S. HRG. 117–188

A DIRE SHORTAGE AND GETTING WORSE: SOLVING THE CRISIS IN THE HEALTH CARE WORKFORCE

HEARING

BEFORE THE

SUBCOMMITTEE ON PRIMARY HEALTH AND RETIREMENT SECURITY

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

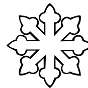
FIRST SESSION

ON

EXAMINING SOLVING THE CRISIS IN THE HEALTH CARE WORKFORCE

MAY 20, 2021

Printed for the use of the Committee on Health, Education, Labor, and Pensions



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46–768 PDF WASHINGTON : 2022

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A DIRE SHORTAGE AND GETTING WORSE: SOLVING THE CRISIS IN THE HEALTH CARE WORKFORCE

Thursday, May 20, 2021

U.S. SENATE,
SUBCOMMITTEE ON PRIMARY HEALTH AND RETIREMENT SECURITY,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:37 a.m., in room 430, Dirksen Senate Office Building, Hon. Bernie Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Casey, Baldwin, Murphy, Kaine, Hassan, Rosen, Collins, Marshall, Cassidy, Braun, and Burr.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIRMAN. Thank you again for being here. Let me thank Senator Collins and her staff for helping us put together this hearing on an issue that I consider to be enormously important.

Let me thank our panelists, two of whom are here with us, and two of them, we see you clearly through modern technology. Thank you all for being here. We look forward to your testimony.

It is no secret that our Country faces many healthcare crises. Too many of our people are uninsured or underinsured. We pay, by far, the highest cost for healthcare of any major country on earth. The costs of prescription drugs are off the wall, and many people cannot afford that.

In the midst of all of that, for whatever reason, and I think we will delve into that today, our Nation, the richest country in the history of the world, simply does not have enough doctors, nurses, dentists, and other medical professionals. And why that is so, I am not sure, but I hope we can learn something about that.

But, the result is that, according to the Association of American Medical Colleges, by 2033, the United States will have a shortage of up to 139,000 physicians. And primary care physicians, we already have a crisis in terms of access to primary care for many people throughout this Country. Primary care alone will be facing a shortage of up to 55,000 physicians.

By the way, as we all know, this does not take into account what COVID–19 has done to the health profession. Anecdotally, I have heard from hospitals, many nurses just exhausted, leaving the profession. Hundreds and hundreds of medical professionals have died

as heroes and heroines fighting COVID–19 and protecting the American people. But, no question that healthcare professionals have taken a very big hit as a result of COVID–19.

The Federal Government, as we all know, plays an enormously important role in how many physicians we have because, through the Medicare Graduate Medical Education program, we fund the vast majority of residency slots in this Country. In 2015, the most recent data available indicates we spent about $16 billion on Graduate Medical Education, providing for roughly 31,000 residency slots a year. Last year, Congress added 1,000 additional slots. That is a step forward, but it is nowhere near enough, I think, to address the crisis that we face.

Very importantly, I think—maybe we can discuss this a little bit today—in addition to expanding those slots, Congress did expand the Teaching Health Center Graduate Medical Education program. That is a much smaller program than what Medicare does, but it focuses directly on the needs to get doctors and others into medically underserved areas.

Very shortly, I will be introducing legislation to address the multiple crises we face, and I just want to very briefly touch on what that legislation will look like.

No. 1—and I hope some of our panelists will speak to this issue, as well. I learned—Senator Collins, I learned recently, calling up New England medical schools, as a matter of fact, that the number of medical students per class is a lot smaller than you would think. For example, if you look at Dartmouth or UVM Medical School, we are talking about 90 or 100 students per class.

Now, I know that it is an intensive effort to train a doctor, but I would think maybe we would want to explore whether we can produce more doctors through larger medical school classes. Ninety or 100 per class seems a little bit small to me.

Clearly, we also—and there is I think widespread, bipartisan support for the understanding that we need to increase payments for direct graduate medical education. The legislation that I will be introducing picks up on work being done by Senators Schumer, Boozman, Menendez, and others, would authorize 14,000 new Medicare-supported medical residency programs—positions over 7 years. Two thousand a year in addition to what we have.

Further, and very importantly, what our legislation would do is to establish new criteria for how the new GME training positions would be allotted to qualifying hospitals with a minimum of 50 percent of new slots going toward primary care.

In other words, the crisis we face is not only a shortage of doctors; it is where those doctors are. They are not in rural Maine, they are not in rural Kansas, and they are not in rural Vermont. We have a hard time attracting them. We do not necessarily need more dermatologists on Park Avenue in New York City. I do not know if we do or not. Probably not. But, we do need them in rural areas all over the Country, and we have to make sure that Medicare understands that.

Another issue that maybe panelists can pick up on, I think we all know that residents are really underpaid. You go 4 years for medical school, you do a year of internship, and the average pay

for a resident is $63,000 a year. So, you have medical debit, right? You have got a few hundred thousand dollars in debt.

Senator MARSHALL. That is triple since I was in medical school.

The CHAIRMAN. Oh, is that right? But costs have gone up a little bit, too. But, if you are living in a big city——

You were making 20,000?

Senator MARSHALL. Twenty-five.

The CHAIRMAN. Working long hours, I expect.

Senator MARSHALL.

[Inaudible]

The CHAIRMAN. All right. Well, that is the whole—that is another story. But, here is one thing that gets to me. While the average resident earns 63,000, which I think is inadequate, primary care residents earn 58,000. So, the discrimination starts right there in the residency program, not to mention what salaries are paid. It does not make a whole lot of sense to me. I think we should increase it.

Our bill will significantly increase funding for the Teaching Health Center Graduate Medical Education program. We have made progress, I am happy to say. And in the American Rescue Plan, some of us worked very hard to double funding for community health centers and triple funding for the National Health Service Corps, and I think we have to continue that effort.

That says to somebody, if you are going to be graduating medical school $300,000 in debt, you are not going to rural Maine, frankly, all right, and we are going to help you pay off that debt if you do go to rural Maine or rural Vermont or rural anyplace.

That is some of my thoughts, and I look forward to this serious discussion.

Senator Collins.

OPENING STATEMENT OF SENATOR COLLINS

Senator COLLINS. Mr. Chairman, thank you so much for holding this very important hearing today.

Our Country is tremendously grateful to the medical community for its colossal efforts during the past year. Many healthcare professionals are exhausted by the physical and emotional toll of caring for COVID patients, and that burden, I think it is important to note, did not fall solely on the medical workers themselves, but also on many members of their families, who have had to cope with separation, long hours, health risks, and stress from closed schools.

In many areas of the Country, there is a fierce competition for nurses, nursing assistants, other medical professionals, and physicians. And as the Chairman has mentioned, for those of us who represent rural states, the competition is particularly stiff. The situation is particularly acute in our nursing homes where low Medicaid reimbursement levels often translate into low wages.

This workforce shortage has been with us long before COVID. It is frustrating to watch year after year. Tens of thousands of qualified nursing school applicants are turned away each year due to a lack of a sufficient number of faculty and a shortage of clinical sites.

We need to break that cycle. At a time when our Nation is aging, and as more and more people are living longer with increasing health needs, these shortages have serious consequences.

Growing up in northern Maine, I know the vital role that nurse practitioners and physician assistants, in particular, play in our healthcare system in rural areas. That is why one of my highest priorities in the Senate has always been to increase funding for workforce programs.

The bipartisan work that the HELP Committee has accomplished to support healthcare workforce training has made a difference. Both the Title VII health professions training and the Title VIII nursing workforce programs were reauthorized by the CARES Act last year. We need to make sure that they are sufficiently funded.

While many health professions desperately need to attract more students, several disciplines stand out. One is addiction medicine, a theme that we heard in the excellent Committee hearing on mental health last month. In March, researchers from Stamford University wrote in the Journal of the American Medical Association Psychiatry that opioid overdoses likely reached a record high in 2020 because COVID has exacerbated stress and social isolation, and interfered with opioid treatment, addiction treatment.

That is certainly true in the State of Maine. Last year, a record 502 Mainers died from overdoses, a tragic toll that exceeded even the deaths caused by COVID–19. Senator Hassan and I recently reintroduced the Opioid Workforce Act, legislation that would create 1,000 new medical residency positions focused on addiction medicine at teaching hospitals. And we are grateful to the American Association of Medical Colleges, which is represented here today, for its endorsement of our legislation.

Another area of unmet need is geriatric medicine. In Maine, there are more than a quarter of a million Mainers who are over the age of 65, and we only have 40 geriatricians. There is an acute need to quickly train more geriatric health professionals and direct service workers to meet the growing demand. And I agree with the Chairman that we need to provide incentives to get them into rural areas through partial forgiveness of their medical school debts.

Last year, the CARES Act included my legislation with Senator Casey to formally establish and authorize funding for the Geriatrics Workforce Enhancement program, the only Federal program designed to increase the number of healthcare professionals with the training to care for older people. Today, there are 48 Geriatrics Workforce Enhancement programs in 35 states, including a terrific program at the University of New England. And I am very pleased that UNE's president, Dr. James Herbert, is testifying today.

Increasing the overall number of healthcare professionals is just part of the shortage equation. Another, as I have mentioned, is making sure that they practice in communities across the Country, including in rural areas. And one way we can do that is expanding where medical residents train.

The December Omnibus Appropriations bill contained a three-year authorization of Teaching Health Centers Graduate Medical Education program, a program that I have championed with Senator Tester. Teaching Health Centers train medical residents in community-based settings, including low-income, underserved rural

and urban neighborhoods. Why does this matter? It matters because we know that people are much more likely to stay where they train. And if we can get people out to underserved areas to do their residencies, they are much more likely to practice there.

I know that I could go on and on. Let me just end by saying that I think telehealth is another avenue to address the mismatch in supply and demand, particularly in behavioral health. The determination and compassion that leads students to choose a career in healthcare are needed now more than ever.

I very much appreciate this hearing, and I look forward to hearing from our excellent witnesses.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you, Senator Collins. This does appear to be an issue where there may be a bipartisan approach to a very serious problem.

We have a great panel, and let me begin with Dr. David Skorton. Dr. Skorton is the President and CEO of the Association of American Medical Colleges, which represents the Nation's medical schools, teaching hospitals, and health systems, and academic societies.

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

STATEMENT OF DAVID J. SKORTON, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, DC

Dr. SKORTON. Thank you, Chairman Sanders and Ranking Member Collins for holding this hearing. I am honored to be included among this distinguished panel, and I look forward to discussing challenges related to the physician workforce.

I am proud to represent academic physicians who daily teach our next generation of doctors, perform life-saving research, and care for some of the Nation's most vulnerable and complex patients. And just one example: Years of federally funded research led to the scientific underpinnings for the mRNA COVID–19 vaccines that are now saving so many lives.

Addressing the Nation's physician workforce shortages and related challenges will require a multi-pronged, public-private approach, including innovation, such as team-based care and better use of technology, in addition to increasing the overall number of physicians.

Our annual workforce report continues to project that demand for physicians will outstrip supply, leading, as the Chairman mentioned, to a projected total physician shortage between 54,100 and 139,000 physicians by 2033, including both primary care and non-primary care specialties. The range reflects a variety of scenarios that may affect the exact future needs, including population shifts, delivery pattern changes, and increased use of physician assistants and advanced practice registered nurses.

The fact is, we have a current and projected shortage of physicians that is ominous and requires our best efforts and your support. Though our report focuses on physicians, I underscore the major contributions of other health professionals.

