

Health Professions Network meets in Tampa

The Fall 2009 meeting of the Health Professions Network (HPN), hosted by the Tampa Bay Convention and Visitors Bureau, was held in Tampa, FL, September 23-26.

The nearly 40 attendees, representing a wide range of health professions professional associations, expressed various concerns within their respective professions: Certification, licensure, recognition/awareness, an aging workforce, practitioner recruitment into rural areas, racial/ethnic workforce diversity, lack of clinical sites for required rotations, health care reform, and lack of leadership.

Keynote speaker **Cecil Wilson, MD, president-elect of the American Medical Association (AMA)**, presented on one of these key issues—health system reform, which has been a perennial subject of debate in national politics since the 1930s. Today, the nearly 50 million of Americans who do not have insurance is “a black eye for our country.” The uninsured live sicker and die younger; the argument that anyone can obtain health care services is a non-starter—the emergency room is not the place for health care.

Aside from the cost in human suffering, the current system is fiscally unsustainable: Between 2008 and 2018, for example, health care costs are expected to rise from \$2.4 trillion to \$4.4 trillion. Part of the current and future growth is due to the impact of unhealthy behaviors. In fact, fully half of health care costs can be attributed to obesity, tobacco use, lack of exercise, substance abuse); 20 percent is due to environmental factors, 20 percent to genetics, and 10 percent lack of access to care.

“Congress has an historic opportunity” to change health care in the nation, said Dr. Wilson, so our legislators need to put aside partisan divisions and work towards consensus. In this environment, the AMA is serving as the voice not only for physicians, but for reason. “When did the health of America become a partisan issue?” asked Dr. Wilson. “My patients don’t give a Q-tip whether I vote red or blue.”

How can allied health assist with the voice of reason and help AMA? Dr. Wilson recommended that HPN members access the AMA’s “microsite” on reform, at www.hsreform.org, for news and updates, and to sign on to the AMA-led Patients’ Action Network, at www.patientsactionnetwork.org.

Building upon Dr. Wilson’s presentation, **Robert G. Brooks, MD, MBA, MPH, associate vice president for health care leadership, University of South Florida**, provided a look at America’s health and the future. His key message: We can’t just change health system delivery and financing, or we won’t be successful—the nation must also address personal responsibility and develop incentives for individual health behavior. Life expectancy in the U.S. has increased by over 30 years since 1900—“but we got lazy,” said Dr. Brooks. “Public health got us clean water, medicine got us transplants, so we thought we could ignore personal responsibility.” In fact, because of the growing toll of obesity on Americans’ health, life expectancy could actually start going down in the future.

Cost pressures are reaching a boiling point as well: By 2016, Medicare spending will take up 20% of the federal budget, up from 16% today, and by 2017, the Medicare trust fund will be exhausted. At the state level, Medicaid is now the single largest expense in state budgets and is overwhelming other key issues.

The major influence driving the rise in health care costs, noted Dr. Brooks, is technological change, or the “march of science.” The U.S. has the best “disease-care” system in the world but not the best “health care” system. Our focus is on acute care, in-hospital treatment, especially end-of-life

procedures, such that one percent of the population is responsible for 27% of health care expenses and five percent for 55%.

To address these issues, we must reconfigure the system more fairly so that basic care is provided, not just high-tech care. But how do we decide? How do we address this vexing question of social justice? How do we fairly distribute the finite resource of health care services, with health wants/needs vastly greater than the available resources in the system?

In other words, how do we address the dreaded “R word?” (That is, rationing). Every country rations care, said Dr. Brooks—the U.S. included. Other countries employ supply-side rationing, by constraining resources (e.g., fewer personnel, less technology); here, rationing is demand-side. Further, it’s important to understand that no country has a purely private or public health care system. In the U.S., for example, the current mix is 54% private and 46% public, compared to 20% and 80% in Italy, or 30% and 70% in Canada. Spending on health care in other countries is rising as well, just not as quickly as here. In short, there are both pluses/minuses in our system and those in other countries, with many lessons to be learned from each other.

In looking at the proposed health care reform plans, one essential question is, “Where is prevention/responsibility?” In the end, the much-debated “individual mandate” to have insurance may not help, unless all Americans learn to practice healthy behaviors.

In closing, Dr. Brooks noted that recent surveys show that public desire for reform is lower now than in 1993. Further, the U.S. is facing a huge budget deficit (both at the federal and state levels), unlike in 1993. With no uniform consensus on what the real problem is (cost or access), the window for changing health care policy may be closing rapidly, with chances for major reform markedly lessened if nothing passes Congress this year.

