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WORKFORCE ISSUES IN HEALTH CARE REFORM: ASSESSING THE PRESENT AND PREPARING FOR THE FUTURE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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CONTENTS

OPENING STATEMENTS

WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

WORKFORCE ISSUES IN HEALTH CARE REFORM: ASSESSING THE PRESENT AND PREPARING FOR THE FUTURE

THURSDAY, MARCH 12, 2009

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:10 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Lincoln, Wyden, Cantwell, Nelson, Carper, Grassley, Hatch, Snowe, Kyl, Crapo, Enzi, and Cornyn.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Amber Cottle, International Trade Counsel; Ayesha Khanna, International Trade Counsel; Neleen Eisinger, Professional Staff; and Chris Dawe, Professional Staff. Republican Staff: Stephen Schaefer, Chief International Trade Counsel; Rodney Whitlock, Health Policy Advisor; Susan Walden, Health Policy Advisor; Michael Park, Health Policy Counsel; Nick Wyatt, Tax Assistant; and Terry Postma, Detailee.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

An old Jewish proverb warns, "Don't live in a town where there are no doctors." Our question today is: will there be enough doctors, nurses, and other providers for the towns in the future? And there is reason for concern. Already, America has too many towns without doctors. There are too many under-served areas in too many parts of rural America.

HHS says that in rural America we have roughly 7,000 fewer primary care doctors than we need, yet a recent study found that only 1 in 50 medical students—only 1 in 50—plans a career in primary care internal medicine. That is down from more than 1 in 5 in the early 1990s. That is a 10-fold change in the wrong direction.

That is just as the need for primary care doctors is increasing. Between 2005 and 2020, the number of Americans over age 65 will grow by 50 percent. As Americans live longer, the burden of illness and disease will continue to grow as well. Our aging population will require a stronger primary care system to help patients effectively manage and coordinate care. Yet, current payment policies place a higher value on specialty care, higher than on primary and

preventive care. We need to invest in our primary care system to help improve quality and lower costs.

I have also heard from hospitals in my home State of Montana and elsewhere about continued problems recruiting nurses. Despite this shortage, nursing schools had to turn away more than 40,000 qualified applicants in 2007 due to shortages in faculty and other constraints.

Today we look at ways to strengthen our Nation's health care workforce. Our Nation's health care providers—doctors, nurses, and other professionals—are on the front line of caring for patients. For health reform to succeed, we need a strong health care workforce.

We must ensure that health care workers have the necessary training and the skills to provide that quality care, and new technologies such as telemedicine can help be part of that solution as well. I do not want to understate that. There is a huge role for telemedicine to address the shortages in certain parts of the country, but that is clearly in no way going to be a complete solution. We just need more people in the primary care areas that I mentioned. We cannot expect to improve patient health if we are not training providers in key areas such as care coordination.

We need to take a hard look at the way that we pay health care providers. As part of that examination, we should ask, first, do today's payment systems properly reward providers who offer high-quality care? Second, do these payment systems encourage medical students to choose careers in critical fields like primary care? Third, do payment systems encourage medical residents to train in settings like community clinics, where many patients are receiving care?

Where the answer is no, we need to make a change. We should work to revise our payment systems. We must also step back and ask whether we have a solid national strategy to strengthen our workforce. Volumes of research have been published on the problems facing our national health workforce, but there is clearly no strategy. We must address these challenges head on. We need to take steps now to place our Nation's health care workforce on a sound footing.

Today we are going to hear from four experts in the field. This discussion can provide a solid foundation for the work ahead. So let us get to work now to ensure that more folks will not have to live in towns where there are no doctors, let us do what we can to ensure that doctors get the training and skills necessary to provide quality care, and let us do what we can to ensure that there will be good health care in towns in America's future.

Senator Grassley?

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you, Mr. Chairman.

Any discussion on health care reform has to include an examination of the health care workforce. One obvious area of focus is what impact expanding coverage to all Americans will have on the health care workforce of the future. It is easy to see that increased health coverage is useless without a workforce to provide the care.

The experience in Massachusetts provides a useful example of how important these issues are in dealing with the workforce. In Massachusetts, health care reform efforts have increased the number of people with health insurance, but there are reports that many people are now finding it difficult to find and get appointments with primary care providers. The challenge of finding primary care providers has put tremendous pressure on emergency rooms and will almost certainly increase health care costs in Massachusetts. Future health care reform efforts ought to proceed with the health care workforce in mind in order to avoid unintended consequences such as those in Massachusetts.

These workforce issues are driven by a multitude of factors, as we are going to hear today, and they have multiple effects on our entire system. These issues and how to respond to them affect not only the basic access to health care, but they also impact quality and cost.

There are many projections of workforce challenges that we face. The Association of American Medical Colleges estimates an overall physician shortage of 124,000 by 2025. The Health Resources and Services Administration projects that the Nation's nursing shortage will grow to more than 1 million by the year 2020. According to a study last year in the *Archives of Surgery*, the number of general surgeons as a proportion of the population fell 26 percent during the past 25 years.

As our population ages, health care workforce shortages are predicted for nursing staff, technicians, general surgeons, and allied health professionals. Rural areas—like my home State of Iowa, and probably even more rural in Montana—are at greatest risk of health care workforce shortages. According to the Health Resources and Services Administration, approximately 20 percent of the United States' population lives in rural areas, but only 9 percent of the physicians practice there. And, as we have a shortage of primary care providers within our existing workforce, disturbing reports continue to show the dwindling percentage of medical students who plan to become primary care providers.

It is as low as 2 percent of current medical students, according to a study in the *Journal of the American Medical Association*. Our country is becoming increasingly reliant upon foreign medical graduates to fill these gaps, particularly in under-served areas. The increased cost of education and lack of sufficient financial incentives for primary care are significant factors in this decline.

These workforce challenges do not just affect the availability of health care, they also have significant impact on how the health care delivery system performs. The Dartmouth Atlas Project and others have shown that regions with greater primary care presence have lower costs, higher quality, and reduced socioeconomic and geographic disparities.

So we need to change incentives to promote an emphasis on primary care. Patients will then have better access to providers who can coordinate their care. We are very interested in delivery system reform as part of the larger health reform effort. The fragmented incentives in place for education in the medical professions only reinforce the fragmented silos of care that we are trying hard to change. We should not expect changes in the delivery system if we

do not pay more attention to the education of medical professionals. The socket has to match the plug.

So, in addition to reimbursement, we need to look at how Federal programs promote workforce development. Over the years, the Federal Government has developed several programs that seek to influence the education, training, and retention of the health care workforce. We should consider reforming graduate medical education to more effectively foster broader workforce goals.

With that, I yield.

The CHAIRMAN. Thank you, Senator.

Now I would like to welcome our witnesses. First, we will hear from Dr. Fitzhugh Mullan, Murdock Head professor of medicine and health policy at George Washington University. Next, Dr. Steven Wartman, who is the president and CEO of the Association of Academic Health Centers. The third witness is Dr. David Goodman, director of the Center for Health Policy Research at Dartmouth College. Finally, we will hear from Dr. Allan Goroll. Did I pronounce that correctly?

Dr. GOROLL. Yes.

The CHAIRMAN. Professor of medicine at Harvard Medical School.

You all have written statements, I presume, which you will have automatically included in the record. We ask you to proceed in any way you wish, starting with you, Dr. Mullan. We hold people to about 5 minutes.

STATEMENT OF FITZHUGH MULLAN, M.D., MURDOCK HEAD PROFESSOR OF MEDICINE AND HEALTH POLICY, GEORGE WASHINGTON UNIVERSITY, WASHINGTON, DC

Dr. MULLAN. Good morning, Mr. Chairman and members of the committee. I am honored to have the opportunity to address you. I have been charged with giving an overview of the workforce, and I will move rapidly to do that. Five minutes is a challenge; we will see how well I do.

I have served as a primary care provider, as an administrator, and a researcher in the field of health workforce research in my life, having been the Director of the National Service Corps and Assistant Surgeon General in the Public Health Service, and now a professor at GW, so I come at these issues from multiple perspectives.

Health care reform needs health care workforce reform. Without it, reform will not succeed. Massachusetts, as observed already, is a living experiment in that: you increase coverage, and the folks are not there to provide it. That will be the case around the country as we move forward.

I want to talk a little bit about the size, shape, and key sufficiency of the current workforce. I ask you to think about it as a life cycle in a diagram here that I am afraid is smaller than it might be. We suggest three portions of that life cycle. That would be, in terms of the physician: medical school, graduate medical education, and practice. Innovation and change need to take place in each sector. Without corollary changes in each sector, we will have far less than the outcomes we want.

The CHAIRMAN. You do not have a copy of that slide, do you?

Dr. MULLAN. It is on the back pages of my testimony.

The CHAIRMAN. All right. Thank you.

Dr. MULLAN. The key in many ways, and often overlooked——

The CHAIRMAN. Yes, we have it. Thank you.

Dr. MULLAN. Good. The key element is actually graduate medical education, with which this committee has a very important role. GME is the keyhole through which everybody has to go, which means U.S. allopathic medical school, U.S. osteopathic medical school, and foreign medical school graduates. So it is the size and shape of graduate medical education that determines the workforce of the country, so I ask you to bear that in mind in your deliberations today and in the future.

The trends in our workforce are that, over the years, it has grown for this workforce. We currently are 280 physicians per 100,000. It puts us about in the middle, a little below the middle, of the density in developed countries; a few are higher, a few are lower. That has grown steadily, and we will level out at about that level with our current inputs. The question that that raises is, is it sufficient? Well, certainly we have huge distributional problems, both geographically as observed, and in primary care versus specialty care.

The basic size, I will testify, in my belief, is sufficient. The notion of doubling it again, as we did in the past, or even increasing it by half again is a very expensive and ill-conceived plan. This, nonetheless, takes into account the fact that we do have an aging population, a growing population. But my judgment is, with several caveats, that the relative level we have is sufficient.

Those caveats are that we need to organize it better and get better effectiveness out of our physicians in terms of distribution and type, and we also should make even more use of two American inventions. We pioneered the physician's assistant and nurse practitioner, and they are very effective. There are about 70,000 PAs and about 100,000 nurse practitioners in practice today. They are more quickly trained and more agile in many ways, and they work extremely well as part of the health care team. I think that is where we need to look to buffer our future needs, as well as reorganization.

Additionally, we have instruments already in place for deployment and use of physicians, but there are, in the case of the first, the National Service Corps, way under-used, and in the case of the latter, community health centers, happily getting some attention. But between those two, we have very good instruments in place. Funding and support are important for deployment.

To spend a quick moment on medical schools issues at hand—they are expanding. This is good. Title 7, which has been the instrument of the Public Health Service Act to get more primary care, more minorities, and better distribution, has been way underfunded and been a target for elimination in the recent past. It needs to be reinvigorated, reconceptualized, and refunded. Of course, the National Health Service Corps needs support as well.

At the graduate medical education level, there are modest reforms that call out to be made. I would characterize these as barrier reduction to community and ambulatory practice, and incentivizing that. In the major reforms category, right now Medicare GME is without a brain. That is, it does not function as an instru-

ment of directing or shaping the workforce. It is $8.5 billion, which is by far the largest Federal investment in health professions education. It needs a new allocation system that aligns Medicare GME with the workforce needs of the Nation. Finally, and you will hear from others on this, practice reform is key, payment reform, organization, and health information technology.

Finally, two concepts that have been raised in various settings. Happily, some of the new legislation that has been proposed—and I think my colleague Dr. Wartman will speak about this—a National Health Workforce Commission is an excellent idea, but a National Center for Health Workforce Studies that would really do much better census and analytic work than we have the capability of doing now, is necessary as well.

For health care reform, we need an enhanced primary care workforce that is smart, well supported, flexible, IT-enabled, and accessible throughout the Nation, all of which are achievable goals with modifications and redirection of legislation and funding that, by and large, exist today.

Thank you.

The CHAIRMAN. Thank you, Doctor. That is very interesting, and provocative, too.

[The prepared statement of Dr. Mullan appears in the appendix.]

The CHAIRMAN. Dr. Wartman?

STATEMENT OF STEVEN A. WARTMAN, M.D., Ph.D., MACP, PRESIDENT AND CEO, ASSOCIATION OF ACADEMIC HEALTH CENTERS, WASHINGTON, DC

Dr. WARTMAN. Thank you. Good morning, everyone. Thank you, Mr. Chairman. I wanted to thank the committee for inviting me here today. I also wanted to thank my wife, Gina, for coming. Thank you, Gina.

The CHAIRMAN. Yes. We all thank you, Gina. [Laughter.]

Dr. WARTMAN. I wanted to point out to the committee that the Association of Academic Health Centers is the only organization that represents all the educational, research, and clinical components of academic health centers. We are not discipline-specific, but we represent all these specialties and all the fields of health care.

Our members are responsible for educating the next generation of health professionals, providing comprehensive health care and cutting-edge research. The message I want to convey to the committee today is that health system reform cannot be successful without simultaneously reforming how we make and implement health workforce policy.

It is critical that a reformed health system have sufficient numbers and types of health professionals who can provide the high-quality care needed to best improve the health of patients and the public. The AAHC report, "Out of Order, Out of Time: The State of the Nation's Health Workforce," discusses many aspects of current health workforce policy that are out of order and why we are running out of time to change.

Our report concluded there is a systemic flaw in our century-old approach to health workforce policy-making. Responsibility for planning and managing the Nation's health workforce is frag-

mented among literally hundreds of Federal, State, and private stakeholders that rarely coordinate their policies or activities.

I am basically here to say, if we do not change how we make and implement health workforce policy at the same time we reform the health care system, the promise of health reform will be seriously undermined.

Allow me to summarize briefly why I believe this is true. First, even without health system reform, the health workforce is already under tremendous stress from powerful social and economic forces, including the aging of our population and the markedly increased need for chronic and long-term care.

Second, there are serious concerns involving the selection of careers in the health professions, including admissions practices, education debt, workplace conditions, reliance on international health care workers, and current payment policies that steer health professionals away from choosing the kinds of careers and communities where they are most needed.

Third, our current health workforce policy-making and planning infrastructure is not adequate to meet these challenges because it is hopelessly fragmented among a wide variety of stakeholders that responds to immediate needs largely in isolation, and with little coordination.

Fourth, health system reforms under consideration by this committee add further stress to the already daunting challenges because, for example, expanding coverage will surely increase expectations and demand for services from health professionals, already in short supply. Implementing health information technology and comparative effectiveness research will require large-scale training of health professionals in order to maximize safety, quality, and cost-effectiveness.

Fifth, we are already behind the curve and need to act now.

All this leads me to conclude that comprehensive health workforce reform is an essential element of effective health system reform and that we need to make workforce reform a national priority in conjunction with system reform.

I recommend immediate appointment of a National Health Workforce Coordinator to begin mobilizing current resources more effectively as an interim step, followed by creation of a permanent, multi-professional, multi-disciplinary national health workforce planning body to bring together all stakeholders to address the challenges we face in a comprehensive, coordinated, and strategic manner.

A permanent national health workforce planning body allows us to assemble all the pieces of the workforce puzzle so we can see the whole picture. A national body can harmonize public and private standards, requirements, and prevailing practices across jurisdictions. A national body can address access to health professions' education and the ability of educational institutions to respond to economic, social, and environmental factors that impact the workforce. And a national planning body can identify unintended consequences among public and private policies, standards, and requirements.

My concern is that we will press forward with health reform without full consideration for the health workforce, all the players

in the health workforce that will be needed to make these reforms successful. I urge you to incorporate a new, integrated and coordinated approach to national health workforce policy as health system reform is considered.

On behalf of the Nation's academic health centers, I look forward to working with you toward that goal. Thank you.

The CHAIRMAN. Well, thank you, Doctor. I think your wife is very proud of you. [Laughter.]

[The prepared statement of Dr. Wartman appears in the appendix.]

The CHAIRMAN. Dr. Goodman?

STATEMENT OF DAVID C. GOODMAN, M.D., M.S., DIRECTOR OF THE CENTER FOR HEALTH POLICY RESEARCH, DARTMOUTH COLLEGE, HANOVER, NH

Dr. GOODMAN. Mr. Chairman and members of the committee, thank you for the invitation to talk about the health workforce and its relationship to health care reform.

Policy about the health workforce today has focused nearly exclusively on physician numbers and has assumed that simply adding more physicians will improve accessibility and quality. These policies ignore two truths: (1) that current growth rates in health care expenditures are unsustainable and will be worsened by indiscriminate growth in physician numbers; and (2) that the workforce we train today will shape, for good or bad, tomorrow's health care system.

What do we know about the physician workforce? In brief, what doctors and nurses do is very important for patient outcomes. Much less important is the number of doctors and nurses providing services in a given region or health care system.

Let me explain this. The notion that there is a single right number of physicians for the U.S. is challenged by the finding that the number of clinically active physicians per capita varies dramatically across regions for every specialty, and you can see this on the map. These are the Dartmouth Atlas of Health Care regions and they show, both for primary care and specialist physicians, very dramatic variation. This variation in physician supply is not explained by differences in patient illness levels or in population health, but by where doctors prefer to practice and live.

The last 20 years of growth in physician supply has shown that, for every physician that settles in a low-supply region, four settle in a region with already high per capita supply. This means that lifting the Medicare funding cap on GME will perpetuate today's variation as new doctors settle in places with already high numbers.

Multiple studies in a variety of settings have shown no benefit with a very high—now, this does not speak to very low supply, which is a bad thing for patients—supply of physicians. This is true both for care of ill newborns, as well as care of Medicare patients. Nor is a high supply of physicians associated with better perceived access to care, better technical quality, or higher satisfaction with the care.

How can it be that more physicians are not always better? Much of what we do as physicians directly improves the health and well-

being of patients, but we know that regions with a higher supply of physicians have problems which can make care worse: greater unnecessary use of the hospital, greater problems with care coordination because care is fragmented over many different physicians. The lesson from places with modest supply is that health care systems are very adaptable to different workforce staffing levels.

If physician supply is not of paramount importance, then what workforce policies will advance health care reform efforts? First, invest in improving what doctors and nurses do. We already have the knowledge and means to improve birth outcomes and lessen the impact of chronic illness. We also know how to better inform and involve patients in treatment decisions through shared decision making. We need to invest more in these activities.

Second, strengthen primary care. We know that medical care provided within health systems dominated by primary care has excellent outcomes at lower cost. Training more primary care physicians and fewer specialists will be necessary, but this does not mean that simply adding more primary care doctors to a region will reform a specialist-based fragmented environment.

Although the primary care medical home offers promise and demonstrations should be pursued, primary care performs best when other elements of the health care system support primary care providers, as in many integrated delivery systems, such as Kaiser Permanente, the Mayo Clinic, the Geisinger Clinic, and the Cleveland Clinic. Once we train primary care doctors and nurses, we need to keep them from drifting into subspecialties by paying them fairly.

Third, our current GME financing system remains entangled with Medicare and favors hospital-based training. All payers should participate in medical education funding.

Fourth, we need to introduce competition and innovation in GME. As an example, the NIH is a model of competitive peer review. I believe we can improve physician training and increase the number of primary care physicians through gradual introduction of competition for Federal GME funds.

Then, finally, I agree with Dr. Wartman that we need a new structure for the development of workforce policy. Currently, the most active Federal entity is the Council on Graduate Medical Education, but its charter has greatly impaired formulation of public policy. In an editorial published last year in the *Journal of the American Medical Association*, I advanced the idea of a permanent health workforce commission to craft evidence-based policies that improve access to care, health outcomes, and the quality and affordability of care.

Three key components. The membership of the commission should extend beyond physicians and include experts in public health, in patient-centered care, as well as nurses and consumers, health care systems, and payers. The commission should consider policy not just related to physicians, but to the broader health workforce. An effective policy will indeed require a dedicated staff that is independent of professional societies and trade associations.

So here is workforce policy that will help, and not hinder, reform, promote the dissemination of medical care in health systems already shown to be effective, and train greater numbers of primary

care physicians, but also implement financing reform that encourages coordinated care, the coordinated care that patients want and need.

Thank you.

The CHAIRMAN. Thank you, Doctor, very much.

[The prepared statement of Dr. Goodman appears in the appendix.]

The CHAIRMAN. Dr. Goroll?

STATEMENT OF ALLAN H. GOROLL, M.D., MACP, PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL, HARVARD UNIVERSITY, BOSTON, MA

Dr. GOROLL. Chairman Baucus, Senator Grassley, members of the committee, thank you for having me here this morning. I am a primary care doctor of 35 years. I have taught generations of Harvard medical students. I am an author. I have been a president of a medical society and a reformer. I am here today because it has broken my heart time and time again to see our fine medical students who came to medical school interested in being physicians—primary care physicians who will have an impact on people's lives—tell me, "Dr. Goroll, I am sorry, I cannot go into the field, it is just not doable."

So I am thrilled that you have taken up a mission to fix this problem because, as everybody has said here today, the issue is not how many people, it is what they choose to do and the perverse incentives that we currently have, which are not dissimilar from what has happened in the banking industry and in finance. I think, today, my message is going to be that addressing the workforce issue requires dealing with the payment issue. If we are going to solve workforce, we are going to have to solve payment. Payment is most distorted in the area of primary care, and I will go into that in just a minute.

Another reason for my being here today is that I am from Massachusetts. We have a saying in Massachusetts that it is easier to get your son or daughter, grandson or granddaughter into Harvard than it is to get a primary care doctor. So, we have a problem. I think there are very important lessons, especially as regards health insurance: if we are going to solve access to health insurance, we have to solve access to primary care. That gets at the issue of how we sequence health system reform.

So let me start with the diagnosis and with a question: why is there a serious and growing shortage of U.S. medical school graduates choosing careers in primary care? And by the way, when you look at the GAO report on the number of primary care physicians, it is somewhat misleading unless you read the fine print. It says we have plenty of primary care doctors. The problem is that many of them come from overseas, many of them are from third-world nations, so we are actually sucking the medical talent of the world into our country because we cannot attract our own U.S. medical graduates into this role.

A lot of the issues are very well described. There was a GAO report; there is a recent Graham Center report. The reasons cited included the indebtedness of students, low pay for primary care, lack of prestige, heavy time demands. But in speaking with my stu-

dents, what they really say is, I came to medical school, as I mentioned a minute ago, to do something significant, to have an impact. What they find is that the real problem, putting all those other issues aside, is that the primary care job today is not doable. What they see are doctors who are struggling. There is high visit volume, rushed care, and inadequate time to do the job properly. As I have alluded to, this sorry state of affairs derives from a "dysfunctional" payment system—a term used over and over again—dominated by Medicare's fee-for-service system, Resource-Based Relative Value Scale (RBRVS).

Being a Harvard faculty member, I do have to take responsibility because RBRVS was designed by my colleagues, Bill Hsiao and Peter Braun at the Harvard School of Public Health, to actually fix the problem that we have right now, which is to rationalize payment and to rebalance the imbalance between procedural care and evaluation and management services. But RBRVS got distorted in its implementation. You folks are expert in knowing that we pay disproportionately for procedures, and we greatly "undervalue"—the term used in the GAO report—the basic doctoring, the evaluation and management services that are the heart and soul of primary care.

Medicare's physician fee schedule basically sets the standard for all health insurance in the United States, so fixing Medicare is essential for fixing health insurance in general, and for fixing the payment system in particular. As we all know, we get exactly what we pay for. We are number one in the world in cost, and we are number 25 to 35 in health outcomes because we have high volumes of expensive procedures and we have too little doctoring. It is totally predictable.

Now, compounding the problem is that, as you know, all physicians get paid out of a single pool. What has been happening is that the ever-increasing proportion of Medicare dollars that goes for expensive procedures decreased the proportion of dollars available to primary care for evaluation and management services.

By the way, there are other physicians who are specialists who are non-proceduralists who also have the same problem. Neurologists, rheumatologists and others have this. This is not unique to primary care, but it is central to primary care.

Consequently, we get exactly what we pay for, as I have mentioned. How do primary care practices respond? Well, the only way they can respond. They respond by increasing volume. Now we are in a death spiral, because as the volume goes up, the time for talking with patients goes down, the time for diagnosis disappears.

What do we end up doing? Harried physicians find that they basically do nothing more than triage. They both over-order elaborate diagnostic tests to meet patients' concerns (because patients do not have time with their doctors), and, finally, they end up making referrals at a very low threshold for things that they have been trained to do themselves.

Finally, also, they cannot afford the multi-disciplinary teams, the health information technology, the infrastructure that is always talked about as essential for high-performing health care. The net result? We have taken our quarterbacks, if you will, and we have

turned them into gatekeepers, that old term. But that is exactly what they are doing right now.

So now, put yourself in the position of our very talented, very excellent medical students and ask the question, if you were a smart, perceptive person, would you choose this field as a career? The answer is obvious. But would you choose this as a career if we fix it? The answer is, absolutely, yes. So I think that we have an opportunity here.

I am going to stop right here and talk about the treatment plan later in the context of our conversation, but I think we have a wonderful opportunity right now to fix and ensure health system reform by fixing the primary care base. And since it is the base of our health care delivery system, we need to start with fixing primary care. It is very doable, and I think it is bipartisan and something that we can all agree upon.

Thank you.

[The prepared statement of Dr. Goroll appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Goroll. I do not know whether you intended this or not. If you did, that is very clever. My first question will be for you to now give a solution. [Laughter.] What do we do? You have all described the problem very, very well. When I talk to primary care doctors, I hear the same thing. I have wondered myself, when I see their appointment schedule, how in the world can they do it? There are so many patients coming in and out, it is like churning. I do not know how they do it. A lot of them do not. But what do you think some of the solutions are here?

Dr. GOROLL. Well, we have to reorient the payment system. Right now, it pays for volume. It pays piecemeal.

The CHAIRMAN. Right.

Dr. GOROLL. Primary care is comprehensive work. Can you imagine if you only got paid for seeing constituents?

The CHAIRMAN. Right.

Dr. GOROLL. That is our life. Yet, your job description is a very comprehensive one.

The CHAIRMAN. We know that part of the problem.

Dr. GOROLL. All right. That is number one. So essentially what I would do—and let me talk very technically for a moment—is I would tease out from Medicare, and Medicaid, the proverbial 800-pound gorilla.

The CHAIRMAN. Right. Right.

Dr. GOROLL. I would tease out RBRVS for payment for primary care. I would do it in a transitional way, starting with practices that are prepared to transform. Those of us who are thinking about this understand there has to be a new social contract; primary care practices have to beef up. They have to be able to be more capable than they are right now. They have to organize differently if they are going to meet the demands without a greatly increased number of physicians.

They are going to have to learn to work in modern systems, with modern teams. If they undergo so-called "practice transformation" and implement reforms such as the medical home model, I would make those practices eligible for a different payment model, one that I think will enhance their practice. There are many different

models that can be tested. Ours would be a risk-adjusted, comprehensive payment with a major bonus for desired outcomes. We align the payment system with the desired outcomes of improved access, cost containment, and higher quality.

I think if we combine payment reform with insurance reform, then we will not have the situation we have in Massachusetts, which is as you folks have pointed out. So we would now empower the practices; we would give them the money that they can now use for investment to become high-performing practices, as Karen Davis and her folks at the Commonwealth Fund have pointed out. I think we then begin to build a strong foundation in the country.

And by the way, if we re-empower the primary care folks, we will get the best and brightest of our medical students to go into this field, not the people who do not have any other choices. That solid foundation, I think, will start to build the base from which to do the other parts of health system reform that we have to do. I would not start a food fight with the specialists on, "You are over-paid." I think what we do is we cut down on the unnecessary procedural work we are doing by enabling primary care physicians to do their job. The savings can be achieved by having time to talk with patients, examine them properly, and make intelligent decisions. That is what I am trained to do.

The CHAIRMAN. What would you do about GME?

Dr. GOROLL. I think GME would—I would not set quotas. I would let the market take care of itself. If we fix primary care, they will come, and they will put demands on primary care training programs. But I think we need to support the faculty. I think we also need to support undergraduate medical education. Title 7 dollars are not even a decimal point in the Federal budget, and yet they have had tremendous impact. So I think we need to look at—and I like the idea of bringing a commission together—what kinds of resources need to be targeted. There is a lot of data on the impact of these programs over the years.

The CHAIRMAN. Let me ask anybody else who wants to pipe up here. Dr. Wartman?

Dr. WARTMAN. Yes. Thank you. I certainly agree that primary care is a centrally important issue in health system reform, but I think we need to remember that we are dealing with a lot of other health professionals who are very, very important and critical to any future health care that we have, whether it is nursing, whether it is allied health, pharmacy, psychology, dentistry, public health; you just name it. It is a very, very long list of dedicated and important individuals.

One of my colleagues gave me an analogy last week. He said, you know, it is like a big jigsaw puzzle. If we keep putting pieces in the box called health care providers, we shake up the box and then we take it out and see what we have, we generally do not have a complete picture.

The CHAIRMAN. That is what happens in Congress every day. [Laughter.] You shake it all up and it is different every day.

Dr. WARTMAN. So you can relate to it. I guess what I am suggesting is that we really need to take an over-arching look at all the different kinds of health providers and ask the question, if we do indeed need more, what is it that we need them to do, and try

to take those pieces out of the box and make it into a coherent picture.

The CHAIRMAN. Why is there such a nursing shortage?

Dr. WARTMAN. Well, I think that nursing shortages occur for a variety of reasons. They are real.

The CHAIRMAN. Why?

Dr. WARTMAN. Two things. One is the ability of nursing schools to, I think, educate and train the number of nurses who are needed is not there. There are faculty shortages, there are other problems.

The CHAIRMAN. Why? Why are there faculty shortages?

Dr. WARTMAN. I would say that probably the incentives for nurses to come and stay on faculty are the salaries and other things.

The CHAIRMAN. How do we change that?

Dr. WARTMAN. Well, I think you need to look at nursing not in isolation from the other professions and say, what can we do to make salary and other lifestyle issues more appropriate for those who would like to train the next generation of health professionals? But I am arguing very strongly here this morning, Mr. Chairman, that an over-arching, concrete look at the entire panoply of health professions and how they might best fit together is what we need to do.

The CHAIRMAN. We understand that. We understand that. My time has expired.

Senator Grassley?

Senator GRASSLEY. Dr. Goodman, you suggested that the number of physicians is adequate, just poorly distributed. Dr. Goroll, your experience in Massachusetts, however, is that there is a severe shortage of primary care physicians in the wake of increased coverage, even though Massachusetts has the highest number of physicians per capita of any of the States.

So could you help clarify whether or not there is truly a workforce shortage?

Dr. GOODMAN. I think that Massachusetts is very instructive. What we have not talked about very much today, just a reminder, that not only does the supply of physicians per capita vary tremendously, but the cost of health care per Medicare beneficiary. I think there has been wide recognition that there is substantial waste and disorganization in health care. If you look at costs and you think of what money buys, the reality is, it buys bricks and mortar and it buys people's time, it buys salaries, it buys physicians.

Massachusetts is emblematic of a health care system that in some parts is extraordinarily good, has the best academic medical centers in the country. At the same time, it is very subspecialty oriented, it is very high-cost, very high-volume, and quite fragmented. In fragmented delivery systems, you can add doctors ever more—and Massachusetts is an example of that—and not result in care that is the care that patients want, not result in care with good outcomes, not result in care that feels accessible to patients.

I share Dr. Goroll's interest in terms of reforming primary care, but we need to recognize that it is within a context of a greater delivery system and of subspecialty supply. Primary care physicians can create their own islands of rationality, but as long as they are in a sea of fragmented care delivery systems that are driven by vol-

ume of subspecialty services, we will always lose the battle of quality of care outcomes and costs.

Senator GRASSLEY. If he spoke for you, and I quoted you accurately, then we will just go on. If you want to say something, please go ahead.

Dr. GOROLL. Yes. I think it represents the distortion of the decision-making of our graduates. Yes, a lot of Massachusetts' data is because we have a huge research commitment, and a lot of our physicians, even though they may be listed as internists, and therefore as primary care doctors in category, are hardly that at all. So the numbers are very deceptive.

The real way to measure this is, how long does it take to get an appointment with a primary care doctor? The Mass Medical Society commissioned a superb study that indicated that it is now about 2 months, and that is if you can get one. In eastern Massachusetts, as I mentioned, it is almost impossible to find a primary care physician. Our local television station had a doctor who could not get a primary care doctor. So, this was a doctor, a lovely, wonderful young physician who could not find a doctor.

So I think what we have is, I would say, a 2-decade distortion of the career choices of our young men and women. And by the way, again, this is not a generational thing. These people are as committed as our generation was, and they are ready to go. But we have to build it, and they will come. I think that that is the mission.

Senator GRASSLEY. Could I also ask Dr. Goodman and Dr. Mullan—this will have to be my last question for this round—the geographic adjustment in Medicare payment is a major factor in difficulties that rural States like my State of Iowa experience in recruiting and retaining physicians. Physicians in rural areas receive significantly lower Medicare payments than those practicing in urban areas. This is especially ironic, since Iowa is recognized as providing some of the highest quality care. I could quote a Dartmouth study, but I will not go into that.

Question: in your view, what has been the impact of the current Medicare geographic adjuster on the shortage of physicians and other health care providers? And a follow-up question: what changes in Medicare reimbursement would you suggest that might help increase the percentage of physicians and other health care professions practicing in rural America?

Dr. GOODMAN. Right. I certainly would agree that hospitals in Iowa, hospitals in Montana as well, hospitals in Utah, have some of the most efficient and high-quality delivery systems, and they do it with a very modest physician full-time equivalent input into patient cohorts. They do it very well for a very modest amount of, if you will, physician labor. So the current geographic adjustment really unfortunately penalizes efficient systems and perpetuates inefficient systems based upon volume.

Now, I am going to make a distinction, because I have mostly talked about physician supply in the context of supply that is at least by, say, HRSA standards, considered adequate, if not ample. The issue of under-service, of health profession shortage areas or medically under-served areas is very real. It is real in my State. I am a former National Health Service Corps physician. It is a per-

sistent problem, but it is also one of all of our problems in our delivery system, one that we really have the best means to take care of.

We do have programs that have been shown to be very effective: the National Health Service Corps, community health centers. We have, unfortunately, persistently under-invested in them. It involves a relatively small number of physicians to rectify these problems. Because of that, most of our work at Dartmouth has really focused on physician supply distribution beyond under-service, because that is where some of our greatest opportunities are in terms of physician labor that is now really quite inefficiently deployed and could help to solve the problems, the needs of other patient populations, without raising costs further.

Senator GRASSLEY. Dr. Mullan, do you have something to add or any disagreement?

Dr. MULLAN. No disagreement. A quick add-on. The Medicare incentives have been less effective than one might want, which speaks to two issues. One is, they could be stronger. They are not very well publicized, not very well used in certain areas.

But the second item is the organization of the system. When we talk about practice reform, I think we need to talk about other ways, not simply cash incentives within the current arrangements, to incentivize other care provision arrangements, which in primary care will certainly help, and probably in the system as a whole will help as well.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. This has been an excellent hearing and a great panel.

It seems to me that thousands of Americans are losing their jobs at the precise time when thousands of new health care providers are needed, and sensible health workforce policies then provide multiple benefits. You have Americans getting good-paying jobs in their communities, jobs that cannot be out-sourced, while at the same time patients in the health care system benefit from having fresh health care provider talent and advocates.

So I want to start with some issues relating to the workforce question. I was interested in your comments, Dr. Wartman, because it really goes to something that has really concerned me greatly as I have gotten into this issue.

For example, under the Workforce Investment Act, the government spends close to $4 billion, and it is not possible to see what is going in, clearly, to the health professions. For example, we would like to know what is going in to training nurses, nurses' aides, and areas where there is a consensus that more talent is needed. I gather that you are very troubled about the fact that some of this money is not spent very efficiently, and that is why you would like someone to serve as a coordinator to try to gather exactly what is being done with the Federal dollars today.

Dr. WARTMAN. Well, I am a big vision person, and I think that we need to have a much better overall vision and perspective on the whole picture and what is going on, what are the inputs, what are the outputs, in terms that everyone can understand in a very transparent sort of way. So, yes, I would agree.

Senator WYDEN. Now, Dr. Goodman, you all at Dartmouth have been doing very good work. I was interested in your idea of competition for GME funding. Now, before a big brawl breaks out over that one, let me ask you, if I might, would there be a way to ensure that that could be structured so that everybody would have a fair chance to be part of it? Because I think, for example, what you all have done at Dartmouth is to show the tremendous value of shared patient decision-making, and that ought to be one of the things that is taught and emphasized, and is clear. Jack Wennberg, for example, has drilled that point home. We ought to be promoting it. How would you structure the competition so as to have schools promoting that sort of approach in their applications for GME funding, so it was done fairly?

Dr. GOODMAN. Thank you. I will try to be brief. I used the example of the NIH because I really feel that that is a model, and that one can set programmatic aims and then—NIH funding is free and fair funding. I mean, there is no favor, really. It is a great model. Right now, GME is fossilized. Those who have had great training programs in the past, or at least large training programs, forevermore will receive funding for those programs. There is very little incentive for innovation, there is very little ability in terms of the government to be able to influence the specifics of training, like incorporating shared decision-making or a notion of population health, or any other curriculum innovation.

This would also allow, for places that traditionally have not had large GME training programs, places like Utah or Montana, to begin to expand their training programs without the assumption that places that have always done it should always do it just because they have done it.

Senator WYDEN. We would like to follow up with you on that.

Let me see if I can get you, Dr. Mullan, on one last point. I think it is well understood that there is tremendous promise with what a lot of people call the medical home. I like to call it the health care home, because I think we ought to be saying that in a lot of instances, individuals other than physicians ought to be the medical team leader.

So, if you take the proposition—Chairman Baucus has focused on it in the white paper, a lot of Senators are interested in this—where do you think would be the best place at the Federal level to say, this is where we ought to lead the effort to train people to have a health care home or be the medical team leader? Would Medicare be the best place to do this? What would be the appropriate place at the Federal level to lead that effort to get the medical team leaders?

Dr. MULLAN. A good question, Senator Wyden. Medicare has had the leading role, de facto role, in health workforce policy because of the enormous impact of Medicare GME, but it has been a role that has not been an active one in the sense of having either the mandate or the capacity to do analytic work, or projections, or then to move the money around, as Dr. Goodman has suggested. The Bureau of Health Professions in HRSA has had a more cerebral role, but no money or mandate to move out in an aggressive way in this regard.

So I think you would need a reorganization or a separate unit set up within the government. I think funding traditionally for workforce programs has come through title 7 to HRSA, which is a different authority, different jurisdiction, which, while we are on the topic, I am delighted this hearing is as broad as it is. For those of us working in the field, the jurisdictional issues between finance and health, for instance, have prevented a big-picture look at issues like——

The CHAIRMAN. Not this year. Not this year.

Dr. MULLAN. This is wonderful for those of us who have been here. So, in answer to the question, I think you put your finger on a real problem in an area for growth in public policy. Right now, the agencies and HHS, neither one has all of the abilities to do it. Between them—that is, HRSA and CMS—there needs to be responsibility for this, and that could be a joint effort or lodged at either one with correct authority.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

I am going to interrupt our proceedings right here—we have a quorum present—to report out the nomination of Mr. Kirk to be USTR. A quorum is now present, and I thank my colleagues for adjusting their schedules and allowing us to have a quorum.

[Whereupon, at 11:05 a.m., the hearing was recessed, reconvening at 11:12 a.m.]

The CHAIRMAN. We will now return to our regularly scheduled programming. [Laughter.]

Senator Nelson, you are next.

Senator NELSON. Thank you, Mr. Chairman.

You all have testified that we need more primary care physicians. I agree with you, and I understand that. But that does not answer the basic geographic dislocation of a high-gross State that was suddenly frozen in its number of residents back in the 1990s and rewards to those States that have not grown, with the result that a State like mine, Florida—Nevada is also in this category—we educate the doctors, but then we do not have the residency slots. And we can address the over-utilization of specialties that you are talking about, but then, once we educate them, they have to go find a residency outside of the State of Florida. Of course, you know that a doctor will usually practice where they have done their residency.

Now, that is what we are trying to get at with lifting the cap. What do you all think about that?

Dr. GOODMAN. Well, since I have taken a very strong stance on this, I would just point to the fact—let me agree that this is a problem, which is one of the reasons why I have suggested that we have competition for GME funds. If we look at the last 20 years, in the last 20 years we have grown physician supply dramatically in this country, but physicians continue to settle—I will say it again: for every physician that settled in a low-supply region, four physicians settled in a region with already very high supply.

So just lifting the cap is not going to rectify the geographic disparities or the specialty disparities. It needs to be more nuanced than that. Because we all, I think, bridle against the idea of a commission or an individual who would decide where these physicians

go, I think the fairest way—and we know the most effective way—is a peer review competitive system. There is no reason why Florida should be disadvantaged because New York got there ahead of them. Florida needs to grow. New York needs to make its case, would be my point.

Senator NELSON. Well, the fact is that Florida is going to surpass New York in total population in the year 2012. From 2012 back to the date that there was the freezing, which is going to be some 14, 15 years, New York has shrunk in population and Florida has exploded in population. We are meeting that population. I want to hear from some of the rest of you. Some of you were nodding your heads, agreeing with me. I want to hear from you. [Laughter.]

Dr. MULLAN. I think the problem you point out is a real one and it will get worse, for exactly the reasons you suggest. Freezing or capping GME funding by Medicare was, as I understand it, an effort to prevent continued cost escalation by more residents with no particular plan, and it served at the moment. You raised a question of the future.

I think it brings up the key question about graduate medical education, which, as you will recall, I suggested was the governor, was the regulator of what we got in the way of workforce eventually. It does need a more nuanced, as Dr. Goodman suggests, approach. It needs to be not simply formulaic with a cap that rises or falls, but it needs a more specific plan. Whether that plan is national, regional, or local, we need to insert accountability planning and accountability into that system. Simply raising the cap under the current circumstances would certainly help in areas of fast growth, but as a national policy would, for the reasons we have described, in my judgment, not make sense.

Senator NELSON. Dr. Goroll, I want to hear from you before my time is up. I want you to tell the chairman how we do this nuanced approach so that we are not constantly behind the 8-ball in high growth States.

Dr. GOROLL. Well, I can only speak for primary care, but I would tell you that I think the standard should be not a political one, but it should be access to, in my field, to primary care. There are validated measures of that. If a State is found to have inadequate access, and I think, since primary care is the foundation, one might say that is a first target that you would want to work on, then that could be the basis to then go to Medicare as an application or a criterion for application for additional slots. One could also apply that to other specialties. There are some standards as to what is an appropriate referral rate. For example, in your State you may have an over-supply in certain specialties, but not enough in primary care. So I think there is a rational way to do this and getting around just an outright cap.

Senator NELSON. Can we work on that, Mr. Chairman?

The CHAIRMAN. We have to, Senator. This is a hugely important problem.

Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman.

I want to congratulate the panel for being a great panel and helping us to understand these matters a little bit better.

Dr. Mullan, you have mentioned the need for a national health commission on workforce. You feel that we need this. Could you just elaborate a little bit more on what having such a commission might yield for us?

Dr. MULLAN. Well, there are two levels of commissions. One would be a Federal commission, which would, with better information, develop long-term recommendations for workforce development in medicine and other health disciplines.

There have been many experiments, or growing numbers of experiments, in State-based activities. I think Utah has really shown the way with the Utah Medical Education Council, which, I am sure you are aware, is under a demonstration authority with Medicare, and has essentially taken responsibility for graduate medical education planning and funding in a local area, a State, in this case.

I think that begins to talk about the nuances that we need for planning and how Medicare could begin to move in a way that was more specified and would have flexibility as the demographics of the country move. They move west, in particular, or south, to move our residency support in concert with that. So, I think that is a very instructive example on a regional level, and it would be good if we had a kind of brain trust on the Federal level that could work with it.

Senator HATCH. Great.

Dr. Goodman, we have been told that there are geographic differences in utilization. How does the physician mix or the availability of certain specialties influence the high use of services in some areas?

Dr. GOODMAN. Well, we have a great deal of information about this now. It is not what we would expect. Let me say that we know that, in general, high physician supply is associated with high utilization of services, but with a particular characteristic: it is services that tend to be, one, much more hospital-based, a lot of intensive care unit days, and fragmented over many, many different types of physicians.

The irony of the geographic variation is that there is a strong correlation in the per capita supply of primary care physicians at this regional level, broad regional level, as there is of special physicians: where you find more of one, you find more of others.

But, if you look within health care systems where the care tends to be dominated by primary care, so the ratio, if you will, favors primary care, this is where care becomes much more efficient, Senator Hatch.

Senator HATCH. Well, thank you. I think this panel has been very helpful to the committee. We have some very tough issues ahead of us and a very short period of time to resolve major health care reform issues, but with your help, we may be able to do some good in this area. I have appreciated every one of your testimonies here today.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Carper, you are next.

Senator CARPER. Thank you, Mr. Chairman.

I just want to say, I fully concur with what Senator Hatch has just said. We have a lot of witnesses who come before this panel and, almost without exception, the panels are of value. This is especially so, so thank you for being here.

In my last job, I was privileged to serve as Governor of the State of Delaware, and we, in our education reform efforts, sought to harness information technology and bring it into not just every school, but every school classroom. I think we were the first State to offer Internet access to every public school classroom in our State. We worked hard to fund and to bring computers into our State, and I think we had the best ratio of students-to-computers of any State in America at one time, and we may still have that.

We found, having done all of that, that a lot of our teachers use the computers for sending e-mail, but not much else, because they had never been trained to use the technology. They were not familiar with how to bring it into the classroom, how to use it to bring the real world into the classroom and to enrich the learning for their students.

We entered into a partnership statewide with Delaware Technical Community College to offer training for our veteran teachers, and that training was augmented by new graduates from colleges and universities who were becoming teachers and were familiar with the technology. Interestingly enough, they trained the veterans. It usually works the other way when people join a school.

Dr. Mullan, I think you mentioned the need for health IT training. Given the experience that we had with respect to our education, our schools, I could not agree more.

Congress provided, in the recently adopted stimulus package, some $19 billion of funding to advance health IT in our hospitals and our doctors' offices. But implementing a health IT program is not enough. For us to see the maximum benefit from our health IT system, doctors, nurses, other health care providers are going to need to learn how to use it effectively, much as we did in that school classroom.

My question to you is: what do medical schools do now? And maybe not just medical schools, but schools that train nurses, too. But what do they do for health IT training? Do you believe that medical schools or residency programs need to do more, can do more?

Dr. MULLAN. That is a good question. I think I cannot speak definitively about it, but I will say we have two things going for us. One is that many academic health centers and teaching settings now have adopted a much more electronic format for information management, so those of us who grew up with the electronic medical record will be much more effective at using it and critiquing it towards the future. The second is, we are blessed with a generation of young people coming on who are much more computer literate themselves, who participate in the changing, growth, and development of the application of the technology.

Senator CARPER. Sort of like my sons do with me. [Laughter.] Does anyone else want to comment?

Dr. WARTMAN. Yes. I just want to mention that we are involved with a project with the American Medical Informatics Association in which we have put together a grant proposal to develop a teach-

ing course in informatics for all clinical students in every health profession as an integrated phenomenon, and it is really a groundbreaking kind of proposal.

I think one of the central problems in IT is that there is no single consistent platform that everybody uses from office to office, from State to State, and around the country. I would like to think of IT more like the interstate highway system. You can get on the highway in Delaware, or you can get on it in Montana, and you pretty much know the rules of the road. The speed limit may change a little bit, but you know how to get there.

Senator CARPER. I do not know if they have speed limits in Montana. [Laughter.]

Dr. WARTMAN. Yes. I am just saying I think it would be great to have some kind of uniform national standards for IT so that everybody can talk to each other and work the system.

Senator CARPER. All right. Thank you.

Another one for Dr. Mullan. If others want to comment, please feel free. But I think you mentioned a proposal, I believe it was in title 7, to use those funds there to create Teaching Community Health Centers. I think that is what you called them, essentially partnerships for training purposes between medical schools and title-supported community health centers, which enjoy a lot of support around here. Could you just drive this initiative in more detail for us, and tell us how it would work effectively with the National Health Service Corps to help improve training and recruit new primary care doctors, especially to under-served areas?

Dr. MULLAN. Teaching in community health centers has always been a challenge because they, of course, are not basically teaching institutions, they are service institutions and usually hard-pressed. So to have the supervision in the way of clinicians to teach, the space in order to have extra rooms to have students, and the communications capability to work with the students and their sending institution, are all add-ons that, in many community health settings, are simply not possible, or if they are they are really ragged.

This is not to say that a lot of teaching has not gone on and does not go on, but this could be much more industrialized. It could be part of what we do invest in on both the health center side and the medical school or teaching hospital side. We have never had an initiative like this that made the Teaching Community Health Center a primary concept supported by financial incentives. This would be a great asset on both the teaching side and on the health center side.

Finally, the National Service Corps, which should be much more prominent in all of this if there were more corps members, would play a role, as many of them do work in health centers. A minor issue to that is, they are required to do 80 percent time clinical work. Now, if they can teach in that, that is good, but certainly giving them recognition for teaching as part of their clinical work would be an important asset to harmonizing the whole system.

Senator CARPER. Thank you very, very much. Thanks to all of you.

The CHAIRMAN. Senator Lincoln?

Senator LINCOLN. Thanks, Mr. Chairman. Thanks to our distinguished panel. We appreciate your willingness to be here and help

us solve these problems. Being married to a physician who has been in academics, in research, and now in private practice, I hear an awful lot of your side of the story. But we are glad you are here, and I am glad that you are here on behalf of my other colleagues.

Many of you have made the point that there are down sides to simply growing our physician supply without making the much-needed changes to the way that we deliver care and pay for care. And while we may not need a gross increase in the number of physicians nationwide, you also have to recognize, I hope, that we have some serious workforce struggles in rural America.

I represent a State that is predominantly rural. We are also a snapshot of where the rest of the country is going to be in the next 10 to 15 years. We are disproportionately elderly. Our elderly are disproportionately low-income, and they disproportionately live in rural areas where they are more difficult to serve.

So it is critically important for us to get it right now because, again, we are already where the rest of the country has not gotten to yet, and it is important. In realigning payment incentives towards primary care, high quality and coordination of care, is that really enough in terms of getting practitioners out into rural areas? We have had difficulties.

We still have problems getting providers to stay in the communities that have made matches. Once they meet their match requirement, they are ready to go somewhere where a spouse can get a better job, or there are better schools, or there is better cultural life, a whole host of different things. Are those three things enough to really see an increase of primary care physicians out there in rural areas?

Dr. GOROLL. There is some very interesting data from the Graham Center that has just been collated on the effectiveness of various interventions for having people stay in rural areas. One of the most powerful is the National Health Services Corps because these folks become part of communities in their service and many of them go on to stay. So I think forming bonds and ties is very, very important, and becoming part of a community which might overcome some of the other cultural problems and barriers for people who would come out there.

By the way, that is why I am not in favor of just a loan forgiveness program for a certain number of years of service, because nothing is more disruptive than somebody who becomes a primary care doctor for 4 years and then says, I have done my duty and I am out of there.

I think if we are going to fix this problem, we are really going to need smarter strategies and longer-term financial inducements. For example, maybe we will give somebody a pension if they stay their career, just like we do in the military; if you serve 30 years, you will be financially secure thereafter. But I think the simple-minded things of, well, these students have a lot of debt, let us just give them debt relief, actually, the data shows that there is no correlation between debt and going into, or not going into, primary care. It has to do with——

Senator LINCOLN. In a rural area, it does.

Dr. GOROLL. No. I am talking about——

Senator LINCOLN. Not just primary care.

Dr. GOROLL. Right.

Senator LINCOLN. But service in a rural area. There is definitely a disparity.

Dr. GOROLL. A separate issue.

Senator LINCOLN. Right. Well, that is my issue, is rural areas.

Dr. GOROLL. I understand. But I think what the data does support is the National Health Services Corps being—and I think Dr. Mullan alluded, to this—reenergized. Remember that show, "Northern Exposure," that was on television? That was an example of somebody becoming part of the community.

Senator LINCOLN. Right.

Dr. GOROLL. And we have to——

Senator LINCOLN. We fought really hard, whether it was in the matches, the loan program, or whatever. Those communities desperately need those physicians and they make every effort to make them a part of the community. But when the incentives become greater in other areas, there is a whole host of different things. I just think it is an important issue that we have to address because that is critical.

I would just like to throw out my second question before I lose my time. Inadequate Medicare reimbursement for geriatic-based services such as care coordination, geriatric assessment, I think is one of the leading disincentives to beginning and continuing a career in geriatrics.

We have seen in a recent report from the Institute of Medicine, in Arkansas alone, there are currently only 56 geriatricians available to care for more than 385,000 adults 65 and older, an estimated shortfall of 142 geriatricians. It is also estimated, in addition, that we will need 337 geriatricians in the year 2030, when the projected population doubles in terms of that age over 65.

So what type of training do we need to think about to support primary care providers so that they are adequately prepared to provide the kind of geriatric assessment and care coordination to service these types of populations, because it is going to be huge?

Dr. WARTMAN. I would like to respond to both questions, if I can, by emphasizing that I think it is really important for the committee to look beyond physicians to solve these problems.

Senator LINCOLN. Absolutely.

Dr. WARTMAN. We have heard, mostly, talk about physicians today. There are a host of other professions that are out there that could be very, very helpful—in fact, in some models that I have seen, instrumental—in bringing care to needed populations, whether they be in the nursing profession at a variety of levels or whether it be in the physician assistant programs, pharmacy in the community, psychology, things of that sort. It is all out there.

Moving beyond just looking at the physicians, we need to consider all health professionals as we put this together, and then you bump right into the problem that I alluded to earlier in my remarks, which is that there are a lot of barriers to making that work well.

Those barriers could be everything from health workforce laws, standards, scope of practice, licensing, credentialing, things of that sort. How do you reimburse team care? What does that mean? How can we improve that? So I think there is a real good opportunity

here to begin to look at the big picture of all the providers that are out there and figure out ways to overcome the barriers that keep them from working very effectively together. My opinion is that, if we rely solely on physicians, we will not have a solution that works.

Senator LINCOLN. Absolutely.

Mr. Chairman, if I could just comment quickly, you are so right. We are working hard on bills now that will provide additional training for nurses, nurse practitioners, and others for specific areas of geriatric training that could be something that would really be night and day in terms of their ability just to really focus on the geriatric population. There are other great institutional settings, like the Geriatric Education Centers, the Area Health Education Centers. I do not know how familiar you all are with AHEC, but it is a wonderful system with our medical school in Arkansas where we can actually get people out into those areas.

But I would also say that it is going to be critical if we are going to use these other medical professionals that the insurance or the delivery has to be able to accept them, because you have communities where you have a whole population of people who may have worked for the same company and the same insurance, and if the coverage does not cover a PA, or whatever, they are going to still have to travel the 2 hours to get the health care somewhere else. So, it all has to fit together.

So we appreciate your help and look forward to working with you on that.

Dr. WARTMAN. Thank you.

Senator LINCOLN. Thank you, Mr. Chairman.

The CHAIRMAN. A point I would like to ask Dr. Mullan is with respect to GME programs. It would make better use of GME by encouraging programs to help teach providers to learn new skills, like health IT, care coordination. I mean, you said GME does not have a brain. So, if we were to give it a brain, assuming it is an intelligent brain, how could an intelligent GME brain operate to help solve some of the questions we are talking about here?

Dr. MULLAN. A very good question, Mr. Chairman, and a tough one. There are two levels on which the brain could be activated: one is the distributional level in terms of allocations, the second would be a content level in terms of influence on what is taught.

On the latter level, one would have more difficulty with the institutions, or the professions, or the specialties not wanting intrusion by the Feds or outside forces as to what we ought to teach. The issue, nonetheless, is an important one because there is a group, the ACGME, the Accreditation Council for Graduate Medical Education, that accredits programs, and they have attempted some degree of course correction with a set of competencies that are now required of all residency programs. I think in the judgment of most, those have had some impact. They certainly have had an impact in terms of what gets done. The outcomes are a little harder to judge. Now, is there a Federal role in that? I think that would deserve debate.

The CHAIRMAN. What do you think?

Dr. MULLAN. I think it would be, beyond some large indicators of what we are concerned with—the absence of instruction in

patient-centered care, or care coordination; that would be good. To get into managing which program does or does not do it would become, I suspect, very entangling very quickly.

But as part of the allocation process, which I think is unavoidable, somehow we are going to have to work out a system in which somebody, some brain, is saying we need more residency training in Utah and less somewhere else. As part of that, there could be content as well.

I am increasingly persuaded that that should not be done from Washington, that it should be done with intermediate organizations, whether they are State-based, regional-based, or a consortium of some sort, which require medical educators—in this case, graduate medical education, folks responsible for graduate medical education—to both look to the needs of their region or their State and talk to Washington about what is warranted in terms of support. So you would need the ability for Medicare to work through intermediaries.

The CHAIRMAN. I want to explore this a little bit. I remember Dr. Goroll earlier saying something to the effect, do not reform GME, just build it and they will come, or something along those lines. That is, change the incentives so that the medical school students want to go into primary care, and then the GME allocation would follow. I will give you a chance to say what you think. Dr. Goroll, what do you think about what Dr. Mullan said?

Dr. GOROLL. There is also another way to drive the GME agenda. I sat on the ACGME for 6 years, and it is very focused on training physicians. (By the way, it is the only educational accrediting body in the country that is not public; that is, it is run by the profession, not by a government body.) It is very interesting in terms of where it stands educationally. They are very thoughtful people there. Its accreditation criteria have become increasingly outcomes-based instead of processed-based for the applicants. So, I think they are a potentially very constructive force.

But I would not have the Federal Government saying there should be training in X, Y, or Z. What I would do is have payment based on outcomes for a substantial amount of physician payment, and now those outcomes are the patient——

The CHAIRMAN. Are you talking about GME payments? We are talking about reimbursement, physician reimbursement.

Dr. GOROLL. Right. But the way you affect GME is, you change the rules of the road for your professional life. If you are now going to get paid according to patient satisfaction, and access, and efficiency, and cost effectiveness, and quality of care, then you as a trainee want from your training program the skill set that is going to allow you to be successful in that. Right now, all it is is, we are going to emphasize training in procedures (e.g., catheterization), and we are going to train you to do as many as you can possibly do. What I am suggesting is, if you change the rules for payment, you will change the agenda in these other areas.

The CHAIRMAN. Dr. Goodman, do you want to say something?

Dr. GOODMAN. Yes. I do not disagree with you, but I think that for the nearly $10 billion in Federal funds that go into GME, that some accountability is in order. So, when programs go back to the Federal Government and seek more funds, there ought to be meas-

urement and there ought to be reporting, and it ought to be against explicit goals and whether they have been achieved or not. They could be curriculum goals or they could be distributional goals. It does not have to involve micromanaging. I think that the worry about micromanaging is really sort of a cover for our old profession's fear of any sort of involvement or at times, quite frankly, accountability in this realm.

GME decisions now, our brain, are the individual decisions of all the teaching hospitals in the U.S., their individual decisions collectively in an uncoordinated way. These are tomorrow's physicians, so introducing some measurement and accountability, I think, would augment and certainly compliment exactly what you are saying.

The CHAIRMAN. Dr. Goroll, what do you think of what Dr. Goodman said?

Dr. GOROLL. I think it makes excellent sense.

The CHAIRMAN. Some measurement.

Dr. GOROLL. I think that makes sense, as long as it is tied into where we are going as a society altogether so this is part of a consistent message. We have, often, in medical school had such mandates or actually such programs. We could name a hundred of them: HIV testing, women's health, on and on. There is a whole agenda, social agenda. But they are not durable because, when people get out in the real world, the rules are different. What I am suggesting is that we make the rules, and that includes payment but that also includes accountability, to be consistent and thoughtful, and again, aiming at what are we really trying to accomplish.

The CHAIRMAN. Thank you.

Senator Grassley?

Senator GRASSLEY. Yes. I just have two questions. The first one will go to Dr. Mullan and Dr. Goodman, and then the last one to Dr. Mullan.

On the first case, one of the concerns I have heard over the years is the challenge of providing off-site training to residents. It makes sense for residents who plan on practicing in settings like community health centers or doctors' offices, to train there. This seems more appropriate than spending the entire time at a hospital.

Based on testimony we have heard this morning, it seems like GME funding rules play a part in this challenge. Can you provide more detail about how GME funding rules are an impediment to off-site training, and what reforms Congress can make to promote off-site training?

