How can we transform the workforce to meet the needs of a transformed health system?

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Health workforce planning in the new world of health reform

- **Lots of people asking**: "How can we align payment incentives and new models of care to achieve the triple aim?"
- **Not enough people asking:** "How do we transform our health workforce to achieve the triple aim? "
- Rapid health system change requires retooling**:**
  - the health workforce ***and***
  - health workforce researchers and policy makers

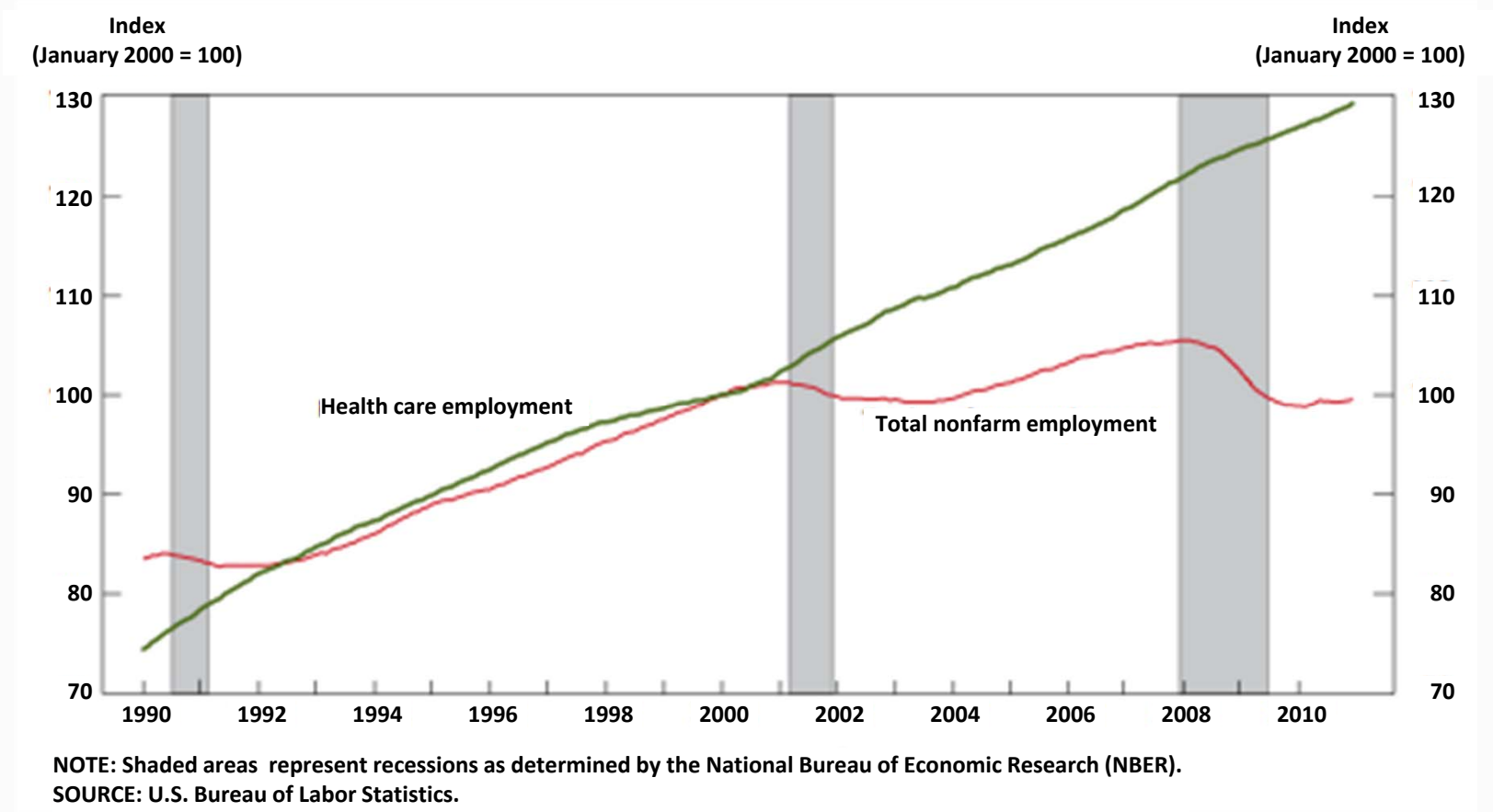
Because with or without health reform, current system is not sustainable

- **Demand side**: aging population, increase in chronic disease, health system consolidation, new models of care, payment policy changes, rising patient expectations
- **Supply Side**: health workforce deployment is rigid, turf wars abound, specialty and geographic maldistribution persists and productivity is lagging

Whether or not states implement health reform, cost and quality pressures are driving health system change

Health care employment has outpaced overall employment

Total Nonfarm and Health Care Employment Indexes, 1990–2010



NOTE: Shaded areas represent recessions as determined by the National Bureau of Economic Research (NBER).
SOURCE: U.S. Bureau of Labor Statistics.

