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Summary of Testimony of Beth Landon
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President-Elect, National Rural Health Association
Senate Health, Education, Labor and Pension Committee
Hearing on Workforce Training Challenges
February 12, 2008

Rural America faces a looming health professions workforce crisis. Already in my state of Alaska, rural primary care positions have vacancy rates of almost fifteen percent. Surveys show that many of these vacancies last up to three years. The crisis is only going to get worse as the baby boomer generation gets older and a large percentage of current health professionals begin to retire. Rural America cannot wait; we must begin to train the future health care workforce today.

We know how this can be accomplished. Studies show that students from rural areas and/or those who were exposed to rural practice while in school are more likely to pick sub-specialties in communities that are in the most need. Programs such as Area Health Education Centers and other programs within the Title VII and VIII lines are essential in providing rural students the skills they need to go to medical school. Other programs such as the National Health Service Corps have been and should continue to be used to help pay for the education of these students that are considering practicing in underserved communities. Finally, graduate medical education should be reoriented so that more students are exposed to rural training and residency programs.

We can and must meet the needs of rural America by providing a health workforce of tomorrow that is stronger, more diverse and better geographically dispersed. We need Congress to act to remove some of the many barriers to the realization of this goal.

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On behalf of the National Rural Health Association (NRHA) and as the director of the Alaska Center for Rural Health, Alaska's Area Health Education Center (AHEC) in Anchorage, Alaska, thank you for this opportunity to testify before the committee on the looming health workforce crisis unfolding in rural America. The NRHA is a national, non-profit membership organization whose mission is to improve the health of rural Americans. The NRHA provides leadership on rural health issues through advocacy, communications, education and research.

Although my comments will specifically address the looming shortages in my home state of Alaska, interactions with my colleagues across the country and the data included in my testimony make clear that similar trends are occurring throughout our nation. In short, while over 62 million Americans call rural home (slightly over 20 percent of the nation's population), less than ten percent of the nation's physicians practice there. Other health professions have similar, if not higher disparities. Studies show that rural areas consistently had the largest gap between predicted need for nurses and numbers employed. This will grow worse, the Bureau of Labor Statistics estimates, within fifteen years there will be over a million nurse openings, most will be in rural areas. Frontier states, those with the most rural of populations like my own, are in even worse shape. Taken together, rural Americans cannot continue to expect access to health care without a concerted effort of all stake holders to address workforce shortages.

As will be clear throughout my testimony, the federal government is not the only stakeholder addressing this situation. However, the federal government is a very important one. Without the efforts of a number of government agencies and programs, states like my own cannot expect to continue to provide basic levels of health care for our citizens, leaving our economic future to the hopes of miracle cures or a post-illness society. Our concern is primarily that without a large federal investment in our future, we cannot assume that our children will have access to health care in rural America.

INTRODUCTION – The Health Workforce Crisis

This committee is well acquainted with the health workforce crisis and the unique challenges of rural Alaska due to the field hearing that you held in Alaska in 2007. I would like to thank Chairman Kennedy, Ranking Member Enzi and Senator Murkowski for this commitment to our state and to the workforce challenges throughout the nation. As was made clear during that hearing, the health workforce crisis faced by Alaska and the rest of rural America is growing and acute. Twenty percent of the U.S. population lives in rural America, yet only nine percent of the nation's physicians are practicing in these areas. This is not a new problem, shortage of physicians, in rural areas of the country, represents one of the most intractable health policy problems in the past century. As a result of these deficiencies, rural

patients are often denied both access to care and high quality care. All told, over fifty million Americans, many of them rural, live in areas that have a shortage of physicians to meet their basic needs.

This will only get worse. Experts predict that by 2030, when over a fifth of our nation's population is over 65 years of age and needing increasing levels of care, the nation will have shortages of at least 100,000 physicians and perhaps as many as 200,000. With demands for health care increasing rapidly, our nation is producing the same number of medical school graduates as we did twenty-five years ago. Yet, we are slated to see a huge number of retirements in the coming years. A third of the nation's active physicians are older than 55 and likely to begin retiring in the next few years. In fact, by 2020, physicians are expected to hang up their stethoscopes at a rate nearly two and a half times the retirement rate of today.

