

# A POLICY FRAMEWORK

# OUT OF ORDER OUT OF TIME

THE STATE OF THE NATION'S  
HEALTH WORKFORCE, 2013



Association of Academic Health Centers®  
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## WHY REVISIT *OUT OF ORDER, OUT OF TIME* FIVE YEARS LATER?

*In 2008, when AAHC released its milestone health workforce report, Out of Order, Out of Time: The State of the Nation's Health Workforce, the country was in the midst of a long and contentious health reform debate. The purpose of the report was to provide an integrated academic health center perspective on health workforce reform and to underscore its crucial importance to the success of broader health system reform. In the interim, two important developments — one obvious and one less so — have changed the environment in which health workforce reforms must be formulated and implemented. This 2013 Policy Framework updates AAHC's analysis to take these changes into account.*

Our 2008 report on the state of the nation's health workforce, *Out of Order, Out of Time*, offered a compelling argument that we were running *out of time* to address what was *out of order* in the nation's healthcare workforce. At that time, our attention was focused on the social, economic, and demographic trends that were driving change in the demand for healthcare services and the health workforce needed to provide that care. Today, AAHC believes that two important changes have occurred in the intervening five years that warrant a reassessment of *Out of Order, Out of Time*: the subsequent enactment and ongoing implementation of the Affordable Care Act (ACA), and the newly emerging disruptive innovations in health care, resulting in a fundamental shift in the way health care is delivered. These changes have significant implications for health workforce policy.

## HOW DOES THE ACA IMPACT THE HEALTHCARE WORKFORCE?

*Five years ago, it was often argued that the solution to the health workforce problem was simply a matter of numbers: we need more people to deliver more care to more patients. With the Affordable Care Act, not only will there be more patients to serve but also significant changes to the payment policies and delivery methods. The totality of the ACA changes must be considered in any sound health workforce policy.*

### COVERAGE EXPANSION AND PAYMENT POLICIES

Coverage expansion and payment policy change are likely to demand delivery system change. Many patients will be receiving mainstream coverage for the first time, placing new demands on the existing health workforce. In addition to issues involving access to care, payment policies will increasingly emphasize population health and cost containment. These changes also require a re-thinking as to the types and locations of healthcare providers that will be needed.

There are several pilot projects included in the ACA designed to make changes to existing payment policies and structures, including the Medicare Shared Savings Program, the Hospital Value-Based Purchasing Program, the Bundled Payment for Care Improvement Program, and others. All of these programs are testing out various methods for incentivizing higher quality, more efficient care. However, in order to achieve that ultimate goal, we must now consider policies that will ensure that our health workforce is adequately trained, distributed, and supported to function in this new environment.

### WHAT KINDS OF DISRUPTIVE INNOVATION WILL IMPACT THE HEALTH WORKFORCE?

*While there is much that policymakers can do to coordinate and incentivize necessary change in the health workforce, there are other dominant forces in play that need to be taken into consideration.*

### ADVANCES IN TECHNOLOGY AND THE CHANGING LOCUS OF CARE

Technological advances will over time transition the locus of care from the venue of the healthcare provider to that of the patient, wherever the patient may be located. An example is monitoring of chronic conditions with increasingly small monitors attached or imbedded in patients and linked to smart-phones providing a steady stream of data that, using a series of algorithms, offer vast diagnostic and management opportunities. This fundamentally changes the care management paradigm from the episodic approach most chronically ill patients receive today. It also requires a different deployment of physicians, nurses, laboratory technicians, and other health professionals – not just in terms of the number of health professionals needed, but in terms

of the education and training needed for each health professional to develop the appropriate skill-set necessary to fulfill these evolving roles.

