



# Two Views on Health Reform and Workforce

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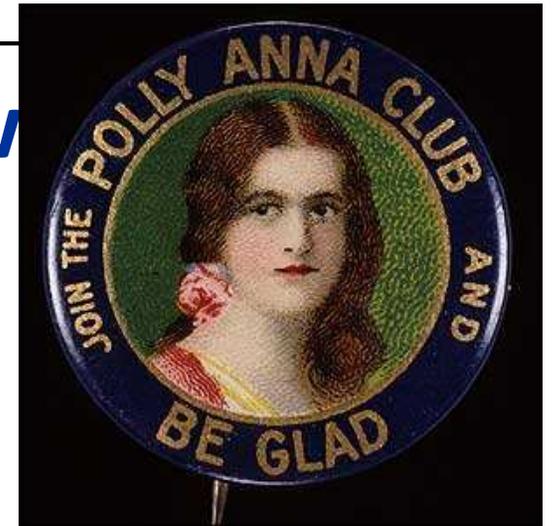


## The negative, cynical view

- Congress added to the existing macro-policy of “nudging” workforce market behavior through profession-specific, producer-focused, grant-structured programs.
  - ❑ No assessment of past performance
  - ❑ No unifying goals stated
- A weak debating structure (Workforce Commission) has been created with no clear guidance over how they are to influence policy. They report to “everyone”
- A potential rival to the GME “1000-pound gorilla” may emerge in the Community Health Center Trust. Teaching centers and primary care extensions may create conflict.

# The positive, constructive view

- Experimentation is encouraged via many new approaches
  - Teaching health centers, a natural extension of current activities gives momentum to multiple programs
  - Outreach structures, that can build on successful AHEC-like activities, can unify the system
  - There is a potential for the expanded programs to create a “tipping-point” for primary care
  - Institutionalizing nurse leadership and acceptance of new professional roles will help meet needs and produce efficiencies
- Structures for coordination across (all) workforce stakeholders are recognized if not encouraged



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# Analyzing health reform and workforce as a newspaper story

whowhatwherewhenhowwhy?

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# Who, what where, when, why, how?

- Who: Will there be an intensification of the multiple program-linked lobby-driven policy tensions?
- What: Will the coordinating structures create a new interprofessional policy culture?
- Where: The states have wildly different cultures and conditions that affect the “mix” of policy approaches
- When: The urgency of “reform” runs up against the realities of training cycles—inevitable frustration.
- Why: Have we turned a corner to patient and community centered-ness? Will we now have clearer workforce policy
- How: Will the money run out?

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# Current Opportunities and Challenges

- ❖ Clear policy putting primary care at center of system reform and improvement
- ❖ 2010 Reauthorization and E X P A N S I O N of role and funding for AHECs, Title VII, Title VIII
- ❖ New programs (trauma, pediatric care) centripetal forces
- ❖ “Disruptive Innovation”: Primary care hubs, teaching centers, PLANNING!!!!
- ❖ Budget realities are a constant threat (Orszag and “de-duplication”)

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# HRSA Strategic Plan

- ❖ Goal II: Strengthen the Health Workforce
  - ★ *Assure the health workforce is trained to provide high quality, culturally and linguistically appropriate care.*
  - ★ *Increase the number of practicing health care providers to address shortages, and develop ongoing strategies to monitor, forecast and meet long-term health workforce needs.*
  - ★ *Align the composition and distribution of health care providers to best meet the needs of individuals, families and communities.*
  - ★ *Assure a diverse health workforce.*
  - ★ *Support the development of interdisciplinary health teams to improve the efficiency and effectiveness of care*

# State Planning/Implementation Grants HRSA

10-284/5

- ❖ Before the State partnership receives a planning grant or an implementation grant, such partnerships and HRSA shall jointly determine the performance measures that will be established for the purposes of the planning grant and implementation grant. Performance measures are both process or outcome measures that allow grantees and the Federal Government to track progress toward meeting stated objectives...
- ❖ The RFA went out in July and NC responded via the Dept of COMMERCE and the Workforce Investment Board (WIB)