Not surprisingly, the Nation's growing aging population continues to be the main driver of increasing demand for physicians

over the next 15 years, on top of current stressors, including behavioral health needs, substance use disorders, and, of course, COVID–19.

Our physician workforce also is aging, and a large proportion are nearing the traditional age of retirement, thus affecting supply, as do physician well-being and our work hour patterns.

It can take more than a decade for a physician to complete medical school and residency training, also known as Graduate Medical Education, or GME. This post-graduate training is required to become licensed for independent practice. U.S. medical schools have increased enrollment by 35 percent and opened 30 new schools since 2002. However, this growth will not increase the workforce without increasing residency training slots, which have not increased enough to address the shortage.

The AAMC has endorsed the Resident Physician Shortage Reduction Act that would raise the cap on Medicare's support for GME and help train approximately 3,500 more physicians each year. We also believe that Children's Hospital and Teaching Health Center GME, as you heard, are critical programs complementary to Medicare GME.

We must also increase private and public efforts to help shape the primary care workforce, increase community-based training and rural practice, and improve workforce diversity. Many successful programs already exist at the Health Resources and Services Administration, but in our view, they need additional investment to increase their scope and reach.

The AAMC convenes the Health Professions and Nursing Education Coalition, which calls for a doubling of HRSA Title VII funding in Fiscal Year 2022.

Furthermore, public service scholarship and loan repayment programs can be effective, targeted incentives for recruiting physicians to help specific vulnerable populations. And I thank you, Senator Sanders, for championing the recent historic investment in the National Health Service Corps.

Intervention earlier in the education pipeline is necessary to increase the number of students from rural, underserved, low income, minorities, and other disadvantaged backgrounds. The programs I have already mentioned will be more successful if we recruit students who are more likely to practice primary care in underserved communities, including those from diverse racial and ethnic backgrounds.

I am very concerned there has been minimal progress in increasing physician workforce diversity. In 1980, when I began my first faculty appointment, Black men made up 3.4 percent of entering U.S. medical students. Today, Black males are 3.6 percent of all U.S. med students. It is inexcusable that we have not moved the numbers in 40 years.

Beyond the efforts of our Nation's medical schools, I would encourage this Committee to speak with families and students from kindergarten through college to better identify and address barriers so that we can work together to expose young people to science, particularly those who are currently underrepresented in medicine.

I thank you again for the opportunity to testify. We stand ready to work with this Committee, with Congress, and with my distinguished colleagues on this panel to improve the Nation's healthcare workforce.

Thank you very much.

[The prepared statement of Dr. Skorton follows:]

PREPARED STATEMENT OF DAVID SKORTON

I am pleased to testify on behalf of the AAMC (Association of American Medical Colleges) on physician workforce challenges and primary care access across the United States, including projected physician workforce shortages as well as policies and programs that seek to improve and diversify our health care workforce and ensure we have enough providers in underserved areas.

The AAMC is a not-for-profit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. [1]

KEY FINDINGS FROM THE ANNUAL AAMC PHYSICIAN WORKFORCE PROJECTIONS

Since 2008, the AAMC has produced reports of national physician workforce projections, including annual reports prepared by independent experts since 2015 leading up to *The Complexities of Physician Supply and Demand: Projections from 2018–2033*. We expect to release a 2021 update to this report in June.

The report's microsimulation model projects the future supply of physicians based on the number and characteristics of the current physician workforce, new physicians trained each year, hours-worked patterns, and retirement patterns. The model projects demand for physicians based on current patterns of health care use, population growth and changing demographics, potential changes to delivery systems—including greater use of managed-care, retail clinics, and increased use of advanced practice registered nurses and physician assistants—and achieving certain population health goals to illustrate the potential impact of improved preventive care. The large projection ranges presented in the report and cited below are the result of comparing a multitude of scenarios and reflect the data challenges and uncertainties of projecting future workforce supply and demand.

AAMC continues to project that physician demand will grow faster than supply, leading to a projected total physician shortage between 54,100 and 139,000 physicians by 2033. We also project:

- A shortage of primary care physicians between 21,400 and 55,200 by 2033.
- A shortage of non-primary care specialty physicians between 33,700 and 86,700 by 2033, including:
  - Between 17,100 and 28,700 for surgical specialties.
  - Between 9,300 and 17,800 for medical specialties. Between 17,100 and 41,900 for the other specialties category.

Demographics—specifically, population growth and aging—continue to be the primary driver of increasing demand for physicians from 2018 to 2033. During this period, the U.S. population is projected to grow by 10.4 percent from about 327 million to 361 million. The U.S. population under age 18 is projected to grow by 3.9 percent, while the population aged 65 and over is projected to grow by 45.1 percent by 2033. Therefore, demand for physician specialties that predominantly care for older Americans will continue to increase. This projected increase in demand for physicians is on top of current stressors that we see driving demand

[1] For background on physician education and training, see AAMC's *The Road to Becoming a Doctor*.

today, such as increased behavioral health needs, substance use disorder, and of course, COVID–19.

On the supply side, a large portion of the physician workforce is nearing traditional retirement age, and supply projections are sensitive to the workforce decisions of older physicians. More than 2 of 5 currently active physicians will be 65 or older within the next decade. Shifts in retirement patterns over that time could have large implications for the supply of physicians to meet health care demands. Also, growing concerns about physician burnout suggest physicians may be more likely to accelerate, rather than delay, retirement.

While the AAMC annual report projects future shortages, the association also includes a separate "Health Care Utilization Equity" scenario that provides additional context to *current* physician shortage estimates. In 2018, the Health Resources and Services Administration (HRSA) estimated that the Nation requires about 14,900 more primary care practitioners and 6,894 mental health practitioners to eliminate all federally designated Health Professional Shortage Areas (HPSAs). The HPSA designation identifies an area, population, or facility experiencing a shortage of primary care or mental health care services, but does not consider non-primary care physician specialty shortages also projected by HRSA, such as cardiology,[2] neurology,[3] and orthopedic surgery.[4]

The "Health Care Utilization Equity" scenario finds that **if underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the US would need an additional 74,100 to 145,500 physicians just to meet *current* demand**. This analysis underscores the systematic differences in annual use of health care services by insured and uninsured individuals, individuals in urban and rural locations, and individuals of differing races and ethnicities. These estimates, which are separate from the 2033 shortage-projection ranges, help illuminate the magnitude of current barriers to care and provide an additional reference point when gauging the adequacy of physician workforce supply.

APPROACHES TO ADDRESSING OR EVEN SOLVING PHYSICIAN WORKFORCE SHORTAGES AND CHALLENGES

Addressing or solving the Nation's physician workforce shortages and challenges requires a multipronged private-public approach, including innovations such as team-based care and better use of technology in addition to increasing the overall number of physicians. Below are physician workforce policies, programs, and actions the AAMC, its member medical schools and teaching hospitals, our Federal partners, and the Nation can build on to improve access to health care for all and help address gaping health inequities.

Overall Physician Shortages

Over the last two decades, the worsening physician shortage has demonstrated the need to increase the number of physicians to help ensure access to care for people, including during the COVID–19 pandemic and into the future. Academic medicine has responded and, since 2002, the number of first-year students in medical schools has grown by nearly 35 percent as schools have expanded class sizes and 30 new schools have opened.[5] While medical schools continue to increase enrollment, this will not be sufficient. To be licensed to practice independently, graduate physicians must undergo further, graduate medical education (GME).

Currently, Medicare caps the number of GME positions it supports at each teaching hospital. One key element of addressing the physician shortage is increasing Medicare support for GME, which will help boost access to high-quality care, particularly for underserved populations in rural communities and urban areas that have been disproportionately affected by the pandemic.

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[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2016. Supply and Demand Projections for Internal Medicine Subspecialties: 2013-2025.

[3] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2017. Health Workforce Projections: Neurology Physicians and Physician Assistants.

[4] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2016. National and Regional Projections of Supply and Demand for Surgical Specialty Practitioners: 2013–2025.

[5] AAMC Medical School Enrollment Survey: 2019 Results, September 2020. *https://www.aamc.org/media/47726/download*.

A broad bipartisan coalition of Members of Congress worked together to provide 1,000 new Medicare-supported GME positions—the first increase of its kind in nearly 25 years—in the Consolidated Appropriations Act, 2021 (P.L. 116–260), which the AAMC estimates will add approximately 1,600 new physicians by 2033. This increase was an important initial investment, but more still needs to be done to help ensure everyone can access the primary and specialty care they need.

To meet this need, Senators Robert Menendez (D-NJ) and John Boozman (R-AR) and Majority Leader Charles Schumer (D-NY) introduced the *AAMC-endorsed bipartisan Resident Physician Shortage Reduction Act of 2021* (S. 834), which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for 7 years, for a total of 14,000 new slots. Much like the year-end package, these positions would be targeted to hospitals with diverse needs, including hospitals in rural areas, hospitals serving patients from federally designated HPSAs, hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps. The legislation has broad stakeholder support and has been *endorsed by over seventy members of the GME Advocacy Coalition representing the broad range of disciplines*. Many of these stakeholder groups also recommend the bill's inclusion in upcoming efforts to rebuild and improve the Nation's infrastructure.

The Opioid Workforce Act (S. 1483), introduced by Senators Maggie Hassan (D-NH) and Susan Collins (R-ME) would similarly increase the number of Medicare-supported GME positions, but would target those positions to increase the number of residents training in addiction medicine, addiction psychiatry, and pain medicine. As the Nation continues to fight the opioid epidemic, it is crucial that we increase access to physicians with focused expertise in treating substance use disorders.

GME programs administered by HRSA, including Children's Hospitals GME (CHGME), Teaching Health Center GME (THCGME), and the Rural Residency Program, help increase the number of residents training in children's hospitals, federally Qualified Health Centers (FQHC), and rural areas, respectively. The AAMC continues to urge Congress to increase annual appropriations for these GME programs in fiscal year 2022, including $485 million for CHGME. We also appreciate the $330 million in supplemental funding for THCGME included in the American Rescue Plan (P.L. 117–2).

Primary Care

While the country still faces primary care physician shortages, the AAMC is encouraged to see increases over the last several years in the number of residents matching to primary care residency programs, the number of primary care resident positions offered in the Match, and the percentage of primary care positions as a proportion of total matches.[6] The National Residency Matching Program (NRMP)[7] reports, "In 2020, primary care specialties offered record-high numbers of positions and had high position fill rates," and "Family Medicine has experienced position increases every year since 2009. In 2020, Family Medicine offered 4,662 positions and filled 4,313 (92.5 percent)."[8]

To help shape the physician workforce, and specifically primary care, the AAMC recommends doubling funding for the HRSA workforce development programs under Title VII and Title VIII of the Public Health Service Act. Under Title VII, the AAMC supports increased Federal funding for the HRSA Title VII Primary Care Training and Enhancement (PCTE) and Medical Student Education programs. PCTE supports training programs for physicians and physician assistants to encourage practice in primary care, promote leadership in health care transformation, and enhance teaching in community-based settings. In AY 2018–19, PCTE grantees trained over 13,000 individuals at nearly 1,000 sites, with 61 percent in medically underserved communities and 30 percent in rural areas.[9]

The HRSA Title VII Medical Student Education is a new program that supports the primary care pipeline by expanding training for medical students to become primary care clinicians, targeting institutions of higher education in states with the

[6] Results and Data: 2020 Main Residency Match, Table 9, All Applicants Matched to PGY–1 Positions by Specialty, 2016–2020, NRMP, May 2020.

[7] For additional background on NRMP and the Match see: *https://www.nrmp.org/intro-to-main-residency-match/*.

