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Amy P. McNulty
Acting Director, Division of the Executive Secretariat
Health Resources and Services Administration
United States Department of Health and Human Services
5600 Fishers Lane
Rockville, Maryland 20857

Submitted to: paperwork@hrsa.gov

Re: Bureau of Health Workforce Performance Data Collection,
OMB No. 0915–0061-Revision

Dear Ms. McNulty,

The Association of American Medical Colleges (AAMC) appreciates the opportunity to comment on the Bureau of Health Workforce Performance Data Collection, OMB No. 0915–0061—Revision. AAMC supports HRSA's goal to continue analysis and reporting of awardee training activities and educational programs, identify intended practice locations, report outcomes of funded initiatives, and collect a description of the program activities of approximately 1,500 reporting grantees to inform policymakers on the barriers, opportunities, and outcomes involved in health care workforce development.

AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 152 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

As a founding member of the Health Professions and Nursing Education Coalition (HPNEC), the AAMC advocates increased funding for Title VII and Title VIII that will ensure the programs can both educate and train professionals to help meet the ever-growing demand for care. As you develop the proposed measures and data collection for Title VII and Title VIII grants, AAMC and the HPNEC member organizations would be pleased to work with you to help ensure that policymakers understand the impact and importance of these programs.

The AAMC understands the importance of collecting data and measuring the effectiveness of these programs, however it is important to balance the administrative burden with the intended outcomes of the grants. We offer the following comments and resources on the five key outcomes identified as the focus of the proposed measures:

1) Increasing the workforce supply of well-educated practitioners in needed professions

Assessing the capacity of the nation's future physician workforce is important to give both the public and private sectors the information they need to make the targeted investments necessary for the health care system to provide high-quality, cost-efficient care and develop the workforce required to create a high-performing health care system that optimizes population health. The pace of change in health care necessitates continuously updating and improving workforce projections. Furthermore, shifts in health policy at the national and state levels create uncertainty about how to plot a successful course toward achieving major goals. For that reason, in 2015, the AAMC contracted with IHS Markit to produce annual updates of national physician workforce projections with the independent firm.

The 2018 report, The Complexities of Physician Supply and Demand: Projections from 2016 to 2030, continues to project that physician demand will grow faster than supply, leading to a projected total physician shortfall of between 42,600 and 121,300 physicians by 2030. The projected shortfall is higher than in 2017's report (40,800−104,900). These estimates reflect model updates and larger shortfall estimates for the starting year based on recently revised federal HPSA designations for primary care and mental health.

A primary care shortage of between 14,800 and 49,300 physicians is projected by 2030. The shortfall range reflects different assumptions about projected rapid growth in the supply of APRNs and PAs and their role in care delivery, trends in supply and demand for primary care physicians, and an estimate by the HRSA that nearly 13,800 primary care physicians are needed to remove the primary care shortage designation from all currently designated shortage areas.

Projected shortfalls in non-primary care specialties of between 33,800 and 72,700 physicians, including a shortfall of between 20,700 and 30,500 physicians in 2030 for surgical specialties. Major drivers of these projected trends continue to be an aging population requiring increasingly complex care concomitant with an aging physician workforce. The range reflects different assumptions about shifting workforce patterns for physicians and other professionals. In the surgical specialties, a largely stagnant projected supply also contributes to projected shortages.

Demographics—specifically, population growth and aging—continue to be the primary driver of increasing demand from 2016 to 2030. During this period, the U.S. population is projected to grow by close to 11%, from about 324 million to 359 million. The population under age 18 is projected to grow by only 3%, while the population aged 65 and over is projected to grow by 50%. Because seniors have much higher per capita consumption of health care than younger populations, the percentage growth in demand for services used by seniors is projected to be much higher than the percentage growth in demand for pediatric services.

