New Jersey State Employment and Training Commission
Health Care Workforce Council
NJ Department of Labor Building, Trenton
August 22, 2011

MINUTES

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

The meeting was called to order at 9:30 am by Chairman Wise and members were welcomed to the meeting. The minutes of July 22, 2011 were approved without revision.

Sidney Seligman, Vice President of Human Resources, St. Barnabas Health Care System has agreed to become a member of the Council. Representing Mr. Seligman by phone today is Beatrice Anzur, Vice President of Employee Development.

II. **Defining NJ Primary Care Physician Needs and the Challenges in Addressing Specific Shortages:** Deborah Briggs, Senior Vice President, Health Policy, New Jersey Council of Teaching Hospitals (NJCTH).

The Council continued the August discussion about New Jersey's primary care physician workforce. Ms. Briggs gave an overview of the New Jersey Physician Workforce Taskforce report and a synopsis from last month's discussion was distributed to members. The modeling process used for the report projects that New Jersey will be short 1,000 primary care physicians within 10 years. When the current retention rate of resident graduates is factored in, the shortage estimate increases to approximately 1,400.

A handout outlining the strategic goals of the Physician Workforce Taskforce was also distributed. The first goal of the Taskforce is the creation of a center for health care and workforce planning. Some states conduct in-depth workforce analysis, similar to the NJCTH physician report, every two years to account for changing trends. All states have some level of primary care physician shortages; this puts New Jersey in a position of competing for primary care physicians. Lack of funding could be a major challenge to the creation of this type of workforce data center. One funding strategy could be to use an existing State statute, enacted more than a decade ago, that created the Advisory Graduate Medical Education Council (AGMEC). The mission of AGMEC is to determine the best way to structure New Jersey medical education to meet physician workforce needs. However, funding for the AGMEC has been phased out and it currently operates with volunteers, making it less robust than the statute intended.   Possible funding through Board of Medical Examiner licensing fees is being considered, similar to the way in which the NJ Collaborative Center for Nursing is funded.

The implementation of the Physician Scope of Practice Survey was explained. The question was asked, what states are leading the way in collecting health care workforce data? The New Jersey Action Coalition and SETC are conducting a survey to learn what about the health care workforce data center efforts of other states. The results of this data center survey should be available in October.

It was noted that the presumption that only doctors can meet the projected shortage in primary care needs to be examined. If the assumption is accepted that only a physician can meet primary care demands, then the projected shortage of 1,400 physicians becomes a critical issue. Determining the proper team model to provide primary care then becomes very important. This is difficult because there are not accepted standards of the appropriate ratio between (for example) physicians and nurse practitioners in a team model of care delivery. A possible role for the Council in determining team ratios was discussed.

A short, medium, and long term strategy of how to address the issues of primary care provider shortages is needed. It may be time to look at scope of practice laws and compare them to what other states are doing. Because of national health care reform, it is particularly important to reevaluate whether pre-reform regulations are appropriate in the current environment. The critical situation of AGMEC was emphasized; this entity has no staff, and therefore is barely functioning. The point was made that dividing into separate bodies – one for physicians and one for nursing – doesn't serve New Jersey well. It was suggested that the Council consider the creation of a single entity, particularly because the future of health care is team work and integration. With adequate start-up funding, a health care workforce data center that addresses the workforce needs of all health care occupations could result in lower health care delivery costs.

Ms. Briggs explained that scope of practice data is necessary in identifying HPSAs (Health Professional Shortage Areas) and that without defined HPSAs federal funding for low redemption, both federal funds and J1 Visa slots are lost. It was added that in the past New Jersey has been at a disadvantage in defining HPSAs because the state is so densely populated. It is reported that the US Department of Health and Human Services – Health Resources and Services Administration is in the process of reviewing and improving the methodology used to determine HPSAs. It was noted that Linda Anderson, at the NJ Department of Health and Senior Services (DHSS), has data on HPSAs.

With current fiscal constraints, a business case needs to be made for data gathering efforts. Ms. Briggs estimated that a center would require $1.8 M for start-up and $1 M for annual support. It will be vital for New Jersey to have access to and supply good data, in order to qualify for federal monies. There should be one entity to bring the State and medical schools together to do strategic planning. This precipitated a discussion of how to fund data collection and analysis without exacerbating access to care shortages and fiscal hardships. It was agreed that alternative funding sources need to be explored.

