New Jersey State Employment and Training Commission
Health Care Workforce Council
Labor Education Center, Room 131
Cook Campus, Rutgers University
February 17, 2012

MINUTES

I. Welcome and Opening Remarks

Robert Wise, Chairman

The meeting was called to order at 9:35 am by Chairman Wise. Introductions were made around the table. The minutes of December 16, 2011 were approved without revision. Chairman Wise thanked Sue Schurman for the use of the facility and providing refreshments. He recognized guest Jessie Crosson, Assistant Professor, UMDNJ School of Family Medicine and Director, New Jersey Primary Care Research Network.

II. Cultivating Interprofessional Collaboration in Health Education

Thomas A. Cavalieri, DO - Dean, UMDNJ School of Osteopathic Medicine

Thomas A. Cavalieri, DO is a geriatric educator and clinician advocating for older adults for more than 25 years. Dr. Cavalieri is currently the Dean of UMDNJ-SOM, a Professor of Medicine and the Osteopathic Heritage Endowed Chair for Primary Care Research. Dr. Cavalieri's resume is extensive and he is truly a "top doc" in so many ways according to Chairman Wise, who thanked Dr. Cavalieri for joining us.

Dr. Cavalieri gave a presentation on interprofessional education (IPE), which he considers timely with regard to health care reform and the ways to increase the quality of care and becoming more efficient and effective. Interprofessional education and practice are essential as we move forward in our health care delivery system. Geriatrics is a discipline where interprofessional training, education and practice are critical. Interprofessional education is about learning with, from and about each other. It is a critical approach whose time has come.

Using the model of interprofessional education in geriatric medicine and dentistry has resulted in the two disciplines coming together to learn with each other and from each other about the common issues of the patient. Meeting local health care needs through collaboration that includes interprofessional education creates a new model of a practice-ready workforce that can strengthen a currently fragmented, health care system. In geriatrics the literature shows dramatic improvement in outcomes when Interprofessional Practice (IPP) is used.

Interprofessional education has been talked since 1972. In 2003, the Institute of Medicine (IOM) moved this concept forward with their report, Bridge to Quality. The vision of the IOM is that "all health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics." The IOM identifies five strategies to achieve this goal including building a consensus around core competencies; integrating into oversight processes; motivating and supporting education leaders; developing evidence-based curricula and teaching approaches; and developing faculty as experts.

The IE movement is being embraced in many venues, including the World Health Organization. From a profession specific aspect the ACGME and IOM also support the concept. Additionally, the Interprofessional Education Collaborative (IPEC), a group of individuals representing six different professional organizations, came together to advance substantive interprofessional learning experiences. They have identified four competencies that represent the domains that all six of these health professionals need to be competent in through the use of interprofessional education.

There are a number of barriers to IPE, the main one being confusion about the true nature of the concept. Additionally, there are nine barriers that affect the process. These are curriculum time availability, limited resources, lack of clinical training sites, scheduling conflicts, faculty development needs, turf battles and cultural challenges connected to each profession, accreditation requirements, perceived value, and the attitudes of the stakeholders.

There are a number of strategies for success in the use of interprofessional education. Support from the teaching facility is very important. A committed experienced faculty, an interprofessional programmatic infrastructure, the creation of a sense of community and shared purpose, adequate physical space, and technology are important strategies necessary for success. It is important to embed interprofessional learning early in training and across the academic and practice curriculum, to adopt experiential approaches as the preferred method of training, to ensure that the faulty are drawn from a full range of professionals, and to acknowledge student participation and effort.

Dr. Cavalieri expressed that the successful use of interprofessional education is critical in the future development of the health care workforce and that the HCWC can help insure that the professional health care workforce is prepared to provide patient centered care in the future by supporting interprofessional education.

Chairman Wise commented that this topic was both timely and appropriate for the Council to discuss because of its interest in team development in health care settings. Dr. Cavalieri's presentation frames the topic for further discussion.

The question was asked if the business aspect of health care is included in interprofessional education. Dr. Cavalieri responded that a good part of the curriculum focuses on the importance of health providers having an understanding of the business of medicine. The challenge is how to support the interdisciplinary team in addition to considering appropriate reimbursement. Conceptually, with the movement toward health care reform and the emphasis on quality health care, health care delivery will be forced in this direction because reimbursement will be linked to quality measures.

