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"The Physician Crisis in Rural America: Who will Treat our Patients?"
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WWAMI Workforce Issues and the Preparation of Physicians to Practice
in Rural and Medically Underserved Areas

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My name is John Coombs and I am a physician on the faculty at the University of Washington School of Medicine. As a family physician and pediatrician and as a member of the Dean's office, my responsibilities include the oversight of the WWAMI Program.

Today it is my privilege to testify before you from my leadership position in the WWAMI Program. As I will outline below, WWAMI (Washington, Wyoming, Alaska, Montana, Idaho) has accomplished much in its nearly 35 years of serving the region. From a federal perspective, I can say that we have only been able to accomplish this record with continuing federal support. We have partnered with the federal government all along the way and I want to begin by thanking this committee and the programs it funds for the support you have given to WWAMI over the years.

At the end of my testimony, I will suggest specific ways that we together can reinvigorate our partnership. Recent years have seen a decline in federal support for what we do. While we appreciate the realities of the federal budget, I hope to convince you that your investments in support of medical education are key to managing the physician crisis in rural America, the subject of this hearing.

WWAMI stands for Washington, Wyoming, Alaska, Montana and Idaho. The University of Washington School of Medicine is the only medical school and academic medical center within this five-state area. The region comprises approximately 27% of the total land mass of the United States. The approximately 10 million people in the region constitute three per cent of the population in the United States. 35% of the people living within this five-state region live in rural communities. This year we are celebrating the 35th anniversary of WWAMI, and are acknowledging the remarkable inter-state partnership that has been developed to allow for public access to medical school for the citizens of the five states. This has only been possible through the cooperative relationship between the people of the five states and the medical school. This is a relationship which has evolved between institutions of higher education, physicians in practice, hospitals, and the state legislatures as we work together to support, in an enduring fashion, this remarkable partnership.

In each of the past 14 years, the University of Washington School of Medicine and the WWAMI Program have been recognized by U.S. News & World Report as the #1 Medical School in the United States in primary care as well as in rural health and Family Medicine. Though the program began with a focus solely on training medical students, our evolution has been toward the development of a continuum of educational services (represented in the attachments as the "WWAMI Educational Continuum") that begins before medical school and extends into community service. It has also evolved into the creation of graduate medical education programs that have allowed for graduates of WWAMI to continue on with their training within the five-state area in family medicine, pediatrics, internal Medicine and psychiatry. In 2002, the Association of American medical Colleges recognized WWAMI with its prestigious Outstanding Community Service Award, applauding the partnership between the UWSOM and communities within WWAMI.

The material that I have provided to you as part of this testimony is the current Executive Summary of Activities in the states of Alaska and Wyoming over the past 12 months. The insert to both of these reports provides a state map, which allows for visual representation of communities where the WWAMI program is based within the states. In addition, on the back of the map page is a pictorial representation of the WWAMI Educational Continuum. This material will give the reader an in-depth glimpse of exactly what WWAMI does within the states of Alaska and Wyoming.

Overall, the outcomes of the program are substantial. 61% of our medical students have returned to practice within the five-state WWAMI area. This compares favorably to the national average return rate (for all medical schools) return rate of 41%. In addition, over the course of the past 20 years, approximately 40%-55% of graduates have entered into residencies in primary care (national average, 7%-10%). Over a similar time frame, 15%-30% of WWAMI graduates have chosen to establish practices in rural and medically underserved areas. Hence, WWAMI ranks highly among the states with regards to return of graduates to practice within the communities where they trained. Similarly, WWAMI ranks highly in providing well-trained physicians ready for primary care careers in rural and medically underserved communities. The

Family Practice Residency Network, which is affiliated with the University of Washington and brings together 17 Family Practice Programs across the five states (one of which is here in Anchorage), has a return rate of 77% of graduates to practice within the five-state area. Of these graduates, 30% practice in communities of less than 25,000 and 15% in communities of less than 5,000 people—most often in communities that are medically underserved and/or rural. Additional information is provided on the state-specific Fact Sheets that are attached to this testimony in conjunction with the Executive Summary Reports.

The WWAMI Program is remarkably cost-effective. The total cost to states averages between $45,000-$55,000 per student, per year for medical student education within WWAMI. This compares favorably to national averages of $60,000 and $120,000 per student, per year in medical schools in states outside of the WWAMI region. In addition, the tuition that is paid by students at the University of Washington School of Medicine is $15,900 per year, approximately $4,000 less than the national average among publicly supported medical schools. This cost effectiveness is consistent with one of the original 1970 goals of the WWAMI Program which was to assist WWAMI states in avoiding duplicative capital costs and the expenses of hiring new faculty. The WWAMI Program would not have been able to accomplish this without cooperation of universities such as the University of Alaska-Anchorage and the University of Wyoming in Laramie. It truly has been an enduring and effective partnership.

