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Chairman Tester, Ranking Member Portman, and Members of the Subcommittee, thank you for the opportunity to testify today on the rural health workforce. I am Tom Morris, Associate Administrator of the Federal Office of Rural Health Policy (ORHP), which is located in the Health Resources and Services Administration (HRSA), but has a Department of Health and Human Services-wide charge to coordinate and advise the Secretary on health challenges facing the 50 million people living in rural America. HRSA appreciates your interest in our work, and welcomes the opportunity to discuss rural health workforce issues.

HRSA Overview

HRSA's mission is to improve health and achieve health equity through access to quality services and a skilled health care workforce. There are approximately 80 different programs authorized in statute and operated by HRSA.

I am pleased to have the opportunity to talk with you today about the Office of Rural Health Policy and some of the activities associated with our goal of strengthening the rural health workforce and enhancing access to care.

The Federal Office of Rural Health Policy

Established in 1987, the Office of Rural Health Policy (ORHP) serves as a focal point for rural health activities within the Department. The Office is specifically charged with serving as a policy and research resource on rural health issues, as well as administering grant programs that focus on supporting and enhancing health care delivery in rural communities. ORHP advises the Secretary, and other components of the Department, on rural health issues with a particular focus on working with rural hospitals and other rural health care providers to ensure access to high quality care in rural communities.

The Department has maintained a significant focus on rural activities for more than 21 years. There are nearly 50 million people living in rural America. Historically, rural communities have struggled with issues related to access to care, recruitment and retention of health care providers and maintaining the economic viability of hospitals and other health care providers in isolated rural communities. My testimony today will review the steps HRSA is taking to address these issues.

Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts. Care in rural communities often focuses on primary care and chronic disease management delivered through rural health safety net providers such as critical access hospitals, Federally-Qualified Health Centers, and rural health clinics. The Administration has charged the Office of Rural Health Policy with implementing the Improving Rural Health Care Initiative. This Initiative focuses on four key areas:

- Moving toward a more evidence-based approach in rural programs;
- Improving recruitment and retention of workforce in rural communities;
- Linking HRSA's telehealth programs to ongoing work with rural communities; and

- Collaborating with other partners in HRSA, HHS and across the Federal Government

Within ORHP, there are targeted programs and activities that we carry out in addressing these key areas. We review and provide technical assistance on the Medicare, Medicaid and other key HHS regulations to assess the impact on rural communities. We also staff the National Advisory Committee on Rural Health and Human Services, which advises the Secretary on rural issues. In addition, we support the Rural Assistance Center, a national clearinghouse for information on rural issues. The Office also supports the Rural Health Research Center grant program to both inform its policy role and to support rural-focused health services research. This includes a significant focus on rural Medicare issues, health care workforce issues affecting rural communities as well as research on quality, health information technology and access to care in rural communities.

The Office additionally funds a number of grant programs that focus on capacity building in rural communities. The State Office of Rural Health grant program provides funding to each of the 50 States to support a focal point for rural activities and each State provides matching funds to support this activity. Other programs that ORHP administers are the Rural Hospital Flexibility Grant program and the Small Hospital Improvement Grant program to work with small rural hospitals and Critical Access Hospitals on quality and performance improvement. In addition, ORHP also has a rural health research center which focuses on mental health issues, given what a significant concern this is in rural areas.

Another program supported by ORHP is the Rural Health Care Outreach program, which provides start-up funding for pilot grants in rural communities. This includes the Rural Health Outreach Services, Rural Network Development, Small Health Care Provider Quality Improvement and Delta States Network grant programs. These community-based programs have a new emphasis on metrics and outcomes while building on successful models. ORHP is committed to building an evidence base for rural health care quality.

Rural Health Workforce

Understanding the particular challenges facing rural America, HRSA actively looks at innovative and evidence-based approaches to improving the rural health care workforce through various programs, including:

Rural Training Track (RTT) Technical Assistance Cooperative Agreement: This unique program focuses on a novel resident training model in which the resident does one year in an academic health center, or larger urban facility, and then spends the rest of the residency working in a rural hospital or clinic. Our research shows that approximately 70 percent of the residents who train in these programs continue to practice in rural communities. Through this grant, we provide support to the existing 23 RTTs nationally, while also working to increase medical student interest in this model and help new RTT programs get established. Last year, RTTs had a match rate for their residents of 80 percent (39 students matched to the 49 open positions), an all-time high. Also, four new programs will be opening this July with an additional three more programs scheduled to open in July 2014, pending accreditation.

Rural Health Workforce Network Grant Program: HRSA supports 1,743 students and residents through this pilot program, which focuses on supporting the development of rural health networks' capacity to recruit and retain primary and allied health care providers. We will track this cohort of students to determine how many continue to practice in rural areas.

National Health Service Corps, Nurse Corps, and State Loan Repayment Program: Since 2009, with investments from the Recovery Act and the Affordable Care Act, HRSA has nearly tripled the size of the National Health Service to nearly 10,000 Corps clinicians. Currently, 45 percent of the Corps clinicians are providing care in rural communities. That includes some 900 physicians, 700 nurse practitioners, 600 physician assistants, 500 dental professionals, and 1,200 mental and behavioral health professionals. In addition, HRSA's primary care and nursing training programs play a critical role in supporting the pipeline of future clinicians for rural and underserved communities. Among rural NHSC providers, studies have repeatedly found that half, or more, continue to live and work in non-metropolitan counties several years after they leave the Corps. In fact, a study funded by HRSA and released this past summer found that NHSC clinicians tend to serve for an average of more than 8 years in the same clinical facilities.