It is no wonder then that states like my own are beginning to show major cracks. Last year, my center, the Alaska Center for Rural Health – Alaska's AHEC, conducted a statewide survey of workforce vacancies across the state. We found that in all types of health providing agencies – hospitals, private and non-profit clinics, dental offices, physician offices, imaging centers, mental health centers, school districts and across 119 different health occupations, that one out of ten positions were unfilled. For key primary care occupations, vacancy rates were much higher. Over fifteen percent for family physicians, twenty percent for general internists, nearly twenty-five percent for pharmacists and around nineteen percent for family nurse practioners (FNPs) and physician assistants (PAs). All of these numbers were higher in rural and frontier areas – PAs over one-quarter of positions and for FNPs over thirty-six percent. Looking at our tribal health organizations, which serve an extremely vulnerable and primarily remote population, the average vacancy rate climbed to 16.5 percent, with notable spikes of 42 percent for pharmacists and over 50 percent for dentists. Further, the survey revealed that it was not uncommon for a position to go unfilled for three or more years.

Similar to national trends, the "Last Frontier" state will face growing challenges in the years to come. While it may seem odd for such a frontier state to complain about a growing population, ours will cause major challenges in the years to come. Alaska has the second fastest increasing elderly population in the nation behind only Nevada. Each of these seniors will place increasing demands on the Alaska health care system, especially the rural underserved system. This is worrisome because the study found that one of the top reasons for vacancies was population growth and an increased need/burden for health services were the reasons for causing strain for the few practicing physicians Alaska has.

In rural Alaska this is of particular concern as there is not an option of simply driving elsewhere in the state for these services. Despite an area larger than the combined sizes of California, Texas and Montana, Alaska has fewer miles of road than any other state. This means that even in the best weather conditions, over 150,000 people in 230 communities, including our state capital of Juneau, can only access services outside their area by air or water transportation. A health care workforce that is able to provide all aspects of basic care is necessary in these communities that cannot reach urban areas in a timely or cost-effective manner. Unfortunately, this is not currently the case as rural Alaska has the worst physician to population ration in the nation. But even in the rest of the nation, rural citizens deserve the ability to access care in their own communities. And Alaska is not unique in the challenges of weather and distance that would make such travel impractical and dangerous.

Our partners in the Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) region are also facing major challenges. Since we share a medical school, this means that if we are all in it together to generate enough health care providers. But none of us are. For instance, the state of Washington with the largest population in the region has entire counties with not a single physician. Ferry County, population of over 7,300 people, has a single doctor. This leaves the state's population without access to even basic care. Statewide, Washington lags behind even my own state of Alaska in the percentage of pediatricians, family practioners, obstetric providers and surgeons to the population. Similarly the state is experiencing nurse vacancies of up to ten percent of all positions. The workforce crisis is throughout the northwest and we must work together to deal with it.

MEETING THE CHALLENGE – Growing Our Own Workforce

Despite the gathering crisis, we know how we can get ourselves out of this hole – we must train our own workforce in rural and frontier America. One reason that we must train our own professionals is the value they provide to our rural communities. Health care is a vital segment of the rural economy, usually the second largest employer in the community. Quality health care in rural America not only provides for the health of the community, but creates jobs, infuses capital into the local economy, attracts businesses and encourages families and seniors to maintain residency within the community. The health folks call this "ensuring access to culturally competent care" and the business folks call it "economic development."

Health professionals who live, train and work in rural areas feel appreciated by the communities in which they serve and know that they are making a difference in people's lives. The difficulty is in getting health professionals to give rural areas a try. Studies have consistently shown that providers who are most willing to practice in rural and underserved areas come from those same areas. In addition, evidence shows that rural residency rotations, brief perceptorships in rural areas, and graduation from residency programs that emphasize rural, underserved health care have the most promise in preparing physicians for rural practice and in lengthening the time that they serve in rural communities.

