear below:

Table 9: Pharmacy Degrees in Montana 1991-2001

Field of Study	Degree	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	Total
Pharmacy	PharmD*	1	2	1	3	2	0	3	4*	2*	1*	19*
Pharmacy	Bpharm	39	44	48	52	52	56	24	30	30	33	408
Pharmacy Tech	AAS	0	0	0	00	0	0	0	1	0	0	1

**The University of Montana inadvertently left out of federal IPEDs reports for 1998-99, 1999-00, 2000-01 the data for the PharmD degree completions. Graduates with the PharmD numbered 36 in 1998-99, 46 in 1999-00, and 40 in 2000-01. Some students earned both the Bpharm and the PharmD and therefore appear under the counts in both categories.*

It is likely that graduates of this program would be sufficient to fill the average annual openings projected for the decade, if they are not recruited to other states. In 2000, however, Montana Pharmacists' median hourly wage ($30.32) and mean hourly wage ($28.77) were second lowest in the region and lagged the U.S. rates of $34.11 and $33.39 respectively.

Laboratory

Eighty-five percent of the information found in a patient's medical record comes from the clinical laboratory. While the number of laboratorians is much smaller than the numbers in nursing, the impact of a staffing shortage is critical for providing quality health care. In Montana many of the laboratories only staff 2-3 employees and, due to the nature of laboratory work, the workers must work weekends and take call. The loss of one person in the laboratory has a huge impact on the laboratory's ability to provide adequate coverage.

According to an American Hospital Association Survey reported in January 2002 the national vacancy rate for laboratory technicians is 9.5%. Shortages are most severe in rural areas, where the vacancy rate for laboratory technologists averages 12%; in urban areas it is 8%. Half of the Medical Technology programs have been closed in the last 20 years from 638 programs in 1983 to 273 programs in 1999. This resulted in a 53% decrease in the number of graduates, from 5,318 in 1983 to 2,491 in 1999.

The State of Montana currently has only one Medical Technology program open at Benefis Healthcare in Great Falls. This program has the capacity for 4 students per year. The Montana Chapter of Clinical Laboratory Management Association (CLMA) conducted

a real time staffing survey for Medical Technologist the last two weeks of January 2002. A total of 72 laboratories were surveyed through telephone calls. The laboratories were comprised of 54 hospital laboratories, 2 university student health laboratories, 8 Indian Health Service laboratories, 1 state laboratory, 2 independent laboratories and 5 clinic laboratories.

Table 10. Results of Montana CLMA Survey

	# Currently Working	# Openings	% Vacancy	Average Age
MT - Medical Technologist (4 year degree or equivalent)	411	28.25	7%	45
MLT- Medical Laboratory Tech (2 year degree)	47	1	2%	Not Available
Lab Assistant or phlebotomist	160	6	3.4%	Not Available

The reasons given for leaving the positions were better pay/benefits, spouse relocation, retirement, illness and no weekend work. The length of time to recruit for open positions ranged from 2 weeks to 24 months.

Physicians and Surgeons

Job Projections for Montana indicates a 24% increase in practitioners over the decade with average annual openings estimated at 73 positions, combining replacements and growth. *WICHE Briefs* caution, "the number of physicians in training has leveled off and is expected to decline over the next few years." Nevertheless, the expectation is that there will be a growing demand for these professionals nationally. A state like Montana, which is dependent on other states and educational institutions for the preparation of its physicians, may need to take special steps to ensure an adequate supply of physicians to meet its needs. Figure 8 on the following page illustrates the access problems for a large number of Montana counties. Table 11 below shows the state-funded graduates of medical and dental programs for the last several years.

