Association of Reproductive Health Professionals

SEXUAL AND REPRODUCTIVE HEALTH WORKFORCE PROJECT

Overview and Recommendations from the *SRH Workforce Summit*

Increasing the capacity of US clinicians to provide high quality sexual and reproductive health care for all Americans is an urgent public health priority

Despite many advances in contraceptive care, little progress has been made in reducing the unacceptably high rate of unintended pregnancy in the United States, even though the Department of Health and Human Services identified reduction of these rates as a key public health priority since 1990. Health disparities are still a major challenge in the US, with the highest rates of unintended pregnancy seen among African-American and Hispanic women and adolescents. The 3.2 million unintended pregnancies each year result in negative health consequences for women and children and drain the limited resources of our health care system.

Health care professionals see the manifestation of these statistics personally in their daily practices. Unintended pregnancy prevention is one of many unmet national goals in sexual and reproductive health (SRH). Unlike other identified health risks such as diabetes, heart disease, and obesity, little concentrated national attention has focused on SRH needs, as defined by the World Health Organization. The need is great, yet there are no funded, cohesive initiatives in place to promote high quality, accessible sexual and reproductive health care as the nation begins to implement the Patient Protection and Affordable Care Act (ACA).

Background

Increasing the capacity of US clinicians to provide high quality sexual and reproductive health care for all Americans is an urgent public health priority. Implementation of the ACA in 2014 will add 30-35 million individuals to the primary health care system, stressing already limited resources to meet the reproductive health needs of these additional patients. The SRH field is engaged in collaboration to devise and implement innovative strategies to meet this increased need. The ACA's focus on primary care and prevention creates an obvious framework for building capacity. The areas for immediate action are developing and implementing new ways to prepare future clinicians, further developing the existing workforce in primary care, incorporating SRH into new models of health care delivery and reimbursement, and leveraging the existing expertise of SRH health professionals to improve delivery of sexual and reproductive health care.

The ACA provides a sea-change, especially through the establishment of the National Prevention, Health Promotion, and Public Health Council (National Prevention Council), and the nation's first ever National Prevention and Health Promotion Strategy (National Prevention Strategy). This report will articulate a range of strategies that will ultimately enable health care providers–particularly those practicing in primary care environments–to provide quality care to meet their patients' needs and improve SRH outcomes at the national level.

Response

Recognizing the urgent need for collective action, the Association of Reproductive Health Professionals (ARHP) developed the *Sexual and Reproductive Health Workforce Project* in collaboration with dozens of other non-profit, foundation, and agency partners. The *Project's* purpose is to increase the availability of and access to high quality sexual and reproductive health care in the US. **The *Project's* strategic focus is to:**

- Target primary care and public health professionals in primary care settings
- Align SRH education, practice, and existing credentialing for primary care and public health professionals
- Prioritize and create opportunities for inter-professional education for all members of the SRH care team
- Develop and support innovative educational models and systems change, using the latest science to inform strategies

Guided by an expert steering committee, the *Project* is being implemented in three linked phases. In January 2013, the *SRH Workforce Summit* convened some 40 experts to:

- Align pre-licensure, competency based sexual and reproductive health education, continuing professional development, and service delivery within a primary care framework
- Recommend concrete strategies and policy activities that will facilitate that alignment
- Map actions to fulfill conditions of success in generating long-term change within the field

The *Summit* reinforced the project's broad scope for including the full range of SRH services, with evidence-based prevention and management of unintended pregnancy including abortion. Care of women and men throughout the life cycle, including adolescents, is central. Client needs are fundamental and should drive decision-making, with a focus on health equity and with particular attention to vulnerable groups: ethnic minority; disabled; lesbian, bi-sexual, gay, transgender, queer; and underserved low-income clients. Creative approaches must be featured to ensure the cultural competence of the workforce and to diversify it to accurately reflect the communities and populations served. Work should derive from public health prevention models that address health disparities and should use innovative technologies to improve training and service delivery and advance existing, effective strategies.

The group confirmed by consensus that there is a strong, documented, unmet need for enhanced SRH training and education for all members of the health care team – particularly in primary care settings and in the context of the ACA implementation. To meet this need, they proposed a clear set of recommendations and next steps.

