TRACK 4

Public Policies to Promote Community-Based and Interdisciplinary Health Professions Education

written by

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PREFACE

From Community-Campus Partnerships to Capitol Hill:
A Policy Agenda for Health in the 21st Century
April 29-May 2, 2000 ~ Washington, DC

Creating healthier communities and overcoming complex societal problems require collaborative solutions that bring communities and institutions together as equal partners and build upon the assets, strengths and capacities of each. Community-campus partnerships involve communities and higher educational institutions as partners, and may address such areas as health professions education (i.e. service-learning), health care delivery, research, community service, community-wide health improvement, and community/economic development. Founded in 1996, Community-Campus Partnerships for Health is a non-profit organization that fosters community-campus partnerships as a strategy for improving health professions education, civic responsibility and the overall health of communities. In just four years, we have grown to a network of over 700 communities and campuses that are collaborating to achieve these goals.

Community-Campus Partnerships for Health's 4th annual conference was designed to broaden and deepen participants' understanding of the policies, processes and structures that affect community-campus partnerships, civic responsibility, and the overall health of communities. The conference also aimed to enhance participants' ability to advance these policies, processes and structures.

This paper – one of nine commissioned for discussion at the conference – played an integral role in the conference design and outcomes and would not have been possible without the generous support of the Corporation for National Service and the WK Kellogg Foundation. On the conference registration form, participants chose a track that interested them the most in terms of contributing to the development of recommendations and possibly continuing to work on them after the conference. Participants were then sent a copy of the commissioned paper corresponding to their chosen track, to review prior to the conference. At the conference, participants were assigned to a policy action team (PAT). Led by the authors of that track's commissioned paper, each PAT met twice during the conference to formulate key findings and recommendations. These key findings and recommendations were presented at the conference's closing session and are reflected in the conference proceedings (a separate publication). These will be considered by CCPH's board of directors as part of its strategic planning and policy development process, and are expected to shape CCPH policies and programs in the coming years.

The complete set of nine commissioned papers is available on CCPH's website at http://futurehealth.ucsf.edu/ccph.html

1. Integrating student learning objectives with community service objectives through service-learning in health professions schools curricula – Kate Cauley
2. Working with our communities: moving from service to scholarship in the health professions – Cheryl Maurana, Marie Wolff, Barbra J. Beck and Deborah E. Simpson
3. Promoting collaborations that improve health – Roz Lasker
4. Public policies to promote community-based and interdisciplinary health professions education – Janet Coffman and Tim Henderson
5. Building communities: stronger communities and stronger universities – Loomis Mayfield
6. Community-based participatory research: engaging communities as partners in health research – Barbara Israel, Amy J. Schulz, Edith A. Parker, and Adam B. Becker
7. Racial and ethnic disparities in health status: framing an agenda for public health and community mobilization – Gerard Fergerson
8. Social change through student leadership and activism – David Grande and Sindhu Srinivas
9. Advocating for community-campus partnerships for health – Charles G. Huntington

EXECUTIVE SUMMARY

Many rural and inner-city communities face persistent difficulties in recruiting and retaining adequate numbers of health professionals with the clinical experience and competencies necessary for successful practice at community-based sites. In addition, despite the increased utilization of interdisciplinary teams at community-based sites, few health professionals participate in interdisciplinary educational experiences. Federal and state governments need to support community-based and interdisciplinary education because health professions education is a “public good” that will not be adequately supplied absent government support. In addition, federal and state governments have a responsibility to ensure that health professional are appropriately prepared to provide medical care and public health services to individuals who receive these services through government funded programs.

There are three major streams of federal government funding for health professions education:

- Medicare
- The Bureau of Health Professions
- The Centers for Disease Control

In addition, there are two major streams of funding from state governments.

- General fund appropriations
- Medicaid

Progress toward expanding community-based and interdisciplinary education in the health professions has been slow and erratic. Fiscal obstacles pose a major barrier. Major fiscal challenges include:

- Lack of eligibility for government revenue streams
- The financial circumstances of teaching hospitals
- Cost limitations

Recent developments in federal and state policies concerning community-based and interdisciplinary education in the health professions include:

- Medicare's GME consortia demonstration project
- Elevation of the profile of interdisciplinary and community-based educational initiatives within the Bureau of Health Professions
- Innovations in Medicaid reimbursement for education
- Use of state general fund appropriations to expand community-based educational experiences

Federal and state funding streams for community-based and interdisciplinary health professions education need to strengthened and expanded. Policies and programs aimed at increasing the number of health professionals from disadvantaged backgrounds must also be strengthened to ensure that United States has a health care workforce that is prepared to meet the needs of all communities. Achieving these goals will require strong leadership from members of Community-Campus Partnerships for Health (CCPH) and other organizations concerned about community-based and interdisciplinary education. Members should be informed about funding streams for health professions education, monitor federal and state policy developments and partner with other individuals and organizations with similar concerns to advocate for change. CCPH should consider a range of options for operationalizing these goals including:

- Forming an advisory council on federal funding for community-based and interdisciplinary education and programs for health professionals from disadvantaged backgrounds;
- Developing of talking points, issue briefs and other materials on these federal policy issues;

- Establishing a clearinghouse for information on state policies in these arenas.

