

1. Introduction: Planning Alaska's Health Workforce

The purpose of this grant application is to complete the comprehensive health care workforce development planning effort for Alaska begun in August, 2009, and leading to an initial plan that was endorsed by the Department of Labor and Workforce Development (DOLWD) Alaska Workforce Investment Board (AWIB) in May, 2010. The process so far has been enabled by the voluntary formation of the Alaska Health Care Workforce Coalition made up of health care providers, agencies and associations. A steering committee from the larger coalition, comprised of representatives from industry, state government, secondary education and the University of Alaska met regularly both face-to-face and via teleconference over a nine-month period to guide work on the Alaska Health Workforce Plan. The basic plan strategies were presented to the larger provider community for discussion and further refinement at various meetings and conferences throughout late 2009 and early 2010.

Impetus for the planning effort came from a variety of sources: concern over the shortage of physicians in the state, especially in primary care; difficulty and expense of recruiting needed health care professionals; the aging of the current workforce; the special challenges of health care delivery in rural Alaska; and the need to create a pipeline of new workers through career awareness beginning in the K-12 system. These concerns had been the focus of study and planning efforts in the past, usually as single issues and often by single organizations or ad hoc groups. However, the scope and severity of the workforce issues facing Alaska made it increasingly clear that a comprehensive, cooperative effort that involved a broad spectrum of stakeholders and that attacked health care workforce development issues on a variety of fronts was needed.

The Coalition early on agreed on several underlying principles. First, because the training needs of the health care industry are substantial and relatively costly, the planning group recognized that particular care must be taken to assure that resources—both public and private—are allocated to areas of highest need, needless duplication is avoided and existing institutions are utilized wherever possible. Priority occupations were tentatively identified from existing data as needing immediate attention in Alaska for one or more of the following reasons: high vacancy rate, high number of vacancies, recruitment difficulty, mal-distribution, insufficient educational opportunities, or criticality to health care delivery.

Second, the group agreed that all training under the plan must be directed at meeting industry standards, state and national licensing requirements and the quality benchmarks established by educational program accreditation agencies.

Third, the Coalition recognized the need for a cooperative, coordinated effort by many industries and agencies in securing broad public awareness and support for developing a pipeline of new workers through the revitalization of K-12 career awareness and technical education programs, and other outreach activities. The draft plan is based on four broad strategic areas that will increase the number of health professionals in Alaska: Engage, Train, Recruit and Retain.

Alerting Alaskans to the opportunities available in the health care field is a first step in securing the necessary workforce. Interest needs to be captured from the earliest years. Public information

campaigns, K-12 career awareness and exploration and outreach to Alaskan job seekers are elements of the *Engage* strategy.

Preparation for a health care career often starts at the middle school and secondary level, where prerequisite math, science and communications skills are developed. Coordination between secondary and postsecondary education curriculum aligns beginning skills in a career pathway to health occupations. Tech/prep university credits while in high school guarantees such alignment. Quality, standards-based postsecondary education delivered as close to home as possible is a next step along a career path in health care. As the practice of health care changes through technology or new care models, those employed in the industry must upgrade skill levels. Finally, experienced teachers must be available to deliver the necessary education and training at all levels. Strengthening secondary math, science and career education, expanding access to training programs in priority occupations, providing continuing education and securing the necessary faculty are elements of the *Train* strategy.

Although the plan speaks to significant expansion of health care career training and education in the state, the size and complexity of the industry indicate that recruitment from outside of Alaska will continue to be needed to fill some positions. Alaska can improve its competitiveness with others seeking similar skilled professionals by more widely disseminating information about employment opportunities and offering more post-graduate experiences within the state. State and federal-supported loan repayment and other financial and quality-of-life incentives can sway the decision to locate or stay in Alaska. Finally, more coordination in recruitment by health care providers could reduce costs. All of these approaches are elements of the *Recruit* strategy.

The final plank in the health care plan is to retain the workforce that has been educated and recruited. To do so requires successful transitioning from training into the world of work and employment that offers sufficient remuneration, adequate supervision and opportunities for professional growth. Assisting employers to provide these workplace elements makes up the *Retain* strategy.

Because the health care industry in the state is so diverse and covers so many disparate occupations, many of the overall strategies in the current draft plan are broad and general in nature. As a next step in the planning process, the Coalition Steering Committee identified several areas for more in-depth analysis and effort. The following focus areas align directly with the required planning elements (*a* through *f*) outlined in the RFP for the Affordable Care Act State Health Care Workforce Planning Grants:

- Refine health career workforce supply and demand data to determine training priorities and track progress in meeting training goals (*a* and *b*)
- Develop occupation-specific workforce development action plans for high priority occupations based on Alaska workforce needs that describe career pathways and are directed at industry standards and state/national licensing requirements (*b* and *e*)
- Assist health care education and training partners to develop plans for expanding career awareness/counseling and program articulation between secondary/postsecondary/professional employment (*b* and *d*)

The Coalition has also begun to identify resources for health care workforce development planning and program delivery (*c*) and to analyze existing policies and regulations that can either advance or hinder comprehensive planning and implementation (*f*). These activities will be

augmented under this planning grant and will result in action plans to secure additional resources, where necessary and to overcome or ameliorate identified barriers.

Completing the comprehensive plan will assist Alaska in meeting the goals of *Healthy People 2010* by securing the workforce necessary to increase the quality and years of healthy life and to ameliorate health disparities

2. Needs Assessment

Many groups have documented Alaska's health care needs in general and the health workforce needs in particular. Among the most recent findings are those contained in the *Report of the Physician Supply Task Force* (August 2006), *Transforming Health Care in Alaska* with related appendices by the Alaska Health Care Commission (January 2010), and the initial *Alaska Health Workforce Plan* by the Health Workforce Planning Coalition (May 2010). These reports have reached a broad consensus on issues, challenges and strengths.

National health workforce challenges have impacted Alaska for many years. The burgeoning nursing shortage and limited numbers of primary care physicians, physical therapists, pharmacists, and other professionals experienced nationally impacted Alaska's health care employers' ability to attract them to the state. The recent recession may have temporarily helped ease Alaska's perennial recruitment difficulties. In all but one of 12 important provider types, Alaska experienced an increase in license-holders in the state between 2007 and 2009.¹ Overall the vacancy rate for Alaska health occupations decreased from 10 percent in 2007 to 8 percent in 2009.² Yet critical shortages continue for many health occupations, especially in rural Alaska.

There are many efforts at play nationally to diminish health workforce shortages across the country, including loan repayment and employment incentive programs, improved reimbursement, expanded graduate medical education opportunities³, electronic records systems adoption, and other incentives and supportive changes. Expanding seats in health professions schools and other training opportunities, including inducements for faculty, strengthening health care workers' knowledge and skills base,⁴ seeking prospective workers from underrepresented populations, and developing new health care worker categories are also recommended. Besides expanding training opportunities and improved recruitment, attention to workforce retention is also an important component to an overall workforce strategy.⁵ Alaska has considered and is making use of all of these methods to expand its essential primary care workforce. The state now needs to consolidate and focus its efforts to meet its present and future health workforce needs.

Health Care Workforce Challenges

¹ Alaska Department of Health and Social Services Health Planning and Systems Development Section, Changes in number of licensed active resident health care providers in Alaska (selected categories), 2007-2009, by labor market area. *Alaska Health Care Workforce 2009*, November 2009, p 2.

² Alaska Center for Rural Health, University of Alaska Anchorage, *2009 Alaska Health Workforce Vacancy Study*, December 2009.

³ Alliance for Academic Internal Medicine, *The Anticipated Physician Shortage: Meeting the Nation's Need for Physician Services*, *The American Journal of Medicine* 122(12), December 2009, p. 1156.

⁴ Tri-Council for Nursing, *Educational Advancement of Registered Nurses: A Consensus Position*, May 2010.

⁵ Americans for Nursing Shortage Relief, *Assuring Quality Health Care for the United States: Building and Sustaining an Infrastructure of Qualified Nurses for the Nation: Consensus Document*.

Health care is one of the largest and most dynamic industries in Alaska, accounting for eight percent of total employment and around 16 percent of the value produced by the state's economy. One out of every 12 employed Alaskans works in the industry; one out of every six dollars spent in Alaska is spent on health care. The industry also accounts for a significant portion of economic growth. Between 2000 and 2009, health care employment increased 46 percent, about five times as fast as the state's population and three times as fast as all other sectors of the economy. With a payroll of more than \$1.4 billion in 2008, it employed more people than state government, oil industry or most other industries.⁶

This growth is estimated to continue. Department of Labor and Workforce Development (DOLWD) data indicate a 30 percent growth rate between 2004 and 2014, twice that of the overall economy. Around 15 percent of the state's new jobs in that period will come from health care; currently, 11 of the top 15 fastest growing jobs in Alaska are in this sector.

