New Jersey State Employment and Training Commission
Health Care Workforce Council
Hunterdon Medical Center, Flemington
April 15, 2011

MINUTES

I. Welcome and Chairman's Remarks: Robert P. Wise, Chair, and Health Care Workforce Council.

The meeting was called to order at 8:45 am by Chairman Robert Wise. Chairman Wise welcomed all members to the meeting. **Approval of minutes:** A motion was made and seconded to approve Council meeting minutes from January and February. No corrections were made. Deborah Zastocki made a motion to accept the minutes. Bill Dwyer seconded the motion and the minutes were unanimously approved with no abstentions. Chairman Wise introduced Ashley Conway, the new State Employment & Training Commission (SETC) staff member who will be coordinating the Council.

II. Occupation Pipelines:

Chairman Wise presented the goal of the meeting as the selection of career pipelines identified through the input of Council members. Selected occupations represented those of the highest priority for the Council to address based on information distilled from Council meetings, sub-committee meetings, and surveys of Council members. Chairman Wise asked for input about whether the occupation priority rankings in the tiered list were consistent with what Council members know.

- It was noted that two things should back up the Council's choices for good triangulation of data: 1) the percentage of the workforce represented by Council priorities and 2), to the extent that the data exist, where the critical workforce shortages exist.

- Data on primary care physician data were made available in Washington last week showing that there will be significant shortages in the next ten years.

Health Resources and Services Administration (HRSA) Grant – Robin Widing, Acting Director, New Jersey State Employment and Training Commission.

Ms. Widing explained that the Department of Labor and Workforce Development conducted a workforce analysis that was included in the grant application. Jason Timian, from the NJ

Department of Labor and Workforce Development (LWD), Office of Labor Planning and Analysis (LPA), will be working with SETC on the health care grant. The HRSA grant focus on primary care was highlighted as an area of expected significant expansion; for instance, Federally Qualified Health Centers (FQHC) are expected to have triple growth. HRSA is also interested in the upskilling of those employed in health care occupations.

Ms. Widing reviewed the major trends impacting workforce issues identified by the Council: Accountable Care Organizations (ACO): 1) regionalization, 2) medical homes, 3) Medicare/Medicaid systems, and 4) reorganization around teams.

Pipeline and Priorities Discussion:

- Access to primary care is a key problem. Barriers are: 1) too few physicians go into primary care and 2) some primary care residencies do not get filled because doctors go in to specialties. The Institute of Medicine (IoM), Massachusetts, and the Affordable Care Act (ACA) recognize that increasingly Advance Practice Nurses (APNs) are moving into those roles.

- It was suggested that pipeline priorities be reordered as: nurse faculty, APN, BSN (Bachelor of Science Nursing), ADN (Associate Degree Nursing).

- Also, it was recommended that Licensed Practical Nurses (LPNs) not be included in the priorties list, because LPNs are not able to get jobs – including at nursing homes. Recently the Board of Nursing turned down an LPN school application because it was felt there were too many schools.

- There is a huge nurse faculty problem in New Jersey. Masters', PhD, and BSN students are being turned away because of lack of faculty. In 2005, just three nurse PhDs were graduated in New Jersey to teach.

- New Jersey Collaborative Center for Nursing has data regarding faculty. It was noted that when examining the faculty shortage, it is necessary to consider the various types of faculty. The PhD faculty who prepare PhD programs, for instance at Rutgers and Seton Hall, are comprised of small, labor-intensive teams. There are two or three research institutions in New Jersey that hire upper-level faculty to teach PhD students. There are also Diploma schools and Associate Degree programs in community colleges; these require a Master's degree to teach.

- The goal of the New Jersey Nursing Initiative program (NJNI) is to increase nurse faculty. Ms Widing informed the Council that Sheryl Hutchison is serving on the NJNI

Data Pillar group and Ashley Conway is serving on the NJNI Education Pillar group. This illustrates that the groups are linked.

- It was suggested to reorder the nurse list with APNs being the most important investment at this point.

- It was noted that this dialogue is worth embellishing for the Council's report.

- Members discussed the distinction between PhD and doctoral prepared nurses. There was agreement that confusion exists about what APNs do and how they are educated. Master's degrees in nursing are not going away, but for APNs a doctorate will be expected in future.

- It was observed that clarifying these distinctions is important. Those in health care professions find this confusing and the public has no clue as to the priorities, the complexities, and the crisis that exist in developing the right kind of professions for the future. Clarification and some description of these connections are important for the Council. The same applies to primary care – programmatically and economically. The Council's arguments should use the language of the lower cost alternative. "Bending the cost curve" is a health care focus for hospitals and health delivery systems in New Jersey in order to take on more of the uninsured and a growing Medicare population. Primary care and Advance Practice Nurse initiatives will be of great benefit in flipping the delivery system upside down and finding lower cost alternatives – a reason Dr. Brenner's work has been effective and celebrated. The work Brenner is doing and that "New Jersey has answers" should be taken advantage of when the Council makes its recommendations.

