



Strengthening Maryland's Health Workforce towards Meeting the Goals of AHEAD

Focus Group
April 10, 2026



AGENDA

Goal: Identify strategic priority areas for future health care workforce development efforts.

- ▶ Brief overview of AHEAD regulatory working group multi-agency work plan and workforce topic
- ▶ High-level overview of Maryland's Rural Health Transformation Plan
- ▶ Focus areas for discussion
 - Workforce Size and Distribution
 - Workforce Pipeline
 - Entry into Practice
 - Optimizing Workforce Deployment



Brief overview of AHEAD regulatory working group multi-agency work plan and workforce topic



Work Plan Overview

- ▶ Last September, Governor Moore issued a directive creating a working group of State regulatory agencies to develop a workplan identifying priority topics to be addressed that have implications for Maryland's performance under the AHEAD Model.

- ▶ Working group submitted plan in October including following topics:
 - Cost-shifting policy
 - Medicare Advantage Market Stabilization
 - Choice and Competition
 - ***Workforce and Graduate Medical Education***
 - Post-Acute Care
 - Total Cost of Care and Primary Care Targets



Workforce and Graduate Medical Education Topic

- ▶ The health workforce serves as the foundation upon which the health system operates
- ▶ Having a sufficiently sized, strategically configured workforce that is well-trained, adequately-resourced, and otherwise supported can contribute to the efficient delivery of care that promotes population health
 - To achieve optimal outcomes, it is also important to have a workforce that understands and relates to the communities it serves
- ▶ Work plan called for developing a strategic plan that holistically addresses workforce development needs, noting that strengthening the health care workforce is also a key element of Maryland's Rural Health Transformation Program
 - It also focused on the role of GME support under the model and how this will be affected by the transition to Medicare global budgets in 2028

Workforce and Graduate Medical Education Topic (continued)



- ▶ Goal for focus group
 - Given the breadth of health workforce issues, with a number of different programs spread across different agencies, we are asking this focus group to help us identify a set of health workforce strategic priorities for the state to address moving forward that are most likely to generate the largest return on investment in the future.

- ▶ Draft report identifying strategic priorities due June 2026, final report in Fall 2026



High-Level Overview of Maryland's Rural Health Transformation Plan



High-Level Overview of Maryland's Rural Health Transformation Plan (for awareness)

- ▶ The Rural Health Transformation Program is a federal initiative designed to improve access to care and strengthen health systems in rural communities
- ▶ Maryland received \$168 million in federal funding for the first year of the five-year program to support rural health system transformation across the state
- ▶ Maryland's plan includes three initiatives:
 - ***Transform the Rural Health Workforce***
 - Promote Sustainable Access and Innovative Care
 - Empower Rural Marylanders to Eat for Health
- ▶ Initial workforce investments focus on expanding health career pathways, strengthening Area Health Education Center programs, and building workforce data infrastructure



Workforce Size and Distribution



Workforce Size and Distribution - Summary of the Issue

- ▶ Health workforce supply depends on how many professionals are trained in various disciplines/specialties and their retention across the state
- ▶ Even when overall supply is sufficient, regional shortages can occur and there may be uneven access within communities depending on factors that affect access to care for certain subpopulations such as disparities in coverage



Workforce Size and Distribution - Summary of the Issue (continued)

- ▶ Data from the Bureau of Labor Statistics indicate that between 2014 and 2024, Maryland's healthcare workforce grew 12.5% compared to 19.3% for the nation
 - However, growth looks more similar when just looking at recent years (2022-2024), 8.6% for Maryland vs. 8.25% nationally

- ▶ Information on certain segments of MD workforce compared to other states:
 - Among the largest number of physicians per capita (393 - 400 per 100k), yet 22 of 24 counties face critical shortages
 - Above average supply of nurse practitioners per capita
 - Close to average supply of physician assistants per capita
 - Above average supply of registered nurses per capita
 - Significant shortages of behavioral health professionals



Workforce Size and Distribution - Summary of the Issue (continued, part 3)

- ▶ 14 of Maryland's 24 counties have health professional shortage areas
- ▶ Roughly 1.2 million Marylanders live in primary care shortage areas
 - However, a number of these designations are currently proposed to be withdrawn
- ▶ Estimates of projected workforce shortfalls in MD:
 - Projected to have 900 fewer primary care physicians than needed by 2030
 - RN shortages are projected to reach 13,850 FTEs, while LPN shortages are expected to grow to 7420 FTEs by 2030 (Maryland among the top six states with the lowest projected adequacy for nurses)
 - Maryland needs approximately 32,786 new behavioral health workers by 2028 to stabilize the system



Discussion Questions - Clinician Shortages

▶ Question 1

- Does the information presented on the prior slides reflect your perception of the current supply of health care clinicians across Maryland?

