

Workforce Planning for a Rapidly Changing Healthcare System

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This presentation in one slide

- My Rhode Island roots make me personally invested in your work
- New payment and care delivery models require broader definition of the health workforce
- As Rhode Island moves from planning to implementation, need to shift from “old school” to “new school” workforce planning approaches
- It’s not just about transforming the workforce — we need to redesign education, practice, payment and regulatory structures that support workforce
- Better workforce data are needed to drive policy change and evaluate outcomes of your work

My Rhode Island roots are deep and strong

My grandparents Mildred and Joseph Finegan were lifelong Rhode Islanders



My husband and I were married on Block Island in 1991



And like any good Rhode Islander, I have passed on to my southern children a love of quahogs and coffee milk



Rhode Island has highest proportion of residents 85 & over in nation

- My mother and her neighbors/friends are in that demographic
- Ensuring workforce is in place to care for Rhode Islanders with chronic disease and to allow elderly to age in place will be critical
- Requires a fundamental shift in how we deploy workforce in teams and in “boundary spanning” roles



New health care teams are emerging: Community Aging in Place—Advancing Better Living for Elders (CAPABLE) Teams

- An Occupational Therapist, a Registered Nurse, and a handyman form team allowing seniors to age in homes
- Provide assistive devices and make home modifications to enable participants to navigate their homes more easily and safely
- After completing five-month program, 75 percent of participants (n=281 adults age 65+) had improved their performance of ADLs
- Symptoms of depression and ability to perform instrumental ADLs such as shopping and managing medications also improved
- CAPABLE is now in 12 cities in 5 States with a mix of payers, including Medicaid waiver in Michigan

And new payment models emerging: Accountable Health Communities Model

“We recognize that keeping people healthy is about more than happens inside a doctor’s office...we are testing whether screening patients for health-related social needs and connecting them to local resources like housing and transportation to the doctor will ultimately improve their health and reduce costs to taxpayers...”

Secretary Burwell,

<http://www.hhs.gov/about/news/2016/01/05/first-ever-cms-innovation-center-pilot-project-test-improving-patients-health.html>

Accountable Health Communities Model Announced

By Centers for Medicare & Medicaid Services, January 19, 2016

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The Department of Health and Human Services today announced a new funding opportunity of up to \$157 million to test whether screening beneficiaries for health-related social needs and associated referrals to and navigation of community-based services will improve quality and affordability in Medicare and Medicaid.

The five-year program, called the Accountable Health Communities Model, is the first Centers for Medicare & Medicaid Services (CMS) Innovation Center model to focus on the health-related social needs of Medicare and Medicaid beneficiaries, including building alignment between clinical and community-based services at the local level.

The Accountable Health Communities Model will support up to 44 bridge organizations, through cooperative agreements, which will

Integra Accountable Health Communities Partnership selected as one of 32 Accountable Health Community Model Grants

“The foundation of the model is universal, comprehensive screening for health-related social needs—including housing needs, food insecurity, utility needs, interpersonal safety and transportation difficulties—in all Medicare and Medicaid beneficiaries who obtain health care at participating sites”

Alley, DE, Asomugha CN, Conway PH, Sanghavi DM. (2016). Accountable Health Communities—Assessing Social Needs through Medicare and Medicaid. *New England Journal of Medicine*. 371; 1: 8-11.

What are the workforce implications of the “seamless social work”* model?

- NEJM article acknowledges challenge in “developing a workforce to deliver interventions to vulnerable populations”
- Who is the workforce that will assess, coordinate and navigate patient needs for clinical and community-based services?
- What are skills and competencies of the navigator? How will navigators be trained?
- Once a referral is made, is workforce available to provide the service?
- Do physicians, social workers, nurses and other health professionals have the skills to take on these “bridging roles”?

How do we get there from here?



As Rhode Island moves from the planning to implementation stages of ***Healthcare Workforce Transformation***, the state will need to shift focus from “old school” to “new school” workforce planning approaches

Reframe #1: From a focus on shortages to addressing the demand-capacity mismatch

Old School

- Will we have too few (nurses, doctors, *insert other health professional*) in the future?