Dr. MULLAN. The current rules for Medicare GME provide a number of barriers to off-site training in both the indirect and direct portions, and they get complicated quickly. But essentially, the system in place, the default system, is one that funds hospitals for residents that are in hospitals. When they move off-site, the hospitals will lose funding for those individuals.

Now, it is a little different for direct and indirect, but that is the essential problem on the hospital side. On the community side, the community health center, the private office, the public health office, they, by current law, do not get the benefit of the training dollars, which stay with the hospital or do not get funded at all. So we need to both reduce the barriers for moving out of the hospital

and provide incentive or assistance to the community-based site that would be doing the training for that period of time as well. So, there are many fine points to that, but those are the essence of it.

Senator GRASSLEY. Anything to add, Dr. Goodman?

Dr. GOODMAN. No.

Senator GRASSLEY. All right.

Then to Dr. Mullan, you testified that the U.S. primary care workforce has become reliant upon international medical graduates. Would changes in the structure of education, training, and reimbursement of health care professionals have an impact on our reliance on international medical graduates?

Dr. MULLAN. The major way in which we could move to become more self-sufficient in the United States is by increasing the number of medical students we train, but not increasing the number of residencies.

Right now, a quarter of our residencies are occupied by international graduates, and about the same number of our physicians in practice are international medical graduates. So, very briefly, we graduate about 18,000 medical students each year from U.S. allopathic and osteopathic schools, and we have about 24,000 physicians who are interns, first-year residents.

The difference, that 6,000, is made up by very able, very eager international, very bright international medical graduates, and there are probably 2 or 3 times that many ready to take the jobs. There is an infinite supply of people who want to come.

If we increase our medical school output, which is happening as we speak—happily, in my judgment—but we do not raise the roof, the ceiling, as it were, the GME dollars for the GME physicians, at least we do not raise it radically, gradually the U.S. graduates will fill in more of those spaces and we will be more self-sufficient.

That is good domestic policy and that is good foreign policy, because around the world there is considerable concern now, as the world tries to get its medical house in order, that the United States and other northern nations are poaching the south relentlessly, and we should, after all, be able to train enough of our own. So this is very good in terms of U.S. global positioning. This also increases opportunities for domestic students. I think we are on a good trajectory.

Senator GRASSLEY. All right. Thanks to all of you for your fine testimony. We will probably be getting back to you sometime.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Dr. Wartman, I want you to know, we have not forgotten your main issue, which is that we need a lot more health providers in addition to doctors, nurses. We very much appreciate that. You gave some clues as to what some of the barriers were. I assume that, therefore, that is a clue to what some solutions are to address those same barriers.

Just a couple more general questions. If we provide universal coverage, if everyone in America has health insurance, as one of you said, that is going to add more stress to access, I guess. We will not have enough primary care doctors with all this new universal coverage. That is part of the problem in Massachusetts. I assume that is right, that you are saying it is going to further exacer-

bate the problem the more this country moves toward universal coverage where everyone has health insurance. Is that true? Is my conclusion accurate or inaccurate?

Dr. MULLAN. It is accurate, in my judgment. I think that just adding more, which we need—certainly universal coverage, but again, without reforming the parts—if we are also interested in addressing costs and outcomes, we are going to have huge problems.

The CHAIRMAN. But is this not going to be more costly?

Dr. MULLAN. It does not have to be more costly.

The CHAIRMAN. I am sorry?

Dr. MULLAN. It does not have to be more costly.

The CHAIRMAN. Some people looking at this and listening to this hearing might say, my gosh, that is going to add that much more cost to an already costly health care system in this country. So what do we do to solve that one? Dr. Goroll?

Dr. GOROLL. Well, if we have 30 percent waste, or even a fraction of that——

The CHAIRMAN. And you think that is what we have?

Dr. GOROLL. Well, I always depend on the Dartmouth data.

The CHAIRMAN. Everybody looks at Dartmouth. Everybody looks at Dartmouth.

Dr. GOROLL. But let us assume Jack Wennberg and his colleagues are off by 50 percent. Let us say it is 15 percent. If we can bring that down by 5 percent, we can cover a whole lot more folks. If we can strengthen primary care—Barbara Starfield's data from Hopkins shows that costs go down when there is strong primary care. So I think that, if we convert that waste into useful dollars well spent and we do that through strengthening the primary care base, we can almost go on a pay-as-you-go basis. I do not think it is hopeless, but I think that, if we do insurance without doing primary care, I think we will have a Massachusetts experience.

The CHAIRMAN. All right. Other comments?

Dr. WARTMAN. I just think that, if you consider the cost of people without insurance, when they do encounter the health system, those costs seem to be very high because they have not had any preventive care, et cetera, et cetera, et cetera. Bringing them in, I think, is a very smart move. I think the real question is, who will take care of them, and what will be their distribution of specialty types? How will they work together and achieve the best health outcomes? I think that is the real question. That could be very affordable.

The CHAIRMAN. That is what everyone is saying.

Dr. WARTMAN. From a workforce perspective——

The CHAIRMAN. I was wondering whether you all four basically agree with that concept. Yes?

Dr. MULLAN. The basic arithmetic of your concern is absolutely unimpeachable. That is, more people, then more problems, more services required.

The CHAIRMAN. Yes.

Dr. MULLAN. But my suggestion, given the circumstances, to be lean is better. That is, a lean workforce will force creativity, force economies. The workforce we have today has been characterized by one of our colleagues as an SUV, in the sense that it is big, comfortable, and very expensive. An SUV is not an answer that we can

afford and not an answer that we should look to. So strategies that will cause us to invest in those parts of the workforce that need gearing up, it will force creativity from the academics and the service sector both in rearranging our system. I think that is where the real savings and the real good policy of the future and good patient care in the future will lie.

The CHAIRMAN. One of you said something that caught my attention. I think I know what you were driving at. It is analogous to the problems in our financial sector in our economy. I think the conclusion is going to be that our incentives are driving people to go to the wrong places. Maybe it was you, Dr. Goroll, who made that comment, or maybe Dr. Goodman. One of you said something along those lines.

Dr. GOROLL. No, I take responsibility for that.

The CHAIRMAN. What did you say?

Dr. GOROLL. Well, it distorts. There are many parallels. Very briefly, it distorts the decisions of our best and brightest people, and they are going to the wrong places. As I started out by saying, they come to me, almost ashamed, because they know what they would like to do and what they want to do, and we have set up a perverse set of incentives. I think it is very fixable. It is very fixable.

One comment about the cost. We have universal health care in the United States: it is called emergency rooms. Emergency room costs—just look at our emergency rooms. If you went in any emergency room in any major city in the United States today, it would look like World War III. That is where universal care is being carried out right now, and it is extraordinarily expensive. So I think there are ways of doing this smartly and not saying that the net investment is not worth it.

The CHAIRMAN. I have to conclude this hearing, but thank you very, very much, all four of you. This has been most helpful. I urge you, frankly, just to keep following up. Senators will have questions. But if you get some bright idea, do not hesitate to let us know. Give us a call. All right.

The hearing is adjourned.

[Whereupon, at 11:53 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Statement of Michael B. Enzi
Senate Committee on Finance
Hearing on Workforce Issues in Health Care Reform
March 12, 2009

Mr. Chairman, thank you for holding this hearing today. Health care reform has to address how to improve quality and lower costs. And, provider workforce issues have to be a major part of that discussion.

Our current fee-for-service healthcare system leads to overutilization and lower quality. There are huge variations in care based solely on geography, with no correlation between higher costs and better quality for patients. The current system also does little to address the needs of high cost patients, who make up less than twenty percent of all patients, but account for approximately eighty percent of all health care spending.

In the same way, our current policies on the health care workforce lack a coherent focus on improving quality and reducing costs. These policies reflect a patchwork approach to subsidize the health care workforce, but lack any coordinated strategy to address geographic variations in quality or incentives to encourage more doctors into the field of primary care. Simply increasing the funding for current programs that are ineffective will not solve these problems.

Health care reform will need to include payment reforms to create incentives for comprehensive, quality care that rewards coordination of care and chronic disease management. We especially need to better identify and manage high cost patients, if we want to ever get a handle on health care spending growth.

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THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change

Linking Workforce Policy to Health Care Reform

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Invited Testimony

The United States Senate Committee on Finance

Hearing on "Workforce Issues in Health Care Reform:
Assessing the Present and Preparing for the Future"

March 12, 2009

Executive Summary

Mr. Chairman and members of the Committee, thank you for the invitation to testify about the health workforce and its relationship to health care reform.

Policy about the health workforce to date has focused nearly exclusively on physician numbers and has assumed that simply adding more physicians will improve accessibility and quality. These policies ignore two truths: One, that current growth rates in health care expenditures are unsustainable and will be worsened by indiscriminate growth in physician numbers. And two, that the workforce we train today will shape, for good or bad, tomorrow's health care system.

What do we know about the physician workforce? In brief, what doctors and nurses do is very important for patient outcomes. Much less important is the number of doctors and nurses providing services in a given region or health care system. Let me explain:

THE SUPPLY OF PHYSICIANS VARIES MARKEDLY AND WITHOUT REGARD TO PATIENT NEEDS OR WANT.
The notion that there is a single, right number of physicians for the U.S. is challenged by the finding that the number of clinically active physicians per capita varies dramatically across regions for every specialty. (Exhibits 1 to 3). This variation in physician supply is not explained by differences in patient illness levels or in population health, but by where doctors prefer to practice and live.

AS PHYSICIAN SUPPLY GROWS, MOST PHYSICIANS SETTLE WHERE SUPPLY IS ALREADY HIGH.
The last twenty years of growth in physician supply has shown that for every physician that settles in a low supply region, four settle in a region with already high per capita supply. These findings mean that lifting the Medicare funding cap on graduate medical education (GME) will perpetuate today's variation as new doctors settle in places with very high numbers.

MORE PHYSICIANS DO NOT LEAD TO HIGHER QUALITY CARE, HIGHER PATIENT SATISFACTION OR IMPROVED HEALTH OUTCOMES.
Multiple studies in a variety of settings find no benefit in a high supply of physicians caring for patients. This is true for the care of ill newborns as well as the care of Medicare patients. Nor is a higher supply of physicians associated with better perceived access to care, better technical quality, or higher satisfaction with the care. (Exhibits 4 to 7).

HOW CAN IT BE THAT MORE PHYSICIANS ARE NOT ALWAYS BETTER?
Much of what we do as physicians directly improves the heath and well being of patients. But we know that regions with a higher supply of physicians have problems which can make care worse: greater unnecessary use of the hospital and greater problems with care coordination because care is fragmented over many different physicians. The lesson from places with modest physician supply is that health care systems are very adaptable to different workforce staffing levels.

IF PHYSICIAN SUPPLY IS NOT IMPORTANT, WHAT WORKFORCE POLICIES WILL ADVANCE HEALTH CARE REFORM EFFORTS?

First, invest in improving what doctors and nurses do: We already have the knowledge and the means to improve birth outcomes and lessen the impact of chronic illness. We also know how to better inform and involve patients in treatment decisions through shared decision making. We need to invest more in these activities.

Second, strengthen primary care. We know that medical care provided within health systems dominated by primary care have excellent outcomes at lower costs. Training more primary care physicians and fewer specialists will be necessary, but this does not mean that simply adding more primary care doctors to a region will reform a subspecialist-based fragmented care environment. Although the primary care "medical home" offers promise and demonstrations should be pursued, primary care performs best when other elements of the care system support primary care providers – as in many integrated delivery systems such as Kaiser-Permanente, the Mayo Clinic, the Geissinger Clinic, and the Cleveland Clinic. Once we train primary care doctors and nurses, we need to keep them from drifting into subspecialties by paying them fairly.

Third, our current GME financing system remains entangled with Medicare and favors hospital-based training. All payers should participate in medical education funding.

Fourth, we need to introduce competition and innovation in GME. The NIH is a model of competitive peer review. I believe that we can improve physician training and increase the number of primary care physicians through the gradual introduction of competition for federal GME funds.

WE NEED A NEW STRUCTURE FOR DEVELOPMENT OF WORKFORCE POLICY

Currently, the most active federal entity in workforce policy is the Council on Graduate Medical Education, but COGME's charter has impaired its effectiveness.

In an editorial published last year in JAMA, I advanced the idea of a permanent health workforce commission to craft evidence-based policy that improves access to care, health outcomes and the quality and affordability of care.

- The membership of the commission should extend beyond physicians and include experts in public health, patient centered care, as well as nurses, consumers, health care systems and payers.
- The commission should consider policy related to the broad health workforce.
- Effective policy requires a dedicated staff that is independent of professional societies and trade associations.

Here is workforce policy that will help not hinder reform: Promote the dissemination of medical care and health systems already shown to be effective and train greater numbers of primary care physicians, but also implement financing reform that encourages the coordinated care that patients want and need.

Linking Workforce Policy to Health Care Reform

Thank you, Mr. Chairman, for the invitation to testify about the health workforce and its relationship to health care reform. For more than twenty years, my colleagues and I at Dartmouth have studied the physician workforce to better understand how we can shape the supply and specialty mix of physicians to improve the quality and affordability of care.

I am a physician who has worked as a primary care pediatrician in rural communities and in an academic medical center. Later, I specialized in allergy and served as chief of the Allergy and Clinical Immunology Section at Dartmouth-Hitchcock Medical Center. I still provide care for patients. Most importantly for this hearing, I have studied regional and provider variation in the health workforce, an have led this effort at the Dartmouth Institute for Health Policy and Clinical Practice, where I am the Director for the Center for Health Policy Research. My collaborators are John Wennberg and Elliott Fisher. I am currently the Co-Director of the *Dartmouth Atlas of Health Care.*

The adequacy of our physician labor force and our graduate medical education (GME) pipeline is critical to the success of health care reform. It will be hard to improve access, achieve better health outcomes and decrease health care expenditure growth rates unless we get workforce policy right.

If we want to have a good idea of what our health care system will look like in the future, we can examine the investments that we make today in the health workforce, particularly in physician training. In 2008, the federal government provided close to $10 billion for GME through Medicare, Medicaid, the VA Health System and children's hospital appropriations. Federal and state monies also fund undergraduate medical education, programs to increase training in primary care, nursing training and training of other health professionals. The immediate cost of these programs are modest compared to the aggregate government expenditures on health care, but the size and professional mix of these training programs can either advance or hinder the quality and affordability of care. The day-by-day decisions of physicians largely determine whether care is effective and whether it is affordable. In turn, the number and specialty of physicians making those decisions strongly affects the type and cost of care provided.

Policy about the health workforce has focused nearly exclusively on physician numbers and has assumed that simply adding more physicians will improve accessibility and quality. This reflects the rudimentary nature of workforce planning in America. At the federal level it, is almost non-existent compared to Canada, the United Kingdom or Australia, and it is located in a fragmented assortment of advisory bodies that are understaffed and have

narrowly defined policy briefs. The Council on Graduate Medical Education is the most visible of these and suffers greatly from its near exclusive attention to physician training, with little committee member expertise in health care delivery or public health. Its primary quantitative planning tools rely on Health Resources and Services Administration supply-and-demand models that assume our primary policy goal is to replicate the current health care system into the future and to train sufficient numbers of physicians to staff that same, but larger, delivery system. These forecasting exercises ignore two truths: First, that current growth rates in health care expenditures are unsustainable. Adding more physicians – especially in non-primary care fields – will further increase health care costs. Conversely, limiting the growth of physician supply could contribute to slowing the growth of health care spending. And second, that the workforce we train today will shape, for good or bad, tomorrow's health care system. In short, we base projections of physician need on the assumption that we want today's delivery system, only bigger, and that is poor policy.

A SKEPTICAL VIEW OF THE CURRENT PHYSICIAN WORKFORCE.

What do we know about the physician workforce? In brief, what doctors and nurses do is very important for patient outcomes, but the number providing services in a given region or health care system has little influence. This is a startling statement given the hue and cry in some quarters about a physician shortage. How could it be that increasing the supply of doctors is not an essential part of improving accessibility and patient outcomes? I am here to present the evidence that supports this assertion, present the reasons why supply has weak effects, and then outline a workforce policy which we have good reasons to believe will lead to more effective and affordable care.

Three findings about the physician workforce are particularly important for today's discussion. First, the per capita number of physicians varies dramatically across regions in the United States and this variation is not explained by what patients need or want for medical care, but by where physicians like to practice and live. Second, as the workforce grows overall, new physicians settle where supply is already highest. And third, higher physician supply is not associated with better patient health outcomes, quality, or satisfaction.

Despite this somber assessment of the overall current deployment of physicians, there are many places in the U.S. that delivery excellent care to diverse populations with a modest physician supply. The successes of these regions and health care systems can point us toward workforce policies that are very likely to be effective in improving patient care and affordability. The evidence, however, is clear that simply adding more doctors will defeat these aims.

THE SUPPLY OF PHYSICIANS VARIES MARKEDLY AND WITHOUT REGARD TO PATIENT NEEDS OR WANTS.

The number of clinically active physicians per capita varies dramatically across regions for every specialty. As one example, the number of subspecialist (e.g., cardiologists, surgeons

and radiologists) physicians per 100,000 population adjusted for differences in age and sex, varies over 200 percent across the nation's 306 hospital referral regions, as defined by the Dartmouth Atlas of Health Care.

Areas with a particularly low supply of specialists include Sioux City, Iowa (84 per 100,000 population), Mesa, Arizona (89), Wichita, Kansas (90) and San Bernardino, California (93). Regions with particularly high supply include White Plains, New York (215), Washington, DC, (195), Salt Lake City, Utah (188) and Boston, Massachusetts (180). (Exhibit 1). The supply of primary care physicians also varies to a similar degree (Exhibit 2) and, in general, the regions with a high supply of primary care physicians also have a high supply of specialists. (Exhibit 3). More primary care physicians are necessary but not sufficient for well functioning delivery systems.[1]

The variation in supply of physicians is not driven by differences in how ill the patients in a region are or the overall population health. The health status of populations is, of course, much worse in some places than others. Consider one example at the beginning of life: Maternal and infant illness levels were much higher in 1995 in New Orleans, Louisiana, where 12 percent had a low birth weight, than San Francisco, California, where the rate was 6.4 percent. While we might hope that there would be many more neonatologists per newborn in New Orleans to care for these greater numbers of premature infants, there were 70 percent more in San Francisco. As seen in Exhibit 4, there is simply no meaningful relationship between low birth weight rates, or any other measure of newborn risk and the supply of neonatologists in neonatal intensive care regions.[2]

A second example is closer to the end of life. In Exhibit 5, cardiologists per 100,000 population are seen to vary over 300 percent across regions. Cardiovascular risk as measured by the rate of acute myocardial infarctions in Medicare beneficiaries differs by over 200% percent[3] But, a higher supply of cardiologists is no more likely to be found in regions with high cardiovascular risk than regions with relatively low risk.

Physicians settle in the same places as other professionals. They settle where income, not illness level, is higher, and they tend to settle close to where they train.

An obvious question is whether the extra physicians *within* these regions tend to patients with greater needs? The answer is mostly not. In studies published in *Health Affairs* and the *Dartmouth Atlas*, we examined the number of physicians caring for chronically ill patients in the last six months of life.[4] (Exhibit 6). Within Manhattan, for example, New

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[1] Dartmouth Atlas of Health Care Working Group; AMA Masterfile data.

[2] Goodman D, Fisher E, Little G, Stukel T, Chang C. Are neonatal intensive care resources located where need is greatest? Regional variation in neonatologists, beds, and low birth weight newborns. *Pediatrics.* 2001;108:426-431.

[3] Wennberg DE. *The Dartmouth Atlas of Cardiovascular Health Care.* Hanover, NH: The Center for the Evaluative Clinical Sciences, Dartmouth College; 1999.

[4] Goodman DC, Stukel TA, Chang CH, Wennberg JE. End-of-life care at academic medical centers: implications for future workforce requirements. *Health affairs (Project Hope).* Mar-Apr 2006;25(2):521-531. Also, see Wennberg J,

York University Medical Center used almost 30 physician clinical full time equivalents (FTEs) per 1,000 decedents, while Beth Israel Hospital used 23 FTEs, Mt Sinai used 20 FTEs, and NY-Presbyterian only 15 FTEs. Patients did not live longer at NYU than NY-Presbyterian; they simply received a lot more care and spent many more days in the hospital, intensive care units and were seen by an extraordinarily high number of different physicians. Similarly within California, patients at Cedar-Sinai Medical Center received 28 FTEs, while patients at UCLA 20 FTEs, and University of California at San Francisco 13 FTEs. There are many hospitals that provide excellent care with a modest number of physicians, including the Cleveland Clinic, Mercy Medical Center in Des Moines, Iowa, the Mayo Clinic (St. Mary's Hospital) in Rochester, Minnesota and the Billings Clinic in Billings, Montana.

Like most things in life, when it comes to doctors, you get what you pay for. Our current reimbursement system perversely rewards a high supply of specialist physicians and high volumes of services, at the same time that it penalizes primary-based care that we know reduces hospitalizations, tests and expensive physician visits. If we want to reshape the workforce to a place a greater emphasis on preventive services and chronic disease management, then we must place a higher value on primary care and that will require reimbursement reform.

AS PHYSICIAN SUPPLY GROWS, MOST PHYSICIANS SETTLE WHERE SUPPLY IS ALREADY HIGH.

The last twenty years of growth in physician supply has shown that physicians strongly prefer to settle in the regions that already have very high physician supply. For every physician that settles in a low supply region, four settle in a region with already high per capita supply.[5]

These findings mean that merely lifting the Medicare funding cap on GME will perpetuate today's variation in the physician workforce as new doctors settle in the same places that attract doctors today. Given the strong reimbursement incentives for subspecialty care, academic medical centers will largely expand subspecialty training programs.

An unfettered lifting of the GME cap would be good public policy only if adding more in the places that already have a lot of physicians, particularly specialists, improved the health and well being of patients. The research at Dartmouth and other places shows that this is not the case.

Fisher E, Goodman D, Skinner J. *Tracking the Care of Patients With Chronic Illness. The Dartmouth Atlas of Health Care 2008.* Hanover, NH: The Dartmouth Institute for Health Policy and Clinical Practice; 2008.

[5] Goodman DC. Twenty-year trends in regional variations in the U.S. physician workforce. *Health affairs (Project Hope).* 2004;Suppl Web Exclusives:VAR90-97.

MORE PHYSICIANS DO NOT LEAD TO HIGHER QUALITY CARE, HIGHER PATIENT SATISFACTION, OR IMPROVED HEALTH OUTCOMES.

There is very good research that shows that evidence-based patient centered care provided by physicians and nurses leads to longer and better lives. There is a similarly strong set of studies demonstrating that the number of physicians, by itself, is not very important. While patients in regions with a *very low* number of clinicians, particularly primary care physicians and nurses, have worse health outcomes than those with merely a *low* supply, regions with a *medium, high* or *very high* supply do not have better outcomes than those with a *low* supply. Simply put, while *very low* supply is bad for patients, little is gained with a *high* or *very high* supply.

Multiple studies conducted by us at Dartmouth and by others have shown in a variety of settings that there is no benefit in a high supply of physicians. These include a high supply of neonatologists caring for ill newborns.[6] Studies have also found that a high supply of specialists, and even primary care physicians, does not lead to lower overall mortality in Medicare patients, or in those with serious illness such as acute myocardial infarctions.[7] The weak relationship between supply and outcomes is further supported by the studies I have already described in which the supply of physicians varies substantially across hospitals when holding outcomes constant in the groups of end-of-life patients.

Nor is a higher supply of physicians associated with better perceived access to care—and higher satisfaction with the care provided in Medicare beneficiaries. Neither is technical quality (physicians and nurses providing evidence-based care to the right patient) better. (Exhibit 7).[8]

It should be noted that while *high* or *very high* physician supply provides little benefits, there continues to be a pressing need for physicians to care for underserved areas and populations. These populations are harmed from *very low* physician supply. We have the means to address the problem of underservice through the continued development of the National Health Service Corps, rural health clinics and community health centers. The American Recovery and Reinvestment Act of 2009 (PL-111-05) has made an important down payment in remediating medical underservice by adding funds for these programs.

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[6] Goodman DC, Fisher ES, Little GA, Stukel TA, Chang CH, Schoendorf KS. The relation between the availability of neonatal intensive care and neonatal mortality. *The New England Journal of Medicine.* May 16 2002; 346(20):1538-1544.

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[8] Goodman DC, Fisher ES. Physician workforce crisis? Wrong diagnosis, wrong prescription. *The New England Journal of Medicine.* Apr 17 2008;358(16):1658-1661.

HOW CAN IT BE THAT MORE PHYSICIANS ARE NOT ALWAYS BETTER?

Much of what we do as physicians directly improves the heath and well being of patients. But there is a large proportion of diagnostic tests and treatments where benefits are uncertain or even harmful. But we know that regions with a higher supply of physicians have problems which can make care worse: greater unnecessary use of the hospital and greater problems with care coordination because care is fragmented over many different physicians. The overuse of specialists can focus care on individual organs without the coordination that could be provided by approaches such as a patient-centered medical home, or even traditional primary care.

The lesson from regions and hospitals with modest physician supply is that health care systems are very adaptable to different workforce staffing levels. Health care systems are tremendously different in their organization of care including the use of electronic medical records; the integration of primary care and specialist physicians; the staffing of advanced practice nurses and physician assistants; and their relative investment in hospital beds, intensive care units and imaging equipment. In our current financing environment, very different organizational styles can all generate comfortable returns on investment. But, quality and costs of care range from excellent to poor. Physicians are the most expensive clinicians and decide on most of the care provided. Health care systems that have become dependent on high physician staffing levels may do well financially but they also drain Medicare, Medicaid and employer-based insurance of money that could be better invested in the many types of care known to be effective.

IF PHYSICIAN SUPPLY IS NOT IMPORTANT, WHAT IS IMPORTANT?

There is so much that works well in health care, including specific treatments and certain types of organization of care, that a complete list would, in fact does, fill libraries. We have the knowledge and the means to improve birth outcomes and lessen the impact of cancer, asthma, diabetes and congestive heart failure. We also know how to inform patients of treatment options and to ascertain decisions from patients that reflect the values and wants of patients, not physicians. Yet even with recent gains in quality of care, clinicians and health care systems fall short in providing care that is technically excellent and patient-centered. Our country has led the world in learning what works in medical care. But our poor record in health care delivery reflects our system of paying for any care, beyond malfeasance, irrespective of quality, patient centeredness or outcomes.

We know that medical care provided within systems dominated by primary care have excellent outcomes at lower costs. This does not mean that simply adding more primary care doctors to a region will reform a specialist-based fragmented care environment. Primary care performs best when well integrated in comprehensive systems of care. Examples range from Kaiser-Permanente and Group Health Cooperative of Puget Sound to integrated delivery systems operating in largely fee-for-service environments. Notable

examples are the Mayo Clinic, the Geissinger Clinic, the Cleveland Clinic, and my own organization, Dartmouth-Hitchcock Medical Center.

HOW CAN WORKFORCE POLICY ADVANCE HEALTH CARE REFORM EFFORTS?

Most of the sound and fury about workforce policy today originates from HRSA type models that project today's utilization into the future and finds that we will be 10-15 percent short of physicians 15-20 years from now. Accepting that this is a "crisis" warranting additional tens of billions of further spending on GME requires ignoring the 200 percent differences in physician supply that I have already described. It also requires an uncritical faith that the invisible hand of the marketplace will guide new physicians to specialize in primary care and to settle where they are needed. Where can we better spend federal dollars?

First, we need to train more primary care doctors and nurses, and then keep them from drifting into subspecialties by paying them fairly for their work in primary care. A recent survey by Hauer and colleagues of senior medical students in 11 medical schools found that only 2 percent planned a career in primary care internal medicine.[9] In our own analyses at Dartmouth, we have found that many physicians trained in primary care are now practicing as hospitalists and emergency room physicians. Robust funding of Title VII and Title VIII will help to reinvigorate primary care training, but teaching hospitals are likely to expand subspecialty training programs at the expense of primary care unless we pay teaching sites higher amounts per primary care resident. The imperative of training more primary care doctors would best be accomplished by redirecting some of current GME dollars. This strategy would encourage greater efficiency in medical care and would spare funds for other proven strategies of improving patient care. Attracting medical students to primary care and curbing the current financial temptations of specialty medicine will also require developing reimbursement systems that favor the care of defined populations, not higher volume of services.

Second, our current GME financing system remains entangled with Medicare and favors hospital-based training. Medicare GME funding is complex, nearly impossible to justify or explain, and works best for maintaining the status quo. It discourages innovation, leaving much of GME trapped in past successes. All payers should participate in medical education funding. Any health care organization, not just "teaching hospitals" should have the opportunity to compete for training funds.

Third, we need to introduce competition and innovation in graduate medical education. For a model, we can look to our outstanding national program of biomedical research, which makes no assumptions about who has the best ideas. The NIH is an example of how a

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[9] Hauer KE, Durning SJ, Kernan WN, et al. Factors associated with medical students' career choices regarding internal medicine. *JAMA.* 2008;300:1154-1164.

competitive peer review process can drive benefits far outweighing the costs. Similarly, I believe that we can improve physician training and increase the number of primary care physicians through the gradual introduction of competition for federal GME funds. The applicants for GME funding could be scored for factors such as training in evidence-based medicine, in chronic illness management, and in shared patient decision-making. It is also to our advantage to have more physician training occur in highly efficient delivery systems and in underserved areas. Applicant scores could be weighted to reflect these societal needs. And just as the NIH targets certain money for cancer research, we could prospectively allocate certain sums to primary care, in particular adult primary care or other high priority specialties.

WE NEED A BETTER STRUCTURE FOR DEVELOPMENT OF WORKFORCE POLICY

I have outlined an ambitious policy agenda that couples the workforce with health care reform. Still missing in these initiatives is a central commission that can broadly advise Congress and the public on health workforce policy. Currently, the most active federal entity is the Council on Graduate Medical Education, but COGME's charter has impaired its effectiveness. COGME is principally concerned with physician education, specifically graduate medical education. It members are all physicians, and most are academic physicians. Although the current Chair of COGME, Dr. Robert Robertson, has done an impressive job at broadening its deliberations, COGME does not have the expertise, funding, or legislative authority to adequately link workforce policy to the delivery of health care.

In an editorial published last year in *JAMA*, I advanced the idea of permanent health workforce commission.[10] The basic goal of the commission would be to establish public accountability for the public funds that we invest in health workforce training. I believe that five principles should guide the commission's charter. First, the public interest in the workforce should be articulated. What should we expect from the national investment in the health workforce? The specific aims should be to craft evidence-based policy that improves access to care, health outcomes, and the quality and affordability of care. Second, the membership of the commission should extend beyond physicians and include experts in public health, patient-centered care, and epidemiology, as well as clinicians, consumers, innovative and efficient health systems, payers, and medical educators. Third, the commission should consider policy related to not just physicians but also nurses, physical and occupational therapists and other clinicians. Fourth, an evidence-based approach to workforce policy formulation requires a dedicated staff to develop the expertise for evaluating the workforce and the likely effect of policy recommendations. This staff needs to engage with health services researchers who are independent of professional societies and trade associations that are potentially conflicted by changes in workforce policy. Fifth, Congress should provide the commission with an increasing degree of regulatory

[10] Paraphrased from: Goodman DC. Improving accountability for the public investment in health profession education: it's time to try health workforce planning. *JAMA*. 2008;300:1205-1207.

responsibility that insulates reform from the self-interests of training programs and clinicians.

SUMMING UP

If we could improve health care by simply training more physicians, we would be left with simple, albeit expensive, workforce policy guided by the training decisions of academic medical centers. A quick survey of the variation in physician supply and associated delivery systems shows that quality and lower costs are already found together in many hospitals and delivery systems. The key to health care reform is to promote the dissemination of these already effective models coupled with training greater numbers of primary care physicians, and financing reform that pays for the care that patients want and need.

Exhibit 1. The primary care physician workforce per 100,000 population, age-sex adjusted, by Dartmouth Atlas Hospital Referral Regions, 2006. Shown is the marked variation in primary care physician supply. This variation is not explained by differences in urban-rural, socio-economic, or health status, but by physician preferences in where they want to live and work. (Source: Dartmouth Atlas of Health Care Working Group; AMA Masterfile data.)

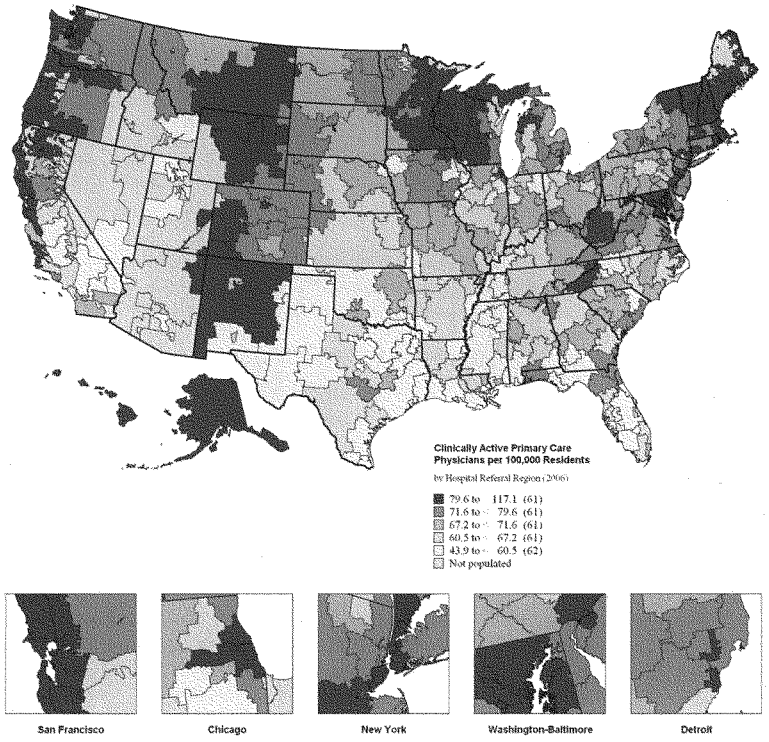

Exhibit 2. The specialist physician workforce per 100,000 population, age-sex adjusted, by Dartmouth Atlas Hospital Referral Regions, 2006. Shown is the marked variation in specialist physician supply. This variation is not explained by differences in urban-rural, socio-economic, or health status, but by physician preferences in where they want to live and work. (Source: Dartmouth Atlas of Health Care Working Group; AMA Masterfile data.)

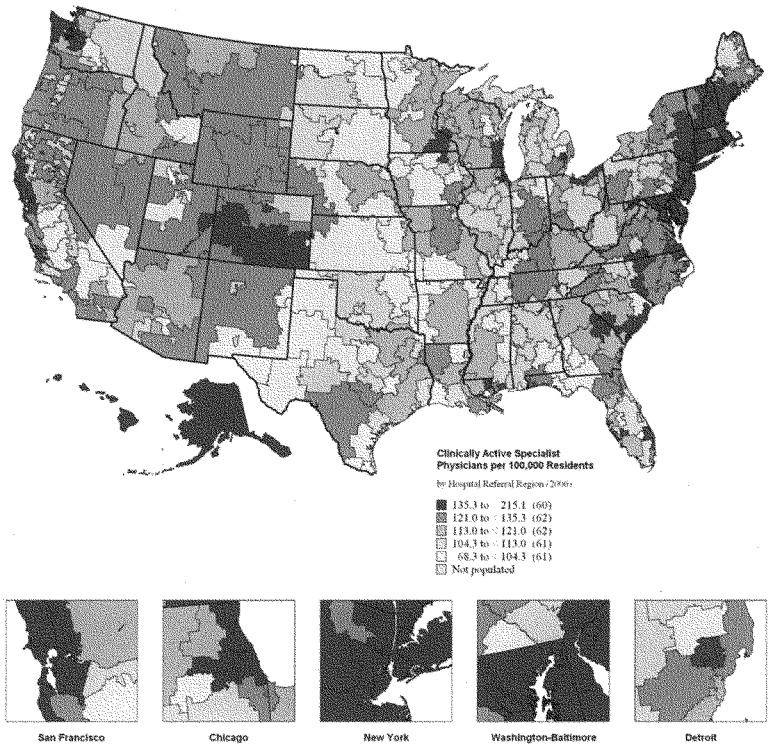

Exhibit 3. The relationship between the per capita supply of primary care and specialist physicians, 2006. This figure shows that there is little substitution at a regional level of primary care physicians for specialist physicians. Physicians have strong preferences for practicing in the same area. (Source: Dartmouth Atlas of Health Care Working Group; AMA Masterfile data.)

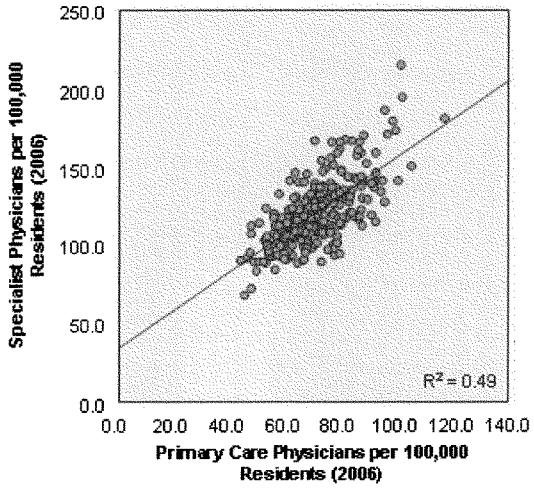

Exhibit 4. Neonatologists and percent low birth weight by neonatal intensive care regions. The percent of low birth weight births (<2500 grams) versus the number of clinically active neonatologists per 10000 live births across neonatal intensive care regions, 1995. There is no meaningful relationship between the two. In other words, neonatologists are not more likely to practice where maternal-infant risk is higher. (Source: Goodman D, Fisher E, Little G, Stukel T, Chang C. Are neonatal intensive care resources located where need is greatest? Regional variation in neonatologists, beds, and low birth weight newborns. *Pediatrics.* 2001; 108: 426-431.)

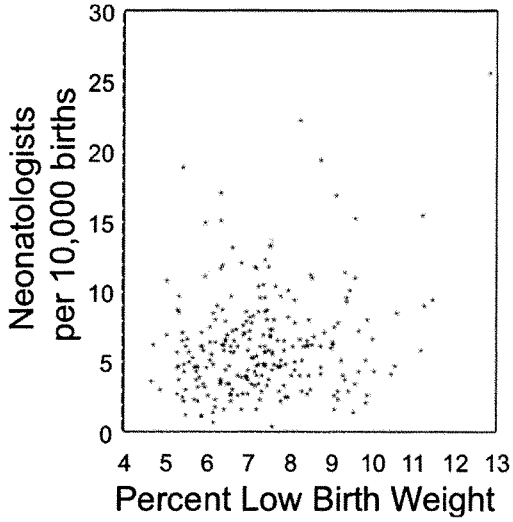

Exhibit 5. Cardiologists and acute myocardial infarction rates. The rate of acute myocardial infarctions per 1000 Medicare fee-for-service beneficiary versus the number of clinically active cardiologists per 100,000 population. There is no meaningful relationship between the two. Just like neonatologists, cardiologists do not practice where patients have higher need for their services. (Source: Wennberg DE. *The Dartmouth Atlas of Cardiovascular Health Care.* Hanover, NH: The Center for the Evaluative Clinical Sciences, Dartmouth College; 1999.)

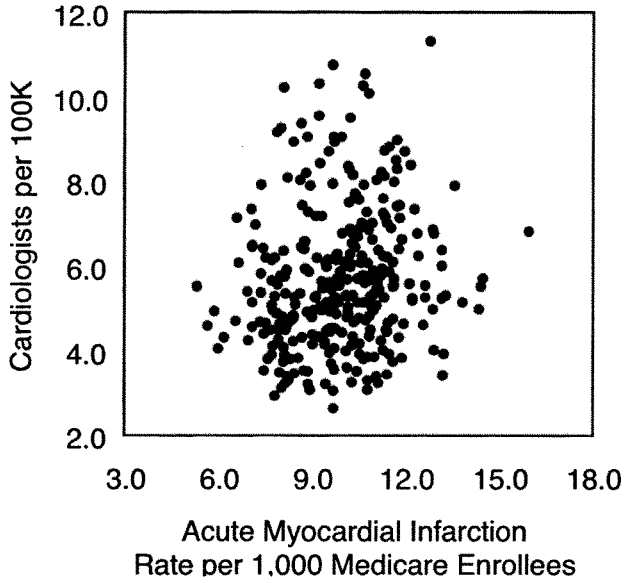

Exhibit 6. Physician full time equivalents caring for chronically ill Medicare patients in the last six months of life assigned to the primary hospital providing care, 2001-2005. Rates are adjusted for differences in age, sex, race, and mixture of chronic illness. The table shows that even within the same city or state, the number of physicians providing care for very similar patient populations differs by more than 2-fold. Benchmarks of physician care efficiency are also shown, and include hospitals in Ohio, Iowa, Minnesota, and Montana. (Source: Wennberg J, Fisher E, Goodman D, Skinner J. *Tracking the Care of Patients With Chronic Illness. The Dartmouth Atlas of Health Care 2008.* Hanover, NH: The Dartmouth Institute for Health Policy and Clinical Practice; 2008.)

Hospital Name	City, State	Number of Deaths	Physician full time equivalents in last 6 months of life per 1,000 decedents		
			Total	Medical Specialists	Primary Care
New York University Medical Center	New York, NY	2,534	27.8	17.6	6.8
Beth Israel Medical Center	New York, NY	4,108	23.4	10.4	10.2
Mount Sinai Hospital	New York, NY	4,985	19.6	8.5	8.6
New York-Presbyterian Hospital	New York, NY	6,061	15.4	6.9	6.1
Cedars-Sinai Medical Center	Los Angeles, CA	4,385	27.7	16.7	7.7
UCLA Medical Center	Los Angeles, CA	1,657	20.0	11.8	5.0
UCSF Medical Center	San Francisco, CA	1,420	13.3	4.6	6.0
Cleveland Clinic Foundation	Cleveland, OH	2,864	14.0	6.0	4.7
Mercy Medical Center	Des Moines, IA	4,583	12.2	6.5	4.2
May Clinic (St. Mary's Hospital)	Rochester, MN	4,236	9.8	4.4	3.3
Billings Clinic	Billings, MT	1,797	7.9	3.9	2.3

Exhibit 7. The supply of physicians in U.S. Hospital-Referral Regions and associated quality of and access to care, 2005. This table shows that in regions with 20% to 89% higher physician supply, the quality of care is not better for acute myocardial infarction, congestive heart failure, and pneumonia. Also, in high physician supply regions Medicare beneficiaries do not perceive access to be higher, or care to be better. (Source: Adapted from Goodman DC, Fisher ES. Physician workforce crisis? Wrong diagnosis, wrong prescription. *The New England Journal of Medicine.* 2008; 358: 1658-1661.)

Variable	Regions in Lowest Quintile of Supply	Regions in Middle Quintile of Supply	Regions in Highest Quintile of Supply	Ratio of Lowest to Highest
Total number of physicians per capita (age- and sex-adjusted per 100,000 population)	169.4	204.8	271.8	1.60
Primary care	61.5	72.7	95.7	1.56
Medical specialists	34.1	44.3	64.3	1.89
Surgical specialists	37.4	43.2	53.4	1.43
Hospital-based specialists	23.8	26.1	28.7	1.21
Medicare composite quality scores				
Acute myocardial infarction	91.0	91.7	93.1	1.02
Congestive heart failure	84.1	85.9	88.6	1.05
Pneumonia	79.5	78.8	79.2	1.00
Medicare access and satisfaction				
Ever had a problem and didn't see a doctor? (% responding no)	91.7	92.8	93.2	1.02
Do you have a particular place for medical care? (% responding yes)	95.0	94.8	95.5	1.01
Satisfied with ease of getting to the doctor? (% responding yes)	94.9	93.5	94.7	1.00
Satisfied with doctor's concern for overall health? (% responding yes)	95.5	94.2	95.7	1.00
Satisfied with quality of medical care? (% responding yes)	96.7	96.3	97.0	1.00

Testimony of Allan H. Goroll, MD, MACP
Professor of Medicine, Harvard Medical School
Physician of the Medical Service, Massachusetts General Hospital
The United States Senate Committee on Finance
Hearing on
"Workforce Issues in Health Care Reform"
March 12, 2009

Chairman Baucus, Senator Grassley, and Members of the Committee:

Thank you for asking me to come before you today to discuss primary care workforce and payment issues as they pertain to health system reform. My comments are based on over 30 years of experience as a primary care physician, medical educator, professional society leader, and reformer. They are also informed by our first two years of experience with Massachusetts' landmark initiative to improve access to health insurance.

Contribution of Primary Care to Health System Effectiveness

Because we are all interested in achieving sustainable, affordable health system reform, let me start by briefly considering the contribution of primary care to the performance of health care systems. The available evidence overwhelmingly shows a strong relationship between access to comprehensive primary care and the effective functioning of health care delivery systems (1). When people have access to primary care, health care costs are lower, health status is better, and health disparities are fewer. The take-home message from the data: if we hope to improve our health care system we are going to need a strong primary care base.

Impact of a Dysfunctional Physician Payment System on Primary Care Practice and Workforce

Why then is there a serious and growing shortage of U.S. medical school graduates choosing careers in primary care (2) at the very time the nation's need is growing? The answers are multi-factorial (3) and include the well known factors of high levels of student indebtedness, low pay for primary care, lack of prestige, and heavy time demands. Less appreciated, but perhaps the most important of all is the current practice environment in primary care, characterized by high visit volume, rushed care, and inadequate time to do the job properly (4). This sorry state of affairs derives largely from a dysfunctional physician payment system, dominated by Medicare's RBRVS fee-for-service system. Although originally designed by my colleagues Hsiao and Braun at the Harvard School of Public Health to help rationalize reimbursement and correct imbalances in physician payment (5), RBRVS has been distorted in its application and now exacerbates these imbalances. Medicare's Physician Fee Schedule currently pays generously for performance of procedures and inadequately for evaluation and management (E&M) services, the basic doctoring that is the hallmark and bread and butter of primary care. Consequently, as

a nation, we get exactly what we pay for: namely high volumes of expensive procedures, many of which are unnecessary or of questionable benefit (6), and too little doctoring. The result: we are first among industrialized nations in per capita health care spending and 25th to 35th in health outcomes (1).

Because all Medicare physician payment comes out of a single pot, the ever-increasing proportion of Medicare dollars that pay for expensive procedures reduces the fraction available to support basic doctoring. Faced with a worsening payment situation and rising expenses, primary care practices try to increase their revenue by ramping up visit volume, which is the basic unit of payment under RBRVS (partially adjusted for complexity). The net result is a practice environment driven by visit volume, leading to unhappy patients and demoralized primary care physicians, who find they do not have adequate time to meet their patients' needs (4). Instead of being able to diagnose and manage in the evidence-based, cost-effective, personalized manner we emphasize in their training, harried primary care physicians often find themselves doing little more than triaging, over-ordering elaborate diagnostic studies (to satisfy patients and keep from being sued), and making referrals – all of which drive up costs without necessarily adding value. Additionally, they are overburdened with administrative paper work and most cannot afford the multidisciplinary teams and modern information technology essential to operating a high performing practice (7). We have indeed relegated the "quarterbacks" of our health care system to serving as "gate keepers." No wonder our best and brightest young men and women in U.S. medical schools (who used to eagerly choose careers in primary care because they wanted to "make a difference") are shunning the field, and nonphysicians are proclaiming they can fulfill this watered-down primary care role, which is a shadow of its original conceptualization and implementation.

An inadequate primary care physician workforce threatens health system reform. In Massachusetts, our landmark health insurance initiative has dramatically reduced the roles of the uninsured (8) - an achievement we are all very proud of. However, because our primary care capacity is inadequate (8), the newly insured (as well as everyone else) are finding it increasingly difficult to find a primary care practice that will take them in. Consequently they are showing up in our emergency rooms in record numbers for nonemergency care, an expensive and inefficient outcome that threatens the financial viability of our initiative (10,11).

As the primary care practice environment worsens, a growing number of primary care physicians are going "concierge," markedly shrinking their practice panels and charging a retainer to the remainder who can pay the premium in return for guaranteed access and more personalized, less rushed care. Distressingly, many patients are now finding themselves "fired" by such practices and "medically homeless." The take home message: health reform in the absence of strengthening the primary care base is not likely to succeed.

Health System Reform Through Physician Payment Reform: Essentials of a Solution

Several principles and recommendations emerge for addressing the primary care workforce issues essential to achieving health system reform:

1. Fundamental reform of payment for primary care is essential to achieving health care reform in the United States and should be a priority for policy makers.
2. Physician payment should support desired outcomes, rather than discourage them; visit volume and piecemeal reimbursement need to be eliminated as the prime determinants of payment; comprehensive or bundled payment might be a better means of encouraging the comprehensive, coordinated care desired (12).
3. Comprehensive or bundled payments should be risk-adjusted so there is no disincentive to care for the sick and needy, as there was under capitation.
4. The payment system should include incentives/bonuses for achieving desired outcomes in the areas of cost, quality, and patient experience; such incentives also require risk-adjustment.
5. Payment to practices should be sufficient to support the infrastructure needed to operate a high-performing practice, such as a multidisciplinary team and health information technology.
6. Although reform of physician payment probably needs to extend beyond primary care, starting with primary care makes sense, because of the field's central role in health system reform and its current crisis status.
7. Medicare should urgently support an intensive research effort to develop and field-test new models of primary care payment; the effort should extend well beyond RBRVS and could be incorporated into practice reform efforts such as those for the patient-centered medical home.
8. Student loan forgiveness may be a useful stop-gap measure for encouraging careers in primary care, but is unlikely to be a sufficient or durable measure in the absence of fundamental payment reform that improves the primary care practice environment.
9. Medicare should consider increasing support of undergraduate and graduate medical education for primary care, but should not mandate numbers or proportions of training positions.

Summary:

A strong primary care foundation is essential to the well functioning of a health care delivery system and to implementing meaningful, sustainable health care reform. A dysfunctional Medicare fee-for-service payment system lies at the heart of the current workforce crisis in primary care, because of its adverse effect on the practice environment. Incremental measures such as tweaking RBRVS and providing loan forgiveness are unlikely to suffice. Fundamental reform of payment for primary care is urgently needed, starting with rigorous field testing of new models that encourage and enable practice transformation. Medicare's central role in U.S. health care can help spur the necessary reform efforts. If we build a strong primary care system, I firmly believe we will have no problem recruiting a new generation of devoted, highly skilled young men and women committed to providing the robust primary care so urgently needed by our nation's citizens.

Thank you for the opportunity to share these thoughts with you.

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Testimony before the Senate Finance Committee

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On

Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

March 12, 2009

Introduction

Senator Baucus, Senator Grassley and members of the Senate Finance Committee, thank you for this opportunity to testify this morning. During the 40 years since I graduated from medical school, I have been a member of the health care workforce of the United States working as a pediatrician, I have directed workforce programs such as the National Health Service Corps while serving as a member of the United States Public Health Service Commissioned Corps, and I have been a student of and commentator on U.S. workforce policy in my current role as a Professor of Health Policy at The George Washington University.

Therefore, it is with experience as a practitioner, administrator, and scholar that I come before you this morning.

In my remarks, I will briefly review the history, demographics, trends, and problems associated with the U.S. health professions workforce. I will focus on the physician workforce which is large, at the center of the delivery system, and closely associated with the costs of the health care system. I will also talk about nurse practitioners and physician assistants who make major contributions to clinical care delivery in the country. Much of my commentary will reference the challenge of providing a strong and efficient base to the U.S. health care system – the sector of practice termed primary care. I will propose a number of areas in which legislative action would, in my judgment, support and augment the training and practice of primary care providers, thereby improving the efficiency and effectiveness of the overall health delivery system.

It has always been difficult to address health workforce policy in the Congress since the jurisdiction for many of the relevant programs is divided between the Finance and the HELP Committees in the Senate and the Ways and Means and the Commerce Committees in the House. I congratulate the Finance Committee for taking a broad look at the issues in today's hearing.

The Demographics of the Workforce

Today, there are over 800,000 practicing physicians in the United States. This number represents a steady increase over the last 50 years in both the number of physicians and the physician-to-population ratio (see Figure 1). In 1965, there were approximately 150 physicians per 100,000 people in the United States. Today, that ratio is more than 270 per 100,000. This long period of increase was initiated in the 1960s by major investments in medical schools by federal and state governments and has been supported more recently by robust Medicare Graduate Medical Education funding that provides incentives for hospitals to train residents.

This density of physicians (272 per 100,000) is slightly below the Organization for Economic Cooperation and Development (OECD) average of 320 per 100,000. For instance, France and Germany have 340 and 350 physicians per 100,000 respectively, whereas Canada and the United Kingdom have 210 and 250 physicians per 100,000 respectively.

The distribution of physicians it the United States trends heavily towards urban and well-to-do areas. Less than 10% of physicians practice in rural areas while 20% of the country's population resides in these areas. Metropolitan areas have a physician-to-population ratio of 93 primary care doctors per 100,000 people while non-metropolitan areas have a physician-to-population ratio of 55 primary care doctors per 100,000 people. Specialists are even more concentrated, with greater than three times the density of specialists in metropolitan areas versus non-metropolitan areas.

American Medicine is highly specialized. Currently, there are 142 Accreditation Council on Graduate Medical Education (ACGME) recognized specialties and combined subspecialties and multiple additional

unrecognized subspecialties. Physicians reporting that they practice primarily as specialists comprise 63% of practitioners whereas those working in the primary care specialties (family medicine, general internal medicine and general pediatrics) comprise only 37% of doctors in practice. This figure is markedly different than it was 50 years ago when 50% of America's physicians were generalists. In Canada, by contrast, 51% of physicians are currently family physicians and GPs.

The situation in primary care, however, is more problematic than the numbers might suggest. Hard work, low pay and "lifestyle" expectations of medical graduates today have resulted in dramatic reductions in interest in primary care in U.S. medical graduates. Between the mid-1990s and today, the number of training positions in family medicine has declined 20% and the percentage of the family medicine residency positions being selected by U.S. graduates has fallen from 72% to 44%. The majority of family medicine positions are now filled by international medical graduates.

A recent questionnaire of senior medical students considering careers in internal medicine showed that only 2% of them wanted to be general internists while 98% planned to pursue a subspecialty. These trends have implications for the future – a future that will require more primary care services for our aging population. A recent study projects that we will be short approximately 40,000 primary care doctors in 15 years – and that doesn't take into account the millions of Americans who will seek primary care when universal coverage is implemented.

Physician Assistants and Nurse Practitioners

The United States is a global pioneer in the creation of new categories of health professionals who contribute to the delivery of clinical services. Separate pilot programs in the 1960s introduced the world to the idea of the nurse practitioner (NP) and the physician assistant (PA). Since those early programs, both professions have grown enormously in size, stature and public acceptance. Approximately 125,000 nurse practitioners have been trained in the United States, the majority of whom are engaged in clinical practice. There are almost 70,000 certified physician assistants in the United States and more than 100 training programs.

Both of these professions are associated with primary care and practice in rural and underserved areas. About 25% of all nurse practitioners are located in non-metropolitan areas and an estimated 85% of them practice primary care. Physician assistants are active across the spectrum of medical specialties with more than one third of them working in primary care practices and approximately one fifth of them working in rural areas.

The Career Lifecycle of a Physician

Before considering questions of the sufficiency of the workforce or policy options to modify its direction, I would like to suggest a framework for considering physician careers. I call this the career lifecycle of a physician. It has three phases --- one of which is educational, one of which is transitional and the final one of which is vocational (see Figure 2). The phases are medical school, graduate medical education, and practice. The first two might be considered "pipeline phases" since they determine the quantity and nature of physicians prepared for practice. The final phase is the "payout" phase when the physicians are actually providing health care to the nation.

This framework allows us to consider capacity, cost and performance in three separate but interlinked longitudinal phases of the career path of physicians.

One further clarification is necessary to understand the dynamics of the physician lifecycle. The governing sector in the lifecycle is graduate medical education (GME). Contrary to popular belief, it is not medical schools that determine the ultimate size and specialty composition of the physician workforce of the country. Rather it is residency programs, taken as a whole, that serve as the final pathway into practice and largely govern the numbers and specialty distribution of the physicians in practice. In order to practice medicine in the United States, one needs a license from a state. All states require one to three years of residency in order to obtain a license. It is also important to recognize that a significant proportion of practicing physicians did not attend U.S. (allopathic) medical schools. Of the current first year residents, for instance, 67% graduated from U.S. allopathic (M.D.) medical schools, 6% from U.S. osteopathic (D.O.) medical schools, and 27% from medical schools abroad (International Medical Graduates or IMGs). Almost all of these physicians will complete residency and enter practice in the United States. Thus, it is the size and specialty offerings of the aggregated residency programs of the country that really determine the future of the U.S. physician workforce.

Sufficiency

As we examine the nation's health care system and as we consider options to increase coverage, fairness, quality, and affordability, we must wrestle with the question of how many physicians we need. This is a central question, not only because it involves the physician production process but also because it has important implications for training requirements for other health professionals (i.e. nurse practitioners and physician assistants.) It also has ramifications for prospective spending in a number of areas including hospital beds, diagnostic testing, medication usage and locations of practice.

Many policy scholars and analysts have written on this topic with strikingly different conclusions. Some have suggested that we are training too many physicians while others issue predictions that we are entering into a period of dramatic physician shortage. These projections are largely dependent on the assumptions made about the health care system of the future. If one bases assumes that the health care system will be highly coordinated with the well organized use of physician services, such is the case in prepaid managed care plans like Kaiser Permanente, the case can be made that we might well have a surplus of physicians. If one assumes the continuation of a minimally organized, specialty dominated, predominantly fee-for-service system that is an extrapolation of today's circumstances, one can make the case for a perpetually escalating need for physicians. Both cases have been argued eloquently.

My view is that the density of physicians (the physician-to-population ratio) that we have at the moment is reasonable and the role of public policy (financing and regulation at the federal and state levels) should be to maintain a physician workforce of approximately the current size. This strategy should take into account projected growth in the size of the U.S. population (which is projected at 1% per year) so that the absolute number of physicians would grow in a modest but consistent fashion.

This strategy would be challenged by critics who would raise objections in the following areas:

1. The American population is aging, and by all measures older citizens require more health care;
2. Physician practice patterns have changed and physicians don't work as many hours as they used to;
3. Technology is advancing and we will need more specialists to deliver the fruits of new technologies to the population:
4. Don't bet on better organization of the health care system.

These observations are all valid. A response to these concerns could certainly be placement of greatly increased numbers of physicians into practice --- whether from U.S. medical schools or from physicians trained abroad at the expense of other nations. However, all evidence indicates this would be a very costly response since physicians are expensive to train and to compensate in practice. Additionally, excellent

evidence shows the association of more physicians and especially more specialist physicians with higher health care costs. This is the case because more physicians and, particularly, more specialty physicians are associated with higher hospital utilization and increasingly costly patterns of practice. Importantly, this evidence shows no benefit in care from this higher intensity of physician practice.

Reforming physician workforce policies in a way that promotes quality and constrains costs requires a different strategy. The essential elements of that strategy are three:

1. The revitalization of a primary care workforce that will be able to staff an organized system of national primary care delivery that needs to be created by reforms in the delivery system. Whether services are delivered in primary care medical homes, accountable care organizations (ACOs), prepaid group practices, or community health centers, the size and skills of the primary care workforce need to be robust;
2. The physician education pipeline needs to produce enhanced numbers of primary care physicians prepared to work in economically comfortable urban and suburban settings as well as in hard pressed inner city and economically challenged communities and rural areas;
3. To the degree that the clinical care workforce as a whole needs more providers to address the changing needs of the population, a strong strategy of support for nurse practitioners and physician assistants should be adopted. The increased use of PAs and NPs should not be limited to the primary care sector. Both professions have demonstrated excellent functionality as team members in all aspects of medical practice from the pediatric office to the operating room. Nurse practitioners and physician assistants are trained more quickly, at less expense than physicians, cost less in practice, and are not, on their own, drivers of ancillary clinical tests and services. Moreover, they represent a highly flexible workforce – an important asset generally lacking in the physician workforce. In contrast, physicians (especially specialty physicians), invest enormous amounts of time, money and deferred income in establishing their capabilities and credentials. Training, retraining, and/or redirecting them is not easily done. Physician assistants and nurse practitioners are, comparatively speaking, "stem cells" and more able as individuals and as professions to focus on areas of emerging or urgent need. NPs and PAs provide a well-proven quality, clinical workforce that can interdigitate with all aspects of physician practice and whose pipeline can be turned up or down as needed to assist in addressing emerging or changing clinical needs.