INTRODUCTION

Despite talk of an oversupply of physicians in this country, many rural and inner city communities face persistent shortages of health professionals. While the United States has made some progress in this arena, there is major concern that the education of these professionals may be inadequate for the challenge of providing medical care and public health services to underserved populations. In particular:

- Although the *practice* of most primary care professionals occurs outside the hospital in community settings**,** the *training* of health professionals, especially physicians, continues to occur largely in hospital-based locations.
- Very little attention in training (as well as practice) is given to understanding the *health of populations.* A thorough exploration of a community's knowledge, prevailing attitudes and socio-cultural behaviors toward health and health care is seen as key to improving their health status, particularly for underserved communities.
- The multidisciplinary nature of primary care practice [e.g., teams of advanced practice nurses, physician assistants, dentists, behavioral health professionals, and physicians] is more commonplace today as new models of quality care emerge and, more importantly, as disadvantaged populations with complex health care needs experience persistent difficulty in accessing care. Yet, more health professions students continue to be trained in isolation from students in other disciplines.

As early as the late 1940s, a growing realization about an acute shortage of health care professionals and hospitals prompted most states to begin supporting health professions education. Later reports of a continued shortage and maldistribution of physicians led the federal government to incorporate payments

to teaching hospitals for graduate medical education and nursing education as part of the new Medicare program established in the mid-1960s.

As evident by their long history of extensive financial support, most states believe health professions education to be a public good—that is, a good or service that benefits the public at large and will not be produced at the appropriate level in the private market because of difficulty in pricing it. Although the community at large, including future patients and health care professionals, benefits from education, it is impossible to charge future beneficiaries. If left to itself, the private market will underproduce health professions education. Managed care organizations and other health plans will not invest sufficient resources in health professions education because education yields general benefits that do not create a strategic advantage for any particular health plan or participating clinical site. Moreover, the costs of training are too great for many health professions trainees to pay entirely without incurring large debts.

ACTIVITY AND ANALYSIS

The Roles of the Federal Government

The federal government supports health professions education through a variety of sources. The largest source of funding for education is the Medicare program. Medicare reimbursement flows primarily to teaching hospitals. Support for community-based training is limited to graduate medical education and no incentives are provided for interdisciplinary education. Although much smaller than Medicare in terms of total expenditures, targeted grant programs administered by the Bureau of Health Professions and the Centers for Disease Control are more critical sources of funding for community-based and interdisciplinary educational initiatives.

Medicare

Most Medicare funding for health professions education is allocated for graduate education (residency training) in allopathic and osteopathic medicine. A much smaller amount of Medicare funding is available for education in dentistry, podiatry, nursing and certain allied health professions (cytotechnology, dietetics, hospital administration, inhalation therapy, medical records, medical technology, occupational therapy, pharmacy, physical therapy, and x-ray technology). Medicare does not provide financial incentives for interdisciplinary education.

Medicare makes two types of education-related payments. Direct medical education (DME) payments reimburse direct costs of educational programs in eligible professions, such as trainees' stipends and faculty salaries. The indirect medical education (IME) adjustment to payments for patient care is intended to reimburse teaching hospitals for additional indirect costs associated with operating educational programs. DME payments are available for training programs in medicine and all other eligible health professions. The IME adjustment, in contrast, takes into consideration only medical residents. In 1998, Medicare expenditures for DME totaled approximately $2.2 billion and expenditures for IME totaled approximately $4.1 billion. Payments to individual teaching hospitals are based on the number of full-time equivalent trainees and the volume of services delivered to Medicare beneficiaries (CBO, 1995; MedPAC, 1999; US GAO, 1994).

Medical residents are the only trainees for whom Medicare reimburses costs associated with community-based education. Under the provisions of the Balanced Budget Act of 1997, reimbursement flows to either a community-based site or the teaching hospital with which it is affiliated, depending on which entity bears the cost of community-based training. Teaching hospitals that bear "all or substantially all" of the costs of training at a community-based site may receive both DME and IME reimbursement for time residents spend at the community-

based site. (Under prior law, teaching hospitals were eligible to receive *only* DME payments for community-based education.) In cases in which the community-based site bears the cost of training, the community-based site may receive Medicare DME payments but not IME payments. Under current regulations, only federally qualified health centers, rural health clinics and managed care organizations are eligible for these payments.

Bureau of Health Professions

Grant programs authorized under Titles VII and VIII of the Public Health Service Act are another important source of federal funding for health professions education. Although Title VII and Title VIII grant programs provide a much smaller amount of funding than Medicare, these programs are important sources of support for community-based and interdisciplinary education because many of them are targeted to promoting these types of educational experiences. Other Title VII and Title VIII programs support initiatives to increase the number of health professionals from disadvantaged backgrounds.