Members asked if there was buy-in of national associations, such as the AMA and the ADA, on the team concept. Dr. Cavalieri replied there was, but there is always the need for more support. Once the accrediting bodies get on board, things will change.

It was asked if the Stratford (the school at which Dr. Cavalieri taught) model could be expanded given the barriers involved. The answer according to Dr. Cavalieri is yes. Each site would be different, but they must be innovative and creative. It is not an easy task. At Stratford, the interprofessional grand rounds have been introduced with the enthusiastic response of students.

The group is interested in the process to get the infrastructure in place to support this project. How do we make it work and more readily accessible to the bedside? This may be possible through pilot programs and seems like a project that is begging for a place to test the model out.

The studies discussed could easily be a pilot supported with data indicating that errors are reduced dramatically in hospitals when teams view issues versus individuals. Also, teams are more creative is solving problems. This resonates well with the efforts that are now underway to cut costs in hospitals. The efficiencies of this approach are part of the solutions we are looking for. The Council requested to hear the results of the conference Dr. Cavalieri will be attending in May regarding interprofessional education and practice. Dr. Cavalieri indicated he would be happy to share the results of the conference with the HCWC.

Are teams on the ground, such as Allied Health, being considered? Dr. Cavalieri indicated they were and that teams need to be inclusive of all aspects of health care.

HCWC is an advisory group to the State Employment and Training Commission. Because all education and training vendors must be approved, it was recommended that schools with this type of program be incorporated into the approved vendor list.

III. Mission Statement Adoption and Data Update

Robert Wise, Chairman
Paul Tattory, Assistant Director, Labor Planning and Analysis
Jason Timian, Labor Market Analyst, Labor Planning and Analysis

Chairman Wise asked for an adoption of the mission statement and asked for comments or questions on the draft mission statement.

Members suggested adding "develop and" to the first sentence before the word strengthen. Council members were in agreement.

There was a motion by Joanne Fillweber to approve the mission statement with the suggested changes. The motion was seconded by Terry Shlimbaum. The motion passed unanimously by voice vote.

Paul Tattory gave a presentation regarding labor market information for the health care sector. One of the indicators the Department of Labor and Workforce Development uses is unemployment insurance claim data. This is a key indicator, but it doesn't represent a complete picture of unemployment for an industry or occupation. UI data is a subset of the total data within an industry or occupation. Another limitation of UI data is that it is self-reported by the claimant with no verification.

With that in mind, we did a comparative analysis of registered nurses and licensed practical nurses over the past three years, December 2009 through December 2011, in terms of how many are collecting unemployment insurance. In 2009, 2,077 Registered and Licensed Practical Nurses were collecting unemployment insurance. This number rose to 2,993 in 2010 and then dropped to 2,883 in 2011. This data is broken down by gender, race, ethnicity, educational attainment, industry affiliation, age, and county of residence. Labor Planning and Analysis is able to separate registered

nurses from LPNs and will provide that data at our next meeting. Breakdowns within categories are also possible.

It was asked if Labor Planning and Analysis is able to track the vacancy rates in hospitals by county against the unemployment numbers to see where parallels or conflicts exist. It was explained that the vacancies cannot be tracked, but the job postings can. Therefore, it is possible to compare postings in health care occupations to claimants' data. This is a great resource for the State.

A member asked for the total number of registered nurses currently collecting unemployment insurance. Mr. Tattory explained that it was virtually impossible to calculate the UI for an occupation given the limitations of self-reporting.

Jason Timian presented the group with labor market information for the health care sector. The health care cluster contributed approximately $34 billion to the Gross Domestic Product in 2009. The health care industry has been the driving force of employment in NJ over the last two decades. From 1990 through 2011, the health care sector added 174,500 new jobs. All other industries combined have had a net gain of only 53,800 jobs. Employment in Ambulatory Health Care Services has more than doubled over the last 21 years. Health care is the only industry that added jobs in the state every year during this period. From 2008 through 2018, it is projected that more than 56,000 jobs will be added. This is an annual increase of 1.3 percent. Additionally, health care employers paid more than $21.3 billion in total wages in 2010, representing 12.2 percent of all wages paid. Health care employment is not affected by season patterns and fared well through the recession. Since October of 2009, the health care industry has accounted for nearly 44% of all job growth in the private sector.

