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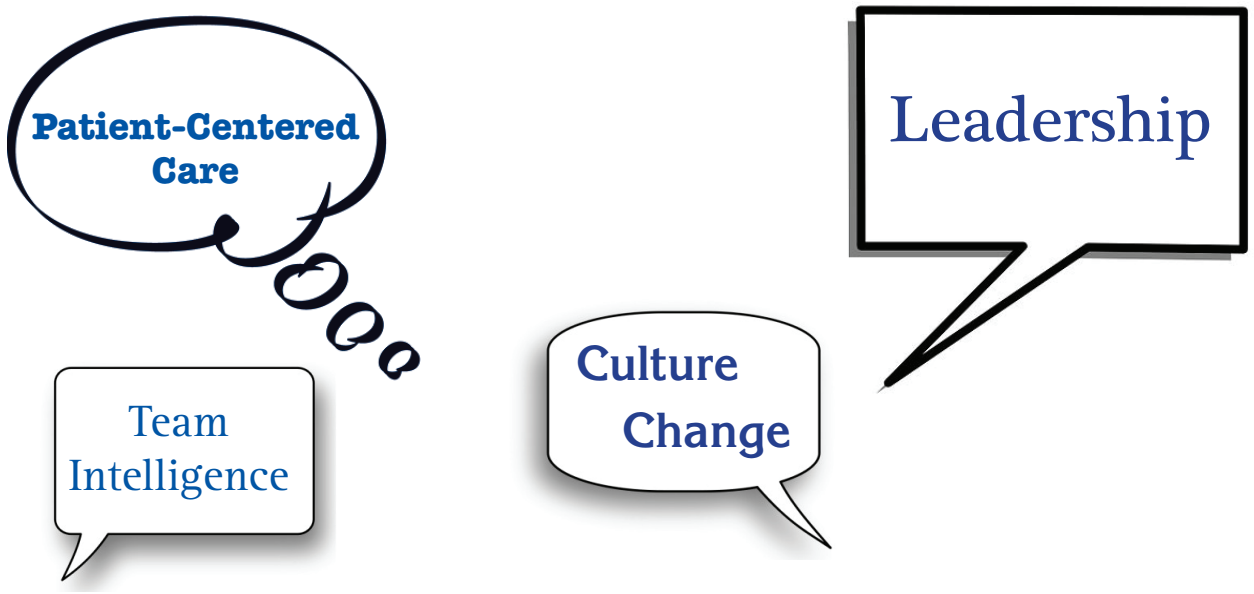

CHANGING THE *CONVERSATION:*

Accelerating workforce transformation in healthcare

Supported by The Healthcare Workforce Transformation Fund Training Grant

Coordinated by Karen Moore, R.N., FACHE, Consultant, KMoore & Associates

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Changing the Conversation:
Accelerating Workforce Transformation in Healthcare

EXECUTIVE SUMMARY

Hospitals and health systems need to accelerate workforce transformation so that they can be successful in making the wide-scale changes needed to redesign healthcare. To gain greater understanding of the realities of workforce needs and challenges over the next 3-5 years, the Massachusetts Hospital Association (MHA), funded by a Workforce Transformation Planning Grant, interviewed a diverse sample of leaders at Massachusetts healthcare organizations and conducted a broad survey of its membership. A complex picture of emerging knowledge, science, and roles emerged, converging on the changing healthcare delivery system. Most of the 459,000 healthcare workers in Massachusetts [1] have been prepared for a model of care that has been hospital-centric. Yet, shifting sites of care, accountability for care management, a more patient-centered focus, and new skills in team care are driving the need for change.

The challenge of retooling the existing workforce is unprecedented. Duress among hospital workers is evident. Despite increased employment rates, healthcare workforce productivity nationally[2] continues to be the lowest throughout all sectors. Respondents want hospital education efforts to be more applicable to challenges they currently face, focusing more on dealing with change management and team training. Specifically, they point to a need for creating value for the workforce where learning pertains directly to supporting team-based approaches to care. And there is a need for a broader understanding of new roles and how they overlap with existing roles, as well as support of individual capacity to cope with a rapidly changing environment.

All efforts at workforce transformation must come from the perspective of the patient, respondents say. Involving patients and chronicling patient journeys through their healthcare experience will be key. Although there have been efforts at improving the patient experience through customer service training and process improvement efforts, some feel these efforts have not had the expected impact. Accelerating transformation will come not just from what workers *do*, but the consciousness with which they do it. It is therefore essential to involve frontline workers in the redesign of healthcare delivery.

Leaders and workers will need to shift from rigid role and task orientation to well-defined career frameworks that promote flexibility to change roles and settings, develop new capabilities, and alter professional focus in response to the changing environment and the needs of patients. Attention to role introduction, team training and inter-professional learning, as well as the individual worker's

[1] Massachusetts Healthcare Chartbook, Executive Office of Labor and Workforce Development, Commonwealth Corporation, Fall 2007, page 7. Accessed 7/25/2014

[2] Kocher and Sahni, "Rethinking Health Care Labor," *New England Journal of Medicine*, October 13, 2011

need for self-care, reflection, and resilience, will allow creativity, innovative learning and compassionate environments of care. Finally, commitment is needed to dedicate resources to support education and training. Given the wide scale of workforce redevelopment needed, this can be facilitated through centralized learning collaboratives, including both public and private funding.

I. INTRODUCTION

The purpose of this report is to obtain a current understanding of how hospital and health systems in Massachusetts are transforming their workforces to meet the needs of the rapidly changing healthcare community.

Massachusetts has led the nation in the redesign of healthcare delivery over the past 10 years. Yet hospitals and health systems the commonwealth are under increasing strain. In the U.S., healthcare expenditures have grown to 17% of Gross Domestic Product (GDP), with projections to grow to 20% by 2020. [3] However, in Massachusetts the unadjusted per capita cost of care is significantly higher than the U.S. average. Even after adjustment for risk factors, spending is 20% higher.

When looking solely at hospital care, Massachusetts exceeded the U.S. average by 41.6%,[4] and in long-term care and home health by 72%.[5] Massachusetts costs continuing on this trajectory will double by 2020. Furthermore, between 2001 and 2011, the Massachusetts state budget has increased by 59% ($5.1Billion) while other social support needs such as public health, mental health education, and others have been cut by $20% ($4 Billion).[6]

Significant shifts are taking place catalyzed by healthcare payment reform to create new and larger health systems, forge new partnerships between providers throughout the continuum of care, and pilot innovative ways to deliver healthcare to meet the "triple aim": improving the patient experience of care (including quality and patient satisfaction), improving the health of the population, and reducing per capita costs of care.

