Future Workforce State

Purpose:

As one of the prescribed workforce milestones, Central New York Care Collaborative (CNYCC) was required to conduct an analysis of the future workforce state necessary for successful DSRIP implementation. The purpose of this analysis was to ensure CNYCC has considered and planned for potential worker impact resulting from system transformation. Health WorkForce New York (HWNY), the contracted workforce vendor for CNYCC, worked with CNYCC partners and staff to gather, analyze, and prepare workforce data in accordance with the New York State Department of Health (NYSDOH) guidelines. The data collected through this process will be used in conjunction with data from the recent Compensation & Benefits Analysis and the CNYCC Training Strategy to inform the required workforce Gap Analysis and Transition Road Map due to NYSDOH at the close of the quarter ending 09/30/16.

Sources of Data/Initial Analysis:

Utilizing a series of webinars and "virtual" office hours, HWNY and CNYCC prepared partners to report the DSRIP future state of their health workforce. Partners were encouraged to consider the full complement of staff necessary to successfully support DSRIP efforts by the conclusion of DY5. CNYCC utilized a survey instrument as part of project implementation planning that included a staffing analysis spreadsheet. Out of the total partner base, 27 partners were selected to report. These partners were selected based on their size, type, and degree of involvement with DSRIP projects, and this partner selection was considered representative of the whole. Each partner who participated in the survey was contracted to participate in multiple projects with the PPS and partner staffing projections were based on their degree of project involvement. Utilizing this method, CNYCC was able to collect future state data from a total of 14 partners, including various sites/sub-sites owned/managed by the partners. The response rate of 51% was considered substantial given the level of competing partner demands. Please refer to Exhibit A for a complete list of participating partners. Partners were provided with the list of job titles identified by NYSDOH as being DSRIP relevant along with the corresponding standard occupation code and job description to aid in uniform data collection.

A summary of the resulting data was prepared for CNYCC review (see Exhibit B). Analysis of the data summary resulted in the following conclusions: Despite four webinars and "virtual" office hours held with the partners, there remained contrasting partner views with respect to

Reporting. While partners were strongly encouraged to think beyond immediate resources and report ideal future staffing needs, it would appear most assessments with respect to staffing for DSRIP were highly conservative. Partners reported: 1) the perception of being limited by what current operations allow in terms of staffing; and 2) concern that they would somehow be obligated to the numbers submitted, which could prove unrealistic given the constraints of current operations.

Partners also reported confusion with respect to the definitions of "redeployment" and "retraining". These terms have meanings, which are highly specific within any given institution. As such, these definitions are not necessarily the same as those provided by NYSDOH within the DSRIP context. CNYCC partners did report minimal redeployment/retraining of staff. However, when questioned further about exact plans for redeployment/retraining, partners describe plans to train existing staff who will retain their current position but will be expected to: 1) take on additional duties; and/or 2) learn new tasks, which will replace old ones. As such, the intention of the partners regarding retraining/redeployment does not appear to fit the DSRIP definitions of these terms.

Minimal reliance on redeployment/retraining was validated through a review of the research literature, including articles from The American Journal of Managed Care, the Annals of Family Medicine, and the Nursing Executive Center Advisory Board. This literature review identified barriers to redeploying acute care staff, as well as issues of timing, union representation, retirement, and overall shortage. According to Kelly, Koppel, and Virkstis, (2016, p. 9) acute care staff possess skills that are not easily transferable to new care delivery models, nor do they necessarily possess the temperament for the work. One example cited is that of critical care nurses drawn to a fast-paced environment, who may not transition well into care managers. With respect to timing, healthcare workers are needed to simultaneously drive change and fulfill change. As such, in many instances new positions must be filled before old positions can be relinquished. Additionally 72% of healthcare workers within CNYCC are represented by labor unions. The multiple agreements which govern the conditions under which union employees may be redeployed are beyond CNYCC's span of control and make involuntary redeployment unlikely. Concerning healthcare workforce shortages and impending large scale retirements, vacancy rates upstate are extremely high with some job titles reporting triple digit vacancies. Given these conditions, the vast majority of "redeployment" is expected to be employees who are able to self- select among numerous available options. For these reasons, New Hires were considered the major area of focus for the remainder of the CNYCC Future State analysis.

