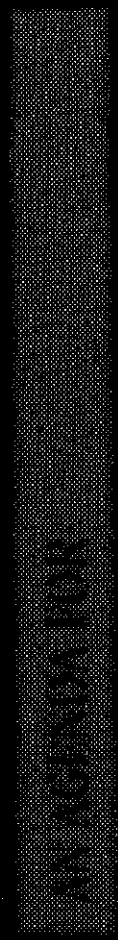
Agenda for Health Professions Reform



AN AGENDA FOR

# Health Professions Reform

February 1993


U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resouces and Services Administration
Bureau of Health Professions

# Foreword

The national debate on health care reform has focused on solving the problems of access, cost, and quality. These issues are inextricably linked to the need for and availability of health care providers. Both the expansion of access and the control of costs through health care reform have significant implications for the numbers and types of health professionals that need to be trained. Yet, limited attention has been given to developing the appropriate number and mix of health personnel needed under health care reform.

The Bureau's mission is to provide leadership to improve the training, distribution, utilization, and quality of personnel required to staff the nation's health care system. Given this responsibility, we have a unique opportunity during this period of reform to play a key role in responding to the health personnel needs of the future. Emphasis must be placed on continuous quality improvement in health professions education and practice to assure quality health care.

The following document represents a two-year effort of the Bureau to develop a shared vision of the essential components of health professions reform. These components are reflected in the seven strategic directions set forth here. The underlying focus of these directions is the development of the "appropriate" personnel to support the expansion of access to primary and preventive care services. This refers not only to producing the appropriate number of practitioners but the appropriate mix of personnel with the appropriate competencies to meet the needs of a diverse population.

This document offers specific strategies to achieve the Bureau's most important goals between 1993 and the year 2000. We recognize, however, that the Bureau cannot achieve these goals on its own. Our strategic directions call for increased collaboration and coordination with state and local government, academia, industry, foundations, and other public and private entities. It is only through such partnerships that we can use our collective resources to meet these goals and accomplish health professions reform — reform that is essential if we are to achieve our mutual goals of universal access, quality service, and the containment of health care costs.

Fitzhugh Mullan, M.D.
Director
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# Introduction

## The Bureau Vision Statement

The Bureau of Health Professions strives to improve the health status of all Americans, particularly the underserved, by enhancing the education, utilization, distribution, and quality of the Nation's health personnel.

## The Bureau Mission

The Bureau of Health Professions provides leadership to improve the training, distribution, utilization, and quality of personnel required to staff the Nation's health care delivery system. This leadership must be responsive to current and emerging developments in health care reform. Currently, the Bureau:

- develops, tests, and demonstrates new and improved approaches to the development and utilization of health workers within various health delivery and financing systems;
- provides financial support to institutions and individuals for high quality health professions education and training programs in order to create a work force that is well-equipped to meet the challenges of the future health delivery system;
- assesses the supply of and the Nation's need for health professionals and develops and administers programs to meet these requirements;
- collects and analyzes data and disseminates information on the characteristics and capacities of health professions production systems;
- provides technical assistance to national, State, and local agencies, organizations, and institutions for the development, production, utilization, and evaluation of health personnel;
- operates the National Practitioner Data Bank, a repository for reports of adverse credentialing actions taken by professional review boards and malpractice payments made on behalf of selected health personnel, which makes information available to those entities conducting formal peer review; and
- administers the Vaccine Injury Compensation Program, a system of "no fault" compensation for individuals, or their families, who may have been injured by the administration of a childhood vaccine.

## The Bureau Strategic Plan

The Bureau has established seven, organization-wide strategic directions to accomplish its mission. These are:

- Promoting primary care education;
- Strengthening and expanding public health education and practice;

- Expanding the capacity of nursing and allied health professions to meet the increasing demands for services;
- Increasing the numbers of health care providers from minority/disadvantaged backgrounds;
- Promoting educational strategies to recruit and retain health care providers for underserved populations;
- Advancing continuous quality improvement in health professions education and practice; and
- Strengthening health professions data, information systems, and education research.