While job growth is good news for the economy, it also place heavy strains on an industry already burdened by unacceptably high vacancy rates in key occupations. For example, state rates for primary care providers as reported by 747 surveyed employers for a 2009 University of Alaska study⁷ ranged from 12.9 percent (community health aide/practitioner) to 37.4 percent (pediatric nurse practitioner). Other troubling rates include occupational therapist and physical therapist at 22.8 and 15.8 percent respectively.

Critical providers also have unacceptable vacancy rates: family physician 10.9 percent, family nurse practitioner 17.2 percent, physician assistant 13.2 percent. Though the vacancy rate for registered nurses has not increased dramatically in recent years due to a major expansion of basic nursing programs and remains at about 10 percent overall, many of the specialties are experiencing much higher rates (nurse-midwife 25.4 percent, psychiatric nurse practitioner 20.5 percent, women's health care practitioner 22.0 percent). Besides a moderately high vacancy rate, the relatively large registered nurse profession was calculated to have over 320 vacant positions. These rates indicate a significant skills gap in the primary health care workforce at the present time, a gap that without increased attention can only worsen. The behavioral health workforce generally was also found to be in short supply. Dental workers were especially limited in rural areas: dentists at only 2.6 percent overall but 7.1 percent in rural communities; dental hygienists 8.0 percent statewide and 15.8 percent in rural Alaska.

Recognizing these conditions, the Alaska Workforce Investment Board (AWIB) has targeted health care as one of the industries critical to Alaska's workforce and economic needs. The Alaska Health Care Commission and many other agencies and groups, such as the University of Alaska, the Department of Health and Social Services, The Alaska Mental Health Trust Authority (AMHTA), and the Alaska State Hospital and Nursing Home Association (ASHNHA), have identified health care workforce development as one of the most critical priorities in assuring health care access in Alaska

⁶ Alaska Department of Labor and Workforce Development, *Alaska's Health Care Industry*, [Alaska Economic Trends](#), March 2010, p. 4

⁷ Alaska Center for Rural Health, University of Alaska Anchorage, *2009 Alaska Health Workforce Vacancy Study*, December 2009.

Health care has unique features that distinguish it from other industries—features of impact, breadth, scope and outlook. These characteristics add to the urgency of assuring that Alaska has a well prepared and sufficient health care workforce.

Impact—The health care industry touches almost every Alaskan, from the new born infant in Ketchikan General Hospital to the elder in Barrow's assisted living facility. The overall health of the state's citizenry is intimately tied to the adequacy and competence of the health care workforce. Meeting Alaska's targets for improved health as envisioned in *Healthy Alaskans 2010*⁸—Alaska's response to *Healthy People 2010*—in the areas of health promotion, health protection, preventive services and access to health care requires attention to the development, upgrading and retention of workers who can address these targets.

Reducing health disparities is one of the goals of *Healthy People 2010*. Access to quality health care for every resident is key to reducing these disparities. Increased access is dependent a well-trained and qualified health care workforce. Training the health care workforce includes many dimensions, one of which is ensure that the workforce is linguistically and culturally competent. Anchorage is the largest city in Alaska, with 42% of the population. Over 80 languages are represented by the children in Anchorage schools. This is one indication of the need for attention to health literacy to be able to communicate health information successfully to a diverse population. Assessment of Alaska's health workforce needs, design of health career pathways that encourage underrepresented minorities to participate, and implementation of accessible health workforce training will begin to address the diversity of the population in order to help reduce health disparities.

Breadth—Health care industry employment can be found in almost every location in the state. Although about half of the jobs are in hospitals and nursing homes, the other half are with small health care provider offices, outpatient and community health centers and home health care. The State of Alaska also provides many career opportunities in the health care field. This breadth indicates that job opportunities are available close to home for many Alaskans.

Scope—Perhaps no other industry employs front-line workers with such a wide range of educational background, from high school diploma or GED through post-doctoral specialization. Although the industry utilizes many highly-skilled professionals, health care is often provided by direct service workers, who assist Alaskans dealing with too prevalent mental health problems, substance abuse, medical illnesses, developmental delays and disabilities, and social stressors, as well as elder care. Career ladders and lattices exist that can move workers to higher-level positions. This wide scope of employment allows many Alaskans to access the industry through entry-level jobs and to construct meaningful, life-long careers.

Outlook—Demand for health care is not cyclical, unlike that for most Alaskan industries. This has distinct advantages. As reported by DOLWD, health care is one of a handful of industries expected to grow in 2010—adding about 500 jobs—while most other sectors will continue to

⁸ Alaska Department of Health and Social Services, Division of Public Health, *Healthy Alaskans 2010, Targets and Strategies for Improved Health*, November 2005

experience a decline.⁹ Because it is not subject to sudden downward shifts in demand, the output from training programs can more easily be matched to current and future industry needs.

While health care is relatively free from the effects of economic fluctuations, it is highly susceptible to other influences. At least four factors are currently driving higher demand for health care services and therefore increasing the need for workforce development: reform efforts, demographics, changes in care models and technology.

Health care reform will greatly expand demand for care, adding coverage for tens of thousands of Alaskans who were previously un- or underserved. The increased demand from this population is likely to be in areas such as primary care, and related therapies and behavioral health services, that currently experience high job vacancy rates throughout the state. Reforms will also spur the growth of new classes of health care positions such as continuum of care managers and health information technicians.

An aging Alaskan population also contributes to increased demand for services. In the decade between 1996 and 2006, the number of Alaskans 65 years and older increased 50 percent, from 30,440 to 45,489. In the latter year, older Alaskans accounted for 7 percent of the total population. DOLWD estimates indicate that this age segment will reach around 134,400 persons by 2030, or about 16 percent of the population. This demographic shift has tremendous implications for workforce development, not only in numbers but also in types of workers needed, such as geriatric nurses, nurse practitioners, psychiatrists, licensed practical nurses and certified nursing assistants. Changes in care models and care objectives will also change the face of the workforce. For example, the move to more outpatient services increases the demand for home health care workers. An emphasis on prevention requires increases in occupations such as health educator and wellness trainers.

Technology influences the health care workforce in many ways. First, access to higher levels of medical technology within the state has an "import substitution" effect on demand as an increasing share of Alaskans can meet their health care needs locally rather than going out of state. Generally, this effect heightens the need for highly-trained specialists. Increasing uses of technology in all areas of care also require continuing skill attainment and development on the part of the existing workforce at all levels, from direct service worker through specialist. Implementation of electronic health records will require the creation of new job classes and related training. Finally, technology—in particular clinical simulation and the Internet—can vastly increase access to health care career education and training across the vast geography of the state.

Physician Supply Challenges¹⁰

The ratio of physicians to population in Alaska is below the national average at 2.05 MDs per 1000 population vs. 2.38 MDs per 1000 population in the US. It is estimated that Alaska should have 10% more physicians per population than the national average because Alaska's rural nature, great distances and severe weather result in structural inefficiencies of the health care

⁹ Alaska Department of Labor and Workforce Development, *Employment Forecast for 2010*, Alaska Economic Trends, January 2010, p. 11

¹⁰ The following discussion is taken from *Securing an Adequate Number of Physicians for Alaska's Needs, A Report of the Alaska Physician Supply Task Force*, DHSS and University of Alaska, August 2006, p.3

system. Alaskan physicians' administrative and supervisory responsibilities in addition to patient care contribute to the need for more physicians to provide patient care services.

Alaska has and should maintain a higher ratio of mid-level providers (advanced nurse practitioners, physician assistants, and community health aides/practitioners) to physicians than the national average, in order to make it feasible to provide high quality and timely care to the population. Without these providers the need for physicians would be even greater.

Geographic and Demographic Challenges¹¹

Alaska experiences many health care delivery challenges, including the logistical difficulties and costs involved in providing care for a relatively small number of people spread over vast geographic distances, a delivery system that is highly fragmented, and an inadequate supply and distribution of health care workers.

Alaska is the largest state in the nation geographically, encompassing an area greater than the next three largest states - Texas, California and Montana - combined. At the same time Alaska's population is among the smallest of the states. Alaska has the lowest population density in the U.S. with 1.2 persons per square mile compared to the U.S. average population density of 79.6; 26.1% of the state's population lives in communities of fewer than 2,500 people. The dispersion of such a small number of people over such a large area increases the difficulty and cost of delivering care.

Approximately 75% of Alaska's more than 300 communities are not connected by road to a community with a hospital. Nearly a quarter of the state's population lives in towns and villages that can only be reached by boat or aircraft. Transportation costs are high and geography coupled with harsh weather conditions pose additional barriers.

Transportation is not just an issue in terms of patients' ability to reach needed services. The cost of moving supplies, staff and equipment required to operate clinics and hospitals in rural Alaska can be formidable. For example, the price of heating fuel and gasoline in the most remote communities of the state reached as high as \$10.00 per gallon this year - the cost of transporting the fuel to these communities was higher than the cost of the fuel itself.