We acknowledge that as rural communities we have a role in this. In Alaska, we have reviewed the literature and found that in addition to training our own health professions, we must commit ourselves to making our communities more attractive to other health professionals. This simply has to do with numbers. Our state recently expanded from ten to 20 medical slots a year at a jointly sponsored WWAMI Medical School and another twelve residency spots; compared to the nearly one hundred physicians we would need to train annually just to keep pace with our current insufficient supply of health professionals. Some key recruitment strategies we employ include considering the needs of the entire family, being willing as a community to open up and accept health professionals that have "outsider" status and finding creative ways to provide clinical, professional and financial support. Once the right person is found, there needs to be continual work to retain that person through community inclusion and support. Otherwise, the high costs of recruitment and training will be spent again with turnover.

Finally, nationwide, there is a body of evidence that family practice and osteopathic physicians, which constitute a majority of rural primary care physicians, are more likely to

distribute themselves in proportion to the population compared to specialists as long as payment methodology is fair for rural and underserved areas. Unfortunately, payment methodology is not fair and medical school students are growing more unlikely to choose general practice compared with subspecialties. While there are a variety of theories for these choices, including following the higher pay, less emphasis on primary care during school, and lack of perceived prestige, it is unclear to what extent each of these play in the individual choices of medical students. What is needed is for Congress to place a priority in public policy to encourage medical students to make the choice to serve their communities and country by serving rural and underserved areas.

PUBLIC POLICY PRIORITY ONE: Title VII and VIII Reauthorization and Expansion

As stated, the workforce shortages faced by my state and the nation are the direct result of the individual choices made by medical students. However, policy makers and educators cannot simply walk away and say that it an individual's choice. Too many factors play a major role in whether a rural student even has the option to serve their community as a health professional. By the time a student enters medical school, they must have years of math and science training. Many rural schools are economically disadvantaged when it comes recruiting these teachers making it difficult for even an eager student to take the classes required for admission to advance programs. Further, many students that may want to become health professionals do not have the mentorship of people from their community to explain the necessity of math and science. Rural communities therefore at an early age often have a large gap between the desire to serve their community and the ability to do so.

At the federal level, a group of forty programs have been developed to help fill this niche. They are known collectively as the Title VII and Title VIII Health Professions and Nursing Education Training Programs. These programs each focus on different facets of the challenge of training health professionals who will serve rural and underserved communities, and minority populations. Like many collective groups of programs, there are some issues of overlap and missing links, but as a whole, the Title VII and VIII programs provide support to students, programs, departments and institutions to improve racial and ethnic diversity, accessibility especially to rural areas and the quality of the health care workforce.

While each of the forty programs deserve your full attention, I would like to focus my remarks on the Area Health Education Centers (AHECs) that I know best. **AHECs are the workforce development, training and education machine for the nation's health care safety-net programs.** In my own experience, I have seen firsthand how our new program, just over two years old, is already making a difference in Alaska. We are successfully encouraging youth to pursue careers in health care, and health professions students who participate in our frontier clinical rotations are selecting employment in those communities. Nationwide, AHECs develop and support the community based training of health professions students, particularly in rural and underserved areas. They recruit a diverse and broad range of students into health careers, and provide continuing education, and other learning resources that improve the quality of community-based healthcare for underserved populations and areas.

The Area Health Education Center program is effective and provides vital services and national infrastructure. Nationwide, in 2006, AHECs introduced over 308,000 students to

health career opportunities, and over 41,000 mostly minority and disadvantaged high school students received more than 20 hours each of health career programs and academic enhancement. AHECs support health professional training in over 19,000 community-based practice settings, and over 111,000 health professional students received training at these sites. Further, over 368,000 health professionals received continuing education through AHECs.

