

House Ways & Means Committee

Rural and Underserved Communities Health Task Force Request for Information

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The Honorable Richard Neal
Chairman
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

Dear Mr. Neal,

On behalf of the Fitzhugh Mullan Institute for Health Equity (Mullan Institute), we are pleased to respond to the request for information for the Rural and Underserved Communities Health Task Force.

The Mullan Institute, located at the George Washington University, is a university-wide initiative that represents the Milken Institute School of Public Health, School of Nursing, School of Medicine and Health Sciences, School of Business, Graduate School of Education & Human Development, and the Trachtenberg School of Public Policy & Public Administration.

Our vision is a health workforce that is committed to achieving health equity, and is therefore:

- adequately distributed across all rural and underserved areas;
- committed to primary and community-based care;
- working in interdisciplinary teams;
- coordinating across sectors to address the root causes of disparities in population health; and
- is internally diverse, inclusive and has fair working conditions for all its members.

We hope you find our response useful and are happy to help answer any additional questions the Task Force may have.

Sincerely,



Patricia Pittman, PhD
Director
Mullan Institute



Candice Chen, MD
Associate Professor
GW Department of Health Policy and Management

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Rural and Underserved Communities Health Task Force Request for Information

Rural and underserved communities face critical health workforce challenges that negatively affect health care access, quality, and cost. In order to effectively address health workforce shortages for rural and underserved communities, a comprehensive approach including shorter term support for new practice models and longer term support for health workforce training is needed.

Maximizing the Health Workforce – Promising Models of Health Care

While the promise of telehealth has been to expand access to care in rural areas, in fact consumers report that for a variety of reasons telehealth is more widely used by the urban, middle class and the young than the homebound elderly in rural areas, for whom it was assumed there would be the most need/benefit. In a 2018 study of consumers, Park and colleagues documented this problem and proposed that states and the Federal government need to do more to incentive provider organizations to invest in telehealth and to form partnerships across health care organizations.¹

Another promising program is Project ECHO, which reduced the need for rural residents to travel long distances to receive specialty care. Project ECHO offers video-based support to teams of primary care providers in rural areas. Teams of specialists at central academic medical centers serve as the expert “hub” and provide weekly case-based consultations with a half dozen local teams on specific priority topics such as hepatitis C, opioid dependency, how to best use community health workers, etc. Each year the model has grown to include new provider groups and new topics.²

Home care services led by nurse practitioners (NPs) in states that allow prescription authority is a promising model that can enhance access for homebound residents in rural areas. Home care companies report that because the cost of physicians is higher than the cost of NPs and large numbers of hours are spent in travel, they prefer the NP workforce for home care, so long as they can resolve prescription needs during this visit. To further facilitate the expansion of this model, Medicare should allow NPs to prescribe home care and develop home care plans.³

We also know that NPs are more likely than physicians to practice in rural areas and their relative importance in rural communities has grown.⁴ Barnes and colleagues reported that in 2016 NPs

¹ Park J, Erikson C, Han X, Iyer Preeti. Are state telehealth policies associated with the use of telehealth services among underserved Populations? Health Affairs. 2018;37(12). www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05101

² The University of New Mexico. About Echo [Internet]. [last revised n.d.; cited 27 Nov 2019]. Available from: <https://echo.unm.edu/about-echo>.

³ American Association of Nurse Practitioners. Improve Medicare patient access to home health service [internet]. [last revised n.d.; cited 27 Nov 2019]. Available from: www.aanp.org/advocacy/federal/federal-issue-briefs/improve-medicare-patients-access-to-home-health-care.

⁴ Auerbach D, Staiger D, Buerhaus P. Growing ranks of advanced practice clinicians – implications for the physician workforce. N Engl J Med. 2018; 378:2358-2360. www.nejm.org/doi/full/10.1056/NEJMp1801869.

constituted 25.2 percent of providers in rural areas, up from 17.6 percent in 2008, and states with full scope-of-practice laws had the highest NP presence.⁵

Data Definitions: In understanding rural-urban differences, it would be helpful to further clarify the definition of urban and suburban areas in Metropolitan Statistical Areas (MSAs). We recommend moving to four classifications: central and outlying counties in large and small MSAs. Classifying medium to small MSAs into central and outlying counties results in small categories, but we believe the differences between central and outlying areas of small MSAs warrant this further classification. Moving to finer geographic classification will improve our understanding of the supply of health care professions.

Building the Future Health Workforce – Education & Training

Graduate medical education (GME) is the residency and fellowship training that occurs after medical school graduation and all states require GME in the U.S. to become independently licensed, therefore, the availability of GME positions in different specialties determines both the overall number and specialty distribution of the workforce. GME programs further impact physician practice locations. Physicians are likely to locate near their GME programs^{6,7} and training in rural and underserved settings increases practice in those settings.^{8,9,10}

Recent federal programs have provided some targeted support to expand residency training in rural and underserved communities. The HRSA Teaching Health Centers (THC) Program provides GME payments to support community-based primary care residency programs, largely located in community health centers. The HRSA Rural Residency Planning and Development Program is supporting the start-up costs of new rural residency programs. Start-up of new GME programs represents a significant time and financial investment to rural and underserved communities – an estimated 2-3 years for planning/accreditation and \$600k to \$2.8 million, depending on setting and development needs.¹¹

⁵ Barnes H, Richards MR, McHugh MD, Martsof G. Rural and nonrural primary care physician practices increasingly rely on nurse practitioners. *Health Affairs*. 2018; 37(6): 908-914.

⁶ Seifer SD, Vranizan K, Brumbach K. Graduate medical education and physician practice location. Implications for physician workforce policy. *JAMA*. 2005;274(9):685-91.