The strategic plan is designed to guide the future course of the Bureau in a purposeful manner by preparing written strategies to meet the health personnel needs of the public in light of health care reform. The Bureau has also developed a series of specific goals and objectives to measure its performance. Generally, these goals and objectives assess whether the work force of health professionals is adequate in number, appropriately trained, properly distributed, and reasonably utilized. Specific action plans, which are not part of this document, will be developed by all programs to guide them in meeting the objectives. The Bureau will monitor its performance based on quantifiable measures and will modify program strategies as appropriate. The Bureau will also modify the strategic plan to meet the changing health care needs of the public.

## Context

The health care system in the United States has gradually become dominated by costly, specialized health care providers, creating a dearth of primary care providers (i.e., family physicians, general internists, pediatricians, nurse practitioners, physician assistants, and certified nurse midwives) limiting the access of millions of Americans to basic health care services. This erosion of primary health care capability is reflected in the increasing number of unserved and underserved rural and inner city areas and of programs that strive to provide health care access to the economically disadvantaged and other population groups with special health care needs. The breadth of this problem was revealed in a recent survey of State Governors in which a shortage of primary care personnel was reported as a significant problem in 45 out of 50 States. Similarly, shortages of nursing and allied health personnel have been reported recently by two national nursing commissions and in an Institute of Medicine study on allied health, confounding access problems even further.

The current dual crises of lack of health care access and escalating health-care costs have resulted in calls for health care reform. Proposals for health care reform have attempted to

balance the seemingly incompatible goals of cost-containment, universal access, and quality. Little attention, however, has been given to those who provide health care services. Because health care is a personnel-intensive industry, it is imperative that any discussion of health care reform address issues related to health personnel availability, employment, and training.

Many health care reform proposals cite the need to increase the supply of primary care providers, i.e., family physicians, general internists, pediatricians, nurse practitioners, physician assistants, and certified nurse midwives. These providers offer continuous, comprehensive care at lower costs.

In order to promote primary care, the Federal government needs to develop consistent national health professions and health care financing policies which favor primary care. At the present, for example, while HRSA urges more generalists and fewer specialists, HCFA's reimbursement policy for health care services favors specialists over generalists. An effort to address the seemingly incongruent nature of the current U.S. health personnel policy has been developed and warrants further examination.

A number of significant, recently released, reports (e.g., the PEW Health Professions Commission's "Healthy America: Practitioners for 2005") have highlighted the need to redirect the focus of health professions education to meet the health care needs of the public. The reports also have indicated the importance of developing an adequate primary care system. A system of health care firmly built on a foundation of interdisciplinary, preventive, community-based, primary health care may be the most effective way to provide high quality, broad-based services at a reasonable cost to the entire population—especially the elderly, populations residing in rural areas, and other populations with special needs.

The goals and objectives that support these strategic directions are designed to be consistent with other Department and Agency guidance as described in such documents as: *Healthy People 2000, The Future of Public Health, PHS Plan to Strengthen Public Health, PHS Minority Health Plan,* and *HRSA Goals and Objectives for the Year 2000,* "HRSA's Long Range Plan to Improve Access to Primary Health Care for Underserved Populations", and "HRSA's Long Range Plan for Health Professionals." In addition, consideration has been given to other relevant reports such as the PEW Foundation's *Agenda for Action*, COGME's *Improving Access to Health Care through Physician Manpower Reform: Directions for the 21st Century*, the Bureau's *Study of Models to Meet Rural Health Care Needs through Mobilization of Health Professions Education and Services Resources*, and the Bureau's *Eighth Report to Congress on the Status of Health Personnel in the United States, 1991*, which call for the redirection of health professions education.

## Principles

The Bureau has developed certain guiding principles as strategies to support its strategic directions and to accomplish the goals and objectives outlined in this plan. The Bureau's success in achieving the goals and objectives outlined here is dependent on the application of these principles. The principles are as follows:

