The Workforce Needed to Staff Value-Based Models of Care

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  - Jacqueline Halladay, MD MPH, Associate Professor in the Department of Family Medicine at UNC-CH
Let 1,000 flowers bloom: ongoing experiments in health system transformation

- Implementation of patient centered medical homes
- Growth of Accountable Care Organizations
- CMS stimulating health system transformation
- Early evidence inconclusive about effect on patient outcomes
- One reason may be because not enough attention paid to reconfiguring workforce as critical element of system redesign
And what will Secretary Burwell’s announcement mean for workforce?

- 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 the health workforce to achieve the triple aim?”

We undertook study to synthesize evidence on workforce implications of new models of care

Study aims to identify:

1. task shifting that is occurring in the delivery of traditional health care services;
2. new staff roles that are emerging to provide enhanced care services;
3. how health care employers are “putting it all together”; and
4. implications of trends for health workforce research and policy
Methods

• Synthesis of post ACA literature

• Focused on staff roles in new models of care that:
  – are new or have undergone significant transformation
  – provide direct patient care
  – address patients’ health care needs in community, ambulatory and acute settings

• Each study reviewed by 2 investigators, 57 studies included in synthesis

• What workforce transformations did we find?
Significant task shifting to deliver traditional health care services

### Examples

<table>
<thead>
<tr>
<th><strong>Medical Assistants</strong></th>
<th><strong>Registered Nurses</strong></th>
<th><strong>NPs and PAs</strong></th>
<th><strong>Pharmacists</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>rapidly morphing, taking patient histories, giving immunizations, providing preventive care services and scribing</td>
<td>refilling prescriptions under protocols, entering and interpreting data from EHRs, creating care plans and providing patient education</td>
<td>managing own patient panels and providing care for bulk of patients with uncomplicated acute, chronic care needs</td>
<td>coordinating drug therapies, developing medication management plans and educating patients. Some states (CA, MT, NM and NC) created advanced practice pharmacists</td>
</tr>
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New roles emerging to provide enhanced care functions

• May be filled by existing staff or new hires

• It’s complicated:
  – Some roles have similar functions but different titles
  – Other roles have different functions but same name
  – Many roles are filled by different types of providers

• Two of most common:
  1. Roles that focus on coordinating care within the health care system
  2. “Boundary spanning” roles that address patient care needs between home and health care settings
Care coordination is big

- Increased incentives to keep patients out of hospital
- In January 2015, Medicare began paying $42/month for managing care for patients with two or more chronic conditions
- Nurses most often taking on roles as care coordinators, case managers and transition specialists
- Nurses increasingly joined by pharmacists, social workers, and other behavioral health providers
Boundary spanning roles growing quickly

- Increasing number of staff focused on roles that shift focus from visit-based to population-based strategies
- Two examples:

<table>
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<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>
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Health care employers struggling to integrate new roles into existing HR infrastructure

- Job descriptions have to be rewritten or created
- Work flows have to be redesigned
- Heterogeneity and overlap in job titles creates role confusion
- Existing staff won’t delegate or share roles if they don’t trust other staff members have competence
- Lack of standardized training and funds to support training
- Time spent training is not spent on billable services
How do we get there from here?

• Front line delivery systems actively re-engineering staff roles and care processes

• But policy structures supporting the workforce have been slower to respond

• We need to shift our focus from “old school” to “new school” approaches
Reframe #1: From a focus on shortages to measuring the demand-capacity mismatch

**Old School**

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

**New School**

- How can we more effectively and efficiently use the workforce already employed in the health care system?
Need to redefine crisis from looming shortage to demand-capacity mismatch

- Perceived primary care shortages could be addressed if health care employers reallocated responsibilities
- Literature shows significant reallocation of responsibilities already under way in new models of care
- Whether this will be enough to meet patients’ needs for care is difficult to know
- Workforce projection models generally don’t account for efficiency and productivity gains from task shifting and new roles

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 patients’ needs in different geographies and practice settings?
Workforce models need to capture plasticity of practice

- Literature demonstrates significant heterogeneity in who provides what health services
- Models need to move away from specialty-specific single projections
- Need models that acknowledge plasticity—health providers will adjust their scopes of services to meet patients needs
- Patients’ health care needs will be met by different workforce configurations in different settings and geographies
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

- 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.

- Health system transformation inhibited by shortage of appropriately trained workers.

- Education system is lagging behind front-line delivery system.
Workforce is shifting from acute to community settings

- Move 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 the workforce in inpatient settings
- Need more innovative, “model” interprofessional practice sites in community-based settings
- Need curriculum to emphasize new skills and competencies in population health, care coordination, informatics, patient engagement etc.
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 professions to workforce planning for patients

Old School
- Health workforce planning

New School
- Planning for a workforce for health
Planning to support a workforce for health, not a health workforce

Increased boundary spanning roles require:

- Workforce planning efforts that include workers in community and home-based settings
- Embracing role of social workers, patient navigators, community health workers, home health workers, dieticians and other community-based workers
- Integrating health workforce and public health workforce planning
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 coordinate care, manage transitions and provide between visit care?
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