The demand for health care in NJ is likely to increase due to the aging population. The percentage of New Jersey residents aged 65 or over is projected to more than double from 2008 top 2028. As this number increases, so will the demands they will place on the health care system, driving employment higher, especially in the areas of gerontology, physical therapy and residential and nursing home care.

Urban center data and the concentration of health care professionals in urban hospitals was commented on. In urban centers, the ratio of specialties demands more personnel than in rural hospitals. Additionally, there was a discussion regarding the issue of New Jersey health care growing. It was observed that the steady and continued growth of health care in New Jersey is not a good indicator in the long term. This underscores future challenges. The previous discussion about IPP focused on quality, not efficiencies. This data confirms this is the trend. However efficiencies have to be the focus. The Council should steer in the direction of recommendations and solutions for process improvements and efficiencies.

IV. Comments, Next Meeting and Closing Remarks

Robert Wise, Chairman

Senator Singer introduced a bill last session that took some of the recommendations and suggestions of the Physician Workforce Report and assigned them to interested bodies such as the Department of Health (DOH) and the Board of Medical Examiners (BME) with the purpose of moving forward with the initiatives in the report. The bill was not specific enough and so, did not move through the complete legislative process and died at the end of the legislative session.

Senator Singer reintroduced the bill in this session. The bill states the DOH should convene a panel of key stakeholders to discuss physician workforce shortages with the various groups for strategic planning at the state level and ultimately integrate the findings into the state plan. The bill also charges the DOH to examine the integration of non-teaching hospitals with community centers to become more actively involved in the teaching process, perhaps through an affiliation with a teaching hospital.

While the intent of the legislation is good, it is considered too vague. Assemblyman Conaway is trying to improve the new bill to be more specific with the intent of creating comprehensive legislation that will provide a building block approach reaching intended outcomes. It is in the discussion stage now.

It was asked if family practice is a component of the legislation. It was answered that the current legislation is broader, but tends to focus on primary care.

Chairman Wise announced the Dr. Brenner would be receiving the Edward J. Ill Award from MD Advantage for his significant achievements in research and medical practice.

The meeting was adjourned at 11:35 am.

The next Council meeting:

Friday, June 15, 9:30 am
Labor Education Center at Rutgers, Room 131, New Brunswick

Member Attendees – February 17, 2012

Barnard, Susan, Bergen Community College
Barnett, Pat, NJ State Nurses Association
Brady, Jane, Middlesex County WIB
Briggs, Deborah, NJ Council of Teaching Hospitals
Cimiotti, Jeannie, NJ Collaborating Center for Nursing
Cooper, Belinda, NJ Hospital Association (for Betsy Ryan)
Daitz, Andrea, Robert Wood Johnson Foundation (for Maryjoan Ladden)
Dickson, Geri, NJ Collaborating Center for Nursing (retired)
DiSandro, Kristin, JNESO (for Virginia Treacy)
Fillweber, Joanne, Johnson & Johnson
Finegold, David, Rutgers Lifelong Learning and Strategic Growth
Krepcio, Kathy, John J. Heldrich Center for Workforce Development
Lamothe-Galette, Colette, NJ Dept. of Health and Senior Services (for Cathleen Bennett)
Mertz, Lynn, Robert Wood Johnson Foundation (for Susan Bakewell-Sachs)
Orchard, Patricia, Horizon Blue Cross Blue Shield of New Jersey
Rieti, Dante, Cumberland/Salem WIB
Rosa, Robert, New Jersey Council of County Colleges (for Lawrence Nespoli)
Schurman, Susan, School of Labor and Management Relations, Rutgers University
Seligman, Sid, Barnabas Health
Shlimbaum, Terry, Delaware Valley and Phillips-Barber Family Health Centers
Wise, Robert, Hunterdon Healthcare

Guest and Staff Attendees – February 17, 2011

Cavalieri, Thomas, UMDNJ
Conway, Ashley, NJ State Employment and Training Commission
Crosson, Jessie, NJ Primary Care Research Network
Harrington, Laurie, John J. Heldrich Center for Workforce Development
Hart, Laura, Health Care Talent Network - Rutgers
Ferdetta, Frank, NJ Dept. of Labor and Workforce Development
Hutchison, Sheryl, NJ State Employment and Training Commission

Lopacki, Sandra, New Jersey Health Care Talent Network, Rutgers

Tattory, Paul, NJLWD

Timian, Jason, NJ Dept. of Labor and Workforce Development

Vetterl, Susan, NJ State Employment and Training Commission