ADVOCATE COMMUNITY PROVIDERS

CURRENT WORKFORCE ANALYSIS

DEPARTMENT OF WORKFORCE,
COMMUNITY, AND GOVERNMENT RELATIONS

PREPARED IN COLLABORATION WITH

CHWS
Center for Health Workforce Studies

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CHWS SURVEY OVERVIEW

Under contract with Advocates Community Providers (ACP) and as part of the Delivery System Reform Incentive Payment (DSRIP) program, the Center for Health Workforce Studies (CHWS) collected data as of December 2015 from ACP partners on their current workforce, compensation and benefits, current training efforts, future training needs, and which staff performed what tasks for medical practices.

CHWS developed two fillable pdf surveys for ACP partners, one for medical practices and one for all other facility types. Surveys were made available through a link to a CHWS web page specifically designed for ACP and included technical assistance materials such as frequently asked questions (FAQs), instructions, and an archived webinar that reviewed the process for completing the surveys. CHWS sent out emails notifying ACP participants of the survey and the webinar, and both CHWS and ACP staff followed up on non-respondents and those with data issues.

Methods

The current workforce surveys requested information on number of staff, full time equivalents (FTEs) of staff, vacancies, average hourly wage, and fringe benefit rates by titles. Based on New York State Department of Health (NYSDOH) rules, data needed to be collected for a number of specific occupations by facility type (hospital inpatient, hospital outpatient, private medical practices, nursing homes, home health care, etc.). ACP and CHWS staff expanded both the number of titles that data was collected for and the number of facility types that there identified for analysis.

Using the NYSDOH guidelines, CHWS staff developed a number of spreadsheets for ACP. ACP was provided with “internal” spreadsheets that included the expanded number of titles and facility types for the general survey and expanded titles for the medical practices survey. ACP was also provided with “DOH external” spreadsheets that only provided that data based on the NYSDOH facility types and job titles. All spreadsheets provided to ACP followed anti-trust guidelines when reporting

compensation and benefits that included only reporting the data in the aggregate and not reporting any job title that had less than five (5) organizations reporting.

For purposes of this report, average annual salaries were calculated by multiply the average hourly wage by 52 weeks and by 37.5 hours working per week.

Survey Responses

ACP supplied CHWS with nearly 1,500 email addresses for the electronic mailing. CHWS received a total of 394 responses to the survey for a response rate of 26%. Of those who responded, 322 responded to the medical practices survey, of which 321 were used and 72 responded to the general survey, of which 71 were used. One response was duplicative and one response was blank.

CHWS SURVEY FINDINGS

The two surveys collected detailed current workforce information on number of organizations, number of employees, full-time equivalent (FTE), and FTE vacancy rate for a total of 121 job titles or occupations within general and medical practice settings, ranging from physicians to allied health professionals.

(1) For occupation distribution among all organizations, out of all 392 organizations reporting:

a. 49.9% of organizations have primary care physicians;
b. 47.1% have physicians in other specialties;
c. 17.9% have primary care physician assistants (PAs),
d. 7.9% have PAs in other specialties;
e. 11.5% have primary care nurse practitioners (NPs),
f. 3.3% have NPs in other specialties;
g. 15.9% have staff registered nurses (RNs); and
h. 49.6% have medical assistants (MAs).

For emerging titles defined by NYS Department of Health, 7.7% of organizations have care managers/coordinators, and 3.3% have patient/care navigators.

Out of 322 medical practices:

i. 53.4% have primary care physicians;
j. 51.6% have physicians in other specialties;
k. 16.8% have primary care PAs;
l. 8.4% have PAs in other specialties;
m. 8.1% have primary care NPs;
n. 3.4% have NPs in other specialties;
o. 6.5% have staff RNs;
p. and 57.5% have MAs.

For emerging titles, 5.0% of organizations have care managers/coordinators, and 3.4% have patient/care navigators.

Of 71 general settings:

q. 32.4% have primary care physicians;
r. 25.4% have physicians in other specialties;
s. 22.5% have primary care PAs;
t. 2.8% have PAs in other specialties;
u. 26.8% have primary care NPs;
v. 2.8% have NPs in other specialties;
w. 57.7% have staff RNs; and
x. 12.7% have MAs.

For emerging titles, 19.7% of organizations have care managers/coordinators, and 2.8% have patient/care navigators.

