Regional Professional Foundations
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One of the least publicized features of President Bill Clinton’s Health Security Act is Section 5008, which provides for regional professional foundations (RPFs), consortia of practicing physicians, academic health centers, medical schools, schools of public health, and other professional organizations. The tasks of the RPFs are to develop programs in professional lifetime learning; to foster collaboration among health plans and health care providers within a region to improve the quality and appropriateness of medical care; to participate in outcomes research; and to develop innovative ways to increase patients’ participation in their choices of medical care. RPFs also are asked to ensure the timely dissemination of information about quality improvement programs, practice guidelines, research findings, and ways of using health professionals most effectively.

We believe that RPFs can fill a gap in programs for assuring quality of care and for improving the scientific and ethical basis of clinical decision making. An innovative, patient-centered health system depends on learning what works and what patients want and on empowering providers to adapt to change. RPFs can build the knowledge needed to improve health care. This Commentary explains how RPFs can enhance innovation and improve quality of care and makes suggestions for their implementation.

Conceptual Framework

Population-based, regional focus. The principal advantage of RPFs is their population-based focus on building a professional infrastructure for quality, outcomes research, and lifetime learning in local communities and regions. The local and regional focus is important because the health care industry also is localized in its organization. In addition, there are extensive variations in practice style among communities within regions. A population-based focus would provide increased knowledge of the illness burden of
populations, including factors such as the costs of preventable illness, accidents, and excess morbidity. Such knowledge would enable providers to better evaluate and plan services.

The ability of the professional health care work force to remain up-to-date and innovative and to adapt to rapid changes in technology, patient demand, and societal expectations depends on a program of lifetime learning tied to the needs of specific providers and health care institutions. Improving the quality of care depends on self-study, which establishes an opportunity for the provider community to learn from its own experiences; efficient learning requires that the experiences of all institutions, providers, and patients serving a community or region be pooled and examined.

The administrative organizations envisioned for either managed competition or a single-payer system under reform do not inherently provide the required population-based, regional, and systemwide focus. While it is possible that “classic” health maintenance organizations (HMOs) may be able to encompass many of these activities, many Americans live in areas where the population density is too low to support this form of managed care on the basis of competition. For states and plans in which practitioners work in more widely distributed practice settings, and for states and regions electing single-payer systems, another strategy is needed.

**Empowering providers and promoting innovation.** Professional activities to develop shared decision making, improve quality, advance the scientific basis of clinical medicine through outcomes research, and support lifetime learning should be viewed as intrinsic to the rational management of modern health care systems. RPFs, supported as part of the business of health care, would provide the infrastructure and financial resources to empower the professions to assume responsibility for these tasks.

**New tasks for academic medical centers.** One of the greatest barriers to innovation in health care is the workforce policy that assumes that medical licensure and specialty certification assure lifetime competency and professional relevance. The president’s plan establishes new roles and responsibilities for academic medical centers in meeting the educational needs of providers over their professional lifetimes. The RPF would offer a real link between practitioners and educational resources—offering the practitioner current information to improve patient care and offering the academic medical center a venue in which to provide that information.

New opportunities also would be created for academic medical centers to expand their teaching and research programs in the evaluative sciences. RPFs would create demand for these programs and would provide an infrastructure for academic medical centers and practicing physicians to conduct clinical trials and other programs to improve the scientific basis of clinical practice. The presence of such an infrastructure should accelerate the
generation of new knowledge and greatly reduce the costs of clinical research.

RPFs also can play a constructive role in graduate medical education. Reform of health care will result in restrictions on the number of specialty residency training slots, perhaps requiring that 50 percent of graduates be from primary care programs. In many areas of the country primary care providers are dispersed across broad geographic areas without an organizational framework. RPFs could organize primary care practices into networks to support and integrate educational and practice experience for primary care residencies; academic institutions would be responsible for academic content, with the RPFs providing logistical support.

Matching providers to new tasks. Important RPF duties would be the enabling functions of matchmaking coverage and financing for providers who take time from practice to participate in its programs. RPFs would have the financial resources (see below) to contract with individual health care professionals and with academic institutions to arrange for their participation in the activities specified in the plan. Individual involvement could vary over time; the provider might commit full time to a sabbatical to learn new skills, participate in outcomes research, or work to establish a program in continuous quality improvement in his or her community. Other providers might want to spend six-month fellowships as members of a patient outcomes research team (PORT). At other times the same persons might be in active practice, involved in a study group, participating in the interpretation of data, or assisting with dissemination activities.