Healthcare employment has outpaced overall employment in the U.S., and yet the healthcare workforce is less productive now than it was 20 years ago. (Productivity is defined as the output of volume of activity per unit of cost.) In an article by Robert Kocher, M.D. and Nikhil R. Sahni, published in the *New England Journal of Medicine* titled "Rethinking Health Care Labor," the authors report that any effort to slow the rate of healthcare spending will require a change in labor structure by reducing

[3] Center for Medicare & Medicaid Services, *National Health Expenditure Projections 2010-2011*, *Forecast Summary*, Table 1, page 4.

[4] The Henry J. Kaiser Family Foundation, *Health Care Expenditures per Capita by Service by State of Residence*, 2009, http://kff.org/other/state-indicator/health-spending-per-capita-by-service/ for notes and sources

[5] Health Policy Commission, *2013 Cost Trends Report*, July 2014 Supplement, p.12

[6] *Building a System of Care for Greater Value*, presentation by Howard Grant, J.D., M.D., for the American College of Healthcare Executives, July 1, 2014

workers, lowering wages, or increasing productivity. Approaches that encourage redesign of care delivery by using a different quantity and mix of workers engaging in a much higher value set of activities will deliver the most value. They go on to cite the need to leverage technology and standardization of work to help eliminate waste. The authors point out that every other major sector of the economy has managed to simultaneously improve quality and consumer satisfaction while reducing cost. The same should be achievable in the healthcare sector.

In a recent *Harvard Business Review* article by Michael Porter and Thomas Lee M.D. titled, *The Strategy That Will Fix Health Care: Providers Must Lead the Way in Making Value the Overarching Goal,* the authors state: "We must move away from a supply-driven healthcare system organized around what physicians do, and toward a patient-centered system organized around what patients need." Dr. Lee remarked in a recent presentation, "The challenge with care delivery for providers is that there are too many people involved, too much to do, no one with all the information, and no one with full accountability. The result is chaos and it leads to gaps in quality, safety and efficiency. The healthcare system is under duress. We need strategies that transcend the payment model. Improvement of value is the most robust strategy for all of the major provider levers for success."

The workforce itself is getting increased attention. How can the workforce transform to achieve the triple aim? Providers and workers are being required to learn new skills, work across new boundaries, and collaborate in unprecedented ways with colleagues as well as with patients and families. However, workforce deployment remains rigid and productivity lags.

II. BACKGROUND

This report was made possible by the Workforce Transformation Fund Planning Grant included in Chapter 224, which was passed in 2013 with the goal of bringing Massachusetts healthcare spending growth in line with growth in the overall economy. The law includes many references to improving the quality of care and builds on two previous laws enacted in 2008 and 2010 that expanded data transparency and reporting on cost trends and drivers aimed to control premium growth. The comprehensive Chapter 224 introduced mandates for providers and hospitals to review current practices and to seek ways to further improve and redesign care.

This grant-funded project, executed by MHA, was designed to gain understanding of the hospital workforce training needs now and over the next 3-5 years from the perspectives of senior executives, middle managers, and frontline staff from MHA member hospitals.

Over the past year MHA has launched The Institute for Care Coordination to provide education on skills and expertise needed to excel at population health/care coordination. The care coordination role is clearly a starting point. Participants in the Institute's educational forums have reported high variability in understanding reform and other new roles being introduced to patient care delivery environments.

The move to new models of care delivery is creating challenges for workers in different ways. Some challenges include understanding the resources available in the community for adequate care planning. One participant who took part in the survey stated: "Care coordination is worse than ever with fragmented and cumbersome electronic health records, changing family dynamics brought on by working families and socioeconomics, and healthcare providers who don't really know the patient." Many of the attendees at the Institute's programs reported a feeling of disempowerment and confusion about whose job it is to "fix things." A significant stressor reported was feeling caught between supporting patients and the expectations for reducing costs without feeling they had a voice or a place for meaningful involvement in change.

This report seeks to unveil information and data gleaned from this project that will help hospitals and health systems with their workforce strategies. It is also intended to assist the Massachusetts Hospital Association over the next 3-5 years to provide needed support, education, and training to accelerate workforce changes in the care delivery environment.

III. METHODS OF INQUIRY

The method of inquiry was twofold:

1. **Qualitative**: Structured interviews with hospital leaders to get insights, perceptions and thinking from those responsible for the planning and delivery of care, and also to inform the design of the quantitative survey.

2. **Quantitative**: The dissemination of a survey to obtain data around knowledge and skill development needed in the hospital workplace.

The project enlisted the support of the Gallup Company for survey design and to conduct some of the interviews.

REPORT OF FINDINGS FROM QUALITATIVE INTERVIEWS

A total of 16 interviews were conducted using a structured interview approach. Participants were all involved with the planning and delivery of patient care services and were selected to represent diverse missions and geographic locations.

	Teaching Hospital	Community Hospital	Other
CEO/COO	0	3	0
CNO/COO	4	1	0
Director/Mgr	2	1	1
Other			4

Following are the set of questions posed to interviewees with summarized descriptions of themes which emerged among the responses.

1. What trends or changes in healthcare delivery are of the greatest interest to you right now?

The responses to this question fell into 6 themes:

- **Declining reimbursements resulting in tremendous cost pressures**
  MHA members are familiar with the overarching issues underpinning the need for expense reduction. However, senior executives and managers should not overestimate their *workforce's* understanding of these issues. There is a great deal of variability in basic understanding of the Affordable Care Act (ACA) and the shift to new payment models or how hospital budgets even work. One of the interviewees who led the educational programming of a healthcare organization stated he had found this was so true that the hospital developed tutorials to be done online that were prerequisites for some of the more advanced educational offerings.

  Not all interviewees led with the concern of reducing expenses. There was considerable awareness of a need to provide healthcare to a population of people whose insurance gives them greater access to care along with the implications for partnerships and collaborations that need to be created in order to achieve them.

- **New methods of care delivery, provider roles and payment models with the development of ACOs and medical homes**
  Most interviewees identified challenges with working across medical subspecialties, coordinating post-acute care, and community/home-based services. New roles are being created or introduced in new settings. One senior nursing leader stated: "A need for Nurse Practitioners is exploding."

In addition, there is a shift of tasks to less-skilled workers while the professional care delivery team expands in its expertise to include pharmacists, nutritionist, and behavioral health specialists. Even these professionals in new settings require more flexibility, new skills, and competencies.