Title VII and Title VIII programs are administered by the US Bureau of Health Professions. Grants are generally awarded to health professions schools. Title VII supports education in medicine, dentistry, podiatry, public health, and allied health (including physician assistants). Support for medical education is targeted primarily to generalist disciplines (family practice, general internal medicine, and general pediatrics). Title VIII grants support nursing education at baccalaureate and advanced practice levels. In fiscal year 2000, total appropriations for title VII and VIII programs were approximately $302 million. (HRSA News Brief, February 7, 2000).

In addition, to discipline-specific grant programs, several interdisciplinary programs are funded under Title VII. The oldest and largest of these programs is the Area Health Education Centers (AHEC), which received an appropriation of

$26 million in fiscal year 1997. AHEC grants support educational programs in medically underserved communities for students in medicine, nursing, and other health professions (US BHPr, 1998). Other BHPr grant programs that support interdisciplinary education are more narrowly focused. The Quentin N. Burdick Rural Health Interdisciplinary Program ($4.1 million) provides grants for interdisciplinary education for registered nurses and other health professionals in rural areas. The Geriatrics Education and Training Centers program supports interdisciplinary education in geriatrics and emphasizes preparation for delivery of geriatric care to senior citizens in underserved communities (US BHPr, 1998).

Centers for Disease Control

The Centers for Disease Control (CDC) is another source of federal funding for community-based education. CDC programs focus on educating health professionals about public health matters and on enhancing the knowledge and skills of practicing public health professionals. The Association of Schools of Public Health administers a cooperative agreement with CDC that funds public health research and training activities at schools of public health. CDC also administers the Public Health Training Network, a distance learning system for public health professionals (CDC website, 2000).

The Roles of States

Most state health policy experts recognize that financial concerns typically are the principal limiting influence to the growth of health professions training outside of hospitals. Many states are supporting various direct and indirect methods for paying a significant portion of the costs of education in these settings. For physicians, states are creating or expanding primary care residencies and directing medical schools to offer or require community-based training experiences for generalist-minded students at both the undergraduate and graduate level. For advanced practice nurses and physician assistants, states in recent years have

begun paying direct and indirect portions of general funds to support training programs, which typically are based in non-hospital settings.

Undergraduate Education

In general, the role of state government in supporting the education and training of health professionals is well established. Historically, state general revenue appropriations for medical, nursing and allied health education have been directed largely to undergraduate training.

In 1997, allopathic medical school revenues from state and local government general funds were worth over $3 billion. Most of this money is unrestricted, and often those funds that go to single institutions are difficult to isolate and analyze. Although the *amount* of funds states devote to medical education has nearly doubled since the early 1980s, the *proportion* of allopathic medical school revenue from state and local appropriations in 1997 was only 8 percent compared to 23 percent in the early 1980s. The shift in the payer mix of medical schools reflects in part the growing importance of patient care or faculty practice plan revenues (33 percent of total revenues in 1996) to the programs. About 60 percent of all allopathic medical schools are state owned or state related and receive state appropriations. Some states also subsidize private schools.

Many nursing and allied health training programs receive public funds as part of a state's allocation of general appropriations to support state colleges and universities. In many states, these funds are made available through a board of higher education.

Graduate Education

Since the inception of the Medicaid program in the middle 1960s, many states have paid what they believe to be their fair share of clinical training or graduate

medical education (GME) costs. Generally, state support for GME takes the form of some or all of the following: 1) operating subsidies to teaching hospitals and clinics, 2) direct support of clinical education programs such as residencies, internships and preceptorships (and of AHECs in some states), and 3) Medicaid reimbursement to hospitals for certain teaching costs. Appropriations are often not separately identified, and several states have found it difficult to isolate service reimbursement from clinical education under Medicaid. Some of these strategies are described further below.

Most states also provide specific funding for training in family medicine and primary care residencies. Legislators in many states often view support for residency training as solving problems of access to primary care by rural residents and indigent populations. Some states have enacted laws that call for studying the feasibility of establishing residency programs in family practice, based on utilizing both community and hospital clinical sites in rural areas.

Recent studies also have found that state support is important to many nurse practitioner and physician assistant training programs. In 1997, 66 nurse practitioner (NP) training programs and 19 physician assistant (PA) training programs received some form of state financial support. On average, state funds represent anywhere from 5 percent to 100 percent of the annual budget of a NP or PA training program, but the percentage is higher for NP budgets (67%) than for PA budgets (36%). State support is defined as 1) general fund (public) appropriations awarded to the program's sponsoring institution, which in turn uses the state money to support the training program, or 2) a training program's receipt of grant funds earmarked by the state for the program**.**

The growing interest by many states to develop or enhance community-based training programs often is depicted in broader state efforts to pressure health professions schools and teaching hospitals to train more generalists and to improve the overall supply of health professionals in rural and medically

underserved communities. These efforts are a major means for states to a) achieve some congruence between the public need and existing supply of health professionals, and b) more carefully account for all state contributions to health professions education.

