Wye River Group on Health Care

A 21st Century Model of Care: Workforce Issues

May 9th, 2006

1:00pm-5:00pm
Franklin Square City Club of Washington
1300 I St, NW

Open

Review Initiative plan: meetings scope and content

Overview of workforce research

- Compare 'pipeline' strategies and tactics
- Discuss similarities/differences

Discussion of synergistic opportunities to enhance existing workforce strategies through expanded collaboration:

- Intra disciplinary strategy: Development of a National Healthcare Workforce Public Policy

- Inter industry strategy: Work with non-healthcare sectors to explore common opportunities to extend the use of existing workforce.
  - Re-evaluate current corporate policy, pension and benefits schemes;
  - Re-visit statutory barriers that promote early retirement

Determine what opportunities best meet the needs of the work group in the context of the entire initiative (i.e., other issue areas, education/training, models, and incentives.)

Summarize

Close

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BACKGROUND INFORMATION

In January 2006 the first baby boomers turned 60. As this bulky generation born between 1946 and 1964 heads toward retirement, we will see vast numbers of skilled workers dispatched from the labor force. This mass exodus is a real threat to organizational performance in all industries.

In the European Union, the number of workers between age 50 and 64 will increase by 25% over the next two decades, while those age 20 to 29 will decrease by 20%. In Japan, 20% of the population is already over 65 years old. Here in the US the number of workers aged 55 to 64 will have increased by more than half in this decade, while at the same time 35 to 44 year olds will decline by 10%.

In reviewing the literature on the healthcare workforce, the context was generally framed narrowly as the availability of people and the interest of individuals in choosing a professional career in healthcare. The challenges to the future healthcare workforce can be simply summarized in a general theme that cuts across all disciplines:

We are likely to face growing shortages of trained professionals able to fill the vacated positions of those retiring, coupled with a growing need for more healthcare service providers as a result of demographics and an increased demand for services.

The case for building a robust pipeline for new healthcare professionals is most apparent in the non-physician disciplines and in the family and general internist physician sectors. These professionals are an indispensable part of the equation to meet the growing needs of an aging America with an increasing prevalence of chronic disease.

A Blue Ribbon Panel report, *"Who Will Care for Each of Us?",* published in 2001 asserted that the ratio of potential caregivers to the people most likely to need care will decrease by approximately 40% between 2010 and 2030. The Panel concluded that America needs an infrastructure of nursing care to meet projected needs of the elderly. They also pointed out that the demand for informal caregivers is likely to have an increasingly negative effect on the overall economy, especially as the proportion of people age 18-64 decreases relative to the elderly population.

It is generally well accepted that the needs of complex geriatric patients with chronic disease are best met through cross-disciplinary approaches. In Europe, shortages of all healthcare service professionals have blurred traditional lines of

authority through increased collaboration. In the US more efforts are being made to provide collaborative educational experiences that lay a solid foundation for effective team-based care.

GENERAL ASSESSMENT OF CURRENT LIABILITIES, CURRENT ASSETS & FUTURE OPPORTUNITIES

Liabilities/Needs

Academic:

- Faculty shortages (nursing/pharmacy), due to aging, difficulty recruiting/retaining
- University compensation low relative to other sites of practice
- Older average age of nursing students (demands/needs different)
- Profession attractiveness (nursing)
- Financial burdens, especially for graduate study
- Loan forgiveness programs are popular with physicians, nurses, psychologists, etc., but are not well funded
- Not enough research on how best to teach today's students
- No uniform national training standards for technical support staff (e.g., pharmacy technicians, certified nursing assistants)
- Significant challenges relate to a need for greater competency in the interdisciplinary aspects of care
- A need for robust evaluation of non-traditional and streamlined or accelerated educational programs for basic and advanced nursing preparation prior to replication (note: differences in the quality of care have been demonstrated between BSN and associate degree nurses)

Workplace:

- Under representation of minorities
- Inflexible work schedules undermine part time students
- Retirement policies may incentivize early retirement
- Need for on-going education/training in all disciplines
- Marked diversity in requirements for entry of technical support staff (e.g., pharmacy technicians, certified nursing assistants)
- Technology sometimes creates more of a burden
- Need for use of IT creates barriers for some older workers who cannot or do not want to learn how to use it.
- Institutions sometimes install IT "solutions" without input from those who will use it
- Expectations health professionals are going up, especially with regard to a need for greater competencies in the interdisciplinary aspects of care
- The ability to practice collaboratively (e.g., physicians, nurses, case managers, pharmacists, etc.) is increasingly critical
- Lack of longevity with employers affects training offerings and benefits

- Health care providers as employers do not seem to consider the health of their employees or the "healthfulness" of their workplaces
- A great deal of care is delivered by small healthcare businesses—surgi-centers, small hospitals
- Institutions have not been loyal to their employees; similarly, some feel employees have not been loyal

Public Policy:

- Board regulations vary from state to state with regard to scope of practice (e.g., pharmacy technicians)
- State law requiring master's degree to teach community college nursing program
- Changes in regulations must always take into account impact on public safety
- We need detailed data on workforce, but the HRSA center which does research on workforce and its needs is not currently funded and the data is not collected frequently enough when it is!
- We do not track where professionals go to practice
- How are health professionals who have licenses in several states counted?
- State by state licensing creates difficulties in today's world of healthcare delivery, but the states s are highly unlikely to give up this source of revenues
- Should look at psychology and nursing "compact arrangements" for potential ways to address licensing and mobility
- Congress is less likely to address these challenges than the private sector; CMS is a big purchaser but is focused on cost/quality issues, not on the impact of workforce issues on cost and quality
- We lack a process of formal workforce planning
- We should not continue to rely on foreign trained health professions to migrate here (e.g., CA only trains 50-60% of its nurses, the rest are imported) even though countries like Philippines and Korea "train for export"

Assets/Opportunities

Academic:

- Formal mentoring and development programs across the career continuum
- 2nd degree bachelors/masters programs *(e.g., Emory Segue program; Duke accelerated program)*
- Web-based media to deliver course work
- Distance learning
- Loan forgiveness/repayment programs *(e.g., Duke)* can be an incentive to attract professionals to geographical areas of need

- On-line masters degree programs *(e.g., Duke/Southern Region AHEC*)
- Partnerships with practice settings, e.g., healthcare institutions/corporations, public health
- Tap advanced practice nurses and other skilled nurses to teach
- Expand faculty capacity by utilizing non nursing disciplines to teach some courses
- Phased retirement for faculty
- Recruit nurses on the verge of retirement and retrain as educators
- Streamline/accelerate basic and advanced nursing preparation
- Joint appointments (university/AMC) with both clinical and teaching responsibilities

Workplace:

- Technological advances i.e. pharmacy dispensing machines; virtual ICUs; home monitoring
- Expanding diversity to recruit into profession
- Flexible work schedules
- Partnerships with colleges/universities to provide clinical experiences
- Health systems support for nursing programs *(e.g., Cedars Sinai Institute for Professional Nursing Development-Cal State U initiative)*
- "Case Manager" role in hospital setting
- Hospitals partnering with academic institutions to loan masters-prepared nurses to teach
- Expand roles of technical support staff (e.g., pharmacy technicians, certified nursing assistants) ensuring proper training/certification
- Tap into the potential for caregivers to be part of the solution
- Consider if there are things to be learned from the DOD & VA
- DOD is addressing workforce issues by contracting for all service unrelated to combat readiness; VA began succession planning some years ago and is trying to incentivize people to stay in an organized system of care

Public Policy:

- Fund Nurse Reinvestment Act
- Increased funding for Nurse Workforce Development Programs administered by HRSA (ANSR Alliance)
- Pharmacy Education Act of 2003 (passed Senate but never became law)
- National Center on Vital Health Statistics (NCVHS) could construct a Health Confidence Index (a Consumer Price Index for health)
- Look at what is happening in the private market, don't wait for Congress
- Tap into the potential for caregivers and self-care to be part of the solution
- Develop a process of formal healthcare workforce planning
- State licensing boards should do workforce data collection and share nationally

PROFESSION SPECIFIC ISSUES

PHYSICIAN WORKFORCE

In the 1980s and 1990s there were predictions of a substantial excess of physicians by the beginning of the 21st century. However, today anecdotal evidence suggests demand exceeds supply for certain types of physicians in some parts of the country. Mounting evidence suggest there may be a shortage within the next few decades, absent fundamental changes in the demand and need for healthcare services and/or in the way healthcare is provided.