- *Increasing emphasis on collaboration* as a means to improve consistently the integration, coordination, and continuity among the various PHS-supported programs, health professions education programs and institutions, private organizations and industries, and State and local governments.
- *Disseminating appropriate information* to improve and expand mechanisms for disseminating, in a systematic and coordinated fashion, the results of effective program efforts, including biomedical, health services, and health professions education research outcomes. Effective use of technology is encouraged. In addition, it is important to expand our audience, to provide information to both new and traditional partners in health professions education and training.
- *Building strong linkages* with credentialing bodies, private foundations, and consumers and to satisfy legislation, regulations, and other governmental (State and local) requirements to support new program directions.
- *Encouraging outcome evaluation along the health professions education continuum* to obtain relevant data for program development and evaluation. The evaluation of our programs is vitally important to our success and the continued development of new programs and priorities. The need exists to define program outcome indicators and methods of measurement. Current common data elements and strategies are not sufficient to meet this need.
- *Promoting cost-effectiveness and efficiency* as an integral part of each strategic direction in order to achieve as much as possible in a time of diminishing resources. This principle is particularly significant given the context of health care reform and its emphasis on cost containment and managed care.
- *Fostering interdisciplinary, community-based health professions education and training* to provide health professions trainees with appropriate skills and knowledge for practice which will serve to reduce barriers to access in culturally diverse settings.

## Strategic Direction #1

# Promoting Primary Care Education

## Issue

Primary health care includes a comprehensive range of public health, preventive, diagnostic, therapeutic, and rehabilitative services, the goals of which are to prevent premature death and disability, preserve functional capacity, and enhance overall quality of life. A wide variety of health professionals deliver primary health care services including public health nurses, preventive medicine/public health physicians, dentists, nurses, optometrists, pharmacists, podiatrists, and allied health professionals. An essential component of primary health care, critical to an effective health care system, is primary medical care. Primary medical care is characterized by the following elements: first-contact care for persons with previously undifferentiated health concerns; comprehensive care which is not organ/problem specific; an orientation toward providing continuous care; and responsibility for coordinating other health services. Health professionals who are trained in primary medical care are "generalists." They are trained in, practice, and receive continuing education in the following competencies: health promotion and disease prevention; assessment/evaluation of undifferentiated symptoms and physical signs; management of common acute and chronic medical conditions; and identification and appropriate referral for other needed health care services. Primary medical care providers include generalist physicians (i.e.,family physicians, general internists, and general pediatricians), certified nurse midwives, physician assistants, and nurse practitioners.

There is a serious imbalance between the supply of primary health care providers, including primary medical care providers, and providers with more narrow specialized training. This imbalance is aggravated further by the declining proportions of practicing health professionals and health professions students pursuing primary care careers. For example, in 1960, more than 50 percent of all practicing physicians in the United States were general practitioners compared with 33 percent in 1992. With the advent of health care reform, this shortage of primary health care providers will be exacerbated by the increasing demand for primary health care services among the formerly uninsured and underinsured. Moreover, the vast majority of health care reform proposals promote cost containment through the expanded use of managed care systems which rely heavily on primary care providers. In order to facilitate health care reform, health professional schools and programs that train primary medical care practitioners must provide the appropriate educational environment to prepare them to deliver low-cost, person-oriented, interdisciplinary, community-based primary medical care.

## Year 2000 Goal

In collaboration and partnership with other public agencies and private entities, assure that an appropriate number and percentage of health care practitioners are qualified primary medical care providers.

## Objectives

1. By 1995, develop a national health work force plan to assure an appropriate supply and mix of primary medical care providers according to specialty, racial-ethnic composition, and geographic distribution.
   - (a) Develop strategies to reach the longterm goal that 50 percent of physicians, both allopathic and osteopathic, will be qualified generalist physicians.
     - (1) Fifty percent of medical school graduates will enter generalist practice.
     - (2) Develop policy targets for retraining an appropriate percentage of specialists to practice general care.
     - (3) Develop training strategies to meet the staffing needs of managed care systems and other ambulatory care settings.
   - (b) By 1995, develop policy targets for primary medical care supply distribution, and generalist/specialist mix among nurse practitioners, physician assistants, and certified nurse midwives.
2. By 1995, develop policy targets for primary health care supply distribution, and generalist/specialist mix among other health care providers.

## Strategic Direction #2

# Strengthening and Expanding Public Health Education and Practice

### Issue

Public Health practice is an essential governmental function which utilizes a variety of health professionals in an interdisciplinary fashion. The core functions of public health are assessment, assurance, and policy development focused on health promotion and disease prevention at the community level, which may include environmental, physical, and mental health, and primary care.

The application of public health values, principles, knowledge, and technologies is essential to realize the benefits of effective health care reform. In order to meet the national health goals adopted as part of Healthy People 2000, we need an adequate supply of well trained and qualified health professionals since public health is a responsibility of all health practitioners and health professionals.

