



CareerSTAT

JOBS FOR THE FUTURE AND THE
NATIONAL FUND FOR WORKFORCE SOLUTIONS

IMPLEMENTING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

IMPACTS ON THE FRONTLINES OF CAREGIVING

By Randall Wilson

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CareerSTAT is an initiative to document and endorse the business case for investments in frontline hospital workers and to establish an employer-led advocacy council to promote investments that yield strong skill development and career outcomes for low-wage, frontline hospital workers.

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EXECUTIVE SUMMARY

The National Fund for Workforce Solutions and its implementation partner, Jobs for the Future, have conducted research examining the impact of the Patient Protection and Affordable Care Act (ACA) on the frontline health care workforce as part of CareerSTAT, an initiative to document and endorse the business case for investments in frontline hospital workers based on health care leader recommendations. This report includes reviews of current literature and data sources, as well as interviews with executives and practitioners in hospitals, primary care clinics, and long-term care institutions.

This report is intended to assist health care leaders, policymakers, and practitioners in gaining a greater understanding of the workforce implications of the ACA in general and, in particular, for frontline workers: the number; the skills needed; and changes in job duties and career paths that result from the ACA.

With the introduction of the ACA, the role of frontline workers will need to be reevaluated and refined, which calls for resources to be invested in this work to ensure ACA goals are met.

Frontline workers include medical assistants, patient intake coordinators, medical coders, dietary staff, and many more.

The ACA is designed to transform health care by extending coverage to the uninsured, while measuring the patient experience, lowering health care costs, and creating better health outcomes.

To hold down costs and improve the quality of care, the ACA changes the way hospitals and other health

care providers are paid for services, while holding them to new performance standards. It supports models such as Accountable Care Organizations and Patient-Centered Medical Homes, to aid in coordinating care for an individual patient across multiple settings.

The ACA is impacting the delivery of health care in other ways, including an emphasis on primary care over hospital-based care. This means greater emphasis on the use of primary care providers and community health centers and a concerted focus on avoiding readmissions, and promoting prevention and wellness. Most organizations have focused on the organizational, strategic, and patient implications of the ACA, but to date, many of them have yet to fully plan for the impact of the ACA on frontline and other workers.

Recently, due to the downturn in the economy, reduced turnover, and delayed retirements, the need for workforce development to fill vacancies and retain staff has lessened. Yet organizations have still focused resources on developing workers who require a college degree, including doctors, nurses, physician assistants, and allied health professionals, with too few focusing attention on the need to prepare frontline workers for higher performance and skill levels.

The volume of workers needed to meet new patient demand, at the frontlines and higher levels, is not yet fully clear, nor is the specific composition of the workforce needed to implement the ACA. While estimates vary as to supply and demand for physicians and support and

technical staff, hospitals contributing to this report did not expect to add staff. However, others say that they are actively hiring for new and replacement positions in underserved communities and high-growth areas in the South and Mountain West regions, where older Americans tend to migrate. More and better data are needed to plan for the skills and workforce needed under the ACA.

The U.S. Bureau of Labor Statistics estimates that the fastest growing health care occupations represent a mix of health care support jobs.

These include personal care and home health aides—required for a rapidly aging population—and other roles, including physical therapy assistants, diagnostic medical sonographers, and dental hygienists. Job growth will concentrate in primary care settings, including physicians' offices and outpatient care centers.

The aims of the ACA—higher-quality health care at a lower cost—will require higher skill and performance levels for all staff. Essential skills include teamwork, effective communication, problem solving, critical thinking, and technology skills.

Skill needs will shift based on the patient care setting. The ACA is accelerating the need for new or enhanced frontline roles in order to implement new models of delivering care. For example, direct care providers need a deeper understanding of

patients with complex physical and behavioral needs; observational skills to ensure patient safety and inform care teams of patient changes; and strong interpersonal skills. Other roles that are evolving include health coaches, educators, care coordinators, patient navigators, care transition managers, and case managers. These roles are not yet well defined or standardized, and in some cases are assumed by existing staff as a part of their regular duties.

Implementing the ACA offers a strategic opportunity to improve patient care and health while improving the jobs and career opportunities of frontline workers.

The opportunities extend to new employment options and skill enhancement; expanded job responsibilities in direct care, administration, and technical support; increased support for investment in talent development and career mobility; and enhanced respect and engagement of this workforce. Serious challenges exist, including: cost constraints, which could limit talent development programs and new hires; insufficient resources to finance new care models and responsibilities; limited educational capacity of smaller providers in outpatient and clinical settings; erosion of career paths, such as from nurse assistant to licensed practical nurse to registered nurse; and a lack of clear standards and credentials for roles, such as care coordinators and patient navigators.

KEY RECOMMENDATIONS

HEALTH CARE EMPLOYERS

- > Implement workforce planning and analysis functions
- > Invest in worker skills and career advancement to ensure success under the ACA
- > Create or augment career ladders to ensure success under the ACA
- > Measure the impact of investments in frontline workforce development on critical outcomes, including patient satisfaction and preventable readmissions
- > Promote greater transparency with employees on core measure results
- > Develop shared standards and definitions for emerging health care occupations

POLICYMAKERS

- > Refocus data collection and projections to better understand present and future needs for health care labor and skills with an eye on frontline workers
- > Examine potential strategies for reforming Medicaid and Medicare reimbursement for paraprofessional services and training
- > Advocate for investment in upgrading of low-quality, but essential, frontline jobs, in particular home health aides, personal care aides, and similar roles

PUBLIC, PRIVATE, AND NONPROFIT EDUCATION AND WORKFORCE ORGANIZATIONS

- > Create incentives for skill development needed to meet ACA goals
- > Help build the capacity of smaller health care employers, especially primary care clinics, to offer training and educational opportunities to frontline staff
- > Enlist public and private workforce entities in piloting, documenting, and scaling promising practices in communities and in health care employers

PHILANTHROPY

- > Support efforts to analyze the impact of the ACA on frontline workers
- > Promote new training investments for frontline workers impacted by the ACA

INTRODUCTION

Much has been said and written about the Affordable Care Act.¹ Debates have extended to the proper role of government in health care and insurance coverage; the adequacy of the legislation to meet its stated goals of lower-cost, higher-quality care with better health outcomes; and our capacity to implement a highly complex set of changes in the ways that we pay for, deliver, and receive health care services. One thing that is beyond debate, is that realizing the goals of the ACA requires the work of millions of practitioners at all levels—from the most highly trained physicians and nurses, to those serving at the “frontlines” of health care, taking vital signs and patient information, maintaining medical records, and providing care for those who are elderly or disabled.

This report presents the implications of the ACA for frontline workers in health care: what kinds of workers are needed, and how many; what skills they will need; how their jobs will change with health care reform; and, centrally, what opportunities the ACA presents for improving the jobs and career possibilities of this critical and overlooked workforce. Implementation of the ACA is a work in progress, from establishment of health insurance exchanges to extend coverage, to creation of new arrangements for financing health services and delivering care. For this reason, the findings reported here should be considered preliminary.

Workforce development initiatives in health care have focused largely on ensuring a supply of highly trained practitioners, such as doctors, nurses, and physician assistants. The role of frontline workers—

such as medical assistants, nursing assistants, patient intake coordinators, medical coders, and even dietary staff—in meeting ACA goals has received far less attention. Yet frontline staff spend a significant portion of time with patients. This makes it vital to understand how the ACA will affect this workforce: the skills and responsibilities these workers will require to improve patient experience and reduce readmissions, and the volume of frontline workers needed to provide care for the newly insured.

To fill this gap and to identify opportunities and challenges ahead for the frontline workforce, Jobs for the Future, with the National Fund for Workforce Solutions—as part of the CareerSTAT initiative—conducted research, including: a scan of current literature and data sources; a series of interviews and discussions with executives and practitioners in hospitals, primary care clinics, and long-term care; and presentations of preliminary results to health care and workforce development representatives. This report summarizes the findings from this research, makes recommendations for further analysis, and offers action steps to address frontline workforce implications of the ACA. It is designed to be a resource for health care and workforce practitioners, policymakers, and all others with a stake in maximizing access to high-quality, low cost health care for all, and access to good jobs and career paths for the workforce that deliver care at the frontlines.²

The report begins with an overview of the Affordable Care Act and the law’s chief goals and

provisions, particularly those most relevant to the health care workforce. It then presents current projections and trends for frontline and middle-skill occupations critical to implementing health care reform. It also discusses some of the limitations of these estimates and possible alternate scenarios.

Presented here are findings from employers and other key informants about the skills and competencies required of frontline health care workers to meet the goals of the ACA. These include general skills needed by all health care professionals, and those needed for particular occupations, including direct care, patient service/administrative roles, and health information technology roles. The report also presents evidence about new roles emerging to support changing models of health care delivery, including health

coaches, care coordinators, and occupations that combine formerly separate roles, such as medical assistant and patient service representative.

The report then explores opportunities for frontline health care workers to take on higher-skilled roles and enter career pathways, and some promising models of workforce development in support of such advancement. It examines new models of frontline employment and training, including examples from Maryland, Ohio, New York, and California, as well as a sampling of health clinics and hospitals that are innovating new models for preparing the ACA frontline workforce. It concludes with recommendations and next steps for ensuring that frontline workers in health care are fully integrated into our efforts to provide high-quality care and improved health at lower costs.

OVERVIEW OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act is transformative. This complex and far-reaching legislation exceeds 2,000 pages and represents the largest expansion of the nation's social safety net in generations. (Medicare and Medicaid were established in 1965.) Outside of policy specialists, few have been able to review all the provisions of the bill, and like any complex legislation, the ACA offers broad guidelines rather than specific instructions on achieving its many goals, such as paying for "value" (performance on health care outcome measures) versus "volume" (health care services provided). As a result, practitioners in government and health care, along with consumers, insurers, and frontline health care staff, have the task of making implementation work on the ground, and that is where specific requirements for the health care labor force will become clear.

The legislation is best understood as an effort to accomplish two things:

- > Make health care accessible to more people
- > Improve the process of delivering care, to lower costs, increase quality, and improve health outcomes

To achieve the first goal, the ACA prevents insurers from denying care to those with pre-existing conditions and extends insurance to those lacking it. This is done through creation or harnessing of

private insurance markets, or "exchanges," from which consumers can obtain information and purchase a policy. It provides for subsidies to make insurance affordable to those buying policies on the exchanges and for the expansion of Medicaid coverage to those with incomes up to 138 percent of the poverty line. Young adults up to age 26 are allowed to remain on their parents' insurance plan. To ensure that the pool of the insured includes healthy Americans, as well as those needing more care, there is a mandate for uninsured individuals to buy insurance or pay a penalty. Moreover, employers of 50 or more workers are required to provide insurance to their full-time staff or face a penalty. Smaller firms (under 25 workers) are eligible for tax credits to cover a portion of the cost of premiums paid for their employees.

The second goal—delivering better care—rests on this insight: The U.S. spends more on health care per capita than any industrialized nation, but achieves less in a variety of outcomes measures, including life expectancy and mortality (Berwick, Nolan, & Whittington 2008).³ In 2010, total health care expenditures topped \$2.6 trillion, or more than \$8,000 per person. Nearly 18 percent of GDP is devoted to it (OECD 2013). While the rate of growth in health expenditures has slowed in recent years, our system remains the world's most expensive, which represents trade-offs with other social goods,

such as education or improved infrastructure. And a good portion of this spending goes to waste: 30 percent, according to the Institute of Medicine, or a total of \$750 billion in 2009. The “waste” includes unnecessary or inefficiently delivered services, missed opportunities for prevention, excessive prices and administrative costs, and fraud (Berwick & Hackbarth 2012; IOM 2012).

