THE WRIGHT CENTER for COMMUNITY HEALTH | THE WRIGHT CENTER for GRADUATE MEDICAL EDUCATION

February 29, 2024

Dear Members of the Commonwealth of Pennsylvania's House Health and Professional Licensure Committees:

On behalf of The Wright Centers for Community Health and Graduate Medical Education, thank you for your service and leadership in expanding equitable access to quality, “whole person” healthcare services. The Wright Center for Community Health is proud to be a Pennsylvania Opioid Use Disorder Center of Excellence (COE) and Coordinating Center for Medication Assisted Therapy, a HRSA designated Federally Qualified Health Center Look-Alike and Ryan White HIV/AIDS provider, a recognized National Committee on Quality Assurance (NCQA) Patient Centered Medical Home, with distinction in Behavioral Health Services Integration and historical School Based Medical Home Recognition. The Wright Center serves over 40,000 patients, operating ten primary care Teaching Health Centers throughout Northeastern Pennsylvania, inclusive of public school settings and a mobile medical and dental unit. The Wright Center for Community Health serves as the cornerstone ambulatory “whole person” health services delivery clinical learning platform for our Teaching Health Center Graduate Medical Education Safety-Net Consortium (GME-SNC), operated by our affiliated entity, The Wright Center for Graduate Medical Education. Together with GME-SNC partners, The Wright Center trains nearly 250 primary care residents and specialty fellows in a community-based, public health needs-responsive, interprofessional workforce development model to advance our shared mission to improve the health and welfare of our communities through inclusive and responsive health services and the sustainable renewal of an inspired, competent workforce that is privileged to serve.

As a FQHC Look-Alike and a Patient Centered Medical Home, The Wright Center is deeply engaged in delivering comprehensive, high quality, equitable and affordable primary health services to seniors, many of whom experience isolation and complex social determinants of health (SDOHs). With the lens of serving vulnerable geriatric patients, The Wright Center is pleased to offer recommendations aimed at enhancing the Commonwealth’s geriatric workforce and elevating the pivotal roles of teaching health centers and community health centers to expand essential primary health services access for this population. All of our initiatives to serve the geriatric population, notably a larger than state and national average size population in our service area, are intentionally designed to contribute to the Institute of Healthcare Improvement’s noble vision of a preferred future “Age Friendly Health System” and Governor Josh Shapiro’s Master Plan for Older Adults.

Background on The Wright Center's Services for Older Adults

In response to the community health needs of older adults in Northeastern Pennsylvania, The Wright Center secured HRSA Teaching Health Center Graduate Medical Education funding to develop an ACGME accredited Geriatrics Fellowship training program. Additionally, we joined the Institute for Healthcare Improvement's network to build an "Age Friendly Health System," and successfully integrated age friendly principles across The Wright Center for Community Health's care delivery processes and The Wright Center for Graduate Medical Education's Sponsoring Institutional curriculum. This has and continues to significantly enrich the overall geriatrics knowledge and skill sets across our provider care teams and primary care faculty and residents. We are proud to employ five board-certified Geriatricians that has enabled our capacity to expand our house calls and nursing home service lines.

Furthermore, several years ago, The Wright Center engaged as the eighth institution in UCLA's John Hartford Foundation supported UCLA Alzheimer's Dementia Unit Network. This service line provides consultation with a geriatrician led care team offering augmented care and case management infrastructure responsive to addressing complex health and SEDH needs and supporting caregivers. The Wright Center also partners closely with the Area Agency on Aging (AAA), and is a key partner supporting the operations and legacy of a federally funded Senior Day and HRSA funded Senior Companion Program at Telespond and the the soon-to-be launching the Telespond based, state supported Elderly Abuse Haven championed by Secretary Jason Kavulich.

Enhancing the Commonwealth of Pennsylvania's Geriatric Workforce

The importance of developing an Age-Friendly Health System and qualified, compassionate Geriatricians and interprofessional care teams has never been so urgent: Pennsylvania still ranks 9th out of the 50 states for the percentage of the state population 65 and older, and by 2034, older adults will outnumber children (according to Census Bureau projections). Further, Lackawanna and Luzerne counties have a significantly higher number of persons 65 years and older compared to state and national averages. The continued development of Geriatric competencies supports the shift into age-friendly health services by helping primary care doctors and care teams align with what impacts and matters most to older adults. Despite the expected national shortage of nearly 30,000 full-time geriatricians by 2025, there are national recruitment challenges in geriatrics: the position fill rate for Geriatric Medicine declined to 41.5 percent in 2023, down from 43.1 percent in 2022. The position fill rate has ranged between 43.1 – 52 percent since the 2019 Match. In 2023, geriatrics offered 419 certified positions (both Internal Medicine and Family Medicine-based programs) and only 174 positions filled.