Sources of Additional Data:

Given the limitations of the partner reported data, CNYCC adopted two additional methods of data analysis as follows: 1) Extrapolation Method: Data from the partners was reviewed with the Project Management Team, as well as Request for Proposal (RFP) responses for project implementation, which included additional partner staffing projections. This data was then extrapolated to project 100% partner participation and response in the form of new hires; and 2) Population Health Method: Using the patient attribution of 200,000 Medicaid lives assigned to CNYCC, as well as population health ratios (i.e. 4% high utilizers with a 40:1 caseload; and 30% transition/intermediate utilizers with a 100:1 caseload), CNYCC was able to determine the total number of health care workers needed to deliver care to the Medicaid patient population under the desired Future State.

200k lives x 4% high utilizers = 8000; 1 caregiver per 40 individuals = 200 caregivers

200k lives x 30% lesser utilizers = 60,000; 1 caregiver per 100 individuals = 600 caregivers

Totals for the positions required were then spread across the relevant job categories using CNYCC staff professional judgement and initial partner data. The Current State was then identified using the census figures from the CNYCC Compensation & Benefits Analysis, which were then adjusted using a case mix correction factor to determine the number of staff required to deliver care to the Medicaid population under the current fee-for-service state. This number was then subtracted from the total Future State derived using the Population Health Method. The resulting numbers represent the required New Hires by position. CNYCC then compared the data derived from both the Extrapolation Method and the Population Health Method and selected the higher of the two numbers to represent the desired Future State.

In its Future State analysis (see Exhibit B), CNYCC identified a total of 29 job titles considered essential to success. To ensure the integrity of this finding, HWNY conducted a review of relevant literature specific to staffing patterns and projections (Kelly, Koppel, Virkstis 2016; Peikes, Reid, Day, et al 2014; Patel, Arron, Sinsky, et al 2013). Investigation of the research included evaluation of methodology as well as study results. The literature-based analysis yielded a total of 22 job titles considered essential to system transformation compared to a total of 30 job titles considered essential to success identified in the CNYC C Future State analysis. However, there was some overlap between job titles/functions (for example: CNYCC identified four job titles related to Social Work, while the literature identified this function once). Once job

title/function were accounted for and a comparison made, 17 out of 22 (77%) were commonly identified.

Finally, CNYCC presented a table of identified job titles to its Workforce Committee for review and feedback. It was noted by Community Based Organization (CBO) representatives that the job title/function of Peer Navigation appeared to be missing. HWNY agrees Peer Navigation functionality should be included in the recruitment strategy outlined in the Transition Road Map.

Conclusions:

The number and types of jobs which CNYCC must recruit to be successful have been identified with the degree of accuracy necessary to justify the overall recruitment strategy defined in the CNYCC Transition Road Map, although the exact degree of staff impact cannot be projected at this time.

Trends Identified for Gap Analysis and Road Map Planning:

Categories of employment expected to be driven by DSRIP were typical and included: primary care, nursing, care coordination/management, and behavioral health. The need for support staff, including: coders/billers, office clerks/administrative assistants, and technical support were also reported. The need for nursing staff was reported at all levels (i.e. Nurse Aides/Assistants, LPNs, RNs, and NPs) and will likely be complicated by localized triple digit vacancies. CNYCC will need to further identify needs/expectations around various levels of care coordination/management to ensure appropriate training content and programs are available to meet DSRIP driven needs. A comprehensive strategy around primary care and nursing will need to be developed that relies on each professional level working to the top of their license. Plans to meet psychiatric needs in terms of MDs and NPs will need to be developed. Innovative strategies such as telemedicine may need to be considered in order to fill higher level physician gaps.

Next Steps:

To complete an effective Gap Analysis and Transition Road Map, CNYCC will need to further analyze, plan, and execute around workforce shortages as follows:

Category of Employment	Action Needed	Timeframe
Primary Care	• Develop comprehensive strategy to ensure all staff work at top of license; • Evaluate each position in the primary care continuum and plan recruitment accordingly; • Consider telemedicine and other strategies to fill top level gaps.	Fall 2016
Nursing	• Develop comprehensive strategy to ensure all staff work at top of license; • Evaluate each position in the continuum and plan recruitment accordingly (i.e. can Medical Assistants replace LPNs?) • Evaluate existing high vacancy rates and plan recruitment strategies accordingly.	Fall 2016
Care Coordination/Management	• Clarify needs/ expectations around this function in order to better identify gaps and plan accordingly	Fall 2016
Behavioral Health	• Evaluate each position in the continuum for possible options (i.e. Can LMHC fill substance abuse and other social worker/ service needs hard to fill?)	Fall 2016

