IMPROVING WORKFORCE EFFICIENCY

Developing and training a health care workforce to meet the increased demand on services due to an increase in access from health reform, an aging population, and an increase in the prevalence of chronic illness is a challenge for the United States healthcare system. The passage of the Patient Protection and Care Affordability Act (PPACA) and its phased rollout over the next few years will offer a new lens through which to examine a set of philanthropic strategies, some new and some already familiar to foundations. Although the PPACA does not explicitly suggest partnerships with foundations, reexamination of foundation strategies is certainly an activity worth employing given the sweeping changes anticipated in the delivery and payment systems.

Mark Miller, Executive Director of the Medicare Payment Commission recently challenged health policy experts to conduct more research on how many professionals will be needed to implement the policy challenges of PPACA, as well as to identify competencies in a system that will be more coordinated and quality focused than in the past. In other words, analyses of how physician and nurse shortages — and training/education — figure into the new PPACA. Thus, a knowledge building agenda is needed by foundations to explore the education, training and supply of healthcare workers against the requirements of the PPACA.

PROBLEM STATEMENT

Unlike most industrialized countries, the United States has barely any semblance of a health workforce strategic plan. One probably is not surprised to learn that the preparation of each generation of health workers is just as fragmented and confusing as the health care system they will one day join. The nation’s healthcare delivery system is a reactionary model in which acute illnesses and specialty care dominate. This model has led to unsustainable spending and utilization growth. Researchers have identified three key areas that will drive the conversion from the current system to a new one focused on primary care, disease prevention, and care coordination for chronic illness. First, there are serious doubts that the current healthcare workforce is sufficient in size to provide the care needed today, let alone in the future as the population continues to age. Second, the current composition of the health care workforce is not optimal. For example, the U.S. is
well known for having a significantly higher ratio of specialists to generalists, compared with its European counterparts. In addition, there is a deficit of nurses, direct care, and mental health workers, among others. Third, the geographic distribution of the healthcare workforce is contributing to the current problem because some areas, usually big cities and the surrounding regions, have more capacity than they need while other locales, particularly inner cities and rural areas, experience significant healthcare provider shortages. In those areas known as federally designated health professional shortage areas, the Health Resources and Services Administration projects that an additional 7,000 physicians are needed right now. These issues can only be addressed by implementing significant changes in health workforce education and training.

The lack of a coordinated health care workforce is already a problem and it is anticipated only to worsen. According to a recent report from the Congressional Research Service: 

Today’s health care provider shortages are projected to increase based on growing patient demand for services. HRSA estimates that by 2020 there will shortages in a number of physician specialties and nearly 67,000 too few primary care physicians. Additionally, a federal advisory group on the nursing workforce estimates that as of 2000 there was a 6% shortage of nurses and that this shortage is expected to grow to 20% in 2020. Enactment of PPACA is likely to further exacerbate health workforce shortages as the newly insured seek health care services.

The concern about increased workforce shortages is warranted based on the recent Massachusetts experience after it enacted similar legislation in 2006. Even with many measures implemented to increase access to health care services, Long and Stockley report that “In fall 2009, one in five adults in Massachusetts reported that they had not received needed health care, and one in seven reported an emergency department visit for a nonemergency condition.” This news, combined with an aging population and an aging healthcare workforce, helps emphasize the importance of the healthcare workforce provisions in the PPACA.

Title V of the PPACA identifies 6 areas relating to the health care workforce. Each area is briefly described below:

Innovations in the Health Care Workforce
- A National Health Workforce Commission as well as a national and regional workforce centers will be created as a means to monitor the nation’s workforce needs.
- Grants will be available for states to conduct comprehensive workforce planning and create development strategies
Increasing the Supply of the Health Care Workforce

- Improve and enhance federal student loan programs for a variety of health professions including primary care and geriatric physicians, nurses, allied health workers, public health workers and people working in underserved areas.