As a result, the Association of American Medical Colleges (AAMC) recommends a modest increase in entry level positions in medical schools and GME programs. To get more clarity on actual needs, research should focus on the influence of market forces, economic incentives and disincentives, the increasing use of information technology, and the role of non-physician providers.

The American College of Physicians (ACP) see a looming crisis in the supply of primary care physicians that could result in a health system that is increasingly fragmented, over-specialized and inefficient, leading to poorer quality care at higher costs. The College recommends that immediate steps be taken to reverse the decline in interest in primary care, and improve the practice and payment environment of existing primary care physicians. The organization believes that a national healthcare workforce policy is needed to reverse the impending collapse of primary care medicine.

NURSING WORKFORCE

Nursing is the largest of the healthcare professions, with nursing care providers representing 53% of the total healthcare workforce. The American Nurses' Association (ANA) says there are currently 2.7 million active registered nurses in the US, with 500,000 not working and a current shortage of 150,000. HRSA projects that, absent aggressive intervention, the supply of nurses will fall 29% below requirements by the year 2020. The Bureau of Labor Statistics predicts that registered nursing will have the greatest job growth of all US professions in the time period 2002-2010. They project more than 1 million vacant positions by 2010. The root cause is said to be the value and image of nursing.

More than the other health professions, nursing has been impacted by changes in career opportunities for women and a resulting decline in the perceived social value of nursing as a profession. To address decreased career satisfaction, there is a strong need to enhance the professionalism, stature and respect of all nursing care occupations.

From a demographic perspective, only Asian Pacific Islanders are proportionally represented. Other ethnic minorities who see themselves as "victims" of

discrimination have little interest in pursuing a profession that is also seen as a victim.

The shortage is found across the board. 60% of nurses are in hospitals, which next to nursing homes is the least hospitable environment. One primary issue relates to appropriate staffing ratios. The use of LPNs and CNAs may not in fact relieve the stress, depending on how work is organized. Furthermore, stipulating nurse ratios by contract does not address the problem if it results in a severe shortage of other staff (e.g., phlebotomists, ward secretaries) whose work has to be assumed by nurses. Ambulatory care facilities are much “Friendlier” from a lifestyle perspective.

The good news is that, according to the National League for Nursing, there was a surge in the number of graduations, admissions, and enrollments for year 2002-2003. One attraction to nursing is a sense of job security. New graduates have several job offers and salaries average $45,000-$50,000, however there is little upward mobility. For example, case managers, who are most frequently nurses with 10-20 years of experience, make $52,000-$57,000.

To create a more desirable work environment and promote recruitment and retention, concerns about limited roles in decision-making, mounting administrative/documentation requirements, and stressful working conditions will need to be addressed, along with the +provision of appropriate wage and benefit enhancements.

Faculty issues are especially acute in nursing at all levels. The deficit of full-time master’s and doctorally prepared nursing faculty is intensifying the overall shortage of nurses. Contributing factors include faculty age and departure from academic life; tuition and loan burdens for graduate study; salary differentials relative to clinical and other positions; and a diminishing pipeline of enrollees and graduates.

PHARMACY WORKFORCE

In 1995, the Pew Health Professions Commission predicted that automation and centralization of services would reduce need for pharmacists and supply would soon exceed demand. Yet in 2000, a HRSA report found that while overall supply had increased in the decade, there was unprecedented demand leading to a shortage. A 2002 study predicted a shortfall of 150,000 pharmacists by 2020!

While the same demographics and administrative demands that affect other healthcare professions are relevant to pharmacy, the dramatic growth in the use of pharmaceuticals has an especially significant impact on this group. Between 1990 and 1999 number of Rx dispensed in ambulatory care setting increased 44% while the number of pharmacists per 100,000 population rose just 5%.