	• Consider telemedicine and other strategies to fill top level gaps.	
Support Staff	• Low vacancy rates in these areas may allow CNYCC to fill gaps without much effort; CNYCC may wish to further clarify roles/expectations to ensure this is the case.	Fall 2016

Exhibits:

Exhibit A – Participating Partners
Exhibit B – Future State Summary Table

References:

Kelly, M., Koppel, J., & Virkstis, K. (2016). Build Your Workforce from the Outside-In: The Nurse Leader's Blueprint for Future Staffing. *Advisory Board of the Nursing Executive Center*, p. 9.

Peikes, Deborah N., Reid, Robert J., Day, Timothy J. (et al) (2014). Staffing Patterns of Primary Care Practices in the Comprehensive Primary Care Initiative. *Annals of Family Medicine 12* (2), 142-149.

Patel, Mitesh S., Aaron, Martin J., Sinsky, Thomas A. (et al) (2013). Estimating the Staffing Infrastructure for a Patient-Centered Medical Home. *The American Journal of Managed Care 19* (6), 509-515.

Future State Staffing Summary Table EXHIBIT B

Job Title	Number of New Hires	CNYCC Current Vacancies	CNYCC Vacancy Rate	6 PPS Vacancy Rate	CNYCC Compens-ation Rate	6 PPS Compensation Rate
Physician Assistant Primary Care	69	1	1.69%	8.64%	$50.16	$51.34
RN Care Coordinators/Case Managers/Care Transitions	54	60	14.18%	14.77%	$29.84	$29.30
Office Clerks	51	8	1.72%	--	$14.48	$14.28
LPNs	47	118	7.4%	7.37%	$18.63	$18.33
Licensed Clinical Social Workers	41	6	3.88%	--	$29.10	$30.11
Care or Patient Navigator	41	19	11.73%	11.11%	$24.00	$25.31
Coders/Billers	21	9	2.49%	--	$17.45	$17.96
Medical Assistants	17	6	2.93%	--	$14.97	$14.63
Nurse Practitioner Primary Care	15	10	7.72%	11.34%	$45.89	$46.97
Nurse Managers/Supervisors	15	36	6.91%	--	$34.10	$34.08
Bachelor's Social Work	26	4	8.00%	--	$21.72	$21.38
Secretaries and Administrative Assistants	15	20	3.43%	--	$16.76	$16.94
Primary Care Physician	14	9	3.45%	10.34%	$104.08	$103.59
Staff Registered Nurses	14	352	6.56%	--	$27.85	$28.33
Nurse Aides/Assistants	14	246	8.67%	10.09%	$13.20	$12.69
Psychiatric Nurse Practitioner	12	7	15.91%	18.79%	$62.96	$60.41
Technical Support	12	7	7.87%	--	$22.67	$22.33
Other Mental Health/ Substance Abuse Titles Requiring Certification	32	16	6.02%	--	$23.43	$24.92
LPN Care Coordinators/ Case Managers	6	3	10.00%	15.93%	$20.70	$19.31
Licensed Master's Social Workers	6	9	4.71%	--	$24.87	$25.67
Care Manager/Coordinator Bachelor's Degree required	6	64	10.29%	7.50%	$22.32	$24.03
Health Educators	6	10	9.50%	--	$22.88	$23.48
Psychiatrists	5	4	6.45%	11.35%	$132.49	$130.96
Janitors and Cleaners	5	44	4.53%	--	$11.95	$12.43
Nutritionists/Dieticians	5	0	0.00%	--	$26.34	$27.66
Social Worker Care Coordinators/ Case Managers/Care Transition	3	16	13.01%	8.72%	$23.07	$22.45
Psychologists	2	2	2.41%	--	$51.22	$49.01
Health Coaches	2	1	11.11%	--	--	$23.19
Patient Service Representatives	2	14	8.14%	--	$16.35	$16.16
1.28 x Original	Emerging title				Highly	Compensated
1.6 x Original	+RFP data				Below	Other
3.57 x Original	+RFP data				PPS	reports