ADDRESSING PRIMARY CARE ACCESS AND WORKFORCE CHALLENGES: VOICES FROM THE FIELD

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BEFORE THE
SUBCOMMITTEE ON PRIMARY HEALTH AND AGING
OF THE
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
UNITED STATES SENATE
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SECOND SESSION
ON
EXAMINING PRIMARY CARE ACCESS AND WORKFORCE CHALLENGES: VOICES FROM THE FIELD

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CONTENTS

STATEMENTS

WEDNESDAY, APRIL 9, 2014

COMMITTEE MEMBERS

Sanders, Hon. Bernard, Chairman of the Subcommittee on Primary Health and Aging, opening statement ......................................................... 1
Burr, Hon. Richard, a U.S. Senator from the State of North Carolina, opening statement .............................................................................................................. 3
Warren, Hon. Elizabeth, a U.S. Senator from the State of Massachusetts ........ 13
Murphy, Hon. Christopher, a U.S. Senator from the State of Connecticut ........ 14

WITNESS—PANEL I

Spitzgo, Rebecca, Associate Administrator Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services, Rockville, MD ............................................................ 5
Prepared statement .................................................................................. 7

WITNESSES—PAN EL II

Brock, Stan, Founder and President, Remote Area Medical, Rockford, TN ...... 17
Prepared statement .................................................................................. 18
Wiltz, Gary, M.D., Executive Director and Clinical Director, Teche Action Clinic, Franklin, LA ............................................................................................................ 19
Prepared statement .................................................................................. 21
Flinter, Margaret, APRN, Ph.D., c-FNP, FAAN, FAANP, Senior Vice President and Clinical Director, Community Health Center, Inc., Middleton, CT ............................................................................................................ 24
Prepared statement .................................................................................. 25
Dobson, L. Allen, Jr., M.D., President and CEO, Community Care of North Carolina, Raleigh, NC .......................................................................................... 29
Prepared statement .................................................................................. 30
Nichols, Joseph, M.D., MPH, Family Medicine Resident, MedStar Franklin Square Family Health Center, Baltimore, MD .................................................. 36
Prepared statement .................................................................................. 38
Kohn, Linda T., Ph.D., Director of Health Care, Government Accountability Office, Washington, DC ............................................................................................................ 43
Prepared statement .................................................................................. 45
Edberg, Deborah, M.D., Program Director, McGaw Northwestern Family Medicine Residency Program, Erie Family Health Center, Assistant Professor of Clinical Family and Community Medicine, Northwestern University Feinberg School of Medicine, Chicago, IL ....................................................................... 51
Prepared statement .................................................................................. 53
Hotz, James, M.D., Clinical Services Director, Albany Area Primary Care, Albany, GA .......................................................... 55
Prepared statement .................................................................................. 57

ADDITIONAL MATERIAL

Statements, articles, publications, letters, etc.:
Letter from Margaret Flinter, APRN, Ph.D., c-FNP, FAAN, FAANP in Response to question from Senator Warren .......................................................... 73
Response to questions of Senator Warren by: Joseph S. Nichols, M.D., MPH .................................................................................................................. 75
James Hotz, M.D. .................................................................................... 76
ADDRESSING PRIMARY CARE ACCESS AND WORKFORCE CHALLENGES: VOICES FROM THE FIELD

WEDNESDAY, APRIL 9, 2014

U.S. Senate,
Subcommittee on Primary Health and Aging,
Committee on Health, Education, Labor, and Pensions,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Bernard Sanders, chairman of the subcommittee, presiding.
Present: Senators Sanders, Burr, Murphy, and Warren.

OPENING STATEMENT OF SENATOR SANDERS

Senator Sanders. Thank you all very much for being here for what is, I think, going to be a very interesting and important hearing. It is a busy day here in the Senate, and I think you’re going to see members gravitating in and out, but we want to thank all of the panelists who are here with us.

The issue that we’re dealing with today is of profound importance and, I think, addresses some of the significant problems facing our dysfunctional healthcare system. The first issue that I would raise and that I hope we’ll get some good discussion on today is how it happens that the United States of America ends up spending almost twice as much per person on healthcare and yet our end results, our healthcare outcomes are not particularly good compared to many other countries around the world.

I think one of the reasons for that, that virtually every study that I have seen tells us, is that we are much, much weaker in terms of primary healthcare, and we put much less resources into primary healthcare, comparatively speaking, than do most other nations. Today, in fact, 60 million people in the United States, nearly one in five, live in areas where there is a shortage of primary care providers.

In fact, while the problem we’re discussing is clearly a national problem, it is even more so a rural problem, in that there are many, many rural communities in this country where it is very hard for people, especially people who do not have a lot of money, to find a doctor or to find a dentist. In fact, we are going to be hearing later this morning from Stan Brock, who founded a wonderful organization called Remote Area Medical, RAM, that sets up free medical clinics at fairgrounds and stadiums in underserved
areas to provide healthcare and dental care to people who cannot otherwise find a doctor or a dentist.

A couple of weeks ago, at our most recent subcommittee hearing, we saw some of the photographs where in the United States of America, people are waiting hours, and sometimes they sleep overnight in their cars in order to gain access to free healthcare or dental care. I hope that we can all agree that in this Nation, presumably the wealthiest nation on earth, this should not be happening.

But the issue is not only one of healthcare and what happens to people when they get sick who cannot access a doctor or a healthcare provider—what happens to those people? And the answer is pretty obvious. They get sicker and sicker, and then they end up either in the emergency room or in a hospital at far more cost to the system than otherwise would have been the case if they could have accessed healthcare when, in fact, they needed it.

One of the great ironies of the moment is that while there are some people who think we save money by cutting back on public health programs, whether it’s Medicare, Medicaid, or whatever it may be, the truth of the matter is we end up spending more money by not providing access to healthcare and dental care when people actually need it. So it’s a question of easing suffering, human suffering; it’s a question of preventing death; it’s a question of preventing serious illness; and it is a question of saving money.

To compound the problem that we have right now, by 2025, we will need over 50,000 new primary care physicians in our country and thousands of other providers, including dentists, nurse practitioners, and physician assistants, to ensure access to the cost-effective primary care services people need. And that comes from the Annals of Family Medicine.

How do we educate those practitioners? How do we get them to the places that we need? It’s not just the question of needing more doctors. Frankly, we don’t need more doctors on Park Avenue in New York. We do need more doctors in rural underserved areas in the country. How do we educate those people? How do we get them to the areas where we need them?

Here’s a startling fact that I hope we will have serious discussion about. In 2011, about 17,000 doctors graduated from American medical schools. Despite the fact that over half of patient visits are for primary care—half of patient visits are for primary care—only 7 percent—7 percent—of the Nation’s medical school graduates now choose a primary care career—7 percent. Why is that? How do we turn that around? And to compound that issue, the average primary care physician in the United States is 47 years of age today, and one-quarter are near retirement. So why that is going on and how we transform it is an issue I hope we will discuss today.

I think some of the answers are fairly obvious. First, we need to change the culture in our medical schools. Medical schools, in my view, especially given the fact that they receive substantial sums of Federal money, should be training and graduating doctors to serve in areas where they are most needed. That should be a major focus. Frankly, many medical schools are doing a good job, but many others are doing a very, very poor job in making sure that we get those health care providers to the areas where we need them.
Second, we are almost unique in the world in saying to young people,

“If you want to go to medical school, fine. If you’re smart enough, you can go to medical school. But guess what? On average, you’re going to graduate $160,000 in debt, and a third of you are going to graduate with more than $200,000 in debt.”

That’s the system we now have.

Well, guess what? If you are a young person graduating with $200,000 of debt, and you want to have a family, you are probably not going to go to rural Vermont or rural North Carolina to practice—probably not. You’re going to probably figure out where you can make the most money possible in order to pay back that debt, and that becomes a huge disincentive in terms of getting doctors to the places where we need them.

In the midst of all of those serious problems, here’s some good news, and I look forward to hearing Rebecca Spitzgo talk about this. In recent years, we have made significant progress in increasing funding in a variety of ways to those entities who are doing a really, really good job in addressing some of the problems that we’re talking about.

I am very proud that in the Affordable Care Act and in the stimulus package—and I worked particularly hard in those areas—we have doubled funding for federally qualified health centers, and we’re going to hear about what they are doing all over America. More and more people are now able to access them. The President’s new budget is, I think, a good budget in helping us to expand that. Let’s talk about that.

But what Ms. Spitzgo is going to talk about in a moment is also one of the important ways that we improve primary healthcare in America, addressing the problem of students graduating with deep debt, and that is the National Health Service Corps. And I look forward to hearing Ms. Spitzgo talk about some of the successes that we’ve had and where we should be going in the future.

Another issue that I hope we will talk about today is that we need to change the salaries and reimbursement rates, in my humble opinion. Primary healthcare is as important as any other area of medicine, and we have got to reward those people who go into primary healthcare. That means changing reimbursement rates.

Fourth, we have got to address the fact that Medicare has promoted the growth of residencies in specialty fields rather than primary healthcare by providing over $10 billion each year to teaching hospitals without requiring any emphasis on training primary care physicians.

Those are some of the issues that I hope we will be addressing today. And, again, I want to thank all of our panelists and Ms. Spitzgo for being here. Now, I’ll give the mic to Senator Burr.

Statement of Senator Burr

Senator Burr. Thank you, Mr. Chairman. Thank you for holding this hearing, which I believe is vitally important. And I appreciate the opportunity to continue our discussion regarding primary care and workforce challenges. I’d like to thank the witnesses for being here today, particularly Allen Dobson, who is a family physician in
North Carolina and president and CEO of Community Care of North Carolina, an entity that’s known far outside of North Carolina with a great track record thus far. With so many witnesses today, I suspect we’ll hear a wide range of perspectives from the primary care trenches. And I’m glad that Allen is here to help share our own experiences from North Carolina.

As we’ve discussed before, the issue of improving access to primary care services, particularly those in rural and underserved areas, is an important challenge we must address. At our primary care hearing last year, I noted the importance of identifying programs with a proven track record of success from which we can build upon, as well as the importance of taking a closer look at the programs to ensure accountability and appropriate stewardship of taxpayer dollars.

Therefore, I am particularly pleased to welcome Linda Kohn with the Government Accountability Office to hear an update on the recent work to look at healthcare workforce programs, including those which seek to address primary care access and workforce challenges.

GAO’s report last fall highlighted how four departments, Health and Human Services, Veterans Affairs, Defense, and Education, obligated $14.2 billion for healthcare vouchers for the healthcare workforce training programs for postsecondary training or education for direct care professionals in 2012. HHS funds the bulk of these programs, many of which HRSA administers. Yet by HRSA’s own projections, the demand for primary care physicians will grow more rapidly than the physician supply, resulting in a projected shortage of approximately 20,400 physicians in 2020, a mere 6 years from now.

HRSA’s analysis indicated that even with the increased use of nurse practitioners, of physician assistants, the primary care provider workforce is not prepared to meet the coming needs. As of January 1 of this year, HRSA had 6,000 designated primary care health professional shortage areas, 6,000. In other words, we aren’t meeting current demand, much less are we preparing for what’s coming at us.

As the Nation faces increasing primary care challenges, it’s essential that we take an honest assessment of the factors driving and exacerbating these challenges. Have we properly aligned incentives to encourage individuals to not only pursue primary care medicine but practice it and practice it in those areas with the greatest and hardest to reach needs? Are incentives driving volume or quality? What can we learn from patient-centric medical home models, such as Community Care of North Carolina?

As Congress explores ways in which we can better target and enhance existing programs to address the workforce challenges impacting our Nation’s patients, it is critical that we understand and examine the root causes and barriers patients face in accessing primary care as well as the best metrics for judging success. I look forward to hearing from our witnesses today about the specific metrics necessary to assess what is and is not working to address our Nation’s primary care needs.

It’s clear from the projections of current and increasing unmet needs that we cannot afford to continue on the current course. I
look forward to hearing suggestions from our witnesses today regarding how we can address primary care access and workforce challenges while ensuring accountability for programs on behalf of patients and on taxpayers.

Thank you, Mr. Chairman. I yield.

Senator SANDERS. Thank you very much, Senator Burr.

Senator Warren.

Senator WARREN. I'd like to just go straight to the witnesses. I don't need to do an opening statement. Thank you, Mr. Chairman.

Senator SANDERS. Senator Murphy.

Senator MURPHY. I'm good.

Senator SANDERS. You're all witnessing something very unusual.

[Laughter.]

Senator BURR. But, hopefully, a trend.

Senator SANDERS. Our first witness is Rebecca H. Spitzgo, Associate Administrator of HRSA's Bureau of Health Professions. She provides national leadership in the development, distribution, and retention of a diverse health workforce. From 2009 through 2013, Ms. Spitzgo was the Associate Administrator of HRSA's Bureau of Clinician Recruitment and Service, where she oversaw the operations of the National Health Service Corps.

Ms. Spitzgo, thanks very much for being with us.

STATEMENT OF REBECCA SPITZGO, ASSOCIATE ADMINISTRATOR, BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD

Ms. SPITZGO. Good morning, Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify on behalf of the Health Resources and Services Administration.

My name is Rebecca Spitzgo. I am the Associate Administrator for the Bureau of Health Professions in HRSA, which is an agency of the Department of Health and Human Services. HRSA’s mission is to improve health and achieve health equity through access to quality services and a skilled healthcare workforce. HRSA supports the training of nurses, physicians, dentists, and other clinicians and encourages providers to work in areas of the country where health resources are scarce.

Across this country in every State, the District of Columbia, and Puerto Rico, there is a student or a clinician whose future in primary care is being made possible by HRSA's workforce programs. HRSA’s grant, scholarship, and loan repayment programs support the healthcare workforce across the entire training continuum from academic training to programs that support clinicians currently providing care to individuals in underserved rural and urban communities.

In recent years, Congress and the administration have strengthened the primary care workforce by funding additional training and educational opportunities, by encouraging community-based residencies and teaching hospitals, by expanding training for a range of primary care providers, and by the historic growth of the National Health Service Corps. To date, the Affordable Care Act has supported the training of an additional 1,700 primary care pro-
viders, including physicians, advanced practice nurses, and physician assistants, as well as 200 behavioral health providers.

This academic year, the Teaching Health Center Graduate Medical Education Program is expanding residency training for more than 300 primary care residents and dentists in community-based settings in 21 States, including HRSA funded health centers. For the upcoming academic year, we expect nearly 600 FTEs will be supported by the Teaching Health Center GME Program. In exchange for scholarship and loan repayment, nearly 8,900 National Health Service Corps clinicians are providing care to millions of patients at more than 5,000 National Health Service Corps sites in urban, rural, and frontier areas.

The fiscal year 2015 President’s Budget includes a new workforce initiative that will help support the residency training of approximately 13,000 new physicians by the year 2024 and grow the number of the National Health Service Corps clinicians to an annual field strength of 15,000 in fiscal year 2015 through 2020. This new investment will increase the supply and the distribution of the healthcare workforce, which, when coupled with the adoption of new, more efficient models of care, will significantly increase access to care.

This new targeted support for the Graduate Medical Education Program will emphasize primary care and will include support for residency training in high-need specialties. The targeted support for the GME Program will support residency training with a strong focus on ambulatory and preventive care and the goal of driving higher value healthcare that reduces long-term costs.

In addition, the fiscal year 2015 President’s Budget includes funding for both rural physician training and for inter-professional training, which will increase the capacity of the primary healthcare teams to deliver quality, coordinated, and efficient care to patients, families, and communities.

Our health workforce programs in HRSA support a wide range of primary care disciplines, including behavioral health and oral health providers. Roughly one in three National Health Service Corps clinicians provide behavioral health services, and more than 1,300 provide oral health services. We are partnering with the Substance Abuse and the Mental Health Services Administration to train and provide placement assistance to approximately 3,500 new behavioral health professionals and paraprofessionals to meet the needs of young people age 16 to 25.

HRSA’s workforce programs also play a critical role in supporting a diverse and culturally competent workforce across the country. Last year, underrepresented minorities and individuals from disadvantaged backgrounds accounted for approximately 45 percent of those who completed HRSA’s health profession training and education programs. And, according to self-reporting, more than half of the nearly 1,100 National Health Service Corps scholars and residents in the pipeline are minorities.

Taken together, HRSA’s workforce programs emphasize the training of the next generation of primary care providers, strengthens the primary care training and development infrastructure, and provides incentives for students and healthcare professionals to choose primary care and to practice where the Nation needs them
most. To meet the health needs of Americans, HRSA will continue to make training, recruitment, and retention of primary care professionals a priority.

Thank you again for providing me the opportunity to share HRSA's primary care workforce priorities with you today. I am pleased to respond to your questions.

[The prepared statement of Ms. Spitzgo follows:]

PREPARED STATEMENT OF REBECCA SPITZGO

Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify today on behalf of the Health Resources and Services Administration (HRSA). My name is Rebecca Spitzgo, and I am the Associate Administrator of the Bureau of Health Professions in HRSA, which is an agency of the Department of Health and Human Services (HHS).

HRSA focuses on improving access to health care services for people who are economically, geographically or medically vulnerable. Our mission is to improve health and achieve health equity through access to quality services and a skilled health care workforce. HRSA's programs support the health care workforce across the entire training continuum, from academic training to programs that support clinicians currently providing care to individuals in underserved and rural communities across the United States. HRSA supports the training of nurses, physicians, and other clinicians, and encourages providers to work in areas of the country where they are needed most.

In accomplishing our goals, we collaborate with colleagues across the Federal Government and with State and local governments, as well as a range of other partners in the private sector, including: community-based organizations, health care providers and academic institutions. Together with these key partners, we are working hard to meet the needs of the American people and to prepare for changes in the health care system to help ensure access to quality, efficient care.

I have been asked to speak to you today about HRSA’s activities regarding the primary care workforce and the Nation’s needs in this area. We appreciate your ongoing interest in HRSA programs and welcome the opportunity to discuss them with you, Mr. Chairman, and the subcommittee.

STRENGTHENING THE PRIMARY CARE WORKFORCE THROUGH RECENT INVESTMENTS

To date, the Affordable Care Act has supported the training of an additional 1,700 primary care providers, including physicians, advanced practice nurses, and physician assistants, as well as 200 behavioral health providers. And, with historic investments from the American Reinvestment and Recovery Act of 2009 (ARRA) and the Affordable Care Act, the numbers of clinicians in the National Health Service Corps have more than doubled from 3,600 in 2008 to nearly 8,900 in 2013. National Health Service Corps clinicians, who are located in every State, are providing care to approximately 9.3 million medically underserved people at more than 5,100 National Health Service Corps approved sites in urban, rural, and frontier areas. Approximately 50 percent of NHSC clinicians serve in HRSA-funded health centers.

The Affordable Care Act also provided $230 million over 5 years to fund the Teaching Health Center Graduate Medical Education (GME) program. This funding has expanded residency training for primary care residents and dentists in community-based ambulatory patient care settings, including HRSA-funded health centers. This program supported more than 300 primary care resident full-time equivalents (FTEs) in 21 States in Academic Year 2013–14. The number of residency programs and resident FTEs supported through this program has doubled each academic year since 2011, and we expect nearly 600 FTEs to be supported in Academic Year 2014–15. There is evidence that physicians who receive training in community and underserved settings are more likely to practice in such environments.

HRSA’s recent investments in nursing programs promote the supply, skills and distribution of qualified nursing personnel needed to improve the health of the public. These training programs increase nursing education opportunities for individuals from disadvantaged backgrounds; improve nurse education, practice and retention while increasing quality of care; assist veterans with transition from military service to nursing school and civilian nursing careers; provide financial support to individuals pursuing an advanced nursing education/training; and, provide financial support to schools of nursing to increase the number of qualified nurse faculty. And, through our scholarship and loan repayment programs, today there are nearly 1,600
advanced practice nurses in the National Health Service Corps and nearly 2,600 nurses in the NURSE Corps working in high-need communities.

BUILDING A PRIMARY CARE WORKFORCE FOR TOMORROW

The fiscal year 2015 President’s Budget includes a new workforce initiative that will help support the residency training of approximately 13,000 new physicians by 2024 and grow the number of National Health Service Corps Clinicians from 8,900 health care providers in 2013 to an annual field strength of 15,000 in fiscal years 2015–20. This new investment in our health care workforce will increase the supply and distribution of the health care workforce, which when coupled with the adoption of new, more efficient models of care, will significantly increase access to primary care and other specialty services.

This new residency training program, the Targeted Support for GME program, will emphasize primary care, but will also include support for residency training in high-need specialties. Building on the Teaching Health Center GME program, it will focus on supporting residency training in ambulatory, preventive care delivered in team-based settings.

The Targeted Support for GME program aims to support residency training with a strong focus on ambulatory and preventive care and the goal of driving higher value health care that reduces long-term costs. In addition, residency programs will be held accountable for training residents and retaining them in primary care service in underserved areas, as well as providing a broad range of training experiences that include team-based care, expanded use of technology, and new, efficient models of care.

The new program includes a $100 million set-aside for children’s hospitals annually in fiscal year 2015 and fiscal year 2016 to be distributed via formula that will continue to support the same types of disciplines currently funded through the Children’s Hospitals GME program. Children’s hospitals and current awardees in the Teaching Health Center GME program will be eligible to compete for funding through the new program. The fiscal year 2015 President’s Budget also includes appropriations language that would make current Teaching Health Center GME balances available until expended and thereby would avoid having these funds expire at the end of fiscal year 2015.

The fiscal year 2015 President’s Budget also builds upon the historic investments through ARRA and the Affordable Care Act that have more than doubled the National Health Service Corps. With more than 85 percent of Corps clinicians continuing to serve in high-need areas after they fulfill their service commitment, the National Health Service Corps helps ensure underserved rural and urban communities have access to quality health care both today and in the future.

Other HRSA investments also emphasize the importance of providing care in underserved communities. For example, 43 percent of individuals who graduated from or completed HRSA-funded health professions training and education programs reported working or pursuing further training in medically underserved communities one year after graduation or completion of their program.

In addition, the fiscal year 2015 President’s Budget includes $10 million for a new Clinical Training in Interprofessional Practice program which will support community-based clinical training in interprofessional, team-based care to increase the capacity of primary health care teams to deliver quality, coordinated, safe and efficient care to patients, families and communities.

The fiscal year 2015 President’s Budget also recognizes the special need for primary care providers across rural America. The Budget includes $4 million for the Rural Physician Training Grant program to provide support for medical schools to recruit and train students interested in rural practice and to develop curriculum that focuses on the unique needs of preparing medical students for rural practice. These grants will focus on recruiting and training health physicians in rural settings with the ultimate goal of increasing the number of medical school graduates who practice in rural communities.

SUPPORTING A DIVERSE WORKFORCE

HRSA’s workforce programs also play a critical role in supporting a diverse workforce across this country. Underrepresented minorities and individuals from disadvantaged backgrounds accounted for approximately 45 percent of those who completed HRSA’s health professions training and education programs during the 2012–2013 Academic Year. According to self-reporting, more than half of the nearly 1,100 National Health Service Corps scholars and residents in the pipeline are minorities. As part of their National Health Service Corps commitment, these future primary
care providers will serve in communities where they are needed most to provide culturally competent care.

And, when we look at specific disciplines, the impact of these programs is even more evident—a diversity not yet achieved in the national health care workforce. For example, in fiscal year 2013 African-American physicians represented 17.8 percent of the Corps physicians, which exceeds their 6.3 percent representation within the national physician workforce, and Hispanic physicians represented 15.7 percent of the Corps physicians, exceeding their 5.5 percent representation in the national physician workforce.

**TRAINING FOR COMPREHENSIVE PRIMARY CARE**

HRSA’s investments in the behavioral health disciplines are also significant. National Health Service Corps providers that include Health Service Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, Marriage and Family Therapists, and Psychiatric Nurse Specialists have more than tripled since 2008, increasing from approximately 700 to 2,440 in 2013. When we add in psychiatric physician assistants, and psychiatric nurse practitioners, roughly one of every three clinicians in the National Health Service Corps (more than 2,800 out of nearly 8,900 as of September 30, 2013) provides behavioral health services.

HRSA and the Substance Abuse and Mental Health Services Administration (SAMHSA) have been partnering to address critical needs in behavioral health professionals and paraprofessionals trained to address the needs of transition-age youth (ages 16–25). This partnership will train and provide placement assistance for approximately 1,800 additional behavioral health professionals and 1,700 behavioral health paraprofessionals. Last week, HRSA and SAMHSA issued funding opportunities for this initiative.

In addition, HRSA funds several programs that support training and education for health professionals to improve the integration of oral health into primary care. And, in the National Health Service Corps approximately 75 percent of the more than 1,300 dentists and dental hygienists are working at health centers or health center look-alikes.

HRSA also is helping to meet the need for new dental providers by expanding the dental workforce training and education programs, as well as by supporting State development and implementation of innovative programs to address dental workforce needs in underserved areas.

**STRENGTHENING AMERICA’S HEALTH WORKFORCE**

Taken together, HRSA’s workforce programs emphasize the training of the next generation of primary care providers, strengthening up the primary care training and development infrastructure, providing incentives for students to choose primary care and to practice where the Nation needs them most, and repaying loans for primary care providers willing to work in some of the Nation’s most underserved areas. To meet the health needs of Americans, HRSA will continue to make the recruitment, training and retention of primary care professionals a priority.

Thank you again for providing me the opportunity to share HRSA’s primary care workforce priorities with you today. I am pleased to respond to your questions.

Senator SANDERS. Thank you very much for your testimony and for the good work that you do. I think you have heard from Senator Burr and myself and, I think, from a whole lot of folks that we have a crisis in primary healthcare.

In recent years, we have doubled funding for the community health center program. We have tripled funding for the National Health Service Corps. Are those investments working?

Ms. SPITZGIO. I would say yes, they are working. We have doubled the size of the National Health Service Corps since 2008, when we had a little over 3,600 clinicians working there. Now, we have over 8,900 clinicians working in underserved and rural communities.

We know from talking to our National Health Service Corps sites and our community health centers that it’s a huge recruitment tool for them. They are really able to attract very talented providers to come and work in those centers by the use of the loan repayment.

Our scholars, when they finish their training, are highly sought after, and everyone says, “I just wish you had more. Bring me all
the physicians you can, train all the physicians, and I know we can place them.” I think they have made a tremendous difference.