- **Societal Issues: Demographics of an aging workforce, mixed generations, lack of diversity in the workforce, and socioeconomic disparity**
  Interviewees discussed the fact that the workforce often does not culturally or ethnically reflect the patient population being served. There are also mixed generations in the workforce. With "organizational culture" defined as "what happens when no one is looking," different cultural perspectives may hinder standardizing approaches to care.

  The willingness of others to speak up when someone isn't following through is seen as important to basic safety. This is challenging in hospitals with strong hierarchical structures and titles such as "Chief" and "Director" or with leaders who may not reflect the cultural diversity of the rest of the workforce.

  Some organizations have reported addressing economic disparity by altering benefits structures for lower paid workers.

- **Shifts away from inpatient utilization**
  An actual or anticipated trend of lower inpatient census was cited. The system of care delivery, such as it is, is set up so it often works easiest once a patient is admitted to a hospital. For example, a patient receiving complex care in the emergency room, who also has a known diagnosis and treatment plan, often ends up in an inpatient bed. Case Managers in emergency rooms have become common and have shifted the focus of emergency room care planning. Interviewees described care planning as getting more complex, requiring knowledge of community services and other aspects of the continuum of care.

  The other significant impact of lower inpatient census is that the inpatient setting has traditionally been where clinicians received their training and are expected to work when entering the workforce. Many clinicians find they cannot get positions in hospitals and are concerned about their career choice. There is growing demand for clinicians in medical homes, outpatient settings and in the community. Even these positions were described as taking an expertise and foundation of learning from hospital experience.

  About half the organizations represented by the interviewees have not yet experienced decreasing inpatient utilization, but are anticipating a future trend. They have been actively looking at populations who are using inpatient services and could have been cared for in a lower-cost setting. Some of these efforts are resulting in shifts of inpatient volume from tertiary care to community hospitals.

- **Information technology and bio-technology**
  Interviewees described the increasing capital needed to develop and stay current with demands for patient care, data, and reporting needs. A physician reported having to spend three hours documenting care after seeing a patient for an hour. Implementation of an Electronic Health Record (EHR) was occurring in all of the hospitals represented. In some cases, the hospital was going from a paper system to an EHR for the first time and others had an EHR and were going to new platforms and vendors. Adopting EHRs requires lengthy planning and implementation periods. Increasing informatics staff, particularly clinicians in these roles, was also a trend.

- **The new consumerism of healthcare and increased access to care**
  More patients have access to care and are covered by insurance plans with higher co-pays and deductibles (that may vary depending on where they go for care). This may result in patients seeking care in lower-cost settings or forgoing care. The patient wants to know what the cost implications for care will be when a plan of care or course of treatment is being discussed, representing increased challenges for providers. At the same time a "retail" environment for healthcare is emerging, giving consumers more choices but disrupting continuity of care opportunities.

2. Has healthcare reform required you to develop new roles or skills in your organization/position? How have you done that? Has it been successful?

All interviewees reported the development of new roles or skills in their organizations as a result of changes in care delivery. However, most discussed the need for a more flexible workforce with 1) existing workers taking on new roles in new models of care; 2) shifting employment settings; and 3) moving between needed specialties and changing services offered.

- **Taking on New Roles: A focus on the role of nursing**
  The need for nurse practitioners and the lack of them was a significant theme. In some cases teaching hospitals partnered with schools of nursing to place advanced practice students in clinical settings. Some curriculum has been developed to address the acculturation of nurse practitioners into primary care practice settings. Despite the decades-long existence of the role of Advanced Practice RNs (APRNs) it was felt that there is still a lack of understanding of their role and how it is differentiated from the physician assistant.

  One senior nursing leader stated that, "the ACA has opened up access to care. However, our systems of care delivery are not ready, particularly for primary care. Massachusetts has not been a leader with regards to the role of the nurse practitioner as it relates to regulation and reimbursement. With an increasing volume of people seeking care, there are delays in access to care. People are being seen when their illness trajectory has moved to a more acute level, resulting in sicker patients being seen in the hospital. This is true for those with mental illness as well."

Many of the interviewees talked about the role of nursing in general and referenced the 2010 Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*. Recognition that care delivery takes a team and nursing care delivery requires support enables nurses to work at "the top of their education" and away from a utilitarian function, and allows them to move towards accountability for care management and coordination.

There is an increasing need cited for nurses with specialty certification in the inpatient setting, such as critical care, emergency care, and surgical nurses (including RN First Assistants to surgeons). Traditionally, new graduate nurses did not enter into these roles but now, almost all of those interviewed described programs to bring new graduates directly into specialty programs with extensive orientation and mentoring. In some cases this has created added stress for staffs that maintain assignment levels while supporting new staff acquiring competency. Some organizations were developing nurse residency programs for new graduates.

- **Shifting employment settings**
  As patients move away from inpatient care there is more demand for experienced RNs in the outpatient setting. Case Managers (most frequently nurses) were recognized as having the significant role change as it related to demands to achieve continuity of care while managing length of stay and utilization of services. These roles are appearing in emergency rooms, medical homes, and following patients across care settings. The training involves becoming more familiar with the services available in a community in order to put together a comprehensive plan of care.

- **New and expanded roles**
  There are new types of health professionals performing new functions. For example, health coaches and patient navigators are being implemented into medical home models. These health professionals can be licensed or unlicensed staff, depending on their focus. In general, higher educational preparation is preferred for population management of complex illnesses.

  In the outpatient setting there has been an expansion of duties for pharmacists, nutritionists, social workers and medical assistants. Technology has made the delegation of functions – such as vital sign monitoring, glucose, and other lab checks – easier. One community hospital adopted a curriculum for the medical assistant role from a teaching hospital model. This enabled them to adapt these models and not have to "reinvent the wheel."

  As workload demands increase for case managers, some organizations are providing support roles (e.g. bachelor-prepared social workers) to do more routine discharge planning. This allows case managers to spend more time on complex cases, patients and families, and with other team members. Additionally, entry-level service roles were identified to assist with workload demands. One example of these roles is "constant companions" which have been implemented to help with the increasing number of patients with behavioral and cognitive issues.

Another way to minimize employed full-time equivalents (FTEs) might be to change the nature of partnerships with vendors. Services such as food services, housekeeping and clinical engineering are frequently outsourced. With increasing accountability for the patient experience, costs of care, and maintaining current knowledge, these partnerships can look more like employed relationships where the staff may be eligible for recognition, receive communications, or participate in staff meetings and improvement activities.