- It was explained that the Affordable Care Act funds nurse-managed clinics. For instance, Advance Practice Nurse clinics provide primary care in a number of communities. Kathleen Jackson, an APN, runs a number of Brenner's clinics in Camden.

- Data exist about where Advance Practice Nurses practice and their specialties. There are about 5,000 APNs in New Jersey. Retention is a problem in New Jersey; a large number of medical students don't stay in New Jersey, but Advance Practice Nurses do stay in the community. More master's students are coming in to be Advance Practice Nurses, so the number will jump in the next year or two.

- Members were asked to consider the symbiotic nature of the discussion. If the data show significant emergency department savings at Cooper Hospital using Brenner's model, the model can be extended to urban centers where there is an excessive use of emergency care. This care can be replaced in a clinic setting using nurse practitioners and redirecting the dollars saved into clinic programs. Additionally, grants and scholarships

could be given to encourage those who cannot afford advanced practice training programs.

- Nurse Practitioners (NPs) are generally educated through a primary care track. Where NPs practice is influenced by: economics (if they are hired in a specialty practice sometimes the salary is higher) and current New Jersey regulations that require a collaborating agreement with a physician. APNs cannot be directly reimbursed for care - rather reimbursement must be through a physician. It was suggested that the ACO comment period is an opportunity for the Council to consider making recommendations for changes, such as direct payment for APNs.

- Members discussed the protocol of Advance Practice Nursing in New Jersey. Currently, an APN must practice under a physician, although the physician does not supervise the work of the APN. The collaborating physician is not legally liable for the APNs practice. An additional issue is that some physicians are requiring APNs to pay to practice under their license. The question was raised - as more practices are bought by ACOs, how you do align issues of practice? The requirement to practice under a physician and the issue of reimbursement are barriers to APN practice.

Models of Care and the Team Approach:

- It was noted that one of the things that made Brenner successful in Camden was the concept of teams. Although there is a lot of talk about teams, not much is being done to implement them.

- NJNI has discussed that there is now an opportunity to be involved in team development to produce a product that could be marketed. For instance, nurses serving as interdisciplinary care coordinators, particularly in hospitals.

- The question was posed, how would you implement the concept of team?

- The ACO concept has engaged hospitals nationwide in trying to understand what the requirements and qualifications for success are. Although vague, there is an interest because there is a requirement. New Jersey might create a defined microcosm that mimicked the ACO, but was New Jersey's own "accountable care team" or "accountable care community organization". This New Jersey organization, or mini ACO, would use a team approach in the community setting with different parameters that would net team emphasis goals: intercommunications skills; shared roles and responsibilities; and a balance of professionals. This model is, in essence, what a medical home is and what an ACO is on regional issues. Instead of an ala carte model of health care education and delivery, we would propose to educate a team that will serve a population in need

showing effective outcomes. Coupled with the interest in Brenner's model this could be a way to generate federal government interest in a New Jersey model.

- Additional New Jersey-based evidence is a network analysis of the highest and lowest performing cardiac units in the state. The data show a big difference in the communications patterns of the high and low scoring units. It is about more than the cost, as some high performing units were relatively low cost. The issue of training professionals cooperatively but then putting them back in a work organization that doesn't support the learning was noted. Also, training is not enough because the design of the work organization must allow people to use the skills they have learned; therefore, the work organization itself needs to be examined.

- A caution was made that if the Council is simply recommending generating professionals to disperse into different models of care it would be a mistake. This would ignore the facts of the future – the future delivery system, the future of effective care, and what the consumer wants. The Hunterdon tag line of "your full circle of care" is used within every discipline creating an interconnectivity among caregivers in the delivery system and in different clinical service lines. The Brenner model moves the team into the community, making the team part of the community rather than forcing community members out of their environment to receive care.

- The point was made that the environment Brenner works in is very different from the other 90% of population. The model requires a cultural shift for the physician and it requires strong leadership.

Coordination of Care:

- At Hunterdon Healthcare, the coordination of care with community clinics is important and the team approach is used to deal with transitional issues. Nurse navigators are used at both health centers. Navigators need to have experience in the present fragmented health systems in order to understand what is needed. This doesn't take a physician - but leadership is important.

- There is a need for the team approach to care in different settings - urban, suburban and rural. Job descriptions will be different depending on geographic area. Local leadership makes this easier.

- The question was asked about navigator patient load. It was answered that this is unclear at this point, but initially it may be 20 to 30 patients assigned to each nurse navigator.

