

# Arkansas Health Workforce Stakeholder Meeting

September 6, 2011



# Key Assumptions & Workgroup Charge

Dr. Joe Thompson

# Health System Transformation: Key Assumptions

- **Supply, capacity and distribution**
  - insufficient to meet the needs of Arkansans
  - likely not to change in the short term
- **Serious gaps in quality and safety**
  - racial and ethnic disparities
  - geographic barriers that negatively impact care in rural and underserved communities



# Health System Transformation: Key Assumptions

- **System changes (Health IT, provider payment and service delivery) will require new and enhanced workforce competencies, skills, training and practice patterns**
- **In 2014**
  - **approximately 251,000 Arkansans will become eligible for Medicaid**
  - **approximately 200,000 Arkansans will qualify for premium subsidies**



# Health System Transformation: Key Assumptions

- **Even absent reforms in the Affordable Care Act, demand for health care services will be driven by**
  - **rapidly increasing population of elder Arkansans**
  - **general population that experiences differentially high rates of chronic disease**



# Charge from the Governor

- **Ensure that Arkansas has the appropriate workforce to meet its health needs, including accessibility, efficiency and quality of care**

# Demand Issues: Lessons Learned

Dr. Joe Thompson

# Assurance of Demand

- **Supreme Court will likely take up the issue of the individual mandate in October**
- **Courts have been unanimous in upholding Congress's power to expand Medicaid**
  - **251,000 newly eligible for Medicaid in Arkansas**
- **Remainder of law, including employer mandate and tax credits for small businesses now and individuals later, are still intact**
  - **41,000 businesses currently eligible for credits**
  - **150,000 to 200,000 individuals eligible for tax credits in 2014**



# Assurance of Demand - Continued

## *Massachusetts After 2006 Health Care Reform*

### **General Internists**

- **Wait times went from 33 to 52 days in the year after reform**
- **Percentage of offices accepting new patients dropped by 13% in the year after reform**

### **Family Medicine**

- **Wait times went from 34 to 44 days in two years after reform**
- **Percentage of offices accepting new patients dropped by 23% over four years after reform**



# Assurance of Demand – Continued

## *Oregon Medicaid Experiment:*

**Medicaid coverage increases the use of health care.**

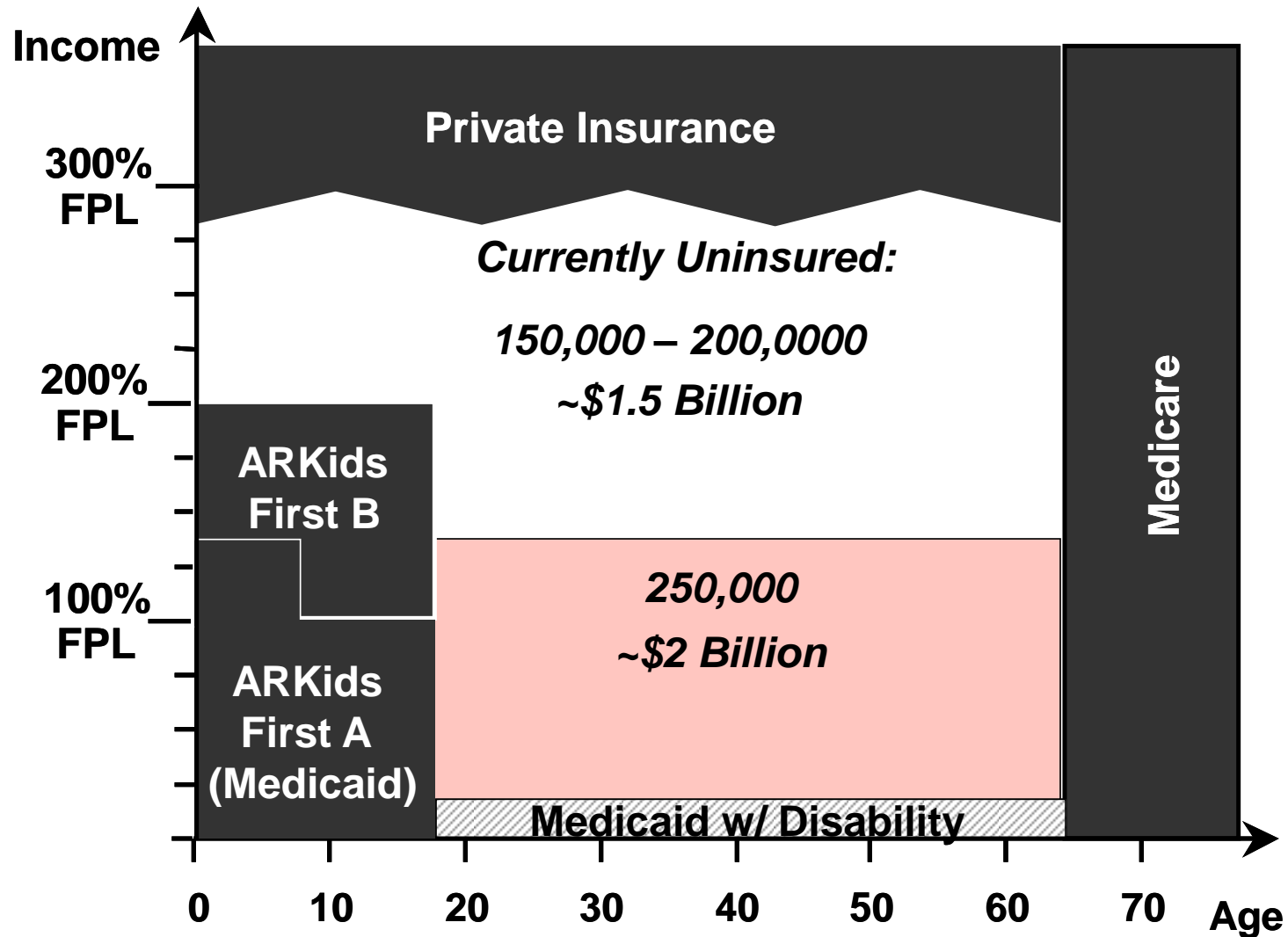
- **35% increase in probability of using outpatient care**
- **15% increase in use of prescription drugs**
- **30% increase in hospital admissions**
- **70% more likely to report having a regular place of care and 55% more likely to have a usual doctor**