Next, **N. Lynn Barnes, MEd, Director of Education, Society of Nuclear Medicine**, looked at two issues: 1) Increasingly stringent requirements for physicians to prove continued competence and 2) Renewed attention to commercial relationships between health care professions and pharmaceutical firms/medical device manufacturers.

Two reports by the Institute of Medicine contributed to the trend for more measurement of physicians’ competence—“To Err is Human,” which estimated that as many as 100,000 deaths in the U.S. annually are due to preventable health care errors, and “Crossing the Quality Chasm,” which found medicine failing to translate knowledge into practice.

To help staunch the public’s loss of public faith in the medical profession, the American Board of Medical Specialties (ABMS) and its member boards moved from a one-time certification process to Maintenance of Certification (MOC), which calls for continuous improvement in care and lifelong learning. Some aspects of MOC require measurement of quality of care at a group level, not just an individual level, and so will affect all health professionals. In addition, other health professions are looking at MOC as well (pharmacy, nursing, radiologic technology). Meanwhile, the federal government is instituting pay for performance, which, as the name implies, will provide financial incentives (and disincentives) to reward (and discourage) certain physician behaviors.

Concerning commercial support, the authors of a recent commentary in the *Journal of the American Medical Association* called for draconian restrictions on industry funding of continuing medical education. The Physician Payments Sunshine Act of 2009 would dictate that all payments to physicians from commercial entities be listed on a national Web site.

The new climate of regulation threatens continuing education as we know it—not just for physicians but for all health professionals. Both professional associations and pharma will have to

make major changes. In the end, practitioners may have to pay for education themselves—an unfunded mandate that may decrease the attractiveness of health care careers.

On Friday, **Stephen N. Collier, PhD, Professor**, and **Harold P. Jones, PhD, Dean and Professor**, both of the **University of Alabama at Birmingham**, spoke on the topic “The Changing Landscape of Health Professions Education.” Dr. Collier began by stressing the ambiguity, uncertainty, and complexity in the US health care system and its future reform (or lack thereof). Some believe our health system is irrational, but it behaves in the way it is rewarded to behave.

Dr. Collier examined some of the recent 10-year projections by the Bureau of Labor Statistics, which are released every two years (the 2008-2018 BLS data should be available in early December). It is difficult to say with any certainty whether the current environment is growing or declining—there are conflicting signals. For example, consider the need for more practitioners in health information technology. In the short term, we may need more coders; long-term, however, automation and more sophisticated software may eliminate many of these fields. Further, workforce needs change more rapidly than educational programs can respond—one must take into account the timeline for getting a program funded, hiring personnel, and obtaining accreditation, to say nothing of the length of time for students to graduate from the program and begin practicing.

HPN attendees agreed that the current situation is complex—making it difficult to predict future workforce needs with any degree of accuracy. For example, we’ve been saying, “We have a health care workforce shortage,” but news reports indicate that hospitals are laying off workers. In Michigan, which has the highest unemployment in the country, graduates have been having trouble getting work. Schools are inundated with those who were laid off from manufacturing jobs, and it’s hard for the schools to get additional funding to expand to meet this growing need.

Following Dr. Collier, Dr. Jones took a look at health care reform. The president is looking at reducing health care costs (“bending the growth curve,” as the saying goes), expanding access, and maintaining or improving quality (and cost-effectiveness) of patient care. Currently, 16% of the US GDP goes to health care costs—the highest in the world. At the same time, insurance premiums are rising rapidly, and state budgets are under pressure. In short, the system may collapse of its own weight.

If you want to understand health care, noted Dr. Jones, just follow the money. The current proposals are focused largely on financing, not workforce. Major factors affecting costs include the number of providers, provider mix, malpractice/defensive medicine, physician payments, and unneeded procedures/tests. Looking to the future, many allied health fields will grow, but not all (for example, imaging may take a hit).

Dr. Collier added that he expects to see a bifurcation of the allied health workforce into higher and lower levels, with growth in the upper level but greater growth at the lower level. Education will be more frequently online and part-time, with higher enrollment in community colleges. For-profit institutions are leading the way in innovation, and responding to students’ desire for convenience. We are also seeing a move back to hospital-based education. Another trend is that allied health students enter programs with inadequate math and science skills. Finally, globalization is playing an increasing role, with more international students coming to the US, and allied health programs moving abroad.