Other roles described were project managers in non-clinical and clinical areas for functions that do not fall within typical clinical service lines, such as diabetes management, palliative care or space/facility planning specialists. Success with these roles was described as "evolving." Some interviewees shared concerns that not enough attention is placed on integrating roles into existing patient care delivery teams. "Frequently other people on the team don't understand a new role and come with their own expectations of what that person should do." At times new roles were described as fragmenting care and slowing things down. The recognition that the delivery of healthcare is complex and requires a team effort is not new. "It's just hard to put coordination into practice with the pace we work at every day," commented one nurse leader. It appeared that many of the hospitals had not developed curriculum, competencies, or evaluation for team-based care.

3. Can you tell me what you think is most helpful to building a workforce? What do you find lacking (or barriers) in transforming the workforce?

The employment market has been strong since 2008 when the economic crisis hit. In fact, all of the organizations represented had experienced layoffs. As a result, most vacant positions have had multiple applicants, allowing organizations to be selective in hiring. The most frequent response to the question was the existing workforce itself. The average length of service in many organizations is 15 years or greater. Despite issues around resistance to change, loyal and experienced staff were the most frequently cited advantages to transitioning the existing workforce. The knowledge of how things work, the willingness to orient and train new employees, and the pride in their work was often described, observed and celebrated at routine organizational events.

Some have reported measureable improvement within work environment satisfaction through more employee engagement. Though some leaders felt designations such as Magnet attracted and retained staff, they could not point to specific evidence to confirm these reports. A senior nursing leader from a teaching hospital with Magnet-designation noted, "For more than 10 years there has been a minimum hiring requirement of a BSN for staff nurses. We've had no problem attracting nurses."

- **Barriers**
  Despite some of the positive experiences, there were barriers to transformation needs that were described. Those include: a fear of delegating transition tasks of care to others; new roles not being embraced by staff; and labor contract language that makes it challenging to create new roles (or expand roles of others). An example cited of the latter was the implementation of

residency programs for new nurses, recommended by the Institute of Medicine's *Future of Nursing Report*. One senior nursing leader reported that in order to implement the residency role for nurses – much like the model for physicians – a lower salary scale would need to be implemented. The organization had been unable to implement the residency program because union leaders would not agree to the lower pay scale.

Other barriers were wide variation in the understanding of healthcare policy and reform, which form the foundation for new strategies being implemented. One director stated, "There's a lot of talk about inter-professional learning, but there really is not much going on. Much of the collaboration needed to deliver care depends on existing relationships and organizational culture."

Though interviewees believed that physicians and employee engagement strategies were making incremental improvements in ways of working more effectively together, there was still a "disconnect" between the top of the organization and the front lines. One manager described the positive results of lean process improvement, but felt that lean wasn't always embraced by senior leaders.

One director stated that although customer service training was available, it didn't necessarily result in staff innately feeling compassion or understanding of the perspective of the patient, family or a colleague. In reflecting on why customer service programs have had mixed success in hospitals, one senior leader stated, "There is an awareness of fatigue in the workplace for education targeted at 'fixing' the staff. Often when there are behavioral problems in the workplace, it comes from fear and lack of communication and understanding. When fear is the basic *modus operandi*, it's difficult to expect change."

Real transformation comes not from what workers are told to do, but the consciousness with which they do it. There is variability in the levels of awareness. This contributes to the ability to accelerate change in the work environment more than has been recognized. Interviewees talked about the resilience of the workforce as "confidence in managing change." If change management programs are not handled correctly, employees develop apathy to imposed programs feeling "this too shall pass."

4. Where do you look to hire people from? What types of people or expertise would you like to have on staff that you feel is currently missing in order for your organization to be successful?

"We may have a strong hiring environment, but the current healthcare workforce was educated and has worked in a model that doesn't exist anymore," stated a senior nursing executive. All but one of the interviewees described strategies to look internally for workforce transformation. The one exception noted: "We like to hire entry-level employees from industries that have placed emphasis on customer service training such as Dunkin Donuts and McDonald's."

One organization reported its internal strategy is to hire from within; this includes hiring and orienting staff without specific positions available, as well as succession planning to promote from

within the organization. Other efforts included screening and interviewing strategies to hire for values and qualities that support teamwork and compassion. What interviewees are seeking are "teachable" staff and the willingness to be flexible to change roles and settings.

The need for better and more seamless career ladders that will allow workers to retrain for different settings, services and populations were also identified.

Several of the interviewees reported challenges with recruiting and retaining nurse directors and managers. There was concern that these roles do not have the supports or salary levels that would make them a desirable career path.

5. What approaches have been taken to support the educational needs and ongoing acquisition of new competencies in the workforce?

A number of approaches are taken to support the educational needs of healthcare workers who are knowledge workers; examples include formal educational classes, attendance at outside conferences, and requiring certain credentials or certifications for the corresponding position.

Time for learning is considered a significant barrier. However the increase in on-line, or in shorter interval education, has made it more attainable for staff to participate. Attending outside education that may teach about an approach to care adopted at a teaching hospital is not viewed as valuable by the staff in a community or post-acute setting. Ideally, as staff develop expertise, they value learning right on the job. Access to supervisors, educators or clinical specialists are ideal, but with budget cuts and with management staff spending more time away from departments, it has been a challenge to maintain these roles or the presence of mentors.

New information systems and the electronic medical record have and will continue to consume training time as these systems are ever changing and regularly upgraded. Every interviewee's organization was working with a hybrid of models requiring staff to navigate through different systems. A senior executive reported that, "A physician told me of a case where he spent a half hour with a patient and it translated to three hours of computer work."

Simulation training is being used for clinical training and increasingly for team training.

6. How is education/training funded? Is the funding adequate?

Organizations reported varied commitment to education and development. For instance, the goal to attain Meaningful Use may result in funding to support IT training. Most organizations provided education for updates on new equipment or education required for implementation of new policies, or credentialing and accreditation requirements.

Teaching hospitals reported more ongoing clinical education and paid for certifications (which typically require demonstration of ongoing learning). Outside conferences were frequently

mentioned for nursing, physician leaders and senior executives. With tight budgets, most organizations are trying to evaluate the best education value. Seeking philanthropy dedicated to education is emerging in community and teaching hospitals.

7. Where there are gaps in providing for educational needs, what would provide the most value?

- Use of technology. For example, access to web-based training was used by all organizations represented. This allows organizations not to have to develop all of the content.
- There is a need for more inter-professional education, including use of simulation technology and models of team training.
- Hospitals want the ability to integrate learning with work immediately. Several organizations described the value of bringing teams together to help solve current problems within their departments.

