# How Can We Transform the Workforce to Meet the Needs of a Transformed Health System?

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# Presentation Overview

- Health system reform- what does it all mean?
- Old school versus new school approaches
- How education, practice regulation, and payment need to change to support workforce transformation

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

**Current system is unsustainable. With or without health reform, cost pressures are driving system change**

**Growth in new models of care**

- Patient Centered Medical Homes
- Accountable Care Organizations
- Clinically Integrated Networks

# What are 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, subspecialties, 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
- Move toward risk-based and value-based payment models

# 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

# Said another way….
# We need a more FLEXIBLE workforce

**What do I mean by flexible?**

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 emerging in new roles and functions
5. Broader implementation of true team-based models of care and education

# We read and synthesized 57 papers so you wouldn't have to…..

- Wanted to better understand dimensions of flexibility
- Conducted a literature search of post ACA literature
- Goal:  synthesize evidence on workforce implications of new models of care
- What did we find?

**We need to shift from old school to new school approaches**

# 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 retrained to take on new roles
- 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?

# Employers actively redesigning medical assistant roles

- Employers are redesigning all health care roles but MA role is undergoing most rapid change
- Practices are:
  - Organizing MAs into provider teams
  - Engaging MAs to do population health management
  - Having MAs document services in EHRs, act as scribes
  - Turning MAs into health coaches
  - Developing MAs as outreach workers
  - Using MAs to help manage high risk patients

Source: Naughton D, Adelman A, Bricker P, Miller-Day M Gabbay R. Envisioning New Roles for Medical Assistants: Strategies form Patient-Centered Medical Homes. Family Practice Management. March/April 2013

# Reframe #3: 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

- Most workforce policy focus has focused on redesigning educational curriculum for students in the pipeline
- **But it is the 18 million workers, <u>including 585,000 MAs</u>, 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
- How will Medical Assistants currently in the workforce retrain for new roles?

# 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
- Do these career ladders exist for MAs?

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

**Old School**

- Workforce planners have traditionally worked with professional groups to plan for future workforce needed

**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?"

# Workforce is shifting from acute to 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
- Will increasingly shift health care — *and the health care workforce* — from expensive inpatient settings to ambulatory, community and home-based settings
- More care will be provided in patients' homes and in the community

# 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

# Reframe #5: From workforce planning *within* care settings to workforce planning *across* care settings

**Old School**

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

**New School**

- Workforce planning with focus on integrating care and managing transitions between home, outpatient and acute settings?

# New types of health professional 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

**Implications**

- All these roles manage 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

# And so we find ourselves here….

# How do we get there from here?


- It's not just about retooling the workforce
- We need to retool the broader system that supports the workforce:
  - Education
  - Practice
  - Regulation
  - Payment

# 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

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.

# On education side: redesign curriculum to prepare MAs for new roles

- Curriculum needs to prepare MAs for expanded roles in chronic care management, health coaching, population health, use of EHRs, patient interviewing etc.
- Need to redesign education system so MAs already in practice can flexibly gain new skills and competencies
- Training must be convenient – timing, location, and financial incentives must be taken into consideration
- Need to prepare faculty to teach new roles and functions

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.

# On practice side: redesign human resource infrastructure to support new roles

- Need to minimize role confusion by clearly defining and 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

# On regulatory side: confusion around delegation of new roles to MAs

> MAs are "widely misunderstood and often underused by health providers"

- Regulatory frameworks vary between states—no uniform, national definition of scope of practice
- Historical underutilization of MA role for fear of "running afoul with regulations"
- Rapid health system transformation has further muddied the waters—lack of consensus about what new roles are appropriate to delegate to MAs

# What can we do to change this?

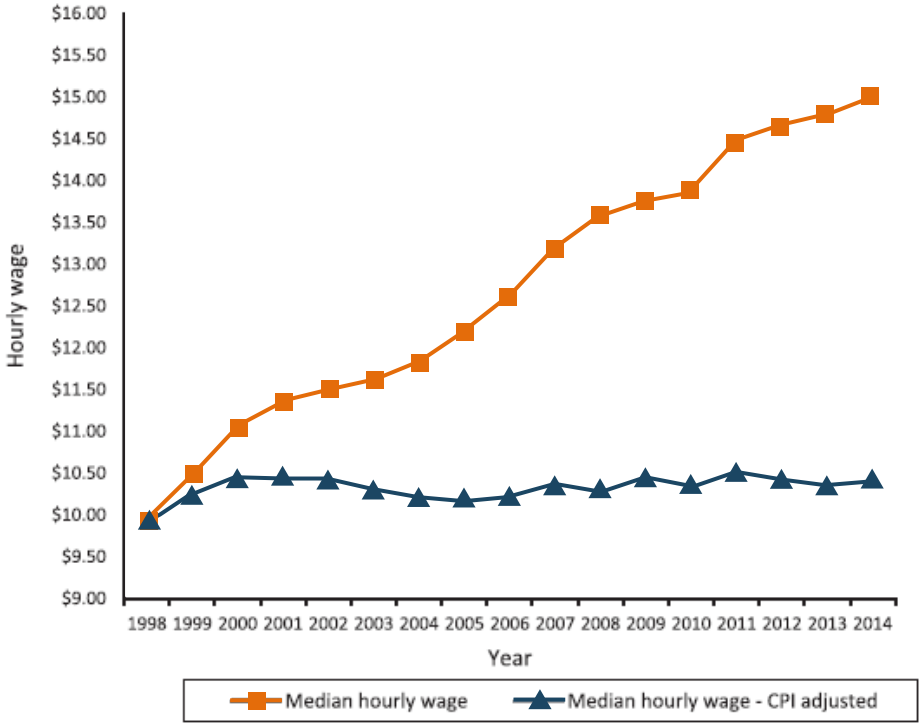
**Need to develop evidence base to support regulatory and practice changes, especially for new roles**

- Evaluate if/how use of MAs improves health outcomes, lower costs, increases productivity and enhances satisfaction (both patient and provider)
- Evaluations could be modeled on similar research about regulation of Nurse Practitioners and patient outcomes in different states

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

- Are funds available to conduct research needed to support MA role redesign?
- Many new MA roles are supported by one-time funds. If payment models don't change rapidly enough, will new roles be sustainable?
- Will MAs see a share of the cost savings these new models bring?

**Figure 2** Median hourly wage increase for medical assistants in the United States, actual versus adjusted for consumer price index (CPI) increase, 1998–2014.




Source: Chapman SA, Marks A, Dower C. Positioning Medical Assistants for a greater role in the era of health reform. *Academic Medicine* 2015 epub ahead of print

# Why Medical Assistants are critical to health system transformation (1)

- With over 585,000 MAs in practice, medical assistants are one of the largest and fastest growing professions
- MAs found across health care settings and patient populations
- MAs are racially, ethnically and linguistically diverse—studies show that racial/ethnic concordance improves patient outcomes
- Emerging evidence that expanded roles for MAs linked to improved patient outcomes in diabetes, hypertension, preventive screening (Chapman 2015)

Source: Chapman SA, Marks A, Dower C. Positioning Medical Assistants for a greater role in the era of health reform. Academic Medicine 2015 epub ahead of print

# Why Medical Assistants are critical to health system transformation (2)

MAs are ultimate “flexible” workforce—flexibility brings innovation to adapt to rapidly changing health system

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