Workforce Planning for a Rapidly Changing Healthcare System

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Sustainable Healthcare Delivery through Sustainable Workforce Development Webinar Series, American Hospital Association

November 1, 2017

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Disclaimer

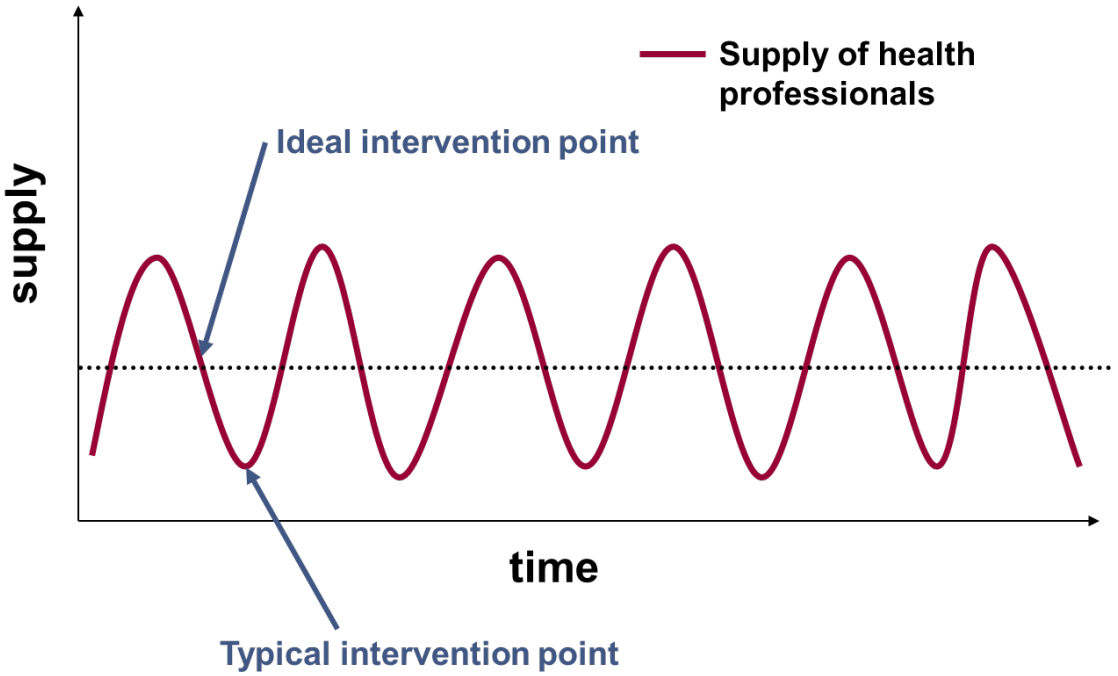
- My work is supported by the National Center for Health Workforce Analysis (NCHWA), Health Resources and Services Administration (HRSA) under cooperative agreement #U81HP26495, The Robert Wood Johnson Foundation and The Physicians Foundation.
- The information, conclusions and opinions expressed in this presentation are mine and no endorsement by my funders or The University of North Carolina is intended or should be inferred.

This presentation in one slide

- Why integrating workforce planning into strategic and financial planning is critical
- New payment and care delivery models require broader definition of the health workforce…
- And a shift from “old school” to “new school” approaches
- It’s not just about transforming the workforce — we need to redesign education, practice, payment and regulatory structures that support workforce
- Health workforce planning resources are available

Why do we care about the health workforce?

