

**SUPPORTING TOMORROW'S HEALTH PROVIDERS:  
EXAMINING WORKFORCE PROGRAMS UNDER  
THE PUBLIC HEALTH SERVICE ACT**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON ENERGY AND  
COMMERCE  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED FIFTEENTH CONGRESS  
FIRST SESSION

SEPTEMBER 14, 2017

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**SUPPORTING TOMORROW'S HEALTH PROVIDERS: EXAMINING WORKFORCE PROGRAMS UNDER THE PUBLIC HEALTH SERVICE ACT**

THURSDAY, SEPTEMBER 14, 2017

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON ENERGY AND COMMERCE,  
*Washington, DC.*

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Burgess, M.D. (chairman of the subcommittee) presiding.

Present: Representatives Burgess, Guthrie, Murphy, Blackburn, McMorris Rodgers, Bilirakis, Brooks, Hudson, Collins, Green, Engel, Schakowsky, Butterfield, Matsui, Sarbanes, Kennedy, and Eshoo.

Also Present: Representative Denham.

Staff Present: Adam Buckalew, Professional Staff Member, Health; Paul Edattel, Chief Counsel, Health; Jay Gulshen, Legislative Clerk, Health; Edward Kim, Senior Health Policy Advisor; Katie McKeogh, Press Assistant; Kristen Shatynski, Professional Staff Member, Health; Waverly Gordon, Minority Health Counsel; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. The hearing will now come to order. The chair will recognize himself for 5 minutes for an opening statement.

Today's hearing provides us with an opportunity to begin discussion on how to best address provider shortages in our country and how to ensure that today's medical students have the skills and resources to succeed in the 21st century. As a physician, I have supported programs that improve access to care and enhance patient experience, and the programs that we are examining today seek to accomplish this goal.

When looking at the data, our mission is clear. The Association of American Medical Colleges estimates by the year 2030, the United States will have a projected physician shortage, anywhere from just over 40,000 to over 100,000 providers.

To address this issue, our hearing will focus on four sets of unique programs: the National Health Service Corps, Teaching

Health Center Graduate Medical Education, Physician Workforce Programs under Title VII of the Public Health Service Act, and Nursing Workforce Programs under Title VIII of the Public Health Service Act. Each of these programs seeks to increase access to providers in underserved areas and promote the training opportunities for medical students and providers to maintain their skills.

For example, programs like the National Health Service Corps and the Area Health Education Centers, supported by Title VII grants, and Teaching Health Centers, tackle these shortages by connecting young providers with underserved communities. These programs are essential to addressing the Nation's provider shortage by connecting providers to those that are not served.

Additionally, Title VII and Title VIII programs support opportunities for continuing medication education for the healthcare workforce, which is not only mandatory for many providers to keep their licenses, but it is also essential to providers as they attempt to keep up with evolving issues and treatments. In an age with modern drugs and the 21st Century Cures Act supporting future innovation, we must ensure that our healthcare workforce is ready for these breakthroughs and prepared for future challenges.

This hearing, however, comes at a precarious time for these programs as we seek to reauthorize them and extend their funding. For Title VII and Title VIII, both of which have expired, yet continue to receive appropriations on a year-by-year basis, a commitment by this subcommittee to reauthorize these programs would ensure longer-term stability, particularly for future generations of providers.

The National Health Service Corps and the Teaching Health Center Graduate Medical Education Program have funding that will expire at the end of the fiscal year, and our subcommittee is working to ensure these programs will continue to operate and serve communities in coming years. As is the case with all programs with mandatory funding, finding offsets can be challenging, but I am committed, and I know others on the committee are committed, to finding a solution and extending these programs.

I want to thank each of our witnesses for being here today and providing their unique insights into the problems ahead. Dr. Adrian Billings, the Chief Medical Officer of Preventive Health Services; Dr. Neil Calman, the President of the American Association of Teaching Health Centers; Dr. Janice Knebl of the University of North Texas Health Science Center; and Dr. Juliann Sebastian, Dean of the College of Nursing at the University of Nebraska Medical Center, are each celebrated providers and experts in their respective fields, and I look forward to hearing from each of them.

And to prove that we are in an area of glasnost where the lion can lie down with the lamb, we have both the University of North Texas and Texas Tech University at our witness table today, and for that, I am extremely grateful.

Now, these are not the only programs that support our Nation's healthcare workforce, but they are each important and deserve our attention. As we move beyond the immediacy, I look forward to delving further into this issue and identifying new opportunities to support providers as well as communities.

And I will yield my remaining time to the gentlelady from Washington, Mrs. McMorris Rogers.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

The Subcommittee will come to order.

The Chairman will recognize himself for an opening statement.

Today's hearing provides us with an important opportunity to begin a discussion on how best to address provider shortages in our country and how to ensure that today's medical students have the skills and resources to succeed in the 21st century. As a physician, I have always supported programs that improve access to care and enhance the patient experience, and the programs that we are examining today seek to accomplish this very goal.

When looking at the data, our mission is clear. The Association of American Medical Colleges estimates that by the year 2030, the United States will have a projected physician shortage ranging from 40,800 providers to as many as 104,900 providers.

To address this looming issue, our hearing will focus on four sets of unique programs: the National Health Service Corps, Teaching Health Center Graduate Medical Education, physician workforce programs under Title VII of the Public Health Service Act, and nursing workforce programs under Title VIII of the Public Health Service Act. Each of these programs seeks to increase access to providers in underserved areas and to promote the training opportunities for medical students and providers to maintain their skills.

For example, programs like the National Health Service Corps, Area Health Education Centers which are supported by Title VII grants, and Teaching Health Centers tackle these shortages head on by connecting young providers with underserved communities. These programs are essential to addressing the nation's provider shortages because they serve as driving forces that can connect providers to underserved communities and can support the care needs of individuals that would otherwise be unavailable without the providers that participate in these programs.

Additionally, programs under Title VII and Title VIII of the Public Health Service Act provide an array of opportunities to support education in health professional schools. These programs range from supporting disadvantaged students to attend medical school to supporting fellowships and faculty positions so that health professional schools can continue to meet the needs of students.

Title VII and Title VIII also support opportunities for continuing medical education for the healthcare workforce, which is not only mandatory for many providers to keep their licenses, but is also essential to providers as they attempt to keep up with evolving issues and treatments. In an age with breakthrough drugs and a 21st Century Cures Act that is supporting future innovations, we must ensure that our healthcare workforce is ready for these breakthroughs and is prepared for future challenges in delivering care.

This hearing, however, comes at a precarious time for these programs as we attempt to reauthorize them and extend their funding. For Title VII and Title VIII which have both expired yet continue to receive appropriations on a year by year basis, a commitment by this Subcommittee to reauthorize these programs would ensure longer-term stability and offer future generations of providers with opportunities to grow and serve our communities.

And for the National Health Service Corps and the Teaching Health Center Graduate Medical Education program which have funding that will expire at the end of the fiscal year, our Subcommittee is hard at work ensuring that these programs will continue to operate and serve communities in the coming years. As is the case with all programs with mandatory funding, finding offsets can be challenging, but I am committed to finding a solution and to extending these programs.

I would like to thank each of our witnesses for being here today and providing their insights on the problems ahead. Dr. Adrian Billings, the Chief Medical Office of Preventive Care Health Services, Dr. Neil Calman, the President of the American Association of Teaching Health Centers, Dr. Janice Knebl, from the University of North Texas Health Science Center, and Dr. Juliann Sebastian, the Dean of the College of Nursing at the University of Nebraska Medical Center, are each celebrated providers and experts in their respective fields, and I look forward to hearing from them.

These are not the only programs that support our nation's healthcare workforce, but they are each important and deserve our immediate attention. And as we move

beyond the immediacy, I look forward to delving further into this issue and identifying new opportunities to support providers and underserved communities.

Mrs. MCMORRIS RODGERS. Thank you, Mr. Chairman.

It is estimated that we could have a nationwide doctor shortage of 23,000 by 2025, and the physician population ratio in rural communities, like mine in eastern Washington, is especially stark. That is why it is so important that we reauthorize the Teaching Health Center Graduate Medical Education Program. This program specifically trains residents in specialties with the largest shortages, such as family medicine and psychiatry. And when compared with traditional Medicare GME residents, the Teaching Health Center residents are more likely to practice primary care, remain in underserved areas, and work in rural communities.

My legislation, H.R. 3394, aims to not only reauthorize this critical workforce program, but expand it to ensure communities have access to primary care doctors and dentists they desperately need.

I want to thank the committee for holding this hearing, and also my colleagues, like Representative Denham, who helped this effort.

Thank you, Chairman.

Mr. BURGESS. The chair thanks the gentlelady.

The chair now recognizes the subcommittee ranking member, Mr. Green of Houston, for 5 minutes for an opening statement.

**OPENING STATEMENT OF HON. GENE GREEN, A  
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman.

I want to thank our witnesses there, and not only our Texans because we don't have to have an interpreter to talk to each other. But I also want to welcome our witness from the University of Nebraska Medical Center. I have a little tie there with my daughter and her husband, doctors there, but more importantly, I have two grandchildren that live in Omaha. So thank you for being here.

Today we are examining the National Health Service Corps Program; the Teaching Health Center Graduate Medical Education Program; H.R. 3728, Educating Medical Professionals and Optimizing Workforce Efficiency and Readiness, the EMPOWER Act of 2017; H.R. 959, the Title VIII Nursing Workforce Reauthorization Act of 2017.

The National Health Service Corps program provides financial support to health professional students and primary care providers who commit to provide service in medically underserved communities. The NHSC program is comprised of four separate programs.

First, the NHSC Scholarship Program, which provides scholarships to healthcare professional students who agree to serve in underserved communities upon the completion of their education and training.

The NHSC Loan Repayment Program, which provides loan repayment assistance to primary care providers in exchange for service in a health professional shortage area.

The NHSC Students to Service Loan Repayment Program, which provides assistance to the medical and dental students in their last year of school in exchange for a commitment to primary healthcare in a health professional shortage area for 3 years.

And finally, the State Loan Repayment Program, which is a Federal-State partnership grant program that provides loan repayment to clinicians who practice in a health professional shortage area in that state.

Together, the program supports a critical workforce in areas that are much in need. The Teaching Health Center Graduate Medical Education Program was established under the Affordable Care Act of 2010 to encourage increased training of primary care and medical and dental residents in community-based settings, such as federally qualified health centers or rural health clinics. It must be reauthorized before the end of the month or it may go away altogether.

Title VII of the Public Health Service Act established the Federal Healthcare Workforce Development Grant programs administered by HRSA that have long enjoyed bipartisan support in Congress. Colleagues on this committee have legislation to reauthorize Title VII. I am pleased to support this legislation.

Finally, we are examining Title VIII of the Public Health Service Act, which established Federal nursing workforce development grant programs administered by HRSA. The programs focus on nursing education, practice, recruitment, and retention. Nurses play a vital role in our healthcare workforce, and this program is essential to the success of delivery of care.

I also want to mention the Health Centers Fund, which provides substantial funding to federally qualified health centers or community health centers, which are on the front line of our healthcare safety net, providing primary care to millions of Americans. The Health Centers Fund runs out at the end of the month. This funding cliff threatens their ability to provide care our constituents depend on, and I cannot stress the importance of extending this funding enough.

Thank you again to our witnesses. I look forward to their testimony.

And I would yield the remainder of my time to my colleague from California, Congresswoman Matsui.

Ms. MATSUI. Thank you very much for yielding me time, and I thank the witnesses for being here today.

As we move forward to improve our healthcare system, bolstering our workforce is a critical piece to the puzzle. I am pleased that we are holding this hearing today to discuss the reauthorization of multiple important healthcare workforce programs, including the Geriatric Workforce Program in Title VII that I worked on with Representative Schakowsky, the Title VIII Nursing Workplace Program, that I worked with on with Representative David Joyce, the National Health Service Corps, and the Teaching Health Centers.

It is estimated by 2030 over 3 million trained healthcare workers will be needed just to maintain the current needs of our Nation's seniors. My geriatrics workforce bill with Congresswoman Schakowsky, included in the Title VII bill we are discussing today, will help meet that need by investing in our geriatric workforce and incentivizing the creation of training programs in underserved communities.

Our Nation's aging population will especially increase the demand on our nursing workforce, and a reauthorization of Title VIII

would ensure that critical nursing education programs can continue.

Investments in our healthcare workforce are investments in the long-term prosperity of our healthcare ecosystem. And I do appreciate the committee's attention to these issues, and I yield back the balance of my time.

Mr. GREEN. I yield back my time.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back.

Not seeing the chairman of the full committee here, is there a member on the Republican side who would seek the chairman's time. Seeing none, is there a member on the Democratic side who would seek the ranking member's time?

For what purpose does the gentlelady from Illinois seek recognition? You are recognized 5 minutes for an opening statement.

**OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS**

Ms. SCHAKOWSKY. Thank you.

I am so pleased we are here today to consider these critical health workforce bills. I would like to thank the distinguished panel for their work in support of these programs. I am pleased to cosponsor H.R. 3728, the EMPOWER Act, to reauthorize the healthcare workplace development grant programs, which we are considering today.

Additionally, as a co-chair of the Seniors Task Force, I was delighted to introduce H.R. 3713, the bipartisan Geriatric Workforce and Caregiver Enhancement Act, with Representative Matsui. This bill works to fully achieve the goals of this hearing, supporting tomorrow's health providers.

Our Nation is facing a severe and mounting shortage of healthcare professionals to meet the needs of older Americans. This growing need is reflected in Illinois. By 2030, it is estimated that the older adult population will increase to 3.6 million and represent almost a quarter, 24 percent, of the Illinois population.

The reauthorization of the Geriatrics Workforce Enhancement Program and the Geriatric Academic Career Awards are critical in addressing this shortage. In Chicago, Rush University Medical Center is one of the outstanding health and education institutions to receive a grant from the Health Resources and Service Administration, HRSA, and have a geriatric workforce enhancement program. At Rush, providers are trained to better care for older adults.

We must continue to support this vital work. I look forward to working with my colleagues on this committee to advance this important bill.

Thank you. And I now yield to Congressman Kennedy.

Mr. KENNEDY. Thank you to my colleague from Illinois, and many thanks to all the witnesses today. Thank you to the chairman and the ranking member for calling this important hearing.

By bringing the expertise of all of the witnesses and their experiences to Washington today, you are helping us strengthen the future of our community healthcare system, including Teaching

Health Centers and the National Health Service Corps. Thank you for your commitment and thank you for your work.

A few weeks ago, I visited a community behavioral health center in a town in my district that has been devastated by the opioid epidemic. A staffer there told me that she volunteers pro bono to ride with the local police department to the homes of every single person who had overdosed, the following day after their episode, to offer compassion, support, and any care that they and their family need. They have been to hundreds of homes. And not once have they ever been turned away.

In our medically underserved and most vulnerable communities there will always be the need for more providers. And there always be providers willing to work long, hard hours, underpaid, to care for their neighbors and to fill the gaps in the hopes that our government at some point catches up. By investing in these workforce programs, we can inspire a new generation of health practitioners who are trained for the communities where they will work and serve and live in for years.

Instead of once again asking our local leaders to bear the burden of our inaction, we should address the healthcare shortage today, starting with these bills, extending the community health centers, and reauthorizing CHIP.

Thank you. And, Mr. Chairman, I would ask to submit for the record the following letter from the Council of Academic Family Medicine. I yield back.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. Does the gentleman yield back?

Mr. KENNEDY. Yes, I yield back.

Mr. BURGESS. The chair wishes to note the presence of our colleague, Mr. Denham from California, not a member of the committee, but certainly has been a valuable Member in providing expertise and emphasis on some of the bills that we are considering today.

That concludes opening statements. The chair would remind members that pursuant to committee rules, all members' opening statements will be made part of the record.

We do want to thank our witnesses for being here today and taking time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement, followed by questions from members.

Today, we will hear from Dr. Neil Calman, Chief Medical Officer, Preventive Health Care Services; Dr. Adrian Billings, President of the American Medical Association of Teaching Health Centers; Dr. Janice Knebl, Dallas Southwest Osteopathic Physicians Endowed Chair and Professor in Geriatrics at the University of North Texas Health Science Center; and Dr. Juliann G. Sebastian, Dean and Professor, College of Nursing, the University of Nebraska Medical Center.

We appreciate your being here today.

And, Dr. Calman, you are now recognized for 5 minutes to give an opening statement.

**STATEMENTS OF NEIL S. CALMAN, MD, FAAFP, PRESIDENT AND CEO, INSTITUTE FOR FAMILY HEALTH, CHAIR, DEPARTMENT OF FAMILY MEDICINE AND COMMUNITY HEALTH, ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI/MOUNT SINAI HOSPITAL, PRESIDENT, AMERICAN ASSOCIATION OF TEACHING HEALTH CENTERS; ADRIAN BILLINGS, MD, PHD, FAAFP, CHIEF MEDICAL OFFICER, PREVENTATIVE CARE HEALTH SERVICES, ASSOCIATE PROFESSOR, DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE, TEXAS TECH UNIVERSITY HEALTH SCIENCES; JANICE A. KNEBL, DO, MBA, DALLAS SOUTHWEST OSTEOPATHIC PHYSICIANS ENDOWED CHAIR AND PROFESSOR IN GERIATRICS, UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER, MEDICAL DIRECTOR, JAMES L. WEST PRESBYTERIAN SPECIAL CARE CENTER; AND JULIANN G. SEBASTIAN, PHD, RN, FAAN, DEAN AND PROFESSOR, COLLEGE OF NURSING, UNIVERSITY OF NEBRASKA MEDICAL CENTER**

**STATEMENT OF NEIL S. CALMAN**

Dr. CALMAN. Thank you, Chairman Burgess, Ranking Members Green, and distinguished members of the subcommittee. Thank you for inviting me to speak to you about the THCGME, or Teaching Health Center Graduate Medical Education Program.

I am a family physician in practice for 40 years in the South Bronx and the Lower East Side of Manhattan. I am President and CEO of the Institute for Family Health, a nonprofit network of 31 federally qualified community health centers, and three family medicine residency programs.

In 2012, we began participating in the new THCGME Program to expand resident training into two severely underserved rural New York communities, and also in Harlem and the South Bronx.

As President of the American Association of Teaching Health Centers, and on behalf of the 57 teaching health centers, I implore you to reauthorize the THCGME Program before it expires on September 30, and to do so for a minimum of 3 years. It is a unique and critically important initiative aimed at ending the primary care physician shortage which plagues our country.

The shortage of primary care in the U.S. creates an underemphasis on basic preventive healthcare, the delayed detection and treatment of serious disease, and the overuse of emergency care and acute hospitalization for many preventable conditions. All of this has driven our healthcare costs to unsustainable levels. Sixty million Americans lack access to a primary care doctor, and by 2020, the U.S. may face a deficit of 20,000 primary care doctors.

The THC programs are accountable for every dollar of funding, and they produce results. Eighty-two percent of teaching health center graduates remain in primary care, compared to 23 percent of other graduates. Twice as many practice in underserved communities, 4 times as many in rural areas, and 16 times as many in federally qualified health centers.

Congresswoman Cathy McMorris Rodgers is very familiar with the THC program in Spokane and has been a champion for increasing our health workforce in medically underserved areas, especially in rural America. We are so grateful to her for introducing bipar-

tisan legislation to reauthorize the program sustainably for 3 years and to fund expansion to help satisfy the pent-up demand throughout the country for new teaching health centers.

We appreciate that Congresswoman Tsongas and 67 other Members of Congress cosponsored this legislation, including Congressman Jeff Denham, who not only cosponsored it, but also introduced his own legislation that would appropriate even more funds for expansion.

Traditional graduate medical education occurs almost exclusively within hospitals, but primary care takes place in the community and doctors offices and in community health centers. To get more doctors in primary care, especially in the areas most in need, teaching health centers move training into the community where residents and their faculty do over 600,000 patient visits each year.

Primary care providers are the first place a person goes to find out if their cough is from common cold or from pneumonia, whether their headache is from stress, an impending stroke, or a brain tumor. They learn to identify and treat anxiety and depression. And they learn to treat pain, while minimizing a patient's risk of developing opioid dependence.

Primary care saves lives and saves money, and the Teaching Health Center Graduate Medical Education Program helps solve our primary care crisis. However, it is 2 weeks away from extinction. We need it reauthorized now and at the level recommended in the HRSA-funded study published last year of \$157,000 per resident per year. We need a 3-year authorization at \$116.5 million per year so that centers will not terminate their training programs and continue recruiting new residents.

When our center extends an offer to a resident, we make a commitment to them for 3 years. A 2-year Federal funding commitment is insufficient to stabilize our programs.

In addition, we have had grossly inadequate funding for the past 2 years, as low as \$95,000 per resident. As a result, some centers were forced to stop recruiting. In my program at the Institute, the decrease in funding from the initial level of \$150,000 per resident per year created a loss of \$2 million a year and forced us to reduce our Harlem residency from 36 to 18 doctors.

The McMorris Rodgers-Tsongas legislation funds \$157,000 in training costs per resident for all 732 current residents and additional funds for up to 10 new programs. This will add another 120 primary care residents.

In closing, I want to stress that the health of all Americans requires that the other programs that you will hear about today are also funded timely and adequately: the National Health Service Corps, which provides doctors who serve in our Nation's community health centers, the community health centers themselves that provide care to 24 million Americans, and Title VII and Title VIII, which support training in the critical disciplines of medicine, nursing, dentistry, and others.

Thank you for giving me the opportunity to testify this morning.  
[The prepared statement of Dr. Calman follows:]

**“The Teaching Health Center Graduate Medical Education Program:  
A Key to Solving the Nation’s Primary Care Workforce Crisis”**

Statement of Neil S. Calman, MD

President, American Association of Teaching Health Centers

Before the House Committee on Energy and Commerce, Subcommittee on Health

September 14, 2017

Chairman Burgess, Ranking Member Green, and Distinguished Members of the Subcommittee:

Thank you for inviting me to speak to you about the THCGME or Teaching Health Center Graduate Medical Education Program.

I am a family physician who has practiced for 40 years in the South Bronx and the Lower East Side of Manhattan. I am President and Chief Executive Officer of the Institute for Family Health, a nonprofit network of 31 Federally Qualified Community Health Centers (FQHCs) and 3 family medicine residency programs.