The cost of delivering services is also made higher by a loss of economies of scale associated with operating hospitals in sparsely populated regions and clinics in nearly every small community in the state - a necessity due to the remoteness and isolation of those locations. Some of Alaska's smallest communities with a clinic have as few as 50 residents. However, the loss of economies of scale to maintain the facilities is off-set somewhat by the innovative workforce solutions used to staff them, such as the Community Health Aide/Practitioner occupation, and the use of tele-health technologies. Many of Alaska's most rural facilities are also highly subsidized by the federal government.

As referred to above, the population of Alaska is increasingly diverse, with about 27% of its residents found to be non-Caucasian in 2005. More than half of those, about 18%, were indigenous Alaska Natives. This continues to be a young and growing population, though improved longevity finds a growing number of Alaska Native seniors as well.

¹¹ The following discussion is taken from *Transforming Health Care in Alaska*, Alaska Health Care Commission, January 2010, p. 21ff
AK HRSA-10-284

Significant health disparities exist between ethnic groups and for those newly arrived in the country. While the health of Alaska Natives has significantly improved in a number of key areas in recent times (e.g. maternal and infant mortality and infectious disease), this population still carries a heavy burden of illness and injury compared to the overall state population and that of the nation. A growing level of chronic disease and disability - often tied to changes in activity level, nutrition and lifestyle choices (such as tobacco use) – is requiring evolution of established models of primary care. Behavioral health issues require attention, including an unusually high rate of suicide, especially among young men. The Alaska Native Tribal Health Consortium and University of Alaska Fairbanks have worked together to train additional behavioral health workers at the village level, termed Behavioral Health Aides. Dental disease has also presented a challenge, and resulted in a new occupational category being adapted from a model used in other countries for employment by the Alaska tribal health system: Dental Health Aides and Therapists.

While there has been rural to urban migration in recent years (30% of Alaska Natives live in Anchorage and the Matanuska-Susitna Borough)¹², many still live in very remote areas of the state in very small communities. Tribal health organizations have been found to have unacceptably high vacancy rates¹³ and long-term difficulty filling critical positions.¹⁴ With concerted efforts to make health professional education available outside of the most urban areas, some of the workforce mal-distribution has eased slightly in the past few years, but generally the urban-rural discrepancy continues.

Alaska has seen significant increases in the numbers of Asian and Pacific Islanders in the past two decades, many arriving in the state directly from their home countries. There is also a small but growing community of African immigrants that have taken refuge in the state. Some of these families have experienced violence, dislocation, stress and attendant illnesses and injuries in their countries of origin. Concerted efforts are underway to provide required health and social services, including translation and culturally sensitive care. Accessible primary care safety net services are very important to helping families settle into the community. Health workforce shortages in safety net organizations have challenged their ability to provide care.

The senior population is the fastest growing age group in Alaska. From a very low level of about 4%, its proportion in the overall population is steadily increasing and, as previously noted, is expected to reach 16% by 2030.¹⁵ This will dramatically change health care demand, increase the need for chronic care management, and seriously tax the capacity of the primary care workforce.

Even now Medicare-insured individuals, seniors and those with serious disabilities, are among the most vulnerable populations in the state. In Anchorage especially, and to a somewhat lesser extent elsewhere in the state, primary care physicians have not only refused to admit new Medicare clients, they have also ejected those nearing 65 and other patients already covered by Medicare from their practices. Primarily due to inadequate reimbursement levels, the complexity

¹² Alaska Department of Health and Social Services, Health Planning and Systems Development, *Alaska Health Care Data Book: Selected Measures 2007*, November 2007, p. 8.

¹³ 2009 Vacancy Survey

¹⁴ SORRAS Study

¹⁵ Eddie Hunsinger, *Population projections, 2007-2030: A look at Alaska's Future*, Alaska Economic Trends, DOLWD, October 2007, p.7.

of caring for these patients and the Medicare paperwork burden are cited as reasons for this decision.

The limited number of primary care physicians per capita (including both family practice physicians and internists) has intensified this problem for seniors and those living with disabilities. While mid-level primary care providers, particularly independent practice nurse practitioners, and community health centers have done a great deal to provide care for additional Medicare-insured patients, most of these practices are now filled to capacity and new solutions are being tried. Most involve setting up new or expanding clinics – finding the required and appropriate workforce will be a challenge.

Health Care System Challenges¹⁶

Alaska's health care "system" is not a system, but an assortment of private, for-profit and non-profit, large and small medical businesses; hospitals and clinics to serve military personnel, retirees and their dependents; and hospitals and clinics owned and operated by tribal organizations. The tribal and governmental systems represent a larger portion of both facilities and service providers in Alaska than in other states, since one fifth of the population (about 135,000) is eligible for services in the tribal system and 14 percent (about 90,000) are covered by the military system. (In the U.S. as a whole the proportions are 2 percent tribal and 4 percent military.)¹⁷

In Alaska, services that are provided by federal or state governments directly (rather than through reimbursement or an insurance program) are mostly Veterans Administration and military services for active duty and former service people in the Army, Air Force and the Coast Guard. State and local government services are limited primarily to the state psychiatric hospital, Pioneers' (assisted living) Homes, public health services,¹⁸ and some locally owned and operated clinics. Governments also play a major role in reimbursing private and tribal providers for the costs of providing care (rather than providing care directly) through Medicare, Medicaid and other programs. Governments also contract with or provide grants to private, tribal and for-profit organizations to provide services.

Alaska's health services have evolved in response to many factors including geography, population needs and traditions and historical events. Most of Alaska's hospitals are former tuberculosis sanatoria built by the U.S. Public Health Service to treat the epidemic of the early 20th century. Then Alaska's location gave it a critical military and communication defense role for the country during World War II and during the Cold War of the 1950s and 1960s. The major role of the federally recognized tribes in planning and implementing a coordinated system of care for Alaska Natives, through an agreement with the Indian Health Service called "compacting," has supported and determined the development of care in rural areas of the state.

¹⁶ The following discussion is taken from *Health Care in Alaska, A Report to the Alaska Health Care Commission* (draft), Health Planning and Systems Development Section, DHSS, May 2010, p3ff

¹⁷ U.S. Bureau of the Census, 2000 Census.

¹⁸ Services include immunizations, well child care, services related to infectious diseases, sexually transmitted disease screening, treatment and partner management, newborn hearing screening, family planning, and home visits for follow-up on referrals of high risk families with children.

There are challenges implicit in having multiple parallel health systems in a small population state. Health care organizations do not have interoperable electronic information systems, care coordination systems, or business management processes. In addition to fragmentation in the delivery of services, there are a variety of payers financing health care services, including Medicare, Medicaid, private insurers, self-insured employers, the military and VA, the Indian Health Service, and individuals.

Alaska has benefited from a strong military presence due to the state's strategic location, a strong tribal health system presence, and decades of representation in senior leadership in the U.S. Senate. Because of these three factors the federal government has played a lead role in development of Alaska's health care system, especially in rural Alaska as well as for medically underserved Alaskans statewide.

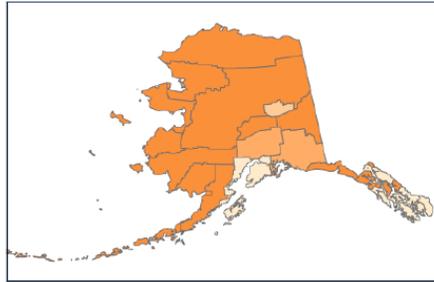
The downside of heavy federal investment in building the health care infrastructure is there are some communities that have multiple health care systems operating side-by-side. For example, one community of 9,000 people has both a community hospital and a tribal health system hospital. Another community of just 6,000 people has a community hospital, a tribal health system clinic, and a military clinic. Alaska's largest city, with a relatively small population of 285,000, has four general hospitals - one military, one tribal, one for-profit, one non-profit – as well as one long term acute care hospital and two psychiatric hospitals. The facilities in these communities also serve regional (and in the largest city's case statewide) populations, but there is still an overabundance of infrastructure that leads to higher costs. The duplication and fragmentation in Alaska's health care "system" is inefficient, and integration where appropriate would be helpful.

The costs health care organizations incur associated with recruitment and contracting for the services of temporary employees to cover vacancies is high. Eighty Alaska health care organizations surveyed in 2005 reported spending \$24 million in the preceding year for vacancies in 12 key health occupations. A high percentage of these costs, especially in rural areas, is due to hiring temporary agency personnel, or “travelers.” At least a portion of these costs may be passed on to consumers and insurers in the form of higher prices.

