Follow Live Tweets From The Event @Ha_events, And Join In The Conversation

#HA_Workforce

HealthAffairs
Health Affairs Thanks These Organizations For Their Financial Support Of The November Issue Of Health Affairs And This Briefing

Robert Wood Johnson Foundation

Josiah Macy Jr. Foundation

AAMC

Tomorrow's Doctors, Tomorrow's Cures®

American Osteopathic Association

American Association of Colleges of Osteopathic Medicine

American Association of Colleges of Nursing

American Nurses Credentialing Center

American Nurses Association

American Association of Colleges of Pharmacy

Health Affairs
Opening Address

Uwe E. Reinhardt, PhD
James Madison Professor of Economy and Professor of Economics and Public Affairs, Princeton University
Panel One:

Setting The Stage For Health Workforce Policy In The ACA Era
Reconfiguring Health Workforce Policy So That Education, Training, And Actual Delivery Of Care Are Closely Connected

Thomas Ricketts, PhD
Professor, Health Policy and Management, UNC Gillings School of Global Public Health

HealthAffairs
Patient Centeredness?

• Measured from
  – Patient’s view
  – Team’s view
  – Professional’s view
  – (Payer’s View)
May Bring Harmony And Effectiveness
Or Not...
Setting The Stage For Health Workforce Policy In The ACA Era

Edward Salsberg, MPA
Director, National Center for Health Workforce Analysis
U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Health Professions

A Health Policy Briefing
With Health Affairs and Academic Medicine
November 14, 2013
Major Developments and Trends Affecting the Health Workforce

- Increasing demand
  - Demographic changes
  - Increasing access via insurance expansion
- Unsustainable cost increases and concern with inefficiencies
- Delivery system reforms and growing size of health care organizations
- Innovations (e.g. increased use of non-physician clinicians; retail clinics, technological advances)
- Increased attention to primary care, chronic care, prevention, behavioral health and population health
Initiatives Affecting Demand and Service Delivery Redesign

- CMMI initiatives impacting and involving the health workforce
- Support for medical homes and ACOs
- Payment reforms
- Support for Interprofessional Practice and Teams
- Promotion of full use of all health workers from advanced practice nurses to home health aides
HRSA Initiatives Affecting Supply

- Teaching Health Centers
- Title VII and VIII promote primary care and community-based training
- National Health Service Corps (NHSC)
- National Center for Interprofessional Practice and Education
National Center for Health Workforce Analysis

1. Expanded and improved health workforce data collection and analysis
2. Improved projections of supply and demand/need
3. Dissemination of findings, data and information especially to key stakeholders
4. Strengthening state health workforce planning capacity
Workforce Composition: Growth of PAs/NPs Compared to Physicians

Percentages of Types of Direct Patient Care Providers, Supply and Production

Currently Practicing

- 18% PAs/NPs
- 82% Physicians

New Providers per Year

- 37% PAs/NPs
- 63% Physicians

Source: National Center for Health Workforce Analysis
Closing Observations

- Growing awareness of the important role of the health workforce in health systems transformation
- A variety of forces are contributing to efforts to make better use of the existing workforce
- Effective health workforce planning is a shared federal-state responsibility
- Maldistribution is critical health workforce challenge; national numbers may mask need in local communities
- More data, research and studies are needed to inform the health workforce decision making and to make health workforce policy more evidence based
Contact Information

Edward Salsberg, Director,
National Center for Health Workforce Analysis
301-443-9355
esalsberg@hrsa.gov

http://bhpr.hrsa.gov/healthworkforce/
RWJF’s Investment in Nursing:

Strengthening the Health of Individuals, Families and Communities

Susan B. Hassmiller, PhD, RN, FAAN
Senior Adviser for Nursing, and director, The Future of Nursing: Campaign for Action

Health Affairs
RWJF: Investing In People

A strong and vibrant health workforce is crucial to improving health and health care

Nursing Investment: $600 M in nursing programming
RWJF’s Strategy Of Partnering

Interdisciplinary collaboration that pairs nurses with other health care stakeholders

- *Partners Investing in Nursing’s Future*
- *Interdisciplinary Nursing Quality Research Initiative*
- IOM study on the future of nursing
Collaborations And Partnering

RWJF and AARP: The Future of Nursing: Campaign for Action

Future of Nursing Scholars

• Philanthropic collaborative to engage other donors
Collaborations And Partnering

RWJF and Group Health Research Institute

- LEAP
- Identify creative workforce practices that enhance efficiency and effectiveness of primary care
Reforming Health Professions, Education Will Require Culture Change And Closer Ties Between Classroom And Practice