(2) For <u>workforce structure</u> within ACP PPS, 34,405 employees are reported, 4,255 or 12.37% are working in the medical practice setting, while 30,190 or 87.63% are in the general setting. Overall, the top 5 occupations in numbers are:

a. RNs (11.1% or 3,824);
b. secretaries and administrative assistants (8.5% or 2,927);
c. nurse aides/assistants (6.9% or 2,383);

d. all physicians (5.9% or 2,046);
e. and other administrative staff (5.5% or 1,894).

In medical practice setting, the top 5 occupations are:

f. physicians in other specialties (17.4%);
g. medical assistants (16.1%);
h. secretaries and administrative assistants (15.4%);
i. other administrative staff (12.8%);
j. and primary care physicians (7.1%).

In general settings, the top 5 occupations are:

- staff RNs (12.5%);
- nurse aides/assistants (7.9%);
- secretaries and administrative assistants (7.5%); other administrative staff (4.5%); and
- clinical laboratory technologists and technicians (4.4%).

(3) The total reported full-time equivalents (FTEs) are 27,565. Compared to 34,405 employees reported, the overall FTEs as percentage of total employees are 80.12% for all organizations, while the numbers are 79.75% for general settings and 81.45% for medical practice settings.

(4) The overall FTE position vacancy rates are 5.78% for all organizations, 5.21% for general settings, and 9.75% for medical practices. Overall, top 5 occupations with highest vacancy rates are:

a. primary care PAs (32.6%);
b. care managers/coordinators (26.4%);
c. psychiatrists (17.8%);
d. social and human service assistants (17.1%); and
e. bachelors' prepared social workers (16.0%).

Occupations without any vacancy are: psychiatric NPs, midwifes, financial service representatives, transportation, technical support, other Health IT, occupational therapy assistants/aides, and physical therapy assistants/aides.

For general settings, top 3 occupations with highest vacancy rates are: primary care PAs (40.0%), psychiatrists (26.4%), and social and human service assistants (17.1%).

For medical practices, top 3 occupations are: care manager/coordinators (63.0%), staff RNs (56.8%), and primary care NPs (24.7%).

Comparing Medical Practice Survey vs. General Survey

The medical practice survey and the general survey listed the different job titles under various categories in which job titles were similar or completed similar/complementary functions. The medical practice survey and the general survey differed in the categories as well as the number of overall job titles listed on the survey. The medical practice survey consists of 13 different job title categories. The general survey consists of 17 different job title categories. The following chart lists the job title categories for the two surveys.

Job Title Categories by Survey Type

	General Survey	Medical Survey
Physicians	Yes	Yes
Physician Assistants	Yes	Yes
Nurse Practitioners	Yes	Yes
Midwives	Yes	Yes
Nursing	Yes	Yes
Clinical Support	Yes	Yes
Behavioral Health	Yes	Yes
Nursing Case/Care Managers, etc.	Yes	Combined
Social Worker Case/Care Managers, etc.	Yes	
Non-licensed Case/Care Managers, etc.	Yes	
Patient Education	Yes	Yes
Administrative Staff	Yes	Yes
Administrative Support	Yes	Yes
Janitors and Cleaners	Yes	Yes
Health Information Technology	Yes	
Home Health Care	Yes	
Other Allied Health	Yes	Yes

Physicians

Overall, 49.9% of organizations reported having primary care physicians, while 47.1% of organizations reported having physicians in other specialties. Primary care physicians represent 1.3% of the total workforce. Physicians in other specialties represent 4.6% of the total workforce. The average FTE as percentage of total number for physicians is 82.74%. Primary care physicians have a 10.1% position vacancy rate, much higher than 2.9% for other specialties.

In medical practice settings, more than half organizations reported having both primary care and other specialties physicians. They consist 7.1% and 17.4% of the total workforce respectively. The average FTE as percentage of total number for physicians is 80.6%. Primary care physicians have a 11.6% position vacancy rate, more than double the rate of 5.2% for other specialties.

In general settings, 32.4% of organizations reported having primary care physicians, while 25.4% of organizations reported having physicians in other specialties. They consist 0.5% and 2.8% of the total workforce respectively. The average FTE as percentage of total number for physicians is 84.97%. Primary care physicians have a 6.7% position vacancy rate, while the rate for other specialties is only 1.1%.

Physician Assistants

Overall, 17.9% of organizations reported having primary care physician assistants (PAs), while 7.4% of organizations reported having PAs in other specialties. Primary care PAs represent 0.7% of the total workforce. PAs in other specialties represent 0.4% of the total workforce. The average FTE as percentage of total number for PAs is 78.81%. Primary care PAs have a 32.6% position vacancy rate, much higher than 5.7% for other specialties.