Key Summit Recommendations

1. ENHANCE HEALTH PROFESSIONAL EDUCATION IN SRH

- **Define core competencies for SRH** across key health professions and disseminate these to education-based provider groups (including those for advanced practice registered nurses, certified nurse midwives/certified midwives, physician assistants, pharmacists, primary care physicians, and registered nurses). Work with educational experts in key health professions to include core competencies for SRH as part of core curricula. Convene an expert group to define core competencies as a priority next step.
- **Expand the definition of the "team"** to ensure team based education approaches to train all professionals working in a health care setting: medical assistants, community service providers, administrators, and office staff as well as other clinical, management, and support staff.
- **Conduct a gap analysis of SRH competencies** across health professions, including inter-professional competencies, to identify areas of need in existing programs for targeted interventions.
- **Compile a clearinghouse of teaching-learning resources and practical tools for practice** such as objective structured clinical examinations, virtual patients, and simulation models that can expedite integrating SRH competencies into primary care clinical training, and delivery. Identify and include existing certification and training programs that relate to SRH competencies.
- **Expand SRH clinical training sites and simulation centers** by, for example, providing incentives for clinical educators and linking pre-licensure/pre-certification training programs with SRH clinical training sites.
- **Enhance faculty development in primary care SRH** by incentivizing faculty to develop expertise and champion this approach.

2. ENHANCE CONTINUING PROFESSIONAL DEVELOPMENT IN SRH

- **Create a national networked system of shared training sites and mentoring networks.** Build on existing capacities such as community health centers and Title X clinics, while also developing and testing new models. Explore developing family planning fellowship sites, academic health centers, Title X training sites, and other existing sites as shared regional centers. Emphasize models for inter-professional and team-based training and learning centers that can be developed efficiently and will serve as a shared resource to the field as a whole.
- **Adapt and create models for inter-professional team training in SRH for primary care and SRH settings.** Emphasize hands-on approaches such as boot camps for specific skills and clinical immersion programs that pair providers to foster ongoing mentoring.

- **Optimize use of educational and information technologies such as telemedicine/telehealth and simulation programs** to design and disseminate resources for SRH training for practicing clinicians. Determine best approaches to integrate technology into SRH clinical training settings and include SRH in developing simulation centers.
- **Expand professional fellowship programs** to train inter-professional teams in sexual and reproductive health, including the clinical capacity of advanced practice registered nurses, midwives, physician assistants, and pharmacists.
- **Leverage the wealth of existing family planning expertise** when developing SRH training, education, and mentoring programs. Work closely with expert family planning providers to design, plan, and implement training programs and models for practice. Draw on this existing expertise to build a younger cadre of providers.

3. IMPLEMENT QUALITY MEASURES AND STANDARDS FOR SRH CARE

- **Compile cost benefit data on SRH provision** to justify incentives for providing high quality SRH care. Convene a working group to develop strategies for addressing administrative and cost barriers, with initial one-page analyses geared toward 1) provider groups and 2) insurers.
- **Develop one Healthcare Effectiveness Data and Information Set (HEDIS) measure on SRH** to be included in the uniform data set and develop and implement a strategy to ensure its approval. Develop a strategy to help increase communication among partners in the field who may be working on similar efforts, including professional organizations and patient advocacy groups.
- **Define SRH quality metrics for use in new models of care** that provide incentives for quality of care/pay for performance. One approach is to develop and disseminate quick-screen methods per the CDC's Preconception Care Toolkit; CDC's Pregnancy Risk Assessment Monitoring System (PRAMS); March of Dimes' reproductive health planning strategies, or the "One Key Question" initiative to screen for reproductive intentions to inform referral, prescriptions, delivery of unintended pregnancy prevention interventions such as contraception, or other services.
- **Develop resources for SRH data collection through electronic health records** and identify incentives to use these to examine quality and performance measures and support policy and legislative changes. Create a library of electronic health record and practice management systems related to SRH. Develop template questions for inclusion in electronic health record systems. Convene a group to drive this work as a next step.
- **Support widespread dissemination and implementation of practice guidelines in sexual and reproductive health**, for example the forthcoming Office of Population Affairs guidance and the CDC Medical Eligibility Criteria. Analyze these standards, including identifying gaps, to inform development of HEDIS measures and electronic health records. Develop point of care decision support tools such as electronic health record integration of the CDC's Medical Eligibility Criteria.

4. CREATE INCENTIVES TO EXPAND AND DIVERSIFY SRH WORKFORCE AND OPTIMIZE PATIENT ACCESS TO CARE

- **Expand loan repayment for clinicians providing SRH in areas of need**, including Title X clinics and community health centers. Explore other opportunities to encourage individuals to become SRH providers such as scholarship funding and priority recruitment.
- **Identify financial incentives for SRH provision** that reflect SRH quality and performance measures.
- **Address credentialing and regulatory barriers that limit the scope of practice** in SRH.
- **Identify and evaluate creative models to enhance access to SRH services**, such as co-locating SRH clinicians in primary care settings and creating integrated systems of referral, services, and electronic health records that facilitate care coordination and seamless or integrated referral for SRH services. Collaborate with organizations working to address barriers to long acting reversible contraceptive methods.
- **Engage with insurers to determine what evidence or policies would incentivize them** to support providing SRH in primary care. Explore perspectives and incentives with other influential groups: federal agencies, provider groups, clinical management teams, and academic learning communities.
- **Leverage existing networks for inter-professional training and education** such as Area Health Education Centers and community health centers. Identify new and innovative initiatives being undertaken by these and other settings and explore ways to evaluate, adapt, and expand these approaches.