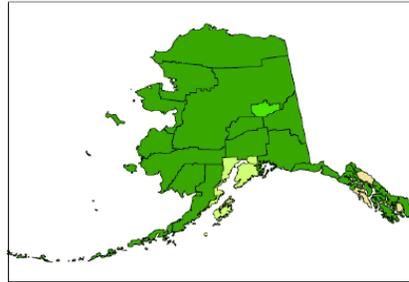
Delivery of health care is dependent on an adequate supply and distribution of qualified health care workers. Fully 27 of Alaska's 30 boroughs and census areas contain federally designated health professional shortage areas. Staff shortages are one of the many challenges the Alaska health care delivery system is dealing with as it faces the future.

FIGURE1. Maps of Alaska’s Health Professional Shortage Areas (July 2010)

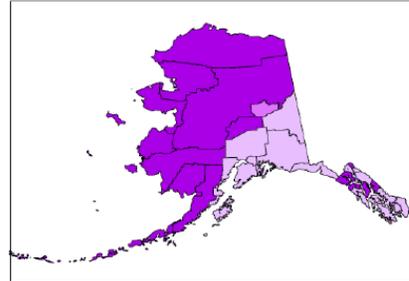
Primary Care HPSAs



Mental Health HPSAs



Dental HPSA



KEY: Dark shading for each type indicates “geographic area” HPSA status; moderate shading indicates partial geographic area or low income population HPSA, light shading indicates that automatic HPSA status is associated with Community Health Center (CHC) or Alaska Native/American Indian populations in the area. For MHPSAs, CHCs receive automatic designation, AI/AN populations do not.

Prepared by Health Planning & Systems Development Section, Health Care Services, DHSS 7/12/2010
 Using <http://www.hpsafind.gov/> accessed 7/11/2010.

Progress to Date in Health Care Workforce Development

Despite these challenges, the state has made significant progress in addressing workforce development needs. These accomplishments will be described in more detail in the Evaluation and Technical Support Capacity section. However, it is important here to note that cooperative effort has resulted in a doubling of the number of nursing graduates from the university system since 2000, a doubling of the number of medical school slots available to Alaskans through the Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) program, doubling of admissions to the physician program offered in Alaska in conjunction with the University of Washington, significant growth in postsecondary health care certificate and degree programs, and the expansion of telemedicine, distance delivery of educational programs, and clinical simulation. The success of these efforts was a major impetus for the members of the Alaska Health Care Planning Coalition to engage in a more comprehensive planning process.

Health Workforce Development Expenditures

The following are the major public annual expenditures for health care workforce planning, program development and training. Private employer expenditures, while estimated to be considerable, are not collected in a systematic manner.

Agency	Purpose	Amount (prior fiscal year)
University of Alaska	Health workforce development program planning only, including policy development, cross-campus coordination of health certificate and degree delivery, data collection and analysis, new program development	\$1,545,000 (\$810,000 state general fund; \$735,000 grant funds)
Alaska Mental Health Trust	Training (non-academic)	\$2,500,000

Authority	Education (academic) Recruitment (marketing) Retention (Wages & Benefits) Direct service worker competencies	(annual allocations of the earnings of the Mental Health Trust)
Department of Labor and Workforce Development	Grants to health care training providers; funding for Individual Training Accounts (ITAs) in health care training programs	\$525,610 (WIA federal funds) \$288,472 (STEP state funds)
Department of Health and Social Services	Health planning and systems development; training for Community Health Aides and workers in behavioral health, public health, Pioneer Homes (assisted living), children's and adolescent's health training, Child Policy Team	\$2,679,000

In addition to the above funds, the following investments have been made in developing and expanding University of Alaska health programs, certificates and degrees, over the decade from 2000 to 2009:

- State and University investments in University of Alaska health programs totaled \$18.6 million
 - Ongoing base (year-to-year) funding of \$8.2 million
 - One-time investments of \$10.4 million
- Overall, cumulative State/University health program investments totaled \$38.5 million
 - \$28.1 million of base funding
 - \$10.4 million in one-time investments

More than \$13.5 million in additional health program investments was received by UAA health programs through contributions from the health care industry, grants from the Alaska Mental Health Trust Authority, and others.

Alaska Workforce Investment Board Members

Alaska's Workforce Investment Board (AWIB) currently has 25 members (June 2010). Its broad membership includes most of those required of eligible partnerships submitting proposals for this ACA State Health Care workforce Development Grant: State secondary education agency, public postsecondary 2 and 4 year institution, health care employer, workforce focused philanthropic organization, and labor organizations. Missing is a State recognized federation of labor. It is expected that this lack will be remedied within the required time period. A full list of AWIB members is found in Section 5.

The AWIB will be engaging with an established health workforce partnership, the Alaska Health Workforce Coalition, to move its health planning efforts forward. A description of this expanded partnership is covered in the next section of this proposal.

3. Methodology

Goal: Complete comprehensive health care workforce development planning that increases the number of primary health care professionals in Alaska

The Alaska Workforce Investment Board (AWIB) is submitting this proposal in partnership with its designated fiscal agent, the Alaska Department of Labor and Workforce Development. The AWIB will administer the grant funds. In order to enhance membership and to carry out grant-funded planning activities, the AWIB will engage with the membership from the AWIB required by the ACA statute and with an existing health workforce partnership, the Alaska Health Workforce Coalition. A Memorandum of Agreement will define the relationships integral to the health partnership. The AWIB itself already includes all but one of the required members. Together with the Coalition’s Steering Committee, the functional health workforce partnership will include at least one representative, and often more than one, of the listed member types.

The partners to this Coalition will also bring considerable expertise and resources to the planning effort. The Coalition is a very broad and inclusive group; its Steering Committee currently includes the following members:

Represented Sector	Participating Institution/Agency
Health care employer	Providence Alaska Health System Fairbanks Memorial Hospital Alaska Native Health Board (ANHB) Alaska State Hospital and Nursing Home Association (ASHNHA) Alaska Department of Health and Social Services (DHSS)
Public 2-year institution of higher education	University of Alaska (UA) University of Alaska Anchorage (UAA)
Public 4-year institution of higher education	University of Alaska University of Alaska Anchorage
State public secondary education agency	Alaska Department of Education and Early Development (DEED) Anchorage School District
State labor agency	Alaska Department of Labor and Workforce Development (DOLWD) Alaska Workforce Investment Board (AWIB)
Philanthropic organization with a workforce focus	Alaska Mental Health Trust Authority (AMHTA)
Labor organization	Laborer’s Local 341
State recognized federation of labor	Alaska AFL-CIO

The Coalition will add two members to its Steering Committee to ensure its membership is also fully in compliance with the intent of the HRSA Planning Grant: a representative from a labor organization (from the AWIB membership) and one from a recognized State federation of labor. There is no formal P-16 or P-20 Council in Alaska.

With respect to the public 2-year and 4-year institutions of higher education in Alaska, the University of Alaska system is the public higher education institution that incorporates both the community college and senior college missions in the state, due to a merger in the 1980s. The

University of Alaska Anchorage (one of three universities in the system) is considered the system's health university. UAA operates community campuses in four communities and the state's last remaining community college in a fifth location, as well as offering a wide range of programs from occupational certificates to graduate studies in Anchorage.

The work of developing the broad outline and strategies of a statewide health workforce plan has been completed. The next steps in fleshing out this plan will require the involvement of many additional players, the collection and analysis of more detailed data and information and the preparation of multiple documents and reports. It is essential at this stage of plan development to engage dedicated staff to provide staff support to the Coalition and AWIB in carrying the project through to completion.

A Plan Coordinator will be hired by the Coalition to support its work which has heretofore relied on volunteer efforts by Coalition partners. The Plan Coordinator will be housed with one of the partners of the Coalition. Grant funding for the Plan Coordinator position will leverage funding committed by the partners. The Coalition will fund 75% of the position; grant funds are sought for the remaining 25%. A part-time project manager (Program Coordinator) will be hired by the AWIB to administer, monitor and report on grant activities.

A small amount of funding is being requested to expand current data collection efforts of DOLWD and DHSS in order to ensure that planning efforts are based on reliable and timely information. Contributions from the Coalition partners will be used in a parallel and complementary data enhancement effort, including analysis and synthesis of the array of data available currently and to be developed as part of the project.

Objective 1: Analyze State labor market information in order to create health care career pathways for students and adults, including dislocated workers.

Problem to be addressed: Create a pipeline for students and job seekers to enter the primary care workforce

Progress to date: The University of Alaska and the Alaska Department of Education and Early Development (DEED) have begun to create career pathways for primary health careers for which education/training programs currently exist in the UA system. The Department of Labor and Workforce Development (DOLWD), Research and Analysis Section, has created an innovative career ladder information system using empirical data from employment records that tracks actual job progression in selected occupations. These empirical data provide a baseline from which pathways can be analyzed.

