Assuring Adequate Specialists, Generalists and a Health Workforce Where it's Needed: How Do We Balance Demands to Improve Quality, Expand Access and Contain Health Care Costs?

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Introduction

The US National Health Quality Strategy has three goals: better care, healthy people/healthy communities, and affordable care.[1]. To achieve these goals, it is important that the appropriate balance and distribution of the healthcare workforce - specialists and generalists across the healthcare professions - be in place. Further, these individuals must be operating at the appropriate level of their practice activities and working effectively in teams.

This brief document is prepared to stimulate discussion about these topics at the 2013 International Health Workforce Collaborative Conference. We present contextual elements that affect the development of US health workforce policy. We also present a sampling of activities in education, policy and regulation to expand the generalist workforce, address career flexibility, and deliver the appropriate balance and range of services across multiple settings to address patient needs. We focus on the Affordable Care Act (ACA), [2] the most transformative US healthcare legislation since the passage of Medicare in 1965, while including references to other initiatives.

US Workforce Policy in Context

US federal policy on workforce reflects a traditional conflict over whether "planning" or "market" approaches should be used to achieve national policy goals. In many areas, American policy-making has historically favored pluralism, choice, decentralization, and market-based solutions, and this bias may be especially keen in regard to workforce issues. It may perhaps be a measure of political antipathy to planning that a Workforce Commission authorized by the Affordable Care Act has been named and initiated but never convened because the Congress has yet to appropriate any funds for it.

Even in the face of public calls for more planning and forecasting,[3] some of our best known forecasters doubt its utility[4] because forecast models relating workforce to health needs have not proven to be very accurate. Forecasts have to model complex tradeoffs between health care and non-healthcare inputs, different kinds of clinical services, as well as tradeoffs within clinical settings of different kinds of health care providers. Trends that appear strong today may be trumped by unforeseen market forces tomorrow. For example, scholars at the beginning of the nineties predicted a surplus of physician specialists based on HMO staffing patterns in the eighties[5] as managed care appeared to define the future of health care, yet many now believe that we are facing severe shortages, especially in the face of changes in demand following the implementation of health reform.

The implementation of national policy goals is complicated in the US by the many organizations with responsibility for producing the physician workforce. Standards for undergraduate medical education (UME) are made by the Liaison Committee for Medical Education (LCME) for MD granting programs and by the American Osteopathic Association's Commission on Osteopathic College Accreditation for DO granting programs. Standard-setting for the majority of graduate medical education (GME) programs has been done by the Accreditation Council for Graduate Medical Education (ACGME). The system for matching undergraduates to graduate residency programs is the National Residency Matching Program (NRMP). These organizations have focused on the quality and effectiveness of training. Decisions about the size and distribution of programs have tended to be made locally according to local and regional more than national workforce concerns.

Federal and State Policy Initiatives

There is general agreement that primary care, whether delivered exclusively by physicians or with other health care professionals, is good for health systems and improves health outcomes,[6] and some have called for an increase in the proportion of physicians in primary care in the US from today's one-third to over 40 percent[7]. With respect to specialty mix and distribution, we have seen a number of policy initiatives in recent years to stimulate expansion of primary care. At the federal level, the ACA legislation incorporated a variety of provisions that address health work force directly and indirectly. For example, the ACA contains provisions that provide increased reimbursement to primary care providers as a way to help make the choice of primary care more attractive. There are also provisions for scholarships, loan repayment, and training demonstration programs to invest in primary care physicians, midlevel providers, and community-based providers. A number of policies are dedicated to increasing the attractiveness of primary care practice in rural or underserved areas. These include increasing access to primary care and community-based settings in training, increasing the number of training spots for primary care physicians, rewarding programs for producing more physicians choosing primary care careers, and locating training opportunities in underserved areas[8]. The ACA also included a new Primary Care Extension Program to provide technical assistance to primary care providers, who tend to be in small practices without much infrastructure support.

At the state level, there is also interest in policies that address specific state healthcare needs, including the attraction and retention of primary care physicians to underserved areas as well as the availability of certain specialists, especially surgeons and psychiatrists, in rural and frontier areas. States have considered a variety of mechanisms to attract physicians, including loan repayment, Visa waivers for foreign medical graduates, and flexible work options.[9] Because primary care physicians often work in small practices, technical assistance and administrative support are also being considered. Given evidence that individuals from rural or frontier areas are more likely to locate their practices in these areas, state legislatures have linked discussions of funding support to state-located medical schools with retention of graduates in those states and with the practice types and locations within the state.[10] These discussions of state needs often extend beyond the discussion of primary care needs, with additional focus on the scarcity of surgeons, psychiatrists, and other specialists and the negative impact that these gaps have on health access[11].