Together with the other Title VII and VIII programs, AHECs have proven their effectiveness. Congress, together with this administration, has shown a commitment to the Community Health Center program to provide safety-net care. This has been a noble approach which the NRHA supports to provide resources to provide care for our nation's most vulnerable populations. But while these resources have facilitated an expansion in CHC facilities, there is a huge shortage of professionals to actually work in them. In fact, it has been shown that CHCs have over 400 physician shortages today for the current health center, not to mention further expansion or retirements in the years to come. In the past, these professionals would have been trained in Title VII and VIII programs. Today, over sixty percent of CHC physicians were exposed to Title VII funding during their time in medical school. Likewise, over fifty-seven percent of National Health Service Corp physicians (detailed in the next section of this testimony) were exposed to this funding during school. Where will our nation's safety net physicians come from if Congress continues recent trends of underfunding and defunding Title VII and VIII programs?

One more word is needed on the effectiveness of the Title VII and VIII programs. The Bush Administration, using their Program Assessment Rating Tool (PART), has labeled these collective programs as ineffective. This is both deceptive and unfair. While each of the forty individual programs has their own program goals and objectives, they were lumped together for a single evaluation. Programs like AHECs were not considered on their own merits. In fact, the PART assessment even singled out AHECs as a program that may be working if they had their own assessment. Second, the long-term measures that the programs were asked to meet were blatantly unfair. The PART measure selected was the "proportion of persons who have a specific source of reliable, continuing healthcare." This measure is impacted by a myriad of factors including insurance coverage, income, geographic location and a host of other factors. Surely, Congress does not expect training programs to be able to cover all of these separate policy considerations. Compare this, as the administration did, with the National Health Service Corp measures that evaluate the number of patients served by NHSC physicians and the placement and retention into underserved areas. These are factors that the NHSC has control over. Title VII and VIII programs also deserve to have measures relevant to the program goals, so that our proven effectiveness is demonstrated to the administration and Congress.

Recommendations: Reauthorize and expand Title VII and VIII Training Programs including Area Health Education Centers that have been proven to be highly effective in training health professionals who will practice in rural and underserved areas. This reauthorization should be for at least five years. Further, these programs have been underfunded and cut since at least fiscal year 2005. Congress must appropriate adequate funding levels for these programs to continue success in training the future rural health workforce. Finally, the PART assessment of these programs should look at each program individually in a way that will actually measure the mission and goals of the individual program.

PUBLIC POLICY PRIORITY TWO: Reauthorization of the NHSC

For more than 35 years, the National Health Service Corps (NHSC) has been recruiting health professionals to serve in communities where needs are greatest. We thank this committee in acknowledging this important program this past fall and urge that the reauthorization is quickly taken up by the full Senate. The communities served by the program include both rural areas, where the nearest clinic may be miles away, and in inner-city neighborhoods, where economic and cultural barriers prevent people from seeking and receiving the health care they deserve. To qualify for a NHSC physician or other health professional, the community must be located in a primary care health professional shortage area (HPSA). Currently, 4,000 NSHC clinicians provide care to nearly six million people nationwide. Tragically, this leaves some fifty million Americans residing in a primary care HPSA without access to the care they need. While the NHSC has been essential in making sure that some of these communities are and will continued to be served in the years to come, more help is needed.

The program was originally created as a scholarship program for those in medical school. For a year of scholarship support, a NHSC scholar agreed to dedicate a year working in an underserved area. The experience with this has been that many of the scholars go on to serve underserved communities their entire careers. More recently, more emphasis has been placed in a loan repayment program. This has been effective in introducing medical school graduates to underserved communities and allowed more participation at a lower cost to the federal government. However, our experience with the two programs shows us that the scholarship program is more likely to generate longer terms of service due to an upfront commitment than the loan repayment programs.

But no matter which portion of the program a student takes advantage of, rural communities need this program to be reauthorized, expanded and slightly modified. Currently, over eighty percent of NHSC applicants are turned down in a given year. The current appropriations of approximately $130 million is not enough. Senator Murkowski introduced a bill last year that would have expanded authorization to $400 million annually. The NRHA strongly endorses these efforts.

