THE HEALTHCARE WORKFORCE

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The Patient Protection and Affordable Care Act (Act) supports greater investments in prevention, primary care, the coordination and integration of care delivery and a prepared workforce.

Nearly all aspects of the new reform law affect the healthcare workforce in one way or another. The most obvious change will be the increased demand for services as more people become insured. The uninsured use between 50-60 percent of the care used by insured individuals, suggesting that a 40-50 percent increase in demand for care may occur as a result of coverage expansion.[1]

Increased access to coverage and health services begins in 2010 but will not be fully implemented until 2014. Between now and then, patients and providers will begin experiencing an increased – and changing – demand for healthcare, requiring changes in how care providers are trained, how they practice, and where services are delivered. While these changes will affect a broad swath of the healthcare workforce, their impact will be most profoundly felt in the area of primary care.

KEY REFORM CHANGES

- **Expands assessment, planning and coordination for the healthcare workforce at the federal and state level.**
- **Offers state healthcare workforce planning and implementation grants.**
- **Expands workforce recruitment, education/training/residency and retention programs for primary care, public health, pediatrics, geriatrics and behavioral health.**
- **Offers grants to schools and individuals to increase the number of physicians/ osteopaths, advanced nurse practitioners, physician assistants, nurses, dentists and allied health professionals.**
- **Offers demonstration projects, diversity education and support to Area Health Education Centers.**
- **Expands funding for primary care and prevention services at community health centers, nurse-managed health clinics and school-based clinics.**

WORKFORCE PLANNING

To support the expected demand for healthcare practitioners, the Act provides funding to plan and implement strategies aimed at increasing primary care positions in the states by 10-25 percent over 10 years (2010-2020). The law:

- Provides states with grants for comprehensive workforce development planning ($150,000 for one year)
- Makes available implementation grants ($1.5 million/year for two years with a possible third year) leading to primary care workforce expansion
- Contains new requirements for states to provide information to a National Healthcare Workforce Commission under these reforms

The new law requires states' Workforce Development Boards to act as the planning bodies for any grants submitted. As of the writing of this report, it appears that neither the Arizona Workforce Development Board nor the Governor's Council on Workforce Policy is applying for one of the state grants. (Such grants were recently announced. Applications were due July 19, 2010, giving states little time to apply.)

Past Arizona workforce planning efforts have largely been carried out in a fragmented manner by a variety of health-related agencies, organizations, associations, colleges, universities or regional bodies with support from local hospitals, foundations and businesses. Those efforts have resulted in some successes, but little has been done on a statewide basis in spite of significant and frequent requests to do so.

However, between 2001 and 2010, the state demonstrated its ability to plan for workforce shortages at a statewide level. To address nursing shortages and meet the demands of an aging population with multiple conditions, the Governor's Council on Workforce formed a task force on nursing shortage (2001-2006). In 2005, with broad support, Senate Bill 1517 appropriated $20 million over five years to expand community college and state-funded university nursing faculty. In 2009, a State Board of Nursing Analysis found that RN enrollment had grown 134 percent, increasing from 2,664 in 2001 to 6,246 in 2009.[2] Unfortunately, student capacity is now declining in public (e.g., state university) RN programs due to limited admissions or closing programs as a result of budget reductions. Nonetheless, private RN program capacity (e.g., Grand Canyon University) remains stable.

Arizona Needs Statewide Health Workforce Planning

Some states such as Pennsylvania have been planning for workforce expansion under healthcare reform even before the bills became law, noting that when states such as Massachusetts implemented significant coverage expansions, access to care was strained and emergency room use grew.[3] States such as Colorado, Ohio, California, Illinois, Nebraska, New York, Iowa, Maryland, and Wisconsin have formed regional collaboratives that bring together government agencies, foundations, and other philanthropic organizations to target financial resources and strategic thinking on creating jobs and careers related to the healthcare workforce.[4]

Arizona has a number of groups able and willing to engage in and help fund a workforce planning process. Unfortunately, without a statewide initiative similar to the former Governor's Council on Workforce Policy for nursing, efforts seem unlikely to reach the level of visibility and consequence necessary to result in significant, coordinated change.

KEY TAKEAWAYS:

- Coverage expansion and other elements of healthcare reform will increase the need for healthcare (especially primary care) providers.
- If primary care and other providers cannot keep pace with demand, patients will go where they can most readily find care – hospital emergency departments.
- Unless there are organized planning efforts among multiple stakeholders, Arizona's efforts to address the state's workforce needs will continue to be fragmented, underfunded and – more than likely – inadequate.
- Arizona should encourage the Health Resources Services Administration (the federal agency charged with releasing workforce planning grants) to allow a second round of applications from states.
- If Arizona does not participate in the federal planning and implementation grants, the Governor's Council on Workforce should develop a task force and charge it with strategic planning related to primary care and prevention, just as it did to address the nursing shortage. The effort should include an assessment of workforce needs, identified strategies and policy changes to address shortages, funding (ideally from public and private sources), and measurable targets against which progress can be measured.