In the past 15 years or more, states have implemented or have considered implementing the following strategies aimed at enhancing undergraduate and graduate health professions training experiences in out-of-hospital settings:

1. *Establishing family practice training programs.* At least 15 states have passed legislation, which specifically encourages or mandates the creation of departments of family medicine or other family practice training programs in state-supported schools. Many of these are freestanding residencies, or those that are not attached directly to a teaching hospital.
2. *Targeted appropriations*. Over 40 states have created special grant programs for family physician training and about half of the states specify appropriations for family practice education. The amount and scope of these appropriations continue to wax and wane.
3. *Outcome-based measures*. About a half dozen states have enacted laws linking education funding to specific and measurable outcomes focusing on the specialty mix of graduates and residents trained. Typically, schools are required to prepare a plan with the goal of training a large proportion (typically 50 percent) of their graduates in primary care by a certain date without additional state funds.
4. *Reforming Medicaid policies for GME to pay for residency training in ambulatory care settings.* A growing number of the 45 states and the District of Columbia that make some level of payment for GME under their Medicaid programs distribute these funds in a manner that is explicitly tied to public accountability. Of the 10 states that require that some or all Medicaid GME payments be directly linked to state policy goals intended to vary the distribution of the health care workforce, three use GME payments to

encourage training of physicians in certain settings (e.g., ambulatory sites, rural locations, medically underserved communities). The goal of encouraging the training of physicians in certain specialties (e.g., primary care) is the most common; it is applied to GME payments by 8 of the 10 states.

5. *Creating requirements or incentives and earmarking general fund appropriations that emphasize community-based education*. State-funded training programs are increasing the number of required and elective clerkships, rotations and other clinical training arrangements, typically in community-based settings, for generalist-minded medical students and residents. Texas' legislature is the only one to mandate all third-year medical students to complete a clerkship in family medicine and require all primary care residents to be offered a rural rotation.

Fiscal Obstacles to Change

Progress toward expanding community-based and interdisciplinary learning opportunities has been slow and erratic. The vast majority of health professionals continue to receive most of their clinical education in hospital-based programs that offer little in the way of interdisciplinary training. Financial barriers are a major reason for this lack of progress. The most important financial barriers facing organizations interested in expanding community-based and interdisciplinary education are summarized below.

<u>Lack of Revenue Streams</u>

Lack of reimbursement is perhaps the most serious financial barrier. Medicare restricts reimbursement for community-based training to medical residents and provides no incentive for interdisciplinary education. In addition, Medicare reimbursement for education is linked to the volume of services delivered to Medicare beneficiaries. Pursuit of Medicare reimbursement is a viable strategy

only for community-based sites whose clients include a large proportion of Medicare beneficiaries.

Most Medicaid programs and other third party payers do not cover the costs of training outside the hospital in ambulatory settings. For Medicaid, reimbursement policies and payment levels differ widely from state to state. Most state appropriations for graduate medical education are to university hospitals and no restrictions on the specialty of the physician being trained nor the location of the training is given. However, an exception are the special appropriations that many states earmark for family physician training.

BHPr grants are important sources of targeted funding for community-based and interdisciplinary education and for initiatives aimed at increasing the number of health professionals from disadvantaged backgrounds. However, appropriations historically have not been adequate to provide funding to every health professions school. In addition, appropriations for BHPr are made on an annual basis, which can result in significant fluctuations in the amount of grant funding available.

Teaching Hospitals' Financial Circumstances

Even though Medicare now reimburses community-based training of residents such training may not expand rapidly. One major reason is that many teaching hospitals are experiencing financial difficulties which they attribute to primarily to reductions in Medicare and Medicaid payments mandated under the Balanced Budget Act of 1997 (see for example, *Boston Globe*, March 19, 1999; *Chicago Tribune*, April 25, 1999; Philadelphia *Inquirer*, April 11, 1999). These financial difficulties have increased pressures on teaching hospitals to constrain costs. These pressures, along with changes in Medicare regulations that increase the financial obligations of teaching hospitals that sponsor community-based training, may lead some teaching hospitals to restrict their participation in community-based educational initiatives. There is a pressing need for systematic research to assess

the impact of these changes in teaching hospitals' financial circumstances on the availability of community-based training for medical residents.

Cost Limitations

Without the benefit of direct grants or payments, many programs find it difficult to cover the costs associated with developing and operating community-based, ambulatory training initiatives. Community-based education, particularly in medically underserved areas often distant from the academic center, is quite expensive. Studies have found operating costs are higher because of the one-on-one nature of training in such settings, extraordinary travel time and distance, and resident needs for additional supplies, medical records and examining room space. Also, trainees typically see fewer patients and are slower at evaluating problems than physicians. Yet, other studies have found that the costs associated with lower faculty and resident patient care productivity are much less when more advanced residents are present.

