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# Health Reform Implementation: Identifying Workforce Needs from the Massachusetts Experience

*Michael Tutty, MHA, MS*

## Massachusetts Health Reform

In 2006, Massachusetts implemented comprehensive health reform with the passage of Chapter 58 of the Acts of 2006. This bill expanded Medicaid coverage, created new subsidized health insurance programs, implemented health insurance market reforms, created an individual mandate, and developed a health insurance exchange (McDonough, Rosman, Phelps, & Shannon, 2006). These health reform efforts were successful at lowering the uninsured rate in Massachusetts—reported to be under 2% by 2010—although minorities continue to report higher uninsured rates (Division of Health Care Finance and Policy, 2010). The growth in the number of insured came from expansions of public programs, as well as from individuals purchasing health insurance in the private market. Despite fears that some employers would discontinue offering employer-sponsored health insurance to their employees, the percent of employers offering health insurance rose from 68% in 2003 to 77% in 2010 (Division of Health Care Finance and Policy, 2011). Massachusetts' health reform efforts would not have been as successful without a strong primary care workforce and significant community-based outreach and enrollment efforts. As the United States implements national health reform, AHECs are positioned well to support the development of this needed workforce.

In Massachusetts, media, partnerships with the business community, and collaborations with not-for-profits were used to implement a broad and sophisticated outreach campaign (Urff, 2011). Outreach/community health workers (CHWs) played a large role in providing individuals with one-on-one assistance in enrolling into eligible programs. CHWs have been credited with assisting a significant portion of those who gained health insurance after health reform implementation in Massachusetts (Rosenthal et al., 2010). The state provided grants to community-based organizations to support these outreach workers and their work in various communities around the state (Dorn, Hill, & Hogan, 2009) and the Mass AHEC Network collaborated with many of these programs to ensure that the CHWs were well trained.



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Success in expanding coverage, however, has not been without its own challenges. Increasing the number of insured residents in

Massachusetts, for example, has put a strain on the health-care delivery system, particularly community health centers (CHCs). Since the law was enacted, total healthcare employment per capita has grown more rapidly between 2005 and 2010 in Massachusetts (9.5%) compared to the rest of the country (5.5%) (Staiger, Auerbach, & Buerhaus, 2011). CHCs have played a critical healthcare delivery role in Massachusetts, with the number of patients utilizing CHCs growing by over 30% between 2005 and 2009 (Ku, Jones, Shin, Byrne, & Long, 2011). Patients using these facilities do not see these healthcare organizations as providers of last resort; rather, patients see them as their medical home, providing culturally competent care (Ku et al., 2011). In 2008, the MassAHEC Network collaborated with the Massachusetts League of Community Health Centers to assess the recruitment and retention challenges for primary care physicians working in CHCs and determined that while a salary is often purported as physicians' biggest concern, for many, working with skilled trained support staff is as or more important (Savageau, Ferguson, Bohlke, Cragin, & O'Connell, 2011).

## Looking Ahead at National Health Reform

In many ways, the Affordable Care Act (ACA) is based on the Massachusetts health reform efforts. Looking at the Massachusetts experience can help project the workforce needs nationally as health reform is implemented. Workforce initiatives should consider planning ahead to grow the work force of community health and outreach workers, primary health-care providers, and allied health and other healthcare support professionals. This is where AHECs can play a substantial role.

Assisting individuals to navigate available subsidized health insurance options and ensuring appropriate use of the health-care system will be an important role in assuring the success of the ACA. To that end, the ACA requires health insurance exchanges to create a 'Navigator Program' and provide grants to these organizations. While the law describes various types of organizations that could be navigators, from not-for-profits to trade and industry groups, each will be required to conduct fair and impartial public education activities to increase awareness of new program benefits (Rosenbaum, 2011). Whether their roles are as formal patient navigators or outreach positions based in hospitals, CHCs, and other community-based organizations, the CHW workforce will play an important role. The Outreach Worker Training Institute (OWTI) at the Central Massachusetts AHEC, is an example of a program offering certified courses to grow and educate

this segment of the workforce. OWTI has created adaptable curricula to reach different minority populations, address a range of healthcare topics, and support CHWs working in different settings. The courses are team-taught, with a CHW as co-instructor to ensure that knowledge provided is immediately applicable in a community setting.

As more individuals gain health insurance nationally, strain on the healthcare delivery system and its workforce will intensify. Particularly important will be supporting the safety net provider primary care workforce as the numbers of patients utilizing safety net providers grows after reform. While Massachusetts is known for having more physicians per capita than any other state (National Center for Health Statistics, 2011), shortages still exist in CHCs as their demand increases. Creating workforce training opportunities to grow the primary care workforce, with emphasis on providing care at safety net provider sites such as CHCs, not only helps grow the workforce, but increases provider satisfaction and retention once they are employed in these settings (Savageau et al., 2011). AHEC-coordinated primary care workforce training opportunities from high school through clinical residency targeted at exploring career opportunities in safety net settings will be essential to providing a primary care workforce to the newly insured.

As currently uninsured individuals—particularly minorities who have been disproportionately uninsured—gain access to the healthcare system, ancillary and support roles to the primary care workforce in the healthcare setting will need to grow (Staiger et al., 2011). Of particular need will be trained medical interpreters to help provide culturally responsive care. The MassAHEC Network has trained over 200 “dual-role” medical interpreters each year since Massachusetts health reform passage (University of Massachusetts Medical School MassAHEC Network, 2011). For many organizations, employing full-time interpreters is cost prohibitive; while less costly, the alternative of telephonic interpretation is not always patient-friendly; training billing and reception staff, medical assistants, and others who are bilingual to utilize their language skills appropriately in their jobs helps improve access. National health reform will create significant workforce needs in many of these ancillary and supporting functions in the healthcare system.

Passing health reform legislation is the first step in a long process to reduce the number of uninsured individuals and improve access. Creating a workforce to support national health reform is a critical component for success. No matter the extent of national health reform implementation in each state, AHECs across the nation will have an important role in educating and developing the workforce that will provide outreach and enrollment services to the newly eligible uninsured individuals and creating the primary care workforce that will care for this newly insured population.

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