The Bureau of Health Professions, as the lead Public Health Service component for the preparation of public health professionals, has determined that there is currently a severe shortage of well trained public health professionals, especially in the disciplines of epidemiology, biostatistics, environmental health, nutrition, and nursing.

The major loci for the preparation of today's public health professionals are schools of public health, preventive medicine programs in medical schools, public health nursing programs, and specialty public health programs in a variety of disciplines. There is a need to have a competency-based, nationally applied set of skills which would assure the quality of all programs offering public health education at the technical, undergraduate, and graduate levels. This must be coupled with efforts to continually assure the competency of the practicing public health professional.

Public Health professional education and training requires strong links to practice to provide competency-based, service-related experiences; increased numbers of properly accredited schools and programs in public health to serve as resources both for other health professions education programs and public health practitioners; and increased opportunities for joint degree programs with related health professions.

### Year 2000 Goal

Provide leadership, direction, and assistance to public and private agencies and entities to improve basic preparation and continuing public health competence of the health professions and public health work force.

## Objectives

1. By 1993, initiate plans for a National Public Health Work Force Plan in the context of the Year 2000 Objectives in collaboration with other Federal, state, and private organizations based upon information available from existing sources which shall be used to guide national, state, and local policy makers in assuring an adequate supply and distribution of a proficient health work force.
2. By 1994, promote strategies to:
   (a) review and enhance the public health components of basic competencies for all health professionals and the specific competencies for public health professionals;
   (b) initiate study to assess the need for and to determine the type of national accreditation standards required for all programs preparing individuals for public health practice;
   (c) develop policies which address critical shortage areas in public health; and
   (d) provide programs for sustaining and improving the practice skills of public health professionals.
3. By 1994, assist in the development and implementation of strategies to assure that increases in disease or condition specific categorical funding include funding increases for training and education to meet community needs.
4. By 1994, develop a "National Plan for Environmental Health Education and Training" which would include a partnership between academia, industry, government, and professional societies to share resources to address the entire range of issues affecting the field of environmental health.
5. By 1995, develop strategies to foster the use of schools of public health in collaboration with health departments to serve as resources for meeting national prevention, research, and community health needs.

## Strategic Direction #3

# Expanding the Capacity of Nursing and Allied Health Professions to Meet the Increasing Demands for Services

## Issue

Health care providers report continuing and emerging shortages and maldistribution in key basic disciplines in nursing and allied health. Increasing controls over rising health care costs are creating a demand for more community-based services provided by professionals other than physicians. The expansion of demand for advanced practice professionals draws from the basic pool of health care providers, which further exacerbates shortages. The demand for more practicing nurses and allied health professionals has contributed to a faculty shortage. This has, in turn, resulted in qualified applicants to educational programs being turned away. Strengthening the basic educational capacity for producing nurses and other allied health professions has not been a central focus of federal health professions programs for a number of years.

## Year 2000 Goal

Develop and demonstrate strategies for enhancing the supply, distribution, and competencies of nurses and allied health professionals engaged in basic practice:

## Objectives

1. By 1995, develop and maintain work force surveillance and analysis systems and generate work force targets for nursing and allied health professions.
2. By 1995, begin developing and demonstrating innovative approaches to continually improve and expand the impact of nurses and allied health professionals through:
   (a) creative uses of technology;
   (b) approaches for working effectively with self-help groups;
   (c) utilization of self and family care approaches;
   (d) utilization of community and lay health workers/advisors;
   (e) utilization of volunteers; and
   (f) changes in practice.
3. By 1995, begin developing and maintaining linkages across Federal agencies as a means of creating overall policy and support for basic educational capacity building in nursing and allied health professions.

4. By 1995, assess health professions educational resources across the Federal Government and work to consolidate these as a means for meeting local and regional educational needs.

5. By 1995, develop training strategies to meet the staffing needs of managed care systems and other ambulatory care settings for nursing and allied health personnel.

6. Develop legislative strategies relating to capacity building for nursing and allied health professions.

7. By 1997, develop the educational capacity to meet the existing and near-term emerging demands for nurses and allied health professionals.