Advances in technology are likely to bring about a gradual decentralization of care delivery, as more tests and procedures are moved to facilities near to or co-located with patients. Sophisticated telehealth networks connecting providers at every level with appropriate specialists will allow many patients to be treated locally who previously had to travel a distance for care. Diagnostics-on-a-chip will make it possible to perform many tests in ambulatory settings and patients' homes in real time rather than sending them out to labs and waiting for the results. Artificial intelligence will support faster and more accurate diagnoses. All these technology-driven changes will shift the number of various health professionals needed to carry out new tasks, and require our health workforce to acquire new skills and expertise, not only involving health professions education, but also creating an enormous demand for mid-career re-training.

### WHAT ACTIONS DO POLICYMAKERS NEED TO TAKE?

*The traditional approaches to workforce decision-making that matches numbers of health professionals in different fields (e.g., medicine, nursing, allied health, dentistry, pharmacy, public health) to imputed healthcare needs are less relevant as transformative change is required to meet a rapidly-evolving national health workforce. No longer can we focus on policy solutions one profession at a time or rely on the development of outmoded skill-sets. The current situation requires the development of an integrated, comprehensive, and forward-thinking national health workforce policy.*

We are running out of time as the need to address the adequacy of the nation's health workforce is ever more urgent. Dramatic growth in our aging population coupled with the sizeable increase of newly insured persons in 2014 as a result of the ACA will strain a healthcare delivery system already struggling under the weight of its current load.

The changing nature of healthcare delivery as a result of new technologies,

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breakthroughs, payment policies, philosophical shifts, and economic reforms will drive new education and practice models for the health professions. Changing demographics and an increase in the insured, coupled with technologic advances, require us not to focus on how care *has* been delivered but on how care *will be* delivered.

Development of an integrated, comprehensive national health workforce policy can be accomplished if all interested stakeholders work together to:

- Create and fund a national health workforce planning body that engages diverse federal, state, public, and private stakeholders;
- Promote harmonization in public and private standards, requirements, and prevailing practices across jurisdictions; and
- Invest in a comprehensive health workforce research component that will:
  - Address development and dissemination of consensus definitions and terminology;
  - Monitor developing technological breakthroughs that require changes in provider numbers, types, and expertise;
  - Identify gaps in data collection and current modeling strategies for supply and demand; and
  - Promote consistent approaches to workforce research across all health professions.

### NATIONAL HEALTH CARE WORKFORCE COMMISSION

The National Health Care Workforce Commission (NHCWC) and the National Center for Health Workforce Analysis (NCHWA) were established by the ACA to work together to achieve the goal of an integrated, comprehensive national health workforce policy. The NCHWA was intended to collect, analyze, and synthesize the current data into supply and demand projections that reflect a move towards more inter-professional, interdisciplinary, team-based care delivery. The NHCWC was intended to take the data generated by the NCHWA and other sources, and develop recommendations for a comprehensive health workforce policy.

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Unfortunately, the NHCWC, whose members were appointed in September 2010, has yet to be appropriated any funds by Congress, and has therefore been unable to take up its charge. AAHC strongly urges Congressional leaders to:

- Provide adequate funding for the Commission, enabling it to commence operation as quickly as possible;
- Urge the Commission to adopt a more ambitious timetable than provided for in the authorizing legislation to develop and submit recommendations for policymakers in order to address the accelerating challenges facing the nation's health workforce; and
- Actively engage the Commission on a regular basis through briefings, hearings, and other forms of public discourse throughout the year to elevate the Commission's visibility, hold Commission members accountable, and encourage dialogue about needed health workforce reforms.

## POLICY RECOMMENDATIONS

Without all of the necessary data and analyses, it is difficult to come to any conclusions about specific policy recommendations with respect to the future of the health workforce. However, there are some key elements that should be included in any policy discussions:

- Strategies designed to incentivize a more diverse pool of students pursuing careers in the health professions;
- Policies that encourage a broader geographic distribution of health professionals, as well as a more adequate mix of specialties among medical students and residents;
- Incorporation of the recommendations of the Institute of Medicine consensus study on the Governance and Financing of Graduate Medical Education; and,
- Implementation of policies that take into consideration emerging health-care technologies and encourage innovative approaches to the delivery of healthcare, including telehealth, interprofessional care teams, value-based payment platforms, and others.