[8] Results and Data: 2020 Main Residency Match, NRMP, May 2020.

[9] Health Resources and Services Administration. Department of Health and Human Services Fiscal Year 2021 Justification of Estimates for Appropriations Committees. *hrsa.gov/ sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf.* Accessed Feb. 10, 2020.

highest primary care workforce shortages. Through grants, the program develops partnerships among institutions, federally recognized tribes, and community-based organizations to train medical students to provide care that improves health outcomes for those living on tribal reservations or in rural and underserved communities. AAMC believes earlier intervention in the educational continuum is also necessary to support additional medical school applicants that are more likely to enter primary care.

Medical education costs can be a significant burden for individuals interested in medicine. While non-financial factors appear to have a greater impact on the specialty choice of medical students,[10] the AAMC is concerned about the impact these costs may have on the physician pipeline. Medical schools and their leadership across the country are committed to reducing this burden and have increased institutional aid, some committing to eliminate debt or tuition altogether in the hopes of increasing interest in primary care.[11] The AAMC also supports Federal efforts to ensure financial stability of primary care providers, including the HRSA Title VII Primary Care Loan, which provides low interest loans to medical students planning to enter primary care. Additionally, the AAMC applauds the recent historic investment of $800 million in the National Health Service Corps (NHSC) under the American Rescue Plan (P.L. 117–2) to help recruit primary care providers to underserved communities through scholarship and loan repayment.

Workforce Diversity

A diverse health workforce contributes to culturally responsive care, helps to mitigate bias, and improves access and quality of care to reduce health disparities, such as those seen during COVID–19. It also improves primary care and access as underrepresented students are more likely to choose primary care specialties.

A common theme across several physician workforce challenges is the need to diversify the population of students entering medical school. According to the AAMC Medical School Enrollment Survey,[12] virtually all medical schools have specific programs or policies designed to recruit a more diverse student body. The majority of respondents to that survey had established or expected to establish programs/policies geared toward minorities underrepresented in medicine, students from disadvantaged backgrounds, and students from underserved communities. Schools also reported a variety of approaches, with a focus on outreach at high schools and local 4-year colleges and admission strategies such as holistic review. In addition to these efforts, AAMC believes earlier and greater intervention is necessary to diversify the physician workforce.

For myriad reasons, there has been minimal progress in increasing the number of physicians from diverse racial and ethnic backgrounds. We need more assertive efforts to cultivate a more diverse and culturally prepared workforce. We need to better understand how systemic barriers such as racism and inconsistent access to quality education, beginning with pre-K, negatively affect diversity in academic medicine. And we must design bolder interventions to address the growing absence of Black men and the near-invisibility of American Indians and Alaska Natives in medical school and the physician workforce, which are national crises.

The AAMC is committed to increasing significantly the number of diverse medical school applicants and matriculants, and last year launched a new strategic plan that will take a multitiered approach with sustained investment, collaboration, and attention over time to significantly increase the diversity of medical students. Our goal is to keep increasing the number of students from underrepresented groups until they are no longer underrepresented in medicine. While AAMC enrollment data show we are moving slowly in the right direction to recruit more students from underrepresented groups entering medical school, there is still much work to be done across academic medicine to ensure our diverse nation is reflected in a diverse physician workforce.

In 2020, the total number of first-year students identifying as Black or African American, Hispanic, Latino, or of Spanish origin, and American Indian or Alaska

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[10] Physician Education Debt and the Cost to Attend Medical School: 2020 Update, Section Six: Debt and Specialty Choice, AAMC, October 2020. *https://store.aamc.org/downloadable/download/sample/sample-id/368/*.

[11] Will free medical school lead to more primary care physicians? Ken Budd, Special to AAMCNews, December 2019. *https://www.aamc.org/news-insights/will-free-medical-school-lead-more-primary-care-physicians*.

[12] Results of the AAMC Medical School Enrollment Survey: 2017, May 2018. *https://www.aamc.org/media/8276/download*.

Native increased. However, this growth was concentrated at a small number of medical schools, reflecting the important contributions historically Black colleges and universities and Hispanic-serving institutions make to the diversity of the physician workforce. In recent years, the AAMC released two reports, Altering the Course: Black Males in Medicine [13] (2015) and Reshaping the Journey: American Indians and Alaska Natives in Medicine [14] (2018), to further explore why diversity efforts have not been more successful. As discussed in these reports, not all racial and ethnic groups saw notable increases in medical school applicants and matriculants. In particular, the reports demonstrated that the numbers of Black or African American medical school applicants and American Indian or Alaska Native medical school applicants had remained relatively stagnant. Even more concerning was the finding reported in the Altering the Course report that the number of Black or African American male medical school applicants and matriculants had actually decreased since 1978. While there have been some increases in the number of Black or African American male medical school applicants and matriculants in the six-years since that report was published, Black or African American male students continue to be woefully underrepresented compared with other medical student groups.

The HRSA Title VII health professions and Title VIII nursing programs play an important role in improving the diversity of the health workforce and connecting students to health careers by enhancing recruitment, education, training, and mentorship opportunities. Inclusive and diverse education and training experiences expose students and providers to backgrounds and perspectives other than their own and heighten cultural awareness in health care, resulting in benefits for all patients and providers. Studies also show that underrepresented students are more likely to serve patients from those backgrounds. [15]

Title VII's health professions diversity programs include:

- Health Careers Opportunity Program (HCOP), which invests in K–16 health outreach and education programs through partnerships between health professions schools and local community-based organizations;
- Centers of Excellence (COE) program, which provides grants for higher education mentorship and training programs for underrepresented health professions students and faculty;
- Faculty Loan Repayment, which provides loan repayment awards to retain minority health professions faculty in academic settings to serve as mentors to the next generation of providers; and
- Scholarships for Disadvantaged Students (SDS), which grants scholarships for health professions students from minority and/or socioeconomically disadvantaged backgrounds.

Studies have demonstrated the effectiveness of such pipeline programs in strengthening students' academic records, improving test scores, and helping racial and ethnic minority and students who are economically disadvantaged pursue careers in the health professions. [16] Title VII diversity pipeline programs reached over 10,000 students in the 2018–2019 academic year (AY), with HCOP reaching more than 4,000 disadvantaged trainees, SDS graduating nearly 1,400 students and COE reaching more than 5,600 health professionals; 56 percent of whom were located in medically underserved communities. [17] This success is even more impressive considering that only 20 schools have HCOP grants and only 17 have COE grants—down from 80 HCOP programs and 34 COE programs in 2005 before the programs' funding was cut substantially.

Title VIII's Nursing Workforce Diversity Program increases nursing education opportunities for individuals from disadvantaged backgrounds, through stipends and scholarships, and a variety of pre-entry and advanced education preparation. In AY

[13] https://store.aamc.org/downloadable/download/sample/sample-id/84/.

[14] https://store.aamc.org/downloadable/download/sample/sample-id/243/.

[15] Stewart, K., Brown, S. L., Wrensford, G., & Hurley, M. M. (2020). Creating a Comprehensive Approach to Exposing Underrepresented Pre-health Professions Students to Clinical Medicine and Health Research. Journal of the National Medical Association, 112(1), 36–43. doi:10.1016/j.jnma.2019.12.003.

[16] Ojo, K. (2020). Preparing Minority Students For Careers in Health: A Case Study Investigation of a Health Careers Opportunity Program (HCOP) (Temple University Press). Temple University. *doi:https://scholarshare.temple.edu/handle/20.500.12613/287.*

[17] Health Resources and Services Administration. Department of Health and Human Services Fiscal Year 2021 Justification of Estimates for Appropriations Committees. *hrsa.gov/ sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf.* Accessed Feb. 10, 2020.

2018–19, the program supported more than 11,000 students, with approximately 46 percent of the training sites located in underserved communities.[18]

The AAMC appreciates that Congress reauthorized the HRSA Title VII and Title VIII programs in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116–136). However, increased funding is necessary for these programs to reach their full potential. For fiscal year 2022, AAMC joined an alliance of over 90 national organizations, the Health Professions and Nursing Education Coalition (HPNEC), in recommending $1.51 billion for Title VII and Title VIII, which includes doubling funding for the HRSA diversity pipeline programs.

Rural Access

Access issues persist in rural communities. While 20 percent of the U.S. population lives in rural communities, only 11 percent of physicians practice in such areas. The Centers for Disease Control and Prevention (CDC) reports that Americans living in rural areas are more likely to die from health issues like cardiovascular disease, unintentional injury requiring emergency services, and chronic lung disease than city-dwellers.[19] People living in rural communities also tend to be diagnosed with cancer at later stages and have worse outcomes.

We know that medical students who grow up in rural communities are much more likely to return to them, and physicians who train in rural areas are ten times more likely to practice full time in those communities.[20] As previously discussed, many medical schools aim to identify potential candidates from rural communities and encourage them to take up medicine;[21] however, in 2016 and 2017, students from rural backgrounds made up less than 5 percent of the incoming medical student body.[22]

As Congress considers improving the Nation's health infrastructure, there is an opportunity to invest in the rural workforce pipeline. AAMC supports The Expanding Medical Education Act (H.R. 801), which would authorize grants to enhance current and establish new regional medical campuses (RMCs), thereby helping expose more future providers to rural and other underserved settings. RMCs are important settings for medical schools to expand their reach and help fulfill their unique missions. Approximately 30 percent of medical schools already have at least one branch campus.[23] RMCs often have targeted missions, such as training future providers in primary care and in rural settings. The funds authorized in this bill would help with the construction of new branch campuses and assist current RMCs in enhancing their facilities, expanding their enrollment, recruiting new faculty, developing curriculum, and planning for accreditation.

To facilitate new rural residency programs, the HRSA Office of Rural Health Policy provides technical assistance and startup funding to rural hospitals under the Rural Residency Planning and Development (RRPD) programs. Specifically, the Rural Training Track required in the RRPD program places residents in rural locations for greater than 50 percent of their GME training and focuses on producing physicians who will practice in rural communities. In fiscal year 2019, the RRPD program provided 27 rural health facilities with funding for graduate medical education.[24] The AAMC supports increasing the $10.5 million Federal investment in the HRSA RRPD.

The HRSA Title VII health professions programs have also proven to be successful in guiding students toward careers in rural and underserved areas. Area Health Education Centers (AHECs) specifically focus on recruiting and training future phy-

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[18] Id.

[19] Rural Americans at higher risk of death from five leading causes. CDC, January 2017, *https://www.cdc.gov/media/releases/2017/p0112-rural-death-risk.html*.

[20] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5007145/*.

[21] Attracting the next generation of physicians to rural medicine, Peter Jaret, special to AAMCNews, February 2020. *https://www.aamc.org/news-insights/attracting-next-generation-physicians-rural-medicine*.

[22] The Decline In Rural Medical Students: A Growing Gap In Geographic Diversity Threatens The Rural Physician Workforce, Health Affairs, December 2019, *https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00924* (Note—this study does not include osteopathic medical school matriculation and enrollment).

[23] Association of American Medical Colleges. Regional Campuses at US Medical Schools. Liaison Committee on Medical Education (LCME) Annual Questionnaire Part II, *https://www.aamc.org/data-reports/curriculum-reports/interactive-data/regional-campuses-us-medical-schools*.