▶ Question 2

- Are there particular specialties or settings of care where shortages are especially pronounced or where there are gaps in data that need to be filled?



Discussion Questions - Clinician Shortages (continued)

▶ Question 3

- What are some of the key issues limiting overall supply of the below professionals and what other challenges may be most pressing for them?

Physicians

Registered nurses

Nurse practitioners

Behavioral health specialists

Physician assistants

▶ Question 4

- What are some of the key factors causing shortages in certain regions of the state for these professionals?



Discussion Questions - Allied Health Workforce

▶ Question 1

- What is the status of the allied health workforce? What types of challenges are most pressing for these types of workers and for whom? Who else might we be missing?

Technicians

Doulas

Counselors

Community health workers

Therapists

Peer support specialists

▶ Question 2

- Are there any types of shortages that should be especially prioritized, and why?

▶ Question 3

- Are there any other questions on workforce supply and distribution we are missing?



Workforce Pipeline



Workforce Pipeline - Summary of the Issue

- ▶ Workforce development is supported through many types of experiential, training, recruitment, and retention programs and incentives.
- ▶ These programs and incentives vary in terms of how much they cost to operate and their impact in on the health workforce. We are interested in better understanding the most effective approaches to support the workforce pipeline.
- ▶ The following are some examples of such programs and incentives.
 - Early exposure to health careers (K–12 awareness and pathway programs)
 - Apprenticeships and other work-based pathways into health professions
 - Career ladder programs (stackable credentials, employer partnerships, etc.)
 - Nursing, allied health, and medical training programs
 - Graduate Medical Education (GME) funding of residency slots
 - Loan repayment, scholarships, and other incentives
 - Conrad 30 J1 waiver program



Workforce Pipeline - Summary of the Issue (continued)

Early exposure to health careers:

- ▶ Early exposure programs can help introduce K-12 students to health professions, encourage them to pursue a health career, and help them prepare academically
- ▶ Examples in Maryland:
 - Maryland Area Health Education Centers (AHEC) student pathway programs
 - Health career academies in some public school systems
 - Hospital-sponsored youth career programs and internships
- ▶ Maryland lacks a centralized system to track whether K–12 pipeline participants ultimately enter the health workforce



Workforce Pipeline - Summary of the Issue (continued, part 3)

Background on health care registered apprenticeships:

- ▶ Maryland currently has 182 apprentices in 8 active programs in healthcare and related occupations through the Maryland Department of Labor
- ▶ These programs combine paid on-the-job training with classroom instruction and are often used for roles such as medical assistants and technicians
 - Enable individuals to gain new credentials while still earning an income
- ▶ Maryland has a Licensed Practical Nurse apprenticeship program where apprentices work under supervision in a variety of healthcare settings
 - Apprentices complete 39 work competencies over the course of two years
 - Currently open to workers who are already employed by a healthcare organization



Workforce Pipeline - Summary of the Issue (continued, part 4)

Graduate Medical Education (GME):

- ▶ In Maryland, GME payments operate within the state's unique hospital rate-setting system administered by the Health Services Cost Review Commission (HSCRC). They:
 - Are incorporated into hospital payment rates established for all payers
 - Contribute to the total cost of care under the AHEAD model
- ▶ GME funding for new residency slots must be approved by HSCRC, although programs can create new slots without HSCRC's approval if they are self-funded
- ▶ Maryland has 46 acute care hospitals statewide with 20 hospitals participating in residency training programs
 - There were 5,222 resident, intern, and fellow FTEs in FY25



Workforce Pipeline - Summary of the Issue (continued, part 5)

Additional information on medical school residents:

- ▶ Maryland ranks 12th in terms of the # of residents it produced between 2015 and 2024
- ▶ Maryland ranks 11th in terms of the number of residents per population
- ▶ Maryland ranks 44th in terms of the number of residents that continue to practice in-state after graduating (53.3% leave to practice in other states)
- ▶ AAMC data appear to indicate that primary care physicians and psychiatrists tend to be relatively more likely to remain in-state compared to other specialties (not specific to MD)
- ▶ Spending more time in rural areas (e.g., rural training tracks) during family medicine residency training found to be associated with higher odds of entering rural practice