Senator SANDERS. I know that you are not a policymaker. You’re an administrator. And it seems clear to me that we have made progress. More and more young people are now taking advantage of the National Health Service Corps, because we have more opportunity out there. If you had your druthers, and you were sitting up here, and you understood the scope of the problem, how much more would we be providing for the National Health Service Corps?

Ms. SPITZGO. I certainly know from our folks and from the interest in our programs and from talking to our sites that are always actively recruiting for clinicians—it just is a continuous process for them—they would like to see us be able to support all of the folks who are interested in being a part of the program, because it is that huge recruitment opportunity. They would love for us to have more scholars that are graduating and finishing our program.

I think as we look at that, the program is very prestigious. There is tremendous interest, not only from students as they go through school, but tremendous interest from the sites that would employ them.

Senator SANDERS. So what you are saying is that you think if we increased funding, you would be able to attract more young people to get into primary healthcare or dental care. Am I hearing that?

Ms. SPITZGO. Yes. I think there is an interest, yes.

Senator SANDERS. All right. Explain a little bit—maybe we have kind of jumped the gun, because I’m not sure that everybody knows what the National Health Service Corps is about. Go into a little bit of detail—the bottom line here is that if I am prepared and agree to work in an underserved area, the NHSC is going to repay my debts. But can you go into some detail about how that actually works?

Ms. SPITZGO. Sure. There’s actually two main components to the National Health Service Corps. First is our loan repayment program, which is for fully trained, educated, and licensed clinicians who may be coming out of school looking for that job and has that educational debt. If they go to work in a health professional shortage area and work at one of our approved sites, they can qualify for loan repayment. The initial loan repayment in a high-need area is $50,000 for a 2-year service commitment. So they agree to work in that high-need area for 2 years.

Then they do have the opportunity to continue in the program. If they have additional qualifying educational debt, they can continue to work there until they actually have paid off all of their student loans.

Senator SANDERS. So if I graduated school $200,000 in debt, how many years am I obliged to work in an underserved area?

Ms. SPITZGO. To completely pay off your debt, if you have $200,000, I’m just going to roughly say I think we’re talking 7 or 8 years with the continuations and continuing to stay in the program. But we do prioritize—once you’re in the program, we fund our continuations first, so you do typically stay if you’re interested.

Senator SANDERS. And you also have a scholarship program, do you not? Say a word about that.
Ms. SPITZGO. We do. The scholarship program is for students who are entering medical school or entering a nurse practitioner or physician assistant program to get their degree. And for every year of funding they receive for their education, they have a 1-year service commitment when they complete their degree, with a minimum of a 2-year service commitment. So if you only got 1 year of funding, you would still have a 2-year service commitment.

For our physicians, we’re talking about typically a 4-year service commitment. But they could start in their sophomore year. They could start in their junior year. It doesn’t have to be in their entry year of medical school. And we do assist in our scholarship program those who go to our highest-need areas, and we do assist with placement and relocation expenses and very much, of course, hope that they have a 4-year commitment, and by the time that commitment is complete, they’ll stay.

Senator SANDERS. But we are not just talking—so everybody understands, this is about physicians. We’re talking about dentists and what other providers?

Ms. SPITZGO. We’re talking physicians—for a scholarship program, nurse practitioners, physician assistants, dentists, and dental hygienists all qualify.

Senator SANDERS. Thank you very much.

Senator Burr.

Senator BURR. Ms. Spitzgo, thank you for being here and thank you for the job that is done at HRSA within HHS. Senator Sanders pointed to success and used the taxpayer investment as an example of the commitment. Let me ask you—what metrics do we have in place that you can point to that show the success of this program?

Ms. SPITZGO. I think the metrics we have in place is, one, we have an extremely low default rate, less than 1 percent, for our loan re-payers. So not only when they get the money to pay back their loans, they complete their service commitment.

We also know that not only do they complete their service commitment, but when they’ve paid all their loans back, they stay in underserved and rural areas. After completing the program, over 80 percent of the folks continue to work in underserved areas after immediately completing the program. And we’ve done a 10-year study that shows that after 10 years, we still have 55 percent of those National Health Service Corps clinicians still working in underserved and rural areas.

Last year, the GAO found that 91 Federal programs obligated $14.2 billion toward healthcare workforce training programs across four departments, HHS, DOD, VA, and the Department of Education. How is HHS working with these departments to ensure that these collective efforts are coordinated without duplications and reflective of the most up-to-date workforce projections as provided by HRSA?

Ms. SPITZGO. We work very closely with our colleagues, first starting, I would say, within Health and Human Services and, for example, CMS. With some of our Graduate Medical Education programs that we fund through HRSA, we work very closely and do audits to make sure that CMS funds are not funding the same residents that were using HRSA funds.
We also work with the Indian Health Service in supporting tribal communities and their workforce programs to make sure that we are complementing each other's efforts. In addition, as we work with Education, they have some loan repayment programs if you work in underserved areas. So our guidances show very much if you have that commitment that you can’t be doing the National Service Corps and also have a commitment somewhere else.

So we do track with them very closely to make sure that we don’t have what we call double-dippers and that we’re not using funds for the same person more than once. We also work with VA to look at their programs, to leverage the good work they’re doing, to see how they are running workforce programs, and to see what we can learn from them, as well as to work very closely together and not to duplicate.

Senator Burr. As you know, HRSA oversees the Children’s Hospital Graduate Medical Education Program, which provides training for pediatricians across the country. As you noted in your testimony, the President’s budget has proposed consolidating that funding under a new residency training program called Targeted Support for GME.

Ms. Spitzgo. Yes.

Senator Burr. This new program will provide funding for the Children’s Hospital Graduate Medical Education Program until 2016, at which time children’s hospitals will need to compete for funding under the new targeted support program. Just this week, the bipartisan Children’s Hospital Graduate Medical Education Reauthorization Act was signed into law, a signal from Congress that this program is working well.

As we work to strengthen our healthcare workforce, do you believe that the President’s proposed new framework will support the pediatric workforce and ensure that we’re making the appropriate investment in training pediatricians?

Ms. Spitzgo. Yes. We do think the new program will also be able to address that, as well as address the primary care residency and the need for those. So the targeted support for the Graduate Medical Education Program is very much geared at supporting primary care residency as well as other high-need residencies where we have a documented shortage.

The program is also looking to take an innovative approach to how we do residency training, and not to just have a payment program, but to also have a discretionary program where we can really have requirements that we’re looking for our grantees to meet so that we’re using innovative models of care. We’re doing team-based care. We’re utilizing electronic health records in a way that really assists to provide a higher quality of care to the patients that are being served.

By having innovative approaches to the way we train our residents, we think that will lead to innovative approaches to the way we deliver care. Those residents will go out and, hopefully, spread that, and all of that will lead to lower costs.

Senator Burr. Ms. Spitzgo, I didn’t misinterpret in any way what we’re doing. We’re changing and we’re making children’s hospitals compete, which does not assure us of the investment in pediatricians. Am I accurate?
Ms. SPITZGO. We feel like the structure of the targeted GME Program is a community-based setting, and many of the hospitals are already operating and run their programs in a community-based setting. We've also moved the funding from a year-by-year discretionary funding to a mandatory funding cycle which will bring more assurance that the funding will continue. So there's 2 years of $100 million that's set aside for the Children's GME in 2015 and 2016, and then we think they will be very well-positioned to compete and also then move into providing some innovative models of care as they do residency training.

Senator BURR. Thank you.

Senator SANDERS. Thank you, Senator Burr.

Senator Warren.

STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you, Mr. Chairman. I think we all agree that access to primary care is essential for keeping people healthy. I want to talk just briefly about a program that Massachusetts has to improve the Commonwealth's primary care workforce by offering loan repayment programs to help doctors with medical school debt.

The University of Massachusetts Medical School, which is ranked by U.S. News and World Report as the fifth best medical school in the country for primary care, has a learning contract that allows students to waive two-thirds of their tuition in exchange for 4 years in primary care or as a specialist in an underserved area. Massachusetts also has a State loan repayment program grant from the National Health Service Corps that provides the commonwealth with Federal funds to match our investment in loan repayment programs for those who work in underserved communities, including doctors, nurse practitioners, and physician assistants.

I wondered, Ms. Spitzgo, if you could just briefly discuss the importance of State programs and, more critically, the role that the Federal Government can play to better support those programs to help us get more primary care physicians.

Ms. SPITZGO. Yes. Thank you. You mentioned the National Health Service Corps State Loan Repayment Program. I think that's an excellent example of one of the programs we've had. We've actually done a lot of retooling of that program so that it is flexible for the States to really direct it to their needs.

So it is a program where they receive a grant from HRSA, and there is a one-to-one matching required. But at that point, the State works within the framework of the National Health Service Corps Loan Repayment Program, but can really customize that program. So they may want to target it to a particular area of the State. They may want to target it to all disciplines in primary care, or they may want to narrowly focus it to just dentists because they really have a shortage.

So we've really tried to emphasize the value of that. It really does give them that flexibility to meet their own needs as well as to meet the needs that—maybe through the national program they're not getting the number of loan repayments they want there. So it can really be a great tool to supplement that.

I think we continue to work with the States. They are our partners as well as local governments. HRSA has a wide portfolio of
programs, but we also can only do so much. We have our partners, and we have foundations, and State and local governments have an important role as well.

Senator WARREN. I appreciate you pointing that out. Some States have worked hard to recognize the shortage in primary care and to try to do something about it. But I think it’s clear that there is still a very big shortage. So we have the opportunity at the Federal level to do more to invest in programs that permit more creativity and more effectiveness on the ground. Thank you.

I also want to turn to a 2007 study from the International Journal of Health Services that found that if the United States increased the primary care workforce by 10 physicians per 100,000 people, we could improve health outcomes and avoid 49 deaths per year for each one of these groups. This is probably because many costly conditions like hypertension and high cholesterol are mostly managed by primary care doctors, as was confirmed by the Journal of the American Board of Family Medicine study earlier this year.

So it seems obvious that part of our long-term strategy to improve outcomes at lower costs in our healthcare system would be to increase the number of doctors trained in primary care. Now, one promising approach is the Teaching Healthcare Center Graduate Medical Education Program, a 5-year initiative established by the Affordable Care Act that trains doctors to treat complex patients in the community, and it costs only $230 million. But this program will expire at the end of 2015.

I wanted to ask you, Ms. Spitzgo, could you speak to the return on investment that we get from investing in training a primary care resident in a community health center as opposed to a traditional residency?

Ms. SPITZGO. Yes. Thank you. As we look at the Teaching Health Center, we feel that program has been extremely successful. It’s a relatively new program, but we’ve seen the doubling of supporting—the number of slots double each year, and it continues to grow. So there is tremendous interest in the community in providing residency care at community-based settings.

We feel like as residents train and they provide care in community-based settings where the bulk of Americans do receive their care, they are very well-trained, and they understand and can appreciate the value of primary care and the need for it and the challenges that go with the delivery of primary care. We are already starting to see some of our graduates that are coming out of that very much going into underserved areas as well as rural areas and are staying in primary care.

Senator WARREN. That’s very good to hear. It’s important to continue to support traditional residencies, but it’s also critical that we support new efficient programs like these. And I’m committed to making sure that our health centers are fully supported and that our training programs don’t lose critical funding in 2016. Now is the time to invest in our future, and this is how we should do it.

Senator SANDERS. Thank you, Senator Warren.

Senator Murphy.

STATEMENT OF SENATOR MURPHY

Senator MURPHY. Thank you very much, Mr. Chairman.
Thank you, Ms. Spitzgo, for being here. I just want to associate myself for 2 seconds with the remarks of Senator Warren. We have one of these community health center residency programs in Connecticut, run actually by a former Congressman from Connecticut, Jim Maloney, in Danbury.

It has worked enormously well, and he points out regularly to me and others that the data suggest that a physician trained in a community health center is 300 percent more likely to stay in an underserved area than someone who is trained in a traditional residency program. That is not, just as Senator Warren said, to create an advertisement for divesting in traditional residency programs. But you get a really good return on your investment in community health centers.

Ms. Spitzgo, I sort of wanted to talk about the problem rather than the treatment at the beginning. I had the chance a couple of years ago to sit down with a group of University of Connecticut medical students who were in their first year. Maybe there were 15 students around the table, and I asked them, “How many of you are considering going into primary care?” One of the fifteen raised their hand, and, of course, that’s a stunning number given that it wasn’t so long ago that half of the kids graduating from medical school would go into primary care.

I asked them what was the reason. And, clearly, the first reason was this subject of most of our discussion today, that they just didn’t believe they were going to get paid at a level that would allow them to pay back their loans. But they also talked about the fact that there was a sense that there was much less prestige involved in going into primary care than there was going into other specialties, and they wanted to be on the cutting edge of medicine, and they were better off to go into cardiology or orthopedics or neurosurgery.

Can you just talk a little bit about why we have a shortage in primary care? And is it simply a matter of reimbursement levels, or are there other things that we should be considering doing or the profession should be considering doing to, I guess, create that level of attraction that used to be there for primary care?

Ms. Spitzgo. I think we have many factors that are driving those decisions. I do believe it starts in the education. It starts with understanding, I think, and valuing primary care and valuing preventive care and the difference that it can make overall in our healthcare systems. It also comes, I think, from the experiences that our students are able to have as they’re going through school and the exposure that they can get to working in an underserved area, working in a rural area, mentoring with a primary care physician who may share those experiences and those challenges.

I think the other part of that goes to where are innovative approaches and our new ways of delivering care? Where does it feel like there’s the ability to have some creativity and to think about doing it differently, which is where I think our new residency program really wants to go. We want to drive some innovation.

This isn’t just seeing a patient every 10 minutes. This is about really being able to provide the level of care and the interaction and working as a team and really looking at new things and new challenges and population health. How do you work all of that into
your practice and bring that? And I think that’s very exciting, and that’s the message we need to get to our students to start having them think differently and appreciate, I think, the value of delivering primary care.

Senator Murphy. To the extent that reimbursement is an issue, as you know, the ACA made a pretty significant investment in raising Medicaid rates for primary care physicians. We’ve seen a remarkable transformation in Connecticut. I’ll just give you the quick statistics.

From 2012 to 2013, we went from 235 APRNs practicing in the Medicaid arena to 578. We went from 1,300 physicians to 2,400 physicians. We went from 25 PAs to 236 PAs. Clearly, that tells us that if you pay physicians in the Medicaid program and you pay practitioners in the Medicaid program close to what it actually costs them to do the work, they’re going to start taking Medicaid clients, many of which are in the underserved areas.

How important do you think it is that we maintain these rates? The ACA only picks up the tab from a Federal perspective for the first 2 years. How important is it for underserved areas and Medicaid populations, in particular, to keep these Medicaid rates for primary care pegged at the Medicare number going forward?

Ms. Spitzgo. I think we do hear regularly, obviously, reimbursement rates can help us drive change and really drive innovation in the healthcare delivery. As we look at our sister agency, CMS, and their innovation models that they are currently funding and testing out, many of them include workforce and looking at rates and really looking at what will drive those changes. So I think as we continue, having the data that you just shared with us and looking at those outcomes and what the difference has made as we’ve made adjustments will very much help to pave the path forward, hopefully, on what is a workable solution.

Senator Murphy. Thank you, Mr. Chairman.

Senator Sanders. Ms. Spitzgo, thank you so much for your testimony.

Now we’ll bring up our second panel. We have a great panel, and I want to thank all of the panelists for being here. We think that at 11 o’clock—although around here, one is never 100 percent positive—there will be a vote. So people will disappear and the chair will rotate a little bit. But we will try to get back—I will get back, for sure, to continue the discussion.

Our first panelist is Stan Brock. Mr. Brock is the founder and president of the nonprofit healthcare organization, Remote Area Medical, called RAM, based in Rockford, TN. He has a very diverse resume.

He worked as a cowboy in the Amazon and later hosted the television wildlife series, Wild Kingdom. After organizing volunteers to deliver medical care in remote villages around the world, he saw the great need here in the United States and founded RAM, which has held over 700 free healthcare expeditions since 1985.

Mr. Brock, thank you for your work and thank you for being here this morning.
STATEMENT OF STAN BROCK, FOUNDER AND PRESIDENT, REMOTE AREA MEDICAL, ROCKFORD, TN

Mr. Brock. Thank you, Mr. Chairman and distinguished members of the committee. Welcome to America, number 37 in the World Health Organization's country rankings. I am a voice for more than half a million patients that Remote Area Medical, RAM, has treated free of charge in 723 mobile medical clinics during the last 28 years.

I know what it is like to be poor and without help. I am one voice of the millions of people who are not a part of our healthcare system. They have been left behind and forgotten. I speak for them today.

I came from a place where there was no doctor, living with the Wapishana Indians in the upper Amazon. Their only recourse when faced with catastrophic injury or sickness was a tribal witch doctor. But at least they had that. Some of the sick that we see here in the United States have nowhere to turn. That is why I created Remote Area Medical.

When I suffered a serious injury, one of the Indians said, "The nearest doctor is 26 days on foot from here." I felt then what so many in our Nation feel today when they need a doctor and cannot get care. For millions of Americans, they might as well be 26 days on foot from the nearest doctor. In fact, one of our patients recently walked 15 miles because he was desperate for medical attention.

Healthcare in America is a privilege of the well-to-do and the well-insured. That leaves about 50 million people flat out of luck. These families live in fear of injury and sickness with no insurance or not enough of it. The predicament of these millions of marginalized Americans raises questions of morality, injustice, and education.

Poor education begets poor health. Poverty feeds on poor nutrition which creates obesity, diabetes, heart disease, and cancer. The vicious cycle lies in wait for each child enslaved in poverty as they pass from beneath the security of State and Federal programs into the barren wastes of adulthood. Many, nursing mouthfuls of decayed and abscessed teeth or suffering from fading vision, will inevitably join the long lines of desperate patients at a RAM free clinic.

I have looked into the distraught faces of Americans imprisoned by poverty, from child to grandparents, all generations lining up by the hundreds in places as diverse as Los Angeles or a fairground in the mountains of southwest Virginia. I have seen our elderly in makeshift wheelchairs, people clutching precious numbered scraps of paper, their RAM free clinic ticket to relief from unnecessary agonizing pain and sickness. They cannot afford healthcare.

This leads some of our American families, with their children, to sleep in tents and cars, often for over 24 hours, waiting for a RAM event to open its door. Blindfolded, you can stick a pin on a map of America and wherever it lands, you will find hundreds, if not thousands, of sick hurting people in need of care that they cannot obtain.

Our people are living in sickness and pain and in need of basic medical attention. At RAM clinics, dental care is the greatest demand with vision services a close second. Eighty-five million Amer-
icans do not have dental insurance, and half of those can’t afford to pay for a dentist without it.

What are they to do? Hospital emergency rooms don’t do dentistry and they don’t make glasses. In most cases, Medicaid does not cover dentistry or vision for adults, and finding a Medicaid practitioner to provide treatment can be a real challenge.

RAM is not a solution to the American healthcare crisis. We need to be in places like Haiti, not Tennessee and California. RAM bridges the gap for those suffering needlessly in our system. A RAM event is logistically strained at 1,200 patients a day, and we are forced to turn away hundreds and sometimes thousands of sick people.

Our healthcare system has failed our people because they either do not have access or they cannot afford it. As a result of the great need of those who are sick or injured, we have reached out to legislators for help. In 1995, RAM asked the State of Tennessee to change the law to allow out-of-State licensed practitioners to provide free care to underserved patients in Tennessee. This highly successful program attracts 60 percent or more of the medical volunteers at RAM events from out of State. A total of 12 States have now adopted the Tennessee model, but this process has taken 20 years.

Doctors are still calling me to say that it is easier to volunteer their services in places like Guatemala than it is here in the United States. I have two pictures here that I’d just like to hold up. Is this 1936 picture of a depression-era mother in California any more revealing than this 2012 picture of a thousand Americans holding up their hands appealing for healthcare before daybreak at a RAM free medical event in Bristol, TN? Where have we gone wrong in the last 76 years that separates these iconic images?

Thank you.

[The prepared statement of Mr. Brock follows:]

PREPARED STATEMENT OF STAN BROCK

Welcome to America—No. 37 in the World Health Organization’s country rankings! I am a voice for more than half a million patients that REMOTE AREA MEDICAL® (RAM®) has treated free of charge in 723 mobile medical clinics during the last 28 years. I know what it is like to be poor and without help. I am one voice of the millions of people who are not a part of our healthcare system. They have been left behind and forgotten. I speak for them today.

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I have looked into the distraught faces of Americans imprisoned by poverty, from child to grandparents, all generations lining up by the hundreds in places as diverse as Los Angeles, or a fairground in the mountains of southwest Virginia. I have seen our elderly in makeshift wheelchairs, people clutching precious numbered scraps of paper, their RAM® free clinic ticket to relief from unnecessary agonizing pain and sickness. They cannot afford healthcare. This leads some of our American families, with their children, to sleep in tents and cars, often for over 24 hours, waiting for a RAM® event to open its door. Blindfolded, you can stick a pin on a map of America and wherever it lands, you will find hundreds, if not thousands of sick hurting people in need of care that they cannot obtain.

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Senator SANDERS. Thank you very much.

Our second witness is Dr. Gary Wiltz. He is a board certified internist and currently serves as CEO of Teche Action Clinic, a network of community health centers based in Franklin, LA, that serves six parishes in southwest Louisiana. He is also the current Chairman of the Board of the National Association of Community Health Centers, which represents more than 1,200 health center organizations nationwide.

Thank you so much for being with us, Dr. Wiltz.

STATEMENT OF GARY WILTZ, M.D., EXECUTIVE DIRECTOR AND CLINICAL DIRECTOR, TECHE ACTION CLINIC, FRANKLIN, LA

Dr. Wiltz. Good morning, and thank you, Chairman Sanders, Ranking Member Burr, and Senator Murphy and Senator Warren. Thank you for that kind introduction, so I won’t repeat that. Just one more fact about NACHC—we represent all of the Nation’s community health centers, and we are serving some 22 million people nationwide in nearly 9,000 rural and urban settings.

I want to talk to the subcommittee today—and thank you for focusing on this issue—about the critical issue of primary care access. I’d like to focus my remarks on the tremendous strides that we’ve made in community health centers in providing access to primary care to millions of people in this country. And at the same time, I want to highlight a looming funding crisis that threatens the program’s very existence.
Last year, Teche Clinic provided care to more than 18,000 underserved Louisianans, 97 percent of whom are low-income. Nearly half of our patients are uninsured, and a third are covered by Medicaid. These are patients that I know very well. You see, I began my service at Teche Action Clinic in 1982 as a National Health Service Corps scholar, and some 32 years later, I'm still there seeing patients every day.

It is from that perspective that I want to speak about what access to care really means. Access is a term that's being frequently used in our healthcare dialog and discussion, but there's little agreement on what it really means. To those of us who serve on the front lines of healthcare delivery, access is more than just having an insurance card. It is more than getting care in an emergency room.

Access is having a place to go for regular, reliable, high-quality preventive and primary care. By its very design, the locally controlled nonprofit health center model breaks down the barriers to healthcare access, including those created by geography and income.

Health centers are also economic engines in some of the most economically depressed communities in the Nation. At our health center in Franklin, we're one of the largest employers in the community. We provide over 150 good-paying jobs, all above minimum wage.

Not only do health centers deliver effective care, but, nationally, we save the health system $24 billion by keeping patients out of costly healthcare settings such as emergency departments. At our health center, we're open 6 days a week, 7 a.m. to 7 p.m. We have demonstrated a decrease in inappropriate emergency room usage by 40 percent.

Just recently, an uninsured man—as Senator Warren alluded to earlier—an uninsured man came to our center on a Saturday evening at 6 o'clock after he knocked off from work, suffering from headaches due to uncontrolled hypertension. We were able to diagnose and treat his problem that evening, saving him from having to stay in an emergency room for hours and a costly $800 bill. More importantly, he was able to return to work the next day without missing that day's pay.

Despite the history of strong bipartisan support from Congress, many communities in need still lack primary healthcare access. Even in communities with a health center, significant unmet need remains. A recent report from NACHC and the Robert Graham Center found that as many as 62 million Americans lack regular access to primary care. So, clearly, our work continues and is not done.

Yet without deliberate congressional action, both health centers and primary care workforce programs—unless we get this remedied, they're going to face a threat to their very existence. Next year, the mandatory Health Center Fund, which currently accounts for more than half of all health centers' dollars, will end unless it is reauthorized. At that point, health centers face a 70 percent reduction in grant funding, leading to significant cuts to operations and elimination of healthcare access in some of the Nation's most
vulnerable communities, even as demand for our care continues to grow. I mentioned earlier that we are soon to open two more new community health centers and two new sites. If these cuts come into effect, not only will we not be able to open those two new sites, but it would force me—and I’m CEO of these community health centers—to lay off over 10 percent of my staff. And, most importantly, 3,000 of our current patients would go without services.

In addition to health centers, the National Health Service Corps, of which I am a proud alumna, and the Teaching Health Center programs also face a funding cliff. The Corps is a vital program that provides scholarships and loan repayments to providers who commit to serving in underserved areas, as I have done for my entire career.

The Teaching Health Center program is an innovative effort, as alluded to earlier, to grow the supply of primary care providers trained in community-based settings. I know my colleagues on the panel will speak more about these workforce programs, but let me just say this. The funding cliff that faces these programs threatens the stability and sustainability of our healthcare system.

Failing to fix this cliff would send the country in the wrong direction by reducing primary care capacity and sending costs spiraling. We strongly urge Congress to address this problem this year so that access to care in our communities can become a reality for years to come. I look forward to your questions.

[The prepared statement of Dr. Wiltz follows:]

PREPARED STATEMENT OF GARY WILTZ, M.D.

Chairman Sanders, Ranking Member Burr and members of the subcommittee, thank you for the opportunity to join you today to discuss such an important—and urgent—topic: the persistent and growing need for access to primary care in communities across this country. My name is Gary Wiltz. I am a board-certified internist and currently serve as chief executive officer of Teche Action Clinics, a network of soon-to-be 10 community health centers serving six parishes in southwest Louisiana whose home base is in Franklin, LA.