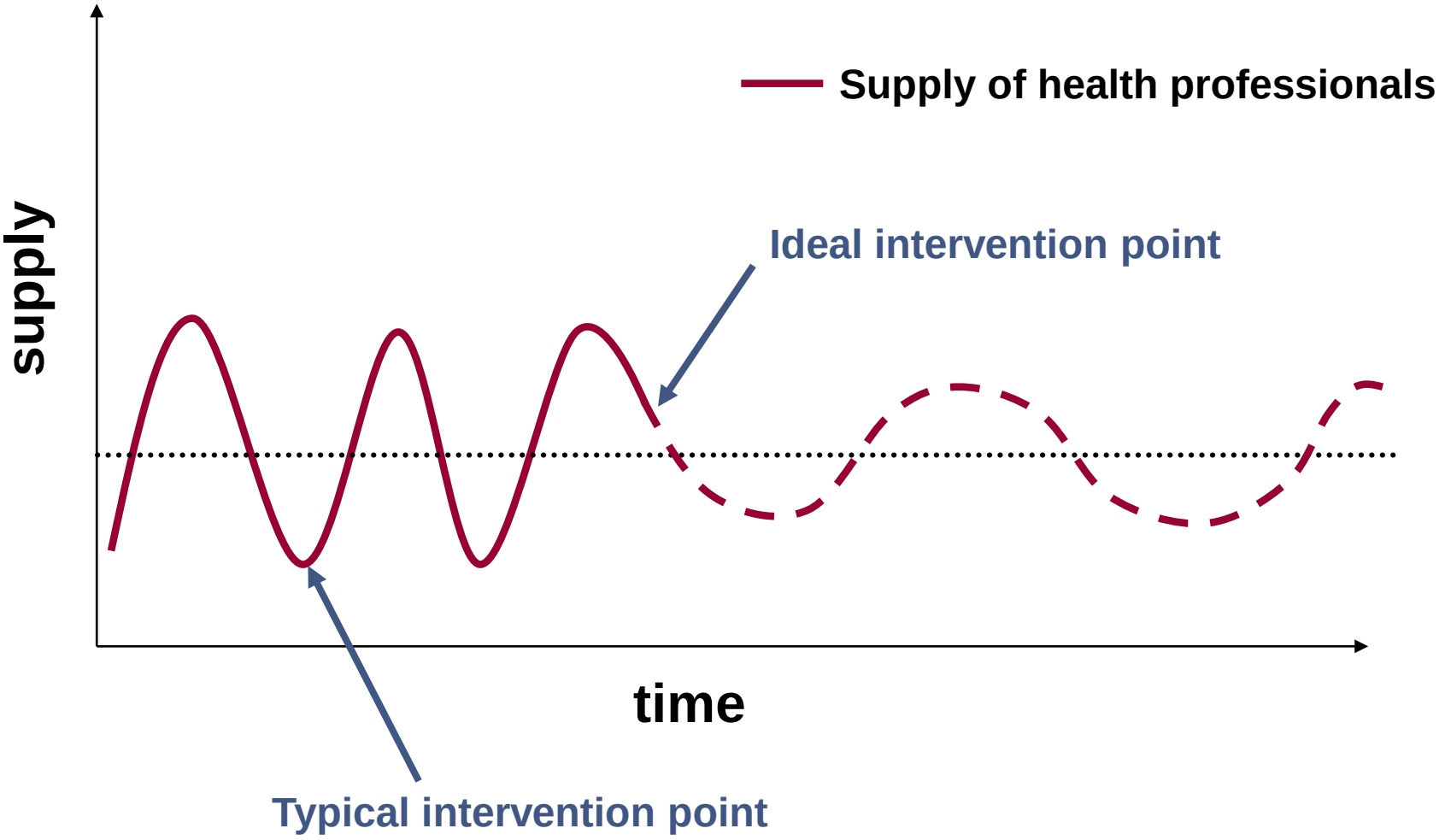
- Workforce is expensive: of **$2.6 trillion** spent on healthcare, **56%** attributed to wages*
- Expensive and inefficient to lurch from oversupply to shortage



*Dunn L. Getting a Handle on Hospital Costs. *Hospitals and Health Networks.* 2015

Health workforce planning the traditional way

Need strategic workforce planning to "smooth" the cycle



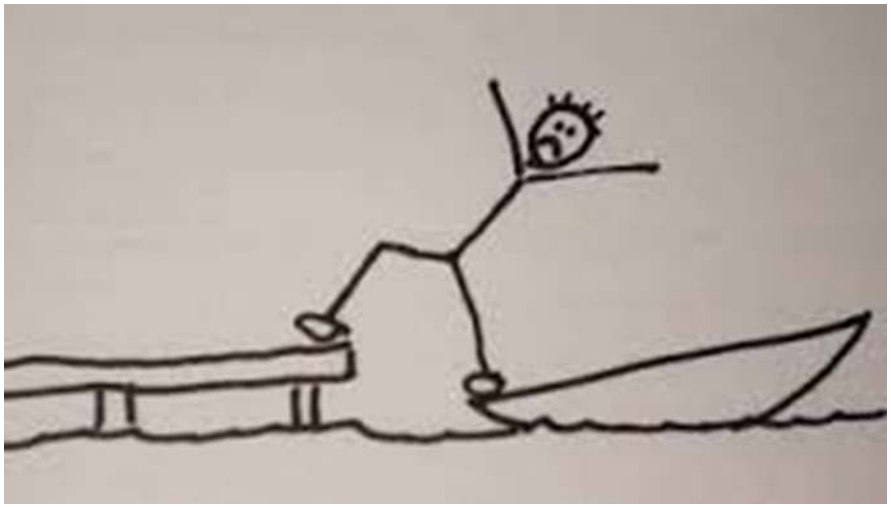
Let 1,000 flowers bloom

- Hospitals and health systems striving to achieve quadruple aim
- Ongoing experimentation underway to transform the way health care is paid for, organized, and delivered
- Less attention paid to aligning workforce and education system to meet needs of evolving system
- Lack of attention to workforce may be reason that new care delivery and payment models are not showing expected outcomes*

*McWilliams JM. (2016). Savings from ACOs-building on early success. *Annals of Internal Medicine, 165*(12), 873-875.
Sinaiko AD, Landrum MB, Meyers DJ, Alidina S, Maeng DD, Friedberg MW, Rosenthal MB. (2017). Synthesis of research on patient-centered medical homes brings systematic differences into relief. *Health Affairs (Millwood),* 36(3), 500-508.