Taking into account Ms. Briggs' analysis, the work of the Council, and the Talent Networks, the available assets are moving toward a systemic solution. This is what foundations want to fund. Without focusing on positions, the Council can begin to focus on how to fund these efforts. Asset mapping needs to be done to make sure they are leveraged and, also, to reduce duplication. The vital data piece, the shift in the health care delivery model, extending efforts that are working, and determining potential savings all tie in well with what the Talent Network will be doing. These efforts involve a broad spectrum of skill needs that may appeal to foundations. Funding this type of effort wouldn't be funding a new initiative - it would use a model that incorporates potential savings from a new model of care.

As new models are considered, the question was posed how pressure can be lifted from existing facilities and whether the shift toward community-based care will make acute care facilities more viable. Deinstitutionalization and the resultant issues were discussed and it was suggested that this is an area to explore further.

The importance of the retention of trained physicians and other health care professionals was revisited. Retention rates in New Jersey are going in the wrong direction and whether the responsibility is institutional or statewide, key groups and constituencies need to come together to address the issue. There are multiple factors that need to be addressed at the State level to make substantial changes to programs that can impact retention, e.g. loan repayment plans.

III. **New Jersey Center for Health Innovations:** Colette Lamothe-Galette, Special Assistant to the Director, NJ Department of Health and Senior Services (DHSS)

The vision of the Center is to harness creative and innovative methods to transform the way health and health care are experienced and delivered in New Jersey. The Center is gathering key stakeholders to discuss best practices for delivery of care, map out models, and create a tool kit for others to use in developing their own models. DHSS launched the Center in March 2011. In looking at health care systems, we know that when a patient enters the hospital for an average four-day stay, he or she sees 24 clinicians and administrators. When an order is submitted for medication, 17 steps are completed before the patient receives the medication. The Center's efforts focus on linking money, people, and technology with the most innovative ideas to deliver cost effective care and care that improves health outcomes. The United States has the highest costs for health care with the worst outcomes, e.g. infant mortality rates and a higher prevalence of chronic health care conditions. The goals of the Center are to identify effective models; gather ideas to deliver better quality and cost effective health care; create best practice tool kits; and develop channels for distributing innovation information statewide, to change this statistic.

Membership of the Center consists of 100 representatives from more than 70 organizations, including providers, associations, advocacy groups, consortia, and others. Ms. Lamothe-Galette gave an example of how Electronic Health Records (EHRs) provide an opportunity to link the care delivered by local health departments to the customers' health care providers. Ideal elements of a health care system were also presented. The Center will be holding quarterly meetings of all members and additionally, has formed the following working groups: wellness and prevention; quality of care; informatics, and health care coordination. Much of the Center's work is guided by plans for developing Healthy New Jersey 2020 (link: https://njlmn.rutgers.edu/cdr/docs/2011-06_Lamothe-Galette.pdf) that are aligned with the federal Healthy People Initiative (link: http://www.hhs.gov/news/press/2010pres/12/20101202a.html). The Center is also doing strategic planning. The next meeting of the Center for Health Innovations membership will be held in September.

It was suggested that the Council should examine EHR and the development of EHR systems in New Jersey. The Council meeting in September will focus on Health Information Technology (HIT) and EHR systems.

The needs of the behavioral health community were discussed. Many people are falling through the cracks and ultimately end up in emergency departments. Understanding population needs would help to determine workforce needs. Ms. Lamothe-Galette explained that DHSS health data is available by county, condition, and population. DHSS is conducting regional meetings with local public health departments (LHDs) this fall to further understand regional needs and issues. It was pointed out that local health departments play an important role in identifying health care needs, although their budgets have been severely cut. The result is that health care that had been done by LHDs is being transferred to hospitals. LHDs are using the MAPP process to strategize implementing programs to meet Healthy New Jersey goals (link: http://www.naccho.org/topics/infrastructure/mapp/framework/)

New Jersey has workforce training money that could be connected to the work that the Center for Innovation is doing. The more bridges that can be created, and the more data is shared, the better the population will be served. Aggregating data and human resources between the Center for Innovation and the HCWC should be undertaken.

It was noted that, based on the work Rutgers has done in other areas with potential donors, it is important to think in terms of systems and of an intervention that can have significant strategic impact and have tangible results. Efforts need to be linked to a different model of care that will reduce costs and improve outcomes in order to write a proposal that will result in funding.

IV. **State Health Care Data Plan:** Dr. Aaron Fichtner, Assistant Commissioner, Labor Planning and Analysis, NJ Dept. of Labor and Workforce Development

Health care is a complicated industry that has additional layers of information, beyond traditional supply and demand, that is needed to fully understand the workforce needs. Staff from Labor Planning and Analysis (LPA) has met with the Health Care Talent Network, Heldrich Center, and SETC to brainstorm health care data issues. The group identified four potential data categories for exploration:

1) Baseline study of Health Care industries looking at industry trends and occupational data: LPA currently collects this data by industry and occupations and a detailed cluster profile report will be shared with the Council in the next month or two.