  Maureen Bisognano, CEO of the Institute for Health Improvement, spoke about "flipping education" in her 2013 keynote address at the Annual Meeting of the Institute for Healthcare Improvement. The concept of changing the traditional classroom model where students learn then go out and try to apply what they have learned gets "flipped where they bring their 'homework' into the classroom and the teacher is more of a 'guide' to unlocking the solutions for the problems encountered."

8. What are some emerging areas of patient care delivery that you think require new skill, roles or responsibilities?

- **Population Health Management**: Although models and evolving certificate programs are out there, there is still a needed for clinicians as well as executives that foster learning and development of evidenced-based practices.
- **Short-term acute care**: The nurse practitioner role in the inpatient setting includes a focus on care management and coordination.
- **Data management**: As more data becomes available regarding outcomes, it needs to be reported in a timely and understandable manner to allow the team to take action. Data specialists embedded in clinical teams would improve this area.
- **Navigators** to work directly with specific patient populations and assist them with care management.
- **Leadership in a transforming environment**: The role of leaders – from senior executives to frontline supervisors – is changing rapidly. There is recognition by interviewees of the barriers presented by the hierarchy. The concept of "team intelligence" was discussed. This is defined by Suzanne Gordon, author and journalist who has studied hospital

environments, as "The active capacity of individual members of a team to learn, teach, communicate, reason and think together, irrespective of position in any hierarchy, in the service of realizing shared goals and a shared mission." Interviewees noted the need for leadership to recognize and support capacity for team learning in their organizations. This ultimately results in less dependence on hierarchy for problem solving. Other examples focused on creating more connection between leaders and front line workers, through initiatives like lean process improvement and regular "rounding" in departments.

IV. SURVEY

The purpose of the survey was to:

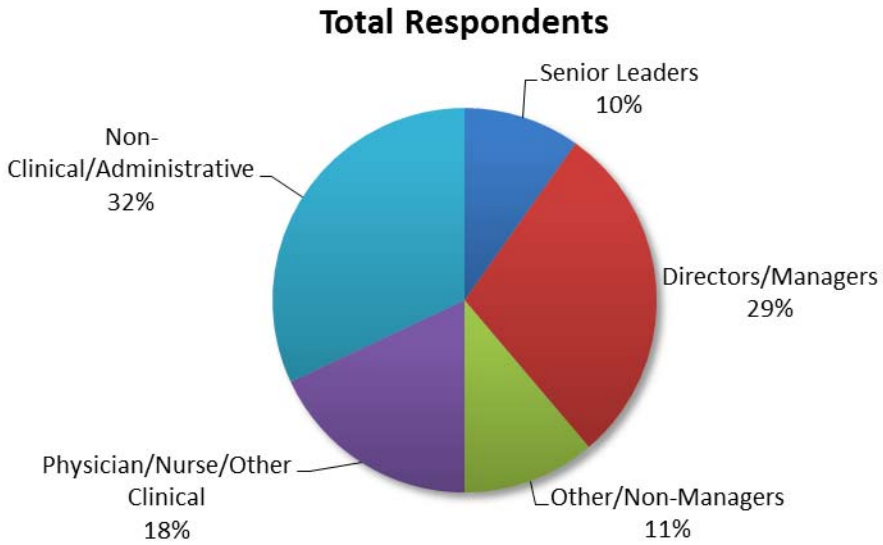
1. Identify priority knowledge, training and education needs in the hospital workplace now and over the next three years;
2. Identify best practices for accessing education and highest value point for the learner;
3. Identify ways MHA can contribute to supporting members' workforce transformation needs.

The survey was distributed electronically to 5,187 individuals from the membership data base. It was available between May 15 to June 1, 2014. There were 438 responses for an 8% return rate.

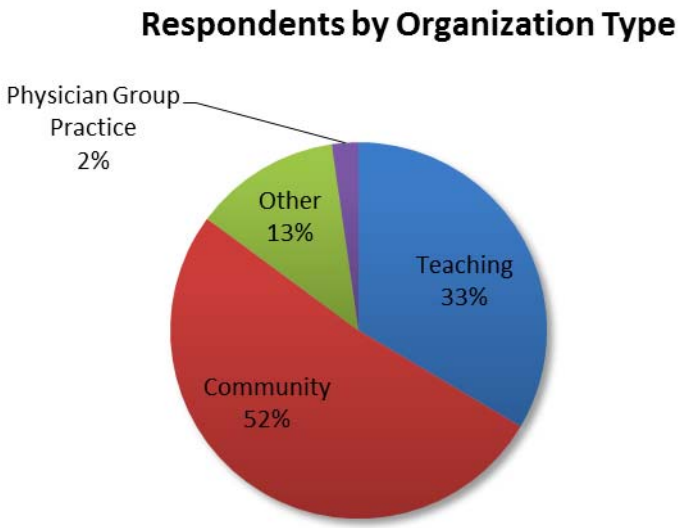
Survey results

Respondents

The following chart shows the breakdown of the roles of the 438 respondents:



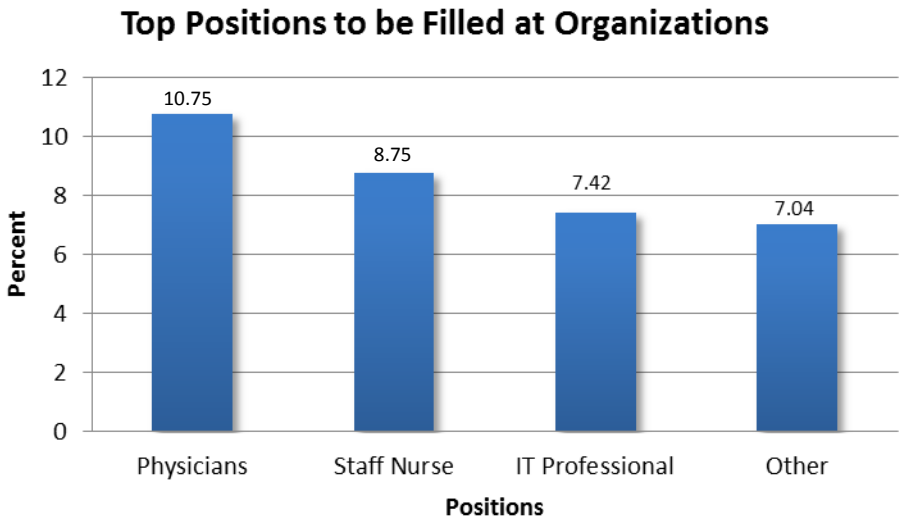
The following chart shows the breakdown of the type of hospital (teaching or community hospital) or practice group.