CHANGING CARE DELIVERY

Healthcare delivery is morphing to meet increasing demands for coordination, cost containment and quality. In response, the workforce charged with delivering care is shifting. Healthcare reform is accelerating many of these changes through strategies aimed at addressing quality and through initiatives that address healthcare workforce composition, scope of practice and training. (See the Quality section of this report.)

Focus on Primary Care

As a result of healthcare reform and other forces changing the way care is practiced, health care will increasingly be delivered in primary care settings. Accordingly, many of the Act's provisions are aimed at increasing the number of primary care providers.

Healthcare reform addresses these changing workforce needs through new health career education loans, scholarships, grants and revised repayment requirements aimed at attracting new entrants to the healthcare workforce. The new law also offers existing workers the opportunity to pursue advanced degrees and supports the development of faculty needed to prepare the healthcare workforce. Funding targets those interested and willing to work in the areas of:

- Primary Care
- Public Health
- Pediatrics
- Geriatrics
- Behavioral Health

Potential recipients include current and future physicians (medical doctors and doctors of osteopathy), advanced nurse practitioners, physician assistants, nurses, dentists and select allied health workers.

Funding allocations are fairly specific over the next few years, becoming less defined over the latter part of the decade. (Such monies – whether allocated or not – ultimately have to be appropriated from year to year, the likelihood of which may change as political winds shift over time.) Current funding allocations expand or include new funding for:

- Use of unused training slots for physician graduate medical education (GME) residents for:
  - Primary care training at non-hospital sites
  - Primary care and general surgery residencies
  - Training in outpatient settings
  - Expansion of residency programs in rural and underserved areas
- Primary care nurse practitioner training programs and demonstrations
- Funding to Area Health Education Centers (AHECs) for recruitment/retention and education (particularly in rural areas)
- Funding for the National Health Service Corps
- Low-interest student loans and scholarships with improved loan repayment requirements
- Support for multiple nursing programs, including funding for:
  - Nurse faculty loans
  - Nurse practitioner fellowships and traineeships in geriatric and elderly care
  - Workforce diversity grants

- Family Nurse Practitioners to work in nurse-managed clinics/community health centers
- Scholarships for mid-career training for public health and allied health professionals

Funding has already started to flow to state universities and the Arizona Board of Regents for health profession education with the award of $2.3 million for nursing education. The grants provide funding in advanced education, practice, quality, retention, workforce diversity and geriatric education.

Shift in Training and Incentives

Health reform funding supports a shift in focus for physician GME residency training from hospital to non-hospital training sites and community health centers in an effort to better prepare physicians and others for delivering primary care in the community. Such change may not occur easily. A medical school physician/dean interviewed stated:

> *"Changes to residency programs (moving to more community-based programs) will mean an active fight from hospital-based programs and require active involvement in the development of the rules and regulations [from primary care programs]."*

The Act also includes other provisions incentivizing the number of primary care professionals. It increases reimbursement to primary care physicians, nurse practitioners and clinical nurse specialists for Medicare-covered services. Further, it provides very modest payment increases for Medicaid primary care physicians for 2013 and 2014 at no extra cost to the state.

While these new opportunities and incentives are perceived by many as needed, it is unclear how effective they may be in helping Arizona meet increased workforce demands. Whether students and health professionals interested in seeking these education and training opportunities receive their training here (where they are more likely to practice) or go out of state will very much depend on the capacity of various educational programs to meet the increased demand. In turn, the capacity of various institutions (including whether they have an adequate number of faculty) will depend on their ability to leverage national as well as state dollars.

State support for the healthcare workforce has diminished during the past few years in this tough budget climate. The state recently cut Graduate Medical Education ($15 million) for residency programs – and there is no indication when funding may return, given Arizona budget difficulties.[5] (In 2009, 41 states provided full funding for GME.)[6] In response, some hospitals have cut their residency programs. Other hospital/university-based programs are "holding on" in the hope that health reform will allow them to receive funding, according to one professional interviewed in charge of such programs. If academic programs cannot find funding to support their residencies, Arizona will most likely see a decline in the number of slots for GME residents, including primary care.

