Georgia Healthcare Workforce Commission Executive Summary

December 2022

Healthcare Workforce Commission

Healthcare Workforce Commission

State of Georgia
Healthcare Workforce Commission
Workforce Assessment and Solutions Executive Summary

July 20, 2022 – December 31, 2022

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December 31, 2022

Office of Governor Brian P. Kemp

Dear Governor Kemp:

Thank you for your commitment to the future of all Georgians and our state's healthcare system. Under your leadership, the Healthcare Workforce Commission was established in April 2022 and members were officially appointed in June. Your challenge to the Commission was to fully examine the state of the healthcare workforce in Georgia and to "identify strategies and recommendations for promoting increased availability, hiring, and retention" of healthcare professionals across all sectors (Executive Order 4.21.22.01). While the work is far from over, the Commission is pleased to present with you the outcome of that work.

The attached Executive Summary and additional Supporting Materials summarize our findings and represent hours of Commission meetings and input from a wide range of interested stakeholders. The Commission convened on 5 separate occasions in locations around the state and conducted countless hours of interviews and research offline.

The data and trends summarized in the report relate to both the demand and supply of the healthcare workforce. It is clear, even in the light of myriad data sources and the need for a centralized, robust data repository for all healthcare professions, that Georgia will need significantly more healthcare providers over the next few years in order to meet the health needs of our citizens. Estimates indicate that our current rate of educational credential completions in nearly all health care job categories is insufficient to meet the projected annual job openings in the next several years.

As feedback from individual Commission members, stakeholder input, and research was synthesized, several themes emerged and strategies for improving Georgia's healthcare workforce aligned as three main opportunities. Our recommendations are focused on strategies that (1) maximize our existing workforce, (2) optimize our education system, and (3) attract new workers. We have highlighted strategies where there is the highest potential for wide-ranging impact that also had broad support from Commission members.

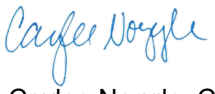
Alongside highlighting specific opportunities within these three broad areas for improvement are additional recommendations related to healthcare infrastructure reinforcements, including data collection and reporting improvements, partnering with the Georgia Board of Nursing to explore regulatory reforms, and occupation-specific recommendations for EMS and Behavioral Health.

The number of ideas, options, and case studies considered was significant. However, the Commission believes solutions to limit workplace violence, incentivize clinicians to become faculty, and craft community-specific training and credentialing programs using the "Quickstart" model hold high potential. Additionally, an expansion of loan forgiveness programs coupled with regulatory and statutory reforms addressing both nursing faculty ratios and scope of practice limitations could both maximize our existing workforce and attract new talent.

The range of these recommendations underscores the fact that no single initiative or single entity can "solve" the healthcare workforce shortage. It will take a broad set of engaged stakeholders and a concerted effort by the State, provider community, and our education systems to address these challenges, with some initiatives being led by the healthcare community while others are better suited for the State to lead. Regardless of which of the Commission's recommendations are further considered for adoption, it is clear that we must thoughtfully act in order to ensure that our workforce is well-suited to support the healthcare demands for current Georgians and to support future economic growth.

On behalf of the members of the Healthcare Workforce Commission, thank you for the opportunity to work on this important topic. We stand ready to assist your administration in next steps.

Sincerely,



Caylee Noggle, Chair of Georgia's Healthcare Workforce Commission

Scott Bohkle
Mary Chatman
Debi Dalton
Sherry Danello
Janee Dock
Clark Hill
Shawn Little
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Pete Quinones
Rick Roche
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Tanya Sudia
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Introduction

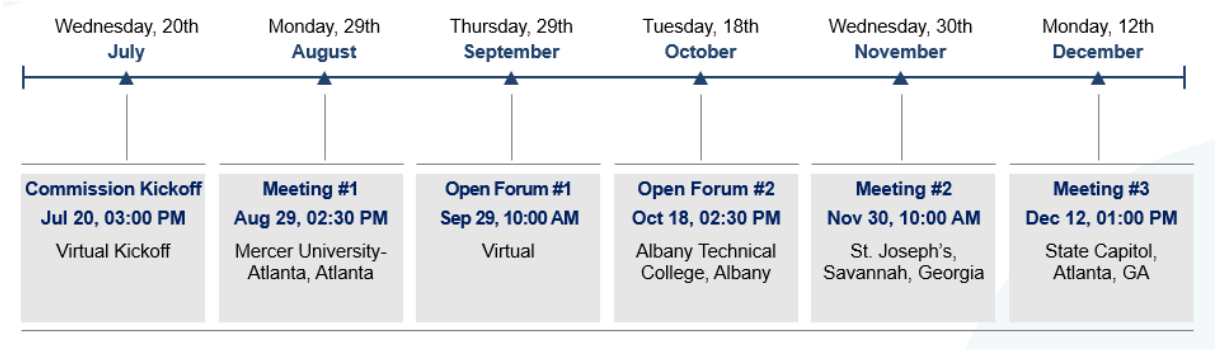
Scope of the Commission

The Georgia Healthcare Workforce Commission ("the Commission") was established via Executive Order by Governor Brian Kemp on April 21, 2022.[1] The Commission was tasked to assess Georgia's current healthcare workforce pipeline, identify significant data-backed trends in healthcare workforce changes, highlight areas of concern within the existing pipeline, and propose a set of recommendations for the state's stakeholders to pursue. Further, Governor Kemp directed the Commission to highlight opportunities to address the challenges faced in Georgia's education, training, hiring, skilling, and retention of healthcare workers. The Commission's recommendation proposes the use of various levers including the expansion of state incentives and programs, updates to regulations, and coordination of private and public stakeholders.