Evaluating the need for health professionals. The effect of physicians and other providers on cost of care and utilization rates will be an important focus of health care reform. RPFs would be ideally positioned to evaluate and deal with regional needs for health professionals. Analysis of various databases makes it possible to calculate numbers of providers per capita for hospital service areas (or for other regional definitions). These estimates of full-time provider equivalents per capita will provide locally developed, accurate profiles of regional work forces that can be used in concert with national workforce planning as well as in the local and regional recruitment, hiring, and placement of providers.

Building infrastructure and recruiting professionals. RPFs could serve as development corporations to organize financing and to build the structures required to address unmet needs, and as agents for assuring each community reasonable access to primary care and other services. They could test innovative service designs that build on local strengths. Community-based services lag far behind prepaid group practice and specialty clinics in capital investment in primary care, both in large urban markets and in rural regions; practice management and information systems, for
example, are often rudimentary, impeding efficient, high-quality health care practice. RPFs also could undertake joint ventures with the National Health Service Corps to identify and address the problems of underserved areas.

Examples From Northern New England

The idea of creating regional organizations focused on quality and lifetime learning is not new. The Regional Medical Program in the 1960s and today’s Area Health Education Centers (AHECs) are concerned with these issues. The AHECs’ mission is to improve the supply and distribution of health care professionals, especially in primary care. Programs have involved thirty-eight states.

For more than a decade we have been involved in developing regional organizations and coalitions that demonstrate the advantages of consortia of practicing physicians, other providers, and evaluative scientists based in academic medical centers. These consortia have undertaken many of the quality assurance tasks proposed for the RPFs.

The Maine Medical Assessment Foundation (MMAF) has developed networks of provider study groups to examine practice pattern variations, conduct outcomes research studies, and disseminate information. One major focus, feedback about variations in the use of many procedures, has reduced apparently inappropriate variations The prostate disease and low back pain PORTS (funded by the federal Agency for Health Care Policy and Research) have worked closely with the MMAF; important products of this collaboration have been advances in understanding the theoretical basis for surgical interventions and the critical importance of shared decision making. The role of patient preference in choice of treatment for prostate disease was first elucidated by studies done by the MMAF’s practicing urologists and its academic collaborators.

In 1987 the Northern New England Cardiovascular Disease Study Group was founded. This voluntary regional consortium initially was convened to investigate the effects of patient case-mix on perioperative mortality associated with coronary artery bypass grafting. It now has undertaken to provide accurate and timely information concerning the management of cardiovascular disease in Vermont, New Hampshire, and Maine. Members include all twenty-four cardiothoracic surgeons, as well as all thirty-one interventional cardiologists, administrators, and scientists associated with all five institutions that provide grafting in this region.

Regional databases for coronary artery bypass grafting, prosthetic heart valves, and percutaneous transluminal coronary angioplasty have been established. The databases are used to assess both current outcomes and
clinically important long-term outcomes. Current studies include a case-control study of the process of care in survivors and nonsurvivors of coronary artery bypass grafting in an effort to apply the techniques of continuous quality improvement to bypass surgery and angioplasty.

Also in northern New England a network of independent primary care physicians known as the Dartmouth COOP Project collaborates with academic researchers and organizes activities for mutual support, continuing education, and practice improvement. Activities include clinical trials, the development of instruments for measuring functional status (which are now in wide use), and collaboration with the prostate disease PORT to develop strategies for managing that disease in the primary care setting.

These projects show the advantages of linking investigation of variations, outcomes research, and postgraduate education into a continuum of activities in practices and locations where variations occur and problems arise. They also show how problems discovered in practice energize providers to design and participate in their own educational and research agenda.

### Recommendations

Under the Health Security Act, RPFs would be organized as not-for-profit corporations in regions approved by the National Quality Consortium. However, the Health Security Act does not provide details on how RPFs would be organized and financed. We suggest the following.

**Planning process.** As soon as legislation is enacted, we recommend that planning grants be offered to any eligible nonprofit entity—a state agency, medical society, medical school, or other organization—that has the support of the region’s providers. The focus of the planning grant would be to specify the geographic territory of the RPF; establish the linkages and cooperative arrangements among academic medical centers and the region’s practice community to participate in the activities of the RPF; and develop a governance structure, select a board of directors, and develop working relationships with state government, neighboring RPFs, academic health centers, health plans, and regional alliances.