I also currently serve as chairman of the board of the National Association of Community Health Centers (NACHC), which represents the more than 1,200 Health Center organizations nationwide. Health centers currently provide care in more than 9,000 rural and urban underserved communities and serve some 22 million patients, which is a direct result of broad, bipartisan support for the Health Center Program in Congress. This support, which extends back decades and has been embraced by presidential administrations of both parties, has led to continued and expanded investment in our model of care. On behalf of all of America’s community health centers, I want to thank you, Mr. Chairman and each member of the subcommittee and Congress for your unwavering focus on this issue. The reason I am here to talk with you today is to discuss the positive impact and tremendous strides Community Health Centers have made in providing access to primary care services to millions of vulnerable Americans throughout the country as well as highlight a looming funding crisis that threatens the very existence of the Health Center Program.

I came to Teche Action Clinic in 1982 as a National Health Service Corps (NHSC) Scholar with a 3-year service commitment, and 32 years later I am still there, serving patients every day. It is from that perspective that I want to speak to the subcommittee today about the notion of access to care. “Access” is a term that gets used frequently in our national health care discussion, but with varying interpretations of its meaning. For some, access means merely having health insurance coverage. Others have suggested that a local emergency room constitutes sufficient access. To those of us who serve on the “front lines” of health care delivery, access is more than just having an insurance card. It is more than getting care in an emergency room. Access is having a place to go for regular, reliable, high-quality preventive and primary care.
Teche Action Clinic is just such a place. In 2013, we provided access to care to more than 18,000 underserved Louisianans, more than 97 percent of who are low-income. Nearly half of our patients are uninsured and nearly a third are covered by Medicaid. We provide not only primary medical care but also oral health, behavioral health, onsite pharmacy, lab, WIC, nutrition counseling, diabetes education, chronic disease management and enabling services including transportation, translation and enrollment services. Like all health centers, our doors are open to everyone regardless of ability to pay. We are a Joint Commission certified Patient-Centered Medical Home, meaning our care is delivered in a coordinated manner by an interdisciplinary team with a focus on increasing safety, improving health and reducing costs.

Community Health Centers like the one where I serve are locally controlled, nonprofit entities. By its very design, the health center model breaks down barriers to health care access, including those created by geography and income. Health centers are also economic engines in some of the most economically depressed communities in the nation. In 2009 alone, Health Centers generated $20 billion in economic impact and were responsible for nearly 200,000 jobs. My health center is one of the largest employers in our community providing over 150 good paying jobs, all above minimum wage.

Community health centers not only deliver effective care, but we have a demonstrated track record that shows that we’re a smart investment of public funds. Nationally, we save the entire health system approximately $24 billion annually by keeping patients out of costlier health care settings, such as emergency departments. At our Franklin site we are open 6 days a week 12 hours a day 7:30 a.m. to 7:30 p.m., and we have been able to decrease inappropriate ER visits in my community by over 40 percent. Just recently, one of my patients, who is employed but uninsured, came to the health center on a Saturday evening after he got off work at 6 p.m. He was suffering from a severe headache due to dangerously high blood pressure. We were able to get him in, diagnose the problem and treat him that evening, which saved him from waiting for hours to be seen at an emergency room and paying over $800.00. Our ability to see him and provide him with services when he needed care also allowed him to go to work the next day.

In addition to providing the right care at the right time at the right price, Health Centers have established an impressive record of delivering high-quality care to our patients. Research has shown that Health Centers provide equal or better care compared to other primary care providers, all while serving communities with more chronic illness and socioeconomic complexity. Health center patients receive more preventive services, such as immunizations, health education, mammograms, pap smears, and other screenings, than patients seen in other settings. Unfortunately, many of the residents in my State, both the uninsured and insured, are unable to access critical primary and preventative care services because they just can’t afford it or do not have access to a health center or other primary care providers. Clearly our work is not done. Despite the strong bipartisan support and the history of investment in our capacity, many communities in need still lack a Health Center or any other form of basic primary care. Even in communities with a Health Center, demand often far exceeds supply and significant unmet need remains due to limited resources. Many Health Centers struggle to recruit and retain a primary care workforce that is prepared to address the challenges of providing care to the medically underserved.

A recent report issued by NACHC and the Robert Graham Center for Policy Studies indicates that as many as 62 million Americans lack regular access to primary care. Access barriers such as geography, income, and insurance status—and the provider shortages that exacerbate them—lead to poorer health outcomes and increased costs for taxpayers. Yet at the very time that this need for expanded access is most necessary, without deliberate congressional action both Health Centers and vital primary care programs face a threat to their very existence. I want to focus the remainder of my testimony on this issue—which we have taken to calling the Primary Care Cliff—and the urgency of addressing it as soon as possible.

The Health Center grant, which supports the operations of the more than 1,200 federally funded health center organizations nationwide, is financed through a mix of annual discretionary appropriations and mandatory funding appropriated through the Health Centers Fund. In the coming fiscal year, if the health centers program were to maintain discretionary funding at current levels and to fully utilize the last remaining year of funding in the mandatory health center fund, we would build the capacity to serve as many as 11 million new patients.

In fiscal year 2016, however, Health Centers face a funding cliff: the mandatory funding, which currently accounts for more than half of all health center dollars, will end unless it is reauthorized. With only discretionary funding at current levels,
Health Centers would see up to 70 percent reductions in grant funding, leading to significant cuts to operations and reduction or elimination of health care access in some of the Nation’s most vulnerable communities. This would occur just as the demand for the type of care Health Centers provide is growing. I mentioned earlier that my center is soon to be 10 sites as we will be opening two new sites in a high-need parish in the next 2 months. If these cuts are to come to fruition, not only would I be unable to open these two new sites, I would be forced to close two additional sites, lay off over 10 percent of my staff and more importantly over 3,000 of my current patients would no longer have access to primary care services in Franklin.

In addition to Health Centers, the National Health Service Corps and Teaching Health Center programs also face looming funding cliffs. The National Health Service Corps is a vital program that provides scholarships and loan repayment to providers that commit to serving in underserved areas, as I have done for my entire professional career. The Teaching Health Center program is an innovative effort focused on growing the supply of primary care providers trained in community-based settings.

I know my colleagues on the panel will be speaking in more depth about these workforce development programs, but let me just say this: taken together, the funding cliff that faces these three programs threatens the stability and sustainability of our health care system. Failing to fix this cliff would send the country in the wrong direction by reducing primary care capacity and sending costs spiraling upward. There is no way we can absorb a 70 percent cut. Instead it will force Health Centers to close sites and lay off workers, meaning a major reduction critical access for the patients and communities we serve.

We strongly urge Congress to address this problem this year—so that health centers and our current and future clinicians can plan for the future knowing that access to care in our communities can be a reality for years to come. I know each of us, as well as the organizations we partner with and represent, is eager to work with you to address this problem. Thank you for your time and I look forward to your questions.

Senator SANDERS. Dr. Wiltz, thank you very much.

If you will forgive me, Senator Murphy has to leave, and he wanted to introduce Dr. Flinter. So I’m going to kind of jump over and we’ll go to Dr. Flinter.

Senator MURPHY. Thank you very much, Mr. Chairman, for your courtesy. I’m just pleased to have my good friend, Margaret Flinter, here with us today. She’s the senior vice president and clinical director of Community Health Center, Inc. It’s the largest FQHC in Connecticut, serving about 130,000 patients in 13 practice settings.

But her expertise here today is really about all the great work that she’s done to develop a model of formal postgraduate residency training programs for new nurse practitioners that are committed to practice as primary care providers, particularly in community health centers. This model now has 15 sites all around the country. For this committee’s purposes, there are sites in Massachusetts, Pennsylvania, South Carolina, and Washington State.

She’s a great friend, but also a real expert in the field of primary care, and I’m delighted to have her join us this morning.

Senator SANDERS. Dr. Flinter, can you live up to all of that?

Ms. FLINTER. I don’t know what else I can say.

Senator MURPHY. And I would just add that she is testifying, despite the fact that she has been up 2 nights in a row watching the UConn Huskies win two national championships.

[Laughter.]

Ms. FLINTER. Go Huskies. And they did a great job.

Senator SANDERS. Dr. Flinter.
Ms. FLINTER. Thank you so much, Senator Murphy. Good morning, Chairman Sanders and Senator Burr and Senator Warren as well. We are so pleased to have the honor to testify before you today.

Primary care has been the defining focus of my entire career, from the time I started as a young public health nurse in rural Connecticut and Georgia and then as a family nurse practitioner primary care provider and a leader at the Community Health Center. I came there in 1980, newly graduated, ink barely dry on my diploma from the Yale School of Nursing, because the National Health Service Corps had the good sense to assign me to what was then a storefront clinic on Main Street, USA, in Middletown, CT.

It was my great good fortune to find a band of deeply committed visionary community organizers and clinicians who are as committed to community health and primary care as I was. And as Senator Murphy has said, from those humble beginnings, we care for 130,000 patients—medicine, dentistry, behavioral health—in community health centers, but also in our school-based health centers around the State, which numbers nearly 200.

Today I want to address three questions that are the focus of so much of my work and I know on your minds. Who wants to be a primary care provider? Second, how do we attract these providers to the areas that need them most, both rural and urban? And, third, how do we retain them once they're there?

First, the workforce shortage issue. You are hearing and will hear compelling testimony from my colleagues. I'll tell you in advance that I've read their testimony, and I support their recommendations, and, in particular, the Teaching Health Center re-authorization, which recognizes, as I do, that it's both about training to the complexity of the care we deliver in primary care and in health centers, but it's also about training to a model of care that is patient-centered and data-driven that focuses on quality and delivering care where people live and work.

You will hear many statements about why there is a shortage of primary care physicians. But I'm going to ask you to step back and ask not just why don't more physicians choose primary care, but who else wants to be a primary care provider, and how do we support them in that choice.

My response is that nurse practitioners still overwhelmingly choose primary care as their specialty. Eighty percent of nurse practitioners specialize in a primary care specialty, and 70 percent are in primary care today. We can attract them and support them and assure their successful transition to the role of a primary care provider by giving them the opportunity for formal postgraduate residency training programs in community health centers. In 2007, I and my colleagues at the health center launched the country's first program after many years of recognizing the need for such a program.

GME legislation has been so successful in preparing physicians, but it has never included nurse practitioner residency training. We
can’t afford to lose new NPs from community health centers, where the first year of practice can rightly be described as one of shock and awe, or deter them from coming to our setting simply because we haven’t done the work required to facilitate a successful transition from brilliant education to practice.

We are now in our seventh year. Our applicants come from all over the country. Twenty-seven of our twenty-eight graduates are practicing as primary care providers all across America. Fifteen other health centers have started programs like ours, and 14 more residency programs will come online in 2014. It now extends beyond the community health centers to include nurse-managed health centers and even large health systems such as, Senator Burr, the Carolina healthcare system in your home State where we’ve had the pleasure of meeting such wonderful leaders.

We’ve come together. We’ve created a national nurse practitioner residency training consortium to set standards and to work for a sustainable stream of funding, such as that that’s available to physicians. And we will seek a legislative commitment based on the fact that in 2010, Congress authorized grants of up to $600,000 a year to implement NP residency training programs in community health centers. But the authorization expires this year, and no grants were ever awarded because the program was never funded. We ask that it be done and reauthorized and funded for 5 years.

My second question: How do we recruit providers to underserved areas, both rural and urban? And I will simply state what others have said: “Expand the National Health Service Corps.” It worked for me in 1978. It worked for 40 of my 200 clinicians on my staff, who at one time in their career were National Health Service Corps, and that cuts across all the disciplines.

And, finally, I want to answer the question: How do we retain the best and the brightest? We do it by not making coming to practice in a community health center a choice between a stimulating career in practice and research and training and being involved in leadership, but rather we can make our health centers the locus of those activities.

That’s what the Weitzman Institute at the Community Health Center does, whether it’s through our Project ECHO model of connecting primary care providers to specialists around the country to focus on the most pressing and difficult issues in primary care, things like the management of chronic pain, dealing with opioid and heroin addiction, managing HIV and hepatitis C, and primary care. We can create these kinds of innovations. We can use technology. We can have our research within the health centers. And we can truly improve the health and the healthcare of all Americans.

I thank you very much for the opportunity to be here today.

[The prepared statement of Ms. Flinter follows:]

PREPARED STATEMENT OF MARGARET FLINTER, APRN, PH.D., C-FNP, FAAN, FAANP

Good morning, Chairman Sanders, Senator Burr, and distinguished members of the Subcommittee on Primary Health and Aging. It is an honor to speak to you today on the issues of healthcare access and workforce challenges across the United States.

Thank you, too, Senator Murphy for your kind introduction, and for all of your efforts to ensure access to high-quality health care for all Americans, first as our
State Representative in Connecticut, then as a Congressman, and now as a U.S. Senator.

I am Margaret Flinter of the Community Health Center of Connecticut, and primary care has been the defining focus of my career, first as a young public health nurse in rural Connecticut and rural Georgia, then as a family nurse practitioner, primary care provider, and executive leader of one of the country’s finest community health centers. I came to the Community Health Center, Inc. in 1980, newly graduated from the Yale School of Nursing as a family nurse practitioner and ready to begin my “service obligation” as a National Health Service Corps scholar. It was my great good fortune that the NHSC assigned me to what was then a small storefront on Main Street in Middletown, CT, where I found a small band of visionary and passionate community organizers and clinicians, like founder and CEO Mark Masselli, and family physician Dr. Carl Lecce, all of whom shared my own vision and passion for primary care and community health.

We put our shoulders to the wheel in building a remarkable community health center, first in Middletown, but over time and in response to requests from community leaders in cities all over Connecticut, we developed community health centers in 12 cities across our State. Through our W.Y.A. or “Wherever You Are” philosophy of going where the need is, we have also pioneered the expansion of statewide, school-based health centers and primary care services in homeless shelters. Today, our Community Health Center has over 130,000 active patients throughout the State. We are known for our clinical excellence but also for our commitment to innovation in addressing complex issues in primary care; for our formal research; and for training the next generation of qualified health care providers.

Today I want to address three questions that are the focus of much of my work and your area of interest today. First: who wants to be a primary care provider? And what must we do, now, to support those who make the affirmative commitment to become primary care providers? Second: how do we entice those providers to practice in underserved areas, both rural and urban, to care for our most vulnerable populations? Third, and just as important: how do we retain these talented, brilliant, and committed individuals in community health centers over the long haul? In answering these questions, I will speak to what we can and are doing, “in the field,” and also, how you are, and can, help us continue to do so.

First, let me address the workforce issue, and particularly the shortage of primary care providers. You are hearing compelling testimony today from my colleagues on this subject, and in particular, the need and strategies for attracting, training, and retaining more physicians in primary care. I support their recommendations and testimony. I am particularly supportive of the Teaching Health Center reauthorization and program, which recognizes, as I will emphasize in my testimony, that we must train the next generation not only to the clinical complexity of primary care in community health centers, but to our model of care—and that is best accomplished by FQHC-based residency training. You are well familiar with the many challenges that contribute to the shortage of primary care physicians—the low percentage of medical school graduates who choose primary care vs. specialties, the salary discrepancies between primary care and specialties, the burden of debt, and the deep frustration with primary care practice of the past few decades, which I believe we are fully capable of reversing—and I will speak to strategies to address that shortly.

But I want to step back. Instead of asking why more physicians don’t choose primary care, why not ask this broader question: Who else wants to be a primary care provider, and how can we support them in that choice and ensure that they will stick with it—particularly in the complex setting of community health centers?

My response is that nurse practitioners still overwhelmingly choose primary care as their preferred specialty, and we can attract, support, and assure their successful transition to the role of primary care provider in community health centers and other complex settings by giving them the opportunity for formal, post-graduate residency training programs in federally qualified health centers and nurse-managed health clinics.

In 2007, I and my colleagues at CHC, Inc. launched the country’s first formal post-graduate residency training program for new nurse practitioners who aspire to practice careers as primary care providers in community health centers. We did this after many years of observing the very difficult transition of brilliantly educated and fiercely committed new NPs as novice primary care providers in the very busy, immensely complicated settings of community health centers. The need and call for residency training for new NPs had been written about, talked about, and studied for years but the brick wall of GME legislative language failed to include NP residency training and impeded its development. We cannot afford to lose new NPs in community health centers—or deter them from coming to our setting—simply be-
cause we have not done the work required to facilitate their successful transition from university to practice.

We decided that someone had to build the model for NP residency training, and so we did. This NP Residency Training Program is full-time for 12 months. It is very intensive training that addresses the clinical complexity of health problems suffered by often uninsured, low-income health center patients, and trains these NPs to a model of high performance primary care—team-based, and integrated with behavioral health; person-focused but also driven by actionable data to achieve better and better outcomes.

We are now in our 7th year and have expanded to eight residents per year. Our applicants come from all over the country—we have had applicants from all but two States—and I can tell you that 27 of our 28 graduates to date are practicing as primary care providers in community health centers and safety net settings all across America, from Louisiana to Iowa, as well as in Illinois, Massachusetts, California and Washington State.

From the time we started and in response to our first published article on the model, we have been asked by others to help them develop NP residency training programs. Today there are 15 NP residency training programs for primary care NPs across the country, and 14 more that will come on line in 2014. They include community health centers, nurse-managed health clinics, and the Veterans Administration’s Five Centers of Excellence in Primary Care Education—plus the Jesse Brown VA Medical Center in Chicago. We have over 60 organizational members nationwide, with six participating facilities in Massachusetts alone—in Belmont, Boston, Cambridge, Charlestown, Leominster and Worcester; another NP residency training site has been established at the Fay Whitney School at the University of Wyoming in Laramie; and now even large health/hospital systems such as the Carolinas Healthcare System in Senator Burr’s home State—with six NP residency training sites—are joining this national movement.

To advance the model of NP residencies, I and my colleagues created the National Nurse Practitioner Residency Training Consortium, which has brought together the leaders of the movement to advance the development of NP residency training nationwide. Our goal is to set and maintain appropriate standards for these residencies and work for a sustainable stream of Federal funding similar to that available for physicians and dentists under GME. In short, we seek a legislative commitment to NP residencies, and we believe we are almost there. In 2010, Congress gave the Secretary of HHS the ability to award grants of up to $600,000 a year to eligible health centers seeking to implement NP residency training programs. However, that authorization expires this year and no grants have ever been awarded because the program was authorized but never funded. It is our request that, this year, the previously enacted provision be reauthorized and funded for another 5 years, because this program is absolutely critical to address the looming primary care workforce shortage we face at least the next 10 years. While our consortium is growing due to the tremendous need in our communities, many of the existing participants advise that they may be unable to continue the training without the provision of Federal funds moving forward. For example, the nationally renowned Portland Community Health Center in Bangor, ME, just advised me that although they will maintain the program next year, it will be cut by two-thirds. They implemented the program and spread information concerning NP residencies within the State but unfortunately say they will be educating at reduced capacity, compared to what they could have done, due to lack of funding.

My second question asked how we can recruit providers to underserved areas, both rural and urban. The National Health Service Corps, originally and brilliantly championed by Senator Warren G. Magnuson of Washington State, has stood the test of time as an effective, efficient, and elegant way to meet multiple critical needs: the need of the new clinician to obtain financial support; the need of the newly graduated clinician to obtain help with loan repayment; and the dire need of communities to acquire primary care providers. Since 1972, the Corps has done just this. I know this first hand. When I made the decision, after several years as a public health nurse, to attend graduate school at Yale, the financial challenge was daunting. In 1978, I was fortunate that the NHSC accepted me as a NHSC scholar, and I gratefully committed myself to a future period of obligated service. Why wouldn’t I? All I wanted—as I have seen with subsequent generations of NHSC scholars and loan forgiveness recipients—was a chance to practice, as a primary care provider, with people and in a community that needed my care.

In preparing for today’s testimony, it occurred to me that I really didn’t have a firm handle on how many members of my medical, dental, and behavioral health staffs had ever been in the NHSC during their careers. I posed that question by email to the staff and invited people to share the “where and when” of their serv-
ice—but also what it meant to them. Time does not permit me to read all 40 of the responses I received. These respondents are all “alums” of the NHSC and include physicians, nurse practitioners (both primary care and psychiatric specialist), PAs, Licensed Clinical Social Workers, Licensed Clinical Psychologists, Dentists and Dental Hygienists. Perhaps most tellingly, while some are currently in their period of obligated service, the majority completed their NHSC service many years ago but chose to stay and work in primary care. As one NP wrote,

“In my experience, the NHSC provided me with the financial support that allowed me to focus my attention directly on the clinical concerns of my patients and connected me with other like-minded clinicians. I remain forever grateful for the opportunity afforded to me by the Corps. For this reason, I would encourage all efforts to increase ongoing support for this wonderful program, and I applaud the NHSC for taking so many steps in recent years to ‘modernize’ their rules, procedures and policies to reflect changing times.”

Finally, I would like to answer my third question: what do we need to do to retain the best and the brightest, the most committed clinicians in primary care? For this, we must look to the cutting edge innovations and opportunities that create an exciting, stimulating, and vibrant career path for clinicians choosing primary care in community health centers. We can’t have a path that says to practice primary care in a community health center, you must forego any thoughts about research, teaching, and mastery of complex challenges through on-going exposure to the best specialists that academic medical centers might offer. Instead, our health centers provide exactly that rich environment. I have had the opportunity to see this through the creation of our Weitzman Institute, founded in 2005 as the Weitzman Center for Innovation in Primary Care, which is an institute with a core focus on delivery system research, applying the science of quality improvement in primary care, and training. And I have seen how powerful a force it is for us at CHC in both attracting—and retaining—our best clinicians.

Finally, I want to speak to overcoming the isolation that can be inherent in primary care as we face some of the most vexing problems. One example is “Project ECHO”—an evidence-based, distance learning approach developed by Dr. Sanjeev Arora at the University of New Mexico and replicated by CHC for FQHCs around the country. Project ECHO–CT. connects a team of specialists, by video, with groups of primary care providers all over the country. Practitioners in the field present their most challenging cases and get expert clinical guidance by telemedicine and, in the process, become expert over time themselves. Nowhere is this more important than in two critical areas of primary care: the diagnosis and management of chronic pain and—and sadly, but closely related—the management of heroin and opioid addiction. We all recognize the danger and precipitous rise in death by opioid overdose, both prescription pill and heroin, in our communities. Dealing with issues like this—alone and without expert support and guidance—is the kind of isolating and frustrating experience that drives people out of primary care. Connecting primary care providers with specialists and each other to treat and manage these complexities is of enormous value, and I would be happy to speak more about this if time permits.

In summary, I answer my three questions again. Who wants to be a primary care provider? Nurse practitioners do, and seek the opportunity for further intensive training appropriate to the complex setting of community health centers. How can we attract the best, brightest and most committed young providers across the medical/dental/behavioral health disciplines? By growing the National Health Service Corps. And finally, how do we retain these providers? Our responsibility, in the field, is to make our health centers not JUST centers of clinical excellence, but also the loci of research, training, and the advancement of science in primary care.

We greatly appreciate your leadership and look forward to your continued support for these initiatives.

Senator SANDERS. Thank you very much.

Senator Burr is going to introduce Dr. Dobson.

Senator BURR. Mr. Chairman, I’m pleased to introduce Dr. Allen Dobson, the present CEO of Community Care of North Carolina. He’s a family physician. He currently serves as the vice president of Clinical Practice Development at Carolina’s Medical Health System in Charlotte, and he is a visiting scholar at the Engelberg Center for Healthcare Reform at the Brookings Institute here in Washington, DC.
Let me just say on a personal note that Allen has been instrumental in reshaping the delivery of healthcare to the most vulnerable in North Carolina and I think nationally. His effort to create and to implement community care has been a model many have tried to figure out and replicate, if not in total, in part.

Dr. Dobson.

STATEMENT OF L. ALLEN DOBSON, Jr., M.D., PRESIDENT AND CEO, COMMUNITY CARE OF NORTH CAROLINA, RALEIGH, NC

Dr. Dobson. Thank you, Chairman Sanders and Senator Burr and members of the committee. It is a great pleasure to be with you today, and, as Senator Burr said, I’m a family physician. I actually started practice 30 years ago in a rural health clinic in a small town, and I still live there, despite the number of jobs—probably too many.

Let me just say that building and supporting a strong primary care infrastructure must be the top priority in health policy today. We believe Community Care is an important model, and just let me say that we spent the last 15 years in North Carolina building a strong community-based primary care system.

Ninety percent of our North Carolina primary care workforce participates in Medicaid, far better than most States. That’s private, community health centers, and others. Why? Because we started paying better for Medicaid, and Community Care was built to provide an infrastructure to support our primary care doctors.

I think the last time I was here, Senator Sanders, I said Community Care is a virtual community health center for all primary care physicians. It’s built on those principles. We provide health informatics and care management services in the community to enable our primary care doctors to better coordinate care and really do true population management in the rural communities and urban communities that they serve.

As a public-private partnership, it’s an infrastructure that covers all 100 counties. We’ve achieved one of the lowest growth rates of Medicaid spending in the country. We’ve saved the State money by avoiding wasteful spending. In fact, over a 4-year period, actuaries have said up to a billion dollars.

Our model is flexible and it serves both urban and rural equally well. What does it do? It helps support primary care doctors in getting PCMH certified. It works in collaboration with the Office of Rural Health, Area Health Education Centers, our Community Health Center organizations, the Division of Medical Assistance and Public Health. We’re the fabric for the primary care workforce. All our FQHCs, rural health clinics, residency programs, public health departments—all are members of Community Care.

So why is primary care important? Well, it’s delivering basic preventive care. It’s also maximizing that 80 percent of care that can be provided at a low-cost setting for our population. And it’s really coordinating the care of people with the most complex diseases and needs. The primary care workforce is where that needs to occur.

The upheaval in healthcare over the last 2 to 3 years has actually made things worse, and we all are here to testify about the pipeline and the primary care infrastructure. From our experience in North Carolina, let me just offer maybe four basic thoughts.
One is we really need to create an effective primary care pipeline in medical education. It starts with GME, looking at how we can get outcomes, but really focusing on training at the site where we know it will make a difference. We know in North Carolina if a med student is trained in a North Carolina medical school, and, more importantly, if they do their training in a North Carolina residency, they're likely to stay. The corollary is if they train in a rural area they will most likely stay.

We need to support our community-based AHECs and particularly support our Teaching Health Centers. It's a great model. Our early results—we have several in North Carolina. They are great partners. It's three or four times more likely, people who train there will stay and get a job at a community health center.

