Primary Care is at the Heart of Health Reform in Minnesota

BY MARK SCHOENBAUM, M.S.W., AND EDWARD VAN CLEAVE, PH.D.

Both the United States and Minnesota are facing an impending shortage of primary care physicians and other providers just as the population is aging and needing their services more than ever. At the same time, policy makers are heralding primary care as essential to health care reform. This article explains why primary care is the focus of so much attention. It also summarizes the work of the Governor’s Health Care Reform Task Force and reports its recommendations for increasing access to primary care in Minnesota.

Increased attention to primary care is coming from many directions. Health care reform and practice transformation efforts often place primary care physicians at the helm of the teams responsible for the ongoing care of patients and increasingly make them responsible for patient outcomes. Population health activities such as those supported by the State Health Improvement Program to reduce obesity and tobacco use also call for broad inclusion of primary care providers. In addition, shortages of mental health care providers, OB/GYNs, geriatricians and other specialists, especially in rural areas, are placing greater demands on primary care physicians, who are being asked to provide these services. All of this is happening at a time when the United States is facing a shortage of primary care physicians and other providers.

Primary care was central to Minnesota’s 2008 landmark health care reform legislation, particularly the establishment of the state’s Health Care Homes program. In its recent work, the Governor’s Health Care Reform Task Force made an explicit connection between the goals of health care reform and the capacity of the primary care workforce and created a work group dedicated to integrating strategies for increasing the workforce into a comprehensive health care reform framework.

As part of its mission, the work group explored the expectations for primary care and the extent to which Minnesota’s workforce is positioned to meet them. In this article, we look at the numbers and describe the recommendations for increasing access to primary care in the Task Force’s “Roadmap to a Healthier Minnesota.”

Minnesota’s Primary Care Workforce: Supply and Demand
As of March 2011, 15,872 physicians with Minnesota mailing addresses held active licenses to practice medicine in the state. Of that total, nearly 29% (or roughly 4,584 physicians) were primary care practitioners—that is, they had earned single general board certifications in family medicine, internal medicine or pediatrics. Although there is no consensus about which specialties comprise the primary care physician workforce, this admittedly conservative definition is consistent with Minnesota Statute 137.38, which defines primary care physicians as family physicians, general pediatricians and general internists.*

*The Minnesota Department of Health’s primary care physician counts originated with data from the Minnesota Board of Medical Practice and includes only those with an active license and who have earned a single general board certification in family medicine, internal medicine or pediatrics. Relying on specialty board certifications, however, does not address primary care-trained physicians working in non-primary care settings such as those employed as hospitalists, in emergency medicine, occupational medicine or in rehabilitation. It also excludes 4,455 licensees with no specialty board certification attached to their Minnesota Board of Medical Practice record, some of whom may or may not be practicing primary care. Therefore, the Department of Health’s physician measure using board certifications serves as a proxy for examining distributions of likely primary care providers.
practice in rural areas to a far greater degree than their counterparts in other parts of the country.† This is because our state has done a better job of encouraging family physicians to practice in rural settings through initiatives such as the University of Minnesota’s Rural Physician Associate Program, its Duluth medical school campus and the state’s loan-forgiveness program.

The distribution of advanced practice registered nurses, especially certified nurse practitioners (NPs), and physician assistants (PAs) is also uneven. Of 2,373 NPs and 1,605 PAs who have Minnesota licenses and mailing addresses, the vast majority were located in urban parts of the state (Table 2). Although these professions were established in large part to address the uneven distribution of primary care physicians, many of these providers are not practicing primary care. A recent AHRQ report estimated that only 52% of NPs and 43% of PAs in the United States practiced in primary care settings.1 However, given the low numbers of specialty physicians in rural Minnesota, it may be reasonable to assume that the majority of mid-level providers practicing in those areas are working in primary care settings, as PAs must work under the supervision of a physician and nurse practitioners must have a collaborative written agreement with a physician in order to prescribe medications.

Another concern is that the state’s primary care workforce is aging. More than a third of Minnesota-based primary care physicians are 55 years of age and older, as are nearly a third of the state’s NPs. In contrast, only 12% of PAs are 55 years of age or older (Table 3). Table 4 shows that certain primary care specialties and certain parts of the state will feel the effect of the aging workforce more quickly than others. The supply of primary care physicians in Minnesota is on a collision course with population trends. Between 2010 and 2025, the percentage of Minnesota’s population age 65 years and older will rise from 12% to 18%, increasing by almost 457,000 people, according to the state demographer. By 2035, the percentage of those age 65 and older will increase to 22% of the population. These are also the people who tend to use the most health care resources.

Looking Ahead
Although it is not possible to predict exactly what will happen in terms of physicians or other primary care providers retiring and leaving practice, analysts agree the demographics point to significant shortages.2,3 Minnesota is expected to have a shortage of between 1,000 and 3,000 primary care providers, and demand for up to 14,000 physicians in all specialties. As far back as 1992, the Minnesota Legislature charged the University of Minnesota

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†Minnesota physician data in Table 1 originated with the Minnesota Board of Medical Practice and was aggregated for the analysis by Minnesota Department of Health. The Agency for Healthcare Research and Quality (AHRQ) used the American Medical Association Physician Masterfile for its estimates. The AHRQ adjusted for retirement and also included physicians self-reported as practicing geriatrics.
Roadmap describes eight broad strategies to achieve the Triple Aim in Minnesota, ranging from paying for the value, rather than volume, of care to centering care around patients, engaging communities and measuring performance. Central to their recommendations is strengthening the health care workforce.

