How Many Doctors, Nurses, and Other Health Professionals Do You Need?

The Impact of New Delivery System Models on Your State's Workforce Needs?

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Associate Vice President for Education

National Governors Association
April 22, 2015

University of Minnesota

National Center for Interprofessional Practice and Education

In collaboration with and acknowledgements to:

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Director, Program on Health Workforce Research & Policy

Cecil G. Sheps Center for Health Services Research,
University of North Carolina-Chapel Hill
University of North Carolina - Chapel Hill

Point:
The Transforming U.S. Health care system demands:

The need to move away from only counting numbers for projecting workforce to. . . .

Answering the question in real time:

Will health professionals be in the right locations, specialties and practice settings with the skills and competencies needed to meet the demands of a transformed health care system by:

- improving the patient experience of care,
- improving the health of populations,
- and reducing the per capita cost of health care?

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

The conclusion . . . . .New Territory: No Recipe for Teams for New Models of Care

Exact numbers of health professionals on teams will depend on the patient population served and skill mix configuration in specific community.

New models of care will deploy traditional health care setting workers with “boundary spanning” community-based workers in new “care” settings (e.g., senior housing, retail health care, hospice, long-term care, wellness centers, YMCAs, and ?)

The need exists for more opportunities for physicians, nurses, pharmacists, medical assistants and others to retool: How the system redesign will get done.

There is little investment in evaluating impact of new models of care and therefore, what is needed.

Skill mix will change under Secretary Burwell’s Medicare value-based proposal and 3rd party payers will follow suit.

States need to invest in better health data monitoring systems to reconnect health professions education with transforming health care: ROI for education, retooling and the health workforce reconfiguration.

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Building the Workforce for New Models of Care

Learner Pipeline

Health Workforce for New Models of Care

Patients, Families & Communities

Today I owe:

How do we create a health workforce in the right locations, specialties and practice settings that has the skills and competencies needed to meet the demands of a transformed health care system while preventing burnout?

How do we improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care simultaneously?

Oh, and am I going to match to the medical residency?

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The National Center is also funded in part by the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation, the Gordon and Betty Moore Foundation and the University of Minnesota.

Difficult thing to know is whether we have enough providers in the new models of care.

Fears of physician shortages grab headlines

The New York Times

Success of health reform hinges on hiring

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Counterpoint: A looming shortage of physicians in Minnesota? Not necessarily

Article by: NEIL A. SHAH | Updated: May 20, 2014 - 6:30 PM

The case for high medical school standards and for better use of a doctor's day.

about opinion

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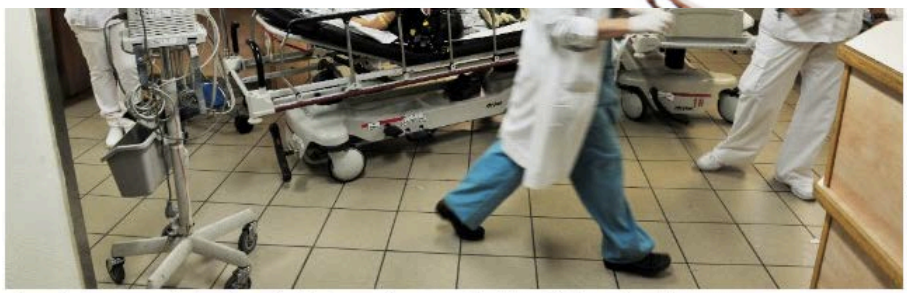
DOCTOR

Lots

By DANI



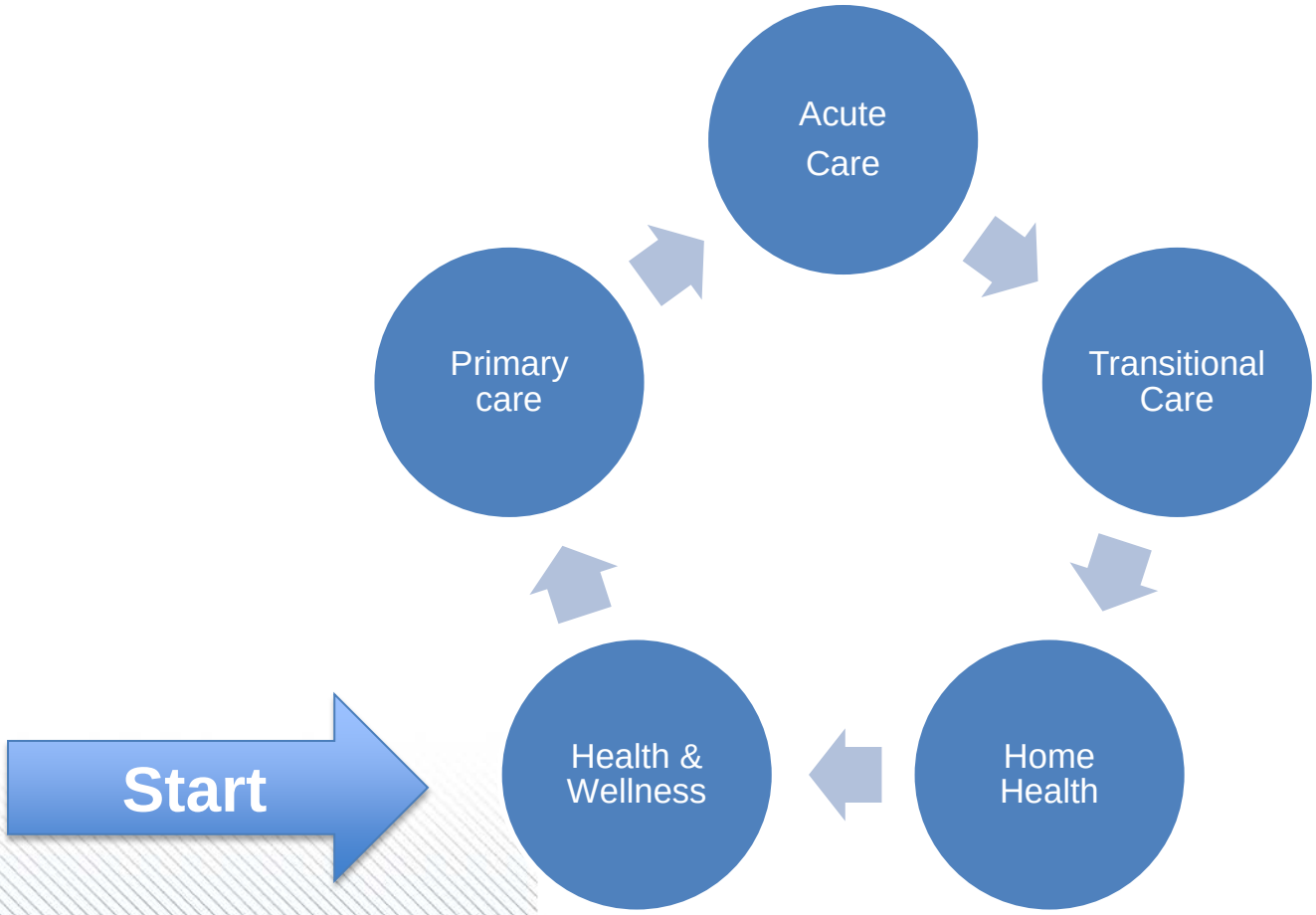
Some doctors worry patients who can't get in to see primary care physicians will clog up hospital emergency rooms.