Strategy to be employed: An Education Committee of the Health Workforce Coalition with representation from the K-12 system, Alaska's Area Health Education Center (AHEC) system, the University of Alaska and other public/private postsecondary training institutions will examine the existing career pathway documents and DOL career ladder information to identify 1) potential barriers to progress along a career pathway; 2) alternative routes for progression and 3) primary care occupations for which pathways still need to be established. The group will also develop a plan for disseminating career pathway information to secondary school counselors, postsecondary academic advisors and employment security job counselors and for training these target audiences in the use of career pathways to assist students and adult clients in career planning.

Objective 2: Identify current and projected high demand State or regional health care sectors for purposes of planning career pathways

Problem to be addressed: Closer coordination between education/training and state employment needs

Progress to date: A Data Committee of the Coalition conducted an initial assessment of occupational priorities for Alaska, utilizing data and information from a variety of sources including the following:

- Department of Labor and Workforce Development, Research and Analysis (DOLWD)
 - Ten-year projections
 - Industry-specific studies
 - Occupational information, ranking and demographics
- Department of Health and Social Services (DHSS)
 - Health Professional Shortage Area (HPSA) analysis
 - Physician Task Force Report
 - Special topics (e.g. dental, pharmacy, license-holders, loan repayment/employee incentives options)
- University of Alaska (Alaska Center for Rural Health/Alaska's AHEC and Office of Health Programs Development)
 - Vacancy studies
 - Recruitment studies
 - Health student data analysis
 - Health workforce demand analysis
 - Special topics (e.g. rural allied health, community health aide/practitioner, nursing, health information technology, pharmacy, geriatric education)

On the basis of the above information, the planning group initially identified 35 occupations that appeared to be in most critical need of attention because of high vacancy rates, high number of vacancies, criticality to health care delivery and other factors. This initial listing was then distributed to various health-related groups to achieve consensus on the occupations/occupational groupings most in need of immediate attention. The 15 top priority groupings listed below include a total of 26 occupations and professions. All of these occupations and professions contribute to the delivery of primary care in Alaska using the definition provided by the Institute of Medicine to be those "engaged in the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practicing in the context of family and community." Because of Alaska's unique care delivery needs and systems (including a strong focus on home and community based services), some occupations that might not otherwise be considered as falling under this definition in other settings are involved in primary care delivery here.

- Primary Care Physician (Family Practice Physician, Internist, Pediatrician)
- Advanced Nurse Practitioner (Family, Psychiatric/Mental Health)
- Community Health Aide/Practitioner

- Pharmacist
- Therapist and Therapist Assistant (Physical, Occupational, Speech-Language)
- Registered Nurse
- Nurse Educator
- Health Informatics Staff
- Oral Health Practitioner (Dental Hygienist, Dental Health Aide/Therapist)
- Psychiatrist
- Social Worker
- Human Service Worker
- Behavioral Health Aide/Village Counselor
- Substance Abuse Counselor
- Direct Care Worker (Home Care Worker, Certified Nurse Assistant, Disabilities Service Worker)

Strategy to be employed: The Alaska Health Workforce Coalition and its Data Committee will continue to refine the information received from the above sources and will initiate development of a data collection infrastructure for Alaska, based on best practices successfully used by other states. Constituent groups for each of the high priority primary care occupations identified above will be convened to develop occupation-specific workforce development action plans built on the four strategies of *Engage, Train, Recruit, Retain*. These plans will include career pathways and establish output targets that will increase the workforce by at least 10 percent over the next five-year period.

Objective 3: Identify existing Federal, State, and private resources to recruit, educate or train, and retain a skilled health care workforce and strengthen partnerships

Problem to be addressed: Support for workforce development planning and implementation efforts

Progress to date: As a result of its planning process to date, the Coalition has identified a significant number of state and federal sources that can support workforce development efforts. These sources include:

State of Alaska	Federal
State agency General Fund	Health Resources and Services Administration
University of Alaska General Fund	Area Health Education Center (AHEC) funding
Alaska Public School Foundation Program	National Health Service Corps Loan Repayment
State of Alaska Student Loan	Indian Health Service Loan Repayment
Alaska Mental health Trust Authority	Medicaid/Medicare Graduate Medical Education
Vocational Technical Education Program (VTEP)	National Institutes of Health
State Training & Employment Program (STEP)	Military loan repayment programs
Student tuition and fees	Carl Perkins Career & Technical Education Act
Tribal Health Organizations	Workforce Investment Act
State Private/Philanthropic	National Philanthropic
Alaska Mental Health Trust Authority	Robert Wood Johnson Foundation
Rasmuson Foundation	
Industry/employer contributions, foundations	

Strategy to be employed: The Coalition will continue to identify sources of support for recruiting, educating/training and retaining needed primary care workers. Each occupation-specific planning group will be charged with identifying specific sources of support for identified activities. Where resource gaps exist, the Coalition and the occupation-specific groups will develop strategies for securing the necessary support. An annotated listing of available resources will be developed and maintained on a central website.

The Coalition will address the issue of sustainability of workforce planning and oversight efforts through developing Memoranda of Agreement among Coalition members. These memoranda will delineate roles and responsibilities including fiscal contribution, personnel assignment and in-kind support for each participating entity.

Objective 4: Describe the academic and health care industry skill standards for high school graduation, for entry into postsecondary education, and for various credentials and licensure

Problem to be addressed: Reducing the need for remedial education and assuring smooth transitions between educational levels along a career pathway and from school to professional employment

Progress to date: Alaska has established academic skill standards for high school graduation. Although the UA system is open enrollment, entering students undergo placement testing to assure that they have the necessary academic skills. Health career certificate and degree programs have both entry-level requirements and exit skill standards, generally tied to state and/or national licensure or certification. To assure that students across the state can access courses that are pre-requisite to entry into a health career program, the university examined the availability of these courses both on campus and via distance. A grid identifying both availability and gaps has been developed.

The State Board of Education recently endorsed the *Alaska Career and Technical Education Plan* which calls for every student to have a personal learning and career plan (PLCP), based on a career pathway. These plans address both high school exit academic and technical skills as well as postsecondary entrance requirements along a given pathway.

Strategy to be employed: Secondary and postsecondary representatives on the Coalition Steering Committee will convene a group of teachers and faculty to develop programs of study linking secondary and postsecondary academic, technical and professional training in high demand primary care occupations. The group will also identify strategies for disseminating the programs of study and for technical assistance to school districts in implementing the plans. University representatives will update the grid of pre-requisites to identify gaps and to develop plans for closing those gaps.

Objective 5: Describe State secondary and postsecondary education and training policies, models, or practices for the health care sector, including career information and guidance counseling

Problem to be addressed: Access to health career training and education

Progress to date: Between 2001 and 2010, aggressive program development at the University of Alaska added instruction and training in a variety of health occupations resulting in more than 80 certificates/degrees in primary care, nursing, direct services, therapies and allied, behavioral and public health. The UA system now serves around 4,200 Alaskans each year who are preparing for and enrolled in health care training and education programs. State-supported regional centers provide additional entry-level training. A key policy for the university system is access and about half of the enrollment in health care programs is through distance delivery. The university makes considerable use of educational technology and clinical simulation in its programming.

The *Alaska Career and Technical Education Plan* emphasizes career information and guidance as part of the personal learning and career plan. The Alaska Career Information System (AKCIS) has considerable information about health careers and is a major tool for both students and advisors. The AKCIS information is also available to adult job seekers, including dislocated workers, through the One-Stop employment security job centers around Alaska.

Strategy to be employed: Occupation-specific work groups, facilitated by the Plan Coordinator, will assess the adequacy of current postsecondary education and training policies and opportunities within Alaska, identify models and best practices, highlight gaps or areas in need of strengthening and develop strategies to close gaps and/or improve policies/offerings. Where an in-state program is not feasible at present, the University of Alaska will seek to identify institutions in other states that could potentially partner to offer the education in Alaska.

The K-12 representatives on the Coalition will work with DEED to develop guidelines and models for the PLCs as well as training for administrators, teachers and parents in the development and benefits of such plans.

Objective 6: Identify Federal or State policies or rules to developing a coherent and comprehensive health care workforce development strategy and barriers and a plan to resolve these barriers

Problem to be addressed: Remove barriers to coordinated and comprehensive health workforce development planning and program delivery

Progress to date: Several recent major state efforts provide information and resources to support comprehensive health workforce development. The Alaska Department of Health and Social Services and the University of Alaska jointly sponsored an in-depth study on physician supply and demand which identified state and federal policies that both supported and were barriers to recruiting and retaining an adequate number of physicians, particularly those providing primary care. Among the barriers were Medicaid/Medicare reimbursement policies, the lack of an independent in-state medical school and limited residency opportunities. The Alaska Health Care Commission, established by executive order to address growing concern over the condition of Alaska's health care system, cited logistical challenges arising from the state's vast geography and sparse population, a fragmented health care delivery system and antiquated primary care delivery models as further barriers. The Coalition in its planning efforts found that state and licensing requirements and procedures could create barriers to recruitment. Federal standards for some training programs also limit Alaska's ability to deliver needed training, for example the Certified Nursing Assistant faculty requirements for long term care experience.