No discussion of the physician workforce would be complete without reference to international medical graduates (IMGs) who constitute approximately 25% of physicians in practice and 27% of physicians in residency training. No American policy body --- certainly not the U.S. Congress --- has ever advocated that we "offshore" one quarter of our medical training or design a system in which our medical schools are only capable of training three-quarters of the physicians we need. Yet that is what we have done.

We can be proud that the appeal of our way of life and the prowess of our medical institutions that have made the United States a magnet for physicians from around the world for the last 50 years. Most have arrived under educational visas and, in overwhelming numbers, have remained in the United States following residency training. This has been an enormous gift to the United States. In steadily escalating numbers, these hard working, smart, and ambitious men and women from all over the world have staffed our health system. They have also allowed us to be casual in our medical education policy. There is no need for planning or precision nor, even, adequate funding for medical schools since large numbers of foreign graduates are always available to fill in the gaps in residency programs and in specialties that are out of favor with American graduates. Sixty percent of international medical graduates come from poor countries --- largely the Indian subcontinent, Africa and the Caribbean. In many small countries the physician "brain drain" is the largest and most destabilizing aspect of their health sector. We are not the only country to rely on foreign trained physicians, of course. At one point, Nelson Mandela personally appealed to Tony Blair to stop "poaching" South Africa's doctors. Recently, global attention has turned to the question of health system strengthening to fights AIDS and end poverty, and yet everywhere one turns the brain drain of

doctors and nurses stands as an impediment to improved health in developing countries. Some have called it "reverse foreign aid."

Heavy reliance on international medical graduates to fill residency positions and undergird the nation's physician workforce is neither good domestic policy nor good foreign policy. Going forward, public policy makers and medical educators should work toward self sufficiency in medical education. That boils down to a single simple principle: U.S. medical schools should graduate approximately the number of students required to fill the first year residency positions offered in the country.

In that regard, the current initiation of new medical schools and expansion of class sizes at existing schools is a positive development. These new U.S. students will undoubtedly find residency positions upon graduation, decreasing our need to draw on the rest of the world to meet our medical needs. This will be an asset in our efforts to promote the U.S. as a good global citizen and also provides an overdue opportunity for more U.S. students to go to medical school in the U.S.

Reform in the Three Sectors of the Physician Workforce

Medical Schools

The principal federal legislation impacting medical schools since 1963 has been the series of programs authorized under Title VII of the Public Health Service Act. From 1963 to 1976 the principal investments were designed to increase the number of medical schools and medical school graduates. Construction grants, capitation funds, and student loans were all used as stimuli for medical schools. The result was a more than a doubling of the nation's annual medical school graduating class from approximately 7,500 students a year in 1960 to 16,000 students a year in 1980. This was an extraordinary achievement of public policy and medical education.

The problems with medical education, however, that concerned policy makers even in those early years went beyond absolute numbers. It was growingly clear that physicians were not equally distributed in the country nor were medical students reflective of the diversity of the population of the U.S. The term "primary care" was first used in the 1960s to focus on yet another problem with medical graduates - the increasing specialization of physicians such that many parts of the country had little access to generalist care.

The result was a new growing set of programs authorized under Title VII of the Public Health Service Act to promote community practice, rural practice, primary care, and opportunities for minorities and disadvantaged students. These included the Area Health Education programs, support for family medicine, general internal medicine, and general pediatrics, the Health Careers Opportunity Program and funding for physician assistants. During this same period, funding for nursing and, particularly, new nurse practitioner programs was similarly increased under Title VIII of the Public Health Service Act.

In the early 1970s, the funding for Title VII programs reached over $2.5billion (2009 dollars) (see Figure 3). In the mid-1970s, the consensus changed with the belief that we were training enough (some thought too many) physicians and Title VII authorizations and appropriations were throttled back. The Title VII programs have functioned in the very modest $200 - 300 million/year range from that time until the present.

In the latter years of the Bush administration, serious efforts were made to eliminate all Title VII funding including support for primary care, minorities in medicine, rural placements and workforce tracking. During the same period, medical school revenues from NIH research funding have risen from $2.4 billion in 1970 to $16.3 billion in 2004 (all 2009 dollars), creating a robust culture of research at medical schools that dominates medical school finances, faculty values and school culture (see Figure 4).

Any serious proposal to reform medical practice in the United States must start with reinventing and reinvigorating Title VII funding to medical schools for the purpose of creating incentives and educational pathways that will select and train students for primary care, rural health, diversity, and social mission. Parallel support for nurse practitioners and physician assistants is important as well.

In the past, critics of Title VII have proposed high standards of measurement, asking "how do we know Title VII funds make a difference?" This is a difficult problem for programs with small funding streams that function within large institutions with many contrary incentives. Nonetheless, an impressive series of studies have shown that Title VII funds affect physician careers positively in regard to primary care, rural placement and minority opportunities. There are many ways in which Title VII could be augmented and strengthened. One of those would be an initiative which provides incentives for the creation of "teaching community health centers" – creating funded linkages between medical schools and Federally Qualified Health Centers (FQHCs) for the purpose of training. Another area in which Title VII needs strengthening is in the ability to collect important data and produce useful policy analyses on the workforce. A national center for workforce studies should be given serious consideration in augmenting Title VII authorities and funds.

Funding for the education of physician assistants and nurse practitioners should be continued and augmented to help provide the build-up of flexible clinicians for health reform.

While the National Health Service Corps (NHSC) it is not an educational program, it is a brilliant but underfunded asset available to redistribute health professionals – physicians, NPs, PAs and others. I say brilliant since it matches the needs of individual health science students/professionals with national needs for practitioners in underserved areas. The program has been "tested" since 1971 and works to the benefit of clinicians and communities. Many clinicians have remained in their assigned communities for long periods or full careers. At times, however, the NHSC has received criticism for not having as high "retention rates" as some would like. There are American communities that for reasons of geography or economy have never been able to retain physicians. To the degree that the NHSC can meet service needs with serial placements in these communities, the program is a success. The principal problem with the NHSC is its size. There are many more communities eager for NHSC help and many more clinicians interested in scholarships or loan repayment opportunities than can be met given the program's budget. Major re-investment in the NHSC would do a great deal to increase access to health services in some of our poorest and most rural communities.

A word should also be said about Community Health Centers which are not teaching institutions but have a stellar record of providing learing sites and supervision for clinical students – often without recompense. Good data now shows that in many communities CHCs are struggling to find sufficient primary care providers to meet their staffing needs. Support through Title VII and Medicare GME for CHC based teaching activities will be essential to allow them to expand to meet the growing needs of the un- and underinsured populations of our country.

Graduate Medical Education

Graduate medical education (GME) grew significantly through the 1980s and early 1990s and leveled off at about 100,000 residents and fellows a year in GME from the late 1990s to the early 2000s. In recent years there has been a small increase in the total number of residents and fellows. Residency programs are unevenly distributed throughout the country, with history playing an important role. The locations of the earliest residency programs 100 years ago are the areas of the largest residency concentrations today including Boston, New York City, Philadelphia and Washington, D.C. In general, the resident physician-to-

population ratio is highest in cities in the Northeast, lower in Southern and Western states, and lowest in rural areas.

The most important financial policy and educational instrument in graduate medical education is Medicare GME. While Medicare has paid for a portion of GME since its inception, the current system was established in 1983 as part of the prospective payment reforms of Medicare. The current system reimburses hospitals that train residents for two costs:

1. Direct costs (DGME) associated with residents, such as salaries, teaching time of faculty, administrative costs; and
2. Indirect costs (IME), which are intended to subsidize the higher cost of patient care in teaching hospitals related to both higher patient care acuity and the presence of residents in the hospital.

The calculation for direct and indirect payments is different, but both are based on the number of residents at a given teaching hospital and, as such, are a form of capitation payment - the more residents, the higher the payment. In 2006, direct GME payments totaled $2.8 billion and indirect GME payments totaled $5.8 billion, a total of $8.6 billion. This total amount represents only 2% of Medicare's expenditures in 2006 and, perhaps, receives less public debate than it might. On the other hand, $8.6 billion far and away the largest federal expenditure related to in any way to medical education.

As part of Medicare, these funds function as an entitlement and are allocated based on established formulas. Medicare legislation requires no community or regional physician needs assessment to qualify a hospital for GME payments, sets no targets for the number or type of resident physicians that a hospital trains and requires no accountability for the type or sufficiency of physicians in the hospital's city, county or state. Concerned with the cost of the program and its potential to escalate, Congress capped the number of federally funded residents in the Balanced Budget Act of 1997. In the last five years, the total number of residents in the country has grown slowly presumably due to the addition of "off-cap" residents and the selection of specialties with longer training periods.

While Medicare GME in its current form has provided a large and stable source of income for teaching hospitals that is understandably of enormous value to those important institutions, it is effectively a Federal payment without a deliverable – a subsidy. The resident compliment of any given hospital is determined by the staffing needs of that particular hospital with, presumably, the input of the chiefs of the clinical services. There is no requirement that the particular hospital or the medical school with which it is affiliated make any judgments about the workforce needs of their community, region or state. The result is that the annual graduates of the over 9,000 residency programs at nearly 1,100 teaching hospitals in the U.S. comprise the workforce of the country with no regard to specialty selection, practice location or regional needs.

Effectively, we are addressing the health care needs of the country with a physician staffing pattern based on hospital needs. This is a core problem for workforce reform. There are many ways in which Medicare GME could be reconceptualized and redirected. For the purpose of this testimony, let me suggest two levels of reform that might be considered. The first I will entitle "modest" and the second "major".

Modest reforms to current Medicare GME would entail modifications in the rules governing the use of GME funds. Currently, there are a variety of financial disincentives to offsite training. Hospitals stand to lose GME payments, both DGME and IME, for residents who spend time offsite (for instance in Community Health Centers, office-based practices, or local public health departments.) The sites, in turn, face either complicated negotiations to obtain GME pass-through funds or the prospect of training residents without receiving the benefit of GME financing.

There is much that could be done to make Medicare GME more user-friendly to primary care and community-oriented training. Reforms in this area would be helpful but would do little to change the basic problem of hospital staffing patterns dictating the nation's physician workforce.

A major reform would require reconstituting the current policy thinking that governs Medicare GME. Rather than seeing GME as a convenient vehicle for teaching hospital support, Medicare GME should be seen as the principal instrument to shape the physician workforce of the country. This perspective would require teaching hospitals to undertake community or regionally oriented analyses of physician workforce needs and make application for training positions based on a fiduciary responsibility to train a complement of residents that corresponds to agreed upon regional needs. This approach might also call for rebalancing regional and sectional allocations of GME funding and therefore physicians to provide a more balanced landscape of GME training.

One problem with envisioning a system of this sort is that many teaching hospitals who are current recipients of GME funding are not large and do not have a large number of teaching programs. In fact, many larger hospitals have specific foci such as cancer or children or surgery that do not equip them to address regional needs. An answer to this problem is the formation of independent consortia of teaching institutions that would, when working together, represent training capacity that could address regional needs in a much more comprehensive fashion. A variant approach would be state based GME organizations that might (or might not) have a link to state government. In either case, the consortium would be able to represent regional needs and work with the Center for Medicare and Medicaid Services (CMS) on residency training targets and GME funding.

A consortium system would require the establishment of many new arrangements within the medical teaching sector. It might also mean that teaching hospitals would have to modify their complement of residency programs in ways that might not be popular with the chiefs of service or the hospital administration. Strong political objection would predictably be mounted against any such reform, but if this most crucial link in the construction of the physician workforce in the United States --- graduate medical education --- is to be modified to meet the needs of an efficient and effective health system in the future, changes will need to be made in the way the federal government does business with the teaching hospitals of the country.

Medical Practice

Reincentivizing and redirecting primary care in the pipeline (medical schools and GME) will amount to little if parallel reforms are not achieved in support for primary care practice. Physicians are smart and ambitious enough that, if the current reimbursement inequities and structural disincentives to primary care practice remain in place, many will abandon primary care during their practice years despite excellent primary care education and support for primary care in their training years. The key areas in the practice environment that will help are practice reimbursement, practice organization, and health information technology.

Primary care physician average annual incomes are currently less than half those of their specialty colleagues. Given high medical school debt, late entry into an economically productive life and demands of the job, it is not hard to understand why primary care careers are severely disadvantaged in comparison to more lucrative specialty options that often have more controlled lifestyles. While physicians receive payment from many sources, the Medicare fee schedule is the primary determinant of physician reimbursement and is a candidate for major restructuring.

The organization of primary care practice is another area of major reform potential. The preponderance of primary care providers still work in solo practice or small groups. This minimizes the opportunity to develop

a full service primary care team benefitting from new information technologies or relating in an effective way to specialty consultants. Larger team based practices with excellent information systems such as medical homes or accountable care organization offer the promise of a new platform for health care delivery. Incentivizing and supporting these forms of practice stands to do a great deal to improve the overall health system, particularly promoting primary care, whose currency is patient well being over time linked to episodes of care provided by other practitioners. Health IT will organize and empower the primary care practitioner in ways that will make the practice of primary care much more effective. Investments in these areas are crucial.

A National Center for Workforce Studies

Underlying reform efforts in all three sectors of the physician workforce is the need for national level analyses and guidelines for workforce policies. Policy changes aimed at reforming the three sectors to address the health care needs of the nation can not be successful without clear workforce objectives, which require the ability to collect important data and produce useful policy analyses on the workforce. A national center for workforce studies should be given serious consideration.

Conclusion

In order to reform the delivery of health care in the United States in a way that is more effective and constrains costs, a number of changes need to be made in the workforce which is an essential governing component of the functionality, quality and cost of the system as a whole.

The number of physicians entering practice in the United States currently is in a zone of adequacy. Many of these physicians are trained abroad and measures should be taken to increase U.S. medical school output so as to decrease our dependence on foreign trained physicians. The training and use of nurse practitioners and physician assistants should be augmented to absorb increased demand in the system due to an aging population.

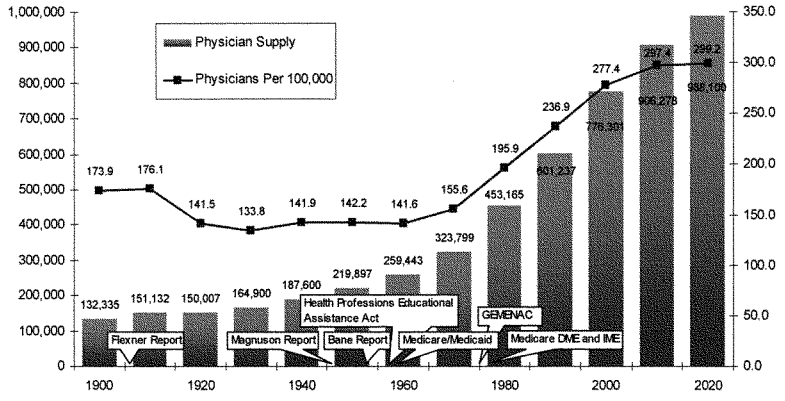
The current system is heavily balanced towards fragmented specialty care, making it inefficient and expensive. Moreover it is unevenly distributed, raising serious concerns of access and equity. Major investments in the pipeline at the medical school and GME level will be essential to rebalancing the system. At the GME level, in particular, where a large investment already exists, modifications need to be made in the system. In the practice sector, primary care is currently severely disadvantaged and reforms in payment systems and practice support will be needed to reincentivize and restructure the practice of primary care across the country.

It goes without saying that this is an important moment in the history of health care in the United States. The Congress has an unprecedented opportunity to lead in the reform of the system for the benefit of all Americans. I very much appreciate the opportunity to testify before you and I remain available to provide assistance in whatever way I can.

Thank you.

FIGURES

Figure 1: Physician Supply 1900 Projected to 2020



Sources: 1900, 1920: US Census occupations; 1910: Schofield (1984); 1930,1940: Stewart WH (1960).
1950-2020: Data provided by the Bureau of Health Professions

Figure 2: Primary Care Workforce Reform

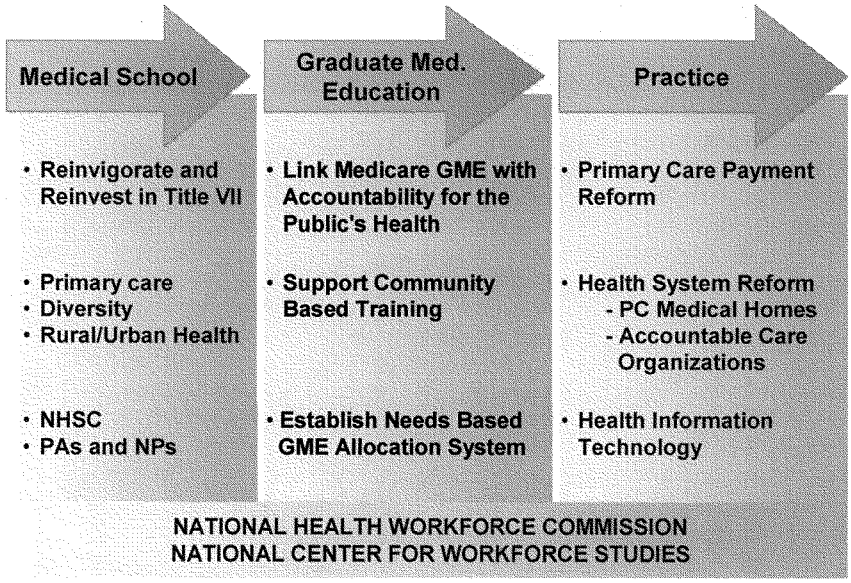
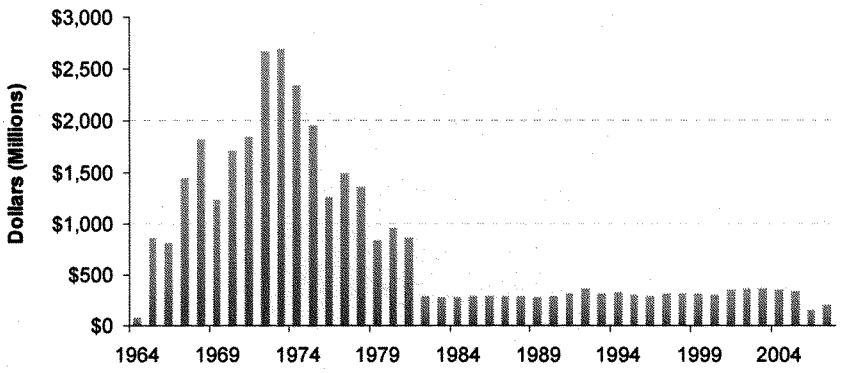
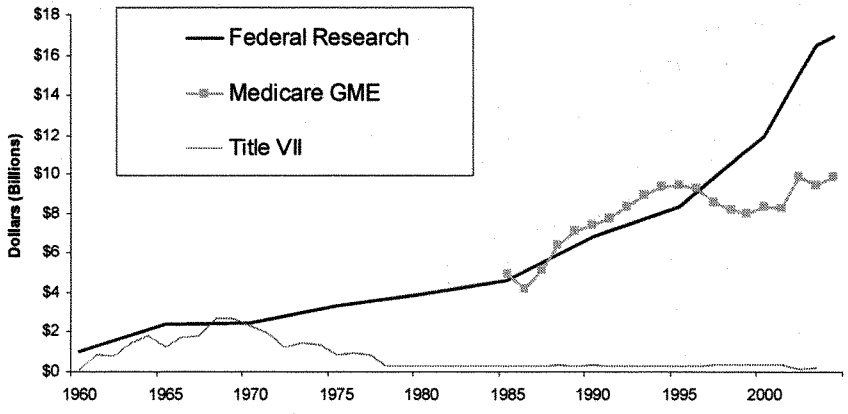


Figure 3: Title VII Funding, 2008 Dollars



Source: Health Resources and Services Administration

Figure 4: U.S. Medical School Revenue, 2008 Dollars



Source: AAMC Data Book, Centers for Medicare and Medicaid Services, Health Resources and Services Administration

WRITTEN STATEMENT OF STEVEN A. WARTMAN, MD, PHD, MACP
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FOR
SENATE FINANCE COMMITTEE HEARING
WORKFORCE ISSUES IN HEALTH CARE REFORM:
ASSESSING THE PRESENT AND PREPARING FOR THE FUTURE
MARCH 12, 2009

Thank you for the opportunity to speak with you this morning. I am Steven A. Wartman, President and CEO of the Association of Academic Health Centers (AAHC). I am pleased to join you today to discuss the findings, conclusions, and recommendations of the AAHC's report, *Out of Order, Out of Time: The State of the Nation's Health Workforce* and their relevance to the Committee's consideration of workforce issues in health care reform.

ASSOCIATION OF ACADEMIC HEALTH CENTERS

The AAHC, representing more than 100 academic health centers[1] nationwide, is dedicated to improving the nation's health care system by mobilizing and enhancing the strengths and resources of the academic health center enterprise in health professions education, patient care, and research. We have called for innovative thinking in the nation's approach to health workforce policy and its contribution to health security, economic development, and job creation. The AAHC is committed to leading by example and working with you and other stakeholders to develop a comprehensive, integrated national health workforce policy agenda and effective planning process as a critically important component of health reform.

SUMMARY OF MY MESSAGE TO THE COMMITTEE

The message I want to convey to the Committee this morning is that ***health system reform cannot be successful without simultaneously reforming how we make and implement health workforce policy***.

It is critical that a reformed health system has sufficient health professionals of the kinds that would most benefit the health of patients and the public. The AAHC report, *Out of Order, Out of Time: The State of the Nation's Health Workforce*, discusses in detail many aspects of current health workforce policy that are "out of order" – including inadequate access to primary care and shortages in many health professions – and why we are running "out of time" to change. The AAHC report concluded there is a systemic flaw in our century-old approach to health workforce policymaking and planning because responsibility for planning and managing the nation's health workforce is fragmented among literally

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[1] The AAHC defines an academic health center as a degree-granting institution of higher education that consists of:

- a medical school (allopathic or osteopathic);
- one or more other health professions schools or programs (e.g., allied health, dentistry, graduate studies, nursing, pharmacy, psychology, public health, veterinary medicine); and
- an owned or affiliated relationship with a teaching hospital, health system, or other organized healthcare provider.

hundreds of federal, state, and private stakeholders that rarely coordinate their policies or activities.

Therefore, I would like to offer this central point: ***if we don't change how we make and implement health workforce policy at the same time we reform the health care system, the promise of health reform will be seriously undermined.***

Out of Order, Out of Time

AAHC's report, *Out of Order, Out of Time: The State of the Nation's Health Workforce,* focuses attention on the critical need for a new, collaborative, coordinated, national health workforce planning initiative. The AAHC report is based on the following premises:

- The dysfunction in public and private health workforce policy and infrastructure is an outgrowth of decentralized decision-making in health workforce education, planning, development, and policymaking;
- The costs and consequences of our collective failure to act effectively are accelerating due to looming social and economic forces that leave no time for further delay;
- Cross-cutting challenges that transcend geographical and professional boundaries require an integrated and comprehensive national policy to implement effective solutions;
- The issues and problems outlined in the report have not been effectively addressed to date because of the inability of policymakers at all levels to break free from historic incremental, piecemeal approaches; and
- Despite many challenges, the prospects for positive change are high.

The AAHC report presents findings, conclusions, and recommendations. The detailed findings include:

- The historic evolution of health workforce policy and how the decentralization of the nation's health workforce policymaking among numerous public and private entities limits their collective ability to address national needs in an integrated, comprehensive, and effective manner.
- The specific problems arising from the lack of an integrative role in current public policymaking and infrastructure, including poor harmonization of policy within and across jurisdictions, the barriers to other stakeholders' ability to bridge those divides, and the consequences of the failure to create shared taxonomies and coordinated research capabilities.
- Specific policy areas where lack of harmonization of various public and private standards and requirements is problematic, including scope of practice laws, licensure, and accreditation.
- How health labor markets are adversely affected by dissatisfaction with jobs and work environment, the limited success of recruitment and retention strategies, and how

market incentives, increased debt, and other financial concerns contribute to suboptimal supply and distribution of the health labor force.

- The challenges facing institutions responsible for health workforce education and training, including constrained resources, adverse impact of elevation of minimum credentials, persistent faculty shortages, the consequences of increased entrepreneurialism and privatization in health workforce education, and the unrealized promise of mainstreamed inter-professional education and practice.

- Increasing reliance on a mobile international health workforce, the economic and individual choices at issue, and the need to evaluate and plan from a national perspective.

- The social and economic trends accelerating health workforce challenges, such as increased demand attributable to aging baby boomers and decreased supply attributable to the looming retirements of baby boom generation practitioners, as well as the changing values and perceptions that accompany changing demographics of the health workforce, and the health professions' ongoing struggle to respond to demographic diversity.

The AAHC report draws several broad conclusions from the detailed findings:

- A broader, more integrated national strategic vision than that which has characterized our historic approach to health workforce policymaking and planning is needed if complex and urgent health workforce issues are to be addressed effectively.

- A mechanism is needed to serve the currently unfilled integrative role that existing health workforce policymaking and planning processes are not designed, and are ill-equipped, to serve.

- National health workforce policy priorities include:

  - Assessing and harmonizing health workforce laws, standards, and requirements to improve their effectiveness and to remove the arbitrary barriers and burdens that the lack of consistency and compatibility creates;

  - Developing innovative policies and strategies that counteract the economic and environmental factors discouraging pursuit of health professions careers at a time when the nation is already facing current and projected shortages in many health professions;

  - Developing innovative policies and strategies that address the economic and environmental factors obstructing access to health professions education, burdening educational institutions, and distorting health workforce objectives; and

  - Developing a national approach to global health workforce issues.

- It is critically important to act immediately to develop and implement an integrated, comprehensive national health workforce policy before intensifying health workforce needs outpace available resources, putting the U.S. at risk of losing its status as the global health care leader.

The AAHC report's findings and conclusions offer compelling arguments that the nation is out of time to address what is out of order in our health workforce. Therefore, the AAHC report recommends that all public and private stakeholders work together to:

- Make the U.S. health workforce a priority domestic policy issue;
- Begin addressing national health workforce issues immediately to avert crises in national workforce capacity and infrastructure;
- Develop an integrated, comprehensive national health workforce policy that recognizes and compensates for the inherent weaknesses and vulnerabilities of current decentralized multi-stakeholder decision-making; and
- Create a national health workforce planning body that engages diverse federal, state, public, and private stakeholders with a mission to:
  - Articulate a national workforce agenda;
  - Promote harmonization in public and private standards, requirements, and prevailing practices across jurisdictions;
  - Address access to the health professions and the ability of educational institutions to respond to economic, social, and environmental factors that impact the workforce; and
  - Identify and address unintended adverse interactions among public and private policies, standards, and requirements.

The AAHC report includes additional recommendations for fulfilling each of these missions.

RELEVANCE OF *OUT OF ORDER, OUT OF TIME* TO HEALTH SYSTEM REFORM

Out of Order, Out of Time is not limited in scope to health workforce issues raised specifically by health system reform, but its findings, conclusions and recommendations are directly relevant to achieving successful health system reform.

First, even without health system reform, the health workforce is already under tremendous stress from powerful social and economic forces, including the aging of the population and the markedly increased need for chronic and long-term care.

Second, there are serious concerns involving the selection of careers in the health professions, including: admission practices, education debt, workplace conditions, reliance on international health care workers, and current payment policies that steer health professionals away from choosing the kind of careers and communities where they are most needed.

Third, our current health workforce policymaking and planning infrastructure is inadequate to meet these challenges because it is hopelessly fragmented among a wide variety of stakeholders that respond to immediate needs largely in isolation and with little coordination.

Fourth, health system reforms under consideration by the Committee add further stress to already daunting health workforce challenges because, for example:

- Expanding coverage to previously marginalized individuals and families, which will increase expectations and demand for services from health professionals already in short supply in many communities; and

- Implementing health information technology and comparative effectiveness research, which will require large scale training of health professionals to adopt them rapidly if they are to achieve their full potential to improve safety, quality and cost-effectiveness.

Fifth, as pointed out in AAHC's report, we are already behind the curve and need to act now.

RECOMMENDATION

All this leads me to conclude that comprehensive health ***workforce*** reform is an essential element of effective health ***system*** reform, and that we need to make ***workforce*** reform a national priority in conjunction with ***system*** reform. I recommend:

- Immediate appointment of a national health workforce coordinator to begin mobilizing current resources more effectively as an interim step; followed by

- Creation of a permanent, multi-professional, multi-disciplinary national health workforce planning body to bring together all stakeholders to address the challenges we face in a comprehensive, coordinated, and strategic manner.

IN CONCLUSION

A permanent national health workforce planning body allows us to assemble all the pieces of the workforce puzzle so we can see the whole picture. It is where we can:

- harmonize public and private standards, requirements, and prevailing practices across jurisdictions;

- address access to health professions education and the ability of educational institutions to respond to economic, social, and environmental factors that impact the workforce; and

- identify unintended adverse interactions among public and private policies, standards, and requirements.

My greatest concern is that we will press forward with health reform without full consideration for the health professional workforce that will be needed to make these reforms successful. I urge you to incorporate a new integrated and coordinated approach to national health workforce policy as health system reform is considered. On behalf of the nation's academic health centers, I look forward to working with you toward that goal.

Responses to Questions for the Record From Steven Wartman
March 12, 2009 hearing on "Workforce Issues in Health Care Reform"

QUESTION: How many new health care workers do your member institutions add to the workforce each year? It would be nice to get these figures in job categories such as GME trained physicians, primary care (family medicine, internal medicine, pediatrics) versus all others; 2 year nurses, 4 year nurses, other allied health, PhDs.

ANSWER: According to our recent census, AAHC member institutions (which represent the majority of public and private academic health centers) collectively produce more than 58,000 new health professionals each year. This includes more than 30,000 allied health professionals, more than 4,000 dentists, more than 2,000 pharmacists, more than 19,000 physicians, more than 4,000 public health professionals, and more than 2,000 biomedical science PhDs.

QUESTION: How does this data compare with the total yearly output in the U.S.? In other words, how many workers do the academic health centers contribute to the overall size of the U.S. Healthcare workforce?

ANSWER: "Health workforce" is a broad term that encompasses the many individuals with and without professional degrees who are required to deliver healthcare in today's complex patient care environment. Academic health centers train almost 100% of U.S.-trained physicians and a significant majority of the nation's dentists, baccalaureate or higher-degreed nurses, optometrists, public health professionals, and veterinarians. Academic health centers also train allied health professionals, pharmacists, social workers and others, but education of these health professionals often occurs at other institutions as well.

QUESTION: Where do your graduates work? In other words, what is their geographic distribution? If you have any data on service in HPSA communities, that would be welcome.

ANSWER: Academic health center graduates work in all practice settings and all regions of the nation, including medically underserved and health professions shortage areas. While the association does not attempt to track geographic distribution of our member institutions' graduates, many of our individual members do track their graduates' career paths and practice sites. Quite often, more than 50% of alumni – particularly alumni of public institutions – remain in their state. In some states, academic health center alumni constitute 70% or more of practitioners in rural and other underserved areas.

Each health profession has its own association that typically tracks some data on members, but the data are not consistent across professions. The difficulty in tracking

these data is an example of how a national health workforce planning body could facilitate consistent and uniform data collection to aid in projecting our workforce needs and maximize the nation's health and well-being.

QUESTION: Do you have projections for faculty losses during the next 5 year period? Again, if you can provide the data by training program that would be super!

ANSWER: Such data, to the degree is exists, is generally compiled by individual health professions, but the data are not consistent across professions. There are already significant and increasing shortages of faculty in many health professions and most analysts project continued difficulty across the health professions. In many of the major health professions, we are hearing of multiple vacant faculty positions at each school.

QUESTION: What, if any, relationships do AAHC members have with federally qualified health centers (and community health centers generally), and what if anything do we have to say about the health workforce impact of health system reform on FQHCs/CHCs?

ANSWER: The AAHC does not systematically collect data regarding its members' relationships with FQHCs and CHCs; the following characterizations are based on anecdotal information (e.g., informal survey responses).

Academic health centers have significant involvement with community health centers generally and federally qualified health centers in particular. Depending on the structure, location, and legal agreements between these delivery sites and the academic health center, the number and kind of students trained in community health centers can vary significantly. Many academic health centers train students in FQHCs and/or CHCs, and some academic health centers report that the amount of training being done is increasing. Academic health centers also supervise medical residents in FQHCs and/or CHCs in addition to student trainees.

In terms of other formal arrangements between academic health centers and FQHCs/CHCs, an array of agreements exists that are difficult to generalize. We can provide examples if that would be of interest. Limited financial resources are among the most frequently mentioned barriers to sustaining and enlarging these beneficial relationships that provide much needed services, especially to very poor, underserved populations.

Issues related to community and federally qualified health centers highlight why a national workforce planning body is needed. Such a body could be instrumental in addressing policies and practices related to community health centers across the country, e.g., ensuring that: education and delivery issues are addressed and analyzed in a coordinated fashion; uniform information is collected, coordinated and disseminated; best practices and evaluations made available regularly; innovative models are shared so they

can be translated to new sites; and any challenges could be quickly and effectively addressed.

QUESTION: What, if anything, does the AAHC have to say about the "medical home" concept and the health workforce impact of health system reform on the medical home.

ANSWER: The medical home concept would have every person enjoy access to a medical home where an advisor and team of providers would help that person navigate the health system and put him or her at the center of care. Putting the patient first is something AAHC believes should always be a priority in any care giving situation.

More study may be needed to see if the medical home is adaptable to all populations and all degrees of illness. If appropriate stakeholders are engaged through a national health workforce planning body, it would be possible to assess this model for the workforce in a comprehensive manner.

QUESTION: What have AAHC's Massachusetts members told us about the impact of the Massachusetts health reforms on the health workforce?

ANSWER: The media has noted that the shortage of primary care doctors is an unintended consequence of health reform in Massachusetts, which is threatening to undermine the initiative. AAHC's member institutions in Massachusetts have not communicated to us any additional observations beyond what has been reported in the media.
Uncertainty regarding the impact of the Massachusetts reforms shines a spotlight on the need to collect consistent health workforce data across jurisdictions to facilitate analysis of the impact of various policy changes. This is one of the many functions the AAHC envisions for the recommended national health workforce planning body.

QUESTION: How would a planning body help address cultural diversity?
ANSWER: Cultural diversity is a significant issue for the health workforce, particularly as we consider the ongoing demographic shifts in the U.S. population. Academic health centers have pioneered initiatives to address many aspects of cultural diversity, from language to health practices to ethics and values.
In the absence of a health workforce planning body to articulate a national agenda for the workforce that includes cultural diversity, these efforts remain largely ad hoc and frequently under-resourced. A national planning body could not only elevate the importance and commitment to cultural diversity, but compare and analyze the approaches taken in different communities and provide tangible support for best practices that have general applicability across communities.

QUESTION: How would a planning body help address interprofessionalism?

ANSWER: Although interprofessional education and collaborative practice (IPECP) have long existed, health professionals, educators and governments around the world are increasingly recognizing the benefits of interprofessional education as a means to prepare future health professionals for collaborative practice. At the global level, the World Health Organization's Department of Human Resources for Health is working on a framework for developing systems to support IPECP.

A national health workforce planning body could harmonize IPECP efforts across the nation and adapt the WHO framework to U.S. health care delivery. It might also assess current U.S. examples of IPECP, establish demonstration projects involving academic health centers and their community partners, and determine and disseminate best practices in the area of IPECP.

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STATEMENT FOR THE RECORD

SUBMITTED TO THE

SENATE FINANCE COMMITTEE

ON

WORKFORCE ISSUES IN HEALTH CARE REFORM: ASSESSING THE PRESENT AND PREPARING FOR THE FUTURE

March 12, 2009

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AARP appreciates the opportunity to provide testimony to the Senate Finance Committee, and we applaud Chairman Baucus and Ranking Member Grassley for calling this hearing to examine the need for an adequate supply and mix of well-trained health professionals. We share your belief that efforts to expand health care access, improve quality and control costs will have limited effect without a focus on who is going to deliver value-added healthcare to more Americans, especially when shortages of health care providers already threaten the delivery of care.

Our testimony will focus on why health care reform legislation produced by this Committee and others should provide lasting solutions to the:

- looming shortage of nurses and faculty to prepare the future nursing workforce;
- lack of cultural competency and diversity of the health care workforce that is critical to reducing health disparities;
- lack of support for family caregivers who are integral partners of an interdisciplinary care team and provide critical care coordination;
- lack of adequate training and preparation of the health care workforce to address the needs of an aging population; and
- lack of primary care providers who are critical to providing quality health care, preventive services, and care coordination.

Shortage of Nurses and Faculty

In December of 2007, AARP helped to launch the *Center to Champion Nursing in America*— a joint initiative of AARP, the AARP Foundation and the Robert Wood Johnson Foundation that seeks to support the development of the nation's capacity to build and maintain a high-quality nursing workforce which will ensure that our country has the nurses it needs to care for all of us, now and in the future.

In 2006, the American Hospital Association reported approximately 116,000 unfilled nursing jobs in American hospitals. What is concerning about that statistic is not only its magnitude, but that five years of concerted effort to stem this shortage has had only a marginal effect: the AHA reported a shortfall of 126,00 nurses in 2001. Furthermore, one out of every six hospitals reported recruiting nurses from overseas to close the gap on their shortages, and over 40 percent of them indicated that their recruitment efforts had been rising. Shortages are not confined to hospitals, however. More than 25,000 unfilled nursing jobs are in our nursing home facilities.[i] [ii] Home health agencies report an 11 percent nursing vacancy rate. [iii] More than 5,000 community health centers that serve those without adequate insurance are experiencing a vacancy rate of 10 percent for registered nurses (RNs) and nine percent for nurse practitioners.[iv] Despite this need, in 2008, 99,000 qualified applicants were turned away from nursing programs due to lack of faculty and other resource constraints.[v]

These shortages are especially harmful to populations already suffering from racial and ethnic disparities in care. Increasing cultural diversity and competencies in the health care workforce as we work to address this shortage will be essential in our efforts to eliminate these disparities.

Without aggressive action, the shortage will only worsen. Researchers estimate that in the next 15 years we could face a shortage of up to a half million nurses,[vi] just as 78 million aging boomers need access to more health care. Fortunately, we have the tools to fix the shortage. Indeed there is no "shortage" of reports and recommendations to reverse course and bolster the supply of nurses. But these recommendations need to be strategically and effectively applied. Too often in the past we have addressed the nursing shortage with short-term solutions that treat the proximal causes, and have failed to appreciate and address the longer-term problems that threaten the nursing workforce and result in cyclical shortages.

Impact on Patient Safety and Costs

Rarely acknowledged but painfully true is that health care costs are directly affected by the shortage of nurses. Costs rise with high turnover rates and avoidable errors that often occur when there are too few nurses.

Substantial costs are associated with errors tied to inadequate nursing staff. An Agency for Healthcare Research and Quality (AHRQ)-funded study undertaken by Dr. Robert Kane and colleagues found that adverse events happen more frequently in hospitals with fewer nurses (e.g., higher rates of pneumonia, shock, gastro-intestinal bleeding, and urinary tract infections).[vii] Most of these events are associated with increased costs. For example, Dr. Kane found that for patients who developed pneumonia while in the hospital, care costs increased by 84 percent.[viii] Treating pneumonia increased total treatment costs by $22,390 to $28,505 per patient.[ix]

The Joint Commission found that 24 percent of unanticipated adverse events in hospitals that resulted in injury, death or permanent loss of function were related to inadequate numbers of nurses at work.[x] New Medicare payment rules that bar payment for certain adverse events – sometimes called "never events" because they should always be prevented – place even greater financial importance on the need for hospitals to prevent adverse events.

Dr. Lucian Leape, one of the leaders in patient safety research, found in a 6-month period at two hospitals that nurses were responsible for detecting 86 percent of medication errors committed by doctors, pharmacists, and others before the error reached the patient. Without sufficient nurse staffing, this important wall of vigilance will crumble.

Staff retention plays a pivotal role in health care costs. The costs associated with replacing an RN can run as high as 150 percent of the base salary, including lost productivity and temporary staffing expenses.[xi] A recent national survey found that health care organizations spend $300,000 more annually in nurse turnover costs for every one percent increase in turnover.[xii] Further exacerbating the nursing shortage, studies show that up to 30% of nursing's time is spent in administrative tasks rather than direct patient care, leaving both nurses and patients unsatisfied.

The "cost" of the nursing shortage extends beyond financial to access, with many parts of the country feeling its effects across settings.

- One hospital in Tennessee reported it was so short in staff that it had to resort to transferring patients – even pregnant women in active labor – to other hospitals.[xiii]

- Nursing homes are unable to admit residents with complex skilled care needs, such as ventilators, serious wounds or feeding tubes due to lack of nursing staff.[xiv]

- Hospital employers in a 2006 study by the Texas Center for Nursing Workforce reported that shortage of registered nurses resulted in overcrowding of emergency rooms, increased patient complaints, and decreased physician and patient satisfaction.[xv]

Reforming Health Care by Building Nursing Capacity

The searing effects of the nursing shortage compel our immediate attention. Likewise, the growing demands on our health care delivery system as the population ages and chronic illnesses increase demand our response. We face the imperative of reforming how we deliver care in order to achieve a greater dividend from the expenditures deployed in improving the health of the public. That means our solutions for the nursing shortage cannot just produce more nurses, but rather a right-sized, richly-skilled, and well-integrated nursing workforce that is poised to meet the needs that the public and an evolving delivery system require. This can be accomplished by:

- Preparing greater numbers of RNs and advanced practice registered nurses to bring primary care, care coordination, and medical homes that are shown to be effective to all consumers, in particular those who are asked to endure their chronic illnesses with inadequate support from the health care system.

- Increasing the number of nursing faculty to meet the growing demand for nursing education.

- Aligning Medicare payments for graduate medical education with the enhanced production of primary care providers, both physicians and advanced practice registered nurses. The training for this enhanced primary care workforce must include skill in chronic care management, transitional care, and geriatric care.

- Designing and promoting payment models that reward cost-effective and interdisciplinary team care including medical homes.

- Promoting educational and clinical practice innovations (e.g., health information technology (HIT), tele-health, distance learning) to ensure the broadest geographic distribution of the primary care and nursing workforce.

Supporting Family Caregivers

No discussion of workforce issues would be complete without taking into account family caregivers -- spouses, partners, children, other family members, friends, and neighbors -- who are assisting their loved ones and are critical to the health and long-term care systems in this country. Family and other unpaid caregivers often act as de-facto care coordinators for individuals with multiple chronic conditions, especially for those with cognitive or functional impairments. Family caregivers provide the majority of home and community-based services for persons with disabilities of all ages. Caregivers can play a critical role in providing quality care to their loved ones and potentially save money by keeping their loved ones out of often more costly settings, such as nursing homes and hospitals.

Assistance by family caregivers can delay or prevent the use of nursing home care. A study published in 2002 found that frequent help with basic personal care from children reduced the likelihood of nursing home entry among persons age 70 and older with disabilities over a two-year period by about 60 percent. Other research demonstrates that providing services to support family caregivers reduces the likelihood of institutionalization.

Further, people who have family caregivers tend to have shorter hospital stays, while the absence of a family caregiver has been linked to more frequent hospital readmissions. Informal care by adult children has been found to reduce Medicare inpatient expenditures of single older persons, as well as expenditures for home health and skilled nursing facility care. Other research has shown that interventions focusing on the roles of family caregivers during care transitions produce positive results, ranging from better patient outcomes in functional status and quality of life to reduced hospitalizations. In addition to these benefits of caregiving, the AARP Public Policy Institute has estimated the economic value of family caregivers' unpaid contributions were about $375 billion in 2007.

Family caregivers can be a critical part of an interdisciplinary care team helping to meet the needs of an individual with multiple chronic conditions. Caregivers who accompany individuals during care transitions provide continuity of care by sharing knowledge of the individuals' past health and support needs. Caregivers help navigate the system to get their loved ones needed services and supports, help with daily activities and even complex medical conditions, and provide other vital mental and emotional support.

However, caring for loved ones can take a physical, emotional, mental and financial toll on caregivers that is well documented. Caregivers face challenges ranging from chronic stress and physical and mental health problems to high annual out-of-pocket costs and economic insecurity caused by loss of wages, health insurance and other job benefits, retirement savings, and Social Security benefits. These challenges are felt even more acutely in the current economic crisis.

To continue in their caregiving role, help ensure the provision of quality care, and reduce costs to public and private payers, caregivers need additional support. This support should come in a variety of forms, such as an assessment of the caregiver's needs to help connect them to needed services such as information, training, and respite care; better discharge planning and transitional care, navigational assistance, and information about providers and the quality of care they provide to support decisions about care options; training to help caregivers care for their loved ones; respite care; better communication with providers as members of the care team helping their loved ones; and support from nurses and social workers. AARP has endorsed the Retooling the Health Care Workforce Act for an Aging America Act (S. 245/H.R. 468) that includes some important provisions to support family caregivers.

Preparing the Workforce for an Aging Population

AARP was pleased to be one of the sponsors of last year's Institute of Medicine (IoM) report, ***Retooling for an Aging America: Building the Health Care Workforce***. This report and subsequent actions by the IoM and others have brought attention to the need to ensure a sufficient workforce at all levels that is competent and prepared to meet the needs of the country's growing aging population. AARP is also a member of the Eldercare Workforce Alliance, a group of 25 national organizations who have joined together to address the immediate and future workforce crisis in caring for an aging America.

The aging of the baby boom generation will create a greater demand for a competent and well trained health care workforce. Yet the IoM study found that the U.S. health care workforce receives little geriatric training and is not prepared to provide older patients with the best care. There is only one physician certified in geriatrics for every 2,500 older Americans and only one-third of baccalaureate nursing programs required a course focused on geriatrics in 2005. Even though Medicare is a primary source of medical education funding, most health care providers receive almost no formal training in geriatrics or gerontology and there are few incentives for them to get this training.

Older patients have unique needs – they are more likely to have multiple chronic conditions, use multiple medications, and have more complex health care needs than younger individuals. A well trained and competent workforce is vital to ensuring that these patients receive quality care. Training for residents in all settings including nursing homes, assisted living facilities, and patients' homes will give practitioners a greater understanding of their patients and enable them to provide patient-centered care. It is also vital that the long-term care workforce, including direct care workers, receive the training and competencies they need to meet the needs of the aging population. Issues such as increasing pay and fringe benefits are also critical to recruiting and retaining this workforce.

More individuals must receive training in geriatrics, chronic care management and other competencies that are essential to meeting the needs of older adults, and challenges

facing the direct care workforce must also be addressed. Towards this end, AARP has endorsed legislation to address these important issues, such as the Retooling the Health Care Workforce for an Aging America Act (S. 245/H.R. 468) sponsored by Senator Kohl and Representative Schakowsky this year and the Caring for an Aging America Act (S. 2708 in the 110th Congress) sponsored by Senators Boxer and Collins last year. These bills take important steps to encourage and provide opportunities for a variety of providers and faculty to receive additional training in areas such as geriatrics, chronic care management and long-term care. The bills also take steps to enhance career ladder opportunities in long-term care, improve competencies of direct care workers, and support and train family caregivers. Ensuring that the workforce is prepared to address the needs of a growing aging population is a critical aspect of ensuring that the workforce can provide quality care to everyone.

Strengthening Primary Care

There are widely acknowledged shortages of primary care providers, whether it is nurses, physicians, or other providers. Yet primary care providers are vital to the provision of affordable, quality health care, prevention, management of chronic conditions, and coordination of care. Primary care providers are the first stop for many individuals entering the health care system. Having an ongoing relationship with a primary care provider can help reduce emergency room visits, ensure the provision of preventive care, catch conditions earlier and treat them before they require more invasive and costly care, ensure better continuity of care and management of medications, and ensure better coordination of care.

Effective practice models that emphasize, encourage, and improve primary care should be expanded and incentives should be created to encourage individuals to practice in primary care. Interdisciplinary care teams should be encouraged, as they can provide quality care for individuals and recognize the valuable role and contributions of multiple care providers. Strengthening the primary care workforce is an essential part of ensuring the provision of quality, affordable health care for all.

Conclusion

We look forward to working with you to address these workforce issues, including developing specific recommendations for the Committee for reforming Medicare's payments to build the health care workforce we need, as well as other issues critical to comprehensive health care reform. Congress, the Administration, and stakeholders must work together to enact comprehensive health care reform this year – it is vital to the health and economic security of us all.

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AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

United States Senate Committee on Finance

Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

March 12, 2009

Testimony for the Hearing Record

Submitted by

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Introduction

The American Academy of Child and Adolescent Psychiatry (AACAP) applauds Senator Baucus for holding this important hearing, and we applaud his commitment to improving America's health care system by addressing the severe workforce crisis.

AACAP is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 8,000 members strong, the AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7 – 12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental illnesses. AACAP supports research, continuing medical education and access to quality care. Child and adolescent psychiatrists are the only medical specialists fully trained in the treatment of mental illness in children and adolescents.

Despite living in the wealthiest nation in the world, many of our children in need of help lack access to a child mental healthcare worker. Less than a third of youth with mental illnesses receive treatment. If left untreated mental illnesses are devastating to our nation's youth and their families. Mental illnesses are implicated in 90% of suicides, which are the third-leading cause of death for young people. Many children with unidentified and untreated mental illnesses fail or drop out of school, fail to develop friendships and social skills, and could end up in the juvenile justice systems. An estimated 70% of arrested juveniles have mental health problems.[1] The recently released Institute of Medicine's report on *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities* again describes the plight of the 14 to 20 percent of U.S. children with a mental illness and the associated annual cost of $247 billion. The report emphasizes development of an effective preventive system, including research, evidence-based preventive intervention, and developing the necessary workforce[2]

The devastating reality is that youth with untreated mental illnesses have a greatly diminished future to live independently. The adverse impact on youth and their families cannot be overstated. A major factor in this epidemic of untreated mental illnesses is a shortage of qualified practitioners.

Shortage of Children's Mental Health Professionals

One of the key barriers to treatment is the shortage of available specialists trained in the identification, diagnosis and treatment of children and adolescents with emotional and behavioral disorders. The Surgeon General reported in 1999 that "there is a dearth of

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[1] http://science-education.nih.gov/supplements/nih5/Mental/guide/info-mental-c.htm

[2] National Research Council and Institute of Medicine (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions). O'Connell ME, Boat T, and Warner K, eds..Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press

child psychiatrists, appropriately trained clinical child psychologists, or social workers.[3]" The *Annapolis Coalition* reports, "there is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and its largely unable to deliver care of proven effectiveness in partnership with the people who need services."

There are currently about 7,400 child and adolescent psychiatrists practicing in the U.S[4]. In 1990, Council on Graduate Medical Education (COGME) reported that the nation would need more than 30,000 child and adolescent psychiatrists by 2000, based on increasing rates of child mental illnesses and managed care staffing models. The Bureau of Health Professions projected that between 1995 and 2020, the use of child and adolescent psychiatrists will increase by 100%, with general psychiatry's increase at 19%. Provider shortages have been documented in private practices, community clinics, public hospitals and public mental health care systems alike[5]. Primary care providers report seeing a large number of children and adolescents with mental health problems, but have difficulty finding available clinicians to take referrals.

The shortage of child and adolescent psychiatrists is due to increased educational debt, pressure and incentives to pursue a primary care career in the 90's, a long training period, further specialization of medicine including psychiatry subspecialties and reimbursement problems in the managed care era. All of these factors discourage medical students from choosing a career in child and adolescent psychiatry. Many other child mental health specialties face similar programs with longer training periods specializing in the developmental needs of children, which lead to additional school loan debt.

The shortage crisis of children's mental health professional shortage is a well recognized national concern and calls to action have been issued by the following national leaders:

- President's New Freedom Commission on Mental Health (2003)[6]
- Council on Graduate Medical Education (2000)
- Accreditation Council for Graduate Medical Education (2006)
- National Health Policy Forum (2004)[7]
- National Technical Assistance Center for Children's Mental Health (2004)[8]
- The United States Surgeon General (1999)[9]

Effects of Shortage

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[3] http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec3.html

[4] The following data has been extracted through an analysis of the American Medical Association Physician Masterfile (September 2008) by the AACAP.

[5] http://www.nhpf.org/library/details.cfm/2469

[6] President's New Freedom Commission on Mental Health (2003), Achieving *the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Publication NO SMA-03-3832

[7] *The Provider System for Children's Mental Health: Workforce Capacity and Effective Treatment,* Nat'l Health Policy Forum, Oct., 2004

[8] *Transforming the Workforce in Children's Mental Health*, Nat'l Technical Assistance Center for Children's Mental Health, Georgetown University, 2004

[9] *Mental Health: A Report of the Surgeon General*, 1999

Without intervention, child and adolescent mental illnesses frequently continue into adulthood. As children with co-existing depression and conduct disorders grow into adults, they are more likely to use more health care services and have higher health care costs than other adults.

- At least one-third of the children being served by the United States mental health care system are diagnosed with 2 or more psychiatric disorders[10].
- It is estimated that 39-80% of the children in the United States child welfare system have mental health needs.
- Research shows that about 70% of youth in the juvenile justice system have a psychiatric disorder and over 20% have serious mental illnesses that significantly impair their lives[11].

The workforce shortage also places a tremendous burden on families who are often told that they must wait months for their child to see a mental health professional or must travel long distances for help. The shortage impacts almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field[12]. There are numerous instances where acutely suicidal or physically violent children and their parents have to wait overnight in an emergency room before being seen by a mental health professional. Even then, subsequent outpatient follow-up is often delayed for weeks leaving families feeling frustrated, alienated and hopeless. Consequently, many children never get to their follow-up appointment, which often leads to more violence, emergency room recidivism, and juvenile detention.

In the rural areas of the country, the workforce shortage is even more severe. It is becoming even more difficult to recruit, train, and retain mental health professionals in rural areas. In fact, half of the counties in the United States do not have a single mental health professional[13].

Addressing the Shortage

Many factors contribute to the shortage of children's mental health professionals. Chief among these factors is the lack of educational incentives in the form of scholarships, meaningful loan repayment programs, training grants and specialty training program support to pursue a career in this field. Recruitment efforts need to be improved and training opportunities must be expanded.

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[10] *Transforming the Workforce in Children's Mental Health*, Nat'l Technical Assistance Center for Children's Mental Health, 2005

[11] *Transforming the Workforce in Children's Mental Health*, Nat'l Technical Assistance Center for Children's Mental Health, 2005

[12] *An Action Plan for Behavioral Health Workforce Development,* the Annapolis Coalition on the Behavioral Health Workforce 2007

[13] Bird, D.C. Dempsey, P., & Hartley, D. 2001 *Addressing mental health workforce needs in underserved rural areas: Accomplishments and Challenges.* Portland, ME: Maine Rural Health Research Center, Muski Institute, University of Southern Maine

Congress must address the critical need for children's mental health workforce training by creating incentives to help recruit and retain child mental health professionals and to improve, expand, and help create programs to train child mental health professional through the following mechanisms:

- Removal of the graduate medical education cap for child and adolescent psychiatry to allow for full funding for an increase in the number of Child and Adolescent Psychiatrists permitted under the Medicare Graduate Medical Education Program and extension of the Board Eligibility period for residents and fellows from four years to six years.
- payments for both direct medical education and indirect medical education funding for child and adolescent psychiatry.
- Support for training in child and adolescent psychiatry for pediatricians through a new training portal.
- Loan repayment and scholarships for all children's mental health professionals.
- Grants to graduate schools to provide for internships and field placements in child and mental health services.
- Grants to help with the pre-service and in-service training of para-professionals who work in children's mental health clinical settings.
- Grants to graduate schools to help develop and expand child and adolescent mental health programs.

I encourage you to enact the Child Healthcare Crisis Relief Act. This bill will help alleviate these drastic shortages of child mental health professionals by providing loan forgiveness and making grants to professional schools to develop, expand, and improve training programs for professionals who serve children and adolescents. Untreated mental illnesses are devastating to children and adolescents. Children with untreated mental illnesses are at a higher risk for suicide, drug abuse, criminal activity, school failure and dropping out. We can only improve our mental health system if we have the workforce in place.

Thank you for the opportunity to submit testimony for the record. If you have any questions or we can be of any help to your committee, please contact Kristin Kroeger Ptakowski, Director of Government Affairs at 202-966-7300, ext 108 or kkroeger@aacap.org.

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American Academy of Nursing
Written Statement to the Senate Finance Committee
On "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future"
Submitted by: Patricia Ford-Roegner, MSW, RN, FAAN
CEO of the American Academy of Nursing
March 12, 2009

The American Academy of Nursing (AAN) respectfully submits this statement on the state of the U.S. health care workforce. AAN's 1,500 members – known as Fellows – are nursing's most accomplished leaders in education, management, practice, and research. The AAN serves the public and the nursing profession by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge.

We are all aware that the United States faces a shortage of nurses and primary care providers. This shortage causes access problems as well as affects the quality of care given to patients and their families. According to recent projections from the U.S. Bureau of Labor Statistics, we will need more than one million new and replacement nurses by 2016.[i] Research shows that when nurses are able to spend more time with a patient, the patient has better health outcomes.[ii],[iii],[iv] Regrettably, research has also found that nurses spend less than one-fifth of their time on patient care activities. The majority of their time is spent on documentation, care coordination, medication administration and movement around the unit.[v]

Investing in and Improving the Workforce

If we are able to achieve comprehensive health care reform, and provide health coverage to all Americans, the problems associated with the current workforce shortage will only worsen. Serious efforts must be made to increase the number of health care providers that will be able to care for our nation's diverse and aging population. I applaud President Obama and Congress for enacting the American Recovery and Reinvestment Act of 2009, which includes $500 million for health professions training; $300 million will be awarded to the National Health Service Corps and the remaining $200 million will be divided between the Nursing Workforce Development Programs (Title VIII of the Public Health Service Act) and the Health Professions Training Programs (Title VII). This is an important step forward in shoring up the workforce. Over the next seven years, the Academy urges Congress to invest $2 billion in the Title VIII Nursing Workforce

Development Programs to support the 400,000 of the one million new and replacement nurses needed by 2016.

In addition to having an adequate number of nurses, we must also ensure our health care professionals have the appropriate expertise to meet the needs of the patient. We must think strategically about current and potential future demands to make sure we have enough providers with the right level of experience and knowledge to address our various health needs. For example, our aging population will need care providers with the right knowledge and training in geriatric care. Recognizing the nation's aging population and unprecedented demands this will create for the U.S. health care system, the John A. Hartford Foundation invested $67 million over the past decade to strengthen and expand geriatric nursing. With support from the Foundation, the American Academy of Nursing launched Building Academic Geriatric Nursing Capacity program to improve the nation's capacity to provide quality nursing care to older persons by producing expert researchers, academicians, and practitioners. I am confident that these practitioners will be invaluable in the very near future.

Can Health Information Technology Help Alleviate Demands?
Adding new nurses and replacing nurses is an essential element to bolster our workforce. But we also must be aware of the limitations, such as an aging population and limited production capacity at America's nursing schools due to the shrinking numbers of nursing school faculty in increasing the supply of nurses. Consequently, we must strategically look at how best to retain the current workforce and alleviate some of the demands that keep providers away from patients. Research demonstrates that inadequate nurse staffing has resulted in increased levels of pain and discomfort for patients.[vi] Furthermore, the high cost associated with replacing a registered nurse range anywhere from $48,000 to $85,000. At the current national turnover rate this translates into an annual cost of $13 billion to $24 billion dollars.[vii]

Recognizing these incredible costs, the American Academy of Nursing established a Workforce Commission charged with looking at new ways to retain nurses and alleviate some of the demands placed on health care providers. The Commission began looking at inefficiencies and workflow problems and developed an improved process for identifying technological solutions to medical/surgical unit workflow efficiencies. In 2005, the Workforce Commission began their Technology Targets Project which engaged 25 hospitals across the country to review and identify normal workflow practices for health care providers and to assess how technology could improve the work environment. The study "Technology Solutions to Make Patient Care Safer and More Efficient," found that while the use of technology has become more common in health care, it has not been adopted in a way that maximizes its potential. Many of the current information system software, device, and equipment technologies add to the complexity of work environments and take nurses away from their critical role of patient observation and early intervention. The results of this study support that nurses and other direct care providers must be involved in the design and testing of new and innovative applications and devices that are user-friendly and affordable. Involving nurses as end users in the early stages of system analysis and design can lead to better adoption of new technology,

as well as identifying how current technology can be adapted for greater user acceptance. Additionally, nurses' participation ensures patients' needs are met as nurses are the largest health care provider group.