[24] Health Resources and Services Administration. Department of Health and Human Services Fiscal Year 2021 Justification of Estimates for Appropriations Committees. *hrsa.gov/ sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf*. Accessed Feb. 10, 2020.

sicians in rural areas, as well as providing interdisciplinary health care delivery sites. In AY 2018–19, AHEC grantees partnered with community health centers, hospitals, and ambulatory practice sites to train future physicians, with 44 percent of the training sites located in rural areas.[25] AHEC training sites focused on interprofessional networks that address social determinants of health and incorporate field placement programs for rural and medically underserved populations. With over 2,700 AHEC scholars in 2018–2019, 36 percent of the scholars came from rural backgrounds, and over half of the scholars received training in rural settings.[26] The AAMC supports doubling AHECs in fiscal year 22 as part of our recommendation for HRSA Title VII funding.

Underserved Communities

Additionally, public service loan repayment programs offered by HRSA, the National Institutes of Health, the Department of Education, the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are effective, targeted incentives for recruiting physicians and other health professionals to serve specific vulnerable populations. Increasing Federal investment in these programs is a proven way to increase the supply of health professionals serving HPSAs, nonprofit facilities, and other underserved communities. For example, the Public Service Loan Forgiveness (PSLF) program administered by the Department of Education encourages physicians to pursue careers that benefit communities in need. In an annual AAMC survey of graduating medical students, over one-third of 2020 medical school graduates indicate an interest in pursuing PSLF.[27] The AAMC supports preserving physician eligibility for PSLF to help vulnerable patients and nonprofit medical facilities that use the program as a provider recruitment incentive.

The NHSC in particular has played a significant role in recruiting primary care physicians to federally designated HPSAs through scholarship and loan repayment options. With a field strength of 13,053 in 2019, including 2,418 physicians, more than 13 million patients relied on NHSC providers for health care.[28] Despite the NHSC's success, it still falls far short of fulfilling the health care needs of all HPSAs due to growing demand for health professionals across the country. Again, we are pleased Congress recognized the vital role the NHSC has in caring for our Nation's most vulnerable patients by providing the program with $800 million in supplemental funding in the American Rescue Plan. The AAMC supports continued growth for the NHSC in fiscal year 2022 appropriations, and we urge Congress to provide a level of funding for the NHSC that would fulfill the needs of all current HPSAs.

Similar to the NHSC, the State Conrad 30 J–1 visa waiver program has been a highly successful program for underserved communities to recruit both primary care and specialty physicians after they complete their medical residency training. Conrad 30 allows physicians to remain in the U.S. in an underserved community after completing medical residency on a J–1 "exchange visitor" visa (the most common visa for GME), which otherwise requires physicians to return to their home country for at least 2 years. Over the last 15 years, the Conrad 30 program has brought more than 15,000 physicians to underserved areas—comparable to (if not more than) the NHSC, at no cost to the Federal Government.

As the 117th Congress considers immigration reform, the AAMC endorses the bipartisan Conrad State 30 and Physician Access Reauthorization Act (S. 948 in the 116th Congress), which among other improvements would allow Conrad 30 to expand beyond 30 slots per state if certain nationwide thresholds are met. We applaud this bipartisan reauthorization proposal for recognizing immigrating physicians as a critical element of our Nation's health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied growth of the physician workforce.

Physician Well-being

Physicians and other health professionals dedicate their careers to keeping people healthy, but too often they do not receive the care they need to address their own

[25] Id.

[26] Id.

[27] Medical School Graduation Questionnaire: 2020 All Schools Summary Report (Rep.). (2020). *https://www.aamc.org/media/46851/download.*

[28] Health Resources and Services Administration. Department of Health and Human Services Fiscal Year 2021 Justification of Estimates for Appropriations Committees. *hrsa.gov/ sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf.* Accessed Feb. 10, 2020.

well-being. AAMC data show that, like the overall U.S. physician population, a large percentage of medical school faculty have experienced higher levels of stress (particularly underrepresented minorities), and nearly a third of medical faculty face one or more symptoms of burnout.[29] In addition to their detrimental effect on health professionals and their families, burnout, stress, and other behavioral health issues negatively affect patient care, patient experience, and overall health outcomes.

There are numerous systemic and other sources for the high levels of stress and burnout that have long plagued health professionals, and the COVID–19 pandemic is only exacerbating the problem. Yet, stigma, bias, and other barriers can hinder health professionals from seeking and receiving care for new or ongoing mental and behavioral health challenges.

The AAMC has endorsed the Dr. Lorna Breen Health Care Provider Protection Act (S. 610), which would take steps to reverse these troubling trends through investments to prevent suicide, reduce burnout, and promote care for mental and behavioral health conditions among health care professionals. While the ability of any single educational intervention on its own to overcome pervasive systemic challenges is limited, we believe that the bill's grants to help train health professionals in strategies to reduce stress and burnout would represent an important effort to raise awareness among health care professionals about the need to prioritize their well-being, particularly if teaching hospitals also are eligible for such awards. We also appreciate the inclusion of grants to promote use of mental and behavioral health care services among health professionals and the bill's two studies to identify the factors contributing to such challenges and evidence-based best practices for reducing and preventing self-harm and burnout.

In addition to support for this important legislation, the AAMC is also part of the National Academies of Medicine's Action Collaborative on Clinician Well-being and Resilience, which aims to expand our understanding of the factors affecting clinician well-being and promote evidence-based solutions to address clinician stress and burnout.

CONCLUSION

The AAMC appreciates the subcommittee's attention to the important topic of physician workforce shortages and the challenges the country faces. We believe there must be a private-public, multipronged approach to bolstering the physician workforce and the diversity of the physician workforce. Academic medicine is committed to working to address the challenges and has made significant investment in both these areas. At the same time, we believe there must be a corresponding increase in the Federal Government's investments for a variety of Federal programs that are already working. The cost of inaction today will result in higher costs and a less healthy population tomorrow. We look forward to continuing to work with you and the Senate HELP Committee to achieve this goal. If you have any further questions please contact me or Matthew Shick, Senior Director, AAMC Government Relations.

The CHAIRMAN. Dr. Skorton, thank you very much.

Our next witness is Dr. Leon McDougle. Dr. McDougle is the 121st President of the National Medical Association, and the first African American professor with tenure in the Ohio State University Department of Family Medicine.

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

STATEMENT OF LEON MCDOUGLE, M.D., MPH, PRESIDENT, NATIONAL MEDICAL ASSOCIATION, COLUMBUS, OHIO

Dr. MCDOUGLE. Hello. I want to thank the Chairman, Senator Bernie Sanders, and Ranking Member, Senator Susan Collins, and other Members of the Subcommittee for the opportunity to discuss the healthcare workforce crisis facing U.S. communities.

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[29] *https://www.aamc.org/system/files/reports/1/february2019burnoutamongusmedicalschoolfaculty.pdf.*

The COVID–19 pandemic has served as a stress test for communities made vulnerable by racism, bias, geography, disability, and socioeconomics. Improving social determinants of health, primary care access, and workforce diversity are central to any solutions that enable communities to overcome a failed stress test and barriers to health equity.

We know that primary care access results in cost savings and improved health disparities and outcomes. Well, why is that? Primary care physicians take a person-focused, as opposed to disease-focused, approach to healthcare. Rural and urban populations with higher ratios of primary care physicians have lower rates of mortality for all causes.

The supply of primary care physicians also improves disparities and health outcomes related to income inequality. In addition, after controlling poor income, inequality, and socioeconomic characteristics, a higher supply of primary care physicians is associated with a four-times greater lowering of total mortality among African Americans.

In regards to specialty selection and healthcare access, we know that African American, Hispanic/Latino, and American Indian physicians are more likely to become primary care physicians and provide care in underserved communities.

Ranked No. 1, No. 2, and No. 3, Morehouse School of Medicine, Meharry Medical College, and Howard University College of Medicine have the highest social mission scores for medical schools. The combined composite, taking into account the percentage of graduates who practice primary care, work in health professional shortage areas, and who are underrepresented in medicine.

Proposed remedies. Yes, I am in agreement with everyone here. Priority should be given to funding more primary care GME positions for hospitals within rural and urban health professional shortage areas, or medically underserved areas.

Yes, priority should also be given to funding more primary care GME positions for hospitals affiliated with medical schools with higher social mission scores.

In addition, I want to focus on a program that the National Medical Association and the Association of American Medical Colleges have collaborated on. It is the Action Collaborative for Black Men in Medicine. A recent study revealed that the percentage of Black men who were physicians has remained at about 2.6 percent for the past 80 years.

In closing, thank you for providing me the opportunity to offer my thoughts and suggestions to improve the healthcare crisis in this Country so that all of our communities can benefit from accessible and empathetic healthcare. The National Medical Association stands ready to assist you in any way that we can to achieve this goal.

[The prepared statement of Dr. McDougle follows:]

PREPARED STATEMENT OF LEON MCDOUGLE

My name is Dr Leon McDougle. I am the 121st President of the National Medical Association, Professor of Family Medicine and Chief Diversity Officer for the Ohio State University Wexner Medical Center. The views I express in this testimony are my own and should not be construed as representing any official positon of the National Medical Association or the Ohio State University.

I want to thank the Chairman, Senator Bernie Sanders, and Ranking Member, Senator Susan Collins, and other Members of the Subcommittee for the opportunity to discuss the health care workforce crisis facing U.S. communities.

The COVID–19 pandemic has served as a stress test for communities made vulnerable by racism, bias, geography, disability, and socioeconomics. Improving social determinants of health, primary care access and workforce diversity are central to any solutions that enable communities to overcome a failed stress test and barriers to health equity.

1. Primary care cost savings and improved health disparities and outcomes:

(A) Primary care physicians take a person-focused, as opposed to disease-focused approach to health care.[1] Communities with higher ratios of primary care physicians have much lower total health care costs, partly because of better preventive care and lower hospitalization rates.[2]

(B) Rural and urban populations with higher ratios of primary care physicians (defined as family physicians, general internists, and general pediatricians) have better health outcomes, including lower rates of mortality for all causes, heart disease, cancer, stroke, infant mortality, low birth weight, and poor self-reported health.

(C) The supply of primary care physicians also improves disparities in health outcomes related to income inequality. In addition, after controlling for income inequality and socioeconomic characteristics (metropolitan area, education level, and percent unemployed) a higher supply of primary care physicians is associated with a four times greater lowering of total mortality among African Americans as compared to the white majority population.

(D) In regard to specialty selection, 45 percent of Black physicians, 43 percent of Hispanic/Latino physicians, 46 percent of American Indian physicians, and 41 percent of Asian physicians were practicing primary care as compared to 35 percent of White physicians.[3]

3(E) In regard to health care access, nearly 50 percent of Black, Hispanic/Latino, and American Indian physicians were practicing in primary care Health Professional Shortage Areas or Medically Underserved Areas as compared to 33 percent of Asian physicians and 38 percent of White physicians.[4]

(F) Ranked number 1, 2 and 3, Morehouse School of Medicine, Meharry Medical College and Howard University College of Medicine, have the highest social mission scores for medical schools. The combined composite taking into account the percentage of graduates who practice primary care, work in Health Professional Shortage Areas, and who are underrepresented in medicine, form the social mission score.[5]

2. Proposed remedies for primary care crisis:

(A) Increase access to primary care, mental health and dental services by establishing more federally Qualified Health Centers in rural and urban health professional shortage areas and medically underserved areas and populations.

(B) Fund additional Graduate Medical Education (GME) residency positions to support training of primary care residents/fellows who agree to a service obligation in a Health Professional Shortage Areas or Medically Underserved Areas or Populations after completion of residency/fellowship training.

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[1] Starfield B. Family Medicine Should Shape Reform, Not Vice Versa. Fam Pract Manag. 2009 Jul-Aug;16(4):6–7. *https://www.aafp.org/fpm/2009/0700/p6.html*.

