

# Health Professions: Title VII of the Public Health Service Act Reauthorization

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National Rural Health Association

The rural population of the U.S. is about 20 percent, or 61 million people. In 1999, less than 9 percent of physicians practiced in nonmetropolitan counties (Rural Health in the United States, Thomas Ricketts, III, ed.). In recent years, distribution and shortages of non-physician providers including nurses, dentists, pharmacists, radiology and laboratory technicians and mental health professionals have also become more apparent. It has been estimated that in urban areas, the average provider to population ratio is 58/100,000 compared to 35/100,000 in rural areas. Recruitment and retention of nurses, lab technicians, radiology technicians and other health professionals is an ongoing problem for rural areas that compete with urban areas to maintain an adequate workforce. In addition, maldistribution of health care professionals is projected to become greater as nationwide shortages increase.

The National Rural Health Association (NRHA) believes that it is essential for rural areas to have an adequate and able workforce to deliver needed health care services. Without adequate numbers of trained health professionals in rural areas, access to health care and quality of life for rural and frontier residents is greatly decreased.

The programs administered by the Bureau of Health Professions in the Health Resources and Services Administration of the U.S. Dept. of Health and Human Services under Title VII of the Public Health Service Act provide one avenue to alleviating the problem of maldistribution and shortage of trained health care professionals in rural America.

The health professions programs provide support to students, programs, departments, and institutions to improve the racial and ethnic diversity, accessibility, and quality of the health care workforce.

These programs are critically important to rural areas because they encourage students to serve in medically underserved areas, including rural and frontier communities. These programs are designed to accomplish the following objectives:

- To meet the nation's needs to increase the supply of primary medical and dental care providers, public health and allied health professionals, and nurses;
- To educate and train more health professionals in fields experiencing shortages, such as nursing, pharmacy, dentistry, public health, and allied health;
- To improve the geographic distribution of health professionals;
- To increase access to health care for underserved populations; and
- To enhance minority representation in the practicing health professional workforce.

The NRHA makes the following overall recommendations for the Health Professions programs:

- Funding for the Health Professions programs has decreased to the point where these programs are under-funded and unable to fully accomplish the goals they were intended to achieve. In addition, these programs have been subject to yearly uncertainty in the appropriations process which prohibits grantees from best utiliz-

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ing federal funds through a continuous, long-term approach to addressing health professional shortages. The programs deserve increased funding across the board to allow them to more effectively address the shortage and maldistribution of health professionals in rural and underserved areas.

- The Health Professions programs should be reauthorized without delay. As part of reauthorization, Congress should create a task force to look at the overall problem of workforce shortages and maldistribution in rural areas. This task force should include providers, Title VII grantees and representatives of national associations active on rural health issues as well as federal partners from the Federal Office of Rural Health Policy, the Centers for Medicare and Medicaid Services and the Bureau of Health Professions in the Department of Health and Human Services and the Department of Labor in addition to other federal partners with an interest in these issues.
- The Health Professions programs should use appropriate evaluation measures showing the outcomes of these programs and how they benefit rural areas. Evaluation should also document the needs present in rural areas that these programs are meant to serve.

The Health Professions Education Partnerships Act of 1998 consolidated the Title VII and VIII programs into seven categories:

- Minority and Disadvantaged Health Professions
- Primary Care Medicine and Dentistry
- Interdisciplinary, Community-Based Linkages
- Health Professions Workforce Information and Analysis
- Public Health Workforce Development
- Nursing Education
- Student Financial Assistance

The NRHA has specific recommendations for the following individual categories within Title VII administered by the Bureau of Health Professions:

### **Minority and Disadvantaged Health Professions**

As part of the reauthorization of Title VII, there should be increased recognition of the growth of minority populations in rural and frontier communities. Grant awards under the Minority and Disadvantaged Health Professions programs should support activities in rural as well as urban communities. The NRHA recommends that adequate funding be provided for Minority and Disadvantaged Health Professions programs.