Lots of uncertainty out there. Makes workforce planning difficult but even more important

- *With* or *without* changes to the ACA, cost pressures will drive change



- Most health care systems operating predominantly in FFS model but know they need to plan for value-based payment in future

What the future holds: key characteristics of new models

- 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
- Interventions focused at both patient- and population-level

A story about population health….

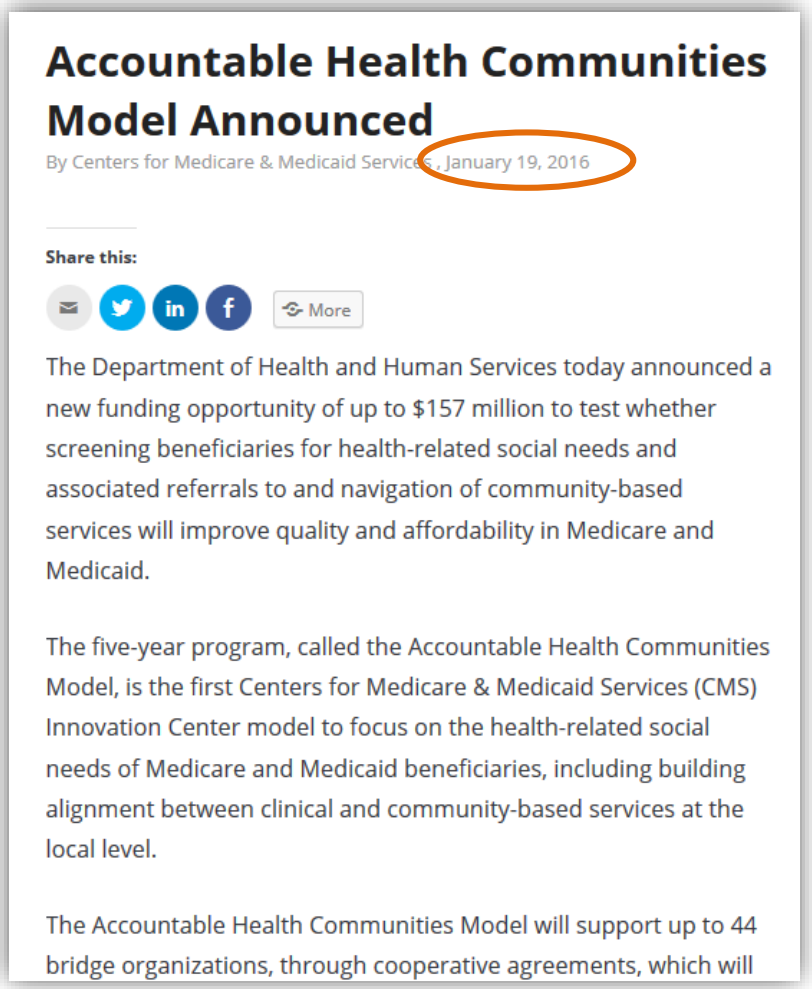
"I am standing by the shore of a swiftly flowing river and hear the cry of a drowning man. I jump into the cold waters. I fight against the strong current and force my way to the struggling man…I lay him out on the bank and revive him with artificial respiration. Just when he begins to breathe, I hear another cry for help…I fight against the strong current, and swim forcefully to the struggling woman…I lift her out onto the bank beside the man and work to revive her with artificial respiration. Just when she begins to breathe, I hear another cry for help….***Near exhaustion, it occurs to me that I'm so busy jumping in, pulling them to shore, applying artificial respiration that I have no time to see who is upstream pushing them all in....***"

(Adapted from a story told by Irving Zola as cited in McKinlay, John B. "A case for refocusing upstream: The political economy of illness." In Conrad and Kern, 2nd edition, 1986, *The Sociology of Health and Illness: Critical Perspectives*. pp. 484-498.)

This is the aim of 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…"

Former 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

Share this:

More

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

32 Accountable Health Community Models will link clinical and community services

"We know that innovation at the state and community level is essential to improve health outcomes and lower costs. In this model, we will support community-based innovation to deliver local solutions that address a broader array of health-related needs of people across the country."

Dr. Patrick Conway, CMS Deputy Administrator for Innovation & Quality

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-04-06.html

How do we get there from here?

