Workforce Planning for a Rapidly Changing Healthcare System

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Disclaimer

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- 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.
• 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

- Supply of health professionals

- Ideal intervention point

- Typical intervention point
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*

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....”

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...”

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

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

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:

<table>
<thead>
<tr>
<th>Panel Managers</th>
<th>Health Coaches</th>
</tr>
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<tbody>
<tr>
<td>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</td>
<td>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</td>
</tr>
</tbody>
</table>
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.

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?

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

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

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

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.

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)

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

- 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.

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](https://bhw.hrsa.gov/health-workforce-analysis/research/research-centers)

[Three Years of Findings](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**.

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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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