New School

- How can we more effectively and efficiently use the workforce already employed in the health care system?



Shortage, No Shortage?

A shortage of workers, skills or training?

- **A shortage of workers?** Prevailing narrative focuses on shortages, but many (not all!) shortages could be addressed by reallocating tasks among providers
- **A shortage of needed skills?** Workers with the right skills and training are integral to the ability of new models of care to constrain costs and improve care (Bodenheimer and Berry-Millett, 2009)
- **A shortage of training?** Lots of enthusiasm for new models of care but limited understanding of implications for workforce training
- **Evaluations of new models of care are mixed.** Perhaps because retooling the workforce was not part of reform efforts?

Reframe #2: From focus on pipeline to focus on retooling existing workforce

Old School

- Redesigning curriculum for students in the pipeline

New School

- Retooling the 18 million workers already employed in the health care system to function in new models of care



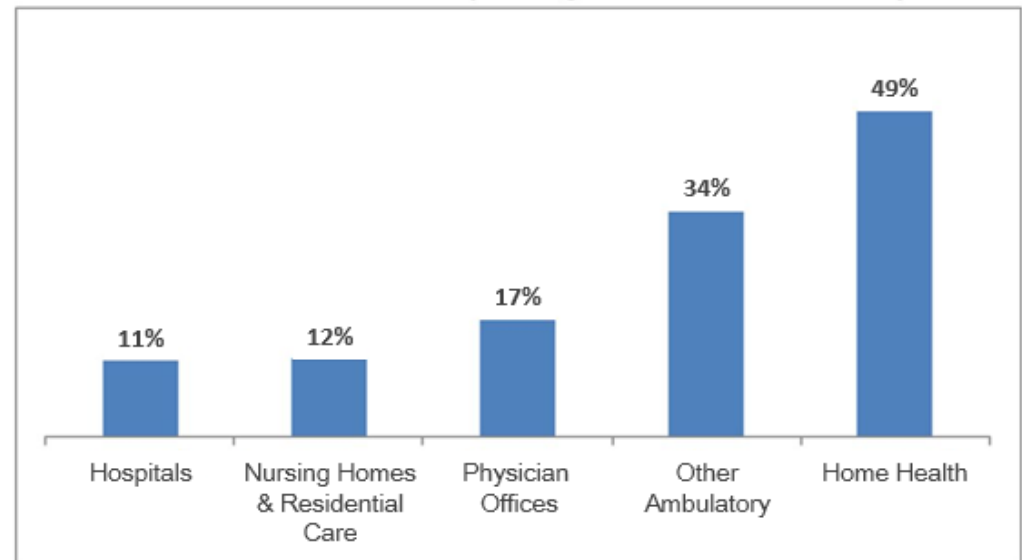
Workforce already employed in the system will be the ones to transform care

- To date, most workforce policy has focused on redesigning curriculum for students in pipeline
- **But it is the 18 million workers already in the system who will transform care**
- Rapid health system change requires not only producing “shiny new graduates” but also upgrading skills of existing workforce
- Need continuing education modules in care coordination, population health management, behavioral health, patient education and engagement, health coaching, quality improvement, geriatrics, oral health and other new skill sets

Workforce is shifting from acute to community settings

- Shift from fee-for-service to value-based payments and fines that penalize hospitals for readmissions are shifting care from inpatient to ambulatory and community-based settings
- But we generally train workforce in inpatient settings
- Need to develop innovative, “model” interprofessional training sites in community-based settings

Exhibit 1: Health Care Job Growth by Setting: December 2007–January 2017



Source: Authors' analysis of BLS Current Employment Statistics data.