5. DEVELOP A MARKETING/MEDIA CAMPAIGN AND OUTREACH TO ADVOCACY GROUPS TO RAISE AWARENESS OF THE IMPORTANCE OF ACCESS TO SRH CARE

Policy and Legislative Priorities

- **Develop strategies to support broad recognition that SRH** is an essential component of primary health care services and improved patient outcomes.
- **Make inter-professional SRH training/education a policy priority** at the Federal and State levels, building on the recommendations and best practices of other national groups, including the US Health Resources and Services Administration's Coordinating Center for Interprofessional Education and Collaborative Practice.
- **Assure Federal and State-level policies regarding use of certified web-based health care delivery and distance learning programs are consistent** across specialties and disciplines.
- **Address state-based regulatory barriers to health professional practice** (especially those for advanced practice registered nurses, midwives, pharmacists, and physician assistants) that limit effective provision of care.
- **Draw on the gap analysis** of SRH competencies to **identify and implement strategic policy advocacy initiatives** on pre-licensure/pre-certification and continuing professional education.

Next steps

- **Establish an information-sharing and coordinating mechanism** to ensure efficiency and synergy of ongoing collaboration to implement recommendations. Summit participants expressed wide support for ARHP continuing to facilitate this effort as a neutral convener. To do so, ARHP needs to secure funding for overall support of the project.
- **Convene expert project teams** representing the field for each initiative to advance work and map out strategies for continued progress.
- **Engage with key constituencies and partners** to identify synergies and develop strategies for action. Draw on the many organizations and alliances already working in key areas: SRH, the ACA, primary care, and training and certification. Include organizations with ties to state-level actors recognizing that the ACA will be implemented largely at the state level.
- **Identify innovative demonstration projects** that meet the above goals and marshal resources to support their adaptation, evaluation, and expansion. Collaboration with The Center for Medicare & Medicaid Innovation could be a key area to pursue.
- **Develop mechanisms for ongoing** re-assessment and coordination to ensure alignment of efforts across SRH education, training, and service delivery.

ARHP's board of directors and staff and the entire *Sexual and Reproductive Health Workforce Summit's* planning team would like to thank the David and Lucile Packard Foundation and an anonymous donor, whose support made this Summit possible.

APPENDIX 1: Summit Participant List

CORE PARTICIPANTS

Helen K. Bellanca, MD, MPH, Health Share of Oregon
Co-chair: Joyce Cappiello, PhD, FNP, University of New Hampshire, and ROE Consortium at Provide
Clare Coleman, National Family Planning & Reproductive Health Association
Catherine Dower, JD, Center for Health Professions, UCSF
Jessica Gonzalez-Rojas, MPA, National Latina Institute for Reproductive Health
Megan Grimm, MPH, Ryan Residency Training Program and Fellowship in Family Planning
Mark Hathaway, MD, MPH, MedStar Washington Hospital Center & Unity Health Care
Amy Levi, CNM, WHNP-BC, PhD, University of New Mexico College of Nursing
Susan Moskosky, MS, RNC, US-DHHS, Office of Population Affairs
Beth Jordan Mynett, MD, Association of Reproductive Health Professionals
Co-chair: Melissa Nothnagle, MD, MSc, Alpert Medical School of Brown University
Michael Policar, MD, MPH, UCSF School of Medicine
Julie Rabinovitz, MPH, California Family Health Council
David Reyes, MN, MPH, RN, APHN-BC, Department of Public Health, Seattle and King County
Pablo Rodriguez, MD, Alpert Medical School at Brown University
Irene Sandvold, DrPH, CNM, FACNM, FAAN, US Department of Health and Human Services
Joan Stanley, PhD, CRNP, FAAN, FAANP, American Association of Colleges of Nursing
Carolyn M. Sutton, MS, WHNP-BC, FAANO, University of Texas Southwestern Medical Center at Dallas
Diana Taylor, RNP, PhD, FAAN, Advancing New Standards in Reproductive Health Program, UCSF
Robert M. Trachtenberg, MS, National AHEC Organization
David Turok, MD, MPH, University of Utah
Carolyn L. Westhoff, MD, Columbia University Mailman School of Public Health
Deborah Williamson, DHA, MSN, CNM, Medical University of South Carolina College of Nursing
Jacki Witt, JD, MSN, WHNP-BC, SANE-E, Title X Training Center, University of Missouri
Sandy Worthington, MSN, WHNP-BC, CNM, Planned Parenthood Federation of America
Phyllis Arn Zimmer, MN, FNP, FAAN, Nurse Practitioner Healthcare Foundation