re Will Expose Doctor
In The U.S., Put More
On Exhausted Physicians

What are the key characteristics of "new" models of care?

- Goal: provide patients with more comprehensive, accessible, coordinated and high quality care at lower costs
- Emphasis on primary, preventive and "upstream" care
- Care is integrated between:
  - primary care, medical sub-specialties, home health agencies and nursing homes
  - health care system and community-based social services
- EHRs used to monitor patient and population health—increased use of data for risk-stratification and hot spotting
- Interventions focused at both patient- and population-level
- Move toward "risk-based" and "value-based" payment models

Today: Everyone is on the team, including patients, families and communities. And, where is the patient's voice in workforce planning?



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Emerging Workforce

Integrating care models:

- oral health and primary care: nurse practitioners and physicians assistants
- mental health and primary care
- public health and primary care
- family medicine and pharmacy

Care coordinators: Patient navigators

Informatics specialists

Community health workers

Health coaching

Genetic counselors: Personalized medicine

Ethics clinicians

Integrated health and complimentary alternative medicine

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Example: Medical Assistant

- ✓ Expanding responsibilities in primary care
- ✓ Patient panel management: gaps in care and prevention
- ✓ Pre-visit chart review – flagging overdue services
- ✓ Contacting patients
- ✓ Health coaching
- ✓ Leading team huddles

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What will be the impact on workforce of Secretary Burwell's announcement on value-based payment goals?


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News

FOR IMMEDIATE RELEASE
March 25, 2015

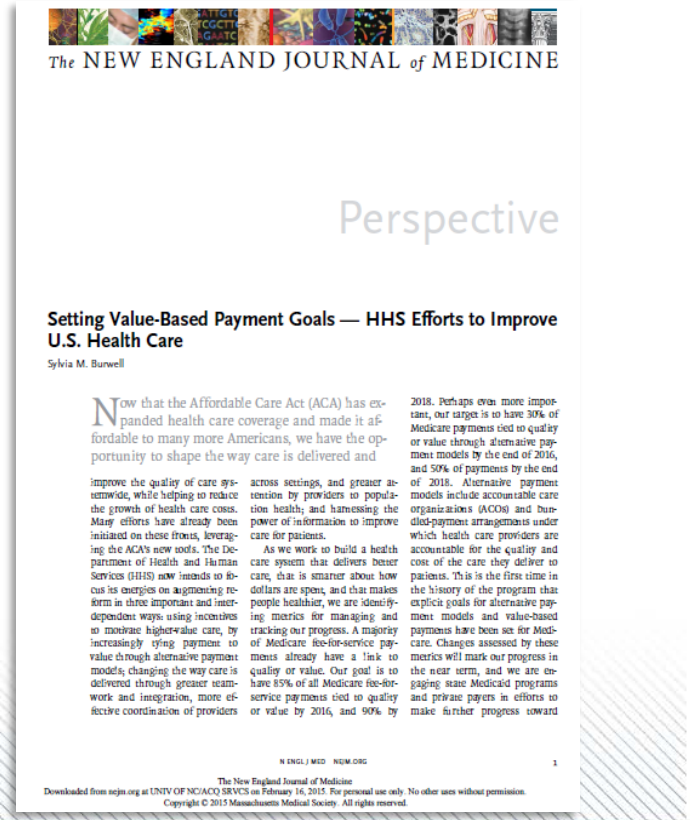
Contact: HHS Press Office
202-690-6343

Better, Smarter, Healthier: Health Care Payment Learning and Action Network kick off to advance value and quality in health care

Over 2,800 patients, insurers, providers, states, consumer groups, employers and other partners have registered; dozens have set goals that meet or exceed HHS's goals

The Affordable Care Act established an ambitious new framework to move our health care system away from rewarding health providers for the quantity of care they provide and toward rewarding quality. These new models have been put to work in Medicare, and have contributed to 50,000 fewer patient deaths in hospitals due to avoidable harms, such as infections or medication errors, and 150,000 fewer preventable hospital readmissions since 2010, when the Affordable Care Act became law.

To engage private sector leaders in building on this success, Department of Health and Human Services Secretary Sylvia M. Burwell was joined today by President Obama, as well as state representatives, insurers, providers,


The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell

Now that the Affordable Care Act (ACA) has expanded health care coverage and made it affordable to many more Americans, we have the opportunity to shape the way care is delivered and improve the quality of care systemwide, while helping to reduce the growth of health care costs. Many efforts have already been initiated on these fronts, leveraging the ACA's new tools. The Department of Health and Human Services (HHS) now intends to focus its energies on augmenting reform in three important and interdependent ways: using incentives to motivate higher-value care, by increasingly tying payment to value through alternative payment models; changing the way care is delivered through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health; and harnessing the power of information to improve care for patients.