I am pleased to provide some background on the substantial benefits for our nation generated by the THCGME program. I am also here today on behalf of my institution and as the President of the American Association of Teaching Health Centers to urge Congress to enact reauthorization

legislation that funds this program sustainably for at least three years and provides for expansion into new communities. The essence of what our association stands for, working with a number of stakeholder organizations, is reflected in the legislation introduced by Congresswoman McMorris Rodgers, Congresswoman Niki Tsongas, Congressman Denham and many members of the Energy and Commerce Committee, H.R. 3394. Put most simply, the teaching health centers and the communities they serve need the program reauthorized before it lapses on September 30 at the level recommended in the HRSA-funded study published last year, which is \$157,000 per resident, per year. That works out to a three-year authorization at \$116.5 million per year so that centers will not terminate their training programs and can continue recruiting new residents. In addition, our coalition of stakeholders has made a strong case for additional funding to cover the cost of adding up to 10 new programs, with up to 60 residents in each class, meaning that during a two-year period, 120 new physicians would be training in teaching health centers to go along with the 732 existing residency slots.

In order to understand why this legislation is so critical, please permit me to share some background about our own teaching health center programs, our residents, and our patients.

The Institute for Family Health – Teaching Health Centers in New York

The Institute employs over 1200 people, including almost 200 primary care physicians and family medicine residents. Last year, we cared for over 102,000 patients who made 650,000 primary care, behavioral health care and oral health visits. The Institute serves high-need, medically underserved communities in the inner-city neighborhoods of the Bronx, Manhattan,

and Brooklyn in New York City, as well as the upstate, rural communities of the Mid-Hudson Valley.

Nearly 80 percent of our patients are African American or Latino; 12 percent are uninsured; 45 percent receive Medicaid and 15 percent receive Medicare; 65 percent are below 200 percent of the federal poverty level; and 18 percent are estimated to require services in a language other than English. Our patients suffer disproportionately from an array of largely preventable health problems prevalent in low-income neighborhoods, including high rates of asthma, diabetes, hypertension, obesity, depression, mental illness, and substance abuse.

One of the communities we serve, in Ellenville, New York, is a poor rural community of 4,000 in the Catskill Mountains, once home to a thriving resort business, abandoned long ago. More recently, Ellenville has become the hub for health services for over 13,000 people in western Ulster County. Outside of our community health center, there are only three family doctors in the area, all of whom have very limited practices. The one primary care doctor who practiced full-scope family medicine retired a few years ago. There hasn't been a new primary care doctor that lived and worked in that community for over 40 years!

Five years ago, when the Teaching Health Center program was started, the Institute for Family Health applied for funding to expand its existing family medicine training program in Ulster County into two new rural communities, New Paltz and Ellenville. One of the first residents to be accepted into this program was Dr. Kristina Ursitti who grew up in Carmel, 60 miles southeast of Ellenville. After a 4<sup>th</sup> grade fieldtrip to the Catskills, she told her parents she was

going to move there when she grew up. While in medical school she did a clinical rotation at Kingston Hospital, a small city in the area. When she found out that the Teaching Health Center program would provide an opportunity for her to do her training in Ellenville, she was sold.

Kristina entered residency training in Ellenville and fell in love with the community. Eager to woo a new doctor who wanted to settle in the area, community agencies got together and offered to pay the down payment for a house for while she was still in training! She now lives and cares for patients in this needy community, and serves as a faculty member in the program where she trained, teaching doctors who she hopes will join her in this growing community health center medical practice.

Dr. Ursitti is one of many doctors who are in training all across the country in our teaching health centers. The Teaching Health Center program has given these young doctors a chance to come home to work in community's close to where they grew up, or in similar communities elsewhere in the country. Their stories tell more than any statistics about the potential of this program to bring new doctors into needy areas.

#### The Primary Care Physician Shortage and Teaching Health Centers

When the program started, I was asked by my colleagues to lead the newly established American Association of Teaching Health Centers, an organization founded to support the new Teaching Health Center programs around the country with technical assistance, organize collaboration among grantees, and to engage in legislative advocacy. I am here today on behalf of that

Association, to implore you to reauthorize the Teaching Health Center Graduate Medical Education program.

The U.S. faces a severe doctor shortage. In fact, by 2020 we will need more than 90,000 physicians to meet the growing demand for health care services across the country. According to the American Academy of Family Physicians, by 2025, the United States will require an additional 52,000 primary care physicians, and the shortage is being felt most deeply in health professional shortage areas (HPSAs) and medically underserved areas (MUAs). As many as 60 million people living in these areas experience disparities in health care access either because they are uninsured, or because they live in rural, urban, or suburban areas without enough primary care physicians. Additionally, we are reaching a critical time, when the number of medical school graduates will be greater than the number of residency slots. Without a residency, medical school graduates are unable to obtain a medical license.

While patient care increasingly occurs in ambulatory settings, such as CHCs, medical education occurs mainly in inpatient hospital facilities. This produces a health care workforce whose skills and experiences are poorly matched to the primary care needs of the population. In order to address the changing healthcare system and address the disparities in the health care workforce, the THCGME is training medical residents in community-based settings, including low income, underserved rural and urban neighborhoods.

The traditional method of residency training, funded primarily by CMS under a Medicare formula, is mainly focused on hospital-based training and the profile of physicians trained no

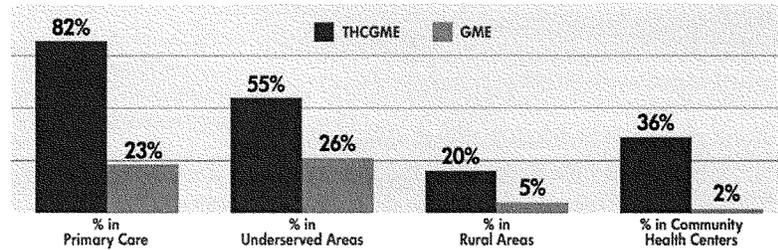
longer matches the nation's needs – too few enter primary care and even fewer choose to practice in rural or underserved locations. In contrast, the THC model uses community-based ambulatory health centers, such as nonprofit community health centers and community consortia, to train primary care residents who will practice 21st century care in underserved communities during their training and after they complete their residencies. During their residency training, THC residents practice in the approved primary care specialties of Family Medicine, General Internal Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry and General Dentistry.

According to the 21st Report of the Council on Graduate Medical Education (COGME), “the shortage in primary care providers, particularly those capable of caring for adults with chronic disease (Family Medicine and General Internal Medicine), overshadows the deficits in all other specialties. One way to address the physician workforce shortage is to train resident physicians in underserved settings, based on the precept that training providers in areas of need will produce the workforce with the necessary skills to serve in underserved areas. Evidence has shown that resident physicians who train in health center settings are nearly three times as likely to practice in underserved settings after graduation. They are also 3.4 times more likely to work in a health center, compared to residents who did not train in health centers. The difficulties in recruiting community-based primary care physicians is also well documented; only investment in the community health care workforce pipeline will help meet the workforce demands. By moving primary care training into the community, THCGME programs are on the leading edge of innovative educational programming dedicated to meeting future health care workforce needs.

Analysis of the THCGME programs continue to show promising results:

### > TEACHING HEALTH CENTER SUCCESSES

Analysis of THCGME programs shows promising results that signal this innovative education model is working:



#### Reauthorization and the Benefits of H.R. 3394/S. 1754

With the looming primary care shortage on the horizon, investments in graduate medical education training will be critical to meet the needs of the evolving healthcare delivery system. The THCGME program is one of the most reliable training models for primary care physicians and has an overwhelming documented success, but has been critically underfunded and is at the brink of collapse. Without immediately strengthening and expanding, the program will unravel just as it is beginning to produce the urban and rural primary care workforce that is desperately needed.

Thankfully, Congresswoman Cathy McMorris-Rodgers, Senator Susan Collins, and other leading Members of the House and Senate have listened to our Association and our counterpart associations and have developed a legislative proposal that achieves many of our objectives in the reauthorization process. It is the bill we hope you will consider including in any legislative package or which we hope you will enact as a free-standing, bipartisan and bicameral bill.

Congresswoman McMorris Rodgers is very familiar with the THC program in Spokane and has been a champion for increasing our health workforce in medically underserved areas, especially in rural America. We are so grateful to her for introducing her bipartisan legislation to reauthorize the program sustainably for three years and to fund expansion to help satisfy the pent-up demand throughout the country for new teaching health centers. We appreciate that Congresswoman Tsongas and 62 other Members of Congress co-sponsored this legislation, including Congressman Jeff Denham, who not only cosponsored it, but also introduced his own innovative legislation that would appropriate even more funds for expansion.

Primary care saves lives and saves money and the Teaching Health Center Graduate Medical Education program helps solve our primary care crisis. However, it is two weeks away from extinction.

We need it reauthorized now, and at the level recommended in the HRSA-funded study published last year, of \$157,000 per resident, per year. We need a three-year authorization at \$116.5 million per year so that centers will not terminate their training programs and can continue recruiting new residents.

We are aware of fiscal pressures that Congress faces but it is important that this Committee fully recognizes the fiscal pressures that we face. When our Center extends an offer to a resident, we make a commitment to them for three years. A two-year federal funding commitment is insufficient to stabilize our programs. In addition, we have had grossly inadequate funding for

the past two years - as low as \$95,000 per resident. As a result, some centers, were forced to stop recruiting new residents. In my program at the Institute, the decrease in funding from the initial level of \$150,000 per resident per year created a loss of \$2 million and forced us to reduce our Harlem residency from 36 to 18 doctors. If Congress again were to provide flat funding of \$60 million, that would work out to roughly \$82,000 per resident, per year, which is around half the national median cost for such training and thus will lead to substantial dislocation, program closures, resident terminations, and a loss of hundreds of thousands of patient visits throughout the nation.

The McMorris Rodgers-Tsongas legislation funds \$157,000 in training costs per resident for all 732 current medical residents and additional funds to establish up to 10 new programs, either entirely new centers or expansion of programs offered at existing centers, which would add another 120 residents to the program. It should be where Congress ends up at the end of the legislative process, not a mere aspirational starting point. Every dollar can be accounted for and will generate tangible benefits for your communities and those of other Members. Lives will be saved, economic growth generated, and we will make a dent in the medical care shortage that plagues too many parts of our country to this day.

In closing, I want to stress that the health of all Americans requires that the other programs that you will hear about today, are also funded, timely and adequately. The National Health Service Corps, provides doctors who serve in our Nation's Community Health Centers, Centers that provide care to 24 million Americans, while Title VII and VIII supports training in the critical disciplines of medicine, nursing, dentistry and others.

Thank you for giving me the time to testify this morning.

Mr. BURGESS. The chair thanks the gentleman.

The chair observes that there is a vote on, on the floor, and we are going to need to take a recess in order to allow members to vote. Unfortunately, this is a fairly long series, so I can't tell you the exact timing, but the committee will reconvene after the series of votes concludes on the floor.

The committee stands in recess.

[Recess.]

Mr. BURGESS. We had heard testimony from Dr. Calman. I believe we are prepared to hear testimony from Dr. Billings.

Dr. Billings, you are recognized for 5 minutes, please.

#### STATEMENT OF ADRIAN BILLINGS

Dr. BILLINGS. Thank you, Chairman.

Chairman Burgess, Ranking Member Green, and members of the subcommittee, my name is Dr. Adrian Billings, and I am a full spectrum family medicine physician with Presidio County Health Services, a federally qualified health center practicing in rural Alpine, Texas. I am here today as a board member of the Association of Clinicians for the Underserved, which was founded by National Health Services Corps alumni over 20 years ago. The mission of the ACU is to improve the recruitment and retention of primary care providers in underserved communities, and the Corps is a critical component of that effort.

I am also a fellow with the American Academy of Family Physicians, an organization that strongly supports the National Health Service Corps program. The Corps was created 45 years ago in a bipartisan manner, and since then, has proven to be a very effective program placing healthcare providers in our Nation's most medically underserved areas. As an alumnus of the National Health Service Corps scholarship program, I am honored to be here to describe the significance of this program upon medical students, healthcare professionals, and underserved communities.

In 1999, as a first-year medical student, I enthusiastically submitted an application for the National Health Service Corps scholarship program, knowing that it would allow me to accomplish my dream of practicing family medicine on the Texas-Mexico border without the burden of school loans that may have forced me down a different path. After completing my family medicine residency and surgical obstetrics fellowship, I moved to Alpine to fulfill my Corps scholarship commitment. I fulfilled my 4-year commitment in the private practice option, as there was little in the way of healthcare infrastructure at the time. When I arrived in Alpine in 2007, I was one of only three family doctors in a 12,000 square mile area serving a total population of 25,000 patients in the vast Big Bend region. In those first 4 years of practice, I was on call 24 hours a day, 7 days a week. My work, although rewarding in many ways, was exhausting.

I was able to graduate medical school debt free because of the National Health Service Corps. And I have chosen to stay because of the sense of calling I still feel to be practicing along the Texas-Mexico border. But our community needed more healthcare access, and so did I. So I made the decision to merge my private practice

with a federally qualified health center in the neighboring community, Presidio County Health Services.

Once we were part of PCHS, the practice received both Federal funding and malpractice coverage that enabled me to recruit family physician partners to share the load. Access was increased, and my working schedule became far more manageable. Thanks to Texas Tech University Health Science Center, I have hosted 300 medical students and residents, four of whom have returned to practice in the Big Bend region, which now has seven practicing family physicians up from three when I first arrived.

I am pleased to report that my story is not rare among Corps alumni. A majority of Corps providers continue to practice in a shortage area 10 years after completing their service obligation, just as I have.

In the last year, the Corps has placed more than 10,000 providers, serving more than 11 million people. Despite this level of service, it would still require around 20,000 more providers to meet today's existing need of our Nation's 15,000 designated shortage areas.

While I could talk about the impact the Corps has had on me and my community all day long with you, I want to be sure to highlight the importance of preserving the program and the urgency of doing so. Without immediate action from this subcommittee, funding for the Corps will expire in 2 weeks. This potential lapse in funding will cause an immediate and severe impact in underserved areas across the country such as my own.

No new awards or continuations will be made after October 1, effectively eliminating the need for the next generation of Corps clinicians and jeopardizing access to healthcare services for millions of people, including my patients. The Corps will continue to function, but only administratively, not programatically. I can assure you as an alumnus that the Corps is one of the most effective programs this country has to enable clinicians like me to choose primary care and to serve in underserved communities.

I truly believe that, based on the merits of the program, the Corps can withstand any kind of debate that focuses on value, impact, and long-term savings. We know that access to primary care saves lives and saves money. And the Corps is designed to increase access to primary care services where we need it most.

I want to thank the subcommittee for the longstanding bipartisan support consistently shown for the Corps, and I appreciate the opportunity to testify before you today on behalf of the Corps, ACU, AASP, and most importantly, the millions of patients living in underserved communities who rely on healthcare services provided by Corps clinicians. Thank you.

[The prepared statement of Dr. Billings follows:]



House Energy & Commerce Subcommittee on Health  
Hearing on Primary Care Workforce Programs

Testimony of

**Adrian Billings, M.D., Ph.D., FAAFP**

Medical Director, Presidio County Health Services

Associate Professor, Department of Family and Community Medicine, Texas Tech  
University Health Sciences Center

Board Member, Association of Clinicians for the Underserved

*September 14, 2017*

Chairman Burgess, Ranking Member Green, and Members of the Subcommittee,

Thank you for this opportunity to speak to you today about the National Health Service Corps (NHSC), a program that has had a profound impact upon my life – both personally and professionally. My name is Dr. Adrian Billings, and I am a full spectrum family medicine physician with Presidio County Health Services (PCHS), a federally qualified health center (FQHC), practicing in rural Alpine, Marfa and Presidio, Texas. I am here today as a board member of the Association of Clinicians for the Underserved (ACU), which was founded by NHSC alumni over 20 years ago. The mission of the ACU is to improve the recruitment and retention of primary care providers in underserved communities, and the NHSC is a critical component of that effort. I am also a fellow with the American Academy of Family Physicians, an organization that also strongly supports the NHSC program. The NHSC was created 45 years ago in a bipartisan manner, and since then has proven to be a very effective program placing health care providers in our nation's most medically underserved areas. As an alumnus of the NHSC Scholarship program, I am honored to be here today to give you a firsthand perspective of the significance this program has on medical students, health professionals and underserved communities.

I was born and raised in Del Rio, Texas, a small town on the Texas-Mexico border 3 hours to the east of Alpine, where I currently live and practice. It was in Del Rio, that my passion for primary health care was cultivated. I was delivered by a family physician, Dr. Ramon Garcia, and he was my primary physician throughout my adolescence. Dr. Garcia became my role model and mentor. After my first year of college, I returned to Del Rio for the summer and worked as an anesthesiology technician, which awarded me the opportunity to scrub in on surgeries and deliver babies with Dr. Garcia. By the end of that summer, I knew I wanted to follow in Dr. Garcia's footsteps and care for patients from cradle to grave, just as he had.

My history with the NHSC began as a first year medical student at the University of Texas Medical Branch at Galveston, Texas. Prior to beginning my medical education, I was completing a

postdoctoral fellowship in the Special Pathogens Branch of the Division of Viral and Rickettsial Diseases at the Centers for Disease Control and Prevention (CDC). One of my colleagues, a Commissioned Corps Officer in the Public Health Service, suggested I apply to the NHSC for support with my medical school tuition and expenses. He thought that the NHSC was the perfect program for me because of my desire to return to the Texas-Mexico border to practice family medicine. I enthusiastically submitted an application for the NHSC scholarship knowing that it would allow me to accomplish my dream without the burden of school loans that may have forced me down a different path.

After completing my family medicine residency and surgical obstetrics fellowship, I moved to Alpine, Texas to fulfill my NHSC scholarship commitment. I fulfilled my four year commitment in the private practice option, as an FQHC did not exist in Alpine at the time. When I arrived in Alpine in 2007, I was one of only three family doctors in a 12,000 square mile area serving a total population of 25,000 in the vast Big Bend area of Texas. In those first years of practice, I delivered up to 70 babies each year, rounded on my patients in the hospital, saw patients in the emergency room, performed house calls for those patients who could not easily get to clinic, and rounded on patients in the nursing home. I did this all without a partner, as I was in solo practice. I was on call 24 hours a day, seven days a week. After my first year in practice I started to feel more and more professionally isolated in such a medically underserved area. I missed the academic environment of working with a team, so I began to host medical students and residents in 2008. Over the years I have had more than 250 students and 36 family medicine residents train with me in Alpine. In hindsight, the decision to host trainees turned into one of the best investments I made because after completing their training, four of the trainees chose to return to our small community to practice with me. This is more than all the providers we had in the area when I started. As a result, access to care in our community has increased and my quality of life has vastly improved. I am

now able to spend more time with my family and my partners have restored my energy to sustain my practice in one of the most medically underserved areas along the US-Mexico border.

My work, although rewarding in many ways, was exhausting. For four years my private practice operated in a manner similar to a FQHC – my practice was located in an underserved area, I served all patients regardless of ability to pay, and I delivered comprehensive primary care services. So I made the decision to merge my practice with a FQHC, Presidio County Health Services, in neighboring towns, Marfa and Presidio. Once we were part of PCHS, the practice received both federal funding and malpractice coverage that enabled the practice to recruit a family physician partner to share the load. Again, access was increased and my working schedule became far more manageable.

I am proud of the accomplishments I have made over these past ten years. I am proud that I continue to practice in the underserved area where I completed my NHSC commitment. I am most proud that I have been able to establish an FQHC practice in Alpine where there had not been one previously. The establishment of an FQHC has enabled a significant increase in access to care for the most underserved patients in the Big Bend of Texas. I am also very proud of the almost 300 trainees who have rotated with me, many of whom have decided to pursue primary care in underserved areas, including the four that have joined us in Alpine. In fact, as a result of this long record of hosting trainees, PCHS and our local hospital, Big Bend Regional Medical Center, will begin a rural family medicine residency with Texas Tech University Health Sciences Center in 2018. This collaboration will further improve access to care.

I was able to go to medical school debt free because of the NHSC, and the program enabled me to help the people of Alpine, Marfa, Presidio, Terlingua, Sanderson, and Ft. Davis, Texas. I have chosen to stay and practice in Alpine and the surrounding region because of the sense of calling I still feel to be practicing out here. The FQHC program's financial and operational support and the ability to teach students and residents have further enhanced and enabled this underserved

practice to not only sustain itself but to grow. I am excited to see what the next 10 years results in for our patients. I am honored to be here today to share my view of the value of the NHSC and to urge the Members of this Subcommittee to extend funding for this vital health care program.

#### **NHSC Background**

The National Health Service Corps (NHSC) program, established in 1972, is designed to incentivize primary care professionals – including physicians, nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, certified nurse-midwives, and dental hygienists – to work in underserved areas in urban, rural, and frontier communities. In exchange for their service, the program helps to alleviate the burden of debt accumulated during the course of their education through scholarship and loan repayment programs. The four NHSC programs are:

**The Scholarship Program (SP)** – Provides a full scholarship for eligible medical, dental, mental and behavioral health students in exchange for service after their training in high need health professional shortage areas (HPSAs). Awards are very competitive, with the program only able to fund 10% of current applications. They look for students who have a real interest in delivering care to underserved communities, and have a high probability of success in their primary care careers. There are about 1,000 scholars now, who will be serving in the field in the years ahead.

**The Loan Repayment Program (LRP)** – This is by far the largest part of the NHSC program, with over 8,500 of the current field strength receiving loan repayment. The program helps students repay school loans in exchange for service, starting with a two year commitment at \$25,000 per year. In order to fund the highest need areas, the program awards loan repayment contracts to applicants serving in the highest scoring HPSAs first. Last year the program was only able to fund applicants down to a HPSA score of 17.

**The State Loan Repayment Program (SLRP)** – This program provides matching funds for qualifying state loan repayment programs. Not all states take advantage of this program, but there are over 1,300 placements in the field through the state loan repayment programs. This is a very cost-effective program from a federal perspective because of the state matching requirement. In addition, since the state is putting up half the funding, they also have more flexibility on how they structure their program within their state. Some fund lower scoring HPSAs and others fund additional provider types not currently eligible under the federal loan repayment program, such as pharmacists and nurses.

**The Students to Service Program (S2S)** – The Students to Service program is the most recent addition to the NHSC toolbox, and the smallest in terms of field strength. However, it is a critical link between the scholarship program and the loan repayment program. The S2S program enables those students who are at a key decision point in their education to be able to choose the primary care path with financial support from the NHSC program.