Workforce Pipeline - Summary of the Issue (continued, part 6)

Incentives:

- ▶ Three primary entities fund loan repayment and scholarship programs in MD
 - US Dept of Health and Human Services, Health Resources and Services Administration (e.g., National Health Service Corps and Nurse Corps)
 - Maryland Dept. of Health
 - Maryland Higher Education Commission

- ▶ Data from the Health Resources and Services Administration indicate 49% of NHSC primary care participants continue to deliver care at the same place where they complete their service obligation and many of those who leave continue to practice in underserved areas



Workforce Pipeline - Summary of the Issue (continued, part 7)

Incentives:

- ▶ Scholarship programs tend to be more expensive per recipient than loan repayment programs and recipients are less likely to continue delivering care where they do their service obligation
 - One reason is that participants commit to service obligations earlier before they may fully understand their longer-term career goals/preferences
 - Can be more effective for those in the pipeline coming from underserved communities

- ▶ Scholarships are also intended to address other priorities
 - Influence career choice (e.g., electing primary care or behavioral health)
 - Encourage lower-income, rural, and other underserved populations to enter a health care profession



Workforce Pipeline - Summary of the Issue (continued, part 8)

Tracking Performance of the Workforce Pipeline:

- ▶ HRSA funds health workforce research centers in CA, DC, MN, NC, NY, and WA
- ▶ Other states operate their own health care workforce data tracking centers
 - CO, IA, MT, NE, NC, SC, TX, UT, VT, and VA
- ▶ The types of information produced by these centers range in terms of:
 - Sources of information
 - Types of workers and specialties tracked
 - Frequency of data reporting
 - How data are presented (e.g., tables, dashboards, maps, etc.)



Discussion Questions - Training Capacity and Early Exposure

▶ Question 1

- Are there workforce roles for which training capacity is particularly limited?

▶ Question 2

- What are key barriers that limit the ability to train these types of healthcare workers in Maryland and how can they be overcome?
 - For example: faculty/preceptor shortages, placement limits, or funding constraints

▶ Question 3

- Are there regions of the state that could benefit from having additional training programs, and if so, what type?



Discussion Questions - Training Capacity and Early Exposure (continued)

▶ Question 4

- Is there a need for new training programs for certain types of workers (e.g., CHWs) or to implement further standardization of training? If so, how can this be accomplished?

▶ Question 5

- Are there challenges with the quality of training programs? If so, what are they and how could they be addressed?

▶ Question 6

- Are there ways that early exposure programs can be strengthened?



Discussion Questions - Employer-Sponsored Training

▶ Question 1

- Are there opportunities to bolster the role of training programs supported by health care employers? If so, how?

▶ Question 2

- Would supporting additional apprenticeship opportunities be a promising approach to increase the number of individuals entering the healthcare profession? If so, for which types of workers, and what are important characteristics of how they should be structured so they are both attractive to potential participants and rigorous? What barriers currently limit healthcare employers from adopting or expanding apprenticeship programs?

▶ Question 3

- How can health care ladders and lattices be used and support to bolster all levels of the health care workforce and support workers?



Discussion Questions - General Medical Education (GME)

▶ Question 1

- Is current funding for GME resulting in a mismatch between the physician workforce that is needed versus the workforce that is being produced? If so, are there aspects of the hospital rate-setting approach that could be contributing to this?

▶ Question 2

- If additional GME funding were allocated to create new medical residencies in rural areas and for specialties particularly relevant to rural areas (e.g., primary care, behavioral health, general surgery, etc.), might it be more likely that such residents would continue to practice in Maryland?

▶ Question 3

- Are there more cost-effective approaches to encourage providers to practice in underserved areas and/or to become primary care and behavioral health specialists?



Discussion Questions - Pipeline Performance

▶ Question 1

- Thinking about the overall workforce pipeline, are there additional ways to strengthen coordination and supports across different segments of the workforce pipeline? If so, what could this look like? For example, are there opportunities to further strengthen connections between K–12 programs, colleges/universities, and/or health employers to ensure candidates receive beneficial supports as their training advances?