As we work to build a health care system that delivers better care, that is smarter about how dollars are spent, and that makes people healthier, we are identifying metrics for managing and tracking our progress. A majority of Medicare fee-for-service payments already have a link to quality or value. Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. Alternative payment models include accountable care organizations (ACOs) and bundled-payment arrangements under which health care providers are accountable for the quality and cost of the care they deliver to patients. This is the first time in the history of the program that explicit goals for alternative payment models and value-based payments have been set for Medicare. Changes assessed by these metrics will mark our progress in the near term, and we are engaging state Medicaid programs and private payers in efforts to make further progress toward

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Principles:

Incentives to motivate higher value care

Alternative payment models

Greater teamwork and integration

More effective coordination of providers across settings

Greater attention to population health

Harness the power of information to improve care for patients

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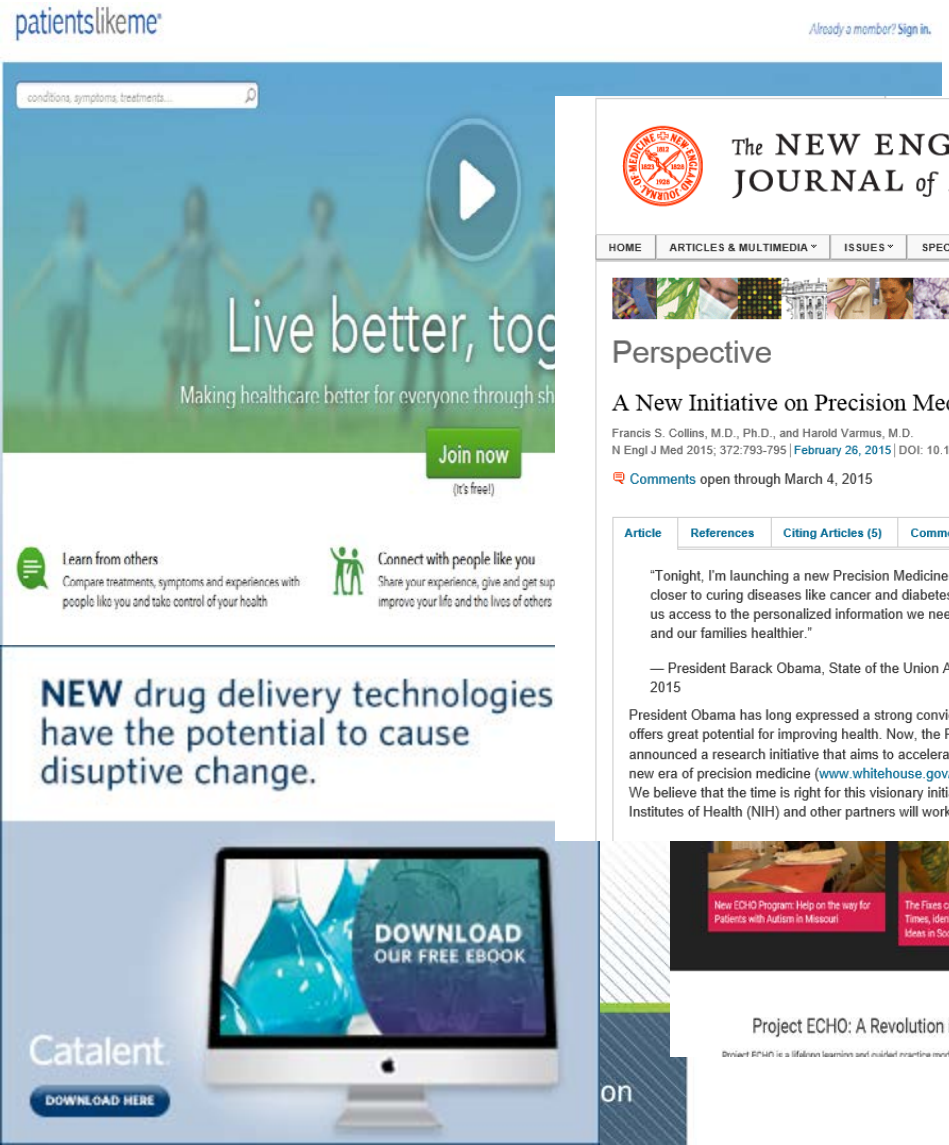
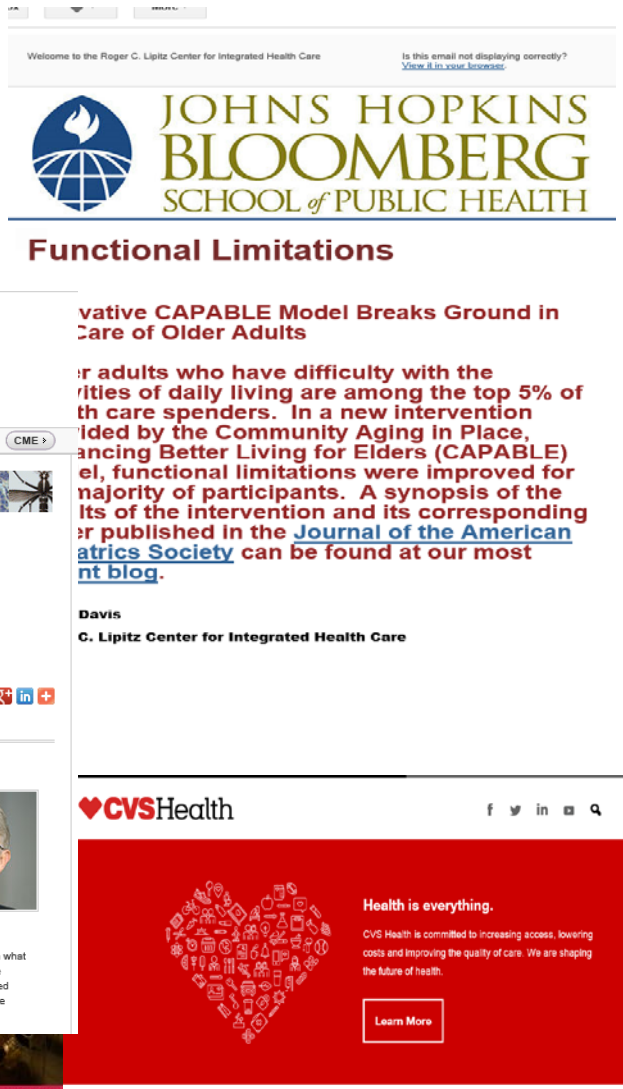
Disruptive Innovations





Let 1,000 flowers bloom: ongoing experiments in health system and education transformation

- Implementation of patient centered medical homes
- Growth of Accountable Care Organizations
- CMS stimulating health system transformation
- Early evidence inconclusive about effect on patient outcomes
- Many higher education IPE curriculum models

Are we paying enough attention to reconfiguring workforce as the critical element of system redesign?