But more people are doing less

- Of $2.6 trillion spent nationally on health care, 56% is wages for health workers
- Workforce is LESS productive now than it was 20 years ago...

Kocher and Sahni, "Rethinking Health Care Labor", *NEJM*, October 13, 2011.


THE
FUTURE

Health reform and the new world of health workforce planning

All about the redesign of *how* health care is delivered — less emphasis on *who* delivers care:

- Patient Centered Medical Home
- Accountable Care Organizations
- Technology

Shift will require more "flexible" workforce with new skills and competencies

Accountable Care Organizations & Patient Centered Medical Homes

Key characteristics

- Emphasis on primary and preventive care
- Health care is integrated across:
  - medical sub-specialties, home health agencies and nursing homes
  - **community- and home-based** services
- Technology used to monitor health
- Payment incentives promote accountability, move toward "risk-based" and "value-based" models of care
- Designed to lower cost, increase quality, improve patient experience

Different health system means different workers

A transformed health care system will require a transformed workforce.

The people who will support health system transformation for communities and populations will require different knowledge and skills… in prevention, care coordination, care process re-engineering, dissemination of best practices, team-based care, continuous quality improvement, and the use of data to support a transformed system

Source: Centers for Medicare and Medicaid Services, Health Care Innovation Challenge Grant, Funding Opportunity Number: CMS-1C1-12-001 , CFDA: 93.610 , November 2011. http://www.innovations.cms.gov/Files/x/Health-Care-Innovation-Challenge-Funding-Opportunity-Announcement.pdf

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

- Community-Based Care Transitions Program
- Shared Savings Demonstration
- Centers for Medicare and Medicaid Innovation initiatives, such as:
  - Multi-payer Advanced Primary Care Practice Demonstration
  - Comprehensive Primary Care Initiative
- Private payer initiatives, such as Cigna's Collaborative Accountable Care Initiative
- PCMH implementation in the VA

What will we learn from these experiments about redesigning the workforce?

Perhaps that we need a more flexible workforce

A more flexible use of workers that will include:

1. Existing workers taking on new roles in new models of care
2. Existing workers shifting employment settings
3. Existing workers moving between needed specialties and changing services they offer
4. New types of health professionals performing new functions
5. Broader implementation of true team-based models of care and education

And that we need more flexible workforce researchers and policy makers

To harvest and disseminate the learning from workforce innovations underway we need to reframe the:

1. Research questions we ask
2. Policies and programs we design and implement
3. Partners we engage in workforce planning

Reframe #1: From numbers to content

Old School

- How many health professionals will we need?

New School

- Does the workforce have the right skills and competencies needed to function in new models of care?

Health professionals taking on new roles in new models of care

- PCMHs and ACOs emphasize care coordination, population health management, patient education and engagement, and many other new skill sets
- Lots of enthusiasm for new models of care but limited understanding of implications for workforce training
- New models of care may not be showing expected outcomes because workforce not systematically included in redesign
- 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)

Reframe #2: From provider type to provider role

Old School

- How many of x, y, z health professional type will we need?

New School

- What roles are needed and how can different skill mix configurations meet these needs in different geographies and practice settings?

Case study 1: Medical assistants in new roles in new models of care

- MAs doing “front” and “back” office duties
- Immunizations, blood draws, other clinical tasks
- Acting as health coaches
- Conducting home visits
- Managing population health
- Working with EHRs and managing registries
- Acting as “scribes”

Case Study 2: More care coordination roles for nurses

- Nurses doing more care coordination for different types of patients
- Managing transitions care across acute, ambulatory, community settings (including patient home)
- Creating care plans
- Engaging and educating patient and family
- Performing outreach and population health management
- Connecting patients with community-based services

Reframe #3: From a focus on the pipeline to a focus on retooling the 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

Because the workforce already employed in the system will be the ones to transform care