In terms of modifications, the rural experience with primary health care shows that not all primary care disciplines are included in the NHSC program. For instance, pharmacists and optometrists are often front line workers on primary care issues in our communities. In Alaska, pharmacy services are often mentioned in our survey as one of the most difficult provider types to recruit with a quarter of all positions vacant. The list of primary care providers should be expanded. Second, the most rural of communities, frontier, are often at a disadvantage in acquiring and keeping a HPSA score that would allow them to recruit NHSC providers. This has to due with the population size being served factored into the equation. Due to the lack of population in rural and frontier communities, our scores often lag behind urban areas. Further, in communities that are able to acquire a single NHSC provider, they often lose their HPSA designation since the number of providers now exceeds the number that would make sense in an urban area. This means many frontier communities can only have one provider to be a HPSA, leaving that person with no coverage if they take a week off. This can be disastrous if that provider leaves the community as they are unable to immediately recruit a provider that will

receive loan assistance. Frontier communities must have automatic HPSAs that protect them from these formulaic mistakes.

In addition, when the Senate considers reauthorization of the NHSC and other programs like Community Health Centers, the 330A Outreach and Network grant programs should be included. These grant programs have a track record of improving quality and access to care in rural communities by allowing communities to tackle unique health challenges in their own community. These grants have been used for a variety of health challenges, including health information technology networks, diabetes prevention, school based health care and workforce challenges. Despite the variety of uses for the program, a quarter of the grants are used annually on workforce projects. This is clearly relevant to the work of this committee. These programs should be reauthorized as they have been very effective as eighty-five percent of the recipients continue the project after grant funding has run out.

Recommendations: The NHSC is an essential program in providing health professionals to underserved communities. It needs to be expanded, fully funded and slightly modified to allow a more appropriate list of primary care providers and communities that are in most need of the program to participate despite flaws in formula. In addition, 330A Grant Programs (Outreach and Network Grants) should be reauthorized.

OTHER PRIORITIES: Rural Graduate Medical Education

This next two topics may be outside the scope of both this hearing and this committee's jurisdiction, so I will be brief, but no workforce discussion is complete without at least mentioning the problems with our graduate medical education and reimbursement structures in this country. First, medical education in the United States has become specialized, centralized and urban, embracing uniform standards of patient care, education and research. While this has led to a higher quality of care than in the old apprentice style system, it has led to a sharp decrease in the availability of health care in some parts of the country. As has been outlined previously, rural students are more likely to practice in rural communities. In fact, studies show that over half of medical students will practice within 100 miles of their medical school, and usually in a similar practice environment to where they trained. Public policy necessitates that medical schools do training in rural communities and recruit from across their states to make sure they have a diverse workforce that serves all communities. However, urban medical schools often favor continuing high quality research and cutting edge procedures at the expense of training a workforce for their state that will practice throughout their state.

Alaska is largely impacted by this trend. We have no medical school in the state. We have recently increased to twenty slots annually through a joint project with WWAMI Medical School that enables Alaskans to study three out of the four medical school years in Alaska. In addition, we have twelve residency slots a year in the Anchorage area. Thankfully this has been extraordinarily successful as seventy-five percent of the graduates of the Alaska Family Residency Program have remained in Alaska, with the vast majority working in underserved communities or with underserved populations. Unfortunately, the program is too small to meet the growing needs of rural Alaska. And our state is not alone.

Policies must change to encourage medical schools to train more health professionals who will practice in rural communities. At the federal level, you have two levers that you can easily pull to help make this change a reality. First, Congress has already placed in statute a waiver to Graduate Medical Education (GME) payment caps to those programs that included integrated rural training tracks (IRTT). Unfortunately, since Congress never defined IRTT, CMS has not implemented this waiver. Congress needs to go back and define what they meant by IRTT so students that are exposed to rural practice and are trained in primary care, obstetrics, pediatrics, emergency medicine and community health are not held to the same cap as Congress implemented for specialty training. Second, Congress should take advantage of the relatively small number of medical schools in this country that operate rural residencies to streamline reporting and payment so that rural residencies get the money directly from Medicare. This would increase efficiency and accountability and make it more likely that rural sites could and would participate in residency training programs.