AAMC's health care−utilization equity (HCUE) analysis models the implications for physician demand if currently underserved populations utilized care at a rate similar to populations facing fewer barriers to care. This analysis illustrates that sociodemographic and geographic imbalances in the supply of physicians and other barriers to accessing care result in historically underserved populations receiving lower levels of care than other groups. This scenario indicates that

differences in disease prevalence and other health risk factors are not the only influences on differences in health care utilization. These estimates are intended to stimulate discussion of how best to address inequity in health care utilization.

Assuming people without medical insurance and people living in non-metropolitan areas had care utilization patterns equivalent to those of their insured peers living in metropolitan areas with similar demographics and health risk factors (e.g., an uninsured person with heart disease living in a rural area was modeled as having the utilization patterns of an insured person with heart disease living in a metropolitan area), demand would shift up by about 4% (equivalent to an additional 31,600 physicians). Moreover, if everyone utilizing care as if they had utilization patterns equivalent to non-Hispanic white, insured populations residing in metropolitan areas (e.g., an uninsured black person with heart disease living in a rural area was modeled as having the utilization rate of an insured white person with heart disease living in a metropolitan area), we estimated a 12% increase in physician demand in 2016—or approximately 95,100 physicians.

2) Increasing the number of practitioners that practice in underserved and rural areas

Previous studies demonstrate that curricular components can influence medical students' career choices and intentions to practice in underserved areas. Race, ethnicity, and socioeconomic background are also associated with students' willingness to serve underserved populations. Yet the shortage of physicians in underserved areas remains an ongoing challenge in the U.S. health care system. As a result, the benefits of increased health insurance coverage and available care may not be fully realized by those without access to a physician. An estimated 72% of the U.S. land mass is currently designated as Primary Care HPSAs, with more than 105 million individuals residing in these areas. Producing a physician workforce that is willing and able to practice in underserved areas is important to the improvement of population health and access to quality health care.

A better understanding of medical students' interests and commitments to practice in underserved areas may help to mitigate the geographic access barriers in the nation's underserved areas. A 2016 AAMC Analysis in Brief examines the factors associated with medical students' commitments to practice in underserved areas, particularly the association between experiences in a free clinic for underserved populations and the intent to practice in underserved areas.

While student intent to practice in underserved areas at matriculation is a major predictor for an intent to do so at graduation, this study shows that students with exposure to free clinics during their medical school education are more likely to become or remain committed to practice in underserved areas, even after controlling for other confounding factors such as student age, gender, race, and ethnicity. The findings suggest that certain curricular interventions such as free clinic experiences in medical schools may enhance students' interests and commitments to practice in underserved areas to address some of our nation's persistent physician workforce shortages in certain geographic locations. Other potential confounding factors—for example, the presence of longitudinal clerkships in underserved areas, other community-based field experiences, or curriculum related to public health or health disparities—may also influence

student commitment to practice in underserved areas. An additional limitation to this study is that students with intent to practice in underserved areas at entry to medical school may self-select to pursue free clinic experiences during medical school. Also, the free clinic experiences available to students across medical schools vary. Medical students' career plans are not likely to solve all of the nation's workforce concerns. However, future research is needed to identify ways to expand and improve free clinic rotations and other practical experiences in medical school to help increase the number of physicians who ultimately practice in medically underserved areas

3) Enhancing the quality of education

Over the last two decades, shifts in demographics, science, and federal policies have had a major impact on health care, a phenomenon that will persist. Accordingly, the education and training of physicians and other health professionals have changed significantly and continue to change. Initiatives are under way to enhance admissions processes, policies, and practices to better identify and select tomorrow's doctors for the health care system of the future. The structure, content, and delivery of medical education continues to be refined as medicine improves, new public health challenges emerge, learning and teaching are better understood, and educators strive to ensure more seamless transitions between the phases of medical education. These and other developments reflect the dynamic nature of health care and the corresponding commitment of medical education to prepare physicians that can adapt and respond to an ever-changing environment.