The Faculty Loan Repayment and Faculty Fellowship program is designed to assist health professions and nursing schools in increasing the number of underrepresented minority individuals in faculty positions. Grant funds are made available on a matching basis for the school to identify, recruit, and select underrepresented minority individuals who demonstrate potential in teaching, administration, or research at a health professions school.

- The NRHA supports the Association of Minority Health Professions Schools' recommendation of language that would expand eligible entities to include non-profit organizations representing minority health professions institutions.

### **Primary Care Medicine and Dentistry**

The NRHA supports the six recommendations of the HRSA Advisory Committee on Training in Primary Care and Dentistry, as follows:

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- Expand Federal support for Title VII, Section 747 programs, retaining its basic structure.
- Maintain a very high priority on educating future primary care providers to deliver effective, high-quality health care for underserved populations.
- Strengthen emphasis on training primary care providers to deliver culturally competent care to an increasingly multicultural population.
- Continue authority for targeted demonstrations projects to assure efficient and timely transfer of research findings and major healthcare initiatives, such as genomics, emerging infections and strategies to combat bioterrorism to the public at large through primary care.
- Emphasize interdisciplinary approaches throughout program policies and design.
- Improve the quality of care, eliminate health disparities, and improve patient safety as a high priority in the education of primary care providers.

The NRHA supports the following recommendations of the American Academy of Family Physicians, Society of Teachers of Family Medicine, Association of Family Practice Residency Directors, Association of Departments of Family Medicine, and the North American Primary Care Research Group. We support the continuation of the current preferences in statute, as well as the following new preferences. The addition of these changes will increase the production of more physicians and other professionals that serve rural and other underserved populations.

- *Addition of a rural preference* - A rural preference should be added for programs and/or academic units that have a track record for 1) recruitment of individuals from rural communities, 2) that provide services to rural communities, or, 3) produce graduates that serve in rural communities.
- *Expansion of the underserved preference* - We support the following addition to the definition of the underserved designation: programs in state designated shortage areas and/or have practices or facilities in which not less than 50 percent of the patients are either recipients of aid under Medicaid, and/or eligible for such aid, and/or are uninsured.
- *Expansion of the current Collaboration Priority eligibility* - We support expanding the current Collaboration Priority eligibility so that more partners are eligible to work together. Given that family medicine collaborates with many disciplines, some of which are not included in the cluster, priority points should be awarded for grant applications that include other disciplines. Eligibility should not be limited to training programs but should also include community partners. Some examples of partners include, but should not be limited to: mental health, obstetrics-gynecology, advanced practice nursing, pharmacy, social work, geriatrics, preventive medicine, and public health.
- *Addition of a geriatric preference* - We support a preference for training programs in medicine and dentistry that include a focus on geriatrics to substantially benefit rural or medically underserved populations and to meet the public health need of state or local health departments. The older population is increasing especially in rural areas and those age 85 and older. Members of this age group are frequent users of health services. Estimates reveal that about 8.2 million health care providers and 17,000 faculty will need training in geriatrics in the near future to meet the demands of serving the increasing older population.

### **Interdisciplinary Community-based Linkages**

The NRHA supports the following recommendations of the National Advisory Committee on Interdisciplinary, Community-Based Linkages:

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- Legislative language should encourage collaborations between institutions that train minority and immigrant populations and these grant programs.
- Legislative language should encourage the design and implementation of funded activities that directly relate to the unique health needs of a region or local area. Grant-funded strategies should be designed within the context of community-based input from the populations who will be served by those who are trained in these programs. The Advisory Committee recommends establishing administrative policies that promote use of community advisory groups as well as training protocols that are uniquely defined for the local service area or population.
- Congress should establish “Interdisciplinary Education Demonstration Projects” to encourage cooperative, community-based ventures between two or more of the following grant programs: Area Health Education Centers (AHECs), Health Education and Training Centers (HETCs), Education and Training Related to Geriatrics, Quentin N. Burdick Program for Rural Interdisciplinary Training and the Allied Health and Other Disciplines program. This new program should require that applicants focus on the Health People 2010 initiatives and the Secretary’s health care initiatives. New appropriations would be necessary to implement this program.
- Federal Agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Food and Drug Administration, should establish formal, funding-based links with HRSA to enable interdisciplinary, community-based programs such as AHECs, HETCs, and Geriatric Education Centers (GECs) to serve as vehicles for translating research into practice. Such new grant programs funded by the research agencies should focus on training remotely located primary health care providers and practitioners who serve disadvantaged populations, such as the poor, minorities and the elderly. The Advisory Committee recommends that one percent of these research agencies’ annual appropriations be designated for the interdisciplinary, community-based programs to disseminate critical research findings to community health care providers and providers-in-training.
- Federal agencies that seek to promote more “population inclusive” research should be instructed to formally establish funding relationships with grant programs such as AHECs, HETCs and GECs. The interdisciplinary, community-based programs can assist Federal research agencies in their objectives to encourage greater participation by minorities and other populations that are often underrepresented in health-related research protocols.
- The HETC program, as one that typically has limited access to non-federal resources due to the nature of its target population and the economic conditions of the region, should not have a “self-sufficiency” requirement. A legislative desire rather than a requirement for self-sufficiency and cost sharing should be expressed for the HETC grant program.

The NRHA, with the endorsement of the National Association for Geriatric Education (NAGE) and the National Association of Geriatric Education Centers (NAGEC), and in recognition of the need for all health care practitioners to be skilled in care of the elderly make the following additional recommendations regarding geriatric education:

- The Geriatric Education Centers program should include training of culturally diverse paraprofessionals, i.e., certified nurse aides, and certified home health aides and caregivers who are key providers of care in the long-term care setting.
- The Geriatric Academic Career Awards program should include doctoral level geriatric nurse educators.

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- The Geriatric Fellowship Program (Training for Physicians, Dentists, and Mental Health Professionals) should allow applicants the option of choosing Physicians (required) and one or both of the other professions, i.e., Dentistry and/or Mental Health. In this way, there is more leeway for applicants who have access to only one or the other.

The NRHA supports the following additional recommendations of the National AHEC Organization (NAO) regarding Area Health Education Centers (AHEC) and Health Education and Training Centers (HETC), both of which have a long history of successful collaboration in and with rural communities:

- Include National Health Service Corps sites in the list of locations in Section 751(a)(1)(A)(iv) with which AHECs are to have agreements for training of individuals through field placements, preceptorships, and/or primary care residencies.
- Expand the statement of requirements for an AHEC program in Section 751(a)(1)(A) to include “support health professionals, including nursing, allied health, oral health, and mental health practicing in the area through educational and other services”.
- Expand the statement of requirements for an AHEC program in section 751(a)(1)(A) to include “conduct training and education programs in cultural competency for health professionals”.
- Amend section 751(a)(1)(A)(vi) and (B) to stipulate that, when an AHEC grantee is a school of nursing, the requirement that at least 10% of the clinical education required of students at the grantee institution occur at sites remote from the primary teaching facility of the school applies to nursing students rather than medical students.
- Amend the matching funds requirements in section 751(a)(2)(B) and 751(c)(2) to allow unreimbursed indirect costs to apply to the match requirement.
- Provide AHEC and HETC grantees with expanded budget authority in regard to the carryover of unobligated balances as has been provided to other Title VII grantees.
- Expand the allowable project period for Model State-Supported AHEC awards from three to five years.

The recommendations presented in this paper, if accepted by the Congress in reauthorizing the Health Professions programs, would strengthen the programs and allow them to be more effective in achieving their stated goals. The National Rural Health Association urges the Congress to reauthorize these programs without delay, and to increase the level of appropriations authorized for these programs. The NRHA also encourages the Congress to adopt the recommendations outlined here for the purpose of improving these programs and the role they serve in increasing access to health care for rural and frontier Americans.

*Questions in regard to this policy brief should be directed to the NRHA Government Affairs Office at 703/519-7910*

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