NOVEMBER 2013 VOL. 32 NO. 11 Published by Project HOPE

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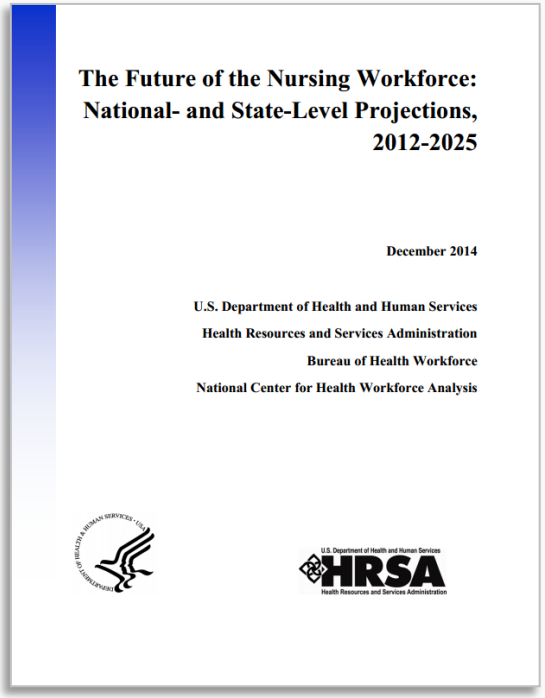
Lesson from the Nursing "Shortage"


The Future of the Nursing Workforce: National- and State-Level Projections, 2012-2025

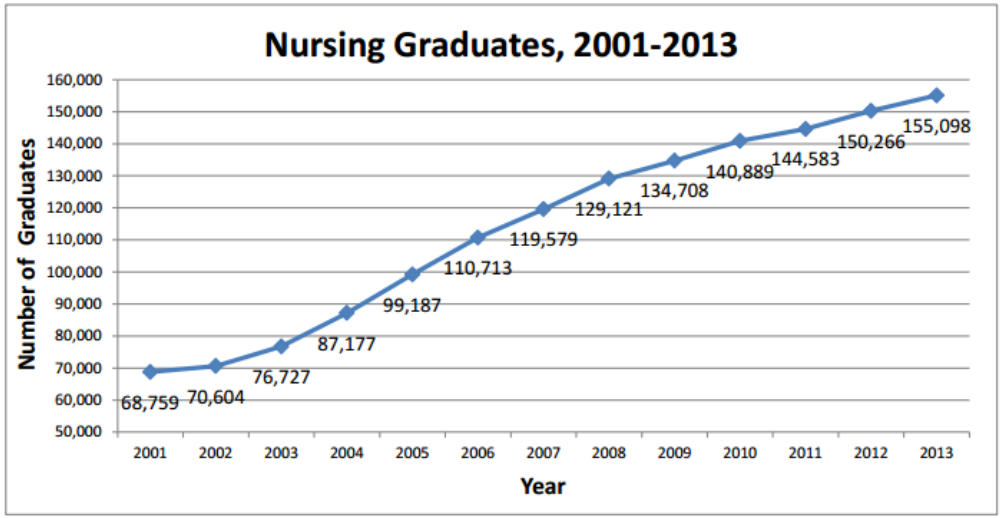
December 2014

U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Health Workforce
National Center for Health Workforce Analysis

Why?

Nursing schools responded to previous projections and significantly increased enrollments

Exhibit 1: Number of Nursing Graduates 2001-2013[a]



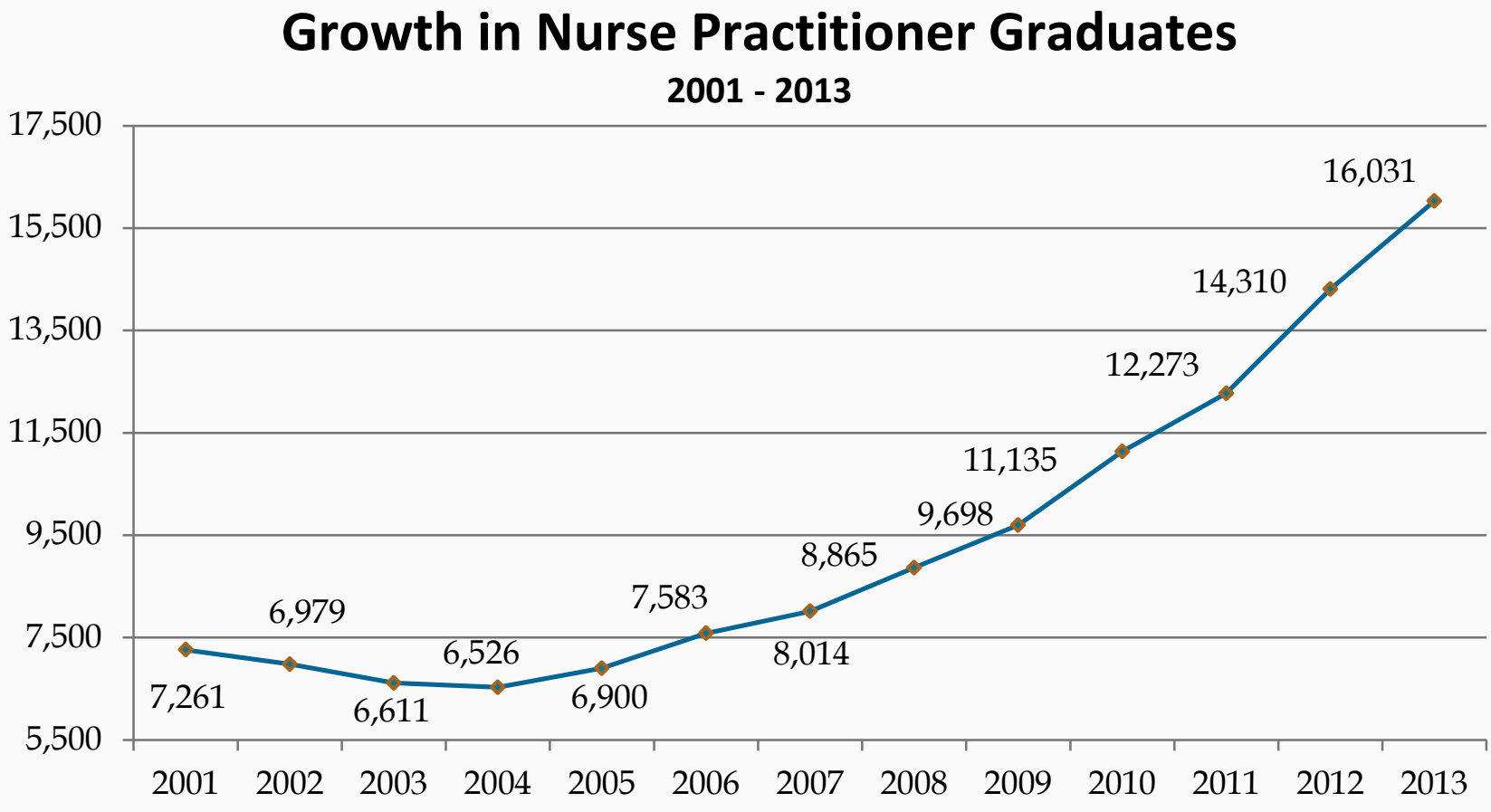
Notes: [a] Data Source: HRSA compilation of data from the National Council of State Boards of Nursing, Exam Statistics and Publications, 2001 to 2013. https://www.ncsbn.org/1232.htm