Since its founding, the NHSC has placed more than 50,000 providers in underserved communities, with more than 10,000 placements in the last year alone. The NHSC has proven to be a successful, sustainable solution to the shortage of providers in thousands of communities across the United States. According to HRSA, 82% of NHSC clinicians who complete their service obligation continue to practice in a shortage area up to one year later, and a majority continue to practice in a shortage area for more than 10 years after completing their service obligation. Despite this level of service, it would still take more than 20,000 additional providers to meet the existing need in the more than 15,000 federally-designated HPSAs across the country.

NHSC placements are made at approved sites providing primary medical, dental and/or mental and behavioral health services. All NHSC providers must be open to all, regardless of ability to pay. Eligible facilities include:

- Federally-Qualified Health Centers
- Indian Health Facilities
- Correctional or Detention Facilities
- Certified Rural Health Clinics
- Critical Access Hospitals
- Community Mental Health Centers
- State or Local Health Departments
- School-Based Clinics
- Certain Private Practices
- Mobile Units
- Free Clinics

#### **Current Status of NHSC Funding**

Since 1972, 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 to expand the program to additional communities. However in FY2011, recognizing this new program funding stream, Congress dramatically decreased the regular appropriation. By FY2012, all regular appropriations had been eliminated and the program became 100% reliant on the mandatory trust fund created under the ACA. However, that funding stream expired in FY2016. Fortunately, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 extended the trust fund for FY2016 and FY2017 at the current rate of \$310 million. Unfortunately, no action has been taken to extend funding beyond FY2017, and the NHSC trust fund now faces elimination. Without Congressional action, the funding for the NHSC will expire on September 30, 2017, which will cause an immediate and

severe impact in underserved areas across the country. This potential lapse in funding will result in a dramatically decreased field strength, jeopardizing access to care for millions of people.

I understand that our country faces record debt levels and there are nearly continuous negotiations on federal spending levels. However, I truly 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. We know that access to primary care saves lives and saves money, and the NHSC is designed to increase access to primary care services where we need it most.

We are grateful to President Trump for including a funding extension for the NHSC for two additional years in his FY2018 budget request. However, the need for primary care services far outstrips the availability, and we are concerned that level funding for the NHSC does not accurately acknowledge this need. As previously mentioned, there are 15,000 HPSAs in the U.S. and they are scored based on need. The primary care and mental/behavioral health HPSAs are scored on a 0-25 scale and dental health HPSAs are scored on a 0-26 scale. Currently funded at \$310 million annually, the NHSC is only able to place clinicians at HPSAs with scores between 17-25. In other words, shortage areas with scores of 0-16 cannot even be considered for a NHSC placement despite the obvious need.

Additionally, the current funding level for the program allows for only 40% of Loan Repayment applicants and a mere 10% of scholarship applicants to be granted awards. I mention this to bring attention to the fact that although it is usually difficult to recruit primary care clinicians to these shortage areas, the NHSC is clearly an effective and popular way to overcome this difficulty. As we look for ways to increase access to primary care, we have literally thousands of passionate health professionals applying to the NHSC to serve in our most needed areas of the country. I would urge you to fund as many of these applicants as possible and help our rural and underserved communities get the primary care access they need today.

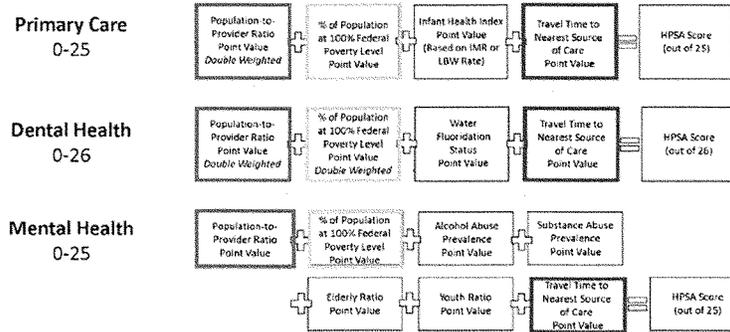
**Conclusion**

Today, the 10,000 plus NHSC clinicians serve 11 million people. We are hopeful that we can strengthen and grow the program to help address the needs of the additional tens of millions of people in our country in need of primary care services, but I am here today to highlight the importance of preserving this program. Without action from this Subcommittee, funding for the NHSC will expire in two weeks. On October 1, 2017, the NHSC will continue to function, but no new awards can be made, effectively eliminating the next generation of NHSC clinicians. As we face a rapidly aging and growing population, primary and preventative care services will become increasingly needed and the NHSC program has proven to be an effective program to address this need. I can assure you, as an alumnus of this program that the NHSC is one of the most effective programs this country has devised to incentivize primary care providers to choose primary care and to serve in underserved communities. I appreciate the opportunity to testify before you today, and we thank you for making the National Health Service Corps a priority. I would be glad to answer any questions you may have.

APPENDIX 1

HPSA Scoring Criteria

HPSA scores are based on a variety of factors and range from 0 to 25 in the case of Primary Care and Mental Health, and 0 to 26 in the case of Dental Health.



HPSA Scoring Calculations

Factor	Primary Care			Dental Health			Mental Health
	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded
Population : Provider Ratio	5	x 2	= 10	5	x 2	= 10	7
% of Population below FPL	5	x 1	= 5	5	x 2	= 10	5
Travel distance/time to NSC	5	x 1	= 5	5	x 1	= 5	5
Ratio of children under 18 to adults 18-64	5	x 1	= 5	1	x 1	= 1	3
Ratio of adults 65 and older to adults 18-64							3
Substance prevalence							1
Alcohol abuse prevalence							1
<b>Max Score:</b>			<b>= 25</b>			<b>= 26</b>	<b>= 25</b>

Mr. BURGESS. The chair thanks the gentleman for his testimony. Dr. Knebl, you are recognized for 5 minutes, please.

**STATEMENT OF JANICE A. KNEBL**

Dr. KNEBL. Thank you, Chairman.

Dr. Burgess, Ranking Member Green, and distinguished members of the subcommittee, thank you for the opportunity to appear before you today and discuss the workforce programs under the Public Health Service Act on behalf of the Eldercare Workforce, which is a group of 31 national organizations representing consumers, family caregivers, healthcare professionals, that includes direct care workers joined together to address the immediate and future need for more expert health professionals to care for all of us as we age.

I am also very pleased to be joined by colleagues from across the country who work tirelessly to improve the health of our Nation's population.

Today, I am here to discuss the Title VII Geriatrics Health Professions programs, which are focused on enhancing the ability of America's healthcare workforce to provide high-quality care for older adults. These Title VII funds support 44 geriatric workforce enhancement programs we call GWEPs, and we are GWEPsters, which trained almost 19,000 emerging health workers or trainees in over 45 professions and disciplines from 2015 to 2016 academic year.

Collectively, the GWEPs are leveraging the skills of geriatric health professionals already in short supply across different professions to educate other members of the workforce, caregivers, and direct healthcare workers. Many of our trainees had little or no exposure to geriatric principles before our programs.

I would like to tell you a story about how GWEP changes the lives in my home State of Texas, where the current population of older adults is 5.9 million and growing, so I have constant job opportunities in Texas. I am at the University of North Texas Health Science Center, located in Fort Worth, Texas, where I am faculty and I am a practicing geriatrician. Our GWEP is called the Workforce Enhancement and Healthy Aging and Independent Living, or the WE HAIL program.

Since January of 2016, we have offered rural communities free programs focused on Alzheimer's disease education to almost 500 older adults and their family caregivers. Caregiving for someone with Alzheimer's disease is extremely stressful and unpredictable. I can speak to this, not only professionally, but personally as both my grandmothers and my mother now is afflicted with Alzheimer's disease. So we really need to try and reduce that stress and help them with problem-solving skills so that they can continue to keep their loved ones at home where they would like to have them.

We have also had training for our physical therapy students and medical students in trying to teach older adults about falls prevention, which, as you know, can be very serious consequences for them. They participated in an evidence-based program called A Matter of Balance that is lay leader training. The students in turn then go out and do falls preventions workshop in senior centers.

And we have basically gone to about 14 of them, touching almost 300 older Texans.

Across health professions training there is a paucity of content focused specifically on ensuring the healthcare workforce of tomorrow has the skills and competence to care for all of us as we age. Our GWEP is filling that role in Texas and the gap because we have trained, to date, almost 2,000 students to be our future doctors, nurses, social workers, pharmacists, physical therapists, dietitians, and physician's assistants, and we have them working as inner professional team training.

We are also working with primary care practices, healthcare systems, and the aging network social services by training inner professional teams of current practicing professionals to try and help them with patient-centered primary care for older adults and looking into the new integrated delivery systems. In fact, we have six more training teams that are going to start Friday, tomorrow, at our university.

This year, WE HAIL has received innovation awards from the National Association for the Area Agencies on Aging and the American Public Health Association. And we believe this demonstrates the widespread recognition for the need for high quality integrated and collaborative geriatrics training for health professions. There are 43 other GWEPs across the United States, and they are trying to improve this current and future care. But the need for the programs will be greater.

As you know, by 2030, we are going to have 20 percent of our population over the age of 65, that will be about 70 million people, and we already have about 19 million caregivers trying to help older adults. And our GWEPs, we are definitely a community of learners and collaborators. We love to share our ideas. We have a national GWEP network, the National Association of Geriatric Education and the John A. Hartford Foundation GWEP Coordinating Center out of the American Geriatric Society.

I know that, like us, my colleagues at the other GWEPs are leveraging their GWEP funding to create lasting change on how they deliver care at their institutions and in their communities, and we are learning from each other about what works and what may not. We may be a small workforce, but we are mighty, and we are tireless advocates on behalf of improving the care for older adults.

This funding offers each of us a platform for making that possible, for demonstrating how attention to core geriatric principles can improve the care we all provide. In just 1 year, according to the Health Resource Service Administration, we have collectively trained almost 19,000 trainees in over 45 professions and disciplines. About 11 percent of our trainees come from disadvantaged backgrounds or underrepresented minorities in their chosen health professions, and we have partnered with almost 400 healthcare delivery sites to provide the trainees with that clinical training experiences in geriatrics. Thanks to our work, over 100,000 faculty and practicing professionals have experienced nearly 1,200 continuing education programs. No surprise to someone who has worked in the field of geriatrics, about 75 percent of our GWEP graduates receive training in medically underserved communities, and upon comple-

tion of the training, are actually going to go back and serve in those communities.

I am very grateful and encouraged by the hard work that this committee has done on the reauthorization of these programs. I am especially grateful to Representative Jan Schakowsky for her leadership in introducing the Geriatrics Workforce and Caregiver Enhancement Act legislation that would increase funding for the only Federal geriatrics program and reestablish the Geriatric Academic Career Award, which was a previously funded program for developing clinician educators that ensures that the geriatric academic workforce will be prepared to train our future geriatric workforce needs.

So, Mr. Chairman, Dr. Burgess, Ranking Member Green, and distinguished members of the subcommittee, addressing the elder care workforce crisis and the other vital health professions programs under the Public Health Service Act is an opportunity we cannot afford to ignore. We appreciate the hard work the committee has undergone to reauthorize all the important health professions program. I thank you so much for this opportunity today, and I look forward to your questions.

[The prepared statement of Dr. Knebl follows:]

Testimony of Janice A Knebl, DO, MBA  
DSWOP Endowed Chair and Professor in Geriatrics  
Interim Chair, Department of Internal Medicine  
University of North Texas Health Science Center

Committee on Energy and Commerce  
Subcommittee on Health

**“Supporting Tomorrow’s Health Providers: Examining Workforce Programs Under the Public Health Service Act”  
September 14, 2017**

Chairman Dr. Burgess, Ranking Member Green, and distinguished Members of the Subcommittee: Thank you for the opportunity to appear before you today to discuss the workforce programs under the Public Health Service Act on behalf of the Eldercare Workforce Alliance, a group of 31 national organizations – representing consumers, family caregivers, and health care professionals, including direct care workers – joined together to address the immediate and future need for more expert health professionals to care for us all as we age.

I am also pleased to be joined by colleagues from across the country who work tirelessly to improve the health of our nation’s population. Today, I am here to discuss the Title VII Geriatrics Health Professions Programs, which are focused on enhancing the ability of America’s healthcare workforce to provide high-quality care for older adults. These Title VII funds support 44 Geriatrics Workforce Enhancement Programs (or “GWEPs” as I call them), which trained 18,451 emerging health workers (or “trainees”) in over 45 professions and disciplines in the 2015-2016 academic year.

**1. Geriatrics Workforce Development**

Collectively, the GWEPs are leveraging the skills of geriatrics health professionals already in short supply across different professions to educate other members of the workforce, family caregivers, and direct care workers. Many of our trainees have had little or no exposure to geriatrics principles.

I want to tell you a story about how the GWEP changes lives in my native Texas, where the current population of older adults is 5.9 million and growing. I am at The University of North Texas Health Science Center located in Fort Worth. Our GWEP is called the "Workforce Enhancement in Healthy Aging and Independent Living," or "WE HAIL" program.

Since January 2016, we have offered rural counties free community programs focused on Alzheimer's disease to 488 older adults and family caregivers. Caregiving for someone with Alzheimer's disease is stressful and unpredictable. In our sessions, we focus on reducing stress and building problem-solving skills, with the goal of keeping loved ones at home for as long as possible. We have had a specific focus on training physical therapy students to teach older adults about falls prevention and 88 students have participated in our A Matter of Balance lay leader training. In turn, they have offered falls prevention workshops in 14 senior centers touching 270 older Americans. This is just one of the many ways that our program helps to reduce unnecessary Medicare and Medicaid spending.

Across health professional training, there is a paucity of content focused specifically on ensuring the health care workforce of tomorrow has the skills and competence to care for us all as we age, particularly as our healthcare needs become more unique with the rise of multiple chronic conditions. Our GWEP is filling that gap in Texas: we've trained some 1,968 students who will be our future doctors, nurses, social workers, pharmacists, dieticians, and physician assistants. We are also working with primary care practices and have trained six interprofessional teams with the goal of expanding person-centered primary care for older adults in emerging integrated delivery systems.

## **2. WE HAIL Program (HRSA GWEP Grantee)**

In July of 2015, the Center of Geriatrics received \$2.55 million from the Health Resources and Services Administration (HRSA) to establish a Geriatric Workforce Enhancement Program (GWEP). UNTHSC is the only awardee in Texas and one of 44 academic medical centers in the nation to receive this funding.

UNTHSC's HRSA program is called the Workforce Enhancement in Healthy Aging and Independent Living, or WE HAIL Program, that is transforming geriatric care in North Texas by improving training for health care professionals and caregivers. Through WE HAIL, leaders in education, health care and aging services in North Texas collaborate to meet the health needs of our region's rapidly growing population of older adults.

***WE HAIL is transforming geriatric education by developing interprofessional training.*** WE HAIL offers training opportunities that promote teamwork by engaging professionals across institutions and disciplines. WE HAIL partners with JPS Health Network, Texas Christian University, and United Way of Tarrant County's Area Agency on Aging. Geriatric training engages various groups across the lifespan of professional development, including:

Medical (Texas College of Osteopathic Medicine) and other health professional students (TCU College of Nursing students in nursing and social work, TCU Dietetics students, UNTHSC Pharmacy, Physical Therapy and PA Studies students);

Family Medicine residents (JPS Health Network and HCA Plaza Medical Center); and

Practicing health professionals, including physicians, physician assistants, nurses, pharmacists, physical therapists, social workers, dieticians.

***WE HAIL is developing training that is community based and experiential.*** In its first year, WE HAIL has successfully established working relationships with our many grant partners to develop innovative learning opportunities. Interprofessional students complete A Matter of Balance Coach training to help in community fall prevention workshops. They develop and deliver health education at senior centers, and learn first-hand about programs and services at Meals on Wheels and the Alzheimer's Association. WE HAIL has developed modules for integrating Community Evidence-Based Programs, and Meals on Wheels home visits into Family Medicine Residency training and a new Geriatric Certificate Program. As

part of their training, medical students and Family Medicine Residents take a Virtual Dementia Tour to learn how to better care for patients and caregivers affected by Alzheimer's disease. The development of clinical decision tools on electronic medical records for use during Annual Wellness Visits help health professionals assess older patients' needs and connect them to community supports. Together, these developments support a collaborative approach to geriatric care.

***WE HAIL is focused on the assessed needs of older adults and their caregivers.*** WE HAIL's team of faculty and content experts develops training around high priority areas that were identified by the United Way's community needs assessment of older adults. Training focuses on the management of chronic conditions falls prevention, safe medication use, low health literacy that affects the healthcare experience and outcomes, and on the care and support of older adults and families affected by Alzheimer's Disease.

***WE HAIL is also supporting caregivers who are important to an older patient's healthcare team.*** WE HAIL expands training for caregivers through community services and programs available in a variety of settings to support clients, families and caregivers and improve their health and quality of life.

This includes evidence based family caregiver programs and podcasts, and the expansion of programs into rural and underserved areas.

***WE HAIL is also developing Geriatric Transformational Champions by partnering with*** TCU Neeley School of Executive Management to provide A Geriatric Practice Leadership Institute (GPLI). In this first year, this institute has brought together teams representing 6 diverse organizations and healthcare disciplines across DFW and has a waiting list for the 2017 cohort.

Leadership training focuses on the knowledge, skills and attitudes needed to lead in patient-centered primary care for older adults and emerging integrated delivery systems.

In addition, WE HAIL has supported and benefited from relationships built with our grant partners.

*We have developed a Health Resource Guide for Caregivers and Older Adults with United Way's Area Agency on Aging Model for Alzheimer's Services.*

*A Being Mortal documentary screening was provided in partnership with Community Hospice and the Coalition for Quality End-of-Life Care.*

*And WE HAIL collaborates with other partners as a member of the Fort Worth Safe Communities Coalition and AARP and the City of Fort Worth's Age-Friendly Plan.*

### 3. Geriatrics Workforce Enhancement Program (GWEP) Numbers for Academic Year 2015-2016

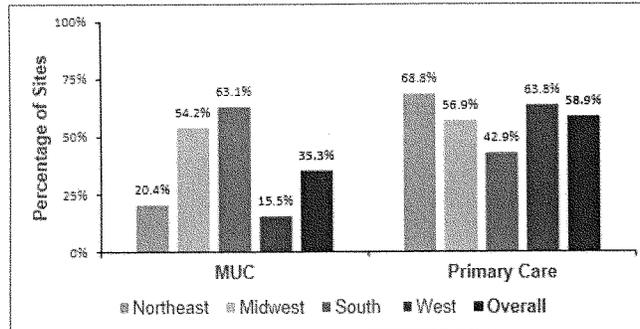
The Geriatrics Workforce Enhancement Program supports several endeavors to enhance geriatrics education and training across the health professions, with an emphasis on integrating geriatrics and primary care. Below is a descriptive summary from the Health Research and Services Administration (HRSA) of the characteristics and accomplishments of the grantees and individual trainees that received program support during Academic Year 2015-2016 ([click here for more information](#));

#### Program Characteristics

Program Region <sup>2</sup>	Grantees	Number of Trainees	Trainee Characteristics				Graduates/ Program Completers
			Underrepresented Minority (URM)		Disadvantaged		
Northeast	12	9,258	928	10.0%	253	2.7%	3,263
Midwest	8	5,255	556	10.6%	718	13.7%	5,221
South	11	2,046	374	18.3%	767	37.5%	1,774
West	13	1,892	195	10.3%	320	16.9%	1,566
<b>Overall</b>	<b>44</b>	<b>18,451</b>	<b>2,053</b>	<b>11.1%</b>	<b>2,058</b>	<b>11.2%</b>	<b>11,824</b>

Note: Program regions are based on U.S. Census Bureau definition.

### Clinical Training Settings



Note: A Medically Underserved Community (MUC) is a geographic location or population of individuals that is eligible for designation by a state and/or the federal government as a health professions shortage area, medically underserved area, and/or medically underserved population. Training settings are not mutually exclusive.

- Over 45 professions and disciplines were trained through GWEP including health professions students, residents, fellows, and practicing professionals. Nearly one in five GWEP trainees were medical students, a third of whom were from the Midwest region.
- Individuals trained included (but were not limited to) those enrolled in fellowships in: Geriatrics, Internal Medicine, Family Medicine, Obstetrics and Gynecology, Palliative Care, Physical Medicine and Rehabilitation, Psychiatry, Geriatric Psychiatry, and General Dentistry; certificates in Community Health Worker, Certified Nursing Assistant, and Pharmacy Aides; Nurse Practitioners specializing in acute care adult gerontology, adult gerontology, family, palliative care, nurse administration, nurse educators, and nursing informatics.
- Overall approximately 11 percent of trainees were from disadvantaged backgrounds or were under-represented minorities in the health professions, the majority from Midwest and West regions.

- GWEP partnered with 365 health care delivery sites (e.g., hospitals, long-term care facilities, and academic institutions) to provide trainees with clinical training experiences in geriatrics, overall nearly 60 percent were in primary care settings.
- Over 104,000 faculty and practicing professionals participated in nearly 1,200 unique continuing education courses offered by GWEP grantees.
- In particular, GWEP grantees had over a third of continuing education courses which were specifically focused on Alzheimer's disease and related dementia.
- Nearly 1,350 courses and training activities were developed, enhanced, and implemented during the academic year, providing training on emerging topics in geriatrics reaching more than 57,500 individuals, 22 percent of whom were either patients, families or lay caregivers.
- The majority of GWEP graduates received training in medically underserved communities (96 percent) and primary care settings (83 percent).
- Upon completion of their training, the majority of students who graduated (75 percent) intended to pursue further training or enter practice in medically underserved communities.

#### Conclusion

The health professions programs authorized under the Public Health Service Act and administered by the Health Resources and Services Administration provide the critical training opportunity in high-need disciplines and settings that improve access to care for all populations.

I am very grateful and encouraged by the hard work done by this committee on the reauthorization of these programs. I am especially grateful to Representative Jan Schakowsky for her leadership in

introducing the Geriatrics Workforce and Caregiver Enhancement Act, legislation that would increase funding for the only federal geriatrics training program, and re-establish the Geriatric Academic Career Awards (or "GACAs"), a previously funded program for developing clinician-educators, that ensures the geriatrics academic workforce is prepared to train the geriatrics workforce of today and tomorrow.

Mr. Chairman, Ranking Member Green, and distinguished members of the subcommittee, addressing the eldercare workforce crisis and the other vital health professions programs under the Public Health Service Act is an opportunity we cannot afford to ignore. We appreciate the hard work the committee has undergone to reauthorize all of the important health professions programs, and I look forward to your questions.

Mr. BURGESS. Thank you, Doctor.  
Dr. Sebastian, you are recognized for 5 minutes, please.