In medical practice settings, 16.8% organizations reported having primary care PAs, while the number for other specialties is 8.4%. They consist 2.2% and 1.6% of the total workforce respectively. The average FTE as percentage of total number for PAs is

78.96%. Primary care PAs have a 15.6% position vacancy rate, more than double the rate of 5.4% for other specialties.

In general settings, 22.5% of organizations reported having primary care PAs, while only 2.8% of organizations reported having PAs in other specialties. They consist 0.5% and 0.2% of the total workforce respectively. The average FTE as percentage of total number for PAs is 78.69%. Primary care PAs have a 40.0% position vacancy rate, while the rate for other specialties is only 5.9%.

Nurse Practitioners

Overall, 11.5% of organizations reported having primary care nurse practitioners (NPs), while 3.3% of organizations reported having NPs in other specialties. Primary care NPs represent 0.4% of the total workforce. NPs in other specialties represent 0.1% of the total workforce. The average FTE as percentage of total number for NPs is 83.96%. Primary care NPs have a 15.1% position vacancy rate, much higher than 6.7% for other specialties.

In medical practice settings, 8.1% organizations reported having primary care NPs, while the number for other specialties is 3.4%. They consist 1.2% and 0.4% of the total workforce respectively. The average FTE as percentage of total number for PAs is 94.72%. Primary care NPs have a 24.7% position vacancy rate, while the rate for other specialties is not reported.

In general settings, 26.8% of organizations reported having primary care NPs, while only 2.8% of organizations reported having NPs in other specialties. They consist 0.3% and 0.1% of the total workforce respectively. The average FTE as percentage of total number for NPs is 76.53%. Primary care NPs have a 6.0% position vacancy rate, while the rate for other specialties is increased to 14.4%.

Midwifery

Only 19 midwives are reported for 4 organizations (one for medical practices, one for general settings), they consist only 0.1% for the workforce without vacancy information reported.

Nursing

Overall, staff registered nurses (RNs) and licensed practical nurses (LPNs) are the major occupations under nursing category. They represent 11.1% and 2.9% of the total workforce, respectively.

Most of nursing occupations are working in the general setting, which have 99% of RNs and 99% of LPNs. In general settings, 20% of workforce belong to nursing roles, compared to only 2% in medical practices. However, the vacancy rate for RNs in medical practice settings, 56.8%, is much higher than the general settings rate of 6.3%. The vacancy rates for LPNs are similar in both settings. The overall vacancy rate for nursing is 8.3%. And the overall FTE as percentage of total number for nursing is 88.2%. Information on nurse managers/supervisors is only captured on the general survey. This title represents 1.4% of the workforce with a vacancy rate of 6.8%.

Clinical Support

Nearly 700 medical assistants (MAs) are employed in medical practices, which are 16.1% of the medical practices workforce. However, only 1.6% of the workforce in general settings are MAs. General settings have nurse aides/assistants as their major clinical support staff, which represent 7.9% of the workforce. Information on nurse aides/assistants is not captured in the medical practice survey. Overall, 12.1% of workforce are working in clinical support roles within the ACP PPS with FTE as percentage of total number of 89.1%. Patient care techs in general settings have the highest vacancy rate of 13.0%.

Behavioral Health

Medical practices have higher percentage of their workforce working as behavioral health roles than the general settings, 6.3% versus 3.9%, respectively. Psychiatrist is the most needed occupation under behavioral health in both settings. The vacancy rate in general settings was 26.4%, and medical practices have a vacancy rate of 14.0%. In both surveys, the rates of FTE as percentage of total number are around 60.0%, which indicate this occupation normally provide services in more than one setting.

Nursing Care Managers/Coordinators/Navigators/Coaches

This category was only provided on the general survey. 95.3% of employees under this category are RN care coordinators/case managers/care coordinators. They represent 0.5% of total workforce with a vacancy rate of 7.6%.

Social Worker Case Management/Care Management

This category was only provided on the general survey. About a quarter general organizations have licensed master social workers. The entire category represents only 1% of the workforce in general settings. Bachelors social workers have the highest vacancy rate of 16.0%.

Patient Education

Less than 0.5% of workforce in both medical practices and general settings reported working as patient education roles. Overall, the vacancy rate for this category is 12.4%.