Physician-led medical homes and medical homes, in general, can help control cost and improve outcomes if supported with an adequate care management infrastructure and an effective population health infrastructure. We've got to do something about the 10-minute visit. You can't handle this in a 10-minute visit.

The second thing is that we really need to accelerate payment reform supporting primary care. We've talked about it, but it's pretty inadequate. We need to create incentives for physicians to see and engage patients and handle the most complex and high-risk populations. We need to make sure the Medicaid rates stay at 100 percent of Medicare.

We need to help States build the capacity in the rural areas and support independent practices. Two-thirds of our Medicaid population in North Carolina are served by some 900 independent practices and FQHCs mostly in rural areas. The care management infrastructure we give for the primary care providers in North Carolina really helps them manage those high-cost patients efficiently.

We also need to decrease the fragmentation that occurs by multiple payers doing it in multiple ways. The Federal Government is no exception. We need to support multi-payer efforts that align the efforts around the delivery system transformation, particularly in primary care, to allow such things as the multi-payer advanced primary care demo to be continued, because that funding allows the primary care workforce to really deliver effectively. So we would ask to support that.

North Carolina has found that if you really support the primary care system and residency training in local settings, the return on investment is there. It has led to local collaboration and care improvement and ultimately improved quality and cost control.

We really need policymakers to help enable our community-based infrastructures to become strong. That includes not just workforce, but health informatics and care management. We think we have pieces that will help inform the national dialog, and we can achieve long-lasting and widespread reform, but it starts with primary care.

Thank you very much for the opportunity to be here.

[The prepared statement of Dr. Dobson follows:]

PREPARED STATEMENT OF L. ALLEN DOBSON, JR., M.D.

Chairman Sanders, Senator Burr and members of the committee, it is a great honor to be with you today to discuss health policy issues that are critical to our
future, both in terms of access to quality healthcare and the overall strength of our healthcare system and economy.

My name is Allen Dobson. I am a family physician in North Carolina and president and CEO of Community Care of North Carolina (CCNC).

In North Carolina, as in most of the country, there has been a whirlwind of change with new payment structures, new technologies, market consolidation, new regulatory requirements, and a new industry of healthcare "consultants" who tell us they have the latest innovation or technology that will fix it all. Despite all of this, building and supporting a strong primary care base remains the top priority in healthcare policy.

Over the last 15 years, North Carolina has built a strong, community-based primary care system. Over 90 percent of North Carolina's primary care workforce participates in CCNC, a Medicaid participation rate far higher than most States. This is the result of North Carolina paying a somewhat higher rate for reimbursements than other States and the support provided to primary care doctors by CCNC. This includes health informatics and low-cost care management platforms that enable the application of population management across CCNC's entire statewide footprint and improve the quality of care delivered.

This unique public-private infrastructure, which covers all 100 of the State's counties, has helped to give North Carolina the lowest Medicaid growth rate in the country (see Figures 1 and 2), making it a national model for quality improvement and cost control. In an independent actuarial study, Community Care was shown to save nearly a billion dollars over a 4-year period in our Medicaid program. CCNC's system works equally well in rural, underserved and urban areas (See Figure 3 for geographic distribution of primary care facilities).
Our model has improved care by building capacity at the provider and community level and linking providers together through a statewide infrastructure that links providers together. We provide support for practices seeking recognition as a Patient Centered Medical Home (PCMH) support and other needed help in collaboration with the North Carolina Office of Rural Health, North Carolina Area Health Education Centers (AHEC), North Carolina Division of Medical Assistance and others.

We have thrived on innovation, fostering change, and establishing a culture of collaboration with all our partners around a common goal, improving the care delivered to our most vulnerable citizens.

Upheaval in the healthcare landscape, however, has accelerated rapidly over the last 2–3 years and our doctors are reeling. Our primary care medical homes are under stress and this will have a significant impact on the future primary care workforce and accesses to quality healthcare for our citizens.

If you are a primary care physician in North Carolina:

• You have probably just bought and implemented an electronic medical record and are now figuring out how to meet meaningful use requirements. You may be with vendors who have promised a Ferrari and delivered a Yugo. Many EHRs still are not capable of providing needed reports or communicating with other systems effectively.
• Despite buying into technology, doctors are inundated with paperwork and clerical tasks often turning physicians into data entry clerks. A recent national survey demonstrated doctors spend 22 percent of their time on paperwork; that is equivalent to 1 day a week of work.
• You may have been promised enhanced reimbursement for becoming an accredited Patient Centered Medical Home and may have invested $30,000 to $40,000 and hundreds of staff hours and have yet to recoup your investment. Promised payment reforms have been slow to come, leaving primary care doctors a volume-based payment system while being told they must prove their value before payment changes can be considered.
• Physicians now have to decide whether to join (or become) an Accountable Care Organization. A recent national survey of emerging ACOs put the price tag for start-up costs at $4M to $10M. The decision of independent physicians to join larger ACOs may be based on money rather than performance.
• There is rapid consolidation of our hospital systems, leaving independent physicians little choice but to take on salaried positions with large health systems. The number of independent hospitals has dropped from 142 to 24. From personal communications I have had with the North Carolina Medical Society and North Carolina Hospital Association, it appears that the number of independent cardiology practices in North Carolina has dropped from 196 to 4 in just the last 2 years.
• While some notable integrated delivery systems have increased healthcare value for purchasers, consolidation also decreases competition and may actually de-
crease local collaboration and innovation as the systems becomes more competitive and proprietary.

- There has also been rapid growth in healthcare technology platforms that promise to activate patients, provide remote monitoring, and control costs. Our State legislators and North Carolina Department of Health and Human Services staff are inundated with information from vendors promoting the latest app or care management solution and promises of savings and return-on-investment. Without a State infrastructure or larger reform plan, more fragmentation will occur.

- Unfortunately, this chaos is also having an impact on recruiting medical students and residents into primary care. While we have increased the number of medical student slots in North Carolina, only 19 percent are choosing primary care specialties (See Figure 4).

I believe that policy options that strengthen primary care are the most important element to a successful national healthcare reform effort. Primary care is essential for delivering preventive care, providing a significant portion of the healthcare needs in a low-cost setting and effectively coordinating care of patients with multiple chronic diseases.

Here are three recommendations from our experience in North Carolina that may be helpful:

1. **Create an effective primary care pipeline.** We need a continuous and coordinated medical education strategy with both undergraduate and graduate medical education policies that increase the supply of primary care doctors in rural areas.

In North Carolina, as in many parts of the country, there is not just a doctor shortage; there is a misdistribution of primary care doctors (along with general surgeons and psychiatrists). While the focus has been on adding more medical school positions (we have added 177 slots in the past 2 years), there is likely to be little impact on the other end of the pipeline unless we tie GME funding to outcomes. In 2005, out of 408 medical students in North Carolina, only 21 percent went into primary care and just 2 percent went on to practice primary care in a rural area. (See Figure 5.)
However, in-state training and community-based GME programs will increase the primary care physician supply:

a. Students who both went to school in North Carolina and completed residency in North Carolina, were more likely to practice in North Carolina (69 percent vs. 42 percent)

b. Residents who trained in community-based AHECs were more likely to practice in North Carolina compared with those trained in conventional GME settings (46 percent vs. 31 percent) and more likely to practice primary care (53 percent vs. 31 percent).

c. We now have two teaching health centers based out of FQHCs in North Carolina and a CCNC practice site; we believe this to be an effective workforce strategy. Residents trained in an FQHC are 3.4 times more likely to choose a job in a community health center.

d. CCNC works with all North Carolina primary care residency programs and North Carolina AHEC

e. CCNC-involved practice are more likely to be involved in education.

We must support and build capacity in primary care in order to improve access in rural area as and control costs. The evidence based around population health is teaching us that physician-led medical homes, supported with care management and effective population health strategies and infrastructure can help control costs and improve outcomes.

However, medical homes cannot function under a reimbursement model where physicians must see patients every 10–12 minutes. Payment structures that incentivize team-based care, population management, quality data reporting, and accountable care are a start; but we are finding that our independent practices are struggling to participate in these new models.

One of our pediatricians said,

"I met with my office manager and my accountant, and we figured out that it costs me $87 an hour to be involved in quality work. I'm not rewarded for it. Doing quality work actually costs me at this point. None of my partners are particularly interested in doing it and they take home more than I do. I do it because it is right and because I see it coming. I also get ulcers when things are not running efficiently and doing quality work has really improved our ability to not let patients fall through the cracks. Some things that used to keep me up at night don't anymore since we have these processes in place. We are delivering better care—no doubt."

2. **Payment reform is needed now and on a larger scale.** It should focus on incentives that allow primary care doctors—especially those in independent practices and FQHCs—to form continuous relationships that engage and activate patients to change behaviors and allow physicians to manage at risk populations. The
Direct Primary Care model where some or all primary care services are capitated with a flat fee is one example that shows promise.

3. **States need structures to support and build capacity in rural areas and for independent practices.** In the CCNC program, two-thirds of our Medicaid population is cared for in approximately 900 independent practices. In fact, despite the consolidation of the last few years, over 60 percent of the Medicaid population is still cared for by independent physicians and FQHCs, the majority in the rural areas of North Carolina. Our independent practices, like FQHCs, take care of a complex case mix and are our higher performers in total cost of care, hospitalization rates and readmission rates. With the exploding costs of “practice overhead,” we need lower cost utilities for practices to subscribe to that will allow them to participate in value-based care.

In North Carolina, we have built a statewide informatics infrastructure that supports our practices and has enabled our practices to identify ED super utilizers, patients who are not getting their medications filled, and those with chronic disease who are missing needed tests like hemoglobin A1Cs. Our platform also allows them to compare their clinical quality data with that of their peers and motivates local clinical management entities to improve population health.

We are now working with our partners including FQHCs to knit together a statewide health information exchange that will allow practices to report quality data and identify populations that need more intensive care management and will allow physicians to use healthcare resources more efficiently.

**SUMMARY**

In North Carolina, we have found that supporting primary care and residency training in local settings has led to local collaboration and care improvement—and ultimately improved quality and cost control. We look to policymakers to help enable community-based infrastructures such as health informatics and care management supporting our primary care that will further improve population health outcomes. Highly functional integrated health systems play an important role, but there will be a need for State-based “utilities” to support rural and independent practices to achieve lasting and widespread reform of our healthcare system.

Thank you for the opportunity to testify before this committee.

Senator SANDERS. Thank you very much, Dr. Dobson. Here’s what we’re going to do. We have a very important vote on the floor. That’s why some members have disappeared and why Senator Burr and I are going to have to disappear. So we’re going to halt this meeting for a few minutes. We will be up as soon as we can. We thank you for your patience.

[Whereupon, at 11:13 a.m., the committee recessed, to reconvene at 11:25 a.m., the same day.]

Senator SANDERS. My apologies again. But here in the Senate, there’s usually about six things happening simultaneously, and that’s the way it is.

We just heard from Dr. Dobson. Senator Burr is going to be returning in a minute. And now we’d like to hear from Dr. Nichols.

Dr. Nichols is a Family Medicine Resident at MedStar Franklin Square Family Health Center in Baltimore. He specializes in family medicine and community health epidemiology, focusing on population health management for medically complex and disadvantaged patients.

He has served on the American Academy of Family Physicians Commission on the Health of the Public and Science. Dr. Nichols is a graduate of the University of Texas School of Public Health and Baylor College of Medicine.

Thanks so much for being with us, Dr. Nichols.
STATEMENT OF JOSEPH NICHOLS, M.D., MPH, FAMILY MEDICINE RESIDENT, MEDSTAR FRANKLIN SQUARE FAMILY HEALTH CENTER, BALTIMORE, MD

Dr. Nichols, Good morning, Chairman Sanders, Senator Warren. I want to thank all the Senators present and not present today for putting aside lingering NCAA rivalries to sit down and talk about this very important issue today. I'm Joseph Nichols, and my path to a primary care career began at the age of three, when I was diagnosed with acute lymphoblastic leukemia, kindling a lifelong interest in medicine as a means to help others in need.

Early on, I entered a pipeline that started at the South Texas High School for Health Professions and continued all the way through the Premedical Honors College—an 8-year full tuition and fees scholarship to the University of Texas Pan American and Baylor College of Medicine. So you can imagine how excited I was to tell my pediatric oncologist about my plan to follow in his footsteps as a doctor for children with cancer.

To my surprise, this wise subspecialist physician, whose life's work saved my life, told me not to subspecialize like him, but instead to go where the need was now greatest, as he had done at the beginning of his career so many years ago. And to him, the need was now greatest for primary care physicians. I took his advice seriously.

Primary care is something everyone needs and deserves, and yet it has a constituency of no one. Nobody raises their hand and says, "I have primary care disease." A majority of first-year medical students enter medical school considering careers in primary care, but, as Senator Sanders mentioned, about 7 percent of U.S. medical graduates will go on to practice primary care.

At my school, at Baylor, students gave a variety of reasons for following other career paths. But in almost every case, my classmates worried about their student loans. Even at the least expensive private medical school in the country, many medical students abandon plans of becoming primary care doctors because of student loan debt. Moreover, most medical students are turned off to the prospect of primary care practice early in their training.

Our first intimate experience with primary care usually comes in our family medicine clerkships as third-year medical students. Most family medicine clerkships expose students to dysfunctional and outdated models of primary care delivery, often in settings where the fewest resources are available and yet where the sickest and poorest patients often seek care because they have no other place to go.

My family medicine clerkship and later experiences with a Title VII-funded Care of the Underserved Track at Baylor were exceptions that proved the rule, and I'm happy to elaborate on why.

But as medical students, we had abundant opportunities to interact with subspecialist physicians who were leading their respective fields, but we had almost no opportunities to be mentored by primary care physicians providing cutting edge care. I was drawn to underserved care because I wanted to discover a better way to care for these patients.

Many of us in the safety net toil day after day trying desperately to rescue patients from a rapidly flowing stream of suffering, sav-
ing them one by one from drowning. Meanwhile, what our healthcare system most acutely and keenly lacks is the ability to work effectively upstream, addressing the forces like poverty, social isolation, and racism that push Americans into the river of disability and poor health every day.

I looked for a family medicine program where I would spend most of my days trying to pull patients out of the river, but with regular opportunities to venture upstream. At Franklin Square, I met patients like Mr. Simms, a loving husband and father who used to support his family until he lost his job as a result of his diabetes. Unfortunately, with the loss of his job, he also lost his health insurance.

There are other patients in our practice like Mr. Simms, including his own son, who already shares many chronic illnesses with his father. And although little Regi is 25 years younger than Mr. Simms, his disease progression lags behind his father’s by only 5 years or so.

Children are supposed to be healthy enough to care for their aging parents. If we do not take swift and decisive action to grow the primary care workforce, already strained safety nets may break, failing from the weight of caring for multiple generations of sick patients simultaneously for the first time in history.

More patients surge down the river and become tangled in the net every day. We must recognize that my patient, his son, and others like them are afflicted primarily by poverty. Although poverty often masquerades as chronic diseases like diabetes, hypertension, addiction, or depression, we must not be distracted by this ruse. We must commit ourselves to moving upstream to prevent others from becoming sick, even as we tend to the sickness that is already upon us.

So what then must we do? We must make the total cost of medical education more affordable for students committed to careers in primary care. Programs like the National Health Service Corps Scholarship Programs and loan repayment programs are especially critical, accountable, and effective. We must identify students likely to enter primary care careers early on, as early as high school, and support these students with a long-range pipeline leading to primary care practice.

We must ensure that students receive their first exposure to primary care in innovative and effective training sites, like revamped academic primary care practices in medical schools or Teaching Health Centers. We must support and expand the Teaching Health Center program. The most vulnerable and most disadvantaged patients continue to fall into the river of disability and illness every day.

Rather than baptizing medical students in the river, let’s give them a boat. The Teaching Health Center is a boat with a motor. Other students deserve to benefit from the excellent sort of training opportunities that I had.

I pray that one day, I’ll live to see the day when a former patient will share with me her ambition to follow in my footsteps. I pray that I will be able to say to her that the problem to which I dedicated my life has mostly been fixed. I pray that she’ll be able to
38
devote her energies to a different challenge, to whatever is then the most pressing matter of her day.

Thank you, and be well.

[The prepared statement of Dr. Nichols follows:]

PREPARED STATEMENT OF JOSEPH NICHOLS, M.D., MPH

Good morning Chairman Sanders, Ranking Member Burr, and members of the subcommittee. My name is Joseph Nichols, and I am a Family Medicine resident at the MedStar Franklin Square Family Health Center in Baltimore, MD. I'm grateful for the opportunity to share with you today the perspective of a young primary care physician anticipating a long career of service to the poor and underserved. My testimony today will focus on the pipeline that led me to become a primary care physician, my view from the front lines of primary care training, and some concrete actions that the subcommittee can take right now to grow the primary care workforce this country so desperately needs and deserves.

I was born and raised in Harlingen, TX, a small community on our Nation's southernmost border with Mexico. My family's world was upended when, at the age of 3, I was diagnosed with acute lymphoblastic leukemia. While I would not wish a diagnosis of cancer on anyone, in retrospect it led to the best things that have ever happened to me. It kindled a lifelong interest in medicine as a means to help others in need, and it helps me to identify with the suffering of patients and families that I treat. I did fine with my treatment, and I went on to enjoy about as normal a childhood as I suspect I could, growing up in that unique part of the world.

Given my lifelong interest in medicine, when the time came, I applied to the South Texas High School for Health Professions, a public magnet high school which offers students a high quality educational experience focused on pursuing careers in health-related fields. "Med High", as it is affectionately known, results from a novel partnership, since 1984, between Baylor College of Medicine and the South Texas Independent School District. Med High has been repeatedly ranked among the top 100 high schools in the Nation by Newsweek and U.S. News & World Report and has demonstrated consistent success in producing health care professionals. Three other students in my graduating medical school class also shared the stage with me at my high school commencement, including our high school salutatorian. Other members of my graduating high school class went on to become dentists, pharmacists, nurses, public health workers, physician assistants, doctoral level researchers, and a variety of other health and nonhealth-related professionals as well.

Until the end of high school, it was my ambition to return to South Texas as a pediatric oncologist. I looked for every opportunity to follow this dream, and so I applied to the Premedical Honors College, what was at the time an 8-year full tuition and fees scholarship offered by the University of Texas Pan American and Baylor College of Medicine.

A number of changes have affected the scholarship program and its sponsoring institutions since my time there. The Premedical Honors College was founded in 1994 as a Hispanic Center of Excellence, with Federal dollars from the Division of Disadvantaged Assistance at HRSA. The Premedical Honors College soon opened it doors to students from all ethnic backgrounds, losing Federal funding. It was for a time supported by funds from both institutions and by a small group of generous private foundations. However these private donors eventually shifted focus to other worthy endeavors. Meanwhile, the endowments of both institutions were hit very hard in the recession. Despite funding challenges, both sponsoring institutions remain committed to the success of the Premedical Honors College, even as The University of Texas Pan American reorganizes itself as the University of Texas Rio Grande Valley, in order to better serve the educational needs of students from the southernmost region of south Texas, and increasingly, Hispanic students from across the Nation.

When I was admitted to medical school as a high school senior, you can imagine how excited I was to tell the pediatric oncologist who inspired my career choice. When I shared with him my hope to follow in his footsteps as a doctor for children with cancer, he expressed great pride for my accomplishments. But to my surprise, he discouraged me from this career path. He explained that he entered the field as a young resident feeling that the abandonment of children with cancer and their families constituted the greatest injustice in medicine of his time. I should state that my doctor not only entered into the field pediatric oncology; he pioneered it. He led the team that produced the first cures for childhood leukemia. By the time I was treated for cancer, his work and the work of many others brought survival rates for several types of childhood cancer above 90 percent, whereas when he was
starting his career, many of these diseases had been a death sentence. More work on childhood cancer remains to be done, but as his career began to wane, he had the satisfaction of seeing other challenges rise to prominence.

This wise physician, whose life’s work saved my life, encouraged me not to follow in his footsteps, but instead to go where the need was greatest, as he had done at the beginning of his career. To him, the need was now greatest for primary care physicians. Moreover, he felt that all the compassion and dedication that had been borne into me as a cancer survivor would make me exceptionally well suited for this equally noble career path.

I took his advice seriously. It occurred to me that primary care is a necessity hiding in plain sight. Primary care is something needed and deserved by everyone, and yet it has a constituency of no one. Nobody raises her hand and says, “I have primary care disease.” This would be the field where I would leave my mark.

The quality and rigor of the advanced placement program at my health careers-oriented high school allowed me to complete almost an entire year of college coursework as a high school junior and senior. So I was fortunately able to finish my undergraduate degree in only 3 years. I invested my year before starting medical school in studying epidemiology at the University of Texas School of Public Health, in Houston.

In public health school, I learned how to think about health in terms of populations. I learned, paraphrasing the words of another physician champion of social justice, that people live not only in bodies, but also in families, neighborhoods, communities and populations. The physical and social environments have a profound impact not only on our health, but also on our potential for health, even at the genetic level. Health is largely a product of where and how people live, learn, work, worship, and play. Those of us working together in the fields of public health medicine cannot therefore meaningfully alter the health or health potential of a person or a group without partnering with people beyond the exam room and the hospital. And the most effective interventions are those which focus not on doing things to people or for people, but rather with people, building on their inherent strengths, and working together to build healthier environments and practice healthier behaviors.

So I was excited after my year at public health school to enter medical school and begin learning how to go about helping people to achieve this thing called health. You can imagine my disappointment when I found that we spent almost our entire time talking about diseases, when clearly health is so much more than merely the absence of disease. Few of my other classmates seemed to notice, or to be bothered by this.

We know that a majority of first year medical students enter medical school considering careers in primary care. Unfortunately we are also aware that far fewer than the majority of medical school graduates will go on to practice primary care. This forces us to consider what we're doing, or not doing, to lose students to other specialties that may not address the pressing workforce needs of our Nation. An important part of medical education is what has been termed the “hidden curriculum”—the inculcation of attitudes and belief systems that are distinct from procedural and intellectual knowledge. This hidden curriculum contains some of the most noble features of our profession, namely compassion, altruism, honesty, and the value of hard work. Unfortunately, the hidden curriculum in many medical schools turns students away from careers in primary care, due to the misperceptions it perpetuates about our specialty, its practitioners and our patients.

You have no doubt heard many other primary care physicians recount stories of attending physicians and classmates discouraging their choice of specialty. In all honesty, I don’t recall being harassed for pursuing a career in primary care while at Baylor College of Medicine. In fact, a good number of my classmates confided in me that they wished they could practice primary care as well. These students gave a variety of reasons for following other career paths.

Some of my classmates said that the breadth and depth of knowledge underlying primary care was too vast and difficult to master. Other students said they lacked or could not develop the social skills necessary to manage long-term relationships with patients in the context of these patients’ families and communities. But in almost every case, my classmates who opted toward subspecialty training and away from primary care did so in part because they worried they could not afford to repay their student loans as a primary care physician.

I’m certain that this point has been made to the subcommittee before. But to show how extraordinary this part of my story is, allow me to tell it another way. Even at the least expensive private medical school in the country, many medical
students abandon plans of becoming primary care doctors because of student loan debt.

So I applied myself in my clinical years, training in the full variety of different types of hospitals available to BCM students, including a large inner-city public hospital, a freestanding children's hospital, a Catholic hospital, a well-endowed private hospital, and the largest Veterans Administration hospital facility. I received excellent preparation for providing high-quality primary care to socially disadvantaged and very complex patients at Baylor College of Medicine. However, I also understand why medical schools struggle in producing primary care physicians, especially for the poorest and sickest patients where primary care doctors are most desperately needed now.

Most students completing a family medicine clerkship are exposed to dysfunctional and antiquated models of primary care delivery, often in settings where the fewest resources are available, and yet where the sickest patients by necessity seek care. Medical students keenly sense the frustration and helplessness, often thinly veiled, of providers trapped in inefficient and inadequate systems.

My family medicine clerkship was an exception that proved the rule. Through some advanced planning and extra effort, I arranged to spend my month-long family medicine clerkship 2 hours east of Houston, training in a 100-year-old rural practice, run by a third-generation primary care physician who was an immediate past president of the Texas Academy of Family Physicians. This practice cared mostly for sick and elderly rural patients who had no other reliable source of primary care available in the rural Texas Hill Country, and they did so by building a practice perfectly suited to the needs of their patients. Doctors there anticipated the need for an electronic medical record in the mid-1990s, and they were already using their EMR to its full capabilities a full 10 years ahead of our more recently determined meaningful use deadlines. These physicians served various key roles in the community, including school board member, trustee of the local bank, director on the board of the local critical access hospital, high school sports team physician, radio talk show host, and local county health officer. Almost all the characteristics of the patient-centered medical home that so many practices are struggling to embrace, even today, were already present in this practice, simply because this seemed like the right way to do things, and because the doctors working there had the capability and commitment to make things better, from one day to the next.

My experiences with an innovative, rural Texas family medicine practice stood in stark contrast to those of my colleagues who stayed in Houston, placed in dysfunctional urban family medicine clinics, where patients were more often than not swept downriver further and further each day, despite the most heroic efforts of the providers. Even though as medical students we trained in nearly every kind of hospital commonly encountered in the healthcare landscape of the United States, our outpatient primary care experiences were, by comparison, an afterthought. We had every opportunity to interact with many subspecialist physicians who were leading their respective fields, but we had almost no opportunities to be mentored by primary care physicians providing cutting-edge care. It was possible for only a small motivated minority of students, like myself, to experience the sort of advanced model of primary care practice in training that is vital for meeting our country's needs.

Many of us in the so-called safety net toil day after day, trying desperately to rescue patients from a rapidly flowing stream of suffering, saving them one by one from drowning. Meanwhile, what our health care system most keenly lacks is the ability to work effectively upstream, addressing the forces like poverty, social isolation, and racism that push Americans into the river of disability and poor health every day.