The respondents ranked the top areas that they see as areas of education needed. The areas they identified in rank order:

1. Creating Engagement Between Patients & Staff
2. CMS/Healthcare Regulation Updates
3. Leadership Development
4. Change Management
5. Data Analysis and Management Skills
6. Conflict Management
7. Emerging Trends in Healthcare
8. Healthcare Technology Trends and Practical Applications
9. Effective Communication
10. Building Resilience in the Workforce

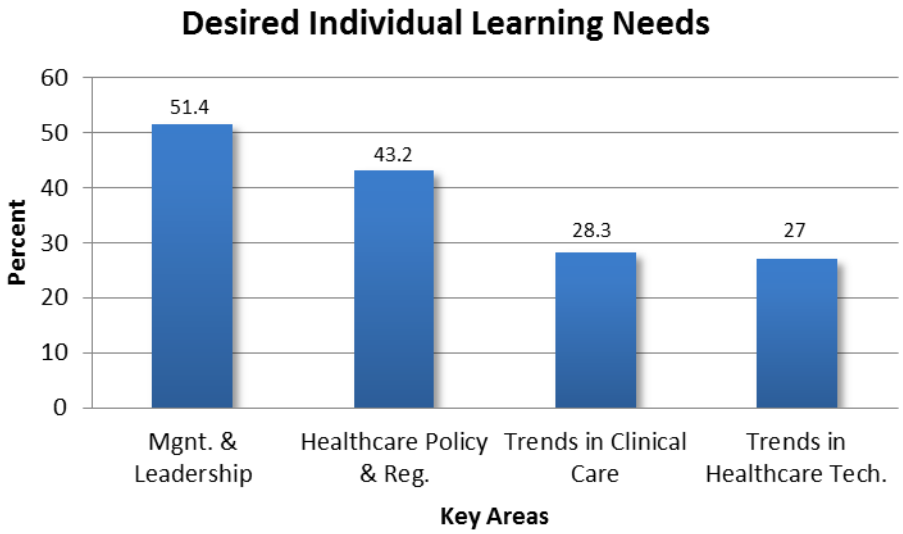
To get a sense of perceived staffing issues within the organization, we asked respondents to indicate the top three positions that their organization needs to fill. Table 3 shows their top four rankings:



We asked respondents to indicate their level of comfort with the knowledge they have in a number of areas. Below are the top 3 areas they indicated the most discomfort, with #1 being the area with the *most* discomfort:

1. Emerging technology and biomedical devices
2. Behavioral health management
3. Population health management

We asked members to rank the areas they are personally most interested in more education:



In moving away from how respondents perceived their own knowledge needs, we asked about how learning needs are viewed for the organization as a whole. The top 6 out of 20 areas of perceived organizational need for knowledge were:

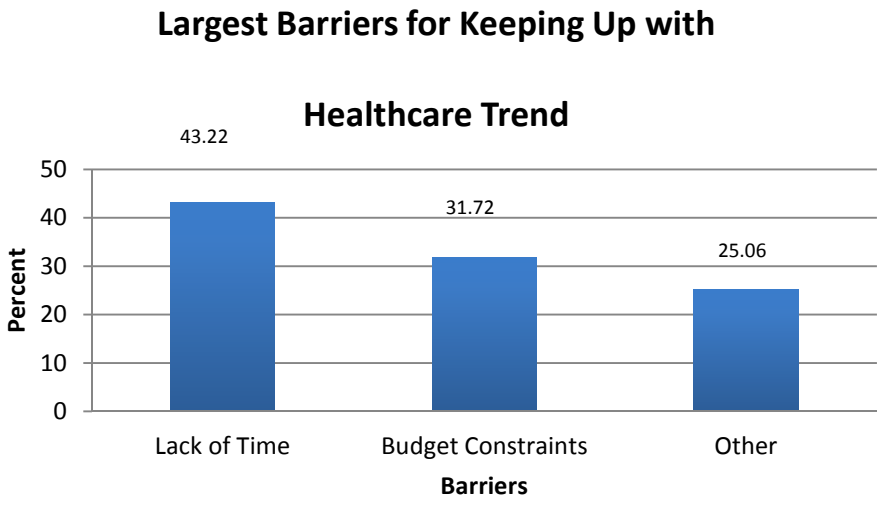
1. Building a resilient workforce
2. Stress management
3. Change management
4. Leadership in a transforming environment
5. Data management and use
6. Population health management

Note: The data show the respondents see the needs of the *organization* differently from their own needs – e.g., low need for change management skills for individual, but high need identified at the organizational level. There is a higher ranking of importance of skill at managing the context for reform over new technical or clinical skill sets. *The prioritization is for the organization to address stress, building a resilient workforce (defined at the ability of the workforce to deal with conflict and change, and to develop leaders with transformational skills.*

We asked respondents "how prepared or unprepared" their organization is currently to meet the emerging healthcare needs of their community.

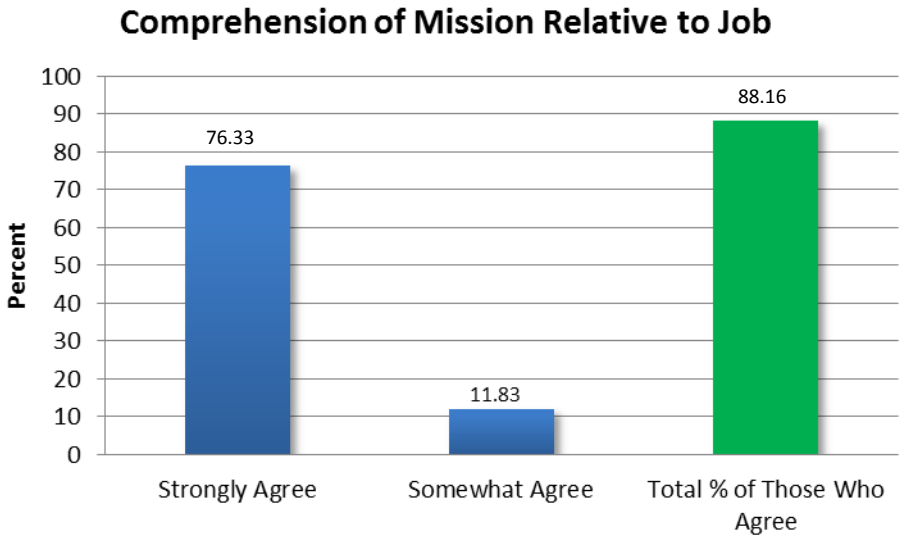
94.19 % of respondents felt that their organization was "prepared", "well prepared" or "very well prepared."

We asked respondents what are the barriers for keeping up with healthcare trends.