In preparation for the next HPN meeting in Washington, DC, which will include a visit to Capitol Hill, **Amy L. Callender, Federal Legislative Manager and NATAPAC Treasurer, National Athletic Trainers' Association**, gave a practical primer on how to communicate with one’s legislators. An effective lobbyist, she noted, needs to be one part advocate, one part educator, and

one part salesperson. Further, Congress needs the expertise/advice of health professionals, especially today, with the challenge of health care reform facing the nation. Other key points:

- Congress legislates by anecdote: compelling stories prompt action
- Congressional staff value individual messages over generic form letters or e-mails, although they do keep a tally of calls/e-mails/letters/etc.
- Legislators need to hear from home: constituents have an impact
- Congress is run by 20 and 30 year olds: Young staffers have power and influence, but need our expertise
- The structure of Congressional offices is very hierarchical
- During your visit, you may have little time to deliver message, and the Congressional staffer may not know much about the issues. It's important to try to make a personal connection and make use of anecdotes. Expect about 15 minutes of time, leave an information packet behind, and be sure to follow up with a thank you note (and be polite!)

HPN strategic planning

During the Tampa meeting, HPN board member **Lynn Brooks** presented the HPN strategic plan for 2010 through 2015. He described the history of the HPN since its formation in 1995 to serve as a forum for communication, discussion, and collaboration among all the health professions. The HPN had undertaken strategic planning in 1998 and 2005. At its spring meeting in Fort Worth, Texas, the HPN held a third strategic planning session, in response to the changing environment in health care and to take advantage of opportunities for growth/exposure.

The elements of the current plan are intended to strengthen the organization, communicate its membership benefits to a larger audience, recruit and engage new members and organizations, develop revenue-generating activities, and enhance relationships with other key health care organizations, to ensure a two-way dialogue between HPN and member organizations. Other goals include:

- Increase public awareness of the health professions
- Recruit students into health care fields
- Serve as an informational resource for policy makers re: health workforce
- Undertake a multifaceted communications plan and PR campaign (making use of Web 2.0 and social media networking)

The key organizations the HPN Board has targeted for enhanced outreach efforts include:

- American Hospital Association (AHA)
- Association of Academic Health Centers (AAHC)
- Association of Schools of Allied Health Professions (ASAHP)
- Health Occupations Students of America (HOSA)

- Health Workforce Information Center (HWIC)
- National AHEC (Area Health Education Centers) Organization (NAO)
- National Consortium on Health Science and Technology Education (NCHSTE)
- National Organization of State Offices of Rural Health (NOSORH)

In addition, the HPN is seeking to enhance relationships with federal bodies, including:

- US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA)
- Institute of Medicine (IOM)
- Agency for Healthcare Research and Quality (AHRQ)

In July 2009, the HPN Board met in Chicago to further discuss these issues. Discussion centered around advocacy agendas of HPN member organizations, topics for summits and webinars (to advance the HPN advocacy agenda), outreach to other organizations, and serving as a clearinghouse of grants information as a member benefit.

Plans for 2010: Webinars, workforce summit, consumer awareness

The HPN is planning a May 2010 invitation-only summit in Chicago on workforce issues, to include representatives who can examine in depth the perspectives of the education community on workforce. Also planned for 2010 are three Webinars on topics of interest to the health professions; in January 2010, Steve Collier and Harold Jones will present on updated Bureau of Labor Statistics data projections for 2008 to 2018 as well as health care reform and the current state of economy and how these factors affect health care workforce.

HPN is also working to implement a two-pronged consumer awareness campaign: One, to create awareness of the health professions and the career opportunities in these fields; two, to address the more fundamental issues (lack of clinical sites, shortage of faculty, inadequate program funding, issues with credentialing and licensure). The economic downturn, for the short term, has obviated the need for the first goal—awareness of the health professions is already there—so now we must face the second challenge.

Save the dates: Meeting schedule for 2010-2011

March 3-6, 2010	Washington, DC
October 13-16, 2010	Raleigh, NC
April 13-16, 2011:	Milwaukee, WI
Fall 2011	Jacksonville, FL

Note: The spring 2010 meeting in Washington, DC, offers a unique opportunity for attendees to meet with key legislators on Capitol Hill.

2010 Membership goal: Double from 76 to 150 organizations

The HPN Membership Committee has set an ambitious goal of doubling HPN membership in 2010, from its current total of 76 to 152 organizations. To meet this target, all current HPN members are encouraged to recruit at least one organizational member.