The Commission comprised 15 members, chaired by Commissioner Caylee Noggle, and remained effective until December 31, 2022.

Timeline

Figure One: Commission Timeline



The Commission commenced with a kickoff on July 20, 2022. Over the next five weeks, the Commission engaged in extensive research on healthcare workforce trends and pipelines across key occupation categories; particularly, research focused on identifying key areas of supply/demand imbalance that adversely impact population health. This material was shared during the First Commission Meeting, held on August 29, 2022 on the Mercer University-Atlanta campus.

Following the First Commission meeting, the Commission began efforts to discern potential root causes of the identified challenges and develop potential solutions for the Commission Members to consider. Two Open Forum sessions were held wherein major stakeholders were invited to provide perspectives on challenges in Georgia's healthcare workforce and to share potential opportunity levers. The Commission then compiled a preliminary set of potential opportunity levers aimed at addressing the challenges identified. Accordingly, the solution set was presented, discussed, and refined during the Second Commission Meeting on November 30, 2022 in Savannah.

1 Executive Order 02.21.22.01, gov.georgia.gov/executive-action

Following discussions and input from the Second Commission Meeting, the Commission refined its recommendations and shared these during the Third Commission Meeting on December 12, 2022.

This report serves as the Executive Summary of the Commission's findings and recommendations through the duration of its efforts, from July 20, 2022, through December 31, 2022.

Executive Summary

Diagnosis

The Commission's efforts began with a supply and demand assessment of Georgia's healthcare workforce, using the U.S. Bureau of Labor Statistics (BLS)'s May 2021 Occupational Employment and Wage Statistics dataset. Relevant healthcare occupations were categorized into seven groups: Primary Care, Nursing Care, Behavioral Healthcare, Pharmacy, Dentistry, Specialty Care, and Emergency Medical Services (EMS), with all analyses aligned to the BLS' Standard Occupation Classification system. Within each group, the Commission segmented workers into Primary Provider or Allied Healthcare occupations to facilitate deeper analysis into the trends and challenges faced per sub-segment.[2]

The Commission notes that current data at the time of this report's publishing is from 2021 and that the state's healthcare workforce shortage varies from suggested projections.

Supply/Demand Gap

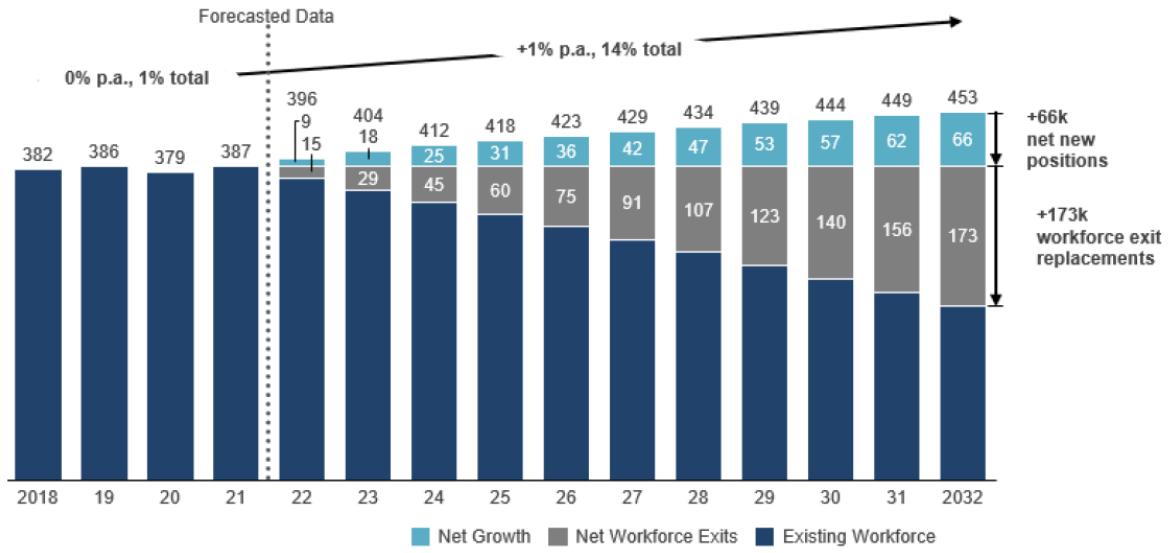
Projected healthcare workforce needs entail adding 66,000 new positions through 2022 (*Figure Two*). This figure accounts for an average of 3.7% of the healthcare workforce being forecasted to exit per year (e.g., retirement, leaving the state).[3] Considering there were four years of flat growth leading up to the forecast period, meeting the projected needs appears challenging and may require additional stakeholder intervention.

2 Lightcast™ (formerly EMSI-Burning Glass)

3 *Ibid*

Figure Tow: Supply/Demand Gap

Georgia healthcare employment forecast
2018 - 2032, thousands



Demand Assessment

Georgia's growing demand for healthcare services is primarily driven by three factors: overall population growth, an aging population, and increasing disease burden among Georgians. On overall population growth, Georgia outpaced the nation's change in population from 2010-2020 (10.6% vs. 7.4%).[4] Further, the state's population older than 65 years has also grown faster than the national average[5]; this population is associated with higher per capita demand for health care services. Regarding disease burden, the state is projected to see increased incidences including of chronic conditions such as obesity, diabetes, kidney diseases, neurological disorders, and substance use disorders[6] which tend to need a higher engagement of health care professionals.