On the positive side, the Alaska Workforce Investment Board has named health care as one of the top eight priority industries for support. The most recent legislative session introduced a state-supported loan forgiveness program that would covers many primary care occupations. Finally, the Legislature is considering several bills that would make permanent the Alaska Health Commission as the focal point for sustained and comprehensive planning and policy recommendations. On the federal level, Alaska can take advantage of several policies and programs that enhance workforce development, such as Health Professions Shortage Area designation for much of the state (see Attachment 8), rural/frontier health status and Indian Health Service (IHS) programs.

Strategy to be pursued: As part of the planning process, the Coalition will continue to identify real and potential policy and regulatory barriers to comprehensive health workforce development and program delivery. The involvement of the state departments responsible for education and labor, as well as the University of Alaska, allows the Coalition to begin to address those barriers caused by state policy. Other parties—such as the Alaska Primary Care Association and the state licensing boards—will be solicited to assist in identifying issues and help craft solutions.

Objective 7: Participate in the Administration's evaluation and reporting activities

Problem to be addressed: Need for accurate, timely, and consistent project impact information

Progress to date: The State of Alaska participates in several HRSA grant programs and has developed procedures that can satisfy reporting requirements.

Strategy to be employed: The AWIB Project Manager will work with HRSA staff to identify reporting requirements and to establish procedures for developing uniform and consistent data sets on health care professionals. The Plan Coordinator will collect and analyze the data/information and provide the results to the Project Manager to prepare and submit required reports.

4. Work Plan

Goal: Complete comprehensive health care workforce development planning for Alaska

Preparatory Activities: Formalize the industry-led Alaska Health Workforce Coalition and its partnership with the Alaska Workforce Investment Board

Activities	Progress & Process Measures	Performance Period	Responsible Organization/ Person
Develop and finalize a Memorandum of Agreement between the AWIB and Coalition Steering Committee partners	MOAs in place	By October 2010	AWIB and Coalition Steering Committee
Determine which Coalition partner will house Plan Coordinator	Decision made	By October 2010	Coalition Steering Committee
Prepare/post position announcements	Position announcements posted	By October 2010	AWIB and Coalition
Recruit/hire Plan Coordinator	Plan Coordinator hired	October 2010	Coalition
Recruit/hire Project Manager	Project Manager hired	October 2010	AWIB
Convene Coalition to review grant materials	Coalition meeting	October 2010	AWIB

Objective 1: Analyze state labor market information to create career pathways for students and adults, including dislocated workers.

Activities	Progress & Process Measures	Performance Period	Responsible Organization/ Person
Convene Education Committee	Committee established	November 2010	Plan Coordinator
Collect and review existing UA career pathways for primary care occupations	Written report of review results	December 2010	Plan coordinator/ Education Committee
Identify primary care occupations for which career pathways are needed	List of needed pathways	December 2010	Education Committee

Review empirical career data from DOLWD Career Ladder project	Written report of review results	December 2010 – January 2011	Education Committee DOLWD R & A staff
Identify alternative career progression routes through DOLWD R&A study	Written analysis of alternative routes	February 2011	Education Committee
Identify potential barriers to progression in a primary care career	Written analysis of barriers	January 2011	Education Committee
Develop strategies to overcome identified barriers	Strategies are recorded	March 2011	Education Committee
Develop dissemination plan, including K-12 schools, postsecondary institutions and One-Stop job centers	Written dissemination plan	May 2011	Education Committee
Develop plan for training teachers, academic advisors and job counselors on using career pathways	Written training plan	May 2011	Education Committee
Create a primary care career pathways site	Website developed and launched	June 2011	Plan Coordinator/ Education Committee

Objective 2: Identify current and projected high demand State or regional health care sectors for purposes of planning career pathways

Activities	Progress & Process Measures	Performance Period	Responsible Organization/ Person
Review/update primary care employment supply and demand data	Revised occupational spread sheet completed	October 2010	Plan Coordinator/ Data Committee
Finalize top priority occupations for first round of planning and implementation with input from affected employers, state and tribal agencies, professional groups and organizations	List of occupations by priority for attention	October – November 2010	Data Committee
Establish occupation-specific work group for each priority occupation	Workgroups are established and meet	November 2010	Coalition/Plan Coordinator
Develop workforce development plan for each priority occupation that includes <ul style="list-style-type: none"> Career pathways, both secondary and postsecondary Creation/expansion of in-state training to meet needs Identification of potential partners for training that 	Occupation-specific plans are developed and disseminated	November 2010 – May 2011	Occupation-specific work groups with Plan Coordinator

cannot be delivered in-state <ul style="list-style-type: none"> • Recruitment strategies • Retention strategies 			
Survey other states to identify elements/characteristics of an effective workforce data monitoring system	Survey instruments and results	November 2010 – April 2011	Data Committee
Develop specifications for an Alaska monitoring system	Written data system specifications/RFP	April 2011	Data Committee
Identify and purchase package components for a data monitoring system	Components are purchased and operating	May – September 2011	Data Committee

Objective 3: Identify existing Federal, State, and private resources to recruit, educate or train, and retain a skilled health care workforce and strengthen partnerships

Activities	Progress & Process Measures	Performance Period	Responsible Organization/ Person
Review existing planning documents to identify sources of support	Matrix of state, federal and private resources	November 2010	Plan Coordinator/ Coalition
Analyze federal law changes in support of workforce development; survey state agencies, professional and health care membership organizations and private funders to identify additional sources	Survey instrument and results	December 2010 – January 2011	Plan Coordinator/ Coalition
Prioritize health care occupations of most critical need and identify sources for occupational-specific education, training, recruitment and retention	Matrix of occupation-specific funding and other resources	November 2010 – February 2011	Plan Coordinator/ occupation-specific work groups
Identify resource gaps	Gap analysis	February – March 2011	
With other affected parties, identify strategies for securing additional resources	Strategic plan for obtaining additional resources	March – July 2011	Plan Coordinator/ occupation-specific work groups
Develop white paper/talking points to support health workforce resource requests to the Governor and	White papers/talking points	April-June 2011 for FY	Plan Coordinator/ occupation-specific

legislature		2013 budget cycle	work groups
Develop Memoranda of Agreement for Coalition participants that detail commitment to <ul style="list-style-type: none"> • Fiscal support for Coalition activities • Personnel assignment to participate in Consortium • Other resources 	Signed MOAs with all agencies/ groups participating in the Health Workforce Coalition	November 2010 – January 2011	Plan Coordinator/ Coalition

Objective 4: Describe the academic and health care industry skill standards for high school graduation, for entry into postsecondary education, and for various credentials and licensure

Activities	Progress & Process Measures	Performance Period	Responsible Organization/ Person
Collect and review existing programs of study that detail secondary and postsecondary academic and skill standards for health care occupations and that articulate between levels of education and from school to professional employment	Written review of existing plans of study	October – November 2010	DEED Coalition representative with assistance of Plan Coordinator
Identify primary care occupational areas for which programs of study need to be developed	List of priority primary care occupations that need plans of study	November 2010	Plan Coordinator/ Education Committee
Convene programs of study work group of secondary and postsecondary faculty	Group is established and meets	November 2010 – February 2011	DEED with assistance from Education Committee
Develop model program of study for each identified occupational area	Written plans of study for each priority occupation	November 2010 – February 2011	Plans of Study work group
Create plan to disseminate models	Dissemination plan	January – February 2011	Plans of Study work group
Create plan to provide technical assistance to secondary and postsecondary administrators and faculty in implementing programs of study	Technical assistance plan	January – February 2011	Plans of Study work group
Review grid of pre-requisite courses for UA health career	Documentation of	November	UA Coalition

occupational degrees and certificates	review	2010	representatives with staff of UA system
Identify gaps in access to pre-requisites	Gap analysis	January 2011	UA Coalition representatives with staff of UA system
Develop plan for expanding access, including distance education, intensives, etc.	Expanded Access Plan	February 2011 for Fall 2011 schedule	UA Coalition representatives with faculty at UA campuses

Objective 5: Describe State secondary and postsecondary education and training policies, models, or practices for the health care sector, including career information and guidance counseling