The above summarizes the accomplishments of WWAMI. Now let me focus on some of the challenges we face in preparing the future rural health workforce.

Over the course of the past five years, WWAMI has seen a drop in student interest in selecting residencies in primary care. We have gone in 1996 from approximately 36% of students entering into family practice to approximately 12% estimated this year. This remarkable decline has resulted from a variety of factors including rising student debt, student interest in assuring that there will be adequate time for personal as well as professional pursuits and changes in the healthcare delivery system. As we look to the future, the effect of this decline in student interest in primary care will be devastating for rural and medically underserved communities.

Looking deeper into the underlying reasons as to why this drop has occurred, we cite the following issues:

- <u>Reduced student interest in primary care</u>
  Long hours, limited pay, and reduced personal time have discouraged students from pursuing careers in primary care. There is frustration among many students that the current healthcare delivery system does not allow the students, once they become doctors, to pursue the principals of primary care, which include continuous patient-centered, comprehensive, compassionate, and coordinated care. The prevailing practice of primary care at the present time also discourages students away from primary care because of the limited time and infrastructure upon which to implement exceptional management of chronic diseases. This is of particular concern with an aging population and the increased incidence of chronic disease among the elderly population. Contributing to this reduction

in student interest is also the increasing requirement for more positions in the current healthcare delivery system in the U.S. The Association of American Medical Colleges now recommends that there be a 30% increase across the country in the number of medical students we train. With this increased demand, students now have many other options in healthcare that allow them to direct their interests away from primary care.

- Increasing Student Debt

  Over the past decade there has been a remarkable increase in student debt upon graduation from medical school. The national average is currently $125,000 per student from public schools, and $150,000+ from private schools. Students in WWAMI from Alaska currently graduate with $94,000 debt per student, with 100% of graduating students incurring debt. Over the past six years, this is up from $50,000 per student with approximately 75% of students graduating with debt.

- Loss of federal funding at the University of Washington School of Medicine/WWAMI

  The following factors have contributed to undermining of support for our programs that are aimed at enhancing student interest in careers in primary care.

  - Loss of Title VII funding. This loss has led to cuts in residency training in programs in Alaska and Wyoming, reduced support of Family Medicine Student Training Programs, the loss of residency faculty development fellowships, and reduced support for the underserved pathway within WWAMI.
  - Loss of the Health Careers Opportunity Program (HCOP) Grant funding ($1.2 million over two years) at the University of Washington. This has led to a severe reduction in our summer UDOC Program which is designed to encourage students from medically underserved areas to follow their interests in health careers.
  - Loss of Center of Excellence for Native American and Native Alaskan funding. Over the past two years, $647,000 has been cut from this program. At the present time, three WWAMI graduates from this program are residents at the Anchorage Family Practice Residency Program, an affiliate of the University of Washington Family Practice Network. A similar loss in Center of Excellence funding in Montana occurred in Pharmacy.
  - Loss of funding for the WWAMI Center for Health Workforce studies and the Rural Health Research Center. These programs fund the creation of vital sources of information (across WWAMI and the nation) concerning the programmatic effectiveness in rural programs. In addition, they inform us concerning workforce needs in rural areas. Funding here has been reduced in the last two years from approximately $2 million per year to $0.6 million per year. This has resulted in our staff declining from 21 researchers to six within our Department of Family Medicine.
  - Reduction of support for National Health Service Core Scholarships.

- The creation of caps on Graduate Medical Education (GME) funding as a result of the Balanced Budget Act of 1996 -
  This has imposed a freeze on GME positions within the WWAMI area. Across the five states, the number of GME positions per 100,000 population is far below the nation's average per state of 34 positions per 100,000 population. In WWAMI, this number is closer to 15 positions per 100,000. Currently the state of Alaska has only 4 residency positions per 100,000.

- Perpetuations of GME losses currently proposed in the President's FY08 budget
  - Medicare IME (Indirect Medical Education) payment reduction, a proposed cut from the GME payments that are attached to the Medicare Advantage Plan payments. There is also a potential proposed cut (as recommended by MedPac) of an 18% reduction in the IME portion going from 5.5% to 4.5%.
  - Proposed Medicaid cuts, including the elimination of GME payments currently provided within Medicaid payments to hospitals. If this is allowed to occur, the anticipated impact will be a loss across the country of $1.76 billion dollars over the next five years
  - Nearly complete elimination of Title VII – The president has proposed that Title VII funding be reduced from $185 million in FY 2007 to $10 million dollars in FY 2008. This is a perpetuation of significant reductions in Title VII over the past six years.
  - Reduced support for payoff of student debt by reduction of funding for the National Health Service Core from $125 million dollars in FY07 to $116 million dollars in FY08.
  - Children's Graduate Medical Education appropriation reduction from $297 million to $110 million (a 63% reduction).