Figure 8. Physicians in Active Practice by County

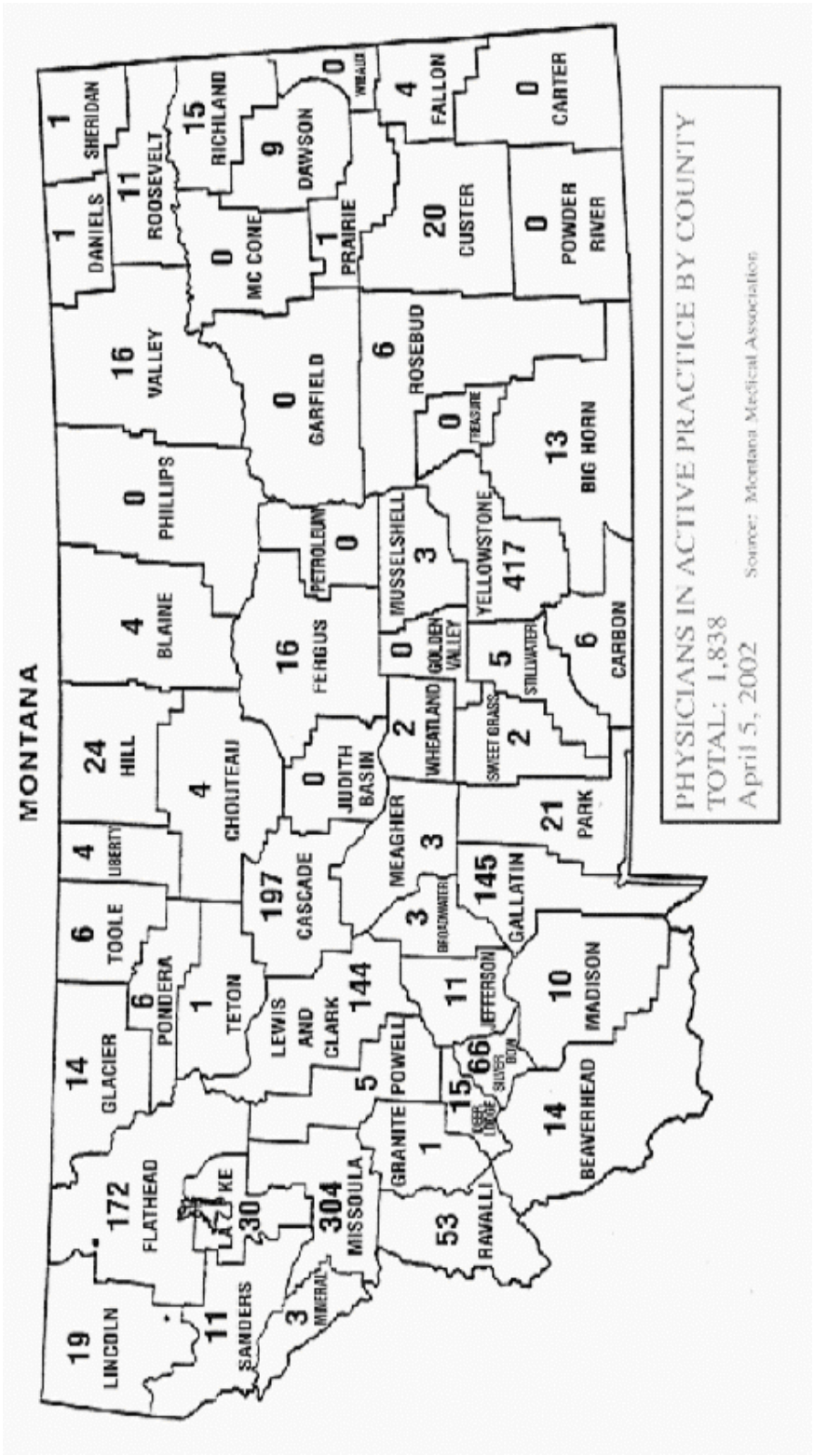


Table 11. Montana WICHE/WWAMI/MN Dental Degrees

Montana WICHE/WWAMI/MN Dental, Medical and Dental Degrees 1996-2001					
Field of Study	**96-97**	**97-98**	**98-99**	**99-00**	**00-01**
WWAMI Medicine	**22**	**16**	**18**	**18**	**26**
WICHE Medicine	**5**	**6**	**5**	**6**	**5**
Total Medicine	**27**	**22**	**23**	**24**	**31**
WICHE Dental	**2**	**1**	**1**	**1**	**2**
MN Dental	**1**	**1**	**1**	**2**	**1**
Total Dental	**3**	**2**	**2**	**3**	**3**

Physician Assistants

This is another health care field where both *Job Projections for Montana* and *WICHE Briefs* indicate a substantially increased demand for the period 1998-2008. From 186 Physician Assistants (PA) in the base year (1998), the workforce is projected to grow by 91 positions or 48.9% by 2008. Entry wages in the base year averaged $21.61 with a mean wage of $26.87. These practitioners work under the license of a physician and can be a mainstay of health care delivery in rural and isolated communities.