The AAN strongly supports the use of health information technology (IT) as a way to alleviate demands on nurses so they can spend more time with patients and improve health care delivery, which will result in better quality of care. However, the AAN also believes that in order for Health IT to maximize its potential, it must be properly developed and deployed. Therefore, the American Academy of Nursing urges the inclusion of a broad array of health care providers, including nurses, which is the largest health professional group in the United States, as integral participants and leaders in the design, development, implementation, and evaluation of Health Information Technology systems and devices.

Providers Practicing to the Full Scope of their License

The Academy also recognizes that when Advanced Practice Registered Nurses are able to provide services to their full scope of practice, they increase access to cost-effective, comprehensive, and high quality care in a patient and community-centered environment. Therefore, before we build on incentives for any one group of health care providers, we should remove artificial barriers so that all health professionals – especially nurses – can practice within the full scope of their license. This will require an honest debate over which health care providers can and should deliver a broad array of services for various health conditions, which will hopefully result in a system that delivers better patient-centered care.

Interdisciplinary Teams

Increasing the number of providers and alleviating some of the demands are crucial first steps in addressing the workforce shortage. But we also must look at innovative ways to use the workforce more efficiently to provide better quality care. For example, there is growing evidence that team-based care, particularly multi-disciplinary teams, can effectively improve care and lower costs for chronically ill patients.[viii,ix,x,xi] Care for the chronically ill accounts for a disproportionate share of health care spending, making this a compelling population to target to help rein in national health care expenditures. In the Medicare program alone, half of all Medicare beneficiaries had been treated for five or more conditions and accounted for 75 percent of all Medicare spending.[xii] Hospital admissions and readmissions are the key drivers of high costs of care for this population,[xiii] and many of these admissions could be prevented with improved care in the ambulatory setting and better transitions from the hospital to home.[xiv,xv ,xvi]

Although team-based care offers great potential to improve quality of care and control costs for the chronically ill, it remains rare in practice. Payment systems do not adequately support the growth of team-based care. The AAN encourages Members of Congress to look at alternative approaches to care that allow individual clinicians such as physicians, nurses, social workers, nutritionists, and others to better organize the way health care services are delivered to achieve a more efficient and convenient health care system that delivers better outcomes for patients.

Conclusion

Again, I appreciate the opportunity to present the American Academy of Nursing's views on the health care workforce. The AAN is committed to working with all of you to ensure that we transform our health care system to one that delivers effective, convenient, personalized, and relevant care to patients, families, and communities. We understand that an essential initial step is to ensure we have enough health care providers to meet the demands of our diverse population. As Congress moves forward in addressing this serious issue, I encourage all of you to reach out to all the health care professions for their ideas on how to improve the health care system and care delivery. It is important to remember that no single group of professionals or politicians will solve these complex problems alone. Any discussion about health reform and the workforce without significant input from nursing leaders fails to draw on critical insight and innovative solutions from the nation's largest health care profession – and will ultimately be unsuccessful.

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Testimony of

American Academy of Physician Assistants

On

Workforce Issues in Health Care Reform:
Assessing the Present and Preparing for the Future

Submitted for the March 12, 2009 Hearing Record

Senate Committee on Finance

Summary of the American Academy of Physician Assistants' Testimony

Physician assistants (PAs) are an important part of the solution to the health care workforce shortage.

- The physician assistant profession was created barely 40 years ago in response to health care workforce shortage issues very similar to those being forecast today.
- PAs represent one of the fastest growing health professions. Today, there are nearly 75,000 PAs in clinical practice; 40 percent (30,000) practice primary care medicine.
- The number of PAs practicing as part of a physician-PA team will soon exceed 100,000. We believe this to be a strong indication of the utility and attractiveness of such a young profession.
- The educational pipeline for physician assistants is shorter than for physicians. Graduate PAs can be in the field in less than three years.
- Accredited PA programs in universities and academic health centers produce close to 6000 graduates a year.
- Studies show that in a primary care setting, PAs can execute at least 80 percent of the responsibilities of a physician with no diminution of quality and equivalent patient care satisfaction.
- By virtue of PA education in primary care and the ability of PAs to work in all medical and surgical specialties, PAs expand access to care in medically underserved rural and urban communities.
- By design, the physician assistant profession extends the reach of medicine and the promise of health to the most remote and in-need communities of our nation.

In addition to the need to produce more primary care physicians, it is critical that Congress support expansion of PA programs as they develop strategies for addressing health care workforce challenges.

- Funds should be made available to PA educational programs to increase the PA workforce, which in turn, will extend physicians' ability to provide.
- The Title VII, Public Health Service Act's, Health Professions Program is successful in training health care professionals for practice in medically underserved communities. Funding for PA educational programs is woefully underfunded and must be increased.
- The single largest barrier to PA educational programs educating more PAs is a lack of clinical training sites. Attention must be directed to investing in the number of these sites, including loan

repayment for preceptors in primary care medical practices and/or the increased use of VA facilities as clinical training sites for PA educational programs.
- Funds must be made available to increase the number of faculty at PA educational programs. Eligible PA students are being turned away because of the lack of faculty and clinical sites.
- Faculty loan repayment, including funding to attract faculty from diverse backgrounds, is also critical for PA educational programs.
- Federally supported student loans and increased opportunities through the National Health Service Corps are key to attracting PA students and clinicians to primary care.
- Graduate medical education funding should be used to support the educational preparation of physician assistants in hospitals and outpatient, community-based settings.

Physician assistants are key to health care reform. However, to be fully utilized, current barriers to care that exist in federal law must be addressed.

- The Medicare statute must be amended to allow PAs to order home health, hospice, and skilled nursing facility care, as welled to provide hospice care for Medicare beneficiaries.
- Medicaid should be updated to require states to reimburse all covered services provided by PAs under the fee-for-service plan. Additionally, Medicaid should recognize PAs as primary care case managers through managed care plans.
- The Federal Employee Compensation Act needs to be updated to allow PAs to diagnose and treat federal employees who are injured on the job.

Physician assistants must be fully integrated into new models of care, such as the primary care medical home and chronic care coordination.

- Their orientation to team practice, their broad medical education, and orientation toward primary care make PAs a perfect addition to the management of patients in a primary care medical home, offering continuity, comprehensiveness, and coordination of care. In many rural communities, a PA is the only health professional available and is the primary care medical home.
- Likewise, PAs provide medical care to elderly populations and manage chronic medical conditions. PAs must be recognized in chronic care medical management and must be allowed to develop treatment plans for patients with multiple chronic care needs.

- Unless PAs are fully integrated into the primary care medical home and chronic care management models, health care reform is likely to pose new, unintended barriers to care for patients treated by PAs.

Additionally, the AAPA believes that a long range solution to the Medicare physician payment system must be part of health care reform.

On behalf of the nearly 75,000 clinically practicing physician assistants (PAs) represented by the American Academy of Physician Assistants (AAPA), thank you for the opportunity to submit written testimony for the hearing record of the Finance Committee Hearing, *Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future.*

AAPA Principles for Health Care Reform

AAPA has a longstanding history of support for universal health care coverage. Among the Academy's key principles for health care reform --

- The AAPA believes the primary goal of a comprehensive health care system reform is to ensure access to quality, affordable, and cost efficient health care for all residents of the United States.
- The AAPA supports a health care system that will provide basic services to all residents.
- The AAPA supports health care that is delivered by qualified providers in physician-directed teams.
- The AAPA supports reform that confronts the limits of care and resources.
- The AAPA believes that fair and comprehensive reform of the medical liability insurance system is needed.
- The AAPA endorses system reform that enhances the relationship between the patient and the clinician.

Physician Assistants

Physician assistants are licensed health professionals, or in the case of those employed by the federal government, credentialed health professionals, who —

- practice medicine as a team with their supervising physicians
- exercise autonomy in medical decision making
- provide a comprehensive range of diagnostic and therapeutic services, including performing physical exams, taking patient histories, ordering and interpreting
  Laboratory tests, diagnosing and treating illnesses, assisting in surgery, writing prescriptions, and providing patient education and counseling
- may also work in educational, research, and administrative settings.

PAs always work with physicians. However, this does not mean that the physician is necessarily on site, nor does it suggest that PAs do not make

autonomous medical decisions. PAs employed by the State Department, for example, may work with a physician who is a continent away and available for consultation by telecommunication.

PAs are located in almost all health care settings and in every medical and surgical specialty. Nineteen percent of all PAs practice in non-metropolitan areas where they may be the only full-time providers of care (state laws stipulate the conditions for remote supervision by a physician). Approximately 41 percent of PAs work in urban and inner city areas. Approximately 44 percent of PAs are in primary care. Nearly one-quarter of clinically practicing PAs practice in surgical specialties. Roughly 80 percent of PAs practice in outpatient settings.

PAs are covered providers within Medicare, Medicaid, Tri-Care, and most private insurance plans. Additionally, PAs are employed by the federal government to provide medical care, including the Department of Defense, the Department of Veterans Affairs, the Public and Indian Health Services, the State Department, and the Peace Corps.

AAPA estimates that in 2008, over 257 patient visits were made to PAs and approximately 332 million medications were written by PAs.

Overview of Physician Assistant Education

Physician assistant programs provide students with a primary care education that prepares them to practice medicine with physician supervision. PA programs are located at schools of medicine or health sciences, universities, teaching hospitals, and the Armed Services. All PA educational programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant, an organization composed of representatives from national physician groups and PAs.

The average PA program is 26 months and is characterized by a rigorous, competency-based curriculum with both didactic and clinical components. The first phase of the program consists of intensive classroom and laboratory study, providing students with an in-depth understanding of the medical sciences. More than 400 hours in classroom and laboratory instruction are devoted to the basic sciences, with over 70 hours in pharmacology, more than 149 hours in behavioral sciences, and more than 535 hours of clinical medicine.

The second year of PA education consists of clinical rotations. On average, students devote more than 2,000 hours or 50-55 weeks to clinical education, divided between primary care medicine and various specialties, including family medicine, internal medicine, pediatrics, obstetrics and gynecology, surgery and surgical specialties, internal medicine

subspecialties, emergency medicine, and psychiatry. During clinical rotations, PA students work directly under the supervision of physician preceptors, participating in the full range of patient care activities, including patient assessment and diagnosis, development of treatment plans, patient education, and counseling.

After graduation from an accredited PA program, the physician assistant must pass a national certifying examination jointly developed by the National Board of Medical Examiners and the independent National Commission on Certification of Physician Assistants. To maintain certification, PAs must log 100 continuing medical education credits over a two-year cycle and reregister every two years. Also to maintain certification, PAs must take a recertification exam every six years.

The majority of PA educational programs offer master's degrees, and the overwhelming majority of recent graduates hold a master's degree.

Title VII Support of PA Education Programs

The title VII support for PA educational programs is the only federal funding available, on a competitive application basis, to PA programs. Unfortunately, the level of support has eroded from the highest level of $7.5 million in FY 2005 to $2.6 million in FY 2007.

Targeted federal support for PA educational programs is authorized through section 747 of the Public Health Service Act. The funds are used to encourage PA students, upon graduation, to practice in underserved communities. These goals are accomplished by funding PA education programs that have a demonstrated track record of: placing PA students in health professional shortage areas; exposing PA students to medically underserved communities during the clinical rotation portion of their training; and recruiting and retaining students who are indigenous to communities with unmet health care needs.

The Title VII program works.

- A review of PA graduates from 1990 – 2006 demonstrates that PAs who have graduated from PA educational programs supported by Title VII are 59% more likely to be from underrepresented minority populations and 46% more likely to work in a rural health clinic than graduates of programs that were not supported by Title VII.
- A study by the UCSF Center for California Health Workforce Studies found a strong association between physician assistants exposed to Title VII during their PA educational preparation and those who ever reported working in a federally qualified health center or other community health center.

The PA programs' success in recruiting underrepresented minority and disadvantaged students is linked to their ability to creatively use Title VII funds to enhance existing educational programs. Without Title VII funding, many special PA training initiatives would be eliminated. Institutional budgets and student tuition fees are not sufficient to meet the special, unmet needs of medically underserved areas or disadvantaged students. The need is very real, and Title VII is critical in leveraging innovations in PA training.

Need for Increased Targeted Support for PA Education

Federal support must be directed to PA educational programs to stimulate growth in the PA profession to meet the needs of universal health care coverage. Targeted funding should be directed to –

- The use of Title VII funds for recruitment and loan repayment for faculty in PA educational programs.
- Incentives to increase clinical training sites for PA education.
- Federally backed loans and loan repayment programs for PA students.

Eliminating Barriers to Care in Federal Law

Eliminating current barriers to medical care provided by PAs that exist in the Medicare, Medicaid, and the Federal Employees Compensation Act (FECA) laws would do much to expand access to needed medical care, particularly for patients living in rural and other medically underserved areas.

- AAPA believes that the intent of the 1997 Balanced Budget Act was to cover all physician services provided by PAs at a uniform rate. However, PAs are still not allowed to order home health, hospice, skilled nursing facility care, or provide the hospice benefit for Medicare beneficiaries. At best, this creates a misuse of the patient's physician's, and PA's time to find a physician signature for an order or form. At worst, it causes delayed access to care and inappropriate more costly utilization of care, such as longer stays in hospitals. For patients at end-of-life, it creates an unconscionable disruption of care.
- Although most States recognize services provided by PAs in their Medicaid Programs, it is not required by law. Consequently, some State Medicaid Directors pick and choose which services provided by PAs they will cover. Others impose coverage limitations not required by State law, such as direct supervision by a physician.

- Although nearly all State workers' compensation programs recognize the ability of PAs to diagnose and treat State employees who are injured on the job, the federal program does not. As a result, federal workers who are injured on the job may be rerouted to emergency rooms for workers' compensation-related care, rather than to go to a practice where the PA is the only available health care professional.

The Medicare, Medicaid, and FECA statutes create federal barriers to care that do not exist in State law. The barriers need to be eliminated to promote increases access to the quality, affordable medical care provided by PAs.

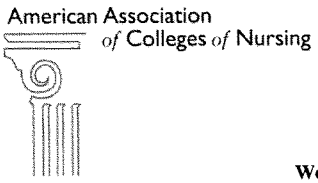
Integrate PAs into New Models of Care

AAPA is concerned that health care reform could create new, unintended barriers to care provided by PAs unless special attention is devoted to ensuring that PAs are fully integrated into the medical home and chronic care coordination models of care.

PAs always work with physicians, but in many rural and other underserved areas, the PA is the face of health care. The PA is the medical professional who develops the care plan and coordinates the care. PAs also own and/or provide care in rural health clinics and others settings that may serve as the patient's primary medical home. It is critical that the medical home and chronic care management models of care recognize the ability of PAs to develop and manage medical care plans, without unnecessary limitations. And, it is important that PA-run clinics and practices be eligible for reimbursement from the new models of care.

Medicare Physician Payment Reform

It is critically important that health care reform legislation contains a long term solution to Medicare's physician payment system. The current system is simply not sustainable, nor is it fair to the health care professionals who provide medical care for Medicare beneficiaries.



Senate Finance Committee Hearing

Workforce Issues in Health Care Reform:
Assessing the Present and Preparing for the Future

March 12, 2009

Statement for the Record
Presented on Behalf of the American Association of Colleges of Nursing

The American Association of Colleges of Nursing (AACN) is the national voice of baccalaureate and graduate nursing education, representing over 640 schools of nursing that educate approximately 270,000 students and employ over 13,000 faculty members. Together, these institutions produce about half of our nation's Registered Nurses (RNs) and all of the nurse faculty and researchers. AACN commends Chairman Baucus and Ranking Member Grassley as well as the Senate Finance Committee for holding a hearing on the healthcare workforce shortages. AACN agrees wholeheartedly with Chairman Baucus' opening statement in which he noted, "For health reform to succeed, we need a strong healthcare workforce." This message is of dire importance as the Administration and Congress look to increase access for all patients. **Without a strong health professions workforce, broadening coverage will simply exacerbate the true problem: access to providers.**

AACN firmly believes that in order for health reform to occur, policy discussions must be done collaboratively with all sectors of the healthcare community. No single provider group or stakeholder can solve the healthcare crisis. RNs are involved in every aspect of health care from practicing in the hospital setting to administering health information technology systems to conducting research on disease prevention. Expert nursing services are provided in long-term care settings such as nursing homes, in our nation's schools and workplaces, and in community health departments only to name a few. Advanced Practice Registered Nurses (APRNs) who have received a master's or doctoral degree, are educated to provide exceptional primary care services as well as specialized services. Above all, nurses are educated to provide holistic and patient-centered care that addresses the needs of individuals, their families, and the community. **For nurses to continue their work, health care must be redefined as a patient-centered system with the opportunity to access all healthcare providers across all settings.**

As a stakeholder in healthcare reform, AACN offers the following statement for the record regarding the March 12, 2009 hearing of the Senate Finance Committee on *Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future.*

Expanding the Nursing Workforce: An Essential Component to Healthcare Reform
The basic premises of health care- quality and safety- are compromised in our current system. One of the major factors impacting compromised quality and safety is the shortage of RNs. In March 2007, the Agency for Healthcare Research and Quality released a comprehensive report on *Nursing Staffing and Quality of Patient Care.* Through this meta-analysis, the

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authors found that the shortage of registered nurses, in combination with an increased workload, poses a threat to the quality of care. Increases in registered nurse staffing was associated with reductions in hospital-related mortality and failure-to-rescue rates as well as reduced lengths of stays.

RNs are the backbone of the healthcare system representing the largest group of healthcare professionals with 2.9 million nurses in the United States.[1] Yet, the ongoing shortage of nurses is contributing to the breakdown of the nation's ability to ensure access to safe, quality, and affordable health care. Unfortunately, the demand for RNs continues to outpace the supply of new nurses entering the healthcare system each year.

Nursing Shortage

On March 6, 2009, the U.S. Bureau of Labor Statistics (BLS) reported that the healthcare sector of the economy is continuing to grow, despite significant job losses in nearly all major industries. Hospitals, long-term care facilities, and other ambulatory care settings added 27,000 new jobs in February 2009, a month when 681,000 jobs were eliminated across the country. As the largest segment of the healthcare workforce, RNs likely will be recruited to fill many of these new positions.

While jobs within the healthcare sector continue to grow, the nursing shortage continues to place a wrench in the ability to fill well-paid nursing positions. According to Dr. Peter Buerhaus (2008), "Over the next 20 years, the average age of the RN will increase and the size of the workforce will plateau as large numbers of RNs retire. Because demand for RNs is expected to increase during this time, a large and prolonged shortage of nurses is expected to hit the US in the latter half of the next decade."[2] According to the latest projections from the U.S. Bureau of Labor Statistics, more than one million new and replacement nurses will be needed by 2016.[3] This estimate takes into consideration the overburdened healthcare system, the growing complexity of nursing care, and the demand for nurses as the baby boomer population ages.

The current supply and demand for nurses demonstrates two distinct dilemmas. First, due to the present and looming demand for advanced health care by American consumers, the supply is not growing at a pace that will adequately meet long-term needs. This is further complicated by the number of nurses who will retire or leave the profession in the near future, ultimately reducing the supply of nurses.

Second, increasing the supply of nurses nationwide is hindered by an ongoing shortage of nurse faculty. While there is an enormous demand from individuals who wish to pursue a nursing education, thousands of qualified students are turned away each year. According to AACN's 2008-2009 annual survey on baccalaureate and graduate programs, U.S. nursing schools turned away 49,948 qualified applicants.[4] The number one reason cited in this survey was a lack of nurse faculty.[4] To address these related workforce issues, substantial efforts must be made to increase the number of faculty who will educate new nurses.

However, the perception that "just more nurses" are needed is flawed. The greatest need is for nurses prepared at the baccalaureate and graduate levels.

Demand for a Highly Educated Nursing Workforce

RNs provide services along the entire spectrum, including lifesaving interventions and preventative care. Patients who enter the nation's hospitals and healthcare facilities typically suffer from multiple co-morbidities such as obesity, diabetes, and hypertension. More acute patients have fundamentally changed the intensity of nursing care. The changes in how health care is delivered have created demand for nurses who can function with more independence in clinical decision-making and case management, perform the traditional role of clinical caregiver, and teach patients how to comply with treatment regimens and maintain good health. Knowing that patients today are more complex and require an advanced level of specialized care, the need for nurses who are highly educated is critical. Therefore, the nursing shortage and its impact on patient care cannot be solved by simply increasing the pipeline. The workforce must be fortified with more highly-educated and well-qualified nurses, specifically nurses with a baccalaureate degree or higher.

Unlike graduates of diploma or associate-degree nursing programs, the nurse with a baccalaureate degree is prepared to practice in all healthcare settings - critical care, outpatient care, public health, and mental health. In addition to the liberal learning and global perspective gained from a four-year baccalaureate education, the curriculum includes clinical, scientific, decision-making, and humanistic skills, including preparation in community health, patient education, as well as nursing management and leadership. Such skills are essential for today's professional nurse who must make quick, sometimes life-and-death decisions; design and manage a comprehensive plan of nursing care; understand a patient's treatment, symptoms, and danger signs; supervise other nursing personnel and support staff; master advanced technology; guide patients through the maze of healthcare resources in a community; and educate patients on healthcare options and how to adopt healthy lifestyles.

The National Advisory Council on Nurse Education and Practice, policy advisors to Congress and the U.S. Secretary for Health and Human Services on nursing issues, has urged that at least two-thirds of the nurse workforce hold baccalaureate or higher degrees in nursing by 2010. Currently, only 47.2% of nurses hold degrees at the baccalaureate level and above.[1] Organizations such as AACN, the American Nurses Association, and the American Organization of Nurse Executives are calling for all professional registered nurses to be educated at the baccalaureate level in an effort to adequately prepare nurses for their challenging and complex roles.

Moreover, nurses with baccalaureate degrees are also four times more likely to pursue graduate degrees in nursing than graduates of other entry-level RN programs.[1] Increasing the number of baccalaureate prepared nurses in the workforce will also help to address the nurse faculty shortage.

The Nurse Faculty Shortage

The nursing educational system in the United States is significantly strained. Despite marked increases in nursing school enrollment and graduations, capacity barriers have prohibited schools from accepting more students. Last year AACN reported that 49,948 qualified applicants were turned away from baccalaureate and graduate nursing programs. The top reason cited by schools of nursing for not increasing enrollment was a lack of faculty. According to a *Special Survey on Vacant Faculty Positions* released by AACN in July 2008, data show a national nurse faculty vacancy rate of 7.6%.[5] Most of the vacancies (88.1%)

were faculty positions requiring or preferring a doctoral degree.[5] Yet, enrollment in research-focused doctoral nursing programs was up by only 1% from the 2007-2008 academic year.[5] More concerning, only about one in ten of our nation's registered nurses hold master's or doctoral degree, which are required to teach. If action is not taken to educate the next generation of nurses and nurse faculty, health care in America will continue to suffer.

Comments and Recommendations

Provider Parity

AACN was glad to hear that many members of the Senate Finance Committee recognized the integral role nurses play in improving patient care. In his opening statement Chairman Baucus noted that "we cannot expect to improve patient health, if we are not training providers in key areas such as care coordination." Care coordination is an essential component of all baccalaureate and graduate nursing education. It is AACN's hope that those invested in healthcare reform understand that nurses posses this critical skill. Congress and the Administration must reexamine the way healthcare providers are used in the current system to ensure high quality care.

- **AACN recommends that the new healthcare model uses the right provider at the right time for the right position.** A physician-centric model cannot sustain the healthcare needs of the nation. Each member of the healthcare provider team is critical. AACN firmly believes that all healthcare providers contribute to the health and safety of America's patients. Therefore, we are concerned that four physicians were selected to speak on behalf of the entire healthcare workforce.

Nursing Education Expansion

A robust nursing workforce is needed before quality, access, and affordability of health care can be addressed. However, as Dr. Steve Wartman stated in his testimony,

> *"The challenges facing institutions responsible for health workforce education and training include constrained resources, adverse impact of elevation of minimum credentials, persistent faculty shortages, the consequences of increased entrepreneurialism and privatization in health workforce education, and the unrealized promise of mainstreaming inter-professional education in practice."*

The workforce hearing did focus on healthcare workforce education. Yet, the discussion from both Committee Members and the witnesses revolved around physician education through federal support such as Graduate Medical Education and the Title VII Health Professions Programs. AACN was disappointed that the Title VIII Nursing Workforce Development programs were not fully highlighted as an effective federal strategy in funding nursing education. While these programs are not under the jurisdiction of the Senate Finance Committee, they are the largest source of federal funding for nursing education, retention, and recruitment. Since four physicians testified, little attention was paid to federal solutions for nursing education.

However, AACN applauds the questions offered by Chairman Baucus regarding the nursing shortage as well as the problems within our educational system such as the severe shortage of nurse faculty. However, AACN firmly believes that the answer provided by the panelist was not sufficient nor did it offer the committee proper insight in to the unique challenges the nursing educational system faces.

- **AACN recommends that experts in nursing education be asked to testify during the ongoing discussions regarding healthcare workforce expansion.** Just as physicians are the *only* experts in the education of their discipline, nurses are the *only* experts in the education of our discipline. One group of healthcare professionals should not speak for another.

The Advanced Practice Registered Nurse's (APRN) Role in Primary Care
AACN commends and agrees with the testimony from both Drs. Fitzhugh Mullan and David Goodman which recognizes that ARPNs are primary care providers. As Dr. Mullan reported, "About 25% of all nurse practitioners (NPs) are located in non-metropolitan areas and an estimated 85% of them practice in primary care." AACN supports Dr. Mullan's message when he stated,

> *"to the degree that the clinical care workforce as a whole needs more providers to address the changing needs of the population, a strong strategy of support for nurse practitioners and physician assistants should be adopted. The increased use of PAs [physician assistants] and NPs should not be limited to the primary care sector. Both professions have demonstrated excellent functionality as team members in all aspects of medical practice from the pediatric office to the operating room. Nurse practitioners and physician assistants are trained more quickly, at less expense than physicians, cost less in practice... Moreover they represent a highly flexible workforce- an important asset generally lacking in the physician workforce.*

It is extremely encouraging to hear physicians recognize NPs as qualified independent providers who can offer cost-effective care and can address the shortage of primary care providers.

- **AACN recommends that as the Administration and Congress work to address the shortage of primary care providers, NPs are used to their full scope of practice.**

- **AACN recommends that NPs are fully recognized and utilized as healthcare providers in leading coordinated care models such as Medical/Health Homes.** Nurse practitioners are fully qualified to provide primary care and given the shortage of primary care physicians, NPs should be use to fill these roles.

Final Comments
AACN is pleased that the Senate Finance Committee held this important hearing. However, the vast majority of the hearing was focused solely on the issues related to physician education and the role of physicians in our healthcare system. While other providers were mentioned, an in-depth discussion of their contribution to the healthcare team was not adequately highlighted.

- **AACN recommends that the Senate Finance Committee hold a series of hearings on the healthcare workforce in which a variety of provider experts are called to testify.**

Based on the discussion during this hearing, it was clear that an entire hearing could be held on primary care providers. This hearing should include a physician, a nurse practitioner, and a physician assistant expert. Additionally, as the largest group of healthcare providers, and

the only profession with a clearly documented shortage, a separate hearing should be held with experts from nursing academia and practice (employer and employee). AACN would be more than willing to provide names of potential witnesses for this hearing. It will be difficult to assess the problems within the healthcare workforce if other perspectives are not heard. Again, AACN commends the Senate Finance Committee for holding this hearing and recommends that further action be taken to fully understand the challenges facing the education, recruitment, and retention of the entire healthcare workforce.

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[1] Health Resources and Services Administration (2004). *National Sample Survey of Registered Nurses.* Accessed February 19, 2008 from http://bhpr.hrsa.gov/healthworkforce/reports/rnpopulation/preliminaryfindings.htm

[2] Buerhaus, P. (2008). Current and Future State of the US Nursing Workforce. *Journal of the American Medical Association,* 300(8), 887-888.

[3] Bureau of Labor and Statistics, (2007). *Occupational projections to 2016.* Accessed July 29, 2008 from www.bls.gov/opub/mlr/2007/11/art5full.pdf

[4] American Association of Colleges of Nursing. (2009). *Enrollment and Gradations in Baccalaureate and Graduate Programs in Nursing..* Washington, DC.

[5] American Association of Colleges of Nursing. (2008). *Special Survey on Vacant Faculty Positions.* Washington, DC.

AMERICAN ASSOCIATION OF OCCUPATIONAL HEALTH NURSES, INC.

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March 20, 2009

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Re: Sstatements for the Record: March 12, 2009 Hearing on Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

As the nation begins to address the problems and shortcomings of our health care system through *Health Reform 2009*, it is important to first understand the issues–rising costs, increased numbers of uninsured and lack of access to quality health care. The convergence of these factors adversely affects not only the health of Americans and their access to affordable, quality health care, but also the ability of the country to compete successfully in a global marketplace. Effective strategy demands a shift from the old health care "disease" model to a "healthy culture/healthy society" paradigm.

Although the U.S. has been touted to have the best health care in the world, a World Health Organization (WHO) report ranked the U.S. 37th out of 190 countries. In 2007, the U.S. spent $2.3 trillion, 16 percent of the gross domestic product (GDP) on health care. The cost is expected to exceed $4.3 trillion, 20 percent of the GDP, by 2017. The U.S. is the only industrialized country where 85 percent of the privately insured population is covered through work related health benefits. As a result, health coverage varies with employment situation, (e.g. company contributions, health care options and costs, individual preference, age, employment status, etc.) resulting in a rising number of uninsured and underinsured Americans (25 million). Currently, the costs for the uninsured/underinsured are largely borne by the insured through higher provider charges and higher premiums.

The impact of the aging workforce on the economy and on business is being felt domestically and globally. Currently, there are seven working age people for every older (retired) person; by 2030 there will be only three workers for every older person. The increasing number of older Americans has far-reaching implications for the national health care system. Data indicates that 75 percent of the nation's health care expenditures are related to treatment for preventable conditions related to lifestyle behaviors such as smoking, lack of exercise, poor nutrition, obesity, alcohol and/or drug abuse, and chronic diseases such as heart disease, cancer, and diabetes (CDC, 2008). Chronic diseases disproportionately affect older adults (125 million Americans) and are associated with disability, diminished quality of life, increased costs for

health care and death (1.7 million). Of this 125 million, 37.2 million or 12.4 percent are age 65 or older; by 2030 this number will more than double to approximately 71 million.

Controlling health care cost is crucial to getting the nation's economy back on track. Therefore, the key to the success of *Health Reform* 2009 is to focus on prevention, especially since 80 percent of health care dollars are spent on preventable conditions. The American Association of Occupational Health Nurses, Inc. (AAOHN) supports a health continuum, which includes prevention, health promotion and wellness management strategies. Health care is a complex multidimensional system. AAOHN recommends a multi-pronged approach including:

- financial incentives for payers, purchasers and users;
- application or implementation of business strategies, such as competitive bidding, demonstrated return on investment, etc.;
- elimination of duplication and waste;
- integration of technology, (e.g. electronic health records); and
- holding individuals accountable for their health.

AAOHN is a national association that represents the specialty practice of occupational and environmental health nursing [registered nurses (RN) or advanced practice registered nurses (APRN)], which is focused on promotion and restoration of health, prevention of illness and injury and protection from work related and environmental hazards for workers and worker populations in all types of workplaces, domestic and international (e.g. hospitals, private and public industry, federal, state and local governments, etc.). In this unique position, the occupational health nurse (OHN) serves as the "health care gatekeeper" for workers and worker populations. Since there are approximately 134.5 million working adults who spend more than one-third of their day at work, the workplace provides an ideal environment in which to have the greatest impact on achieving optimal health for workers and worker populations, and for achieving a "healthy" bottom line for the nation.

Thank you for your consideration. We look forward to the opportunity for collaboration on developing solutions for these pivotal health-related workforce issues.

Sincerely,

Richard J. Kowalski, RN, MSA, COHN-S
President

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March 12, 2009

The Honorable Max Baucus
Chairman, Finance Committee
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Dear Chairman Baucus:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), I would like to thank you for holding today's hearing entitled "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future." We commend you for including the physician workforce shortage in discussions on large scale health care reform, and we strongly believe that a sufficient primary care physician workforce is an integral part of expanding access to health care services to all Americans. We appreciate the opportunity to provide our perspective to the ongoing workforce debate.

As you know, our country faces a serious shortage of primary care physicians, and steps must be taken to increase the physician supply over the next decade. Simply increasing the overall number of practicing physicians may not solve our workforce shortages. We must focus on training primary care physicians, encouraging physicians to open practices in underserved areas, and reforming the way physicians are paid under Medicare which currently has a direct negative impact on choice of training in family practice.

Over the next decade, it is estimated that our population will grow by 25 million people and the number of Medicare beneficiaries is expected to double within the next 20 years. A shortage in the number of primary care physicians could not come at a worse time. By 2030, over 20 percent of the population will be comprised of Medicare beneficiaries, who own average, us significantly more health resources than those patients under the age of 65. We must work to ensure an adequate primary care physician workforce is available to meet future demand.

In recent years, the availability of primary care physicians has deteriorated significantly leaving over 50 million Americans currently living in health profession shortage areas. Additionally, an estimated 50 million people lack adequate access to primary care physicians. Our current workforce problems stem from a number of converging factors including deficiencies in the graduate medical education payment system, current physician reimbursement policies, regulatory burdens, and other issues.

With respect to physician workforce, the ACOFP has acknowledged three priorities for policymakers:

- Increase Training Capacity
- Reinvigorate the Practice of Primary Care Medicine
- Improve the Health Care Marketplace

INCREASE TRAINING CAPACITY

As the debate on the future needs of the physician workforce goes on, the ACOFP recognizes that it is essential we begin education and training a larger supply of primary care physicians. Current GME policies have led to the over-specialization of the physician workforce as well as geographic disparities in access to care. Additionally, GME is subsidized by the Medicare program without reference to ensuring the appropriate distribution of physicians by geographic location or specialty. These, as well as other policy issues can be corrected by reforming the financing of GME.

Due to the fact that residency programs tend to be centered around larger metropolitan areas, many regions across the country remain underserved. According to data included in the Fiscal Year 2009 Inpatient Perspective Payment Rule, there are 1,047 hospitals with teaching programs. This represents approximately 30 percent of all non-federal hospitals in the United States. Upon further review you find that 595 (57 percent) of these hospitals are in ten states. Data shows that most physicians tend to start their practice within 100 miles of where they train, we believe it is necessary to provide significantly more training opportunities in rural and non urban communities.

Reform of the BBA 97 Cap on FTE Residency Positions

The Balanced Budget Act of 1997 (BBA) created the current cap on full-time equivalent (FTE) residency slots, with the intent of addressing an apparent oversupply of physicians in the 1990's. Rather, the cap created an arbitrary limit on training capacity, thus our current workforce shortages. Other BBA provisions, including the 3-year rolling average, have had a negative effect on community-based and rural programs – leading to the decline in number of primary care physicians in these areas. A decade after its enactment, evidence shows that the policies set forth in the BBA have had a negative impact upon graduate medical education.

The ACOFP does not support proposals to increase training capacity in one community or state by decreasing it in others. We urge Congress to consider eliminating the cap on funded FTE's as established in the BBA. Although, the ACOFP does not believe that every hospital in the country should be allowed to increase their overall cap independent of careful review, we do believe that the current limitations on funded GME positions should be overhauled for a more thoughtful policy. We believe that teaching programs in underserved communities and emerging population areas be allowed to increase their overall training capacity to better meet workforce demands. Moreover, the ACOFP strongly believes that increases in funded FTE's should emphasize primary care and those medical specialties most in need in designated communities.

Increase the Number of Training Facilities

Teaching hospitals provide a substantial percentage of safety net services to uninsured and underinsured populations while concurrently providing for the training of health professionals. However, the pipeline for educating physicians often does not incorporate ambulatory training venues that more closely resemble "real life" practice environments. For instance, community health centers have expanded to serve 16 million individuals in over 1,000 sites, yet they face high vacancy rates for primary care physicians.

As mentioned previously, there are over 2,500 hospitals in the United States that do not have teaching programs currently. Many of these are smaller community, suburban, and rural hospitals that often lack the necessary infrastructure and capital to develop a new teaching program. Currently, there is a 12

month to 18 month lag between hospitals beginning a teaching program and receiving direct and indirect graduate medical education payments from CMS. The ACOFP believes that providing bridge loans to these facilities to assist with expenses incurred during the program's inception and its eligibility for GME funding is a reasonable means of encouraging the development of new training programs.

This proposal is clearly laid out in the "The Physician Workforce Enhancement Act of 2009" (H.R. 914). This legislation directs the Secretary of Health and Human Services (HHS) to establish an interest-free loan program whereby hospitals committed to starting new osteopathic or allopathic residency training programs in one of eight medical specialties or a combination of these specialties (family medicine, internal medicine, emergency medicine, obstetrics/gynecology, general surgery, pediatrics, preventive medicine, or mental health) could secure start-up funding to offset the initial costs of starting such programs. Hospitals are required to repay the amount in full over a defined period of time, thus reducing the long-term financial impact upon the federal government.

Finally, given that a substantial portion of family medicine, general internal medicine, and pediatric training occurs in non-hospital, ambulatory settings, the ACOFP urges the Committee to investigate changes in law that would allow non-hospital sites and/or facilities to receive direct and indirect GME payments. We believe a demonstration project may be a reasonable means of investigating this proposal. At a minimum, we believe that it is reasonable to investigate methodologies whereby the direct GME money would follow the resident to such non-hospital based settings.

Reform and Reduce Regulatory Burdens

Over the past 10 years a complex and convoluted set of regulations have hindered graduate medical education, often resulting in loss of training capacity. Many of these issues center around the interpretation of legislative language by the Centers for Medicare and Medicaid Services (CMS) and the subsequent regulations promulgated. To encourage the preparation of a physician workforce equipped to meet the health care needs of the nation, the ACOFP believes that the current prohibition against counting resident time spent in education and research activities should be eliminated in all training settings.

Existing criteria for Medicare teaching hospital affiliation agreements are narrow and unnecessarily rigid. To encourage collaborative activity and facilitate high quality training, the ACOFP believes that these criteria should be expanded to provide additional bases for affiliation and allow for greater flexibility in developing and executing agreements. For example, hospitals that are part of established educational consortia should be allowed to enter into affiliation agreements at any time and aggregate their FTE resident caps despite current geographical limitations.

With respect to payments, we believe it is necessary to maintain the IME adjustment at the current 5.5 percent level and to raise direct GME payments for all teaching hospitals to 100 percent of the regionally-adjusted national average. We also believe that CMS should be prohibited permanently from eliminating the federal match for state support of GME under the Medicaid program and permanently barred from decreasing or eliminating the IME adjustment for capital costs.

These reforms to the graduate medical education system are an essential component of the development of a health care workforce equipped to meet the current and future demands for primary care and other underrepresented physician specialties. We strongly encourage the Committee to recommend that CMS make these changes administratively. If administrative resolution is not possible, we urge the Committee to consider implementing these recommended changes.

REINVIGORATE THE PRACTICE OF PRIMARY CARE

At least 56 million Americans, almost one in five of the population, are now "medically disenfranchised"—having inadequate access to primary care physicians because of shortages in their area—according to "Access Denied," a county-by-county study by the National Association of Community Health Centers and the Robert Graham Center, a research group that focuses on primary

care. Among Medicare beneficiaries, about 3 percent—more than 1.3 million people—have difficulty finding a new primary care physician, a government survey found in 2007.

Additionally, a November 2008 white paper by the American College of Physicians said the number of U.S. medical graduates entering residencies in family medicine and internal medicine has decreased by half in the last decade. A confluence of factors have contributed to this decline as graduates seek out higher-paying specialties over the longer hours and lower reimbursements for services predominantly provided by primary care physicians. The ACOFP believes that fundamental reforms to the GME system and health care market will be necessary to reverse this trend.

In addition to the health care system's failure to attract new physicians to primary care and general surgery, older physicians are frequently choosing early retirement, which is expected to exacerbate the projected shortages. A survey released in November by the Physicians' Foundation that detailed practicing physicians' frustrations found that nearly 60% would not recommend medicine as a career to young people and about half of all physician respondents said they plan to reduce their patient load or stop practicing within the next three years.

These providers cite professional dissatisfaction attributed primarily to problems in the delivery system associated with both public and private payers. Hours spent on paperwork and phone calls for prior authorizations demanded by Medicare, Medicaid, and commercial insurance companies reduce the time spent with individual patients, as does the pressure to take on as many patients as possible to stay in business. Over the past decade, physicians have seen their reimbursements fall more than 20 percent below increases in medical inflation. Today, the earnings of primary care physicians are, on average, half or a third of other specialists. Finally, the recognized need for practice improvements such as electronic prescribing and electronic health records only add to the financial stress on primary care practices.

The ACOFP believes that the system needs new strategies starting with medical school training, which currently favors overspecialization. Our recommendations for achieving the goal of increasing the supply of primary care physicians and general surgeons include forgiveness of medical school debts for graduates who go into these needed fields, restructuring the payment system for these providers and establishing "patient-centered medical homes."

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth, and adults supported by the American Osteopathic Association, American College of Physicians, American Academy of Family Physicians and the American Academy of Pediatrics. The PCMH is a health care setting that facilitates partnerships between individual patients, their personal physician, and when appropriate, the patient's family.

Coordinated, integrated care offered through the medical home should be led by a physician working closely with other health care professionals to ensure that treatment is effective and based on a physician's diagnosis. However, the projected shortage of physicians will make it difficult to provide the highest quality of care available through a medical home. In many cases, these shortages may lead to substandard care in which patients only have access to non-physician providers, who are essential members of the health care team, but are not equipped to oversee the complex medical needs of most patients—especially Medicare beneficiaries.

Finally, we believe that geographic inequalities in the physician workforce lead to geographic disparities in quality of care and that reforms are necessary to effectively implement the physician-led medical home. The ACOFP is encouraged by your commitment to this concept and looks forward to working with you on its implementation through the demonstration project and beyond.

IMPROVE THE HEALTH CARE MARKETPLACE

The current Medicare reimbursement system and private payer reimbursements based on Medicare policies offer limited financial incentives for physicians to pursue careers in primary care, particularly in

underserved areas. Numerous factors are keeping physicians from entering the primary care workforce, including declining revenues, inadequate practice support for providing necessary care, and high levels of indebtedness. As a result of the current system, medical students are more apt to pursuing specialties and subspecialties that offer higher reimbursements and more manageable practice environments.

According to Bruce Steinwald, director of health care for the U.S. Government Accountability Office, there are broad variations between Medicare payments for primary care and those for subspecialty services. In Boston, for example, Medicare pays primary care physicians $103.42 for a 25- to 30-minute visit with an established patient who has a complex medical condition as compared to $449.44 paid for a diagnostic colonoscopy, a procedural service of a similar duration.

These payment disparities are exacerbated by technological improvements that enhance the ability of certain subspecialists to provide more complex services in a shorter period of time, leading to an increase in payments and making these specialties more attractive career options for medical students. In contrast, primary care physicians rely primarily on office visits and "cognitive skills" for their income and, thus, are limited in their ability to reduce time with their patients without compromising the quality of patient care.

The ACOFP believes that the value of primary care services and their ability to control health care costs justifies a restructuring of the payment system. In a metro area with a population of 775,000, increasing the proportion of primary care physicians from 35% to 40% would yield significant savings. Studies have shown that improving access to primary care physicians would:

- Reduce emergency department utilization by 15,000 visits a year.
- Reduce surgery by about 2,500 cases a year.
- Reduce hospital admissions by 2,500 a year, saving an estimated $23 million annually.

While a permanent fix to the current Medicare payment system and the sustainable growth rate (SGR) formula is necessary to avoid drastic cuts for all physicians and resulting barriers to access, this is of particular importance to primary care physicians. The ACOFP supports a broad restructuring of the physician payment formula that promotes a steady increase in the supply of physicians across all specialties and geographic regions—with an emphasis on primary care. We believe such policies will allow us to better meet the needs of our aging population in the years to come. This would include coordinated payments and other incentives for physicians to work with health care teams to coordinate and manage care of their patients.

Again, we thank you for the chance to provide comments on this important issue. We hope our comments and recommendation provide the Committee with direction on the best way to tackle the future physician workforce shortages our nation faces. The ACOFP and our members stand ready to aid you in this endeavor.

Respectfully,

Jan D. Zieren, DO, MPH, FACOFP *dist.*
President

CC: The Honorable Charles Grassley, Ranking Member
Members, Finance Committee

United States Senate

Committee on Finance

Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

March 12, 2009, at 10:00 AM

215 Dirksen Senate Office Building

Testimony for the Hearing Record
Submitted by the American College of Rheumatology

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My name is Raphael Hirsch, MD, and I am a pediatric rheumatologist at the Children's Hospital of Pittsburgh of the University of Pittsburgh Medical Center. I serve as a board member of the American College of Rheumatology, a nonprofit professional association representing over 6,000 U.S. rheumatologists and over 1,000 rheumatology health professionals. Thank you for this opportunity to submit testimony regarding the emerging physician workforce shortage. Not only is there an increasing shortage of primary care providers – or as some would argue a maldistribution, but there is also a severe shortage of pediatric subspecialties, among which is pediatric rheumatology.

Arthritis is commonly thought of as a disease of adults and the elderly. It is not often recognized that young children get arthritis. The peak age of onset of juvenile arthritis is 2 years old. There are over 294,000 children with juvenile arthritis – an autoimmune disease that affects the bone and joints. These diseases can be severe and sometimes life-threatening. Juvenile arthritis is among the most common chronic diseases in children, and while the nation hears the call to address juvenile diabetes, I would like to highlight that there are more children living with physician-diagnosed juvenile arthritis than who have juvenile diabetes.

Children with arthritis and rheumatic conditions need special care from pediatricians who are trained through rheumatology fellowships and who are knowledgeable about the health needs of a developing child. Diagnosis and treatment of juvenile arthritis is quite different than the treatment of adults, and there is broad agreement about the need for a pediatric subspecialty in rheumatology. Provider substitutes for pediatric rheumatology are limited. Adult rheumatologists have limited experience with childhood rheumatic disease and lack training on the unique clinical and psychological needs of these pediatric patients. Additionally, many do not feel comfortable caring for these children and prefer to refer them to a pediatric rheumatologist.

Pediatric rheumatology is one of the most under-represented pediatric subspecialties in the United States. As of 2009, there are only 237 board certified pediatric rheumatologists nationwide. Astonishingly, nine states (Ark., Ind., ME, Mo., N.D., Nev., S.D., W. Va., and Wyo.) do not have a single pediatric rheumatologist (see map).

Pediatric rheumatic diseases require frequent and ongoing medical care. The shortage of pediatric rheumatologists results in long wait times for appointments, delayed diagnosis and treatment, and could lead to misdiagnosis and inappropriate treatment. Negative implications of this shortage go beyond clinical practice and access. With this shortage, there is limited time for clinical research to promote the advancement of medical discoveries and treatments.

Almost one-third of pediatric rheumatology patients are insured through Medicaid which, as you know, consistently reimburses physicians below the rates of private insurers and Medicare. As a result, pediatric rheumatology practices typically receive low reimbursement rates that limit clinical revenue and threaten their financial viability. Additionally, general pediatric residents receive little training in the diagnosis and treatment of juvenile rheumatic diseases, and so they are not adequately prepared to recognize and treat these patients.

At the request of Congress, the Department of Health and Humans Services studied the problem, and the Health Resources and Service Administration released a report in 2007 entitled, "The Pediatric Rheumatology Workforce: A Study of the Supply and Demand for Pediatric Rheumatologists." The report concluded that a 75 percent increase is needed to address the pediatric rheumatology shortage. It found that physicians attributed this shortage to low salaries, inadequate reimbursement, and poor working conditions. From these findings, the report identified a number of solutions and made recommendations to address the severe shortage in pediatric rheumatology.

The "Arthritis Prevention Control and Cure Act" (H.R. 1210) would implement two HRSA recommendations by financing fellowship training programs to increase the number of trainees and improve the financial viability of the subspecialty and create a loan repayment program to incentivize medical students to choose the field of pediatric rheumatology and agree to practice in medically underserved areas. Both recommendations represent opportunities that could help to address the severe shortage in the nation.

On behalf of the American College of Rheumatology, pediatric rheumatologists and health professionals across the country, the 294,000 children and families living with this debilitating condition, and all Americans whose health care is jeopardized from the physician workforce shortage, we urge Congress to address the pediatric subspecialty shortage—and overall shortage—to ensure Americans have access to necessary care.

Thank you for your consideration and the American College of Rheumatology urges timely congressional action in the 111th Congress.

Statement
of the
American College of Surgeons

Committee on Finance
United States Senate

Workforce Issues in Health Care Reform:
Assessing the Present and Preparing for the Future

March 12, 2009

The American College of Surgeons (ACS) commends Chairman Baucus and the Senate Committee on Finance for holding this important hearing on "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future." On behalf of its more than 74,000 members, the ACS is grateful for this opportunity to present a statement describing the surgical workforce challenges facing our nation.

While many raise concerns about the adequacy of the nation's primary care workforce, it is important to note that the primary and preventive care these physicians provide is but one component of our nation's health delivery system, and, though important, primary care is not alone among physician specialties in facing a workforce shortage to meet the needs of patients. The ACS and others have continued to warn that the nation's health care workforce challenges extend beyond primary care, and we are already seeing signs of an emerging national crisis in patient access to surgical care. In conversations with Congressional leaders and their staff members, the ACS is also increasingly hearing how a growing number of hospitals in Senators' and Representatives' home states and districts are struggling to keep and find surgeons to care for their constituents.

The Problem—An Emerging Crisis

One of the areas where the ACS has seen this crisis emerging most rapidly and most acutely is among our nation's general surgery workforce. General surgeons are specifically trained to provide comprehensive surgical care, and because their expertise is broad, they are qualified to manage a wide variety of medical conditions, ranging from oncology to gastrointestinal maladies, from endocrine surgery to ruptured aneurysms, and from hypertension to breast surgery. When patients require complex, multi-system care, a general surgeon can fill the gap between other physician specialties. In the case of major trauma, general surgeons are frequently on the frontlines of emergency care, saving lives on a daily basis. Think of it this way: If primary care is the medical home, then general surgeons are the first responders when that home is on fire.

Last April, the *Archives of Surgery* published an analysis of the trends of the general surgery workforce between 1981 and 2005. The analysis showed that the number of general surgeons as a proportion of the population declined by over 25 percent during that 25 year period. Even though the American population grew by more than 60 million people between 1981 and 2005, the number of general surgeons actually declined by 4.2 percent over the same time span. While this decline was felt in both rural and urban areas, rural areas continued to have significantly fewer general surgeons per capita than their urban counterparts. In addition, whereas in 1981, of the general surgeons practicing in rural areas, only 39 percent were between the ages of 50 and 62; now over 50 percent are between the ages of 50 and 62. Further complicating the outlook for general surgical care, the *Archives* study showed that while the number of general surgical residents has remained fairly static at approximately 1,000 per year since 1980, increasing numbers of general surgical residents are specializing. Whereas in 1992, a little over half of all general surgery residents entered a fellowship, now over 70 percent

of all general surgery residents choose to pursue a fellowship. Some may question what effect increased specialization, sub-specialization, and the development of new technologies and treatments has had on the number of general surgeons in the United States, but the *Archives* article pointed out that there is no evidence showing a relationship between these developments and the number of general surgeons.

In addition, other research shows that general surgery is not alone among surgical specialties facing significant workforce challenges at present and in the years ahead. The Dartmouth Atlas has compiled similar findings not only in general surgery but in other surgical specialties as well. Dartmouth data showed a 16.3 percent decline in the per capita number of general surgeons between 1996 and 2006 as well as per capita declines of 12 percent, 11.4 percent, and 7.1 percent in urology, ophthalmology, and orthopaedic surgery, respectively. Further, the Bureau of Health Professions projects an increase of only 3 percent among practicing surgeons between 2005 and 2020—with projected declines in thoracic surgery (-15%), urology (-9%), general surgery (-7%), plastic surgery (-6%), and ophthalmology (-1%). Over the same time period, BHP projects that the number of practicing primary care physicians will increase by 19 percent.

Implications for Patients

Needless to say, the data shows that this is not simply an anecdotal problem, but rather one with implications for all Americans in urban, suburban, rural and frontier areas. The implications of the trends are felt most significantly in local hospitals, particularly in rural and lesser populated areas. In an April 8, 2008 article in the *Billings Gazette*, Charles Rinker, MD, FACS, a general surgeon from Bozeman, Montana, highlighted how Livingston, Montana, a town that had three general surgeons in 1976 was now fortunate to still have one. He also highlighted the case of another general surgeon who after being on call every day and night over 16 years finally moved from Butte, Montana to Tacoma, Washington so he could spend more time with his family.

In the March 21, 2008 edition of the *Des Moines Register*, Thomas Foley, MD, FACS, a general surgeon in Marshalltown, Iowa, discussed similar problems facing his state, pointing out that of the 28 Iowa communities looking for general surgeons, over half had populations of 10,000 or less. In Arkansas, between 1997 and 2004, twelve counties saw a decline in the number of practicing general surgeons, and seven Arkansas counties lost all of their general surgeons. In those seven counties, five hospitals significantly reduced their services and two had to close their doors.

These trends just described are not confined to these states but illustrative of problems seen across the country. Further evidence of these trends is included in the chart attached to the end of this testimony. Regardless, the trends in these states have implications not just for their citizens, but for the millions of Americans who visit and travel through these states as well. In spite of all the technological advances in medicine, it is almost hard to fathom that whether or not someone survives or dies in an automobile accident may well be determined by the state and locale of where that

accident occurs, but that is the present situation posed by our nation's surgical workforce challenges.

Surgery's Unique Challenges

The long-term outlook for the future of surgery contributes to fewer medical students and residents choosing surgery as a specialty. Unlike many other medical specialties, there are no good substitutes or physician extenders for a well-trained general surgeon or surgical specialist when it comes to trauma care or surgical emergencies. Surgical training is vastly different from other physician training programs. Mastery in surgery requires extensive and immersive experiences that extend over a substantial period of time. Whereas non-surgical residencies can be completed in as few as three years, surgical residencies require a minimum of five years and often several more for specialties such as cardiothoracic surgery. Of course, the rigor of a surgical residency is certainly not for everyone: the work hours, sleep cycles, and intensity fit a surgical resident's personality much in the same way dermatology, internal medicine or pediatrics fits another. However, the prospects of declining payment coupled with rising practice costs; increasing liability premiums and the escalating threat of being sued; a crippled workforce leading to more on-call time, higher caseloads, and less time for patient care; and an uncertain future for the U.S. health care system understandably deter would-be surgeons from making the extra sacrifices necessary to become a surgeon.

The decrease in the numbers of general surgeons most directly impacts the 54 million Americans who are cared for in small and rural hospitals. While some of the rural workforce challenges relate directly to the difficulty in recruiting surgeons to those areas, some are also the result of a lack of workforce reinforcement. For instance, the level of on-call time is greatest in rural areas; as in the case of the Montana surgeon, some general surgeons are forced to take call 24 hours a day, 7 days a week. Needless to say, after spending several intensive years in residency, such a requirement may not, understandably, be an attractive one for a surgeon who has likely already sacrificed several years of family time during training. In addition, older surgeons in rural areas know that retirement or a less stringent workload may be further off than planned. Surgeons in rural areas also have a lower day-to-day volume of the types of procedures they are expected to perform at any given moment, making them less confident about the quality of care they will be able to provide and adding to liability concerns. For those who stay in rural areas, these issues are of great worry, and many surgeons are choosing to leave rural areas for the relative professional security of a more populated place to practice.

Solutions—Preserving and Improving Access to Surgical Care

The ACS has developed several proposed measures and would be open to other solutions that improve patient access to surgical care and ensure the needed surgical workforce in the future. To that end, it is important to support the residency programs that already exist and to promote the development of additional residency programs as

well, particularly in rural areas. In addition, it is important to develop appropriate supports and incentives for medical students who are interested in pursuing a surgical career while also, as much as is possible, eliminating the disincentives that push medical students away from the surgical profession. To this end, the ACS would encourage the Committee to strongly consider the following policy options:

- Preserve Medicare funding for graduate medical education (GME) and eliminate the residency funding caps.
- Fully fund residency programs through at least the initial board eligibility.
- Include surgeons under the Title VII health professions programs, including the National Health Service Corps (NHSC) program, making them eligible for scholarships and loan assistance in return for commitment to generalist practice following training.
- Alleviate the burden of medical school debt and promote rural/underserved care through loan forgiveness programs that stipulate work in rural/underserved areas.
- Extend medical school loan deferment to the full length of residency training for surgeons.
- Allow young surgeons who qualify for the Economic Hardship Deferment to utilize this option beyond the current limit of three years into residency.
- Increase the aggregate combined Stafford loan limit for health professions students.

The College also supports legislation that seeks to increase the number of residency training programs. At present, a majority of residency training programs exist in or near major metropolitan cities. While the current programs continue to excel at producing high quality surgeons, they do not adequately distribute surgeons to communities across the nation. A major obstacle often preventing the establishment of new residency training programs are the costs associated with the creation of such programs. The Physician Workforce and Graduate Medical Education Enhancement Act (H.R. 914), which was introduced by Representative Michael Burgess, MD (R-TX) and Representative Gene Green (D-TX), would establish an interest-free loan program where hospitals committed to starting new residency training programs in one or a combination of seven medical specialties, including general surgery, could secure start-up funding to offset the initial costs of starting such programs. By providing a greater number of residency training programs in previously underserved areas, the surgical workforce shortage could be reduced for many states. In addition to the measures previously discussed, the ACS believes this legislation would be an appropriate step toward addressing the workforce challenges we are witnessing in rural areas. The ACS will continue to support this and other legislation that helps ensure patient access to surgical care.

Surgeons complete their training and enter their profession with full knowledge that certain requirements will be made upon their time and family life, and this includes serving on on-call panels for emergency and trauma care situations. Yet, as has been already noted, there are structures and disincentives within our current health care

system that complicate this task and complicate surgeons' ability to provide the emergency and on-call services on which all Americans depend. In addition, these on-call responsibilities can be particularly significant in rural and lesser populated areas, further complicating efforts to recruit surgeons to these areas. To support these surgeons' commitment to provide emergency surgical care, particularly in rural areas, and to help avert an emergency surgical workforce crisis, the ACS encourages the Committee to consider the following measures:

- Include surgeons in bonus payment structures for health professional shortage areas.
- Allow surgeons access to Medicare's disproportionate share program, currently restricted to hospitals, when they operate on patients they see in the emergency department (ED) or as a result of care provided under the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).
- Provide tax relief to surgeons who perform EMTALA-related care. This could be based on overhead costs as related to the Medicare physician fee schedule.
- Adjust Medicare practice expense pools for each specialty to account for uncompensated care related to ED or EMTALA-related care as is done for emergency medicine.
- When hospitals pay stipends to surgeons who take emergency call, Medicare should recognize these costs as is currently done for critical access hospitals.
- Provide liability reform for surgeons who perform EMTALA-related care.
- Expand the Federal Tort Claims Act to include surgeons who provide services to patients who are referred through their primary care physician at a community health center.

Finally, the most immediate challenge for patient access to surgical care is the precarious reimbursement situation confronting surgeons and surgical practices. As the Committee is well aware, Medicare payments to physicians will be cut 21.5 percent on January 1, 2010 if Congress does not act. The ACS calls on this Committee and Congress to take action to stop this cut, to provide an increase in Medicare payments for all physicians in 2010, and to initiate reform for Medicare's physician payment system this year. The ACS greatly appreciated the leadership of Chairman Baucus and the bipartisan work of this Committee to enact the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) last July that reversed the 10.6 percent cut in Medicare physician payments. In addition, MIPPA included the largest Medicare payment increase for physicians since 2005 by replacing a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase this past January. MIPPA also made changes to how work was valued under the Relative Value Scale, increasing payments for some surgical services. In spite of these important measures, Medicare payments for many surgical procedures have been reduced significantly over the past twenty years and, in some cases, they have been cut by more than half from reimbursement levels in the late 1980's. In spite of these payment trends and the workforce challenges just outlined, some, most notably the Medicare Payment Advisory Commission (MedPAC), have proposed financing increased reimbursement for primary care by simply cutting reimbursement for care provided by other physician specialties. Such proposals, while

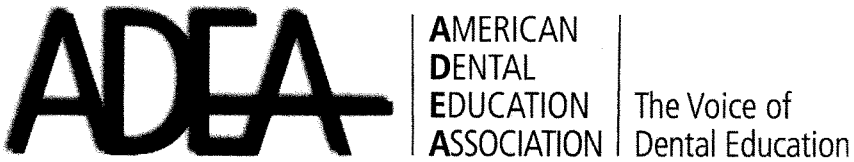
seeking to promote efforts to help Americans better manage their care, would further exacerbate the workforce challenges previously described and ironically establish a reimbursement structure that would ultimately undermine patients' ability to access the life-saving acute care services that only surgeons are qualified to provide. After all, increasing Americans' access to health insurance coverage will have little value if Americans cannot obtain the care they need from the appropriate physician. As a result, it is critical that Congress take steps now to ensure a stable surgical and a stable physician workforce for all Americans for years to come. The ACS supports efforts to prevent disease and to manage patient care not only because it is in the best interests of the patient and health care system but also because, when these patients need surgery, they are much less likely to encounter complications and much more likely to recover quickly from the operation. However, regardless of how well patients' care is managed, acute situations requiring prompt and definitive access to surgical care will continue to occur.