Despite recognition of such undeniable historical systemic deficiencies and limited notable progress in planning a preferred future for caring for elderly Pennsylvanians, significant, illogical

barriers persist precluding expansion of our federally funded Geriatric Fellowship. Traditionally, geriatric fellowships often remain unfilled due to healthcare industry standards that fail to attract today's workforce. These barriers are related to the industry drivers of volume of visits and services delivered which absolutely undermines age friendly health system operations requiring intentional, value-driven time investments of provider care teams. Recognizing this formidable national debacle, The Wright Center discovered and utilized an American Council for Graduate Medical Education (ACGME) exception that offers the innovative solution of recruitment of exceptionally qualified applicants to complete a Geriatrics fellowship before they complete a primary care residency in internal medicine or family medicine. This allowed us to launch the Geriatrics fellowship and to more effectively recruit Geriatric fellows to expand the geriatrics workforce for older adults. However, the ACGME continues to stress that this is an exception and not the standard without proposed alternative solutions to produce the workforce America needs. Hence, updated systematic language has not yet been assimilated in stakeholder organizations to support this innovative recruitment initiative. This creates language and logistical confusion regarding the post-graduate year (PGY) of physicians recruited for training as most “fellows” are advanced learners, at a minimum a PGY4.

This ultimately led to a paralyzing disconnect with the Pennsylvania Board of Medicine (BOM), as the BOM firmly believes that early career physicians completing a fellowship prior to residency are post-graduate year four (PGY4), rather than a PGY1. This is illogical semantics and extremely unfortunate. The post-graduate training year distinction is crucial because progression to fellowship by traditional means of first completing a residency requires successful completion of USMLE step 3. The BOM’s refusal to acknowledge and responsibly adjust the semantic implications related to post-graduate year training of the ACGME endorsed recruitment exception of exceptionally qualified candidates for a Geriatrics fellowship paralyzes the pre-residency fellowship innovative solution to address the geriatrics workforce needs of Pennsylvanias and our nation.

As a result, in academic year 2022, the three fellows joyfully and successfully recruited for our Geriatrics fellowship program were traumatically unable to even start the pre-residency geriatric fellowship for this reason, despite tireless, unproductive advocacy and discussions with the ACGME and the BOM which should have been energized by the shared public trust purpose of responsibly and responsively generating the primary care and public health workforce Pennsylvanians’ need. The Wright Center had to accept this traumatic, nonsensical reality and work quickly to identify funding sources to transition the fellows into a primary care residency program to protect the fellows from deportation. This anecdote represents one of the many ways that policymakers and providers should better work together to identify and remove outstanding barriers to building an “Age Friendly Health System” that better honors and cares for older Pennsylvanians. Together, we can navigate through historical boundaries and semantic barriers, inspired and aligned with Governor Shapiro’s Master Plan for Older Adults, to demonstrate a

national Geriatrics workforce solution to be emulated and replicated across the country. We can collaboratively prompt and inspire necessary conversations with the ACGME regarding the post-graduate year semantics implications of their innovative exception which is potentially an awesome solution awaiting fruition to meet the Geriatrics workforce needs of the American people.

Elevating the Role of Teaching Health Centers

The pervasive clinical workforce gaps will require a reformative approach to address systemic challenges in the healthcare system driven by the highly competitive, siloed nature of the healthcare system. Notably, a robust primary care infrastructure is the cornerstone of a strong healthcare system, yet primary care has long been overlooked in the US and there is an imbalance between specialty and primary care. A key lever for the General Assembly to address maldistribution challenges, particularly as it relates to physician maldistribution, is bolstering and investing in the teaching health center graduate medical education program.

A simple look at the level of CMS funded positions for hospital-based graduate medical education, which happens to largely take place in large, academic, integrated delivery systems in urban or suburban areas, in comparison to the level of HRSA funded positions for teaching health center positions, provides a clear image of the ongoing contributors to maldistribution. Since the funding is going primarily to these settings, large, academic, integrated delivery systems become some of the most competitive employers and therefore attractive residency sites for physician learners. Policymakers must shift perspectives to recognizing graduate medical education funding as a public resource that must be invested in communities of greatest need or health professional shortage areas (HPSAs). This can be actualized by the General Assembly following suit of other states and investing in its network of teaching health center graduate medical education programs.

Teaching Health Centers and Graduate Medical Education Safety Net Consortiums (GME-SNC) are replicable, scalable solutions to our Commonwealth's primary care workforce shortages, maldistribution, and related health, healthcare, and healthcare career disparities. The GME-SNC model counterbalances historical hospital-centric dominance of public GME investments and alleviates the discordance between where most care is delivered and where healthcare workforce is trained. GME-SNCs should be supported by accrediting and state licensing agencies and the house of medicine because of their undeniable public health value and community benefit impact. State Medicaid investments in GME should be preferentially directed to such community based solutions that uphold public trust. This can force multiply the impact of HRSA's pioneering Teaching Health Center Graduate Medical Education program. GME-SNC's inclusive, hopeful spirit and innate cultural energy of "We Can Do More Together" are powerful antidotes for several ailments of U.S. healthcare and medical education systems rooted in unnecessary, traumatic divisiveness.