Activities	Progress & Process Measures	Performance Period	Responsible Organization/ Person
Cooperate with DEED work group in developing guidelines and models for personal learning and career plans (PLCP), including career information and counseling	Written guidelines for PLPCs	October – December 2010	Education Committee
Develop with DEED a plan for training and technical assistance in the use of PLCPs that includes school administrators, teachers and parents	Training and technical assistance plan	October – December 2010	Education Committee
Survey in-state and Lower 48 institutions to collect information on models and best practices for both career information/guidance and training programs	Survey results	October – November 2010	DEED Coalition representative
Identify models and best practices to promote careers in primary health occupations that fit the Alaska situation	Written description of models/ promising practices	November 2010	Plan Coordinator/ Education Committee
Develop plan for adoption/adaption of best practices in career guidance in Alaska K-12 and postsecondary systems	Best practices adoption plan	January – March 2011	Plan Coordinator/ Education Committee
Identify models and best practices in education/training for high priority health occupations	Written description of models/ promising practices	January – March 2011	Occupation-specific work groups

Develop plan for disseminating/ replicating best training practices/models	Best practices in training adoption plan	January – March 2011	Plan Coordinator
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Objective 6: Identify Federal or State policies or rules to developing a coherent and comprehensive health care workforce development strategy and barriers and a plan to resolve these barriers

Activities	Progress & Process Measures	Performance Period	Responsible Organization/ Person
Review prior planning efforts, such as the Physician Supply Task Force, the Alaska Health Care Commission and other studies to identify state and federal policies regarding health care workforce planning	Written review of literature and findings/ recommendations from earlier studies	November 2010	Plan Coordinator/ Coalition
Create annotated list of policies/rules	Annotated list	December 2010	Plan Coordinator
From the above list, identify rules and policies that present barriers to workforce development, such as Medicare/ Medicaid reimbursement rates, licensing procedures, training program requirements such as CNA, etc.	List of policy/ regulatory barriers	December 2010 – January 2011	Coalition/ Occupation-specific work groups
Identify other barriers to workforce development, such as low population density, isolation of many communities, high transportation costs, etc.	List of non-regulatory barriers	December 2010 – January 2011	Plan Coordinator/ Coalition
Identify those barriers that can be addressed by Coalition organizations and develop a plan for resolving the barrier	List of barriers/plan	January 2011	Coalition/AWIB
For other barriers, identify agencies and other partners that must be involved in resolving the issue(s)	List of other agencies and partners	January 2011	Coalition
Select priority areas to be addressed for correction/ remediation	Priority listing of barriers to be addressed	January 2011	Coalition with partners
Convene workgroups to develop plan for resolving issues	Workgroups established and meet	January – May 2011	Coalition/Plan Coordinator
Explore options for innovative staffing and training delivery such as the Community Health Aide/Practitioner, telemedicine and distance delivery to address identified barriers	Written information on successful innovations	January – May 2011	Coalition/ Occupation-specific work groups

Develop white paper/talking points around proposed solutions for use with Governor/Legislature	White papers and talking points	June – July 2011 for 2012 session	Plan Coordinator
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Objective 7: Participate in the Administration’s evaluation and reporting activities

Activities	Progress & Process Measures	Performance Period	Responsible Organization/ Person
Work with HRSA staff to identify evaluation and reporting requirements	Written evaluation and reporting plan	November 2010	AWIB Project Manager
Set up system to collect necessary information	Information/Data collection system	November – December, 2010	AWIB Project Manager/ Plan Coordinator
Collect and analyze required information	Written analysis	January – Sept. 2011	AWIB Project Manager/ Plan Coordinator
Prepare and submit required reports to HRSA and AWIB	Written progress reports	September 30, 2011	AWIB Project Manager
Disseminate completed plan and related information and data	Completed plan is disseminated to policy makers, legislators, constituent groups throughout Alaska and nationally, as requested	September 30, 2011 and following	AWIB Project Manager/ Plan Coordinator

5. Resolution of Challenges

There are several challenges both to comprehensive workforce planning and plan implementation in Alaska, two of which—geography and a disbursed health delivery system—were described at some length in the Needs Assessment section above. Other arise from the relative newness of state and private institutions and the lack of fiscal and human resources.

Geography: The vastness of the state, the paucity of road networks and the resulting isolation of many of Alaska's communities is a constant challenge to any cooperative, comprehensive effort. With respect to the current grant proposal, assuring the involvement of health agency personnel and care providers in workforce planning from all regions of the state means overcoming significant logistic issues. Face-to-face meetings are expensive and difficult to schedule, particularly during the winter months. To help ameliorate the issues of distance and poor weather, the state has long utilized teleconferencing and electronic mail to conduct meetings and communicate. The advent of on-line meeting software has added a higher level of sophistication and utility to teleconferences. These meeting tools will be used extensively for meetings of the Coalition as a whole and by its committees and work groups. Implementation plans will include methodologies that have been successful in the past in opening access to both training and care delivery across the state. These include distance education technologies, telemedicine, traveling instructors/care givers, intensive training sessions and increasingly, simulation.

Disbursed Health Care Delivery System: The many actors and agencies that make up the Alaska health care system provide considerable richness to the state but also result in duplication of effort and non-congruent systems and procedures. The challenge is to identify all of the parties that should be involved in a comprehensive planning effort and then establish processes that allow meaningful participation by all concerned. The Alaska Health Workforce Coalition is the most representative group to date that has tackled this issue. As can be seen from the list of participants in Attachment 5, the Coalition has representatives from all levels of health care: policy makers, public and private providers, secondary and postsecondary education and training institutions. Additional members will be brought in to participate in the occupation-specific plans, to expand the data collection/analysis effort and to assist DEED and the UA system in expanding career counseling and career pathways.

The Memoranda of Agreement that will be developed and signed among Coalition Steering Committee members and other Coalition partners will contain commitments to joint funding and advocacy for the completed plan and plan strategies. White papers and talking points prepared through the planning process will provide a consistent message to the Governor, the legislature and Alaska's Congressional delegation as to the financial resources and policy additions/changes necessary to prepare an adequate and highly-trained health care workforce.

Newness of Institutions: Alaska is still a relatively young state, with institutions that are still evolving, particularly in rural Alaska. For example, secondary education was not available in most village sites until the mid 1970's. Many of the rural high schools that currently operate have very limited ability to deliver a solid academic program, much less career counseling and technical education.

Delivering effective career and technical education to rural schools is a major plank in the *Alaska Career and Technical Education Plan*, adopted by the AWIB Board and the State Board of Education in May, 2010. The Coalition through its DEED representative will collaborate with

the groups that are working on these issues to ensure that health care career pathways and career counseling are included.

Changes in federal policy over the past several decades have resulted in a new sector of health care delivery—the tribal health system. This new system greatly expands access to health care and opportunities for health care employment. However, it operates under a separate policy environment and management system. Active participation by representatives from the tribal system will allow consideration of the particular workforce development issues faced by these entities.

AWIB itself is a new institution and is continuing to explore ways in which it can more effectively function as center for policy direction in all areas of workforce development, including health, as well as in the more traditional heavy industry and natural resource occupations. AWIB's designation of health care as one of the eight priority industries and the representation on AWIB of health workforce educators and providers help to overcome this potential barrier.

Certain regulatory or procedural barriers may also stem from the lack of full maturity on the part of state institutions. For example, professional licensing in the state has undergone several administrative changes over the past decades and as a result, has developed inconsistencies in procedures across licenses. Nor have all licensing procedures kept pace with changes in the national and Alaska health care environment. The Coalition will work with the state division of licensing to examine barriers posed by the system and to identify remediation strategies.

Funding: The Alaskan comprehensive planning effort has to date been supported by volunteer labor, communications and travel support by participating organizations. This volunteer effort resulted in a draft plan what was endorsed by AWIB this spring. Further effort, however, requires staff support to collect and organize information and data, arrange and staff Coalition and committee meetings, prepare required reports and disseminate information. Limited funds for travel for at least one face-to-face meeting of the Coalition and for improving data collection are also required. The required level of support is beyond the ability of participating institutions to provide. The current grant request is designed to overcome this potential barrier to continued planning through a combination of HRSA funds and cash and in-kind contributions by Coalition members.

Funding to implement the completed plan will also present a challenge, as desires will almost certainly outstrip available resources. However, Alaska has a good track record of pooling resources, particularly in health care. As reported in the following section, the combined efforts of the university system, industry and the legislature has resulted in a tremendous increase in health care certificates and degrees over the past decade. Hybrid staffing such as a joint Mental Health Trust, DHSS and University of Alaska position is another example.

As part of the planning process, the Coalition and its various committees and work groups will identify funding needs and potential state, federal, local, industry and philanthropic sources. Where new resources are required, the Coalition will develop supporting documentation for use with the Governor, the Legislature and the Congressional delegation. The Plan Coordinator will also provide supporting information for institutions and agencies seeking public and private grant funds and/or industry support.

6. Evaluation and Technical Support Capacity

Alaska has considerable experience, knowledge and skills in creating health care workforce development plans and in cooperative effort in executing these plans. In 2002, the health care industry and the university system determined that the nursing shortage was the major workforce issue facing Alaska and mounted an aggressive campaign to increase the number of nurses trained in the state. As a result, the enrollment in nursing programs doubled to more than 220 AAS and BS admissions each year, with over 200 graduates annually. The AAS nursing program has expanded from one site (Anchorage) in 2002 to 12 sites currently.