The ACS is grateful for the opportunity to provide a statement regarding these important challenges facing our nation's surgical workforce. The ACS remains committed to enacting reforms of Medicare's payment system that preserve and further patient access to surgical care and to the range of important services provided by our colleagues in medicine. The ACS looks forward to working with this Committee to avert this cut and to initiate the much needed reform of Medicare's payment system this year. The American College of Surgeons stands ready to work with Chairman Baucus, Ranking Member Grassley and all members of this Committee to ensure that all Americans will continue have access to the comprehensive health care services that America's surgeons and physicians provide.

1996-2006 Percentage Change for Physicians Per 100,000 Residents*								
State	Total Physicians	Cardiologists	General Surgeons	Neurosurgeons	Ophthalmologists	Orthopaedic Surgeons	Urologists	Primary Care
AZ	**-0.10%**	9.69%	**-19.67%**	**-23.14%**	**-28.93%**	**-26.48%**	**-7.20%**	1.82%
AR	10.24%	20.48%	**-8.64%**	43.69%	**-12.09%**	**-9.40%**	**-19.21%**	9.80%
DE	16.19%	28.71%	**-13.85%**	**-28.34%**	**-17.41%**	3.05%	**-11.01%**	16.92%
FL	5.30%	8.19%	**-24.43%**	**-11.43%**	**-14.92%**	**-21.38%**	**-14.26%**	9.45%
ID	18.82%	57.17%	**-8.09%**	**-12.27%**	**-12.79%**	12.49%	5.30%	29.66%
IA	15.30%	45.30%	**-12.65%**	0.60%	**-12.26%**	**-4.18%**	**-1.75%**	19.70%
KS	9.59%	49.43%	**-7.49%**	15.29%	12.21%	4.95%	**-6.26%**	16.71%
KY	12.51%	35.45%	**-23.59%**	**-21.17%**	**-4.16%**	**-7.76%**	**-8.88%**	13.94%
ME	24.84%	10.32%	2.99%	**-5.46%**	**-8.05%**	**-6.27%**	10.71%	37.72%
MA	6.82%	**-2.72%**	**-23.72%**	**-18.71%**	**-6.76%**	**-15.29%**	**-15.81%**	12.41%
MI	8.83%	**-2.40%**	**-22.04%**	12.47%	**-12.22%**	**-11.76%**	**-16.91%**	14.42%
MT	12.33%	**-3.54%**	**-15.18%**	**-13.49%**	**-20.92%**	11.03%	4.09%	19.00%
NJ	**-4.08%**	**-3.25%**	**-33.32%**	**-6.56%**	**-18.77%**	**-16.15%**	**-13.39%**	**-7.61%**
NV	8.91%	0.63%	**-27.77%**	**-5.66%**	**-18.70%**	**-2.96%**	**-13.80%**	15.77%
NM	10.50%	17.53%	**-14.02%**	**-32.17%**	**-25.55%**	**-20.14%**	**-22.15%**	16.42%
NY	4.21%	10.95%	**-25.37%**	**-0.28%**	**-12.46%**	**-9.40%**	**-14.61%**	8.00%
ND	15.17%	22.78%	**-11.73%**	**-21.30%**	**-16.08%**	9.70%	**-12.04%**	17.26%
OR	17.97%	25.34%	**-0.20%**	**-5.38%**	**-6.67%**	**-5.74%**	**-8.37%**	25.78%
TX	9.14%	30.84%	**-18.86%**	4.60%	**-9.65%**	**-5.52%**	**-7.51%**	11.37%
UT	16.74%	23.33%	**-1.01%**	11.46%	5.78%	**-8.45%**	**-12.21%**	28.12%
WA	14.69%	15.32%	1.04%	**-19.28%**	**-12.88%**	**-7.33%**	**-6.86%**	23.01%
WV	13.13%	11.08%	**-12.05%**	6.23%	**-2.79%**	**-4.47%**	**-24.09%**	16.19%
WY	21.65%	35.08%	8.12%	89.71%	6.04%	37.26%	**-9.92%**	14.53%
National Percentage	***10.33%***	***14.44%***	***-16.31%***	***-0.46%***	***-11.43%***	***-7.08%***	***-12.01%***	***14.35%***

*100,000 per Hospital Referral Regions, which is defined by documenting where patients were referred for major cardiovascular surgical procedures and neurosurgery in their respective states.

*All Physician data obtained from the Dartmouth Atlas of Health Care Database



Statement of the
American Dental Education Association (ADEA)
1400 K Street NW, Suite 1100
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The United States Senate Committee on Finance

Hearing on "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future"

March 12, 2009

Introduction

The American Dental Education Association (ADEA)[1] welcomes the Finance Committee's examination of workforce issues, particularly with regard to the impending health professions shortages that must be addressed to succeed in achieving comprehensive health care reform. As oral health is necessary for overall health, it is vital that there is a strong dental and allied dental workforce accessible to all Americans.

To that end, as Congress moves forward on health reform, ADEA believes that any comprehensive reform of the U.S. health care system should provide universal coverage to all Americans and access to high-quality, cost-effective oral health care services. Health care reform must also include investments in dental public health that improve our nation's capacity to meet the health care needs of patients, communities, and other stakeholders. ADEA has a number of recommendations on how to modify the workforce to ensure that coverage and access needs of our country are met. Additionally, ADEA has approved a statement and a number of principles on health reform. That statement is attached to be entered into the record.

In order to make informed decisions concerning changes in the education, distribution, and incentives of the workforce, it is important to understand current and future oral health needs, the current and future size of the dental workforce, as well as regional, ethnic, and racial disparities affecting who receives needed care.

The challenge to Congress and the dental community is twofold: How to expand the capacity of the dental workforce and how to improve access to oral health care. According to Delta Dental Plans Association, 134 million Americans do not have dental insurance. The lack of dental insurance is a significant barrier to receiving needed preventive and restorative care. Since the untimely death of 12-year old Deamonte Driver one year ago, Congress and the dental community have worked to address access to dental care. ADEA applauds Congress and President Barack Obama for including a guaranteed dental benefit in the Children's Health Insurance Program Reauthorization Act (CHIPRA). Deamonte was a young Maryland boy who died from an infection caused by an abscessed tooth that spread to his brain. All of us know this tragedy could have been avoided if his Medicaid coverage had not lapsed and if he had better access to dental care.

The Dental and Oral Disease Burden in the United States

It has been eight years since the U.S. Surgeon General's report[2] comprehensively examined the status of the nation's oral health (Table 1 provides a summary of the report's major findings). The report stated that "Oral health is a critical component of health and must be included in the provision of health care and the design of community programs." It also declared that "oral health is essential to the general health and well-being of all Americans." Unfortunately, millions are left wanting and needing dental care. According to the Surgeon General, there are "profound and consequential oral health disparities within the population," particularly among

[1] The American Dental Education Association represents all 58 dental schools in the United States, in addition to more than 700 dental residency training programs and nearly 600 allied dental programs, as well as more than 12,000 faculty who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge, where the majority of dental research is conducted, and where significant dental care is provided. ADEA member institutions serve as dental homes for a broad array of racially and ethnically diverse patients, many who are uninsured, underinsured, or reliant on public programs such as Medicaid and the Children's Health Insurance Program for their health care.

[2] U.S. Department of Health and Human Services. Oral health in America: a report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

"racial and ethnic minorities, rural populations, individuals with disabilities, the homeless, immigrants, migrant workers, the very young, and the frail elderly."

Over the past 55 years, discoveries stemming from dental research have reduced the burden of dental caries (tooth decay) for many Americans. However, the Surgeon General's report concluded dental caries to be America's most prevalent infectious disease among children, five times more common than asthma and seven times more common than hay fever. The burden of the disease, in terms of both extent and severity, has shifted dramatically to a subset of our population where grave oral health disparities exist. About a quarter of the population now accounts for about 80 percent of the disease burden. Dental caries remains a significant problem for vulnerable populations of children and people who are economically disadvantaged, elderly, chronically ill, or institutionalized. This high-risk group includes nearly 20 million low-income children (nearly all are eligible for Medicaid or CHIP). Early childhood caries is found in children less than five years of age. It is estimated that two percent of infants 12-23 months of age and 19 percent of children 2-5 years of age have tooth decay in the U.S.[3] ADEA concurs with the American Academy of Pediatrics which recommends that all children should visit a dentist in their first year of life and every 6 months thereafter.

Table 1: Major Findings of the U.S. Surgeon General's Report

- Oral diseases and disorders in and of themselves affect health and well-being throughout life.
- Safe and effective measures exist to prevent the most common dental diseases—dental caries and periodontal diseases.
- There are profound and consequential oral health disparities within the U.S. population.
- More information is needed to improve America's oral health and eliminate health disparities.
- The mouth reflects general health and well-being.
- Oral diseases and conditions are associated with other health problems.
- Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth and teeth.
- Each year, millions of productive hours are lost due to dental diseases. Children miss 51 million hours of school due to treatment problems. Workers lose 164 million work hours because of dental disease.
- Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health as well.

The U.S. Population and the Dental Workforce

The U.S. Bureau of Labor Statistics (BLS), which placed the number of practicing dentists at 161,000 in 2006,[4] projects a nine percent growth in the number of dentists through 2016. This would bring the total number of practicing dentists to 176,000. Unlike in medicine where specialists abound, about 80 percent of dentists are solo practitioners in primary care general dentistry. The remaining one of nine practice in recognized specialty areas including: 1) endodontics; 2) oral and maxillofacial surgery; 3) oral pathology; 4) oral and maxillofacial radiology; 5) orthodontics; 6) pediatric dentistry; 7) periodontics; 8) prosthodontics; and 9) public health dentistry.

[3] Savage MF, Lee JY, Kotch JB. Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs. Pediatrics 2004;(114)4.

[4] U.S. Bureau of Labor Statistics, http://www.bls.gov/oco/content/ocos072.stm, accessed February 5, 2008.

Table 2: Approximate Number of Dentists U.S. 2006	
General Dentists	136,000
Specialists	34,878
Orthodontists	9,400
Oral and Maxillofacial Surgeons	7,700
Pedodontists	4,978
Prosthodontists	3,300
Periodontists	5,100
Endodontists	4,400
Other dentists and specialists	5,756

The vast majority of the 176,634 professionally active dentists in the U.S. are White non-Hispanic. At the present time, the U.S. population is 303,375,763.[5] At the time of the last census, when there were 22 million fewer people, the largest segment of the U.S. population was White (75 percent). Today, Blacks, Hispanics, and American Indians represent more than 25 percent of the U.S. population. By the year 2050, nearly one in five Americans (19 percent) will be an immigrant, compared with one in eight (12 percent) in 2005.

Table 3: U.S. Population by Race and Hispanic Origin for the United States: 2000[6]		
Race and Hispanic or Latino Number	Number	Percent of total population
RACE		
Total population	**281,421,906**	**100.0**
One race	274,595,678	97.6
White	211,460,626	75.1
Black or African American	34,658,190	12.3
American Indian and Alaska Native	2,475,956	0.9
Asian	10,242,998	3.6
Native Hawaiian and Other Pacific Islander	398,835	0.1
Some other race	15,359,073	5.5
Two or more races.	6,826,228	2.4
HISPANIC OR LATINO		
Total population	**281,421,906**	**100.0**
Hispanic or Latino	35,305,818	12.5
Not Hispanic or Latino	246,116,088	87.5

Dental Hygiene, Dental Assisting, Dental Laboratory Technology

The allied dental workforce, comprised of dental hygienists, dental assistants and dental laboratory technologists, is central to meeting increasing needs and demands for dental care. About 167,000[7] dental hygienists, 280,000[8] dental assistants and 53,000[9] dental laboratory technologists were in the U.S. workforce in 2006. Both dental hygiene and dental assistants are among the fastest growing occupations in the country with expected growth of 30 percent and 29 percent respectively through 2016 bringing the total numbers of dental hygienists to about 217,000 and dental assistants to 361,000. Only about 2,000 dental laboratory technologists will be added to the workforce by 2016. The ability to increase the number is limited with only 21 accredited training programs.

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[5] U.S. Bureau of the Census, http://www.census.gov/population/www/popclockus.html, February 5, 2008.
[6] Source: U.S. Census Bureau, Census 2000 Redistricting (PL 94-171) Summary File, Tables PL1 and PL2, http://www.census.gov/prod/2001pubs/c2kbr01-1.pdf, February 5, 2008
[7] U.S. Bureau of Labor Statistics, http://www.bls.gov/oco/pdf/ocos097.pdf, accessed February 5, 2008.
[8] U.S. Bureau of Labor Statistics, http://www.bls.gov/oco/ocos163.htm, accessed February 5, 2008.
[9] U.S. Bureau of Labor Statistics, http://www.bls.gov/oco/ocos238.htm, accessed February 5, 2008.

Dental hygienists are licensed professionals who perform a variety of clinical tasks while dental assistants work alongside dentists during dental procedures and provide assistance. However, both dental hygienists and assistants perform substantial routine preventive and certain other radiographic and treatment services in compliance with state practice acts. Dental laboratory technicians fill prescriptions from dentists for crowns, bridges, dentures, and other dental prosthetics and may specialize in one of five areas: orthodontic appliances, crowns and bridges, complete dentures, partial dentures, or ceramics.

Dentist Shortage or Maldistribution

Some say we have a dental shortage. Others say we have a maldistribution of dentists to meet the nation's oral health needs. No matter how one defines it, there can be no doubt that there is a significant access problem for millions of Americans. We must acknowledge that the current dental workforce is unable to meet present day demand and need for dental care.

If every man, woman and child were to have dental insurance and a dental home where they received regular care , the nation would clearly have an insufficient number of dentists to ensure that everyone who needed and wanted dental care achieved optimal oral health. The need and demand for dental services continues to increase; in large measure this is due to the population explosion. Also, Baby Boomers as well as the geriatric population are retaining their teeth and there is a growing focus on increasing access and preventive dental care.

Each year, academic dental institutions (ADIs) which include dental schools, allied dental programs and postdoctoral/advanced dental education programs (dental residencies) graduate thousands of new practitioners who join the dental workforce. About half of the 4,500 new dentists who graduate take their state licensure exam and begin private practice as general dentists while others may join the military or the U.S. Public Health Service. Approximately 2,800 graduates advance their education in dental specialty (residency training) programs. Nearly 23,000 allied dental health professionals graduate from ADIs each year and join the dental workforce. Approximately 14,000 dental hygiene students, 8,000 dental assistants, and 800 dental laboratory technologists graduate annually.

According to the U.S. Surgeon General, the ratio of dentists to the total population has been steadily declining for the past 20 years. At that rate, there will not be enough active dentists to care for the population by 2021. The number of Dental Health Professions Shortage Areas (D-HPSAs) designated by the U.S. Health Resources and Services Administration (HRSA) has grown from 792 in 1993 to 4,048 in 2008. In 1993, HRSA estimated 1,400 dentists were needed in these areas, by 2008, that number grew to 9,432. Nearly 48 million people live in D-HPSAs across the country. Although it is unknown how many of these areas have the infrastructure to financially support a dentist, it is clear that more dentists are needed in these areas.

Need/Demand for Dental Care

Americans spent roughly $91.5 billion on dental procedures in 2006; the vast majority of this amount was paid out of pocket ($40.6 billion) or through private insurance ($45.3 billion) while $5.5 billion was paid through public programs, Medicare ($0.1 billion) and Medicaid/State Children's Health Insurance Program ($5.3 billion).[10] Mostly this was spent on fillings, crowns, implants, and high-end restorative procedures.

[10] Catlin, Aaron, Cowan, Cathy et al., Health Spending in 2006, Health Affairs, 2008, 27 (1): page14-29.

The disproportionate burden of oral diseases and disorders indicates that specific population groups are in greater need of oral health care. Millions of Americans experience dental pain daily but cannot afford to buy dental insurance or pay for dental care out of pocket. Since few oral health problems in their early stages are life-threatening, people often delay treatment for long periods of time. The extent of oral health care disparities clearly indicates that many of those in *need* of oral health care do not *demand* oral health care. Often, when they do seek care, it is hospital emergency rooms or others in the limited and underfinanced dental safety-net system – ADIs, community health centers, school-based clinics, and municipal clinics. This system of care cannot effectively deal with the magnitude of the problem.

Nor can charity dental care provided by dentists solve the access problem. Each year, ADIs eagerly join with dentists and others in the community to participate in Give Kids a Smile Day. This national initiative by the American Dental Association focuses attention on the epidemic of untreated oral disease among disadvantaged children. The Seventh Annual Give Kids a Smile Day held on February 6, 2009 provided care to 465,800 children. Taking part were 45,700 dental professionals, including 12,500 dentists. While this event is noteworthy, it is not a solution to the problem.

Although many people in the U.S. do not receive basic preventive dental services and treatment, most oral diseases are preventable if detected and treated promptly. Preventive care is essential to contain costs associated with oral health care treatment and delivery.

Access to Care and Academic Dental Institutions

U.S. academic dental institutions (ADI) are the fundamental underpinning of the nation's oral health. As educational institutions, dental schools, allied dental education, and advanced dental education programs are the source of a qualified workforce, influencing both the number and type of oral health providers. They play an essential role in educating and training the future oral health workforce and conducting research that leads to advances in oral health. All U.S. dental schools operate dental clinics and most have affiliated satellite clinics where preventive and comprehensive oral health care is provided as part of the educational mission. All dental residency training programs provide care to patients through dental school clinics, hospital-based clinics and in other community settings. Dental hygiene programs operate on-campus dental clinics where preventive oral health care (cleaning, radiographs, fluoride, sealants, nutritional and oral health instruction) can be provided 4-5 days per week under the supervision of a dentist. All care provided is supervised by licensed dentists as required by state practice acts. All dental hygiene programs have established relationships with practicing dentists in the community for referral of patients.

As safety net providers, ADIs are the dental home to a broad array of vulnerable and underserved low-income patient populations including racially and ethnically diverse patients, elderly and homebound individuals; migrants; mentally, medically or physically disabled individuals; institutionalized individuals; HIV/AIDS patients; Medicaid and Children's Health Insurance Program (CHIP) children and uninsured individuals. Dental school clinics also serve as a key referral resource for specialty dental services not generally accessible to Medicaid, CHIP, and other low-income uninsured patients. All ADI services are provided at reduced fees. In addition, ADI's provide millions of dollars of uncompensated care annually.

Strains on Academic Dentistry

The math is simple. There is an increasing need and demand for dental care. There is a current shortage of dental faculty to educate and train the future dental workforce. Several new dental schools and allied dental education programs have opened and more are scheduled.

There is a critical need to recruit new dental and allied dental faculty and retain existing faculty members to meet the nation's oral health workforce needs.

The number of vacant budgeted faculty positions at U.S. dental schools increased throughout the 1990s, with a peak of 358 positions in 2000. Following this peak, the number of vacancies declined, falling to 275 in 2004-2005. Since that time, there has been a rapid increase in the number of estimated vacancies, reaching 417 in 2005-2006, falling slightly to 406 in 2006-2007. These faculty shortages may be exacerbated by the aging of the dental school faculty. Currently 34 percent of faculty members are over age 50.

At the present time there are 58 U.S. dental schools in 34 states, the District of Columbia and Puerto Rico. There are 714 dental residency training programs located in 44 states, the District of Columbia and Puerto Rico. There are close to 600 allied dental programs in all 50 states and the District of Columbia.

Growing demand for dental care in certain areas of the country has precipitated the opening of four new dental schools since 2000: the Arizona School of Health Sciences (Phoenix AZ); the University of Nevada Las Vegas; Nova Southeastern University (Fort Lauderdale, FL); and Midwestern University (Glendale, AZ). Two new dental schools are seeking accreditation: Western University of Health Sciences (Pomona, CA) and East Carolina University (Greenville, NC). Six states (Arkansas, California, Illinois, Maine, Nevada and Texas) are considering new dental schools.

Applications, Diversity and the Dental Pipeline
Interest in the dental profession remains high and competition for first-year positions is robust. For 2008, the applicant to enrollee ratio for dental school is 2.7 to 1. Since 1989, first year enrollment in dental school has increased nearly 20 percent.

Despite efforts to increase diversity, as in other health professions, the number of African American, Hispanic, and Native American students in dental schools remains disproportionately low compared to their numbers in the U.S. population. In 2007, the total pre-doctoral first-year enrollment in dental school was 4,918. Of that number, 1,093 were Asian or Pacific Islander, 274 (22 percent), 274 were Black or African American (6 percent), 283 were Hispanic or Latino (6 percent), and less than one percent (.07) was Native American. For another 257 applicants, their race or ethnicity was not reported.

Increasing diversity in the dental profession is vital to achieving optimal oral health for racial and ethnic minority groups, which experience a higher incidence of oral health problems and have more difficulty accessing dental care. Recognizing that enrollment of underrepresented minorities (URM) has remained largely constant, ADEA member institutions have been actively engaged in programs that bolster underrepresented minority recruitment and retention into dentistry and have partnered with foundations and others to make headway:

- The "Pipeline, Profession, and Practice: Community-Based Dental Education" program is sponsored by the Robert Wood Johnson Foundation (RWJF) and receives support from the California Endowment and the W.K. Kellogg Foundation. The five-year initiative was launched to help increase access to oral health care by linking dental schools to communities of need and to boost URM and low-income (LI) students' enrollment numbers in dental schools. Dental Pipeline I was such a success that the RWJF and the California Endowment will continue the program with Pipeline II adding a mentoring portion to the program as well.

- The "Summer Medical and Dental Education Program (SMDEP)" is a collaborative program administered by ADEA and the Association of American Medical Colleges and funded by the Robert Wood Johnson Foundation (RWJF). The program offers academic enrichment for disadvantaged undergraduate freshmen/sophomores. In this program students gain exposure to medicine and dentistry and receive assistance about how to plan for medical or dental school. Nearly 1,900 students have participated (333 dental and 1,564 medical) of which 71 percent have been women, 48 percent have been Black or African American, 21 percent have been Hispanic or Latino, and two percent have been American Indian.

- ADEA received a grant from the Josiah Macy, Jr. Foundation to serve as the host organization and coordinator for the program entitled *Moving Forward: Bridging the Gap* to increase the diversity of the dental workforce in the United States. The program will create a flexible seven-year dental curriculum, modeled after one currently used in medicine, to prepare underrepresented minority and low-income (URM/LI) students for the practice of dentistry.

RECOMMENDATIONS TO ADDRESS DENTAL WORKFORCE CHALLENGES

Congress can take immediately steps to address the challenges facing the future of the dental workforce. The answer lies in prioritizing resources of manpower and funding to tackle these challenges. ADEA stands ready to work with Congress and our colleagues in the dental community to ameliorate the access to dental care problems the nation faces and to meet the needs for the future dental workforce. Specifically, we recommend:

1. Restore Dental Graduate Medical Education for Programs in Non-Hospital Settings

Congress should bolster support for dental residency training in both hospitals and non-hospital sites through Medicare Graduate Medical Education (GME). While all medical residency training positions are supported by Medicare GME only some dental residencies receive Medicare GME funding. No dentist may practice a specialty without first having successfully completed post-doctoral residency training. ADEA encourages dental graduates to pursue postdoctoral dental education in either general dentistry, advanced dental education program or a dental specialty. The current number of positions and funding for these programs is insufficient for all dental graduates to participate. To accommodate advanced education in general dentistry and specialties additional funding for these training positions is needed. Meeting this challenge would help to strengthen the dental workforce and would help provide access to care.

2. Make Dentistry Eligible for Title VII Administrative Academic Units, Predoctoral Training, Faculty Development

Academic dental institutions are ineligible to compete for three important programs within the Title VII available to primary care medicine; namely the Academic Administrative Units in Primary Care (AAU), Faculty Development in Primary Care (FD), and Predoctoral Training (PDTP) Programs. Congress should increase funding for these programs and broaden eligibility to include dentistry. In its November 2001 report to Congress, the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) also recommended this modification.

- Academic Administrative Units in Primary Care grants establish and improve primary care units so that they are equal to other departments or divisions in the medical school. Resources may be used to enhance the ability of the primary care unit to significantly expand their primary care mission in teaching, research and faculty development. ADEA

suggests general and pediatric dentistry and dental public health units be added within the dental school.

- Faculty Development in Primary Care grants help to plan, develop, and operate programs, and pay stipends, for training of physicians who plan to teach in family medicine, general internal medicine and general pediatrics training programs. Four grant types: Type I Primary Care Clinician Researchers; Type II Primary Care Master Educators; Type III Primary Care Community Faculty Leaders; and Type IV Community Preceptors. ADEA suggests training for dentists who plan to teach in general and pediatric dentistry and public health dentistry be added.
- The Predoctoral Training grants help to plan, develop, and operate or participate in predoctoral programs in family medicine, general internal medicine and general pediatrics. ADEA suggests that both general and pediatric dentistry and public health dentistry be added.

3. Establish a Dental Disproportionate Share (DDS) Program for Academic Dental Institution Clinics

The capacity of ADI clinics to meet the needs of publicly insured and uninsured patients is compromised by inadequate payments from Medicaid and other Federal and state programs which threaten their financial viability as critical dental safety net providers. ADEA urges Congress to establish a Medicaid allotment for each state and territory that would be distributed in quarterly payments to qualified dental clinics with a pediatric Medicaid, CHIP, and uninsured dental patient load equal to 30 percent of their pediatric patient-mix. Payments from the allotment would be based on a specified percentage of Medicaid payments for children's dental services in the previous quarter. ADEA is eager to explore this proposal with the Committee.

4. Maintain Support for Title VII General and Pediatric Dentistry

Support for Title VII programs is essential to expanding existing or establishing new general dentistry and pediatric dentistry residency programs. Title VII general and pediatric dental residency training programs have shown to be effective in increasing access to care and enhancing dentists' expertise and clinical experiences including outpatient and inpatient care that affords residents an excellent opportunity to learn and practice all phases of dentistry. Support for General Dentistry and Pediatric Dentistry Residency Training programs is essential to building a primary care dental workforce that is effective in increasing access to care for Medicaid and CHIP populations and other vulnerable populations including patients with developmental disabilities and geriatric patients. The value of these programs is underscored by reports of the Advisory Committee on Training in Primary Care Medicine and Dentistry and the Institute of Medicine.

5. Restore Adequate Funding for Title VII Diversity Programs

The only federal programs designed specifically to strengthen and diversify the health professions are the Title VII Centers of Excellence (COE) and Health Careers Opportunity Program (HCOP). After several years of cuts these programs are thankfully being restored thanks to Congress, however, they remain woefully under funded. Congress should return their funding to FY 2005 levels.

Table 4: COE and HCOP Funding by FY

	FY05	FY06	FY07	FY08	FY09
COE	$35 million	$12 million	$11.88 million	$12.77 million	$20.6 million
HCOP	$33 million	$4 million	$3.9 million	$9.8 million	$19.1 million

These programs work in diverse communities to assist institutions in developing a more diverse applicant pool and to strengthen the academic performance of underrepresented minority students enrolled in health professions schools. These programs enhance the pipeline of undergraduate and pre-college students entering health professions and make grants to community-based health and educational entities to support these activities.

Conclusion

The United States spends more money per capita on health care than any other country in the world. Yet there are still many underserved groups that do not have access to oral health care. In a handful of states, the need for oral health care is so great that other medical professionals are being utilized to provide services traditionally provided by oral health care professionals.[11] A sustained federal commitment is needed to meet the challenges oral disease poses to our nation's citizens including children, the vulnerable and disadvantaged.

Congress must address the growing needs of educating and training the dental professions workforce to meet the growing and diverse needs of the future. To address the complex circumstances facing our dental workforce, solutions will almost certainly involve a broad spectrum of interests that includes oral health and public health care professionals, representatives from minority interests, insurers and other payers such as businesses, and consumers. To that end, ADEA stands ready to partner with Congress to develop and implement a national oral health plan that guarantees access to dental care for everyone, eliminates oral health disparities, bolsters the nation's oral health infrastructure, eliminates academic and dental workforce shortages, and ensures continued dental health research.

ADEA thanks the Committee for considering these recommendations addressing dental workforce issues.

[11] Article attached from Fosters Daily Democrat, "Maine trains family docs to do basic dentistry", October 15, 2008, accessed at www.fosters.com, March 23, 2009.

ORAL HEALTH CARE: ESSENTIAL TO HEALTH CARE REFORM *

The United States spends more than two trillion dollars annually on health care.[1] Our health care system is the best in the world, best in advanced life-saving procedures, best in educating talented and skilled health professionals, and best in research innovations advancing practice. But, despite these accomplishments, access to health care is beyond the reach of more than 47 million Americans.[2] In 2003 the U.S. Surgeon General issued "A National Call to Action to Promote Oral Health" in which he reported that the number of Americans without dental insurance was more than 2.5 times the number who lack medical insurance.[3] Even more Americans, approximately 130 million adults and children, lack dental coverage.[4]

Studies show that uninsured individuals with serious symptoms seek health providers half as often as similarly ill people who have insurance; it is worse for individuals without dental insurance.[5] As few oral health care problems in their early stages appear to be life-threatening, uninsured individuals often delay treatment until problems become serious or acute. Allowing these inequities to persist deprives millions of Americans of oral health care, thus not only diminishing their health and wellbeing but also creating significant financial consequences.[6]

Principles for Health Care Reform

The American Dental Education Association (ADEA),[7] whose member institutions serve as dental homes to thousands of patients, supports the following principles for providing oral health care coverage and access to affordable oral health care services:

1. **The availability of health care, including oral health care, fulfills a fundamental human need and is necessary for the attainment of general health.** Every American should have access to affordable diagnostic, preventive, and primary health care services, including dental care. Oral health care services are proven to be effective in preventing and controlling tooth decay,[8] gum infections, and pain, and can ameliorate the outcomes of trauma. These services should not be considered different than other forms of health care. Coverage must ensure that individuals are able to obtain needed oral health care and provide them protection during a catastrophic health crisis.

2. **The needs of vulnerable populations have a unique priority.** Health professionals, including those providing oral health care services, must individually and collectively work to improve access to care by reducing barriers that low-income families, minorities, remote rural populations, medically compromised individuals, and persons with special health care needs experience when trying to obtain needed services. The equitable provision of oral health care services demands a commitment to promotion of public health, prevention, public advocacy, and the exploration and implementation of new models of oral health care that provide care within an integrated health care system. New models will involve expanded roles for allied dental professionals as well as other health professionals, including family physicians, pediatricians, geriatricians, and other primary care providers as team members.[9]

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* Approved as "ad hoc interim policy" by the ADEA Board of Directors, June, 2008.

3. **Prevention is the foundation for ensuring general and oral health and for controlling costs within the U.S. health care system.** Adequate financing for oral health care promotion and education, dental disease prevention, and early detection and treatment is essential to a reformed health care system. Prevention and wellness hold the promise of stemming escalating costs and treating diseases at early stages before expensive emergencies occur. Improving oral health by multiple preventive approaches (including periodontal disease management) has saved more than $4 billion per year in reduced treatment costs. Prevention of dental diseases ranks above HIV screening and influenza immunization in cost savings.[10] Information released by the Coalition on Oral Health Care estimates that for every $1 spent on prevention in oral health care, as much as $50 are saved on restorative and emergency dental procedures. Dental costs for children who receive preventive dental care early in life are 40 percent lower than costs for children whose oral health is neglected.[11] Oral cancer treatment costs in the earliest stages of the disease are estimated to be 60 percent lower than those at an advanced stage of disease.[12] Every dollar invested in community water fluoridation yields approximately $38 in savings on dental treatment costs.[13]

4. **The financial burden of ensuring coverage for health care, including oral health care coverage, should be equitably shared by all stakeholders.** Access to affordable health care services requires a strong financial commitment that is a responsibility shared by all major stakeholders, including federal and state governments, employers, individuals, private insurers, and other payers. To ensure health, oral health care services must be an integral component of financing and delivery systems regardless of whether the care is provided by a public or private insurance program or in a community or individual setting. The burden of uncompensated care and the cost shifting that occurs adversely impacts U.S. businesses, limits governments' capacity to address other pressing economic and social concerns, and strains the health care safety net to the breaking point.

5. **A diverse and culturally competent workforce is necessary to meet the general and oral health needs of our demographically changing nation.** Racial and ethnic diversity of health professionals contributes to improved access to care, greater patient choice and satisfaction, and enriched educational experiences for students.[14] Proposals to reform the U.S. health care system should include adequate funding for programs that are designed to increase the number of underrepresented minorities in the health professions. This would ensure a workforce that is prepared to meet the needs of a diverse population that continues to expand. Academic dental institutions, which educate and train oral health care professionals, have a distinct responsibility to educate dental and allied dental health professionals who are competent to care for the changing needs of society. This responsibility includes preparing oral health care providers to care for a racially and ethnically diverse population, an aging population, and individuals with special needs.

6. **Our nation's domestic productivity and global competitiveness are negatively impacted by the huge and growing number of Americans without health care, including oral health care.** More than 51 million school hours and 164 million hours of work are lost each year due to dental related absences.[15] Furthermore, the cost of caring for Americans without insurance in emergency rooms and other settings is estimated to add $922 to the average cost of premiums for employer-sponsored family coverage.[16] This hidden tax on employers, employees, and safety-net providers who absorb the cost of uncompensated care consumes revenues that could be used to fund research and make capital investments. Recognizing that most workers and their families receive health insurance coverage through their employers, any proposal to reform the U.S. health care system must ensure that the economic viability of American businesses is maintained and that they are able to compete in a global market.

ADEA Policy Statement

Good oral health is essential for general health. Every American should receive the care necessary for good oral health. Any comprehensive reform of the U.S. Health Care System must include coverage and access to affordable oral health services.

Most dental diseases are preventable. Early dental treatment is cost effective. Children who receive preventive dental care early in life have lifetime dental costs that are 40 percent lower than children who do not receive this care.[17] The cost of providing preventive dental treatment is estimated to be 10 times less costly than managing symptoms of dental disease in a hospital emergency room.[18] Yet, more than 130 million adults and children lack dental insurance coverage.[19]

As the voice of dental education, the American Dental Education Association (ADEA) believes that dental educators and researchers have a moral obligation to promote access to oral health care, and that ensuring the oral health of all is the shared responsibility of individuals, the private sector, and federal, state, and local governments. Academic dental institutions are vital public trusts and national resources. They educate the future dental workforce; conduct dental research; inform communities of the importance and value of good oral health; and serve as safety-net providers to ensure access to effective oral health care.

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1 Poisal, JA, Truffer C, Smith S, Sisko A, Cowan C, Keehan S, Dickensheets B, Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact. Health Affairs, 21 February 2007: W242-253.

2 DeNavas-Walt C, Procter BD, Lee CH, Income, Poverty, and Health Insurance Coverage in the United States: 2005, U.S. Census Bureau, August 2005, pg. 18.

3 U.S. Department of Health and Human Services. *National Call to Action to Promote Oral Health,* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, Spring 2003.

4 Source: NADP/DDPA 2007 Dental Benefits Joint Report: Enrollment, August 2007.

5 Ayanian JZ,Weissman JS, Schneider EC, Ginsburg JA, Zalavsky AM, *Unmet Health Needs of Uninsured Adults in the United States, JAMA.* 2000;284:2061-2069.

6 The death in 2007 of 12-year old Deamonte Driver in Maryland dramatically demonstrates the tragic human consequences that can occur when someone is unable to get dental care. His untimely death resulted from complications of an acute dental infection that spread to his brain. When he was finally able to get care, the cost of his hospitalization was estimated at approximately $250,000. Had he gotten treatment earlier, the cost would have been closer to $80. This story emphasizes the importance of identifying individuals with acute dental needs in the U.S. health care system and ensuring they obtain timely and necessary treatment.

7 The American Dental Education Association (ADEA) represents all 57 dental schools in the United States in addition to 714 dental residency training programs and 577 allied dental programs, as well as more than 12,000 faculty who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge; where the majority of dental research is conducted; and, where significant dental care is provided. Academic dental institutions are safety-net providers and serve as dental homes to hundreds of thousands of patients, many of whom are underserved low-income patients covered by Medicaid and the State Children's Health Insurance Program.

8 US Department of Health and Human Services. Diagnosis and management of dental caries throughout life. Rockville, MD: National Institutes of Health, NIH Consensus Development Program, conference statement, March 26-28, 2001.

[9] Haden NK, Catalanotto FA, Alexander CJ, Bailit H, Battrell A, Broussard J, *Improving the oral health status of all Americans: roles and responsibilities of academic dental institutions*: the report of the ADEA President's Commission, J Dent Educ. 2003; 67(5): 563-583

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[11] Sinclair SA, Edelstein B, *Cost effectiveness of Preventive Dental Services*, Washington, DC, Childen's Dental Health Project, February 2005.

[12] Zavras A, Andreopoulos N, Katsikeris N, Zavras D, Cartsos V, Vamvakidis A, *Oral cancer treatment costs in Greece and the effect of advanced disease*, BMC Public Health 2002, 2:12. Available at: http://www.biomedcentral.com/1471-2458/2/12.

[13] US Department of Health and Human Services. *Cost Savings of Community Water Fluoridation.* Atlanta, GA. Centers for Disease Control and Prevention Division of Oral Health website, August 2007. Available at: http://www.cdc.gov/Fluoridation/fact_sheets/cost.htm. Accessed June 19, 2008.

[14] Smedley BD, Butler AS, Bristow LR, In the nation's compelling interest: ensuring diversity in the health care workforce. Washington, DC, Institute of Medicine, Board on Health Sciences Policy, Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Health Care Workforce. National Academies Press; 2004.

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[16] Stoll K, Thorpe K, Pollack R, Jones K, Schwartz S, Babaeva L, *Paying a Premium The Added Cost of Care for the Uninsured*. Washington, DC, Families U.S.A., June 2005.

[17] Sinclair SA, Edelstein B, *Cost effectiveness of Preventive Dental Services*, Washington, DC, Childen's Dental Health Project, February 2005.

[18] Pettinato E, Webb M, Seale NS, A comparison of Medicaid reimbursement for non-definitive pediatric dental treatment in the emergency room versus periodic preventive care, Pediatric Dentistry, 2000: 22(6), pp. 463-468.

[19] Source: NADP/DDPA 2007 Dental Benefits Joint Report: Enrollment, August 2007.

Article published Oct 15, 2008

Maine trains family docs to do basic dentistry

FAIRFIELD, Maine (AP) _ Maine has come up with a way to help deal with a shortage of dentists: Family doctors are getting trained on how to pull teeth, lance abscesses and apply fluoride.

Dr. Sarah Spencer, who's in her third year of residency in Fairfield, is one of those doctors learning basic dentistry. She says it was "pretty intimidating" at first, but she's getting the hang of it.

"She did 11 teeth on two patients with me looking over her shoulder and she did a good job. And the patients were well served," Dr. James Schmidt, president of the Maine Dental Association, said Wednesday.

Dr. William Alto and two other doctors from the Maine Dartmouth Family Medicine Institute, which has offices in Fairfield and Augusta, began building the training program in 2003 because of the shortage of dentists, especially in rural parts of the state.

There are fewer than 600 dentists in Maine, or about one dentist for every 2,200 Mainers, Schmidt said. That compares to the national average of one dentist for every 1,600 people.

There are several reasons for the lack of dentists: MaineCare reimbursements are too low, Maine is a rural state and there's no dental school in the state, Alto said.

Schmidt, former chief of dental services at the Togus VA Hospital, was enlisted by Alto to join in the program to train family physicians in Dentistry 101.

So far, about 40 family practice residents have gone through the program at the Maine Dartmouth Family Medicine Institute. The goal isn't to transform them into dentists, but simply to make them aware of oral health issues — without going overboard, Schmidt said.

If they're comfortable doing so, physicians learn to administer local anesthesia and to remove loose teeth that have single roots, he said. They also can tackle other relatively simple tasks like lancing an abscess or applying fluoride to children's teeth, he said.

Expanded access to dental care is important because oral health has been linked to overall health, but not all dentists are thrilled with the new program, Schmidt said.

"It's not popular among all dentists," Schmidt said. "My passion is for all of our citizens to have access to good care ... I don't really care who provides the service, as long as the service is appropriate, done well and the follow up is good."

American Health Care Association

National Center for Assisted Living

STATEMENT
Of

The American Health Care Association and National Center for Assisted Living
for the
Senate Committee on Finance:

"Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future"

March 12, 2009

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL), which represent nearly 11,000 dedicated long term care providers, commend Chairman Baucus, Ranking Member Grassley, and Members of this Committee, for allowing our profession to express our views and ideas surrounding our commitment to resolving the ongoing workforce crisis to better equip us to care for our senior and disabled population today and in the years to come.

Americans are living longer and our nation's aging population is growing. Each year, more than 3 million Americans are cared for by one of the nearly 16,000 nursing facilities nationwide with nearly 80 percent relying on Medicare or Medicaid to pay for the care they need Millions more of America's seniors depend upon care and services offered by assisted living communities or in their own homes. The demand for long term care is projected to more than double by 2040 – with as many as 9.3 million older Americans expected to rely on paid long term care services every year – either in a nursing facility or with paid home care.

The long term care sector accounts for 1.1 percent of the nation's Gross Domestic Product. A major driver of economic activity, long term care employs approximately 3 million individuals, generates more than $56 billion in annual tax revenue, and indirectly contributes nearly $372 billion to the U.S. economy each year. Even so, we struggle to recruit and retain a long term care workforce that can meet the growing needs of our profession and our nation.

Human contact is essential to treating long term care patients and residents, and you will never be able to replace the role that people play in providing long term care. AHCA/NCAL has long recognized that the provision of high quality long term care and services is dependent upon a stable, well-trained workforce. However, America's long term care system is currently suffering from a chronic supply and demand problem

when it comes to our labor force. Addressing this challenge on both fronts is the only real means to sustain the provision of high quality long term care.

Long Term Care – A Workforce in Crisis

There is a current crisis with caregiver shortages in long term care that will only be further exacerbated in the coming years. The most rapidly growing age group in America is those aged 85 years and older, and is expected to quadruple by 2050. These are the precise individuals who will require essential long term care services in the very near future.

These trends are further compounded by the impending care needs of the nearly 80 million baby-boomers who are set to retire in the not too distant future. Their retirements will not only signal the future care needs of this generation, but will also signal the departure of our most experienced nurses, administrators, therapists, and caregivers who are currently employed in our nation's nursing facilities and assisted living residences.

A 2008 Institute of Medicine (IOM) report, "*Retooling for an Aging America: Building the Health Care Workforce*," concluded that there is an urgent need to prepare the health care workforce to better serve our aging population. The study found less than one percent of all nurses are certified gerontological nurses, even as the population of older people is on track to double by 2030. Absent any change, by 2020, the supply of nurses in the United States will fall 29 percent below projected requirements – resulting in a severe shortage of nursing expertise relative to the demand for care of medically complex, frail older adults.

While the need to expand the current workforce to meet growing demands is imperative, it can not be ignored that the number of current vacancies in nursing facilities across the country is staggering. Our recent Nursing Position Vacancy and Turnover Study estimated that nearly 110,000 health care personnel full-time equivalents (FTE) were needed nationwide to fill vacant nursing positions. Of those vacancies, the study found, approximately 19,400 were for registered nurses and 24,200 for licensed practical nurses, while the significant majority was for Certified Nurse Assistants (CNAs) – nearly 60,300 open positions.

Vacancies and turnover in the long term care profession compromise sustained quality improvements and increase costs. In fact, a recent report from the *National Commission on Nursing Workforce for Long-Term Care* concluded that "efforts to recruit and train new nursing staff are estimated to cost nursing facilities over $4 billion each year – more than $250,000 annually for each nursing home in the nation."

While efforts to recruit and train new qualified long term caregivers are costly, our profession has been aggressively pursuing potential nurses and caregivers. An unfortunate truth exists that nursing education programs are forced to turn away well-qualified applicants for the sole reason that there are not enough nurse educators to train these potential caregivers. In fact, the National League of Nursing found that 99,000 qualified applicants were not accepted into nursing programs in 2008 primarily because of faculty and resources shortages.

The Current Financing System Fails to Support Workforce Needs

Despite the growing demand for long term care, the current financing mechanisms rely heavily on public programs with Medicaid and Medicare funding the greatest portion of nursing facility care.

Although Medicare reimbursement rates do have a component that accounts for wage increases for skilled nursing facilities, there is a significant time lag between rising labor rates and increases in reimbursement rates. Recruitment costs and increases in the federal minimum wage or other salary increases are often not represented in state Medicaid reimbursements and states are not obligated to adjust their reimbursement under Medicaid despite higher wage costs.

Clearly, this has the potential to create a still greater cost squeeze on facilities than is already the case, and places increased pressure on already strained state Medicaid programs and budgets. A recent *Eljay, LLC*, study projected that states would cumulatively under fund the actual cost of providing quality nursing facility care by $4.2 billion in 2008. The study further showed the average shortfall in Medicaid nursing home reimbursement was $12.48 per patient day in 2008 - a 38 percent increase from 1999.

The Future Long Term Care Workforce – Solutions & Strategies

Looking to the future, we need to acknowledge the growing role that nursing facilities play in providing short-term post acute care. A recent *United Hospital Fund* report documents the growing role that nursing facilities play in furnishing short-term care for people continuing to recuperate after a hospital stay. The report also found that the "number of patients staying in a nursing facility for less than two months more than tripled," from 1996 to 2005 in New York. In addition to this rise in short-stay patients, the study further concludes that, "between 1996 and 2005, both long-term residents and short-term patients have become more disabled, and more of them are cognitively impaired." The authors indicate that the findings of this study are representative of national trends. In light of this shift, recruiting and retaining staff is especially critical, because caring for higher acuity patients with more cognitive impairments requires a more highly trained and educated workforce.

We are committed to being a solution to the nation's current healthcare workforce shortage. Overcoming this shortage will have a tremendous positive impact on patient and resident care and services. As a founding member of the newly developed National Healthcare Career Network, we have established the AHCA/NCAL Long Term Care Career Center which will help our profession attract the well-trained, qualified workforce needed to care for America's frail, elderly and disabled by providing member companies with the only career network dedicated to linking more than 100 participating professional societies and healthcare job seekers to the jobs you are looking to fill. The career center will fill a needed gap, providing qualified candidates with a job board featuring healthcare employment opportunities.

As Congress and the Administration takes on the tough task of health care reform, we stand ready to work with you to achieve patient-centered, cost-effective, and sustainable long term care that is part of our nation's overall health care system. We all agree that not only do consumers deserve the highest quality care and services across the spectrum of health care settings, but also employees deserve well-paid, positive work environments. As the profession responsible for the care of our nation's most vulnerable citizens, we are proud of the advances we have made in delivering high quality long term care services and we remain committed to sustaining these gains in the years and decades ahead.

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Statement

of the

American Medical Association

to the

Committee on Finance

United States Senate

RE: Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

March 12, 2009

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to submit a statement on our nation's health care workforce needs. We hope our comments provide you with further guidance on legislative mechanisms needed to address the looming health care workforce shortages. We commend Chairman Baucus, Ranking Member Grassley, and Members of the Committee on Finance for recognizing that the health care workforce is a vital component to health care reform and access to care.

Workforce experts predict that a growing and aging population, advances in medicine that lead to longer life, an aging physician workforce, and universal coverage will significantly impact supply of and demand for physician services in the U.S. There is agreement from many sources that the U.S. faces a physician shortage. A 2005 Council on Graduate Medical Education (COGME) report projected that by 2020, the shortage of physicians will reach 85,000. In November 2008, the Association of American Medical Colleges (AAMC) estimated a shortage of at least 124,000 physicians by 2025 across all specialties. It is critical that Congress, working with the physician community and others in the health care industry, take immediate action to address the future physician workforce needs of the nation, particularly in specialties that face shortages and in underserved areas.

Graduate Medical Education

The current expansion of medical schools and growth in medical student enrollments will not address the physician shortage unless the number of U.S. graduate medical residency slots are increased as well. Only by increasing the number of physicians in residency training will the number of practicing physicians in the workforce grow. A growing and aging patient population will directly benefit from an increase in the number of practicing physicians. Therefore, fully funding graduate medical education (GME) positions and

lifting the cap on Medicare-supported GME slots are essential steps to ensure that we have a fully trained health care workforce to serve the future needs of patients.

The Balanced Budget Act (BBA) of 1997 capped the number of medical residents each teaching hospital could claim for reimbursement under Medicare. Medicare does not generally reimburse teaching hospitals for training residents if the number exceeds the capped number of residency slots. COGME recommends removing the current cap on residency slots and increasing the number of funded slots by 15 percent. Additionally, a peer-reviewed study published in the *Journal of the American Medical Association* (JAMA) in 2008 projects an additional 21,000 residency spots will be necessary within the next decade. A 2008 Institute of Medicine (IOM) report calls for the reduction in duty hour shifts for resident physicians in order to enhance patient safety. Expanding the number of GME positions would also help cover the shorter shifts if the IOM recommendations are adopted.

The AMA also recommends lifting the cap on Medicare-funded residency slots for undersupplied specialties and underserved areas, and fully funding GME by preserving Medicare and Medicaid funding of GME and investigating additional sources of GME funding. In addition, we recommend allowing greater flexibility in GME and other programs to encourage training in non-hospital settings while enhancing the quality of training for resident physicians. Finally, we recommend bringing together a variety of local, regional, and national stakeholders including representatives from state medical schools, academic health centers, teaching hospitals, physician specialty societies, public health, and policy leaders to determine and make recommendations on geographic and specialty distribution physician workforce needs and how meeting these needs should be funded.

Title VII Health Profession and Diversity Programs and the National Health Service Corps

Through low interest loans, loan guarantees, loan repayment programs, and scholarships to students, as well as grants and contracts to academic institutions and non-profit organizations, Title VII of the Public Health Service Act is an essential component of the nation's health care safety net. Title VII programs help increase the supply of primary medical care and preventive medicine specialists and help ensure that health care professionals are trained to provide quality care, represent the diverse makeup of the general population, and are available to communities across the country, particularly those in underserved areas. The Title VII primary care cluster is the only federal funding dedicated specifically to the education and training of the primary care workforce. Data indicates that Title VII funded programs have increased the family physician workforce in rural and low income communities.

While the diversity of the population of physicians-in-training and in practice is far from optimal, Title VII programs have helped to increase the diversity of the workforce. They include vital health professions programs such as Centers of Excellence, Scholarships for Disadvantaged Students, Health Careers Opportunity Program, and Faculty Loan

Repayment Program/Minority Faculty Fellowship Program that provide both policy leadership and support for health professions workforce enhancement and educational infrastructure development. Increasing funding for Title VII programs would improve the geographic distribution, quality, and diversity of the health professions workforce. Area Health Education Centers and Regional Centers for Workforce Analysis are necessary to improve the supply, distribution, diversity, and quality of the health care workforce, ultimately increasing access to health care in medically underserved areas.

Congress last reauthorized these Title VII programs in 1998. Since then, many of the Title VII health professions and diversity programs have faced significant cuts. The AMA was pleased that H.R. 1, the "American Recovery and Reinvestment Act of 2009," (P.L. 111-5) included needed health professions funding that could be allocated toward Title VII health profession and diversity programs. Reauthorizing and fully funding these programs are crucial to developing a well-prepared, well-distributed, and diverse health care workforce.

The National Health Service Corps (NHSC) is also vital to addressing the health care needs of our nation. The NHSC recruits and retains primary care physicians (i.e., general internal medicine, general psychiatry, general pediatrics, OBGYNs, etc.) and other health care providers (i.e., nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, and dental hygienists) in underserved rural areas by providing incentives through loan forgiveness programs and scholarships. The NHSC improves access to health care for underserved areas, provides incentives for practitioners to enter primary care, reduces the financial burden that the cost of health professions education places on new practitioners, and helps ensure access to health professions education for students from all backgrounds. Since its creation, the NHSC consistently has received significantly more applications for positions than it is able to support with the funding provided by Congress.

However, in the past five years funding for the NHSC has been cut by over $47 million, a 27 percent reduction from the $171 million in FY 2003 that was already insufficient to meet the nation's health care needs. As a result, the NHSC reduced the number of new annual scholarship and loan repayment awards by over 30 percent during that period. While H.R. 1 provides funding for the NHSC over the next 2 years, the NHSC estimates it will only result in an additional 4,250 NHSC practitioners.

The AMA recommends restoring full funding for Title VII health profession and diversity programs and increasing funding for the NHSC program. For FY 2010, the AMA recommends a combined appropriation of $235 million for the NHSC. This figure represents the amount authorized under the "Health Care Safety Net Act of 2008" (P.L. 110-355) for NHSC Recruitment ($156,235,150), with a proportionate increase in the NHSC Field appropriation.

International Medical Graduates

Many communities, including rural and low-income urban areas, have problems attracting physicians to meet their health care needs. To address these unmet needs, many of these communities have turned to international medical graduates. A program that is essential for addressing physician shortages in underserved areas is the J-1 Visa waiver program, which allows international medical graduates to remain in the U.S. after their residency if they have agreed to practice in a medically underserved location for at least 3 years, working specifically in H-1B Temporary Worker status. The AMA supports permanent reauthorization of the Conrad State 30 J-1 Visa Waiver Program; a program authorizing state health agencies to place physicians annually in either federally designated Health Professional Shortage Areas or Medically Underserved Areas where it is difficult to recruit physicians. The AMA also recommends increasing the number of Conrad 30 program slots and exempting from immigration caps physicians with H-1B visas who have completed their J-1 visa waiver service requirements.

Medical Student Debt

With an average debt for medical student graduates of $155,000, debt plays a major role in medical students' career decisions, as well as discouraging individuals from socioeconomically-disadvantaged backgrounds from applying to medical school. High medical student debt is a significant hardship throughout the loan repayment period, especially during the three to seven years of training in medical residency programs. The average first-year stipend for medical residents is low, and makes it difficult for residents to train in urban areas where the cost of living is high. The high debt burden that many medical graduates face often influences their career choices. Borrowers with high loan debt are often deterred from entering public health service, practicing medicine in underserved areas, starting a career in medical education or research, or practicing primary care medicine. Loan deferment and forgiveness programs are necessary for ensuring that health care professionals represent the diverse makeup of the general population, and are available to communities across the country, particularly those in underserved areas.

In order to alleviate high medical student debt burdens, the AMA recommends creating more opportunities for debt relief through tuition assistance and loan forgiveness for service programs, low interest rates for medical student loans, income tax exemptions for medical student scholarships, inclusion of dependent costs in the "cost of attendance" definition to permit trainees to claim dependent costs in loan eligibility calculations, and expansion of loan forgiveness programs to medical teaching faculty. Loan forgiveness should especially be considered for primary care and other specialties with critical shortages. Additionally, the AMA strongly supports reestablishing the "20/220 pathway" for economic hardship loan deferment. The elimination of the economic hardship deferment, also known as "the 20/220 pathway," which expires on June 30, 2009, requires new medical residents to choose between making required monthly payments under the newly created income-based repayment program or deferring under forbearance, which dramatically increases their repayment costs. Reinstating the 20/220

pathway would allow medical residents to better manage their high debt burden and focus on their medical training and development during the critical and challenging years of residency.

Medicare Physician Payment System Reform

We need to find ways to keep practicing physicians caring for seniors and encourage the best and brightest students to become physicians; permanent Medicare physician payment reform will help us achieve that goal. As a result of the flawed Medicare physician payment formula, known as the sustainable growth rate, or SGR, physicians face cumulative cuts of over 40 percent in the coming decade, including a 21 percent cut scheduled for January 1, 2010. Physicians cannot absorb these steep losses, especially when physician practice costs are expected to increase by at least 20 percent at the same time that rates are being cut. In addition, these cuts affect physician workforce issues. As discussed above, the COGME and AAMC are already predicting severe physician shortages across all specialties by 2020 and 2025, respectively. Other studies forecast shortages in a number of specialties, including primary care, cardiology, emergency medicine, general surgery, geriatric medicine, oncology, neurosurgery, and thoracic surgery. Multi-year cuts in Medicare are nearly certain to exacerbate these shortages by making medicine a less attractive career and encouraging retirements among the 35 percent of physicians who are 55 or older.

Conclusion

The AMA appreciates the leadership of the Committee and remains committed to working closely with you on further developing legislation in order to ensure that the nation has an adequate, fully trained, accessible health care workforce to meet the needs of our growing and aging population. Addressing the current and future physician workforce needs of the nation is a critical component of health care reform. Fully funding GME and increasing GME positions, particularly in specialties that face shortages and in underserved areas, bringing together a variety of health care experts to assess and make recommendations on our physician workforce needs and how meeting these needs should be funded, increasing funding for the Title VII health profession and diversity programs and the NHSC, alleviating high medical student debt burdens, and reforming the Medicare physician payment system will help to ensure that every American has access to physicians and high-quality health care in the coming years.

Statement
of the
American Nurses Association
to the
United States Senate Committee on Finance

Workforce Issues in Health Care Reform:
Assessing the Present and Preparing for the Future

March 12, 2009

The American Nurses Association (ANA) deeply appreciates the Committee's recognition of the importance of workforce issues to healthcare reform, and the valuable focus brought to the issue by the hearing held on March 12. ANA is the only full-service professional organization representing the interests of the nation's 2.9 million registered nurses, and advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, and sharing a constructive and realistic view of nursing's contribution to the health of our nation.

While the day's discussion centered primarily on solutions to the physician shortage, we would echo the comments made by some witnesses emphasizing that, in order to meet our nation's health care needs we must ensure that we have an integrated national healthcare workforce policy that looks beyond physicians to ensure that the valuable contributions of Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs), and others on the health care team are appropriately recognized and integrated as we move forward with healthcare reform.

There are a wide variety of ideas currently circulating on health care reform, but all include a focus on prevention and screening, health education, cultural competency, chronic disease management, coordination of care and the provision of community-based primary care. These are precisely the professional services and skills that registered nurses bring to patient care. As the largest single group of clinical health care professionals within the health system, licensed registered nurses are educated and practice within a holistic framework that views the individual, family and community as an interconnected system that can keep us well and help us heal. Registered nurses are fundamental to the critical shift needed in health services delivery, with the goal of transforming the current "sick care" system into a *true* "health care" system.

RNs are the backbone of hospitals, community clinics, school health programs, home health and long-term care programs, and serve patients in many other roles and settings. Advanced Practice Nurses, in particular Nurse Practitioners and Nurse Midwives are proven providers of high-quality, cost effective primary care. The support, development and deployment of this keystone profession is essential for any quality health reform plan to succeed.

It is precisely because of the integral role nursing plays in health care that we urge the committee to give increased attention and focus to addressing the growing nursing shortage as part of health care reform. The Bureau of Labor Statistics (BLS) reports that the health care system will require more than 1 million new nurses by the year 2016, and the potential increased coverage promised by healthcare reform will only exacerbate that shortfall.

Attention to and investment in faculty and workforce recruitment and development is vital. Given that we are losing so many new nurses within the first year of practice—as many as 1 in 5 according to a 2004 national study, nurse retention strategies such as attention to safe staffing must play a vital role in efforts to address the nursing shortage as well. Without attention to these areas of concern we will not meet the needs outlined by the BLS. More to the point, if we do not undertake such efforts, our healthcare delivery system will not meet the needs of the American people, whether under our current system or a new paradigm created through healthcare reform.

While the hearing discussion focused a majority of time and attention toward physician education and training toward primary care—certainly a component of workforce reform—there was little in-depth attention given to the significance of the growing nursing shortage and the neglected systems that exist within our communities, such as public health and preventive services, community clinics, hospitals, mental health services, long term care, primary health care, schools, work places, and other venues where health services are delivered. Although reform of Medicare Graduate Medical Education (GME) and efforts to grow the physician population are needed (and we would argue that Graduate Nursing Education deserves significant attention as well) such efforts in isolation will not result in the creation of a health workforce that will be able to meet the care needs of the United States.