Key Findings

After predicting a shortage a decade ago, HRSA now forecasts that nationally RN supply will outpace demand between 2012 and 2025.

Source: NCHWA, BHW, HRSA: http://bhpr.hrsa.gov/healthworkforce/supplydemand/nursing/workforceprojections/nursingprojections.pdf.

Growth in Nurse Practitioner pipeline mirrors RN growth



THE GEORGE WASHINGTON UNIVERSITY WASHINGTON, DC

Chart courtesy of Ed Salsberg, George Washington University.

Source: American Association of Colleges of Nursing and National Organization of Nurse Practitioner Faculties Annual Surveys

[1]Counts include master's and post-master's NP and NP/CNS graduates, and Baccalaureate-to-DNP graduates.

But it's not just nurses. PA pipeline has also expanded rapidly

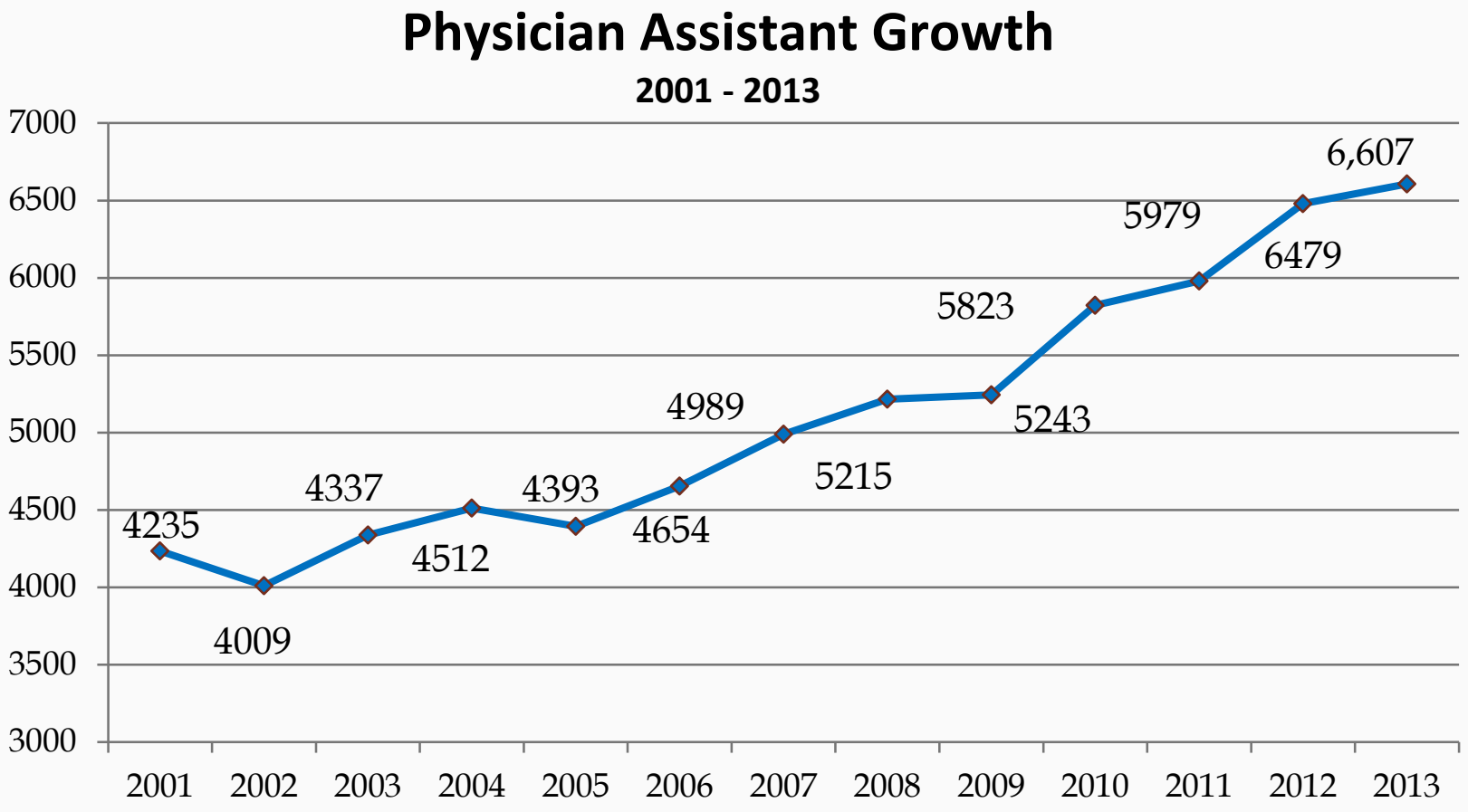


Chart courtesy of Ed Salsberg, George Washington University.
Source: National Commission on Certification of Physician Assistants "Certified Physician Assistant Population Trends "; 2013 data from personal communication with NCCPA, January 2014.