To counter these trends—“bending the cost curve” while improving quality—the ACA requires rethinking health care and its financing and delivery in fundamental ways:

- > From treating sickness to promoting wellness and prevention
- > From paying by volume of services to paying for value, or performance outcomes
- > From emphasizing acute care to primary or outpatient care
- > From treating care in isolated episodes to coordination across the continuum of care and across disciplines
- > From treating chronic disease in isolated individuals to managing care among populations
- > From paper-based management of patient records and transactions to electronic health records
- > From doctor (and system)-centered care to patient-centered care, with decision making shared by caregivers, patients, and their families

This ambitious agenda will be pursued by changing the way health services are paid for and the way they are carried out by practitioners, including the staffing and location of care. At the same time, the law extends responsibilities for health improvement to patients, families, and communities.

The ACA authorizes a variety of mechanisms to realize the goal of better care and improved health at lower cost. They include payment reforms, such as “value-based purchasing” and bundled payments, in place of paying practitioners a fee for individual services. These aim to drive down costs and increase efficiency, as well as hold hospitals and physicians to high performance standards.

Ways of gauging standards include survey-based measures of patient experience (Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS); outcome measures, based on heart attacks, congestive heart failure, and pneumonia, as well as incidents of hospital-acquired infections; and rates of preventable readmission of patients after 30 days. Failure to meet these standards results in a reduction in Medicare reimbursement, with the percentage rising incrementally from 1 to 2 percent cuts between 2013 and 2017. By August 2013, 225 of the nation’s hospitals had received payment reductions totaling \$227 million for excess readmissions in the second round of penalties (Macdonald 2013).

Health reform has also brought changes in the way care delivery and payments are organized. It enables hospitals, clinics, and physicians to form networks known as “Accountable Care Organizations,” or ACOs. This arrangement encourages health practitioners to coordinate care for an individual patient across multiple settings, and holds them accountable for the quality and cost of care for 5,000 Medicare recipients. Budgets are tied to per-patient costs, and payments hinge on meeting quality metrics. ACO member-providers share cost savings and also share in decision-making across the continuum of care (AHA 2010).

Another key institutional lever for achieving lower cost, higher-quality care is the Patient-Centered Medical Home (PCMH). Like ACOs, the PCMH model predates the ACA, but the law supports states in expanding or initiating PCMH sites.⁴ It also shares with the ACO the goal of improving coordination of care, and facilitating transitions or “hand-offs” between acute care, outpatient, and home-based or long-term care. The medical home, however, is centered on primary care. It may be anchored in a clinic or physician practice, but at its core, it is not a physical place, but a model for organizing primary care (AHRQ n.d.). The Commonwealth Fund, an advocate for improved access to health care, defines Patient-Centered Medical Homes as:

“A primary care site that provides patients with timely access to care, including availability of appointments after regular office hours (especially evenings and

weekends), partners with patients to manage health conditions and prevent complications, coordinates all care, and engages in continuous quality improvement.” (Abrahms et al. 2011)

The essence of the medical home is a provider who serves as the central point for day-to-day health maintenance and for referring patients to specialists. The provider could be a physician, a nurse practitioner, or physician assistant, in some models. In all cases, the goals are patient-centered and coordinated care no matter who is providing it, or where; reducing costs (by avoiding duplication); and improving the overall quality of care. The ACA provides grants, demonstration programs, and a variety of incentives to refine and scale Patient-Centered Medical Homes (Hawkins & Groves 2011).

The medical home is accountable for quality improvement, cost control and, in some cases, the patient experience rating. To control costs, all staff—from clinicians to support staff—are expected to function at “the top of their license,” certification, or job description. For clinicians, this means focusing on patient diagnosis and treatment, and delegating more routine functions to frontline staff, such as refilling prescriptions, ordering mammograms, or entering medical record data. It implies expanded duties and skill development for staff serving doctors and nurses, such as medical assistants, practice managers, or patient service representatives and similar “front desk” roles.

Just as the roles of individual staff change under ACA—and in medical homes in particular—so does the organization of the workplace. The PCMH and ACO models were developed to improve coordination among care locations, but also within them. Team-based, interdisciplinary care is required to deliver coordinated and comprehensive care. Teams might consist of physicians, advanced practice nurses, physician assistants, medical assistants, nurses, pharmacists, nutritionists, social workers, educators, behavioral health specialists, and care coordinators (AHRQ n.d.; Altschuler et al. 2012). A research study concluded that 47 percent of the tasks a physician performs could be delegated successfully. The researchers observed that this degree of delegation assumes that non-clinicians can take on many

routine chronic care services such as “patient education, behavior-change counseling, medication adherence counseling, and protocol-based services delivered understanding physician orders” (Altschuler et al. 2012). To be sure, team-based care, especially with delegation on this model, requires a change in work culture that challenges traditional top-down models of organization and specialization, and encourages collaboration and information sharing.

A further touchstone of the ACA is the goal of changing both the location of care and the ability to treat specific populations effectively. This means emphasizing the use of primary care, including physician practices, community health centers, and other outpatient settings. By expanding access to care, redirecting care from emergency rooms, and reducing preventable readmissions to the hospital, costs can be lowered and long-term outcomes improved—especially for populations living with chronic diseases, such as diabetes or heart conditions.

Among the measures to promote greater use of primary care, in addition to PCMH, are 10-percent bonuses for physicians, nurse practitioners, and physician assistants to treat Medicare patients, and increased reimbursements to those serving beneficiaries of Medicaid (Davis et al. 2011; Abrahms et al. 2011). These policies recognize the need to strengthen the primary care workforce by expanding access to care and reducing disparities. They also assume a changed role for acute care, where only the sickest patients, or those needing highly specialized care, will be treated in hospitals.

Other policies authorized by the ACA also shift the focus of care from hospital to clinic or home. These measures give priority to avoiding hospitalization and remaining in one’s home; patient self-management of chronic disease; and prevention of disease. The measures include demonstration programs that offer in-home primary care services for high-need Medicare beneficiaries, and extension of full Medicaid benefits to those receiving home- and community-based services. These policies acknowledge a rapidly aging population and older individuals with higher acuity (Spetz 2012). These policies also have a concerted focus on so-called

“frequent fliers”—individuals with multiple chronic conditions and other characteristics that predict recurring use of emergency and acute care service, including poverty, substance abuse, or obesity. The frequent user population represents just 5 percent of the patient population, but accounts for almost 50 percent of health expenditures, or \$623 billion (Schoenman 2012).⁵ To better manage the health of this population, the ACA supports innovative care models, such as Medicaid Health Homes, community care teams, and other practices that stress coordinated care, preventive services, and self-management of chronic conditions.

Central to improved treatment of these patients is better coordination of care. When coordination among providers breaks down, it is not only costly, but dangerous, as when medical records are not shared or updated: people fail to get the care they need, or suffer when medical errors occur.⁶ Building on the Patient-Centered Medical Home model, the ACA allows higher reimbursement for primary care sites designated as Health Homes, but with service directed to Medicaid enrollees with one or more chronic illnesses or a “serious and persistent mental illness.” In addition to fostering links among health providers and assisting patients with transitions, Health Homes also emphasize referral to and coordination with community and social support services (Abrahms et al. 2011; Shockley et al. 2013).

Prevention of illness is also a critical priority of health reform. The ACA dedicated over \$2 billion to a Prevention and Public Health Fund to support prevention, wellness, and development of the public health infrastructure, including the professional workforce. The bill also sets aside funds to encourage health screenings, immunization, and community-based prevention activities to reduce chronic disease rates and health disparities (Spetz 2012). Provisions for health insurance require

payers to provide physicals, mammograms, and other preventive services at no cost. Reimbursement for such services will be extended to non-physician providers, such as nurse practitioners and physician assistants.

Helping patients manage their own care is essential to achieving the “triple aim” of the ACA (lower costs, improved care, and better health outcomes). It can be as simple as ensuring that, when leaving the hospital, a patient already has another doctor’s appointment scheduled, and then following up with reminders to see that appointments are kept or that prescribed medications are taken. Patient education is central—learning about the proper diet, exercise, and other areas that lower risk of disease or complications from chronic conditions. It involves both coaching (setting goals with the patient, for weight loss or smoking cessation, for instance) and case management (ensuring that patients can locate a physician or specialist, obtain social services, or consult a behavioral health provider).

A long-standing institution that has made such services central to its mission is the community health clinic, including Federally Qualified Health Centers. These health centers, which date back to the 1960s, serve a largely disadvantaged population, and are primarily supported by Medicaid. The ACA (and the federal stimulus bill, or American Resource and Recovery Act) expanded support for community health centers through grants for capital improvements and expanded preventive and primary care services (HRSA n.d.).

A program in the ACA provides grants or contracts for care coordination services provided by community health teams that work with primary care practices to integrate clinical and community preventive and health promotion services and offer health coaching and support for medication management (Thomas 2012).

LABOR DEMAND AND THE AFFORDABLE CARE ACT

This section presents estimates of frontline worker demand in key occupations, offering alternative projections to illustrate the possible range of workers needed. It also notes the factors that could shift demand for workers in one direction or another. It does not offer original projections or analysis of workforce demand, which are beyond the scope of this paper.

Even as technologies such as telemedicine and robotic surgery evolve, caregiving remains a labor intensive, face-to-face activity, especially for an aging population. Providing care to tens of millions of newly covered consumers could conceivably increase the need for health care workers at every level, from physicians and pharmacists to home health aides and physical therapy assistants. It is less clear, however, how many additional hands will be needed. Our care models are changing rapidly, and implementation of health reform is in its infancy.

Employers interviewed for this study could not predict their staffing needs in the coming years, in large part because the likely impacts of health reform are not clear, just as the operating model—use of ACOs, and other means to coordinate care and rein in costs—is still taking shape. Moreover, methods for projecting the future health care labor force, such as those used in U.S. government estimates, are hobbled by assumptions that future trends in labor demand will mirror the past. More likely, the ACA era—and its accompanying forces, such as an aging population—will be marked by discontinuities and disruption of past patterns.

The demand for frontline health care workers under the ACA depends on many factors, including:

- > The number of additional patients who will acquire access to health care, whether through exchanges, Medicaid expansion, or employer-provided coverage
- > The level of additional health care services demanded by new users
- > The capacity of health care providers to provide care and employ practitioners and supporting staff
- > Local supply and demand conditions (i.e., rural areas with significant shortages of health practitioners vs. regions with a surplus; capacity of education and training providers to produce trained workers)
- > Care delivery and staffing models used by individual health care organizations or practices, such as the ratio of patients per clinician, and the proportion of non-physician staff on teams
- > Crosscutting trends that may encourage trimming staff as well as adding them, such as lower reimbursements, or technological innovations

Of course, large trends outside of health reform, particularly the aging population and its more intensive needs for care and chronic disease management, and state and national politics, will also drive frontline workforce demand in the ACA era—especially in the direct care occupations, such as nursing assistants, mental health workers, home health aides, and physical therapy assistants.

In late 2013, the health care exchanges had just opened for enrollment. On January 1, 2014, the newly enrolled became eligible to receive health insurance coverage. Current estimates suggest that the insured population from ACA mechanisms will increase by approximately 27 million, with up to 17 million entering through expanded Medicaid, and the balance through health benefit exchanges and employer-based insurance (Wayne 2013).⁷ The Congressional Budget Office anticipates that 14 million will enroll in 2014, and another 6 million the following year (CBO 2013).

The actual number added to the rolls, and the rate at which coverage increases, will depend on personal calculations of risk and benefit—particularly among young and healthy individuals, who are essential to the insurance market's success. It will depend, too, on how well this highly complex system is implemented, from the “navigators” who seek out and assist the uninsured, to the computer systems and staffing arrangements for processing applications. (Predictably, for such a large and untested undertaking, the initial launch and online enrollment has been beset with serious technical glitches). And, of course, politics will play a role, given ongoing federal and state controversies about the legitimacy of “Obamacare.” Approximately half of the states have refused to use ACA support to expand Medicaid coverage (KFF 2013).