Medical schools and teaching hospitals are continuously enhancing the quality of medical education. Admissions committees at each medical school use broad-based selection criteria, including prior academic achievement and assessments, as well as evidence of the values and attitudes necessary to be an excellent and compassionate physician. Medical schools are testing new ways to consider personal characteristics, such as how well applicants work in teams, how they interact with diverse people, and their ability to be resilient, adapt to different situations, and think critically. Many medical schools use holistic review, a flexible, individualized way of assessing applicants' capabilities with balanced consideration of experiences, attributes, and academic metrics.

Recent changes to the AAMC-sponsored Medical College Admission Test® (MCAT®) added two new sections covering critical thinking as well as behavioral and social sciences, in addition to the existing content on biological sciences, physical sciences, and verbal reasoning, among other areas. Additionally, many institutions are implementing recruitment initiatives to address emerging national and local health care needs. According to a 2017 survey of all medical school deans, 89% of respondents reported specific admissions programs or policies designed to recruit a diverse student body interested in caring for underserved populations—including programs and policies geared toward minorities underrepresented in medicine, students from disadvantaged backgrounds, and students from rural and underserved communities.

The content of medical student education is continually revised to reflect scientific advancements, medical breakthroughs, delivery system changes, and social issues. For instance, the emphasis in medical care has shifted from treating acute conditions to managing more

chronic illnesses, and physicians now increasingly treat problems related to aging. As a result, while maintaining a fundamental basic science and clinical curriculum, educators have modeled instruction around the management of chronic illness and have incorporated topics and themes such as geriatrics, pain management, palliative care, and others in the curriculum. Schools also include enhanced instruction on topics such as disease prevention and health promotion, population health, addiction, communication skills, social determinants of health, emergency preparedness, and medical informatics, among others.

The structure of medical school is also changing, with themes such as earlier clinical experiences, curricular structures integrating the basic and clinical sciences, emphasis on interprofessional educational opportunities, and case-based learning. Learners are exposed to a broad variety of health care settings and instructional modalities capitalizing on new technologies and capabilities. Increasingly, they are expected to achieve milestones in broad foundational domains of competency rather than merely amassing a litany of facts. And they have opportunities to better appreciate the societal and community factors that affect their patients' health. Schools are also reporting innovative approaches to advancing their specific missions, such as requiring students to complete nonmedical community service in the surrounding neighborhood, establishing dedicated tracks in primary care and rural health, promoting medical research experiences, or founding regional medical campuses at sites distant from the main campus.

In Graduate Medical Education (GME), too, innovations abound. Educational experts are designing curricula and programs in response to community health needs. They are exploring opportunities to optimize the duration of GME by, for example, shortened educational pathways. An AAMC pilot project is currently testing the feasibility of moving away from a "one-size-fits-all" model of time-based advancement to competency-based advancement across the continuum from medical school through residency and practice. According to data from the Accreditation Council for Graduate Medical Education (ACGME), which includes the AAMC and four other organizations in its not-for-profit membership corporation, 88% of pipeline programs in both primary and nonprimary care specialties place residents in nonhospital and ambulatory settings for some of their training. And educators are reviewing the feasibility of holistic review for residency positions.

4) *Increasing recruitment, training, and placement of under-represented groups in the health workforce*

Data collection to assess the outcomes and impact of pipeline and workforce programs is essential to advancing work in this field. It is critical to determine program effectiveness and to understand if the program is meeting goals to increase the number of individuals pursuing health professions.

The AAMC serves at the national program office for the Robert Wood Johnson Foundation (RWJF) Summer Health Professions Education Program (SHPEP), along with the American Dental Education Association. The SHPEP program is focused on increasing diversity in the

health professions and offers a free 6-week academic enrichment program for college students. RWJF has been committed to this program since 1989.

There is a robust data collection and management process that allows for the assessment of outcomes and impact that starts at the point of application. All applicants receive a unique identifier that can be later used to track application, acceptance, matriculation and graduation from MD granting institutions using AAMC data. Other application data has also been used to match to the National Student Clearinghouse database for outreach programs, and other health professions databases.