**Increased use of preventive care**

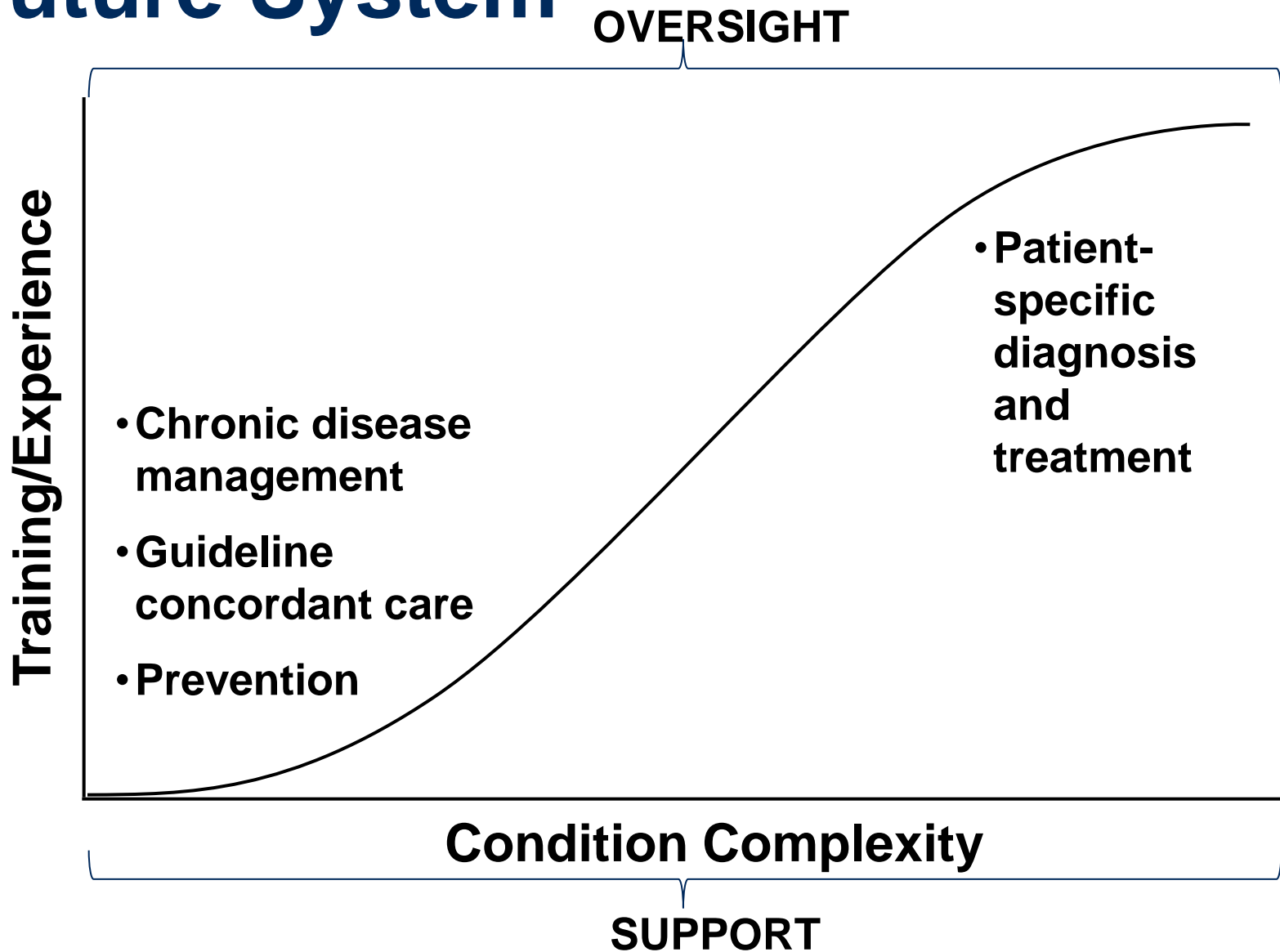
- **60% increase in mammograms**
- **20% increase in cholesterol monitoring**