RECENT DEVELOPMENTS

This section highlights recent developments in federal and state funding policies that have implications for community-based and interdisciplinary education. We include both policy changes that have been enacted through changes in statutes and regulations as well as major proposals from Members of Congress, expert panels and educational associations.

Federal Government

Medicare

GME Consortia Demonstration Project

In January 2000, the Health Care Financing Administration (HCFA) released a Request for Proposals for a three-year demonstration project to evaluate GME

consortia. This demonstration project, authorized under the Balanced Budget Act of 1997, seeks to evaluate the ability of consortia to increase the number of generalist physicians, expand community-based ambulatory training and enhance the quality of training. Participating consortia will receive a single Medicare DME payment for residency training at all participating organizations. (IME adjustments will be provided separately to participating teaching hospitals.) To be eligible to participate in the demonstration project, a consortium must be composed of a teaching hospital and at least one of the following organizations: another teaching hospital, an allopathic or osteopathic medical school, a managed care entity, a medical group practice, a Federally Qualified Health Center or an entity furnishing outpatient services. Participating consortia may allocate a portion of DME payments to support the training of non-physician clinicians who already hold graduate degrees. However, because HCFA was appropriated no additional funds by Congress for this initiative, experts believe that teaching hospitals have few incentives to relinquish payments to community providers that offer training. In fact, to date, HCFA reports receiving no applications to participate in the consortia demonstration.

Direct Payment of IME to Community-Based Sites

In its 1998 report on federal GME policy, the Pew Health Professions Commission recommended direct payment of IME to community-based sites that train residents (Pew Commission, 1998). One obstacle to implementing such recommendations is the lack of a methodology for estimating the indirect costs of training in community-based sites. The methodology Medicare currently uses for IME payments is inappropriate for community-based sites, because payments are made as adjustments to Medicare reimbursement rates for inpatient services. Researchers are analyzing the costs of educating health professionals in ambulatory settings to enhance understanding of the types of costs incurred in ambulatory settings and their magnitude (see for example Boex, et al, 1998, and

Boex, et al, 2000). This work is a necessary precursor to the development of an IME reimbursement methodology for community-based sites.

MedPAC's Proposal for Replacing Medicare DME and IME Payments

In August 1999, the Medicare Payment Advisory Commission (MedPAC) issued a report on Medicare GME policy in which it called for replacing Medicare's DME and IME payments with a new payment to teaching hospitals for "enhanced patient care" which would be paid as an adjustment to Medicare payments for inpatient care. MedPAC also recommended that "enhanced patient care" payments be made to non-hospital training sites that provide care to Medicare beneficiaries provided two conditions are met. First, the costs of providing patient care in such a setting must be higher in organizations training residents. Second, Medicare beneficiaries must receive "enhanced services" not available in non-teaching organizations (MedPAC, 1999, p. xiii). Payment to these non-hospital sites might be made as an adjustment to the prospective payment system Medicare plans to implement for outpatient care. MedPAC proposes to apply similar criteria to determine whether Medicare should support education in other health professions. The evolution of MedPAC's recommendations and efforts to implement them should be monitored carefully. However, it is important to recognize that changes in Medicare policy will affect only those community-based educational sites that serve large numbers of Medicare beneficiaries.

Decoupling GME Payments from Medicare

Medicare patient volume would be a less critical factor if proposals to decouple GME funding from Medicare were enacted. These proposals call for the establishment of a GME trust fund that would be administered separately from the Medicare program. There are important differences among the major trust fund proposals with regard to proposed revenue streams and priorities for allocating funding. The National Bipartisan Commission on the Future of Medicare proposed

to use general revenues. The Pew Health Professions Commission, Representative Cardin (D-MD) and Senator Moynihan (D-NY) proposed to tax health plans and combine these tax revenues with funds from Medicare, and possibly Medicaid. The Pew Commission and Cardin proposals would have allocated funding to all sites engaged in residency training, whereas the Moynihan bill limited payments to teaching hospitals.

Bureau of Health Professions

Elevation of the Profile of Community-Based and Interdisciplinary Education

BHPr was recently reorganized to create a new Division of Interdisciplinary and Community-Based Programs that will administer grant programs for interdisciplinary and community-based education, such as the AHEC Program and the Burdick Rural Interdisciplinary Program that were previously administered by discipline-specific divisions. In addition, the Health Professions Education Partnerships Act of 1998 required BHPr to establish a new advisory committee on community-based and interdisciplinary health professions education. The formation of this division and advisory committee has elevated the profile of community-based and interdisciplinary education within BHPr and may serve as a catalyst for expansion of BHPr initiatives in these arenas.

Faculty Loan Repayment Program Now Includes Part-time Faculty

The Health Professions Education Partnerships Act of 1998, Public Law 105-392, modified BHPr's faculty loan repayment program for faculty from disadvantaged backgrounds in a manner that may make it a useful tool for recruiting community-based faculty. This program repays up to $20,000 per year in loans for educational expenses for health professions faculty from families with low incomes and/or other socioeconomic disadvantages. Prior to the enactment of this legislation, only full-time faculty were eligible to participate. By extending eligibility to part-time faculty, the program can now be utilized by faculty who split

their time between teaching and clinical care. Given that many community-based health professions education sites serve disadvantaged populations, this program may be well suited for recruiting faculty from backgrounds similar to their clients.

