



Submitted electronically via ruralhealth@bipartisanpolicy.com

**Association of
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September 6, 2019

Senator Tom Daschle
Senator Olympia Snowe
Governor Ronnie Musgrove
Governor Tommy Thompson
Bipartisan Policy Center
Rural Health Task Force
1225 I St NW, # 1000
Washington, DC 20005

Re: Reforming America's Rural Healthcare System

Dear Senators Daschle and Snowe and Governors Musgrove and Thompson:

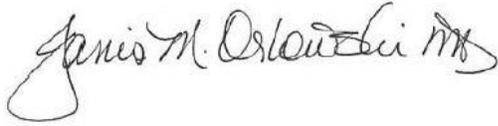
The Association of American Medical Colleges (AAMC or the Association) welcomes the opportunity to provide the attached comments in response to the Bipartisan Policy Center's (BPC's) Rural Health Task Force's comment solicitation on solutions and ideas to support reforming America's rural healthcare system.

The 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 154 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.

Major teaching hospitals, many of which are safety-net hospitals, care for vulnerable populations that often cannot seek treatment elsewhere. Simultaneously, teaching hospitals are tasked with training future physicians, as well as other health care providers, to meet the nation's health care needs. To understand the impact of physician training on the nation's physician workforce, the AAMC collects a wealth of data on such topics as physicians' choice of specialty choice and where they choose to eventually establish their practices. Additionally, AAMC members has engaged in alternative payment and delivery models in order to better care for patients.

We would welcome the opportunity to expand on the information we have outlined in the attached document, as well as other issues impacting academic medicine. Please feel free to contact Mary Mullaney at mmullaney@aamc.org or 202.909.2084 with questions.

Sincerely,



Janis M. Orlowski, M.D., M.A.C.P.
Chief Health Care Officer

Attachment

Rural Workforce and Graduate Medical Education

With projections showing a physician shortage of up to nearly 122,000 physicians by 2032¹, AAMC believes that the focus to increase the number of physicians should be on ensuring a robust physician pipeline to guarantee there are enough physicians to meet growing demands. While attention should be paid to safeguard access to care in underserved areas – including rural communities – there are many reasons that influence where physicians ultimately choose to practice.

Each year the AAMC surveys graduating medical students to better understand their choice of specialty.² The results show that choice is driven primarily by factors such as lifestyle, skills and interests including work/life balance the medical student seeks. Another factor impacting practice locality is that married physicians may choose not to practice in rural settings because their partners may not be able to find employment in these areas.³ Specialty choice often dictates where a medical student chooses to perform his/her residency and subsequently establish a practice. For example, there must be enough patients to meet the residency requirements established by the Accreditation Council for Graduate Medical Education (ACGME), the organization that currently accredits allopathic residency programs, and on July 1, 2020 will begin to accredit osteopathic residencies as well.

We believe that there are individuals who would thrive in rural and underserved communities and efforts should be made to expand residency training opportunities in these settings. Currently, urban hospitals can partner with rural hospitals and nonhospital settings to form Rural Training Tracks (RTTs)⁴ to promote training in rural settings. Residents must spend 50 percent of their training time at the rural hospital. However, RTTs are currently limited to primary care residents. Congress should expand RTTs to include other specialties in order to promote training in rural settings. While the urban hospital within the RTT can increase their resident limit (*i.e.*, cap) to accommodate residents within the RTT, rural hospitals are not offered this flexibility. In order to promote training in rural areas, rural hospitals should also be able to increase their full-time equivalent resident cap in order to accommodate more residents.

Some medical schools seek to identify incoming students who are interested in practicing in rural areas while many others are working to expand students' knowledge of the unique opportunities in rural and underserved communities by taking students to these communities as part of their curriculum. Medical students live in small towns and train with local doctors as well as engage in organized outings and cultural experiences. Medical schools should be encouraged to partner with rural and underserved communities in order to expose students to these unique care settings. AAMC agrees that offering medical students' opportunities to experience living in rural communities and understanding how a rural practice differs from a practice in an urban area will help identify more physicians who will choose to establish their practices in these settings.

Rural Participation in New Payment and Delivery Models

Rural providers face unique challenges in adopting new delivery models. Success or failure in many of these models depends upon a variety of factors including timely access to care, the number of patients

¹ https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf

² <https://www.aamc.org/download/498790/data/2019gqallschoolsummaryreport.pdf>

³ <https://jamanetwork.com/journals/jama/fullarticle/2733664>

⁴ https://store.aamc.org/downloadable/download/sample/sample_id/204/

treated as part of the bundle, and a facility's infrastructure. In addition, rural providers are often operating on leaner budgets and treating a population with higher prevalence of chronic conditions. Due to these considerations and other challenges faced by rural communities in providing health care to their residents, participation in new delivery models may be difficult for rural communities.

Individuals residing in rural communities tend to be lower-income and have a higher disease burden.⁵ Oftentimes they must travel longer distances to seek needed care because there are no facilities near them or due to a scarcity of local providers. Also, due to a smaller population base, some providers may struggle to attain the volume of patients required to manage population risk, which puts them at a disadvantage for most new models. Success in some models requires enough volume – approximately 100 cases per year – to smooth out the wide swings in costs per patient and it may be impossible for rural providers to meet this volume threshold. In addition, a smaller population base combined with a scarcity of providers makes it difficult for rural providers to adopt comprehensive team-based care models, such as patient-centered medical homes, that require integration of services including behavioral health, clinical pharmacy, and social work, to name a few.

Moreover, new delivery models generally require providers to take on greater financial risk, especially after an initial start-up period. Because rural providers survive on smaller budgets, it may be virtually impossible for them to take on any degree of financial risk, essentially eliminating any opportunity for them to participate in new delivery models even if they wanted to.

However, we believe that there are opportunities to invest in rural communities to improve the health status and access to needed health care for rural residents. As noted, since successful new delivery models rely on timely access to care, policymakers should invest in ways to improve rural communities' access to treatments for medical emergencies, particularly those where early clinical intervention is key – heart attack and stroke. Clinicians agree that successful, long-term clinical outcomes for patients that suffer life-threatening conditions is dependent upon early treatment. These models should not mandate financial risk for rural providers, because such risk could jeopardize their ability to invest in essential services or even their overall financial viability.

Policymakers should invest in ways to promote healthier lifestyles, including chronic care management. Investments should focus on primary and secondary care and prevention, as well as community-based population health, to address the drivers of chronic illness and injury that are more prevalent in rural populations. Lack of local healthcare infrastructure and expertise can be overcome to some degree with broad adoption of telehealth services. A prerequisite to effective telehealth care is broadband access, which is lacking in many rural parts of the country. Synchronous and asynchronous provider-to-provider connections allow for distant specialty expertise to be far more accessible to rural physicians and other healthcare providers, reducing professional isolation and enabling patients to receive more of their care locally. Similarly, virtual care services delivered directly to patients via video visits and remote patient monitoring modalities can ensure more convenient and timely access to the right level of care needed by patients in rural and remote communities. While telehealth services will not eliminate the need for comprehensive policies to ensure an adequate rural workforce, they can augment these efforts and overcome some of the pressing economic pressures on rural critical access hospitals and clinics.

⁵ <https://www.ruralhealthinfo.org/topics/rural-health-disparities>