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U.S. Senate Committee on Health, Education, Labor, and Pensions
Chair Bernard Sanders
Ranking Member Bill Cassidy, M.D.
HealthWorkforceComments@help.senate.gov

March 20, 2023

Senators Sanders and Cassidy:

The Rural Policy Research Institute (RUPRI) Health Panel is pleased to submit comments in response to your request for input of March 2, 2023 to help identify bipartisan solutions to remedy our nation's health care workforce shortages. The RUPRI Health Panel was established in 1993 to provide science-based, objective policy analysis to federal policy makers. As you would expect, our comments are directed to meet the needs of rural people and places for essential health care services. The Panel provides analysis and recommendations to help achieve a high performing rural system, grounded in assuring equity for all rural residents through achieving and maintaining strong pillars of access, affordability, quality, and community health. Opportunities to strengthen those pillars depends on optimum use of a healthcare workforce, making the efforts of the HELP Committee critical to the future of rural health. The Panel's comments reflect our assessment of opportunities for advancing rural health published in 2018, which included six workforce policy suggestions. Increasing the supply of health care workers in rural is necessary but not sufficient to address the workforce crisis; policy changes should also seek to leverage community, technology, and payment solutions which are responsive to today's rural health context and pave the way to the future.

Securing an adequate supply of health care professionals in rural communities

A great deal of attention is rightly focused on a fundamental need for more health care professionals, especially given looming retirements and decisions by practicing professionals to discontinue their clinical work. The general need is particular acute in many rural places that have a long history of designation as health professions shortage areas. Public policy interventions may be appropriate when market-based solutions are unable to lead to desired ensure access to essential health care services due to the inadequate supply of health professionals.

The Panel concurs with the statements made during the February 16 hearing of the HELP committee that federal support for training programs should continue and be enhanced, but with a rural lens we suggest the following:

- **Continue to require a rural priority in graduate medical education funding**. We suggest strengthening this approach by giving *priority to residency training sites located in rural communities*.
- **Provide grant funding to establish residency programs with rural sites**. Investments are needed to establish new residency programs and/or sites, as well as technical assistance to be sure the programs meet all requirements of accrediting bodies. Rural health care organizations (HCOs) would benefit from one-time grants to set up the programs. The Rural Residency Planning and Development Program in the Health Resources and Services Administration (HRSA) is a current source of such funding, and its continuation would address this recommendation.
- **Continue scholarships and loan repayment programs for health care professionals (including physicians, nurses, dentists, social workers, and physician assistants)**. Evidence should drive decisions about professions to target, in order to match rural needs. For example, the Panel's 2018 document recommended targeting professionals that meet the need for primary care in rural places, which would include physicians, nurse practitioners, and physician assistants (the later classifications staff Rural Health Clinics, and are essential in meeting needs for emergency services in remote facilities, supported by board-certified emergency care physicians through telehealth).
- **Provide grants to develop and enhance health professions pipeline or pathway programs**. Programs that generate interest in the sciences among rural students during grades K-12, followed up by admission to undergraduate institutions and community colleges that provide opportunities for rural internships and other rural-focused training start the pipeline early to generate health professions students with roots in rural places. Those early educational programs can then be integrated with pipeline programs for students in clinical training, including existing programs focused on increasing the diversity of health professionals and focused on geographical distribution of graduates.
- **Prioritize programs meeting the most acute rural needs**. Evidence-based targeting of funding for training sites and locations that meet scholarship and loan requirements should focus on places most in need. In 2023, as rural HCOs emerge from the public health emergency, data are showing the shortage of nurses to be most acute in skilled nursing facilities. *One approach to addressing this priority need is to integrate Licensed Practical Nurses* back to the bedside in skilled nursing facilities and hospitals. In addition, programs that provide revenue for HCOs to use in recruitment should encourage retaining those who complete scholarship and loan requirements while working in those HCOs. **Medicare Conditions of Participation and payment policies should recognize the essential roles of all health professionals as a means of encouraging career choices made by persons inclined to live and work in rural communities.**

Building and sustaining effective person-centered health homes in rural communities

The Panel has long advocated a focus on person-centered health homes as the cornerstone of health systems meeting rural (and other areas) needs. These are *not* patient-centered medical homes; they are health teams addressing all health-related needs of community residents. The teams incorporate non-clinical staff who are essential to meeting the health needs of patients. Several terms are used to identify these workers: community health workers, lay health workers, patient navigators, community liaisons are

examples. Regardless of the labels, federal workforce policies should recognize the importance of this classification.