Rocky Mountain College offers the only PA educational program in Montana. This program has granted the following bachelor's degrees recently: 1998-99 @ 12 PAs, 1999-2000 @ 21 PAs, and 2000-2001 @ 22 PAs. There are, as well, programs available through the WICHE Professional Student Exchange Program (PSEP) at 10 institutions in the region. Only 21 WICHE students are now enrolled from Arizona and Nevada. Costs per year are projected to increase from $7,200 in FY 03, to $8,500 in FY 04, and to $8,800 in FY 05.

Radiology Technologists

The Montana Hospital Association's (MHA) 2001 Nursing and Allied Health Workforce Shortage Survey reported a 15.8% turnover rate. Both vacancy and turnover rates varied sharply across the five MHA regions ranging from zero to 33%. According to *Job Projections for Montana*, there will be an 18.9% increase in positions in this field 1998-2008. Montana median hourly ($14.29) and mean hourly ($14.63) wages for radiological technologists or technicians lag the U.S. rates of $17.31 and $17.93 respectively. Montana currently has two certificate programs: at Flathead Valley Community College and at University of Montana College of Technology-Missoula.

Respiratory Therapists

In response to the 2001 MHA survey, facilities reported a 10.5% vacancy rate for respiratory therapists and a 24.8% turnover rate. RTs wages are second lowest in the region and lag the U.S. average with a median hourly wage of $15.02 and a mean hourly wage of $15.21. Projected growth of 51.6% over the decade means that respiratory therapists will be in demand. Existing programs of study at the certificate and associate degree levels are likely to see steady enrollments. Degree production in the field is set forth below:

Table 12. Respiratory Degrees

Field of Study	Degree	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	Total
Respiratory Care	AAS	13	15	13	10	11	9	13	9	11	21	125
Respiratory Care	C	22	23	21	12	12	11	22	10	12	0	145

The University of Montana College of Technology Respiratory Care program has been notified that it has been granted initial accreditation from the Commission on Accreditation of Allied Health Education Programs. This status is a public recognition granted to a new program that has adequate plans and resources and has demonstrated that its graduates are likely to achieve established outcome standards.

Speech Pathology and Audiology

According to the Montana Speech and Hearing Association (MSHA), there are currently 298 licensed speech and language pathologists, 42 licensed audiologists, and 13 dually licensed practitioners in Montana. This number falls short of the Department of Labor and Industry base year data which shows 434 positions in 1998 (*Montana Occupational Projections, 1998-2008)* and projects a 29% growth or an average of 13 new positions annually over the decade.

What is certain is that the state has been without a masters program in speech pathology and audiology for 15 years since the University of Montana closed its program during a budget rescission in the mid-1980s. To be licensed to practice in Montana, an individual must hold a masters degree in the field. If the person has not done undergraduate work in the field, the masters degree can extend beyond two years of full-time study. School districts have experienced some difficulty filling positions, and this deficiency was cited in an April 2000 evaluation report from the U.S. Department of Education on the State's compliance with implementation of the Individuals with Disabilities Education Act (IDEA).

According to MSHA officials, all areas of the state are now beginning to experience difficulty in recruiting speech/language personnel. The problem becomes most acute in the rural/remote areas with the eastern portion of the state experiencing the most difficulty. Personnel typically want to locate in or near more populated areas (Great Falls, Billings, Bozeman, Missoula, Kalispell). However, wages play a role as well. When Missoula schools recruited special education personnel Fall 2001, low salaries were the chief reason cited by out-of-state applicants who turned down offers, although the median hourly rate of $21.29 and the mean hourly rate of $22.45 in Montana are not too far away from the national average rates of $22.42 and $23.31 respectively. The speech pathology FTE in Missoula went unfilled into the academic year and was eventually filled by several part-time employees.