Somewhere I survived medical school. I must take a moment to thank the then-Dean of Students at BCM. He is a kind and wonderful man who was and is incredibly supportive of his students, and of me in particular. He went out of his way to encourage each student selecting a career in primary care, confiding in us that he (a Harvard educated surgeon who had graduated with honors from medical school at Baylor) did not feel personally capable of undertaking a career path as challenging as primary care. “You are the real doctors,” he told me, summarizing his admiration for primary care. As wonderful as it was to hear the Dean of Students affirm my career choice, it saddens me that he shared this message with me privately, and at the end of my third year of medical school, after all of my classmates had selected their medical specialties, rather than at the very beginning of our training and over the course of our difficult first few years.
I decided to pursue my family medicine training in a residency program where I would spend most of my days trying to pull patients out of the river, but with regular opportunities to venture upstream. At the MedStar Franklin Square Family Health Center, we take primary care to our patients. We follow some patients in the nursing home. We sometimes go on house calls for patients that cannot make it into the office to see us, often bringing along reinforcements from our multidisciplinary care management team, including a nurse care coordinator, medical and clinical social workers, and a pharmacist, along with medical and pharmacy students from a variety of schools, including Johns Hopkins School of Medicine. In between, my journeys upstream have taken me to our local county health department, the Maryland State health department, the governing body of the American Academy of Family Physicians, the Robert Graham Center, and the U.S. Capitol, on more than one occasion.

I met patients like Mr. Simms, whose story I’m sharing with you today with his permission. Mr. Simms is a loving husband and father, who used to support his family working 12 hour shifts 5 or more days a week as the manager of a chain restaurant serving 24-hour breakfast. An unfortunate combination of eating too much of his restaurant’s food, not getting enough exercise outside of working such long hours, and a genetic predisposition resulted in Mr. Simms developing diabetes in the prime of his working years. His disease was advanced by the time it was diagnosed, and he needed insulin therapy from the beginning. His long and irregular schedule, and the lack of a refrigerator at work where he could safely store his insulin, prevented him from giving himself the medications he needed to manage his disease.

He soon lost his job after he developed a serious infection of one of his feet, requiring amputation of several toes. This would be the first of many surgeries and complications to befall Mr. Simms as a result of his diabetes. Unfortunately, with the loss of his job, he also lost his health insurance. I met Mr. Simms almost 20 years after his diagnosis. He was uninsured and had nearly been bankrupted by his medical bills. And like many Americans, he was nearly underwater on his mortgage. His wife continued working, and she made just enough money to prevent him from being eligible for many of the more common forms of public assistance. Mr. Simms worked out a deal with the bank that enabled him to keep his house; however, he was required to maintain very strict limits on his debt, which any further medical bills would upset, resulting in the loss of his home.

Caring for Mr. Simms, and patients like him, I became adept at considering the myriad social and economic forces that affect health in America. On some rare occasions, I can even use these forces to my advantage. For instance, the great majority of medications that I use routinely are found on the $4 list of medications available from big-box store pharmacies. These medicines are tried-and-true, and I take two of them myself every morning. It is tempting to believe that this is an affordable way of providing patients with good quality medical care. Four dollars for a 30-day supply of medicine suddenly becomes expensive for patients living on a fixed income who need to fill six or more of these prescriptions every month. Meanwhile many essential medications remain absent from these lists.

My patient, Mr. Simms, is a personal hero of mine. Despite multiple partial amputations of both feet, prolonged hospitalizations and nursing home stays, and the recent loss of an eye to a complication of diabetes, he remains cheerful, and he continues to teach our residents and our care coordination staff about the needs of patients like him. There are already other patients in our practice like Mr. Simms, including his own son. Little Regi, as everyone knows him, already shares many chronic illnesses with his father. Although Little Regi is 25 years younger than Mr. Simms, his disease progression lags behind his father’s by only 5 years or so. The moral of this story: If we do not take swift and decisive action to grow the primary care workforce and to empower it with the tools it needs to address the upstream causes of chronic disease, already strained safety nets may break, failing from the weight caring for multiple generations of medically complex patients simultaneously, for the first time in history.

More patients surge down the river and become tangled in the net every day. We must recognize that my patient, his son, and others like them are afflicted primarily by poverty. Although poverty often masquerades as a chronic disease like diabetes, hypertension, addiction, or depression, we must not be distracted by this ruse. We must commit ourselves to moving upstream to prevent others from becoming sick, even as we tend to the sickness that is already upon us.

So what then must we do?
First we must shorten the path to medical training. BCM and other medical schools have previously successfully experimented with a 3-year medical school curriculum, during a time in the past when a shortage of physicians was feared. We have the opportunity to refocus medical education not on learning everything that one needs to know, but rather on learning how to learn. Recognizing that medical school is simply a stepping stone into a lifelong process of learning, empower each graduate with the tools that she will need to tailor a lifetime of learning and practice to meet the needs of her patients.

Next we must make the total cost of medical education more affordable for students committed to careers in primary care. In doing so, we must consider the total cost of training, from undergraduate education through the duration of residency. Programs like the National Health Service Corps Scholarship Programs and Loan Repayment Programs are especially critical, linking students and residents to training in primary care specifically for the disadvantaged and underserved.

Next we must identify students likely to enter careers in primary care early on, as early as high school, and support these students with a long range pipeline approach leading to medical school admission and to eventual primary care careers. Invest in novel and effective educational programs, such as health professions magnet high schools, as key sections of this pipeline. Patch the pipeline along every section with extra support and advisement for students from disadvantaged backgrounds, helping the students that will be most likely to practice and be effective at delivering primary care to disadvantaged patients in the future. This investment will pay great returns in the future. In the meantime, we need to increase primary care production now, so the early experiences of students entering medical school in the next few years present a critical opportunity to retain trainees in the primary care pipeline.

Encourage the development and expansion of advanced primary care training sites in academic medical centers through grants for research and training, especially targeted at the academic primary care practices where most students receive their first exposure to primary care. Create the same opportunity for medical students early in their training to emulate primary care innovators as they have to be impressed by subspecialists. While we must continue to advance all fields of medicine, in the near future we should focus funding for research and training especially on primary care, which has urgent catching up to do.

Support and expand the Teaching Health Center program as a better approach to caring for and training with the medically underserved. The most vulnerable and most disadvantaged patients continue to fall in the river of illness and disability every day. Rather than baptizing students in the river, let’s give them a boat. The Teaching Health Center is a boat with a motor. The students and residents that train in Teaching Health Centers will receive the specialized training they need to become the primary care physicians that must, in the coming years, right the inequities that underlie the majority of the excess healthcare costs that we as a nation collectively bear. And while we set about growing the primary care workforce we need and deserve, our sickest patients will benefit from improved medical care in the mean time.

I want to conclude by saying that my education does not belong to me; I did not purchase it or win it. It’s rather something with which I have been entrusted. Like all medical students, my education was heavily subsidized by Federal and State funds, in addition to the numerous scholarships which I also received from public and private sources. I feel a profound responsibility to use my education and skills in service to society, and to pass these skills and knowledge on to the next generation of physicians, who will care for myself, my family and my neighbors in the future. I want nothing more or less than to belong to my community, to dedicate my labors to its health and well-being, and for us to care for one another.

Even though my story may seem exceptional, I am not. While it requires a lot of hard work to get where I am today, I also had a tremendous amount of help from a great number of people and programs. I’m a living example of a well-researched finding that individuals coming from socially or educationally disadvantaged backgrounds are more likely to pursue careers in primary care. I’m also confident that without the ongoing support of a number of unique programs stretching back to high school, I would not have been able to achieve admission to medical school, and I would not have been able to pursue this goal. Other students deserve to benefit from the excellent sort of training opportunities that I had, and these sorts of programs show great promise for growing the primary care workforce our country needs and deserves.
And I pray I live to see the day when one of my former patients will share with me her ambition to follow in my footsteps, helping others as I once helped her. I pray that I may have the satisfaction of saying that the problem to which I have dedicated my life has been vastly improved. I pray that she will devote her energies to a different challenge, what is then the most pressing matter of her day.

Thank you, and be well.

Senator SANDERS. Thank you, Dr. Nichols.

Senator Burr.

Senator BURR. Mr. Chairman, I have the pleasure today to introduce Dr. Linda Kohn, Director of GAO's office that has the healthcare team where she works on issues related to public health, health information, technology, and quality management. I want to thank her today for the work that that group has done to help us navigate where we should go based upon the assessments that they've made.

And, Linda, GAO does incredible work, work that is invaluable to the Congress and, I think, to the American people. Would you please convey to your colleagues there how grateful we are—especially your team, and to the rest—how grateful we are for the work that they do. In many cases, you bring reports out that enlighten us on things we didn't know, are not always what everybody wants to hear, but are the facts that are best used to foundationally fix what's broken. Thank you.

STATEMENT OF LINDA T. KOHN, Ph.D., DIRECTOR OF HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. KOHN. Thank you very much for that kind introduction. Chairman Sanders, Ranking Member Burr, members of the committee, I'm pleased to be here today to discuss our work on Federal investments in health workforce training and the availability of data related to the supply of and demand for healthcare professionals.

Last fall, we issued a report that identified Federal programs that support postsecondary education for direct healthcare professionals in fiscal year 2012. Shortly after that, we issued another report that examined HRSA's actions to project the future supply of healthcare professionals, including physicians, physician assistants, and advanced practice nurses.

My statement today is based on those two reports. Together, they provide a snapshot of the Federal efforts in ensuring that a well-trained and diverse healthcare workforce is available to provide care in this Nation.

Our first report that identified Federal training programs is fairly limited in scope. It represents a first cut at trying to compile as comprehensive a list as possible for the Federal programs that provide support for training of healthcare professionals. So we tried to identify the programs, and for each one identified, the number of trainees in the program and the Federal obligations for 2012.

As noted before, we found that four departments, HHS, VA, DOD, and Education, supported 91 training programs for direct healthcare professionals and obligated a total of about $14 billion in 2012. The largest amount of money went for postgraduate residency training for physicians, dentists, and others, commonly
known as Graduate Med Ed or GME. We identified seven programs that totaled about $11 billion or 78 percent of the $14 billion total. That was through HHS, mainly Medicare and Medicaid, but VA and DOD also supported GME programs.

So if $14 billion was spent in total, and $11 billion of that went to GME, that leaves about $3 billion or 22 percent of the pie for all the other 84 programs that we identified. Some of those programs provide financial assistance, such as scholarships or loans. Others, as we heard, provide financial assistance in exchange for a commitment to work in a specific facility or location.

Some of the programs supported primary care, but not all of them. Overall, HRSA administered the most programs. But the most money went through CMS for GME.

We identified several challenges in compiling comprehensive information about the scope of the programs, and, partially, it's because these programs do cross multiple departments and multiple agencies within a department. So getting comparable information was not always possible for us. For example, we identified programs at HHS, VA, and DOD where the number of trainees was not available, or maybe we could only get the information at an aggregate level. We couldn't break it down at a program level.

The Department of Education has several programs that support postsecondary training for various types of students, including health professionals. But those programs aren't specifically targeted for health professionals. So we weren't able to break it down in terms of how many health professionals were also included in those programs, even though we know those programs are there.

Our second report focused on HRSA efforts to produce workforce projections. HRSA is the agency responsible for monitoring the supply and demand for healthcare professionals. And we reported in September 2013 that HRSA last published its workforce projections in 2008, based on data from 2000.

Since 2008, HRSA awarded five contracts for studies to support updated projections, but had not published any of those projections at the time of our work, although four were planned. After we issued our report last fall, HRSA published the projections for the primary care workforce to 2020.

We recognize the challenges in producing workforce projections, but there is a long lead time for any policy changes, such as altering the number or mix of training to affect the supply of healthcare professionals. And HRSA has also acknowledged the long lead time for any interventions that might be possible.

But together, these two reports aimed to shed some light on what might be considered fairly basic information: What is the Federal investment in workforce training programs for direct healthcare professionals? How many programs are there? How much money is being expended? What is known about how many health professionals we need? We hope this underlying information contributes to your discussions.

That concludes my prepared remarks, and I'm happy to respond to any questions. Thank you.

[The prepared statement of Ms. Kohn follows:]
A well-trained and diverse health care workforce is essential for providing Americans with access to quality health care services, including primary care services. To help ensure a sufficient supply of physicians, nurses, dentists, and other direct care health professionals for the Nation, the Federal Government has made significant investments in health care workforce training through various efforts. As Congress considers funding existing or additional training programs that would address any potential shortages of health care professionals, timely and up-to-date estimates of future supply and demand for health care professionals are critical.

This statement addresses (1) the scope of the Federal Government’s role in health care workforce training and (2) the availability of data related to projecting health care workforce supply and demand. It is based on findings from two recent GAO reports. The first report identified Federal programs that supported postsecondary training and education for direct care health care professionals in fiscal year 2012, including information about program purpose, funding, and targeted health professionals. The second report examined actions HRSA has taken to project the future supply of and demand for physicians, physician assistants, and advanced practice registered nurses (APRN) since publishing its 2008 physician workforce report. These products used a variety of methodologies, which are detailed in each report.

Lack of timely, regularly updated data creates challenges for projecting health care workforce supply and demand. The Health Resources and Services Administration (HRSA)—an agency within HHS—is responsible for monitoring the supply of and demand for health care professionals. At the time of its September 2013 report, GAO found that, since publishing a 2008 report on physician supply and demand, HRSA had awarded five contracts to research organizations to update national health care workforce projections. However, HRSA had failed to publish any new workforce projections. While HRSA created a timeline in 2012 for publishing a series of new workforce projection reports, the agency missed its original goals for publishing them and had to revise its publication timeline. HRSA’s report on the primary care workforce was published in November 2013, more than 3 years after the contractor originally delivered its report to HRSA for review.

Chairman Sanders, Ranking Member Burr, and members of the subcommittee: I am pleased to be here today to discuss our work on Federal investments in health care workforce training and the availability of data related to projections of supply
and demand for health care professionals. A well-trained and diverse health care workforce is essential for providing Americans with access to quality health care services, including primary care services. A number of reports published by government, academic, and health professional organizations have projected national shortages of some types of health care professionals, which could result in patients experiencing delays in receiving, or a lack of access to, needed care. To help ensure a sufficient supply of physicians, nurses, dentists, and other direct care health professionals for the Nation, the Federal Government has made significant investments in health care workforce training through various efforts. These efforts include Federal programs that train health professionals directly, award grants or make payments to institutions training health professionals, and provide financial assistance to health professional students through stipends, scholarships, loans, or loan reimbursement. In addition, as Congress considers policy options to address health care workforce issues—such as funding training programs that would address any potential shortages of health care professionals—timely and up-to-date estimates of future supply and demand for health care professionals are critical. The Health Resources and Services Administration (HRSA)—an agency within the Department of Health and Human Services (HHS)—is responsible for monitoring the supply of and demand for health care professionals.

This statement addresses (1) the scope of the Federal Government’s role in health care workforce training and (2) the availability of data related to projected health care workforce supply and demand. It is based on findings from two recent GAO reports. The first report, Health Care Workforce: Federally Funded Training Programs in Fiscal Year 2012, identified Federal programs that supported postsecondary training and education for direct care health care professionals in fiscal year 2012, including information about program purpose, funding, and targeted health professionals. The second report, Health Care Workforce: HRSA Action Needed to Publish Timely National Supply and Demand Projections, examined actions HRSA has taken to project the future supply of and demand for physicians, physician assistants, and advanced practice registered nurses (APRN) since publishing its 2008 physician workforce report.

Each of the reports cited in this statement provides detailed information on our scope and methodology. This statement is based on work that was conducted from March 2013 through September 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

BACKGROUND

The U.S. health care workforce includes a spectrum of health professionals requiring varying levels of postsecondary education and training, ranging from diploma programs to graduate degrees and postgraduate training. Some professionals who deliver direct health care services to patients require clinical training through a health care institution—such as internships, residencies, or fellowships—in addition to completing graduate-level educational requirements before being eligible for full licensure. These professionals include physicians, certain pharmacists, podiatrists, clinical psychologists, and dentists seeking a dental specialty.

To maintain an adequate health care workforce, the future supply of health care professionals must be projected and compared to the expected demand for health care services to determine whether there will be enough providers to meet the demand. Such projections can provide advance warning of shortages or surpluses so that health care workforce policies, such as funding for health care training programs, can be adjusted accordingly. In its 2008 physician workforce report, HRSA noted that due to the long time needed to train physicians and to make changes to the medical education infrastructure, policymakers and others need to have infor-
We have also previously reported that producing supply and demand projections on a regular basis is important so that estimates can be updated as circumstances change.\textsuperscript{6}

**SUBSTANTIAL FEDERAL FUNDING FOR HEALTH CARE WORKFORCE TRAINING PROGRAMS EXISTS, BUT OBTAINING COMPREHENSIVE INFORMATION ABOUT THE SCOPE OF SUCH PROGRAMS IS CHALLENGING**

In our August 2013 report, we found that four Federal departments—HHS, the Department of Veterans Affairs (VA), the Department of Defense (DOD), and the Department of Education (Education)—administered 91 programs that supported postsecondary training or education specifically for direct care health professionals in fiscal year 2012. All together, the four departments reported obligating about $14.2 billion for health care workforce training programs in fiscal year 2012, with HHS funding the most programs (69) and having the largest percentage of total reported funding (82 percent).\textsuperscript{7} See table 1 for additional details about the number of health care workforce training programs administered by HHS, VA, DOD, and Education and the funds the departments reported obligating for them in fiscal year 2012.

Table 1.—Health Care Workforce Training Programs Administered by Four Federal Departments and Funds Obligated for These Programs in Fiscal Year 2012

<table>
<thead>
<tr>
<th>Department</th>
<th>No. of health care workforce training programs funded</th>
<th>Obligations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health and Human Services</td>
<td>69</td>
<td>$11.7 billion</td>
</tr>
<tr>
<td>Department of Veterans Affairs</td>
<td>12</td>
<td>$1.7 billion</td>
</tr>
<tr>
<td>Department of Defense</td>
<td>7\textsuperscript{*}</td>
<td>$0.9 billion</td>
</tr>
<tr>
<td>Department of Education</td>
<td>3</td>
<td>$2 million</td>
</tr>
</tbody>
</table>

Source: GAO summary of Department of Defense (DOD), Department of Education (Education), Department of Health and Human Services (HHS), and Department of Veterans Affairs (VA) information.  
Note: DOD, Education, HHS, and VA obligated a total of about $14.2 billion for health care workforce training programs in fiscal year 2012. Amounts listed in this table do not add to $14.2 billion because of rounding. \textsuperscript{*}One of DOD’s seven programs represents multiple clinical and instructional health professions education programs. For the purposes of this statement, we characterized them as a single program because DOD could not provide consistent program-level information.

In total, across all four departments, the majority (78 percent) of Federal funding for health care workforce training in fiscal year 2012—about $11.1 billion—went to seven programs that supported postgraduate residency training for physicians, dentists, and certain other health professionals, called Graduate Medical Education (GME) (see fig. 1). Two programs administered by HHS’s Centers for Medicare & Medicaid Services (CMS)—Medicare payments to teaching hospitals and other entities for Direct Graduate Medical Education (DGME) and Medicare payments to teaching hospitals for Indirect Medical Education (IME)—accounted for about 66 percent of total reported health care workforce training funding.\textsuperscript{8} CMS’s Medicaid program also made payments to teaching hospitals for GME, and HRSA, another agency within HHS, administered two programs that supported GME in settings

\textsuperscript{5}Health Resources and Services Administration, *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand* (Rockville, Md.: 2008).


\textsuperscript{7}GAO asked department and agency officials to provide obligations, including those for which expenditures have been made, for each program in fiscal year 2012. The term obligation refers to a definite commitment by a Federal agency that creates a legal liability to make payments immediately or in the future. Agencies incur obligations, for example, when they award grants or contracts to private entities. An expenditure is the actual spending of money by the issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate a Federal obligation. The total reported obligations do not include amounts obligated in prior years that were expended in fiscal year 2012.

\textsuperscript{8}For the purposes of this statement, we considered Medicare DGME payments and Medicare IME payments to be separate programs. Medicare DGME payments cover the teaching costs of training residents, such as resident stipends, administrative overhead, and supervisory physician salaries. Medicare IME payments support the higher patient care costs associated with training residents, such as the ordering of more tests and increased use of emerging technologies.
other than teaching hospitals.\(^9\) VA and DOD also administered GME programs; however, the funding information VA provided to us accounted for resident salaries and benefits, while the funding information provided by DOD accounted for only certain administrative costs to operate its GME program.

### Figure 1: Proportion of Total Reported Federal Funding Obligated for Health Care Workforce Training by Graduate Medical Education (GME) and Other Programs, Fiscal Year 2012

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Funding Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>78%</td>
<td>$111.1 billion</td>
</tr>
<tr>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>22%</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Percentages do not add up to 100 because of rounding.*

The remaining Federal funding for health care workforce training—about $3.2 billion—went toward 84 HHS, VA, DOD, and Education programs that:

- provided financial assistance to direct care health professional students and professionals,
- provided or supported instruction or clinical training for direct care health professionals, or
- provided a combination of these and other training support services.

Across all 84 non-GME programs, trainees received differing levels of assistance, ranging from participation in short-term continuing education courses to full support for tuition and books and a stipend for living expenses. These 84 programs targeted various types of health professionals and eligible individuals. See table 2 for additional information about the number of non-GME training programs targeting various categories of health care professionals.

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\(^9\)Medicaid payments for GME and the two HRSA programs—the Children’s Hospitals GME Payment program and the Teaching Health Center GME Payment program—provided funding for both direct costs of resident training, such as resident salaries and benefits, and indirect funding to reflect the higher patient care costs associated with resident education.
Table 2.—Number of Non-Graduate Medical Education (GME) Training Programs That Target Certain Categories of Health Care Professionals

<table>
<thead>
<tr>
<th>Category of health care professionals targeted</th>
<th>No. of training programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students, professionals, or faculty in multiple health professions</td>
<td>47</td>
</tr>
<tr>
<td>Nurses only</td>
<td>18</td>
</tr>
<tr>
<td>Physicians or physician assistants only</td>
<td>8</td>
</tr>
<tr>
<td>Dentists or dental hygienists only</td>
<td>6</td>
</tr>
<tr>
<td>Behavioral health professionals only</td>
<td>4</td>
</tr>
<tr>
<td>Physicians and dentists only</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>84</td>
</tr>
</tbody>
</table>

Source: GAO summary of Department of Defense, Department of Education, Department of Health and Human Services, and Department of Veterans Affairs information.

Note: We included both programs that solely targeted direct care health professionals and programs that targeted direct care health professionals among other professionals if the program purpose or objectives specifically identified direct care health professionals.

1 These programs targeted three or more types of health professionals.

Compiling comprehensive information about the scope of Federal support for health care workforce training is challenging because multiple Federal departments administer such programs, and we found that the departments did not always have comparable program information. For example, at the time of our review, we relied on a multitude of sources to identify training programs and program information in the absence of a comprehensive listing of such programs. In some cases, the level of detail in the information we obtained from the four departments varied or data were not available. For example, HHS and VA were not able to account for the number of health professional trainees supported by certain programs they administer. In another example, DOD was unable to provide information about funds obligated or the number of trainees supported by each of its multiple non-GME clinical training and education programs for military medical personnel. Therefore, we reported the number of trainees supported and amount of funds obligated at an aggregate level for these DOD programs. The funding information reported by DOD also did not include amounts for salary and benefits of residents in its GME programs, whereas other departments included these amounts in their reported GME funding.

The scope of our August 2013 review of Federal programs that supported postsecondary training and education for direct care health care professionals had some limitations. For example, we limited our review to programs that specifically targeted postsecondary training and education for direct care health care professionals in fiscal year 2012. There could be additional programs or funding that supported health care workforce training that did not specifically target direct care health professionals. For instance, in fiscal year 2012, Education administered programs—such as the Subsidized and Unsubsidized Stafford Loan Programs, the Direct PLUS and Perkins Loan Programs, Pell grants, and Federal Work Study—that support postsecondary training or education for various types of students, including direct care health professionals. However, these programs do not specifically target health professionals, and we could not determine the number of direct care health professionals supported by these programs or the total amount of funds from these programs that supported such training. Additionally, there may be other programs that support health care workforce training but that did not obligate funds in fiscal year 2012.

LACK OF TIMELY, REGULARLY UPDATED DATA CREATES CHALLENGES FOR PROJECTING HEALTH CARE WORKFORCE SUPPLY AND DEMAND

In addition to administering 50 health care workforce training programs, HRSA is responsible for monitoring the supply of and demand for health care professionals and disseminating workforce data and analyses to inform policymakers and the public about workforce needs and priorities. The Bureau of Health Professions (BHP) within HRSA has multiple responsibilities related to workforce development, including conducting and contracting for studies on the supply of and demand for health care professionals. In 2006, we found that HRSA had published few national workforce projections despite the importance of such assessments to setting health care workforce policy, and we recommended that HRSA develop a strategy and establish
timeframes to more regularly update and publish national workforce projections for
the health professions.10

At the time of our September 2013 report, we found that HRSA had awarded five
contracts since 2008 to research organizations to update national workforce projec-
tions but that HRSA had failed to publish any new reports containing projections
since those contracts had been awarded. While HRSA created a timeline in 2012 for
publishing a series of new workforce projection reports, the agency missed its origi-
nal goals for publishing these reports and had to revise its timeline for publishing
them. (See table 3)

Table 3.—Health Resources and Services Administration’s (HRSA) Original and Revised Timelines
for Publishing Updated Workforce Supply and Demand Projections, as of September 2013

<table>
<thead>
<tr>
<th>Report</th>
<th>Description</th>
<th>Original goal for publication</th>
<th>Revised goal for publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>Projects supply of and demand for the primary care workforce to 2020.</td>
<td>No goal date</td>
<td>Fall 2013</td>
</tr>
<tr>
<td>Clinician specialty</td>
<td>Projects supply of and demand for physicians, physician assistants, and certain advanced practice registered nurses (APRN) to 2025.</td>
<td>December 2012</td>
<td>Summer 2014</td>
</tr>
<tr>
<td>Nursing workforce</td>
<td>Projects supply of and demand for nurses, including APRNs, to 2030.</td>
<td>September 2013</td>
<td>Fall 2014</td>
</tr>
<tr>
<td>Cross-occupations</td>
<td>Projects supply of and demand for more than 20 health professions to 2030.</td>
<td>2013</td>
<td>2014</td>
</tr>
</tbody>
</table>

Source: GAO review of HRSA information.