Through cooperative planning and implementation efforts, the University of Alaska (UA), the Alaska Mental Health Trust Authority (AMHTA), the Alaska Legislature and Alaska's health care industry have demonstrated a commitment to increasing in-state health career training and education opportunities in recent years. UA now has 80 health programs statewide in various fields including allied and behavioral health, emergency services, health management, medical office management, nursing, primary care, public health, direct services and therapies.

Efforts continue. For example, in partnership with the health care industry and with financial support from health care organizations and the state Legislature, UA has recently added, expanded and engaged in assessments for a number of programs, including:

- Doubled the number of basic nursing graduates (as mentioned above)
- Added a Nurse Educator master's track
- Added a distance RN to BS program
- Doubled medical program admissions; plans being developed for future expansion
- Added radiologic technology program sites in six locations
- Developed cooperative programs with outside universities for occupational, speech and language therapies and audiology
- Expanded the distance Master's of Social Work program
- Worked on articulation of behavioral health programs from certificate through doctorate
- Provided a number of rural allied health training opportunities via distance delivery
 - Pharmacy technology
 - Limited radiography
 - Health care reimbursement (biller/coder)
 - Personal care attendant
 - Certified nursing assistant
 - Dental assisting
 - Phlebotomy and clinical (lab) assistant
 - Disabilities services
- Doubled the Master's of Public Health program to 70 distance students; achieved initial accreditation
- More than doubled admissions to the Physician's Assistant program while offering the entire program in Alaska
- Completed an assessment of pharmacy education options for Alaska
- Funded a physical therapy careers assessment
- Prepared a geriatric education assessment
- DHSS, UA and AMHTA jointly-sponsored a behavioral health coordinator position in UA system's Office of Health Programs

- Established the Area Health Education Center (AHEC) Program Office and Centers in 5 regions of the state;

In the area of behavioral health, the Mental Health Trust has supported and funded the following projects

- UAA and UAF Ph.D. program in Psychology
- Distance MSW Program expansion
- BSW Intensive Cohort-Rural Alaska Native Students and Tribal Employees
- Endorsement in Children’s Behavioral Health
- UAA and UAF Human Services
- Training Academy for Rural Behavioral Health
- Trust Training Cooperative
- Early Childhood Mental Health Certification
- Clinical Psychology Internship
- Tele-behavioral Health

In 2006, the University of Alaska partnered with the Department of Health and Social Services to develop a comprehensive plan to increase the number of physicians in the state. *The Report of the Alaska Physician Supply Task Force* contains detailed recommendations for the university, the state and the health care industry, several of which have already been implemented through coordinated advocacy and action. For example, the number of slots reserved for Alaskans at the University of Washington through the WWAMI program have doubled—from 10 to 20—due to increased state support. A new state funded loan repayment program has been introduced in the legislature which includes physicians as well as other health care professionals. Several groups are currently working to address another recommendation—that of increasing the number of residency positions in Alaska—in family practice and other specialties.

The Governor established the Alaska Health Care Commission in 2009 to address the major issues facing the health care systems: fragmentation, cost, lack of access and shortages in many critical care professions. After a year of study and review, the Commission issued a report, *Transforming Health Care in Alaska*, in January 2010. One of the five strategies for transforming the existing system spoke to developing the health care workforce through the following action steps:

- Make workforce a priority on health care reform and economic development agendas
- Strengthen the pipeline of future health care workers
- Support workforce innovation and adaptation as patient care models evolve
- Direct workforce planning to be more coordinated
- Increase the supply of primary care physicians by
 - Supporting educational loan repayment and financial incentives for recruitment
 - Expanding the WWAMI Alaska medical school program as resources allow
 - Supporting planning for primary care residency programs¹⁹

Collaboration among the members of the health workforce partnership is exhibited by participation in these earlier efforts as well as by representation on the Coalition. These

¹⁹ Alaska Health Care Commission, *Transforming Health Care in Alaska, 2009 Report/2010-2014 Strategic Plan*, January 2010, p. 9

collaborative linkages will be explicated through the Memoranda of Agreement that will be executed with each participating entity.

Because this is a planning grant, evaluation will be largely formative and will be used to review progress and make necessary changes in order to accomplish the activities outlined in the work plan. The major summative evaluation event is the production of a statewide comprehensive plan for developing Alaska's health care workforce. The final plan will contain specific action plans for each of the occupations identified as high priority.

Formative evaluation will consist of tracking and documenting the Progress and Process Measures listed in the work plan, including meeting minutes, lists of committee members and meeting attendance, written plans, white papers and guidelines. Monthly progress and expenditure reports to the Coalition and AWIB will be prepared by the Plan Coordinator. Required reports to HRSA will be made on the determined schedule, with the final Progress Report to BHP at the end of the grant period. The AWIB Project Manager will oversee and ensure compliance with grant requirements.

Information in the form of quantitative data on workforce supply and demand that may be requested by HRSA will be collected and reported. To ensure that the data are consistent with HRSA efforts to develop uniform data collection across states on licensed health professionals, the Coalition will research other states' efforts and, where possible, purchase/adopt data modules in use elsewhere. Limited funds are being requested in this grant to support the development of this data collection infrastructure and contributions from Coalition partners will provide additional data strengthening.

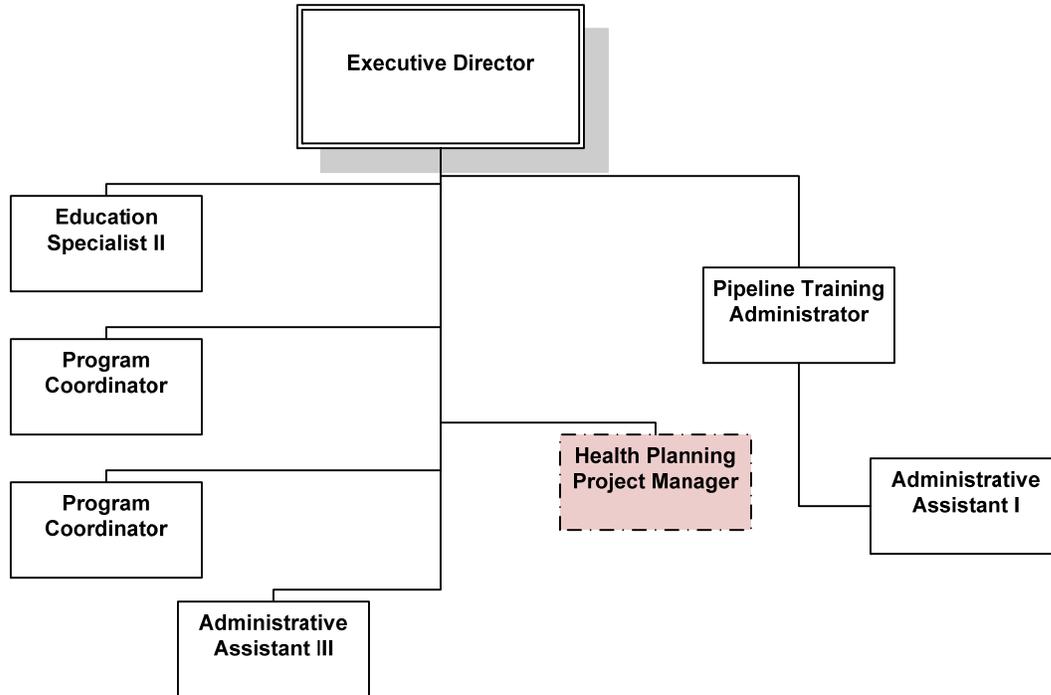
7. Organizational Information

The Alaska Workforce Investment Board membership list is found in Section 5. The functional health partnership for purposes of carrying out the activities of this planning grant will combine the appropriate AWIB membership with that of the Alaska Health Workforce Steering Committee, as has been described in the Methodology section.

The staff of the AWIB Office will be increased by a Project Manager at .5 FTE to administer the grant. The Coalition steering committee will hire a Plan Coordinator to oversee and complete all planning activities.

The overall project organizational chart is found in Attachment #6. The AWIB Office itself is configured as follows:

**Alaska Workforce Investment Board
FY 2011**



8. No Waiver of Rights or Claims

On behalf of the named plaintiffs in the lawsuit filed by 20 states including Alaska in federal district court in Florida, case number 3:10-cv-91-RV/EMT, the Secretary of the Department of Health and Human Services agrees that, by submitting this proposal for an Affordable Care Act: State Health Care Workforce Planning Grant, the State of Alaska in no way waives, compromises, or prejudices any rights, claims, or legal arguments it has asserted or will assert in the above-referenced lawsuit.