**STATEMENT OF JULIANN G. SEBASTIAN**

Ms. SEBASTIAN. Good afternoon. My name is Juliann Sebastian, and I serve as the chair of the board for the American Association of Colleges of Nursing. I want to sincerely thank Chairman Burgess and Ranking Member Green for holding this important hearing, and for the opportunity to testify today on behalf of H.R. 959, the Title VIII Nursing Workforce Reauthorization Act of 2017.

I would also like to extend my gratitude to two members on this subcommittee, Representatives Doris Matsui and Kathy Castor, who introduced this legislation with their bipartisan colleagues, Representatives David Joyce, Tulsi Gabbard, Rodney Davis, Suzanne Bonamici, and Patrick Meehan.

I also wish to thank House Energy and Commerce Committee members who have cosponsored this legislation, Representatives Anna Eshoo and Eliot Engel.

AACN represents 810 baccalaureate and graduate schools of nursing across all 50 states and the District of Columbia. Our membership extends to over half a million individuals, including 19,000 full-time faculty members, more than 497,000 nursing students, and the deans who lead these institutions.

AACN, along with 50 other national nursing organizations, fully supports the reauthorization of these programs. This bill is a necessary step toward ensuring that not only direct recipients continue to benefit from Title VIII, but that patients and communities across the country are afforded high-quality nursing care through a workforce that is highly educated, innovative, and diverse.

At my school, Title VIII funding has provided vital learning and career opportunities for nursing students in each of our academic programs. As an example, Title VIII funding has allowed us to expand rural emergency and acute care courses for nurse practitioner students planning to work in critical access hospitals.

Nebraska has a large number of critical access hospitals, 64 in total. Many rely on nurse practitioners for important clinical care needs. Because nurse practitioners at critical access hospitals must be able to meet health needs across the gamut, from primary care, to urgent and emergency care, and critical care, our faculty are committed to finding ways to help students learn to meet the health needs across this full continuum.

Our advanced rural hospital care program was initiated with Title VIII funds. So far, 34 nurse practitioners have completed courses that will help them meet needs in critical access hospitals, and another 14 nurse practitioner students are in process. Faculty also recently received Title VIII funding through the advanced nursing education workforce program that will expand the number of family nurse practitioner and psychiatric mental health nurse practitioners able to practice in rural and underserved areas.

This grant allows us to support both students and the preceptors by using telehealth, which, as you know, is an increasingly important part of care in rural areas. The majority of the counties in our State are rural, so it is important to us to educate undergraduate and graduate students in this way. Mine is only one of hundreds

of examples of how Title VIII dollars yield an invaluable return on investment.

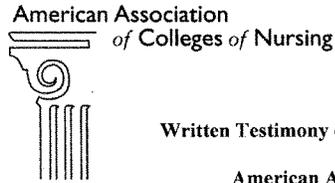
I would like to highlight a couple more stories. At Vanderbilt University School of Nursing in Nashville, Tennessee, Title VIII funding has been used to support nurse managed health clinics, which not only provide clinical training, but provide primary care services to over 900 patients a year. Ninety percent of the individuals served by Vanderbilt's nurse managed clinic live below 200 percent of the Federal poverty line. From 2012 to 2016, the clinic improved blood pressure control in patients with hypertension from 18 to 61 percent.

Another example, at Western Carolina University School of Nursing, a recently graduated student received financial assistance through the Nursing Workforce Diversity Program, which aims to increase the number of individuals underrepresented in the profession of nursing. She was an honor student and has taken a position as a registered nurse in a rural community hospital in the western part of the state.

I hope these several examples show how Title VIII is a critical pipeline for students, faculty, institutions, and the patients they serve.

I thank the subcommittee members for this opportunity to share the tremendous impact of Title VIII programs and how its recipients' careers have and will continue to improve our Nation's health. I applaud the subcommittee for bringing H.R. 959 to this hearing, as it is a necessary legislative step to modernize the programs and support America's patients, their families, and the communities in which they live. Thank you.

[The prepared statement of Ms. Sebastian follows:]



**Written Testimony of Juliann G. Sebastian, PhD, RN, FAAN  
Chair of the Board  
American Association of Colleges of Nursing**

**Prepared for Energy and Commerce Committee, Health Subcommittee Hearing “Supporting Tomorrow’s Health Providers: Examining Workforce Programs Under the Public Health Service Act”**

**H.R. 959 Title VIII Nursing Workforce Reauthorization Act of 2017**

**September 12, 2017**

On behalf of the American Association of Colleges of Nursing (AACN), I respectfully submit this testimony for the U.S. House Energy and Commerce Committee, Health Subcommittee hearing titled, “Supporting Tomorrow’s Health Providers: Examining Workforce Programs Under the Public Health Service Act.” As the title of this hearing reinforces, the Nursing Workforce Development Programs [42 U.S.C. 296 et seq.] have provided critical support for the nation’s nursing pipeline for over five decades. It is essential that H.R. 959, the Title VIII Nursing Workforce Reauthorization Act of 2017, is passed to ensure their future sustainability.

As the national voice for baccalaureate and graduate nursing education, the AACN represents over 810 schools of nursing that educate over 497,000 students and employ more than 19,000 full-time faculty members. Our member institutions prepare the nation’s Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs, including Nurse Practitioners, Certified Registered Nurse Anesthetists, Certified Nurse-Midwives and Clinical Nurse Specialists [CNSs]), nurse faculty members, and nurse scientists. Through the decades, Title VIII funding has been instrumental for schools of nursing across the country to utilize the dollars in ways that achieve progress in enrollment and graduations, expansion in clinical sites, increasing faculty, and promoting outreach to the surrounding communities through nursing care. In doing so, they are fulfilling the mission of

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Title VIII in meeting the demand for services where they are needed most, including rural and underserved communities. Title VIII helps deploy a highly-educated nursing profession to increasingly diverse communities in all corners of the country. For some smaller schools that do not have the resources to compete for larger grants—private or public—Title VIII funding has been a saving grace in their ability to increase enrollments and start programs tailored to their individual community.

### ***The Importance of Supporting the Future Nursing Pipeline***

As integral members of the healthcare team, and as the largest sector of the workforce with nearly four million licensed providers and students,<sup>1</sup> nurses collaborate with other professionals to improve the quality of health and health care in the United States. Nurses serve in a multitude of settings, including hospitals, long-term care facilities, community centers, local and state health departments, schools, workplaces, and patients' homes. RNs and APRNs treat and educate patients across the entire life span and ensure that individuals follow through with care plans for optimal health outcomes.

As demand for nursing services continues to increase, noted economists present four distinct challenges facing the workforce supply. According to Buerhaus, Skinner, Auerbach, and Staiger,<sup>2</sup> the aging of the baby boomers, the shortage and uneven distribution of physicians, nurses' retirements on the rise, and rapid changes to the health delivery system related to value based-purchasing creates an unprecedented uncertainty for the future. It is to this point that the Title VIII programs sustainability are paramount. They are, at their core, workforce supply-and-demand programs addressing the

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<sup>1</sup> National Council of State Boards of Nursing. (2017). *Active RN Licenses: A profile of nursing licensure in the U.S. as of February 23, 2017*. Retrieved from: <https://www.ncsbn.org/6161.htm>.

<sup>2</sup> Buerhaus, P., Skinner, L., Auerbach, D., & Staiger, D. (2017, July). Four Challenges Facing the Nursing Workforce in the United States. *Journal of Nursing Regulation*. 8(2), p. 40-46.

baseline and the bottlenecks, the high demand regions and vulnerable populations. They have been essential in facing the challenges of the past and will be needed for those in the immediate future. Title VIII funding bolsters the workforce and upholds its ability to deliver this care.

***Nursing Workforce Development Programs: Supporting Nurses and Patients***

The Title VIII programs are designed to address unique aspects within the nursing workforce and the demand for patient services. They have increased diversity, improved access to care—especially in rural and underserved areas—and bolstered innovations in academic institutions. According to the Health Resources and Services Administration (HRSA), in Academic Year 2015-2016 alone, Title VIII programs supported the educational and career aspirations of over 61,000 students and practicing nurses.<sup>3</sup> Moreover, the programs support institutions in their ability to expand the pool of nursing faculty and clinical training, including that which occurs in Nurse-Managed Health Clinics (NMHCs). Below are highlights referenced by HRSA on some of the successes the programs achieved last year:<sup>2</sup>

- Grantees of the Nursing Workforce Diversity program supported 7,337 students and partnered with 595 clinical training sites, of which nearly half were located in medically-underserved areas;
- The Nurse Faculty Loan Program supported 2,330 students preparing to become future faculty, of which nearly 80% were pursuing a doctoral degree;
- Support through the NURSE Corps Loan Repayment and Scholarship programs resulted in 55% of grantees voluntarily extending their service contracts in a region experiencing a critical shortage of health providers;

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<sup>3</sup> U.S. Department of Health and Human Services. (2017). Health Resources and Services Administration Fiscal Year 2018 Justification of Estimates for Appropriations Committees. Retrieved from: <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-2018.pdf>

- The Advanced Education Nursing Grants supported 10,238 students and partnered with over 2,596 clinical training sites, of which over half were in primary care settings;
- The Nurse Education, Practice, Quality, and Retention program supported partnerships between students and clinical training sites, and 87% of sites were located in medically-underserved areas.

***H.R. 959: Title VIII Nursing Workforce Reauthorization Act of 2017***

H.R. 959 would reauthorize the programs through Fiscal Year 2022; make changes to modernize the programs, thus aligning them with current trends in the profession; and offers technical changes to streamline the statute. AACN and 50 other national nursing organizations representing the cross-section of academia, research, practice, and regulation leadership fully support the goals of this legislation. In addition to reauthorizing the programs through FY 2022, H.R. 959 proposes the following changes:

*1. [42 U.S.C. § 296j] is amended to include the definition of Clinical Nurse Specialist in the Advanced Education Nursing Grants.*

Rationale: Given there are four APRN roles, including CNSs, this change would ensure that all four roles are delineated in Title VIII statute. CNSs are graduate-prepared nurses who specialize in an area of practice defined by a population (such as pediatrics or geriatrics), setting (such as a hospital), or disease type (such as diabetes).

*2. [42 U.S.C. § 297t] is amended to include Clinical Nurse Specialists as eligible to serve on the National Advisory Council on Nurse Education and Practice.*

Rationale: Including CNSs as eligible members ensures well-rounded representation on this Council, which provides recommendations to HRSA.

3. [42 U.S.C. § 296j] is amended to include *Clinical Nurse Leader* in the definitions of advanced education nurses in the *Advanced Education Nursing (AEN) Grants program*.

Rationale: The Clinical Nurse Leader (CNL) oversees the lateral integration of care for a distinct group of patients. The CNL evaluates patient outcomes, assesses cohort risk, and has the decision-making authority to change care plans when necessary. Its inclusion allows for parity with other master's degree programs that can apply for the AEN program.

4. [42 U.S.C. § 296] is amended to include "Nurse-Managed Health Clinics" in the Title VIII Definitions.

Rationale: Nurse-Managed Health Clinics are recognized as a prime model of efficient and cost-effective primary health care. NMHCs are effective in providing individualized care that includes health promotion, disease prevention and early detection, health teaching, management of chronic conditions, treatment of acute illnesses, and counseling. NMHCs, run by nurse practitioners, traditionally focus on populations underserved by the larger healthcare system and are learning environments for healthcare providers.

Again, AACN appreciates the Subcommittee's leadership for holding a hearing to discuss the merits of H.R. 959, and urges the Subcommittee to pass this legislation swiftly and unanimously on behalf of America's patients.

Sincerely,



Juliann G. Sebastian, PhD, RN, FAAN  
AACN Board Chair

Mr. GUTHRIE [presiding]. Thank you.

I thank the witnesses for their testimony, and we will now move to questions, the first portion of the Q&A. And I will begin the questioning and recognize myself for 5 minutes for that.

For Dr. Calman, I like the approach that the Teaching Health Centers program helps local providers like community health centers grow their own workforce. Can you explain how this residency program boosts staff ranks at rural and community health centers over the long term?

Ms. CALMAN. I am sorry, could you repeat the last sentence?

Mr. GUTHRIE. Oh, could you explain how this residency program boosts the staff ranks at rural and community health centers over the long term?

Dr. CALMAN. Sure. The program is really geared towards taking medical students and bringing them into programs in rural and underserved areas. And when they train in those areas, they have a much higher probability of staying in those areas. So if you think about bringing people who might normally train in a regular big hospital in the city, but now moving them out into the community for their 3 years, they develop relationships in those communities. It is a different style of practice to practice in a small rural community. You learn different skills, you learn to be more self-reliant, as Dr. Billings explained. You get a sense of self-reliance that allows you to go out into places where there are not a lot of doctors and not a lot of specialists. And so, we are creating that pipeline for people so that you can go into these communities and serve.

Mr. GUTHRIE. Thank you.

Dr. Knebl, in your testimony, you mentioned that a majority of geriatrics workforce graduates who receive this training announce commitments to further pursue training or in a practice in medically underserved communities. In your experience, how do these programs specifically help medically underserved communities?

Dr. KNEBL. So as we were talking about, number one, it is underserved, but through these programs, because they are interprofessional, we are training members of the whole healthcare team to go out. And so those trainees that will go out to those areas, obviously, will all then have more knowledge and skills. And I know that a lot of our trainees are going to these areas because we partner with our county hospital, John Peter Smith Hospital, which has one of the largest family medicine residencies in the whole country. And so they actually track where their residents are going.

And so to have the enhanced training in geriatric care, where a lot of the older adults are actually living, if you look at the data as to rural communities, and so to get, then, those trainees back out there, along with, then, the other members of the healthcare team, nursing, physical therapy, pharmacy, PAs, et cetera, we believe that is going to help enhance that, and then the care ultimately for the older adults.

Mr. GUTHRIE. OK. Good. This is for you, but I will also let Dr. Sebastian go first, and then anybody else can add to this. But many of the Title VII and VIII programs has curriculum development and continuing education components. How do your programs help the health professions workforce quickly adapt to the Nation's most pressing healthcare concerns? So how are the continuing edu-

cation components of these programs addressing you in emerging public health issues? So Dr. Sebastian?

Ms. SEBASTIAN. The Title VIII funds are the ones I will speak to initially. And those funds, we are unable to secure those funds unless we propose programs that, in fact, are nimble and highly responsive to local healthcare concerns and to national health priorities. So the curricular enhancements and the curricular changes that are put in place as a result of these funds are inherently focused on contemporary issues, such as mental health concerns, education, and more primary care providers for rural and underserved areas, incorporation of telehealth, which I mentioned was one example in our local school, as well as the opioid crisis and more specific kinds of contemporary health issues.

Mr. GUTHRIE. OK. Thank you.

Dr. Knebl?

Dr. KNEBL. Yes. I will just add to that, that what we have tried to do out of the GWEPs, my personal GWEP, the WE HAIL program, we actually did a community needs assessment in collaboration with our health systems in our community. And we heard from them what the major issues were. And that then gave us the focus for the CME programs for the healthcare practitioners.

So the areas that came up, just to share with you, is Alzheimer's disease, falls and fall prevention, medication management for older adults because of the challenges they can have, health literacy so that the healthcare workforce can speak in a way to that older adult and their family so they understand what they need to do, and chronic disease management. So we took what the community felt were the issues, and that is how we developed the curriculum that now we are disseminating, not only locally, but also throughout Texas and in many rural communities.

Mr. GUTHRIE. Well, thank you very much. My time has just expired. So I will yield back, and I will recognize the ranking member, Mr. Green of Texas, for 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Dr. Billings, I want to thank you for joining us, and the whole panel today. And I know we talked earlier about the National Health Service coordinated issue with community-based clinics. Dr. Billings, can you explain how the National Health Service Corps helps community health centers like the Presidio County Health service recruit providers?

Dr. BILLINGS. The National Health Service Corps is a vital workforce pipeline to community health centers throughout the country and our territories. Approximately 5,000 providers every year fulfill their loan repayment and/or scholarship repayment within a community health center. Without the National Health Service Corps, community health centers undoubtedly would close down because they would not have providers to take care of the patients.

Mr. GREEN. I have a very urban district in Houston and our FQHCs are so valuable in our area, it is a safety net. By the way, this committee actually proposed, and we passed finally, to give volunteer doctors in FQHCs tort claims protections. So a doctor maybe wants to cut half their practice, they can still work and treat people.

Could you explain what a failure of Congress to extend the National Health Service Corps would mean to community health centers like yours?

Dr. BILLINGS. That would be in 2 weeks when we go off the cliff, if we go off the cliff, there will be an immediate cessation of loan repayment beginning October, November. That is the first round of loan repairs. So there will be an immediate and drastic effect on taking care of patients and the patients that need the access to care the most.

Mr. GREEN. Thank you.

Dr. Sebastian, the numbers I have heard, according to the Health Resources and Service Administration, we are expected to experience a nursing shortage of approximately 150,000 people, 2030. I understand that one cause for this is shortage of sponsors in nursing schools due to the limited supply of nursing faculty. Would you elaborate on the challenges attracting students and professionals into the nursing faculty workforce?

Ms. SEBASTIAN. Yes. Nursing faculty, one of the challenges that we experience is the competition in terms of wages with the clinical practice arena. So that is often a big challenge in terms of recruiting nursing faculty. We are working very hard and, actually, with the support of the Nurse Faculty Loan Program, to attract more students into faculty roles. And that particular component of Title VIII has been very helpful to attract students who then can, in fact, look towards some relief from their loans as a result of the provisions of the Nurse Faculty Loan Program.

Mr. GREEN. Some numbers we see is that graduations in baccalaureate programs in nursing, U.S. nursing schools turned away 64,000 qualified applicants from baccalaureate or graduate studies in 2016 due to the insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. Most nursing schools responding to the survey pointed that the faculty shortage is the reason for not accepting all of these qualified applicants.

How does Title VIII programs help increase the supply of nursing faculty and the number of students accepted in nursing programs?

Ms. SEBASTIAN. Well, a prime example is the Nurse Faculty Loan Program, and as you pointed out, all of those factors influence our ability to hire faculty, not just the salary issue. Salaries have actually improved in some components of the nursing faculty ranks, but also issues related to budget, inability to provide additional clinical site placements. So I would say that the Nurse Faculty Loan Program is one huge example.

But the other opportunities that are provided by the advanced nurse education workforce, which is a slightly new program this year, help us get more students into graduate programs, who then may be interested in the future in faculty careers.

Mr. GREEN. Thank you. Mr. Chairman, I yield back my time.

Mr. BURGESS [presiding]. The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questioning.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it so much, and I thank the panel for their testimony today.

Dr. Knebl, according to the Alzheimer's Association, more than 5 million Americans are living with this disease, with projections rising up to 16 million by 2050. How do these geriatric workforce programs integrate Alzheimer's disease and related dementias education to families and caregivers of older adults?

Dr. KNEBL. Well, thank you so much for that question. We actually had an opportunity to have a separate addition onto our grant funding to actually address the Alzheimer's disease and related disorders education. How we are doing it, and I can give you that example from our program, is that we actually have partnered with the North Central Texas Chapter of the Alzheimer's Association, in addition to a dementia-specific care center, in terms of delivering certain types of programs actually to patients and their caregivers. There are evidence-based programs. One is a stress-busting program, one is a REACH program where you actually are able to send in a dementia care specialist into the home to give the family member respite and also education. And so we are doing that collaboration with those programs and actually assisting them with some funding to expand the reach.

We then also have our students as part of this so that then they can learn from this, and some of our family medicine residents are actually getting to get exposure to these programs.

Another thing we are doing is, you know now we have the Medicare Annual Wellness Visit, where you have to do screening for memory disorders. So what we are doing through our county hospital—and many people don't know how we got this to happen and I probably shouldn't say it too loud, because maybe they will say don't do it. But, basically, what they are doing is we have an electronic health record at the county hospital called Epic, and some of you may be familiar with that.

So through the Epic, we are now building platforms within it to be able to more adequately assess older adults, particularly those with cognitive impairment. We then make referrals to the community-based organizations, such as Alzheimer's Association. They can now look at the Epic platform. We are giving them access so they can see what is going on with that patient. They can then follow up. They can then reach out to the family to help them, and then they put notes in there about what their providing to that patient and family that then when the primary care doctor sees the patient back in the clinic, we see it. We close the loop between the primary care doctor, the referral to the community agency, and we make sure that patient and family is getting taken care of. So that is something we are doing out of our GWEP that I am very excited about.

Mr. BILIRAKIS. Can I ask you, when you said the welcome to Medicare, which actually my dad, Congressman Bilirakis, authored many years ago, so I want to brag about that.

Dr. KNEBL. You should.

Mr. BILIRAKIS. He is a wonderful person, and he has done an outstanding job over the years. But does that include a mental health screening? Is it required? It is required?

Dr. KNEBL. Yes. Well, we are adding in extra tools, because this is a geriatric clinic that is out of our county hospital. So we are putting mental health for depression screen, we are doing fall risk assessments, we are doing basic assessments of daily living, instrumental daily living. We are doing all those types of assessments as part of this. So there might be a patient that is determined to be a fall risk, we will then refer them to the senior citizens services, it is called 60 and Better, who does the congregant meal programs and actually provides the Matter of Balance classes. We would then have that person follow up. And again, they would have access to seeing the information.

Mr. BILIRAKIS. How widespread is that throughout the United States, what you are doing?

Dr. KNEBL. It is not. Our hope is, if you are reauthorizing, we can now apply to now take this out beyond Fort Worth, Texas.

Mr. BILIRAKIS. OK. Thank you.

A question for Dr. Billings. You and your colleagues are certainly no strangers to the growing shortage of medical professionals across the country. And someone probably has touched on this, but in your testimony, you acknowledged the National Health Service Corps as an effective, even popular way to overcome the recruitment barrier for medical shortage areas. What other ways are stakeholders working together to recruit and retain medical talent in historically underserved areas, and why are they not as successful? And how can they be improved?

Dr. BILLINGS. Sure. Thank you for the question. So through the National Health Service Corps, there is a state loan repayment component where approximately at least 37 states take advantage of Federal money to utilize in for state-specific needs that perhaps health professional shortage area scores don't go down low enough to fund because of the overwhelming need that is out there in the United States.

Currently, only 10 percent of scholarship applicants are able to be funded every year, and only 40 percent of loan repayment applicants are currently funded. There is certainly a huge need, and there is interest by health students throughout the disciplines, and we are not meeting that need for the interest that the students have, that want to go into primary care. And we want to be able to enable that.