Supply Assessment

Georgia's healthcare workforce includes approximately 393,000 individuals,[7] a figure that is net of inflows (driven by in-migration and increasing volume of healthcare graduates) and outflows (driven by graduates' attrition from the state and workers' retirement). 2020 began with ~379,000 individuals and saw net inflows of 2,000 workers from migration[8] and additional retention of ~13,000 graduates from local health institutions.[9] Georgia retains 58% of its healthcare graduates, putting Georgia in the median of its regional peers.[10] However, Georgia faces impending challenges as 20% of nurses, behavioral health, and specialty care workers are over 55 years old and likely to retire over the next decade.[8]

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4 US Census Bureau

5 U.S Census Bureau, American Community Survey

6 McKinsey Vulnerable Populations dashboard; data from 2021 Compile, 2021 Decision Resources, LLC, 2020 Algorex Healthcare Technologies, LLC, 2021 Carrot Health

7 Lightcast™ (formerly EMSI-Burning Glass), U.S Census Bureau, National Center for Education Statistics

8 Lightcast™ (formerly EMSI-Burning Glass)

9 National Center for Education Statistics - Integrated Postsecondary Education Data System database

10 *Ibid*

Workforce training is largely borne by public and private post-secondary institutions, and nearly 50% of healthcare graduates come from 20 institutions.[11] Moderate and incremental capacity increases at these institutions could have a sizable effect on total annual workforce development. Beyond available seats, Commission Members identified that educating the future workforce is further constrained by factors such as faculty shortages, cost of education, and access to desired programs.

Commission's Recommendation

Recommendations to increase the size of the healthcare workforce are grouped into three areas for improvement:

1. Maximizing our existing workforce
2. Optimizing our healthcare education system
3. Attracting new workers

Alongside the three areas for improvement, our Commission also provides recommendations on healthcare infrastructure reinforcements concerning data and collaborating with Georgia's Board of Nursing. Our Commission also provides occupation-specific recommendations for EMS and Behavioral Health that may bolster the ultimate goals of this effort.

Our Commission acknowledges that our efforts to examine drivers of the state's healthcare workforce supply and demand imbalances and potential opportunity levers largely focus on the nursing-related profession and allied healthcare workers. We realize that the healthcare workforce contains more diverse occupations and that there is an imperative to address other shortages as well, e.g., physicians in primary and specialty care. Many of the recommendations contained here could also support those shortages.

A. Maximizing our existing workforce

Among the opportunities considered to maximize our existing workforce, our Commission would like to highlight retaining workers in the workforce, profession, and state, and supporting healthcare providers in operating at top of license within scope of practice limits.

On retaining existing workers, across professions and geographies, Commission Members noted a prevalent trend of healthcare workers either leaving their employers or leaving the profession altogether. Whether that move consisted of physicians to early retirement, nurses to agency staffers, or EMS professionals to truck driving, to name a few, the stress of this exodus is felt across the already stretched-thin workforce. Beyond anecdotes, data reveals the same story. In a recent national survey, 47% of current healthcare workers indicated that they intended to leave their roles in the next 2-3 years.[12] Moreover, Georgia's healthcare workforce is losing a consistent 3.7% of its workers each year that is not being replaced by new graduates.[13] For workers who continue in the workforce, our Commission additionally noted a need for healthcare providers to operate at top of license to enable both a personal sense of satisfaction at work and efficient, effective care delivery.

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11 Lightcast™ (formerly EMSI-Burning Glass), National Center for Education Statistics - Integrated Postsecondary Education Data System database, Gray Associates

12 Elsevier, Clinician of the Future Report 2022: elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf

13 Lightcast™ (formerly EMSI-Burning Glass)

Considering these phenomena, the Commission would like to highlight three key example initiatives to maximize Georgia's existing healthcare workforce by better retaining existing workers and achieving top of license delivery within scope of practice limits:

1. **Address workplace violence which is a driver of attrition**

   Healthcare workers already operate in a challenging workplace environment with everyday difficulties delivering patient care and exacerbated stresses brought on by the COVID-19 pandemic. On top of these issues, healthcare workers also often deal with workplace violence. Nationally, healthcare workers are five times as likely to suffer a workplace violence related injury compared to workers overall. In addition, the rate of reported workplace violence increased by over 60% among healthcare professionals from 2011 to 2018.[14] In one survey, over half of healthcare workers reported deciding to leave their jobs due to physical and emotional tolls as well as the demanding nature/intensity of their workload, all of which can be exacerbated by incidents of workplace violence.[15]

   It is important to note that the damage of workplace violence occurs in the moment and can continue beyond it as well. Our Commission's experience has been that strictly punishing those who commit violent acts in a medical setting is unlikely to deter similar actions in the future, nor is it likely to retain workers after a violent incident. Therefore, stakeholders should uphold a zero-tolerance policy for violence backed by measures that address workplace violence via prevention, immediate response, and post-incident support for victims. In interviews, Commission Members suggested that healthcare stakeholders could consider piloting programs with measures such as establishing staff and systems for alert and de-escalation in the moment of violent situations, particularly in high-incidence areas such as psychiatric wards and emergency rooms; and supporting legislative efforts to strengthen prosecution in a manner that optimally preserves victims' safety, privacy, and emotional wellbeing. Additionally, healthcare employers could consider preventive measures such as public service announcements clearly stating behavioral expectations and penalties for offenses; regularly conducted workplace violence prevention courses (e.g., mental health trainings, de-escalation trainings); closer collaboration with police to ensure appropriate training to distinguish between violent acts primarily driven by psychiatric conditions versus other criminal acts, and a clear incident reporting system for healthcare workers.