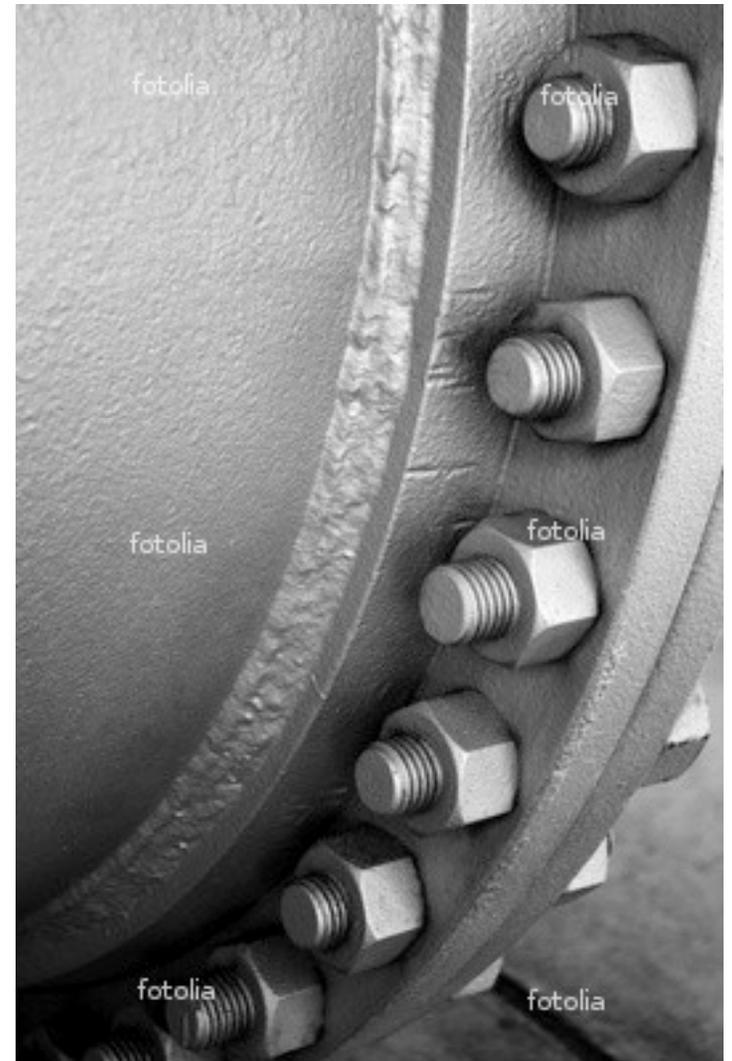
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# A new “WHO”–Public Health is back in the game and prevention expanded

- A modified return to support of public health workforce with specific funding
- Stimulus from a prevention emphasis and a semi-“trust” approach to funding
- Likely slop over from the expansion of preventive services funding in Medicare and elsewhere that may promote health education and broader environmental activities.
  - New preventive services coverage may stimulate “demand” for helping professionals and greater efficiency

# We know we have “pipelines” into health professions

- ❖ What keeps the pipeline together?
  - ❖ AHECS
  - ❖ Primary Care “sector”
  - ❖ Community focused programs



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# Evaluation of workforce programs

