ACA and workforce, providers-- US and Connecticut
health care critical to CT’s economy

- 12 cents of every dollar spent in CT goes to health care
- $30.4 billion in 2009
- One out of eight CT workers is employed in health care services
- Employment not affected during recession
Health care workforce growing faster than other occupations
US workforce changes over time

Major industries with highest employment, by state 1990

CT health care workforce high
CT health care workforce growing faster than US average
"The Act funds scholarships and loan repayment programs to increase the number of primary care physicians, nurses, physician assistants, mental health providers, and dentists in the areas of the country that need them most. With a comprehensive approach focusing on retention and enhanced educational opportunities, the Act combats the critical nursing shortage. And through new incentives and recruitment, the Act increases the supply of public health professionals so that the United States is prepared for health emergencies.

"The Act provides state and local governments flexibility and resources to develop health workforce recruitment strategies. And it helps to expand critical and timely access to care by funding the expansion, construction, and operation of community health centers throughout the United States."
What the ACA means to providers

- No more bad debt, or at least less of it
- More funding to medical care
- Pressure to coordinate care, join larger groups, ACOs
- More scrutiny on quality of care
- Support for care coordination, HIT → lower admin costs
- More Medicaid clients
- Higher primary care rates – Medicare and Medicaid
- Workforce supports?
What the ACA means to providers

• Financial disclosure of relationships with manufacturers and drug companies
  – Open Payments just released last week, controversial
• Grants for primary care training programs*
• Redistributes GME toward primary care slots
• Scholarships for primary care students*
  – Eases requirements
• Loan forgiveness and direct incentives for primary care*
• new National Healthcare Workforce Commission
  – Appointed, never convened
  – Congress won’t release the $2 million to run it
2014 CT physician survey

- 59% see state of medical profession as somewhat or very negative
- Half would not recommend medicine as a career
- 25% intend to retire or cut back on hours over next 3 years
  - Another 10% will pursue a nonclinical job
- 47% work in practices 1 to 10 physicians
- Largest share spend 6 to 10 hours/wk on paperwork
- 34% are overextended/overworked
- Give CT a C grade for ACA as a vehicle for reform
ACA and doctors

• Debate over numbers needed, types, where
• Payment and delivery reforms will drive more responsibility, financial risk
• Competition from retail clinics, NPs, etc.
• More Medicaid patients
• Younger doctors more concerned about lifestyle issues, less interest in running a business, more comfortable with technology and teams
• Concerns about burn out, especially primary care
• Expect move to larger practices, across care continuum
ACA and doctors

- Intend shift incentives from specialty to primary care
- More transparency
  - quality, prices, conflicts of interest to public
- More accountability
  - paid based on quality of care
- Emphasis on best practices, guidelines
  - Less art, more science
- ACA increases market forces to join larger groups
  - CT still predominantly small practices, very independent
- Training funds—new and shift to primary care, underserved areas/populations
- Incomes may re-balance
- Push for diversity
ACA and nursing

- Nursing shortage abated due to delayed retirements, economic downturn
  - Permanent solution?
- ACA incentives for NPs and CNPs – boost Medicare payments 10% 2011-2015
- Expands nursing student loan, training programs
- Creates Nursing Managed Health Centers
  - nurse led clinics in underserved areas
- Funding sufficient?
- CT law passed to allow NPs independent practice
ACA and hospitals

- Seeing reduction in LOS, admissions due to reforms
- More insured patients – could increase ED use, generally profitable for hospitals
- Readmission penalties
- CT cuts to DSH in response to expected reduction in uninsured
- ACA Payment reforms – move from volume to value, coordinate care, ACOs
- Medicare payment changes -- market basket adjustment
- Reductions for high rates of hospital-based infections
- More transparency, reporting
- Nonprofit accountability
  - Schedule H to describe charitable activities
  - Community health needs assessment
ACA and teaching health centers

- New entity, created by ACA
- To address primary care needs in underserved areas
- Primary care residency programs at CHCs
- Evidence that graduates are more likely to practice permanently in underserved areas
- Growth marginal
  - Too little funding
  - Administrative constraints on CHCs to run them
ACA and dental workforce

- Growing understanding of link between oral and physical health
- Concerns about underserved areas and populations
  - HRSA – need 9,500 professionals to reduce ratio in shortage areas to 1 to 3,000 people
- Support dental training programs
- Faculty loan repayment
- Alternative dental providers – controversial
- Funding authorized, not appropriated
- CT very contentious scope of practice issues
  - i.e. dental hygienists practicing without on-site dentists in safety net settings
ACA and community health workers