The other huge need is, of course, we have about 10,000 field strengths within the National Health Service Corps every year. To meet the need of the patients, the health centers, the critical access hospitals, the rural health clinics, the Bureau of Prisons, Indian Health Service facilities, we need a field strength of 28,000 to meet the basic need of today. There is just a huge need. There is a lot of work to be done, and it is very, very important that we continue to support and enable these students that have expressed a desire to go out and serve the underserved, that we somehow enable them to realize that dream and train them in that setting as well.

Mr. BILIRAKIS. OK. Thank you.

I yield back, Mr. Chairman.

Mr. BURGESS. The gentleman's time has expired.

The chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. ESHOO. Thank you, Mr. Chairman.

I want to thank each one of you for what you do, first of all. I want to thank you for the passion that you have brought into this hearing room. A lot of hearings are very dry, and they are always full of important information. But there is no doubt in my mind, and I think all of my colleagues, that you care so deeply, so passionately about what you do. I think you are a blessing to the American people. You really are, and I thank you for that.

I am really privileged to represent Lucile Packard Children's Hospital, Stanford University Medical Center, and, of course, the school. All of these issues are interwoven into my congressional district, as well as a community health center in one of—most people don't think that there are poor people in Silicon Valley, but there are, there are. There are really underserved people that now are being served so much better because of the new community health center in East Palo Alto, which has always been a poor community.

So, the extensions of these programs and the Affordable Care Act, as well as the Teaching Health Center Graduate Medical Education, which was established in the Affordable Care Act, are a real source of pride to me in supporting them and in the architecture that the ACA had, underappreciated by some, unknown by others, but certainly you have highlighted what that infrastructure—we talk about infrastructure in the country. You have spoken to a magnificent part of the infrastructure of our country and how we need to build on that, because there are communities that are in need, certainly in rural areas of our country and elsewhere. So thank you again.

I wanted to come back mostly to thank you. I have a flight to catch in just a little while, so I will be real quick with my questions.

To Dr. Billings, are there other specialties within primary care, dental, and mental health that could benefit from being eligible to participate in the Public Health Service Corps?

Dr. BILLINGS. That is a really great question. And that has been a source of debate for many, many years. We know the need for meeting comprehensive primary care with the current funding level of the National Service Corps is not being met. That is evident in the 10,000 field strength that we have. Yet the need is for 28,000 participants to meet the basic need of comprehensive primary healthcare that we need. We would be more than happy to have a conversation once we are meeting in a current comprehensive primary care need of expanding that.

One of my biggest challenges as a boots on the ground physician is, when I reach my level of I feel that my patient needs to go to a specialist, how do I get them to one? Who is accepting Medicaid?

Ms. ESHOO. I was successful at adding a provision in the 21st Century Cures Act that designated pediatric mental health professionals to be eligible. A little bit of a fight to do that, but I prevailed, so that they could participate in the Public Health Service Corps. So I appreciate your sharing that with me.

Is the program's current per resident funding level appropriate? Who can answer that?

Dr. CALMAN. Yes, I guess that is for me. So the Teaching Health Center Graduate Medical Education program was originally fund-

ed, as you said, at a level of \$150,000 per resident per year. So that was based on a historical analysis of what it costs to train a resident.

What actually ended up happening when it was reauthorized was people forgot to take account of the fact that the number of programs had been growing, and also the programs had been ramping up from just having first-year residents to having first, second, and third-year residents. As a result of that, the funding was reduced to \$95,000 per resident per year, which is really only two-thirds of the dollars that are needed to support just the resident salaries and the faculty salaries in those program. That number is now up to \$116,000.

And so the program should be happy that they got a little bit more money, but not happy about how it happened. How it happened was programs dropped out at the lower reimbursement level. They couldn't support the residents, they couldn't support the faculty. And so we lost a lot of training slots through this new program.

As you said, when you think about a program starting, the remarkable thing was there are 57 new programs that developed across the country in the short period of time that this program's been in existence. All of them geared towards one thing: training doctors for underserved rural and urban communities. Fifty-seven new programs that just literally grew out of nowhere, got accredited, went through the enormous accreditation process, and all expecting that the funding would be there to continue.

And so we are really in crisis now and about to lose more programs. Two more programs closed just at the beginning of this academic year. A critical program in inner city Detroit and a program in rural Oklahoma, both lost, programs that had been started up through the initial funding but couldn't sustain themselves on the inadequate funding that we currently get.

Ms. ESHOO. Well, we obviously need to reauthorize. That is absolutely essential, it is critical. But we can't be self-congratulatory by simply doing that. I think that you have all made the case, the nurses, everything that you are doing at the county hospital, that the funding has to be appropriate for it.

Dr. CALMAN. Totally.

Ms. ESHOO. No one sends their kids off to college and says, well, I am going to pay for room and board, but I am not paying for your tuition. What kind of a deal is that? So we have work to do, and I hope the outcome will be worthy of the work that you do—

Dr. CALMAN. Thank you very much.

Ms. ESHOO [continuing]. And what you have chosen to do with your lives. You really are great Americans. Thank you.

Dr. CALMAN. Thank you.

Ms. ESHOO. God bless you. Thank you.

Mr. BURGESS. The gentlelady's time has expired.

The chair recognizes the gentlelady from Washington, Mrs. McMorris Rodgers, 5 minutes for questions, please.

Mrs. MCMORRIS RODGERS. Thank you.

And I agree, I still admire the work that you do, and I appreciate your commitment moving forward.

Just a few questions. Dr. Calman, I wanted you to address, and I know this has probably somewhat been addressed in other questions, but how would your health center be able to make up for the loss in funding for each residency slot if the THCGME program is allowed to expire on September 30? If this is even financially possible, how would shifting these dollars impact core primary care services for your patients?

Dr. CALMAN. So it is not really possible. The community health centers that are the sponsors of the vast majority of the Teaching Health Center slots really don't have excess income. And so, what we have really seen is a loss of program slots. You really can't sustain the program on inadequate funding. We lost 170 positions since the start of this program just a few years ago with the reduction in the funding that came with the last inadequate reauthorization. These are 170 doctors that would have been out practicing in needy communities that can't be replaced at this point.

And so we will continue to lose slots. We will continue to see programs close, like the two that I just talked about that have just closed, because you can't sustain the funding for these programs. These are real costs.

The difference between this program and regular graduate medical education is that we are accountable for every dollar. Every dollar goes to either a resident's salary, a faculty member's salary, or other program costs that we have to account for in every allocation.

Mrs. MCMORRIS RODGERS. So the legislation H.R. 3394 provides funding for 3 years at, roughly, \$157,000 per resident per year. Would you address why this level is so important to the teaching health centers like mine in Spokane and across the country?

Dr. CALMAN. Sure. So in the original authorization of this program, there was a demand that the Secretary get an outside entity to do a study of the actual cost of residency training, and that study revealed that the actual costs were \$157,000 per resident per year, on average. So if the funding isn't reauthorized at that level, we are basically putting the program in deficit to start. And you can't really do that.

And I think we really have to see this as an investment. This is an investment, because in every study of primary care, the more primary care providers you have in a community, the lower the healthcare costs in that community. The more specialists you have in a community, the higher the healthcare costs in that community. So this is an investment. We are investing in the training of primary care people to reduce healthcare costs and to be able to provide better care in communities that have no doctors at this point or few doctors.

Mrs. MCMORRIS RODGERS. So building on that just a little bit, would you agree that the THCGME program is accomplishing the objectives Congress laid out when it was established? And how does your association know that this program is actually producing physicians that go on to practice in primary care?

Dr. CALMAN. So we track outcomes. This is an outcome-based program, like all grant programs. And so we can tell you that the percentage of regular graduates that go into primary care is normally 23 percent. Eighty-two percent of the Teaching Health Center grad-

uates stay in primary care. There are twice as many that stay in underserved areas. There are four times as many that stay in rural areas, and 18 times as many graduates of teaching health center programs go into community health centers, federally qualified community health centers, than come out of the normal GME program. So we are responsible for outcomes.

And, in fact, in your current legislation, there is a whole new set of criteria and outcome measures that must be reported from the programs around the country.

Mrs. MCMORRIS RODGERS. Thank you, Dr. Calman.

I have several letters of support in favor of H.R. 3394 that I would like to submit for the record.

And with that, I yield back.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from New York, 5 minutes for questions, please.

Mr. ENGEL. Thank you very much. And I would like to throw my lot in with Congresswoman McMorris Rodgers.

I am glad, Dr. Calman, that you explained about the September 30 deadline. And I want to particularly welcome you, since—

Dr. CALMAN. Thank you.

Mr. ENGEL [continuing]. I am a fellow New Yorker. You do good work in my home city, and we thank you and your very good institution for what it does.

H.R. 3394, sponsored by Congresswoman McMorris Rodgers, would provide a 3-year extension to the teaching health center program. I wanted to focus on that.

I have heard from advocates that an extension of at least 3 years is critical. So, Dr. Calman, can you explain why the program would benefit from a longer term extension?

Dr. CALMAN. Sure. When we bring a new resident into our program, we commit to them for the full length of their primary care training, which is 3 years. So the residents know this. And we get questions from applicants. The average program that runs a teaching health center gets over a 1,000 applications for a handful of positions. The residents that we want—

Mr. ENGEL. It is like the House of Representatives.

Dr. CALMAN. The residents we want are obviously the best and most committed people. They come in and they ask, how do I know you are going to be able to complete my training? How do you know that you are going to have the funds to complete the training? Because the teaching health center funds expire in very short term. And so it is based on that commitment.

That commitment is built into the accreditation that we all had to get because the ACGME, the accrediting entity, says that once we take a resident, we are responsible for the completion of their training in our program. And so, we need long-term funding in order to provide that security to the program applicants and also to the programs.

Mr. ENGEL. Well, thank you. And H.R. 3394 also contains additional funding for expansion of the program. So let me ask you

again, Dr. Calman, is there currently demand for new teaching health centers and new residency slots in the program?

Dr. CALMAN. So there is enormous demand. As I said, our own program gets over 1,500 applications for eight positions. So we know there is demand for more residency training slots. We also know that there is demand for new programs, because as president of the American Association of Teaching Health Centers, I get these inquiries all of the time. We get calls from community health centers saying they really are interested in building this sort of pipeline track within their programs by starting a training program, because maybe that area of their state has had a problem recruiting or a problem maintaining an adequate workforce.

And so all over the country there are places that are contemplating starting new training programs. And the only thing standing between this and a much larger solution to our Nation's primary care crisis is the level of funding and the number of programs we can fund, because every program trains exclusively in primary care, and according to the new legislation that is proposed, would be training people in underserved communities.

Mr. ENGEL. Thank you. I hope we can pass this bipartisan, bicameral bill as soon as possible so that teaching health centers can continue to provide much needed care to our communities.

I want to take this opportunity to raise another program facing September 30 deadline, and that is community health centers. I have heard from community health centers in my district concerned about this approaching deadline. And one organization I have heard from is HRH Care, which operates two centers in my district, but serves about 14,000 of my constituents. And here is what they told me: They said that if Congress fails to authorize community health centers, in the next 2 weeks, centers will be forced to eliminate the Medicaid-assisted treatment needed by New Yorkers and others struggling with addiction to opioids, and centers will end weekend and evening hours, making it much harder for working families to get to a doctor. The list goes on.

So I want to commend the chairman for having today's discussion, but obviously, we cannot have it take place in a vacuum. Congress must enact a long-term, well-funded extension of the community health center program without delay, and the health of all of our constituents is at stake.

So thanks to all the witnesses. Thank you, Dr. Calman. Thank you, Mr. Chairman. I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman does yield back.

I recognize myself for questions.

And, Dr. Calman, let me, just as a point of clarification, but for someone who is watching this hearing today, I don't want them to get the mistaken impression that you are paying your residents \$157,000 a year.

Dr. CALMAN. Oh, thank you. We wouldn't have any problem recruiting.

Mr. BURGESS. That is exactly right. When I was a resident at Parkland Hospital, my first year, I think it was well under \$10,000 that we earned. But that is the total cost of providing that educational experience, correct?

Dr. CALMAN. Exactly. It pays for the residents' salary, all the faculty salaries, all the administration of the program, all of the people who are doing recruiting and everything else, and substantial faculty, because these programs require faculty. Remember that in primary care, you are being trained to cross a broad range of areas, and so the faculty have to be able to teach people how to do minor surgical techniques, and they have to be able to train in OB/GYN, and they have to be able to train in train across a broad range of areas.

So all of those costs are built into the 157. It is a total cost of training.

Mr. BURGESS. And I do want to point out that this committee, early in the year, passed the Improving Access to Maternity Care Act, to expand the ability to place maternity healthcare providers in medically underserved areas. It actually passed on the floor of the House and is awaiting activity over in the Senate.

There is a recurring theme here that you may encounter awaiting activity over in the Senate. I shared Mr. Engel's concern that we finish up our work and both houses get the work done and get the programs approved.

Let me just ask Dr. Billings and Dr. Knebl, we have the National Health Service Corps that focuses on the distribution of primary care providers, and then Title VII and Title VIII that we are also talking about this morning. So how do Title VII and Title VIII collaborate with the National Health Service Corps? What is the coordination between those programs? And, Dr. Knebl, let me start with you, and then, Dr. Billings, I would like your input.

Dr. KNEBL. So some of the focus, obviously, for us is really the geriatric training under the Geriatric Workforce Enhancement Programs, and that is to really try to enhance the education in geriatrics for primary care, and also for the whole primary care health profession team.

So I would say that I see the inner phase because we are very focused on assisting primary care programs to increase the geriatric content in education. And everything that we develop is to be shared among all types of education programs in the area of primary care. And then, as we were talking about earlier, the continuing medication education programs for people in practice.

So that we are taking a multipronged approach. We are starting in the undergraduate area of education for health professions, then into the residency programs, but then also when people are in practice.

So I would say the different products and programs that we develop are then applicable and able to be utilized in these primary care residency programs.

Mr. BURGESS. Great.

Dr. Billings.

Dr. BILLINGS. Healthcare is delivered by a team. It is not the physician. It is not a midlevel provider. It is truly a team. And the Title VII and Title VIII dovetail very well with the National Health Service Corps and with regards to the training of the students that are entering into service in the National Health Service Corps. The Area Health Education Programs that are funded through these

programs help to place students in underserved areas for their training. So it is just vital. We are a team.

Mr. BURGESS. Thank you.

And, Dr. Sebastian.

Ms. SEBASTIAN. Yes, I see the National Health Service Corps program and Title VIII, particularly, as very complementary. So the National Health Service Corps Program provides scholarship and loan repayment for students such as nurse practitioner students. Close to 90 percent of nurse practitioners actually practice in primary care areas, again, as part of a team.

Title VIII provides some funding to students, but also funding for the other costs associated with educating students, the cost of placing them in underserved areas, faculty supervision, the curricular issues that we want to provide for the students—or the curricular opportunities we wish to provide for the students.

So the two programs are in fact very complementary and I think work very well side by side.

Mr. BURGESS. Very well. Thank you.

I want to thank all of you for being here today. And I apologize that we had the interruption for votes in the middle of the hearing. It is an important hearing, quite clearly.

But seeing that there are no further members wishing to ask questions, once again, we extend our thanks to the witnesses.

We have received outside feedback from a number of organizations on these bills, so I would like to submit statements from the following for the record: the Eldercare Workforce Alliance, the Health Professions and Nursing Education Coalition, the Healthcare Leadership Council, Doctors Hospital at Renaissance, the National Association for Geriatric Education, and of course, the statement from our colleague who was here earlier, Congressman Denham, also, the American Association of Nurse Anesthetists.

Without objection, so ordered, those comments will be part of the record.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. Pursuant to committee rules, I remind members they have 10 business days to submit additional questions to our panel for the record. And I ask the witnesses to submit their response to those questions within 10 business days of receipt of those questions.

Without objection then, the subcommittee stands adjourned.

[Whereupon, at 1:12 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

#### PREPARED STATEMENT OF HON. GREG WALDEN

Today, our country is on the precipice of a health provider shortage, impairing our ability to meet the increasing demand for services, especially in primary care. Underserved areas, like many of the rural counties in eastern Oregon, are acutely experiencing this shortage now. That is why it is so important that the federal government maintain its long-standing investment in the education and training of health professionals.

Today's hearing will examine four health professional education and training programs that will prepare current and future clinicians to meet the nation's growing health needs and increase access to care. We will hear testimony from experts who are here to speak about the successes and challenges facing the different types of workforce programs under the Public Health Service Act.

Dr. Neil Calman, President and CEO of the Institute for Family Health, will speak about the Teaching Health Center Graduate Medical Education program, which supports the training of residents in primary care.

Dr. Adrian Billings, Medical Director of Presidio County Health Services will share his experience in the National Health Service Corps, a program that has been improving recruitment and retention of health practitioners in underserved areas through scholarships and loan repayments since the 1970s.

Both of these programs face a reauthorization deadline. It is my goal to move forward in a bipartisan manner on these extenders before the end of the month and ensure they are fully and responsibly offset.

We will also hear from Dr. Janice Knebl, Chair and Professor in Geriatrics at the University of North Texas Health Science Center about Chairman Burgess's H.R. 3728, EMPOWER Act of 2017, which reauthorizes health professions workforce programs under Title VII of the Public Health Service Act. This reauthorization includes the re-organization of the geriatric health professional grant program to reflect changes that the Health Resources & Services Administration has pursued to improve outcomes for geriatric patients.

Finally, we will hear from Dr. Juliann Sebastian, Dean of University of Nebraska's College of Nursing, about Representative Joyce's H.R. 959, the Title VIII Nursing Workforce Reauthorization Act of 2017, important legislation that reauthorizes critical nursing education workforce development programs under Title VIII of the Public Health Service Act.

These are important programs that we rely on, in one way or another. I'd like to thank our witnesses for being here with us today to give an update on how these programs are performing, so we can identify the best path forward in supporting their critical services.

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#### PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

I'm pleased we are holding this hearing to discuss programs critical to the success of our health workforce. A strong health workforce is the bedrock of a strong health system overall. It's essential that we continue to sufficiently invest in all our health workforce programs to ensure they are meeting the country's needs.

The National Health Service Corps (NHSC) Program provides financial support to health professional students and primary care providers who commit to provide service in medically underserved areas. The incentives provided by this program help place providers in the communities that need them the most. However, without congressional action, funding for NHSC will expire on September 30, 2017. I strongly support extending funding for this program.

Similar to NHSC, funding for the Teaching Health Center Graduate Medical Education (THC GME) Program is also set to expire at the end of the fiscal year. Teaching Health Centers train primary care medical and dental residents in community based settings such as Community Health Centers. THC graduates are far more likely to remain in primary care and to practice in rural and underserved communities compared to traditional GME graduates. Without renewed funding before September 30th THC residencies could potentially be interrupted or terminated. I strongly support H.R. 3394, introduced by Representative McMorris Rodgers (R-WA), which would fund the program for 3 years at an improved funding level. H.R. 3394 would provide THCs the financial stability they need to adequately train a class of residents.

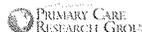
H.R. 3728, the Education Medical Professionals and Optimizing Workforce Efficiency and Readiness (EMPOWER) Act of 2017, introduced by Representatives Burgess (R-TX), Schakowsky (D-IL), and Bucshon (R-IN), would reauthorize the programs in Title VII of the Public Health Service Act that received funding through the FY 2017 Appropriations process. Title VII programs provide valuable training to our nation's healthcare professionals. I support the reauthorization of these programs and thank the bill's sponsors for their work on this issue.

Finally, H.R. 959, the Title VIII Nursing Workforce Reauthorization Act of 2017 would reauthorize the Title VIII programs that received funding through the FY 2017 Appropriations process. Programs in Title VIII of the Public Health Service Act improve nursing education, practice, recruitment, and retention. A well trained nursing workforce benefits all Americans and I strongly support these programs. I thank the bill's sponsors, Representatives Joyce (R-OH) and Matsui (D-CA), for their bipartisan work on this issue.

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## COUNCIL OF ACADEMIC FAMILY MEDICINE

Association of Departments of Family Medicine  
 Association of Family Medicine Residency Directors  
 North American Primary Care Research Group  
 Society of Teachers of Family Medicine



September 13, 2017

Chairman Michael Burgess  
 Energy and Commerce  
 Subcommittee on Health  
 2336 Rayburn House Office Building  
 Washington, D.C. 20515

Ranking Member Gene Green  
 Energy and Commerce  
 Subcommittee on Health  
 2470 Rayburn House Office Building  
 Washington, D.C. 20515

Dear Chairman Burgess and Ranking Member Green:

The Council of Academic Family Medicine (CAFM) represents teachers of and researchers in family medicine. In anticipation of the upcoming hearing on "Supporting Tomorrow's Health Providers: Examining Workforce Programs Under the Public Health Service Act," we are sharing our positions on two critical issues in your jurisdiction: Teaching Health Centers (THC) and Title VII primary care funding. We ask that this be included in the statement record of the hearing.

### Teaching Health Centers:

We encourage you to promptly reauthorize the Teaching Health Center Graduate Medical Education (THCGME) program, which will expire on September 30, 2017.

Teaching health centers (THCs) play a vital role in training the next generation of primary care physicians, with more than 700 medical residents handling an estimated one million patient visits in FY2017 in underserved rural and urban communities. These centers are responding to the crisis-level shortage of primary care physicians by delivering doctors to communities where they are needed most. We are advised that a higher percentage of THC graduates remain in primary care practice and practice in underserved urban and rural communities than graduates of traditional GME programs<sup>1</sup>, reflecting the benefits that accrue from a well-designed program.

We believe that in reauthorizing the THC GME program, Congress should extend its duration for at least three years. In addition, we believe that reauthorization legislation should establish sufficient annual funding amount, of at least \$116.5 million for current programs so that a per resident allocation more truly reflects the cost of training each resident than the current funding level of \$60 million. Moreover, we ask that you include additional funding in the second and third year of the authorization to allow for new residencies to join the THCGME program. We are advised that the insufficient current funding level, coupled with the uncertainty regarding the program's expiration in September, has led some programs to reduce their resident slots, which is particularly unfortunate given the shortage of primary care physicians and the fact that some THCs have over 100 applicants for every available residency slot.

### Title VII:

We urge the Committee to pass a straight reauthorization for the health professions program, Primary Care Training and Enhancement, authorized under Title VII, Section 747 of the Public Health Service Act under the jurisdiction of the Health Resources and Services Administration (HRSA.) The Primary Care Training and Enhancement Program has a long history of funding training of primary care physicians.