During the planning process RPFs would develop their initial work plans, including model networks of quality and programs in lifetime learning. The applicant agency would be given access to Medicare data on local and regional health care service areas, including variations in resource allocation, practice patterns, patient outcomes, and workforce distribution.

**Geographic boundaries.** We recommend that the geographic boundaries of the RPFs be no smaller than the referral areas of academic medical centers (as defined by population-based patient origins studies) and large enough to reach a critical mass of patients, academic medical centers, and
professional schools. The referral areas of academic medical centers often will overlap state boundaries; in northern New England there are five such referral areas, as determined by the patterns of referral for bypass surgery (the most regionalized of all "routine" services). These areas overlap four states, and only two—the Manchester, New Hampshire, and Bangor, Maine, referral areas—rest entirely within one state. Taken together, the five areas have a population of about 2.4 million, barely enough to support the benchmarking needed for organizing a regional network of quality for bypass surgery. There are three medical schools in the region. We believe that a smaller population would be inadequate to support a well-organized program in lifetime learning, and we suggest that in regions such as northern New England, RPFs should embrace multiple referral areas to achieve the proper economies of scale to establish networks of quality.

**Governance.** The mission of RPFs should set the tone for the development of a governance system that fosters the ethical and technical goals and objectives set by legislation. Providers must be represented so that there is no question that the organization speaks for their needs. At the same time, there must be representation from other constituencies so that the RPF truly acts in the public interest. We believe that the RPFs should function as a true collaboration among academic medical centers, practicing physicians, and other providers. The experience of the MMAF indicates that providers across the region will cooperate with strong community-based leadership. At the same time, medical schools and academic medical centers provide expertise and collaboration in the many components of lifetime learning, the evaluative clinical sciences, and other research methods. To be successful, the professional partnership must be composed of equals.

**Funding.** The initial planning grants should be for $250,000 per year for one to two years. This will provide start-up funds for organizations to convene meetings, write bylaws, incorporate, appoint boards of directors, and recruit initial staff. The financial base of the RPFs should be health care dollars. The cost of core staff should not, except in unusual circumstances, exceed the amount now allocated to the peer review organization (PRO) program in the region. Most of the workers involved in the RPFs’ programs, however, already will be engaged in the regions’ health care industries, with their practice-based incomes sustained by health care dollars. Their time and effort will be secured through the RPFs’ authority to contract with providers to undertake the specific tasks defined by their work-force plans. We recommend that the RPFs have the opportunity to use up to 5 percent of the per capita outlays of health care expenditures in their regions, subject to assurance that their activities will not increase the total outlay for care above any amount that the state, the relevant health alliances, or the federal government set as a target. The revenues would come proportion-
ately from the regional alliances, corporate alliances, and Medicare. Keeping within the target should pose no special difficulties because most RPF activities would engender costs less than the costs of practicing medicine, and they should at worst be budget-neutral.

National oversight. We recommend that the National Quality Consortium (Section 5009) review each planning grant and recommend applicants for funding by the National Quality Management Council. The applications would be evaluated according to the following criteria: (1) Only one application will be accepted per region; (2) regions must be of sufficient size (or have well-defined organizational relationships with neighboring RPFs) to provide the needed economies of scale for benchmarking quality and organizing lifetime learning; (3) the work plan must specify the working relationships developed with constituent states and alliances; (4) the work plan must specify model networks of quality that outline the region’s strategies for promoting shared decision making and improving the processes and outcomes of care; and (5) the work plan must specify model programs in lifetime learning and explain how these programs meet the goals of promoting innovation and quality.

We also recommend that the RPFs be viewed as voluntary in the sense that not all regions may want or be able to develop a work-force plan or form the cooperative arrangements that are the basis for implementing such a plan. We believe, however, that the incentives to achieve these arrangements should compel most regions to form an RPF; most practicing physicians will recognize this as an empowering opportunity.

NOTES

5. Space limitations preclude full discussion of these activities and research here. A bibliography is available from the authors at the Center for the Evaluative Clinical Sciences, Strasenburgh Hall, Room 332, Dartmouth-Hitchcock Medical Center, Hanover, New Hampshire 03755-3863.
6. Ibid.