Needs and Resources:

- It was pointed out that school-based clinics and school nurses are important, particularly in rural areas, but funding for these clinics is being decimated. This is particularly troubling in light of the childhood obesity epidemic.

- Some schools are linked to Federally Qualified Health Centers (FQHC) – a fact that may be important for New Jersey to tap into and that could lead to funding. There are a set of mandated services that FQHCs must offer. It is unclear what will happen in light of the recent funding and reimbursement rates in the 20 FQHCs and 100 satellite centers in New Jersey.

- It would be worthwhile to create a map which overlays the school clinics with FQHCs in each county in New Jersey. Also, the mapping of other services – such as community health workers, public health partners, and initiatives – would be useful. This will help in understanding where the resources are needed and which efforts are effective.

- Mapping could also illustrate that groups are not always linked as well as they should be. The facts are that 58% of hospital beds are empty, more than 30 hospitals have closed over the last 10 years, and one-third are in financial danger. How do you make sure there are enough hospitals left to feed into? Linkages and relationships are needed throughout the system.

- There is enough money in the New Jersey health delivery system to redesign health care and to significantly improve health status. It is not a question of how much we need, rather, how it is redirected and used. For instance, specialty access is an issue for many clinics, but many times it is an issue of the need for more creative delivery. Members discussed health care system innovations.

Return to Pipeline:

Chairman Wise asked if any additional occupations were identified. **Speech and respiratory therapists** were suggested. **Technicians** need to be defined more clearly. **Mental health** accounts for 30% of all charity care expenditures in New Jersey; mental health needs to be put in the "parking lot" for further exploration. Should shortages in mental health be focused on? What "low hanging fruit" can the Council help ramp up? With success comes more funding, for instance, making progress with nurses' aides. **Physician's Assistants** should be added to the list as an important mid-level part of the team. **Social work** is important when addressing issues using a team model. FQHCs are moving toward hiring **Licensed Clinical Social Workers (LCSWs)**, who are reimbursable, as opposed to an MSWs or BSWs without certification. **Community health workers**, at health centers and in public health, also were suggested as additional pipelines for exploration.

Teams and Pipelines:

- Considering the education track for any of the professions and how they integrate together in their learning is important. If the expectation is that people will be working in teams, then they should be learning in teams. This integration should be possible without creating a whole new system. If a team concept is developed, professionals could be added to the team by definition and by need. The team leader may be a physician, a nurse, or other professional. Members agreed that educating collaboratively is important in order to avoid educating in silos.

- The importance of relationship coordination is a focus of the book "High Performance Health Care" (High Performance Health Care: Using the Power of Relationships to Achieve Quality, Efficiency and Resilience - Jody Hoffer Gittell). Gittell's significant finding was that developing collaborative and team skills and competencies need to start in the training. At the undergraduate, and even at the master's level, there is not an emphasis on learning to work in multi-disciplinary teams. How does this get built into the curriculum?

- The practice of team safety is growing dramatically and finding significant success in reducing errors, for instance, by calling a "time out". The use of teams is understated in its importance but is growing. The Council should address that more curricula development should include the application of teams. Fifty-one percent of doctors are employed rather than in private practice and they need to learn to be part of a team.

- Rutgers' School of Labor and Management Relations perspective on teams is that focusing on the supply side of skill production without looking at the demand side of how skill is actually used can result in the overproduction of skill in underutilized areas. These skills then get lost and don't create long-term change in the workforce development system. It was advised not to forget the demand side – where are these skills going to be used and what is the context? The emphasis on teams, interdisciplinary decision making, teambuilding, and communications is important for health care professions both individually and collectively.

- In addition to embedding team competencies in training and education, consider measuring not only the individual's team skills or technology fluency, but the group's skills and offering some sort of certificate. Does the organization have team competency and is it being executed?

- The discussion returned to the idea of a New Jersey state accountable community care organization where there would be certification, recognition, and validation for all of the skill sets that a successful team has. These skill sets would be practiced because it is

known that they create better outcomes of care, are more efficient, are cost effective, and will be attractive for an individual to join. The joining aspect of the medical profession is raising and the isolation and "I want to be on my own" attitude is declining across all professions.

- It was suggested that the Council has the potential to help on the level of state policy representation and support. Organizations go after grants that they consider important to what they have the potential to develop. In general, a lot of money is being wasted by going after grants to do things that don't really need to be done, resulting in people being trained for jobs that don't exist. But what is important for the entire state in health care? The reports and ideas generated by the Council can be used by the state when considering whether applying for grants makes sense in light of the expectations for the industry.

- Ms. Widing stated that the ideas generated in this meeting presented a framework for the direction of the Council.