1 Includes nurse practitioners, certified registered nurse anesthetists, and certified nurse-midwives. Clinical nurse specialists are not included.

At the time of our September 2013 report, the most recent projections from HRSA
available to Congress and others to inform health care workforce policy decisions—
such as distributing physician training slots to medical specialties that were pro-
tected to experience shortages—were from the agency’s 2008 report. That report was
based on data that were, at that time, more than a decade old.

As of July 2013, HRSA had received some of the contracted reports for its review,
and others were under development. The first report, which included projections for
the primary care workforce to 2020, was delivered to HRSA in July 2010, but HRSA
was still reviewing and revising the draft when we released our study in September
2013. We recommended that HRSA expedite the review of that report, and the agen-
cy published its projection in November 2013.11

Chairman Sanders, Ranking Member Burr, and members of the subcommittee,
this completes my prepared statement. I would be pleased to respond to any ques-
tions that you may have.

Senator SANDERS. Dr. Kohn, thank you very much.

Our next panelist is Dr. Deb Edberg, program director at the
McGaw Northwestern Family Medicine Residency Program at the
Erie Family Health Center in Chicago. She is also an Associate
Professor of Clinical Family and Community Medicine at the
Northwestern University Feinberg School of Medicine.

Throughout her career, Dr. Edberg has worked at community
health centers in the Cook County Health System. She received her
medical degree from Jefferson Medical College and completed her
residency training in family medicine at the University of Con-
nnecticut.

Thank you very much, Dr. Edberg, for being here.
STATEMENT OF DEBORAH EDBERG, M.D., PROGRAM DIRECTOR, McGAW NORTHWESTERN FAMILY MEDICINE RESIDENCY PROGRAM, ERIE FAMILY HEALTH CENTER; ASSISTANT PROFESSOR OF CLINICAL FAMILY AND COMMUNITY MEDICINE, NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE, CHICAGO, IL

Dr. Edberg. Thank you. Chairman Sanders, Ranking Member Burr, Senator Warren, my name is Debbie Edberg, as the chairman has said, and I am the program director for the Northwestern Family Medicine Residency Program, one of the original 11 Teaching Health Center residency programs, housed at Erie Family Health, which is a 57-year-old federally qualified health center serving more than 50,000 patients annually at 12 locations throughout Chicago and the surrounding suburbs.

I am here today to talk about the Teaching Health Center Graduate Medical Education program and describe the urgent need to reauthorize this critical program as soon as possible. On behalf of Erie and the American Association of Teaching Health Centers, representing the 36 Teaching Health Centers nationwide, thank you so much for allowing me to speak at this subcommittee hearing.

The THC program represents a proven and powerful strategy to address some of the key challenges confronting our health care system. These include ensuring access to care amidst a growing shortage of primary care providers and reducing persistent health disparities that plague our Nation’s communities.

First authorized in 2010, the Teaching Health Center program is a 5-year program that directly funds primary care residency positions in community-based and ambulatory care settings like Erie. It is the only primary care physician and dentist residency program managed and directed by community health centers themselves.

Different from traditional GME funding, which funds hospitals to train physicians in acute care settings, the THCGME funds go directly to community ambulatory care centers. This is where we train our residents to address healthcare issues such as chronic disease management and prevention of serious illness in an outpatient setting before they become emergent conditions requiring expensive hospital care. Today, 36 Teaching Health Centers train more than 300 residents who are providing more than 700,000 primary care visits in underserved communities nationwide.

Our 24 residents spend the bulk of their time providing comprehensive primary care to patients at our health center in Humboldt Park, a low-income, predominately Hispanic community on Chicago’s west side. Last year alone, our Teaching Health Center residents provided care to 7,200 patients through 13,200 visits. For most of these patients, other options for affordable high-quality, community-based primary care were extremely limited or non-existent.

The THC program has come far in a relatively short period of time, growing from 11 to 36 sites and expanding the health system’s capacity to care for tens of thousands of people living in our country’s most underserved urban, low-income, and rural communities. But there is still much to do. Authorization for the Teaching Health Center program expires in 2015, and the need for imme-
diate reauthorization has become critical in the face of extreme provider shortages and a changing healthcare landscape.

We know that close to 50 million people lack access to primary care because of physician shortages in their communities. These shortages are projected to reach 91,500 by 2020, half of which will be in primary care.

In order to improve health outcomes, reduce disparities, and contain costs, there is an urgent need to ensure and expand our Nation’s capacity to provide high-quality affordable primary care. That is what FQHCs do, and we do it well.

FQHCs or community health centers are a major sector of health care, serving 22 million people, or 1 in every 15 Americans, and this number is rapidly growing. Despite the promise and scope of community health centers and the urgent need for more primary care providers, we face a significant challenge in recruiting the number of qualified primary care physicians necessary to meet demand.

The THC program is the only Graduate Medical Education program in the country that provides funding directly to the community health center in order to train primary care physicians, and we know that many medical students, including the best and brightest among them, want this opportunity. In 2013, Erie received over 872 applications for eight residency slots and made a 100 percent match for our top choices of residents in the incoming class.

Engaging and retaining bright and energetic people like these into a career in community-based primary care was the original promise of the Teaching Health Center program, and it’s working. Physicians trained in health centers are three times more likely to work in a community health center or other safety net primary care settings. All eight of our last year’s graduates from our residency stayed in primary care settings, seven remained at community health centers, and five stayed at Erie.

Today, this innovative program stands at a crossroads. Its success is in jeopardy without legislation authorizing its continuation after 2015. Because of the 3-year term of the primary care residency, Teaching Health Centers are already feeling the detrimental impact of this potential loss in support.

This year, THC programs will have to decide whether they will accept residents who cannot be guaranteed funding for their full 3-year residency program or leave valuable primary care residency slots vacant. Students are also approaching THC residency opportunities with increasing reluctance for fear that they will not be able to complete their residency in a stable environment.

To ensure this program continues to thrive, we respectfully request your support in working to immediately reauthorize the THCGME program through the Senate HELP Committee. On behalf of Erie and the American Association of Teaching Health Centers, we are extremely grateful to Chairman Sanders for introducing Senate bill 1759, which supports this reauthorization.

We are also thankful to those on this committee who have been supportive of this bill, including Senator Casey of Pennsylvania and Senator Kay Hagan of North Carolina. Finally, I would like to
thank our own Senators, Hon. Richard Durbin and Mark Kirk, who have supported the mission of Erie for years.

Once again, on behalf of Erie and the patients we serve, I very much appreciate the chance to testify today, and I welcome your questions.

[The prepared statement of Dr. Edberg follows:]

PREPARED STATEMENT OF DEBORAH EDBERG, M.D.

Chairman Sanders, Ranking Member Burr, and distinguished members of the subcommittee: My name is Deborah Edberg. I am a family physician and program director for one of the original 11 Teaching Health Center residency programs, housed at Erie Family Health Center in Chicago. Erie is a 57-year-old federally qualified health center (or FQHC) serving more than 50,000 patients annually at 12 locations throughout Chicago and the surrounding suburbs. Like all of our Nation’s 1,200 FQHCs, our health centers are located in low-income and medically underserved communities and provide comprehensive primary care regardless of patients’ insurance status or ability to pay.

I am here today to talk about the Teaching Health Center program and describe the urgent need to re-authorize this critical program as soon as possible. On behalf of Erie and the American Association of Teaching Health Centers, representing the 36 Teaching Health Centers nationwide, thank you so much for allowing me to speak at this subcommittee hearing.

The Teaching Health Center Graduate Medical Education Program represents a proven and powerful strategy to address some of the key challenges confronting our health care system. These include ensuring access to care amidst a growing shortage of primary care providers and reducing persistent health disparities that plague our Nation’s communities. First authorized in 2010, the Teaching Health Center program is a 5-year program that directly funds primary care residency positions in community-based and ambulatory care settings like Erie. It is the only primary care physician and dentist residency program managed and directed by community health centers themselves. Different from traditional GME funding which funds hospitals to train physicians in acute care settings, the THCGME funds go directly to practicing community ambulatory care centers where their clinicians design and teach a curriculum that is reflective of the opportunities and challenges in caring for medically underserved communities in an outpatient setting. This is where we address health care issues such as chronic disease management and prevention of serious illness before they become emergent conditions requiring expensive hospital care. Today, 36 Teaching Health Centers train more than 300 residents who are providing more than 700,000 primary care visits in underserved communities nationwide.

Erie is a partner in the Northwestern McGaw Family Medicine Residency Program, which brings together Erie, our academic partner Northwestern University, and Norwegian American Hospital, the disproportionate share hospital in our community. We accepted our first class of eight residents in July 2010 and graduated our first class last summer.

Our 24 residents participate in hospital rotations at Northwestern Memorial Hospital and Lurie Children’s Hospital. But they spend the bulk of their time providing comprehensive primary care to patients at our health center in Humboldt Park, a low-income, predominately Hispanic community on Chicago’s west side. Last year alone, our Teaching Health Center residents provided care to 7,200 patients through 13,200 visits. For most of these patients, other options for affordable high quality, community-based primary care were extremely limited or non-existent.

The THC program has come far in a relatively short period of time—growing from 11 to 36 sites and expanding the health system’s capacity to care for tens of thousands of people living in our country’s most underserved urban, low-income and rural communities. But there is still much to do. Authorization for the Teaching Health Center program expires in 2015 and the need for immediate reauthorization has become critical in the face of extreme provider shortages and a changing healthcare landscape.

As was discussed previously in prior hearings, the provider shortage in this country is acute and growing. Close to 50 million people lack access to primary care because of physician shortages in their communities. According to the National Association of American Medical Colleges’ Center for Workforce Studies, physician shortages are projected to reach 91,500 by 2020, half of which will be in primary care.
And with tens of millions of people becoming eligible for health care coverage through the Affordable Care Act, a perfect storm is brewing. Without enough providers, many of these newly insured individuals may remain without care or continue to be relegated to emergency rooms. Meanwhile, overloaded Medicaid providers will be required to limit the number of patients they see, reduce the services they provide, and spend less time with their current patients (Zyzanski, et al, 1998). In order to improve health outcomes, reduce disparities and contain costs, there is an urgent need to ensure and expand our Nation’s capacity to provide high-quality affordable primary care.

That is what FQHCs do. And we do it well. FQHCs or community health centers are a major sector of health care, serving 22 million people, or 1 in every 15 Americans (NACHC, 2013) and this number is rapidly growing. Community health centers provide one-quarter of all primary care visits for the Nation’s low-income population. The White House Office of Management and Budget rated community health centers as one of the most effective Federal programs (OMB, 2007). And we continue to grow into communities where we are needed most.

Despite the promise and scope of community health centers and the urgent need for more primary care providers, we face a significant challenge in recruiting the number of qualified primary care physicians necessary to meet demand. The Teaching Health Center program is the only graduate medical education program in the country that provides funding directly to the community health center in order to train primary care physicians and we know that many medical students—including the best and brightest among them—want this opportunity. For example, in 2013, Erie received over 872 applications for eight residency slots and made a 100 percent match for our top choices of residents in the incoming class. Currently we have 2 residents that are Piacanaco Scholars, meaning that they are among the top medical students graduate going into family medicine in the country. We have a resident that has been consulting for the World Health Organization and setting up community assessments in national and international communities, a resident that started and was CEO of a small church-based community health center while getting his MBA in medical school and a resident that started a sustainable community health center in Bolivia.

Our newly recruited eight Teaching Health Center residents join our current residents as nationally recognized scholars, as well as volunteers within domestic and international non-profit organizations, advocates, authors, researchers and refugees. Their backgrounds are diverse but they share a passion and commitment to working with underserved patients in community-based settings.

Engaging and retaining bright and energetic people like these into a career in community-based primary care was the original promise of the Teaching Health Center. And it’s working. Physicians trained in health centers are three times more likely to work in community health centers or other safety-net primary care settings. All eight of last year’s graduates from the Northwestern McGaw Family Medicine Residency stayed in primary care settings, seven remained at community health centers and five stayed at Erie.

These talented doctors increase our Nation’s capacity to provide care in underserved communities. But they are also the leaders of tomorrow. In addition to direct experience, the McGaw program provides a rigorous academic curriculum that emphasizes leadership in health policy, community engagement, and research. The Teaching Health Center program invests in students, patients, communities and long-term solutions to some of the most critical challenges facing our health system and our society.

Today this innovative program stands at a crossroads. Its success is in jeopardy without legislation authorizing its continuation after 2015. Because of the 3-year term of the primary care residency, Teaching Health Centers are already feeling the detrimental impact of this potential loss in support.

This year, for the first time, THC programs will have to decide whether they will accept residents who cannot be guaranteed funding for their full 3-year residency program or leave valuable primary care residency slots vacant. Erie, in particular, relies on support through the Teaching Health Center program to fund all 24 of our family medicine residency slots in their entirety. Students are also approaching THC residency opportunities with increasing reluctance for fear that they will not be able to complete their residency in a stable environment.

To ensure this program continues to thrive, we respectfully request your support in working to immediately reauthorize the THCGME program through the Senate Health, Education, Labor, and Pensions (HELP) Committee. On behalf of Erie and the American Association of Teaching Health Centers, we are extremely grateful to Chairman Sanders for introducing Senate bill 1759, which supports this reauthorization and ensures that Teaching Health Centers will continue to guarantee a well-
trained, passionate workforce prepared to meet the needs of underserved communities nationwide. We are also thankful to those on this committee who have been supportive of this bill including Senator Casey of Pennsylvania who is a co-sponsor and a member of this distinguished subcommittee and Senator Kay Hagen of North Carolina, who has been supportive of our reauthorization efforts for the past year. Finally, I would like to thank our own Senators the Honorable(s) Richard Durbin and Mark Kirk, who have supported the mission of Erie for years and who, I trust, will continue to make the type of high-quality, compassionate, and affordable healthcare we provide as an FQHC possible.

Once again, on behalf of Erie, and the patients we serve—I very much appreciate the chance to testify today, I welcome your questions, and I would be happy to be of assistance to you and the committee in the future.

The author wants to thank Rachel Krause and Dana Kelly for their assistance in the preparation of this testimony.

Senator SANDERS. Thank you very much.

Last, but very much not least, is Dr. James Hotz. Since 1978, Dr. Hotz has been the clinical services director of Albany Area Primary Healthcare, a community health center he helped found in south Georgia. He is a graduate of Cornell University and the Ohio State University School of Medicine. During medical school, he worked in the office of Congressman Dr. William Roy who drafted the legislation to create the National Health Service Corps legislation.

He then joined the National Health Service Corps as a commissioned officer after completing an internal medicine residency at Emory University. He is also on the faculty of the Medical College of Georgia and Mercer University School of Medicine, served on the Admissions Committee of Mercer, and is a former president of the Georgia Association for Primary Healthcare. The film, Doc Hollywood, was based off of Dr. Hotz's story.

Dr. Hotz, thanks so much for being with us.

STATEMENT OF JAMES HOTZ, M.D., CLINICAL SERVICES DIRECTOR, ALBANY AREA PRIMARY CARE, ALBANY, GA

Dr. Hotz. Thank you very much for that kind introduction. Chairman Sanders and Ranking Member Burr, it’s a pleasure to be here and speak before the members of the committee.

Thirty-five years ago, I made this decision to go down to Albany, GA, and it changed my life. Thirty-six years ago, I married a Tar Heel and brought her down to Albany with me. So I have a lot of affection for the State of North Carolina.

My job is to really tell you the view from the trenches and what it’s like. You’ve heard a lot of the national statistics about what happened and what things are like. But let me tell you what happened when I came to work in Congress 40 years ago with Congressman Roy, who was a physician from Kansas, and Congressman Paul Rogers. They were drafting very innovative legislation back then, expanding public funding for residency programs in family medicine, PA programs, community health centers. But their crown jewel was the National Health Service Corps.

Yes, Roy and Rogers worked together, and their legislation was called by the DC pundits the Happy Trails legislation. Those of you who are as old as I am remember Roy Rogers, the singing cowboy, and his theme song was Happy Trails. What has happened to these happy trails? They brought millions of physicians to communities where they could take care of and provide primary access for people throughout the country.
But you wanted a view from the trenches. Let me tell you what it's like down in Albany, GA. Three million people have received primary care service visits from our community health center, two-thirds of them through National Health Service Corps people. I am here to speak about the National Health Service Corps.

While I worked for the Congressman, I worked on a piece that added dentists and scholarship people to the National Health Service Corps. And I asked for advice from Congressman Roy, and he said, “Join the Corps and let us know how it works.” I’m telling you, there's never been a program that works this well.

The National Health Service Corps has been our foot in the door for recruiting. How do you recruit people from Washington, DC, or from Atlanta to come down to the swamps of southwest Georgia? It's through the Corps.

We have 52 clinicians that now help take care of our 34,000 patients we see. Eighty percent fall below poverty. We have the largest rural HIV program in the country—see 1,000 people. Twenty-four of these people were recruited through the National Health Service Corps. We have 286 years of experience with these folks, or 24.2 years for our average tenure of stay. Those are metrics, Senator Burr, that I think are very important from the field.

Unfortunately, the demand for Corps clinicians and loan forgiveness greatly outstrips our current supply. Last year, we had six people apply to try to get loan forgiveness. Only three could get it. We have three spots that are open in our center right now that we can't fill because we don't have that available. We just don't have enough slots.

We currently have five slots open. We've never had slots open in our center. It's the most difficult recruiting we've faced. Why is it difficult? A lot of people have talked about the fact that we're not training enough primary care clinicians. I chair our State's AHEC primary care work group, and I have extensive written testimony that I've submitted that tells you that people aren't going into primary care.

But I'm going to give you a view from the trenches. You wanted to know about debt. I have four kids who have gone through this, all of whom during medical school have rotated at our health center, all of whom have decided to go into primary care, and their debt is not $145,000. These are kids that had no debt going into medical school. They lived in low-cost cities in Georgia—Macon and Augusta—and their debts are $227,000, $224,000, $313,000, and one who's in his third year of medical school is at $189,000—$1.15 million in debt.

Every one of these kids rotated at our center. All of them wanted to go into primary care. But my oldest, who's now starting to do these debt payments—and I've submitted what that looks like, a screen shot of his loans—he either pays off at $4,000 a month in 10 years, or he pays off until he's 57 years old. He said, “Dad, I don't know if I can afford to stay where I am.” He works at a community hospital in Rome, GA, taking care of poor people, and I am very proud of him.

But the future of the National Health Service Corps, this very important program that's going to put people out there, is in jeopardy. In fiscal year 2015, it goes away unless you people do some-
thing about it. And time is of the essence. I can tell you in my 40 years of experience, there's never been a program that puts primary care clinicians in underserved areas like the National Health Service Corps. It is the crown jewel.

But don't take my word for it. We have 50 organizations that have signed a letter that says this is an important thing to do, and I don't think there's 50 organizations that agree to anything like this. This is the best program out there, and everybody agrees with it. But this funding will expire unless you do something about it. We need a long-term solution to this problem.

I would like to say it's a pleasure to come before this committee and talk about this issue. But the solution is not in academic medicine. The medical schools are not going to solve the problem. As I learned 40 years ago from Dr. Roy, the solution is really in your hands. You're the ones who are going to fix this problem, as you did 40 years ago.

So will that happy trail to primary healthcare continue? The answer is going to be if you guys do it.

Thank you very much. I'll be glad to answer any questions.

[The prepared statement of Dr. Hotz follows:]

PREPARED STATEMENT OF JAMES HOTZ, M.D.

Hello Chairman Sanders, Ranking Member Burr, and members of the subcommittee. Thank you for this opportunity to speak to you today about a program that is near and dear to my heart, the National Health Service Corps (NHSC). My name is Dr. Jim Hotz, and I am the Clinical Services Director for Albany Area Primary Health Care (AAPHC) in Albany, GA, an organization I helped found 35 years ago. Over these past 35 years, I have helped start and have been on the board of a variety of different organizations that have been attempting to provide a high quality medical home for the underserved of the Nation. I have helped to start a community health center system, a regional AHEC, a family practice residency program, a regional planning agency, a regional rural HIV program, and a regional cancer control coalition. I have been chairman of a regional hospital board, an AHEC, a State primary care association and a statewide primary care workgroup and have been on the clinical faculty of two medical schools and a family practice residency program. All of these organizations are attempting to cope with the challenge of supporting local health care systems within the context of a diminishing supply of primary care clinicians. Unfortunately none of these local programs can solve what is a national workforce policy crisis. These experiences have made me realize how crucial it is to have this hearing on "Addressing Primary Care Access and Workforce Challenges: Voices from the Field." It is my belief that the NHSC is the single most effective policy innovation this country has ever developed to address the primary care workforce challenge. I am here today on behalf of the Association of Clinicians for the Underserved (ACU), which was founded by NHSC alumni over 15 years ago. The mission of the ACU is to insure the NHSC will continue to be an effective solution to the access needs of the medically underserved of this Nation.

Medical school creates an apprenticeship learning environment where the student often has a life changing experience while working under the supervision of the inspirational master clinician. Exactly 40 years ago I had the direction of my life changed by Dr. William Roy. Health reform was a major issue in Washington at that time and I wanted to become involved. I asked my curriculum advisor at Ohio State if he could help me construct an experience in DC that would satisfy my community science requirement and allow me to use vacation time to work as a legislative aid in Congress. I told him I wanted to be where "the action was" in health reform and he told me I needed to ride the "Happy Trail." I didn't know what that meant, except that it was a song sung by Roy Rogers. However, in Congress at the time were Congressman Dr. William Roy of Kansas and Congressman Paul Rogers of Florida—"Roy" and "Rogers." They had become the architects of the most dynamic health reform legislation since Medicare and Medicaid. Local DC pundits jokingly called it the "Happy Trails Legislation." Being a physician, Dr. Roy could offer clinical rotations for students to learn health policy and earn medical school credit and
in return he got cheap source of labor. A group of us worked with Dr. Brian Biles who was Dr. Roy’s chief of staff to craft legislation on a menu of programs that were to serve as the infrastructure for health reform. The master blue print was put forth in “Building a National Health-Care System” by the Committee for Economic Development (CED) in April 1973. This 105-page document was created by over 100 men who represented Fortune 500 companies, academic institutions or major foundations and felt the urgent need to address “the health care bill that increased sharply—between 1965 and 1972 national health expenditures rose from $39 billion to $83 billion, or from 5.9 to 7.6 per cent of GNP,” and “Per capital annual expenditures rose from $78 to $394.”

Dr. Roy, in an amazingly productive 4-year tenure, worked with Cong. Rogers to put in place an infrastructure to manage an effective, efficient health system based on the recommendations of these members of the CED who were in fact successful managers of effective and efficient business systems. Dr. Roy introduced the HMO act of 1972 that revolutionized health care financing and made prepayment less wasteful and keeping people healthy. Yes, the HMO was delivered by a Kansas Obstetrician! Roy and Rogers collaborated to preserve and promote the community health centers program through a major restructuring and reauthorization bill in 1973. But the program Dr. Roy and Cong. Rogers were most proud of was the National Health Services Corps. They realized health care could only be effective and efficient if primary care was available in all communities. They saw the infant National Health Services Corps as the solution to the primary care distribution problem in this country. During a blizzard on December 31, 1970 and minutes before the midnight deadline, President Richard Nixon signed Public Law 91–623 the “Emergency Health Personal Act of 1970.” In his award winning book “The Dance of Legislation,” Eric Redman describes how the NHSC was born through the heroic efforts of Senator Warren Magnuson of Washington. What isn’t covered in the book is that Dr. Roy with Cong. Rogers adopted this infant legislation and allowed it to grow through a series of amendments over the next 4 years. These amendments helped shape the NHSC into the most effective program ever devised to distribute primary area clinicians to underserved communities. I helped work on the National Health Services Manpower Act (H.R. 14357) that added the scholarship component to the NHSC and greatly expanded the size and diversity of the field strength of the Corps. The vision of Dr. Roy was “any physician who practices—in an area designated to have a shortage—the Secretary shall pay in full the principle and interest of any outstanding educational loan.” Now medical school could be affordable not only to the wealthy but even the inner city or poor farm kid could finance his dream of a medical education.

After using up all my vacation and elective time I returned to Ohio State intending to eventually go back to work in DC. Dr. Roy decided to run for Senate in the fall of 1974 but got beaten by Bob Dole in a very bitter campaign by less than 5,000 votes. I called and offered my condolences and asked for advice on my career. Dr. Roy said “join the NHSC and make a difference before you come back here!” I followed his advice and convinced Jim Bingle, my brother-in-law, to volunteer with me into the Commissioned Corps of the NHSC in 1978. I had lived with Jim during medical school and figured if he was dumb enough to live with me he probably was dumb enough to join the NHSC and make $32,500 which was the starting salary back then. Through Cong. Roger’s continuing efforts, the “Happy Trails” legislation flourished under President Carter and community health centers and the NHSC grew rapidly. Unfortunately with this rapid growth was some pain and the NHSC was having trouble finding a match for the two of us. I was finishing my Internal Medicine training at Emory in Atlanta and one of my instructors Dr. Neil Shulman offered to help place me in Georgia. He arranged a meeting with Dr. Jim Alley, director of Public Health in Georgia and an appointee while Jimmy Carter was Governor of Georgia. Dr. Alley arranged for Bingle and me to be assigned to Georgia to help develop a community health center in areas of greatest need. We were given several options for communities to serve and preferred Athens which was near Atlanta but were tricked into visiting several very poor counties in south Georgia that had no doctors. Dr. Shulman wrote a humorous account of this adventure that was made into the movie “Doc Hollywood.”

We initially worked at a Health System Agency in Albany, GA and with community groups wrote a grant and to develop a community health center program that became Albany Area Primary Health Care (AAPHC). Dr. Bingle and I remained in the Commissioner Corps for 6 years after which he left to return to Ohio and do a fellowship in cardiology. I stayed on and for the first 10 years of AAPHC every one of our recruits were from the NHSC and most were obligated scholars. Our success in those early years were a byproduct of the legislation of Dr. Roy and Cong. Rogers—the NHSC, Community Health Centers, and the Health System Agency—
the Happy Trails Legislation indeed created a happy trail of access for the underserved of south Georgia.