Demand for health care labor will depend on other factors beyond the volume and rate of enrollment in insurance: the degree to which newly covered individuals use care, how intensively they use it, and in what venues. Research on usage patterns by those newly enrolled in health insurance indicate an increased use of services, and insured persons use more services than the uninsured, controlling for age, health, and socioeconomic status. This extends to doctor's visits, management of disease, screenings and other preventive practices, and use of prescribed medications (Spetz 2012; Buchmeuller et al. 2005). A recent study of utilization by young people allowed to join or remain on their parents' policies found that use of care increased by 8 percent across all modes, with greater utilization in primary care (Antwi et al. 2013). Other studies point to “pent-up demand,” as those

previously uninsured, who have postponed care, seek treatment (Kirzinger et al. 2012).⁸ Demand for care can increase substantially in such cases. Following the establishment of universal health care in Massachusetts, demand for care by the newly insured spiked, triggering lengthy waits for medical appointments and a shortage of practitioners—leading some to visit emergency rooms (Long et al. 2012). Following this initial wave of enrollment and heightened demand, ER visits fell again (KFF 2012).

It is a safe assumption that millions more will be covered by health insurance in the coming years, and will seek care, in clinics, hospitals, and physician's offices. What impact will this have on health care employment overall, and on demand for specific categories of workers?

Expert opinion on overall trends and their magnitude is mixed. There are both popular and scholarly reports that claim that tens of millions of new patients will require an upsurge in hiring new workers, particularly in primary care. The Association of American Medical Colleges projects a shortage of 45,000 physicians over the next decade (AAMC 2010). Similarly, Gleckman (2011), in *the Journal of the Catholic Health Association*, states that expansion of coverage to the currently uninsured “will dramatically increase demand for primary care and exacerbate the shortages of health professionals.” More modest forecasts predict a need for an additional 7,200 primary care providers over this time period (Huang & Finegold 2013). Implicit in the call for more primary care providers and facilities to avert shortage is a corresponding need for mid-level and support personnel, such as nurse practitioners, pharmacists, medical assistants, and coders to staff new or expanded clinics and practices.

Massachusetts' experience implementing health reform is instructive. Between 2001 and 2005, preceding the onset of reform, growth in health care employment in the Commonwealth equaled the national rate, or about 8 percent. In the following four-year period, coinciding with Massachusetts reforms, growth was nearly double the national rate (9.5 percent versus 5 percent), with the largest additions of jobs occurring shortly after

implementation. Employment growth during this period in Massachusetts was concentrated among administrative, technical, and support staff, including health information technicians and nurse aides. Growth in professional (treatment and diagnosing) employment was more modest (Staiger et al. 2011).

A contrary view holds that gaps in the supply of physicians and other health care staff will not be severe in the wake of health reform. Researchers at Georgetown University's Center on Education and the Workforce even assert that "the net effect of Obamacare on health care jobs" should be negligible (Carnevale et al. 2012). While acknowledging that real shortages will likely occur—notably in the ranks of primary care doctors and other occupations such as nurses, pharmacists, and physical therapists—they believe that such shortages will be geographically concentrated in particular regions. Even now, some 54 million Americans live in areas of health professional shortage, areas also plagued by high unemployment and poor health conditions (Tulenko 2012). And shifts in demand owing to the ACA may lead to a worsening mismatch of patients and providers, especially in the South and Mountain West, which stand to see the largest growth in Medicaid enrollment (Goodell et al. 2011).

The model of care delivery will also shape the workforce demand picture. To the extent that practitioners adopt medical home and similar team-based models of coordinated care, the degree of clinician "shortage" could be lessened. This is because such models delegate certain functions to non-clinician team members, changing the patient load as well as the number of doctors required to treat them (Altschuler et al. 2012; Salsberg 2013).⁹ In a delegated care model that emphasizes team use, both clinics and hospitals could see higher demand for non-physician staff, both mid-level (physician assistants, nurse practitioners) and frontline, including medical assistants, pharmacy technicians, health coaches, and similar occupations.

The stress on cost reduction could also work against large increases in labor demand. Hospitals are experiencing cost pressures in several ways.

One is pay-for-performance arrangements that impose penalties, through reduced Medicare reimbursement to providers, for failure to reach targeted readmission rates and other required measures. Another is independent of the ACA: the automatic, across-the-board federal budget cuts, or "sequestration," imposed in spring 2013 through the Budget Control Act. Like many other items in the federal budget, Medicare reimbursement payments to physicians, as well as costs for physician-administered drugs, are reduced by two percent (AMA 2013).

Hospital leaders interviewed for this study were uncertain about long-term staffing needs, but generally did not expect to add to payrolls in the next one to two years, in part due to cost concerns and uncertainties about patient demand and implementation of new delivery models. Others are reducing staff levels. Major hospitals in Connecticut, Ohio, Virginia, and other states announced cutbacks in 2013. Lawrence and Memorial Hospital, in New London, Connecticut, cited the "sheer magnitude" of cuts in Medicare and Medicaid funding as a source of financial stresses and resulting cuts in both managerial and line staff. Northern Virginia's largest health system, Inova, eliminated 147 jobs in September 2013 (Keedle 2013; Palmer 2013; Fischer 2013a, 2013b).

The impact of value-based purchasing and potential costs from penalties for not meeting targets for avoidable readmission, patient satisfaction, or infection rates, contributes to the reluctance to increase staff investments, according to hospital representatives. And the parallel trend of rising consolidation of services, as large systems absorb or acquire smaller hospitals and medical practices, may also limit growth in health care employment. Functions such as human resources, billing, coding, collection, and other financial and administrative services are vulnerable if seen as duplicative after acquisition and mergers of systems and practices. Health care recruiting consultants in Boston report that mid-level managers, such as nurse managers, could see layoffs as hospitals achieve savings by reassigning direct supervision of staff nurses to nursing directors (Donnelly 2013).

Finally, a long-term factor in employment levels is the prospect for improving the productivity of health care workers. Robert Kocher and his colleagues (2011) argue that the health care sector has added jobs at high rates recently due to a lack of labor productivity improvement, or output per worker. The productivity rate in health care actually fell between 1990 and 2011; only three sectors (construction, personal services, and education) showed less improvement (Carnevale et al. 2012). Current or future adaptations of technology, job organization, and staffing mix, among other changes, could result in greater output—however measured—from the same staffing levels, or from current output levels with fewer staff. Some providers are employing a third option, improving productivity through delegation of tasks to non-physician members of the care team (see page 10) or changing the proportions of staff comprising the care team, as when the ratio of paraprofessionals, such as nurse aides or clinical technicians, to nurses, is increased (see page 19).

ESTIMATES OF WORKFORCE DEMAND

Employment in health care has grown steadily, even during the recession years, when other industries shed jobs, and long-term projections show substantial increases in the sector.

The U.S. Bureau of Labor Statistics projects an addition of 5.7 million new jobs in the broad “health

care and social assistance” sector, 2010-2020, or 28 percent of all new jobs created during that period. This represents a growth rate of 33 percent, compared to 14 percent for all other U.S. industries (Henderson 2012). The BLS attributes this increase to an aging population, coupled with longer life expectancy and new treatments and technologies. For health care occupations (which are largely in the health care sector, but could be in any industry, including retail, education, and manufacturing), growth rates will be similar: a growth of 29 percent, from 10 to 13 million employed. Researchers at the Georgetown Center for Education and the Economy projected this rate of occupational growth as well (Carnevale et al. 2012).

The fastest growing health care occupations, according to BLS estimates, represent a mix of health care support jobs, including personal care and home health aides, and technician roles, including physical therapy assistants, diagnostic medical sonographers, and dental hygienists. An alternate projection by a data firm, EMSI, which extends from 2013 through 2023, predicts growth in similar areas, but at slightly more modest rates of growth and job creation. *Frontline occupations are shaded in blue in tables 1-3 below and on page 12.*

The highest levels of job growth are projected to occur in a mix of professional occupations (such as nurses and physicians), allied health fields (sonographers, physical therapist assistants, EMTs), and support occupations (home health and personal care aides), with the largest new additions for

TABLE 1. OCCUPATIONS WITH THE GREATEST JOB GROWTH, 2010-2020 (IN THOUSANDS)

| OCCUPATION | 2010 EMPLOYMENT | 2020 EMPLOYMENT | CHANGE | % CHANGE |
|--|------------------|------------------|-----------------|--------------|
| Registered Nurses | 2,737.4 | 3,449.3 | 711.9 | 26.0% |
| Home Health Aides | 1,017.7 | 1,723.9 | 706.3 | 69.4% |
| Personal Care Aides | 861.0 | 1,468.0 | 607.0 | 70.5% |
| Nursing Aides, Orderlies, and Attendants | 1,505.3 | 1,807.2 | 302.0 | 20.1% |
| Medical Secretaries | 508.7 | 718.9 | 210.2 | 41.3% |
| Licensed Practical and Licensed Vocational Nurses | 752.3 | 920.8 | 168.5 | 22.4% |
| Physicians and Surgeons | 691.0 | 859.3 | 168.3 | 24.4% |
| Medical Assistants | 527.6 | 690.4 | 162.9 | 30.9% |
| Total, All Occupations | 143,068.2 | 163,537.1 | 20,468.9 | 14.3% |

Source: U.S. Bureau of Labor Statistics, OES

TABLE 2. FASTEST GROWING HEALTH CARE OCCUPATIONS: 2010-2020 (IN THOUSANDS)

| OCCUPATION | 2010 EMPLOYMENT | 2020 EMPLOYMENT | CHANGE | % CHANGE |
|--|------------------|------------------|-----------------|--------------|
| Personal Care Aides | 861.0 | 1,468.0 | 607.0 | 70.5% |
| Home Health Aides | 1,017.7 | 1,723.9 | 706.3 | 69.4% |
| Biomedical Engineers | 15.7 | 25.4 | 9.7 | 61.7% |
| Veterinary Technologists and Technicians | 80.2 | 121.9 | 41.7 | 52.0% |
| Physical Therapist Assistants | 67.4 | 98.2 | 30.8 | 45.7% |
| Diagnostic Medical Sonographers | 53.7 | 77.1 | 23.4 | 43.5% |
| Occupational Therapy Assistants | 28.5 | 40.8 | 12.3 | 43.3% |
| Physical Therapist Aides | 47.0 | 67.3 | 20.3 | 43.1% |
| Medical Secretaries | 508.7 | 718.9 | 210.2 | 41.3% |
| Physical Therapists | 198.6 | 276.0 | 77.4 | 39.0% |
| Dental Hygienists | 181.8 | 250.3 | 68.5 | 37.7% |
| Audiologists | 13.0 | 17.8 | 4.8 | 36.8% |
| Health Educators | 63.4 | 86.6 | 23.2 | 36.5% |
| Medical Scientists, Except Epidemiologists | 100.0 | 136.5 | 36.4 | 36.4% |
| Mental Health Counselors | 120.3 | 163.9 | 43.6 | 36.3% |
| Veterinarians | 61.4 | 83.4 | 22.0 | 35.9% |
| Total, All Occupations | 143,068.1 | 163,537.1 | 20,468.9 | 14.3% |

Source: U.S. Bureau of Labor Statistics, OES

TABLE 3. FASTEST GROWING HEALTH CARE OCCUPATIONS 2013-2023 (IN THOUSANDS)

| OCCUPATION | 2013 EMPLOYMENT | 2023 EMPLOYMENT | CHANGE | % CHANGE |
|---|-----------------|-----------------|---------|----------|
| Home Health Aides | 1,086,244 | 1,562,590 | 476,346 | 44% |
| Veterinary Technologists and Technicians | 86,026 | 119,881 | 33,855 | 39% |
| Diagnostic Medical Sonographers | 58,478 | 77,806 | 19,328 | 33% |
| Physical Therapist Assistants | 71,957 | 94,825 | 22,868 | 32% |
| Occupational Therapy Assistants | 31,865 | 41,700 | 9,835 | 31% |
| Physical Therapist Aides | 50,917 | 65,986 | 15,069 | 30% |
| Audiologists | 13,736 | 17,394 | 3,658 | 27% |
| Physical Therapists | 206,374 | 261,142 | 54,768 | 27% |
| Emergency Medical Technicians and Paramedic | 235,682 | 296,977 | 61,295 | 26% |
| Dental Hygienists | 193,311 | 240,358 | 47,047 | 24% |

Source: EMSI

nurses and home health aides. Other occupations that are driven by an aging population needing home or residential care are also predicted to grow, including nursing aides and licensed practical nurses.