Emerging Titles

Slightly more than one percent (1.3%) of total workforce are under this category with 7.7% of all organizations have the position of care manager/coordinator. 1.7% and 1.3% are the percentages of workforce for medical practices and for general settings. The vacancy rate for care managers/coordinators is 63% for medical practices, while it's only 2.0% for general settings.

Administrative Staff

Seven percent of workforce in general settings and 12.8% in medical practices are under this category. The vacancy rates are 3.2% and 7.0%, respectively. Overall, 1.0% of the total workforce are executive staff, 0.8% are financial staff, and 0.4% are human resources professionals.

Administrative Support

Overall, this category represents 19.1% of the total workforce, while secretaries and administrative assistants represent 8.5% of total. The medical practice survey only captured two titles while the general survey captured 10 titles. The overall vacancy rate is less than 4%.

Janitors and Cleaners

Nearly two percent (1.8%) of workforce in general settings are under this category, the rate for medical practices is 3.5%. The overall FTE as percentage of total number is 75.6%, which indicates some of these employees are working part-time. The overall vacancy rate is 1.5%.

Health Information Technology

Slightly more than one percent (1.3%) of total workforce are under this category for general settings. The most needed occupation is hardware maintenance with vacancy rate of 16.1%. The FTE as percentage of total number is about 90.0%. No information on this category is reported on the medical practice survey.

Home Health Care

This category was only provided on the general survey. Certified home health aides are 2.0% of the general workforce, while personal care aides are 1.2% of total. No vacancy rate information was reported for home health aides.

Other Allied Health

This category contains 11 DOH required occupations and represent 24.6% of the total workforce. The top three occupations (except all others) in numbers are clinical laboratory technologists and technicians (4.1%), pharmacy technicians (1.1%), and occupational therapists (0.5%). The top three most needed occupations in terms of vacancy rate are occupational therapists (9.5%), pharmacists (7.8%), and speech language pathologists (7.3%). The overall FTE as percentage of total number is 84.7% and vacancy rate is 5.2%.

ACP Organizational Impact Assessment Symposium

Overview

On Tuesday, May 31st Advocate Community Providers (ACP) Department of Workforce, Community, and Government Relations convened a symposium in its headquarters to assess the organizational impact of the Delivery System Reform Incentive Payment (DSRIP) program on the workforce. The event was titled “The Workforce: Challenges and Opportunities for Neighborhood Medical Practices and Providers,” and consisted of a presentation by the Center for Health Workforce Studies, ACP’s workforce subject matter expert, and a fishbowl discussion facilitated by Diego Ponieman, MD, MPH, ACP Chief Medical Officer.

The purpose of this organizational impact assessment enabled ACP to define a target workforce state that is in line with DSRIP program's goals. Through a “fishbowl discussion,” participants exchanged ideas and concerns on the project by project impact on the workforce of each of the sectors: hospitals, physicians, Community Based Organizations, and ACP. The exchange was incorporated on the workforce impact projections, and helped make decisions about the need for the re-training and re-deployment of staff. For this purpose, the discussion remained specific and included the impact on mission, organizational structure, staff lines, talent, organizational culture, budgets, and strategic plans. Some of the questions the group addressed were: how will DSRIP affect my staff? how much will it cost to implement? who will help me implement the changes that DSRIP projects require? What is the role of ACP? The event was attended by sixty-three providers and staff throughout ACP’s network.

Opening Presenters

The meeting opened with brief remarks from Moises Perez-Martinez, ACP Director, Workforce, Community, and Government Relations, and Mary Ellen Connington, Chief Operating Officer. They provided an overview of DSRIP program and the role of ACP in assisting on the workforce transformation this requires. Mr. Perez-Martinez welcomed people to the meeting, talked about the overall goals of the ACP DSRIP projects, and

the goals of the symposium. Ms. Connington talked about the importance of working in the community, and that the community aspect of the health care system needs to be transparent and easy to understand in order to function properly. Ms. Connington also stated that in creating this new culture we need people to buy into the transformation of the system. The fee for service practice should be viewed as a thing of the past, and the value based payment system should be the aim of all health care providers moving forward.