The nature of the work is fundamentally changing, from a focus on “counting and pouring” to pharmaceutical care services. But the pressure to fill more scripts leaves less time for counseling patients. Deteriorating working conditions lead to higher stress, diminished professional satisfaction, fatigue and errors.

A decrease in applicants in the late 90s has now been reversed, partly because the shortage led to hire salaries and made the profession more appealing. This has exacerbated the problems with faculty recruitment, as, now reversed, led to faculty shortage, and the pay differential with retail and other positions makes recruiting more difficult.

Gender changes are also influencing the profession. The majority of PharmDs are now women who work on average 6% fewer hours.

A 1999 white paper by APhA, NACDS, & NCPA emphasized the need to augment the pharmacist workforce through the use of pharmacy technicians and enhanced technology.

PSYCHOLOGY WORKFORCE

There are 150,000 practicing psychologists, 80,000 PhDs and the rest practicing with other degrees. 55% of psychologists are in solo or group practice. The largest group of practitioners is in their 50s. However, there has been no diminishing of interest in psychology as a career, so there is no pipeline issue at this time.

However, there is some churn in the profession, as younger psychologists can’t get on panels, and the older ones are sick of the bureaucracy of managed care.

KEY POINTS FROM DISCUSSION ON A NATIONAL HEALTHCARE WORKFORCE POLICY

- The shear size of the healthcare system, the number of jobs it creates and the amount of revenue it generates means it is a huge force to be reckoned with and has clout! However, there is a need to use economic models and put issues into a business case. The “hook” is the current financial situation. AHA has tried to use this approach but they cannot deliver the message credibly.

- We need unity of message, which requires that professional association members need to get the message to “bring voices together.”

- We should frame issues with policy statements that are relevant to the current situation. There are multiple issues requiring multiple statements that must be delivered to multiple audiences by credible messengers in clear and relevant language. In other words, use multiple leverage points.

- It is critical to acknowledge the failures in the system, but this information can be used to demonstrate we are not focused on the right things.

- We need a systematic approach to workforce planning. Everyone is feeling the *chaos* and looking at it as a workforce issue.

- We must be able to envision what the delivery system *could* look like. We should NOT assume that people will wish to have their care delivery tomorrow the way it is delivered today. New models must use the skills and knowledge of all healthcare professionals and existing resources to optimize the population's health.

- There is no on-going process for tracking workforce data/needs. We don't *really* KNOW if we have enough of various healthcare workers until it is carefully studied. Compiling relevant metrics is an important first step. Only the federal government has the ability to integrate data residing at the state level and within organizations.

- Where is the "center of gravity" for health policy today? The states frequently function as incubators/drivers for national public policy. We need to identify two or three key issues and develop state model legislation.

- Clarity of recommendations, delineation of levers and accountabilities (including those for health system stakeholders/professionals) is critical

- Must address the need for health industry employers to proactively address the work environment and workforce concerns.

- The chasm between regulatory and private market forces needs to be bridged. Private market incentives will drive change

- Professionals need to be able to be fluid and mobile as their career evolves. Multi-state licensure issues are increasingly significant and will need to be addressed in some way for all health professions.

- The focus should be on the work environment as a primary issue, and identification of "best practices," as growth in demand may work itself out through different delivery strategies.

- Our discussion identified some issues that are not necessarily impacted by governmental policy. Similarly, the issues span several levels of government and other policymaking entities. Ultimate recommendations should focus on the appropriate locus of policymaking.

POTENTIAL SYNERGIES WITH OTHER SECTORS/PROFESSIONS REGARDING WORKFORCE AND RETIREMENT

Outside of healthcare concerns related to the future workforce are especially acute in manufacturing, aerospace, defense, and professional services, both here and abroad. Some sectors are addressing the issue by sending work off shore or moving to automate as much as possible.

Although corporate America foresees a significant workforce shortage as boomers retire, it is not dealing with the issue. ¾ of the 1400 global companies interviewed by Deloitte last year said they expected a shortage in salaried staff over the next 3-5 years. Yet few of then are looking to older workers to fill the need.

