Health Workforce Research Brief
August 2017

Fitzhugh Mullan Institute for Health Workforce Equity
THE GEORGE WASHINGTON UNIVERSITY

What's Changing in the Health Workforce in Next Generation Accountable Care Organizations?

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BACKGROUND

In 2016, the Center for Medicare and Medicaid Services (CMS) launched the Next Generation (Next Gen) Accountable Care Organization (ACO) with 18 initial participants. Significant research has been dedicated to assessing whether ACOs help lower cost and improve quality of care[1,2], but relatively few studies have focused on how workforce roles have shifted to achieve these goals. We know that there is variation in care models across ACOs, which could explain some of the differences in ACO outcomes with no evidence that a single care model is emerging.[3] This study explores workforce strategies in Next Gen ACOs to identify common themes with regard to changes they believe are responsive to Next Gen and other value based care payment programs. We also examine the use of Next Gen waivers to advance the use of telehealth, home visits, and reduce hospital stays prior to admission to a skilled nursing facility (SNF), and ask whether these changes are affecting the workforce.

METHODS

We invited leadership at the 18 Next Gen ACOs to participate in semi-structured telephone interviews to discuss how the health workforce might be changing to support the Next Gen ACO model. Seven sites agreed to participate. Two sites indicated they were no longer a Next Gen ACO, three declined, and we received no response from five. We recorded interviews and transcribed them. Each was subsequently reviewed for thematic patterns by two research team members.

FINDINGS

Most of the key workforce changes that participants referenced were established prior to implementation of the Next Gen ACO, often as part of participation in earlier Medicare ACOs, or patient centered medical home (PCMH) activities. All of the ACOs emphasized the importance of ***team-based primary care*** and ***care coordination/care management teams*** that cover multiple practices or regions, sometimes with a focus on managing transitions of care.

Staffing models and ratios varied across ACO, but generally included the following key roles: ***RN care managers*** for medically complex patients; ***social workers as case managers*** for those with complex psycho-social needs; ***behavioral health specialists*** to provide short term counseling services and connect patients with psychiatrists or other counseling services for ongoing behavioral health needs; ***clinical pharmacists*** for high-risk patients with complex medications and/or medication adherence challenges; ***care coordinators*** (sometimes referred to as ***health navigators*** or ***patient care advocates***) to help with logistics, such as ensuring patients have an appointment and checking with them to see if they

KEY FINDINGS

1. Next Gen ACOs report varying scale and scope of their investments in team-based primary care and in care management/care coordination teams for high risk populations
2. Most expanded workforce roles that they believe support the Next Gen ACO were established years earlier and frequently support all patients, versus Next Gen exclusively.
3. Competing demand and other factors have prevented most ACOs from rolling out wider scale changes for one or more workforce strategies (e.g. embedding behavioral health in primary care, hiring more medical assistants to enhance team based care, or implementing telehealth).
4. Future research should develop metrics for assessing the scale and scope of workforce investments to support value based care in order to better understand how workforce contributes to quality and cost.

showed up; ***data analysts*** that develop robust ***risk stratification models*** are needed to ensure resources are targeted to the right patients. Most of the participating sites were also developing ***in-house ACO leadership*** and management expertise, building off of their own earlier experiences with value based care, and some were providing consulting services to other organizations with these human resources.

In addition, new jobs are emerging at a handful of sites. ***Encounter specialists*** are typically medical assistants who participate in team huddles to develop the care plan, remain in the room during the patient encounter to document the visit (similar to scribes), assist with care plan reinforcement, and schedule any follow-up appointments. ***SNFists*** are primary care physicians that function like hospitalists except they are in a skilled nursing facility (SNF) doing rounds and helping to coordinate care. ***Community paramedics*** are firefighter EMTs that go to patients homes post- hospital discharge to support the care plan and check on food security and patient safety. ***ED navigators*** are paramedics that help divert away from ED admissions – when appropriate – and help connect patients with next day urgent care or specialist appointments. ***Extensivists*** are primary care providers who focuses on highly complex patients in collaboration with a pharmacist, health navigator, behavioral health specialist (LCSW), and an encounter specialist (role discussed above).

Bandwidth issues (lack of time amidst other transformation efforts), unclear regulations, shortages of particular professions, cultural barriers, and/or financial constraints, in some cases prevented sites from adopting new roles, jobs or fully expanding new approaches. All of the ACOs indicated workforce investments were funded by the health systems in the hopes of shared savings. Most view these as a strategic investment in the transition to value based care and indicated that the new resources are not always exclusive to Next Gen patients, but the shared savings helps to cover costs. Few sites took advantage of the new Next Gen waivers that allowed telehealth visits for non-rural patients or home visits post discharge, stating they were too complex. However, most did take advantage of the new SNF waiver of a three day hospital stay. In some cases, sites placed staff at the SNF to help improve coordination between hospitals, SNFs and primary care.

CONCLUSION

Informants report that there are a plethora of new roles and new jobs emerging in the context of a shift to value based payment, but that transforming the workforce to support value based care takes time. Most of the new workforce roles and jobs identified were initiated as part of earlier value based care activities at the health system and are consistent with workforce roles identified in studies of earlier ACOs.[3]

POLICY IMPLICATIONS

Findings from this study suggest that health systems view investing in team based care and care coordination staff for the Next Gen ACO as an investment in their larger ongoing transition to value based care. Given the variation in workforce staffing across sites, as well as the risk stratification approaches used, future research should develop an approach to standardize the measurement of workforce investments conceived in the context of efforts to shift to value based care. New workforce metrics could help inform staffing configurations vis-à-vis different risk models to maximize improvements in quality and cost of care. This work could also help identify payment models that best incentivize health systems to invest in optimal staffing configurations.

References:

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This work is funded through HRSA Cooperative Agreement U81HP26493: Health Workforce Research Centers Program