2. **Provide loan forgiveness to help graduates stay in Georgia**

   Losing trained talent is one of the biggest challenges facing Georgia's healthcare workforce. An analysis tracking location of employment vs. graduation, highlights that 58% of recent Georgia healthcare graduates stay in Georgia after completing their program, whereas leading regional peers' retention rates hover closer to 70%.[16] While this movement may be in part due to broader economic and personal factors outside the scope of our Commission, there are nevertheless several steps that could be taken to improve retention.

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14 Bureau of Labor Statistics

15 NSI National Health Care Retention & RN Staffing Report

16 Lightcast™ (formerly EMSI-Burning Glass), Bureau of Labor Statistics

In multiple interviews with our Commission Members, it was noted that loan forgiveness could be used as a tool to incentivize students to remain in state after graduation. Student loans are a national issue with which many graduates – including healthcare workers – struggle. Nursing graduates accrue between $40,000-54,999 in debt on average, while physicians accrue upwards of $200,000.[17] The state of Georgia could explore relieving students' financial burden by providing opportunities for loan forgiveness to those who elect to remain in state for at least a set number of years post-graduation. Moreover, retaining workers in-state is a challenge that extends beyond healthcare workers themselves. Increasing additional pull factors such as broader economic opportunities for significant others or cost of living may influence healthcare workers' decisions to remain in state.

Georgia has implemented the Physicians for Rural Areas Assistance Program (PRAA) which provides loan forgiveness to healthcare workers willing to practice in rural areas. With resources for targeted marketing and expansion, piloting a similar loan forgiveness program could serve and attract a wider population across workforce occupations throughout the state.

The pilot of a loan forgiveness program could be a collaborative effort involving the state of Georgia, educational institutions, healthcare employers, and financial entities. The state could provide funds that educational institutions use to expand seats for high demand needs, and healthcare employers could match a portion of these funds as investment into their future talent pools. Loan forgiveness for students who decide to enroll could be structured so that financial assistance is tied to the goal of students putting down roots and staying in the healthcare workforce in-state beyond the required duration of the forgiveness program.

3. Explore potential updates to scope of practice limitations

For various healthcare occupations, clinical supervisory requirements involving oversight from a higher licensed professional exist with the intention of protecting patients via safe, high quality care delivery. Studies across multiple health professions have shown that clinical supervision is associated with effectiveness of care, and particularly in demonstrating significant improvements in the process of care that may improve compliance with processes that are associated with enhanced patient health outcome.[18] At the same time, our Commission recognizes that Georgia is now in the minority of states with restrictions on certain healthcare occupations such as nurse practitioners and physician assistants,[19] and that research also suggests that in appropriate circumstances, removing practice restrictions on certain healthcare occupations and granting full practice authority has the potential to improve access to care without compromising quality or increasing costs.[20] Our Commission believes that exploring updating scope of practice limitations could

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17 Webster, P., & North, S. E. (2022, February 10). *Health Professions Educational Debt: Personal, professional, and psychological impacts 5 years post-graduation*. Frontiers in medicine.

18 Snowdon, D.A., Leggat, S.G. & Taylor, N.F. Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience? A systematic review. BMC Health Serv Res 17, 786 (2017). https://doi.org/10.1186/s12913-017-2739-5

19 Denson, C., * Timmons, Edward. Addressing Georgia's Healthcare Disparities: The Benefits of Full Practice Authority for Nurse Practitioners and Physician Assistants. Georgia Public Policy Foundation. 2022 Sep 15. https://www.georgiapolicy.org/publications/addressing-georgias-healthcare-disparities-the-benefits-of-full-practice-authority-for-nurse-practitioners-and-physician-assistants/

20 Yang B.K., Johantgen M.E., Trinkoff A.M., Idzik S.R., Wince J., Tomlinson C. State nurse practitioner practice regulations and US health care delivery outcomes: A systematic review. Medical Care Research and Review. 2020 doi: 10.1177/1077558719901216.

potentially ease pressure on the healthcare workforce in two ways: by allowing certain categories of healthcare occupations to independently operate under their own licenses without additional clinical supervision, and by allowing them to perform more advanced work in healthcare settings that could decrease work burden on other clinical providers.

The potential impact of revising scope of practice limitations applies especially in rural areas. Rural areas can often operate on skeleton crews of healthcare workers that must re-direct advanced procedures to better-equipped facilities. For instance, this is especially true of surgical procedures that require anesthesia, because, while a rural facility may have a surgeon, they may not have an anesthesiologist. In many rural areas, demand for anesthesiologists is filled by nurse anesthetists who must currently operate under the license of a physician even if that physician does not have expertise with anesthesia. Should an expanded scope of practice for nurse anesthetists be granted, they could perform their current duties without placing a physician at risk who must oversee them but has no expertise in their area. This phenomenon is present for other forms of care beyond anesthesia, but this example shows how capabilities and staff needed especially in rural care could benefit from regulation that optimizes responsibilities to appropriately trained staff.

