The Health System is Transforming: Now What?

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Ohio MEDTAPP Summit: “Transforming Healthcare Through State-University Partnerships”
Here’s our agenda

• Context: The health system is rapidly changing: What are the workforce implications?
• Interprofessional education and practice
• Shortage, or no shortage? How do you know?
• The Medicaid workforce
• Social accountability
• Are we all rowing in the same direction? The need for effective relationships
The Context: Health system transformation is underway

• Emphasis is on primary and preventative 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 outcomes

• Payment incentives promote accountability for population health

• Designed to lower cost, increase quality, improve patient experience
The Context: Workforce planning for a rapidly changing health system

- **Lots of people asking:** “How can we align payment incentives and new models of care to achieve the triple aim of better care for individuals, better health for populations and lower costs?”

- **Not enough people asking:** “How can we transform our health workforce to achieve the triple aim?”

- Rapid health system change **requires retooling:**
  - the skills and competencies of the health workforce
  - the questions health workforce researchers ask and answer
  - the types of programs we develop and implement to create a flexible, adaptable, and continuously learning workforce
Flexible workforce, with new competencies, needed in transformed system

A more flexible use of workers will be needed to improve care delivery and efficiency that includes:

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
1. Existing workers will take on new roles in new models of care

- Most workforce policy focus has been on redesigning educational curriculum for students in the pipeline
- But it is workers already in the system who will transform care
- **Action Needed**: more continuing education opportunities to allow workers to upgrade their skills and gain competencies needed in new models of care, such as:
  - care coordination
  - transitions of care
  - population health management
  - patient education and engagement
2. Existing workforce will shift from acute to ambulatory, community- and home-based 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
  - Rapid consolidation of care

- Will increasingly shift health care—and the health care workforce—from expensive inpatient settings to ambulatory, community and home-based settings

**Action Needed**: need to shift health workforce training to community-based settings; current workforce not prepared to meet patient on “their turf”
3. Existing workforce will 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 more generalists, fewer specialists

- Need better articulation agreements and career ladder opportunities to support continuous learning
Re: #4. It’s not just about numbers needed in future, it’s about new health professional roles

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

- All of 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
Re: #5. Need to develop true team-based models of care and education

- How do new roles “fit” with existing health professionals in team-based models of care?
- Chicken or egg: what comes first, team-based practice or team-based education?
- Significant professional resistance exists
- Need to identify new competencies, standardize and credential (?) new skills

Real and lasting change cannot happen without simultaneously addressing payment, regulatory and education policy
Want to learn more on IPE/IPP?

- LEAP = Learning from Effective Ambulatory Practices
  - Ohio LEAP Practice: Neighborhood Family Practice, Cleveland

- National Center for Interprofessional Education and Practice
  [https://nexusipe.org/](https://nexusipe.org/)

- UCSF Center for Health Professions, Innovative Workforce Models
  [http://futurehealth.ucsf.edu/Public/Center-Research/Home.aspx?pid=539](http://futurehealth.ucsf.edu/Public/Center-Research/Home.aspx?pid=539)

- IOM Global Forum on Innovation in Health Professional Education

- And also... Health Careers Pathways (H2P) Consortium
Part 2:
Switching Gears
News of physician shortages grabs headlines

The New York Times

Success of health reform hinges on hiring 30,000 primary care doctors by 2015

Doctor shortage, increased demand could crash health care system

By Jen Christensen, CNN
updated 5:37 PM EDT, Wed October 2, 2013

The Washington Post

In The U.S., Put More On Exhausted Physicians
These estimates of shortfalls tend to overlook (mal)distribution

- Most shortage estimates are at the national level.
- But there is wide variation in the distribution of physicians (and other health professionals) by both specialty and geography.
- What if supply is adequate – but providers are just in the “wrong” place or not serving the populations most in need.
These estimates of shortfalls by specialty also overlook reality of practice

- Physicians flexibly adjust scope of services they provide according to training, practice context and personal preferences
- Counting heads overlooks real world practice where there is:
  - **Between-specialty plasticity** – physicians in different specialties provide overlapping scopes of services
  - **Within-specialty plasticity** – physicians within the same specialty have different practice patterns
Using plasticity turns workforce modeling upside down

- We developed a model that does not produce estimate of *noses needed* by specialty
- Instead, it asks: what are patients’ needs for care and how can those needs be met by different specialty configurations in different geographies?
Selected modeling efforts

- Sheps Center, FutureDocs Forecasting Tool
  www2.shepscenter.unc.edu/workforce

- HRSA non-primary care specialties

- HRSA nursing model... coming soon...?

- AAMC... in development (using OH as pilot location)
Who’s in the Medicaid Workforce?

• How do you know??
• Big issue for behavioral health
• Big issue for oral health
• What are innovative models of that integrate behavioral and mental health?
• GME and Medicaid – accountability is coming, and soon
Accountability

- Many resources are put into health professional education
- Is the “right” workforce going to the “right” places to serve the “right” populations at the “right” time?
- What’s the return on investment for state funds used to train and deploy the workforce?
- Who’s evaluating these efforts?
In NC, most med grads leave state and don’t practice in needed specialties and geographies.

NC Medical Students: Retention in Primary Care in NC’s Rural Areas

Total Number of 2005 NC med school graduates in training or practice as of 2010:

408

Initial residency in primary care

261 (64%)

In training/practice in primary care in 2010:

155 (38%)

In primary care in NC in 2010:

86 (21%)

In PC in rural NC:

10 (2%)

Class of 2005 (N=422 graduates)

Source: North Carolina Health Professions Data System with data derived from the Duke Office of Medical Education, UNC-CH Office of Student Affairs, ECU Office of Medical Education, Wake Forest University SOM Office of Student Affairs, Association of American Medical Colleges, and the NC Medical Board, 2011.
What do workforce stakeholders need to do to help transform workforce

1. Harvest and disseminate learning from workforce innovations
2. Reach outside for new ideas and new partners
3. Focus on the practice, hospital and health system, not just the clinician
4. Identify and codify emerging health professional roles and then train for them
5. Plan for the spread and sustainability of innovations at the time they are initiated
6. Build Evidence Required to Support Changes in Licensure, Credentialing and Accreditation

How do you get stakeholders to work together and speak the same language?

1. Build strong, effective partnerships
2. Communicate and trust
3. Have a strong, neutral facilitator

- **North Carolina**: NC Institute of Medicine (http://www.nciom.org)
- **Colorado**: Colorado Health Institute (http://www.coloradohealthinstitute.org/)
Questions?

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North Carolina Health Professions Data System
http://www.shepscenter.unc.edu/hp

Health Workforce Technical Assistance Center
http://www.HealthWorkforceTA.org
Extra Slides
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