Elevating the Role of Community Health Centers

As we work to grow a competent healthcare workforce, it's also equally important that we invest in our existing community health infrastructure. The Commonwealth is home to 54 FQHCs and FQHC Look-Alikes, covering 395 locations across 54 of Pennsylvania's counties. Forty-eight percent of FQHC and FQHC Look-Alikes locations are in rural communities. These critical essential community providers serve almost 1,000,000 patients annually, or 1 in 13 Pennsylvanians. The patients served include:

- 88.35% of the patients are at or below 200% of the Federal poverty level.
- 13.06% of patients are uninsured. This number is expected to grow as Pennsylvania and the country undergo the Medicaid Unwinding.
- 48.57% of patients are on Medicaid or CHIP.
- 2.86% of patients are homeless.[1]

Community Health Centers ensure patients can access and afford quality care through sliding fee discounts with income eligibility based on federal poverty standards. They offer enrollment assistance for health insurance coverage, provide care for all individuals regardless of ability to pay or demographic factors, and serve as patient centered medical homes, offering longitudinal, comprehensive primary, dental, mental, behavioral and addiction health services throughout patients' lives. Despite the sweeping benefits of Community Health Centers, the Commonwealth does not provide base funding to support their mission, services, or growth.

Investing in Community Health Centers is a strategic cost saving intervention for the Commonwealth, as Pennsylvania health centers save the health care system $1.59 billion per year.[2] It is crucial that Federally Qualified Health Center Look-Alikes be included in such state investments to ensure they are futuristic and unifying rather than divisive amongst the community ehealth center network. Health Centers across Pennsylvania are continually faced with narrowing margins and increased costs throughout their organizations. In addition to covering the cost of caring for the uninsured and to make up for inadequate Medicaid reimbursement, Community Health Centers are facing additional unfunded costs for a myriad of services that are needed to care for all their patients truly and comprehensively. At the same time, attacks on the 340B program, which enables covered entities, such as FQHCs and FQHC Look-Alikes, to stretch scarce federal resources as far as possible, inflation, and increasing workforce challenges are directly impacting the ability to provide care.

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[1] Combined Pennsylvania Health Center Program Awardee Uniform Data System (UDS) Data, Reporting Period: 2022 https://data.hrsa.gov/tools/data-reporting/program-data/state/PA and Pennsylvania Health Center Program LookAlike Uniform Data System (UDS) Data, Reporting Period: 2022 https://data.hrsa.gov/tools/data-reporting/programdata?type=LOOK-ALIKE&state=PA

[2] Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs, September 1, 2009, https://www.rchnfoundation.org/wp-content/uploads/2013/01/Bending-the-Curve-9-1-09--nal.pdf

There are also additional costs associated with telehealth services. FQHCs and FQHC Look Alikes quickly embraced telehealth services at the beginning of the pandemic. The use of telehealth is now a critical part of the care being delivered in both rural and urban communities. Nowhere is telehealth more important than in the delivery of behavioral health, addiction and recovery services.

Throughout the pandemic and moving forward, Pennsylvania's Community Health Centers have taken care of Pennsylvania's most vulnerable populations and have filled in the gaps to serve as the state's public safety net for much of this population across both rural and urban settings. The Wright Center would urge the esteemed members of the House Health and Professional Licensure Committees to consider a line item of $25 million in the Pennsylvania State Budget (FY 2024-25), to assist Community Health Centers, both FQHCs and FQHC Look-Alikes, in covering the cost for providing care to uninsured Pennsylvanians and to assist in covering many of the additional unfunded costs, such as Community Health Workers, transportation, translation services, care coordination, and technology costs.

Through bolstering the Commonwealth's geriatric workforce, teaching health centers and community health centers, we can increase healthcare access, advance health equity, and deconstruct disparities and divisive systematic dysfunctions that traumatize our healthcare workforce while under-serving Pennsylvanians. It's truly time for unifying, intentional, logical change to accelerate a preferred future vision for Pennsylvania's healthcare and workforce development systems. With our current Governor, Administration, and Legislature, we can lead the nation in public health solutions if we get our act together. If you have any questions about the information or recommendations outlined above, please feel free to reach out to me at thomasl@thewrightcenter.org or to Laura Spadaro, Vice President of Primary Care and Public Health Policy at spadarol@thewrightcenter.org.

Sincerely,

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