Source: Turner A, Roehrig C, Hempstead K. What's Behind 2.5 Million New Health Jobs? *Health Affairs Blog*. March 17, 2017.
<http://healthaffairs.org/blog/2017/03/17/whats-behind-2-5-million-new-health-jobs/>



Existing workforce will also need more career flexibility

- Rapid and ongoing health system change will require a workforce with “career flexibility”
- “Clinicians want well-defined career frameworks that provide flexibility to change roles and settings, develop new capabilities and alter their professional focus in response to the changing healthcare environment, the needs of patients and their own aspirations” (NHS England)
- Need better and seamless career ladders to allow workers to retrain for different settings, services and patient populations



Reframe #3: From a focus on workforce planning for professions to workforce planning for patients

Old School

- Health workforce planning

New School

- Planning a workforce for health



Planning to support a workforce for health, not a health workforce

- Instead of retrofitting care models to meet the competencies and roles of the existing workforce....
- Need to ask “**what are patient’s needs for care and how might health professional roles, regulation, education and practice be redesigned to meet those needs?**”
- Expand workforce planning efforts to include workers in community and home-based settings
- Embrace the role of social workers, patient navigators, community health workers, peer counselors, home health workers, community paramedics, dietitians, medical assistants, other community-based workers



Social workers play increasingly important boundary spanning roles

We conducted systematic review of RCTs and found that social workers are serving three roles on integrated behavioral health/physical health teams:

- Behavioral health specialists: provide interventions for patients with mental health, substance abuse and other behavioral health disorders
- Care Managers: coordinate care of patients with chronic conditions, monitor care plans, assess treatment progress and consult with primary care physicians
- Referral role: connect patients to community resources including housing, transportation, food, etc.

Fraser M, Lombardi B, Wu S, Zerden L, Richman E, Fraher E. Social Work in Integrated Primary Care: A Systematic Review. Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research. September 2016. http://www.shepscenter.unc.edu/wp-content/uploads/2016/12/PolicyBrief_Fraser_y3_final.pdf

Evolving roles in oral health care

- **Community Dental Health Coordinator (ADA Model)**
 - Dental care “navigators” supervised by dentists, do outreach, community education, refer community members to dentists
- **Direct Access Hygienists**
 - perform dental hygiene procedures in specific settings without the immediate or direct supervision of a dentist
- **Dental Therapists**
(MN, ME, VT and tribal lands in AK, WA, OR)
 - Independently provide preventive and restorative care (oral exams, restorations, simple extractions, place crowns, etc.)
 - In MN, at least 50% of patients must be from underserved populations



Employers actively redesigning medical assistant roles

- Unlicensed MA role undergoing rapid change
- Significant heterogeneity in MA training and scope of practice
- Primary care practices are:
 - Engaging MAs to do population health management
 - Having MAs document services in EHRs, act as scribes
 - Training MAs to be health coaches
 - Developing MAs as panel managers and outreach workers
 - Using MAs to help manage high risk patients
- We are undertaking study to understand skill gaps, workforce development needs and satisfaction of MAs in primary care settings

Reframe #4: From workforce planning *within* care settings to workforce planning *across* care settings

Old School

- Workforce planning focused on numbers needed in acute, outpatient, long term care and other settings

New School

- Workforce planning from the patient's perspective — who will coordinate care, manage transitions and provide between-visit care?



Other new roles are emerging in evolving system

Emerging Roles

- Patient navigators
- Case managers
- Care coordinators
- Community health workers
- Care transition specialists
- Living skills specialists
- Patient family activator
- Peer and family mentors
- Peer counselors

Implications

- All play role in patient transitions between home, community, ambulatory and acute care health settings
- Evidence shows improved care transitions reduce unnecessary hospital admissions, lower costs and improve patient satisfaction

But it's complicated

- New roles may be filled by existing staff or new hires
- Some roles have similar functions but different titles — care managers and case managers
- Other roles have different functions but same name — patient navigators
- Depending on setting and patient population, roles are often filled by different types of providers — medical assistants, social workers, nurses, etc.