Expanding beyond rural areas, our Commission continually noted a need for healthcare providers to operate at top of license to ensure both satisfaction in one's work and efficiency in care provision. Beyond having all healthcare workers operate at the top of their licenses, stakeholders could consider modifying healthcare workers' scope of practice in all settings to rebalance workload currently reserved for higher licensed individuals. Doing so would free the higher licensed individuals to practice more advanced procedures and see more patients in aggregate. Such a change could empower the current workforce to meet rising demand for healthcare and possibly help retention through creating a more purposeful and sustainable work environment.

B. Optimizing the healthcare education system

Pain points in the healthcare education pipeline compound the attrition problem throughout the healthcare workforce. While the healthcare education system presents nuanced challenges with multiple variables, two trends emerged during the Commission's research: healthcare graduates are leaving the state at higher rates compared to peers and, through either the decision to drop out or never enter schooling, the financial feasibility of school can be prohibitive to Georgia students.

Regarding graduates' decision to leave the state, the Commission found that 42% of Georgia healthcare graduates leave the state after graduation compared to 26% in Texas or 36-37% in Florida and North Carolina.[21] Before making that decision to leave the state, however, Georgians may make the decision to drop out of a healthcare education program or never enter due to financial infeasibility. Indeed, across the nation, nursing graduates finish school with an average debt of over $28,000.[22] For Georgians to make the decision to seek education in healthcare pathways, that education should be affordable and new programs

21 Includes 60 occupations across healthcare practitioners and technical (29-0000), healthcare support (31-0000), community and social service (21-0000) and life, physical and social science (19-0000); share of grads who remain in-region after completing their degree; based on profiles (LinkedIn, Career Builder, etc.) updated since 2018 for graduates of higher ed institutions

22 New York State Nursing Association

should be focused on proven efforts that could help retain healthcare workers in the state after graduation.

The Commission highlights two example initiatives to optimize the healthcare education system by increasing availability of total seats and faculty:

1. **Stand up Quick Start for healthcare**

   To attract businesses in new and emerging industries to the state, Georgia currently funds and facilitates the nationally recognized Georgia Quick Start program through the Technical College System of Georgia (TCSG). Quick Start utilizes the instructional design capabilities of TCSG to provide rapid, targeted training to future employees of new businesses in Georgia. Such a program could be expanded or used as a model to accelerate developments in our healthcare industry. Quick Start for healthcare could involve a program through which current healthcare employers could offer practical, clinical-based training for uncertified workers to obtain certification and move into allied health pathways (including qualified high school students as applicable). The consultation and technical assistance offered by Georgia Quick Start could lead local communities in the design and implementation of the appropriate pathways and collaborations that lead to a more robust workforce, recognizing that solutions must be specific and customized to each community.

   Nationally, allied healthcare workers comprise most healthcare workers.[23] In Georgia, the number of healthcare certificates (primarily allied health and technical roles) has trended downward by 4% over the past five years.[24] Interviews with individual Commission Members revealed that, when allied healthcare positions go unfilled, nurses, physicians, and other healthcare professionals end up operating below their license to fulfil patient needs. Given professionals' desire to contribute meaningfully according to their training, this phenomenon leads to further burnout and disaffection among healthcare professionals that exacerbates the extant shortage.

   Given some of our Commission Members noted the high cost of providing training programs for select healthcare pathways relative to the tuition charged, Quick Start could consist of a collaboration between the state and healthcare employers that combines multiple funding sources to create the training curriculum, facilities, and incentives needed to recruit workers for immediate handoff and employment in a healthcare setting. The program could include measures such as establishing healthcare-focused Centers of Excellence that include high-fidelity patient simulators to support instruction for allied healthcare workers, working with hospitals to create dedicated education units, providing opportunities within state hiring procedures to hire "affiliate" faculty to address the clinical faculty shortage, virtual training for select didactic elements, and collaborating with high schools as appropriate to recruit into the program. The program could increase the number of clinical experience opportunities available, serve as a recruiting tool for healthcare fields, support worker retention in-state, and provide downstream benefits to other healthcare workers.

   The Georgia Quick Start model has been effective at supplying the necessary workforce to support economic development projects statewide, and the Commission

23 Association of Schools Advancing Health Professions

24 Lightcast™ (formerly EMSI-Burning Glass), National Center for Education Statistics – Integrated Postsecondary Education Data System database

recommends tapping into that existing model to support the workforce demands of the existing healthcare industry.

2. Explore earn-to-learn programs for healthcare students

Several of our Commission Members pointed in interviews to the need to support healthcare students in continuing their education to progress into high-need roles. Students pursuing healthcare education take on significant responsibilities that require substantial time, energy, and cost. Commission Members noted that leaving the workforce to pursue further graduate degrees may become less feasible for those with other personal and professional responsibilities (e.g., children, ailing family members, student debt repayment).

By allowing "earn-to-learn" programs, healthcare institutions could support graduate students in earning wages while completing their required clinical hours. Such programs could attract more students to pursue education in healthcare pathways.

Additionally, several of our Commission members noted that a key pain point in the education pipeline rests with the cost of education: some students take on high-hour part- or full-time jobs to afford education while also working to meet intense academic obligations present in healthcare programs. These strains sometimes impact student performance, causing students who may have been excellent healthcare workers to fail out or drop out of their programs. Allowing clinical students at some or all levels to receive compensation for the clinical work they perform could decrease or remove the need to maintain additional employment to pay for school, and thus improve retention and the number of new healthcare professionals graduating each year.