Center for Health Workforce Studies

Dr. Robert Martiniano of the Center for Health Workforce Studies (CHWS) presented an overview of the potential changes in the health care systems and summarized the finding from the two surveys CHWS conducted in conjunction with ACP. He discussed the difficulties in explaining what DSRIP is and it functions to people who may be unclear about the program. However, an easy answer to that question is DSRIP is "Health Care Reform" plain and simply. Better jobs need to be available in primary care focusing on wellness and prevention in order for the program to be successful. Additionally, health care must be integrated at all levels in order to educate patients instead of shifting them around from specialist to specialist causing confusion and frustration. A vital part of the process is understanding population health and linking health care to community resources. We must understand what obstacles our patients are facing in their daily lives in order to address the numerous health issues that plaque them. Dr. Martiniano posed many questions in regards to how we could achieve successful outcomes during this stage of transformation; How are we training our current staff? To what capacity are we participating in patient engagement? How can we provide training for providers who want to learn how to use up to date technology? It is crucial to work people up to the level of training necessary in order to educate patients, this is especially important for smaller practices who are extremely under staffed. Dr. Martiniano also pointed out the possibility of substitutions for our workforce, such as nurse practitioners or physician assistants for primary care providers or clinical social workers for psychiatrists. Additionally, Dr. Martiniano identified opportunities for

sharing staff, especially in smaller practices, such as community health workers, certified diabetes educations, and behavioral health staff.

Fishbowl Discussion

A fishbowl technique was used to maximize the efficiency of the discussion among participants. The participants sat in the center of the room in a closed circle and dialogue. Rather than a presenting, the participants engaged in conversation, which was facilitated by Diego Ponieman, MD, MPH, ACP Chief Medical Officer.

Some of the questions the group will address including the effect of DSRIP on the workforce, the role ACP, and the use of community health workers. Participants in the fish bowl included:

- Diego Ponieman, MD, MPH, ACP Chief Medical Officer, and Moderator
- Sandy Baldwin, MD
- Betty Cheng, LCSW
- Felix Florimon, MD
- George Hall, MD
- Ana Olivero, MD
- Vincent Wang, MD
- Ming Zhu, MD

PCMH level 3

Dr. Ponieman stated that changes of health workforce are on the horizon. This revolution is raising opportunities while suffering from challenges at the same time. Dr. Ponieman asked how the PCMH Level 3 requirement helped or hindered this effort. He noted that the goals of the "health care reform" should be expanded from single providers to the whole primary care team. As the physician in Patient-Centered Medical Home (PCMH) level 3 (2013), he described how his team with three members works, and pointed out several questions that interest PMCH providers, regarding to workforce utilization, financial arrangement, and train-retrain deploy. Although PCMH experience

is important for outpatients, the providers are facing many challenges. One respondent noted that larger practices usually have more responsibilities than supports in term of reporting data to the federal government or to the state's government. Another provider noted that one staff is designated to manage PCMH, and those activities are not related to patient care.

Those practices are required to carefully deploy the team although many staffs are not currently trained in that way. Competency becomes essential for a team to success. How to pool all the workers together as a team based is one of the challenges they are facing, especially given the training siloes. Providers are expected to support each other to perform all needed services. Another respondent was concerned about disengaged patients or people whose health is in high danger. When the system is shift to "population health," it is additional work for physicians, especially those in small practices who need to work on IT and to upload patient's records. It is even more challengeable to shadow elderly or disengaged patients and fulfill their records. The system with updated data will be welcome in order to support providers' performance.

Patient Engagement

Patients always go to emergency departments to seek primary care services. However, emergency rooms are responsible for keeping patients alive, not necessarily treating the patients. Dr. Ponieman then asked how to prevent patients from using emergency rooms for primary care. One provider emphasized the critical roles staffs playing in addressing and educating patients. Let patients know the rules of the game instead of frustrating and confusing them. Team work is expected once patients walk in the practice with an understanding that they need to provide needed services to improve patient outcomes. Short research or phone calls with patients is also useful in guiding patients properly. Another physician addressed the important of educating patients from different perspective, by pointing out the possibility of communication with patients. Doctors are supposed to understand patients' fear and what they are suffering from. Explaining the situations and having them under control will calm patients and avoid unnecessary emergency room visits.

The importance of front desk was also stressed by many physicians. The shift of health care system requires more message exchanges among providers. Physicians need to train their front desks to receive patients' phone call and to react to certain situations. Many primary care physicians are proactively discouraging patients from emergency room visit, unless it is absolutely necessary. They explain that patients are more accessible with their primary care physicians instead of waiting in the emergency room for hours without being cured. Doctors need to devote more time and efforts to preventing patients from emergency room visits and readmission into hospitals. They have to extend their office hours and become more flexible with their schedules for patients who are not available for a doctor appointment during normal (9-5) office hours. There are several practices opening twenty-four hours seven days a week to give their patients daily access to health care services. However, there is a high cost of staffing those practices. One provider noted that physicians are putting in extra efforts to prevent patients from emergency room visits, but not receive enough benefits as payback.