Bureau of Primary Health Care

National Health Service Corps Reauthorization

The legislation authorizing the National Health Service Corps (NHSC) is up for renewal this year. As Congress proceeds to consider a reauthorization bill, some leaders are advocating that NHSC strive to better integrate educational and service delivery activities at NHSC sites. Under current law, NHSC administers a Fellowship program for health professions students. NHSC is also pilot testing Educational Partnership Agreements between NHSC and health professions schools (Sonia Reig, NHSC, presentation, 6/4/1999). The goals of both of these programs are to enhance the preparation of health professions students for delivery of care to underserved populations and improve retention of NHSC Scholarship and Loan Repayment recipients in underserved communities.

States

State Appropriations as Means

Texas

An extensive 1989 law requiring the Texas Higher Education Coordinating Board, the newly established Center for Rural Health Initiatives, medical and other health professions schools to cooperate to improve and expand programs for rural areas, has significant implications for community-based training. Included are provisions that: 1) encourage and coordinate the creation or expansion of a

rural preceptor program among medical schools and teaching hospitals; and 2) require family practice residency programs to provide an opportunity for residents to have a one-month rotation through a rural setting.

The effect of the rural rotation requirements has been beneficial—both because rural practice was incorporated into the core curricula for medical students and because it was elevated to the level of an optional rotation in residency programs. As a result, there are increased opportunities to expose more physicians in training to rural practice. At least 20 percent of medical school graduates practice in a rural county.

A follow-up 1995 law had two important provisions. First, it established a new statewide preceptorship programs in general internal medicine and general pediatrics modeled after the existing family practice preceptorship program. Created by the state legislature in 1983, the Family Practice Preceptorship Program provides state funds to medical students at each of the eight state schools for an elective four-week opportunity to work at a primary care physician practice site.

Second, the law created three family practice residencies to provide services in economically depressed or rural areas of the state, and provided support for an additional 150 community-based primary care residency positions phased in over five years, although per-resident allotments do not increase. In part, the rationale behind increasing state support for graduate training is that funds for community-based faculty to supervise residents is inadequate.

West Virginia

The state's comprehensive approach to health professions education includes training medical students and creating medical residency rotations in rural areas and recruiting students to those rotations based on criteria designed to foster

primary care. Eight "primary health care education" sites under the Rural Health Initiative (RHI) have been established for medical, other health professional and allied health education. State law identifies performance indicators, which have been used to evaluate program performance for the various sites.

A 1991 law obligates the state to commit $6 million annually to the initiative for five years. About $4 million of the total goes to medical schools and $2 million to help equip hospitals and clinics to give students "hands-on" experience. Funds for the initiative are lodged in the West Virginia University Health Sciences budget, but other sources of private, user and community support are required. Students from seven health professional schools, including three medical schools (one osteopathic), are rotating through the combined RHI/Kellogg network. (The RHI represents matching support for the W.K. Kellogg Foundation community partnerships project, which is now completed.)

Arkansas

Beginning in the 1970s, the University of Arkansas for Medical Sciences (UAMS) responded to a mandate from the state to deliver family practitioners and other health professionals directly to small towns around the state. During that time, UAMS was designated as an Area Health Education Center (AHEC) to address the need for more primary care physicians, and by the mid-1980s, the six principal AHEC sites in concert with an established network of several underserved community sites, were delivering multidisciplinary training programs for various health professions students and residents.

UAMS and its AHEC program have developed interdisciplinary health professions education as its institutional goal. Full and part-time faculty in medicine, nursing, pharmacy and several health-related professions staff the program. The current six-year plan charges UAMS to develop more and improved interdisciplinary education. Components include an affiliated network

of rural hospitals to provider professional and consumer educational programs to endangered health care providers. Community health centers and community colleges have recently joined the program. Another component is the distance education/telehealth interactive video program linking rural hospitals and AHECs with UAMS.

Medicaid GME Policy and Payments as Means

Michigan

Medicaid GME policy in Michigan changed significantly in 1997 when the state sought to structure payments to bring physician education more in line with its specific public policy goals to train appropriate numbers of primary care providers, enhance training in rural areas and support education in ways of particular importance in the treatment of the Medicaid eligible population. All GME funds previously included in Medicaid fee-for-service hospital patient care payments and MCO capitation rates were carved out and directed for redistribution into two different pools.

The historic cost pool is meant to reimburse hospitals based on their 1995 costs incurred for medical education. A second pool, the primary care pool, seeks to encourage the education of young physicians in the primary care fields of general practice, family practice, preventive medicine, obstetrics and geriatrics.