The drive to lower the cost of care and keep patients out of hospitals, if possible, is reflected in projections of where job growth will occur: in primary care settings—such as offices of health practitioners—and outpatient, laboratory, and other ambulatory care settings.

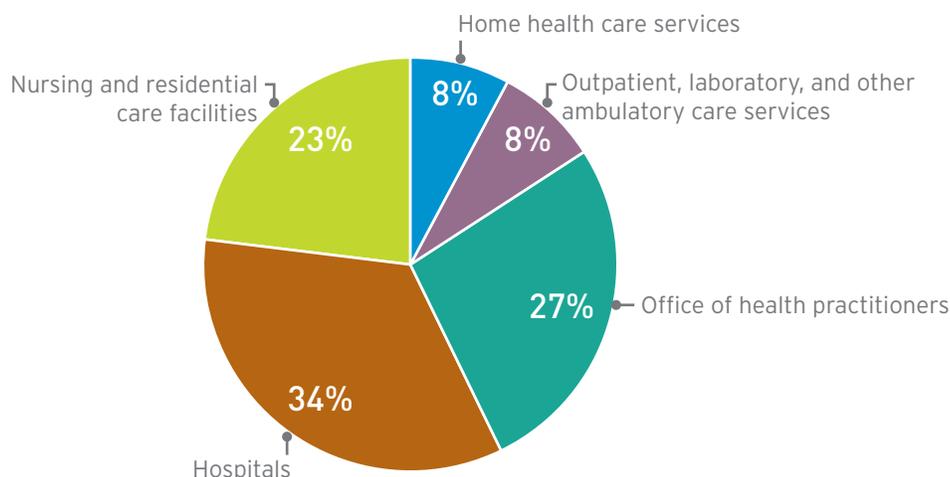
Hospitals remain the single largest employer among the health care sectors, employing about 4.7 million. While acute care is likely to remain the largest employer of the group, other sectors, notably offices of health practitioners, and other outpatient and ambulatory care services, will grow at a faster rate and add more jobs—consonant with the pivotal role assumed for primary and preventative care under the ACA. As Figure 1 and Table 4 (see page 14) indicate, employment in offices of health practitioners will nearly equal that of hospitals by 2020, and lead all other sectors of health in employment, with a projected addition of almost 1.4 million jobs. At the frontlines, this will induce greater needs for both clinical staff, such as medical assistants and physical therapy assistants, and administrative and technical staff, such as health service managers, medical secretaries, health

information and medical records technicians, and patient service representatives.

Outpatient, laboratory, and other ambulatory care settings are projected to add an additional 394,000 jobs. This will generate demand for skilled emergency medical technicians, medical laboratory technicians, and a range of other therapeutic and diagnostic occupations, including occupational therapist assistants.

An aging population, led by the baby boomers, is driving employment in the fastest growing sector (home health services) and occupations (home health aide, personal care aides). Nursing care and residential care facilities, while not growing as rapidly, are projected to add almost as many new jobs (822,000) as will hospitals. In 2010, 40 million Americans were 65 or older; this number is projected to nearly double between 2010 and 2040, as will the proportion in this cohort, to over one in five persons. The greatest growth in utilization of health care services in recent years has been among older Americans, especially those 75 and older (Okrent 2011).¹⁰ Between now and 2050, the “oldest old,” or those aged 85 or older, could grow almost fourfold, from 5 to 19 million (agingstats.gov). The latter group is the most prone to serious, multiple health conditions, as well as dementia, and will require larger numbers of both home-based and facility-based caregivers.

FIGURE 1. HEALTH CARE EMPLOYMENT BY SUBSECTOR: 2010



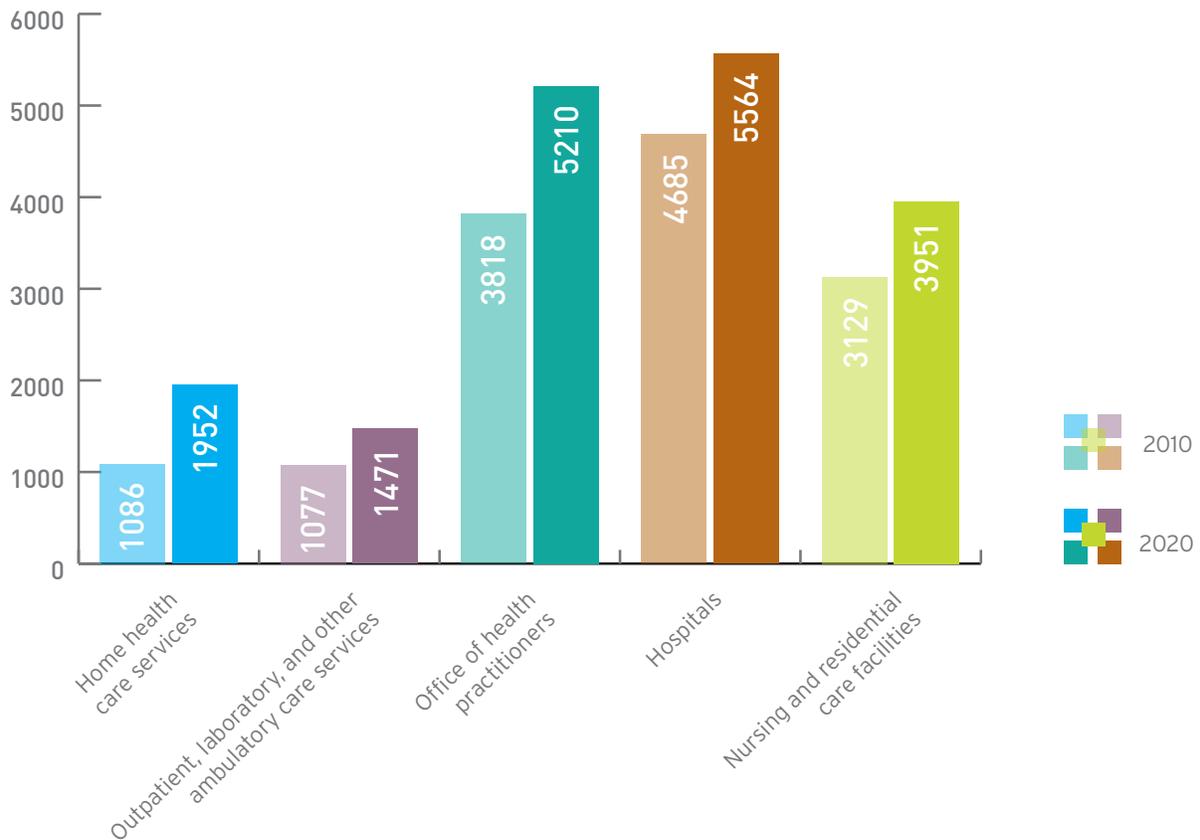
Source: U.S. Bureau of Labor Statistics, OES

TABLE 4. HEALTH CARE JOBS BY SUBSECTOR: 2010-2020 (IN THOUSANDS)

| OCCUPATION | 2010 EMPLOYMENT | 2020 EMPLOYMENT | CHANGE | % CHANGE |
|--|-----------------|-----------------|--------|----------|
| Home health care services | 1086.6 | 1952.4 | 865.8 | 79.7% |
| Outpatient, laboratory, and other ambulatory care services | 1077.1 | 1471.2 | 394.1 | 36.6% |
| Office of health practitioners | 3818.2 | 5209.6 | 1391.4 | 36.4% |
| Hospitals | 4685.3 | 5563.6 | 878.3 | 18.7% |
| Nursing and residential care facilities | 3129 | 3951 | 822 | 26.3% |

Source: U.S. Bureau of Labor Statistics, OES

FIGURE 2. HEALTH CARE JOBS BY SUBSECTOR: 2010-2020



Source: U.S. Bureau of Labor Statistics, OES

SKILLS IN DEMAND

In this section are findings on education, skills, behaviors, and functions that are needed or anticipated for frontline workers in the ACA environment. This includes an overview of employer responses, with an examination of general or transferrable skills in demand in all or most occupations, including licensed professionals as well as frontline support occupations. Additionally, this section presents skills needed by workers in specific categories: direct care; patient service/administrative; and health information technology. This is followed by a discussion of emerging occupations and roles for frontline workers, skills needed, and opportunities for career development.

In addition to reviewing labor statistics and current literature, a range of health care employers were interviewed concerning their workforce needs and plans in response to the ACA, with the majority being executives and managers of human resources, workforce, and organizational development and learning. While most represented hospital systems, several employers worked in primary care or long-term care settings.

The workforce picture for these employers is, for the most part, uncertain. This reflects the fledgling state of implementing health reform, and the unknowns surrounding levels of patient enrollment, care usage, and the mechanics of new payment arrangements. Equally unclear are the specific practices that providers will use to achieve desired changes in cost, quality, and population health outcomes. But this uncertainty also reflects more general features of U.S. health

care institutions. Long-term and strategic planning for workforce, whether on a local or national scale, is relatively rare, especially for unlicensed and pre-Baccalaureate occupations. C-Suite attention turns to staffing concerns when immediate pain is greatest, as in times of severe nursing shortage, or high turnover of support staff, such as patient care assistants.

Responses tend to fall into one of several categories, suggesting a continuum of planning and workforce readiness:

- > **High uncertainty, with labor forecasts and plans considered to be premature.** Many senior executives are “scrambling,” as one put it, to discern the ACA’s high-level financial implications, especially changes in Medicare payments. In the same category are health care employers who are focused on looming workforce issues not directly related to the ACA. An example of the latter is meeting the Institute of Medicine’s target of 80 percent Bachelor of Science-prepared nurses. And all of the institutions are racing to meet the October 2014 deadline for incorporating ICD-10, the new system of diagnostic billing codes. Staff will be required to learn and apply 68,000 codes, compared to 13,000 under the previous system.
- > **Early stages of planning or applying new care delivery practices and accompanying training.** This group includes hospitals and outpatient practices that are seeking PCMH or ACO status, and/or in the initial stages of training staff to respond to new requirements for increasing

patient satisfaction, lowering readmission rates, and other measures of quality and cost reduction. This group also includes providers who are beginning to change the responsibilities of frontline staff, as through increased delegation of tasks from nurses and other licensed professionals, and, in some cases, shift the ratio to incorporate higher proportions of support staff relative to licensed ones.

- > **Substantial or full implementation of new practices and staff roles to support them.** These providers are more likely to include primary care settings, including community health centers and major hospital systems, that were implementing systematic changes in care delivery prior to passage of the ACA. They are running full-fledged PCMHs, Health Homes, and other new models of improved care coordination and population health management. Reassignment of roles, and in some cases, new hires to fill additional demand for emerging functions (care managers, health coaches) are occurring. Education and training programs are underway or planned.

Even when health care providers are further along the spectrum of workforce readiness for the ACA, they are generally not contemplating large additions to staff to treat newly enrolled patients or to implement new models of delivering care. At Boston's Brigham and Women's Hospital, for instance, Geoff Vercauteren, director of workforce development, stresses that efforts are focused on training current staff and not on developing external pipelines. Other contributors to this paper, from health care and the research community, echoed this view. Critical new functions such as "care coordination" or "care management" require differently skilled staff, but not necessarily large infusions of new staff. Maxine Golub, senior vice president of New York's Institute for Family Health,

summarized the landscape this way: "all of the jobs have gotten harder."