Enhancing Health Care Workforce Education and Training

- Training opportunities and grants will be available for primary care, dental, mental health, nursing, public health, and direct care programs.
- Education and training grants for those working with individuals with disabilities
- Education and training grants for improved cultural competency across health professions
- Grants to improve the community health workforce
- Grants to improve the rural health workforce

Supporting the Existing Health Care Workforce

- Increased funding for minority applicants for health professions
- Primary care extension program to educate providers about evidence-based therapies, health promotion, chronic disease management, and mental health

Strengthening Primary Care and Other Workforce Improvements

- Gives the HHS Secretary increased discretion to redistribute unfilled residency positions and modifies rules for residency training programs
- Increases funding for primary care residency programs at teaching health centers
- Establishes a demonstration program to increase graduate nurse training

Improving Access to Health Care Services

- New and expanded funding for federally qualified health centers
- States and medical schools will be eligible for grants to support the improvement and expansion of emergency medical services for children
- New grants for coordinated and integrated services through primary and specialty care in community-based mental health settings.
- Creates a Key National Indicator System and Commission

ANTICIPATED ISSUES OF HEALTH CARE REFORM IMPLEMENTATION

Although much of the legislation pertaining to workforce issues appears straightforward, states have a very difficult task as they seek to address their deficiencies in health care workforce planning and implementation. The biggest barrier to effective planning is the current lack of reliable estimates of the current healthcare workforce. There have been repeated calls for national, regional, or state databases that would contain up-to-date information about the workforce that could be analyzed and then used for planning purposes. This would include information about all health professionals and also direct care workers, along with family
caregivers. Without this information it is extremely difficult to accurately determine future health workforce needs.

Another challenge for states will be to leverage all of the opportunities for grants and federal assistance while facing tough economic circumstances that have likely decreased their capacity for this very type of endeavor. Put another way, there are legitimate concerns about states’ capability to apply for the available assistance, and if they receive funding whether they will have the infrastructure in place to implement effective policies and programs.

THE PIPELINE: RECRUITING AND TRAINING FUTURE HEALTHCARE WORKERS

Connecting young people to careers in healthcare is critical for these youth and for society. A flourishing and employed youth sector is a vital customer base, an economic development stimulus, and a check on further declines in poverty in low-income neighborhoods. A landscape of economically-pressured families with young people who lack the skills to drive economic growth is an untenable picture of life in America.

To make communities healthy — places where people want to work, live, and play — some policy advocates recommend the dual goal of promoting economic self-sufficiency among disconnected youth and of creating viable employment opportunities. The healthcare sector is vital to achieving this goal. It can offer many and varied opportunities for both entry level or more advanced education for young people.

Vocational education, career and technical education, tech-prep, youth entrepreneurship, school-to-work transition activities, apprenticeships, academies, internships, charter schools with a career focus — these are all separate yet similar strategies for connecting vocational sectors (such as health) with classroom and worksite education. One particular model that has been well documented by the NYC-based MDRC is Career Academies. These small ‘schools within schools’ can be found in over 2500 high schools in America. In addition to work-based learning and traditional educational practices, each school is focused on a sector. The healthcare sector comes in along with other career foci such as business, finance, hospitality, or computer technology.

OPPORTUNITIES TO LEVERAGE HEALTHCARE FOUNDATION INVESTMENTS

There are numerous examples of the PPACA’s connection to the education and training of healthcare workers:

- PPACA’s primary concerns are quality and safety, and therefore, we can expect a greater focus on a better prepared workforce, a diversity of continuous learning opportunities, a sharp focus on preventable medical errors, new training technology deployed to all tiers of medical and health workers, and work redesign initiatives.

Recommendation: Medical error training and use of new training technologies are just a few areas in which foundations might play a role strengthening training and incumbent worker career paths. Grantmakers In Health funding partner have acquired
a deep understanding of appropriate foundation roles through previous experience with business groups, local coalitions, providers and in some cases, the human resources/training units of employer/providers. These lessons might be summarized and examined against the backdrop of PPACA to guide future development of foundation roles.