We appreciate that this view was shared by some on the panel and valued the Chairman's questions regarding the origins of and solutions to the nursing shortage. However it was clear that there was not sufficient time and expertise available to delve deeply into his questions.

Finally, we whole-heartedly agree with the comments made by Dr. Wartman:

"I think it's really important for the Committee to look beyond physicians to solve these problems—and we've heard mostly talk about physicians today. There are a host of other professions that are out there that can be very, very helpful-- and in fact some models that I've seen, instrumental --in bringing care to needed populations, whether they be in the nursing profession at a variety of levels, whether it be in the physician assistant programs, pharmacy in the community, psychology, things of that sort, it's all out there. Moving beyond just looking at the physicians, we need to consider all health professionals as we put this together, and then you bump right into the problem that I alluded to in my earlier remarks: there are a lot of barriers to making that work well. And those barriers could be everything from health workforce laws, standards, scope of practice, licensing, credentialing, things of that sort. How do you reimburse team care? What does that mean? How could we improve that? So I think there is a real good

opportunity here to begin to look at the big picture of all the providers that are out there and figure out ways to overcome the barriers that keep the from working very effectively together. My opinion is that if we rely only on physicians we won't have a solution that works."

Because these questions are so fundamental, ANA urges the Committee to hold another hearing involving experts on the nursing profession, as well as representatives of other professions to further explore both the nursing shortage, as well as ways that we can reduce the barriers in our current system that prevent full integration, coordination, and collaboration at all levels among our nations health care workforce. Again we appreciate the dialogue that the committee started on the 12th, and hope that you will continue this discussion. In order to be successful in transforming our nation's health care system, we must have a holistic workforce policy that full recognizes the vital role of nurses and other providers.

ANA looks forward to working with Chairman Baucus, Ranking member Grassley, the Senate Finance Committee, and other progressive voices seeking comprehensive health reform, in order to assure that the promise of universal coverage is fulfilled through accessible, high-quality, affordable health care for all.

AOTA® The American Occupational Therapy Association, Inc.

Occupational Therapy: Skills for the Job of Living

STATEMENT FOR THE RECORD
COMMITTEE ON FINANCE AND THE HEARING ON
Workforce issues in Health Care Reform: Assessing the Present and Preparing for the Future
March 12, 2009

Contact:
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The American Occupational Therapy Association (AOTA), representing the professional interests of more than 140,000 occupational therapy practitioners and students across the United States, submits this statement for the record of the March 12, 2009 hearing. We appreciate the opportunity to provide this information regarding workforce issues for occupational therapy as they relate to the broader health care reform debate.

AOTA recognizes the need for health care reform and like other stakeholder groups understands the impact that increased coverage will have on the need for qualified health care professionals. An increase in coverage will lead to additional demand for services that are essential to the health and well being of recipients. Of concern to all stakeholders in this discussion is how to best insure that recipients of medical care have access to all necessary and beneficial health care services like occupational therapy.

Addressing shortages in primary care physicians is a major challenge but AOTA believes it is only part of the solution and that in order to achieve any significant reform to our health care system, shortages need to be identified and addressed across the entire spectrum of health care providers to include occupational therapy practitioners.

A recent study by the Robert Wood Johnson Foundation estimates that by 2014 there will be a massive growth in the need for non-physician health professionals with an estimated 43,000 new positions in the field of occupational therapy alone. While the projected need for practitioners is increasing dramatically the projected supply of occupational therapy practitioners is not increasing at an adequate rate to meet the projected demand. As of April 2006 there were 146 accredited occupational therapist education programs with the total number of students enrolled reaching 11,138. Even a steady growth of occupational therapy students in subsequent years will fall well short of meeting the projected growth in demand for qualified practitioners. When considering these numbers for the future in the context of the already existing shortage of occupational therapy practitioners it becomes clear that steps need to be taken to enable occupational therapy programs to graduate more practitioners. Shortages of qualified occupational therapy practitioners can be viewed as a result of both increased demand and a reduced supply of qualified practitioners. The supply of new graduates from occupational therapy and occupational therapy assistants programs decreased sharply between 1999-2004 with enrollment data showing that the number of occupational therapy students decreased 43% from a peak of

17,665 in 1999 to 10,008 in 2004 and the number of occupational therapy assistant students decreased by 54% from 7,903 in 1999 to 3,662 in 2004. Many of these decreases can be attributed to changes in the marketplace, effected primarily by changes in Medicare payment for occupational therapy services instituted by the Balanced Budget Act of 1997.

While the number of students in both occupational therapy and occupational therapy assistant programs are steadily on the rise, the growth is far short of meeting the current or future need and will leave patients in vital care settings without access to valuable occupational therapy services.

Occupational therapy practitioners provide essential services to a variety of populations in various settings across the lifespan including services in early intervention, with veterans, with the elderly, in home health settings, with autism patients and numerous other critical areas. The future need for qualified professionals is poised to drastically increase making it imperative that shortages in qualified occupational therapy practitioners are addressed to protect and promote the health and well being of patients.

Several state governments, including those in California, Hawaii, Maryland, and Connecticut, have identified shortages of occupational therapy practitioners and initiated steps during recent legislative sessions to address this area of need. In Maryland Governor Martin O'Malley's Workforce Investment Board identified occupational therapy as a health care profession experiencing a shortage of qualified practitioners and legislation was subsequently passed implementing a loan forgiveness program to include occupational therapy students. Connecticut Governor M. Jodi Rell also signed legislation providing loan forgiveness for allied health professionals specifically including students enrolled in occupational therapy programs.

AOTA believes that there is a dire need to address current and future workforce shortages in the field of occupational therapy. Limited access to qualified practitioners will adversely affect the ability of patients to receive the most appropriate services and will negatively impact patient outcomes. Continued workforce shortages will hinder the effectiveness of major health care reform if not addressed.

Congress has passed a mechanism that can be used to improve workforce shortages. Most recently occupational therapy was included as a profession of national need under the College Opportunity and Affordability Act of 2008 (PL:110-315). Under this program occupational therapists are eligible for loan forgiveness. AOTA urges Congress to fund this important new program.

In addition, AOTA supports increased funding for the health professions education programs, authorized under Titles VII and VIII of the Public Health Service Act and administered through the Health Resources and Services Administration (HRSA), support the training and education of health care providers to enhance the supply, diversity, and distribution of the health care workforce, filling the gaps in the supply of health professionals not met by traditional market forces. They are the only federal programs

designed to train providers in interdisciplinary settings to meet the needs of special and underserved populations.

AOTA would also like to stress the important role HRSA can play in helping to address health care workforce shortages. In the past HRSA has funded five regional health workforce study centers. Funding for these programs was cut two years ago and has not been reinstated even though their work would be critical to improving and monitoring workforce trends. These Workforce Research Centers analyze trends in the supply of and demand for key health professionals. Re-establishing these centers will improve planning and decision making by policy makers, employers, educators, and young people making career decisions.

Again, AOTA thanks you for the opportunity to comment on this important issue raised by this hearing and look forward to continue working with the Committee to address workforce issues and any other issues relating to health care reform.

The Written Statement of the
American Organization of Nurse Executives (AONE)

for

The Senate Finance Committee Hearing on

"Workforce Issues in Health Care Reform:
Assessing the Present and Preparing for the Future"

The American Organization of Nurse Executives (AONE) represents over 6,000 Registered Professional Nurses in nursing leadership and executive practice. AONE is a well respected national, representative association for professional nurses in senior healthcare administration, nursing practice, academia, and nursing .leadership positions. The majority of AONE's membership of registered professional nurses is comprised of leaders in the management of clinical operations and the delivery of direct patient care services. In these positions, AONE's members have seen first hand the impacts of the worsening nursing shortage as it has continued over the last 10 years.

Nursing Demographics

Nursing is the largest health care profession with an estimated 2.9 million in the United States.[1] Nurses and advanced practice nurses (nurse practitioners, nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists) work in a variety of settings, including primary care, public health, home care, long-term care, surgical care facilities, and hospitals. Approximately 59 percent of RN jobs are in hospitals.[2] A federal report published in 2004 estimates that by 2020 the national nurse shortage will increase to more than 1 million full-time nurse positions. According to these projections, which are based on the current rate of nurses entering the profession, only 64 percent of projected demand will be met.[3] A study, published in March 2008, uses different assumptions to calculate an adjusted projected demand shortfall? of 500,000 full-time equivalent registered nurses by 2025.[4] According to the U.S. Bureau of Labor Statistics,

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[1]Steiger, D.M., Bausch, S., Johnson, B., Peterson, A. (2006) *The Registered Nurse Population: Findings from the March 2004 National Sample Survey of Registered Nurses.* Health Resources and Services Administration, U.S. Department of Health and Human Services. On the Internet at: http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/. (Accessed December 9, 2008).
[2] Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, 2008-2009 Edition,* Registered Nurses. On the Internet at: http://www.bls.gov/oco/ocos083.htm (Accessed December 9, 2008).
[3] Health Resources and Services Administration. (2004) *What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?* On the Internet at: http://bhpr.hrsa.gov/healthworkforce/reports/behindrnprojections/4.htm. (Accessed December 9, 2008).
[4] Buerhaus, P., Staiger, D., Auerbach, D. (2008). *The Future of the Nursing Workforce in the United States: Data, Trends, and Implications.* Boston, MA: Jones & Bartlett.

about 233,000 additional jobs for registered nurses will open each year through 2016, in addition to the approximately 2.5 million existing positions. Based on these scenarios, the shortage presents an extremely serious challenge in the delivery of high-quality cost effective services, as the nation looks to reform the current healthcare system. Even considering only the smaller vacancy projection, this shortage still results in a critical gap in nursing service, essentially three times the nursing shortage in 2001.

The Bureau of Labor Statistics reports that registered nursing will have the greatest growth rate of all U.S. occupations in the time period spanning 2006 – 2016. Despite this projected expansion in the profession, the health care system may well require more than 1 million new nurses to meet the growing demand and to replace retiring nurses during this decade. The Health Resources and Services Administration (HRSA) predicts that the supply of RNs will fall 26% (more than one million nurses) below demand by the year 2020.

Efforts to Address the Nursing Shortage

Since passage 45 years ago, Title VIII programs have been the largest source of federal funding for nursing education. These programs supported the education and careers of thousands of nurses, advanced practice registered nurses, and nurse faculty. In recent years, despite the educational and lobbying efforts of the nursing community, Title VIII funding has remained virtually stagnant—unable to keep pace with inflation or rising educational costs. The inclusion of Title VIII programs in the overall stimulus package passed by the Congress makes investment in these programs essential if indeed our nation moves toward true health care reform.

The current nursing shortage is now 10 years old, and its impact has been felt by all aspects of health care delivery, making access to care a difficult challenge for our neediest and most fragile populations, the poor and the uninsured. Despite the growing interest in the nursing profession, there has been an inadequate number of nursing faculty available to educate new nurses. It is estimated that over 140,000 qualified applicants were turned away from accredited nursing programs in 2007. The sagging economy has heightened the interest in nursing careers, causing waiting lists to grow even longer. Nursing schools are at a competitive disadvantage when trying to attract masters prepared nurses as faculty to teach in nursing programs. The major issue is that nurse faculty positions pay $20,000 to $30,000 a year less than clinical nursing positions in hospitals and other health care facilities. This situation has been further exacerbated by burgeoning state budget deficits and cuts imposed on state educational programs, especially nursing programs that carry higher per student costs than other programs because of the clinical component Additionally, a rapidly aging population with a growing demand for health care services is expected to overburden a health care system that is currently under stress. Nursing programs are projected to be unable to produce enough nurses to meet the demand for RNs over the next 13 years.

AONE working with its colleagues in Congress, the nursing, and healthcare communities can point to successes in dealing with the shortage. Title VIII Nursing Programs will receive funding through the American Recovery and Reinvestment Act (H.R.1) recently signed into law by President Obama. Under the new law, $200 million will be equally distributed to Title VII and Title VIII programs administered by the Health Resources and Service Administration (HRSA) of the Department of Health and Human Services. This distribution of funds will provide at least $100 million for both the Title VII and Title VIII programs over fiscal years 2009 and 2010. This is in addition to the annually appropriated level of $171 million for FY2009. This amount is a $13.6 million increase over the FY 2008 level. Although these increases will provide a welcome boost to the program, this funding pattern is woefully inadequate to addressing the true needs of the shortage.

Nursing in Healthcare Reform

Solutions to the nursing shortage in the view of AONE must be addressed from a systems perspective that includes the entire universe of health professionals, not just nurses. To achieve this goal, AONE supports a structure such as a commission that would address workforce policy. Such a commission has been suggested in health services literature and in the testimony offered before the Senate Finance Committee. It is our understanding that draft legislation creating a National Health Workforce Commission is under development.

By addressing health care shortages from a systems perspective, the cyclic shortages that have faced nursing over the years could be eliminated. A commission like this would have to have the authority to address all issues impacting the health care workforce and develop policies that improve access to care, health outcomes, and the issues of quality and affordability.

Consensus by members in the nursing community have found Title VIII nursing education programs to be valuable for the opportunities that they provide for the education and training of professional and advanced practice nurses but severely under funded when compared to the enormity of the total needs of the profession. Efforts to build on this legislation coupled with the oversight and policy guidance of a National Workforce Commission could help direct the comprehensive reform that is needed if our nation is to produce the number of health professionals, especially the number of nurses, it needs now and in the future.

The Healthcare Environment

An issue of great importance to AONE is the health care environment and the tremendous impact it has on the quality and safety of the care provided but also the impact it has on the ability to retain qualified nurses. A study based on a review of more than 6 million patient discharge records was published in the *New England Journal of Medicine* in May, 2002. The researchers found that hospitalized patients had better outcomes when a greater proportion of their nursing care was provided by RNs and when the number of hours of RN care per

day increased. Specifically, nursing shortages were found to correlate with longer lengths of stay, increased incidence of urinary tract infections and upper gastrointestinal bleeding, higher rates of pneumonia, shock, and cardiac arrest. Increased hours of RN care resulted in fewer "failure-to-rescue" deaths from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, and deep venous thrombosis.

A study published in the January/February 2006 journal *Health Affairs* showed that if hospitals increased RN staffing, more than 6,700 patient deaths and four million inpatient days could be avoided each year. With the research showing the important benefits of more nursing care, studies are also showing that hospital nursing can be emotionally and physically draining, especially for new graduates and those with two years or less of experience. The Advisory Board has reported that the cost of replacing a nurse can vary from $22,000 to $64,000.per nurse depending upon nursing expertise.

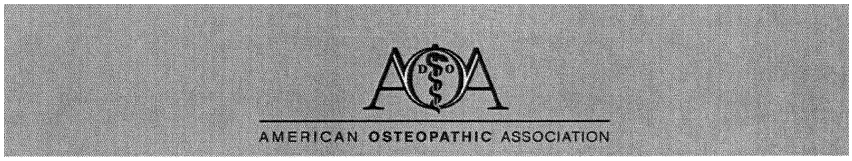
Patients are in hospitals for nursing care. Nursing represents over 40 percent of hospital expenditures and is the largest component of the healthcare workforce; but yet there are very limited federal efforts directed to training and retaining nurses at the bedside. Unlike the Graduate Medical Education (GME) program that has been the pivotal vehicle for of physician training in hospitals over the last 40 years, bedside nursing education programs have not had the support or the funding to sufficiently address the complexity and acuity of today's hospital environment. Because of the critical role nursing plays in quality and patient safety, nursing clinical education should be viewed with the same importance as we look to reshape healthcare and move toward healthcare reform.

Nursing Intensity

Research has shown that competent nursing care is critical to ensuring quality outcomes and patient safety. AONE has been on the forefront of efforts to have an accurate data driven accounting of nursing's contribution in achieving measurable quality patient outcomes. It is AONE's view that understanding the concept of Nursing Intensity and tracking it through each patient's hospitalization will improve overall payment accuracy, lead to a better understanding how nursing care hours and costs are allocated to individual patients and by DRG within and across hospitals, identify hospital nursing performance, and inform policy makers on the state of inpatient nursing care in the United States.

Efforts to achieve meaningful healthcare reform will require the broad participation of constituencies but will also require the courage to think outside of the box of current models and to work collaboratively for the greater good to create a quality healthcare system for all that is safe, affordable, and equally accessible to all.

Please direct comments or concerns to Jo Ann Webb, Senior Director of Federal Relations and Policy for AONE at jwebb@aha.org.



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March 12, 2009

The Honorable Max Baucus
Chairman, Finance Committee
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Baucus:

The American Osteopathic Association (AOA) would like to thank you for holding today's hearing and for your continued leadership on health care workforce issues. We are especially pleased that the physician workforce shortage is being included in discussion on broader health care reform. It is our belief that expanding access to health care coverage must be coupled with expanding access to health care services and the best way to accomplish this is by ensuring every American has coverage through an insurance policy and access to primary care, general surgery, and specialty care physicians. We appreciate the opportunity to weigh in on related workforce issues from the physician perspective.

It is well documented that our country is on the brink of a major shortage of physicians and other health care professions. Most policy experts now agree that the United States must increase its overall physician supply within the next decade. While the number of physicians in active practice is important, the AOA also believes we must recognize that simply increasing the number of physicians may not resolve our physician shortages. Instead of focusing solely on the number of physicians, we also must focus on training physicians in the most needed specialties, encouraging them to practice in communities in need, and reforming the health care system to provide a stable and equitable reimbursement system that is less influential upon career choice and discourages overspecialization.

Our current physician shortage comes at a time when it is estimated that the population of the United States will grow by 25 million people over the next decade and the number of Medicare beneficiaries will double within the next 20 years. By 2030, individuals over the age of 65 will account for over 20 percent of the population. Since Medicare beneficiaries, on average, use significantly more health resources than those under 65 the need for more physicians and other health care professionals will increase significantly.

Access to primary care and general surgery in the United States is declining at alarming rate and presents a major challenge to policymakers. Today, over 50 million people in the United States live in areas that are designated as health profession shortage areas and an estimated 50 million people lack adequate access to primary care physicians. We believe our current problems stem from a number of converging factors including deficiencies in the graduate medical education payment system, current physician reimbursement policies, regulatory burdens, and other issues.

The AOA has identified three priorities with respect to physician workforce development which are as follows:

- Increase Training Capacity
- Reinvigorate the Practice of General Medicine—Primary Care and General Surgery
- Improve the Health Care Marketplace

INCREASE TRAINING CAPACITY

While academic and policy experts debate the needs and expectations of the future physician workforce, the AOA recognizes that we must begin to educate and train a larger cadre of physicians now, particularly in primary care and general surgery. Current GME policies are largely responsible for the over-specialization of the physician workforce and geographic disparities in access to care. At this time, GME is subsidized by the Medicare program without reference to ensuring the appropriate distribution of physicians by geographic location or specialty. Reforming the financing of GME should address these and other policy issues.

Under the existing system, many regions across the country remain underserved, largely due to the fact that residency programs tend to be clustered around larger metropolitan areas. According to data included in the Fiscal Year 2009 Inpatient Perspective Payment Rule, there are 1,047 hospitals with teaching programs. This represents approximately 30 percent of all non-federal hospitals in the United States. Upon further review you find that 595 (57 percent) of these hospitals are in ten states. Given the fact that most physicians tend to stay in the geographic area in which they were trained, we believe that it is necessary to provide substantially more training opportunities in rural, suburban, and exurban communities.

Reform of the BBA 97 Cap on FTE Residency Positions

The current cap on full-time equivalent (FTE) residency slots, created by the Balanced Budget Act of 1997 (BBA), was intended to address a perceived oversupply of physicians in the 1990's. Instead, the cap has created an arbitrary limit on training capacity that is contributing to our current shortages. Additional BBA provisions, such as the 3-year rolling average, have impacted negatively community-based and rural programs—contributing to the decline in the number of primary care physicians. After 10 years, it is apparent that these policies have had a negative impact upon graduate medical education

The AOA does <u>not</u> support proposals that would seek to decrease training capacity in one community or state in an effort to increase it in others. For this reason, the AOA urges Congress to consider eliminating the cap on funded FTE's as established in the BBA. While we do not believe that every hospital in the country should be allowed to increase their overall cap independent of careful review, but we do believe that the current limitations on funded GME positions should be

overhauled for a more thoughtful policy. We suggest that teaching programs in underserved communities and/or regions—especially those in emerging population areas—be allowed to increase their overall training capacity to better meet the needs of their communities. Furthermore, we strongly urge that increases in funded FTE's be limited to primary care, general surgery, and those medical specialties most in need in designated communities.

Increase the Number of Training Facilities

Teaching hospitals provide a substantial percentage of safety net services to uninsured and underinsured populations while concurrently providing for the training of health professionals. However, the pipeline for educating physicians often does not incorporate ambulatory training venues that more closely resemble "real life" practice environments. For instance, community health centers have expanded to serve 16 million individuals in over 1,000 sites, yet they face high vacancy rates for primary care physicians.

As mentioned previously, there are over 2,500 hospitals in the United States that do not have teaching programs currently. Many of these are smaller community, suburban, and rural hospitals that often lack the necessary infrastructure and capital to develop a new teaching program. Currently, there is a 12 month to 18 month lag between hospitals beginning a teaching program and receiving direct and indirect graduate medical education payments from CMS. The AOA believes that providing bridge loans to these facilities to assist with expenses incurred during the program's inception and its eligibility for GME funding is a reasonable means of encouraging the development of new training programs.

This proposal is clearly laid out in the "The Physician Workforce Enhancement Act of 2009" (H.R. 914). This legislation directs the Secretary of Health and Human Services (HHS) to establish an interest-free loan program whereby hospitals committed to starting new osteopathic or allopathic residency training programs in one of eight medical specialties or a combination of these specialties (family medicine, internal medicine, emergency medicine, obstetrics/gynecology, general surgery, pediatrics, preventive medicine, or mental health) could secure start-up funding to offset the initial costs of starting such programs. Hospitals are required to repay the amount in full over a defined period of time, thus reducing the long-term financial impact upon the federal government.

Finally, given that a substantial portion of family medicine, general internal medicine, and pediatric training occurs in non-hospital, ambulatory settings, the AOA urges the Committee to investigate changes in law that would allow non-hospital sites and/or facilities to receive direct and indirect GME payments. We believe a demonstration project may be a reasonable means of investigating this proposal. At a minimum, we believe that it is reasonable to investigate methodologies whereby the direct GME money would follow the resident to such non-hospital based settings.

Reform and Reduce Regulatory Burdens

Over the past 10 years a complex and convoluted set of regulations have hindered graduate medical education, often resulting in loss of training capacity. Many of these issues center around the interpretation of legislative language by the Centers for Medicare and Medicaid Services (CMS) and the subsequent regulations promulgated. To encourage the preparation of a physician workforce equipped to meet the health care needs of the nation, the AOA believes that the current prohibition against counting resident time spent in education and research activities should be eliminated in all training settings.

Existing criteria for Medicare teaching hospital affiliation agreements are narrow and unnecessarily rigid. To encourage collaborative activity and facilitate high quality training, the AOA believes that these criteria should be expanded to provide additional bases for affiliation and allow for greater flexibility in developing and executing agreements. For example, hospitals that are part of established educational consortia should be allowed to enter into affiliation agreements at any time and aggregate their FTE resident caps despite current geographical limitations.

With respect to payments, we believe it is necessary to maintain the IME adjustment at the current 5.5 percent level and to raise direct GME payments for all teaching hospitals to 100 percent of the regionally-adjusted national average. We also believe that CMS should be prohibited permanently from eliminating the federal match for state support of GME under the Medicaid program and permanently barred from decreasing or eliminating the IME adjustment for capital costs.

These reforms to the graduate medical education system are an essential component of the development of a health care workforce equipped to meet the current and future demands for primary care and other underrepresented physician specialties. We strongly encourage the Committee to recommend that CMS make these changes administratively. If administrative resolution is not possible, we urge the Committee to consider implementing these recommended changes.

REINVIGORATE THE PRACTICE OF PRIMARY CARE

At least 56 million Americans, almost one in five of the population, are now "medically disenfranchised"—having inadequate access to primary care physicians because of shortages in their area—according to "Access Denied," a county-by-county study by the National Association of Community Health Centers and the Robert Graham Center, a research group that focuses on primary care. Among Medicare beneficiaries, about 3 percent—more than 1.3 million people—have difficulty finding a new primary care physician, a government survey found in 2007.

Additionally, a November 2008 white paper by the American College of Physicians said the number of U.S. medical graduates entering residencies in family medicine and internal medicine has decreased by half in the last decade. A confluence of factors have contributed to this decline as graduates seek out higher-paying specialties over the longer hours and lower reimbursements for services predominantly provided by primary care physicians. These trends also are seen in the area of general surgery which, like primary care, has seen dramatic reductions in their workforce over the past decade. The AOA believes that fundamental reforms to the GME system and health care market will be necessary to reverse this trend.

In addition to the health care system's failure to attract new physicians to primary care and general surgery, older physicians are frequently choosing early retirement, which is expected to exacerbate the projected shortages. A survey released in November by the Physicians' Foundation that detailed practicing physicians' frustrations found that nearly 60% would not recommend medicine as a career to young people and about half of all physician respondents said they plan to reduce their patient load or stop practicing within the next three years.

These providers cite professional dissatisfaction attributed primarily to problems in the delivery system associated with both public and private payers. Hours spent on paperwork and phone calls for prior authorizations demanded by Medicare, Medicaid, and commercial insurance companies

reduce the time spent with individual patients, as does the pressure to take on as many patients as possible to stay in business. Over the past decade, physicians have seen their reimbursements fall more than 20 percent below increases in medical inflation. Today, the earnings of primary care physicians are, on average, half or a third of other specialists. Finally, the recognized need for practice improvements such as electronic prescribing and electronic health records only add to the financial stress on primary care practices.

The AOA believes that the system needs new strategies starting with medical school training, which currently favors overspecialization. Our recommendations for achieving the goal of increasing the supply of primary care physicians and general surgeons include forgiveness of medical school debts for graduates who go into these needed fields, restructuring the payment system for these providers and establishing "patient-centered medical homes."

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth, and adults supported by the American Osteopathic Association, American College of Physicians, American Academy of Family Physicians and the American Academy of Pediatrics. The PCMH is a health care setting that facilitates partnerships between individual patients, their personal physician, and when appropriate, the patient's family.

Coordinated, integrated care offered through the medical home should be led by a physician working closely with other health care professionals to ensure that treatment is effective and based on a physician's diagnosis. However, the projected shortage of physicians will make it difficult to provide the highest quality of care available through a medical home. In many cases, these shortages may lead to substandard care in which patients only have access to non-physician providers, who are essential members of the health care team, but are not equipped to oversee the complex medical needs of most patients—especially Medicare beneficiaries.

Finally, we believe that geographic inequalities in the physician workforce lead to geographic disparities in quality of care and that reforms are necessary to effectively implement the physician-led medical home. The AOA is encouraged by your commitment to this concept and looks forward to working with you on its implementation through the demonstration project and beyond.

IMPROVE THE HEALTH CARE MARKETPLACE

The Medicare reimbursement system, and private payer reimbursements based on Medicare policies, offer few if any financial incentives for physicians to pursue careers in primary care and general surgery, particularly in underserved areas. Declining revenue, inadequate practice support for providing necessary care, and high levels of indebtedness are keeping qualified physicians from entering the primary care and general surgery workforce. Many medical students pursue medical specialties and subspecialties that offer higher reimbursements and more manageable practice environments as a result of the current system.

There are wide variations between Medicare payments for primary care and those for subspecialty services, according to Bruce Steinwald, director of health care for the U. S. Government Accountability Office. In Boston, for example, Medicare pays primary care physicians $103.42 for a 25- to 30-minute visit with an established patient who has a complex medical condition as compared to $449.44 paid for a diagnostic colonoscopy, a procedural service of a similar duration.

These payment disparities are exacerbated by technological improvements that enhance the ability of certain subspecialists to provide more complex services in a shorter period of time, leading to an increase in payments and making these specialties more attractive career options for medical students. In contrast, primary care physicians rely primarily on office visits and "cognitive skills" for their income and, thus, are limited in their ability to reduce time with their patients without compromising the quality of patient care.

The AOA believes that the value of primary care services and their ability to control health care costs justifies a restructuring of the payment system. In a metro area with a population of 775,000, increasing the proportion of primary care physicians from 35% to 40% would yield significant savings. Studies have shown that improving access to primary care physicians would:

- Reduce emergency department utilization by 15,000 visits a year.
- Reduce surgery by about 2,500 cases a year.
- Reduce hospital admissions by 2,500 a year, saving an estimated $23 million annually.

While a permanent fix to the current Medicare payment system and the sustainable growth rate (SGR) formula is necessary to avert drastic cuts for all physicians and resulting barriers to access, this is of particular importance to primary care physicians and general surgeons. The AOA supports a broad restructuring of the physician payment formula that promotes a steady increase in the supply of physicians across all specialties and geographic regions—with an emphasis on primary care and general surgery. We believe such policies will allow us to better meet the needs of our aging population in the years to come. This would include coordinated payments and other incentives for physicians to work with health care teams to coordinate and manage care of their patients.

Again, we appreciate the opportunity to provide comments on this important issue. We hope our comments and policy recommendations provide the Committee with guidance on how to best address the nation's future physician workforce. The AOA and our members stand ready to assist you in this endeavor.

Respectfully,

Carlo J. DiMarco, DO
President

CC: The Honorable Charles Grassley, Ranking Member
Members, Finance Committee

APTA
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Statement for the Record

By

American Physical Therapy Association

United States Senate
Committee on Finance

"Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future."

March 12, 2009

Chairman Baucus, Ranking Member Grassley and Members of the United States Senate Committee on Finance:

Thank you for your attention to addressing workforce issues in health care reform. This issue is of critical importance in your discussions of health care reform, maintaining a high quality health care delivery system and ensuring a productive society. Developing, maintaining and empowering an adequate workforce in rehabilitation are priorities for the American Physical Therapy Association (APTA). APTA stands ready to work with the U.S. Senate Committee on Finance to meet this policy challenge. APTA appreciates the opportunity to submit written comments for the record to provide the Committee with a perspective on workforce issues in the physical therapy profession.

APTA is the professional association representing more than 72,000 physical therapists, physical therapist assistants, and students of physical therapy with a mission to advance physical therapy research, practice and education. Physical therapists (PTs) are licensed health care professionals who diagnose and treat individuals of all ages, from newborns to the elderly, with medical problems or health related conditions that limit their ability to move and perform functional activities in their daily lives. PTs examine each individual and develop a plan of care using treatment techniques to promote the ability to move, reduce pain, restore function and prevent disability. Physical therapists practice in a variety of settings, including hospitals, home health, private practices and a number of federal programs. Physical therapists, at a minimum receive a master's degree from an accredited physical therapist education program before taking a national examination that permits them to practice under state licensure laws.

The following comments outline the workforce challenges in the physical therapy profession, a rationale for addressing these issues in health care reform and policy recommendations to meet these challenges as the Committee discusses workforce related issues. APTA strongly supports congressional action to include the following as you develop health care reform legislation:

- Fund for Clinical Education Sites for Physical Therapists;
- Funding for Physical Therapy Fellowships;
- Faculty Development Funding;
- Grants to Physical Therapy Programs to Expand Capacity; and
- Expanding Scholarship/Loan Repayment Programs to include Physical Therapists.

Scope of Workforce Challenges: Increasing Demand for High Quality Rehabilitation by Physical Therapists

The Department of Labor estimates a job growth for physical therapist positions of 47,000 jobs, or 27% between 2006 and 2016. (1) The demand for high quality rehabilitation services provided by physical therapists continues to grow and will experience its greatest growth in upcoming decades. The Institute of Medicine's recent report, *The Future of Disability in America*, estimated that there are currently between 40 and 50 million individuals in the United States that report some kind of disability. (2) The report also indicates that these numbers will significantly grow in the next 30 years as the baby boom generation enters late life when the risk of disability is at its highest. In addition to the proportion of individuals needing physical therapy due to disabilities or active aging, the increasing incidence of chronic conditions per capita in our population will also stress the supply of physical therapists. For example, the increased prevalence of diabetes, obesity and cardiovascular disease all have a dramatic impact on the need for rehabilitation professionals, such as physical therapists. Ensuring an adequate supply of physical therapists to meet the rehabilitation needs of individuals with disabilities, those with chronic conditions, and seniors will require investment by federal programs charged with maintaining an adequate and qualified health care workforce.

A Look at the Current Physical Therapist Workforce

The demand for physical therapists continues to rise. We believe our nation does not have an adequate number of physical therapists to meet the growing rehabilitation needs of patients. The scope of this challenge is extensive, with increasing needs for quality rehabilitation services in various settings. Issues include staffing concerns in outpatient private practice to acute care hospitals and skilled nursing facilities to the physical therapists caring for veterans and working in the Indian Health Service.

According to the American Hospital Association, therapists (physical therapists and occupational therapists) represent the area for which the greatest percentage of vacancies exists in hospitals across the nation, at 11.4 percent. (3) Based on a survey of human resource directors, APTA estimates that the physical therapist vacancy rate is 13.6 percent. APTA's recently conducted studies on workforce issues indicated that vacancies rates were high in additional settings for both physical therapists and physical therapist assistants. In the outpatient private practice setting vacancy rates for full-time physical therapists were 13.1% and 8.8% for physical therapist assistants. In skilled nursing facilities, the vacancy rates were even higher for full-time physical therapists at 18.6% and 16.6% for physical therapist assistants. The workforce studies also examined turnover rates and the average time to fill positions. Turnover for physical therapist positions was highest in the skilled nursing facility setting. The highest percentage of survey respondents in skilled nursing facilities and outpatient private practices reported the average time to fill a full time physical therapist position was 2-5 years. In the hospital setting, the greatest number of respondents to the survey reported the average time to fill a position was 61-180 days. (4,5,6)

Compounding the demographic challenges that continue to increase the demand for physical therapist is the national need to provide rehabilitation to the more than 31,000 servicemen and women who have returned home to recover from wounds sustained in service in the war in Afghanistan and Iraq as well as to meet the needs of the aging veteran population. Increasing the physical therapist workforce to address needs within the Unites States Department of Veterans Affairs, the Department of Defense, and in community-based settings is essential. Physical therapists play an integral role in rehabilitation of veterans as they cope with injuries from the battlefield. To ensure the proper care and recovery of those who have sacrificed to protect us, efforts to enhance the workforce of physical therapists in all federal programs is essential.

Meeting workforce challenges to improve access for all patient populations will be a critical part of health care reform. Vacancy rates for physical therapists in the Indian Health Service are estimated to be 23 percent. Patients served in the Indian Health Service have a high rate of diabetes. In addition, it is estimated that two in five American Indian/Alaska Native children are overweight, compared to one in five children in the general population. (7) Physical therapists provide interventions to increase physical activity among patients and to improve health status to reduce associated chronic disease risks.

Physical therapy continues to be one of the health care professions facing increasing workforce stress. APTA contends that demand is outpacing supply. In response, the profession continues to strive to balance efforts to educate a high quality physical therapist workforce to meet an increasingly complex and diverse patient population. APTA estimates that approximately 172,000 individuals comprise the current workforce. The United States Department of Labor estimated that physical therapists held 173,000 jobs in 2006. (8) The number of jobs is greater than the number of practicing physical therapists because some physical therapists hold two or more jobs.

Over the past decade, the number of physical therapists increased from 99,249 to the current 172,000. These changes reflect a combined growth rate of 66 percent. Unfortunately, we believe the demand for qualified physical therapists has outpaced this aggressive growth. Past efforts to address this demand though the use of foreign-trained physical therapists has been inadequate due to low passage rates on national licensure exams. Due to the extensive education and practice requirements of physical therapists, the use of other health care professions and paraprofessionals is limited and would not be able to meet the complex rehabilitation needs of individuals and communities. APTA is working with policy makers to develop strategies to increase the domestic labor force to fill these highly skilled jobs.

In addition to overall demand outpacing supply, the distribution of the physical therapist workforce is also a challenge. The distribution of the physical therapist workforce is disproportionate in underserved areas of our country, both rural and urban. One study of note, conducted by staff at the Sheps Center for Health Services

Research at the University of North Carolina - Chapel Hill, for The Council of Allied Health in North Carolina, looked at the distribution of the health workforce in North Carolina. This study found that counties designated as Health Provider Shortage Areas (HPSAs) currently have approximately 1.2 PTs per 10,000 residents while the remaining counties have about 4.0 PTs per about 10,000. (9) Ensuring the distribution of physical therapists to all areas of our country, especially when many of these areas have higher incidents of chronic disease and disability is critical to improving health care availability and accessibility.

Training the Next Generation of Physical Therapists: Current Program Capacity Challenges

While studies show that the need for physical therapists will increase, physical therapy education programs have not expanded rapidly enough to meet this growing need. According to *APTA's Education Fact Sheet* (an annual survey of physical therapy programs) there are currently 210 accredited physical therapy programs across the country. In 2006, there were 5,337 degrees conferred, and a projection of approximately 6,000 graduates in 2009. Not surprisingly, most students (99%) have jobs within 6 months of graduation. Programs have an average class size of 39, while the average number of applicants for the programs is 144. For the 2007-2008 academic year, there were approximately 1,896 full time faculty members in physical therapy programs with 146 full time faculty position vacancies. (10) Investment in faculty development and program capacity expansion is needed to ensure that more students can receive the education they need to meet the growing rehabilitation needs of patients.

Need to Address Physical Therapist Workforce during Health Care Reform

As noted in Chairman Baucus' recent paper *Call to Action* on health care reform and in President Obama's recent bipartisan White House Summit on Health Care Reform addressing the issues of health care workforce will be a critical part of health care reform. APTA looks forward to the opportunity to work with the Congress as it considers proposals to address the workforce issue across the continuum of care. As noted during the Summit, caring for patients is not limited to the acute care hospital setting or the emergency room but reform efforts should focus on ensuring patients return to their communities and regain their optimal function and on prevention of chronic diseases.

Physical therapists are an important member of the health care team. Ensuring an adequate physical therapist workforce can aid in chronic disease management including type 2 diabetes and obesity. Health care reform must manage the chronic diseases that represent 75% of all health care costs in our country. Physical therapists are frontline providers in the management of chronic disease and the prevention of the secondary complications and impairments associated with these disease states.

An estimated 21 million Americans had diabetes in 2005—nearly 7% of the population. Over the previous 8 years, the number of new cases of diagnosed diabetes increased by 54%. (11) Diabetes has many disabling consequences, and physical therapists are trained to provide care that can assist in preventing or diminishing the impact of the disease. This care can improve the quality of life of those diagnosed and reduce a heavy burden on our nation's health care system.

In various hearings on health care reform and in the Chairman's *A Call to Action*, it has also been noted that obesity is creating strain on the health care system. Direct health care costs of obesity are estimated to be more than $61 billion annually, while the health care costs associated with physical inactivity topped $76 billion in 2000. (12) Obesity also can lead to lower productivity and loss of work days. Researchers found that workers who are obese had 183.63 lost workdays per 100 full-time employees, compared with other workers who had 14.19 lost workdays per 100 full-time employees. (13)

Physical therapists develop treatment plans for individuals throughout the lifespan that promote the ability to move, reduce pain, restore function, and prevent disability. For those who are overweight or obese, physical therapists balance the progression of the exercise prescription with the need for joint protection and safety during exercise. Evidence shows that those with increased physical activity and increased fitness have markedly better outcomes across all weight classifications, and increased fitness can prevent and/or ameliorate the effects of obesity. Physical therapists are educated in the medical model of health care that makes them uniquely qualified to management patients with multiple impairments, pathologies, and chronic conditions.

Policy Recommendations:

1. **Funding for Clinical Education Sites**

A significant concern in the area of workforce development is the lack of clinical education sites. This is not as significant an issue for physicians since hospitals have access to Graduate Medical Education (GME) funds for the purpose of providing medical students and residents with clinical education experiences needed to be a qualified physician.

Hospitals, nursing homes, and physical therapist practices have no such resource to help address the costs of quality clinical education and thus it is often difficult for physical therapist education programs to find clinical education sites for students. ***APTA urges the Committee to establish a fund for the reimbursement of costs associated with the clinical education of physical therapists.***

2. **GME Funding for Physical Therapy Fellowships**

With 75% of all health care costs associated with chronic disease, it is essential that sound clinical education models be established to educate and train a quality health care workforce. In physical therapy, clinical education has begun to transition to

clinical fellowships. These fellowships offer a model for funding of clinical education. Currently, there are 22 fellowships and 41 residencies in physical therapy that provide extensive post-licensure education and training to physical therapists. APTA would encourage the expansion of GME funding to accredited clinical fellowship programs in physical therapy. The current size and scope of these programs offer a great opportunity to pilot this innovative model of clinical education in a financially responsible manner. ***APTA would encourage the Senate Finance Committee to authorize a demonstration project to expand Graduate Medical Education (GME) funding to a sample size of the clinical fellowships and residencies in physical therapy.***

3. Faculty Development Funding

APTA was pleased that a portion of the resources in the American Recovery and Reinvestment Act were directed to programs within the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) for the purpose of faculty development. However, additional resources are necessary in order to make teaching positions in our nation's academic centers an attractive option for qualified professionals. Without additional faculty it will be difficult to address the workforce challenges that exist in physical therapy and other professions. ***APTA encourages Congress to continue expanding funding for physical therapist faculty loan repayment.***

4. Grants to Existing Physical Therapy Programs to Expand Capacity

Expansion of current physical therapist education programs should be a priority. HRSA does not presently have the authority to directly fund the expansion of physical therapist programs. The only funding available to physical therapist programs is multi-disciplinary funding through the Allied Health Special Projects and Grants Program. While this funding is helpful, it does not allow individual physical therapist programs to receive dedicated funding exclusively for the purpose of expanding capacity. Other health professions have this authority within Title VII and Title VIII of the Public Health Service Act. ***APTA would strongly support new authority that enables HRSA to better address the supply of domestically-educated physical therapists.***

5. Expanding Existing Scholarship/Loan Repayment Programs to include Physical Therapists

As with many professions, student loan debt burden is a significant concern for physical therapists and can influence their practice options upon graduation. In 2007, the average total costs of tuition and fees for a doctor of physical therapy student attending an in-state public; out of state public; or private institution was $38,000, $67,000 and $76,000 respectively which does not include the costs of undergraduate education. According to a recent survey conducted by the APTA research department of recent graduates (1-5 years out of school) the average loan debt related to PT programs was $63,849 with the total

average debt for this group of students being $96,149. In this same survey, when asked if the amount of debt affected the job choice they made as a physical therapist 63.4% responded yes. Conversely in 2006, the median annual income for a physical therapist with less than three years experience is only $54,000. The loan debt compared to average salary limits the employment opportunities for physical therapists, especially in rural and urban underserved areas where reimbursement and salaries tend to be lower than the average.

The National Health Service Corps is striving to address the health needs of some 4 million underserved individuals across the nation. As with the health professionals serving in the Corps today, physical therapists are committed to improving the health of the nation's underserved communities. The prompt and coordinated services provided by health professionals including physical therapists can help to avoid hospitalization, decrease the length of institutional stay, reduce the amount of care required after discharge, prevent complications, and improve the individual's level of function. Currently, physical therapists are not eligible to participate in the National Health Service Corps Student Loan Repayment Program. *The Physical Therapist Student Loan Repayment Eligibility Act* (HR 988) would ensure that physical therapists are part of the team providing the comprehensive health care that is the National Health Service Corps' mission.

APTA encourages Congress to pass legislation to add physical therapists to the National Health Services Corps. This would assist in enhancing access to essential rehabilitation care in community health centers and assist workforce needs through physical therapy recruitment and retention.

Conclusion

APTA commends the Chairman and the Finance Committee for having the "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future" hearing. APTA looks forward to working with the Committee as it develops policy solutions to address health care workforce issues in its health care reform proposals this year. For additional information or background please contact Kelly Lavin, APTA's Director of Federal Government Affairs at (703) 706-8548.

Thank you again for the opportunity to submit comments and offer recommendations to address the unique challenges that face the physical therapist workforce to meeting the rehabilitation needs of the patients we serve.

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Senate Finance Committee

Hearing on

Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

March 12, 2009

Statement for the Record
Submitted by the

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The American Society of Health-System Pharmacists (ASHP) respectfully submits the following statement for the record to the Senate Finance Committee Hearing: Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future.

As the national professional association representing over 35,000 pharmacists who practice in hospitals and health systems, ASHP can offer unique and vital feedback on this important health care issues. Pharmacists in hospitals and health systems are experts in medication use who serve on interdisciplinary patient-care teams. They work with physicians, nurses, and other health care professionals to ensure that medicines are used safely, effectively, and in a cost-conscious manner. For more than 60 years, ASHP has helped pharmacists who practice in hospitals and health systems improve medication use and enhance patient outcomes. This includes working with patients to help them access the medications they need and to use them safely and effectively.

As the health care reform debate moves forward and takes shape, attention must be given to the education and training pharmacists receive. Pharmacists are the third-largest health profession in the United States, and are typically the health care practitioner patients see the most. While Congress and the Administration consider innovative health reform concepts such as the patient-centered medical home model, promotion of wellness programs and services, and a more coordinated, team based approach to care, pharmacy workforce and training challenges must be addressed to ensure an adequate supply of well-trained pharmacists.

Specialized Pharmacy Residency Programs

Pharmacists practicing in hospitals and health-systems care for critically ill patients on highly complex medication regimens. Therefore, postgraduate training programs such as pharmacy residencies are essential to providing pharmacists with hands-on training needed given the complexity and risk of medications used in hospitals and health-systems. Completion of a residency upon graduation (postgraduate year one or PGY1) from pharmacy school is beginning to be the norm for pharmacists practicing in hospitals. Additionally, pharmacists who wish to pursue enhanced clinical roles can do so by completing a second-year residency program (postgraduate year two or PGY2) that specializes in a particular disease state or condition, or specializes in a particular patient population such as geriatrics. PGY2 pharmacy residency training is an organized, directed, accredited program that builds upon the competencies established in PGY1 residency training. These programs increase the resident's depth of knowledge, skills, attitudes, and abilities to raise the resident's level of expertise in medication therapy management and clinical leadership in the area of focus. In those practice areas where board certification exists, graduates are prepared to pursue such certification.

PGY2 specialized pharmacy residency programs are offered in the following areas: ambulatory care, cardiology, critical care, drug information, emergency medicine, geriatrics, infectious diseases, informatics, internal medicine, managed care pharmacy systems, medication safety, nuclear pharmacy, nutrition support, oncology, pediatrics,

pharmacotherapy, health-system pharmacy practice management, psychiatric pharmacy, and solid organ transplant.

The Centers for Medicare & Medicaid Services (CMS), in the fiscal year 2004 Hospital Inpatient Prospective Payment System (HIPPS) rate-setting rule, eliminated funding for second-year, specialized pharmacy residency programs. At the time, CMS left the door open for future funding of these programs if hospitals could demonstrate that completion of such residencies before beginning work in these specialties met the definition of "industry norm." CMS defined "industry norm" to "mean that more than 50 percent of hospitals in a random, statistically valid sample require the completion of a particular training program before an individual may be employed in a specialty." ASHP submitted survey data July 2004 that showed 82% of hospitals that employ clinical pharmacy specialists have a requirement that candidates complete a PGY2 residency program. In July 2008, ASHP conducted another survey of its membership and 80% of respondents stated that if there were an adequate supply of specialized residency trained pharmacists, they would require this training before filling clinical pharmacist positions.

Second-year, specialized pharmacy residency programs are vital to our health care delivery system. The lack of federal funding for these programs has already brought about a reduction in the number of institutions providing specialized residency training. The long-term impact of CMS's decision will be a significant reduction in the number of qualified clinical pharmacists and pharmacy practice leaders needed to ensure appropriate management of high-risk medication therapy in hospitals. Further, the Veterans Health Administration, Public Health Service, and the Department of Defense continue to see the value of these programs by providing the necessary funding for them. Only the Medicare program has cut its funding for these programs.

In a study published by the *American Journal of Health-System Pharmacy*, an intensive care unit clinical pharmacist saved a hospital as much as $280,000 over a 4.5-month period by preventing potential adverse drug events. The pharmacist, who had completed both a general residency and a specialized residency in critical care pharmacy practice, conducted patient care rounds, chart reviews, and other interventions.

ASHP strongly supports residency training, both first and second year, and urges the Committee the restore funding for these programs with the Graduate Medical Education (GME) pass-through payment system within Medicare. As demands on our health care delivery system increase, the demand for residency-trained pharmacists practicing as an integral member of the multidisciplinary care team will increase as well. ASHP believes these programs are essential to providing the highest-quality care possible, while minimizing the risk of adverse drug events due to medication-related problems.

Loan Forgiveness

ASHP supports including pharmacists within the health care professions that participate in the National Health Service Corps (NHSC). This program allows participating health

care professionals to reduce their student loan balance, participate in scholarship programs, and experience student resident/rotations in community health settings in exchange for practicing in rural or underserved areas. Currently, pharmacists are not included among the health care professionals who are eligible to participate in the NHSC. Similar to other health professions, pharmacy is also experiencing a workforce shortage, which is particularly evident in rural areas. Congress can help alleviate this burden by allowing pharmacists to participate in the loan forgiveness program under the NHSC.

Given the additional funding made available to the Health Resources and Services Administration (HRSA) under the American Recovery and Reinvestment Act of 2009 specifically for loan forgiveness under the NHSC, ASHP believes that this is an appropriate time for pharmacists to be eligible for the program. Additionally, a recently published report by the Health Workforce Information Center titled "The Adequacy of Pharmacist Supply: 2004 to 2030," shows that there is still a shortage of pharmacists nationwide, (http://www.healthworkforceinfo.org/topics/resources.php?id=118).

Conclusion

We appreciate the opportunity to share our views and provide input on health care workforce issues. It is clearly time for Congress to address health care workforce challenges by funding critical pharmacy training programs that have been shown to produce cost avoidance and improve patient care, and alleviating the burden on access to care in rural areas by allowing pharmacists to participate in the loan forgiveness programs under the NHSC. Funding for PGY2 pharmacy residency programs will entail a minimal cost to the Medicare program, but its benefits vastly outweigh the initial cost. Pharmacist participation in the NHSC will not require any additional funding for HRSA. In both of these cases, public health will be well served by addressing these critical programs. Further, neither of these issues involve the creation of a new entity within HHS to run or oversee residency programs or the NHSC. Congress now has an opportunity to invest in the health care workforce that is well trained and capable of providing the highest-quality care possible to an ever-increasing number of people who need it.

United States Senate

Committee on Finance

Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

March 12, 2009, at 10:00 AM

215 Dirksen Senate Office Building

Testimony for the Hearing Record
Submitted by the American Society of Pediatric Nephrology

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My name is Lisa Satlin. I am Chief of the Division of Pediatric Nephrology at the Mount Sinai School of Medicine (MSSM), and also am President of the American Society of Pediatric Nephrology, an organization of pediatric nephrologists and affiliated health care professionals. Our primary goals are to promote optimal care for children with kidney disease through advocacy, education and research; and to disseminate advances in clinical practice and scientific investigation. Pediatric nephrologists in North America are a diverse and active group of academic pediatric nephrologists and practitioners, pediatric department chairmen, medical school deans, and physicians employed in the pharmaceutical or biotechnology industry. Pediatric nephrologists are clinicians, basic scientists, clinical and translational researchers, and advocates for pediatric patients with renal disease. Regardless of the primary activity of pediatric nephrologists in North America, they are likely to participate in some capacity as a clinician, teacher, researcher, and mentor to future pediatric nephrologists.

Chronic Kidney Disease (CKD) affects up to 13% of the US general population. The roots of CKD's major causes in adults - diabetes and hypertension - first present in childhood and adolescence. About one-third of children with CKD are born with abnormal kidneys/urinary tracts. Without proper care and effective interventions in childhood to prevent or treat hypertension and precursors of diabetes, and without cures and more effective treatments for kidney disease in childhood as can only be provided by pediatric nephrologists, Medicare spending on ESRD will continue to increase and more children and adolescents will undergo evaluation and treatment for early signs of progressive kidney disease and precursors to renal failure and cardiovascular diseases. Additionally, approximately 20,000 children will be born with congenital kidney abnormalities while 2,000 infants will die from genitourinary disease; and 1.2 million children under the age of 7 will develop urinary tract infections that can permanently damage kidney tissue.

It is most important to note, as is consistent with the testimony of other pediatric subspecialty groups, that children cannot be treated like "little adults." That is, that the shortages felt by pediatric nephrologists cannot be fixed by substituting in adult nephrologists or even general pediatricians. ASPN outlined the unique needs of the pediatric population with end stage renal disease (ESRD) in a 2005 position paper on quality care.

> Children with [ESRD], who undergo dialysis and/or transplantation, have unique needs. Needs that include an emphasis on the importance of growth and development, school attendance and performance, family dynamics, nutrition, and psychosocial adjustment of the child and family to a chronic disease. Growth failure has long been recognized in children with chronic renal failure and in the past, most children with renal insufficiency exhibited profound growth retardation. The need for adequate, sustained growth and normal development set children apart from

> adults with chronic renal failure. Many factors contribute to growth failure in children with ESRD including the degree of renal failure, inadequate caloric intake, renal osteodystrophy, intercurrent infections, anemia, metabolic acidosis and renal tubular defects. Therapeutic intervention with adequate nutrition, correction of metabolic acidosis, appropriate use of phosphorus binders and vitamin D analogues, as well as growth hormone therapy have been shown to improve growth in children with ESRD. Attainment of final adult height has substantial implications for school and job performance, and psychosocial well-being. [1]

I am submitting for the record the ASPN's latest statistics on the pediatric nephrologist workforce, which show the graying of the pediatric nephrologist population. In fact, according to our survey, over 77% of nephrology certified diplomates are over the age of 46, while there were 0% under the age of 31, and only 2.9% between the ages of 31 and 35. Not only is the age distribution a problem, but so is the geographic distribution. Mr. Chairman, in your home state of Montana, there are **zero** pediatric nephrologists, but there are patients that need to be served. To do so, outreach programs from Seattle and Denver send physicians to Billings, Missoula and Great Falls for clinics. Additionally, some patients travel to Salt Lake City for care. Montana is not alone: Hawaii, North and South Dakota, and Wyoming also have no pediatric nephrologists while states such as Mississippi, Alaska, Idaho, and Oklahoma only have **one**.

On behalf of the American Society of Pediatric Nephrology, I urge Congress to address the pediatric subspecialty shortage as well as the overall physician shortage. The 150,000 children and adolescents suffering from kidney diseases depend on the reversal of these shortages. Thank you for your consideration and the ASPN joins all of the other pediatric subspecialty and physician and patient groups in urging timely action in the 111th Congress.

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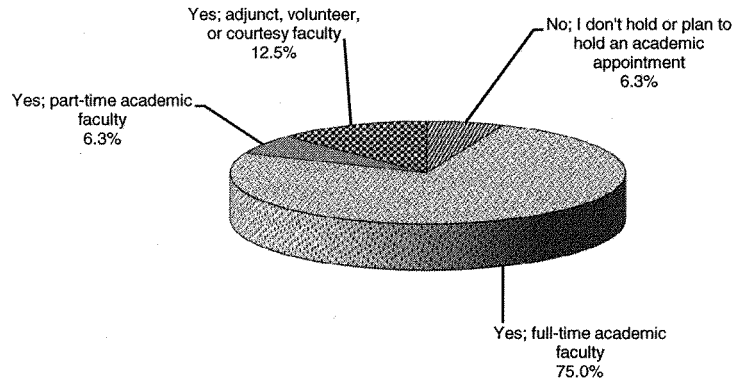
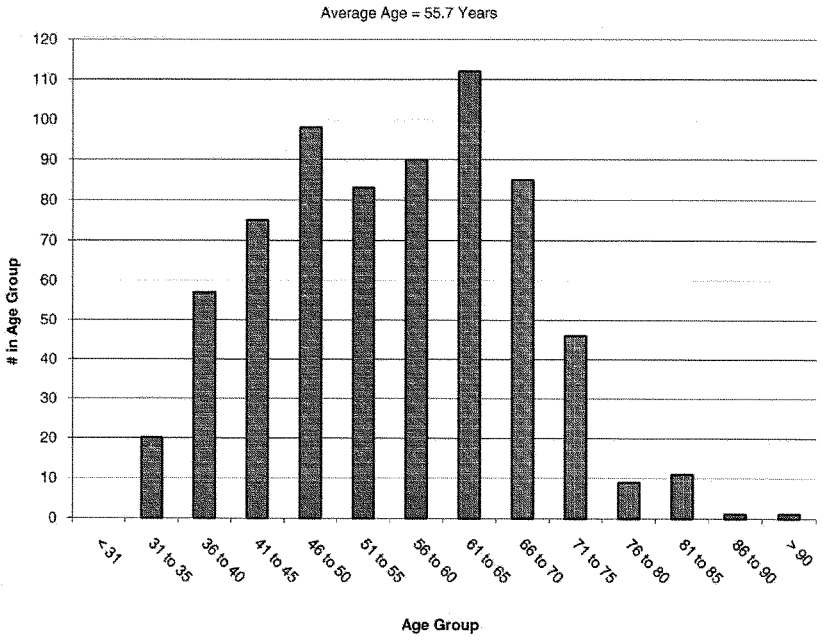
2008 Nephrology Examination
First-time Applicants (n=64)
Career Survey - Academic Affiliation

Academic Affiliation	# of Applicants	% of Applicants
No; I don't hold or plan to hold an academic appointment	4	6.3
Yes; full-time academic faculty	48	75.0
Yes; part-time academic faculty	4	6.3
Yes; adjunct, volunteer, or courtesy faculty	8	12.5



Nephrology Certified Diplomates
Age Distribution

Age Group	# in Group	% in Group
< 31	0	0.0%
31 to 35	20	2.9%
36 to 40	57	8.3%
41 to 45	75	10.9%
46 to 50	98	14.2%
51 to 55	83	12.1%
56 to 60	90	13.1%
61 to 65	112	16.3%
66 to 70	85	12.4%
71 to 75	46	6.7%
76 to 80	9	1.3%
81 to 85	11	1.6%
86 to 90	1	0.1%
> 90	1	0.1%
Total	688	



Note: While the number of certified subspecialists in Nephrology is 727, this variable is calculated on only those who provide birth year information. The age is not available for 39 subspecialists.

Number of ABP-certified Nephrology Diplomates by State (as of 12/31/08)

State	Number of ABP Diplomates in Nephrology	Child Population	Physician-to-Child Ratio (per 100,000 children)
Alabama	9	1,123,537	0.8
Alaska	1	182,218	0.5
Arizona	7	1,669,866	0.4
Arkansas	4	700,537	0.6
California	57	9,383,924	0.6
Colorado	3	1,192,679	0.3
Connecticut	6	820,216	0.7
Delaware	1	205,646	0.5
District of Columbia	5	113,720	4.4
Florida	24	4,043,560	0.6
Georgia	7	2,531,609	0.3
Hawaii	0	285,694	0
Idaho	1	407,712	0.2
Illinois	18	3,199,159	0.6
Indiana	7	1,586,518	0.4
Iowa	4	711,403	0.6
Kansas	3	696,082	0.4
Kentucky	9	1,003,973	0.9
Louisiana	8	1,079,560	0.7
Maine	3	279,467	1.1
Maryland	14	1,356,797	1
Massachusetts	19	1,432,856	1.3
Michigan	12	2,446,856	0.5
Minnesota	9	1,260,282	0.7
Mississippi	1	768,704	0.1
Missouri	10	1,424,830	0.7
Montana	0	219,498	0
Nebraska	3	446,145	0.7
Nevada	3	660,002	0.5
New Hampshire	2	298,186	0.7
New Jersey	19	2,063,789	0.9
New Mexico	3	500,276	0.6
New York	38	4,413,414	0.9
North Carolina	12	2,217,680	0.5
North Dakota	0	142,809	0
Ohio	27	2,751,874	1
Oklahoma	1	899,507	0.1
Oregon	6	862,908	0.7
Pennsylvania	20	2,786,719	0.7
Rhode Island	3	233,115	1.3
South Carolina	6	1,059,917	0.6
South Dakota	0	196,890	0
Tennessee	9	1,471,486	0.6
Texas	33	6,623,366	0.5
Utah	4	816,822	0.5
Vermont	1	131,353	0.8
Virginia	10	1,826,179	0.5
Washington	17	1,536,368	1.1
West Virginia	2	387,381	0.5
Wisconsin	8	1,321,279	0.6
Wyoming	0	125,365	0
	469	73,901,733	0.6

Note: The population of children listed in the table is based on the US Census Bureau Population Estimates as of July 1, 2007, and includes all children under the age of 18. The number of diplomates includes only specialists under the age of 66 with known addresses.