A third pool, the Innovations in Health Professions Education Grant Fund, was established with GME funds formerly included in capitation payments to MCOs to foster innovations in health profession education and accelerate the pace of change currently sweeping the state's health care delivery system. Grants are awarded on a competitive basis to programs that support the goals of the new GME initiative, with emphasis on innovative training in managed care arrangements. Only consortia consisting of at least a hospital, a university and a

managed care organization are eligible to apply. Common to all grantees are the use of multidisciplinary team approaches to education and service and the involvement of community in improving health outcomes. One grantee focuses on delivering both an urban and rural community-based education experience for nurses, pharmacists, physician assistants and social workers.

Tennessee

In 1996, Tennessee, under its replacement Medicaid program (TennCare), became the first state to stipulate that GME money flow directly to medical schools, thus circumventing the requirement that teaching hospitals may use only GME funds to educate students in hospital-based settings. Graduate medical education funding now will follow residents to training sites and be distributed to the state's medical schools to pay the residents' basic stipend and provide conditional stipend supplements that encourage primary care training in community sites as well as the placement of those trainees in underserved areas. That represents a radical departure from Medicaid's status quo support for GME before TennCare and the turmoil that followed in 1995 when it briefly stopped paying for GME altogether.

Early problems with TennCare centered on the lack of primary care providers in many rural areas of the state. It was during the process of restoring GME support by TennCare that the need to change the way GME funds were distributed and set certain standards of performance became apparent. The plan developed by the TennCare GME Working Group is to be phased in over a five-year period. By July 1, 2000, 50 percent of the aggregate residency positions under the sponsorship of the state's four medical schools must be in one of the primary care specialties. Each medical school now must comply with rigorous annual state reporting requirements.

RECOMMENDATIONS

General

For Policymakers

- Conduct rigorous studies to determine and document total reimbursable costs of graduate health professions education for the primary care and public health disciplines occurring in both hospital and nonhospital settings;

- Explore supplemental funding for community-based training from other sources such as foundations, private health plans, health care providers and general governmental revenues. The federal government or the states could take the lead to pool funding from multiple payers of health professions education. Currently, New York exercises a "tax" on health plans to support GME; Minnesota now uses revenue from the state's tobacco settlement to support medical education and research.

For CCPH Members

- Become informed about the funding streams for initiatives in community-based and/or interdisciplinary education;

- Monitor policy developments, including proposed changes in appropriations, authorizing legislation, regulations and recommendations from expert panels. Advocate for increased funding for programs aimed at expanding community-based and interdisciplinary education and at increasing the number of health professionals from disadvantaged backgrounds, as well as for policy changes that promote these types of educational experiences;

- Develop alliances with other organizations concerned about funding for community-based and interdisciplinary education such as other organizations

that provide similar experiences, as well as associations of health professions schools, health professionals and community-based organizations that provide public health or medical services.

Federal Policies

Medicare Policy

- Expand the range of community-based sites that are eligible to DME reimbursement (where costs of community-based training are not covered by teaching hospitals);

- Develop a methodology for reimbursement of community-based sites for IME;

- Once a methodology is developed, amend the Medicare statute to permit reimbursement of community-based sites that incur training costs for both DME and IME.

Bureau of Health Professions Policy

- Increase funding for AHEC and other Bureau of Health Professions (BHPr) grant programs that support community-based and interdisciplinary education and for programs aimed at increasing the number of health professionals from disadvantaged backgrounds;

- Ensure that methodologies used to award discipline-specific Title VII and Title VIII grants provide incentives for health professions schools to provide training in community-based sites;

- Provide health professions schools with greater flexibility in implementing community-based and interdisciplinary educational initiatives supported by

BHPr grants, as well as initiatives aimed at increasing the number of health professionals from disadvantaged backgrounds;

- Expand eligibility for BHPr grants, especially for allied health disciplines and community-based organizations;

- Decrease grant periods to permit funding of a greater number of new initiatives.

Bureau of Primary Health Care Policy

- Encourage community health centers, migrant health centers and other Bureau of Primary Health Care grantees to participate in health professions education;

- Educate grantees about revenue streams for community-based health professions education;

- Continue efforts to enhance partnerships between the National Health Service Corps and health professions schools;

- Consider options for improving coordination of educational activities and care delivery at NHSC sites.

Office of Community Access Programs

- Encourage the Health Resources and Services Administration (HRSA) to fund partnerships through the new Office of Community Access Programs that support health professions education as well as delivery of health care services to underserved populations.