GENERAL SKILLS NEEDED

Meeting the challenges of providing better care and improved outcomes at lower cost will require new or improved skills across the spectrum of health care workers. Training to higher performance standards will require both skill-specific training—in key areas such as customer service or technology—and general orientation to new processes and procedures of quality measurement, care coordination, and patient-centered care. It will also mean cross training, to ensure that care team members understand one another's roles and can work flexibly as new challenges arise.

- > **Re-conceptualizing the job.** Employers expressed a need for all staff to view their roles differently. For Megan Perry, president of Sentara Northern Virginia Medical Center in Woodbridge, Virginia, professional and paraprofessional hospital staff need to change their focus from "how to take care of sick people" to "how to keep people well." This means keeping patients out of the hospital by focusing on behaviors that promote wellness and prevent chronic conditions, such as diabetes, from escalating.
- > **Working in collaboration.** While team-based models of care were already in process prior to the ACA's adoption, the drive to meet quality goals has accelerated their implementation, according to employers. As noted, such teams require practitioners to work across disciplines and to transcend hierarchies, which is a major shift in behavior, as well as protocol and process. Major hospitals, such as Virginia's Inova Health and Massachusetts's Beth Israel Deaconess Medical Center, actively screen for teamwork skills in all staff during interviews. For frontline workers, functioning successfully on a care team

requires understanding the interdisciplinary model, as well as assertiveness.

- > **Communicating effectively.** Interpersonal or “soft skills” are more salient than ever, whether within the care team, or with patients, family members, and health care providers—such as primary care physicians, specialists, rehab facilities, or home care agencies—throughout the continuum of care. Providing good customer service to patients has become paramount for the ACA goal of improved patient experience, as measured by HCAHP Survey scores.

As Virginia Hospital Center’s Chief Nursing Officer Diane Vrosos observes, it’s not just about “being nice,” it is the anticipation of patients’ needs and expectations. For nurses and patient care assistants, “active listening skills” are critical to responding to patient needs, diagnosis, communication, and follow-up. According to Executive Director Elizabeth Toups, the Joint Employer Education Fund of SEIU UHW United Healthcare Workers West, a labor-management partnership, has analyzed HCAHP scores at various sites represented by the union to determine specific training needs.

- > **Problem solving and critical thinking.** Staff at all levels need the ability to recognize and solve non-routine problems creatively. Hospitals and clinics looking to improve the delivery process and workflow, such as Boston’s Beth Israel

Deaconess Medical Center, screen for problem-solving ability in job candidates at all levels.

- > **Using technology.** The advent of electronic health records (EHR), and the effort to use new technologies more generally for storing, retrieving, and conveying patient data, are transforming health care jobs across the care continuum. Roles such as housekeeping or nutrition services are affected when EHRs are used in planning patient meals. Needed technology skills range from basic computing skills to competency in proprietary EHR systems, or ability to analyze and communicate information from large data sets.
- > **Knowledge of geriatrics.** While this is most critical in long-term care and home-based care, health care professionals in all settings will need additional training and expertise for treating an aging population.

SKILLS NEEDED IN SPECIFIC OCCUPATIONS

The emerging requirements of frontline jobs in the ACA era are clearer if we examine skill expectations in major occupational areas. The following section outlines these skill needs in direct care, administrative roles, and health information technology.

DIRECT CARE

These workers are the most numerous of the frontline workforce, sometimes referred to as the “eyes, ears, and hands” of health care (Dawson & Surpin 2000). Within long-term care, nursing assistants and related occupations, home health aides, and personal care aides provide an estimated 80 percent of the paid care that elderly and/or disabled patients receive (PHI 2012). Their role becomes pivotal to improving the quality of that care, and to assisting in keeping costs down by helping patients remain at home, or ensuring that discharged patients avoid unnecessary readmission to the hospital.

Public policy prior to the ACA has sought to emphasize home-based care over institutional care, such as skilled nursing facilities. “Rebalancing” of Medicaid funds to support home and community-based care has been in place for several years, and the ACA continues in this vein.¹¹ The ACA also established demonstration programs for states to support training and skill enhancement for direct care workers, including personal and home care aides as well as nursing assistants.¹²

As more patients with higher acuity remain at home, but require monitoring and treatment—or make transitions between hospital, rehab facility, and home—caregivers will require: higher skill levels; deeper knowledge of diseases, such as congestive heart failure; ability to work with dementia and mental health issues; and facility with acute care procedures such as wound dressing and catheterization. With hospitals focused increasingly on higher acuity patients, direct care

staff will require higher education levels, according to Boston-based workforce director Vercauteren. According to Heidi Veltman, area administrator for Kaiser Permanente in Northern Virginia, direct care workers who may be unaccustomed to support surgery will need to know the procedures and tools to assist physicians in outpatient surgery.

Equally important are communication and problem-solving skills, to assist patients with complex physical and behavioral needs. Newly established training grants are developing innovative instructional models and standardizing curriculum for personal care aides, while establishing career paths from PCA to nursing assistant, home health aide, and licensed practical nurse (Sturgeon 2012).

Under the ACA, as noted, providers such as home care services will be collaborating more closely with primary and acute care entities. As described by Lisa Gurgone, executive director of the Massachusetts Council for Home Care Aide Services, home health aides will thus need training to assist transitions and share knowledge with the full care team. Training in supervisory skills is also needed.

Given the frequency and intensity of contact that direct care workers have with patients, a central competency, now and in the future, is observational skills. Nurse aides and home health aides are in the best position to notice changes in a patient’s condition. The evidence on reducing hospitalization for older adults with chronic conditions highlights the importance of “enhanced communication about changes in residents’ conditions among nursing home providers and staff, primary care clinicians,

and hospital staff," as illustrated by a Georgia pilot program that lowered hospital admissions by 50 percent for nursing home residents (Lipson & Simon 2010).

Active participation in care planning teams by aides is critical to such communication. At Philadelphia's Inglis Foundation, which provides long-term care to adults with disabilities, this capacity is paramount for nursing assistants. At meetings of the multidisciplinary care team, CNAs' observations—"Mr. Jones at 7 p.m. is a different person"—are "bumped up to a higher value," according to Training and Development Director Lynn Pecora. Here and elsewhere, training for team participation stresses soft skills, such as assertiveness, as well as observational skills.

Observation is also essential to ensuring patient safety and reducing errors, especially in acute care settings. Several Boston hospitals engage patient care assistants and other team members

in a procedure known as "timeout." The training for timeout works to foster confidence and communication skills in direct care workers, teaching them to double-check IDs and wristbands, and teaching them the confidence to stand up and call the timeout if they have doubts about the situation. The entire disciplinary team is trained together, so that everyone hears the same message at the same time.

Direct care workers in hospitals—sometimes employed as patient care assistants or clinical technicians—are in some cases being used in greater numbers relative to nurses, due to cost concerns. For Virginia's Inova Alexandria Hospital, the preferred staffing mix is a ratio of 65/35 nurses and "clin techs," or clinical technicians, according to Nursing Director Mary Dixon. They are seeking a higher-skilled individual in this "clin tech" position, and look for ability to document patient information in the EPIC electronic health record system they have implemented.

ADMINISTRATION

This occupational group encompasses clerical and administrative roles, including medical secretaries, receptionists, unit clerks, and patient service representatives, and roles that sometimes straddle administrative and clinical functions, such as medical assistants. Their importance has grown in primary care as practices and clinics assume or seek Patient-Centered Medical Home status, as well as in acute care, where staff in admission and discharge roles become pivotal to improved coordination of care and reduced readmissions.

The skill requirements and responsibilities in these roles are also changing in response to cost pressures, as when physician practices reduce labor costs by combining front desk and medical assisting roles in a single position. Kate Davis, a Maryland-based director of learning and organizational development, explains: In some cases, reduced admissions in acute care, and corresponding increases in primary care, have led providers to reassign and retrain acute care staff, such as patient care assistants, to administrative roles in outpatient settings, such as medical office administration or reception.

The advent of PCMHs, care teams managing chronic diseases, and similar efforts to coordinate care and lower costs, have heightened the importance of key administrative functions. The National Committee for Quality Assurance identified the following “medical home domains” as vital to PCMH status: patient tracking and registry functions; test tracking; referral tracking; enhanced access and communication; and performance reporting. As a

result, all staff in administrative and management roles, and those supporting them, must work at the “top of their job description,” as in other health occupations, while taking on new goals and functions (Bellisario 2012).

- > At Maryland’s Medstar Montgomery Medical Center, primary care practices require higher-skilled medical receptionists and unit clerks. This is not a traditional medical receptionist, explains Davis, but a professional with training on three distinct technical systems linked to electronic health records. This position also serves in a customer service/front desk role.
- > At Virginia Hospital Center, medical practice administrators also need EHR skills, as well as familiarity with accounting, human resources (knowledge of how to manage a small group practice), and understanding of practice operations, according to President & CEO James Cole.
- > Philadelphia’s Jefferson Family Medicine Associates, a large academic health center and early adapter of PCMH practices, employs a number of “registrars” who are cross-trained for registration, scheduling, billing, and referrals, as well as medical records management (Zawora 2013).

The medical assistant position is one of the fastest growing occupations in the U.S. economy. It is the single largest occupational category in primary care, comprising about one-half million workers. There is very little standardization of training for

medical assistants, and entrance requirements range from short-term, postsecondary training to more formal credentials, but the latter are relatively rare.¹³ Medical assistants generally practice under the supervision of a licensed physician, nurse practitioner, or physician assistant. Their traditional role may encompass clerical functions (handling reception and telephones, scheduling appointments, maintaining files) and/or clinical ones, including rooming patients, preparing them for exams, and taking vital signs (Dower & Blash 2012)

Medical assistants are emerging as a central focus of occupational changes and elevated skill demands. For cost and coordination reasons, there are more examples emerging of hybrid roles, where administrative and clinical staff are cross-trained to perform both functions. At a primary care practice of Ohio's Humility of Mary Health Partners, Paul Oliver, vice president of business development and physician enterprises, reveals that medical assistants are further trained to assume practice administration duties, with a 15 percent increase in salary. Assuming such duties requires skills in supervision, scheduling and routing of patients, and troubleshooting of all kinds.

The expanded role for medical assistants is especially prominent in clinics that have assumed the role of PCMHs. Medical assistants are taking on roles critical to patient self-management and improved coordination of care (Bates 2010). At Jefferson, for example, the medical home process requires them to assume increased responsibility for patients, assisting with chart review and updates, and also engaging patients in managing their health during medical visits as well as outside and between visits (Zawora 2013). In one Virginia hospital system, medical assistants must do more than "simply room patients"; they may be trained in some cases

to be diabetes "experts," assisting patients with diet, exercise, nutrition, and doing finger sticks. Recent analysis of national hiring data found similar evidence of these duties in assisting patients with chronic diseases (Boerner 2012).

In a series of 14 case studies initiated by the Hitachi Foundation, the Center for Health Professions at University of California San Francisco has documented a wealth of examples of primary care providers expanding the role of medical assistants, as well as providing career steps for an occupation that has often lacked them. Of special interest are the ways that trained medical assistants in these settings are serving ACA goals of supporting care coordination, patient education, and redesign of work operations to improve patient service and efficiency. In many cases, they are assuming new or expanded roles as health coaches, community health workers, home visitors, and patient navigators. *(These functions will be discussed in greater detail on page 24, "Emerging Frontline Roles in Health Care.")* Some clinics, such as Colorado's High Plains Community Health Center, are also training and promoting medical assistants into different positions, such as pharmacy technician or limited license radiologic technicians (Dower & Blash 2012).

These innovations, while promising, are potentially limited by licensure, and the current state of medical assistant education and training. Research on innovative clinical practice in California, for instance, found that medical assistants were not adequately prepared by their training to assume functions like clinical database management or patient education (Hahn & Sussman 2011; Chapman et al. 2012).