[2] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Q. 2005 Sep; 83(3): 457–502. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/*.

[3] AAMC Analysis in Brief. Analyzing Physician Workforce Racial and Ethnic Composition Associations: Physician Specialties (Part I). Volume 14, Number 8. August 2014. *https://www.aamc.org/media/7616/download*.

[4] AAMC Analysis in Brief. Analyzing Physician Workforce Racial and Ethnic Composition Associations: Geographic Distribution (Part II). Volume 14, Number 9. August 2014. *https://www.aamc.org/media/7621/download*.

[5] Mullen F, Chen C, Peterson S, Kolsky G, Spagnola M. The Social Mission of Medical Education: Ranking the Schools. Ann Intern Med. 2010;152:804–811.

Priority should be given to funding more primary care GME positions for hospitals within rural and urban health professional shortage areas or medically underserved areas and populations.

Priority should also be given to funding more primary care GME positions for hospitals affiliated with medical schools with higher social mission scores.

Require all persons involved with GME selection of residents and fellows, along with medical school admissions committee members and application screeners to undergo implicit bias awareness and mitigation training and adopt holistic review best practices.

(C) Support HRSA programs such as the Health Career Opportunity Program and Center of Excellence grants and Scholarships for Disadvantaged Students to ensure sustainability and growth of a diverse health care workforce.

(D) Incentivize universities and medical schools to partner with under-resourced urban and rural school systems to establish K–12 health sciences academies to increase the number students from disadvantaged backgrounds, (e.g. homeless, in foster care, or qualify for a free or reduced-priced lunch in elementary or high school, whose parents never graduated from college, persons with a disability) entering physician, biomedical science, and other health professions careers.

(E) Involve residents of HPSA and MUA/P neighborhoods in decisions about those who best provide needed resources or attributes in their communities when determining recipients of National Health Service Corps Scholarships.

(F) Expand the number of National Health Service Corps Scholarships and provide additional incentives for physicians to remain in the community once their obligated service time has expired.

(G) Expand National Health Service Corps loan repayment availability as an additional incentive for physicians to remain in the community once their obligated service time has expired.

(H) Establish HRSA funding to support the Association of American Medical Colleges (AAMC) and National Medical Association (NMA) Action Collaborative for Black Men in Medicine. A recent study of the historical trends of African American physicians from 1900 to 2018, revealed that the percentage of physicians who were African American has increased by only 4 percent in 120 years, from 1.3 percent in 1900, 2.8 percent in 1940 to 5.4 percent in 2018.[6]

In addition, **the percentage of African American men who were physicians has remained about 2.6 percent for the past 80 years**. *https://www.aamc.org/what-we-do/diversity-inclusion/action-collaborative-black-men-medicine*.

(I) Support THE ANTI-RACISM IN PUBLIC HEALTH ACT OF 2021

- Create a "National Center for Anti-Racism" at the Centers for Disease Control and Prevention (CDC).
- Create a Law Enforcement Violence Prevention Program within the National Center for Injury Prevention and Control at the CDC.

In closing, thank you for providing me the opportunity to offer my thoughts and suggestions to improve the health care crisis in this country so that all of our communities can benefit from accessible and empathetic health care. The National Medical Association stands ready to assist you in any way that we can to achieve this goal.

The CHAIRMAN. Well, Dr. McDougle, thanks very much for your comments.

Now I would like to welcome our next witness, Ms. Shelley Spires.

Ms. Spires.

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[6] Ly DP. Historical Trends in the Representativeness and Incomes of Black Physicians, 1900–2018. J Gen Intern Med. 2021 Apr 19. doi: 10.1007/s11606–21–06745–1. *https://www.newswise.com/pdf-docs/161860566877749-LyJGIM-4–19–21.pdf*.

[Brief silence]

The CHAIRMAN. Ms. Spires, we cannot hear you. You are on mute.

Ms. SPIRES. Sorry.

The CHAIRMAN. Okay.

STATEMENT OF SHELLEY SPIRES, CHIEF EXECUTIVE OFFICER, ALBANY AREA PRIMARY HEALTH CARE, ALBANY, GA

Ms. SPIRES. Good morning, Chairman Sanders, Ranking Member Collins, and Members of the Subcommittee. Thank you for inviting me to speak to you today on this very important topic.

I am here today on behalf of the Association of Clinicians for the Underserved, known as the ACU, as a member of its board of directors. The ACU is a non-profit, transdisciplinary organization of clinicians, advocates, and healthcare organizations united in common mission to improve the health of America's underserved populations, and to enhance the development and support of the healthcare clinicians serving these same populations.

I am the CEO for Albany Area Primary Health Care in Albany, Georgia. We serve over 45,000 patients.

Prior to serving as CEO, I spent most of my career in human resources, which has allowed me to have experience at delivering care to the underserved and recruiting and retaining the workforce to support these needs.

Three things that I would like to talk about today that can work as a foundation to my experience is, one, the people who do this work are committed, they are mission-driven, and they are dedicated. The patients who receive the care, they are resilient, smart, and inspiring. Federal support for these people are critical and pays huge dividends.

Let me give you a little more detail about each of these.

I tell you about the people that are committed, mission-driven, and dedicated. It makes more sense to kind of give you some ideas about the realities of working in an underserved population.

Many patients have a chronic condition, sometimes untreated and neglected. This makes for a more intense and long, ongoing complex care given to this complexity of patients.

High numbers of our patients are low income and living in poverty. Ninety-one percent of health center patients are at or below 200 percent of the Federal poverty level.

Most of our patients are members of ethnic and racial minority groups. This supports the fact that culturally competent care is vital to effectively care for their specific needs.

Working in systems of high quality, patient-centered work surrounded by colleagues that share the same goals and mission has defined the Association of Clinicians for the Underserved. Being a board member, that is one of the things that drove me to providing a service under the board based on the fact that we spearhead advocacy for the National Service Corps and support the workforce retention and recruitment efforts.

The term "burnout" among healthcare providers was a huge topic prior to COVID. It did not go away. Unfortunately, those new demands placed on providers as a result of the pandemic have only exasperated the impact of burnout.

While burnout is important overall with a real impact on staff retention, the other side of the human capital coin is recruitment. Recruiting staff to work in underserved areas is, in a word, tough. This goes for all staff, and particular focusing on clinical staff.

The good news is we have existing programs that help with these challenges, but these systems could always have some additional investment. Among the programs that can always benefit from more investment that can provide a substantial return are your National Service Corps and your Nurse Corps programs. Since its inception in 1972, the NHSC has expanded not only in numbers of clinicians, but the types of clinicians, which shows we continue to adapt to the needs of the healthcare system, which is reflected in its workforce.

While there are countless examples of the National Service Corps and what it has done for addressing the workforce shortages, it is vital to recognize that the health equity and health equality are key components of Federal health policy. The NHSC is an important vehicle to achieve these goals by delivering services to our underserved areas and through the workforce that delivers these services.

Ensuring greater racial and ethnic diversity of the healthcare workforce is essential for increasing access to culturally competent care for all of our Nation's communities. Just to give a better context or better picture, the latest data shows African Americans make up 6 percent of the U.S. physicians; 4.4 percent Hispanic and Latino. This data in contrast to the Corps' demographics is 7.2 percent African Americans; 18.2 percent Hispanic and Latino.

Unfortunately, historically, there has been insufficient funding to support all clinicians who are interested in the National Service Corps. In recent years, 10 percent were awarded the scholarship. Forty percent were awarded loan repayment programs. The result aided in not being able to fund applicants in some of America's most neediest communities.

While the current field strength of the NHSC is greater than 16,000, serving more than 16 million people, there is still a shortage. Statistics indicate that nearly 33,000 additional clinicians across disciplines are needed to care for hundreds of millions of people who reside in these shortage areas.

Another component is our THCs, our teaching health centers. They are located in community-based, ambulatory care settings and serve a large number of Medicaid patients. It has been stated many times before, people who train in these underserved areas are likely to remain in practice in the same similar setting, remembering that residency often trains individuals and predicts the practice style regarding quality and cost.

I would also like to call your attention to barriers to some of the other issues that we face in recruiting healthcare professionals—behavioral health. Most FQHCs and RHCs are not positioned financially to take on such large salaries. This salary is very hard to offset when you are serving underserved, uninsured, and an underinsured population. These are the people in most need.

I happened to have at least four psychiatrists to interview and decline due to salary. The interest is there because of the mission of what we do, but the salary is the barrier. Colleagues across the

Country continue to collaborate on ideas how to share resources to meet these needs.

I would like to leave you with just a few concrete suggestions and actions for Congress.

Increase funding for National Service Corps and Nurse Corps. We estimate total annual program costs for the NHSC to be $1.5 billion, taking into account existing funding and minimum of 400 million in Fiscal Year 2022. Annual appropriations is needed in order to address the need.

Support the creation of state loan repayment and increase funding or re-appropriate funding for teaching health centers. The NHSC program has proven time and time again to be an effective program.

I appreciate the opportunity to testify before you today, and thank you for recognizing the urgent need that we face amongst our workforce.

[The prepared statement of Ms. Spires follows:]

PREPARED STATEMENT OF SHELLEY SPIRES

Chairman Sanders, Ranking Member Collins, and Members of the Committee.

Thank you for inviting me to speak to you today on this very important topic. My name is Shelley Spires, I am here today on behalf of the Association of Clinicians for the Underserved—the ACU—as a member of its Board of Directors. The ACU is a non-profit, transdisciplinary organization of clinicians, advocates and health care organizations united in a common mission to improve the health of America's underserved populations and to enhance the development and support of the health care clinicians serving these populations. I am also the Chief Executive Officer of Albany Area Primary Health Care, Inc., a rural federally Qualified Health Center serving over 45,000 patients in Albany, Georgia. Prior to serving as CEO, I spent most of my career in human resources at the same institution. My professional experience has made me an expert at delivering care to the underserved and recruiting and retaining the workforce to support these efforts.

To begin, I'd like to share three important things that are foundational to my experience serving the underserved:

The people who do this work are committed, mission driven and dedicated.

The patients they care for are resilient, smart, and inspiring.

Federal support for all of these people is critical and pays huge dividends.

Let me give you a little more detail about each of these.

The people who do this work are committed, mission driven and dedicated. In my experience working at the health center, I've witnessed this more times than I can count, but most recently with the pandemic. While the Albany area had numerous private outpatient practices close their doors due to the risk of the pandemic, AAPHC kept our doors open to continue serving patients. One of the critical resources that enabled us to continue to do that successfully is our providers. Our providers understand what it means to address a situation head on instead of running from it. They were troopers and were standing strong on the front lines of this pandemic battle we were fighting and continue to fight to this day.

When I tell you that the people who do this work are committed, mission driven and dedicated, it may be helpful for me share a more about the realities of working in and with underserved populations. Many patients live with chronic conditions, sometimes long untreated or neglected, making their initial care more intensive and their ongoing care more complex. High numbers of our patients are low income or living in poverty. Nationally more than 91 percent of health center patients are at or below 200 percent of the Federal poverty level. Most of our patients are members of ethnic and racial minority groups. This, along with many other factors, makes culturally competent care absolutely vital to understanding and effectively caring for their specific needs. In my own community, we witness these and other realities on a daily basis. In fact, during a vicious COVID outbreak early on in the pandemic, our community faced incredible hardship. People were dying every day, we had an employee and spouses of employees die, and yet we stood strong. My team pulled together to eliminate barriers, use innovative ideas to continue caring for our pa-

tients, and made sure that the quality of care never deteriorated. At the end of the day, it was our team, our model of patient centered care, and our commitment to our collective mission to care for those in need that carried us through one of the worst challenges we have faced.

