The Workforce Needed to Staff Value-Based Models of Care

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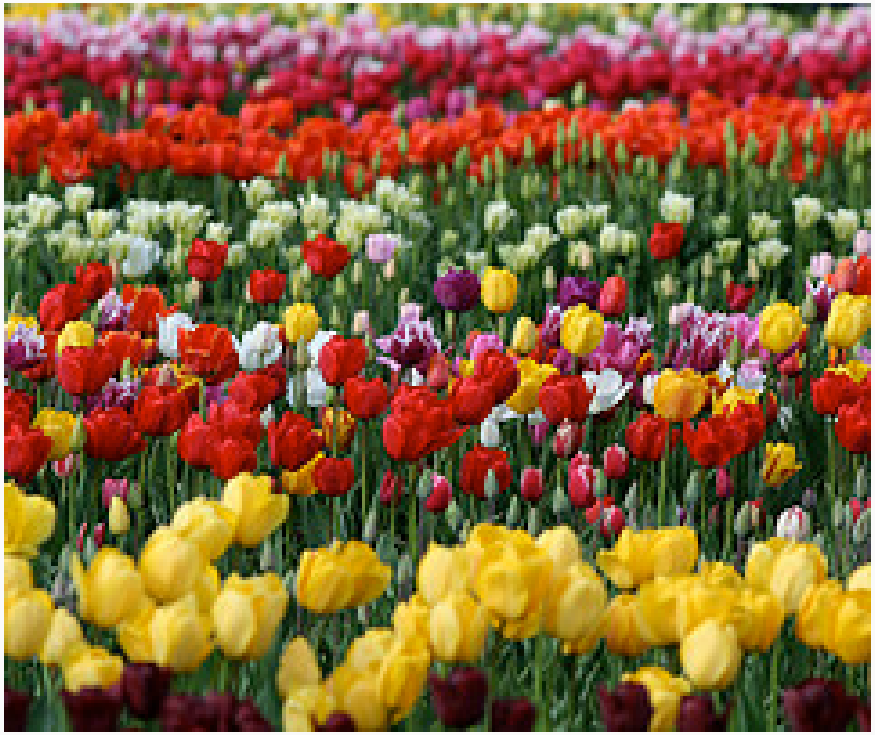
Let 1,000 flowers bloom: ongoing experiments in health system transformation

- Growing number of patient centered medical homes, accountable care organizations and integrated delivery systems
- CMS actively funding demonstration projects
- Secretary Burwell recently announced 50% of Medicare payments tied to value by 2018



New models of care: key characteristics

- 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:
  - medical sub-specialties, 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 payment, risk-stratification and hot spotting
- Payment based on value, not volume

Intense focus on payment and care delivery models, less focus on workforce changes needed to staff new models

- Undertook study to synthesize evidence on workforce implications of new models of care
- Funded through HRSA Cooperative Agreement U81HP26495-01-00: Health Workforce Research Centers
- Collaborators: **Rachel Machta, BS**, PhD student at UNC-CH and **Jacqueline Halladay, MD MPH**, Associate Professor in the Department of Family Medicine at UNC-CH
- Our findings suggest need to shift from “old school” to “new school” workforce planning

Reframe #1: From numbers to content

Old School

- Will we have enough health professionals?

New School

- Does the health workforce have the skills and competencies needed to function in new models of care?

New roles in new models of care

- PCMHs and ACOs emphasize care coordination, population health management, patient education, health coaching, data analytics, patient engagement, quality improvement etc.
- Early evaluations suggest new models of care not showing expected outcomes
- Could be because: 1. education system not adequately preparing graduates to practice in new models of care and/or 2. existing workforce not retooled with new skills and competencies
- 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 patients' needs in different geographies and practice settings?

Many 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
  - Depending on setting and patient population, roles are often filled by different types of providers
- Two of most common:
  1. Roles that focus on coordinating care within health care system
  2. "Boundary spanning" roles that coordinate patient care between health care system and community-based settings

Care coordination within health care system is big and getting bigger

- 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 part of team with pharmacists, social workers, dieticians and others

Boundary spanning roles growing quickly

- Increasing number of staff focused on roles that shift focus 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

Reframe #3: From focus on pipeline to focus on retooling existing workforce

Old School

- Redesigning curriculum for health professional students in the pipeline

New School

- Retooling the 18 million workers already employed in the health care system

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

- To date, most workforce policy focus has been on redesigning educational curriculum for students in the 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 to identify and codify emerging health professional roles and then redesign pipeline and continuing education programs to train workers to take on these roles

Workforce is shifting from acute to community 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
- But we generally educate health workforce in inpatient settings
- Current workforce not adequately prepared to work in ambulatory settings and patients' homes

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 deployment in different settings, services and patient populations

Reframe #4: From health workforce planning to planning for workforce for health

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 who typically practice in community and home-based settings
- Embracing role of social workers, patient navigators, community health workers, home health workers, mental health workers, dieticians and other community-based workers
- Integrating health workforce and public health workforce planning

Retooling:
How do we get there from here?

It's not just about retooling the workforce. We need to retool the system that supports the workforce: education, reimbursement and regulation needs to be more responsive to changes in front-line health care delivery

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—four year, two year and continuing education

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 nursing workforce for new roles

- Need to redesign education system so workers 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
- Clinical rotations need to include "purposeful exposure" to high-performing teams

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

Regulatory system needs to be restructured

> *"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
- better evaluation of pilot workforce interventions to understand if interventions improve health, lower costs and enhance satisfaction
- to establish a national clearinghouse to provide up-to-date and reliable information about scope of practice changes in other states

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)

Who is going to pay for all this retooling we need to do?

- Adequate and sustainable payment models to retool and redeploy the workforce are lacking
- Many workforce innovations are supported by one-time funds. If payment models don't change rapidly enough, will these interventions be sustainable?
- 1,000 flowers are blooming but are adequate dollars available to conduct research and evaluations necessary to develop evidence base needed to support workforce redesign?

Funders and Collaborators

- This work is funded through HRSA Cooperative Agreement U81HP26495-01-00: Health Workforce Research Centers Program

- Collaborators:
  - **Rachel Machta, BS**, PhD student at UNC-CH
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