HEALTH INFORMATION TECHNOLOGY

Technology is changing health care jobs across the spectrum, and creating higher skill demands in many areas, from physicians and nurses to patient care technicians and medical assistants. Its adoption is also raising the profile of jobs focused specifically on technology and information management. The latter extends to emerging positions for managing electronic medical records and ensuring their integration in various health care functions. It also encompasses traditional health information management, particularly medical coding. A third strand in health IT is the growing area of health informatics, which involves not only management and integration of data, but analysis that puts data to use for improving health care delivery. A final strand includes traditional information technology functions: programmers and systems analysts that support computer and technology applications throughout the hospital or clinic.

The demand for HIT workers and HIT skills is driven by policies predating the ACA. Adoption of electronic health records was accelerated by the Health Information Technology for Economic and Clinical Health (HITECH) Act, passed in 2009 as part of the federal stimulus bill (American Recovery and Reinvestment Act). The bill authorized incentives for hospitals and other providers to adopt and “meaningfully use” EHRs, and established workforce programs.¹⁴ The latter include university-based centers for developing curricula; consortia to build community college capacity for EHR training; and a competency exam for students and professionals in

the field (Mohla et al. 2013). To date, the workforce efforts of the Office of the National Coordinator, which oversees federal support for EHR adoption, have expanded training and technical assistance capacity in over 90 community colleges and universities (Mohra et al.).

The ACA built on this platform by making EHRs central to the success of medical homes, accountable care organizations, and other policies to promote team-based care and coordination across providers (USDOL 2011). By speeding the exchange of information, EHRs, according to a 2013 report to Congress, help chronically ill patients “get the right care at the right time, avoiding unnecessary duplication of services and preventing medical errors” (Mohra et al. 2013).

The U.S. Department of Labor has built a “competency model” illustrating the knowledge, skills, and abilities needed to work with EHRs and other information technologies in health care. It is a dual model, containing a “health focus,” and an “IT focus.” Those in health occupations (medical assistants or medical records and health information technicians) “need a broad knowledge of the health industry supplemented with IT concepts,” while IT workers (computer support specialists, trainers, or project managers) need solid grounding in IT concepts as they apply to the business, culture, and operations flow of delivering health care (USDOL n.d.). The occupations emerging at the confluence of these skill areas are not well defined yet, and much

of this work is conducted by Bachelor or Master's-level specialists in IT or health informatics, or health professionals who have completed certificate programs in implementing health IT. But there are clear opportunities for frontline and mid-level health care positions to provide technical support and project management services to users in the planning, implementation, and use of EHRs.

About 40 percent of HIT workers are now employed in hospitals, according to the U.S. Bureau of Labor Statistics, with the remainder employed in physician offices, nursing homes, home health services, and other outpatient settings. Job prospects for HIT workers "should be very good, particularly for technicians with strong computer skills" who will be "in particularly high demand," according to the BLS (Conn 2010).

This demand is less apparent in hospitals, especially in the area of health information management, including medical coding. While hospitals are rapidly gearing up for the conversion to ICD-10 medical codes, there is no evidence of significant new hiring planned for medical coders to meet this need. Rather, acute care employers prefer to train experienced coding staff in the new system. Boston hospitals, according to recruiters there, prefer that new hires already possess ICD-10 training (Donnelly 2013). Employers in many regions also spoke of the need for prior acute care experience, creating

barriers in some cases for newly trained coding candidates who lack health care backgrounds or who have only coded in outpatient settings. In general, candidates for coding and other entry- to mid-level HIT positions need a solid grounding in health care concepts, including medical terminology, anatomy, and physiology; strong detail orientation; good analytical skills; and ability to work across disciplines.

Recruitment consultants and hospital representatives also express doubt that electronic health records will create large new employment demands. In consultant Donald Bellefeuille's view, the "tail end" of EHR implementation in hospitals will not lead to job expansion. Moreover, major hospitals are outsourcing much of this work to contractors. Bellefeuille also expects to see technical advances in HIT systems reduce employment in some cases: "as systems get smarter, we'll need fewer people" (Donnelly 2013).

One area with specialized skills that could generate new demand is the analysis of medical and population health information—"big data"—generated by health care providers and disseminated by the U.S. Department of Health and Human Services. Skills required could vary from basic computing skills to predictive modeling and advanced statistics (Sheina 2012).

EMERGING FRONTLINE ROLES IN HEALTH CARE

If the goals of the ACA are to be realized, then the work of delivering care will need to change—in the jobs people do, the tasks they are assessed for during recruitment, the way they are evaluated, and the way they are trained and rewarded. Like many other aspects of U.S. health care in the ACA era, the workforce picture is still coming into focus. But we can glimpse some of the changes arriving in the roles that are emerging in hospitals, health clinics, medical homes, and communities. These roles are not yet well defined, but they are likely integral to the ACA goals of a more efficient, patient-centered, and coordinated model of care delivery. They all share in common “case identification and intervention to attempt to produce better outcomes,” as Catherine Craig and her colleagues (2011) of the Institute for Health Improvement, observe. And they all respond to the need to avoid preventable readmissions to hospitals, assist patients in managing their health, and assist the most chronic users of health care.

New or enhanced roles or occupations associated with new delivery models include health coaches or educators, care coordinators, patient navigators, care transition managers, and case managers. In practice, these roles often overlap, and they lack standardized definitions. Some organizations have created new positions under these or similar titles, but these are also frequently job functions or responsibilities assigned to those in existing occupations, such as nurses, social workers, medical assistants, patient access representatives, or

community health workers. The latter position is not a new role, but is often a model for some of those emerging, and is also taking on greater importance, in community settings and in traditional health care venues, such as hospitals, which have not traditionally used CHWs.

Few of these roles and positions originated with the ACA; some hospitals and clinics carried out case management and care coordination functions under various names prior to the legislation. They have deeper roots in the Health Management Organizations (HMOs), which were established in the 1970s to control costs and coordinate care, and in Centers for Medicare & Medicaid Services (CMS) pilot case management programs that employed nurses to follow up with assigned Medicare patients (Craig et al. 2011). A limitation of these mechanisms was the absence of individuals who had (or established) a genuine, personal connection with individual patients. In contrast, the model of community health workers—which grew out of outreach to lower-income and marginalized populations, such as Native Americans and migrant farmworkers—was predicated on the relationship of community members sharing a common culture and, sometimes, health condition.

Community health workers assist patients with navigating health and social services and with managing their own care. They may also act as community organizers and advocates, targeting root causes of health conditions, such as the availability of housing. Their employers are sometimes health providers, but are just as likely to be community-based organizations or public health entities.

SUPPORT FOR INNOVATION IN EMERGING ROLES

Today's models resemble the HMO and CMS pilots of the 1990s in their use of focused and aggressive case management (Craig et al. 2011), but without the threat of denial of service to patients, as with HMOs. They adopt much of the CHW model, but are more likely to be employed directly by health care providers, rather than in a community-based organization. Practitioners in these roles are less in a position to challenge systemic issues extending beyond individual or population health, but may have access to greater resources and stability, a continuing barrier for community health workers who rely on short-term, often disease- or behavior-specific grants.

A spur to recent experimentation in care delivery roles as well as payment models is the ACA-initiated Center for Medicaid & Medicare Innovation. CMMI has conducted two rounds to date of innovation grants targeting beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program (Abrahms et al. 2011).¹⁵ In the initial round, announced in May 2012, CMMI's awards included a number of medical home, prevention outreach, disease management, and care coordination initiatives, among other models. In many cases, specific emerging roles necessary to carry out the work were highlighted.

- > Beth Israel Deaconess Medical Center in Boston is employing **care transition specialists** to help integrate care between hospital and primary care practices, with the aim of reducing readmissions and improving care.
- > An earlier CMMI innovation award targeting **care transition** supported efforts of Cincinnati

hospitals to lower readmissions. According to Greater Cincinnati Health Council's Dora Amin, the hospital-based specialist meets with Medicaid fee-for-service patients before discharge, and follows up with calls and home visits to ensure that the patient is following the care plan and receives needed information and supports, including transportation or physician referrals.

- > Several CMMI awardees are highlighting **community health workers**. A multistate consortium based at Duke University employs CHWs on a care team working to reduce deaths and disability from diabetes using information technologies to support communication, care delivery, and patient education. A New England-based asthma consortium is engaging CHWs and asthma educators to support patient self-management, environmental interventions, and culturally competent care. The Michigan Public Health Institute was given support to train and integrate CHWs into primary care teams. CHWs so trained will coach patients on self-management, while encouraging regular primary care visits (CMS 2012).
- > In the San Francisco Bay Area, Asian Americans for Community Involvement (AACI) received a CMMI award to train Asian and Hispanic youth and veteran AACI caseworkers in **patient navigation**. Working with California's Career Ladder Project, a statewide workforce intermediary, and three community colleges, AACI will train current staff as well as create new roles for patient navigators, nurses, and customer service representatives. The newly created Patient Navigation Center will assist patients with translation, appointment scheduling, referrals, transportation, and application help for social services, as well as after-hours and self-care assistance (Solis 2013).

One of the largest (\$20 million) and most comprehensive CMMI grants is underway in East Baltimore. "J-CHIP" or Johns Hopkins Community Health Partnership, links Johns Hopkins Medicine (the School of Medicine and the Johns Hopkins health care system), state and local government, and a network of health care employers and

community-based organizations, in a demonstration of new models of care coordination and delivery. The grant focuses on in-patients of The Johns Hopkins Hospital and on high-risk individuals with multiple conditions and risk factors in East Baltimore neighborhoods. It is as much a community development and organizing strategy as one of care management. CHWs and grassroots volunteers—“neighborhood navigators”—will assist clinic-based teams in locating and educating patients, identifying barriers to care, and assisting them in navigating the continuum of care. Individuals in similar roles will assist acute care patients with risk screening, post-acute services, and medication management. J-CHIP is conceived as a “learning laboratory” to experiment with and incorporate:

Existing and new care management roles, including, but not limited to: nurses, health coaches, embedded nursing case managers, behavioral health providers, call-center staff, community health workers, patient navigators, care coordinators, community mentors, and volunteers (J-CHIP 2012).

A number of organizations are experimenting with other specific roles, notably health coaching and care coordination.

HEALTH COACHES

Health workers assuming the role of “health coach” take on some of the duties tasked to CHWs and patient navigators, especially in the area of educating patients in managing their health conditions and taking preventative steps to improve their health, such as exercise, better nutrition, or smoking cessation. These roles, however, are often developed by redefining and retraining frontline workers in existing positions, such as medical assistants, often creating a career ladder for workers who previously lacked one.

- > Union (UNITE HERE) Health Center (UHC) in New York City created the coaching role as part of a systematic transformation of its clinics—which serve UNITE HERE union members and their families—and the jobs of patient care assistants (medical assistants). UHC adopted the Patient-Centered Medical Home model in the course of

shifting from an occupational health focus to a multiservice health center. In its new incarnation, UHC was reconceived as an “ambulatory intensive care unit”—shifting health management responsibility to patients, with assistance and education from frontline workers. The latter are the “first floor” or first point of contact with patients, and develop one-on-one relationships to promote self-management of health and support healthy behaviors. Patient care assistants, with completion of nine competency-based training modules, can be promoted to health coach. In this role, workers establish self-management goals with patients and follow up by telephone to continue health education; they also conduct patient support groups. They may continue PCA or medical assistant tasks such as admitting and taking blood pressure and other measures. Each primary care team works with two health coaches (Blash et al. 2011; UHC & NYACH 2012).

- > AtlanticCare’s Special Care Center, in Southeastern New Jersey, is, like UHC, an ambulatory intensive care center. It is also trade union-based (serving beneficiaries of the Hotel Employees and Restaurant Employees International Welfare Fund), but has opened up to serve a wider patient population. It serves medically complex patients and seeks to attain the ACA “triple aim” of lower costs, improved care, and better health outcomes through care coordination. Health coaches, in concert with clinicians and specialists, are integral to these goals. In a departure from the UHC model, the Special Care Center recruited medical assistants, licensed practical nurses, and other frontline staff to perform as health coaches (Blash et al. 2010). The coaches are assigned based on their language and cultural background to a patient, and may meet with them independently as well as in conjunction with a physician visit. They assist patients with developing and adhering to health goals, and identifying barriers to meeting them.