## WHAT IS THE KEY ROLE OF ACADEMIC HEALTH CENTERS?

*Academic health centers function at the intersection of health professions education, biomedical research, and patient care. Due to their size, the number of health professionals they employ, and their preeminent role in educating and training the health professions workforce, academic health centers are an integral part of the solution. However, given recent policy changes, these institutions are developing new models and approaches.*

Academic health centers are unique in that their educational and research operations are integrally connected to patient care, all of which ultimately depend on the health workforce. Given their vantage point as engines of economic development within their communities and throughout the nation, academic health centers have a responsibility to analyze current issues and develop new approaches to solving persistent problems. The Association of Academic Health Centers (AAHC) and its member institutions urge public and private stakeholders to recognize the urgent need for action and commit themselves to transformative change, following the blueprint laid out in this report. In return, our members offer themselves up as potential laboratories for this change. We stand ready to collaborate with Congress and the Administration to develop a healthcare workforce that meets the needs of the population, and works as one entity to improve the health and well-being of all.

For example, health reform and the current budget deficit environment are set to disrupt academic health centers' clinical revenue streams in several ways. The political impetus to close the federal budget gap will continue to focus on physician and hospital reimbursement as a target for deficit reduction. In addition to deficit-driven reimbursement reductions, the ACA lays out a roadmap for shifting current reimbursement models to a more evidence-based and population-based approach. It creates an incentive to move a substantial portion of Medicare beneficiaries into accountable care organizations (ACOs), a new risk-sharing arrangement that includes significant obstacles to the participation of many academic health centers. It also creates state and federal health insurance exchanges, which will alter the market environment in which academic health centers operate.



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Moreover, the behavioral response of other stakeholders to the ACA may have an even greater long-term impact on academic health centers than the ACA itself. There is already evidence of states returning to Medicaid managed care as a means to contain costs. Private payers (insurers and self-insured employers) are expected to gradually adopt Medicare-like reimbursement changes and resist the levels of cost-shifting they have tolerated in the past.

The technology-driven changing nature of clinical care itself – from a hospital-centric acute care system to a more distributed, patient-centric, chronic care management system – also poses significant risks for academic health centers. Decisions about whether and how to reconfigure future hospitals in a less hospital-centric environment, and whether to acquire and how to integrate physician groups, entail significant financial risks. Taken together, all these changes involve market dislocations that academic health centers must carefully navigate.

The academic research enterprise is under no less pressure. Inflation-adjusted NIH research funding has been on a downward trajectory for a substantial period of time. The labor costs of conducting research, a significant component of the overall cost, tend to increase faster than inflation. Many academic institutions have struggled to commercialize their discoveries, which they had hoped would defray a portion of research costs. The recent economic crisis and slow recovery has limited the ability of endowments to fill the gap. Although pharmaceutical companies have outsourced a significant portion of their research in recent years, academia has not always competed successfully for those research funding dollars.

The story is much the same for the education enterprise. The labor costs associated with education, a major component of the overall cost, also tend to increase faster than inflation. Tuition costs have risen to levels that discourage enrollment and increasingly influence students' career choices. Some institutions have responded by attempting to create endowments that provide tuition-free education, but many institutions are not in a position to raise such endowments. This “perfect storm” of financial stress has encouraged some institutions to experiment with new and creative alternatives, such as modular online instruction, but many have done so in isolation rather than in collaboration with others. Often, cultural inertia remains a substantial obstacle to cooperative solutions.

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The endemic and deeply-rooted nature of these challenges strongly suggests that they cannot be successfully addressed by modest or incremental optimizations of the current academic health center paradigm. Instead, disruptive innovation on a large scale appears necessary to achieve the needed improvements in cost-efficiency and effectiveness. Yet, such large-scale infrastructure change necessitates comparably large-scale workforce change, illustrating the need for a national health workforce policy that supports change.





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