Of its seven recommendations regarding the state’s health care workforce, five directly relate to primary care. They are:

1. Invest in high-need infrastructure and workforce services to increase access and foster interprofessional competency.
   Support is needed to increase access to mental health and substance abuse care by primary care and traditional mental health and substance abuse professionals. In this vein, the Task Force recommends:
   - Providing educational and training grants and fostering interprofessional competencies in the delivery of mental health and substance abuse care. Efforts are needed to better integrate these disciplines with medicine and to improve the capacity of primary care providers to respond directly to the mental health and substance abuse issues they are regularly presented with in their practices.
   - Improving access to a broad range of medical, mental health and other health services in rural Minnesota by supporting and expanding telehealth and related technology.

2. Explore and remove regulatory barriers to the advancement of the nursing workforce.
   Nursing is by far the largest sector of Minnesota’s licensed health care workforce, and nurses play critical roles in all health care settings. The Task Force recommends:
   - Removing practice barriers by adopting the Advanced Practice Registered Nursing (APRN) Consensus Model and enacting the APRN Model Act and Rules. Currently, Minnesota’s Nurse Practice Act mandates that APRNs must practice in settings that provide for a collaborative arrangement between an APRN

### The Primary Care Workforce and Health Reform

Developing needed primary care capacity will require ongoing investments in both the production and the distribution of providers. It will also necessitate support for the type of practice transformation—such as health care homes and community care teams (teams of people from multiple organizations that address patient and family health needs) that is central to reform. Minnesota cannot train its way out of these expected shortages; therefore, it also must make changes in the way care is delivered.

The Health Care Reform Task Force’s recommendations, outlined in “Roadmap to a Healthier Minnesota,” published in December 2012, call for a comprehensive approach to reforming health care. The

### TABLE 4

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### FIGURE

**Primary Care Provider Supply and Demand—Minnesota**

- **Demand under health care reform**
- **Baseline demand**
- **Current pipeline supply (graduates)**
- **Current providers: effects of retirement and attrition**

With pursuing strategies to increase the number of medical school graduates who enter primary care and choose to practice in rural and underserved areas. Although the university and other higher education institutions in the state have been increasing class size and opening new programs to train more physicians and other primary care providers, their rate of production is far lower than what will be needed to replace the clinicians leaving practice. At current rates, state medical schools will produce approximately 1,200 new primary care physicians in the next 15 years. Both nationally and in Minnesota, this spells a clear gap in provider capacity by 2025 (Figure).
and a physician. In addition, only those APRNs who maintain a signed written prescriptive agreement with a physician have prescriptive authority.

- Funding a study of the impact of Minnesota joining the Interstate Nurse Licensure Compact, including an analysis of state reciprocity and barriers to using telehealth. The Compact allows nurses licensed in a participating state to practice in any other state that belongs to the Compact without obtaining an additional license.

3. Support existing health professions training sites and funding new sites for primary care physicians, APRNs, physician assistants and pharmacists through the Medical Education and Research Costs (MERC) program.

MERC is the state’s investment in Minnesota’s clinical training system. The Legislature reduced funding for MERC in 2011 in order to close a budget gap. Increasing MERC funding will greatly stabilize health professions training. In addition, investing new resources specifically in primary care training will support the shift to team-based, primary-care-centered care, which is a foundation for achieving health reform goals. Specifically, the Task Force recommends:

- Increasing MERC funding through the existing mechanism.
- Establishing a new state-based fund for primary care training of physicians, APRNs, physician assistants and pharmacists.

4. Increase the number of health professionals in underserved areas by increasing funding for the state’s Health Professional Loan Forgiveness Program and opening the program to a wider group of providers.

Loan forgiveness is a proven strategy to encourage health professionals to practice where they are most needed. Research also confirms that providers who are offered loan forgiveness if they practice in an underserved area tend to stay there, making a long-term contribution in exchange for a relatively modest upfront investment by the state. The Task Force recommends increasing funding for loan forgiveness and expanding eligibility to include not just physicians, nurses and physician assistants but also licensed mental health professionals, licensed alcohol and drug counselors, dental therapists and advanced dental therapists, dental hygienists, occupational therapy practitioners and physical therapy practitioners.

5. Increase diversity in the health care workforce by supporting a range of health professions diversity programs.

Members of ethnic and racial minority groups are not proportionately represented in Minnesota’s health care workforce. The Task Force recommends:

- Providing opportunities for students to explore health careers and emphasizing science, technology, engineering and math competencies throughout the K-12 curriculum.
- Supporting programs that train and mentor students from underrepresented minority groups to pursue health care careers.
- Assisting foreign-certified physicians and mental health professionals in obtaining Minnesota licensure.

Strategies to increase reimbursement to safety net providers for primary care, mental health and substance abuse treatment are among the Task Force’s other workforce recommendations. In addition, the Task Force recommends exploring improvements to and expansion of the state’s health care home program, which pays certified clinics to provide care coordination, and improving access to dental care by integrating dental therapists and advanced dental therapists into dental practices.

Conclusion

The Health Care Reform Task Force developed its Roadmap during a year-long process that included formal meetings, testimony and structured conversations across the state. Unique among Minnesota health policy efforts, the Roadmap acknowledges the centrality of the primary care workforce to the state’s health reform goals and its efforts to transform the health care system. It also presents an opportunity to address the state’s need for primary care physicians and other providers as state and federal health reform efforts unfold.

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REFERENCES


5. Minnesota Department of Health analysis.