One participant noted that the trust between the patient and the provider helps improve outcomes for patients. The application of advantage technology, such as electronic medical records, while benefiting the health care system, are considered as additional work load to doctors at the same time, especially in smaller practices. A more efficient and easier to use EMR needs to be created, not only reduce the fragmentation in health care delivery but also for doctor to reap the benefit for their extra work. How to balance between work load and benefits for patients and for providers should be taken into consideration when it comes to the reform of the system. Finally, one provider noted that physicians worried that elderly patients have hard time to see their physicians. They are limited by disability, mobility, and/or financial resources and may not be able to get to their primary care providers for care.

Care Management

Care management is the team-based approach, which designed to assist patient and their support system more efficiently. One of the physicians noted that she does her own care coordination. She tracks patients outside of the practice and seek for coordination with other providers. Another participant noted that ACP guidelines need to be established on who needs care and case management. One participant noted that the team makes the decision who gets care and case management services. The community, and its resources, is also important to determine the needs for care management. Patients prefer to turn to their communities for services they need. It then requires the team the work together to provide services to the patient, including understanding what services are located in the patient's community.

Care management, in today's system, is facing innovations and focusing on home basis services. Rather than hiring extra workforce, physician practices should train or retrain the employees such as social workers, not only assist physicians in the practice, but also follow up patients afterwards. Medical assistants could also be trained to take on more case or care management functions within private practices.

Community Health Workers

Community health workers are a newly introduced concept to many health center and might functions differently within different communities. Community health workers can take on case or care coordination functions. The role of community health workers is to expand to various duties with constant training, in order to provide efficient care services for the patients. The characteristic of community health workers depends on the population they serve. Physicians believe that one of the most important duty for community health worker is staying connected with the patient, and understanding what is going within the home environment. Community health workers are able to deliver services and to promote healthy personal behavior that could ultimately lead to better patient outcomes. For example, community health workers can to offer home visit services for patients and pinpoint personal or environmental issues which could not be

identified through phone call. One provider noted that other than community health workers, front desk staff are in charge of outreach in some practices as well. Electronic medical records are also being used by some physicians for care management by organizing patients' records and separating them based on the urgency of the situations. However, this strategy might be hard to achieve if referrals are not completed or if the provider receives results from the patients rather than specialists. This also assumes an integrated EMR that small practices may not have.

Cultural Competency

Cultural competency was another issue discussed in the meeting. Over the decades, cultural competency is always an important topic in physician trainings. The diversity of patient population makes cross-cultural operations in achieving the goals of DSRIP program more urgent than ever before. Not only staffs, but also whole team should be involved in cultural competency training. They are usually asked to be trained to understand the communities served. Being culturally sensitive can asset doctors to work efficiently in a cultural diverse environment. Staffs are also encouraged to work with patients from different culture backgrounds. Additionally, diversity in the teams and human connection help with overcoming cultural barriers between doctors and patients. One provided noted that while a physician may speak the patient's language, that does not mean the patient can fully understand the doctor. Even people sharing same ethnicity might act differently due to various backgrounds. One physician emphasized on the "human" level of cultural competency. The goal of cultural competency is to create more human atmosphere and make the medical practice a comfortable place for patients. Besides being tolerant to different cultures, showing respect will reduce the distance between doctors and patients. For example, how people address others at the first greeting may bring their relationship to a different level.

APPENDIX

Subject Matter Expert's Presentation

Health Workforce and Health Reform: What Are the Issues? What Are the Data Telling Us?

The Workforce: Challenges & Opportunities for Neighborhood Medical Practices & Providers

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CHWS
Center for Health Workforce Studies

The Center for Health Workforce Studies at the University at Albany, SUNY

- Established in 1996
- Based at the University at Albany School of Public Health
- Committed to collecting and analyzing data to understand workforce dynamics and trends
- Goal to inform public policies, the health and education sectors and the public
- Broad array of funders in support of health workforce research

CHWS
Center for Health Workforce Studies

The Changing Health Care Landscape

Goals of health reform

- To increase access to basic health care services
- To provide high quality, cost-effective care
- To improve population health

New York's Health Reform Programs

	Delivery System Reform Incentive Payment (DSRIP) Program	State Health Innovation Plan (SHIP) State Improvement Model
Goals	• Large-scale reform of the delivery system accountable for safety net patients • 25% reduction in avoidable hospital use over 5 years	• Integrated, value-based care through population health-based care delivery models and payment innovation • 80% of New Yorkers impacted within 5 years
Scope	• All providers that qualify as Safety Net providers, along with coalitions (PPS) of other proximate providers • All Medicaid patients attributed to those coalitions	• All primary care practices • All payers • All New Yorkers
Units	• Provider Performing Systems (PPSs)	• Primary care practices (of any size or affiliation)
Payment models	• Provider incentive payments based on project milestones and outcomes; Value Based Payment	• Range of payment models, unique to payers but aligned across them, including P4P, shared savings, capitation, etc.