During the past 35 years, AAPHC has had over 3 million patient visits in one of the poorest and most rural areas in the State. It is estimated that over 2 million of these primary care encounters were delivered by a clinician recruited through the NHSC. AAPHC now has offices at 14 different sites in seven counties and last year had 33,267 users of our health care system. Over 75 percent of our patients are an ethnic minority, 80 percent live in poverty, and 25 percent have no health insurance. We provide services from “womb to tomb”—Obstetrics to Geriatrics; from “head to toe”—Dentistry to Podiatry; and in everything in between with Pediatrics, Internal Medicine, and Family Medicine and last year had 136,287 clinical visits.

The NHSC has been an invaluable “foot in the door” for our primary care recruiting. The swamps of southwest Georgia are not a natural attraction for the medical professional of today. But once clinicians join our group they receive deep professional satisfaction from the practice environment we provide. Out of a total of 52 clinical providers currently employed by AAPHC, 24 have been recruited or retained using the NHSC. Currently we have 16 physicians, 2 dentists, 5 PAs and 1 Certified Nurse Midwife who were recruited or retained through the NHSC. Our overall clinical retention rate is 9 years and for our 24 NHSC awardees this tenure is:

1. 1–10 years = 13 clinicians;
2. 11–20 years = 7 clinicians; and
3. 20+ years = 4 clinicians.

The NHSC has led to 286 years of service with an average tenure of 24.2 years. Although the NHSC field strength has expanded to nearly 8,900 in 2013, the demand has greatly outstripped the supply and last year the NHSC received twice as many applications as it had resources to fill. Of those applications six came from AAPHC. Where once our recruiting was facilitated by the NHSC, we have not been able to secure loan forgiveness and have lost three recruits in the past year who said they would have come if the loan forgiveness was available. We have not been able to recruit a scholar since 2011 and are down to three scholars fulfilling an obligation and four clinicians who are currently enrolled in loan forgiveness.

Shelley Spries who has been in charge of recruiting at AAPHC for the past 13 years says the past couple years have been the most difficult she has experienced. For over a decade we had no vacant positions and we currently have five. Several of these positions have been vacant for over a year. This is now my 36th year of recruiting for AAPHC and I completely agree with Shelley.

There are a number of reasons recruiting is so challenging. First and foremost is the overall shortage of primary care physicians being produced by the GME system of the United States. I chair the Georgia statewide AHEC Primary Care Work Group and since 2008 we have been conducting a summit and producing a detailed analysis of the problem and offering a series of recommendations to our State. The following is a brief review of the workforce problems we discovered:

- An American Journal of Medicine article (2008) predicted the GME “funnel” caused by the Balanced Budget Act of 1997 which capped Medicare funding for GME. The article forecast a rapid expansion of our total medical school enrollment from 18,560 in 2005 (2,800 DOs and 15,760 MDs) to 25,136 in 2012 (5,227 DOs and 19,909 MDs), but there would be no expansion of PGY1 slots. There were 24,269 such slots in 2005 and projected to be the same in 2012. Where once we imported 5,709 U.S. and foreign International Medical Graduates (IMGs) to fill open slots, by 2012 there weren’t even slots available for 867 U.S. medical school graduates. This prediction has largely held true and less and less of these graduates have gone into primary care.
- This article also predicted a primary care shortage of 45,800 by 2025.
- A Journal of the American Medical Association article (2008) showed that even in the three major residency programs producing primary care, many were not staying in primary care:
  - Family Medicine: 3,018 and 95 percent Primary Care = 2,867.
  - Internal Medicine: 8,550 and 45 percent General IM; Of General IM, 50 percent loss to hospitalist (NEJM 11/27/08) = 1,967.
  - Pediatric Medicine: 2,645 and 61 percent Primary Care = 1,967.
- Net Yearly Primary care production = 6,447.
- The Robert Graham Center in Annals of Family Medicine (2012) predicted a shortage of 52,000 primary care physicians in 2025 taking into account the ACA and change in residency production.
- The Association of American Medical Colleges predicts a shortage of 91,500 doctors by 2020 and in a report from this subcommittee last year 1/29/2013 you stated,
“According to the Health Resources and Services Administration, we need 16,000 primary care practitioners to meet the need that exists today.”

AAPHC is now recruiting from a pool of primary care physicians that is shrinking at a time when demand is dramatically increasing. To make the situation even worse, we are recruiting physicians who are experiencing a substantial increase in educational debt. Many are either selling out to the highest bidder like well-funded hospitalist programs, doing fellowships specializing in higher paying fields like cardiology or oncology that often pay three to four times what primary care does or they are signing up with programs that offer significant loan relief programs. Once the NHSC was the premier program for debt relief but now it cannot meet even 50 percent of the current demand. The maximum amount of loan relief was recently cut from $155,000 for 5 years continuous service to now a max of $100,000 for 5 years. For programs with HPSA scores of less than 14 the amount was reduced to $30,000 for 2 years. This reduction comes in the face of medical school debt that now often exceeds $250,000 for recent grads. The vision of Dr. Roy of the NHSC being a vehicle for relief of all medical school debt for practice in an underserved area is becoming a greater challenge given current NHSC resources.

How big is the problem and how big is the fix? In a 2008 NEJM article, the average debt was $145,000 for public medical schools and $180,000 for private school. However the total debt for all medical students was estimated to be $2 billion—the amount we paid in 1 month for “cash for clunkers.” In a 5/28/2011 New York Times article, Bach and Kocher estimated, “we could make medical school free for roughly $2.5 billion.” They recommended a payback for students choosing to specialize but none for those going into primary care.

For those who want a view from the trenches, I asked my four children to share their debt experience with this committee. All four were HOPE scholars at the University of Georgia and had zero debt at the time of graduation. All four were provided with health and auto insurance by me. They all lived on frugal budgets during medical school in the low cost cities of Macon and Augusta, GA. They went either to Mercer, a private school that receives State support, or to the State school, the Medical College of Georgia (MCG). My oldest, George, is now an internist working with Floyd Memorial, the community hospital in Rome, GA. My second son, Jim, is in Internal Medicine Residency at Indiana University and will be a chief resident next year, planning a career in primary care. My daughter, Mary, is in her first year of a primary care Internal Medicine program at the University of South Carolina—Greenville. My youngest son Steve is in his second year of medical school at Mercer University in Macon.

Here is the debt they face:

- **George—Mercer University School of Medicine 2005–9**
  - Current debt: $227,329.55.
  - Interest: 2.1 to 7.65 percent.
  - Minimum payment of: $1,536.58.
  - Loan Payoff Date: 3/7/37!
  - He is currently trying to make payments of $3,886.09 to pay off in 10 years. He selected Rome to be near his wife’s family and to be able to work in a community like Albany. Unfortunately his area has no HPSA score above 14 and the hospital can only afford minimal debt relief. He likes his practice and does traditional office and hospital internal medicine, but admits once he starts a family he may need to reconsider his options. Currently he is my only child who is paying off his debt but he has communicated many times to his sister and brothers the reality of the debt crunch when it becomes payback time!

- **Jim—Medical College of Georgia 2007–11 (the lowest cost school in the State)**
  - Current debt: $224,446.
  - Interest: 6.8 to 7.9 percent.

- **Mary—Mercer University School of Medicine 2009–13**
  - Current debt: $313,009.
  - Interest: 6.8 to 7.9 percent.

- **Steve—Mercer University School of Medicine 2011–present**
  - Current debt: $189,236.
  - Interest: 6.8 to 7.9 percent.

**Total debt of children = $1,154,620.**

Our Primary Care Workgroup in Georgia discovered that one way the medical schools financed their expansion was by increasing tuition. This had the unfortunate result of dramatically increasing medical school debt which had the unintended con-
sequence of reducing the likelihood these students would choose a lower paying career in primary care. An article in Academic Medicine January 2013 explored the question, “Can Medical Students Afford to Choose Primary Care?” The conclusion was that “Graduates pursuing primary care with higher debt levels ($250,000 to $300,000) need to consider additional strategies to support repayment—use of Federal loan forgiveness.”

Medical School Tuition in Georgia 2005–2012:
- Emory—38,000 to 45,000; increase of 25.0 percent.
- MCG—10,850 to 24,726; increase of 108.6 percent.
- Mercer—30,220 to 41,457; increase of 37.0 percent.
- Morehouse—24,000 to 36,903; increase of 53.8 percent.
- PCOM (DO started 2008)—33,587 to 40,812; increase of 21.0 percent.

AAPHC physicians like myself are on the clinical faculty at Mercer and MCG and each of my children either did 4-year rural continuity tracts at our practice or took multiple electives here. They each say these rotations helped convince them to select careers in primary care internal medicine and they expressed an interest in the NHSC and working at a community health center but wonder if the NHSC program will be a viable option for them when they graduate and if they will be able to afford to stay in primary care.

Today the NHSC places roughly 8,900 clinicians across the country. These placements are for doctors, dentists, dental hygienists, nurse practitioners, physician assistants, certified nurse midwives and a variety of mental health provider types. In fact, the largest group of providers is in mental health today, comprising 28 percent of the total field strength. These 8,900 providers provide care to nearly 10 million people across the country.

There are three main parts of the NHSC, including the Scholarship program, the Loan Repayment program and the recent Students to Service program that helps fourth year medical students choose primary care by paying off their debt in exchange for service. However, the largest part of the NHSC is the Loan Repayment program, and this is what most people think of when they speak of the Corps. The Loan Repayment Program pays off a portion of student debt for every year of service in a Federal shortage area. These are not Federal employees. Each placement is an employee of the site itself, which uses the NHSC Loan Repayment program as a recruitment tool—but it is more than that. It really is a way the Federal Government leverages local resources. While it isn’t a required match of Federal funds, each site pays their employee much more than the $25,000 or $15,000 they receive in Federal loan repayment. So in essence, the Federal Government is only picking up a small slice of their compensation and getting all the benefits to boot. Being able to place a primary care clinician in an underserved area for $25,000 or less per year is an incredible deal for the Federal Government for sure.

CURRENT STATUS OF NSHC FUNDING

Starting in 1974, funding for the NHSC had been through regular, annual appropriations. This changed under the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA). Both of these laws provided new mandatory funding for the program that was intended to better address the shortages across our country. However, recognizing this infusion, in fiscal year 2011 Congress dramatically decreased the appropriation, and then in fiscal year 2012 eliminated it altogether. The program now relies completely on this mandatory funding stream for 100 percent of its operations.

And the ACA funding ends in fiscal year 2016, meaning the program is completely defunded unless Congress chooses to either extend the mandatory funding, or once again provides funding through the annual appropriations process. I understand that neither of these routes will be easy to navigate. Our country faces record debt levels and there are nearly continuous negotiations on Federal spending levels.

However, I really believe that based on the merits of the program, the NHSC can withstand any kind of debate that focuses on value, impact, and long-term savings. Access to primary care saves lives and saves money, and the NHSC is designed to increase access where we need it most.

Last month the President proposed one way to address the funding issues facing the NHSC. His proposal expanded the program in fiscal year 2015 with a combination of annual appropriations and the creation of a new mandatory trust fund. Then for the following 5 years, the program would be funded at $710 million per year through fiscal year 2020.

I would say there are positive and negative things about this proposal, but we applaud the President for putting it on the table. Just raising the issue, starting the debate about the future of this program is important, and we are very appreciative.
But the challenge is now in your hands. Is the NHSC a valuable program? Based on my 40 years of experience, I would say most definitely. Is the program threatened? Clearly. How should you fund it, and what funding level would achieve the goals of the program? That is up to you to decide. But I would urge you to do it sooner rather than later. The debt levels are exploding, primary care shortages are increasing and recruitment and retention in underserved areas is getting harder and harder.

CONCLUSION

It is amazing how fast these last 40 years have passed. Dr. Roy returned to practice medicine in Kansas, ran for office twice and lost, and has been a regular columnist for the Topeka Capital-Journal. Congressman Rogers went on to decades of distinguished service in Congress and died just a couple years ago. Their “Happy Trails” legislation has made an extraordinary contribution to increase health care access in this country. It has provided the path for my career and been a source for primary care over 3 million visits at AAPHC. Will it provide a trail for my children and other future primary care clinicians? Without the NHSC, what will be the solution? Neil Shulman and I along with one of my patients Vic Miller wrote a sequel book and screenplay to “Doc Hollywood.” In this book, “Where Remedies Lie”, we describe what happens to “Doc Hollywood” as he confronts the challenges of providing primary care access to a rural region in the Deep South whose citizens are poor and black. His “Remedy” was a “Happy Trail” of the NHSC and the community health center program.

In a PBS interview in 1996, Dr. Roy stated how proud he was of his legislative legacy, but especially of the NHSC. “I’d worked hard on the National Health Services Corps to get physicians into rural and underserved areas,” he told the reporter. Since its birth in 1970 over 45,000 primary care clinicians have used its help to go to underserved communities. It is one of the “crown jewels” of public health policy and may face extinction in 2016 if you do not act.

I just want to say thank you to the subcommittee for holding this hearing, discussing the importance of the Federal programs aimed at increasing access to primary care, and most of all, raising the profile of the National Health Service Corps. Dr. Roy 40 years ago inspired me to follow the “Happy Trail” that has led to a fulfilling career at AAPHC. The National Health Services Corps has been part of my life for 40+ years, and I can assure you it is the most effective program this country has ever devised to distribute primary care clinicians to the underserved communities. You are now the ones who must keep the “Happy Trail” open for the citizens you serve. I would be glad to answer any questions you may have.

APPENDIX 1

Current Loan Statement for one of the Hotz children. All loans are medical school-related.

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<th>Disbursement Date</th>
<th>Type of Loan</th>
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Senator SANDERS. Senator Warren has to leave in a few minutes.

Senator Warren, why don’t you begin?

Senator WARREN. Mr. Chairman, I think I’m not even going to have time for my questions. But I’m going to do this. I want to say three things. I have questions around student loans and the current difficulties that this puts on anyone, but, particularly, on those who are going into primary care, where their pay is, on average, going to be about half that of people going into specialties. So I’m going to submit questions for the record around student loans.

The second thing I’m going to submit questions for the record around is why we’re not doing better on integrating nurse practitioners and physician assistants. We know that if we fully use nurse practitioners and physician assistants, we could cut the impact of the shortage of primary care physicians by as much as two-thirds. So I’ll have some questions for the record about that.

But the third thing I want to say is thank you to all of you for being here. You are committed. You are out there. You are on the front lines. You are training the next generation. You are making it happen. You come to us and you remind us that we know what the problem is. We just all say the same things. We get what is wrong.

We see innovative solutions. We see effective solutions. We can see what needs to be done. It is now up to Congress to put the resources into it so that these programs can be fully implemented, so they can be fully funded, so we can have the right regulations in place for you to do your jobs for the American people.

I appreciate your being here. But I really see this as the pressure being back on us to do what we ought to be doing here in Congress to support you and your work. Thank you. Thank you for being here.

Thank you, Mr. Chairman. I’m sorry that I have to leave.

Senator SANDERS. Thank you very much, Senator Warren.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Dr. Hotz, your best quality is your decision as to who you married and where she was from. Let me say that.

[Laughter.]

But I say to you, as I say to the rest of you, thank you for the work you do in the trenches. More importantly, thank you for your
willingness to come up here and share with us information that is vital to the decisions we've got before us.

Dr. Kohn, prior to GAO conducting its review of the federally supported healthcare workforce programs last year, was there a comprehensive list of all the federally funded healthcare workforce training programs in the country?

Ms. Kohn. We didn't find one. We didn't find one, and we did try. To get our work, we had to check the budget. We had to check departmental budgets and budget justifications. We had to look at prior publications, published articles. We went to all the different agency websites.

We checked a compendium that wasn't complete as a compendium of Federal programs. That didn't quite get us where we needed to go. So in the end, we ultimately had to go to every department, every agency, and do program by program by program to get the information that we published.

Senator Burr. Mr. Chairman, let me just take a personal moment, if I could. One, we've got two GAO reports, and we've got this line of witnesses up here. And this is what really irks me. Here we had the Assistant Director of HRSA here. But your testimony wasn't important enough for her to stay. And this is a person on the front line of it.

I think, we've got to stress with these agencies that this is not just for us. It's for the folks that are implementing the programs that we set up, and it's important not that their staff be here, because they're the ones that drive their staff.

It's important that they be here to hear your stories, to hear the nuances that exist, because in a lot of cases, we're trying to thread a needle, trying to determine 30-year-old programs and their effectiveness and the resounding need to continue it, trying to look at all the healthcare dollars that we spend in workforce programs and figure out what doesn't work. What can we do away with, and can we double down on something else that everybody agrees does work?

We might hear that from you, but if the people that implement the programs don't hear it firsthand, we're not going to be as effective. We may thread half the needle, but not all of it.

Let me ask you, Dr. Dobson, because the chairman, I know, is going to be patient with me up to the end of my 5 minutes. I think you've got some interesting perspectives from the standpoint of North Carolina. How does the CCNC model address primary care access, and what could other States learn from Community Care and the experiences we've gone through?

Dr. Dobson. I think the No. 1 thing is that we bring people together at the very local level and say this is a shared responsibility to take care of your citizens in your community. You have groups of primary care doctors. You have public health departments. You have these resources. It's really around coordinating the care. Community Care comes in and provides the support to knit it together in an effective manner.

I think one of the issues around workforce and getting people to do primary care is this—it is the money, but it's also the prestige. I think CCNC has helped people say, "Well, primary care is important in North Carolina."
Senator BURR. You’ve got a Medicaid beneficiary that walks in the door and doesn’t have a medical home. You’re creating a medical home for them by a primary care doc. Who else is at the table?

Dr. DOBSON. Besides the primary care doc? The hospital, the community health center, social services, public health, everybody who works in that community, and understanding that every community is different. In a rural area, or in my town, the health delivery system is our clinic and the local drugstore. That’s what we have. It’s very different than Charlotte or urban areas. So you have to work with what you have.

Senator BURR. But you bring the full consortium of disciplines, medical disciplines, to the table to assess what’s the best course to follow.

Dr. DOBSON. And the flexibility to say it is a function of what the healthcare system has to provide. So what do we do if we don’t have a community health center in our community? We work with the rural practices there, and they get extra support, because we could not do it without them.

Senator BURR. Mr. Chairman, let me just say that—because I was involved very early on with Allen on this quest that has turned into what I think is an unbelievable success for our State—the participants—when I say participants, the medical professionals—weren’t driven by how much money they were getting out of this. The model was set up where everybody at the table focused on a patient’s healthcare—was focused on outcome.

And I think this is something we lose when we talk about policy and we talk about how you structurally put it. If we’re not focused on outcome, then we’ve made a huge mistake, because at the end of the day, the metrics ought to carry through all the way from a standpoint of not only how we do it and is that successful, but did we change the health outcome of the individual?

Because I think we all know if we can’t take individuals that are sick and get them well quick and keep them well, if we can’t take those with chronic illness and put them on a maintenance program that eliminates the hospital visits or the ER visits, then there’s not enough money in healthcare, period, no matter how much we all collectively might put in, to handle people that are not making the right decisions based upon good medical counsel.

So CCNC has done that. I think others realize the successes in their markets and how similar they are. That just happens to be our market.

I thank the chair.

Senator SANDERS. Thank you very much, Senator Burr.

I’m going to pick up from where Senator Warren left off by suggesting that as a Nation, we spend a lot of money on healthcare. We really do. We spend almost twice as much as do the people of any other country, and yet we heard from Mr. Brock that all over America, you have people who are desperate, who are spending their nights in a car to try to get their teeth pulled and so forth.

Let me ask you this. In terms of money, if we address the crisis of primary healthcare—we heard that we need some 50,000 new primary care physicians by 2025. That’s going to be an expensive proposition. But here’s my question. Do we save money, or do we
waste money by investing in primary care? Is this, in fact, a good investment, or should we see it as just another expenditure?

Why don’t we just start with you, Dr. Hotz? Is this a good investment?

Dr. Hotz. There’s a number of studies that have been done on that. The American College of Physicians, the internists, looked at that, and there’s a substantial saving in primary healthcare. You can actually look at the cost of healthcare driven by the number of primary care physicians per 100,000 population, and there’s a lot of us who really invest in this.

It’s interesting—we mentioned a lot about the National Health Service Corps. I’m here representing the Association of Clinicians for the Underserved, which is made up of old Corps docs who believe in what we’re doing, because we know we make a difference. The data is overwhelming. There’s white paper that the ACP put out that goes chapter and verse—

Senator Sanders. Are you making a difference financially?

Dr. Hotz. Do we make a difference financially?

Senator Sanders. Yes. Are we saving money by investing in primary care?

Dr. Hotz. Yes. Healthcare is less—if you look at the proportion of the number of primary care docs in health systems of care—pick a nation. It’s always cheaper. The more primary care docs, the better the ratio. The data is overwhelming. It’s the only way you bend the curve. And look at what people are investing in. The ACOs and the people who are trying to bend the cost curve—it’s primary care.

Senator Sanders. Dr. Edberg, let’s just go right down the line, please. The question is: Is it cost-effective for America to invest in primary care?

Dr. Edberg. If I could, I’ll share a quick story I heard from my chairman of family medicine, who told me about a friend of hers who was a 65-year-old man who had been complaining of chest pain and went straight to the cardiologist. He had the EKG, the stress test, and ended up with a cardiac catheterization—all normal.

He mentioned to her, “You know, my chest is still hurting.” And because she was a family doctor and knew him well, she said, “Do you not play the bass at church?” And he said he did, and she said, “I think you need to get a stand for your bass.” It was the pain that was just from the bass resting against his chest.

I think we can obviously see the tens of thousands of dollars that were wasted in the workup when he could have just gone to his primary care physician.

Senator Sanders. Thank you.

Dr. Flinter.

Ms. Kohn. GAO’s work didn’t examine that issue. But we do know from the listing that we have—didn’t focus on primary care, but we know there’s at least 23 or 24 programs that do explicitly talk about primary care, even though we know there’s more programs than just the ones that explicitly say it. We know there’s more programs doing primary care. So I think by having the list, there’s the potential to be able to start looking at specific programs and start being able to answer those questions.

Senator Sanders. Dr. Flinter.
Ms. FLINTER. Yes. We absolutely save money by investing in primary care.

Senator Burr, I thought you might have been alluding to something a little different in your question about who's there around the table. So I just want to speak to that element. It's really a team in primary care these days, and we did not really get a chance to talk about how important the advancement of the model of primary care that we have today is, with the full integration of our behavioral health specialists with our primary care providers and the nutritionists, the diabetes educators, sometimes the chiropractors and other people, to make sure that we're delivering the right care to the right people at the right level and at the right cost.

And in this we have metrics. I know how important that is to everyone. I look at the community health centers and the Uniform Data Set, this UDS report. You can see for all of us, individually as organizations, collectively as a system of primary care, how well we are doing at things that we know directly reduce cost. Every 1 percent reduction in the hemoglobin A1C of a diabetic is associated with a reduction in cost, and you can look and see, individually or collectively, how well we're doing with that. And that has to be as much our passion as reducing suffering, because in this case, reducing suffering and reducing dollars goes hand in hand, and that's really the path we want to be on.

Senator SANDERS. Dr. Nichols.

Dr. NICHOLS. Senator Sanders, in response to your question, yes, absolutely. Starting with some very profound research that was done by the late Barbara Starfield at the Johns Hopkins School of Public Health and the work that has continued at the American Academy of Family Physicians, Robert Graham Center, has consistently shown that primary care is, in fact, an excellent investment for our Nation's health.

Many of these studies have been cited in your reports on primary care. However, if there are any members of the Senate whose memory requires a refresher, I'd be happy to forward those studies to them.

Senator SANDERS. Thank you.

Dr. Dobson.

Dr. DOBSON. Yes, absolutely, the return on investment is large. In the aggregate, it's a long-term investment. But there are short-term savings that can be had. And I do apologize, but I probably didn't answer the question that Senator Burr asked, that we do create teams in the community that deal with need. It's primary care. It's creating teams around patients.

The biggest short-term investment for the GAO and others is on the complex patients. How do you take care of them? We've got some very interesting work around—when you ask the primary care doctors what they need to take care of the really complex—I need care management, I need people, I need psychiatrists, I need a team around this patient.

We've gotten down to saying if we can identify which patients coming out of the hospital need a home visit within 24 hours, and if three home visits prevent a re-admission—but we change the trajectory of that patient's care for 365 days, which means that's your return on investment. And we're getting more data to be able to
say how many people need to get back to their primary care place of care within 5 days, within 7 days, to really make a difference. That’s where your money will come to support the long-term investment, and we need to do more research around it. But that’s—absolutely, there’s a return on it.

Senator SANDERS. Dr. Wiltz.

Dr. Wiltz. Community health centers serve 15 percent of Medicaid recipients at 1 percent of the cost. We save the system $24 billion. We have a model that works. It’s proven. The triple aim of quality, cost, and outcomes—we’ve had study after study that shows this.

We exist in a medical neighborhood, so the hospitals, all of the elements that you talked about—we’re a part of that whole. We’re not saying we’re the panacea, that we can solve all the problems. But I do think, and we’ve proven in our history, that we are a big part of the solution.

Senator SANDERS. Mr. Brock.

Mr. Brock. We’re talking about a loss of productivity here among these people. The age group of the people that we see is predominantly between the age of 29 and 64. We’re only seeing 2 percent or 3 percent children at these events. So we’re talking, really, about the workforce.

All of them, although they may be there primarily for dental care and vision care, are really there in great need of basic medical care as well and, particularly, I might, add mental health problems. We could hold one of these RAM programs every day of the year and see a thousand people, without a doubt. So it’s an incredible loss of productivity.

Senator SANDERS. Thank you. That’s a very good point. I went way over my time.

Senator Burr.

Senator BURR. Mr. Chairman, I’m done except to say thank you once again to all of our witnesses today. This has been invaluable from a standpoint of the information you’ve supplied to us.

Thank you, Mr. Chairman.

Senator SANDERS. Thank you very much.

Let me ask you this. If there was an understanding here in Congress of what you all just said, that investing in primary healthcare not only keeps people healthier but saves money, and if somebody said, “You know what? We need 50,000 or 60,000 new primary care physicians by the year 2025” and looked at it almost from a military perspective—we’ve got a mission, and we’ve got to accomplish that mission—how do we do it?