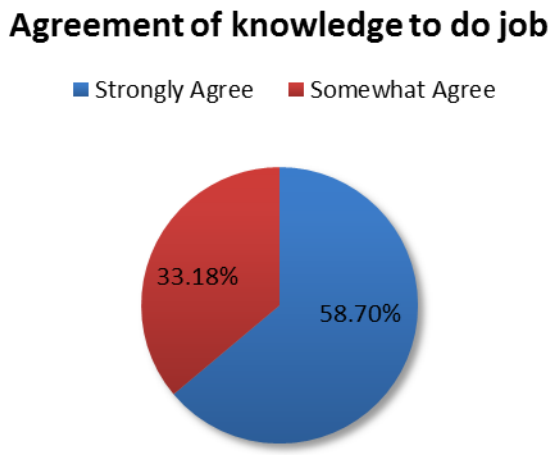
Note: Lack of time and Budget Restraints made up nearly 75% of the ranking of barriers to keeping up with healthcare trends.

We asked respondents to reply to this statement: I understand how my job is related to the mission and purpose of my organization.

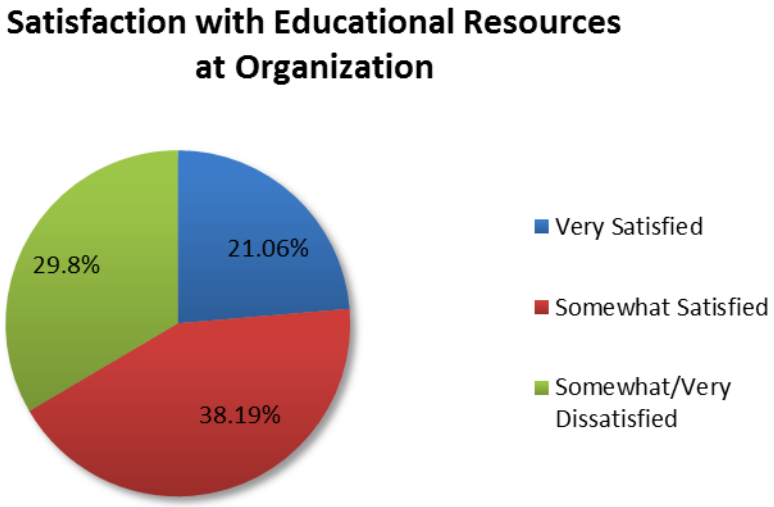


Note: 0% said "don't know/not sure" This may reflect the emphasis over the past decade on the patient experience, customer service, importance of teamwork, introduction of process improvement teams, root cause analysis, and assuring that employees are knowledgeable regarding the mission and vision of the hospital.

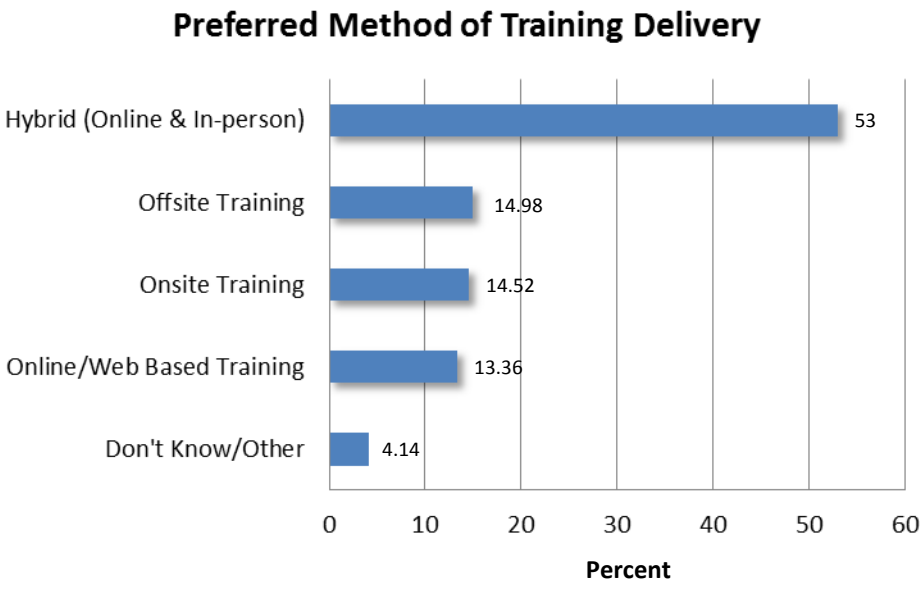
We asked respondents to reply to this statement: I have the knowledge I need to do my job right.



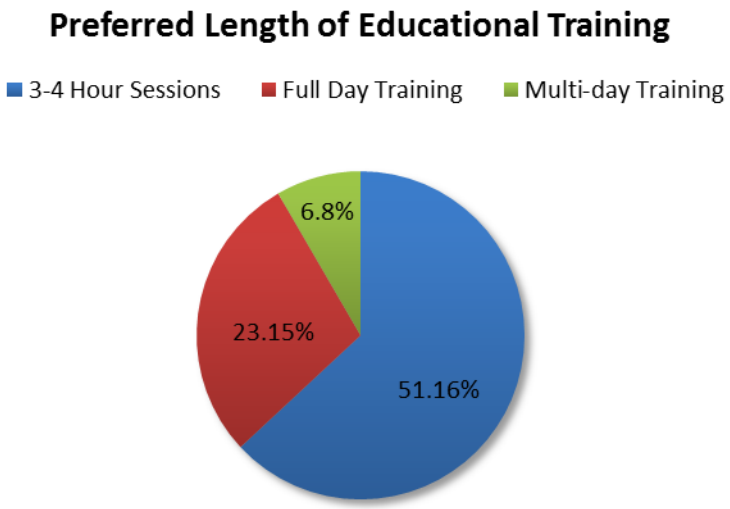
We asked respondents about the general level of satisfaction with resources provided for education in their organization:



Methods of training preferred are indicated below. Hybrid training was identified by far as the most preferred.



Preferences for length of training:



Note: Less than 7% preferred a multi-day training session

V. SUMMARY OF FINDINGS

A picture emerges of a workforce that understands the efforts and strategic changes their organizations are making to respond to healthcare reform. The respondents also report feeling a high degree of connection to the organization's mission. However, the degree of conflict and stress within the organization and learning across teams appears to be undergoing significant challenges.

Respondents prefer to use their limited time on learning – specifically that which directly applies to the knowledge needed for their roles. This learning should be delivered in ways that result in adding value to those issues with which they are currently struggling. The approach to learning may differ depending on the topic. For example, learning to work as a team is not conducive to webinar format. Inter-professional learning done in an environment that is not viewed as relevant to an individual's work environment may not have added value either.