## Strategic Direction #4

# Increasing the Numbers of Health Care Providers from Minority/ Disadvantaged Backgrounds

## Issue

High on the agenda of health care reform is increasing the numbers of minority and disadvantaged individuals in the health and allied health professions to care for the underserved. Shortages of such individuals adversely affect access, quality of care, and costs. Minorities are underrepresented in the health professions, health professions schools, and on the faculties of such schools. In 1991, although minorities constituted 22 percent of the U.S. population, they accounted for only 8 percent of practicing physicians, and 12.7 percent of allopathic medical, 7.8 percent of osteopathic medical, 9.4 percent of optometry, 11.2 percent of pharmacy, 13.5 percent of dental, and 14.2 percent of nursing (RN) school enrollments. Among medical schools, the only health professions schools for which data are available, in 1991, underrepresented minority faculty accounted for only 3.2 percent of all medical school faculty. Both the disparity in health status among minority and disadvantaged populations and the socioeconomic/cultural characteristics of such communities affect the nature and direction of health care reform. Although it is apparent both minority and non-minority health care providers would benefit, few training opportunities specific to minority health issues or cross-cultural implications in the delivery of health care are offered.

## Year 2000 Goal

1. Achieve equitable representation of minority students and faculty in health professions schools.
2. Increase competence, regarding health and socioeconomic/cultural issues of minority/disadvantaged populations, among the graduates of health professions schools.

## Objectives

1. Increase the numbers of underrepresented minorities to a level of 20 percent of all first year matriculants, in each of the health professions school disciplines.
2. Increase the numbers of disadvantaged non-minority individuals to an equitable level of all first-year matriculants, in each of the health professions school disciplines.
3. Increase by 30 percent the numbers of underrepresented minority individuals serving as tenured tracked faculty in each of the health professions school disciplines.

4. Introduce one course, which addresses health conditions prevalent within minority communities and implications of socioeconomic/ cultural issues on health, in 30 percent of each of the health and allied health professions school disciplines.

5. Introduce one faculty/student research project, which focuses on health conditions prevalent within minority communities and implications of socioeconomic/cultural issues on health, in 30 percent of each of the health and allied health professions school disciplines.

## Strategic Direction #5

# Promoting Educational Strategies to Recruit and Retain Health Care Providers for Underserved Populations

## Issue

Universal health care access and cost control strategies are hindered, in part, by the maldistribution of our nation's health professions work force. As a result, millions of Americans, particularly those living in inner city and rural communities, do not have access to providers to screen them for preventable disease, counsel them on measures to take to protect their health, diagnose and properly treat their common health problems, and prevent unnecessary hospitalization and death.

A number of barriers in the educational system hinder the recruitment and retention of health care providers for underserved populations and areas. These include:

- a lack of special recruitment initiatives and admissions policies targeting those most likely to practice in underserved rural and urban areas;
- insufficient exposure to community-based faculty role-models;
- inadequate curricula and insufficient educational experiences in community-based settings serving the underserved, such as community/migrant health centers (C/MHC) and health departments;
- insufficient educational support networks (e.g., telecommunications, computerized continuing education) to maintain competency and enhance the attractiveness of continued practice in underserved areas.

## Year 2000 Goal

To assure, through targeted education-service strategies, that health professionals are appropriately trained and geographically distributed to assure access to quality health care for all Americans.

## Objectives

1. By the end of 1993, implement a system to identify and track graduates whose practice serves the underserved.
2. By the end of 1994, fully implement grant funding preferences that reward programs with demonstrated success in producing graduates who serve the underserved.
3. By the end of 1995, establish faculty development, continuing education, and information dissemination systems targeting National Health Service Corps, M/CHC, and other community-based faculty and practitioners that serve the underserved.

4. By the end of 1997, increase by 20 percent, the number of health professions students who have a greater likelihood of practicing in underserved rural and urban areas.

5. By the end of 1997, increase by 25 percent, the number of students and residents trained in community/migrant health centers, health departments, and other community-based facilities providing primary health care to the underserved.

6. By the end of 1997, increase by 20 percent, the number of graduates who choose to practice with underserved populations or in underserved areas and the percentage who continue for ten years or more.

## Strategic Direction #6

# Advancing Continuous Quality Improvement in Health Professions Education and Practice

## Issue

Emerging changes in the health care delivery system pose important challenges to the education and practice of health professionals. Significantly, however, current policies regarding the quality of health professions educational preparation and clinical practice do not often facilitate creative and adequate responses to the nation's health problems, and, consequently, are at times unresponsive to the changing needs of the public. These policies are frequently at variance with health care reform objectives of access and cost containment, and, as such, warrant redefinition. For example, current accreditation policies in graduate medical education are often cited as significant barriers to widespread training of primary care medical residents in ambulatory sites and managed-care settings. State licensure requirements and Federal reimbursement policies, further, are similarly cited as significant barriers to demonstrating new work force patterns involving mid-level health practitioners.