And so have pharmacists

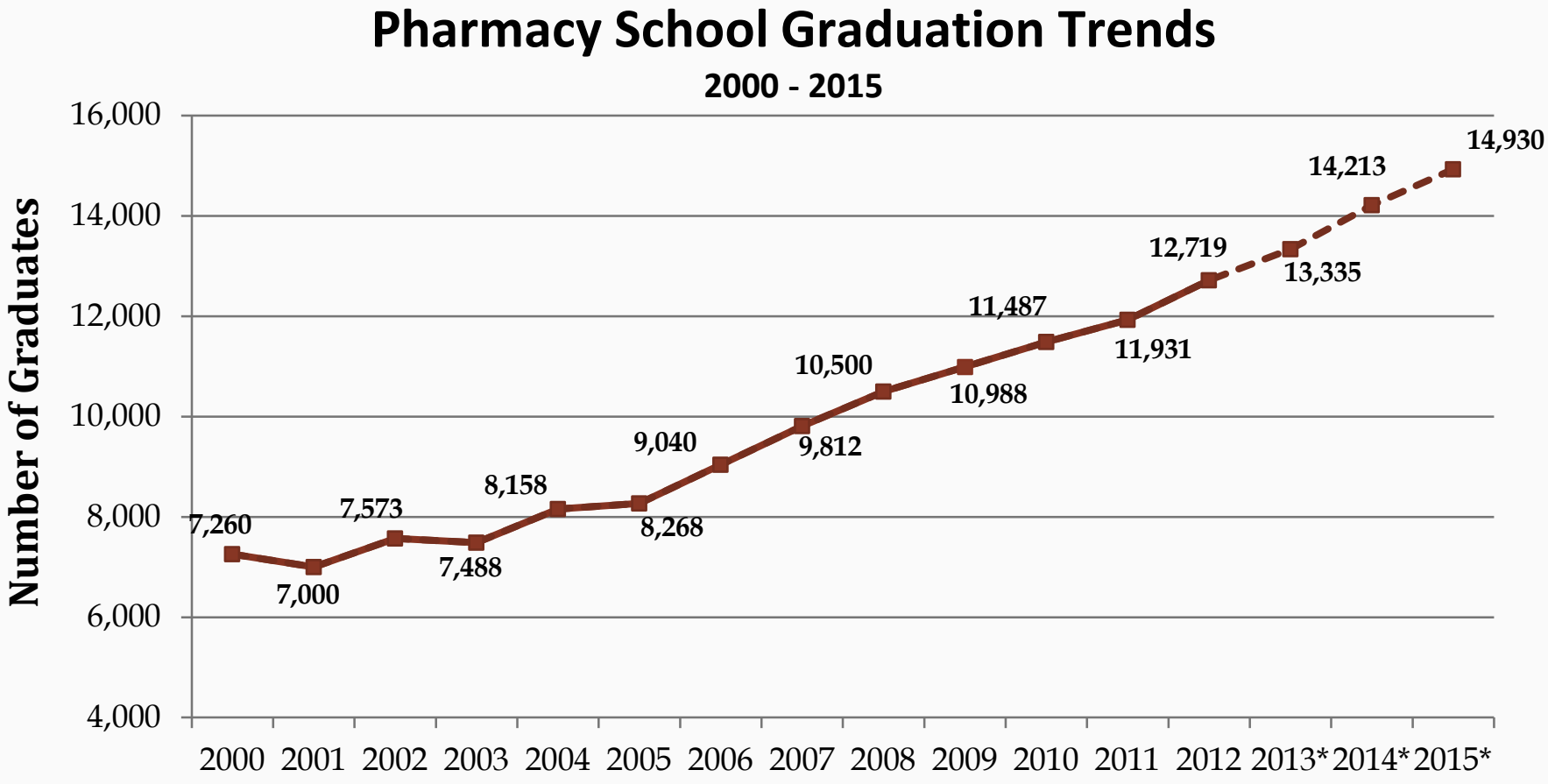


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Chart courtesy of Ed Salsberg, George Washington University.

Source: AACP 2012 Enrollment. Data represent first professional degrees including B.S. Pharmacy, B.Pharm., and Pharm.D.

*Note: Graduation projection figure based on enrollment data.