Working in systems that support high quality, patient-centered work—surrounded by a network of colleagues with shared ideals and goals—has defined the Association of Clinicians for the Underserved since its inception. This is part of what drew me to join the Board of ACU and it is these shared ideas and goals have driven ACU to lead and spearhead advocacy for the National Health Service Corps (NHSC), to support workforce retention and recruitment. The NHSC has always been an invaluable tool for recruitment and retention of clinicians to underserved areas. However, it is worth noting that as the health care system has evolved, so too have the demands placed on clinicians. These demands are evident in the needs of the patients and the requirements in the way that they provide care.

The term "burnout" among healthcare providers was a huge topic of discussion prior to COVID. It did not go away during the pandemic. While health care providers may have forced the burnout that existed prior to COVID into the background as the pandemic provided a big shot of adrenaline, the longstanding burnout problem lingered, and the new demands placed on providers as a result of the pandemic exacerbated the impact of burnout. While the light at the end of the tunnel *may* be in sight for COVID, the pandemic of provider burnout continues and is likely to strike our health care workforce with a vengeance. We are already seeing this and in fact, burnout is now a bona fide medical diagnosis. The World Health Organization has noted that the syndrome of burnout is characterized by three dimensions: (1) feelings of energy depletion or exhaustion; (2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and (3) reduced professional efficacy.

Burnout has an impact on patient care: it not only produces less engaged employees, but also is linked to reduced patient satisfaction, reduced quality and value of care that is delivered—and it increases the risk for a healthcare error or mistake. Burnout costs our healthcare system millions of dollars, a cost that is well beyond the loss of organizational knowledge that results from employee change. We need serious efforts to measure—and perhaps mitigate—burnout recognizing all of these impacts. Patients are also beginning to demand that the problem be addressed. They simply want safe more engaged care, delivered by more empathetic care teams, something all of us should want.

While burnout is important overall, with a real impact on staff retention, the other side of the human capital coin—recruitment—is also difficult in the underserved setting. Recruiting staff to work in underserved areas is, in a word: tough! This goes for all staff, with a particular focus on our clinical staff. New graduate family practice, internal medicine or pediatric physicians, many with an average of 125,000 dollars in debt, can work in a hospital and make 30–40 thousand dollars a year more compared to what we can offer in a community health center. Market forces, in general, don't lift up the underserved.

I can speak to the challenges of recruitment and retention, both in my current capacity as CEO and in my experience in my former position with HR. Challenges that come with rural areas include the geographic location, a lack of many services and amenities that new, younger providers are looking for, the burden of student debt, and the need to understand our population. I make a conscious effort to pay attention to my providers and what they are telling me about "burnout". I have spent time over the last couple of years trying to develop systems that allow us to work smarter and not harder. Trying to research ways to make patient care, patient flow, and the clinic environment a place that my staff enjoy coming to work. There is a lot of stress associated with the underserved population—high risk patients, managing multiple chronic illnesses with limited resources, and documenting in an Electronic Medical Record.

The good news is that we have existing, functional programs that can help with recruitment, retention, and workforce shortages, but these systems need additional investment.

Among the programs that can always benefit from more investment and can provide a substantial return on that investment are the National Health Service Corps (NHSC) and Nurse Corps programs. Since its inception in 1972, the NHSC has expanded not only in numbers of clinicians but also in types of clinicians. Notably, the Corps—which initially counted physicians as its dominant workforce component—now counts behavioral health clinicians as its largest workforce component. In 2009, a majority of the Corps was physicians (35 percent); in 2017, behavioral health pro-

viders made up the majority of clinicians in the NHSC (30 percent), with nurse practitioners taking second place at 23 percent and physician participation down to 20 percent. The NHSC continues to adapt to the needs of the U.S. healthcare system and reflects that in its workforce.

Over the past several years the program has expanded to respond to national crises such as the Zika outbreak (in 2017) and the substance abuse disorder crisis (in 2019). What began as one program—a scholarship program—now encompasses six complementary but distinct opportunities to serve under the NHSC: The scholarship program and multiple loan repayment programs including the students to service program.

While there are countless examples within the NHSC that can be cited to highlight its long-standing record of success in addressing workforce shortages in medically underserved areas, it's vital to recognize that health equity and health equality are key components of Federal health policy. To this end, the NHSC is an important vehicle to achieve these goals: both by delivering services to underserved areas, and through the workforce that delivers these services. A study by the Robert Graham Center documenting the impact that the NHSC has had on health equality during its first 30 years showed that the NHSC has assigned its resources preferentially—and delivered its most consistent service—to counties with large minority populations.

Ensuring greater racial and ethnic diversity of the health care workforce is essential for increasing access to culturally competent care for all of our Nation's communities. A more diverse workforce delivers better results in many settings, including healthcare settings, and is better suited to meeting the overall needs of our Nation's diverse population, particularly in the most underserved areas. Historically and currently, many racial and ethnic and minority groups are underrepresented nationally within the major health professions. As a result, the NHSC is a success story and is deliberate in continuing its work to increase the number of minority clinicians.

To provide greater context to the present statistics on clinical workforce diversity, the latest data available shows that African Americans make up 13 percent of the U.S. population but they comprise only 6.9 percent of U.S. advanced practice nurses (nurse practitioners and nurse midwives) and 4 percent of U.S. physicians. Of actively practicing advanced practice nurses in the US in 2018, 81.8 percent were white, 7.9 percent were Asian and 0.2 percent were American Indian or Alaska Native. Data on practicing physicians in the United States in 2013 showed that 48.9 percent were white, 11.7 percent were Asian, 4.4 percent were Hispanic or Latino, and 0.4 percent were American Indian or Alaska Native. These statistics are in contrast to the composition of the NHSC: 13 percent are African American, 10 percent are Hispanic, 7 percent are Asian or Pacific Islander, and 2 percent are American Indian or Alaska Native.

In the Corps' physician workforce, in 2016, African American physicians accounted for 17.2 percent and Hispanic or Latino physicians 18.2 percent. Unfortunately, there are no currently available workforce data on national estimates of LGBTQ+ or other under-represented minority groups. Historically there has been insufficient funding to support all clinicians interested in participating in the NHSC. In recent years an average of just 10 percent of Scholarship Program applicants 40 percent of Loan Repayment Program applicants have been funded. There remains a large gap in terms demand versus opportunity. The result is that with large numbers of applicants not being funded, thousands of positions needed to provide clinical care to America's neediest communities remain unfilled. In 2018, there were nearly 5,000 open NHSC-approved positions in Health Profession Shortage Areas across the country that remained unfilled due to inadequate field strength—this has been a persistent problem each year since.

While the current field strength of the NHSC is greater than 16,000, which serves more than 16 million people, severe workforce shortages persist in every corner of the Nation. The most recent Designated Health Profession Shortage Area Statistics indicate that nearly 33,000 additional clinicians across disciplines are needed to care for hundreds of millions of people who reside in health profession shortage areas. While we are incredibly grateful for the infusion of funding invested into the NHSC through the American Recovery Act, much more needs to be done to truly address the clinical workforce shortages that remain.

In addition to the NHSC, there are other programs worth considering as a part of the solution in addressing workforce shortage issues across the Nation. For example, the Federal Government also oversees graduate physician training—so called Graduate Medical Education, or GME. A Government Accountability Office report in 2017 showed that training of residents remains concentrated in urban areas,

which continued to account for 99 percent of residents, despite some growth in rural areas from, 2005 through 2015. Given that many residents stay in the same communities where they train, investment of GME dollars both for rural hospitals, but also for primary care training, is critical. But investing in hospital-based training programs—where many hospitals train residents in traditionally primary care specialties like internal medicine or pediatrics—is not a complete solution to this problem. Most of these residents go on to specialize, and hospitals are not required to track and report on career paths of graduates who work in primary care or underserved settings.

Another component needed to create a workforce dedicated to the underserved is further investment in teaching health centers (THCs). Initially supported under the ACA, the Teaching Health Centers program began development and evaluation in 2011, and now exist in a majority of states and train close to 1,000 residents a year.

THC programs are located in community-based ambulatory care settings and serve a large number of Medicaid patients. From a workforce perspective, those who train in these underserved areas are likely to remain in practice in the same or similar settings, with location of residency training often predicting practice style regarding quality and cost. If additional Medicare GME funding was unavailable, reallocating approximately 5 percent of the current $6.5 billion per year that funds Centers for Medicaid and Medicare Services indirect medical education would achieve budget neutrality to expand THCs significantly. There is a real opportunity to impact CMS deciding on GME slots that benefit the national need, and not just slots that generate higher incomes for academic medical centers.

I would also call to your attention to some state laws that provide barriers to care, especially behavioral health care, at a time in our Nation when the behavioral health crisis is worsening every day. In many states, laws or regulations require organizations to employ a psychiatrist to oversee behavioral health programs. This needs to change and no longer be a requirement in any state. While it is true that all behavioral health clinics would benefit from psychiatrist oversight, recruiting one and retaining one even for several hours a week is a barrier to care. We have seen, during the COVID public health emergency, that overdoses have increased, and mental health has worsened. There is a national psychiatric prescriber shortage. When these providers can—and often do—make $200 an hour in private practice, it is all but impossible for a community health center to recruit a psychiatrist even with a starting salary of $250,000 and loan repayment opportunities. The result is that there are no behavioral health programs at many institutions that need them, effectively restricting access to care for thousands upon thousands of high need individuals.

This issue is one that is very real to Albany Area Primary Health Care. The conversation around Behavioral Health and the needs in our area and our country is continuous. Most federally Qualified Health Centers and Rural Health Centers are not financially sound enough to take on a salary for a Psychiatrist. This salary is very hard to offset when you are serving underserved, uninsured, and underinsured populations. These are the people who need it most and we struggle to meet the needs. I have had at least four Psychiatrists interview and ultimately decline an offer due to the salary. I can get them to interview because of their interest in the mission of our organization, but the salary is always insufficient to keep them. I and my colleagues across the country continue to try and be innovative and creative with trying to meet these needs through collaborations and partnerships because we believe persistence pays off. However, my goal is to hire a psychiatrist to be a part of our team and the challenges in doing so remain significant and unrelenting.

Toward this same end, we need HRSA to change how it makes program awards. At present, awards are made on an annual basis. This is convenient for the government but does not address the real world of provider recruitment in the field. You see, when I try to hire new graduate doctors, perhaps I can offer $30,000 in loan repayment, IF they apply AFTER I hire them and IF that loan gets granted 6 months down the road. My competition for that newly minted doctor is the local hospital, which can guarantee prior to signing an extra $30,000 loan repayment, and a higher salary. This is all done in an age where twenty-somethings can get whatever they want delivered to their doorstep in a day. The competition has changed. We need systems to change to support this.

Again, to give you a personal example of the reality of what this challenge looks like in practice, I have had a couple of physicians that declined our offer due to the competition offering a sign on bonus (which would equate to loan repayment), pay off their loans to relieve the interest, and commit to a 5-year contract. FQHC's just do not have that kind of money, so the idea of creating more than one application

cycle would be a fabulous way to market our organization and clinicians wouldn't have to wait for the reward and can prevent the interest from accruing while awaiting the award.