George Thibault, MD
President, Josiah Macy Jr. Foundation

Health Affairs
Panel Two: Restructuring Medical Education
A New Pathway For Medical Education

Stephen C. Shannon, DO, MPH
Boyd R. Buser, Marc B. Hahn, John B. Crosby, Tyler Cymet, Joshua S. Mintz, Karen J. Nichols
Five Key Principles

• Focus on team-based, patient-centered care.
• Build on competency-based curriculum.
• Provide continuous, longitudinal, education-based experience.
• Administer via medical schools, in collaboration with GME providers with clinical experience in variety of settings.
• Focus on healthcare delivery science.

www.BlueRibbonCommission.org
A NEW PATHWAY TO EDUCATE PRIMARY CARE PHYSICIANS

TRADITIONAL OSTEOPATHIC MEDICAL EDUCATION
Time-based: 7 years for primary care specialties

YEAR 1
Medical School: Years 1-3
From the first year, students engage in classroom and laboratory learning, as well as clinical experiences in a wide variety of learning environments reflective of the modern healthcare system.

YEAR 2

YEAR 3

YEAR 4
Medical School or Residency: Year 4
Residency: Year 5
Upon demonstration of required measurable competencies in third or fourth year, students may transition seamlessly to residency with medical college’s partner health care provider.

YEAR 5

YEAR 6

YEAR 7

YEAR 8+
Residency or Primary Care Practice: Years 6-7
Primary Care Practice: Years 8+
Depending on how efficiently they develop the competencies needed to provide patients with high quality, value-based primary care, students will spend 5-7 years in undergraduate and graduate medical education before completing the full course of primary care specialty training. They are then eligible for board certification and may enter practice as primary care physicians.

YEAR 1

YEAR 2

YEAR 3

YEAR 4

YEAR 5

YEAR 6

YEAR 7

YEAR 8+

Primary Care Practice: Years 8+
Students spend 7 years in undergraduate and graduate medical education before completing the full course of primary care specialty training. They are then eligible for board certification and may enter practice as primary care physicians.
Policy Issues

• Redesigning admissions criteria to identify students suitable for the Pathway.

• Devising and overseeing creation of seamless educational continuum from undergraduate through graduate medical education.

• Ensuring ability of graduates to gain licensure and board certification.

• Accreditation.

• Financial Consideration
Accelerating Physician Workforce Transformation Through Competitive GME Funding

David C. Goodman, MD MS
Russell Robertson, MD

HealthAffairs
GME Is Lagging Behind Change In Health Care

Training is:
• Primarily hospital-based.
• Lacks an emphasis on longitudinal care.
• Fails to train for a future with clinical teams.
• Insufficient in developing skills needed to improve care and lead change.
• Within a training pipeline that is frozen in time – teaching hospitals enjoy an entitlement of 1997 positions with autonomy in the specialty mix.
• And, meritorious new programs can rarely receive funding.
Change Will Require Accountability Though Competitive Funding

- Public body sets annual programmatic funding priorities (Example: ↑5% primary care or innovative training in longitudinal care.)
- Programmatic priorities would be updated annually, providing incremental guidance for GME and physician workforce change.
- Each year, 10% of all training programs would apply and compete for training grants. New programs could apply and existing programs could compete for more positions.
- Applications peer-reviewed by GME study sections.
- Awards would be for ten-years, with a 5 year review.
Advantages And Criticism

• Over a decade, every program would be reviewed against peers.
• Meritorious programs would expand; weaker programs would lose a portion of their funding.
• Change would be incremental – priorities could be adjusted year by year.
• Stability would be assured with ten year grants.

• Criticism and questions:
  – Untested
  – Threatens existing large and powerful teaching hospitals.
  – Will the guiding public body act wisely?
  – Is there an interest in changing the status quo?
Physician Workforce Planning In An Era Of Health Care Reform

Atul Grover, MD, PhD
Chief Public Policy Officer, AAMC

HealthAffairs
Approaching Shortage Of 130,000 Physicians
Three-Pronged Approach

• Team care/IPE

• New delivery models **AND**

• Training an additional 4,000 physicians/year
A Growing, Aging Population Matters

Physician Utilization per 100,000 people by Age

IME Is A Patient Care Payment

Created because of concerns about the inability of Medicare coding to “account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents”

(House Ways & Means Committee Rept., No. 98-25, March 4, 1983 and Senate Finance Committee Rept., No. 98-23, March 11, 1983 [emphasis added]).

“to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals.”