It is also unclear whether educational opportunities and small increases in pay will be enough to attract aspiring healthcare professionals to primary care. Primary care physicians are generally viewed as being unhappy with their lot. Their many challenges include:

- Lower income than other physicians
- Stress from seeing large numbers of patients, often with multiple health problems in brief visits
- Demands for 24/7 care delivery
- Challenges finding places to practice and live in underserved areas where they can make a life for themselves and their families, including work for a spouse, good schools for their children and social and cultural amenities

Roles of Other Providers, Foreign Medical Graduates

In addition, uncertainty about how Medicare fees for doctors will change in future years may offset any new incentives aimed at attracting primary care practitioners. A planned 21 percent decrease in Medicare payments for evaluation and management services, a major portion of the services offered by primary care practitioners, is set to occur in November 2010. Such reductions have usually been cancelled, but the issue that remains is the lack of consistent and improving incentives to provide primary care.

Nurse practitioners and physician assistants are expected to play a greater role in primary care given the increased demand for care and the anticipated shortage of primary care physicians. Foreign medical graduates may also help fill Arizona's primary care gap.

U.S. primary care residencies often go unfilled, leaving openings for foreign graduates to enter the country to complete their training. Many stay on, setting up practice and becoming citizens. According to a Massachusetts policy expert interviewed, 25-40 percent of the primary care physicians in that state are foreign graduates at any given time. Foreign medical graduates currently represent 30.5 percent of the primary care physicians practicing in Arizona.[7] However, it is unclear whether international attention on Arizona's new immigration law might affect our state's draw of foreign professionals.

The state and various educational institutions already administer an array of programs (grants, stipends, loan forgiveness, university and college funding and practice opportunities) aimed at attracting health profession students. Under health reform, funding for these programs will expand significantly. To maximize their effectiveness, the state must define more clearly what students they want to prepare to respond to statewide defined needs, not single institution needs. State monies for students and programs should go to support policy that enhances the health of Arizona's citizens and meets defined outcomes.

KEY TAKEAWAYS:

- Some physician GME residency training will shift from hospitals to non-hospital training sites (such as community health centers) to better prepare physicians and others for delivering community-based primary care. Clinical and public health settings of all types should begin to explore how they might support that shift and cooperate in designing practice experiences for physicians, nurse practitioners, physician assistants and other students.
- Arizona's healthcare training and education providers and programs should apply for federal workforce funding as soon as possible rather than waiting, since politics or priorities may shift, affecting funding availability.
- Arizona's schools and universities need the capacity to respond to expanded demand for educational programs, or students (and faculty) will seek opportunities out of state. Such capacity depends – at least in part – on stable state funding.
- To effectively meet the state's workforce needs, Arizona should tie public funding for workforce related programs to policies that produce and attract health professionals who will offer the types of services needed by our state's population in the locations where there is a defined shortage or gap in available resources.

INTEGRATED CARE DELIVERY

The increased emphasis on primary care and prevention in the reformed health system comes along with new expectations for coordinated care delivery through "medical/health homes," expanded use of electronic medical records, changes in payment approaches and new accountability for care quality and outcomes, all of which will demand new skills and attention.[8] These and other changes in technology and healthcare delivery will demand workforce education/re-education for all in the field.

Group Health Cooperative of Seattle, a provider that has conducted a medical home pilot project since 2006, found they needed more resources, enhanced staffing ratios and a different mix of staff to deliver care based on the new model. They found that "physicians and care teams require reasonable–size practice populations to allow physicians to know their patients better, comprehensively address their needs, and avoid burnout."[9]

Learning new skills and changing practice patterns will likely result in new stresses and strains for health professionals. In particular, some physicians may not be happy with new requirements and demands on visible accountability. Said one nurse practitioner educator interviewed, "Nurses think rules and follow rules. Physicians don't follow rules. They make the rules."

Primary care providers in small practices will be required to offer broader services that are well planned and coordinated with other providers and services. If they cannot or will not provide these services themselves, they may join organizations that already have such capabilities, possibly breaking existing alliances and forming new ones.

Some physicians practicing solo or in small groups, older physicians and other practitioners may simply decide not to accept the required changes and retire or pursue other work – depleting the primary care workforce even further. Larger systems of care, which already provide some coordinated and integrated care, will have to respond to new demands and have the requisite systems in place to do so. However, incorporating physicians who decide to join or contract with them may engender stress and disruption for all those involved.

KEY TAKEAWAYS:

- Healthcare reform will alter how health care is practiced. Existing staff may need to be retrained and the organization and composition of staff may need to be altered to respond to changing practice patterns.
- Practitioners will be increasingly pressured to form alliances and meet accountability requirements, resulting in the exit of some providers who are unhappy with the new demands.