OFFICIALS AND FUNDERS

Peter Belden, MBA, William and Flora Hewlett Foundation
Lana Dakan, MPH, David and Lucile Packard Foundation
Karen Gluck, MHSA, Susan Thompson Buffett Foundation
Stephen Heartwell, DrPH, Susan Thompson Buffett Foundation
Bonnie Adams Kapp, New Morning Foundation
Marilyn Keefe, MPH, MPP, US-DHHS, Office of Population Affairs
Alison MacDonald, Office of US Senator Jeanne Shaheen
Beverly A. Parson, MBA, Teva Pharmaceuticals
Hallie Schneir, White House Office of Public Engagement
Sara Singleton, Senate HELP Committee

STAFF

Geoffrey Knox, Facilitator
Allison Tombros Korman, MHS, Consulting Program Manager
Elizabeth McGrory, ScM, Writer
Wayne C. Shields, President and CEO
Amy Swann, MA, CAE, Vice President

APPENDIX 2: *Sexual and Reproductive Health Workforce Project* Overview

The goal of the *Sexual and Reproductive Health Workforce Project* is to increase availability of and access to high quality sexual and reproductive health care in the US. The *Project* is being led and coordinated by the Association of Reproductive Health Professionals (ARHP) in collaboration with dozens of non-profit, foundation, and agency partners. The *Project* focuses on sexual and reproductive health for women and men throughout their lives and its scope includes evidence-based prevention and management of unintended pregnancy, family planning, abortion, and preconception care. Guided by an expert steering committee, the *Project* is being implemented in three linked phases designed to identify, develop, and implement strategies toward its overall goal.

PHASE 1: NEEDS ASSESSMENT AND LANDSCAPE ANALYSIS (2010–2012)

The first phase comprised a needs assessment and landscape analysis that included surveys of potential collaborators, interviews with key opinion leaders, a compilation of existing programs of note, and a compendium of relevant research. This analysis reinforced three key priorities: (1) sexual and reproductive health must be a priority for primary care as US health care systems change in the coming years, (2) the clinician workforce must be better trained in SRH, and (3) advanced practice clinicians (nurse practitioners, physician assistants, certified nurse midwives, certified midwives, and pharmacists) are a critical workforce for delivering this care. There is a pressing need for continuing education, training, and professional recognition for health care professionals in SRH to ensure high quality patient care.

PHASE 2: *SRH WORKFORCE SUMMIT* AND WORKING GROUPS (2012–2013)

In anticipation of the *SRH Workforce Summit*, three working groups were convened to work on (1) pre-licensure education, (2) continuing professional development, and (3) service delivery. Each group's specific approach was tailored by its particular perspective and all sought to identify the following:

- effective SRH delivery models and standards that encompass innovation, public health, and preventive care and address SRH disparities;
- emerging models of primary care delivery and ways in which SRH could be built into these models;
- emerging payment structures that should encompass SRH care;
- current and future SRH workforce needs among primary care professions; identify scope of practice restrictions that may adversely impact delivery of SRH for each discipline of the team, and
- strategies to attract primary care professionals to practice in underserved areas.

Through their own extensive knowledge and background, review of key reports and research, and interviews with diverse experts, these groups laid out a range of recommendations, research questions, and policy activities.

For the two-day *SRH Workforce Summit*, ARHP brought together some 40 diverse professionals who all play multiple key roles in professional education, service provision, advocacy, and policymaking. Through lively discussion and debate, the participants considered the working groups' findings and identified a number of recommendations and research questions, as well as immediate next steps.

PHASE 3: COORDINATION AND IMPLEMENTATION (2013–2015 AND BEYOND)

The Project's third phase involves building on Summit recommendations by (a) coordinating consistent communications between all sectors of the SRH field and helping to initiate collaborative activities, (b) developing inter-professional working groups for cross-sector activities/pilot projects that advance the capabilities of the SRH workforce, and (c) encouraging efficient investment of resources from all donor sectors in sustainable, evidence-based programs and activities.

Appendix 3: Key References

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