The concept of quality pursued in health professions educational and practice settings typically provides limited attention to outcome assessments and public input. Traditional paradigms of quality in these areas also need redefinition to assure excellence in health care that is responsive to the changing needs of the public. A shift to continuous quality improvement (CQI) is needed to focus on processes and systems, rather than individual efforts, in quality management applications.

When legal recourse is necessary, alternatives to the tort system and programs supporting quality assurance and medical liability reform will improve the access, equity, and cost effectiveness of health care services. Public policy strategies here need to balance the concerns of both the practitioner and the patient in order to maintain a mutual trust.

## Year 2000 Goal

Provide national leadership to assure that health professions educational accreditation and certification policies, as well as government policies regarding health professions education support and professional affairs, ensure public safety, facilitate meeting access and cost containment objectives of health care reform, and achieve measurable outcomes of success in liability management.

## Objectives

1. Promote accreditation and certification policies that:
   (a) call for active school involvement in using outcome data to evaluate and improve education;
   (b) respond to emerging health professions work force needs;
   (c) foster redefinition of health professions curriculum;
   (d) expand training experiences in ambulatory sites in medically underserved settings; and
   (e) involve educators, employers, and payors in their formulation.
2. Promote government policies and initiatives that:
   (a) reinforce innovation in health professions educational programs;
   (b) improve the effectiveness and appropriateness of clinical practice; and
   (c) permit innovative and cost-effective approaches to health work force utilization.
3. Promote continuous quality improvement in health care education and practice, and policies and programs that:
   (a) increase the role of education-service networks in disseminating professional practice guidelines;
   (b) improve the scope of comparative information for the public regarding health professionals and their practice; and
   (c) facilitate life-long learning for health professionals.
4. Promote innovative programs that effectively address assurance of clinical competence, issues of medical liability, and concerns of public safety and trust, and initiatives that:
   (a) support quality assurance in clinical practice as it moves to CQI;
   (b) disseminate information on trends and issues in credentialing, including effective programs and strategies in quality improvement and risk management, and effective outcomes analysis; and
   (c) advance tort reform aimed at eliminating legal barriers affecting access to health care.

Strategic Direction #7

# Strengthening Health Professions Data, Information Systems, and Education Research

## Issue

The availability, accessibility, and maintenance of data sufficient to provide information with which to conduct policy analysis in health professions issues have diminished in recent years. At the same time, development of research methods for analyzing health professions policy has not kept pace with the many structural changes in health services delivery, partially due to the lack of adequate data for addressing policy questions.

Even the most basic information on the supply and distribution of and requirements for health personnel must be based on timely and comparable data. Data for health professions policy analysis should be both descriptive of individual health professions occupations and useful in examining some of the legal, economic, and other relationships between various professional groups and sectors of the health care delivery system. These data must also relate to the demographics, education, utilization, and quality of health personnel as well as to the capacities of relevant education and training programs.

Research methods for addressing present and future policy issues must be developed using information systems based on data sets that are both comparable and compatible as well as available and accessible to researchers. Current and historical methodologies should be refined to address the changing issues in policy analysis. Alternative methodologies and new information systems may be needed to support research and analysis of new and proposed health policies, especially with regard to analysis of initiatives for health care reform.

## Year 2000 Goal

Establish a comprehensive program of primary and secondary data collection, information development, and policy analysis related to health personnel supply, distribution, requirements, and education in a changing health care system.

## Objectives

1. By 1993, implement and periodically refine a system for monitoring and analyzing the impact of health care reform proposals on health professions supply, distribution, and requirements.
2. By 1994, execute a system for attaining and maintaining quality data and producing information for conducting health professions policy analysis.
3. By 1994, implement and periodically refine a multi-year plan for health professions education research relative to health care reform initiatives.
4. By 1994, implement and periodically refine an evaluation component to all Bureau program initiatives, based on sufficient data collection and related analytical methods.
5. Develop legislative strategies related to health professions data systems.