As the health system grapples with rapid change and significant uncertainty, need to shift focus from “old school” to “new school” workforce planning approaches

This section draws on work in press by E. Fraher and B. Brandt, “Toward a System Where Workforce Planning, Education and Practice are Designed Around Populations, Not Professions”

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

Old School

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

New School

- How can we more effectively and efficiently deploy the workforce already employed in the health care system on interprofessional teams?

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 teams?** Need to empower teams of licensed and unlicensed providers to reallocate work flows and redesign care pathways

- **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 education

Sources: Bodenheimer TS, Smith MD. Primary care: proposed solutions to the physician shortage without training more physicians. *Health Affairs (Project Hope)*. 2013 Nov;32(11):1881–6.

Reframe #2: From a focus on provider type to recognizing plasticity of provider roles

Old School

- Assumes professions and specialties have fixed and unique scopes of practice

New School

- Recognizes “plasticity” of real world practice—professions and specialties have overlapping and dynamic scopes of practice

Workforce is highly flexible. We need to encourage practicing to fullest scope

- Plasticity recognizes that roles will dynamically change depending on patients' need for services, the setting and the availability of other providers
- Instead of retrofitting care models to meet existing competencies of the existing workforce, need to ask what are patients' needs for services and
  - How might health professional roles be redesigned to meet those needs?
  - How could patient pathways be redesigned to meet care needs across settings?

Myriad of new roles emerging in evolving system

Emerging Roles

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

Implications

- Many 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

Boundary spanning roles growing quickly

"Boundary spanning" roles reflect shift from visit-based to population-based strategies

Two examples:

Panel Managers	Health Coaches
Assume responsibility for patients between visits. Use EHRs and patient registries to identify and contact patients with unmet care needs. Often medical assistants but can be nurses or other staff	Improve patient knowledge about disease or medication and promote healthy behaviors. May be medical assistants, nurses, health educators, social workers, community health workers, pharmacists or other staff

Social workers play increasingly important boundary spanning roles

We conducted a systematic review of randomized control trials (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

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**.

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

Old School

- Silo-based workforce planning for individual professions

New School

- Workforce planning for services, patients, families and communities

Health workforce planning or planning a workforce for health?

Upstream, population health approach requires us to:

- Expand workforce planning efforts to include workers in broad range of health care, community and home-based settings
- Embrace the role of social workers, patient navigators, community health workers, home health workers, community paramedics, dieticians and other community-based workers
- Determine how to integrate the public health workforce into health workforce planning

Where does the public health workforce fit in?

- "Public Health 3.0" (Oct 2016) seeking to maintain traditional strengths ***and*** confront challenges of aging population with chronic disease
- Public Health 3.0 calls for a "Chief Health Strategist" to develop community partnerships
- Recent survey by National Association of County and City Health Officials (NACCHO) found that 58% of local health departments were collaborating with hospitals on community health needs assessments (CHNAs)
- But are CHNAs being used for workforce planning?

Source: Office of the Assistant Secretary for Health, US Department of Health and Human Services. A Call to Action to Create a 21st Century Public Health Infrastructure. Washington, DC. October 2016. https://www.healthypeople.gov/sites/default/files/Public-Health-3.0-White-Paper.pdf

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

Source: Szanton SL, Leff B, Wolff JL, Robers K, Gitlin LN. (2016). Home-Based Care Program Reduces Disability And Promotes Aging In Place. *Health Affairs*; Sep 1;35(9):1558-63.

Reframe #4: From focus on pipeline to focus on retooling existing workforce

Old School

- Focus on redesigning training for students in pipeline

New School

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

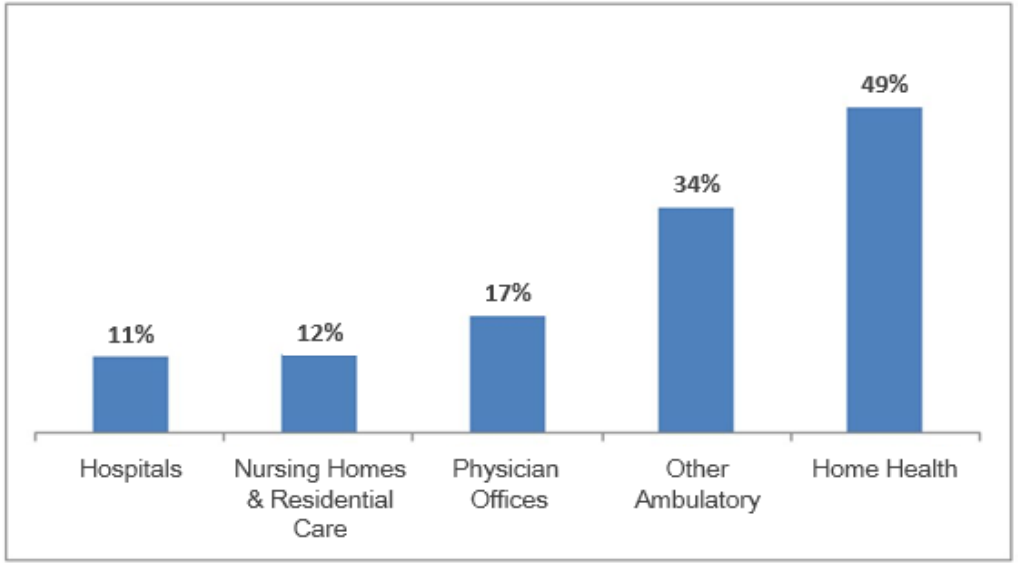
Workforce already employed in the system will be the ones to transform care