⁷ Flaga EB, Gibbons C, Finnegan S, et al. Family medicine graduate proximity to their site of training: Policy options for improving the distribution of primary care access. *Fam Med*. 2015;47(2):124-130.

⁸ Goodfellow A, Olloa JG, Dowling PT, et al. Predictors of primary care physician practice location in underserved urban or rural areas in the United States: A systematic literature review. *Acad Med*. 2016;91(9):1313-1321.

⁹ Morris CG, Johnson B, Kim S, Chen F. Training family physicians in community health centers: A health workforce solution. *Fam Med*. 2008;40(4):271-276.

¹⁰ Phillips RL, Petterson S, Bazemore A. Do residents who train in safety net settings return for practice? *Acad Med*. 2013;88(12):1934-1940.

¹¹ Education Health Center Initiative. Education Health Center Toolkit. [last revised March 2011; cited 27 Nov 2019. Available from:

https://static1.squarespace.com/static/5996f966e4fcb50cf8969259/t/59973a6ad7bdce74d661b324/1503083118690/ehc_iToolkit.pdf.

Further opportunity exists for targeted expansion of GME in underserved communities. However rural and underserved GME programs need sufficient and sustainable funding to be successful. These programs are intentionally located in community-based organizations with smaller overall budgets and slimmer operational margins. Evidence also suggests that smaller, more community-based residency programs do not benefit from economies of scale and have higher per resident costs.¹²

GME represents the largest public investment in health workforce. In 2015, Medicare provided \$12.5 billion in GME payments to teaching hospitals;¹³ Medicaid provided \$4.2 billion; and the VA provided \$1.5 billion.¹⁴ Two smaller programs, Children's Hospital GME and THCGME were funded in FY 2019 at \$325 million and \$126.5 million, respectively. The THCGME program requires Congressional action to continue beyond December 20, 2019. Medicare GME reform has been recommended to increase transparency, accountability, and impact of the program on national health workforce needs.^{15,16}

Residency training for dentists, nurse practitioners, psychologists, and others are promising strategies to address high need workforce for rural and underserved communities. Medicare GME supports dental residency programs and targeted dental GME can increase workforce and oral health access in underserved communities. Nurse practitioner and psychology residency programs in community health centers are developing to address the critical workforce needs of health care organizations focused on providing high quality, cost-efficient primary care for underserved communities.¹⁷

In addition to residency programs, health professions schools (e.g. medical, nursing, physician assistant, dental, and other) are a critical factor in ensuring a pipeline for residency programs and health workforce for rural and underserved communities. Medical school rural programs have been shown to be effective in increasing the rural physician workforce. In 2008, Rabinowitz, et al. estimated if 125 medical schools had just 10 students per class in rural training programs, it would more than double the number of rural doctors produced over the next decade.¹⁸ The Rural Physician Training Grants program, Section 749B of the Public Health Service Act (PHSA), which would have supported rural-focused training, has never been funded. Additional Title VII and VIII programs of the PHSA play an important role in supporting health career opportunities, recruitment, and training of health professionals for rural and underserved communities.

¹² Ben-Ari R, Robbins R, Pindiprolu S, et al. The costs of training internal medicine residents in the United States. *Am J Med.* 2014; 127(10):1017-1023.

¹³ Chen C, Yung Y, Petterson S, Bazemore A. Changes and variation in Medicare graduate medical education payments. *JAMA Intern Med.* Published online October 7, 2019. doi:<https://doi.org/10.1001/jamainternmed.2019.4429>.

¹⁴ U.S. Government Accountability Office. Physician workforce: HHS needs better information to comprehensively evaluate graduate medical education funding (GAO-18-240). [last revised 29 Mar 2018; cited 27 Nov 2019]. Available from: www.gao.gov/products/GAO-18-240.

¹⁵ Institute of Medicine. 2014. Graduate medical education that meets the nation's health needs. Washington, DC: The National Academies Press. <https://doi.org/10.17226/18754>.

¹⁶ Medicare Payment Advisory Commission. Aligning incentive in Medicare. Washington, DC: Medpac; 2010 Jun [cited 27 Nov 2019]. Available from: http://medpac.gov/docs/default-source/reports/Jun10_EntireReport.pdf?sfvrsn=0.

¹⁷ Community Health Center, Inc. Training the next generation – Supporting Future Leaders in primary care. [last revised n.d.; cited 27 Nov 2019]. Available from: www.chc1.com/what-we-do/training-the-next-generation/.

¹⁸ Rabinowitz HK, Diamond JJ, Markham FW, Wortman JR. Medical school programs to increase the rural physician supply: A systematic review and projected impact of widespread replication. *Acad Med.* 2008;83(3):235-243.

Finally, in light of the growing population of older Americans, the long-term services and supports (LTSS) workforce (including home health aides, personal care aides, and nursing assistants) will be critical for health outcomes and quality of life as public and private payers innovate in this area. LTSS workforce is particularly challenging for rural and underserved communities.¹⁹ Addressing the LTSS workforce can be achieved through targeted health workforce development programs through the Centers for Medicare & Medicaid, HRSA programs, such as the Geriatrics Workforce Enhancement Program, as well as Department of Labor economic opportunity programs, such as the apprenticeship programs.

¹⁹ Coburn AF, Lundblad JP. Rural long-term services and supports: A primer. Iowa City, IA: Rural Policy Research Institute; 2017 Nov [cited 27 Nov 2019]. Available from: www.rupri.org/wp-content/uploads/LTSS-RUPRI-Health-Panel-2017.pdf.