But it's not just about retooling the workforce

Real and lasting change cannot happen without simultaneously redesigning the infrastructure that creates and supports *a workforce for health*:

- Education
- Practice
- Regulation



We need to better connect education to practice

“Revolutionary changes in the nature and form of health care delivery are reverberating backward into...education as leaders of the new practice organizations demand that the educational mission be responsive to their needs for practitioners who can work with teams in more flexible and changing organizations...”

- But education system is lagging because it remains largely insulated from care delivery reform
- Need closer linkages between health care delivery and education systems

How do we redesign structures to support new roles? ➡ Education

- Training must be convenient – timing, location, and financial incentives must be taken into consideration
- Need to prepare faculty to teach new roles and functions
- Clinical rotations need to include “purposeful exposure” to high-performing teams in ambulatory settings
- Academic-Practice partnerships needed:
 - assess if new grads ready for practice
 - identify professions, settings and roles in which the workforce is over- and under-skilled
 - ensure we don’t produce more workers than market demands

How do we redesign structures to support new roles? ➡ Practice

- Need to minimize role confusion by clearly defining competencies and then training for new functions
- Job descriptions have to be rewritten or created
- Work flows have to be redesigned
- Lack of standardized training and funds to support training is big obstacle
- Existing staff won't delegate or share roles if don't trust other staff members are competent
- Time spent training is not spent on billable services



How do we redesign structures to support new roles? ➡ Regulation

“The workforce innovations needed to implement ACA programs require an adaptable regulatory system capable of evolving with the health care environment. The health profession regulation system in place today does not have the flexibility to support change

To create a more dynamic regulatory system, we need to:

- develop evidence to support regulatory changes, especially for new roles
- evaluate new/expanded roles to understand if interventions improve health, lower costs and enhance satisfaction (patient and provider)

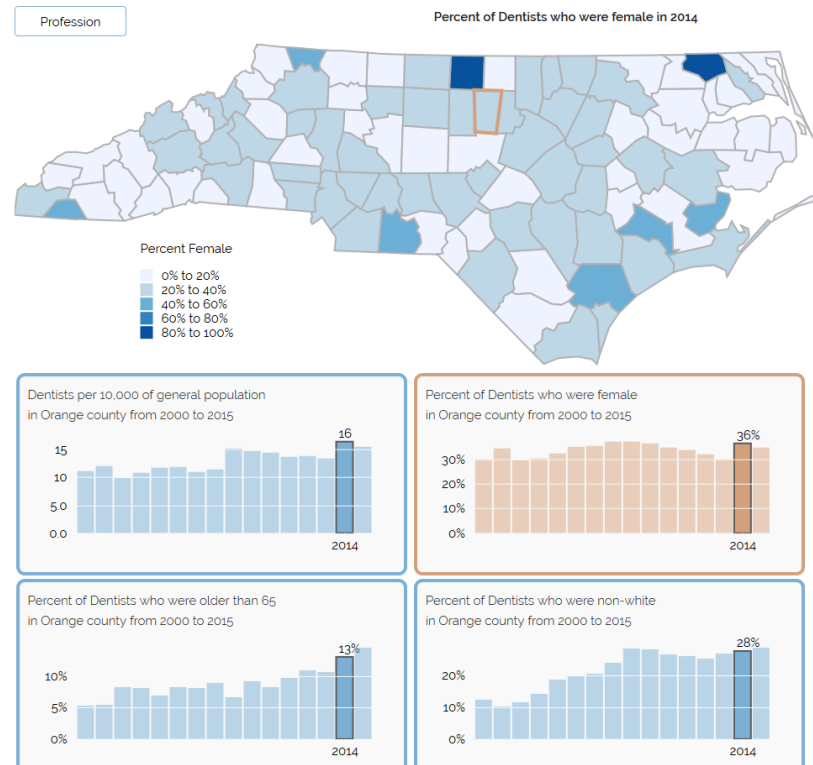
You will need data to drive policy change and evaluate outcomes of your efforts