CCPH Activities to Influence Federal Policy

- Focus CCPH's activities on strengthening relevant programs administered by HRSA agencies (i.e., BHPr, BPHC, Office of Community Access Programs). CCPH should focus on HRSA funding streams because these programs are available to a larger number of CCPH members than Medicare funding, and because HRSA programs are more narrowly targeted to expanding community-based and interdisciplinary education and increasing the number of health professionals from disadvantaged backgrounds;

- Develop an advisory council composed of representatives of other organizations with interests in improving federal programs aimed at expanding community-based and interdisciplinary education and increasing the number of health professionals from disadvantaged backgrounds. The advisory council would advise CCPH regarding pending legislation and regulations, as well as strategies for advancing CCPH's agenda in these areas. Where feasible and appropriate, CCPH should partner with organizations represented on the advisory council to advance policies of mutual interest;

- Develop talking points, issue briefs and other materials that CCPH members can use to educate Members of Congress and staff at BHPr, BPHC and other agencies about the need to support community-based and interdisciplinary education and efforts to increase the number of health professionals from disadvantaged backgrounds.

State Policies

State General Fund Appropriations

- Target or weight appropriations to:

- State initiatives aimed at increasing the number of health professions from disadvantaged backgrounds (e.g., Governors' schools/other K through 12th grade enrichment programs, post-baccalaureate programs for unsuccessful health professions school applicants);
- Undergraduate and graduate training programs that stress community-based and multidisciplinary education.

Undergraduate Education

- Develop incentives to expand community-based and interdisciplinary training by using general fund appropriations to institute a requirement (e.g., a third-year family practice clerkship for medical students) that stresses significant experience in out of hospital community settings.

Graduate Education

- Use general fund appropriations to:
  - Increase per-capita spending for training in primary care and public health;
  - Locate more primary care residency and graduate nursing training in community-based underserved areas;
- Institute an *inner city or rural rotation option that stresses significant experience in out of hospital community settings* for all graduate health professions students;
- Institute an *option that provides for a significant experience in multidisciplinary education* for all graduate health professions students.

<u>Medicaid Policy</u>

Changes in Medicaid policy would require or encourage states to:

- Link Medicaid GME payments to performance, specifying that a significant portion of medical school and residency training occur in out-of-hospital settings known to be in short supply of health professionals *or* are related to achieving better service for Medicaid recipients and other underserved or uninsured populations.

- Expand eligibility for and distribution of Medicaid GME payments to certain out of hospital providers of graduate medical, nursing and allied health education qualified to directly receive these payments. These institutions may include, but are not limited to:
  - Schools of medicine, nursing, dentistry and affiliated graduate training programs,
  - Ambulatory care sites such as federally qualified health centers, other community health clinics, private group practices, and MCOs that provide training, and
  - GME consortia.

<u>CCPH Activities to Affect State Policy</u>

- Develop a *state policy clearinghouse* containing information on programs and policies aimed at expanding community-based and multidisciplinary education and increasing the number of health professionals from disadvantaged backgrounds. Such information might include:
  - "Models that work" descriptions;
  - Bibliography of other relevant sources (e.g., resource guides, books, websites)
  - Contact information and links to relevant state-based organizations; and
  - Information on/links to relevant upcoming conferences and workshops.

QUESTIONS FOR DEVELOPMENT OF PUBLIC POLICIES

A number of topics need to be considered when developing public policies to expand community-based or interdisciplinary education. The following list of questions is intended to serve as a guide for individuals interested in developing viable and effective public policies in this arena. The questions may be helpful to policymakers and to individuals and organizations interested in influencing public policies. These questions could be adapted to address other public policy topics such as increasing the number of health professionals from disadvantaged backgrounds.

1. What does the public want from their health professions schools? What are the public's priorities? Appropriate health care workforce vs. ability to attract federal research dollars vs. biotechnology vs. institutional prestige vs. public health vs. community service?

2. How effective are publicly-supported health professions schools in preparing professionals to meet public needs?

- What is the school's mission with respect to primary care, public health and geographic distribution of graduates? What is the school's mission with respect to multidisciplinary training?
- What proportion of school applicants graduated from high school in non-metropolitan counties and inner-city communities? How does that proportion compare with the proportion of the state's population living in these areas?
- How many schools require a family practice clerkship for medical students?
- What proportion of graduates are doing their post-graduate training in the state? How many post-graduate training programs are located outside of hospitals? What proportion of graduates are doing their state-based post-graduate training in primary care? What proportion of physician residencies require a rural or inner city rotation? How many are based in medically underserved areas of the state?

- What proportion of graduates are in primary care and public health practice in the state? What proportion of graduates are practicing in the state's medically underserved areas? Is there a process for tracking and reporting such information to training programs and the general public?

3. How can government improve the chances that publicly supported health professions schools will prepare health professionals to meet public needs?
    - Is it appropriate for government to become involved in defining and monitoring the missions or expected achievements of publicly supported schools? Should the federal or state government establish regular reporting requirements for training programs and enforceable penalties for noncompliance?
    - Should government appropriations remain unrestricted or should they be linked to performance with respect to these achievements?
    - Should the federal and state governments provide more support to education for nurse practitioners and physician assistants?
    - Is there value in Medicare and Medicaid paying for graduate medical education in other ways that better matches the public's workforce needs?

4. What is an appropriate and fair level of government support for graduate health professions education? Should public support for graduate training be directed toward creating new programs or strengthening existing programs?

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