Now, I think we’ve heard a lot of good ideas today, and I would throw out that maybe someone wants to comment,

“Are we going to do that when kids are graduating school $250,000 in debt? Are we going to do that if we don’t have a stronger National Health Service Corps? Are we going to do that if we do not have something the equivalent of a community health center in every neighborhood in the United States of America?”

How do we do that?

If you were sitting up there making that decision—let me start with you, Dr. Wiltz.
Dr. Wiltz. I think I mentioned this before, but you have to get them when they're stem cells. You have to get a kid when they are undifferentiated and they're still open to the possibilities, not a rotation in their third year of medical school. They have to be exposed in junior high and high school and be a part of the community and have that experience of working in a team.

Senator Sanders. So if we say to young people in elementary school and high school and college,

“You’re going to be able to go to medical school regardless of your income, but we need a commitment from you of X number of years to serve in underserved areas.”

Do you think that would be a significant step forward?

Dr. Wiltz. I think all the numbers bear it out. If you're only able to fund one out of every seven applicants for the scholarship, that tells you the need is there. I have 10 nurse practitioners that are on the loan repayment program, and we still have others that are trying to apply for it.

So the willingness—the American people will serve, if we make the venue possible and fund it. And the access issue with community health centers—the new applications point to—that people are continuously applying. HRSA could tell you that they’re only funding about a third, if not less, of all the applications that we’re getting. So the need is still there.

Senator Sanders. This is despite a huge expansion of the program.

Dr. Wiltz. That’s correct. The need is still there.

Senator Sanders. Other thoughts?

Dr. Hotz.

Dr. Hotz. We describe it as four rights. You’ve got to get the right students in. There are plenty of students like Dr. Nichols that are applying. I was on the medical school admissions—get them in, make certain we have the medical schools and the other training programs getting the right people in.

They have to have the right debt. My belief is that we ought to forgive all the debt for anybody who want to go to underserved areas, as long as they stay there. Ms. Spitzgo talked about the ability to take that debt and get them there—very important.

You have to have the right training programs at the right size. Right now, we only train 24,000 people per year, even though our medical school is going to graduate more. We have to go up probably 5,000, and it ought to be in primary care, and it ought to be in Teaching Health Centers.

Those are the things that we have to do. And then we have to treat them right in medical school. All of my kids have done continuity tracks out in rural areas and working at health centers, at the education health centers.

Those are the four rights. Get the right student in, the right debt, leverage them when they are most vulnerable, when they’re stem cells, get them into the right medical schools, and you can—and the University of Alabama has a program, and 75 percent of their people go out and do family medicine, because the State of Alabama pays for people to go into family medicine in rural areas. And then make certain that you get the right size—and when you expand GME, make certain that you expand it in primary care.
Senator Sanders. Dr. Nichols.

Dr. Nichols. Thank you, Senator Sanders. I want to make the point that those future family physicians of 2025 are this very year in their freshman year of high school. The clock is ticking, and the onus is on us within the next 3 years to start identifying some of these students and offer them an entry way into this pipeline.

There are many Senators on this committee, Senator Burr included, who have a lot of experience with pipelines, perhaps pipelines of a different sort. But the pipeline we’re talking about here today is a pipeline that carries even more valuable cargo. Instead of oil, we’re talking about primary care docs.

But the principle is very much the same and should be familiar to any of them. The pipeline has to start at the right place, you’ve got to plug all the leaks along the way, keep greedy private interests from siphoning off the cargo along the way, and get the pipeline to where it needs to go. It needs to start in high school. It needs to run all the way through to an eventual primary care practice in the places where we need them.

We need to keep hospitals from siphoning them off as subspecialist physicians. And we need to pay them, the point being that I think we’re a lot more valuable than oil. In fact, I’m worth my—I think I’m easily worth my weight in oil.

Actually, my weight in oil—I did the math this morning. It’s $55. I think if we can all agree that a primary care doc is worth about $55—all the time and energy we spend talking about oil pipelines. Maybe we should spend a little bit more time talking about the primary care pipeline.

Senator Sanders. Dr. Flinter.

Ms. Flinter. No surprise. I’m going to take an opportunity to speak directly to nurse practitioners as primary care providers. Ten thousand new nurse practitioners enter the workforce every year, and, trust me, those specialists and hospital systems are beginning to go after them, just like they’ve gone after the primary care doc. That’s why we need to create opportunities for nurse practitioners who have a passion to combine everything that is nursing with everything that is medicine and primary care and practice in our community health centers and in other underserved settings.

When we sort of did the back of the envelope math on whether we could authorize these nurse practitioner residency training programs, 15 health centers could produce 100 nurse practitioners who have already completed their doctor of nursing practice or their master’s program. Over 5 years, that’s 500 people, each with a minimum panel of 1,000 patients. That’s 5,000 people. It’s a math problem as well as an issue of opportunity and ability.

But we can do it. It’s really a matter of committing ourselves to this course, building the infrastructure, and that infrastructure stays. It doesn’t disappear at the end of a year or two. Thank you.

Senator Sanders. Dr. Dobson.

Dr. Dobson. I’d add to the comments—let me share a conversation we had with some students and residents in North Carolina. When asked, “What would you like to do when you get done?” And they thought, “Well, my only choice is to either work at the health system or search out some other alternative.” And they said, “But,
gosh, if I could be a small business and be a primary care doctor in a small town, I might actually do that.”

The problem is we don’t have an infrastructure to support those choices. So the question is we’ve got to get the right people in. We really need to train them where they’re going to practice and in the style they’re going to practice. It’s important if you want somebody to practice in a rural area, they need to understand what it’s like. Training them in a big city is not going to get them in a small practice.

They need to exit without debt or with less debt, and then we need to even give them a life of significance in their communities where they’re supported and feel part of something, because it’s—trust me, I still live in a town of 1,000, and I know how healthcare goes, because I go to the grocery store and it takes me an hour, because I get stopped on every aisle with people.

Senator Sanders. Try being a Senator going to the grocery store.

[Laughter.]

Dr. Dobson. Exactly, Senator. I think there are a lot of opportunities to really make significant strides in health policy. And, remember, in my testimony, I said a significant number of the patients are still cared for by small, independent practices. They’re small businesses in the community.

We’ve tried to create a virtual community health center, including our health centers, to support these small rural practices. They’re extremely significant and important in our rural areas. I think we can crack this nut, and the return on investment is there. We have to save the money and keep putting it upstream.

Senator Sanders. Thank you.

Mr. Brock.

Mr. Brock. It’s a question of opportunity, and just because boys and girls maybe come from a minority group or an underprivileged group, that doesn’t mean they’re not bright and that they couldn’t meet these academic standards. In my case, I came from an underprivileged home back there in England. But I was a fairly bright kid, I think, and I knew—I was told that there was an opportunity to go to one of Britain’s finest schools if only I could pass the examination to get there.

I worked hard at the books, and I took that examination, and I went to one of the finest schools in Britain totally free, with books paid for, everything paid for. I could have gone all the way to university and all the way to become a doctor at no cost. I’d like to see some kind of a program for these underprivileged kids here. I didn’t take advantage of mine because I ran off to Brazil to become a cowboy. But I could have become a doctor, and it would not have cost me a nickel.

Senator Sanders. The point that you raise—and I think Dr. Hotz also raised it and others—it’s not a radical idea that we’re talking about. I mean, in many countries around the world, people graduate medical school with, amazingly enough, no debt whatsoever, because those nations feel that it is in the country’s best interest to have doctors.

Maybe people can comment on this—my understanding is that if the U.S. military wants a doctor, what they will say to you is, “Young man, young woman, congratulations. We’re going to send
you to medical school, and in payment, you’re going to give us 5, 7 years of your life.”

Dr. Hotz, is that true?

Dr. Hotz. Yes. We had an expression back when we were working on this. We called it “Give me five.” Give us 5 years, and you’re debt free, and that’s what the military does.

Senator Sanders. And it works.

Dr. Hotz. It works.

Senator Sanders. Yes, Dr. Nichols.

Dr. Nichols. I’m actually an example of the sort of program that Mr. Brock is describing. The program I alluded to, the Premedical Honors College, since 1994, has been a really innovative partnership between Baylor College of Medicine and the University of Texas Pan American, which is soon to be renamed the University of Texas Rio Grande Valley, being reorganized to better serve Hispanic students from the poorest areas of Texas and Hispanic students all over the country, in fact, now coming to this school.

But the need was for primary care physicians, particularly, that could provide culturally sensitive care to patients on the border with the United States and Mexico. Since 1994, 297 students have matriculated into the Premedical Honors College.

As of June 2013, 206 have successfully completed their undergraduate components, getting bachelor of science degrees from UTPA; 181 graduates have entered a Texas medical school, 145 at Baylor College of Medicine, but some at other schools as well; 124 students have earned their M.D. degrees, including myself; and 51 of us have completed our advanced training and are now in practice, 24 of those 51 in south Texas, and that’s without any particular requirements, just feeling an obligation to come back and practice.

The majority of the rest of them that are not practicing in south Texas are practicing in underserved areas in San Antonio and other Hispanic enclaves of underserved and the urban areas of Texas. Thirty-seven students are currently enrolled at Baylor, and 42 are currently enrolled at UTPA, so the pipeline continues. Despite the loss of Federal funding years ago, the pipeline continues.

Senator Sanders. Let me just conclude, first of all, thanking all of you, personally, for the work you are doing. As we have heard many times this morning, you’re in the trenches. You are saving people’s lives. You are working in an area that gives hope to people in your community who, I suspect, if you were not there, would not know what to do. You have also given us this morning a whole lot of good ideas about where we have got to go.

But let me conclude in a hopeful way. I think we know where we have got to go, and I think virtually all of you have raised those issues about where we need to go. So our job now is to pick up that ball and run with it, and let’s see if we can transform our healthcare system and put a much greater focus on primary care.

Thank you all very much for being here this morning. The meeting is adjourned.

[Additional material follows.]
ADDITIONAL MATERIAL

COMMUNITY HEALTH CENTER, INC.,
MIDDLETOWN, CT 06457
May 18, 2014.

Hon. ELIZABETH WARREN,
SH–317 Hart Senate Office,
U.S. Senate,
Washington, DC. 20510.

DEAR SENATOR WARREN: Thank you for the honor of testifying before you and the Senate HELP Committee's Primary Care and Aging Subcommittee on April 9, 2014. It is my pleasure to respond here to the question you posed to us at the end of the hearing.

In your remarks, you said, "Not every medical incident requires a doctor to get the job done. Last November, the Health Resources and Services Administration released a report estimating that the projected primary care shortage could be cut by more than two thirds if nurse practitioners and physician assistants were fully integrated into the primary care delivery system. It’s important to think creatively about ways to fully mobilize this workforce. For example, the VA defines its own scope of practice for nurse practitioners and physician assistants, without regard to which State the facility is located in. And the government authorized support for nurse practitioner residency programs—including those in Massachusetts—but Congress never funded the initiative. All medical professionals have a role to play in meeting the increasing demand for health care in this country, and all of them should have the chance to practice up to the level of their training."

Your question was then: "What steps can Congress take to help ensure that our health care system uses the full range of providers to reach the highest number of patients, in the most efficient way possible?"

Let me answer your question by addressing three different areas: (1) the importance of nurse practitioners and physician assistants as full primary care providers in the U.S. health care system, and the steps we can take to support and ensure their choice of primary care as the focus of their primary care careers; (2) the critical importance of the primary care team in ensuring outstanding clinical care and increasing the capacity of each and every primary care provider to manage far more patients in a way that is both clinically effective and satisfying to patients and providers alike; and (3) the steps that Congress can take to help ensure use of the full range of providers to reach the highest number of patients in the most efficient way possible.

First, let me address the importance of NPs and PAs as primary care providers. You are correct when you say that, "not every medical incident requires a doctor to get the job done." We have nearly a half century of experience and research since Dr. Loretta Ford first developed the expanded role of nursing and created a new role, that of nurse practitioner, established for nurses prepared at the graduate level, who can provide a full range of preventive, acute, and chronic care to individuals and families. The scope of this new nursing role was broadened to include diagnoses, treatment, and management of health problems. Over the decades, as the education, training, and certification of NPs has advanced, NPs have become central and critical to the U.S. primary health care system. The American Academy of Nurse Practitioners (AANPs) estimates that one-fifth of all primary care services in the United States are delivered by an NP in settings that range from private practice to community health centers; from nurse-managed health centers to retail clinics; from schools to correctional facilities; and beyond. Unlike physician residents in medicine, the majority of NPs still choose a primary care focus for their practice careers, although they are also well-represented in non-primary care specialties, such as acute care. I am very appreciative of the efforts of the Federal Government over many years to support and increase the capacity of our Nation’s universities to develop our fine system for educating nurse practitioners and preparing them for practice in all areas.

We have ample evidence to document the quality, safety and acceptability of care provided by NPs in primary care. In my decades of practice and leadership as an NP, I have seen the slow but steady progress over time in our State scope of practice laws that have gradually, but far too slowly, moved in the direction of independent practice by NPs. Today, 19 States allow fully independent NP practice
The Nation. However, Congress never funded this initiative. I would therefore ask practitioners in community health centers and nurse-managed health clinics across the country. It is exceedingly important when we think about the primary care team as well as the primary care provider—when we think about expanding the role of physicians, NPs, and PAs—into this role. As I stated during my testimony, we are doing this at a time when primary care has never been more exciting—or more challenging. The complexity of patient clinical co-morbidities, the need to provide what was formerly considered specialty level care in primary care in collaboration with specialists, the range of treatment options, the advances in research and technology, and the redesign of primary care practice—combined with the need for every PCP to manage larger panels of patients than ever before—can be overwhelming to those who are new to practice. These factors combine to demand that we create postgraduate residency training opportunities for those new NPs who aspire to this role. We simply have to ask, “who wants to be a primary care provider?” and ensure that we have done everything in our power structurally, and in terms of the transition from their excellent education to practice, to support them. That’s why we at CHC, Inc. in Connecticut created the country’s first formal postgraduate NP residency training program, and why so many other FQHCs around the country are following suit. We are very happy to see that several institutions are developing similar programs for PAs, and some are combining their postgraduate residency training programs in what are called “Advanced Practice Clinician” residencies, which are inclusive of both NPs and PAs. It is clear, based on our 7 years of experience in designing and hosting NP residency training programs, that new NPs who aspire to practice careers as primary care providers, in the challenging setting of FQHCs, want, need, and deserve this opportunity for further training and the mastery, confidence, competence, and potential for leadership in practice that come with such additional training.

The second area I would like to address is the potential for primary care teams to significantly increase their capacity to manage larger panels of patients and thus reduce the “shortage” of primary care providers in a different way. I am the national co-director of a Robert Wood Johnson-funded project called, “PCT-LEAP” for “Primary Care Teams: Learning from Effective Ambulatory Practices”. I am a co-director of this RWJF project, along with Dr. Ed Wagner of the McColl Institute at Group Health in Seattle, and Dr. Tom Bodenheimer of the Center for Excellence in Primary Care at the University of California at San Francisco. On May 15, 2014, I had the pleasure of hosting Dr. Wagner and Dr. Bodenheimer at the Community Health Center, Inc.’s Ninth Annual Weitzman Symposium on Innovation in Community Health and Primary Care. We reviewed the evidence from the PCT-LEAP project and other projects studying “exemplary” primary care practices around the country. It is exceedingly important when we think about the primary care team as well as the primary care provider—when we think about expanding the role of medical assistants, redefining the role of the primary care nurse, integrating behavioral health clinicians into the team, adding pharmacists whether directly or by electronic consultation, adding health coaching as a skill for all members of the team, and supporting the entire team with timely, actionable data on care and gaps in care—that we are creating a new day in primary care, where patients maintain their satisfying and healing relationship with their own MD, NP, or PA as their primary care provider, but also know and are well-cared for by a high performance team of individuals committed to their best healthcare and health. As Dr. Wagner said, “the future of primary care is already here; it’s just not evenly distributed.” His comment illustrates the point that while we have identified many practices that have now achieved the goal of constituting a high performance primary care team, our next challenge is to disseminate the knowledge and tools to expand these teams across the country.

Finally, I would like to answer your question about how Congress can support these efforts. You noted that Congress in 2010 authorized Section 5316 of the Affordable Care Act, a provision that would provide residency training for new nurse practitioners in community health centers and nurse-managed health clinics across the Nation. However, Congress never funded this initiative. I would therefore ask...
you to support the reauthorization and funding of section 5316 in the amount of $75 million through fiscal year 2019, as currently included in S. 2229, the “Expanding Primary Care and Workforce Act,” introduced by Senator Sanders on April 9, 2014. Properly funding section 5316 would establish a demonstration project with 20 to 25 sites nationwide, where a minimum of three nurse practitioners would be trained as residents at each site, each year, for 3 years. Each site would be funded up to $600,000 per year. The Sanders bill would also reauthorize and create a mandatory appropriation for the National Health Service Corps (NHSC) of $4.9 billion through fiscal year 2020; appropriate $10 million for the National Health Care Workforce Commission; reauthorize the Nurse Faculty Loan Program through fiscal year 2019; reauthorize the Primary Care Residency Expansion Program through fiscal year 2019; and reauthorize the Area Health Education Centers (AHECs) through fiscal year 2019.

Second, I would ask your support for reauthorization and funding of the Teaching Health Center Graduate Medical Education (THCGME) program, along with the expansion of that program to include residency training for new NPs and other health care professionals, so that FQHCs can innovate and develop residency training programs not only for physicians but also for other professionals such as NPs and PAs. Reauthorization of the THCGME program is funded at $800 million in S. 2229, though use of the funds is not expanded to include NPs or PAs; unfortunately, the bill as drafted supports only training of physician residents. That should be changed.

Third, I would ask your continued support for the community health center program in general. The Sanders bill, S. 2229, also creates a mandatory appropriation for FQHCs of $25 billion through fiscal year 2020.

Fourth, I would suggest that Congress focus on those primary care settings that have already developed highly innovative models of high performance primary care and have systematically developed the infrastructure, training, and tools to help other practices achieve the same goals. In my organization, we have developed a rigorous approach to dissemination, training, and on-going support for other highly motivated practices, whether they seek to implement NP residency training; to transform from provider-centric to team-based primary care; to develop new data systems to support care; or to tackle the highest complexity issues we see in primary care, such as managing chronic pain and addiction.

We at CHC, Inc. in Connecticut are ready and able to work with others, and we have the structure in place through the adoption of the Project ECHO (Extension for Community Health Outcomes) telemedicine model first developed in New Mexico to help primary care providers manage Hepatitis C in primary care with the support of specialists. At CHC, Inc., we have adopted, refined, and grown the Project ECHO model and now help organizations across the country and the world improve their primary care practices through this case-based, distance learning opportunity that provides support over time to primary care practices tackling ambitious goals of transformation and improvement. I would urge Congress to consider the establishment of one or more national training centers to fulfill exactly this urgently needed role using our model.

Thank you for this opportunity to respond to your question, and for your commitment to good health and health care for everyone.

Sincerely,

MARGARET FLINTER, APRN, PH.D., C–FNP, FAAN, FAANP,
Senior Vice President and Clinical Director,
Community Health Center, Inc.

RESPONSE BY JOSEPH S. NICHOLS, M.D., MPH TO QUESTIONS OF SENATOR WARREN

The research is mixed on how student debt factors into the decision to pursue a medical career in primary care. Primary care doctors make, on average, a little more than 50 percent of what a specialist makes, so the burden of debt certainly weighs heavily on them. Medical students graduate with an average of about $170,000 in student loan debt. That’s a lot, but debt at graduation tells only half the story. According to the American Association of Medical Colleges, a doctor who started off with $175,000 in debt can end up repaying more than $300,000 once interest is factored in. The interest rate is not set at the cost to the government. Instead, it is set at a level that is projected to produce billions of dollars in profits. A recent GAO report estimated that the Federal Government will bring in $66 billion off the loans it made between 2007 and 2012.

Question. Recognizing that these are estimates, and of course estimates can change, what are your thoughts about the U.S. government turning a profit on stu-
dent loan interest rates at a time when Federal policy should be making it as easy as possible for medical students to choose careers in primary care?

Answer. Thank you, Senator Warren, for the question and for your leadership on this issue.

Almost no one can afford the cost of a medical school education. This is because, in addition to the high sticker price, there are numerous intangible costs to medical education that are subsidized by Federal and State Governments. Therefore, every medical student graduates with a significant amount of debt, whether or not this debt can be added up in the form of student loans. However, the message medical students receive from the Federal Government upon graduation is that our educational loan debt is the debt that is of most interest to our society.

The contract between medical school graduates and society must be rewritten in a way that challenges our doctors to begin their careers with service in the places where they are most needed. If broader opportunities existed, many medical school graduates would gladly exchange their financial debt for a social debt, repaid not with monthly payment amounts that only inflated sub-specialist wages can support, but with service to the sickest patients in the areas of the country experiencing the most need.

The Federal Government currently profits tremendously off of the interest charged to our student loan debt. However this profit is shortsighted when measured in dollars and cents, considering the huge opportunity cost of the health needs that could be met if this monetary debt was effectively transformed into a social debt repaid through service.

Clearly, this situation calls for expansion of current, time tested and effective loan repayment programs incentivizing service as a primary care provider to medically underserved areas. Future expansions of these programs should aim to entirely eliminate the debt faced by physicians who commit their careers in service of the greatest needs of our society.

RESPONSE BY JAMES HOTZ, M.D. TO QUESTIONS OF SENATOR WARREN

The research is mixed on how student debt factors into the decision to pursue a medical career in primary care. Primary care doctors make, on average, a little more than 50 percent of what a specialist makes, so the burden of debt certainly weighs heavily on them. Medical students graduate with an average of about $170,000 in student loan debt. That’s a lot, but debt at graduation tells only half the story. According to the American Association of Medical Colleges, a doctor who started off with $175,000 in debt can end up repaying more than $300,000 once interest is factored in. The interest rate is not set at the cost to the government. Instead, it is set at a level that is projected to produce billions of dollars in profits. A recent GAO report estimated that the Federal Government will bring in $66 billion off the loans it made between 2007 and 2012.

Question. Recognizing that these are estimates, and of course estimates can change, what are your thoughts about the U.S. government turning a profit on student loan interest rates at a time when Federal policy should be making it as easy as possible for medical students to choose careers in primary care?

Answer. Senator Warren, I appreciate your recognition of the negative impact that student loan interest rates have on medical students selecting careers in primary care. At a time when our Nation needs an additional 52,000 primary care physicians to satisfy the demands of 2025, it makes no sense to have a Federal loan program that increased the cost of student loans by $66 billion from 2007 to 2012! Instead of recruiting the additional 5,000 primary care physicians we need each year; the current loan structure is creating a marketplace that drives physicians out of primary care practice. In a thought provoking New York Times letter on May 28, 2011 Peter Bach and Robert Kocher propose, “Why Medical School Should Be Free.” They point out that “for roughly $2.5 billion per year—we can make medical school free.” Their suggestion is to keep medical school free for those electing primary care and to have those going in higher paying specialties pay back the cost of their education. This would be one option.

A more moderate proposal would be to expand the National Health Service Corps loan forgiveness program to forgive the loans of all primary care practitioners going to areas of greatest need in this country. Another option would be to restructure the current student loan interest and repayment mechanisms to incentivize primary care. A menu of options could run from lower interest for those selecting primary care to no interest and some principal reduction for those selecting primary care in the most underserved areas. With a $66 billion profit generated in the 5 years up to 2012 there seems to be room in the Federal student loan program for revisions that would create economic incentives to distribute the primary care workforce to
areas of greatest need in this country. I am optimistic that Congress can find ways to restructure the current Federal loan program to better meet not only the primary care needs but also the larger workforce needs of the people you serve.

In keeping with the “Voices from the Field” theme of the hearing I would like to show the pressure the current Federal loan program places on someone I know well who is trying to start a career in primary care. My oldest son, George, resisted the temptation of higher paying specialty opportunities after completing an internal medicine residency. He took a job with a regional hospital in Rome, GA and joined a primary care practice that has its doors open to all in the community. His income is less than half what a specialist would make but this was his calling and his wife supported the decision and all started out smoothly. He was making four times his salary as a resident, Rome was near his wife’s home, they bought a small house, they were used to living on a tight budget, and then they started paying his medical school loans! They elected an amount slightly under their monthly mortgage payment and after paying $1,650.49 a month from 10/2012 to 4/2013 they were shocked to see they had made 7 payments totaling $11,553.43 and ALL went to interest! The principal had not been reduced at all, and unlike the home mortgage none of this was deductible. George and his wife took a hard look at their financial situation. Until then the loan was just an abstract threat, but now reality has set in. They had to make some hard decisions—to tighten the budget more and pay off a larger amount each month or else this debt monkey would be on their back for 25 more years—or George could decide to go back into a higher paying specialty. Fortunately for the people of Rome, they decided to stay, cut down more on spending and increased their payments to $3,886.09 a month so they would be out of debt in 10 years. That first payment was made on 3/7/14 and $893.04 went to principal and $2,993.05 to interest.

Before 2006, George was able to get part of his Stafford Loan at 2.1 percent. After 2007 until his graduation in 2008, the interest rates skyrocketed to 6.55 and 7.65 percent. My youngest son, Steve, is in medical school now and his rates are also in the same range—from 6.8 to 7.9 percent. For Steve and most of his classmates these loans are significant only when a family member, friend or a physician faculty member tells them of the grim reality of debt, high interest and the pain of repayment. That is when this debt storm starts raining down on the dreams of a career in primary care. Unfortunately there has also been a relentless increase in medical school tuition to pay for expanding class sizes resulting in substantially larger medical school debt at a time in which the interest rates have risen to painfully high levels. It is clear what the future primary care “Voices from the Field” are saying, “Help!”

Senator Warren and subcommittee members the time for action is now. The first step in “Addressing Primary Access and Workforce Challenges” is in addressing the excessive burden of medical school debt and interest. This can happen in a number of ways, including a reduction of interest rates, a reduction in tuition costs or full loan repayment. Each of these can be achieved by strategic use of the National Health Service Corps program, and I’d be happy to work with you to make that a reality.

Thank you Senator Warren for this opportunity to answer your timely and insightful question and I hope my comments will be of help. I am here on behalf of the Association of Clinicians for the Underserved and you can feel free to contact me or the Association if there are any further questions or if we can be of any service in the future.

[Whereupon, at 12:20 p.m., the hearing was adjourned.]