- 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 in care coordination, population health management, behavioral health, patient education and engagement, health coaching, informatics, 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

Goal: flexible workforce that can adapt to rapidly changing health care system

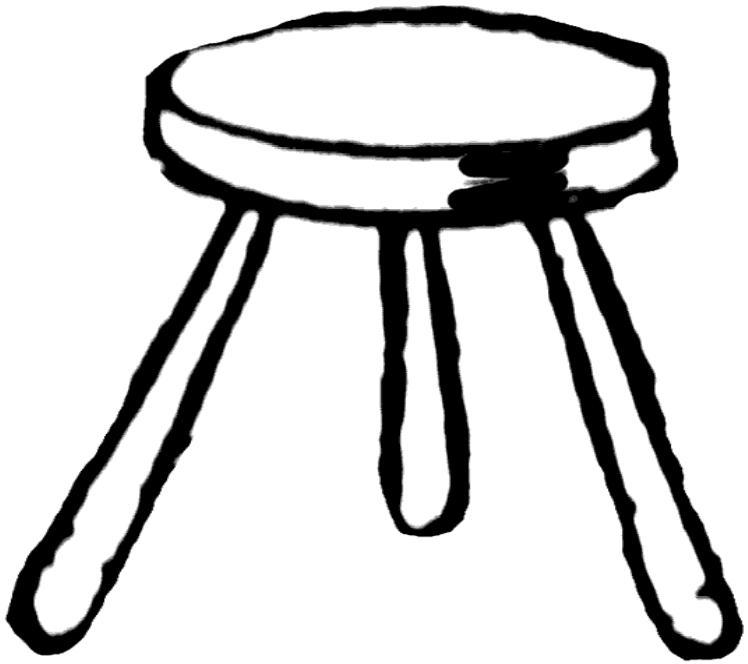
Both new entrants to the workforce

And our “seasoned workers”

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

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.

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 to:
  - assess if new grads are 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

Source: Fraher E, Spetz J, Naylor M. Nursing in a Transformed Health Care System: New Roles, New Rules. LDI/INQRI Research Brief. June 2015; 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.

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 they don't trust that other staff members are competent
- Time spent on 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*

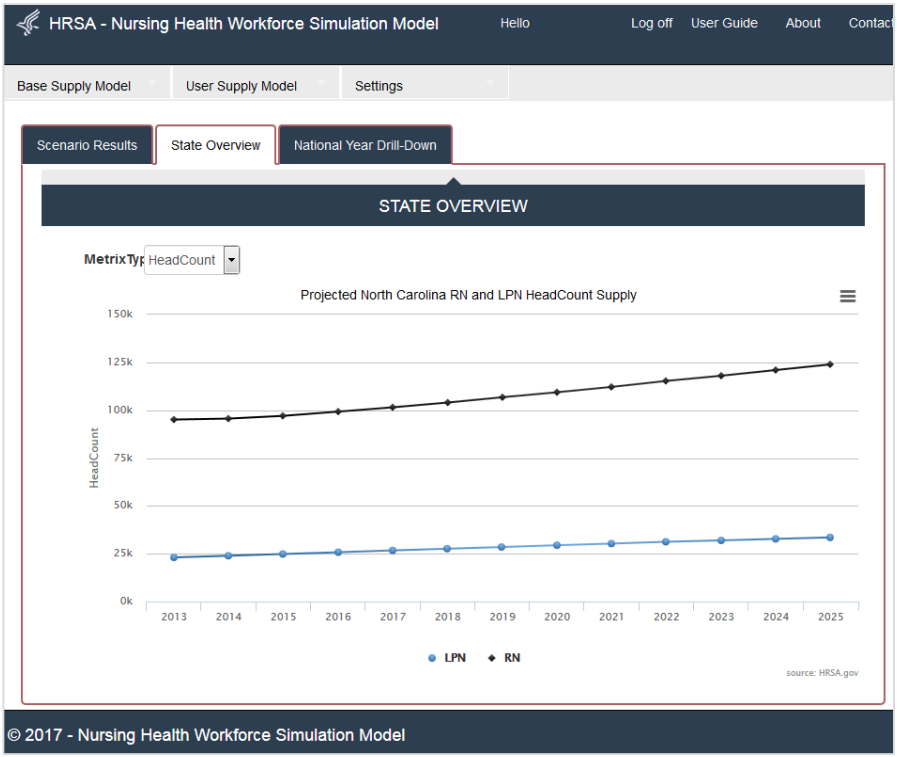
To create a more dynamic regulatory system, we need to:

- 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)

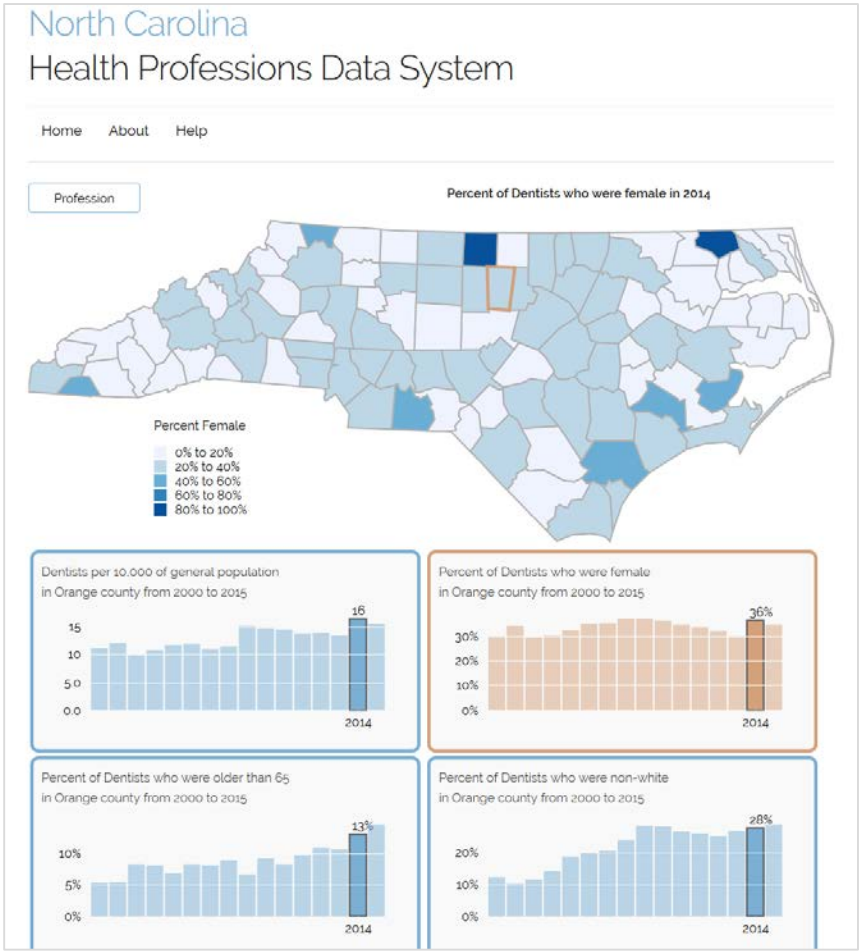
Source: Dower C, Moore J, Langelier M. It is time to restructure health professions scope-of-practice regulations to remove barriers to care. *Health Aff* (Millwood). 2013 Nov;32(11); Fraher E, Spetz J, Naylor M. Nursing in a Transformed Health Care System: New Roles, New Rules. LDI/INQRI Research Brief. June 2015.