Testimony Prepared for the Senate Finance Committee

Hearing on "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future" March 12, 2009"

The Critical Role of Behavioral Health

In Health Care Reform

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March 23, 2009

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Senator Baucus, Senator Grassley, and Members of the Senate Finance Committee, we are pleased to provide written testimony[1] to the Committee concerning the critical role of the behavioral health[2] workforce in supporting the movement toward healthcare reform. The Annapolis Coalition on the Behavioral Health Workforce is a national not-for-profit organization formed to work on improving the quality and quantity of people providing prevention, treatment and recovery supports to individuals with mental and substance use conditions. Since 2000, the Coalition has functioned as a neutral convener of diverse individuals, groups, and organizations that recruit, train, employ, license, and receive services from the workforce (Hoge & Morris, 2002; Hoge & Morris, 2004; Hoge, Morris, & Paris, 2005). The Coalition conducts strategic planning, identifies innovation, and has provided technical assistance in workforce issues to federal and state agencies, private organizations, and commissions, including the New Freedom Commission on Mental Health (2003) and the Institute of Medicine (IOM, 2006).

At the request of the Substance Abuse and Mental Health Services Administration, as part of their response to the President's New Freedom Commission, the Annapolis Coalition has conducted an intensive, collaborative, year-long process of developing recommendations for strengthening the behavioral health workforce. The report, *An Action Plan for Behavioral Health Workforce Development* was released in March of 2007, and is available free at www.annapoliscoalition.org or at www.samhsa.gov.

In our testimony, we will briefly review the crisis in the workforce, outline the action steps that we believe can shape positive change, and make the case for attention to behavioral health workforce inclusion in the larger workforce issues being addressed by healthcare reform.

A Workforce Crisis

Across the nation there is a high degree of concern about the state of the behavioral health workforce and pessimism about its future. Workforce problems have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field. The issues encompass difficulties in recruiting and retaining staff, the absence of career ladders for employees, marginal wages and benefits, limited access to relevant and effective training, the erosion of supervision, a vacuum with respect to future leaders, and financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources.

Most critically, there are significant concerns about the capability of the workforce to provide quality care. The majority of the workforce is uninformed about and unengaged in health promotion and prevention activities. Too many in the workforce also lack familiarity with resilience- and recovery-oriented practices and are generally reluctant to engage children, youth, and adults, and their families, in collaborative relationships that involve shared decision-making about treatment options. It takes well over a decade for proven interventions to make their way into practice, since prevention and treatment services are driven more by tradition than by science. The workforce lacks the racial diversity of the populations it serves and is far too often insensitive to the needs of individuals, as these are affected by ethnicity, culture, and language. In large sections of rural America, there simply is no mental health or addictions workforce.

There is overwhelming evidence that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the changing needs of the American population. While the incidence of co-occurring mental and addictive disorders among individuals has increased dramatically, most of the workforce lacks the

[1] Portions of this testimony are excerpted from the Executive Summary of *An Action Plan for Behavioral Health Workforce Development* (Hoge et al, 2007).

[2] The term "behavioral health" is an umbrella term used to address both mental and substance use conditions.

array of skills needed to assess and treat persons with these co-occurring conditions. Training and education programs largely have ignored the need to alter their curricula to address this problem and, thus, the nation continues to prepare new members of the workforce who simply are underprepared from the moment they complete their training.

It is difficult to overstate the magnitude of the workforce crisis in behavioral health. The vast majority of resources dedicated to helping individuals with mental health and substance use problems are *human resources*, estimated at over 80% of all expenditures (Blankertz & Robinson, 1997a). As this report documents in its complete version, there is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness in partnership with the people who need services. There is equally compelling evidence of an anemic pipeline of new recruits to meet the complex behavioral health needs of the growing and increasingly diverse population in this country. The improvement of care and the transformation of systems of care depend entirely on a workforce that is adequate in size and effectively trained and supported. Urgent attention to this crisis is essential.

Defining the Workforce

A broad definition of workforce was adopted for this planning process. It included the behavioral health workforce, consisting of individuals in training or currently employed to provide health promotion, prevention, and treatment services. This group includes professionals with graduate training, as well as individuals who have associate's or bachelor's degrees, high school diplomas, or even less formal education.

Persons in recovery and their family members are explicitly recognized as pivotal members of the workforce, as they have critical roles in caring for themselves and each other, whether informally through self-help and family caregiving or more formally through organized peer- and family-support services. These individuals are the unsung heroes and heroines of the workforce and provide a unique perspective that enhances the overall relevance and value of the care provided. While other health and human service providers, such as primary care providers, emergency room staff, correctional staff, and teachers, have major roles in responding to the needs of individuals with mental and addictive disorders, these segments of the workforce were not addressed in this planning process due to time and resource constraints. Their critical role in the informal behavioral health workforce is acknowledged and their workforce development needs unquestionably warrant attention in a subsequent planning effort.

A Common Agenda

The behavioral health field has not historically spoken with one voice. As recommendations emerged from the panels and work groups formed to conduct the action planning, there often was controversy. But as the discussions progressed, as language differences were explored and resolved, and as assumptions were probed and made transparent, it became clear that there are many commonalities regarding workforce issues across the various sectors of this field. It also became abundantly clear that the people working in these diverse sectors have much to learn from each other and much to be gained by working together on a common workforce agenda.

The objective of the planning process was to examine workforce issues broadly across the behavioral health field in order to identity a set of *core*, *common* or *cross-cutting* goals and objectives that have broad relevance to all sectors of the field. This Action Plan was not intended to be, nor can it function as, the definitive and detailed plan for a specific sector, population, government agency, or private organization. However, it is designed to serve as a resource that can inform, focus, and help guide any agency, organization, or sector of the field as it devises a detailed action plan tailored to its specific history, needs, and current priorities. In fact, the value of this planning effort rests on the assumption that a broad array of stakeholders will move the workforce

development agenda forward in their own spheres of influence, informed by the recommendations of their peers as outlined in this report.

As we have become more cognizant of the intimate linkage between mental and substance use conditions and general health status, the importance of having well trained behavioral specialists available is ever more critical. Just a few examples of the power of linkages between behavioral health and general healthcare: Persons with serious mental illnesses have their life expectancy reduced by a staggering 25 years—death caused not by their mental illnesses but by heart attack, stroke, complications of diabetes, etc. (Parks et al, 2006). Research increasingly shows a connection between behavioral health diagnoses and a wide range of health conditions (general quality of life, increased medical costs, poorer general health outcomes and higher mortality rates) associating significantly poorer outcomes when the behavioral health issues remain untreated (Creed, Morgan et al, 2002; Gaynes, Burns etal, 2002); Cienchanowski, Katon et al, 2000).

GENERAL FINDINGS FROM THE ACTION PLANNING PROCESS

Workforce problems are evident in every element or dimension of the behavioral health field. Concerns about the workforce also exist among every group of stakeholders concerned about the future of prevention and treatment for mental health and substance use problems.

Children and adolescents. There is a critical shortage of individuals trained to meet the needs of children and youth, and their families. As just one example, the federal government has projected the need for 12,624 child and adolescent psychiatrists by 2020, far exceeding the projected supply of 8,312. Currently there are only 6,300 such psychiatrists nationwide, and relatively few are located in rural and low-income areas (American Academy of Child and Adolescent Psychiatry [AACAP] Task Force, 2001). There is an even more severe shortage of practitioners trained and credentialed to treat adolescents with substance use disorders.

Only five states require adolescent-specific knowledge for licensure (Pollio, 2002). Furthermore, behavioral health professionals who have been trained to provide behavioral health prevention and intervention in the nation's schools are in significantly short supply, or are hindered by the constraints of their position to use such skills. Beyond the issue of workforce size, the training programs that do focus on prevention and treatment for children and youth, and their families, have not kept pace with current trends in the field, which have been shifting toward strengths-based and resilience-oriented models, a systems-of-care approach, and the use of evidence-based practices (Curie, Brounstein, & Davis, 2004; McLellan & Meyers, 2004; Meyers, Kaufman, & Goldman, 1999).

Older adults. There is a pronounced shortfall in the current workforce of providers with expertise in geriatrics, and this deficit is expected to worsen. Only 700 practicing psychologists view older adults as their principal population of focus, well short of the estimated 5,000 to 7,500 geropsychologists necessary to meet current needs (Jeste et al., 1999). Similarly, only 640 members of the American Psychiatric Nurses Association (APNA, 2002) have a subspecialization in geriatrics. In 2001, there were only 81 geriatric psychiatry fellows in training in this nation, and 39% of the available fellowships went unfilled (Warshaw, Bragg, Shaull, & Lindsell, 2002). These numbers suggest that creating more training opportunities may be a necessary, yet insufficient, workforce strategy.

People with substance use conditions. As described in the introduction to this report, only 20% of the individuals in this country who need substance use disorders treatment each year receive it. This is due, in part, to severe difficulties in recruiting and retaining qualified staff in sufficient numbers (Gallon, Gabriel, & Knudsen, 2003; Hall & Hall, 2002; Northeast Addiction Technology Transfer Center, 2005). In the most compelling study of this issue, McLellan, Carise, and Kleber (2003) found a 50% turnover in frontline staff *and* directors of substance

use disorder treatment agencies in a single year. Furthermore, 70% of the frontline staff members in these agencies did not have access to basic information technology to support their daily work.

People in rural and frontier communities. In rural America, the workforce crisis is particularly acute. More than 85% of the 1,669 federally designated mental health professional shortage areas are rural (Bird, Dempsey, & Hartley, 2001), and they typically lack even a single professional working in the mental health disciplines. It has been extraordinarily difficult to recruit, train, and retain professionals in rural areas. Traditional approaches to workforce development center on "programs and professionals" and often fail to address local needs. Few training programs offer any significant focus on rural behavioral health service delivery.

Services for people of color. Workforce distribution issues relate not only to geography but also to race and culture. U.S. Census figures indicate that 30% of the nation's population is drawn from four major ethnic groups: Latinos, African Americans, Asian American/Pacific Islanders, and Native Americans. However, the behavioral health workforce lacks such cultural diversity, particularly in mental health. For example, non-Hispanic Whites currently account for 75.7% of all psychiatrists, 94.7% of psychologists, 85.1% of social workers, 80% of counselors, 91.5% of marriage and family therapists, 95.1% of school psychologists, and 90.2% of psychiatric nurses (Duffy et al., 2004). Cross-cultural training has the potential to improve quality of care and service use among people of color (Fortier & Bishop, 2003), but the workforce at large cannot be characterized as culturally or linguistically competent.

Workforce issues are a personal matter for individuals with mental health and substance use problems. While the experiences of those who receive care vary greatly, the individuals whose voices were heard during the process of compiling this Action Plan were, by and large, very dissatisfied with the workforce. There was considerable anger about what many of these individuals described as the stigmatizing attitudes among the workforce about persons with mental and addictive disorders. Other complaints about the workforce focused on inadequate understanding and support for recovery- and resilience-oriented approaches to care and a basic lack of empathy and compassion. These complaints should be of deep concern to the field, given the importance of therapeutic relationships as a basic foundation for all efforts to care effectively for people in need.

Another group that voiced strong concerns comprised managers within organizations that employ the workforce. Their constant lament was that recent graduates of professional training programs are unprepared for the realities of practice in real-world settings, or worse, have to unlearn an array of attitudes, assumptions, and practices developed during graduate training that hinder their ability to function. In an era of scarce resources, the specter of education and training programs that lack relevance to the needs of the American population and to current prevention and treatment approaches raises considerable alarm.

As in general health care, the delay in translating science into services is a major concern in behavioral health. Within the workforce, the change in practice patterns appears to occur with the changing generations of treatment providers and prevention specialists. Underlying this troubling dynamic is the fact that educational systems emphasize the teaching of specific practices. Their focus is typically on teaching "content" as opposed to teaching and instilling in students a "process" of continuous, lifelong, real-world learning.

Training in behavioral health now occurs in disciplinary or sector silos. Furthermore, there is little collaboration among the disciplines on workforce development efforts, such as competency development, despite the presence of many shared competencies across professions. Three other tensions impede cooperation on a strengthened national workforce development agenda or dissemination of workforce innovations across sectors and disciplines: the divide between the mental health and addiction portions of the field; the split between

treatment and prevention that exists within mental health and within addictions; and, in all sectors, the separation between the traditional treatment system and the recovery community.

There is a striking lack of data, not only about the workforce but also about workforce development practices. The scattered information that does exist has no uniformity, which hinders cross comparison or aggregation of the data to examine trends. The reliability of workforce data is generally open to question. There is little consensus about key workforce variables, and there are few benchmarks that organizations can use as a reference point in assessing the magnitude of their workforce problems or success in addressing them. Published studies on interventions to strengthen the workforce seldom use solid research designs and methods and are often simply anecdotal reports.

As training, prevention, and treatment organizations attempt to address workforce issues, there is a notable tendency to do what is affordable rather than what is effective. The most glaring example is the provision of single-session, didactic in-services or workshops, which are the most frequent approach to staff training and development. These are the mainstay of training efforts even though there is clear evidence of their ineffectiveness in changing practice patterns. System and agency managers are increasingly hungry for workforce tools of proven effectiveness, yet relatively few interventions or models are well described, portable, and easily adapted to different settings. There are pockets of innovation across the nation, but these are uniformly underfinanced and difficult to sustain, and are seldom disseminated or replicated in other locales; the full Action Plan includes many examples of promising innovation.

Despite the dire state of the workforce, there are a number of causes for optimism about the future. Many dedicated members of the workforce and many committed leaders in the behavioral health field understand the critical need to address seriously the many issues outlined above. The issues now are receiving federal, state, and local attention. The existing pockets of innovation are good starting points as building blocks for more comprehensive and systematic solutions to current workforce dilemmas. The field can and must move forward to tackle the workforce challenge

SEVEN STRATEGIC GOALS: AN OVERVIEW

The distillation of the reports and recommendations of the multiple expert panels and work groups yielded a set of seven final action goals (Table 1). Goals 1 and 2 focus on broadening the concept of workforce. Persons in recovery, children, youth, families, and communities are not simply recipients of prevention and treatment services. They are active in promoting and maintaining health and wellness, defining their unique needs, caring for themselves, supporting each other, and providing guidance about when, where, and how services should be delivered. Their roles as both formal and informal members of the behavioral health workforce must be greatly expanded. Goals 3, 4, and 5 are traditional workforce goals that focus on strengthening the workforce. The recommended objectives and actions identified for these goals reflect activities related to best practices in recruitment and retention, training and education, and leadership development. Goals 6 and 7 involve creating improved structural supports for the workforce, such as technical assistance on workforce practices, stronger human resources departments, greater use of information technology, and a national research and evaluation initiative to yield improved information on effective workforce practices. These goals are reviewed in the sections that follow.

GOAL 1: Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

From the perspective of workforce planning and development, priority attention must be given to the role that persons in recovery, children, and youth, and their families, have in caring for themselves and each other and could have in educating the traditional workforce. The amount of service provided by behavioral health professionals and other health and human services providers simply pales in comparison to the volume of self-care, peer support, and family caregiving. Individuals with mental health and addiction problems, along with their families, are a human resource that too often has been overlooked or underutilized. A core strategic goal must be to recognize these persons as part of the workforce and to develop their capacity to care for themselves and each other effectively, just as the field must attempt to strengthen the professional workforce.

Goal 1 in this Action Plan calls for a significantly expanded role for individuals in recovery and families in the workforce. Five major objectives have been identified to achieve this goal. The first is to create fully informed individuals and family members by providing better knowledge through educational supports. Shared decision-making is a second objective, to be accomplished by training individuals, families, and providers in collaborative approaches to care. Two additional objectives focus on formal roles in the workforce for persons in recovery and family members through expanded peer- and family-support services and through increased employment of these individuals as paid staff in prevention and treatment systems. As a final objective, engaging persons in recovery and family members as educators of the workforce is designed to shape the education of providers and to foster more collaborative relationships between those receiving and providing care.

GOAL 2: Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

The importance and centrality of the role of communities in promoting and maintaining behavioral health and wellness was captured by Wagenaar and colleagues (1994), who stated that "[T]he community is not simply the *site* for the intervention but the *vehicle* for change." Expanding on this notion, it is clear that communities are the locus for defining their health needs, priorities, and strategies, which leads to a broad vision of person-centered, family-centered, and community-centered approaches to behavioral health and wellness. Communities are a key element of the workforce in a manner quite parallel to the way in which persons in recovery, children, youth, and families are core to the workforce, as described above under Goal 1.

Expanding the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness emerged as a core strategic goal, which is relevant to all sectors of behavioral health. The proposed vehicles for accomplishing this goal center around three objectives. Most critical is an expanded effort to build five core competencies in communities, related to assessment, capacity building, planning, implementation, and evaluation (www.cadca.org; DHHS, 2004). A second objective involves renewed efforts to develop competencies within the behavioral health workforce related to community development and community collaboration. As a final and more immediate objective, it is recommended that every behavioral health organization formally reassess its current connections to local groups, organizations, and coalitions, and implement a plan to increase, strengthen, and diversify these ties.

GOAL 3: Implement systematic recruitment and retention strategies at the federal, state, and local levels.

Recruiting and retaining competent staff members in adequate numbers is a major problem for individuals managing local prevention and treatment organizations and state behavioral health systems. Qualified providers clearly are not available in sufficient numbers in some sections of the country, largely rural in nature, and for some populations, such as children, youth, and the elderly. Most organizations and systems have been unsuccessful in recruiting a culturally and linguistically diverse workforce. While stability in staffing over time is considered a cornerstone of program and treatment consistency and therapeutic relationships (Connor et al., 2003), high rates of turnover among counselors, for example, has been noted to threaten the stability of

addiction counseling centers, undermine quality of care, and strain finances due to the costs associated with recruiting, hiring, and training replacements (Knudsen, Johnson, & Roman, 2003). The retention problem among the behavioral health workforce appears to exceed that of teachers and nurses, professions considered by society to have unacceptably high rates of turnover.

A set of eight objectives has been identified to address the recruitment and retention crisis. Information and evidence on effective recruitment and retention practices must be disseminated routinely to managers in the field as a form of technical assistance. As a second objective, it is incumbent on each prevention or treatment organization to implement a data-driven continuous quality improvement process in which interventions tailored to the recruitment and retention problems that face each organization are implemented and evaluated. Expanded financial incentives are necessary in the form of training stipends, tuition assistance, and loan forgiveness. Wages and benefits must become commensurate with education, experience, and levels of responsibility if members of the workforce are to be retained. Progress on this objective should begin with closer collaboration between behavioral health systems and federal or state departments of labor, which have expertise in benchmarking wages and benefits across professions and estimating a "living wage" for each area of the country.

It is recommended that state and local organizations implement "grow-your-own" strategies to recruit and develop a more diverse and stable workforce, with a priority focus on residents of rural areas, culturally and linguistically diverse populations, persons in recovery, youth, and family members. This strategy involves engaging local residents in entry-level positions and promoting their long-term professional growth, development, and advancement within the organization or system of care. Increasing the cultural and linguistic diversity of the workforce is a specific objective that can be fostered by establishing a clearinghouse for dissemination of culturally competent practices; increasing staff development on such practices across all levels of the workforce; ensuring a critical mass of culturally competent faculty, trainers, and mentors; and developing standards and adequate reimbursement for interpreters who are trained to work in behavioral health.

GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.

In virtually every setting in which the Annapolis Coalition sought input for the Action Plan, three interrelated themes emerged: (1) The content of current training and education frequently is not relevant to contemporary prevention and treatment practices, nor is it informed by empirical evidence; (2) teaching methods often are ineffective in changing the actual practice patterns of the people being trained; and (3) access to training and education is often quite limited, particularly in rural communities and for culturally diverse populations. These concerns were expressed about preservice professional training, the initial training offered to direct-care nondegreed or bachelor's-prepared staff, and the continuing education of all members of the workforce. The concerns were not specific to a particular sector of the field or discipline, but were described as generally applicable to the field as a whole.

The strategic planning process yielded seven objectives designed to promote the relevance, effectiveness, and accessibility of training and education. The first objective centers on the further development of core competencies and focused competencies for specific areas of practice. There is a glaring need to develop core competencies for mental health practice, similar to those developed in the substance use disorders sector of the field. Equally important is the need to link organizations that are working on competency development in different sectors of the field, so that they can inform each other's efforts and avoid duplication or, much worse, the development of narrow competency sets that miss essential elements of practice. The second objective focuses on the development of competency-based curricula. Further work on this objective is needed across the many areas of practice in behavioral health, and there is an immediate need for portable, model curricula to be developed for entry-level nondegreed and bachelor's-degreed personnel working in mental health systems. As

a third objective, it is incumbent on organizations that provide education and training to adopt teaching practices that have evidence of effectiveness, and for organizations that accredit training programs to require such adoption.

Expanded use of information technology can serve to increase access to training, and thus constitutes a fourth objective for this goal. The fifth goal is to ensure that every member of the behavioral health workforce develops basic competencies in the assessment and treatment of persons with substance use disorders and co-occurring mental and addictive disorders. This will require a national initiative to identify and overcome the obstacles that have prevented major progress on this critical objective. An additional objective is to shape demand for relevant and effective training by educating prospective students about best practices in education to help them become more informed consumers as they select from among educational options. Finally, the field must identify and implement strategies to encourage and sustain the use of newly acquired skills in practice settings to counter the tendency for systems, organizations, and supervisors to thwart rather than support constructive changes in practice patterns.

GOAL 5: Actively foster leadership development among all segments of the workforce.

The stark reality is that most leaders currently in the behavioral health field are part of the "graying" workforce, nearing retirement. Unfortunately, many of the federally funded training stipends and leadership programs that supported both the entry of these individuals into the field and their professional development no longer exist. Simultaneously, the pressure on leaders has increased exponentially, driven by demands for increased access, efficiency, and quality in the organizations that they manage. Leadership is essential and needs to be explicitly developed among all segments of the behavioral health workforce, including persons in recovery and families, educators, prevention specialists, treatment providers, policy makers, and the individuals who manage accreditation, certification, and licensure systems. In fact, developing and expanding a cadre of leaders among persons in recovery, youth, and family members is particularly critical in achieving transformation of current service systems and models of care. Leadership must be broadly defined to encompass not only organizational and change management, but also coalition and community building, team and program management, and the provision of supervision.

To achieve this strategic goal, the competencies necessary for leadership roles in behavioral health must be identified. Particular attention must be given to developing core leadership competencies that can be adapted to the different sectors of this field. The development of competency sets for supervisors is also a high priority. Available curricula for leadership development must be identified and further developed to ensure that the core competencies are adequately addressed. Increased support should be allocated to the formal, continuous development of emerging leaders in the field. This will involve expanded training initiatives, release time to participate in training, mentorship opportunities, and recognition and rewards tied to advancement. Leadership development initiatives should be formally evaluated and refined based on the resulting data regarding the impact of these efforts.

GOAL 6: Enhance the infrastructure available to support and coordinate workforce development efforts.

The issue of infrastructure to support and sustain the workforce emerged at every turn in the planning process. There are few structures through which to coordinate existing efforts to develop the workforce, and the structures that do exist tend to be specific to content, discipline, or practice setting. Few organized vehicles exist for assembling, analyzing, and disseminating knowledge on workforce practices or providing technical support. There are few sources of financial support to develop innovative workforce practices. The current financing infrastructure for behavioral health services actually undermines the workforce, in various ways, as it

strives to provide safe and effective care. Other infrastructure problems involve the paucity of reliable and valid data to inform workforce practices, the generally weak capacity in the human resources departments and training units of behavioral health organizations, and the limited information technology available as an aid for training, a tool to assist the workforce in providing prevention and treatment services, or as a vehicle for tracking and managing workforce activity.

Eight objectives were identified to support the achievement of this strategic goal. First and foremost is the need to develop a technical assistance infrastructure that links existing sources of workforce expertise and expands capacity to provide information, guidance, and support to the field on effective workforce development practices. This should be complemented by a standing SAMHSA workforce team and a federal task force charged with prioritizing, coordinating, and implementing federal interagency efforts on workforce development. It is recommended that the federal government and private foundations establish workforce development funds to support demonstrations and dissemination of innovative workforce practices. The economic market for services must be altered so that it more effectively supports improvement in care and strengthens the workforce, through mechanisms such as increased parity in coverage for behavioral health and greater use of provider payment incentives.

Additional infrastructure objectives focus on the increased use by all stakeholders of data to track, evaluate, and manage key workforce issues through their continuous quality improvement processes. The human resources and training infrastructures, which have been downsized in many organizations, must be strengthened in terms of their role, resources, and levels of expertise. Information technology should be increasingly employed, not only to train the workforce, but also to provide it with real-time decision support, to track and manage work flow, and to reduce the enormous burden of redundant and purposeless reporting of clinical and administrative data. Many of these objectives can be promoted by identifying and accrediting "Magnet Centers" in workforce best practices that can model and disseminate effective practices in recruitment, retention, training, and education.

With so many unmet needs among persons with mental illnesses and substance use disorders, there is a natural reluctance to invest in infrastructure. Policy makers and program managers tend to pour every available dollar into direct service. And yet, this is precisely the dynamic that has contributed to a workforce that is now inadequately prepared and supported. The cogent analysis of workforce financing provided by Horgan and colleagues as part of this planning process, which appears in the full report, describes how organizations have "stretched" or "diluted" inadequate resources to meet demand, leading to "...under-capitalization, substitution of lower-cost workers, ... downward pressure on workers' incomes..." and difficulty providing evidence-based, quality care. Like most other resources, human resources require maintenance, development, and support in order to be effective and efficient. Infrastructure development is simply essential to sustain the human resources in this field.

GOAL 7: Implement a national research and evaluation agenda on behavioral health workforce development.

A recurrent finding during the planning process was the lack of reliable and valid data on the status of the workforce and on workforce development strategies. Despite the centrality of the workforce to the delivery of care, it is but occasionally the focus of scholarly articles and reviews (Hall & Hall, 2002; Mor Barak, Nissly, & Levin, 2001), and seldom the focus of research. While many behavioral health organizations are increasing efforts to address their workforce problems, it is uncommon for the outcome of these efforts to be evaluated with even a modicum of rigor. With few exceptions, the evidence on workforce practices and interventions remains largely anecdotal.

CONCLUSION

Health care reform requires a revitalized and strengthened workforce, and it is critical that this workforce is prepared to comprehensively address the health needs of Americans, including their behavioral health needs. The Annapolis Coalition believes that significant investment is required to make this a reality, and we recommend that in its deliberations the Senate Finance Committee give significant attention to incorporating behavioral health issues into all of its efforts on workforce. We believe that the seven goals of *An Action Plan for Behavioral Health Workforce Development* provide a blueprint for strengthening this sector of the workforce, and commend its detailed implementation tables to the Committee for its consideration.

We thank the Chairs and Members of the Committee for this opportunity to present testimony on this important topic.

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Statement

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Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

Submitted for the Record to the
Senate Committee on Finance

March 12, 2009

The Association of American Medical Colleges (AAMC) welcomes the opportunity to submit this statement for the record in junction with the March 12, 2009 Senate Finance Committee hearing "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future." The AAMC applauds the Committee for conducting this hearing and for identifying the physician workforce as an essential component of the national dialogue on health care reform.

The AAMC is a not-for-profit association representing all 130 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and 94 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians.

A more effective health system will require a wide range of health professionals, other care givers and ancillary staff. They will need to be well-educated, able to work together in teams, distributed across the nation and all its communities, and focused on the needs of each patient. The AAMC and its member institutions—who deliver approximately one fifth of all clinical care in this country—are committed to helping design and implement an improved delivery system and to educating and training the workforce necessary to assure access to high quality care. We are prepared to work with Congress, the federal government, other health professions and the education community in this effort.

Medical schools educate recipients of MD degrees, while teaching hospitals both train and provide a dynamic learning environment for future physicians and almost all other health professionals (e.g., nurses, physical therapists, physician assistants, and other members of the health care team). Medical schools and teaching hospitals work in partnership to maintain a setting where the creation of new knowledge and treatments, cutting edge care, provider training, and care for the most vulnerable can all occur together. Congress recognized the value of supporting this environment when it created Medicare's Prospective Payment System by ensuring adequate patient care payments through the Indirect Medical Education (IME) adjustment.

The AAMC thanks the Committee for its long-standing recognition that IME payments are intended to cover the higher costs of patient care at teaching hospitals. As specified in House Ways and Means and Senate Finance Committee reports from March 1983, "This adjustment is provided in light of doubts... about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents ... the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals."

Teaching hospitals and teaching physicians are a critical piece of the health care safety net. Health care reforms must include a redesign of the health care delivery and financing system, while preserving the greatest strengths of the current health care system, including its educational and training capacity.

The nation is facing a shortage of physicians, nurses and other health professionals that could endanger both access to and quality of care. The nation must adopt a multi-faceted strategy to assure access and quality including both health systems redesign and increasing the supply of health professionals.

I. The AAMC's Health Care Reform Principles

The AAMC and its members are committed to the following principles and believe that academic medicine must play a pivotal role in improving health and health care and in achieving positive changes in the health care system. We believe that, with a concerted national effort from both the private and public sectors, the goal of affordable, quality health care for all is achievable and sustainable within the next decade. The AAMC's reform principles are available at: http://www.aamc.org/newsroom/pressrel/2008/081028.htm. In summary they state that:

- Health care coverage that is affordable, transportable, and continuous, and that combines the best of public and private systems, should be available to all.
- The health care delivery system must be restructured to facilitate health promotion and disease prevention while providing high-quality, cost-effective diagnosis and treatment of illness as well as palliative care.
- Health care financing mechanisms should be sustainable, equitable, explicit, accountable, and promote efficiency and quality.
- Existing programs that serve defined populations should be maintained until superior alternatives can fully replace them.
- The supply of health care practitioners must be adequate and reflect the population and its health care needs.
- Any reconfiguration of the health care system should recognize and provide stable support for the costs inherent in health research, technology development, and the provision of necessary specialized services to the broader society.

II. Background on the Physician Workforce

Physicians are an essential component of an effective health system. Yet the nation faces a number of interrelated challenges to assuring access to physician services for all Americans. These workforce challenges have the potential to undercut the ability of the nation to effectively implement health reform. These include:

- An overall shortage of physicians that is particularly serious among historically underserved populations;
- Geographic maldistribution which will be exacerbated by the overall shortage;
- Specialty maldistribution which is also likely to be exacerbated by the overall shortage;
- A physician workforce that does not adequately reflect the racial and ethnic diversity of the U.S. population; and
- Heavy reliance on graduates of foreign medical schools.

Addressing these challenges will require a variety of policies and programs. Fortunately, the nation has a number of policy levers and programs that can help address these issues. However,

it is critical to understand which policies and programs are most effective in addressing each challenge. For example, the AAMC believes that the National Health Service Corps (NHSC), the Title VII health professions training programs, and physician payment policies are the best tools to address the geographic and specialty maldistribution problems while direct graduate medical education (GME) support through Medicare and Medicaid is most effective in helping assure an adequate overall supply of physicians.

In-depth analyses demonstrate that under all reasonable scenarios for the future, including expanded access and increased emphasis on primary care and prevention, the nation will face a significant shortage of physicians.

The AAMC has carefully analyzed the most current available data on the physician workforce and population trends and concluded that the nation is likely to face a major shortage of physicians in the future – including both primary care physicians and specialists. In fact, millions of Americans already face shortages. An estimated 64 million Americans live in a federally designated Health Professional Shortage Area (HPSA). Over the past six years studies by 23 states and 20 specialties have concluded that their state or specialty is likely to face a shortage. The nation's community health centers are reporting growing difficulties recruiting needed physicians. Hospitals and health systems have had to increase their efforts and investments to recruit and retain physicians.

Between 1980 and 2005, the nation's population grew by 70 million people—a 31 percent increase. By 2030, as baby boomers age, the number of Americans over age 65 will double from 35 million to 71 million. These changes will significantly increase the demand for physician services because patients 65 and older typically average six to seven physician visits per year, compared with two to four visits annually for those under age 65. While medical advances and enhanced prevention will enable Americans to live longer, healthier lives, these individuals also will require additional health services as they age. The aging of the nation will be mirrored by the aging of its physicians; over one-third of the current physician workforce is aged 55 or older and is likely to retire in the coming decade.

The AAMC recently updated its analysis of future supply and demand for physicians and concluded that under any set of plausible assumptions, the U.S. is likely to face a growing shortage of physicians. While physician supply is projected to increase slightly between now and 2025, demand is projected to rise at a far faster rate, potentially leading to a shortage of between 125,000 and 159,000 physicians by the same year. While most specialties will face shortages, we are particularly concerned with the potential impact of a shortage on the delivery of primary care. Primary care services are a critical component of an effective and efficient health care system. These shortages are expected to have a disproportionately negative effect on those populations that are already underserved; the Health Resources and Services Administration (HRSA) estimates that an additional 30,000 health practitioners are already needed to alleviate current health professional shortages.

An acute physician shortage will profoundly affect access to health care, including longer waits for appointments and the need to travel farther to see a physician. Shortages can also contribute to higher costs through increased use of emergency rooms and decreased use of preventive

services. In addition, physician shortages can reduce the quality of care if practitioners are overloaded or if individuals are forced to delay treatment.
Some researchers suggest that the overall supply is adequate and that the access problems we are experiencing today are caused by the geographic and specialty maldistribution as well as inefficiencies of the health care system. The AAMC recognizes that there is a maldistribution problem and that there are inefficiencies, but based on our analyses we have concluded that even if these problems were addressed the nation is still likely to face a shortage of physicians.

We are very concerned that documented variations in current physician distribution and utilization are occurring, but this does not obviate the need for additional physicians. There are also errors of omission, or underuse of services, and identifying and eliminating individual over-utilization is difficult and fraught with moral hazard. There is a growing literature and concern nationally with health care disparities, especially for racial and ethnic minorities and the economically disadvantaged. Study after study has concluded that lack of access to care has contributed significantly to these disparities. Health reform is likely to lead to a needed increase in use of health services, including physician services, to reduce disparities. It will take several years to identify preferred interventions and there is no guarantee that this will significantly reduce the use of services in the foreseeable future—more likely, it will shift the nature of services that are provided in an effort to improve health care outcomes.

In response to growing uncertainty regarding the adequacy of the physician supply, in 2004 the AAMC established its Center for Workforce Studies to gather and analyze data on the supply, demand and use of physicians. The Center is committed to providing the medical education community, the public, and policymakers with data on current and likely future physician workforce needs. In recent months, the Center has issued a number of documents including its 2008 report *The Complexities of Physician Supply and Demand: Projections Through 2025,* the *2008 Physician Specialty Databook,* and the compilation document *Recent Reports and Studies of Physician Shortages in the U.S.* These reports are available, along with additional information, at http://www.aamc.org/workforce.

III. Summary of Recommendations

1. The AAMC recommends a multi-faceted response to growing shortages to assure an adequate supply of physicians to support health care reform.

2. The AAMC supports efforts to shape the physician workforce through the use of incentives, such as payment policies, and programs like the NHSC and Title VII (which have a proven track record). The AAMC opposes the use of GME financing policies which have not proven effective for this purpose.

3. The AAMC strongly supports the development of the medical home, which – though not a cure-all for current fragmentation of the delivery system – offers a powerful potential model likely to improve patient care satisfaction and outcomes.

4. Access problems are most severe in rural and inner city communities with limited economic resources, the areas where we need physicians the most. The AAMC strongly

supports the NHSC which has proven to be the most effective program for addressing needs in underserved areas.

5. The AAMC strongly supports a robust, sustained investment in the Title VII health professions training programs, which help improve the diversity, distribution, and supply of the health professions workforce, with an emphasis on primary care and interdisciplinary training.

6. The AAMC continues to advocate for and promote efforts to increase the enrollment and graduation of racial and ethnic minorities from medical school; it is committed to promoting the education and training of medical education and health care leaders from racial and ethnic minorities.

IV. Recommendations

1. **The AAMC recommends a multi-faceted response to growing shortages to assure an adequate supply of physicians to support health care reform**

AAMC has recommended a multi-faceted response to help address the growing shortages of physicians including a modest increase in physician supply and improvements in health services delivery. Perhaps our most widely recognized recommendation for forestalling future shortages is our call for a 30 percent increase in medical school enrollment and a commensurate increase in GME positions to accommodate this growth. However, it is important to make clear that this is only one part of our recommended solution – a necessary part – but only one component. We also strongly support efforts to improve efficiency and productivity and to increase the development of health care teams and the use of non-physician clinicians. The AAMC's projections of future shortages estimate that two-thirds of the projected shortage would need to be made up by systems improvements and that the recommended 30 percent increase in medical school enrollment and GME would only address about one-third of the projected shortages.

The AAMC recommended a phased increase of 30 percent in medical school enrollment between 2002 and 2015 and a commensurate increase in GME. Over the past 20 years, the number of first-year enrollees in U.S. medical schools per 100,000 people has declined annually as the number of physicians entering medical school has remained constant while the population has grown. Consequently, the U.S. has been producing fewer doctors each year relative to our growing and aging population. As a result, the current system relies on physicians educated outside the country, some of whom are U.S. citizens, but most are foreign-born and immigrate to the U.S. to train and practice. Today, one in four residents-in-training and physicians practicing in the U.S. attended medical school abroad. In addition to concerns about self-sufficiency in the health professions, U.S. reliance on foreign physicians has been criticized for contributing to the global "brain-drain" of physicians from developing nations challenged by severe health professional shortages of their own.

It is important to note that we must act today to prevent tomorrow's shortages. It can take several years to add medical school capacity, as such efforts involve obtaining approvals and/or funding and adding infrastructure such as faculty and laboratories. Any increase in first-year

medical school enrollment will then require, at minimum, seven more years before the nation will see an increase in the size of the physician workforce. Medical students must complete four years of medical school before then entering residency training in their chosen specialty, which can take anywhere from three to seven years.

The AAMC projections of future supply estimate that the overall number of physicians will only increase by 8 percent between now and 2025 if current enrollment and retirement patterns remain the same; yet, the U.S. Census Bureau estimates that the U.S. population will grow by 20 percent during this same interval and demand is projected to increase 27 percent during this same interval due to the population growth and aging of the population. Assuming that GME can expand to accommodate the 30 percent increase in allopathic medical school enrollment, this would only result in an additional 7 percent increase in the overall physician workforce by 2025. In comparison, HRSA estimates the number of nurses was able to increase by 8 percent in a four year span between 2000 and 2004.

Because capacity-building and educating/training a physician may require a decade or more, the nation must invest in the growth of the physician workforce while it concurrently works to improve the delivery system and achieve a better balance between the health workforce and the needs of the population.

It is also important to note that increasing the number of physicians alone will not correct geographic maldistribution, lack of cultural competence in the provision of care, or health care disparities. The nation not only needs more doctors, it also needs a more racially and ethnically diverse workforce that is responsive to and capable of providing optimal care for an increasingly diverse population. Medical students from racial and ethnic minority groups are also more likely to practice in underserved communities and care for a disproportionate number of disadvantaged patients.

A comprehensive strategy must include the increased use of nurse practitioners, physician assistants, and other health professionals while improving efficiency and making better use of physicians' unique knowledge and skills. Health care delivery models also will need to be re-examined to ensure that teams of professionals can provide efficient, effective services that improve the health of populations.

2. **The AAMC supports efforts to shape the physician workforce through the use of incentives (such as payment policies) and programs like the NHSC and Title VII, which have a proven track record. The AAMC opposes the use of GME financing policies which have not proven effective for this purpose.**

An effective health care system requires an adequate supply of physicians in a wide array of specialties. There is extensive concern that the nation does not have an adequate supply in a number of core specialties including primary care specialties, geriatrics, general surgery, and psychiatry. There have been numerous calls for action to address shortages in these and other specialties. The AAMC agrees that action is needed to encourage a physician workforce to meet the priority health needs of the nation. The AAMC believes that there are a range of policies and programs that can be used in support of this goal; this includes payment policy, the NHSC and Title VII.

GME financing policies are not an effective tool to shape physician specialty distribution, especially if the problem to be addressed relates to specialty choice by medical students. Encouraging hospitals to add residency positions does not increase medical student interest in a specialty. Adding support for more training will not increase the overall supply; changes in payment policy that make a specialty more rewarding are likely to be far more effective, as is the availability of NHSC loan repayment awards.

Today, Medicare pays each teaching hospital a portion of a hospital-specific capitated, or "per resident," amount based on the hospital's "direct graduate medical education" (DGME) costs in FY 1984 or FY 1985. The base year per resident amount is updated annually by an inflation factor. Medicare's portion of the per resident amount is calculated based on the program's share of total hospital inpatient days.

Each hospital has two separate per resident amounts. Since 1993, each hospital receives slightly higher payments for residents training in primary care specialties and slightly lower amounts for residents in subspecialties. Primary care specialties include family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, and obstetrics/gynecology.

In addition, Medicare pays lower amounts for residents in subspecialties. After the period required for a resident's initial board certification in the first specialty in which the resident begins training (not to exceed a maximum of five years), Medicare pays only 50 percent of its share of the per resident amount. The 50 percent payment continues indefinitely, as long as the resident remains in an accredited program.

The maximum period of five years is extended for up to two years for training in a geriatric or preventive medicine residency or fellowship. For primary care "combined" residency programs, such as internal medicine/pediatrics, the Balanced Budget Act of 1997 (P.L. 105-33) defined the period of board eligibility to be the minimum number of years of formal training required to satisfy the initial board requirements of the longest program plus one year.

Medicare now imposes a limit on the number of residents it supports. The limit is based on the number of FTE residents in approved allopathic or osteopathic training programs, before application of the 50 percent weighting factor, that were reported on the hospital's most recent cost report period ending on or before December 31, 1996. Dental and podiatric residents are excluded from the residency limits. The Medicare program continues to make DGME payments for residents who graduated from U.S. and foreign schools of medicine, as long as they are in approved residency training programs.

Medicare's GME funding should not be used as an instrument to alter workforce specialty composition. Further, programs should be allowed greater flexibility in order to encourage training in non-hospital settings. Current regulations that prohibit that counting of educational time in outpatient settings must be changed and programs proven to increase the supply of primary care physicians (NHSC, Title VII) should be fully funded to address shortages of primary care physicians.

Peer-reviewed literature suggests that the specialty choice decision process is complex and that students make their decisions based on a variety of factors, including interest in the particular aspect of medicine, access to mentors and role-models in the field, ability to balance work and home life, and not just income potential and education debt (as many often characterize the decision). Medical education and training appear to have less impact on specialty choice than the practice environment for primary care. Previous attempts to alter specialty composition have failed when they relied on changes to Medicare's reimbursement to teaching hospitals that offset some of their GME costs. For instance, current Medicare GME payments for resident costs associated with sub-specialty training are one-half of reimbursement for physician trainees in their first residency; the exception to this policy is for geriatrics fellowships, which are reimbursed at the full rate. Yet, many training positions remain unfilled in geriatrics, and most physicians will go on to sub-specialize despite GME policies that favor primary care.

While the nation engages in discussions to address the long-term threats to the viability of Medicare and Medicaid, we must not de-stabilize the current system's ability to train a health care workforce that serves the needs of these and other patients.

3. **The AAMC strongly supports the development of the medical home concept, which – though not a cure-all for the currently fragmented delivery system – offers a powerful potential model likely to improve patient care satisfaction and outcomes.**

Many Americans feel "medically homeless" in a health care system that is difficult for patients to navigate when they need care or advice. Patients and providers alike are deeply dissatisfied with the current delivery system. New models of care delivery must be developed, focusing on patients and their problems while improving delivery and outcomes.

The medical home is a concept or model of care delivery that includes an ongoing relationship between a provider and patient, around-the-clock access to medical consultation, respect for the patient/family's cultural and religious beliefs, and a comprehensive approach to care and coordination of care through providers and community services. Its functions are similar to those of effective primary care proposed several decades ago by the Institute of Medicine (IOM), the World Health Organization (WHO), and others. In fact, the term was originally coined in 1967 by the American Academy of Pediatrics (AAP), but the concept in its current form was formulated by the academy in a 1992 position paper as an "approach to providing comprehensive primary care."

Much evidence supporting the medical home model is extrapolated from the literature evaluating primary care, case management, and other approaches to improving care coordination and prevention. The limited evidence available from studies more closely examining the role of the medical home is encouraging. Further studies are needed to better define the core functions of the medical home, its optimal implementation, and how strategies might need to be adjusted for populations with different degrees of acute and chronic illness. Perhaps the greatest challenge will be the additional resources required to adopt medical homes before cost savings (if any) are realized.

The AAMC's call for an expansion of medical education and training in the U.S. will help ensure that physicians are available to care for a growing population of aging and chronically ill citizens. However, the Association and its members believe that physicians and other health care providers are only the first step to improving the health of communities and that patients must be able to access effective care for both prevention and treatment.

Despite the need for better information about optimal form and function, and the attendant challenges to implementation, the AAMC believes that the medical home model holds great promise for improving the health of populations and individuals.

In March 2008, the AAMC adopted a position statement endorsing the medical home model and committed to working with its member institutions to better understand how the medical home model can be adopted in academic and community settings. Moreover, the Association and its members look to these new models of care to train and educate physicians in a delivery system that improves patient satisfaction and outcomes while improving the value of health care. The AAMC's full statement is available at:
http://www.aamc.org/newsroom/pressrel/2008/medicalhome.pdf

Specifically, the AAMC recommends that:

- Every person should have access to a medical home – a person who serves as a trusted advisor and provider supported by a coordinated team – with whom they have a continuous relationship.
- The federal government must invest in the further research necessary to better understand how to measure the core functions of the medical home and to develop an evidence base for how the model is best implemented.
- Payment for the medical home model should appropriately recognize and reward health care providers for their contributions to prevention, patient care, and care coordination.

4. **Access problems are most severe in rural and inner city communities with limited economic resources, the areas where we need physicians the most. The AAMC strongly supports the NHSC which has proven to be the most effective program for addressing needs in underserved areas.**

The NHSC is widely recognized — in Washington and in the underserved areas it helps — as a success on many fronts. It improves access to health care for the growing numbers of underserved Americans, provides incentives for practitioners to enter primary care, reduces the financial burden that the cost of health professions education places on new practitioners, and helps ensure access to health professions education for students from all backgrounds.

The NHSC provides scholarships to health professions students and loan repayment awards to practitioners in exchange for at least two years of service in a HPSA. NHSC awardees can apply for annual award continuations (or "amendments") for additional years of school or to pay down the remainder of their student loan debts. The NHSC also funds a State Loan Repayment

Program (SLRP), which involves a dollar-for-dollar match between the NHSC and the State, to provide loan repayment for practitioners to work in that State.

Designed to provide comprehensive health care that bridges geographic, financial, cultural and language barriers, the NHSC works to unite communities in need with caring health professionals, then supports those communities' efforts to build better systems of care. According to the NHSC Advisory Council, more than 78 percent of clinicians continue to practice within the community where they were placed beyond the term of service; 52 percent of the program's alumni have remained in their original communities of service for more than 15 years. Additional studies have indicated that NHSC awardees contribute positively to the long-term growth of the non-NHSC physician workforce in underserved communities, rather than providing temporary staffing that competed with and impeded the supply of other local physicians.

The high price tag of a medical education can pose a daunting figure to aspiring physicians and may influence their decisions as they shape their careers. In 2008, 87 percent of U.S. medical students graduated with a median indebtedness of $155,000. The NHSC provides financial incentives designed to recruit and retain primary care providers from all backgrounds into geographically underserved areas. However, this task is increasingly more difficult as the program operates under a thinly stretched operating budget.

In the past five years funding for the NHSC has been cut by over $47 million, a 27 percent reduction from the $171 million in FY 2003 that was already insufficient to meet the nation's needs. As a result, the NHSC has reduced the number of new annual scholarship and loan repayment awards by over 30 percent during that period (from 1,353 awards in FY 2003 to 943 in FY 2008). At that funding level, the NHSC was unable to award qualified scholar applicants, and 12 students were turned away for every 1 accepted. Similarly, there were 3 times as many practitioners in underserved areas seeking loan repayment than accepted applicants.

By its own calculation, the NHSC falls more than 30,000 short of a field strength that would begin to meet the needs of the nation's underserved areas. Currently, the NHSC estimates its total field strength at just over 3,500 practitioners. While the "American Recovery and Reinvestment Act of 2009" (P.L. 111-5) provides an important boost over the next two years, the NHSC estimates it will result in at most 4,250 additional NHSC practitioners. Furthermore, these additional practitioners will be lost in future years if the NHSC is unable to fund award continuations or maintain the same level of new annual awards.

As the nation faces serious health professions shortages, additional funding is necessary to increase new NHSC annual awards and the total NHSC field strength. The AAMC has joined a group of concerned NHSC stakeholder associations in recommending $235 million for the FY 2010 NHSC appropriations. This figure represents the amount authorized under the "Health Care Safety Net Act of 2008" (P.L. 110-355) for NHSC Recruitment ($156,235,150) with a proportionate increase in the NHSC Field appropriation. This recommendation is supported by the National Advisory Council on the NHSC March 2007 report *Priorities for Reauthorization and Legislative Updates*, which called for a doubling of the program.

As we enter a new political era, comprehensive health care reform will require careful consideration and time. However, the NHSC is a proven investment that we can make now. By building on the past success of the NHSC, we can address some of the key challenges facing America's health care system: provider distribution, access to care, medical education debt, diversity in medicine, and a dwindling health professions workforce.

5. **The AAMC strongly supports a robust, sustained investment in the Title VII health professions training programs, which help improve the diversity, distribution, and supply of the health professions workforce, with an emphasis on primary care and interdisciplinary training.**

Through loans, loan guarantees, and scholarships to students, and grants and contracts to academic institutions and nonprofit organizations, the Titles VII and VIII health professions programs under the Public Health Service Act support the education and training of the full range of health care providers, including physicians, dentists, pharmacists, nurses, psychologists, and public and allied health professionals. Designed to improve the supply, diversity, and distribution of the health care workforce, these programs pick up where traditional market forces leave off. For example, the Title VII diversity programs increase minority representation in the health professions by strengthening the pipeline to a health career. Similarly, the primary care medicine and dentistry programs expand the primary care workforce, while the interdisciplinary, community-based linkages programs facilitate training in rural and urban underserved areas.

Together with Title VIII nursing education programs, the health professions programs are a critical component of the health care safety net, training a diverse supply of health professionals who are more likely to serve in community health centers and other rural and urban underserved settings.

As a result of a 51.5 percent funding cut in FY 2006, many Title VII programs were forced to cease their activities. The AAMC thanks Congress for the increases for Title VII health professions programs in the recently enacted "American Recovery and Reinvestment Act" (ARRA, P.L. 111-5) and the FY 2009 Omnibus Appropriations Act (H.R. 1105). This funding will provide a much-needed boon to the health care workforce while improving the health of the country. We look forward to working with Congress to continue to reinvest in the programs, as funding levels for almost all Title VII programs remain below the comparable FY 2005 levels. For example, the component of Title VII tasked with the compilation and analysis of national health workforce needs and shortages – the Workforce Information and Analysis program – has received no appropriation since FY 2006.

The AAMC is grateful to President Obama for his support for the health professions programs throughout his tenure in the Senate and during the presidential campaign; we also eagerly anticipate details of the Administration's proposal for an investment that "Strengthens the Health Professions Workforce," as outlined in the FY 2010 Budget Overview document. As Congress and the new Administration work to improve health care access for an increasingly diverse nation, it will be essential to ensure that a diverse, well-trained health care provider workforce is in place to meet the additional demand. With its emphasis on diversity, primary care, and special

and underserved populations, continued and increased support for the Title VII programs is critical to any comprehensive federal health care workforce strategy.

Additionally, the AAMC supports the continuation and reauthorization of the Title VII programs with improvements to enhance the productivity and accountability of the programs. Recognizing that a new approach to the Title VII programs is needed to strengthen them and improve their prospects for long-term survival, the AAMC in September 2004 appointed a committee to review the missions and effectiveness of the programs and propose recommendations as Congress considers reauthorization. The AAMC Committee agreed that the programs' shared goals should continue to be enhancing primary care, bringing care to underserved areas, and improving the diversity of the health care workforce. The Committee also agreed that the reauthorization of the Title VII programs should improve accountability of the programs by creating outcomes measures and enhancing the collection and analysis of data to monitor the programs' impact.

A copy of the AAMC Committee's final report is available at: http://www.aamc.org/advocacy/library/laborhhs/t7reauth.pdf . The AAMC looks forward to working with your colleagues on the Senate Committees on Appropriations and Health, Education, Labor, and Pensions, to reinvest in and revitalize the Title VII programs.

Further, the AAMC expects to continue to collaborate with HRSA, which administers the NHSC and the Titles VII and VIII programs. We are optimistic that under the leadership of HRSA Administrator Mary Wakefield, Ph.D., R.N., FAAN, HRSA will again prioritize the nation's health resources programs, including the health professions programs. In particular, we hope that HRSA will bolster the agency's Bureau of Health Professions, which administers most Title VII programs.

6. **The AAMC continues to advocate for and promote efforts to increase the enrollment and graduation of racial and ethnic minorities from medical school; it is committed to promoting the education and training of medical education and health care leaders from racial and ethnic minorities.**

A more culturally and ethnically diverse society requires a more diverse and culturally competent health care workforce to address health disparities among racial, ethnic, and economic groups. The nation's teaching hospitals and physicians provide frontline care for the medically underserved – especially those who are uninsured or underinsured. Supporting the efforts of medical schools and teaching hospitals to mitigate health and health care disparities is fundamental to achieving better health for all.

Efforts to address health and health care disparities have coalesced around evidence that increasing diversity in the health professions workforce and improving cultural competence training for physicians will result in an increased quality of care for all. Studies repeatedly show that African American, Hispanic/Latino, and Native American physicians are more likely to practice in underserved communities and to care for a disproportionate number of disadvantaged patients. Additionally, a diverse physician workforce contributes to greater health care access for the underserved as studies have documented increased patient satisfaction in encounters with physicians from similar racial and ethnic backgrounds. Diverse environments help health

professionals acquire skills for treating people from a wide range of backgrounds and understanding of how culturally determined factors affect health, and cultural competence training across the medical education curriculum equips all physicians to provide optimal health care to patients from diverse backgrounds.

The AAMC maintains an unwavering commitment to expanding diversity in the physician workforce through outreach, pipeline programs, and holistic review in the admissions process. The federal government should renew its commitment to Title VII and other efforts to diversify the health care workforce and improve health status.

V. Conclusion

The issues surrounding the physician workforce and potential shortages are complex, particularly within the context of broad health care reform. As indicated by our reform principles, the AAMC and our member institutions believe that academic medicine must play a pivotal role in improving the health of our nation, as well as achieving positive changes in the health care system as a whole. This includes the development and implementation of policies to assure the production of an adequate supply of well-educated physicians who are prepared to meet the future health care needs of all Americans. We are committed to working closely with you, the Committee, the full Congress, and the Administration to achieve these goals.

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Written Statement
of the
Association of periOperative Nurses
To the
United States Senate Committee on Finance

Workforce Issues in Health Care Reform:
Assessing the Present and Preparing for the Future

March 12, 2009
215 Dirksen Senate Office Building

The Association of periOperative Nurses (AORN) appreciates the Committee's recognition of the importance of workforce issues to health care reform, and the valuable focus brought to the issue by the hearing held on March 12. AORN is the national association committed to improving patient safety in the surgical setting. AORN is the premier resource for perioperative nurses, advancing the profession and the professional with valuable guidance as well as networking and resource-sharing opportunities. AORN promotes safe patient care and is recognized as an authority for safe operating room practices and a definitive source for information and guiding principles that support day-to-day perioperative nursing practice. AORN's Syntegrity standardized perioperative framework is a cornerstone for public policy efforts to collect data to better understand workforce activity in the operating room and its impact on patient quality. www.AORN.org

While the hearing discussion centered primarily on solutions to the physician shortage, we would echo the comments made by some witnesses and the ANA statement emphasizing that, in order to meet our nation's health care needs we must ensure that we have an integrated national healthcare workforce policy that looks beyond physicians to ensure that the valuable contributions of Registered Nurses (RNs), and others on the health care team are appropriately recognized and integrated as we move forward with Health Care reform.

There are a wide variety of ideas currently circulating on health care reform, but all include a focus on quality, performance measurement, and evidenced based decisions. These are precisely the priorities that registered nurses bring to patient care. As the largest single group of clinical health care professionals within the health system, registered nurses are educated and practice within a holistic framework. Registered nurses are fundamental to the critical shift needed in health services delivery, with the goal of transforming the current system into a system that measures and values patient centered, quality care.

RNs are the backbone of the operating room in hospitals and ambulatory surgery centers. The registered nurse as a circulator for every patient for every surgical procedure is a standard to provide high-quality care. When utilizing a registered nurse as first assistant in surgery, the health care system adds the benefit of cost effectiveness to high quality.

The shortage of surgeons available as first assistant and the mandated reduction in permitted work hours of surgical residents has contributed to the need for registered nurse first assistants (RNFA) to step in to provide first assistant services, thereby ensuring continued delivery of quality surgical patient care. The RNFA is a technically skilled and highly knowledgeable health care professional who is educationally prepared, clinically experienced and available to function in this capacity.

The support, development and deployment of this keystone profession is essential for any quality health reform plan to succeed. It is precisely because of the integral role nursing plays in health care that we urge the committee to give increased attention and focus to addressing the growing nursing shortage as part of health care reform. The Bureau of Labor Statistics (BLS) reports that the health care system will require more than 1 million new nurses by the year 2016, and the potential increased coverage promised by health care reform will only exacerbate that shortfall.

Attention to and investment in faculty and workforce recruitment and development is vital. Given that we are losing so many new nurses within the first year of practice—as many as 1 in 5 according to a 2004 national study, nurse retention strategies such as attention to safe staffing must play a vital role in efforts to address the nursing shortage as well. Without attention to these areas of concern we will not meet the needs outlined by the BLS. More to the point, if we do not undertake such efforts, our health care delivery system will not be meet the needs of the American people, whether under our current system or a new paradigm created through health care reform.

While the hearing discussion focused a majority of time and attention toward physician education and training toward primary care—certainly a component of workforce reform—there was little in-depth attention given to the significance of the growing nursing shortage. Although reform of Medicare Graduate Medical Education (GME) and efforts to grow the physician population are

needed (and we would argue that Graduate Nursing Education deserves significant attention as well) such efforts in isolation will not result in the creation of a health workforce that will be able to meet the care needs of the United States.

We appreciate that this view was shared by some on the panel, valued the Chairman's questions regarding the origins of and solutions to the nursing shortage. However it was clear that there was not sufficient time and expertise available to delve deeply into his questions.

Because these questions are so fundamental, AORN agrees with ANA and urges the Committee to hold another hearing involving experts on the nursing profession, as well as representatives of other professions to further explore both the nursing shortage, as well as ways that we can reduce the barriers in our current system that prevent full integration, coordination, and collaboration at all levels among our nations health care workforce. Again we appreciate the dialogue that the committee started on the 12th, and hope that you will continue this discussion. In order to be successful in transforming our nation's health care system, we must have a holistic workforce policy that full recognizes the vital role of nurses and other providers.

AORN looks forward to working with Chairman Baucus, Ranking member Grassley, the Senate Finance Committee, and other progressive voices seeking comprehensive health reform, in order to assure that the promise of universal coverage is fulfilled through accessible, high-quality, affordable health care for all.

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STATEMENT OF

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to the

FINANCE COMMITTEE
UNITED STATES SENTATE
WASHINGTON, D.C.

"WORKFORCE ISSUES IN HEALTH CARE REFORM:
ASSESSING THE PRESENT AND PREPARING FOR THE FUTURE"

March 12, 2009

The Coalition to Protect Senior Care thanks Chairman Baucus, Ranking Member Grassley and the Senate Finance Committee for holding the hearing on "Workforce Issues in Health Care Reform". As all of us today here fully realize, our nation faces an ongoing crisis in terms of the long-term care workforce shortage.

Mr. Chairman, consider this startling demographic fact: The most rapidly growing age group in America is those aged 85 years and older. They will quadruple in number by 2050. These are the aging citizens who will require essential long-term care services in the future, as this cohort is most likely to require long term care and services – much of it delivered in our nation's nursing homes.