What Changes With Health Reform?

- Shift in focus away from acute care to primary and preventive care
- Service integration: primary care, behavioral health and oral health
- Better coordination of care
- Payment reform, moving away from fee-for service and toward value based payment
    - incentives for keeping people healthy and penalties for poor outcomes, e.g., inappropriate hospital readmissions

Guiding Principles

- Person-centered
- Coordinated across different providers
- Active management of transitions across care settings
- Increased provider communication and collaboration
- Clear accountability for the total care of the patient

Workforce Implications of Health Reform

- New models of care are increasing in number (Patient Centered Medical Homes, Accountable Care Organizations, Preferred Provider Systems, Medical Villages)
- Team-based approaches to care are frequently used in these models
- Team composition and roles vary, depending on the patient population
- Teams may include: physicians, NPs, PAs, RNs, social workers, LPNs, medical assistants, and community health workers, among others

Multidisciplinary Teams Have Positive Impacts on Patient Outcomes

- "The provision of comprehensive health services to patients by multiple health care professionals with a **collective identity** and **shared responsibility** who **work collaboratively** to deliver patient-centered care."

  Source: Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington, D.C.: Interprofessional Education Collaborative.

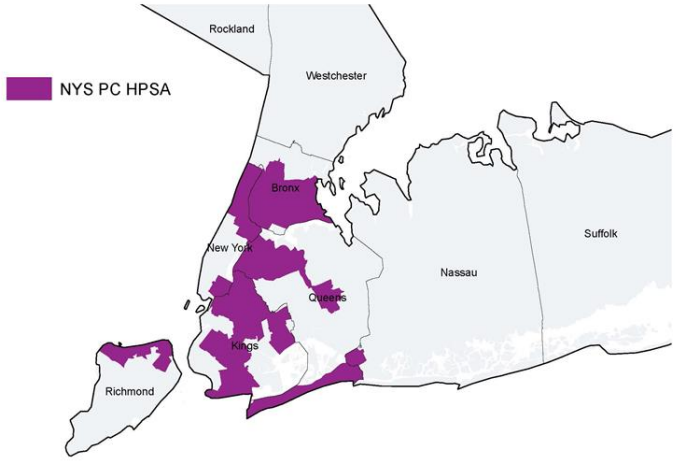
- Research suggests health care teams with greater cohesiveness and collaboration are associated with:
  - Higher levels of patient satisfaction
  - Better clinical outcomes
- The most effective and efficient teams demonstrate a substantial amount of shared responsibility (scope overlap)

So What's the Problem?

- Maldistribution of available primary care capacity
- Health professions education programs are not consistently exposing students to team-based models of care or training them in emerging functions
- Scope of practice restrictions
  - Health professionals not always allowed to do what they are trained and competent to do
  - Shared responsibility (scope overlap) needed for team-based care is challenging to achieve

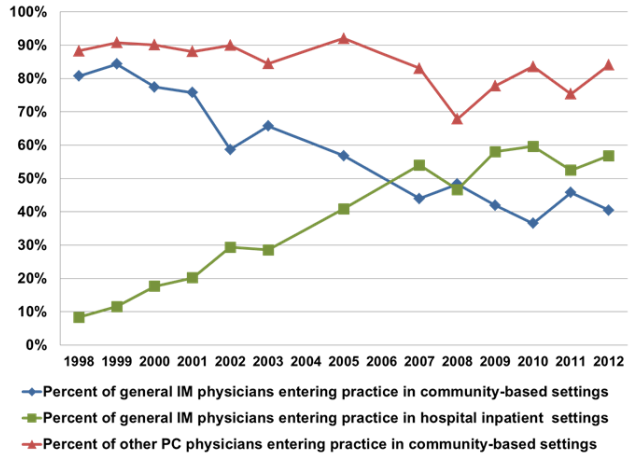
CHWS Center for Health Workforce Studies