Moreover, while "earn-to-learn" programs would be intended to primarily target Georgia students, our Commission acknowledges that the spirit of this measure could also be adapted to potentially support industry-wide expansion of healthcare workers in the academic setting to support more opportunities for students (e.g., stipends or other financial measures to support clinical workers whose potential moves to academia involve a pay decrease compared to compensation for clinical practice).

3. Offer faculty incentives

Over the past few years, Georgia has seen a downward trend of 4% annually in the number of healthcare certificates awarded in the state[25]. Our Commission Members emphasized that to expand the number of seats in healthcare education programs, additional faculty will be needed to provide learning opportunities to those students. One primary way that our Commission would like to encourage additional faculty to join the healthcare education workforce is to explore offering incentives for qualified clinically trained individuals to spend time teaching.

The state of Georgia could explore offering incentives to attract nurses and other healthcare workers to spend at least a portion of their time teaching; these incentives could vary in nature, but examples could include funding loan forgiveness for healthcare educators. Our Commission noted that healthcare workers operating in clinical care settings tend to be more highly compensated than those in academic

25 Lightcast™ (formerly EMSI-Burning Glass), National Center for Education Statistics – Integrated Postsecondary Education Data System database

settings, leading workers to deprioritize teaching opportunities in favor of care delivery. Providing additional incentives to healthcare workers who could be qualified to teach could raise the number of faculty and thus increase learning opportunities for students.

Beyond shrinking compensation gaps across clinical and teaching settings to attract potential faculty, providing incentives for faculty could also retain workers who want more flexibility in their responsibilities. Healthcare workers could expand their roles from solely clinical duties to also academic ones, potentially leading to higher job satisfaction. In addition, providing incentives for faculty is one of several ways to potentially retain workers who are near retirement by converting them from purely clinical to teaching roles, thus capitalizing on their substantial knowledge of the field while also benefiting future healthcare worker generations.

C. Attract new workers

Attracting new workers to Georgia and our healthcare industry could take several forms. While the need for healthcare workers has only grown with the increasing prevalence of chronic illness combined with a global pandemic, the number of healthcare degrees granted has flattened and certifications awarded have decreased by 4% annually.[26] Among Georgia graduates, 17% studied healthcare pathways compared to 18% for regional peers and 20% for economic peers.[27] If the state matched its economic peers in share of healthcare graduates, it could see an additional ~3,000 graduates in the state each year.[28]

The Commission recognized that, to increase the share of students studying healthcare pathways, stakeholders may need to focus on creating early and accessible opportunities to enter healthcare combined with a robust financial support system for future clinicians. The Commission would like to highlight two key example initiatives to attract new workers by targeting a larger pool of students with outreach and incentive programs:

1. Optimize marketing of dual enrollment opportunities in healthcare fields for high school students

The current healthcare educational pipeline is not producing healthcare workers at a sufficient rate to fill all new positions in the state each year. The total retained capacity of the healthcare education system (total graduates x in-state retention rate) falls short of the forecasted demand (new positions + retirement replacements) by 8,100 positions per year over the next five years.[29] Many healthcare professions require at least a certification to practice, and others require college degrees. Some of these certifications could be completed alongside high school coursework to provide graduating students with certifications that enable them to enter the workforce immediately after graduation.

Healthcare stakeholders in Georgia could explore opportunities to encourage high schools to host allied healthcare training programs; or create healthcare occupation training programs in collaboration with technical colleges or other accredited institutions that students could engage in as part of their school day (*see section B1*

26 Lightcast™ (formerly EMSI-Burning Glass), National Center for Education Statistics- IPEDS dataset

27 Includes all degree and certificate completions for health professions and related programs (CIP 51)

28 *Ibid*

29 Lightcast™ (formerly EMSI-Burning Glass), Bureau of Labor Statistics

above). The Dual Enrollment program in the state already fosters this sort of collaboration between Georgia high schools and eligible post-secondary institutions, but as our commission noted during Commission Meeting Two, increased marketing and resources especially earlier in students' high school journeys could entice more students to pursue healthcare professions through this pathway.

A collaboration like this could enable Georgia students to make use of state education funding to receive sought-after healthcare credentials and obtain employment immediately after high school graduation. It could also help alleviate the shortage of allied healthcare workers and place more Georgians in healthcare pathways that may lead to further credentialing and promotion in healthcare.

2. **Create additional scholarship opportunities for healthcare education**

Cost of attendance can be a major barrier for students interested in pursuing higher education in healthcare. Simultaneously, many scholarship opportunities are focused on academic merit measured by quantifiable metrics such as GPA and test scores, but as many of our Commission members noted during Commission Meeting Two, GPA is not always a direct indicator of success in the medical profession. Many students may lack certain qualifications for merit aid due to external responsibilities affecting academic performance (such as working several jobs or personal obligations to family), but those same students who may meet basic requirements for becoming credentialed in the field also may have the potential to become leading healthcare professionals if given appropriate financial support. Georgia has made significant advancements in offering college financial assistance to students, in terms of the HOPE Career Grant that offers free tuition in critical shortage fields for certain programs and for launching Georgia Completion Grants targeting students that are nearing completion of their degree.