Resources

You will need data to drive workforce transformations



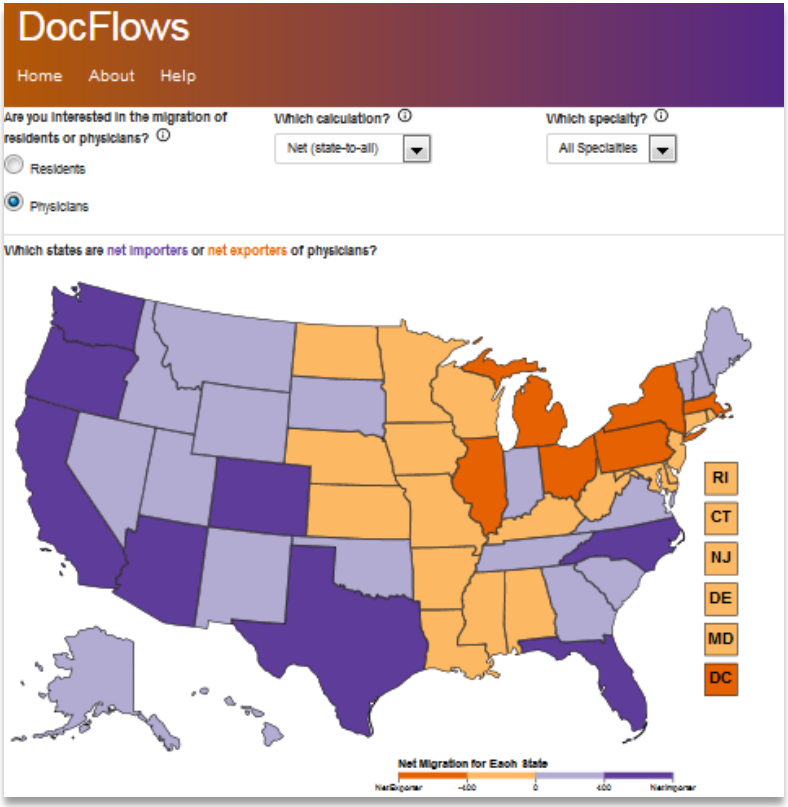
https://webnursingmodel.hrsa.gov/



nchealthworkforce.sirs.unc.edu

Our new DocFlows App seeks to provide states with physician workforce data

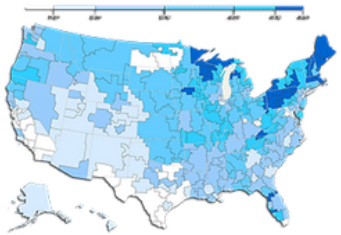
- Data visualization tool allows users to query, download and share maps showing interstate moves by residents and actively practicing physicians in 35 specialties
- Where are your residents/physicians moving?
- From which states are you importing residents/physicians?
- DocFlows available at: docflows.unc.edu



https://www2.shepscenter.unc.edu/workforce

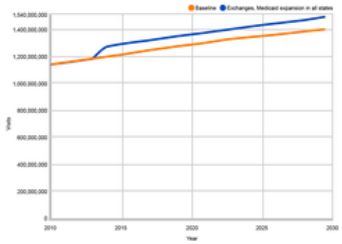
FutureDocs Forecasting Tool

HOME | ABOUT THE PROJECT | THE MODEL | HELP | CONTACT



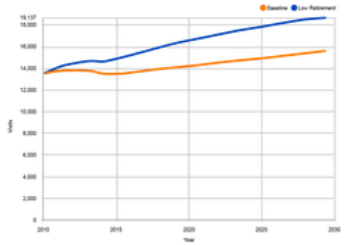
VISUALIZE DATA AT STATE AND SUB-STATE LEVELS

Use the tool to view physician supply, healthcare service use, and shortages/surpluses at the national, state, and sub-state levels.



PROJECT THE EFFECT OF MEDICAID EXPANSION

Use the tool to project how the utilization of health care services will change under different assumptions about Medicaid expansion.



UTILIZATION, SUPPLY, SHORTAGE/SURPLUS TO 2030

Use the tool to examine how physician supply, healthcare service use, and shortages/surpluses will change between 2011-2030 under different scenarios.