CARE COORDINATORS

Care coordination is critical, as we have seen, to lowering cost while improving the quality of

care. There is no single job title or description for this role, which can vary among health care organizations. Health providers implementing the role of care coordinator vary in where this function is located (licensed professionals or support occupations). This may reflect the fluidity of this role, as some hospitals may grant greater responsibility for managing patient care to the coordinator, or the scope of practice rules may limit such responsibilities to licensed practitioners. But the variations may also reflect the novel and relatively untested nature of care coordination and, generally, of new care models in today's rapidly changing care environment.

MedStar's Good Samaritan Hospital in Baltimore, for example, created two post-acute care coordinator positions to manage patients at risk for readmission within 30 days. Registered nurses are tapped for this role. Similarly, Humility of Mary Health Partners in Ohio, currently fills patient care coordinator positions with RNs and social workers. This policy is not set in stone, however. HMHP also enlists licensed practical nurses in some cases and, as HMHP VP Paul Oliver explains, a medical assistant, with proper training, could take on the role. The staffing of post-discharge care coordination is also in flux at Maryland's MedStar Montgomery Medical Center. According to MedStar's Kate Davis, it is not yet clear whether non-nursing staff will assume this role. Common to all of these staffing choices, however, is a change in philosophy about managing patient care. As Molly Seals, VP of human resources at HMHP, notes, implementing this role requires nurses to see it as part of their job to coordinate their patients' care throughout the process—before, during, and after their hospital stay.

Elsewhere, skilled frontline workers are assuming comparable roles—assisting patients in scheduling physician appointments and following their care plan; coordinating referrals; and identifying needed services, including medical (screenings and preventative care) and social (assistance with housing or substance abuse). In New York City, Health Homes have been established in a number of sites to offer care to Medicaid patients with chronic conditions and/or persistent mental illness. At New York's Health and Hospitals Corporation,

for instance, care coordinators are not required to be licensed staff, though some hold Bachelor's degrees in social work. More critical, here and at other Health Homes in NYC, is experience working in the community and strong communication skills (Shockley et al. 2013). Care coordinators and care navigators in the Health Homes are often supervised by "care managers" who hold licensed positions as nurses or social workers.

TRAINING FOR NEW AND EMERGING ROLES

Key to successful implementation of new and emerging patient care roles is training. In some cases, employers that have developed dedicated workforce units within hospitals and other facilities are taking on the training role, often bolstered by workforce intermediary organizations or partnerships. Cincinnati hospitals, which are seeking to expand medical assistant use and functions, participate in the Greater Cincinnati Health Careers Collaborative. Johns Hopkins Medicine is collaborating with the Baltimore Alliance for Careers in Healthcare to train and use career coaches for developing the community- and facility-based workforce in J-CHIP. MedStar Montgomery Medical Center and HMHP are working to align their frontline workforce development programs with the needs and opportunities presented by the ACA. Industry associations, such as the Greater New York Hospital Association, or the Community Health Center Association of New York State, are emerging as innovators. Labor-management partnerships in health care, such as Philadelphia's District 1199C Training and Upgrading Fund (National Union of Hospital and Health Care Employees/AFSCME), or New York's 1199 Training and Upgrading Fund (Service Employees International Union), are on the forefront of developing workforce education plans that meet the needs of patients, employees, and providers.

- > SEIU's 1199 Training and Upgrading Fund convened health care employers and union members in the New York region to develop a curriculum and training program for care coordination. It targets "care managers," the

Fund's general term for a variety of occupations, ranging from patient navigators and community health workers to case workers and medical assistants engaged in care coordination. Comprising 24 modules, the 48-hour training is geared to adult learning styles and is customizable to individual work sites. Topics covered include the ACA; basics of chronic disease and wellness, as well as mental illnesses; communication skills, including working with interdisciplinary care teams; care transitions; and third-party payer systems. While the program has yet to be evaluated rigorously, over three-quarters of workers surveyed believed that they had a better understanding of care coordination and how the ACA affects their work. Moreover, over 90 percent of health system enrollees expressed satisfaction with care manager services (Chenven 2013).

- > The Commonwealth of Massachusetts established the Health Care Workforce Transformation Fund in 2012 as part of cost-cutting legislation. It establishes a series of grant competitions, made on a rolling basis, to support training, education, and career advancement programs for current or unemployed health care workers, including those in emerging fields and care delivery models. Implementation of the fund

has been accompanied by "listening sessions" with industry, unions, and other stakeholders to determine training needs. The fund is issuing planning grants, to be followed by awards for implementing training programs (Commonwealth Corporation 2013).

- > New York State's Health Workforce Retraining Initiative awards grants for purposes similar to those in Massachusetts, under the joint management of the Departments of Health and Labor. In addition to assisting workers who are laid off or at risk due to industry changes, it provides "training which promotes the development of new models of integrated care management, such as medical homes, health homes, or interdisciplinary team based care, for example care coordinators, community health care workers, chronic disease managers, and linkages between population health and health care" (NYSWIB 2012; NYSDOL & NYSDH 2012). As explained by Maxine Golub of New York's Institute on Family Health, awards have been used to build workforce skills in support of New York City region's community health clinics, including Patient-Centered Medical Homes and Health Homes, in such areas as use of EHRs, care coordination, and teaching the basics of a PCMH or ACO, among other skill and knowledge areas.

CONCLUSION

The new influx of patients and new pressures on health care providers to meet cost and quality goals offer a strategic opportunity to develop and reward lower-wage, lower-skilled, but essential workers. Yet realizing the potential for frontline workers to facilitate new models of care and work organization (and obtain wage and career improvements) will be challenging.

THE OPPORTUNITIES FOR THE FRONTLINE WORKFORCE

Health care in the United States has traditionally relied on a large, but largely underpaid and underutilized, workforce. The frontline workforce is disproportionately female, nonwhite or Hispanic, lower income and lower skilled, in terms of educational attainment and preparation for postsecondary credentials. And it remains largely invisible, whether to policymakers, patients and their families, or to licensed professionals in health care. Yet the role of this workforce is critical to delivering care and promoting health. The ACA only increases the importance of recruiting, training, and retaining a skilled workforce in clinical support, technical, and care coordinating roles.

The convergence of the ACA with dramatic changes in technology, demographics (aging patients and workers, greater ethnic diversity), and concern with rising inequality, creates a vital opportunity to raise the profile of this workforce while improving the care extended to patients and the efficient use of health care resources. Hospitals, clinics, nursing

homes, and home health providers face a financial and legislative mandate to do more with less or face government penalties. New and old patients alike need workers at all levels with the skills and education necessary to deliver excellent care.

While frontline workers are not the only piece of the ACA puzzle, they are an essential one. They spend more time with patients than any other occupational segment. With increased diversity in population, they are more likely to mirror the patient population—especially those with the most chronic health care needs—and most likely to be trusted navigators, advocates, and recruiters to this population. Those now employed are well-versed in the systems, procedures, and work culture of their organizations, and well-placed to assume new roles in support of practitioners called to work at the top of their licenses.

Key opportunities created by the ACA and its environment include the following:

- > Entry-level job opportunities for youth, young adults, new immigrants, and less-skilled candidates, especially in direct care and administrative roles
- > Expanded job responsibilities in established occupations, such as positions that merge “front desk”/clerical and clinical functions, or expanding medical assistant roles to include care coordination or patient education
- > New positions that offer opportunities for career advancement, especially in emerging roles, in areas such as health coaching and community

health work, management and integration of electronic health records, and advanced patient service and administrative positions

- > Potential for increased investment in training and development of frontline workers in these positions, offering potential for more rewarding employment and job mobility
- > Greater understanding of and support for frontline workers' contributions and improved status and respect from colleagues, patients, and leadership, as well as decision makers in government, workforce, and educational circles

THE CHALLENGES FOR THE FRONTLINE WORKFORCE

Today's environment also presents serious challenges for realizing these opportunities and to frontline workers overall. Among the major challenges are the following:

COST CONSTRAINTS

However individual providers fare on "pay for performance" measures, all are likely to be trying to do more with less—lower reimbursements, fewer acute care patients, and tighter budgets all around. Several hospital contributors expect this to place greater constraints on talent development, particularly those directed to the frontline workforce. One former HR director predicted that cost reductions could affect tuition assistance for incumbents. While the payoffs on such investments may yield long-term returns, human resource executives have to answer to hospital CFOs on a more immediate basis.

The opportunities for training and employing workers in new occupations to improve care and lower costs is limited, too, by the lack of reimbursement for activities such as patient navigation or care coordination, outside of specific grants provided under the ACA or other public or private funding sources (JHF 2012). As one informant reminded us, "you can't build a new building without financing."

EDUCATIONAL CAPACITY OF SMALL PROVIDERS

A focal point of achieving patient care improvements, as we've seen, is in outpatient care, including primary care practices and community health clinics. These organizations, by themselves, typically lack the staff capacity, budgets, and relationships with colleges and other training providers enjoyed by hospitals operating their own workforce programs for frontline staff.

POTENTIAL JOB LOSSES OR DESKILLING

The financial and organizational dynamics of implementing the ACA are complex and are likely to have multiple and unpredictable effects. In an environment of cost saving, frontline workers could see their roles and tasks expand without change in composition or job advancement. Some health care employers may employ lower-paid and lower-skilled workers as a means to reduce staff at higher levels, as when nursing levels are reduced relative to support roles, such as patient care assistants. Technology and job reorganization may reduce demand or lead to elimination of some jobs, while hospitals could see reduced employment as patient care shifts to outpatient settings.

"MISSING RUNGS" AND OTHER BARRIERS TO CAREER MOBILITY

A number of factors, not all related directly to health reform, have eroded career ladders or intermediate job steps that afforded mobility to entry-level or lower-skilled health care workers. For instance, the declining use of licensed practical nurses by hospitals has largely eliminated an attainable step between nursing assistant and registered nurse, particularly for those who must work full or part time while attending school. More recently, the 2010 recommendations by the Institute of Medicine that 80 percent of nurses hold Bachelor's of Science degrees in nursing by 2020, pose similar challenges to job entry and advancement for lower-income and less skilled workers for whom lengthy college attendance is problematic (IOM 2012; Casselman 2013). Finally, heightened credential requirements ("credential creep") in many allied health fields, such as doctoral

degrees for physical therapists, also present severe hurdles for career advancement.

LACK OF STANDARDIZATION OR CREDENTIALS FOR NEW ROLES AND FUNCTIONS

While there is a plethora of new roles emerging under the rubric of care coordination, navigation, and patient education, we lack knowledge on which models work, as well as standards and templates for the duties, skill requirements, and competencies needed to perform new or enhanced occupational roles. As Institute on Family Health's Maxine Golub commented, "you can't download the job description" for a care coordinator, among other roles. This creates inefficiencies in start-up of new models—reinventing the wheel—and complicates the development of needed training and curricula. It also limits frontline workers' ability to take such training in new roles and apply it toward credentials with value in the labor market, transferability to new employers, and attainment of college credits that "stack" or articulate with existing credential programs.

INSUFFICIENT REWARDS FOR NEW ROLES

Due to financial constraints, corporate policies, or other barriers, frontline workers may be granted increased responsibilities without the compensation of improved pay (raises, promotions, bonuses). There is little systematic information concerning changed or new job roles in health care, but anecdotal information (and past experience in the frontline labor market) counsels concern.

RESTRICTIVE SCOPE OF PRACTICE

Delegation of certain caregiving responsibilities to non-licensed team members, such as medical assistants or clinical technicians, can raise concerns with professional licensing boards and associations, particularly those governing nursing. As emerging roles and occupations, such as care managers, grow in prominence, similar challenges are likely to arise, especially given the lack of clear guidelines about their scope and required supervision. (Challenges like this have also arisen with efforts to expand the roles of nurse practitioners.)