Primary Care Health Professional Shortage Areas in New York City



CHWS Center for Health Workforce Studies

More New PC Physicians Plan to Work in Inpatient Settings in New York



Source: Center for Health Workforce Studies

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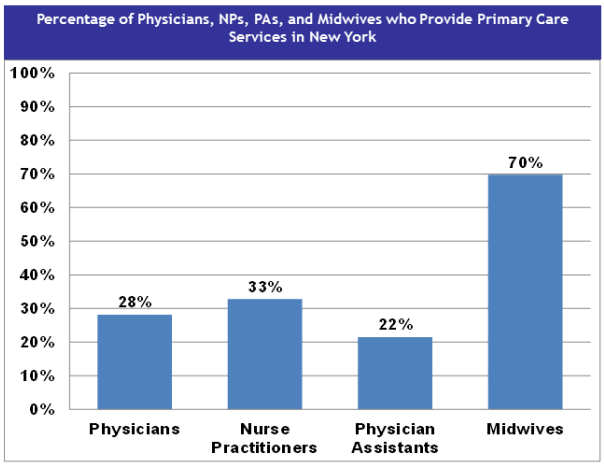
Who Are New York's Primary Care Practitioners?



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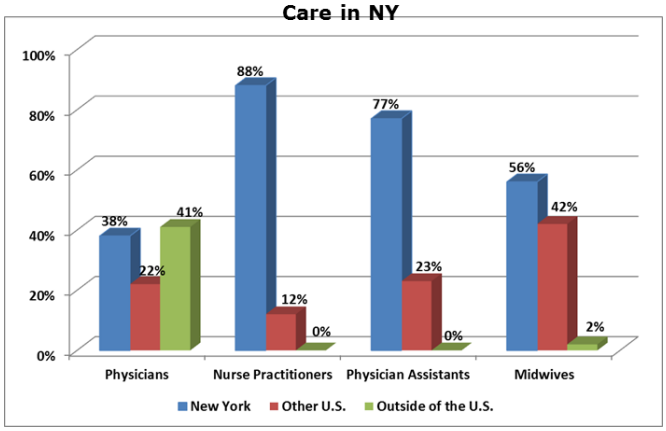
Are We Growing Our Own Primary Care Practitioners?

Training Location of Physicians, NPs, PAs, and MWs Who Provide Primary Care in NY



Source: Center for Health Workforce Studies

Are We Training the Future Health Workforce for Team-based Practice?

- Health professions education typically occurs in **disciplinary siloes**
- The **focus on specialized clinical roles** can interfere with team delegation and collaboration
- Doctors, nurses, and others get **little guidance on how to interact effectively** with each other in support of team care
- There's **limited exposure to emerging models of care** that demonstrate use of group-based decision making

Are We Training the Health Workforce for Emerging Functions?

- Effective chronic disease management
- Patient engagement
  - Health coaching
  - Motivational interviewing
- Care coordination
- Population health
- Data analytics

Looking Ahead: What Do We Need?

- Better data on the state's health workforce to support effective health workforce planning
- Better prepare the state's health workforce (new and existing) for the changing health care delivery system
  - More inter-professional education and training in support of inter-disciplinary team based care
  - Increased focus on ambulatory care and primary care
  - Support the development of new knowledge and skills
- Increased efforts to provide practice transformation support to private practices

What Is The Data Telling Us?

Medical Practices – Who?

- Small practices with limited number of physicians/providers
- Extensive use of medical assistants
- Limited use of NPs, PAs, and RNs
- Limited use of care coordination staff

Medical Practices – What Does the Staff Do?

- Staff have multiple responsibilities
  - Physicians – clinical and administrative
  - Medical assistants – clinical, administrative, and clerical functions
  - Office managers/office administrators – IT, clerical, finances, administration
  - Secretarial/reception – multiple tasks

Medical Practices – Training Capacity and Needs

- Small practices – limited training
- Larger practices – more extensive training

- Required/Conducted
  - Electronic Medical Record
  - HIPAA/Protected Health Information

- Training Needs
  - Care coordination
  - Patient Centered Medical Home
  - Patient Engagement
  - Reinforcement of previous training

Where Are We Going – Workforce?

- Where is the reduction in the workforce?
    - Acute care inpatient
    - ED

- Where is the expansion in the workforce?
    - Primary care providers
        - Physicians
        - NPs
        - PAs
    - Care coordination
        - Care/case managers
        - Patient navigators
        - Community health workers
    - Building the team
        - RNs
        - LPNs
        - Medical assistants

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