The high demand for long-term care workers resulting from the demographic tidal wave approaching is further documented by an American Health Care Association (AHCA) study examining staff vacancy rates in our nation's nursing homes. The extensive analysis found that approximately 52,000 certified nurse assistants (CNAs) are needed immediately – just to meet existing demand for care in nursing facilities alone. As CNAs perform almost 80 percent of direct patient care tasks, they are a vital part of assuring quality objectives within any given facility are achieved.

Despite the growing demand for care coupled with the need for a more robust workforce, the current financing mechanisms supporting our infrastructure rely heavily on public programs. Medicare and Medicaid together fund the largest percentage of nursing home care, 62.1 percent, with the lion's share, 45.4 percent, coming from Medicaid, according to the Georgetown

University Long-Term Care Financing Project. Just seven percent of all payments come from private insurance.

Unfortunately, on the Medicaid front, reimbursement for care in our nursing homes has long been inadequate – and contributes significantly to the fragility of our workforce. This Medicaid funding shortfall has been calculated at $4.2 billion nationwide in 2008, or to put it another way, a loss of $12.48 per patient, per day, according to independent research by *Eljay, LLC.*

Further, Mr. Chairman, recruitment costs and increases in the federal minimum wage or other salary increases are often not represented in state Medicaid reimbursements. Obviously, this has the potential to create a still greater cost squeeze on facilities than is already the case, and places increased pressure on already strained state Medicaid programs and budgets – which have already been cut in a number of states.

In terms of Medicare, funding stability and quality care go hand-in-hand. It is important for the Obama Administration and Congress to ensure that in shaping a final budget for 2010, the adequacy of federal Medicare funding from Washington is always the first policy priority. Medicare cuts of any nature would not just turn back the clock on the quality improvements we have worked so hard to achieve, but further undermine the already rickety, interdependent long-term care-financing structure.

We commend key members of both the U.S. Senate and House for recently writing on a bipartisan basis to Senator Obama asking that he consider the overall adequacy of long term care funding in determining the FY 2010 federal budget. We believe portions of the letters merit inclusion in today's hearing record:

In their letter to the President, U.S. Senators Debbie Stabenow (D-MI), Ron Wyden (D-OR) and Pat Roberts (R-KS) state, *"Approximately 80 percent of patients in skilled nursing centers rely on Medicare or Medicaid to pay for their long term and post acute care. Given that the fastest growing segment of our population are those 85 and older, our nation's need for skilled nursing services will continue to grow. Providing appropriate funding for both Medicare and Medicaid will ensure that this population will have access to quality care when the need arrives... Funding stability will ensure providers' ability to deliver safe, high quality care to patients, who are characterized by more medically complex conditions than ever before."*

A letter from U.S. Reps. Earl Pomeroy (D-ND), Shelley Berkley (D-NV), Shelley Moore Capito (R-WV) and Ginny Brown-Waite (R-FL) to President Obama says the following: *"We are writing to respectfully ask that in drafting your Fiscal Year 2010 (FY 2010) Budget, you do not propose Medicaid and Medicare payment policy recommendations that will adversely affect long term care delivery... We respectfully request that you and the Office of Management and Budget (OMB) do everything you can to foster the stability of the long-term care community. Your leadership is needed not only to sustain the continued provision of safe, high quality care, but also to better meet the needs of patients who are experiencing more medically complex conditions than ever before."*

Looking to the future, Mr. Chairman, the House lawmakers' letter is prescient in that we need to acknowledge not just the growing demand for care, but also the growing role that skilled nursing facilities play as providers of short-term post acute care.

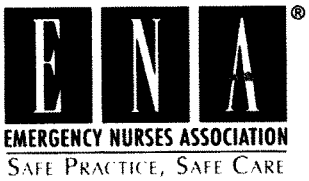
A significant 2008 *United Hospital Fund* report, for example, found that the number of patients staying in a nursing home for less than two months more than tripled from 1996 to 2005 in New York State. In addition to this rise in short-stay patients, the study further concluded, "between 1996 and 2005, both long-term residents and short-term patients have become more disabled, and more of them are cognitively impaired."

Thus, as more short stay patients arrive in our facilities, the key lesson is that when Medicare funding for skilled nursing services is stable, quality of care and services improves. Yet, when it is inconsistent and unstable – especially in the face of growing demand – our nation's long-term care infrastructure deteriorates. More broadly, when nursing facility operating margins face ongoing reductions, our facility administrators are far less able to recruit and retain qualified care givers, modernize aging physical plants and equipment, invest in new technology, and meet the increasingly complex care needs of our aging population.

We all agree consumers deserve the highest quality care and services across the spectrum of health care settings, just as our workforce requires funding stability to ensure we preserve every seniors' right to quality long term care. We are proud of the advances we have made in delivering high quality long-term care services and we remain committed to sustaining these gains in the years and decades ahead.

Working together cooperatively and constructively, Mr. Chairman, we will be aggressively advocating for the stronger long term care workforce we will need today and in the years and decades ahead to ensure the growing number of U.S. seniors requiring long term care and services will always have access to them.

Thank you.



Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

Senate Finance Committee

March 12, 2009

Submitted by:

Emergency Nurses Association
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The Emergency Nurses Association (ENA) appreciates the opportunity to submit written testimony for the record on the impact of workforce issues in the healthcare reform debate. As the only professional nursing organization for more than 36,000 emergency nurses across the United States, ENA is dedicated to defining the future of emergency nursing and emergency care. As an advocate for patient safety and quality care, we believe that public officials should work to provide all individuals with equitable access to comprehensive health care services, including the medical conditions of mental disorders, alcohol and substance abuse, and addictions.

Emergency services and trauma care have reached a crisis in the United States, chiefly due to crowding and boarding, lack of health care providers, and the burden of uncompensated care. ENA contends that everyone in the nation should have access to a health home for basic care, health promotion, and non-urgent medical needs. Proposals for health care reform should remove those factors that impede individuals from attaining the necessary quality care to which all persons are entitled.

SUMMARY OF THE NURSING SHORTAGE

Nursing is the largest health care profession in the United States. According to the National Council of State Boards of Nursing, there were nearly 3.4 million licensed RNs in 2006.[1] A federal report published in 2004 estimates that by 2020 the national nurse shortage will increase to more than one million full-time nurse positions. According to these projections, which are based on the current rate of nurses entering the profession, only 64 percent of projected demand will be met.[2] A study, published in March 2008, uses different assumptions to calculate an adjusted projected demand of 500,000 full-time equivalent registered nurses by 2025.[3] According to the U.S. Bureau of Labor Statistics, about 233,000 additional jobs for registered nurses will open each year through 2016, in addition to about 2.5 million existing positions. Based on these scenarios, the shortage presents an extremely serious challenge in the delivery of high-quality cost effective services, as the nation looks to reform the current healthcare system. Even considering only the smaller projection of vacancies, this shortage still results in a critical gap in nursing service, essentially three times the 2001 nursing shortage.

The emergency nurse has a vital role in health care reform made more precious owing to the nursing shortage. ENA recommends increased funding for the Title VIII Nurse Workforce Development Programs at the Health Resources and Services Administration (HRSA), especially in the area of nurse faculty preparation. Specifically, ENA requests a funding level of $215 million for these programs in FY 2010. The federal investment in nursing education is less than six hundred-thousandths of the total federal budget. In 1974, during the last serious nursing shortage, Congress appropriated $153 million

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[1] National Council of State Boards of Nursing, (2008). *2006 Nurse Licensee Volume and NCLEX® Examination Statistics. (Research Brief Vol. 31)*. On the Internet at: https://www.ncsbn.org/08_2006_LicExamRB_Vol31_21208_MW(1).pdf. (Accessed March 20, 2009).

[2] Health Resources and Services Administration. (2004) *What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?* On the Internet at: http://bhpr.hrsa.gov/healthworkforce/reports/behindrnprojections/4.htm. (Accessed March 20, 2009).

[3] Buerhaus, P., Staiger, D., Auerbach, D. (2008). *The Future of the Nursing Workforce in the United States: Data, Trends, and Implications*. Boston, MA: Jones & Bartlett.

for nurse education programs. In today's dollars that would be worth $592 million, approximately three and a half times what the federal government is spending now.

IMPACT OF THE NURSE FACULTY SHORTAGE ON NURSING VACANCIES

In 2006, the American Hospital Association reported that hospitals needed 116,000 more RNs to fill immediate vacancies, and that this 8.1 percent vacancy rate affects hospitals' ability to provide patient care.[4] Government estimates indicate that this situation only promises to worsen due to an insufficient supply of individuals matriculating in nursing schools, an aging existing workforce, and the inadequate availability of nursing faculty to educate and train the next generation of nurses. At the exact same time that the nursing shortage is expected to worsen, the baby boom generation is aging and the number of individuals with serious, life-threatening, and chronic conditions requiring nursing care will increase. Consequently, more must be done today by the government to help ensure an adequate nursing workforce for the patients of today and tomorrow.

A particular focus on securing and retaining adequate numbers of faculty is essential to ensure that all individuals interested in – and qualified for – nursing school can matriculate in the year they are accepted. In the 2006-2007 academic year, 99,000 qualified applications – or almost 40 percent of qualified applications submitted to prelicensure RN programs – were denied due to lack of capacity.[5] Aside from having a limited number of faculty, nursing programs struggle to provide space for clinical laboratories and to secure a sufficient number of clinical training sites at health care facilities. The results of the disparities in workforce supply and demand are played out in staff shortages in the majority of emergency departments across the country – from staff who are struggling to provide care, to ED crowding, to ambulance diversions, and to the patients who ultimately suffer. The situation is only going to get worse as the population ages.

CAPACITY OF THE PUBLIC HEALTH INFRASTRUCTURE

HRSA's National Center for Health Workforce Analysis reports that the nursing shortage makes it challenging for the health care sector to meet current service needs. Nurses make a difference in the lives of patients from disease prevention and management to education to responding to emergencies. Even though the Unites States spends more than $2 trillion annually on health care – more than any other nation in the world – tens of millions of Americans suffer every day from preventable diseases like type 2 diabetes, heart disease, and some forms of cancer that rob them of their health and quality of life.[6] In addition, major vulnerabilities remain in our emergency preparedness to respond to natural, technological, and manmade hazards. An October 2008 report issued by Trust for America's Health entitled ***Blueprint for a Healthier America*** found that the health and safety of American

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[4]American Hospital Association, (2007) The *State of America's Hospitals: Taking the Pulse, Findings from the 2007 AHA Survey of Hospital Leader*. On the Internet at: http://www.aha.org/aha/content/2007/PowerPoint/StateofHospitalsChartPack2007.ppt. (Accessed December 3, 2008).

[5] National League for Nursing. (2009) *Nursing Data Review 2006-2007: Baccalaureate, Associate Degree, and Diploma Programs*. On the Internet at: http://www.nln.org/research/slides/index.htm. (Accessed March 20, 2009).

[6] KaiserEDU.org. "U.S. Health Care Costs: Background Brief." Kaiser Family Foundation. On the Internet at: <http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358> (Accessed March 20, 2009).

depend on the next generation of professionals in public health.[7] Further, existing efforts to recruit and retain the public health workforce are insufficient. New policies and incentives must be created to make public service careers in public health an attractive professional path, especially for the emerging workforce and those changing careers.

Culturally competent health care providers are also essential to the provision of high quality health care in this nation. Ideally, the health care workforce should reflect the cultural diversity of the general population. Studies have shown that people are most comfortable receiving care from someone of their own cultural and ethnic background. Studies provide evidence that minority practitioners are more likely than their Caucasian counterparts to serve in minority and medically underserved communities.[8] It is critical that we invest in strategies to encourage this diversity in nursing, and work to enhance cultural competence among nurses of all ethnic backgrounds.

An Institute of Medicine report notes that nursing shortages in U.S. hospitals continue to disrupt hospitals operations and are detrimental to patient care and safety.[9] Hospitals and other health care facilities across the country are vulnerable to mass casualty incidents themselves and/or in emergency and disaster preparedness situations. As in the public health sector, a mass casualty incident occurs as a result of an event where sudden and high patient volume exceeds the facilities/sites resources. Such events may include the more commonly realized multi-car pile-ups, train crashes, hazardous material exposure in a building or within a community, high occupancy catastrophic fires, or the extraordinary events such as pandemics, weather-related disasters, and intentional catastrophic acts of violence.

Since 80% of disaster victims present at the emergency department, nurses as first receivers are an important aspect of the public health system as well as the healthcare system in general. The nursing shortage has a significant adverse impact on the ability of communities to respond to health emergencies, including natural, technological and manmade hazards. Over the last eight years, millions of dollars have gone to strengthen our country's disaster preparedness. However, one area still has not received the level of support it needs to prepare for mass casualty episodes. It is emergency care providers and hospitals – the ones who provide emergent medical care for patients and family members during a disaster. Hospitals and EMS have been under funded, under supported and, in many cases, left out. It is the emergency care system of our country that is currently the most fragile, most oversaturated, and most fragmented of all healthcare areas.

RECOMMENDATIONS

In order to resolve the systemic health care crisis in the country, the Emergency Nurses Association believes that health care reform proposals must address the following workforce issues.

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[7] Trust for America's Health. (2008) *Blueprint for a Healthier America: Modernizing the Federal Public Health System to Focus on Prevention and Preparedness*. On the Internet at: http://healthyamericans.org/report/55/blueprint-for-healthier-america (Accessed March 20, 2009).

[8] The Sullivan Commission. (2004). Missing Persons: Minorities In The Health Professions. On the Internet at: www.aacn.nche.edu/Media/pdf/SullivanReport.pdf. (Accessed March 20, 2009).

[9] Institute of Medicine. Committee on the Future of Emergency Care in the United States Health System. (2007) *Hospital-Based Emergency Care: At the Breaking Point*. On the Internet at: http://www.iom.edu/?id=48896. (Accessed March 20, 2009).

1. Increase funding for the Nursing Workforce Development Programs under Title VIII of the Public Health Services Act at a level to meet current and future health care needs.

2. Increase nurse faculty scholarship funding to develop the next generation of educators and advanced practice nurses.
3. Maximize education funding for healthcare professionals who commit to practice in underserved areas.

4. Provide funding for health care worker education to deliver "culturally proficient" care, e.g., ethnic, religion, gender.

5. Support funding of incentives to develop a primary care workforce sufficient to meet the nation's health care needs.

6. Support and increase the use of advanced practice nurses in appropriate settings.

3/24/09

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National League
for Nursing

Testimony

of

National League for Nursing

to

Committee on Finance
United States Senate

Hearing on

**Workforce Issues in Health Care Reform:
Assessing the Present and Preparing for the Future**

March 12, 2009

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The National League for Nursing (NLN) represents leaders in nursing education and nurse faculty across ***all*** types of nursing programs in the United States – doctorate, master's, baccalaureate, associate degree, diploma, and licensed practical. With more than 1,200 nursing school and health care agency members, 29,000 individual members, and 18 regional constituent leagues, the NLN is the premiere organization dedicated to excellence in nursing education and preparing the nursing workforce to meet the needs of our diverse populations.

Dovetailing with the Senate Finance Committee's attention to health system reform is the NLN's emphasis on high-priority infrastructure determinants that will ensure health coverage for all people in America while improving health care quality. The NLN applauds the Committee's attention to policy that will reinvest in the education of a 21st century health care workforce, a critical component to delivering system reform goals and providing high-value care for every dollar invested. We appreciate this opportunity to add more evidence to the health care workforce issues facing the nation today.

EDUCATION CAPACITY AND THE NURSE PIPELINE

Committee members likely are aware that today's nursing shortage in their respective states is not insignificant. Reported in 2007 by the American Hospital Association, 116,000 more registered nurses (RNs) were needed in hospitals across the nation to fill immediate vacancies.[1] The U.S. Bureau of Labor Statistics (BLS) reports the nurse workforce to be the predominant occupation in the health care industry.[2] The BLS calculations show the present nurse workforce at well over four times the size of the medical workforce, and the BLS occupational employment projections indicate that RNs will experience the largest numeric increase in new jobs, among professional and related occupations, with a growth of 23 percent in employment change between 2006 and 2016.[3]

The current nursing shortage has persisted for the past eleven years, representing the longest lasting shortage in over 50 years.[4] The shortfall is expected to worsen through 2015 and 2020, with the deficit reaching nearly three times the size of the current shortage.[5]

The NLN's ***Nursing Data Review 2006-2007: Baccalaureate, Associate Degree, and Diploma Program*** casts a wide net on all types of nursing programs, from doctoral through diploma, to determine rates of application, enrollment, and graduation. The survey creates a true picture of nursing education, contributing to an exact understanding of the importance of the nursing workforce today and of the dimension of the challenges continuing into tomorrow.[6]

Key findings of the data review include:

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[1] American Hospital Association, (2007) *The State of America's Hospitals: Taking the Pulse, Findings from the 2007 AHA Survey of Hospital Leader.* On the Internet at:
http://www.aha.org/aha/content/2007/PowerPoint/StateofHospitalsChartPack2007.ppt. (Accessed March 20, 2009).
[2] Bureau of Labor Statistics, U.S. Department of Labor. *Employment outlook: 2006–16, Occupational employment projections to 2016.* On the Internet at: http://www.bls.gov/opub/mlr/2007/11/art5full.pdf (Accessed March 20, 2009).
[3] Bureau of Labor Statistics. *Employment outlook: 2006–16.* op.cit.
[4] Buerhaus, P., Staiger, D., Auerbach, D. (2008). The Future of the Nursing Workforce in the United States: Data, Trends, and Implications. Boston, MA: Jones & Bartlett.
[5] Ibid.
[6] National League for Nursing, (2009). Nursing Data Review 2006-2007: Baccalaureate, Associate Degree, and Diploma Programs. On the Internet at: http://www.nln.org/research/slides/viewall_0607.htm. (Accessed March 20, 2009).

- **Demand for spots in nursing programs continues to dramatically outstrip supply.** An estimated 99,000 qualified applications – or almost 40 percent of qualified applications submitted to prelicensure RN programs – were rejected in 2006-07.

- **Yet capacity continued to grow, although more slowly.** Though indicators point to some expansion in the RN workforce pipeline – the nation added 64 additional prelicensure RN programs between 2006 and 2007; the rate of growth was slower than in the previous year.

- **Admissions have grown.** Associate degree in nursing (ADN) programs admitted 12.3 percent more new students than last year. Baccalaureate admissions continued to grow as well albeit at a slower rate (5.6 percent in 2006-07) than in recent years. Diploma admissions were down slightly (4.2 percent).

- **Enrollments jumped.** Driven by an increase in ADN enrollment, the nation's ranks of prelicensure nursing students grew by almost 20,000, or 6.7 percent between 2006 and 2007. By contrast BSN programs did not change significantly during this period.

- **Graduation rates slowed in 2007.** Prelicensure graduations increased by only 3 percent between 2006 and 2007 after two years of more than 8 percent annual growth. Associate degree graduations accounted for the larger share of the increase, rising by 4.3 percent. Growth in baccalaureate program graduations slowed to only 2.3 percent, after a dramatic rise of almost 20 percent last year.

NURSE SHORTAGE AFFECTED BY FACULTY SHORTAGE

The NLN research provides evidence of a strong correlation between the shortage of nurse faculty and the inability of nursing programs to keep pace with the demand for new RNs. Increasing the productivity of education programs is a high priority in most states, but faculty recruitment is a glaring problem that likely will grow more severe. Without faculty to educate our future nurses, the shortage cannot be resolved.

Nurse faculty vacancies were described as acute by the NLN in its 2006 research, ***Nurse Educators 2006: A Report of the Faculty Census Survey of RN and Graduate Programs.***[7] Three years ago, there was an indication that the nurse faculty vacancies in the United States were growing even as the numbers of full- and part-time educators increased. The estimated number of budgeted, unfilled, full-time positions countrywide in 2006 was 1,390. That number represented a 7.9 percent vacancy rate in baccalaureate and higher degree programs, which is an increase of 32 percent since 2002; and a 5.6 percent vacancy rate in associate degree programs, which translated to a 10 percent rise in the same period.

As reported in the NLN ***Nursing Data Review 2006-2007***, the faculty vacancy situation rose appreciably in one year. The study showed that nationwide more than 1,900 unfilled full-time faculty positions existed in 2007, affecting 36 percent of all schools of nursing.[8] In response, 84 percent of nursing schools attempted to hire new faculty in 2007-2008. Of those, 79 percent found recruitment

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[7] National League for Nursing. (July 2006). News release – *Nurse Educators 2006: A Report of the Faculty Census Survey of RN and Graduate Programs.* On the Internet at: http://www.nln.org/newsreleases/nurseeducators2006.htm. (Accessed March 20, 2009).

[8] National League for Nursing, (2009). *Nursing Data Review 2006-2007.* op.cit.

"difficult" and almost one in three schools found it "very difficult." The two main difficulties cited were "not enough qualified candidates" (cited by 46 percent of schools), followed by inability to offer competitive salaries (cited by 38 percent).[9] While graduations in the 2008–2009 school year from master's and doctoral programs in nursing rose by 12.8 percent (or 1,918 graduates) and 4.5 percent (or 24 graduates), respectively, projections still demonstrate a shortage of nurse faculty.[10]

TRENDS STRESSING FACULTY SHORTAGE

The present nurse faculty staffing deficit is expected to intensify as the existing nurse educator workforce reaches retirement age. A 2006 ***NLN/Carnegie Foundation Preparation for the Professions Program*** national survey of nurse educators found that with 48 percent of nurse faculty over the age of 55, fully one-half of today's nurse faculty workforce is expected to retire by 2015, while just over one in five (21 percent) expect to retire within the next five years.[11] The NLN/Carnegie data also distinguished the nurse faculty cohort from the rest of the academic workforce by age: Where 48 percent of nurse educators are age 55 and over, only 35 percent of U.S. academics and only 29 percent of health science faculty are over the age of 54.[12]

GENDER/RACE/ETHNIC DIVERSITY LIMITS FACULTY CAPACITY

An April 2007 Robert Wood Johnson Foundation policy briefing paper suggests that as educators retire, nursing programs will yield a dual loss from the "decrease in the total number of faculty available to teach entry-level students and a reduction in the number of seasoned educators who can orient and mentor new faculty and advise graduate students."[13] Untapped resources of talent, from which schools of nursing could nurture replacements for experienced faculty or additional faculty to handle enrollment expansion, are minority populations among the nurse faculty workforce: males and underrepresented racial-ethnic groups (e.g., American Indians, Asians, African Americans, Hispanics).

Data indicate the nurse faculty workforce largely remains homogenous, not reflective of the nation's population or of the nursing student population. In 2007, the percentage of male graduates from prelicensure RN programs held steady at 12 percent from 2006.[14] Although the prelicensure RN programs' class of 2006 had been considerably more diverse than in previous years, 2007 brought little change in the percentage of racial-ethnic minorities graduating. Fewer than 23.6 percent of new graduates were from minority backgrounds in 2007 compared with 24.5 percent in 2006.[15] These numbers contrast adversely to our nation, which is enriched by cultural complexity where 34 percent of our population identifies as racial and ethnic minorities.

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[9] Ibid.
[10] Ibid.
[11] Kaufman, K. (May/June 2007). *Nursing Education Perspectives.* Introducing the NLN/Carnegie National Survey of Nurse Educators: Compensation, Workload, and Teaching Practice. Vol. 28, No. 3:164-169. On the Internet at: http://nln.allenpress.com/pdfserv/i1536-5026-028-03-0164.pdf. Accessed March 20, 2009.
[12] Ibid.
[13] Robert Wood Johnson Foundation. *Charting Nursing's Future, April 2007 – The Nursing Faculty Shortage: Public and Private Partnerships Address a Growing Need.* On the Internet at: http://www.rwjf.org/pr/product.jsp?id=18661. Accessed March 20, 2009.
[14] National League for Nursing, (2009). Nursing Data Review 2006-2007. op.cit.
[15] Ibid.

The ***NLN/Carnegie*** study affirmed that 96 percent of nurse faculty are female, compared to the three-fifths of the U.S. postsecondary faculty who are males.[16] Noting that the underrepresentation of racial and ethnic minorities among nurse educators "may be attributed to discrimination or socio-economic disparities that impinge disproportionately upon minority groups trying to enter a high-skill occupation", the 2006 study nonetheless reports that "nursing also lags significantly behind the remainder of academia with respect to diversity." Seven percent of nurse educators are minorities, and "16 percent of U.S. faculty belong to a racial minority group."[17]

The homogeneity of the nurse faculty plays out as a unique capacity constraint limiting nursing schools' ability to provide culturally appropriate health care education to develop a health care system that understands and addresses the needs of the nation's rapidly diversifying population. Factors such as biases and stereotyping, communication barriers, cultural sensitivity/competence, and system and organizational determinants contribute to health care disparities, generating a compelling need for workforce diversity.

SALARIES, WORKLOAD STRESSING FACULTY SHORTAGE

Although educators find fulfillment in being a teacher and in providing graduates who deliver quality health care, salaries are a significant issue for nurse educators. The ***NLN/Carnegie*** study of nurse educators from the 2005-2006 academic year found that nurse faculty earn only 76 percent of the salary that faculty in other academic disciplines earn.[18] Accounting for this variation may be the education level of nurse faculty, where nurse educators "hold doctoral degrees at only half the rate of their counterparts across other academic disciplines."[19]

Colleges and universities also are reporting that the nurse educator's compensation is not competitive with that of nurses in clinical settings. NLN notes that although few data are available on salaries of nurses with doctorates, the U.S. Department of Health and Human Services ***Preliminary Findings: 2004 National Sample Survey of Registered Nurses (NSS-RN)***[20] data on salaries of master's-prepared nurses can be used to compare the competiveness of nurse faculty salaries. The ***NLN/Carnegie*** study reports "nurse faculty salaries (annualized to a 12-month calendar) rank only eighth among the 11 positions evaluated by the NSS-RN study. Not only are master's-prepared nurse faculty paid 33 percent less than nurse anesthetists, but they are also paid 17 percent less than head nurses and nurse midwives, and approximately 12 percent less than nurse practitioners and clinical nurse specialists with the same educational credentials."[21]

Workload is another factor distinguishing the nurse faculty specialty. According to the ***NLN/Carnegie*** survey, 90 percent of the nurse educators who responded work full-time. Many of these add administrative duties to teaching responsibilities, resulting in a 56-hour average work week.[22] During

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[16] Kaufman, K. (May/June 2007). op.cit.

[17] Ibid.

[18] Kaufman, K. (July/August 2007) *Nursing Education Perspectives.* Compensation for Nurse Educators: Findings from the NLN/Carnegie National Survey with Implications for Recruitment and Retention. Vol. 28, No. 4: 223-225. On the Internet at: http://nln.allenpress.com/pdfserv/i1536-5026-028-04-0223.pdf. (Accessed March 20, 2009).

[19] Ibid.

[20] Steiger, D.M., Bausch, S., Johnson, B., Peterson, A. (2006) *The Registered Nurse Population: Findings from the March 2004 National Sample Survey of Registered Nurses.* Health Resources and Services Administration, U.S. Department of Health and Human Services. On the INternet at: http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/. (Accessed March 20, 2009).

[21] Kaufman, K. (July/August 2007) op.cit.

[22] Kaufman, K. (September/August 2007) *Nursing Education Perspectives.* More Findings from the NLN/Carnegie National Survey: How Nurse Educators Spend Their Time. Vol. 28, No. 5: 296-297. On the Internet at: http://nln.allenpress.com/pdfserv/i1536-5026-028-05-0296.pdf. (Accessed March 20, 2009.)

academic breaks, nurse educators reported working on average over 24 hours per week, and those with administrative responsibilities exceeding 31 hours per week. In addition to their work inside their primary academic institutions (PAI), more than 62 percent of nurse faculty picked up work outside their PAI, averaging an additional day each week (7-10 hours).[23] With 45 percent of nurse faculty reporting dissatisfaction with their current workload, "over one in four nurse educators who said they were likely to leave their current job cited the desire for reduced workload as a motivating factor."[24]

THE FEDERAL FUNDING REALITY

Today's undersized supply of appropriately prepared nurses and nursing faculty does not bode well for our nation, where the shortages are deepening health disparities, inflated costs, and poor quality of health care outcomes. Congress moved in the right policy direction in passing the ***Nurse Reinvestment Act*** in 2002. That act made Title VIII Nursing Workforce Development Programs a comprehensive system of capacity-building strategies to develop nurses by providing schools of nursing with grants to strengthen programs, through such activities as faculty recruitment and retention efforts, facility and equipment acquisition, clinical lab enhancements, and loans, scholarships and services that enable students to overcome obstacles to completing their nursing education programs. Yet, as the Health Resources and Services Administration's Title VIII data show, it is abundantly clear that Congress must step up in providing critical attention and significantly more investments to address seriously this ongoing systemic problem.

Nursing Education Loan Repayment Program (NELRP) – In FY 2007, NELRP received 4,711 eligible applications and made 315 initial (2-year) awards and 271 amendment (3-year) awards, with total obligated funds of $18,373,815.48. Whereas, in FY 2008, NELRP received 6,078 eligible applications and made 232 initial (2 year) awards and 203 amendment (3 year) awards. The total obligated funds were $18,898,427.87.

Nursing Scholarship Program – In FY 2007, 4,894 eligible applications were submitted to the Nursing Scholarship Program, and 172 applicants were selected to receive scholarship awards, or 3.5 percent of the applicants received scholarships.

Advanced Education Nursing (AEN) Program – This program supports the graduate education that is the foundation to professional development of advanced practice nurses, whether with clinical specialties or with a specialty in teaching. In FY 2007, the AEN grants supported 5,978 nursing students across specialties.

NURSING RESEARCH AND THE SCIENCE OF NURSING EDUCATION

Integral to improving the safety and quality of patient care and to reducing health care costs and demands is nursing research. Equally important is research in the science of nursing education – an advanced practice of knowledge, skills, and abilities that promote a unique environment for effective learning of the growing health care knowledge base, and of sophisticated therapeutic procedures and

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[23] Ibid.
[24] Ibid.

technologies. Critical to enhancing research within the nursing profession is the infrastructure development that increases the pool of nurse investigators and nurse educators, expands programs to develop partnerships between research-intensive environments and smaller colleges and universities, and enriches career development for minority researchers. As noted by the expanding list of non-nursing journals that publish the investigator findings of National Institute of Nursing Research-sponsored research, an investment in research extends far beyond just the nursing community and produces research results for ***all*** health care providers.

As the only organization that collects data across all levels of the nursing education pipeline, the NLN can state with authority that the nursing scarcity in this country will not be reversed until the concurrent shortage of qualified nurse educators is addressed. The Committee's commitment to building an environment that prepares a qualified health care workforce composed of broad-based, inter-professional partnerships will help ensure better health, deliver measurable improvements, narrow the health inequalities gap, and with time, potentially lower health care costs for everyone in our nation. Absent national efforts of some magnitude to match the health care reality facing our nation, a calamity in nurse education and in health care generally may not be avoided.

RECOMMENDATIONS

1. Support maximizing education funding for health care professionals who commit to practice in underserved areas.

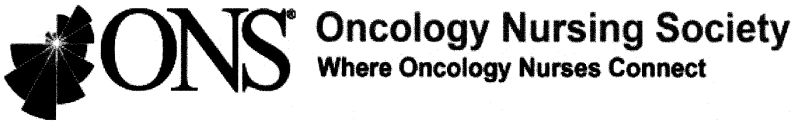
2. Expand investments in resources for health care worker education and services that meet the challenges of a diverse, ever-changing health care environment, e.g., geriatric and culturally competent care, comparative effectiveness research.

3. Use evidence-based policy strategies and strengthen effective existing health care capacity building to increase recruitment and retention of underrepresented minorities (i.e., representing ethnic, cultural, racial, gender diversity) and of the financially disadvantaged in health professions, including nurse educators.

4. Ensure a stable funding source to maintain and expand the health professions faculties through evidence-based intervention strategies, including faculty education programs that enhance continuous development of nurse faculty as educator-scholars, and research funding for the science of nursing education.

5. Implement a system emphasizing wellness and prevention, ensuring a stable funding source that maintains and expands existing educational infrastructure for the health professions.

6. Collect and analyze data to ensure that programs developed to strengthen the health professions workforce are meeting intended goals.



Written Statement for the Record

of the

March 12, 2009 Hearing

on

Workforce Issues in Health Care Reform:
Assessing the Present and Preparing for the Future

Submitted to

Committee on Finance
United States Senate

Submitted by:
Brenda Nevidjon, RN, MSN, FAAN
President
Paula Rieger, RN, MS, AOCN, FAAN
Chief Executive Officer

March 26, 2009

Oncology Nursing Society
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Oncology Nurses Society (ONS)
Written Statement Submitted for the Record
Senate Finance Committee Hearing
Workforce Issues on Health Care Reform
March 2009

Introduction

On the behalf of the Oncology Nursing Society (ONS) – the largest professional oncology group in the United States, composed of more than 37,000 nurses and other health care professionals dedicated to ensuring and advancing access to quality care for all individuals affected by cancer – we commend Chairman Baucus and Ranking Member Grassley for holding this important hearing to examine ways to address the nation's current health care workforce needs. We thank you for this opportunity to express our thoughts and articulate our concerns regarding this important public health issue.

As part of its mission, ONS honors and maintains nursing's historical and essential commitment to advocacy for the public good. We work collaboratively with policymakers, cancer and nursing community advocates, and other stakeholders at the local, state, and federal level to advance policies and programs that will reduce and prevent suffering from cancer. As part of this effort, ONS seeks the integration of the nursing perspective throughout the policymaking process. To that end, we very much appreciate this opportunity to present our views on the current and growing nursing workforce shortage, which poses a significant threat to access to care throughout our nation.

The Nursing Shortage – An Existing and Growing Crisis

The Health Resources and Services Administration predicts that the nursing shortage will grow to 41 percent by 2020.[1] Furthermore, according to a 2008 report entitled, *The Future of the Nursing Workforce in the United States: Date, Trends and Implications,* the shortage of registered nurses in the U.S. could reach as high as 500,000 by 2025. A number of years ago, one of the biggest factors associated with the shortage was a lack of interested and qualified applicants. Fortunately, due to the efforts of ONS, our nursing community partners, and other interested stakeholders, the number of applicants is growing. Now, efforts to recruit and educate individuals interested in nursing have been thwarted by the shortage of nursing faculty; nursing programs are turning away qualified applicants to entry-level baccalaureate programs, because there are not enough professors available to teach them. According to the American Association of Colleges of Nursing's 2008-2009 survey, schools of nursing turned away 49,948 qualified applicants to baccalaureate and graduate programs, primarily due to insufficient numbers of faculty. Of those potential students, nearly 7,000 were students pursuing a master's or doctoral degree in nursing, which is the education level required to teach. The number of full-time nursing faculty required to "fill the nursing gap" is approximately 40,000, and, currently, there are less than 20,000 full-time nursing faculty members.

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[1]Health Resources and Services Administration. *Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020.*

While these estimates for the future shortage of nurses are astonishing, they do not account for any increased demand for nursing services that likely will stem from a national expansion of health care coverage to more Americans. We are concerned that this increase in demand will occur at the same time the nation is experiencing an unprecedented demographic shift – the aging of a significant proportion of the population, a change which brings with it increasing rates of chronic disease and conditions that require nursing care. For example, the risk for cancer increases with age and, due to the demographics of the aging of the baby boomer generation, the number of people with cancer is expected to increase significantly in the next decade. As the total number of nurses will drop precipitously in the coming years, we likely will experience a commensurate decrease in the number of nurses trained in the specialty of oncology. With an increasing number of people with cancer needing high-quality health care, coupled with an inadequate nursing workforce, ONS has concerns that our nation could quickly face a cancer care crisis of serious proportion, with limited access to quality cancer care, particularly in traditionally underserved areas.

ONS already has seen evidence of the adverse impact of the current shortage on access to cancer care in oncology physician offices and hospital outpatient departments. Through surveys, our members, in both physician office-based practices and hospital-based settings, have reported that when a nurse leaves their practice, they often are unable to hire a replacement, due to the shortage – leaving them short-staffed and posing significant challenges in their ability to provide care to many of their patients. In a 2008 survey, more than 35 percent of respondents in both settings reported that the nursing shortage in their area affected their ability to meet the needs of their patients.

Studies consistently show that a key component of the provision of quality care is the number of registered nurses available to care for patients; when there are more registered nurses in an infusion center or hospital-based setting, there are fewer complications. As you may know, a study in the New England Journal of Medicine found that nursing shortages in hospitals are associated with a higher risk of complications – such as urinary tract infections and pneumonia, longer hospital stays, and even patient death[3]. Vacancies in all care settings create significant barriers and pose threats to ensuring access to quality care.

Further, of additional concern is that our nation also will face a shortage of nurses available and able to conduct cancer research and clinical trials. With a shortage of cancer research nurses, progress against cancer will take longer, because of scarce human resources, coupled with the reality that some practices and cancer centers resources could be funneled away from cancer research to pay for the hiring and retention of oncology nurses to provide direct patient care. Without a sufficient supply of trained, educated, and experienced oncology nurses, we are

[3] Needleman J., Buerhaus P., Mattke S., Stewart M., Zelevinsky K. "Nurse-Staffing Levels and the Quality of Care in Hospitals." *New England Journal of Medicine* 346:, (May 30, 2002): 1715-1722.

concerned that our nation may falter in its delivery and application of the benefits from our federal investment in research.

Bolster the Nation's Nursing Workforce to Safeguard Public Health

ONS maintains that addressing the nation's nursing workforce shortage must involve all stakeholders and necessitates myriad actions by government, the private sector, and individual citizens. To that end, ONS has undertaken numerous initiatives through which we are helping to address the shortage, including providing job shadowing and mentoring opportunities; developing specialized programs for students and younger nurses; and awarding scholarships for all levels of nursing education.

In addition, ONS believes that there are a number of steps that the federal government can take to support and strengthen the nation's nursing workforce. ONS feels strongly that the federal government must take a comprehensive approach to addressing the "perfect storm" brewing in our nation's health care system: a growing shortage of nurses occurring contemporaneously, as the population of individuals needing care is expected to skyrocket. We respectfully call upon Congress to implement policies, support programmatic efforts, and boost federal investment in initiatives to increase the health care system's capacity to handle both current and anticipated demand for nursing care.

Specifically, in the 1st Session of the 111th Congress, ONS urges Congress and the Administration to strengthen the nation's oncology nursing workforce by:

- Providing $215 million in FY 2010 funding for the Nurse Reinvestment Act and other Health Resources and Services Administration nursing workforce programs and $178 million for the National Institute of Nursing Research to ensure the nation has an adequate supply of oncology nurses to provide quality care and conduct cancer research;

- Expanding and prioritizing funding for – and promoting through authorizing legislation – programs that encourage nurses to become and serve as faculty;

- Recognizing and reflecting the true economic value of oncology nurses' essential contributions to patient safety and outcomes by ensuring that Medicare policies and payments capture and cover the full range of inpatient and outpatient oncology nursing services (e.g., patient treatment education, supportive care, and end-of-life care), including those provided by advanced practice nurses;

- Encouraging health care entities to maintain nurse staffing levels that: (1) are determined with input from nurses; (2) promote patient safety; and (3) are appropriate for the patient population and acuity;

- Evaluating and recognizing the contributions of nurses to patient safety and health care outcomes, by encouraging the collection of nursing sensitive indicators through a set of nationally standardized performance measures, as recommended by the National Quality Forum (NQF) in its 2004 publication, "National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set;"

- Preserving and promoting oncology nurses' scope of practice, including within the Medicare and Medicaid programs; and

- Incorporating and including nurses and advanced practice registered nurses as integral providers in the provision, coordination, and reimbursement of care delivered as part of coordinated care models, including "medical homes."

Conclusion

Without an adequate supply of nurses, there will not be enough qualified oncology nurses to provide quality cancer care to a growing population of people in need, and patient health and well-being could suffer. ONS maintains a strong commitment to working with Members of Congress, our nursing community partners, patient organizations, and other stakeholders to ensure that the oncology nurses of today continue to practice tomorrow, and that we recruit and retain new oncology nurses to meet the unfortunate growing demand that we will face in the coming years. By taking the policy actions – and providing the FY 2010 funding levels – detailed above, we believe Congress will make significant progress in helping to ensure that our nation has a sufficient nursing workforce to care for the patients of today and tomorrow, and that our nation continues to make gains in our fight against cancer.

We thank you again for your consideration of our views and appreciate your leadership in holding this important hearing. Please feel free to call upon us, if we can be of any assistance to you, or your staff.

"Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future."

United States Committee on Finance

March 12, 2009

Testimony for the Hearing Record

Submitted by the Pediatric Work Force Work Group

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The Pediatric Work Force Work Group applauds Chairman Max Baucus for his interest in the very important issue of health care workforce policy. As the Senate Finance Committee continues to move ahead on health care reform this year, Chairman Baucus knows that efforts on health care reform are only as strong as our nation's health care providers who are on the front lines caring for patients and their families.

While today's hearing will focus on a discussion of the supply of adult primary care physicians, we recognize that Chairman Baucus has also stated publicly his concern that workforce challenges extend beyond primary care providers. We are grateful that Chairman Baucus will strive to address the medical needs of all Americans.

The Pediatric Work Force Work Group is a coalition of pediatric medical subspecialty, pediatric surgical specialty and related organizations that has been meeting for over two years to discuss a shared concern over the critical shortage of specialists available to care for our nation's children. We agree with the recent findings of the Maternal Child Health Bureau Federal Expert Work Group on Pediatric Subspecialty Capacity which concluded that lack of access to pediatric subspecialty care has reached crisis proportions and that the supply of trained pediatric specialists is hazardously low.

The Pediatric Work Force Work Group recognizes that Congress has reauthorized the Universal Newborn Screening Act, passed the Paul Wellstone and Pete Domenici Mental Health Parity Act and enacted Children's Health Insurance Program reauthorization and expansion legislation earlier this year. States such as Massachusetts are passing universal health care legislation, while President Obama has said he wants Congress to pass legislation to cover the nation's 55 million uninsured.

More children will be served by these expanded programs, but more demand will mean an increased need for pediatric medical subspecialists and pediatric surgical specialists who are currently in very short supply.

We were pleased to see a request for a Government Accountability Office study on the supply of pediatric specialists in the CHIP legislation passed early this year, and are looking forward to working with Finance Committee staff to develop solutions to address the workforce needs in the pediatric specialty area.

The Pediatric Work Force Work Group respectfully submits these comments and our White Paper for inclusion in the March 12, 2009 hearing record on "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future." Thank you.

PEDIATRIC WORKFORCE WORK GROUP

MEMBER ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry

American Academy of Ophthalmology

American Academy of Pediatrics

American Association of Neurological Surgeons/Congress of Neurological Surgeons

American College of Rheumatology

American Society for Gastrointestinal Endoscopy

American Society of Pediatric Nephrology

Child Neurology Society

National Association of Children's Hospitals and Related Institutions

Council of Pediatric Subspecialties

- **Academic General Pediatrics**
- **Adolescent Medicine**
- **Allergy & Immunology**
- **Cardiology**
- **Child Abuse**
- **Child Psychiatry**
- **Critical Care**
- **Dermatology**
- **Developmental & Behavioral**
- **Emergency Medicine**
- **Endocrinology**
- **Gastroenterology**
- **Genetics**
- **Hematology – Oncology**
- **Infectious Disease**
- **Neonatology**
- **Neurology**
- **Pulmonary Medicine**
- **Rheumatology**

Pediatric Work Force Work Group White Paper: Workforce Issue
The Pediatric Work Force Work Group is a coalition of pediatric medical subspecialty, pediatric surgical specialty and related organizations that has been meeting since 2007 to discuss a shared concern regarding the critical undersupply of pediatric medical subspecialists and pediatric surgical specialists.

The Work Group is grateful to Chairman Baucus for his recognition that work force supply issues are one of the biggest problems confronting the health care system today. Most sources agree that by the year 2020 there will be a projected shortage of almost 200,000 physicians in the United States, with an especially serious shortage of specialty physicians.

A recent survey conducted by the Physician's Foundation of 270,000 primary care and 50,000 specialty physicians reported that: eleven percent of respondents plan to stop taking new patients or retire within three years; thirteen percent say they plan to seek a job in a non-clinical setting, away from patient care; twenty percent say they will cut back on number of patients seen; ten percent say they are working only part time.[1]

These data refer to physicians providing care to adult patients. Data collected by the American Academy of Pediatrics, the National Association of Children's Hospitals and the Maternal and Child Health Bureau's (MCHB) Federal Expert Work Group on Pediatric Subspecialty Capacity corroborate the finding that ***it is increasingly difficult, if not impossible, for our children to access the pediatric medical subspecialty and pediatric surgical specialty care that they need.***

The pediatric specialty medical organizations in our Work Group have conducted their own surveys to document the shortages of physicians within their respective clinical areas.[2] These surveys have been done in collaboration with federal government agencies such as the Health Resource Services Administration, the General Accountability Office and private research entities including the Institute of Medicine, the University of Pennsylvania, The Lewin Group and Berkeley Policy Associates.

Our findings reflect those released in November 2007 by the MCHB Federal Expert Work Group on Pediatric Subspecialty Capacity, **which concluded that lack of access to pediatric subspecialty care has reached crisis proportions and that the ratio of fellowship-trained/board-certified pediatric subspecialists and pediatric surgical specialists to children who need care is hazardously low.**[3]

The MCHB Federal Expert Work Group on Pediatric Subspecialty Capacity was established in 2004 to develop strategies to improve access to pediatric subspecialty care. Its members were affiliated with the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the Child Health Corporation of America, Family Voices, Shriners Hospitals, the National Association of Children's Hospitals, the American Association of Medical Colleges, federal and state government agencies and various academic and health policy institutions.

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[1] *"The Physician's Perspective: Medical Practice in 2008;"* The Physician's Foundation; November 2008.
[2] Reference specialty studies list on p. 10 on Pediatric Subspecialty Capacity.
[3] MCHB Federal Expert Work Group on Pediatric Subspecialty Capacity; November 2007.

In November 2007 the MCHB Federal Expert Work Group met for the fourth and final time and released their final recommendations. The panel concluded that the lack of access to pediatric subspecialty care is due to several related factors: an insufficient number of pediatric subspecialists, dramatically increased demand for pediatric subspecialty care, a fragmented system of pediatric primary and specialty care, and inadequate financing of medical education.[4]

In the United States there are about 28,000 pediatric medical subspecialists and surgical specialists to care for over 80 million children. While the number of pediatric subspecialists has increased somewhat in the past ten years, many pediatric subspecialties report very low numbers of physicians being trained. The American Board of Pediatrics reported that in 2006 there were only 21 first year fellows training in adolescent medicine, 29 in developmental behavioral pediatrics and 32 in pediatric rheumatology.[5]

While smaller numbers of physicians are entering subspecialty training in pediatrics, the workforce of all pediatric subspecialties is aging. With the exception of pediatricians specializing in emergency medicine, a relatively new subspecialty, the mean age of pediatric subspecialists exceeds fifty years.[6]

At the same time the workforce is shrinking, the demand for pediatric subspecialty care has reached unprecedented levels. Over the past decade, the pediatric population has experienced dramatic increases in the incidence and prevalence of conditions such as attention deficit hyperactivity disorder, asthma, depression, diabetes, obesity and increased demand for surgical correction of cleft lip and palate, congenital heart disease and orthopedic anomalies. Advances in medical and surgical care, technology and pharmaceuticals have resulted in improved survival for infants and children with formerly fatal conditions, but the increased number of NICU patients has greatly increased the need for pediatric surgical specialists.

The Pediatric Work Force Work Group recognizes that Congress has just reauthorized the Universal Newborn Screening Act, passed the Paul Wellstone and Pete Domenici Mental Health Parity Act and enacted SCHIP reauthorization and expansion legislation earlier this year. Additionally, increasing numbers of states such as Massachusetts are passing universal health care legislation. More children being served by these expanded programs will mean increased demand for pediatric medical subspecialists and pediatric surgical specialists.

President Obama has also promised that he will make universal coverage for all children a legislative priority. Once expanded health care insurance coverage becomes available at the state and federal level, this will contribute to an additional increased demand for pediatric specialty care.

Research conducted by our pediatric specialty organizations conclude that a medical student makes career choices early in their training based on exposure to a certain type of practice, aptitude, interest, life style and economic factors. Life style and economic factors are of great importance. For many years, medical students, residents and young physicians have demonstrated a preference for those specialties with a controllable lifestyle so as to achieve a

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[4] MCHB Federal Expert Work Group on Pediatric Subspecialty Capacity; November 2007.
[5] American Academy of Pediatrics, 2006.
[6] American Board of Pediatrics, 2006.

work-life balance. Beyond medical school training, to become a pediatric specialist will take an average of six years to complete training.

Regarding economic considerations, the average loan indebtedness at the end of a medical student's three years of residency is $ 151,342 for a public school student and $ 205,707 for a private school student.[7] This reality drives decisions for the medical student facing choices about incurring more debt if they elect to pursue additional training in a pediatric specialty field. Unfortunately, inadequate reimbursement, especially in comparison to those in adult medicine subspecialties, is another harsh reality that serves as a disincentive to entering pediatric subspecialties. Stated another way, why should a pediatric residency graduate elect to pursue further training in fellowships to incur more debt, delay earning a reasonable salary, and then get reimbursed less than their adult colleagues who go straight from residency into practice?

Another dilemma is the shortage of residency programs available to provide the additional years of training necessary to produce pediatric specialists. Teaching hospitals need to be given incentives such as increased and expanded GME payments to encourage the continued growth and availability of specialty training. Any changes to GME funding must consider the essential teaching role of children's hospitals, which do not receive GME funding through Medicare.

The Children's Hospital Graduate Medical Education Program (CHGME) administered through HRSA was created by Congress to address the inequities of pediatric GME funding since free-standing children's hospitals generally do not treat Medicare patients. However, CHGME per resident payment amounts continue to lag behind comparable Medicare amounts. Even so, many children's hospitals train residents and fellows well above their cap.

We are encouraged that the Senate Finance Committee plans to conduct hearings on the physician work force issue, and would like to provide testimony about the impact the shortage of pediatric medical and surgical specialists is having on the provision of child health care.

In addition, our coalition would be very grateful if Chairman Baucus would request an expansion of the Government Accountability Office study of the demographic and practice characteristics (including reimbursement and medical liability cost) of pediatric medical subspecialists and pediatric surgical specialists requested in the recently passed CHIP legislation.

Clearly, the MCHB Federal Expert Work Group on Pediatric Subspecialty Capacity produced a well-researched analysis of Pediatric Subspecialty Capacity in 2007 and several of our coalition members conducted surveys to document the undersupply of pediatric medical subspecialists and pediatric surgical specialists. However, our coalition believes there is need for an updated, comprehensive and detailed analysis by a respected federal government agency of the critical undersupply and distribution of all pediatric specialty physicians.

We respectfully suggest that GAO consider including the following data in their analysis:

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[7] *"Medical School Tuition and Young Physician Indebtedness"*, AAMC, 2007.

1.) Demographic Information. This analysis could examine information such as age, gender, race & ethnicity, and geographic location of pediatric specialists. Additionally an analysis could be conducted to determine barriers to care in underserved areas such as urban and rural locations.

2.) Medical Education. This analysis could look at year of medical school graduation, year of residency graduation, years between graduation from medical school and completion of pediatric residency, medical school attended, institutions offering pediatric residency and fellowship training, board certification information, geographic location of medical school and residency training. An analysis of availability of pediatric fellowship programs could be examined to determine if there are a sufficient number of programs and fellows in the pipeline to meet projected future need. GAO could examine the effect of inadequate CHGME payment in this section. (It should be noted that the Association of American Medical Colleges or the Children's Hospital Graduate Medical Education Program at HRSA has this information readily available.)

3.) Medical Activities. This analysis could examine hours per week in all medically related activities, percentage of time in various activities, main activity, percentage of time in various specialties, where physician spends most time per specialty designation.

4.) Medical Practice Characteristics. This analysis could explore type of medical practice (university-based, solo practice, group practice, etc.), faculty membership, practice setting, numbers and types of specialists in practice setting, procedures performed or interpreted for reimbursement, Medicare and Medicaid accepted in practice, typical duration of new outpatient visit, typical duration of return outpatient visit, length of wait for a new visit, length of wait for a return visit, referral sources, patient insurance type, reimbursement for typical new patient visit, reimbursement for typical return patient visit.

5.) Economics and Income. This analysis could also consider the economic considerations that contribute to the decisions medical students make when they are selecting their careers. Issues such as student loan indebtedness and the effect of loan forgiveness could be examined, as well as what percent of a physician's practice consists of unfunded or underfunded care.

6.) Patient Case Mix. This analysis could explore the complexity and severity of patient conditions at time of referral from primary care physician; the numbers of patients referred by primary care and severity of patient condition at time of referral, and the ratio of providers per children in a given population area.

7.) Attitudes and Impressions. This analysis could explore physician satisfaction through a variety of questions. Factors that influence career satisfaction and longevity could be examined.

8.) Geographic Analysis. This section would present data about distribution of pediatric specialists; physician availability based on geographic location and size of city; length of wait for routine and emergency visits; patient insurance type; work hours in each practice and income data and travel times to receive care. (For example, children living in the

western United States must travel exceptionally long distances to reach pediatric specialists.)

The Pediatric Work Force Work Group will be happy to provide copies of the work force surveys they have conducted and will make their physicians and resources available upon request for further discussion of the data and policy needs to support an action plan to address the shortage of pediatric specialists.

Please further note that the Council of Pediatric Subspecialties has just become involved with the Pediatric Work Force Work Group and their leadership has not had an opportunity to sign off on the recommendations of the White Paper as this document goes to print.

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Statement for the Record
Service Employees International Union

Before the Senate Finance Committee Hearing on
Workforce Issues in Health Care Reform:
Assessing the Present and Preparing for the Future

March 12, 2009

SEIU's Perspective on the Healthcare Workforce

The Service Employees International Union (SEIU) represents more than 1.1 million of the 13 million nurses, doctors and healthcare workers that form the backbone of the U.S. healthcare system. SEIU believes that through healthcare reform, the United States must develop a healthcare workforce that contributes to lowering overall healthcare costs and improving overall quality as we provide coverage for all. The healthcare workforce is a critical component to success in achieving a sustainable healthcare system that rewards prevention, care coordination, and care to aging and special needs populations.

Last year, the United States spent more than $2.4 trillion on a healthcare system that cost too much and often delivers too little, too late. The healthcare system is "broken," and we must address the healthcare workforce if we are to undertake a comprehensive approach to fix it:

- There are approximately 116,000 unfilled nursing jobs in America's hospitals and more than 25,000 unfilled nursing jobs in our nation's nursing homes.[1]
- We're facing a critical shortage of primary care doctors in urban and rural areas throughout the United States.[2]
- The shortage of doctors and nurses is just the tip of the iceberg: Our healthcare system must grow by nearly 3 million workers by 2016 to keep pace with projected demand.[3]
- Our new healthcare system must expand its reach and capacity in order to deliver cost-effective, preventive care to the roughly 47 million uninsured and 20 million underinsured Americans who currently go without adequate healthcare services.[4]
- The number of Americans who will need long term care and services will increase from approximately 10 million today to 15 million in 2020 and 27 million in 2050[5].

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A Prepared Workforce to Serve All Communities

Across the United States, even people with health insurance cannot find primary care providers, specialists or reliable, trained homecare workers. There are crippling shortages in nursing, pharmacy and other healthcare fields. Barriers to access care are most acutely felt in many communities of color, and in rural areas. Given the importance of bending the curve of healthcare expenditures, the role of chronic diseases in driving the explosion in healthcare costs, and the disproportionately high prevalence of a number of chronic diseases in minority populations, it is imperative that our new healthcare system invest in creating the workforce required to prevent these conditions, detect them early, and more effectively manage these diseases once they are diagnosed.

The most-effective prevention and coordination of patient care requires the entire patient care team to achieve the best outcomes and improve healthcare quality. This means not just doctors and nurses but also other allied health workers, including health educators, community health workers, social workers, physical therapists, nutritionists, home care workers, and medical interpreters.

SEIU members are acquiring the training to improve overall health equity and better serve diverse communities whose healthcare disparities are well-documented. The union's largest labor-management healthcare training program focuses on both creating career pathways and increasing cultural competency to reduce barriers to care. For example, Denise Cherenfant emigrated from Guyana to New York City when she was in her late teens. For more than 19 years, she's worked at the Daughters of Jacob Nursing Home, an area of the Bronx with a very high percentage of Korean Americans. During this time, with the help of the 1199SEIU Workforce Training and Employment Fund, Denise advanced from a certified nurse's aid (CNA) to a physical therapy assistant and received her Bachelor of Science in Nursing (BSN) degree. In addition to her BSN, Denise also enrolled in Korean language and culture classes. As a result of her new fluency in Korean and increased understanding of Korean views on health, aging and the role of the family, the rapport and trust Denise has been able to establish with her residents and their families has made a real and immediate difference in their quality of life. Our country and healthcare system needs to create more opportunities so that healthcare workers such as Denise have the skills to improve healthcare quality and advance their careers.

Overall Recommendations:

1) Healthcare reform must promote a well-distributed, highly trained, and culturally competent healthcare workforce. A significant federal investment in essential training and education of the non-physician workforce is needed as part of healthcare reform legislation in 2009.

2) Training in new technologies and new systems must be provided to both incumbent healthcare workers and new recruits.

3) It is critical that efforts to expand and diversify the healthcare workforce be prioritized to underserved areas and communities. Cultural competence as well as native language competency must be included in the recruitment and training of the healthcare workforce, and must be rewarded by healthcare employers.

Nurses

As a union representing more than 85,000 nurses, SEIU believes that increasing nurse education, retaining experienced nurses in the profession, improving working conditions, and building the nurse workforce through training and upgrading of incumbent healthcare workers will strengthen and stabilize the nurse workforce for a reformed delivery system. The national rate of nurse attrition within the first few years of nursing is approximately 35 percent; among an existing union training program for incumbent healthcare workers that rate is less than 5 percent.

- A nurse faculty loan and scholarship program could facilitate increased capacity of nursing education. Nurse faculty salaries must be increased. Colleges, hospitals and nursing homes could collaborate to develop and lend practicing nurses as faculty.

- Retention of experienced nurses is also critical to securing the healthcare workforce. Labor-management partnerships between providers and labor organizations result in increased retention rates, open up nursing to nontraditional students, and improve quality of care. Federal support for these efforts should be available, such as would be authorized in *The Nurse Training and Retention Act of 2007* (S 2064), introduced in the 110th Congress by Senator Durbin.

- Mentorship of new nurses is critical to increasing nurse retention. By pairing new nurses with experienced nurses for support, mentoring and assistance with the transition into practice, both new and experienced nurses are far more likely to remain in their profession.

- Nurse residency programs for returning nurses and for nurses who are transferring from one specialty to another can also improve retention.

- Work environment policies that increase patient safety and workplace safety must be promoted; including improved staffing ratios, limits on mandatory overtime, protection for whistleblowers, safe patient handling techniques, and prevention of workplace violence.

Chronic Care, Care Coordination, Long Term Care

SEIU represents nearly 400,000 home care workers, and has seen unprecedented growth in the demand for home-based care across the country. The challenge in creating a secure, sustainable long term care system is that demand is projected to grow with the aging of the population, while the pool of available workers is projected to shrink. Home care workers on the front line of care must be well-trained and well-compensated to ensure a stable workforce of sufficient size, stability, and quality. Jobs that used to be limited to "chore services" are increasingly multifaceted and demanding, and unfortunately, many states require minimal training for home care workers and many agencies that provide home care services are lightly regulated.

- Apply Medicaid and Medicare quality measurements to drive improvements in long term care.

- Reform Medicaid and Medicare reimbursement policies to reward higher wages and other progressive employment practices that lead to lower turnover and better patient outcomes and satisfaction. For example, Sens. Kerry and Grassley have introduced the *Empowered at Home Act of 2009* (S. 434) which provides Medicaid transformation grants to promote innovations. *Retooling the Health Care Workforce for an Aging America* (S. 254) also promotes demonstrations to reward higher workplace standards.

- Demand greater accountability from Medicare and Medicaid participating provider agencies, through revised "conditions of participation," for instance, to meet higher standards for service quality and workforce retention and development.

- Incorporate the home-based care workforce into wellness and prevention strategies. With additional training and as part of teams, homecare workers can expand their services to include responsibilities related to prevention, chronic disease management, and health promotion.

- Coordinate policies across the U.S. Department of Labor and the Department of Health and Human Services to invest in greater training and education, as would be authorized under S. 245.

- Expand the role of community health workers in education, prevention, and primary care.

- Recognize the value provided by unpaid caregivers and provide supports and services to them.

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