Teaching Health Center Graduate Medical Education Program: The Affordable Care Act established the Teaching Health Center Graduate Medical Education payment program, providing $230 million in fiscal years 2011-2015. This program funds primary care and dental residency programs with a focus on community-based training. This includes a number of rural sites; in fact, 15 of the 22 funded Teaching Health Centers are serving rural communities.

Visas and Rural Physicians: Rural communities also benefit from a number of programs that provide J1-Visa Waivers to foreign-trained physicians in exchange for agreeing to practice in rural areas that need them most. Last year, HHS supported 33 J1-Visa waiver clinicians. In addition, through the State Conrad 30 program, States can recommend up to 30 J1-Visa waivers for clinicians willing to practice in underserved rural areas. The Appalachian Regional Commission and the Delta Regional Authority, which serve predominantly rural areas, also can support J1-Visa waivers. HRSA regularly engages with these entities to develop a strong framework for building alliances and promoting health community models in diverse regions such as rural communities.

National Rural Recruitment and Retention Network (3RNet): HRSA supports the 3RNET, which is a national network of health care recruiters that connects practitioners, who want to practice in rural areas, with rural areas in need of clinicians. In 2012, this organization placed 1,767 clinicians in rural communities. Many of the States participating in 3RNet play a key role in working with communities to identify which program best meets a community's particular needs. They link the clinician seeking to practice in a rural area with the appropriate program to support them, whether it is the NHSC loan repayment program, a State loan program or one of the J1-Visa Waiver options.

Telehealth: For 20 years, HRSA has been investing in telehealth programs. Telehealth improves access to a broad range of care in rural communities by providing video links to specialty care not always available in a rural community. With HRSA support, the Institute of Medicine recently convened a group

of experts to examine the role of telehealth in a changing health care environment. The report from that meeting noted that new and emerging applications of telehealth, such as home monitoring and E-emergency and E-intensive care services, are providing critical support to rural clinicians and the patients they serve. The report also notes that the cost of this technology has considerably decreased in recent years. As a result of this, HRSA has developed a national network of Telehealth Resource Centers to work with providers. These Centers will help them leverage this technology, not only to increase access to care, but also to support existing rural clinicians and improve health care outcomes. Telehealth has been a particularly important vehicle for delivering mental health services to isolated communities.

Mental Health: Access to mental health services can be a particular challenge for veterans in rural areas. In this regard, HRSA is currently supporting a pilot program examining how to use telehealth, and health information exchange, to enhance the coordination of care for veterans in rural areas. Additionally, ORHP is funding projects in Montana, Alaska and Virginia and has a memorandum of agreement in place between HHS and the U.S. Department of Veterans Affairs (VA) to promote the use of technology to enhance care for veterans.

HRSA recognizes that primary care settings have become a gateway for many individuals with both behavioral health and primary care needs. To address these needs, more and more health centers are integrating behavioral health care services into their primary care model. HRSA has expanded access to mental health services in community health centers. In 2012, 70 percent of rural community health centers across the nation offered behavioral health services to their patients in additional to serving as a key access point for primary care.

HRSA's work on this front extends to the National Health Service Corps as well. Designed to extend the reach of National Health Service Corps providers while minimizing patients' travel distances to seek care, the Corps began allowing providers practicing in eligible sites to offer telehealth services to patients at distant sites. This initiative has been particularly significant in increasing access to mental and behavioral health services in rural areas. Nearly one in three clinicians in the Corps (2,919 as of September 2012) is a behavioral health practitioner, including psychiatrists, clinical psychologists, clinical social workers, licensed professional counselors, marriage and family therapists, and psychiatric nurse specialists.

HRSA is committed to cross-agency collaboration and partnerships to help address mental health needs in rural areas. One such example is the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). This initiative promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether treated in specialty behavioral health or primary care provider settings. As part of the CIHS initiative, as well as in the telehealth programs and other initiatives described above, HRSA recognizes and emphasizes the importance of protecting the privacy and security of health information, including substance abuse and mental health information.

White House Rural Council

Rural communities have also benefited from the collaborative work of the White House Rural Council, which was created by the President through an Executive Order in July 2011. The Council, which includes representation from all of the Cabinet-level agencies, is focused on enhancing the ability of Federal programs to serve rural communities through collaboration and coordination across Federal agencies. The Council has focused on enhancing rural economic development and job creation. Health workforce is a key driver of rural economies, where a small rural hospital is often one of the primary employers in the community. Through the work of the Council, HRSA has expanded eligibility for the NHSC Loan Program to Critical Access Hospitals (CAHs) in 2012. This provides another important tool for the 1,331 CAHs across the country. As a result of this change, 173 CAHs are now designated as service sites for the NHSC and 18 clinicians working in CAHs are now receiving loan repayment support.

The Council has also focused on expanding the health information technology (health IT) workforce. The Department of Labor's Bureau of Labor Statistics projects that the number of jobs for Medical Records and Health Information Technicians will grow 21 percent between 2010 and 2020. HHS is working with the Department of Education and the Department of Labor to promote the development of new health IT programs in rural community colleges. Later this year, we intend to support the awarding of up to 10 Rural Health IT Workforce Network Training Grants. These grants will develop a health IT training curriculum and then develop an associate degree program for HIT professionals in rural areas. HRSA will then make those curriculum materials available through the Department of Labor and the Department of Education so other rural community colleges can leverage this investment and start their own programs.

HRSA is proud of our programs and the work in which we are involved to increase access to health care for Americans living in rural areas. Our programs are making a difference in the quality and quantity of healthcare provided.

I appreciate the opportunity to testify today, and I hope this testimony will inform the Subcommittee's future deliberations on the important issue before you. I would be pleased to answer any questions you may have.