Some point to certain circumstances that may mitigate the problem, to some extent. Peter Cappelli of the Wharton school argues that baby boomers will not be retiring from work in the number people expect, partly because pensions will not be as generous as they had hoped and, in many cases, these boomers will not want to retire. Mr. Capelli predicts the labor force may in fact rise from 153 million to 159 million by 2010. A Harris Wall Street Journal poll recently reported that 30% of Americans over 54 years old doubt they will have sufficient funds for old age.

Whether they want to work or need to work, according to a report last year from Merrill Lynch, "baby boomers fundamentally will reinvent retirement." Similarly, the Conference Board was quoted as saying; "working in retirement, once considered an oxymoron, is the new reality."

If this argument has merit, we should recognize it as an opportunity to help address the growing need for healthcare workers, and find ways to exploit it. We should work with other industries to adapt public and corporate policies to encourage older workers to stay employed.

Consider the fact that many businesses have institutionalized early retirement. At many professional services companies, such as law and accounting firms, partners are encouraged to move out at an early age, often as young as 55, to make room for juniors partners, enticed with the promise of partnership. If the reward system is changed, the age profile will change, too.

The US should consider these examples from other countries—both the positive and negative lessons.

- In Germany and France older workers often earn 60 to 70 % more than their younger counterparts, age 25 to 30, for doing the same work.
- In Britain, they earn about the same, resulting in a very active older workforce.

- In the US, the Age Discrimination and Employment Act discourages the rehiring of older workers by requiring that all employees receive equal benefits.

Governments also have a role to play in influencing the use of older workers. While in some countries the tax system works against older workers, in others the government creates specific incentives to keep older workers employed and productive. Consider these examples:

- Switzerland has specific legislation enabling people to stay on 5 years beyond statutory retirement age.
- Britain will not let a taxpayer receive a pension and a salary from the same employer.
- In Japan it is common to rehire retired workers on one year renewable contracts.
- In the US pension schemes often withhold benefits from a retired person who chooses to work more than 40 hours a month.

How can older workers best be tapped to meet labor shortages in healthcare? Obviously, healthcare is already doing some things right, as it ranks at the top of AARP's list of industries most friendly to older workers. Energy companies and government are among the others listed.

In addition to addressing corporate and public policies that may create incentives for early retirement or essentially preclude employment after retirement age, we will also need to address cultural biases that represent barriers to remaining in the workforce, including poorly founded myths around older worker productivity that stymie their engagement.

KEY POINTS FROM DISCUSSION ON WORKFORCE AND RETIREMENT

In a general sense, the US Chamber advocates for flexibility, recognizing that different employers have different needs in recruiting, retaining and promoting their workforce. Approximately 50% of employers offer pensions (deferred or not) and approximately 50% of employees are eligible for them, but the two are not necessarily correlated.

An employer today has a great challenge in managing a diverse workforce, as it is particularly hard to make everyone "happy" when different individuals value different benefits. Increasingly employees see the total benefit package, including health insurance and pensions as part of salary.

Phased Retirement:

The treasury Department has issued regulations on phased retirement, but what this term really means is unclear. Many see nursing as a front runner on this concept and look to learn a good deal about it from nursing. Universities have used phased retirement models well.

Some company pension plans and some regulations inhibit employees from remaining active in the workforce. For example, you generally can't collect a pension if you work more than a certain number of hours a week. Also, employers may not have to continue to contribute to retirement plans if an employee works less than 1,000 hours/ month, though an employer may want to do so for a loyal, long-term employee. Problems may arise if only some employees are targeted because of ERISA's non-discrimination rules. Some ERISA issues can be circumvented by having an employee retire, then come back as a contractor, but this raises other independent contractor issues. There are several challenges in coming up with a strategy for phased retirement that is fair and worthwhile for an employer.

Relevance to specific healthcare professions:

Nurses are new to this pension issue. Most are in 401K plans. Health insurance is generally a more important issue. However, nurses in general want ANA to work to ensure they have some type of retirement plan and that it is portable.

Case management "inherits" nurses leaving acute care into their call centers. ~24% are in managed care; 25% in-patient and some in workers' comp. The largest growing segment is independents. They may not see much value in defined contribution pensions and their frequently small employers may find it too expensive to offer.