To further expand access to opportunity for Georgia students, healthcare and education stakeholders could consider increasing the opportunities for students who demonstrate ability to meet competency-based criteria for credentialing, regardless of their ability to meet specific merit-based criteria. For instance, Georgia could consider expanding eligibility for financial aid programs to students interested in upskilling to the next higher credential in healthcare. Stakeholders could also consider funding new healthcare-focused scholarships that provide expanded eligibility (e.g., with practicums administered by one's healthcare institution as one of several measures for scholarship eligibility). To support attraction through retention, there could be consideration of preferencing students who commit to stay and work in Georgia post-graduation.

Healthcare infrastructure reinforcements

Notwithstanding the above recommendations, our Commission identified that the healthcare workforce and state of healthcare generally could see marked improvements with some broad state-level initiatives as well as occupation-specific initiatives.

Infrastructure reinforcement initiatives include establishing uniform standards and a clearinghouse for data related to the healthcare workforce pipeline (e.g., program vacancy information, most needed degrees/certificates, how many licensed and credentialed

individuals are practicing) to track the current state of the workforce (including the student pipeline) and any subsequent changes. Additionally, collaborating with the Board of Nursing to consider how they could support advancing the healthcare workforce agenda could alleviate educational and clinical constraints on the current workforce.

Occupation-specific example recommendations center around EMS and Behavioral Health. While both sub-segments of healthcare may benefit from application of the above recommendations, they may also benefit from specific attention due to their keystone positions in the healthcare ecosystem.

Cross-cutting initiatives

1. **Establish uniform standards for data collection and a central clearinghouse through which providers can view current healthcare workforce data**

   To measure any of the impact of our recommendations or mitigate the gaps in the present workforce in the future, healthcare stakeholders around Georgia may benefit from a centralized data clearinghouse with uniform reporting standards. Throughout interviews with members of our Commission and public Commission meetings, our Commission unanimously emphasized the need for improved data to make important decisions in a timely fashion regarding their respective sectors of the healthcare industry. Current data is held across various state offices and exhibits varying degrees of reporting from stakeholders around the state.

   Such a data clearinghouse could exist within an existing state department charged with maintaining widely interoperable state-level data. It may benefit from established, required reporting schedules and formats, and data fields that could be published to stakeholders in the state upon validated quality and likelihood of impact. These reporting schedules and formats could be attached to extant healthcare provider questionnaires already carried out across the state. Data fields could include but not be limited to academic/training program vacancy information, average time to fill vacancies, most needed degrees/certificates, salary by geographic region, how many licensed and certified individuals are practicing, placement of healthcare workers in provider setting (bedside vs. non-clinical areas), healthcare workers by zip code, and many others. Mandatory up-to-date reporting could benefit the entire state as it seeks to fill its supply/demand gap and meet the growing need of healthcare workers. With a closer to real-time view of the state's needs, our Commission and future stakeholder efforts could then continue to provide targeted recommendations that maximize impact per state investment.

   Regional peer states that exhibit greater retention and training of healthcare workers (such as North Carolina) often have extensive state-level data clearinghouses used to inform their decisions.[30] While a data clearinghouse is unlikely to singlehandedly improve the workforce supply, it is a foundational investment that enables other initiatives and efforts to succeed.

2. **Collaborate with Georgia Board of Nursing to alleviate educational and clinical bottlenecks**

30 Sheps Health Workforce NC

The Board of Nursing sets the regulations that govern nursing licensure and education in the state. Though it subscribes to several national standards (such as requiring the NCLEX instead of a local nursing exam), the Board of Nursing maintains jurisdiction over many state-level regulations that affect the way nurses practice in the state and the way educational institutions structure their nursing programs.

From individual interviews and public Commission Meetings, our Commission Members believe that a deep collaboration with the Board of Nursing to produce potential changes in state regulation could enable education stakeholders to increase the number of faculty and students in their programs and ease care provision by practicing nurses. Example changes could include allowing part-time faculty to be counted in required student-to-instructor ratios, updating the ratio of permitted part-time teaching faculty allowed in clinical settings, modifying licensure requirements for foreign-trained nurses, considering alternative discipline systems for reports against nurses, and exploring adjustments to admissions criteria and student supports (e.g., financial and non-financial incentives for students caring for children and/or family members, pathways for military medics to enter the healthcare civilian workforce).

These potential changes could help remedy the shortage of instructional faculty, provide experienced nurses with the flexibility to teach and practice simultaneously, and increase the number of students allowed within educational institutions. Combined with initiatives to increase interest in healthcare pathways and increase clinical capabilities, updates to these regulations could provide non-resource-intensive pathways to bolster Georgia's workforce.

Additionally, our Commission raised earlier the potential of having "earn-to-learn" programs support healthcare students in earning wages while completing mandatory clinical hours. For any such "earn-to-learn" programs, our Commission recognizes that it would benefit to have the Board of Nursing's collaboration in downstream impacts, e.g., updating their annual reporting methodology to appropriately credit students' clinical hours; and, working with institutional stakeholders to ensure that students are guided towards appropriate certifications to facilitate appropriate payer reimbursement for the clinical hours that the students serve.