- We created online data visualization tool
- Explore 15 years of data on 19 health professions in NC
- Total supply, supply per 10K, percent female, percent over 65, percent minority
- State and county-level data
- Interactive map and bar charts
- Can download data for use in presentations or for analysis
- nchealthworkforce.sirs.unc.edu

North Carolina

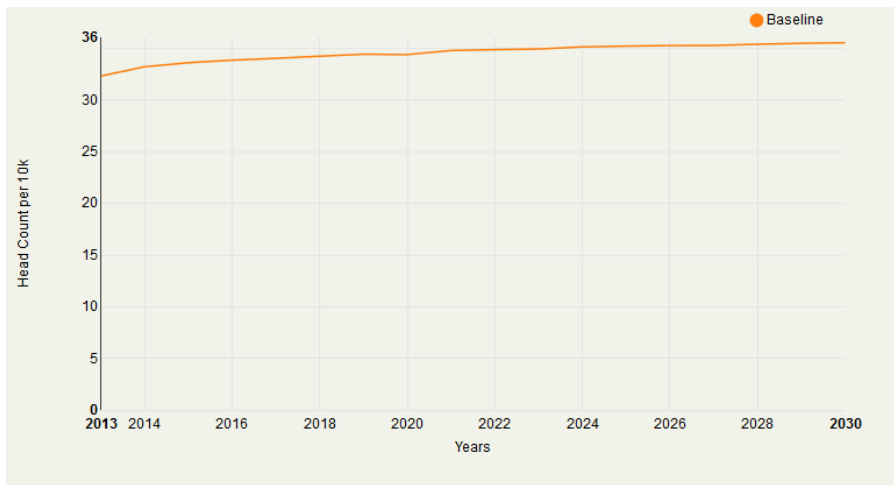
Health Professions Data System

Home About Help

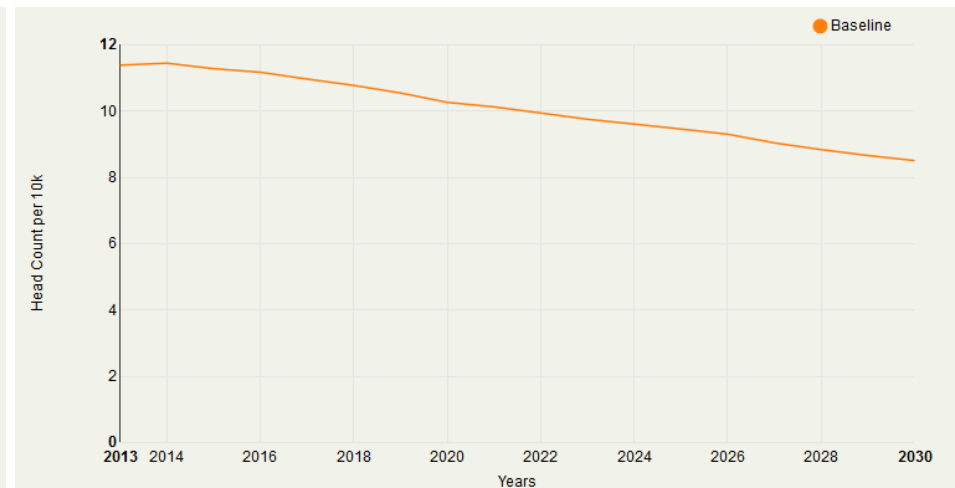


Our FutureDocs Forecasting Tool has physician projections for all states for 36 specialties

Overall physician supply per 10K pop in Rhode Island forecast to slightly increase



But model forecasts declining supply of primary care physicians per 10K pop



<https://www2.shepscenter.unc.edu/workforce/model.php>

Even sexy visualizations require messaging

Messaging findings requires courage and savvy because data sometimes:

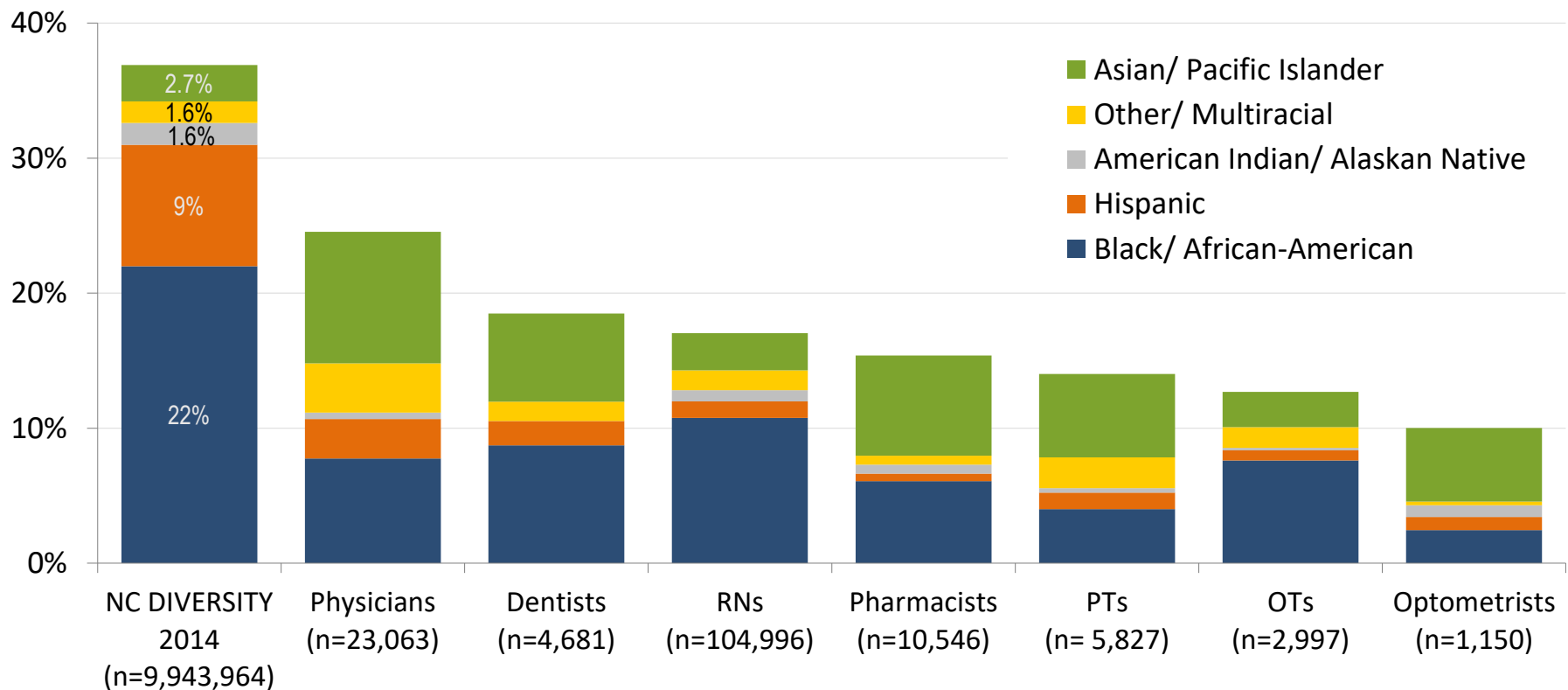
- reveal “uncomfortable truths”
- highlight inequities
- highlight uncertainty about future
- run counter to advocacy agendas



**At their best, data challenge status quo,
create new knowledge, spur policy action
and disrupt the prevailing narrative**

We use licensure data to highlight diversity of NC workforce lagging behind population

Diversity of NC Population versus Select Health Professions
North Carolina, 2014



Sources: North Carolina Health Professions Data System with data derived from North Carolina licensing boards, 2014. Figures include active, instate, dentists, nurses, pharmacists, PTs, OTs and optometrists and active, instate non-federal, non-resident-in-training physicians licensed as of October 31 of the respective year.
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