U.S. Congress, 1999
Panel Three:
New Models Of Care And Reaching Vulnerable Populations
Workforce Implications Of New Models Of Primary Care

David Auerbach, PhD RAND
Peggy Chen, MD, MPH
Mark Friedberg, MD, MPH
Ateev Mehrotra, MD, MPH
Rachel Reid, MD
Peter Buerhaus, RN, PHD
Christopher Lau, BS

HealthAffairs
Provider Shortages?

• AAMC projects shortage of 45,000 primary care physicians by 2025
  – Aging, slow supply growth, ACA
• Projections extrapolate today’s way of delivering care to the future
• What if that changes?
Investigated Two Models

• Nurse-Managed Health Centers
  – ~0.5% of primary care today
  – Surveyed 30 centers
  – Almost exclusively staffed by NPs

• Patient-Centered Medical Home
  – ~15% of primary care today
  – Analyzed data from Penn pilot project
  – *Medical homes used more NPs and PAs*
  – Panel sizes varied
Primary Care Delivery Models

- Traditional practice
  - MD: 6.9; NP+PA: 2.6

- Patient-Centered Medical Home
  - MD: 6.1; NP+PA: 3.7

- Nurse-Managed Health Center
  - MD: 0.8; NP: 10.4

Staffing per 10,000 patients
Shortage Forecasts

- **Primary care provider supply and demand scenarios**

Website courtesy of Anna Mehrotra (@annamehrotra)
Conclusions

• Shortage projections are very sensitive to changes in primary care delivery models
  – Standard labor force projections don’t account for these changes

• Growth of the PCMH and NHMC models would ameliorate projected imbalances
  – Can eliminate physician shortage
  – Though panel size is key, uncertain for PCMH
PCMH Grows From 15% to 45%

New models do not diffuse
Prevalence of PCMH is 45%
NMHC Grows From 0.5% to 5%

New models do not diffuse

Prevalence of NMHC is 5%
Diffusion And Panel Size Increase

- New models do not diffuse
- Both models diffuse and PCMH panel size increases 20%

Expected provider supply - demand

- MD
- NP
- PA
Primary Care Provider FTE: 2010 And 2025

- All: 2010 - 291,000, 2025 - 361,000
- Physician: 2010 - 210,000, 2025 - 216,000
- Nurse Practitioner: 2010 - 56,000, 2025 - 103,000
- Physician Assistant: 2010 - 30,000, 2025 - 42,000
The Effects Of Expanding Primary Care Access For The Uninsured: Implications For The Health Care Workforce Under Health Reform

Sheldon M. Retchin, MD, MSPH
Alan W. Dow, MD, MSHA, Arlene Bohannon, MD, Sheryl Garland, MHA, Paul Mazmanian, PhD

HealthAffairs
The Affordable Care Act And Implications For The Healthcare Workforce

- The ACA will expand Medicaid coverage for adults in at least 26 states

- However, there is evidence the health care workforce and care delivery systems will be inadequate to meet the care needs of the expansion

- The health care workforce and care delivery structures will need to be tailored to meet the needs of specific groups within the population
Exporting The Current Model(s) Of Care For The Newly Insured Is A Flawed Strategy

• The number of people who will enroll in the expanded Medicaid program range from 8.5 to 22.4 million

• Previous researchers have estimated that approximately 4,500 to 12,100 new providers will be required

• With the coverage expansion there is an opportunity to understand the unmet needs of the uninsured

• Targeted strategies of care for the uninsured could be designed by examining the unmet needs to more efficiently address the newly insured population.

• The results of these new strategies, approaches, and initiatives could reshape health care, improving quality, cost, and equity across the system
Virginia Coordinated Care (VCC) Program

• Established in 2000 to coordinate care for uninsured in Central Virginia – the VCU Health System in Richmond, Va

• Provided “medical homes” to over 27,000 patients who below 200% FPL

• Partnered with 50 community-based physicians to improve access to care

• Recognized as a model for managing care for uninsured patients
Procedures

• We examined clinical and utilization data for patients enrolled in the VCC program from July 1st 2011 through June 30th 2012

• We used diagnostic and utilization information from the VCC claims database, which includes data from providers external to VCUHS

• Although the patients were uninsured, their enrollment in the VCC gave them ‘preferred’ access to the provider network
Establishing Utilization Categories For Workforce Planning

- **Medical complexity:**
  - Prescribed medications,
  - Emergency department utilization,
  - Total hospital costs,
  - Selected diagnoses

- **SpecificCare**
  - HIV
  - Substance abuse
  - Neoplasms
  - Dermatologic conditions
  - Spinal cord injuries

- **ComplexCare**
  - > $20,000 in total annual costs,
  - > 12 ED visits, or
  - 6+ prescriptions and either
    - $7,001+ in hospital costs or
    - ≥ 6 ED visits