<sup>1</sup> Primary Care Residents in Teaching Health Centers: Their Intentions to Practice in Underserved Settings After Residency Training; Zohray Talib, MD, Mariellen Malloy Jewers, MIA, et al. Academic Medicine (online ahead of print Aug 22, 2017.)

The most recent Congressional reauthorization modified the Title VII health professions programs to direct HRSA to prioritize training in the new competencies relevant to providing care in the patient-centered medical home model. It also calls for the development of infrastructure within primary care departments for the improvement of clinical care and research, as well as innovations in team management of chronic disease, integrated models of care, and health care transitions. Its purpose is not only, as the President's budget contends, to increase workforce numbers, but to also increase the value and training of the primary care workforce. In fact, these programs have accomplished both aims.

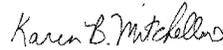
Multiple studies have recognized the value of this program.<sup>i</sup> Primary care health professions training grants under Title VII are vital to the continued development of a workforce designed to care for the most vulnerable populations and meet the needs of the 21st century.

We look forward to working with you in support of both of these vital programs.

Sincerely,



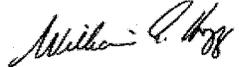
Stephen A Wilson, MD  
President  
Society of Teachers of Family Medicine



Karen B Mitchell, MD  
President  
Association of Family Medicine  
Residency Directors



Valerie Gilchrist, MD  
President  
Association of Departments of  
Family Medicine



William Hogg, MD  
President  
North American Primary Care  
Research Group

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<sup>i</sup> <http://www.jgme.org/doi/full/10.4300/JGME-D-09-00001>  
- Fryer GE Jr, et al. The association of Title VII fund physician specialty and practice location. *Fam Med.* 2002;34(6):436-440.  
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**JAMES L. MADARA, MD**  
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September 11, 2017

The Honorable Cathy McMorris Rodgers  
Republican Conference Chair  
U.S. House of Representatives  
202A United States Capitol  
Washington, DC 20515

Dear Representative McMorris Rodgers:

On behalf of the physician and medical student members of the American Medical Association (AMA), I want to express our support for H.R. 3394, the “Teaching Health Centers Graduate Medical Education (THCGME) Extension Act of 2017,” which would reauthorize the THCGME program for an additional three years and supports program expansion to serve more rural and underserved communities.

Since its enactment in 2010, the THCGME program has helped increase the number of primary care medical and dental residents training in rural and underserved communities. In the current academic year alone, the THCGME program supports 732 residents in 57 primary care residency programs, across 24 states. These centers are located predominantly in Federally Qualified Health Centers, rural health clinics, and tribal health centers, which prioritize care for underserved and vulnerable populations. Reports have shown that residents who train at teaching health centers are also more likely to practice primary care and remain in underserved or rural communities, improving patient access to care.

The THCGME Extension Act of 2017 will ensure that this vital program can continue in the future and provides additional funding to direct more resources to the communities that need it the most. The legislation also maintains the program’s strong transparency and accountability requirements that guarantee the success of the program. We appreciate your leadership on this important issue and look forward to working with you to advance this legislation.

Sincerely,

A handwritten signature in black ink, appearing to read 'James L. Madara'. The signature is fluid and cursive, written over a light blue horizontal line.

James L. Madara, MD



**Statement for the record to the  
House Energy and Commerce Committee,  
Health Subcommittee  
hearing  
Supporting Tomorrow's Health Providers:  
Examining Workforce Programs Under the Public Health Service Act  
September 14, 2017**

On behalf of the American Academy of Family Physicians (AAFP), representing 129,000 family physicians and medical students, thank you for the opportunity to submit this Statement for the Record for the U.S. House Energy and Commerce Committee Health Subcommittee regarding critical primary care workforce programs. The AAFP strongly supports the key primary care programs under discussion during today's hearing, specifically the Teaching Health Center Graduate Medical Education Program (THCGME), the National Health Service Corps (NHSC), and Title VII's Primary Care Training and Enhancement Program.

In particular, the AAFP urges legislators to support the funding levels contained in the *Training the Next Generation of Primary Care Doctors Act of 2017 (HR 3394)*, sponsored Rep. Cathy McMorris Rodgers and supported by 13 bipartisan members of the Energy and Commerce Committee. The bill reauthorizes and funds the THCGME program to train primary care physicians for three years. Unless Congress acts, the efficient and highly successful THCGME program will expire on September 30, 2017.

***Primary Care is Associated with Better Patient Outcomes and Lower Costs***

Primary care (comprehensive, first contact, whole person, continuing care) is the foundation of an efficient health system. It is not limited to a single disease or condition, and can be accessed in a variety of settings. Primary care (family medicine, general internal medicine and general pediatrics) is provided and managed by a personal physician, based on a strong physician-patient relationship, and requires communication and coordination with other health professionals and medical specialists.

The benefits of primary care do not just accrue to the individual patient. Primary care also translates into healthier communities.<sup>i</sup> For instance, U.S. states with higher ratios of primary care physician-to-population ratios have better health outcomes, including lower rates of all causes of mortality; mortality from heart disease, cancer, or stroke; infant mortality; low birth weight; and poor self-reported health, even after controlling for sociodemographic measures (percentages of elderly, urban, and minority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and smoking).<sup>ii</sup>

The dose of primary care can even be measured – an increase of one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3%, or 49 fewer deaths per 100,000 per year.<sup>iii</sup> High quality primary care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering per capita costs.<sup>iv</sup>

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*Primary Care Access is Vital for Improving Senior Care, Population Health, Disparities*

The AAFP believes building the primary care workforce is an important return on investment and workforce programs help ensure high quality, efficient medical care is more readily available. By reducing physician shortages and attracting physicians to serve in communities that need them, these programs also help improve the way care is delivered and help meet the nation's health care goals.

*Elderly Populations*

With the aging of the U.S. population, primary care access is critical. By the year 2050, the number of people 65 years of age and older will nearly double increasing the population of Medicare patients, 82% of whom have chronic health conditions.<sup>v</sup> As a country, we will only succeed at caring for this population by strengthening primary care, a specialty that is highly skilled in addressing the needs of patients with chronic diseases and multiple conditions. Better chronic care management is associated with fewer trips to the hospital and appropriate utilization of less expensive medical care.<sup>vi</sup>

Patients, particularly the elderly, with a usual source of care, such as a physician and a medical home, are healthier and have lower medical costs because they use fewer health care resources and can resolve their health needs more efficiently.<sup>vii</sup> In contrast, those without a usual source of care have more problems getting health care and more often do not receive appropriate medical help when it is necessary.<sup>viii</sup> Research also indicates that patients who gain a usual source of care adjust their health seeking behavior, which again translates into fewer expensive emergency room visits, unnecessary tests and procedures, and better care coordination.<sup>ix</sup> Therefore, it is in the national interest to support programs with the potential to help improve patient access for this population.

*Population Health Concerns*

Primary care access is also essential for achieving better population health outcomes. For example, immunizations are a 21<sup>st</sup> century public health success, yet less than half of the adult population is fully immunized. A 2016 report published in *Health Affairs* indicates that the economic costs of vaccine-preventable disease is between \$4.7 billion and \$14 billion per year.<sup>x</sup> Although vaccines are available in many different locations, such as pharmacies and in workplaces, primary care physicians play an important role as immunizers. The doctor-patient relationship can be instrumental in helping patients overcome their hesitancy or educating them when new immunizations are recommended. Doctors also understand patients' medical histories and risk factors. For example, primary care physicians can help diabetes mellitus patients understand how the condition compromises their immune system and why their vaccinations should be up-to-date.

*Health Disparities*

The current uneven distribution of physicians has an impact on the health of a population. A U.S. Centers for Disease Control and Prevention study indicated that patients in rural areas tend to have shorter life spans, and access to health care is one of several factors contributing to rural health disparities.<sup>xi</sup> The report recommended greater patient access to basic primary care interventions such as high blood pressure screening, early disease intervention, and health promotion (tobacco cessation, physical activity, healthy eating).<sup>xii</sup> The findings highlighted in the CDC's report are consistent with numerous others on health equity, including a longitudinal study published in *JAMA Internal Medicine*, indicating that a person's zip code may have as much influence on their health and life expectancy as their genetic code.<sup>xiii</sup> Therefore, it is imperative that physician care is accessible for all.

*Physician Shortage and Maldistribution*

The current physician shortage and maldistribution remain significant physician workforce challenges. A 2017 Government Accountability Office (GAO) report indicates that physician maldistribution significantly impacts rural communities.<sup>xv</sup> The patient-to- primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas.<sup>xv</sup> According to GAO, one of the major drivers of physician maldistribution is that medical residents are highly concentrated in very few parts of the country. The report stated that graduate medication education (GME) training remained concentrated in the Northeast and in urban areas, which continue to house 99% of medical residents.<sup>xvi</sup> The GAO also indicated that while the total number of residents increased by 13.6% from 2001 to 2010, the number expected to enter primary care decreased by 6.3%.<sup>xvii</sup>

Combined, the primary care workforce programs at issue in today's hearing are essential resources to begin to solve the lack of primary care physicians and patient access to primary care. We urge the committee to support these programs with an understanding of their potential for helping meet the country's health care needs. Supporting primary care workforce programs also makes primary care specialty a more attractive and economically viable choice for medical students.

*Teaching Health Center Graduate Medical Education (THCGME) Program*

The THCGME program is a highly successful primary care training program that has been proven to be effective in increasing primary care training and retention in community-based settings. This program directly addresses three major concerns regarding physician production: the serious shortage of primary care physicians, their geographic maldistribution, and the need for physicians who serve underserved populations. In addition, its accountability requirements serve as a model for other GME programs.

Residents in the THCGME program train exclusively in primary-care specialties. Two-thirds of the THCGME residents are training in family medicine or pediatrics.<sup>xviii</sup> The THCGME program accounts for less than 1% of the annual federal spending devoted to GME, yet it is the only program dedicated to training primary-care physicians and dentists. Residents in the program train in community-based settings (including federally qualified health centers), and tend to be concentrated exactly where more primary care is sorely needed: rural and underserved areas.

The THCGME program appropriately trains residents who then stay in the community. THCGME residents are trained in delivery system models using electronic health records, providing culturally competent care, and following care coordination protocols.<sup>xix</sup> Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.<sup>xx</sup> Residents who train in underserved communities are likely to continue practicing in those same environments.<sup>xxi</sup>

American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.<sup>xxii</sup> By comparison, fewer than 5% of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.<sup>xxiii</sup> Thus, the most effective way to encourage family and other primary-care physicians to practice in rural and underserved areas is not to recruit them from remote academic medical centers but to train them in these settings.

AAFP urges the extension of the efficient and highly successful THCGME program.

*National Health Service Corps*

The AAFP supports the objectives of the National Health Care Corps (NHSC) and assists the Health Resources and Services Administration in making information available to family medicine residents regarding practice opportunities and benefits in the program. The AAFP advocates for reauthorization and appropriate funding of the NHSC and for reinstatement of the goal of full funding for the training of the health workforce and the elimination of disparities in health care due to race, class, income, geography, language, or immigration status.

Since 1972, the NHSC has offered financial assistance to recruit and retain health care providers to meet the workforce needs of communities across the nation designated as health professional shortage areas (HPSAs). NHSC providers served more than 10 million people, providing a range of clinical services. NHSC providers represent a diverse group of clinicians – 13% are African American, 10% are Hispanic, 7% are Asian or Pacific Islander, and 2% are American Indian or Alaska Native. Clinician types include physicians (26%), dentists and dental hygienists (14%), nurse practitioners, physician assistants and certified nurse midwives (21%), and behavioral health providers (28%). NHSC members are placed in areas of highest need based on the HPSA site score. Scores range from 0-25 for primary care, dental, and mental health HPSAs.

Congress, as part of the bipartisan *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), provided a trust fund for the NHSC which expires at the end of FY 2017. The Administration's budget proposed that the NHSC receive mandatory funding in FY 2018 at the MACRA-authorized level of \$310 million. However, this will fall short of the need for NHSC placements in two-thirds of the nation's HPSAs. The AAFP urges that the Committee support a program level of at least \$380 million for the NHSC in FY 2018 to allow for an increased NHSC field strength to meet the need of Americans in the many HPSAs with no NHSC placements.

*Title VII, §747 Primary Care Training & Enhancement (PCTE)*

Title VII, Section 747 of the *Public Health Service Act*, as administered by HRSA, strengthens medical education for physicians to improve the quantity, quality, distribution, and diversity of the primary care workforce. An *Annals of Family Medicine* study<sup>xxiv</sup> projects that the changing needs of the U.S. population will require an additional 33,000 practicing primary care physicians by 2035. Another study<sup>xxv</sup> noted that meeting the increased demand for primary care physicians requires the expansion of the PCTE program. The AAFP was grateful to the House for providing \$39 million for the PCTE program in the FY 2018 appropriation package. AAFP also strongly supports the introduction by Dr. Michael Burgess and Congresswoman Jan Schakowsky of the *Educating Medical Professionals and Optimizing Workforce Efficiency and Readiness Act of 2017* ([HR 3728](#), EMPOWER Act) to reauthorize this important program.

*Conclusion*

Given their role in supporting high quality, low cost primary care access for those who need it, we urge the committee to support long term reauthorization and to provide full funding to help ensure these programs meet country's essential health care needs.

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- <sup>ii</sup> Shi L. The relationship between primary care and life chances. *J Health Care Poor Underserved*. 1992 Fall; 3(2):321-35
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- <sup>vi</sup> Reid B. Blackwelder, MD, Leaders Voices Blog, (October 2014), We're Doing Our Part to Keep SGR Issue On Congress' Radar, [http://blogs.aafp.org/cfr/leadervoices/entry/we\\_re\\_doing\\_our\\_part](http://blogs.aafp.org/cfr/leadervoices/entry/we_re_doing_our_part)
- <sup>vii</sup> Gillfillan, R. J., Tomcavage, J., Rosenthal, M. B., Davis, D. E., Graham, J., Roy, J. A., & ... Steele, J. D. (2010). Value and the Medical Home: Effects of Transformed Primary Care. *American Journal of Managed Care*, 16(8), 607-615
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- <sup>x</sup> Modeling The Economic Burden Of Adult Vaccine-Preventable Diseases In The United States. *Health Aff (Millwood)*. 2016 Nov 1;35(11):2124-2132. Epub 2016 Oct
- <sup>xi</sup> Moy E, Garcia MC, Bastian B, et al, Leading Cause of Death in Nonmetropolitan and Metropolitan Areas – United States, 1999 – 2014, *MMWR, Surveill Summ*, 2017; 66 (No.SS-1); 1-8. DOI: <https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm>
- <sup>xii</sup> *MMWR*, 2017
- <sup>xiii</sup> Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, Morozoff C, Mackenbach JP, van Lenthe FJ, Mokdad AH, Murray CJL. Inequalities in Life Expectancy Among US Counties, 1980 to 2014 Temporal Trends and Key Drivers. *JAMA Intern Med*. 2017;177(7):1003–1011. doi:10.1001/jamainternmed.2017.0918
- <sup>xiv</sup> U.S. Government Accountability Office, May 2017, GAO 17-411, <http://www.gao.gov/assets/690/684946.pdf>
- <sup>xv</sup> Hing, E, Hsiao, C. US Department of Health and Human Services. *State Variability in Supply of Office-based Primary Care Providers: United States 2012*. NCHS Data Brief, No. 151, May 2014
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- <sup>xvii</sup> *Ibid*
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- <sup>xxii</sup> E. Blake Fagan, MD, et al., Family Medicine Graduate Proximity to Their Site of Training, *Family Medicine*, Vol. 47, No. 2, at 126 (Feb. 2015).
- <sup>xxiii</sup> Candice Chen, MD, MPH, et al., Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions, *Academic Medicine*, Vol. 88, No. 9, p. 1269 (Sept. 2013).
- <sup>xxiv</sup> <http://www.annfammed.org/content/13/2/107.full>
- <sup>xxv</sup> <http://www.annfammed.org/content/10/2/163>

**American Academy of Family Physicians  
American Association of Colleges of Osteopathic Medicine  
American Association of Teaching Health Centers  
American Congress of Obstetricians and Gynecologists  
American Osteopathic Association  
Council of Academic Family Medicine  
National Association of Community Health Centers**

**Joint Statement for the Record**

**Hearing of the Energy and Commerce Subcommittee on Health  
on  
Supporting Tomorrow's Health Providers:  
Examining Workforce Programs under the Public Health Service Act**

**September 14, 2017**

On behalf of the hundreds of thousands of physicians, medical students, and health centers represented by our seven organizations--the American Academy of Family Physicians, American Association of Colleges of Osteopathic Medicine, American Association of Teaching Health Centers, American Congress of Obstetricians and Gynecologists, American Osteopathic Association, Council of Academic Family Medicine, and the National Association of Community Health Centers--we thank the subcommittee for working to address physician workforce issues in rural and underserved communities in a comprehensive approach.

Our organizations encourage Congress to enact the "Training the Next Generation of Primary Care Doctors Act of 2017" (H.R. 3394), and fund the Community Health Centers Fund (CHCF) along with the National Health Service Corps (NHSC) by September 30, 2017. These programs work together to change the landscape of access to care in underserved communities nationwide.

The Teaching Health Center Graduate Medical Education (THCGME) program is a vital source of training for primary care residents who expand access to care in both urban and rural medically underserved communities throughout the country. Failing to reauthorize the program for a minimum of three years and with a sustainable per resident allocation by September 30 could force teaching health centers (THCs) across the country to close, which would have immediate impact on patients, disrupt the training of resident physicians, and end a successful effort to address primary care shortages.

Located in 27 states, THCGME programs currently train more than 700 residents in much-needed primary care fields that have the largest shortages nationally, including family medicine, internal medicine, pediatrics, obstetrics and gynecology, psychiatry, geriatrics, and dentistry. Those resident physicians will provide more than one million primary care medical visits to patients living in underserved communities this year alone.

True to the intent of the THCGME, physicians who train in these programs are far more likely to stay in those communities and continue providing primary care. Data show that when compared to traditional postgraduate trainees, residents who train at THCs are more likely to practice primary care (82 percent

vs. 23 percent) and remain in underserved (55 percent vs. 26 percent) or rural (20 percent vs. 5 percent) communities.<sup>1</sup> It is clear that the well-designed THCGME program not only plays a vital role in training our next generation of primary care physicians, but helps to bridge our nation's physician shortfall. The program also tackles the physician maldistribution problem, and helps to address the need to attract and retain physicians in rural areas and medically underserved communities. In academic year 2015-2016, nearly all residents received training in primary care settings and 77% of residents trained in Medically Underserved Communities (MUCs).<sup>2</sup>

If enacted, H.R. 3394 would reauthorize the THCGME program for three years, matching the length of residency training, and include a per-resident allocation that better reflects the cost of training. In addition to providing much-needed stability to the program, the legislation also creates a pathway for the addition of new THC residency programs.

Established in 1972, the NHSC incentivizes primary care providers to work in the highest need areas of our country. NHSC consists of more than 10,000 primary care medical, dental, and mental health and behavioral health professionals who provide care to approximately 11 million medically underserved people<sup>3</sup> at more than 5,000 sites that are designated as Health Professional Shortage Areas.

Like the THCGME and the NHSC, funding for the CHCF will expire on September 30. Without immediate action, services provided by Community Health Centers, which serve as the primary medical home for more than 27 million people in 9,800 rural and urban communities across America<sup>4</sup> will be put in jeopardy.

We deeply appreciate the subcommittee's commitment in training the future primary care workforce. We look forward to working with members of the subcommittee to ensure the enactment of H.R. 3394, and the continued funding for the CHCF and the NHSC.

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<sup>1</sup> <http://aathc.org/know-the-facts/>

<sup>2</sup> <https://bhwh.hrsa.gov/grants/medicine/thcgme>

<sup>3</sup> <https://nhsc.hrsa.gov/corpscommunitymonth/index.html>

<sup>4</sup> <http://www.nachc.org/about-our-health-centers/>

**Oncology Nursing Society****Statement for the Record****Before the House Energy and Commerce Committee****Subcommittee on Health****“Supporting Tomorrow’s Health Providers: Examining Workforce Programs  
Under the Public Health Service Act”****Thursday, September 14, 2017**

Chairman Burgess, Ranking Member Green, and members of the Subcommittee, the Oncology Nursing Society (ONS) would like to thank the House Energy and Commerce Health Subcommittee for the opportunity to provide input on the reauthorization of Title VIII Nursing Workforce Development Programs.

The Oncology Nursing Society (ONS) is a professional organization of more than 39,000 registered nurses and other health care providers dedicated to excellence in patient care, education, research, and administration in oncology nursing. ONS members are a diverse group of professionals who represent a variety of professional roles, practice settings, and subspecialty practice areas. As advocates for the nursing profession and our cancer patients, ONS welcomes the opportunity to inform the Subcommittee about the importance of the health care workforce programs included under the Public Health Service Act.

For five decades, the Title VIII Nursing Workforce Development Programs have helped build the supply and distribution of qualified nurses needed in all health care settings. The Title VIII programs bolster nursing education at all levels, from entry-level preparation through graduate study, and provide support for institutions that educate nurses to practice in rural and medically underserved communities.

Toni Flaspeter is an Oncology Nurse Navigator for Medstar Washington Hospital Center in Washington, DC and is one of the many ONS members who have benefited from Title VIII. She is a recipient of a Health Resources and Services Administration (HRSA) Nurse Corps Loan Repayment Program scholarship. After completing her undergraduate education, Ms. Flaspeter was accepted into an accelerated second bachelor’s degree in nursing program at Georgetown University in Washington, DC. Because this was a second bachelor’s degree, she had a difficult time finding any scholarships or financial aid to assist in the pursuit of her nursing career despite her searching efforts. After graduating with a BSN, she had accumulated significant school debt, and it took many months to find employment. She was paying approximately \$1,400 a month in student loans.

In order to meet her student loan obligations, Ms. Flaspeter worked 12-hour shifts as a registered nurse five to six days a week, taking overtime, night and holiday shifts as much as possible to maximize her income, while still dealing with the pressure of living paycheck to paycheck. Additionally, she took part time jobs and lived on a very tight budget. While she describes the Title VIII program application process as “very intense” with having to upload about 30 documents, it

ultimately helped to pay for 60 percent of her unpaid education over a two-year period. The Title VIII assistance was instrumental in improving her finances, mental health, and productivity. Ms. Flaspeter was so encouraged by the Title VIII program and its benefits that she decided to mentor other nursing applicants through the scholarship process.