All of these reductions (and proposed reductions) have significantly influenced the ability of WWAMI and other similar programs across the country continue to support the preparation and training of physicians to practice in rural and medically underserved areas and to achieve our remarkable outcome record. To successfully turn this around, interventions will be required in which we enhance student interest in primary care and support the continuation and expansion of programs like WWAMI.

I would strongly recommend that this committee consider support of the following federal initiatives as a way to restore efforts on the part of programs such as WWAMI. This will assist us in continuing to provide effective medical education programs that are consistent with the workforce needs within the five states, and across the nation.

Specifically, I would recommend the following measures be considered and taken:

- Address the reduction in student interest and create financial incentives to entering primary care residencies and practice.
  To successfully do this over time, the reimbursement for primary care physicians and

physician practices will need to be enhanced far above where it is today. This reimbursement and support for primary care practices (such as the institution of measures to create medical homes for all patients, electronic medical records, and the establishment of evidence-based approaches to disease management among others) will need to occur. Specifically,

- Encourage the increased number of medical students in training by increasing the nation's medical school capacity consistent with the AAMC's recommendation of a 30% increase. Within the WWAMI states, we are currently anticipating an increase of 22% in seats for medical students over the course of the next two years. This includes 10 additional seats from the state Alaska, 6 seats from the state of Wyoming, and 20 seats within the state of Washington. In addition, discussions of increases in seats for medical students are currently underway in Montana, and to a lesser degree in Idaho.
- Encourage students to enter primary care residencies through tuition support programs like the National Health Service Core to offset the increasing amount of student debt, and to reduce financial disincentives to entering into primary care.
- Restore federal support for educational programs for physicians in training, giving particular attention to those programs that address the shortage of doctors in rural and medically underserved areas. This can be best done by restoration of Title VII, HCOP and Center of Excellence Funding. We should also direct assistance to medical schools and residency training programs that promote (and are held accountable for) physicians entering practices in primary care and other needed specialties (such as general surgery and psychiatry) particularly in medically underserved areas.
- Eliminate caps within the Medicare Program for primary care residency positions and rural track programs in specialties needed in rural America. Besides family medicine, general internal medicine and general pediatrics, this should also include innovative programs in rural track training in general surgery and in psychiatry. Many of these programs may be urban-based in addition to having rural locations in the program.
- Expand training opportunities in rural and medically underserved communities. This should include the support for graduate medical education programs which combine urban and rural training (such as in rural track training). Enhance the supply of future accountable rural practitioners and increase access to rural and medically underserved citizens to top quality healthcare. Current examples of this in WWAMI include
    1. The continuation of rural track training with the WWAMI Family Medicine Network.
    2. The development (currently being considered) for rural track training in general surgery.
    3. Support for rural-track psychiatry programs such as our programs based in Eastern Washington, Idaho and Wyoming. This last example is of particular importance given the burgeoning problems in mental health,

including meeting the needs of veterans who have returned from National Guard duty to rural communities over the past ten years.

- Continued support for Area Health Education Center (AHEC) funding and programs that promote recruitment of high school students into health careers.
  Programs such as the AHEC currently in place within WWAMI provide infrastructure and allow physicians in training to do community-based rotations in rural and medically underserved areas. This support needs to continue.

- Encourage programs that promote educational relationships between Community Health Centers (CHCs) and academic medical centers.
  Within WWAMI we are currently exploring community academic linkages that would allow for increased educational opportunities within CHCs that serve rural and medically underserved populations. CHCs are rapidly becoming the greatest provider of primary care in rural and underserved urban communities, yet the supply of physicians to meet this need is far below demand. This would allow for greater opportunities to train students and residents within CHCs, and would help to alleviate the workforce shortages that challenge the CHCs.

- Restore funding for the Office of Rural Health Policy, Rural Health Research Centers and the Bureau of Health Profession Centers for Health Workforce Study across the country. The absence of funding for these programs has severely limited our ability to evaluate and assess efforts that are currently in place to craft innovations that address many of the needs that I have addressed today. In addition, funding for the nation's Centers for Health Workforce Studies (CHWS) (which has been completely eliminated within the Bureau of Health Professions) needs to be restored such that regions can have at hand the ability to assess current workforce needs

In conclusion, it has been my privilege to present this information to you today and to provide, in a short period of time, advice to policy-makers and leaders as to how we might best face the future challenges of providing for physician needs within rural and medically underserved communities. The University of Washington School of Medicine and WWAMI have long appreciated the support provided by the 10 U.S. Senators serving our five-state region, along with your colleagues from the House of Representatives. WWAMI stands ready to build upon this remarkable partnership. We will need your continued help and support in order to accomplish this task.

I look forward to answering questions that you might have around specific issues. I pledge to you to continue to provide support to this committee and your staff as we move ahead in the federal agenda to support educational solutions to future workforce needs within the United States.

Thank you for your attention.