Nearly 9,000 additional MDs and DOs students enrolled by 2018

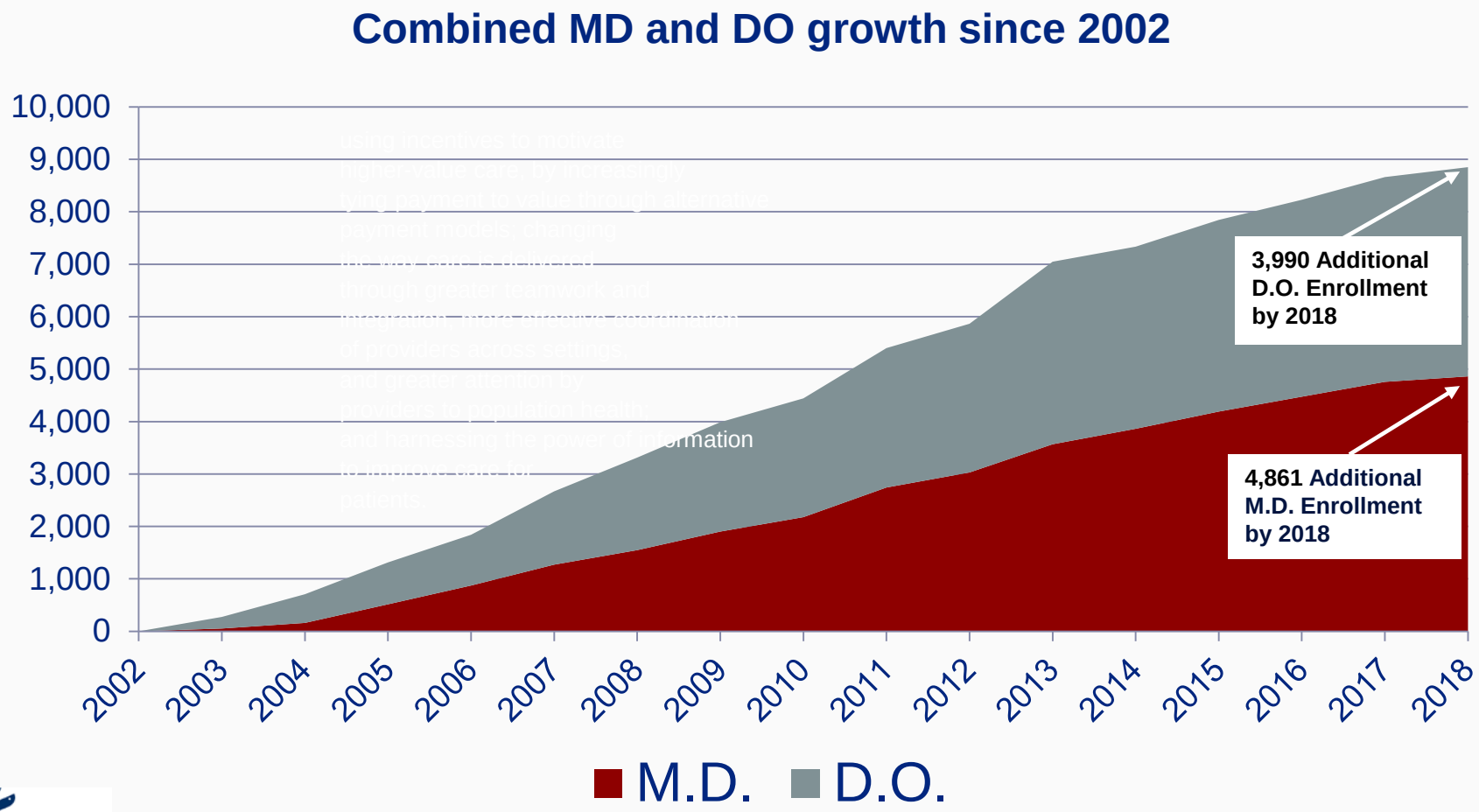

Chart courtesy of Clese Erikson, Association of American Medical Colleges.
Source: Results of the 2013 Medical School Enrollment Survey; 2013 AACOM Survey of Colleges of Osteopathic Medicine

Examples of emails I receive:

Barbara-

I am an XX student at XXXX University. In our program, we are to find our own preceptors. I am currently in my first rotation (Family Practice Clinic) and have been having extreme difficulty in finding a pediatric preceptorship. I am not sure if you are the appropriate person to contact, but I am definitely in desperate need of a pediatric preceptorship and have exhausted all of my options.

As a Health Professions Student Coordinator, are you able to aid me in finding a pediatric preceptorship opportunity that would start early June 2015, ending early August 2015? I am required to complete 144 hours per clinical rotation, and my hours are very flexible.

Thank you for your time,

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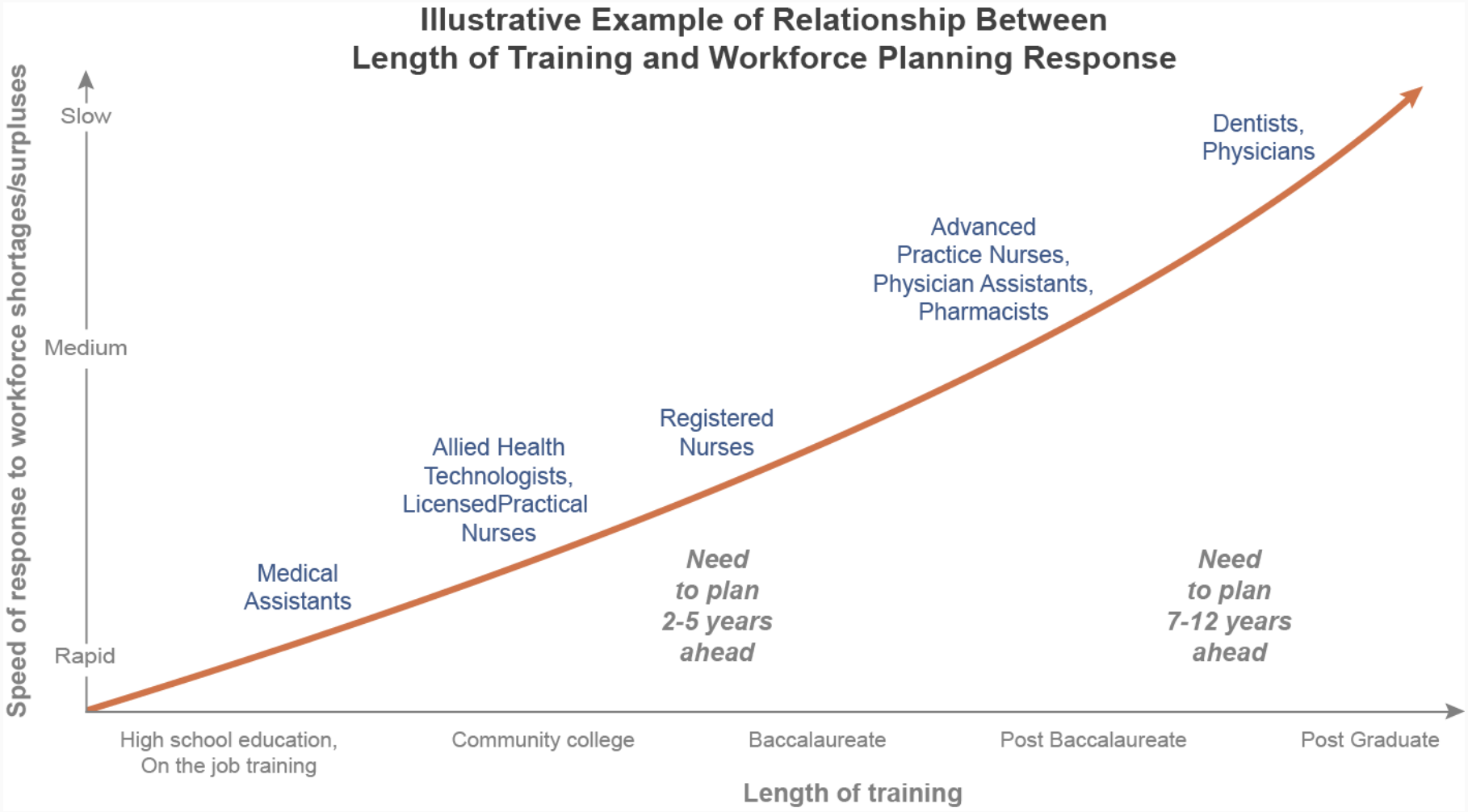
Health professions programs react independently and on different timelines



How to smooth the cycle?