BUILD YOUR MODEL

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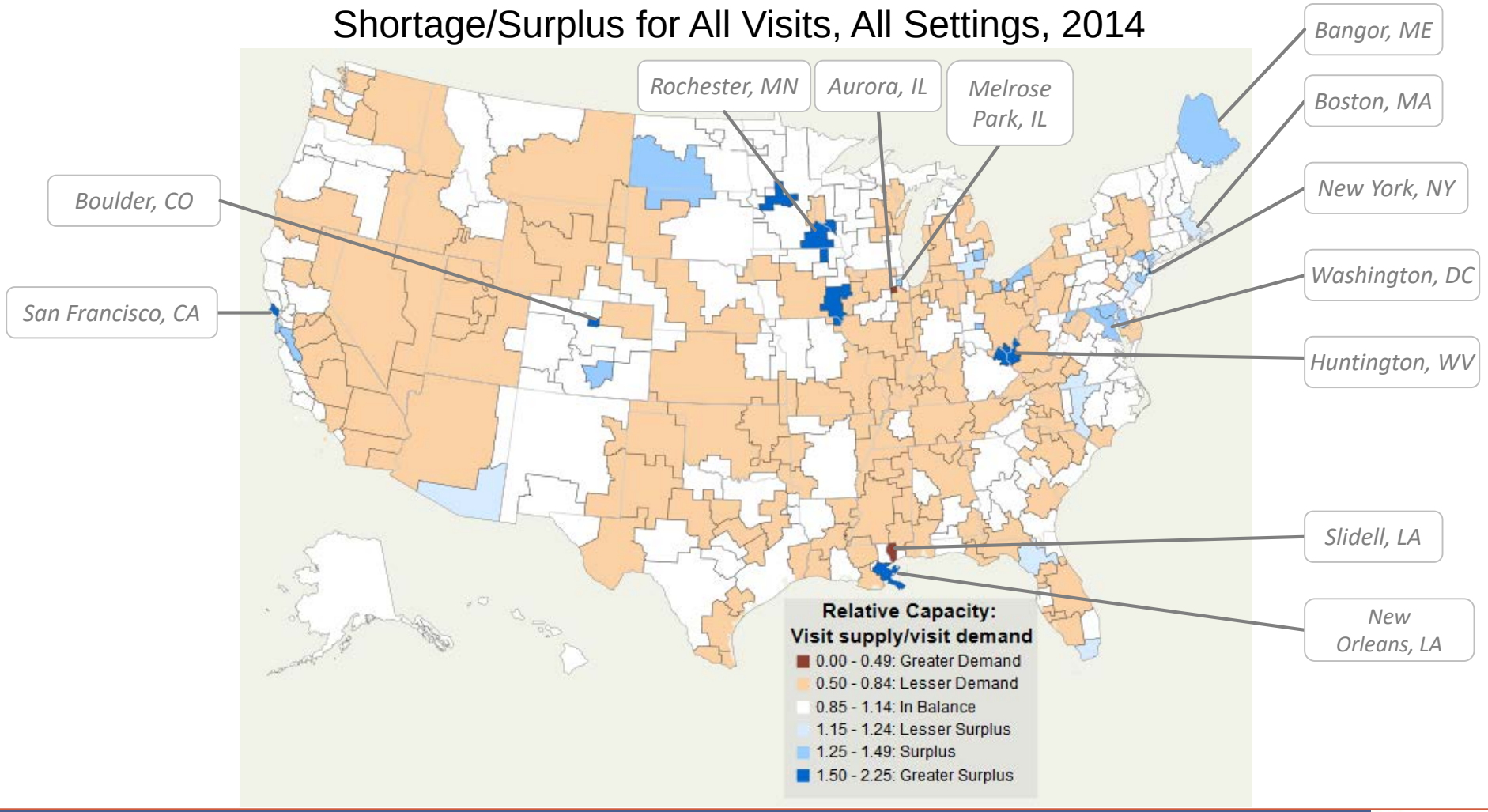
This project is funded by a grant from The Physicians Foundation.

THE PHYSICIANS FOUNDATION Empowering Physicians Improving Healthcare

Model highlights that we are a nation of “haves” and “have-nots”



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

THE PHYSICIANS FOUNDATION Empowering Physicians Improving Healthcare

Speaking of shortage… what's going on in nursing?

National nursing models are mixed: some suggest shortage, others excess supply

Example: HRSA's model

- Nursing Health Workforce Simulation Model, https://webnursingmodel.hrsa.gov/
- Supply and Demand Projections of the Nursing Workforce: 2014-2030 (July 2017) https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/NCHWA_HRSA_Nursing_Report.pdf

- HRSA projects 39 percent growth in RN supply will exceed 28 percent growth in demand resulting in a projected excess of about 293,800 RN FTEs in 2030
- Biggest shortage states: California, Texas, New Jersey, South Carolina
- Biggest surplus states: Florida, Ohio, Virginia, New York
- Does that feel right?

Carolina Health Workforce Research Center:

Flexible use of healthcare workers and emerging health workforce topics

Mission: Conduct and disseminate timely, policy-relevant research on the flexible use of healthcare workers and emerging health workforce topics to improve the quality and efficiency of health care.

What we do: Produce research, data, and analyses to help shape policy; develop new methods and tools to analyze workforce data; build the science of workforce research by disseminating findings; mentor the next generation of health workforce researchers.

Workforce Transformations:

Shifting roles, settings, skills and geography

GME

Utilization of therapeutic services

Nursing

Social work

http://www.shepscenter.unc.edu/programs-projects/workforce/projects/carolina-health-workforce-research-center/

HRSA-funded Health Workforce Research Centers

- Seven HWRCs support research to assist decision-makers at the federal, state and local levels to better understand health workforce needs.
- Themes include allied health, behavioral health, emerging health workforce topics, long-term care, oral health, technical assistance
- For a list of HWRCs, see https://bhw.hrsa.gov/health-workforce-analysis/research/research-centers

http://www.gwhwi.org/uploads/4/3/3/5/43358451/final_report_03.15.17.pdf

What We Value:
National Center Vision

We believe **high-functioning teams** can improve the experience, outcomes and costs of health care.

National Center for Interprofessional Practice and Education is studying and **advancing the way stakeholders in health work and learn together**.

National Center Funders

Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067

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The Nexus

Creating a deeply connected, integrated learning system to transform education and care together

What I didn't cover and my top 6 list of things to keep your eye on

Important topics I didn't cover

- Rural workforce challenges (and opportunities)
- Technology
- Diversity
- Growing role (and voice) of patients
- Other?

Keep your eye on these issues

- GME reform
- Behavioral health payment changes
- Nursing shortages
- Growing role for RNs in primary care
- Growing role of LPNs outside of long-term care
- Medicaid transformation

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