Title VIII Nursing Workforce Development Programs are a direct investment in the nursing workforce, patient well-being, and the sustainability of our nation's health care system. The Title VIII Nursing Workforce Reauthorization Act (H.R. 959/S. 1109) has already been introduced with strong bipartisan support in both the House and Senate. ONS urges you to demonstrate your commitment to America's future nursing workforce by passing reauthorization legislation in a timely manner.

Thank you again for taking our written comments into consideration. The Oncology Nursing Society looks forward to working with the Subcommittee on issues of importance to the nursing profession and our cancer patients.

ADVOCATING  
 TEAM CARE  
 FOR OLDER  
 ADULTS



**Eldercare  
 Workforce  
 Alliance**

**Committee on Energy and Commerce  
 Subcommittee on Health  
 “Supporting Tomorrow’s Health Providers: Examining Workforce Programs Under the Public Health Service Act”  
 September 14, 2017  
 Submitted on behalf of the Eldercare Workforce Alliance**

Mr. Chairman Burgess, Ranking Member Green, and Members of the Subcommittee:

We write on behalf of the Eldercare Workforce Alliance (EWA), a coalition of 31 national organizations - representing health care professionals, family caregivers, consumers, direct care workers, and providers – joined together to address the health care workforce needs in caring for an aging America. As the Subcommittee begins hearing about workforce programs under the Public Health Service Act, the Alliance thanks you for your hard work on the reauthorization of these programs designed to increase the number of health care professionals, specifically the geriatrics program that I represent that care for America’s growing population of older adults and support family caregivers in the essential role they play in this regard.

**1. Number of Americans Aging Over 65 Expected to Double**

The number of Americans over age 65 is expected to double between 2000 and 2030, totaling more than 70 million people and accounting for almost 20% of the American population by the end of the next decade. Today’s health care workforce is inadequate to meet the special needs of older Americans, many of whom have multiple chronic physical and mental health conditions and cognitive impairments. Of equal importance is supporting the legions of family caregivers who annually provide billions of hours of uncompensated care that allows older adults to remain in their homes and communities. Without a national commitment to expand

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*The positions of the Eldercare Workforce Alliance reflect a consensus of 75 percent or more of its members, and do not necessarily represent the position of individual Alliance member organizations.*

training and educational opportunities, the workforce will continue to grow even more constrained and care for our nation's older adults will be compromised. This is why the Title VII geriatrics programs, and other health professions programs are so critical to ensuring there are skilled eldercare workers and well-supported family caregivers available to meet the complex and unique needs of older adults.

### **2. Education & Training: Meeting the Needs of Older Adults**

High-quality care for older adults, many of whom have multiple complex chronic conditions, requires a provider team with a diverse range of skills for addressing this population's physical, mental, cognitive, and behavioral needs. The lack of training requirements for both health professionals and the direct care workforce results, in part, from a lack of recognition that older adults have distinct health care needs. Exposure to geriatrics and gerontological principles and practices will be essential for training all direct care workers and health care professionals, serving older adults. The Eldercare Workforce Alliance (EWA) calls for a focus on recruitment, training, retention, and compensation of health care providers serving older adults, as well as reimbursement to support participation in interdisciplinary teams.

The Title VII geriatrics workforce program, also known as the Geriatrics Workforce Enhancement Program (or GWEP), is administered by the Health Resources and Services Administration. GWEP is the only federal program that increases the number of faculty, across disciplines, who have geriatrics and gerontology expertise and who provide training (including training of interdisciplinary health care teams) in clinical geriatrics and gerontology. The Alliance urges the administration and Congress to provide adequate funding and to protect these programs.

### **3. Investing in the Direct Care Workforce**

High turnover, low wages, and a shortage of qualified home care workers endanger the independence of millions of older Americans who want and rely on these services to remain living at home. Increasing funding for eldercare training and other new educational opportunities for direct care workers will not only help to meet

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the growing demand for home- and community-based services, but will also provide the recognition and respect the direct care workforce deserves.

Direct care workers—including nursing assistants, home health aides, and personal care attendants—provide critical support to older adults in need of long-term services and supports, providing 80 percent of paid hands-on services delivered.

Current direct care worker training standards are inadequate to prepare workers to meet the increasingly complex needs of older adults. For example, the minimum federal training requirement for nursing assistants is just 75 hours of training; the Institute of Medicine recommends a minimum of at least 120 hours. For personal care attendants, training requirements vary by state, with no requirements whatsoever in 11 states. To meet the demand for services and address high rates of turnover—particularly for the home care services that enable older adults to remain living at home—direct care worker jobs should offer comprehensive training, certification, and career advancement opportunities.

Furthermore, the Alliance believes that with the appropriate training, supervision, and support, some home care workers can play an enhanced role in improving the safety and quality of care for older adults and family caregivers. Wages would also be commensurate to the Advanced Direct Care Worker’s training and experience and higher than those of current direct care workers, creating an incentive to remain in this field. We recommend fostering Advanced Direct Care Worker (DCW) roles to help meet the current and future demand for a high-functioning eldercare workforce.

#### **4. Incentivizing the Eldercare Workforce**

Health care providers who care for older adults serve a complex, challenging population, and evidence shows that working with this population is highly satisfying. However, significant barriers, including financial disincentives, exist to recruiting and retaining both direct care workers and health care professionals, in aging. Financial incentives to increase the number of people who specialize in geriatrics and gerontology, such as

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funding to attract knowledgeable academic faculty, loan forgiveness, and scholarships should be offered. Additionally, compensation for direct care workers should be addressed through means such as establishing minimum standards for wages and benefits paid under public programs and targeting reimbursements to ensure that public funds directly improve compensation for direct care workers. EWA believes that extending federal minimum wage and overtime protection to this essential workforce can bolster worker recruitment and retention, thereby improving quality of care.

#### **5. Supporting Consumers and Caregivers**

Family caregivers —of which there are 42.1 million in the United States—provided more than 40.3 billion hours of unpaid care in 2009. In that same year, the estimated economic value of U.S. family caregivers' unpaid contributions totaled approximately \$450 billion. Moreover, almost half of family caregivers perform medical or nursing tasks for people with multiple chronic conditions (both physical and cognitive). Providing support and training opportunities to family caregivers is essential. Family caregivers must be valued members of health care teams, with health care providers identifying family caregivers, assessing their needs, and offering training and support.

Funding should be made available to ensure adequate training opportunities for family caregivers are available in the community. Both long-standing and new models already offer programs that assist caregivers in making decisions and solving problems. New models of care that provide resources and supports to maximize family caregiver physical and mental health and well-being, are also needed.

#### **6. Preserve Medicaid for our Nation's Older Adults and Those Who Care for Them**

Medicaid has become the principal payer for long-term services and supports (LTSS) in the United States, including nursing home and home- and community-based services, covering 62 percent of such costs. Reductions in Medicaid spending could be catastrophic for older adults, their families, and their communities.

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Cuts to Medicaid could also impact employers, as increased family caregiving responsibilities increases employees' time away from work. Moreover, Medicaid cuts could be devastating to the economic security of health care workers who are paid hourly and could increase their reliance on federal and state programs.

#### **7. Support Greater Investment in Geriatrics and Health Professions Programs**

EWA supports Rep. Jan Schakowsky's bill "Geriatrics Workforce and Caregiver Enhancement Act (H.R. 3713)" that reauthorizes the program at a level of \$51 Million. The bill supports two critical objectives. First, it would formally establish funding for the Geriatrics Workforce Enhancement Program (GWEP). Second, it would reestablish the Geriatric Academic Career Awards (GACAs), a previously funded program for developing clinician-educators. By supporting the GWEP and the GACAs, the Geriatric Workforce and Caregiver Enhancement Act would:

- Foster education and engagement with family caregivers by training providers who can assess and address their care needs and preferences.
- Promote interdisciplinary team-based care by transforming clinical training environments to integrate geriatrics and primary care delivery systems.
- Improve the quality of care delivered to older adults by providing education to families and caregivers on critical care challenges like Alzheimer's disease and related dementias.
- Reach underserved and rural communities by ensuring clinician-educators are prepared to train the geriatrics workforce of today and tomorrow.

#### **8. Conclusion**

Our nation faces a severe and growing shortage of eldercare professionals with the skills and training to meet the unique healthcare needs of older adults. Fully funding this program and eventually expanding it to other

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states will invest in an eldercare workforce than can support well-coordinated, high-quality care for all older Americans.

Mr. Chairman, Ranking Member Green, and distinguished members of the subcommittee, addressing the eldercare workforce crisis and the other vital health professions programs under the Public Health Service Act is an opportunity that cannot afford to be ignored. We appreciate the hard work the committee has undergone to reauthorize all of the important health professions programs under Title VII and I look forward to your questions.

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**EWA Member Organizations**

AARP  
Alzheimer's Association  
Alzheimer's Foundation of America  
AMDA – The Society for Post-Acute and Long-Term Care Medicine  
American Academy of Nursing  
American Association for Geriatric Psychiatry  
American Geriatrics Society \*\*  
American Nurses Association  
American Physical Therapy Association  
American Psychological Association  
American Society of Consultant Pharmacists  
American Society on Aging  
Caring Across Generations  
Coalition of Geriatric Nursing Organizations  
Community Catalyst  
Cooperative Development Foundation ^  
Council on Social Work Education  
Family Caregiver Alliance  
Gerontological Society of America \*\*  
Hartford Institute for Geriatric Nursing  
LeadingAge  
National Alliance for Caregiving  
National Association for Geriatric Education  
National Association of Area Agencies on Aging (n4a)  
National Association of Social Workers  
National Consumer Voice for Quality Long-Term Care  
National Cooperative Bank  
National Council on Aging  
National Hispanic Council on Aging  
NCB Capital Impact/THE GREEN HOUSE® Project ^  
PHI - Quality Care through Quality Jobs  
SEIU Healthcare  
Social Work Leadership Institute

**Federal Liaisons**

US Department of Veterans Affairs  
Administration for Community Living  
Health Resources and Services Administration (HRSA)  
Office of Women's Health, HHS

*\* Alliance Co-conveners*

*^ Non-voting Members*

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September 14, 2017

The Honorable Michael Burgess  
Chair  
Subcommittee on Health  
Energy and Commerce Committee  
United States House of Representatives  
Washington, D.C. 20515

The Honorable Gene Green  
Ranking Member  
Subcommittee on Health  
Energy and Commerce Committee  
United States House of Representatives  
Washington, D.C. 20515

Dear Chairman Burgess and Ranking Member Green:

On behalf of the Health Professions and Nursing Education Coalition (HPNEC), I write to thank you for your support of the Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing workforce development programs. HPNEC is an alliance of over 60 national organizations representing schools, programs, communities, health professionals, and students dedicated to ensuring the health care workforce of tomorrow has the training and resources needed to adequately serve the country's health care needs, including those in the most underserved communities.

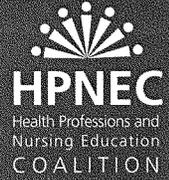
Current and growing workforce shortages remain a health care access barrier for individuals in rural communities, children and families on low incomes, seniors, and veterans. Title VII and Title VIII are among the only federally-funded programs that seek to improve the supply, distribution, and diversity of the health professions workforce, with a focus on primary care and interdisciplinary training. These programs help shape the workforce in targeted ways, such as promoting interprofessional, team-based care; promoting practice in underserved areas, rural, and inner city communities; and filling other gaps in the health care workforce.

As demand for health professionals grows in the face of current and impending shortages, a robust investment in education and training is key to ensuring the health care workforce is adequately supplied. The full spectrum of Title VII and Title VIII programs is essential to prepare our next generation of medical professionals to adapt to the changing health care needs of the nation's growing and aging population, as well as to respond to critical and emerging public health concerns, including the opioid epidemic. Again, we thank you for your continued support of Title VII and Title VIII workforce programs, and look forward to working with you to ensure Congress continues its longstanding commitment to investing in the health professions workforce.

Sincerely,

A handwritten signature in black ink that reads "Tyler Hanson". The signature is written in a cursive, flowing style.

Tyler Hanson, JD  
HPNEC Executive Director



## Health Professions Education Programs

*Preparing the next generation of health professionals to meet the nation's health care needs*

FY 2018



The Health Professions and Nursing Education Coalition (HPNEC) is an alliance of more than 60 national organizations (listed on back of brochure) representing schools, programs, health professionals, and students dedicated to ensuring that the health care workforce is trained to meet the needs of our diverse population.

## The Title VII Health Professions and Title VIII Nursing Workforce Development Programs

The Title VII health professions and Title VIII nursing workforce development programs, authorized under the Public Health Service Act and administered by the Health Resources and Services Administration (HRSA), provide education and training opportunities in high-need disciplines and settings and provide financial aid to health professions students. Through loans, loan guarantees, and scholarships to students, as well as grants and contracts to academic institutions and nonprofit organizations, Titles VII and VIII ensure the nation is equipped with a workforce that reflects the population it serves, while providing well-coordinated, quality care and improving access to care for all populations.

The programs have a longstanding history of adapting to meet the nation's health care workforce needs. Today, the nation is growing and becoming increasingly diverse and faces a rapidly growing, aging population. Now more than ever, support is needed for Titles VII and VIII, the only federally funded programs that improve the supply, distribution, and diversity of the workforce, to ensure health professionals are prepared to address the health care challenges of today and the future.

Title VII and Title VIII programs include:

- **Primary Care Medicine.** Expands the primary care workforce in general pediatrics, general internal medicine, family medicine, osteopathic medicine, and physician assistants through the following programs: Primary Care Training and Enhancement (PCTE), academic units for PCTE, Physician Assistants in Primary Care, and Interdisciplinary Interprofessional Joint Graduate Degree.
- **Primary Care Dentistry.** Expands the dental primary care workforce in general, pediatric, and public health dentistry through the following programs: Pre- and Postdoctoral Training, Residency Training, Faculty Development, and Faculty Loan Repayment.
- **Minority and Disadvantaged Students.** Increases minority representation in the health professions through the following programs: Health Careers Opportunity Program (HCOP), Centers of Excellence (COE), Faculty Loan Repayment, and Scholarships for Disadvantaged Students (SDS).
- **Interdisciplinary, Community-Based Linkages.** Supports community-based training of health professionals in rural and urban underserved areas through the following programs: Area Health Education Centers (AHEC); Leadership in Public Health Social Work Education; Teaching Health Center Development; Graduate Psychology Education; Mental and Behavioral Health Education and Training; Behavioral Health Workforce Education and Training (BHWET), including training for social work; and Allied Health Training.
- **Public Health Workforce Development.** Supports education and training in public health and preventive medicine through the following programs: Public Health Training Centers, Preventive Medicine Residency Training, and Loan Repayment for Pediatric Subspecialists.
- **Workforce Information and Analysis.** Supports the compilation and analysis of data on the nation's health workforce, including longitudinal evaluation of the Title VII and Title VIII programs through the National Center for Health Workforce Analysis and the Regional Centers for Health Workforce Analysis.
- **Student Financial Assistance.** Assists health professions students in financing their education through the following programs: Primary Care Loans (PCL), Health Professions Student Loans (HPSL), and Loans for Disadvantaged Students (LDS).
- **Nursing Workforce Development.** Provides federal support for the supply and distribution of qualified nurses for practice in rural and medically underserved communities through the following programs: Advanced Nursing Education; Nursing Workforce Diversity; Nurse Education, Practice, Quality, and Retention; NURSE Corps; and Nurse Faculty Loan Program.
- **Geriatrics Workforce Development.** Integrates geriatrics and primary care to provide coordinated and comprehensive care for older adults through interprofessional continuing education, faculty development, academic-community partnerships, geriatrics fellowships, and caregiver training. The Title VII geriatrics programs provided continuing education on Alzheimer disease and related dementias, among other topics, to more than 162,000 providers.

*HPNEC recommends \$580 million to sustain and strengthen the nation's investment in the Title VII health professions and Title VIII nursing workforce development programs in FY 2018.*

**Title VII and Title VIII programs work collaboratively to improve the supply, distribution, and diversity of the primary care workforce and train the next generation of health professionals to meet the nation's health care needs. Across the country, the programs connect students to high-demand health careers and health professionals to rural and urban underserved communities and ultimately help communities achieve better health.**

The Title VII and Title VIII programs play an important role in improving the diversity of the health care workforce and connecting students to health careers by supporting recruitment, education, training, and mentorship opportunities. Additionally, it takes years to train health professionals. Titles VII and VIII support aspiring health professions students throughout the educational pipeline, helping to ensure the health care workforce will reflect the population it serves.

- Studies have demonstrated the effectiveness of such pipeline programs in strengthening students' academic records, improving test scores, and helping minority and disadvantaged students pursue careers in the health professions.
- An inclusive workforce heightens cultural awareness and exposes individuals to backgrounds and perspectives other than their own, providing benefits for all. In fiscal year (FY) 2014, 60% of Titles VII and VIII program completers were underrepresented minorities and/or from disadvantaged backgrounds.<sup>2</sup>
- Title VII's SDS program seeks to alleviate financial barriers for economically disadvantaged students pursuing health professions education. In academic year 2015–2016, SDS graduated 2,151 students.<sup>3</sup>

*As the nation's population continues to become increasingly diverse, a well-prepared, diverse, and culturally competent workforce will be essential to ensure the nation's health care needs are met and to address racial and ethnic health disparities.<sup>4</sup>*

- The Title VIII Advanced Education Nursing Traineeship and Title VIII Nurse Anesthetist Traineeship programs supported more than 6,200 nursing and nurse anesthesia students in 2014–2015, exceeding their target by 94%.



- Titles VII and VIII also provide training and continuing education opportunities for practicing professionals and faculty in new care delivery models and concepts, such as team-based education and training, cultural competency training, and mental and behavioral health issues. In academic year 2015–2016, the Title VII COE program reached more than 4,768 health professionals through clinical training. Approximately 59% of COE grantee sites were located in medically underserved communities. In the same academic year, the Title VII AHEC program provided continuing education to more than 203,028 practicing health professionals across the country.<sup>4</sup>

**Titles VII and VIII support the development of the primary care workforce, including in underserved areas and populations.** By providing education and training experiences in community-based settings, students, residents, and faculty work directly with vulnerable populations. Further, these experiences help guide Title VII and VIII participants to careers in underserved communities or caring for vulnerable populations.

- In academic year 2015–2016, Public Health Training Center grantees delivered unique continuing education courses to 185,163 practicing professionals in the workforce. Of those, 22% were practicing in medically underserved communities.<sup>5</sup>
- Studies show that Title VII program participants are more likely to work in community health centers or serve in the National Health Service Corps, bolstering the primary care workforce and improving access to care for rural and underserved communities.<sup>6</sup>

In academic year 2015–2016, Title VIII Advanced Nursing Education (ANE) program grantees partnered with 2,596 health care delivery sites, provided clinical and experiential training to 10,238 trainees, and produced 2,051 graduates. HRSA estimates that 43% of the ANE grantee sites were in medically underserved communities.<sup>7</sup>



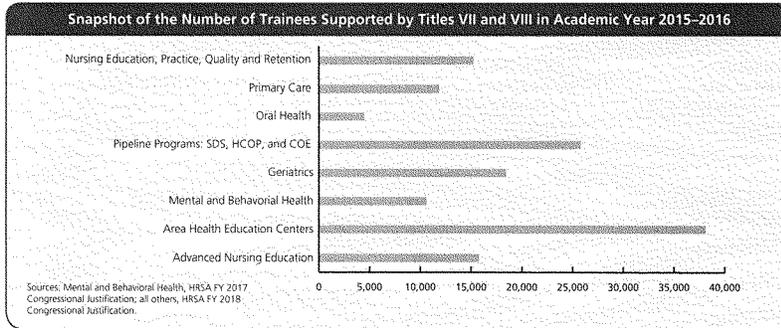
Titles VII and VIII are structured to allow grantees to test educational innovations, respond to changing delivery systems and models of care, and address timely topics in their communities. By assessing the needs of the communities they serve, Titles VII and VIII are well positioned to fill gaps in the workforce and increase access

to care for all populations. The programs emphasize interprofessional education and training, bringing together knowledge and skills across disciplines to provide effective, efficient, and coordinated care.



Titles VII and VIII train professionals to meet the needs of vulnerable populations, including children and seniors. Within 20 years, one in five Americans will be over the age of 65 and one in four Americans will be under the age of 19.<sup>8</sup> In academic year 2015–2016 alone, Title VII's Geriatrics Workforce Enhancement Program (GWEP) trained 18,451 students and fellows in geriatric-specific degree programs, field placements, and fellowships.<sup>9</sup>

A recent survey confirms that students who receive support from Title VIII nursing programs say seeking a competitive salary becomes less of a priority, making practicing in a rural or medically underserved area a realistic opportunity and helping to increase access to care.<sup>10</sup>



1. Association of American Medical Colleges. 2012. Survey Results Demonstrate the Importance of HCOP and COE Pipeline Programs in Preparing the Next Generation of Health Professionals.  
 2. HRSA FY 2017 Congressional Justification.  
 3. HRSA FY 2018 Congressional Justification.  
 4. Ibid.  
 5. Ibid.  
 6. Annals of Family Medicine. 2008. Impact of Title VII Training Programs on Community Health Center Staffing and National Health Service Corp Participation.

7. HRSA FY 2018 Congressional Justification.  
 8. Committee on the Future Health Care Workforce for Older Americans. Institute of Medicine. Rebuilding for an Aging America: Building the Health Care Workforce. [http://www.educareworkforce.org/files/document/research/IOM\\_Report.pdf](http://www.educareworkforce.org/files/document/research/IOM_Report.pdf)  
 9. HRSA FY 2018 Congressional Justification.  
 10. American Association of Colleges of Nursing. 2015. Title VIII Student Recipient Survey.  
 11. U.S. Census Bureau. 2012.