- **ChronicCare**
  - $7,001 – $19,999 in hospital costs,
  - 6 – 12 ED visits, or ≥ 6 prescriptions

- **EpisodicCare**
  - < $7001 in hospital costs,
  - < 6 ED visits, and
  - < 6 prescriptions

- **Diabetes**
- **Mental health**

- Increase complexity level by one for diagnosis of any of the following:
  - Bipolar disorder
  - Chronic obstructive pulmonary disease
  - Congestive heart failure
  - Coronary artery disease
  - Psychosis

Determine costs and number of enrollees for each level of complexity
Distribution Of Total Health Care Costs In The VCC Program

Concentration of VCC costs by enrollees

<table>
<thead>
<tr>
<th>Average Annual Costs</th>
<th>Percent of Total Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 9%</td>
<td>39.5%</td>
</tr>
<tr>
<td>Top 21%</td>
<td>69.8%</td>
</tr>
<tr>
<td>Top 37%</td>
<td>86.3%</td>
</tr>
<tr>
<td>Bottom 63%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Average Annual Costs</td>
<td>$15,104</td>
</tr>
<tr>
<td></td>
<td>$8,363</td>
</tr>
<tr>
<td></td>
<td>$3,326</td>
</tr>
<tr>
<td></td>
<td>≤ $733</td>
</tr>
</tbody>
</table>

Percent of Enrollees, ranked by average annual cost
Distribution Of Total Health Care Costs In The U.S. Population

Concentration of Health Care Spending in the U.S. Population, 2004

Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Comparison Of VCC And US Spending Patterns In Top Deciles: The Uninsured Have A “Flatter” Spending Distribution

![Bar chart showing percent of total spending on health care for Top 10% and Top 20% categories for VCC and US. The chart shows that the uninsured have a “flatter” spending distribution compared to VCC.](health-affairs-bar-chart)
Disease Prevalence Rates In VCC Enrollees

- Mental health: 27.2%
- Coronary artery disease: 18.9%
- Diabetes: 16.9%
- Chronic pulmonary disease: 12.2%
- Cancer: 10.0%
- Asthma: 7.2%
- Drug use: 5.1%
- Mild liver disease: 4.9%
- Alcohol use: 3.5%
- Heart disease: 3.4%
- Congestive heart failure: 2.6%
- AIDS/HIV: 2.6%
- Cerebrovascular disease: 2.3%
- Renal disease: 1.8%
- Rheumatic disease: 1.5%
- Peripheral vascular disease: 1.5%

Source: VCU Health System Enterprise Analytics compiled by VCU Office of Health Innovation using v2 of the VCC Flat File, October 2013.
Note: Prevalence based on primary and secondary ICD-9CM diagnoses codes from MCV Hospital, MCV Physician, or VCC Community Provider Claims.
Workforce Models For The Coverage Expansion Under The ACA: Novel Approaches Are Necessary

• EpisodiCare patients (~63%) represented only a small amount of overall health care costs (~14%): non-physician providers could furnish the majority of care.

• The most complex patients, ComplexiCare (9% of patients, 40% of costs) and SpecifiCare (12% of patients, 30% of costs) groups, represent greatest potential for controlling costs - interprofessional teams, using a community-centered rather than clinic-centered model, may be most successful for these patients.

• For patients with mental illness—the most common reason for hospital admission in this group of uninsured patients—medical case management improves both health and cost outcomes.

• By distributing the work of primary care away from physicians, new models could allow physicians to focus their increasingly scarce expertise on innovation in care and on the most complex cases.

• Correctly structuring care teams for medically complex patients and those in need of only episodic care is essential for meeting the workforce demands of coverage expansion under the ACA.
<table>
<thead>
<tr>
<th>Mental Health &amp; Addiction Workforce Development: Federal Leadership Is Needed To Address The Growing Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael Hoge, PhD</td>
</tr>
<tr>
<td>Professor, Yale School of Medicine and Senior Science &amp; Policy Advisor, Annapolis Coalition on the Behavioral Health Workforce</td>
</tr>
</tbody>
</table>
Mental Health & Addictions

- A large “treatment” gap
- Longstanding workforce concerns
- The workforce shortage
- Three forces exacerbating the crisis
  - The aging population
  - Increasing racial & cultural diversity
  - Healthcare reform
Mental Health & Addictions

- Policy recommendations
  - Broaden the concept of “workforce”
  - Strengthen the workforce
  - Create structures to support the workforce

- The need to scale up & sustain action
- Why so little action is taken
- Federal leadership on 4 critical tasks
Remarks

US Rep. Allyson Schwartz
Pennsylvania
Remarks

US Rep. Aaron Schock
Illinois
Thank You!