SCOPE OF PRACTICE

The scope of care provided by licensed primary care practitioners is not discussed in the Act. However, growing emphasis on cost control and workforce shortages – which are magnified through many of the Act's provisions – will necessitate changes in who delivers healthcare services.

Decisions related to scope of practice (who can practice what healthcare services) rest with states. Teasing out which practitioner can provide what services (and at what price) is important to address if Arizona hopes to meet increased and changing workforce needs resulting from healthcare reform.

Physicians, nurse practitioners, physician assistants, dentists and others offer some level of primary care within the scope of their state authorized license, but the "scope" of that care is often in contention. Physicians control the definition of "medical practice" and other providers must seek to "carve out" pieces of that care and have it included in their scope of practice, which still does not prevent physicians from providing the same types of care. Said one physician/dean interviewed, "Physicians need to allow a non-physician team model to predominate and leave physicians to focus on what they do best."

The 2010 report, *Who Will Provide Primary Care and How Will They Be Trained?* states:

> *"Coupled with efforts to increase the number of physicians, nurse practitioners, and physician assistants in primary care, state and national legal, regulatory, and reimbursement policies should be changed to remove barriers that make it difficult for nurse practitioners and physician assistants to serve as primary care providers and leaders of patient-centered medical homes or other models of primary care delivery. All primary care providers should be held accountable for the quality and efficiency of care as measured by patient outcomes."* [10]

A recommendation noted in a previous SLHI policy primer on regulating the health workforce noted:

> *"Blurred and conflicting boundaries between scopes of practice do not facilitate care for the public. Arizona should review its licensure and scope of practice acts to ensure that they are flexible enough to allow health professionals to practice to the fullest extent of their technical training and ability. Narrow definitions of practice will make shortages worse with technical rules and limits on practice. A proliferation of different and narrowly defined levels of skills will leave everyone trying to protect their turf and few paying attention to society's needs."*[11]

KEY TAKEAWAY:

- Increased emphasis on primary care, medical/health homes and coordinating teams suggest that using personnel in the most appropriate and expansive roles possible may be a good – and possibly necessary – idea if we are to meet patient demands for care.

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References

1 Hadley, J., & Holahan, J. (2003, February 12). How much medical care do the uninsured use, and who pays for it? *Health Affairs* (web exclusive) Retrieved August 2, 2010 from http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.66v1.pdf

2 Randolph, P. (2009). The 2009 Arizona State Board of Nursing summary and analysis of annual reports from Arizona nursing education programs . Phoenix, AZ: Arizona State Board of Nursing.

3 State of Massachusetts. House Bill 1192, 2007. Retrieved August 2, 2010 from http://www.mass.gov/legis/bills/house/185/ht01pdf/ht01162.pdf. See also NASHP (2009, November 17). Preparing for health reform: A conversation with state policy makers [Webinar]. Denver, CO: National Academy of State Health Policy. Inglehart, J.K. (2009, October 21). Reform and the health care workforce: Current capacity, future demand. *New England Journal of Medicine* (online edition). Retrieved August 2, 2010 from http://heatlhcarereform.nejm.org/?p-2129 See also Kowalczyk, L. (2010, July 4). Emergency room visit grow in Mass. *Boston Globe.* Retrieved August 3, 2010 from http://www.boston.com/news/local/massachusetts/articles/2010/07/04/emergency_room_visits_grow_in_mass/

4 National Fund for Workforce Solutions. National fund locations. Retrieved August 3, 2010 from http://www.nfwsolutions.org/locations

5 Arizona State Senate. (2008, September 26). Arizona State Senate issue brief. Phoenix, AZ.

6 Inglehart, J. K. (2010, July 21). Health Reform, Primary Care, and Graduate Medical Education. NEJM, 3770.

7 Hughes, R., & Stemmler, P. (2009, December). Goodbye, hello: Framing the future of primary care [Part one]. Phoenix, AZ: St. Luke's Health Initiatives.

8 Cronoewett, L., & Dzau, V. (2010). Chairman's summary of the conference. In: B. J. Culliton & S. Russell eds. *Who will provide primary care and how will they be trained?* Durham, NC: Josiah Macy Jr. Foundation. Retrieved August 5, 2010 from http://www.josiahmacyfoundation.org/documents/jmf_Chair

9 Lockhart, C. A.; & Hughes, R. A. (2004, October). Controlling the curve: Health workforce regulation in Arizona. [*Arizona Health Futures Policy Primer*]. Phoenix, AZ: St. Luke's Health Initiatives.

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