• PPACA is also focused on safety net challenges. There is funding, for example, for creating a ladder of career development opportunities for community health workers. This influx of funding and support will become increasingly important, especially as new immigrant groups and others seek advancement in the healthcare sector. One brief example of this “safety net” challenge is a study by the Center for the Health Professions at the University of California, San Francisco. This research examines the role of medical assistants (MA) in community clinics where the utilization of MAs has been growing. Improvements in clinic operations (for example moving people through the centers) are documented, but the study also notes training challenges that were barriers to expanding utilization of MAs. The authors report that traditional MA education and training does not adequately prepare MAs for clinical database management or roles in patient education; and, as a consequence, the career paths for the MAs are compromised. Foundations can find many roles to play in assisting neighborhood health centers and healthcare personnel with the new demands from technology and other sources under PPACA.

• PPACA addresses work and career development in other ways. For example, through state legislation, the Act allows localities to build training and licensing for certain employees which would ultimately support and contribute to the central functions of comprehensive primary care centers. Foundations should monitor state policy efforts around licensing and encourage, as needed, inclusion of new competencies promoted by the PPACA.

• PPACA is encouraging comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute. Foundations can both influence and benefit from this type of patient outcomes research. For example the new group’s agenda might involve studies that measure the impact of work design and training initiatives on patient outcomes. Pilot programs and demonstration are also cited in the Act with at least five pilot projects and 30 demonstrations mentioned. There are opportunities to ensure that quality and safety concerns, the nature of work settings, and on-the-job-training are considerations in the patient-centered outcomes agenda.

• PPACA offers grants to states to conduct comprehensive workforce planning and create workforce development strategies. Many foundations have an extensive background in this area and could supplement federal resources in order to ensure that states are able to maximize their resources and create lasting infrastructure to support long-term planning efforts.
• Much of the PPACA legislation explicitly or implicitly requires data that will need to be analyzed in order to identify needs at the state-level. In many cases it may be beneficial for foundations to partner with states to identify, collect, analyze, and disseminate this data in a timely manner.

• Despite its extensive set of reforms, PPACA is somewhat limited in its attempts to address the family caregiver component of home and community health care. This did not appear to be a primary concern as part of this legislation, but the importance of family caregivers cannot be understated. It may be wise for foundations to look at ways to better integrate these individuals into the new models of care.

• Funders can benefit from learning about prior attempts by philanthropic organizations to shape the health care workforce. One such history can be found at the Robert Wood Johnson Foundation, which has worked to shape the health care workforce for over two decades. A key lesson learned is that any vision must be clear and all goals should be apparent and concise and take into consideration the variability of local and regional labor markets. For any PPACA component that offers the opportunity for Foundation involvement there must be reasonable and specific pathways that can be articulated in a manner that avoids confusion and offers the best possible chance for success.

Although the focus of this paper is the PPACA, other legislation needs to be noted for its direct connection to the health workforce field. The Health Information Technology for Economic and Clinical Health (HITECH) amends the current Public Health Act by adding new funding opportunities to advance health information technology. Under HITECH, millions of dollars will be directed toward community colleges to help prepare young people on new technological advances as they are trained to work in the healthcare sector. Recommendation: with the support of foundations, high schools and community colleges can redesign healthcare training that builds on modern IT application in health settings.

This background paper was prepared by Andrew Hahn, PhD and Jeffrey Sussman, MPH, PhD Candidate.

The Schneider Institutes is based at Brandeis University. It is chaired by Professor Stanley Wallack, and directed by Christopher Tompkins. The Schneider Institutes are objective, university-based entities that provide research assistance to the Federal government on the major problems it faces in financing and delivering care to the elderly, disabled and poor. Its role is to solve complex health care problems, and to link research studies to policy change. The Schneider Institutes have become one of the largest academically based health policy research centers in the United States.

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