- From public health sector, disparities
- Community-based workers that focus on care coordination, prevention and disease management
- Ongoing CER on effectiveness, appropriate populations, supervision, training, certification, savings
- ACA includes CDC grants to improve health in underserved areas through CHWs
  - Not funded
- CMS now allows payment of CHWs through Medicaid
- Exchange navigation function
- Team based care and payment reforms encourages use of CHWs
- ACA State Innovation Model grants – many include CHWs
ACA and CHCs, free clinics

• Difference between CHCs and free clinics
  – 15 CHC programs in CT with multiple sites, 7 CT free clinic sites
• CHCs are highlighted throughout the ACA
• Teaching Health Centers
• Payment improvements
  – Primary care reimbursement in rates
  – Equalize private plan Medicaid and Medicare payments
• $11 billion for program expansion
• $1.5 billion/5 years for National Health Service Corp funding
  15,000 more providers
• Navigator funding to enroll uninsured in AccessHealthCT
Workforce shortage concerns

• Concern that people will buy coverage but not be able to access health care
  • MA experience
• Drivers – aging population, aging health care workforce, young adult out-migration, academic concerns in pipeline
• Need for new skills – HIT, teams, CER, new technologies, problem solving, patient safety, patient education/self-help
Workforce shortage concerns?

- Differing perspectives on whether there is a primary care shortage
  - NPs, PAs counted
  - New delivery models – i.e. teams
  - Technology – i.e. e-consults
  - Demand not clear
Options

• Train more primary care physicians
  • Probably not enough
  • Maybe not even the optimal option
• Expand scope of practice
• Teams can care for more people, better
• Engage nurses, pharmacists, CHWs – everyone working at the top of their license
• Standing orders for coaches – to coordinate, prevention, ongoing chronic care needs
• Increase self-care options
• Harness technology – i.e. telemedicine, e-consults, decision support
Other trends impacting workforce

- Aging population, aging health care workforce
- Rebalancing LTC from institutions to home care
- Growing HIT needs
- Emphasis on quality over volume
- Care coordination emphasis
- Care for people in context, social determinants
- Focus on patient-centered care
- Emphasis on self-management of health, patient education
CT aging population

CT population change
2000-2030

% change

age

65+ 45-64 25-44 18-24 under 18

-20 -10 0 10 20 30 40 50 60 70 80
CT aging population needs

need for primary care providers/100,000 population

<table>
<thead>
<tr>
<th>Age</th>
<th>Need for Providers</th>
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<tbody>
<tr>
<td>75+</td>
<td>280</td>
</tr>
<tr>
<td>65-74</td>
<td>160</td>
</tr>
<tr>
<td>45-64</td>
<td>100</td>
</tr>
<tr>
<td>25-44</td>
<td>50</td>
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<tr>
<td>18-24</td>
<td>20</td>
</tr>
<tr>
<td>under 17</td>
<td>20</td>
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</table>
The federal Health Resources and Services Administration designates Health Professional Shortage Areas as having shortages of primary medical care, dental, or mental health providers.

As of Sept 2009: http://bhpr.hrsa.gov/shortage/
Qualified CT nursing students turned away

Qualified Students Turned Away from CT Baccalaureate and Graduate Nursing Programs (Applications)
CT needs more nursing faculty
CT nursing faculty aging

Average Age for CT Faculty
2004-2013

52 52 53 54 53 53 53 54 54 54
Requirements of top 30 CT health care job

- 45% require a bachelor’s degree
  - 33% high school diploma
  - 11% associate’s degree
  - 11% graduate/professional degree
- 34% require under 1 year experience
  - 26% require 1-3 years experience
  - 31% require 4-7 years experience
  - 9% require 7+ years experience
Still to do

• ACA primary care incentives – need funding
  • Will they be enough?
  • Concern about co-opting new primary care slots to specialty care
• Better data on workforce capacity and future needs
  • Consider primary care, behavioral health, nursing, pharmacy, other areas of shortage
• Improve pipeline programs, supports
• More training slots, faculty
• Family caregiver support
  • More elderly get care from family members than paid caregivers
• Long term care – capacity, rebalancing
CT thoughtleaders on workforce