SHPEP is able to track outcomes since 1989 with the support of our data warehouse housed at the AAMC. To date, our data show that over 7,114 of the participants are physicians. Since the inclusion of dentistry in 2006, data show 589 are dentists. A 2015 impact independent impact study conducted by Mathematica Policy Research showed that the (1) program successfully recruits students from economically disadvantaged communities and racial and ethnic minorities; (2) the program's participants are about 8 percentage points more likely to apply to medical or dental school; and (3) 10 percentage points more likely to matriculate than non-participants relative to a matched comparison group.

Using databases like the American Medical Association (AMA) Physician Masterfile and National Provider Identifier, we will study the workforce outcomes to include practice specialty, type of practice, and practice location. Research shows that using national databases can also support learning about workforce outcomes. For example, the use of national databases show that American Indian and Alaska Native physicians are more likely to practice family medicine and in rural areas. Also, African American, American Indian and Alaska Native, and Latino physicians are more likely to practice in locations where 20% or more of the population reported as living in poverty, in primary care HPSAs and medically underserved areas (MUAs).

AAMC offers the following "lessons learned" from SHPEP as you consider proposed measures and data collection for Title VII and Title VIII diversity pipeline programs:

- Financial investment is necessary to support the ongoing data collection and maintenance of the data warehouse, and evaluation
- There are existing national databases at the health professions and higher education associations that can be leveraged to "track" educational and career outcomes.
- National organizations can provide stability in the collection and maintenance of program data to reduce the burden on individual programs that may be encumbered by limited technology, staff turnover, and funding uncertainties.

5) *Supporting educational infrastructure to increase the capacity to train more health professionals in high demand areas.*

Fixing the doctor shortage requires a multi-pronged approach. This includes innovations such as team-based care and better use of technology to make care more effective and efficient. AAMC-

member medical schools and teaching hospitals have been leading the movement to work better in teams with other health professionals like nurses, dentists, pharmacists and public health professionals. These institutions also are developing the new knowledge of what works in health care – not only reading the textbooks – but writing the textbooks to advance the delivery of care.

In 2002, the AAMC called for a 30% increase in medical school enrollment and a commensurate increase in GME training positions. Although medical school enrollment has increased by more than 30% since 2002, this alone will not be sufficient to produce enough physicians to meet the needs and desires of the nation. Until the Medicare cap on residency funding is lifted, this growth in medical school enrollment will not be reflected in a proportionate increase in new physicians, as each medical school graduate needs to complete residency training before entering practice.

As part of the multi-pronged approach to alleviating the doctor shortage we also need additional federal support to produce about 3,750 more doctors a year by lifting the cap on federally funded residency training positions. Teaching hospitals are operating 10,000 residency positions without Medicare support, but cuts to Medicare and other clinical reimbursements jeopardize the ability of teaching hospitals to cross-subsidize with clinical revenue these positions.

The AAMC strongly supports bipartisan GME legislation introduced in both the House of Representatives and the Senate, the Resident Physician Shortage Reduction Act of 2017 (H.R. 2267; S. 1301), which takes an important step towards alleviating the physician shortage by gradually providing 15,000 Medicare-supported GME residency positions over a five-year period.

Of course, this legislation alone will not relieve the doctor shortage. The AAMC also supports non-GME incentives and programs, including Conrad 30, the National Health Service Corps (NHSC), Public Service Loan Forgiveness (PSLF), and the HRSA workforce development and diversity pipeline programs to recruit a diverse workforce and encourage physicians to practice in shortage specialties and underserved communities.

Thank you again for the opportunity to provide additional information related to these five key outcomes. If you have any questions, please contact Matthew Shick of my staff, mshick@aamc.org or 202-862-6116. We look forward to continuing to work with you to help ensure that policymakers understand the impact and importance of these programs.

Sincerely,

Karen Fisher, JD
Chief Public Policy Officer