**Federal Funding for Health Professions and Nursing Education  
Under Titles VII and VIII of the Public Health Service Act  
FYs 2015-2016**

STATE	FY 2015	FY 2016	FY 15-16
Alabama	\$13,808,056	\$14,817,756	\$1,009,700
Alaska	\$1,768,111	\$2,007,884	\$239,773
Arizona	\$7,137,007	\$5,548,161	-\$1,588,846
Arkansas	\$2,891,801	\$3,753,218	\$861,417
California	\$31,617,621	\$38,803,207	\$2,185,586
Colorado	\$7,532,793	\$7,628,408	\$95,615
Connecticut	\$7,551,043	\$7,429,721	-\$121,322
Delaware	\$830,395	\$454,356	-\$376,039
District of Columbia	\$6,864,882	\$5,211,216	-\$1,653,666
Florida	\$16,052,445	\$15,884,646	-\$167,799
Georgia	\$12,509,834	\$12,564,006	\$54,172
Guam	\$310,650	\$316,314	\$5,664
Hawaii	\$5,365,345	\$4,808,639	-\$556,706
Idaho	\$1,039,380	\$1,162,875	\$123,495
Illinois	\$15,738,149	\$17,273,094	\$1,534,945
Indiana	\$6,813,286	\$7,217,346	\$404,060
Iowa	\$3,327,809	\$3,134,485	-\$193,324
Kansas	\$2,432,352	\$1,556,993	-\$875,359
Kentucky	\$6,992,365	\$6,786,994	-\$205,371
Louisiana	\$9,756,649	\$7,707,054	-\$2,049,595
Maine	\$1,614,039	\$2,242,903	\$628,864
Maryland	\$5,932,052	\$4,584,268	-\$1,347,784
Massachusetts	\$11,396,881	\$14,323,257	\$2,926,376
Michigan	\$10,624,249	\$10,986,797	\$362,548
Minnesota	\$2,648,518	\$3,666,218	\$1,017,700
Mississippi	\$3,269,762	\$3,309,918	\$40,156
Missouri	\$8,751,676	\$9,045,578	\$293,902
Montana	\$3,376,085	\$3,647,741	\$271,656
Nebraska	\$3,522,135	\$3,505,196	-\$16,939
Nevada	\$2,080,627	\$1,797,295	-\$283,332
New Hampshire	\$2,264,814	\$3,082,102	\$817,288
New Jersey	\$7,668,418	\$6,974,934	-\$693,484
New Mexico	\$3,382,640	\$2,982,164	-\$400,476
New York	\$26,609,601	\$29,288,118	\$2,678,517
North Carolina	\$16,744,959	\$18,224,434	\$1,479,475
North Dakota	\$1,864,954	\$3,306,572	\$1,441,618
Ohio	\$13,226,696	\$10,741,857	-\$2,484,839
Oklahoma	\$771,869	\$691,299	-\$80,570
Oregon	\$3,214,840	\$3,092,869	-\$121,971
Pennsylvania	\$16,430,389	\$17,797,478	\$1,367,089
Puerto Rico	\$6,292,494	\$4,735,787	-\$1,556,707
Rhode Island	\$1,798,171	\$2,219,942	\$421,771
South Carolina	\$3,802,945	\$5,029,726	\$1,226,781
South Dakota	\$2,292,658	\$1,811,341	-\$481,317
Tennessee	\$16,323,747	\$18,268,039	\$1,944,292
Texas	\$21,428,484	\$24,785,533	\$3,357,049
Utah	\$2,577,505	\$2,326,553	-\$250,952
Vermont	\$1,147,225	\$985,868	-\$161,357
Virginia	\$10,032,792	\$10,719,062	\$686,270
Washington	\$8,525,760	\$9,030,496	\$504,736
West Virginia	\$2,325,922	\$3,259,813	\$933,891
Wisconsin	\$5,976,969	\$7,172,115	\$1,195,146
Wyoming	\$849,988	\$842,821	-\$7,167
<b>Total</b>	<b>\$389,109,827</b>	<b>\$403,443,497</b>	<b>\$14,333,670</b>

Source: HRSA, Bureau of Health Professions, FY 2016

## Members of the Health Professions and Nursing Education Coalition

Academic Pediatric Association  
 Alliance for Academic Internal Medicine  
 American Academy of Family Physicians  
 American Academy of PAs  
 American Academy of Pediatric Dentistry  
 American Academy of Pediatrics  
 American Association for Dental Research  
 American Association of Colleges of Nursing  
 American Association of Colleges of Osteopathic Medicine  
 American Association of Colleges of Pharmacy  
 American Association of Colleges of Podiatric Medicine  
 American Association of Nurse Practitioners  
 American College of Osteopathic Internists  
 American College of Physicians  
 American College of Preventive Medicine  
 American Dental Association  
 American Dental Education Association  
 American Dental Hygienists' Association  
 American Geriatrics Society  
 American Music Therapy Association  
 American Nurses Association  
 American Occupational Therapy Association  
 American Organization of Nurse Executives  
 American Pediatric Society  
 American Psychiatric Association  
 American Psychological Association  
 American Public Health Association  
 American Society for Clinical Laboratory Science  
 American Society for Clinical Pathology  
 Association for Prevention Teaching and Research  
 Association of Academic Health Centers  
 Association of American Medical Colleges  
 Association of American Veterinary Medical Colleges  
 Association of Chiropractic Colleges  
 Association of Departments of Family Medicine  
 Association of Family Medicine Residency Directors  
 Association of Medical School Pediatric Department Chairs  
 Association of Minority Health Professions  
 Association of Public and Land-grant Universities  
 Association of Schools of Allied Health Professions  
 Association of Women's Health, Obstetric and Neonatal Nurses  
 Council on Social Work Education  
 Eldercare Workforce Alliance  
 Emergency Nurses Association  
 Hispanic-Serving Health Professions Schools  
 HIV Medicine Association  
 International Certification & Reciprocity Consortium  
 National AHEC Organization  
 National Association for Geriatric Education  
 National Association of Clinical Nurse Specialists  
 National Association of Community Health Centers  
 National Association of Pediatric Nurse Practitioners  
 National Athletic Trainer's Association  
 National Council for Diversity in the Health Professions  
 National Council of Asian Pacific Islander Physicians  
 National Hispanic Medical Association  
 National League for Nursing  
 National Organization of Nurse Practitioner Faculties  
 North American Primary Care Research Group  
 Oncology Nursing Society  
 Pediatric Policy Council  
 Physician Assistant Education Association  
 Society for Pediatric Research  
 Society of General Internal Medicine  
 Society of Teachers of Family Medicine

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September 14, 2017

The Honorable Michael C. Burgess, M.D.  
Chairman  
Committee on Energy and Commerce  
Subcommittee on Health  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Chairman Burgess:

Thank you for your commitment to supporting our nation's healthcare workforce. As the Subcommittee prepares to hold a hearing on this important topic, the Healthcare Leadership Council (HLC) welcomes the opportunity to share our thoughts with you.

HLC is a coalition of chief executives from all disciplines within American healthcare. Our members – the nation's leading hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, pharmacies, post-acute care providers, and information technology companies – are committed to advancing a consumer-centered healthcare system that values innovation, accessibility, and affordability.

The United States requires a strong and stable healthcare workforce. A growing and aging population, expanded health insurance coverage, and initiatives to improve health outcomes have all led to rising patient demand for healthcare services. To meet this demand, there needs to be a trained and highly skilled workforce that can assist consumers in receiving the care they need to maintain and improve their health. This workforce should feature the use of interdisciplinary healthcare teams where physicians and nonphysician providers work together to improve patient care. HLC asks the Subcommittee to continue to support the below programs under the Public Health Service Act that train these professionals and direct them to serve in the communities that need them the most.

National Health Service Corps

The National Health Service Corps (NHSC) offers loan repayment assistance to healthcare providers who practice in underserved areas. More than 10,000 primary care medical, dental, and mental and behavioral health practitioners are currently participating in the NHSC, and more than 10 million people rely on one of these providers for their care. Additionally, the NHSC serves as an effective and efficient

recruiting tool, since many providers continue to practice in underserved areas after they fulfill their NHSC commitment.

Teaching Health Center Graduate Medical Education

Graduate Medical Education (GME) is critical to training our nation's physicians and ensuring that patients have access to quality care. The Teaching Health Center GME (THCGME) program focuses on training doctors in community-based primary care settings such as in Federally Qualified Health Centers (FQHCs). FQHCs bridge coverage and access gaps for vulnerable Americans, and the THCGME program provides care while also educating physicians on how best to treat this population.

Title VII and Title VIII

The Title VII and Title VIII programs aim to improve the supply, diversity, and distribution of the healthcare workforce. Through loans and scholarships to students, as well as grants and contracts to academic institutions and nonprofit organizations, the programs support the training of our country's health professionals.

For example, the Title VII diversity programs increase racial and ethnic minority representation in the health professions by providing academic enrichment and career development. The Title VII primary care and oral health programs expand the primary care workforce, and community-based linkage initiatives, like the Area Health Education Centers, facilitate community-based training. Together, these programs play an important role in the healthcare safety net by ensuring a supply of well-trained health professionals who are more likely to serve in rural and underserved areas and FQHCs.

The Title VIII programs are committed to providing support to nurses and nursing students. They are the largest source of federal funding for nursing education, and help to recruit and retain nurses to serve in rural and underserved areas. This assistance is greatly needed as our country's nursing shortage continues to grow and as nurses take on an expanded role in the healthcare team.

Thank you again for your support of the healthcare workforce. HLC looks forward to continuing to work with you on this important issue. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435.

Sincerely,



Mary R. Grealy  
President

**Testimony Submitted by:**

**Kathryn Hyer, Ph.D., M.P.P.**  
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**College of Nursing/School of Aging Studies**  
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**<http://agingstudies.cbcs.usf.edu/faculty/khyer.cfm>**

*Submitted to the:*  
*House Energy and Commerce Committee*  
*Subcommittee on Health*  
*For the hearing: "Supporting Tomorrow's Health Providers: Examining*  
*Workforce Programs Under the Public Health Service Act"*  
*September 14, 2017*

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As the president of the National Association for Geriatric Education (NAGE), I am pleased to submit this statement for the record supporting your work to reauthorize Title VII of the Public Health Service Act and particularly the Geriatrics Workforce Enhancement Program (GWEP) administered by the Health Resources and Services Administration (HRSA). I want to thank you Chairman Burgess and Ranking Member Green for moving forward with this hearing and this needed reauthorization. Thank you also, Chairman Burgess, for working with us on the geriatrics provisions in your bill, H.R. 3728, the "Educating Medical Professionals and Optimizing Workforce Efficiency and Readiness Act of 2017" or "EMPOWER Act. We owe a special thanks to Representative Schakowsky for drafting a stand along bill, the "Geriatrics Workforce and Caregiver Enhancement Act" (H.R. 3713) that authorizes the GWEP and also the Geriatrics Academic Career Awards (GACA) program, and increases funding for both programs and

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addresses rural and underserved areas, as well. We also appreciate the support of original cosponsors Representatives Matsui and McKinley.

Finally, let me congratulate one of your witnesses today, Dr. Janice A. Knebl, who directs the GWEP in your home state at the University of North Texas Health Science Center called the “Workforce Enhancement in Healthy Aging and Independent Living,” or “WE HAIL” program. NAGE is proud to have the Texas GWEP as a member and Dr. Knebl as a well-respected colleague.

In FY 2015, HRSA combined the geriatric education programs in Titles VII and VIII of the Public Health Service Act, including the Geriatric Academic Career Award, as well as portions of the Alzheimer’s Disease Prevention, Education, and Outreach Program to establish the Geriatrics Workforce Enhancement Program (GWEP). The GWEP is now the only federal program designed to develop a health care workforce specifically trained to care for the complex health needs of older Americans with the most effective and efficient methods, providing higher quality care and saving valuable resources by reducing unnecessary costs.

Proven results from activities under the GWEP and its predecessor programs include an important increase in the number of teaching faculty with geriatrics expertise in a variety of disciplines, plus thousands of health care providers and family caregivers better prepared to support older Americans with complex chronic conditions. Therefore, NAGE requests an authorization of \$51 million for these programs, which are critical to cost-effective care for the burgeoning elderly population. In 2015, HRSA provided funding for 44 GWEPs. GWEPs were funded at \$38.7 million in FY 2017. Our funding request would allow for approximately eight additional GWEPs in rural and underserved communities. In this request, we propose to reestablish the Geriatrics Academic Career Award (GACA) by providing \$5.2 million each year to fund GACAs across the

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country, a critical program to develop the academic leaders needed to continue to train health care students.

We recognize that the Subcommittee faces difficult decisions in a constrained budget environment, but we believe that a continued commitment to geriatric education programs that help the nation's health workforce better serve the older and disabled population must be a top priority. Our nation's health care educational system has not trained enough health care professionals with the knowledge, skills, and training in geriatrics that is needed to care for America's growing population of older adults and to support their family caregivers. Although currently there are only 44 GWEP sites in 29 states, we can multiply the GWEPs impact with a modest increase in funding.

The nation faces a shortage of geriatric health professionals and direct service workers. There simply are not enough geriatricians, geriatric nurse practitioners and other health professionals with the knowledge, skills, and training in geriatrics needed to care for our rapidly growing population of older adults and to support their family caregivers. Too often, the result is expensive walk-in care. We believe that support for GWEP-based geriatric education supports your important work to establish a sustainable future for the nation's health care and Social Security systems by ensuring that (a) health care specialists trained in geriatric care do not become a rare and expensive resource and (b) direct service workers and family caregivers are prepared to support a lower cost, independent lifestyle for community residing elders.

In FY 2016, GWEPs continued the impressive work of the GECs:

- Approximately half of the GWEPs provide education for areas that are more than 50% rural and a quarter focus on areas that are 25-49% rural.

- In the 2015-2016 academic year, GWEPs provided 1,650 different continuing education courses to approximately 94,000 health care professionals and students from disciplines such as medicine, nursing, allied health, health services administration, social work, and psychology.
- They collaborated with acute care, long-term care and community-based service providers on Evidence-Based Practice Programs designed to reduce rates and improve outcomes of care relating to delirium, depression, falls, pain, and diabetes in older adults.
- At USF and a number of other GWEPs, health professions students and residents are rotating through Federally Qualified Health Centers that are accredited as Patient Centered Medical Homes. These students are learning to provide integrated geriatrics primary care to older adults and are our best hope of meeting the urgent need for primary care providers.
- GWEPs provided 200-hour interprofessional Faculty Development Programs to prepare faculty to teach geriatrics and interprofessional team-based care.
- Further, GWEPs created opportunities for healthcare providers in underserved, rural and remote areas of the country to learn from and consult with top experts in geriatric care through Interactive Televideo (ITV), interactive teleconsults, and synchronous webcasts, and made available thousands of hours of online geriatric education programs that healthcare professionals can access 24-hours per day.

In FY 2016, new GWEP awardees received expanded authorization to provide to family caregivers and direct service workers with instruction on prominent issues in the care of older adults, such as Alzheimer's Disease and other dementias, palliative care, self-care, chronic disease self-management, falls, and maintaining independence, among others. The expanded GWEP mission coincided with the publication of a 2016 National Academies of Sciences, Engineering,

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and Medicine (NASEM) report *Families Caring for an Aging America*. The report acknowledges that training and engagement must go beyond the health care professions team and directly support the family caregiver so that a greater number of older adults will be able to stay in their communities longer and with better care thereby saving valuable resources in the health care system and improving health outcomes. GWEPs are doing just that. HRSA estimates that 52,352 paid and family caregivers will participate in GWEP training programs over the three-year grant period. For example, the GWEP at Virginia Commonwealth University is partnering with several Area Agencies on Aging, the local Alzheimer's Association, and dementia-focused community care agencies to train staff and family caregivers. The NASEM report questioned whether the GWEP had the necessary resources to succeed, stating "With current funding, the GWEP caregiver curriculum...reaches only a small fraction of the relevant providers. Work to date falls far short of a systemic and comprehensive effort..."

In summary, GWEPs have improved the supply, distribution, diversity, capabilities, and quality of health care professionals who care for our nation's growing older adult population, including the underserved and minorities. They train physicians, nurses, social workers, dentists, mental health professionals and caregivers. Some of the professionals trained through GWEPs will become academicians in geriatric medicine, dentistry, and psychiatry, thereby giving additional cohorts of professionals the skills they need to properly serve older Americans. Furthermore, GWEPs create and deliver community-based programs that provide patients, families, and caregivers with the skills to care for older adults and improve health outcomes, including Alzheimer's disease education. In some states, the GWEP is offering training to first responders to keep elders safe in their communities.

We thank you for your past support and need your continued support for geriatric programs to adequately prepare the next generation of health professionals and care providers for the rapidly changing and emerging needs of the growing and aging population.

On behalf of NAGE and those who have benefitted in Florida and from our colleagues around the country, thank you for your thoughtful consideration of our request for reauthorizing the GWEPs and GACAs. NAGE is a non-profit membership organization representing GWEPs, Geriatric Education Centers, Centers on Aging, and other programs that provide education and training to health care professionals and others in geriatrics and gerontology.

**Statement for the Record  
Supporting Tomorrow's Health Providers  
House Committee on Energy and Commerce, Subcommittee on Health**

**Jeff Denham**

**September 14, 2017**

Chairman Burgess, Ranking Member Green, Members of the Committee. This hearing provides an opportunity to highlight an issue I am passionate about and have a special interest in, as it is of particular importance to California's Central Valley and the community I represent. I thank you for the opportunity to come before the committee.

We have several important healthcare reauthorization deadlines that Congress must act on immediately. One of these deadlines, which I have been working tirelessly to raise awareness about, is the expiration of the Teaching Health Center Graduate Medical Education (THCGME) program. This program was created in 2010 to address the shortage of primary care physicians in rural and medically underserved communities. As such, it is a critical source of training for physicians in rural and underserved areas, and essential to addressing primary care shortages across the nation. THCGME must be re-authorized and expanded at robust levels before September 30, 2017. Otherwise, the program will be unable to continue to serve its vital purpose of training primary care physicians in the highest-need areas.

I have been working with the Committee, and in particular Rep. Cathy McMorris Rodgers, to introduce legislation that reauthorizes THCGME for three years and at higher funding levels than were reauthorized in the most recent two-year extension (MACRA, P.L. 114-10). This increased funding and longer extension are necessary for the program to function as it was intended and meet our primary care physician needs. That is why I am an original cosponsor of H.R. 3394, the Teaching Health Centers Graduate Medical Education Extension Act of 2017, which currently has 66 bipartisan cosponsors.

Furthermore, I introduced my own bill to expand this program. H.R. 3451, the Creating Additional Residency Expansion (CARE) Act, provides more expansion funding, specifically creates new centers for residency programs, and allows existing programs to expand. This will allow more Teaching Health Centers to start training residents. My community needs this bill to become law. Expanding the THCGME program is a critical piece to addressing the overall physician and specialty care shortage in California's Central Valley.

With the deadline to reauthorize fast approaching, I urge Members of the Committee and House Leadership to act quickly to extend the THCGME program so that it can continue to meet the needs of our nation's underserved communities.

**Statement for the Record  
to the  
House Committee on Energy and Commerce  
Subcommittee on Health**

**Supporting Tomorrow's Health Providers:  
Examining Workforce Programs Under the  
Public Health Service Act**

**Bruce Weiner, MS, CRNA  
President, American Association of Nurse Anesthetists**

**14 September 2017**

### **Introduction**

Chairman Burgess, Ranking Member Green, and Members of the Committee, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthetists (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 50,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 43 million anesthetics to patients each year in the United States. CRNAs provide acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

The House Energy and Commerce Subcommittee on Health's hearing, entitled "Supporting Tomorrow's Health Providers: Examining Workforce Programs Under the Public Health Service Act" comes at an important time. Title VIII programs play a critical role in ensuring that there are enough nurses to meet the demand of an ever growing healthcare system in America. They also guarantee that the nursing workforce is available to treat Americans in the most underserved areas of our country. The President's proposed budget for FY18 proposed deep and painful cuts to these programs. The House Appropriations Committee's proposed cuts of \$18.27 million and the consolidation of the Title VIII programs would also have a devastating impact on nursing education, the workforce, and the patients those nurses serve.

### **Future Nursing Workforce Needs**

The growth of the healthcare industry coupled with a growing and aging population is creating increased demand for nurses across the country. A recent U.S. Department of Health and Human Services (HHS) report looking at the supply and demand projections for the nursing workforce through 2030 projects a shortage in nurses in states across the U.S. with some states facing a possible deficit exceeding 10,000 nurses by 2030<sup>1</sup>. The nursing shortage is exacerbated by an increasingly aging nursing workforce population, which is more prone to an increase of retirements in the coming years.

The same HHS study gives a stark warning about the uneven nature of shortfalls that will exist in the nursing workforce in the coming years, stating "national estimates mask large geographic disparities in adequacy of supply." Title VIII funding plays a crucial role in ensuring that disparities in access to healthcare are addressed and remedied. Title VIII funding for Nursing Workforce Development enables many students to use their nursing education to move to and serve in rural and medically underserved areas. CRNAs in particular play a pivotal role in

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<sup>1</sup> US Dept. of Health and Human Services, Health Resources and Services Administration, "Supply and Demand Projections of the Nursing Workforce: 2014-2030," (2017)  
[https://bhwh.hrsa.gov/sites/default/files/bhwnchwa/projections/NCHWA\\_HRSA\\_Nursing\\_Report.pdf?utm\\_campaign=eneews08172017&utm\\_medium=email&utm\\_source=govdelivery](https://bhwh.hrsa.gov/sites/default/files/bhwnchwa/projections/NCHWA_HRSA_Nursing_Report.pdf?utm_campaign=eneews08172017&utm_medium=email&utm_source=govdelivery)

ensuring access to care for those living in rural and underserved areas. In FY 2011, the Advanced Education Nursing Traineeship Program graduated 7,744 nursing students, of which 97% went on to medically underserved areas.

**Ensuring Access to Healthcare**

Title VIII provides funding to a number of very important nursing workforce development programs, including Advanced Nursing Education, which contains the Nurse Anesthesia Traineeship funding, as well as the National Nurse Service Corps which incentivize nurses to practice in underserved areas. 73% of all CRNA programs report applying for federal funding under Title VIII to help recruit and train nurses. Of these requests, one hundred percent of programs report requesting Nurse Anesthetists Trainee Program funding, making it all the more critical that this these funds continue to be available.

In many rural and underserved counties across America, CRNAs are the only anesthesia providers. Maintaining the availability of these services and ensuring a continuing flow of new CRNAs and nurses to our most vulnerable and underserved communities is critically important.

**Conclusion**

Title VIII funding has been an integral part of our healthcare system for over 50 years. We encourage the continuation and expansion of these programs as an essential tool to ensure an adequate nursing workforce. CRNAs and many of our nursing community colleagues work in our nations most underserved areas, and Title VIII funding helps to make those services a reality. While we understand that budget decisions are never easy, and Congress has tough choices to make to work towards balancing the budget, we urge you to help ensure America's health is a top priority by preserving funding for all of the Title VIII Nursing Workforce Development Programs, and supporting the Title VIII Nursing Workforce Reauthorization Act of 2017.