The impact of no state program to train practitioners may be complicated by the fact that many in the field are nearing retirement age. Unfortunately, the professional association, the Office of Public Instruction, and the licensing agency do not collect demographic information on licensees, so a special study would be needed to project retirements. At this time there is no obvious pipeline for replacement personnel, although OCHE has sought assistance from the Legislature, WICHE and higher education institutions in other states.

Current strategies for training a new generation of speech pathologists and audiologists for Montana are limited. OPI provides $2,500 stipends annually to personnel who enroll in a masters program in speech-language pathology and sign an agreement to work in Montana public schools two years after receiving their degree. OPI is also developing a brochure to attract people to the field. In the last legislative session, OCHE proposed adding WICHE slots in speech pathology and audiology and is currently working with the University of Wyoming and Idaho State University to ensure access to their masters programs for Montana residents.

Direct Care Professions

According to the Montana Department of Labor & Industry, the direct care/auxiliary health professions represented 22% of the health care workforce, almost 6,900 workers, in 1998. This number is expected to grow as the demand for direct care services, and especially alternatives to nursing home care, increases. According to a 2001 Montana Health Care Association survey, long-term care facilities average almost four vacant Certified Nurse Assistant positions at any time, up a position from 1999. The reported vacancy rate was 12.5%. CNA vacancies grew from 282 to 403.

According to the Department of Public Health & Human Services, Senior & Long Term Care (SLTC) Division, significant turnover exists for Personal Care Attendants (PCA) and for Respite Care Workers/Homemakers. PCAs provide assistance with activities of daily living such as dressing, bathing, eating, shopping, meal preparation and light housekeeping. PCA services are provided to approximately 3,000 senior citizens and people with disabilities each year under the Medicaid program at a cost of $23 million. While the degree of difficulty in recruiting PCAs varies from location to location, retention is a serious problem across the state with annual turnover rates of 50% to 100% not uncommon. According to a SLTC review of local provider wages, salaries ranged from $6.00 to $9.00 per hour for PCAs and from $5.75 to $7.50 for Respite Care and Homemaker Workers. All providers reported significant turnover and indicated that the wage levels contribute considerably to this problem.

Low wages are a major obstacle for recruitment and retention of direct care staff for state operated facilities (such as the Montana Developmental Center and Eastmont Training Center) and for privately operated group homes and community-based settings. In 2000, the Montana Association of Independent Disabilities Services (MAIDS) conducted a wage survey to compare member organization wages paid with those paid by state government for similar occupations. The results indicated that private provider wages are even lower than those paid for state government employees. Table 13 shows the results of this survey.

Table 13
Wage Study Comparison for the Year 2000
Completed between the DPHHS Disability Services Division
and the Montana Association of Independent Disability Services (MAIDS)

Staff Position	Private Provider *Weighted Wage	State Institution *Weighted Wage	% Difference
Habilitation Aide I	$ 6.34	$ 6.94	9%
Habilitation Aide II	$ 6.72	$ 8.77	31%
Habilitation Specialist	$10.58	$13.83	47%
Habilitation Tech I	$ 7.39	$10.08	37%
Habilitation Tech II	$ 8.61	$10.66	24%
Vocational Specialist	$ 9.44	$13.86	47%
Family Support Specialist	$ 12.55	$13.86	10%
Supported Living Coordinator	$ 10.67	$13.86	30%

**The weighted wage accounts for the length of service for both private and state workers. This wage represents a much more actual perspective of the disparity between public and private compensation.*

At the time of the wage comparison survey, annual turnover rates for the private sector were 120-200%. There continues to be a discrepancy of 23– 8% between private provider wages and state institution wages in Montana.

In an informal study completed by the Montana Association of Disability Providers (MAIDS) and the Montana Children's Initiative Provider Association (MCI) in December 2001, there was an average of 30% openings across all staff positions. According to the survey most people left their jobs for better salary and benefits and because of scheduling conflicts. The average age for credentialed staff tends to be from the middle 30s to middle 40s. Direct care technicians' ages range from early 20s to late 30s.

PART 4
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