I'd like to leave you with some concrete suggestions of actions that Congress can take to make a noticeable, needed, and meaningful impact to address the Nation's workforce shortage and to support people in underserved areas:

1. Increase funding for the national health service corps and nurse service corps. We estimate total annual program cost for the NHSC to be $1.5 billion. Taking into account funding already in place for the NHSC, $310 million in mandatory funding and $800 million via the American Recovery Act, a minimum of $400 million in fiscal year 2022 annual appropriations is needed in order to address existing need within health profession shortage areas.
2. Support the creation of state loan repayment programs in all states and territories with dedicated funding to enhance workforce recruitment and retention on a state-by-state basis.
3. Increase funding, or reappropriate funding, for Teaching Health Centers to at least double the size of the program and corresponding funding in the coming year.
4. Congress passed a historic increase to the Medicare graduate medical education (GME) program at the close of last year—the first increase to the program in nearly 25 years. The expansion was part of the year-end Consolidated Appropriations Act, 2021. The legislation includes 1,000 new Medicare-supported GME positions. Congress should direct future expansions to enhancing the primary care and behavioral health workforce.
5. Allow providers working in an FQHC the ability to waive DEA fees—this could be modeled from the present Veteran's Administration (VA) system.
6. Similarly, consider expanding the VA approach and policy to redeploy workforce to areas of need via telemedicine, apply the same concept to support areas of higher need for the underserved. Unfortunately, cross-state licensure as well as payer reimbursement prohibits this at present.
7. Allow federally qualified health centers to participate in government supported insurance programs. Many health centers that serve the underserved are smaller organizations and are forced to spend a significant amount of operational dollars on health insurance. Allowing FQHCs the opportunity to participate in government support insurance programs would enable these health centers to invest a greater percentage of their operating revenue in salaries for recruitment and retention.

Conclusion

As a nation we are facing an urgent and critical issue with clinical workforce shortages, one that is predicted to worsen in the coming years. The Association of American Medical Colleges predicts that we will see a shortage of up to 55,000 primary care clinicians within the next 10 years—this is to say nothing of the damages and additional strain placed on primary care workforce as a result of the pandemic and chronic burnout faced by countless numbers of providers. Today, more than 16,000 NHSC clinicians serve 16 million people across the country. I stand before you as someone who has personally witnessed the incredible impact, value and effectiveness of this program. We are hopeful that we can strengthen and grow the National Health Service Corps and other key programs to help address the urgent need of millions of people who need access to primary health care services.

Let us all take a moment to remember that these people have faces and names, they have families and children, and they have hopes and dreams. These are the people and patients we care for every day at Albany Area Primary Health Care. They are our neighbors. They are your constituents. They are the babies that our team welcomes to this world, they are the hands we hold as they manage their chronic illnesses and persevere, and they are the faces we hold in our hearts as they make their final transition from this life. The NHSC program has proven time and time again to be an effective program. I can assure you as someone working in an underserved community to care for those in need, in my opinion, the NHSC is one of the best programs this country has devised to incentivize primary care medical providers to be able to choose primary care and to serve in underserved communities. I appreciate the opportunity to testify before you today. We thank you for recognizing the urgent need to do more to address the Nation's clinical workforce shortages and making the National Health Service Corps a priority as we work col-

lectively to solve this critical issue. I would be glad to answer any questions you may have.

The CHAIRMAN. Well, thank you very much, Ms. Spires.

Senator Collins will introduce the next panelist.

Senator COLLINS. Thank you, Mr. Chairman.

I am delighted to introduce Dr. James Herbert of the University of New England, who is here to testify. He is the sixth president of the University of New England. During his tenure, UNE has launched a Center for Excellence in Public Health, which has strengthened its partnership with external clinical partners and has built a health workforce pipeline to underserved areas in New England.

He has a long and distinguished record. He is an internationally renowned psychologist who has done research into the treatment of mood and anxiety disorders and is a fellow of the Institute for Science and Medicine, the Association for Contextual Behavioral Science, and several other groups.

I am going to stop so that he can get to his testimony. But, suffice it to say that we are delighted to have him leading UNE in the State of Maine and here with us today.

STATEMENT OF JAMES D. HERBERT, PH.D., PRESIDENT, UNIVERSITY OF NEW ENGLAND, BIDDEFORD AND PORTLAND, ME

Dr. HERBERT. Thank you so much, Chairman Sanders and Ranking Member Collins. I appreciate the kind introduction.

Just by way of context, the University of New England is Maine's largest private university. We have campuses in Biddeford and Portland, Maine, and in Tangier, Morocco, and we consider ourselves—although a private university, we very much have a public mission.

As you probably know, Maine has the oldest population in the Nation, and we are tied with Vermont as being the most rural state. We also have one of the oldest healthcare forces in the Nation, and the challenges that we face in Maine are harbingers of what the rest of the Country is not only facing, but will increasingly face as our Nation ages and as urbanization creates pockets of need not only in urban areas, but especially in our remote, rural areas.

I would like to address five specific strategies that I believe can go a long way to addressing the healthcare workforce crisis. At the University of New England, we are trying to act on each of these five strategies, and I would be happy to share any—answer any questions or share any ideas about what we are trying to do. But, let me hasten to add that I am not suggesting that we have all the answers that we figured it out. But, what we have found is that the key to moving the needle forward, regardless of strategy, are strategic partnerships between higher education, government, business, and the non-profit sector.

The first thing we need to do—and Senator Sanders, you touched on this exactly—is we simply need to increase the number of healthcare professionals we train, including doctors. The single biggest challenge to doing that is the limited availability of clinical

training opportunities, as you both have noted and as my fellow panelists have noted.

As financial margins have tightened over the past three decades, practicing clinicians have less time to devote to clinical training. We must support partnerships between universities and healthcare systems to develop additional GME and other clinical training opportunities.

Now, this is not the only infrastructure limitation. Standing up new educational facilities or expanding existing ones involves significant startup costs. This is true both in the case of GME, but also in the case of expanding the size of medical schools. For example, at UNE right now, we are looking to expand the size of our medical school significantly, but that involves building new facilities.

The CHAIRMAN. How large is your medical school now?

Dr. HERBERT. One hundred and sixty-five, and we are looking to go to 200, and then a little beyond 200.

Another barrier is the difficulty in hiring and retaining qualified faculty members who can typically earn more in direct care clinical services than they can as university professors. Support, such as that displayed by both of you, Senators Sanders and Collins, for strategic healthcare funding for faculty is vitally important to continuing those programs.

The second thing we must do is we must train more healthcare students who look like the communities that they serve. It is well established that individuals from underrepresented groups are more likely to seek out practitioners who share their identities and backgrounds. Studies have found that minority patients who are treated by clinicians who look like them are more likely to use needed health services and less likely to delay care.

Now, it is not enough if you both—as you have both noted, it is not enough to merely train more professionals. We must encourage them to practice in underserved areas following graduation, especially in rural and tribal communities. Like Maine, most states have vast rural areas with highly distributed populations, and these communities have far less access to healthcare.

Programs that provide financial support in terms of loan repayment programs, there are Federal programs administered by HRSA. There are state programs, a new one in Maine. These kinds of programs are absolutely critical, and I thank you for your continued support of them.

Fourth, we must leverage the power of technology to serve underserved communities. Digital health and emerging developments in telemedicine have enormous potential to transform healthcare delivery. Of course, these tools depend upon reliable and robust broadband systems, and I am delighted that the most recent COVID–19 stimulus legislation included funding for broadband infrastructure.

Finally, we must fundamentally change the prevailing educational model. Anyone who has recently been a patient in a hospital or has cared for a hospitalized loved one understands how siloed the practice of healthcare tends to be.

In response, a new educational model has emerged in which students from diverse disciplines are explicitly trained to work to-

gether, across traditional boundaries, in multidisciplinary teams. This is known as interprofessional education, or IPE for short, and this model has been shown to improve clinical outcomes, to reduce medical errors, to increase patient satisfaction, and to decrease provider burnout.

One particular area that highlights the importance of this kind of collaborative, team-based approach is geriatrics. Diseases of aging often encompass a broad scope of conditions: heart disease and diabetes treated by primary care practitioners, isolation by social workers, oral health by dentists and hygienists, and so on.

At UNE, we are weaving geriatric training throughout all of our healthcare professionals. So, rather than just merely training more geriatricians, we are weaving training in geriatrics and in behavioral health across all of our healthcare professionals in this team-based approach.

I am pleased that working together with Maine's junior senator, Angus King, and the University of Maine and other statewide partners, we are one of 48 organizations to have received funding through HRSA's Geriatric Workforce Education program.

In conclusion, successfully addressing America's healthcare workforce crisis will require not merely acting on each of these five strategies in isolation, but seamlessly integrating them. And strategic investment of resources will be required, but much of the work reflects cultural changes that will require strong leadership, a willingness to innovate, and coordinated partnership, again, between academia, government, industry, and the non-profit sector.

I am grateful for your time and happy to address any questions. Thank you very much.

[The prepared statement of Dr. Herbert follows:]

PREPARED STATEMENT OF JAMES HERBERT

Thank you for the opportunity to speak with you today. It's a sincere honor to share some thoughts on strategies for addressing our Nation's healthcare workforce crisis.

My name is James Herbert, and I am the president of the University of New England (UNE). UNE is Maine's largest private university, with campuses in Biddeford and Portland Maine and in Tangier Morocco. We are a comprehensive university that houses Maine's only medical school and only physician assistant program, and northern New England's only dental school. We're the largest provider of healthcare professionals to the state of Maine,[1] and we take great pride in being a private university with a public mission.

As you probably know, Maine is the oldest state in the Nation,[2] and is tied with Vermont as being the most rural[3] state. We also have one of the oldest healthcare workforces in the country.[4] The challenges we face are in some sense harbingers

[1] UNE offers programs in 14 health professions, including osteopathic medicine, dental medicine, pharmacy, physician assistant, nursing, nurse anesthesia, dental hygiene, occupational therapy, physical therapy, social work, nutrition, athletic training, applied exercise science, and public health.

[2] Maine has the highest median age in the U.S.: 45.1 relative to the national average of 38.5 (US Census Bureau, 2019a). At 21.3 percent Maine also has the highest percentage of citizens over 65 in the U.S. (*US Census Bureau, 2019b*).

[3] *US Census Bureau, 2019b*

[4] At 36 percent, Maine ranks 5th in the Nation for the percentage of active physicians who are age 60 or older (AAMC, 2019). In 9 of 16 Maine counties, 50 percent or more of physicians are 55 or older (Skillman & Stover, 2018). Over 50 percent of Maine's registered nurses are 50 or older (Maine Nursing Action Coalition, Center for Health Affairs NEONI, 2017). Approximately 60 percent of Maine's dentists are older than 55 (State of Maine Board of Dental Practice, 2019). Maine ranks in the top quartile of states with geriatrician shortages (Maine Senior Guide, 2019).

of what the rest of the country will increasingly confront as our Nation ages and as urbanization creates pockets underserved populations in our cities as well as in our vast remote rural areas.

I won't repeat the testimony of my colleagues about the growing shortage of healthcare professionals across our country, as I'm sure you already appreciate the scope of the problem. Rather, I will offer ***five specific strategies*** that I believe can go a long way to addressing the crisis. I will also offer some examples of how we at UNE are attempting to implement each of these strategies. This is not to imply that we've figured out all the best solutions, but rather to provide some specific examples of how higher education can partner productively with government, business, and nonprofit sectors to move the needle in important ways on this critical problem.