2) Workforce supply data could combine three sets of information: 1) graduates of higher education (from the Higher Education Commission) and post-secondary training providers (from LPA). These sources provide good data on the beginning of the occupational supply chains.

3) Licensing data: LPA will be meeting with Division of Consumer Affairs and other state agencies to determine what licensing data is available and how to combine data sets.

4) Employer data: Employers report to LPA on every employee by social security number; this creates a wage record system of longitudinal data that includes detailed information on all employed persons in New Jersey.

LPA is exploring creative ways to combine these data sets to understand workforce supply. For instance, LPA is able to profile unemployed persons with data from unemployment files and One-Stop Career Centers. This can help us understand where untapped labor pools are. In the dynamic health care industry, it is challenging to try to predict workforce demand in light of industry trends. With input from the Council members and other groups, we can begin this work.

Worker mobility was discussed. Dr. Fichtner said that mobility is greater for individuals with higher levels of education, who tend to leave the state at a higher rate.

The question was asked, how are self-employed individuals tracked? Dr. Fichtner responded that for those who are truly self-employed, there is very little data. If they are incorporated and hire others they can be tracked through wage record data.

The new Job4Jersey website (link: http://jobs4jersey.com/) was briefly highlighted. LWD is actively encouraging recipients of unemployment insurance to upload resumes into this job matching website. These will eventually produce a pool of data that can be analyzed.

LPA is in the process of building a database of proprietary and private post-secondary trainee information. These organizations are required to submit student information to state, but this requirement hasn't been enforced in the past. It was noted that the State of Florida has been a leader in combining high school and post-secondary data.

Members also discussed job titles. Many new job titles are nuanced – how will the data systems capture this? The US Department of Labor and New Jersey use standard titles and occupation codes for uniformity; these codes are changed as needed.

Recruiting people into health care occupations was also discussed. Popular media is useful in communicating this information to job seekers; an example is the *Parade* magazine which provides a top list of jobs each year. It is vital to have occupational information that is verified and validated for job seekers, new workers, and counselors to use to better understand the career paths. Council members cited a number of current efforts that do this including:

- Middlesex County's health care career calendar is distributed to all 9th graders in the county.

- NJ Career Assistance Navigator (link: http://njcan.org/) is a website for online career awareness and management.

- "Could this be your life?" (link: http://ncrc.rutgers.edu/life/index.html) is an interactive game format to help youth make career decisions.

- "Explore Healthy Careers" (link: http://explorehealthcareers.org/en/home) is a national effort with general information on careers.

It was agreed that making future projections about health care workforce needs is challenging. The question was posed, how do we as a group get the kind of input we need to determine how those curves will bend and what will be needed in the future? Another key discussion will be how to recognize and place greater value on the contributions of front line health care workers.

The meeting was adjourned at 11:00 am.

Member Attendees – August 22, 2011

Anzur, Beatrice, St. Barnabas Health Care System (for Mr. Seligman) (phone)

Barnard, Susan, Bergen Community College

Barnett, Patricia, NJ State Nurses Association

Brady, Jane, Middlesex County Workforce Investment Board

Briggs, Deborah, NJ Council of Teaching Hospitals

Ceserano, Justine, NJ Primary Care Association (for Ms. Grant-Davis)

Daitz, Andrea, Robert Wood Johnson Foundation (for Dr. Ladden)

Fichtner, Aaron, NJ Dept. of Labor and Workforce Development (for Commissioner Wirths)

Finegold, David, Rutgers School of Labor and Management Relations

Garlatti, Betsy, NJ Commission on Higher Education (phone)

Lamothe-Galette, Colette, NJ Dept. of Health and Senior Services (for Commissioner O'Dowd)

Moran, Janet, Camden County WIB Chairperson (phone)

Rieti, Dante, Cumberland County Workforce Investment Board (phone)

Ryan, Elizabeth, New Jersey Hospital Association

Salmond, Susan, UMDNJ School of Nursing

Savage, Judy, NJ Council of County Vocational-Technical Schools (phone)

Wise, Robert, Hunterdon Healthcare

Guest and Staff Attendees – August 22, 2011

Conway, Ashley, NJ State Employment and Training Commission

Cooper, Belinda, NJ Hospital Association

Horst, Michele, NJ State Employment and Training Commission

Hutchison, Sheryl, NJ State Employment and Training Commission

Schurman, Susan, Rutgers School of Labor and Management Relations

Timian, Jason, NJ Department of Labor and Workforce Development