Magnets:

- Members discussed the magnet hospitals as an example of team delivery of care. New Jersey has more magnet hospitals, on a percentage basis, than any other state. These hospitals demonstrate a higher effectiveness in their outcomes of care than non-magnet hospitals. The magnet hospitals attract nurses and other professions; they typically have low vacancy rates and low turnover rates. The bar for the magnet hospitals is set high: it requires a change in the practice of nursing, the coordination of care has to include all professions in a multi-disciplinary approach, and the level of importance has to rise to the board level in order to be recognized as a magnet institution. This model reduces the hierarchy of the old model and builds the team.

- New Jersey therefore has a successful team model in its magnet hospitals, which has high effectiveness in outcomes of care and lowers costs in the institutions. The Council should explore how this model could be replicated in communities, in non-institutional settings, to allow for greater access across New Jersey. Hunterdon and other hospitals have already begun to extend their system of care into the community; this includes school-based programs, mental health services, and public health partnerships with retail pharmacies. Members also discussed the vital importance of organizational behavior to the success of these efforts.

III. Update from the NJ Department of Health (DHSS) – Current Initiatives and Priorities:
Cathleen Bennett, Director of Policy and Strategic Planning, NJ DHSS

Ms. Bennett provided the presentation "Health Care Workforce Challenges" and PowerPoint handout.

The role of hospitalists was discussed. Ms. Bennett stated that there is an evolving role for hospitalists in NJ and is part of the life-style issue because it provides intellectual challenge and better hours.

- The role of doctors needs to be re-examined. How much medical education is needed to treat patients in the primary care setting? What percent of primary care work can be done by someone other than a doctor? What percent does the doctor need to do? This is the question that needs to be addressed rather than trying to meet a mandate of where ACOs are going.

- Much of the work of primary care entails monitoring, education, and compliance. This is where the team becomes important. Complicated patients need to be seen by a medical doctor and the multiple factors involved need to be reviewed and understood.

- Members discussed the role of physicians in a multidisciplinary team model.

- In clinical placements, students generally do not learn in teams. Part of the residency program at St. Peters, New Brunswick integrates physician learning with the learning of other disciplines. It was suggested for the Council to have a meeting at the new building on the St. Peters' campus.

IV. Updates from Council Members:

Geri Dickson provided Council members with a comprehensive outline of the data collection efforts of the NJ Collaborating Center for Nursing, from 2003 – 2011. She also distributed the Center's March 2011 publication, "Where We Are and Where We Are Going."

Jason Timian provided Council members with the latest NJ Labor Market View, "New Jersey's Economic Health Depends on Health Care Industry." This report outlines the key role health care plays in our state economy. The health care industry contributed over $32 billion to New Jersey's Gross domestic Product in 2008, roughly 7% of all output.

V. Next Steps

Chairman Wise indicated that the May 20th meeting of the Health Care Workforce Council will be cancelled to allow work to be accomplished in the task forces. The next meeting of the full Council will be held on June 17, 2011 at the Hunterdon Medical Center in Flemington. Chairman Wise thanked all members who attended in person and on the phone for sharing their insights with the group. The meeting was adjourned at 10:45 am.

Member Attendees – April 15, 2011

Bakewell-Sachs, Susan, NJ Nursing Initiative [phone]
Barnard, Susan, Bergen Community College (for Mr. Ryan)
Barnett, Patricia, NJ State Nurses Association
Bennett, Cathleen, NJ Department of Health and Senior Services (for Commissioner O'Dowd)
Brady, Jane, Middlesex Workforce Investment Board
Ceserano, Justine, NJ Primary Care Association (for Ms. Grant-Davis)
Cooper, Belinda, NJ Hospital Association (for Ms. Ryan)
Daitz, Andrea, Robert Wood Johnson Foundation (for Dr. Ladden)
Dickson, Geri, NJ Collaborating Center for Nursing
Dwyer, William, PSE&G Children's Specialized Hospital
Egreczky, Dana, NJ Chamber of Commerce Foundation
Finegold, David, Rutgers School of Labor and Management Relations
Flatley, Jeffrey, NJ Dept of Labor and Workforce Development (for Commissioner Wirths)
Orchard, Patricia, Horizon Blue Cross Blue Shield of New Jersey
Savage, Judy, NJ Council of County Vocational-Technical Schools
Schurman, Susan, Rutgers School of Labor and Management Relations
Weaver, Kathy, Newark Alliance
Wise, Robert, Hunterdon Healthcare
Zastocki, Deborah, Chilton Memorial Hospital

Guest and Staff Attendees – April 15, 2011

Conway, Ashley, NJ State Employment and Training Commission
Hutchison, Sheryl, NJ State Employment and Training Commission
Kocsis, Violet, Hunterdon Healthcare
Mertz, Lynn, NJ Nursing Initiative [phone]
Shlimbaum, Terry, Hunterdon Healthcare
Timian, Jason, NJ Department of Labor and Workforce Development
Widing, Robin, NJ State Employment and Training Commission