The survey demonstrates that workforce transformation must be done in such a way as to add value to the organization and the individual. As healthcare changes from a volume to a value proposition, so must the approach to the development of the workforce. Understanding of roles, team learning, and individual resilience are the foundation for transforming the current workforce. Responses suggest that if the environment is supported correctly, the staff itself will engage in a way to assure their learning needs are met in what is more likely to be a more productive, efficient and rewarding manner.

VI. WEAKNESS/BIASES AND LIMITATIONS

The survey and assessment was an initial inquiry into the dynamics present in MHA member organizations. The condition of anonymity was important to supporting the authenticity of the information obtained. The approach of examining concurrent qualitative with quantitative data is ideal but may not directly correlate. The assessment of workforce transformation needs was obtained from the opinions of a broad representation of individuals in healthcare. This serves as a starting point for the reinforcing and restraining forces of change and ultimately a path to support the healthcare workforce transformation. No patients or families participated in the survey.

There was significant emphasis and discussion regarding the role of nursing in the context of healthcare reform. This may reflect the number of nurses interviewed; however, literature supported their perceptions. The importance of the interdisciplinary team and new roles emerging are recognized. Additional study and references included in this report point to opportunities to look wider and deeper into other team roles and skill sets.

VII. CONCLUSIONS

Healthcare expenditures account for a significant percentage of the national and state economies and continue to grow. Healthcare organizations in Massachusetts and their workforces are increasingly strained as more people enter the healthcare system as a result of coverage expansion, demanding new approaches to care delivery. It is widely recognized that developing and supporting a productive workforce is essential to lowering per-capita costs of care. It is time to expand on how to align payment systems and new models of care with how to transform the healthcare workforce in order to deliver new models of care.

We appear to be fortunate in Massachusetts that within our healthcare organizations there is an appreciation for the workforce's knowledge, loyalty, and pride in what they do. It is therefore also important to look closely at the strengths of the workforce. The survey respondents report strong belief in their hospitals and feeling connected to the mission. However, the unprecedented challenge of retooling the current workforce for the present and foreseeable circumstances presents larger barriers to remodeling effective care delivery.

Early adopters are piloting new roles which are intended to give greater attention to team-based delivery of care and accountability for outcomes.

Team training efforts are in their early stages. There is significant focus on the role of nursing as a next point of focus. As with all early innovations, there are lessons to be learned, improvements to build upon, and knowledge to disseminate. However, there are considerable cultural barriers to changing the workforce. It's important to note that lack of progress on a wide scale-change, however, will come at a great cost of limited productivity that is already at a 20-year low. The burden of that cost could significantly obstruct the ability to make advancements in the redesign of care delivery.

Engagement of frontline workers is critical in order to connect strategic vision with execution. Most healthcare workers have important ideas for improving healthcare delivery. It is understood that fixed, layered, fragmented approaches to any work, but especially complex work where there are frequent decision points, requires people and teams working with intelligence. The new "team intelligence" develops with a foundation of a resilient workforce energized by possibility instead of fear, understanding instead of confusion, and authority that comes with ownership. Clear and ongoing communication between leadership and the frontlines is critical.

Health system change will require a workforce with role and career flexibility.
Leaders and workers need to shift from rigid role and task orientation to well defined career frameworks that provide flexibility to change roles and settings, develop new capabilities and alter professional focus in response to the changing environment and the needs of patients. Labor unions will also need to bring a new vision of potential to what will create career longevity and opportunity and work with hospitals to create new and more flexible structures.

Start with the question: What does the patient need?
Many of the interviewees used examples of complex care journeys with family members. By retooling the workforce and acknowledging patient stories, staff will be able to create ideal journeys that include the patient and family perspective. Knowing the patient, integrating care and managing transitions between home, outpatient, and acute settings is critical to define and train as a team, evaluating results from the patient perspective.

Moving ahead and reframing subsequent questions:
As greater understanding is acquired around disease management, care coordination, and patient needs the next step is to pose more questions:

- Does the workforce have the right skills and competencies needed to function in new models of care?
- What roles are needed and how can different skill configurations best meet these needs in different geographies and practice settings?

Important considerations to moving ahead:

- A focus on having fewer team members around a smaller population of patients.
- Training individuals for new roles with education and training that is convenient, timely, and with financial incentives that are taken into consideration.
- Training teams to accept new roles; other team members need to understand the content of new roles and feel the individual is appropriately trained to take on the new role. They also need to understand how the new role fits into work flow and overlaps with their current role.
- Attention to individual resilience and vitality: educating providers and supporting work environments that value self-care, reflection, and respect will promote creativity, innovation, and compassion.

- Leadership commitment to resourcing workforce transformation including the development and support for transformational leadership skills and standardizing their own work to partner with frontline workers.
- Apply focus to redesigning curriculum for students in the pipeline to include new settings for education and exposure to roles and accountability for care.

It will take a consistent commitment of resources to achieve the retooling of the current workforce during a challenging time for healthcare. Considerations for new ways of funding or partnering with other organization will need to be considered. This funding will not be just organization based, but should be aimed at supporting wide scale change.

ACKNOWLEDGEMENTS

Deep appreciation must be extended to the 16 individuals who represented frontline staff, managers, directors, senior leaders and hospital CEO's who made themselves available for the interviews. Their candor and personal commitment to understanding and addressing the needs of the workforce was evident.

Several other leaders provided perspective for this report representing two organizations that serve to lead change in healthcare in Massachusetts and beyond: Sharon Gale, CEO, Organization of Nurse Leaders of Massachusetts and Rhode Island and Joanne Healy, Senior Vice President, Education and Development for the Institute for Healthcare Improvement.

The Gallup Company was engaged for assistance with the structured interview questions and survey design. However, its staff went well above and beyond their scope by accessing support from their considerably talented team in order to produce meaningful information.

And lastly, the staff of the Massachusetts Hospital Association whose specific job it is to understand the learning and education needs of those who are responsible for future care delivery and who are making our hospitals and health systems the safest, best experience for all patients and families. Recognition goes especially to Pat Noga, RN, PhD, Vice President, Clinical Affairs; Kirsten Singleton, CAE, Executive Director, Center for Education & Professional Development; and Jill Ettori, Marketing & Events Specialist. Lynn Nicholas, FACHE, CEO, championed the application for funding for this report so that the conversation about workforce needs could be elevated knowing the power of collective thought and collaboration throughout the Commonwealth.

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