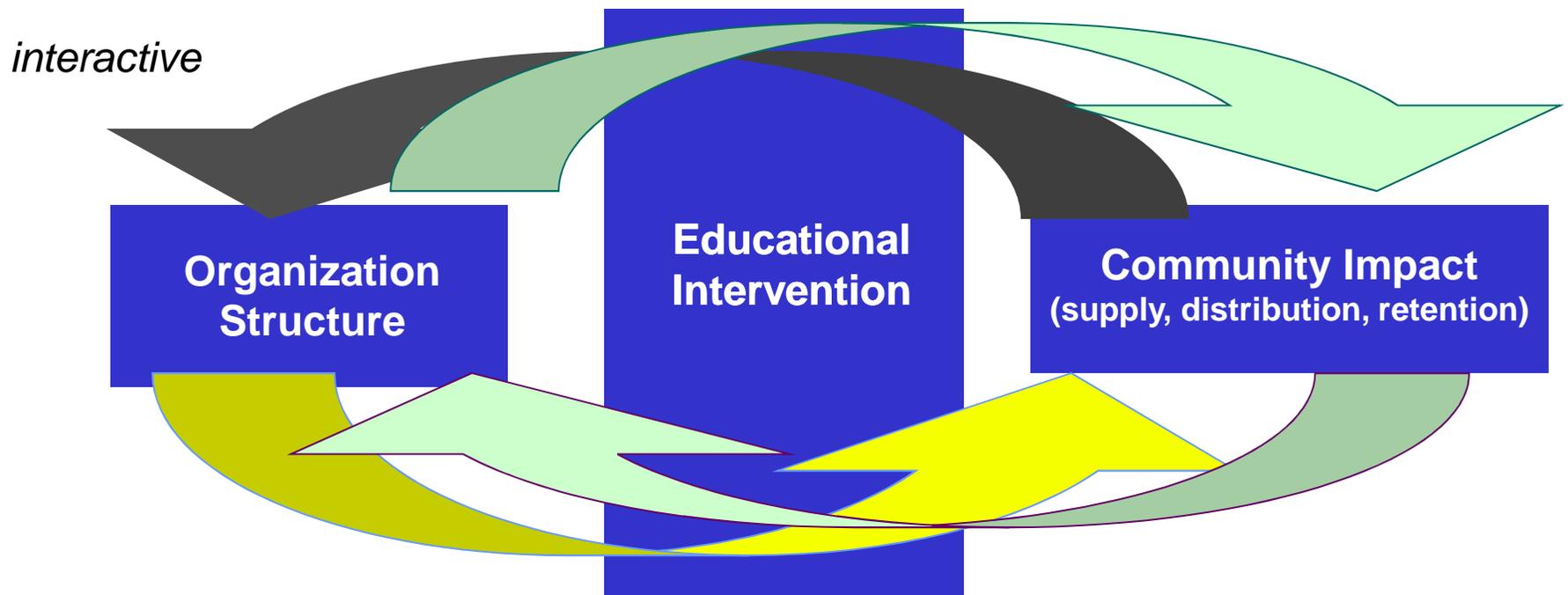
- ❖ Teed up by: “maintenance and improvement of effectiveness and capabilities”
- ❖ definitions of
  - ★ effectiveness (outputs, impacts, objectives)
  - ★ capabilities (structure, process and inputs)
- ❖ ACA AUTHORIZES grants and contracts to “propose and implement effective program and outcomes measurement and evaluation strategies.”
- ❖ A North Carolina person is now head of HRSA’s Evaluation process

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# Evaluation can be Positive and Negative Feedback

- ❖ AUDIT for positive production
- ❖ ASSESS for fidelity of system, use of evidence based methods and appropriateness of interventions and staffing
- ❖ EVALUATE to identify failures and lesson and places where changes need to occur

# Project Logics are linear, BUT workforce programs have an *Interactive* Perspective



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# Wild Cards

- ❖ The push to make medical education “socially conscious” (Mullan’s rankings)
- ❖ AHECs will be pushed into leadership in some states where they may fail
- ❖ Nurse-led programs will take advantage of new IOM report (Nurse-Doctor movement)
- ❖ GME via all-payer system is being talked about more and more (tie that to specialty steering)
- ❖ ACOs and Medical Homes WILL realign roles and create new “delegation opportunities

# Grinch or Pollyanna, you choose

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