Scope of practice expansions for nursing, pharmacy, and other health professionals have often been justified on the grounds that services must be made available for otherwise underserved citizens[12]. The Federation of State Medical Boards (FSMB) and individual state medical boards are focusing attention on physician re-entry in order to facilitate the expansion of physician services.[13] There are state and federal proposals to remove regulatory barriers to the use of tele-technology to increase access to specialty care in underserved areas (email, telemedicine). The Federation of State Medical Boards has proposed compacts among the states to allow physicians to register to provide tele-medical services while still ensuring quality protection to patients.[14]

Health System Reform

Some of the most important, and potentially transformative, policy efforts will influence healthcare workforce indirectly. Delivery reform in the ACA reframes the debate over generalists and specialists by focusing on the creation of systems of care that would be responsible for managing the health of populations and for making available a suitable mix of services, physicians and other health professionals, as necessary to meet the population's health needs rather than on workforce solutions per se.

These efforts are directed to experiments in delivery re-engineering that can create better systems of care offering more integrated experience of care for the patient through cross-disciplinary teams, care coordination, and prudent use of specialty care.

These reforms take several different forms but all would be intended to create more systematic care around patient needs to encourage efficient production on the one hand and better coordinated care on the other. These involve one of three strategic approaches, all promoted through various provisions of the ACA.

- ***Bundled payment for episodes of care*** - Changes in reimbursement to drive quality improvement, integration of care, with accountability for population health and efficient delivery
- ***Integrated delivery systems -*** Demonstrations of new models of delivery are being encouraged at two levels through many provisions of the ACA. At the primary care level, the Patient-Centered Medical Home is being developed as the entry point for patients. While dominated by primary care with a view to managing patients through the continuum, there is equal recognition of the need to assure a well-coordinated "medical neighborhood" of specialty care for referral. Accountable Care Organizations, which would be responsible for all care to a population, including primary, acute, and chronic care are being developed under a Medicare Shared Savings Program.
- ***Community-based care coordination*** – Demonstration programs through community health teams, i.e., extra-medical delivery support systems that collaborate to integrate, coordinate, and tailor care to patient needs for low-income

Achieving Workforce Goals through Medical Education

A variety of formal and informal activities are occurring within medical education and health professions education that will influence the make-up of the healthcare workforce and, as importantly, the ways in which healthcare professionals work together to deliver both primary and specialized care. At the undergraduate medical education (medical school) level, medical

schools have adopted student-centered curricular models that allow accelerated entry into primary care disciplines. At its February 2013 meeting, the LCME (the accrediting body for allopathic medical education programs) approved a new standard (ED 19-A) focused on training medical students to function collaboratively on inter-professional healthcare teams[15]. The Accreditation Council for Pharmacy Education has incorporated standards emphasizing inter-professional educational experiences for several years.[16] A federally funded National Center for Interprofessional Practice and Education was recently inaugurated at the University of Minnesota.[17]

At the graduate medical education level, movement toward integration of the Osteopathic and Allopathic GME Accreditation organizations could offer an opportunity for expansion of primary care residency sites to a larger community of graduating medical students as well as the opportunity for a single accreditation system to standardize curriculum and institutional systems for physicians-in-training[18].

It has also been suggested that federal funding for Graduate Medical Education (GME) should be used as leverage to achieve specific outcomes in training, including more emphasis on generalist skills and training in quality improvement, safety practices, and team-based care. The Medicare Payment Advisory Commission (MedPAC) proposed in 2010 that up to one-third of federal support for GME be withheld to hold programs accountable for specific training outcomes, related particularly to skills associated with patient transition management and care coordination and working in teams, in addition to building knowledge of safety and improvement science.[19] Many viewed this proposal as superfluous because so many of the outcomes MedPAC sought were already in the process of being built into accreditation standards.

Congress never acted on this recommendation. In the meantime, the ACGME, in association with the medical specialty boards, has completed the first phase of the Milestones Project, which establishes outcome-oriented milestones for each of the six competencies, which include issues like teamwork, inter-professional communication, and system-based practice. These will help demonstrate whether the ACGME is producing graduates with the skills the public demands. In addition, as part of The New Accreditation System, a new system for evaluating the quality and safety of the clinical environments in which residents are trained is being implemented to make sure that training environments are modeling the practices that residents are expected to absorb.

The American Board of Medical Specialties is in the process of reconsidering its criteria for the approval of new specialties and subspecialties. Current discussion has suggested that the criteria may include:

- An area of clinical practice that is not routinely performed by physicians within the sponsoring specialty.
- A distinct and definable patient population that has a type of care need so unique that a "stand alone " body of medical knowledge and care principles have been developed solely to meet the needs of that patient population, requiring at least 12 months of training.
- Improved access and quality without negative impact on the cost of care.

- Sufficient numbers of training programs and trainees to sustain the area of s/sub and to allow for a sustained critical mass of trainees necessary for trainee testing validity and training program accreditation.

Conclusion

The regulation of the physician training pipeline has focused on educational standards rather than workforce composition. Policies have been developed at the both the federal and state level to try to overcome the drive toward specialization, increase the number of physicians seeking training in primary care, and attracting physicians to practice in rural and underserved areas. More recently, these workforce questions of balance and distribution have been reframed as delivery system problems best resolved in health care organizations that will be held accountable for the care of populations. These delivery system solutions are likely to focus on the development of primary care teams, working across professional boundaries to allow all members of the team to work at their highest level of capability and training. Clearly, there is a movement toward solutions that are developed across sectors and organizations (federal government, state, systems), and models that will call for greater integration across the continuum of medical education and across the health professions.

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