Occupation-specific initiatives

1. Emergency Medical Services

One of the key entry points to medical care rests in EMS. In Atlanta, investigations have shown that in critical situations, the average Atlanta resident waits nearly 30 minutes for EMS to arrive, and rural areas face the especial challenge of needing to cover more ground to reach patients.[31] One Commission noted that in rural areas, healthcare providers may additionally lack necessary equipment or expertise to perform some life-saving procedures which requires patients to be transferred to a provider with appropriate capabilities and resources. For smaller rural EMS providers, these transfers can take up to five hours and, if they have multiple transfers, can

31 Polansky, R. Atlanta News First. "In an emergency, expect to wait 30 minutes for an ambulance in Atlanta." 2022 Jul 11. https://www.atlantanewsfirst.com/2022/07/11/when-seconds-count-atlantas-ems-response-times-are-rising-by-minute/

occupy entire departments, leaving nearby emergencies without EMS teams to assist them. In many cases, minutes can mean the difference between life and death.

Interviews by Commission Members with EMS administrators noted that challenges include decreased availability and accuracy of data surrounding training, decreased transferability between counties, and increased costs to EMS providers to train new workers. Moreover, certain state regions lack technical colleges to train EMS professionals and require that prospective EMS workers enter private training or travel long distances to attend courses. Our Commission Members noted a set of potential breaking points in the current EMS system, including the possibility that the largely government-based revenue stream could limit the ability to offer competitive salaries, a lack of incentive in the education system to expand spots due to the cost associated with training EMS professionals, and a lack of prosecution of violence against EMS workers.

EMS also faces issues along the rural and urban divide. Interviews by Commission Members with EMS administrators also highlight that in rural settings, transfers or spikes in calls can occupy all staffed EMS providers and lead to longer response times. In urban areas, providers struggle to find needed employees, suffer from long wait times at healthcare provider drop-off locations, and run sometimes-dilatory calls to low acuity cases because current compensation dynamics disincentivize utilizing telemedicine to avoid running those calls.

In response to these issues, our Commission recommends that technical schools expand their capacity to train EMS workers, explore hybrid course options to connect rural areas to remote campuses, and implement approaches that allow instruction programs to reward effective instructors and remedy underperforming programs. On supporting care delivery, our Commission suggests exploring regulatory changes that would allow, under the right circumstances that keep patients safe, both rural and urban providers to use two EMT-R licensed medics to provide EMS transports for low acuity, non-emergent patients. We encourage the Insurance Commissioner to work with the EMS agencies and insurance providers to ensure EMS licensed providers are incented appropriately to respond to calls using telemedicine where appropriate to reduce the cost of care to payers, relieve the burden on overstressed Emergency Departments, and improve efficacy in the EMS system.

2. Behavioral Health

Behavioral health has historically been underfunded compared to physical health: interviews with Commission Members noted that throughout Georgia, this has resulted in aspiring providers facing limited provider training opportunities, existing providers facing higher risk of burnout from difficult working conditions (e.g., related to staffing shortages, workplace violence), and individuals and families finding it more difficult to access care, especially in rural areas.

From a macro-regulatory perspective on the economics of behavioral health care provision, the Georgia General Assembly voted unanimously in April 2022 to pass the Mental Health Parity Act, ensuring that the state will now enforce parity in insurance

coverage for behavioral health.[32] In time, enforcing parity will help address mental health workforce shortages by ensuring equity in provider reimbursement by insurers which should incentivize more providers to take both public and private insurance, make behavioral health treatment more financially accessible for individuals and their families, and reduce long wait times for treatment.

In the near term, besides ensuring that behavioral health is supported appropriately in aforementioned example initiatives that are implemented (e.g., exploring creation of scholarships for individuals seeking to enter the behavioral health workforce), our Commission recommends exploring several potential measures that could support increasing the talent pipeline and retaining existing professionals. For example, stakeholders could support more on-the-job, practical training for behavioral health support positions, expand roles of behavioral health support positions (e.g., allow med-techs to supply medications vs. having nurses do it); ease credentialing for qualified providers (e.g., for qualified providers who want to practice both in Georgia and in other states), and maintain flexibility in Georgia's telehealth regulations to make evidence-based practice permanent (e.g., updating stipulations on service origination so providers can be reimbursed for care delivered from the safety and privacy of non-facility sites).

Additional Opportunities for Consideration

Our Commission recognizes that the priority initiatives discussed above address only part of the challenge of expanding Georgia's healthcare workforce. We considered these initiatives within a broader set of potential levers aimed at maximizing our existing workforce, optimizing the healthcare education system, and attracting new workers. Each of these opportunity levers can be addressed in multiple ways to contribute to increasing the healthcare workforce. For instance, to retain existing workers through methods discussed earlier—addressing workplace violence and utilizing loan forgiveness—stakeholders could also guide students earlier on to encourage staying in Georgia post-graduation. As our Commission Members discussed, two primary factors that determine where someone moves after school are where their school is located and where they originally came from.

Such action could be done through measures such as having local post-secondary educational institutions hold Georgia-only career fairs or encouraging career counselors to prioritize Georgia institutions for employment. An example program could encourage the prioritization of Georgia healthcare employers in the first wave of career fairs and counseling, potentially increasing retention in the state. A successful attempt at this program would require coordination between universities, employers, industry associations, and university career services departments, and would focus on students soon to enter the workforce.

Acknowledgement

As we close out, our Commission Members wish to express thanks to Governor Kemp for highlighting the importance of addressing our state's healthcare workforce needs, to all our staff for the time and energy dedicated to exploring root causes and opportunities to address

32 Carter Center, "With New Law, 2022 is the Year for Mental Health in Georgia"

the challenges, and to all members of the public who engaged with us and shared input via our Open Forums, Commission Meetings, and general correspondence.