Example federal vs. state roles in workforce planning

	Federal Roles	State Roles
Data	Invest in better data and workforce projections	Invest in better data and workforce projections to illuminate regional/state variations
Strategy	(Unfunded) National Health Workforce Commission was supposed to use data to advise Congress and the Administration	States seeking strategy guidance through National Governors Association and Health Workforce Technical Assistance Center.
Education	Need targeted, evidence-based, investments in training (and retraining!), address maldistribution issues	Need targeted, evidence-based, investments in training (and retraining!), address maldistribution issues
Money	Lead in innovation of payment policy to shape future workforce	Strategically use state appropriations and Medicaid dollars to shape workforce

Myriad of policy questions that need to be asked and answered:

How can Medicaid funds be used to better support GME training slots for comprehensive primary care in new models and rural and underserved populations?

Who is serving Medicaid populations and where are the gaps?

How Medicaid dollars used by states to support the workforce needed in new models of care? Such as:

- Pharmacists
- Community health workers and other workers supporting social determinants of health
- In-home workers providing social and medical care
- Social workers
- Integration of care: primary care, oral health, mental health

How will care coordination and care management be paid?

How should other payers be engaged?

What should the new partnership models be between higher education and health policy to assure a workforce for new models of care?

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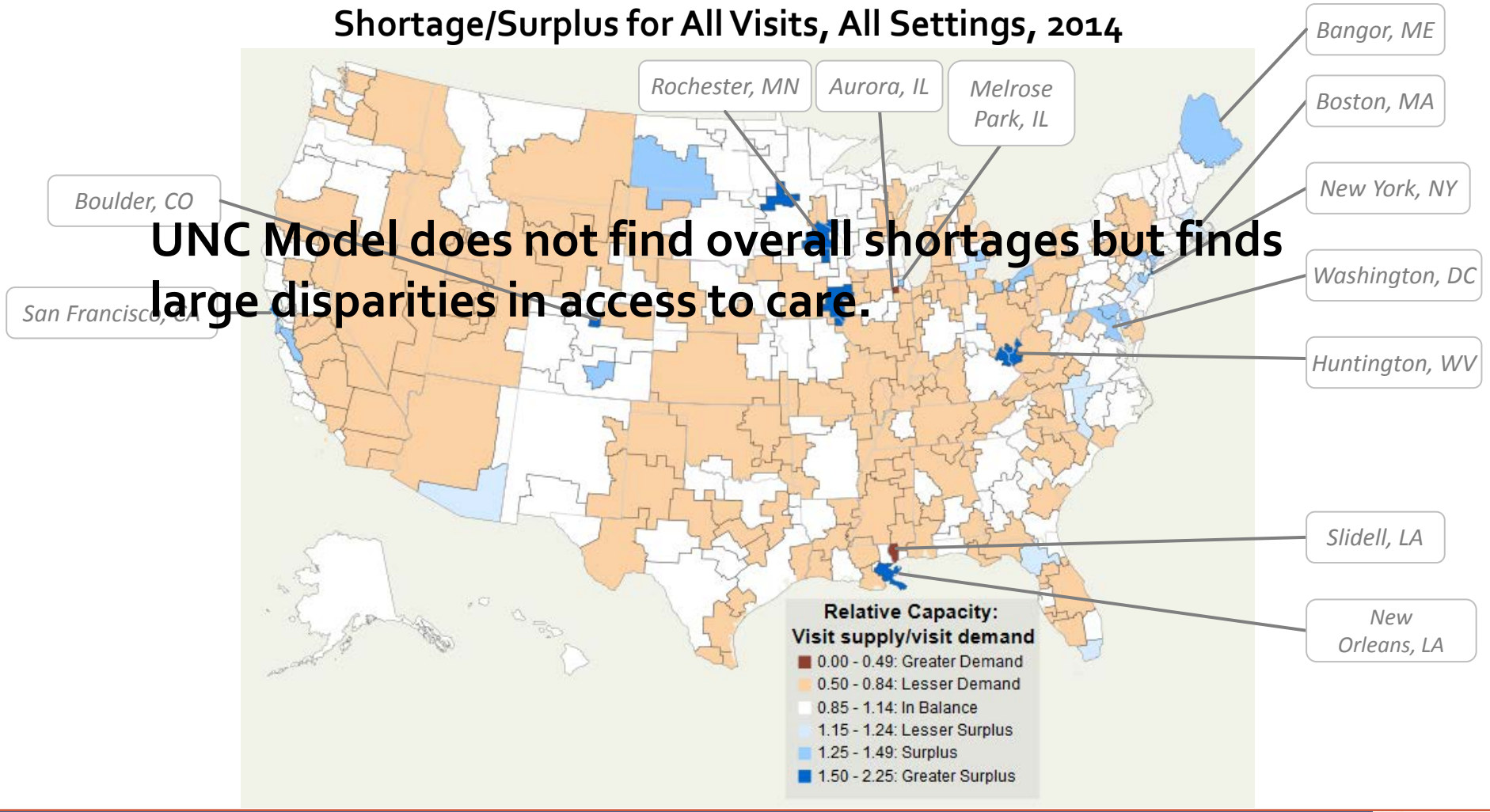
UNC Sheps Center
Future Docs Modeling



UNC Model does not find overall shortages but finds large disparities in access to care.

This project is funded by a grant from The Physicians Foundation.

National Center Workforce Real Time Data Strategy:

Does intentional and concerted interprofessional education and interprofessional practice (new models of care):

1. improve the triple aim outcomes on an individual and population level?
2. result in sustainable and adaptive infrastructure that supports the triple aim outcomes of both education and practice?
3. identify ecological factors essential for achieving triple aim outcomes?
4. identify factors essential for systematic and adaptive infrastructure in the transformation of the process of care and education?
5. identify changes needed in policy, accreditation, credentialing and licensing for health care provision and education?

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Follow our work

Program on Health Workforce Research and Policy
Cecil G. Sheps Center for Health Services Research

University of North Carolina – Chapel Hill

www.healthworkforce.unc.edu

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University of Minnesota

www.nexusipe.org (new website to be launched May 1)

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Program on Health Workforce Research & Policy, Cecil G. Sheps Center for Health Services Research, UNC Chapel Hill

- Health Resources and Services Administration Cooperative Agreement U81HP26495-01-00: Health Workforce Research Centers Program
- The Physician Foundation
- Robert Wood Johnson Foundation

National Center for Interprofessional Practice and Education University of Minnesota

- Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067
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- Josiah Macy Jr. Foundation

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