- To date, most workforce policy focus has been on redesigning educational curriculum for students in the 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 to identify and codify emerging health professional roles and then train for them:
  - develop more community- and home-based clinical placements
  - identify and support innovative, "model" interprofessional practice sites **in community-based settings**

Because the workforce is shifting from acute to community settings

- Changes in payment policy and health system organization:
  - Shift from fee-for-service toward bundled care payments, risk- and value-based models
  - Fines that penalize hospitals for readmissions
- Will increasingly shift health care — *and the health care workforce* — from expensive inpatient settings to ambulatory, community and home-based settings
- But we generally train the workforce in inpatient settings
- Current workforce not prepared to meet patient on "their turf"

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 #4: From a focus on workforce planning for specialties to workforce planning for patients

Old School

- Workforce researchers have focused on estimating the noses needed by specialty and profession type

New School

- What if we started by asking "what are patients' needs for care and how can we redesign the workforce to better meet those needs?"

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

Increased focus on caring for patients in community and home will mean:

- Expand planning efforts to include workers in community and home-based settings
- Embrace role of social workers, patient navigators, community health workers, home health workers, dieticians and other community-based workers
- Better integration between health workforce and public health workforce planning
- Workforce plan for population health, **not** for needs of professions

Engaging clinicians and patients in designing new models of care (1)

- New Zealand doing innovative work engaging clinicians and patients in designing future health care system
- Transforming from ground up, rather than top down
- Constructing “idealized patient journeys” in mental health, aged care, primary care, maternity services, rehabilitation services, eye health and musculoskeletal health
- Designing ideal patient pathways by disease area and identifying workforce changes that enable new models of care

Engaging clinicians and patients in designing new models of care (2)

- Process involves asking clinicians to:
  - Identify clinical vignettes that account for majority of patient encounters in each clinical service area
  - Work with patients and health workforce experts to describe a typical patient journey versus the “ideal” journey for each vignette
- Ideal journey must meet doubling of demand at cost < 140% and no decrease in access or quality
- Process produces two results:
  - Identifies what workers, infrastructure and system changes are needed to enable scenarios
  - Develops implementation plan that identifies barriers to implementing idealized journeys

Reframe #5: 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 integrate care and manage transitions between home, outpatient and acute settings?

New types of health professional roles are emerging in evolving system

Emerging Roles

- Patient navigators
- Nurse case managers
- Care coordinators
- Community health workers
- Care transition specialists
- Living skills specialists
- Patient family activator
- Home health aids
- Peer and family mentors

Implications

- All these professions play role in managing 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

Retooling:
How do we get there from here?

- **Retooling the workforce:** education, reimbursement and regulation needs to be more responsive to changes in front-line health care delivery
- **Retooling workforce research:** all of our work is critical to develop evidence base needed to inform policy change in education, reimbursement, and 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—four year, two year and continuing education

Source: Ricketts T, Fraher E. Reconfiguring health workforce policy so that education, training, and actual delivery of care are closely connected. *Health Aff* (Millwood). 2013 Nov;32(11):1874-80.

And redesign education to prepare current workforce for new roles

Training individual health professionals for new roles

- Training must be convenient – timing, location, and financial incentives must taken into consideration
- Standardized versus flexible training?
  Both are needed since functions will vary by context

Training teams to accept new roles

- Other team members need to understand:
  - content of new role and feel individual(s) appropriately trained to take on the new role
  - how new role fits into workflow and overlaps with their role

Source: Ladden et al. The Emerging Primary Care Workforce. Preliminary Observations from the Primary Care Team: Learning from Effective Ambulatory Practices Project". Academic Medicine; 1013, 88(12): 1830-1835.

It's not just education that is lagging, regulatory system needs to be restructured

> *"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
  - better evaluation of pilot workforce interventions to understand if interventions improve health, lower costs and enhance satisfaction
  - to establish a national clearinghouse to provide up-to-date and reliable information about scope of practice changes in other states

Source: Dower C, Moore J, Langelier M. It is time to restructure health professions scope-of-practice regulations to remove barriers to care. *Health Aff* (Millwood). 2013 Nov;32(11)

And last but not least, who is going to pay for all this retooling we need to do?

- Adequate and sustainable payment models to support new roles, retrain the workforce, and support team- and community-based practice and education etc. are lacking
- Many workforce interventions are supported by one-time funds. If payment models don't change rapidly enough, will these interventions be sustainable?
- Are adequate dollars available to help do the research and evaluations necessary to develop the evidence base needed to support workforce redesign?

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