INADEQUATE WORKFORCE DATA AND PLANNING

As this report has demonstrated, there are deep gaps in our knowledge of the present and projected health care workforce, and no more so than for the frontlines of caregiving. The talent management lifecycle for frontline workers, including recruitment, retention, engagement, development, and retirement, is not well charted. This reflects the lower status, or "invisibility," of these positions, as well as the "fragmentary and confusing" state of health care data and workforce planning overall in the United States (Hahn & Sussman 2011). The Bipartisan Policy Center also raised these concerns about the state of health care workforce data:

"Fragmented and inconsistent data collection, variance in methodological assumptions and rigor, mistrust among professional groups, and wide differences in regulatory and educational context contribute to an incomplete understanding of workforce supply and demand" (2013).

Under the ACA, some important steps have been taken to improve our workforce knowledge. The National Center for Health Workforce Analysis was established at the Health Resources Services Administration, U.S. Department of Health and Human Services. The center's ambitious agenda includes development of more complex and refined models of forecasting, as well as inventory and dissemination of data sets for a variety of health professions. This work, while admirable, still leaves large omissions in our understanding of non-licensed or inconsistently regulated occupations, such as medical assistants, community health workers, or direct caregivers.

THREATS TO THE AFFORDABLE CARE ACT

Continuing political challenges and technological setbacks in the ACA's early implementation add uncertainty to the process for employers, consumers, and workers who could potentially benefit from new or expanded positions and accompanying training. The resistance of half of the states to accepting Medicaid expansion, as noted, also complicates workforce planning.

RECOMMENDATIONS

To realize the opportunities and meet the challenges posed by the Affordable Care Act for the frontline workforce in health care, it will take thoughtful planning and collaboration among many, including employers, policymakers, educators, and conveners. Each has a clear and important part to play in solving the issue.

The following steps or practices should be considered by federal and state policymakers, health care employers, trade unions and other workforce organizations, education and training institutions, researchers, and philanthropic and civic institutions:

HEALTH CARE EMPLOYERS

- > Implement workforce planning and analysis functions within health care organizations using a cross-disciplinary approach. Include clinical and non-clinical leadership, human resources, finance and operations.
- > Implement a scenario planning process that looks at the current state of patient volume by type of patient and potential changes to ACA and evaluates the need for workforce, including volume of workers needed.
Example: no increase, 50 percent increase, and 100 percent in patient volume to hospitals, ER's, medical homes, and wellness centers within an organization's planning model, using historical patient volumes and staffing ratios.
- > Map current workforce skills within the organization and invest in programs that fill the

skills gap including, career coaching, patient satisfaction training, and development.

- > Create or augment career ladders to address increases in patient volume, potential retirements of staff, and the need for different kinds of skills to be successful under ACA.
- > Measure the impact of investments in frontline workforce development against patient satisfaction and safety outcomes.
- > Promote greater transparency with employees by sharing core measures and outcomes, and enabling them to take pride in accomplishments and to know how to improve individually and within their work teams.
- > Actively participate in identifying and solving workforce challenges by partnering with other employers (health care and non-health care) in the organization's city, state, or region to share best practices, supply/demand data, job descriptions, and pool resources and funding.
- > Collaborate and share information with policymakers, educators, public and private funding organizations, and other employers to assist in creating solutions to workforce challenges together and in a time- and cost-effective manner.
- > Develop shared standards and definitions for the emerging health care occupations, in consultation with other health care employers, industry and professional associations, policymakers, workers, and unions.

- > Enhance opportunities for lower-skilled workers to enter the field and advance by ensuring that job requirements and standards are not too restrictive as to limit entry into the field, but preserve patient safety.
 - » Build on the experience of Massachusetts, which developed a process for certification of community health workers.

POLICYMAKERS

- > Support a robust research agenda to better understand present and future needs for health care labor and skills in support of the goals of the ACA, with a particular eye to frontline, or non-licensed, positions.
 - » Employ the most current, forward-looking forecasting methods, as recommended by HRSA (National Center for Health Care Workforce Analysis), but broadened to include a full set of frontline occupations, based on input from industry.
 - » Refocus research efforts to identify and describe the job duties and education currently required, or necessary, for emerging jobs.
 - » Fund and convene the National Health Care Workforce Commission, to deepen the research agenda and ensure diverse voices, including frontline workers, are represented in its deliberations.
 - » Investigate the business impact of new care models, occupations, and education and training strategies supporting them.
 - » Support rigorous evaluation of innovative care models and associated workforce and training strategies.
- > Re-examine state-specific standards that make it harder to practice in different states; ease relicensure requirements.
- > Examine potential strategies for reforming Medicaid and Medicare reimbursement for paraprofessional services and training.

- > Advocate for investment in upgrading of low-quality, but essential, frontline jobs, in particular home health aides, personal care aides, and similar roles focused on outpatient care.

PUBLIC, PRIVATE, AND NONPROFIT WORKFORCE INSTITUTIONS AND CONVENERS

- > Invest in new or expanded workforce development systems and infrastructure to:
 - » Support skill development and attainment of necessary credentials
 - » Build the capacity of smaller health care employers, especially primary care clinics, to offer training and educational opportunities to meet rising skill requirements and fill new occupational roles.
- > Enlist public and private workforce entities (Workforce Investment Boards, partnerships, consortia, community-based organizations, and educational institutions) in piloting and scaling promising practices, in communities and in health care employers.
- > Aggregate demand for workforce development in small providers through parent organizations, and/or workforce intermediaries. Some community health centers have the scale and experience to manage frontline workforce initiatives.
 - » Build on models such as the East Boston Neighborhood Health Center, which houses a satellite campus of nearby Bunker Hill Community College.
- > Build on existing health care investments and sites, including the Health Professions Opportunity Grants, CMMI, Workforce Innovation Fund, and Trade Adjustment Assistance Community College Career Training grants.
- > Reach out to new or underutilized sources of funding, including insurance and corporate foundations, and similar sources.

- > Ensure pathways include a series of stackable credentials and/or certificates with labor market value, as well as multiple entry and exit points.
- > Explore and determine how career pathways can take into account expanded roles for frontline workers (such as community health workers, health coaches, and patient navigators), and the potential to create new positions or “rungs” on the career ladder in light of changes brought about by the ACA.
- > Explore needs and opportunities for upgrading the skills and roles of current frontline workers, (such as medical assistants, nursing assistants, and patient service representatives) to facilitate adoption of new care delivery models, including care coordination, chronic disease management, and integrated care teams.
- > Consider replicating and scaling public investment programs now targeting ACA workforce objectives, including the Massachusetts Health Care Workforce Transformation Fund, and New York’s Health Workforce Retraining Initiative.

PHILANTHROPY

- > Support efforts to analyze the impact of the ACA on frontline workers. Advocate for and invest in upgrading of low-quality but essential frontline jobs, in particular home health aides, personal care aides, and similar roles.

ENDNOTES

¹ We will abbreviate the legislation as the ACA. Its full title is the Patient Protection and Affordable Care Act (PPACA). Public Law 111-148. 111th Congress, Second Session. (Accessed July 10, 2012.)

² The focus of this paper is limited to impacts of the ACA on workers in health care occupations, and/or workers in the health care industry. It does not investigate potential impacts of the ACA on workers outside of health care, such as the prospect of employers responding to mandated insurance coverage by lowering employee hours to part-time status, or laying off staff. In Massachusetts, the insurance mandate has not been accompanied by employment reductions; see Dubay et al. 2012.

³ According to World Health Organization statistics (2010), the United States ranked 31st among nations in life expectancy and 36th in infant mortality. More recent data published by OECD (2013) places the U.S. at 26th in life expectancy,

⁴ PCMHs must meet standards set by the National Committee for Quality Assurance, which were established with primary care providers in 2007. The standards, or Joint Principles of the Patient-Centered Medical Home, require primary care practices to meet criteria in these areas: enhance access and continuity; identify and manage patient populations; plan and manage care; provide self-care support and community resources; track and coordinate care; and measure and improve performance (Shockley et al. 2013).

⁵ Data from the Medical Expenditure Panel Survey also show that 20 percent of all (non-institutional) personal health spending, or \$275 billion, was accounted for by just 1 percent of the population in 2009.

⁶ One in seven Medicare patients admitted to hospitals, annually, is subject to a harmful medical mistake. Almost one in five is readmitted to the hospital within 30 days (Levinson 2010).

⁷ This figure could be considerably lower, however, given that at least half of the 50 states are resisting the extension of Medicaid benefits. The Kaiser Family Foundation estimates that over five million potential recipients in the “coverage gap”—those above Medicaid eligibility limits, but not eligible for tax credits to join an insurance exchange—could be excluded by such policies (Kaiser Family Foundation 2013). Enrollment levels in the next 1-2 years could also be lowered if technical problems continue with the federal website (health.gov), and by the Obama Administration’s decisions to delay enrollment deadlines for small businesses for one year, and to allow those now insured with low-quality plans to keep them for one year.

⁸ Studies by PricewaterhouseCoopers (2012) estimate that the newly enrolled are more likely to be lower income, older, and speak a language other than English. They are less likely to have full-time employment or a college degree. Only a quarter have had previous health insurance.

⁹ Alstchuler et al. (2012) estimate that, without delegation from physicians to other staff, the average “patient panel” for a medical practice would be 983, which predicts a shortage of clinicians; with delegation, 1,947 patients per physician, which would make surplus more likely than shortage. The author acknowledges that this model is complicated by local variations in the distribution of clinicians, as well as other variables, implying that some areas would still experience shortage.

¹⁰ See Reinhardt (2003) for a contrary view, which argues that an aging population contributes only a fraction of the increase in demand and associated cost increases in U.S. health care. He finds, based on literature review and analysis of the Medical Expenditure Panel Survey, that aging in the population over time is too “gradual a process to rank as a major cost driver in health care,” though in any given year, per capita spending for older patients is 3-5 times the amount spent per younger patient.

¹¹ The Center for Medicare & Medicaid Services (CMS) established the “Money Follows the Person” demonstration in 2007, and extended it through 2016 in the ACA. It also authorized matching funding for states to provide community-based attendant services for those needing institutional-level care; enhanced the level of federal matching for states to raise the level of long-term care services offered through the community (vs. nursing facilities); and created a demonstration program (Independence at Home), which uses home-based primary care teams to support chronically ill Medicare beneficiaries who remain at home, while lowering costs and improving health outcomes (PHI 2010).

¹² Among the ACA workforce programs targeting direct care are the Personal and Home Care Aide State Training program—PHCAST—with grants focusing on developing core competencies and certification programs for personal and home care aides, and the Health Professions Opportunity Grant, which funds community colleges and other education and service providers in training individuals on public assistance (or others with low incomes) for health occupations.

¹³ Washington State recently formalized requirements for Medical Assistants-Certified. Washington’s regulations for medical assistant credentials specify multiple paths to fulfillment, including completion of an accredited program or an acceptable apprenticeship (of which there is one in development), and passing the certification exam within five years, for both incumbents seeking to be “grandfathered in” and for new credential requirements. The legislation can be found at <http://apps.leg.wa.gov/wac/default.aspx?cite=246-827>.

¹⁴ Under the HITECH Act, the Center for Medicaid & Medicare Services defined standards for receiving incentives to use electronic health records, based upon “meaningful use” of the EHRs. The criteria for meaningful use vary by stage of implementing EHRs, but at the early stage of data capture and sharing, they include electronically capturing health information in a standardized fashion, using it to track key clinical conditions, communicating the information to coordinate care, and using the information to engage patients and families in their care. For more information, see <http://www.healthit.gov/providers-professionals/how-attain-meaningful-use>.

¹⁵ At this writing, the second round of CMMI awards have not yet been announced. Round One grantees were announced in May and June 2012.

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