- **Provide grant funding to establish training programs for lay health workers**. These programs could be based in local community colleges, creating opportunities for rural residents to train in local institutions for new occupations in their home communities.
- **Establish payment policies supporting nonclinical members of health teams**. Medicare, Medicaid, and other public programs should recognize the contributions of these workers to health maintenance (which can result in less utilization of high-cost clinical care) with payment to HCOs employing them. In the current fee-for-service environment, that would require special payment. As discussed later in this letter, new value-based payment models can create flexibility to use payment streams in the most effective way possible, which is likely to include meeting this personnel need.

Addressing needs beyond clinical personnel

As indicated above, meeting the health needs of rural residents requires a workforce of professionals and lay workers far broader than the historical emphasis on clinicians (and even more narrowly on physicians and nurses). Maintaining a delivery system that provides *access* to essential services in local communities requires that the system be *affordable*, which requires administrative personnel trained to manage complex organizations and participate in multiple and changing payment systems.

- **Request a federal report on administrative workforce needs in HCOs**. Congress should secure a report identifying gaps in essential positions, including those the c-suite of HCOs (executive, operating officers, finance officers, clinical leadership), and those in completing the tasks necessary to adapt to changes in payment systems and organizational relationships – coders being a leading example. The report should focus on where positions are particularly difficult to fill, i.e., rural and other underserved areas.
- **Provide grant funding for training programs to increase the supply of personnel for key positions, and for training of incumbents.**

Leveraging changes in technology and payment policies to support the health care workforce

During the public health emergency (PHE), the use of telehealth as a means of providing services spiked to high percentages of all patient encounters before declining to levels that are still higher than pre-PHE experiences. Those experiences have raised the possibility that one means of addressing health professions shortages is through continued growth in the use of telehealth. The Panel has published two documents assessing the capacity and implications of telehealth for meeting the objectives of a high performing rural health system. We agree that effective use of this technology should be part of a comprehensive approach to meeting workforce needs. However, our key consideration in our most recent document is to recognize that telehealth constitutes a modality for providing care, but does not necessarily substitute for other care modalities.

- **During the continuation of PHE-related waivers and payment policies facilitating the use of telehealth, Congress should request studies assessing *all impacts of providing services through telehealth, on local access to professionals and quality of care***. Assessments should include evidence of any unintended consequences. For example, if telehealth using providers not present in communities replaces network requirements for proximity to those professionals, what are the consequences for community residents not insured by the plans providing access to tele-providers?

Will local clinics not part of the network be sustainable? If not, what policies might be needed to connect residents to services? In the realm of quality of care, are telehealth services comparable to in-person care? The answer should include examining potential for missing adverse health conditions by not having direct in-person interactions with patients.

- **Congress should request a report analyzing the impacts of telehealth on the productivity of health care professionals and others in health systems**.

As payment systems continue to evolve to include new methodologies oriented to value rather than volume, there will be opportunities to assure we are paying for the services we need, including all occupations in the broader conception of the health care workforce articulated by the Panel in our comments.

- **Congress should use oversight to assure that the development and evaluation of new payment models (e.g., value based payment) consider the effects on recruiting and retaining all essential workers, clinical and nonclinical.**

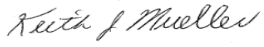
<u>Continuing to advance to a high performing rural health system</u>

While not a direct issue in sustaining the quantity of health care workers needed to meet needs in access and community health, we cannot overlook the need for high-quality, equitable patient care services. There is a relationship between workforce strategies to meet access needs, quality of patient care, equity goals, and effects on community health. As policies and actions evolve to use different personnel to deliver services (e.g., non-physicians to deliver clinical services formerly delivered only by physicians), or use of technology to deliver services without requiring person-to-person interaction, we must measure outcomes to assure at least comparable quality. Even when using professionals with the same training (e.g., traveling nurses vs. on-site nurses), we should be certain to adhere to protocols that deliver high-quality outcomes are followed with the same dedication. The Panel continues to review new ways of delivering and financing services with the commitment to help shape them in ways that address all four pillars of the high performing system while also advancing health equity.

<u>Concluding comments</u>

Congratulations to the HELP Committee for taking on the important issue of assuring an adequate health care workforce that maximizes opportunities for all residents to live the healthiest lives possible. The Panel appreciates this opportunity to provide comments consistent with our framing of a high performing *rural health system*. We are anxious to help the Committee in any way we can as you consider specific policies and oversee existing policies. Issues about the appropriate, sustainable blend of personnel in rural places will be critical, and resolving them will require a deep understanding of the dynamics of sustaining essential services. Policies targeting rural places will need to be crafted in ways that when implemented meet original objectives. The Panel offers our assistance to the Committee as you continue your important work.

Sincerely yours,



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