To compound the difficulty in training a rural health workforce, the cost of going to medical school continues to rise. Even in public medical schools, the cost has risen 900 percent in the last twenty-five years. Rural students and those that will go into rural medicine cannot afford these levels of debt as they will get paid less than sub-specialists and those that choose to practice in urban settings. Congress should continue to examine ways to reduce this debt burden either through the previously mentioned NHSC program, more GME payments to reduce tuition or other tax incentives. These should be predicated on a commitment to practicing in rural, underserved areas.

Recommendations: Graduate medical education in this country has become specialized, centralized and urban. Congress should work to make sure that medical education continues to train rural practitioners by defining IRTT and encouraging more rural residency programs. Finally, the debt level of medical school graduates is out of control and needs to be reigned in for students that choose to practice in underserved areas.

OTHER PRIORITIES: Fair Reimbursement Structure

Finally, without fair payment for rural health professionals, many will choose to either reduce or eliminate the number Medicare patients they see, relocate their practices to areas of the country where they are paid better, retire earlier than they intended, or a combination of all three. These inequalities must be addressed.

While payment structures are complicated and diverse, there is one element of the Sustainable Growth Rate for physicians that further complicates the ability to recruit and retain rural physicians – the Work Geographic Practice Cost Index. There are a number of indices that factor in different costs of operating a practice in different areas including the extra costs of rent in urban areas. But the index that adjusts for work costs is both imprecise and unfair. Physicians have the choice of practicing all across this nation. Pay must be comparable in a rural community for them to even consider these facilities. It is the same work. It should be paid the same. It is unfair and bad public policy to pay better served communities more. Due to these unfair payment structures, in Alaska, Medicare payments only reflect about 40 percent of serving a Medicare patient. This is both not sustainable, nor is it fair for our rural communities.

We would have a better understanding of how these decisions have impacted rural America if the Medicare Payment Advisory Commission (MedPAC) had proportional rural representation. Current law states that the Commission must be "balanced" between urban and rural commissioners, yet only two of the seventeen commissioners have rural credentials. With one rural commissioner departing this spring, we face having only one rural commissioner on MedPAC when twenty-seven percent of the Medicare population resides in rural America.

In addition to Medicare, rural communities disproportionately rely on the Medicaid and State Children's Health Insurance Programs. While the stereotype of those covered by these public programs may be the urban poor, thirty-two percent of rural kids were on one of these public programs, compared with only twenty-six percent of those in urban America. Any federal changes to Medicaid and SCHIP need to take this into consideration, so that rural providers continue to accept these payment rates to take care of our most vulnerable kids.

Recommendations: Enact legislation that fixes the Medicare physician payment system so that it realistically reflects physician practice costs and does not unfairly pay less to those providers that serve these communities that need their help the most. Second, ensure proportional representation on MedPAC. Finally, protect payments to Medicaid and SCHIP that cover rural children.

CONCLUSION

Over the next twenty years, this nation's health professions workforce shortage will reach the crisis proportions being experienced today in rural, frontier, and other underserved areas. My state of Alaska is already in the midst of it. We know from experience that this will force us to try new things – we have already heavily invested in health information technology both as a means of training our health professionals and to monitor patients from a distance. But this will not solve all of our problems.

We must have culturally competent health professionals in our communities. We must have more providers in our CHCs so that the most vulnerable population are served. We want to make sure that our grandparents are able to receive the care they deserve in the community that they have spent their lives. We also want to make sure that our children are able to receive the checkups early in life that they need to be productive citizens. But this will not happen if we do not begin training the future rural health workforce today.

In rural and frontier states all across this nation, including my own of Alaska, we are willing and able to begin to make the changes necessary to train and recruit this workforce. But a number of barriers are in our way. Congress must act appropriately and eliminate the barriers at a federal level, and invest in our future. Without these efforts and funding for Title VII and VIII programs, the National Health Services Corp, graduate medical education and a fair reimbursement structure, we will not be able to train the professionals we know we need. We look forward to working with you to make sure that the predicted crisis does not come to pass.

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