▶ Question 2

- To what extent do current tracking systems allow for assessing the effectiveness of programs across the pipeline in shaping workforce supply, specialty choice, and provider distribution over time? Are there opportunities to develop better systems to evaluate pipeline performance and track what happens to individuals at different stages in the pipeline, including where they end up working? If so, are there other state examples that could inform a Maryland workforce data tracking system?



Entry into Practice



Entry into Practice - Summary of the Issue

- ▶ Licensure, certification, and employer recruitment processes affect how quickly trained individuals can enter the health workforce
- ▶ For full licensure, regulatory and administrative processes such as credential verification and onboarding requirements can delay workforce entry, but with electronic systems and other strategies the process can be accelerated
- ▶ Interstate licensure compacts can help facilitate workforce mobility and telehealth across state lines by avoiding the need for clinicians to apply for full licensure, while still preserving state oversight of licensure
 - Maryland participates in a number of interstate licensure compacts such as the Medical Licensure Compact, Nurse Licensure Compact, and Psychology Interjurisdictional Compact



Entry into Practice - Summary of the Issue (continued)

- ▶ However, interstate compacts are not without their challenges, such as the presumption that other states' licensing standards are acceptable
 - For example, a nurse might have attended a nursing program in another state that Maryland would not have approved

- ▶ Clinicians must also be credentialed by facilities and health plans in order to practice in such facilities or be paid by health plans



Discussion Questions - Licensure

▶ Question 1

- What licensure requirements/processes create the greatest barriers to expeditious entry into practice for physicians, nurses, allied health professionals, and other health workers in Maryland? How could they be addressed?

▶ Question 2

- Are there issues related to interstate licensure compacts that should be addressed? For example, do regulatory or administrative barriers remain? Are challenges with allowing clinicians from other states to practice in Maryland who would not be considered up to Maryland's standards? How could these issues be addressed?



Discussion Questions - Credentialing

▶ Question 1

- What challenges exist with credentialing in health care facilities and health plans? How could they be addressed?

▶ Question 2

- Does credentialing not exist for certain types of health care workers and should it exist? What are the implications of not having credentialing in terms of both payment and care delivery?



Discussion Questions - Other Entry into Practice Issues

▶ Question 1

- Are there other factors that affect the timeliness of entering practice? How could they be addressed?

▶ Question 2

- Do the implications of such factors differ across care settings (hospitals, long-term care, community health, rural areas)? If so, why and how can this be addressed?



Optimizing Workforce Deployment



Optimizing Workforce Deployment - Summary of the Issue

- ▶ Workforce effectiveness and retention are shaped by factors such as how healthcare teams are structured and function, employee compensation, workplace environment and culture, opportunities for professional development, and whether skills are being fully maximized
- ▶ Key workforce challenges include lack of system-oriented thinking, understaffing and workload pressures, and inadequate compensation that can lead to burnout and attrition
 - Health care workers experience workplace violence, burnout, moral injury, and mental health concerns at higher rates than the general public



Discussion Questions - Retention Factors

▶ Question 1

- Are there unique ways in which health care workers in Maryland are affected by burnout, workload pressures, inadequate compensation, workplace violence, and unhealthy workplace cultures that are affecting retention of health care workers in the State? Are there data that illustrate this? What could be done to address these issues?

▶ Question 2

- What segments of the health care workforce are most affected by burnout and what factors are contributing to such burnout? How can these factors be addressed through public policy?

▶ Question 3

- What types of retention factors are particularly pronounced in underserved areas and how could these be addressed?



Discussion Questions - Optimization

▶ Question 1

- What can be done to further support team-based care models involving interdisciplinary collaboration/respect and system-oriented thinking?

▶ Question 2

- Do health care workers in Maryland receive adequate training and professional development opportunities? If not, what types of workers lack such opportunities and what types of opportunities are they missing? Are there any issues with continuing medical education?

▶ Question 3

- Are there opportunities to further expand scope of practice for certain workers to maximize their full potential?



Discussion Questions - Assessment

▶ Question 1

- Are there workforce data systems or performance measures currently used to track workforce outcomes, and how effective are they in informing workforce policy decisions?

▶ Question 2

- How effective is the coordination across state workforce programs and agencies in supporting workforce planning, and what improvements could strengthen the overall impact of these efforts?



Thank you!

Andre Chappel (andre.chappel@maryland.gov)

Mahlet konjit-Solomon (Mahlet.konjit-Solomon@maryland.gov)