*(“The Effects of Medicaid Coverage—Learning from the Oregon Experiment,” NEJM, July 20, 2011)*

# Potential Arkansas Health Insurance Coverage



# Future System



# Dealing with Demand: A New Care Delivery System

Dr. Dan Rahn

# Meeting Current & Future Demand: A New Care Delivery System

Care Concept	What does this mean for the health workforce?
Utilize case managers, care coordinators, patient navigators, etc.	Key components to help improve patient outcomes and allow providers to focus on necessary care
Provide team-based care	Working in teams rather than as individuals; represents a shift from current thinking and practice
Facilitate use of non-physician providers (APNs and PAs)	Allows all clinicians to practice to top of license; APNs/PAs performing preventive and basic evidence-based care, allowing docs to do what they were trained to do
Utilize HIT	Utilize HIT as a tool to maximize ability of workforce to provide quality, efficient care for patients



# AHRQ: Definition of the Medical Home

- **Patient-centered**
- **Comprehensive care**
- **Coordinated care**
- **Superb access to care**
- **A systems-based approach to quality and safety**

**Health information technology, significant workforce development and fundamental payment reform are critical elements in successfully operationalizing and implementing the key features of a medical home.**



# Patient-Centered Primary Care Collaborative

- **Personal physician – ongoing relationship with a personal physician**
- **Physician directed medical practice – leads a team of individuals who collectively take responsibility for ongoing care**
- **Care is coordinated and/or integrated – across all elements of system and community, so that patients get care when and where they need and want it in a culturally appropriate manner**

Joint Principles of the Patient Centered Medical Home by AAFP, AAP, ACP and AOA – February 2007 (adopted by AMA and over a dozen 18 specialty care organizations)

# Patient-Centered Primary Care Collaborative

- **Whole person orientation – responsibility for providing or coordinating all care for all stages of life**
- **Quality and safety – evidence-based medicine, clinical decision support tools, voluntary performance measures, patient participation, IT utilized appropriately**
- **Enhanced access – open scheduling, expanded hours, new options for communication**
- **Payment – recognize added value of PCMH**



Accreditation Standards for  
Patient Centered Medical  
Homes: Two Examples  
(NCQA & Joint  
Commission)

Dr. Paul Halverson

# PCMH Accrediting Bodies: NCQA and The Joint Commission

## SHARED STANDARDS FOR PCMH ACCREDITATION

**Team-based, continuity of care** in which a qualified, patient-chosen primary care clinician is leading the individual patient care team (physician, APN or PA)

**Access to care** includes clinician availability (via expanded hours, telephone, email, web portal, etc.) as well as culturally and linguistically appropriate patient care and communication

**Comprehensive, coordinated care** is provided internally through development and monitoring of individual care plans and treatment goals, and externally across facilities and transitions of care

**Patient involvement** where patient is part of the care team and is given self-management tools, goals and personal and community resources to support his or her participation in the care plan

**Systematic data collection** used for performance monitoring and to inform and affect improvement activities



# How PCMH Principles and Accreditation Standards Play Out in Everyday Clinical Practice

Dr. Paul Halverson

# PCMH principles and standards: how do they play out in everyday clinical practice?

- ***Patient centered, comprehensive care***
- ***Coordinated, integrated team based care***
- ***Superb/enhanced access to care***
- ***Continuity of care***
- ***Patient involvement***
- ***Population management***
- ***Health IT***



# Strategic Plan Draft Outline

Dr. Joe Thompson

# Strategic Plan Draft Outline

- **Basic overview of the approach to writing the strategic plan, not yet comprehensive**
- **Recommendations from workgroup (and other content experts) will be further explored by staff, then incorporated into recommendations sections**
  - **2-3 Year Recommendations**
    - **Primary**
    - **Secondary**
  - **Long-Term Recommendations**
- **Outline is evolving and changing every day; it will become more detailed**



# Questions for Stakeholder input

- **What are your ideas about what needs to be done to prepare the workforce?**
- **How do we make your idea a reality?**
  - **Create a new body/additional work hours**
  - **Create a new skill in the existing workforce**
  - **Create more capacity in the existing workforce so that workers have more time to do their jobs (more hours in the day through admin efficiencies, etc.)**