First, ***we need to increase the number of doctors, nurses, and other healthcare professionals we educate***. Although there are a number of challenges to doing so, by far the most important is the availability of clinical training experiences, which has been well documented by the Department of Health and Human Services Health Resources and Services Administration (HRSA).[5] As financial margins have tightened and clinician workloads have increased over the past three decades, practicing clinicians in various healthcare settings have less time to devote to training students.[6] The single most important thing we can do to increase the number of healthcare providers is to support partnerships between universities and healthcare systems to develop additional residencies, clerkships, practica, and other training opportunities.

At UNE, one way we have expanded clinical training opportunities is by working with partners in rural and underserved primary care sites and federally Qualified Health Centers. One advantage of such placements is that students learn how to deliver compassionate care to Maine's most vulnerable residents, many of whom are uninsured and also navigate chronic physical and mental health conditions. The precepting clinicians in these settings are dedicated to treating underserved patients, sometimes with limited access to specialized professional support.[7] These settings afford students exposure to a broad range of conditions and allow them to perform a wider variety of procedures than they might in more specialized urban settings.

Clinical training opportunities are not the only infrastructure limitation to producing more healthcare professionals. Standing up new educational facilities, or expanding existing ones, involves considerable startup costs. Recognizing the region's significant unmet oral healthcare needs and the fact that there was no dental school in all of northern New England, in 2013 we partnered with both Federal and state governments, regional industry, non-profits, and philanthropists to establish a dental school. Senator Collins was critical in helping to secure Federal support for that project. And the people of Maine passed a $3.5 million bond to support not only creation of the school itself, but also community dental clinics around the state to help them increase their capacity to provide dental care and to take our students on rotation. The school was created with an explicit focus on addressing underserved populations, as reflected in its mission statement: " . . . *to improve the oral health of northern New England and rural and underserved populations*."

Another barrier to training more healthcare professionals is the difficulty hiring and retaining qualified faculty members, who can typically earn more in direct care clinical settings and yet require a higher level of training and credentialing than those working clinically.[8] At UNE, we are developing a specialized track within our dental program to educate students who are interested in pursuing an academic career.[9] Support such as that displayed by Senators Collins, Sanders, and others for strategic loan repayment programs targeting those assuming faculty positions in dentistry, nursing, and other allied health professions is critical to ensuring the future of the healthcare workforce. Loan repayment programs improve access to graduate/doctoral education by encouraging qualified individuals to advance their education and subsequently become employed as faculty.

Second, ***we must intentionally recruit more students who look like the communities we need to serve***. It is well established that individuals from underrep-

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[5] U.S. Congress: Advisory Committee on Interdisciplinary, Community-Based Linkages. (2018).
[6] Benbassat, 2020; Cox & Desai, 2019; Hanna, 2019; Graziano et al., 2018; Konrad et al., 2010; Krehnbrink et al, 2020; de Villiers et al., 2018; Rodriguez, 2013.
[7] Hempel et al., 2015; Lee et al., 2016.
[8] Christmas et al., 2010; Feldman et al., 2015; Girod et al., 2017; Nauseen et al., 2018.
[9] McAndrew et al., 2011.

resented groups are more likely to seek out practitioners who share their identities and backgrounds.[10] Studies have found that minority patients who are treated by race/ethnic-concordant clinicians are more likely to use needed health services and are less likely to delay seeking care.[11]

In Maine, we have a growing immigrant population, especially from Central and Eastern Africa, and not surprisingly, this community experiences significant healthcare discrepancies relative to the broader population.[12] To address this issue, not only has UNE increased recruitment efforts targeting students of color across the entire university, we recently began "Advanced Standing" programs in dentistry and pharmacy, designed to accelerate the time it takes for foreign-trained immigrant professionals to achieve a U.S. degree and become eligible for licensure. We have also developed partnerships with local community colleges to matriculate students from our immigrant communities into certain healthcare programs (e.g., dental hygiene).[13]

Third, it's not enough merely to train more professionals, ***we must encourage them to practice in underserved areas following graduation, such as in rural, medically underserved, and tribal communities***. Like Maine, most states have vast rural areas with highly distributed populations, and these communities have far less access to healthcare.[14] The U.S. Government has invested in programs, administered through the Health Resources and Services Administration, that provide financial support in the form of loan repayment to graduates who serve in disadvantaged areas. These programs are absolutely critical, and we thank congressional leadership for their ongoing support.

At UNE, we have successfully used various strategies to encourage our graduates to practice in rural areas. We intentionally recruit students from rural areas, both from Maine and around the country. Students from small towns and other nonurban areas are more likely to return to such communities after graduation.[15] Regardless of where they come from, we place students in clinical training sites in underserved rural areas as part of their education to give them a taste of rural practice and lifestyle.

Each year, many graduates exposed to these crucial settings during rotations return for employment, inspired by the commitment to quality patient care they witnessed, as well as their love of small-town life.[16] Finally, in concert with state and philanthropic partners, we have developed loan repayment and scholarship programs to incentivize practice in rural settings. These efforts have paid off; over the past decade we have made dramatic inroads in addressing the needs of rural communities. For example, 40 percent of UNE medical school graduates who practice in Maine do so in health profession shortage areas (HPSAs) designated by the U.S. Government, positively impacting the HPSA designation of five counties.[17] And in our dental school's first four graduating classes (2017–2020), we educated 250 dentists, 63 of whom are currently practicing in Maine. Nearly one in five is employed in a federally Qualified Health Center, a non-profit community clinic, or the Vet-

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[10] Shen et al., 2018; LaVeist et al., 2003.

[11] Saha et al., 2000; LaVeist & Nuru-Jeter, 2002.

[12] Drewniak et al., 2017.

[13] National Academies of Sciences, Engineering and Medicine, 2021.

[14] The US Department of Health and Human Services has designated nearly 200 geographic areas in Maine as health professional shortage areas for primary care, dental medicine, and mental health (US DHHS, 2019). Maine also has 51 medically underserved areas/populations, defined as areas having too few primary care providers, high infant mortality, high poverty, and/or a high elderly population (US DHHS, 2019). Nearly all of Maine's medically underserved areas are in Maine's congressional District Two, the second most rural congressional district in the country (US DHHS, 2019).

[15] American Academy of Family Physicians, 2016; Lee et al., 2021; University of Wisconsin, 2020;

[16] UNE's dental school clinical model is an excellent example of success in this regard. UNE places students in up to two 12-week clinical rotations in settings throughout northern New England, working in collaboration with a network of FQHCs, community clinics, and even private dental offices. Students provide billable services while receiving supervision from the preceptor and most importantly, learning about the community they serve. We are grateful for the U.S. Department of Health and Human Services on-going funding to Maine's network of health centers providing access to many of our marginalized residents, while also offering much-needed clinical placements to students.

[17] NCAHD's Enhanced State Licensure Data, 2016; The Robert Graham Center, 2012.

eran's Administration, and four in ten are practicing in Maine's most disadvantaged areas.[18]

Fourth, ***we must leverage the power of technology to reach underserved communities***. The COVID–19 pandemic has introduced many Americans for the first time to the value of telehealth, as we all learned to access healthcare providers via videoconferencing.[19] Telehealth and digital medicine have enormous potential to transform healthcare delivery, particularly in underserved areas.[20] In addition to patients accessing their providers through secure videoconferencing platforms, primary care providers in remote locations can themselves access specialist colleagues in urban tertiary care hospitals and university health centers for expert consultation. And emerging digital medicine and artificial intelligence technologies will increasingly allow clinicians to monitor patient symptoms and even deliver certain treatments remotely over the internet. These technologies can also enhance the reach and effectiveness of continuing medical education programs. At UNE, we are moving toward integrating robust telehealth training for all of our health profession students in close partnership with our various training sites. Of course, telehealth and digital medicine services are only as available as the broadband network that supports them, and like much of the country, many of Maine's most rural counties lack sufficient and reliable connectivity. I am delighted that the most recent COVID–19 stimulus legislation included funding for broadband infrastructure, a portion of which is headed to our rural state. This will make an enormous difference in narrowing Maine's digital divide, and will ensure rural Maine residents can benefit from UNE's clinical and educational expertise, regardless of where they live.

Finally, ***we must fundamentally change the prevailing educational model***. Anyone who has recently been a patient in a hospital, or who has cared for a hospitalized loved one, understands how siloed the practice of healthcare tends to be. One often gets the sense that the various professionals are all practicing their respective crafts with little coordination or communication among themselves. This siloed practice is a result, at least in part, of the traditional discipline-centered model of educating healthcare professionals. In 2001, the Institute of Medicine issued a groundbreaking report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, which laid out the case for dramatic, systemic changes to health care organization and delivery. In response, stakeholders from academia, health systems, and government convened to determine how best to address the Institute's recommendations. In 2012, these efforts led to the development of a new educational model in which students from diverse disciplines are explicitly trained to work together, across traditional boundaries, in multi-disciplinary teams. Known as "interprofessional education"[21] or "IPE" for short, this training model prepares students with team-based competencies, attitudes, and skills that complement distinctive disciplinary knowledge. Interprofessional health care teams offer more than any one discipline can achieve alone, and this is especially critical as patients' health conditions are becoming increasingly complex.[22] Growing evidence suggests that interprofessional collaborative practice[23] improves clinical outcomes,[24] reduces medical errors,[25] increases patient satisfaction,[26] and decreases provider burnout.[27]

The IPE training model, especially when paired with digital health technologies, can be instrumental in meeting the needs of underserved communities. The combination of IPE and telehealth allows doctors, mid-level practitioners, and other primary care practitioners to effectively expand their scope of practice, while also extending specialist care to those for whom it is otherwise out of reach.

One particular area of healthcare that exemplifies the value of this kind of collaborative approach is geriatrics. Diseases of aging often encompass a broad scope

[18] This is particularly noteworthy given that Maine has the fewest dental providers participating in Medicaid or CHIP in the entire country, according to research by the American Dental Association's Health Policy Institute.

[19] Wosik et al., 2020.

[20] Kichloo et al., 2020.

[21] Interprofessional Education occurs when two or more professions learn about, from, and with each other to improve collaboration and the quality of patient care.

[22] Mayo & Williams-Woolley, 2016.

[23] According to the World Health Organization, interprofessional collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, care givers, and communities to deliver the highest quality of care (World Health Organization, 2010).

[24] Lutfiyya et al., 2019.

[25] Anderson & Lakhan, 2016; Hardisty et al., 2014; Irajpour et al, 2019; Lygre et al., 2017; Wilson et al., 2016.

[26] Will et al, 2019.

[27] Cain et al., 2017; Dow et al., 2019.

of conditions and disciplines: heart disease and diabetes treated by primary care practitioners; mobility issues by physical and occupational therapists; isolation by social workers; oral health by dentists and hygienists, and so on. At UNE, we weave training in geriatrics throughout all of our health profession programs. Thanks to legislation sponsored by Senator Collins and supported by Maine's Junior Senator Angus King, and working closely the University of Maine and multiple statewide partners, UNE is one of 48 organizations nationally to have received funding through HRSA's Geriatrics Workforce Education Program, which aims to create a more age-friendly health system by transforming primary care practices and engaging and empowering older adults.

At UNE, we have been pioneers in IPE over the past decade for all of our healthcare programs, and, once again in close coordination with our clinical partners, we are now standing up a university-wide Institute to deepen our commitment to this training model.

In conclusion, successfully addressing America's healthcare workforce crisis will require not merely acting on each of these five strategies in isolation, but seamlessly integrating them. Although strategic investment of resources will be required, much of the work we confront reflects cultural changes that will require strong leadership, a willingness to innovate, and coordinated partnership between academia, government, industry, and the nonprofit sector.

I am grateful for the committee's time and attention, and appreciate your efforts to address our Nation's healthcare workforce crisis. Thank you.

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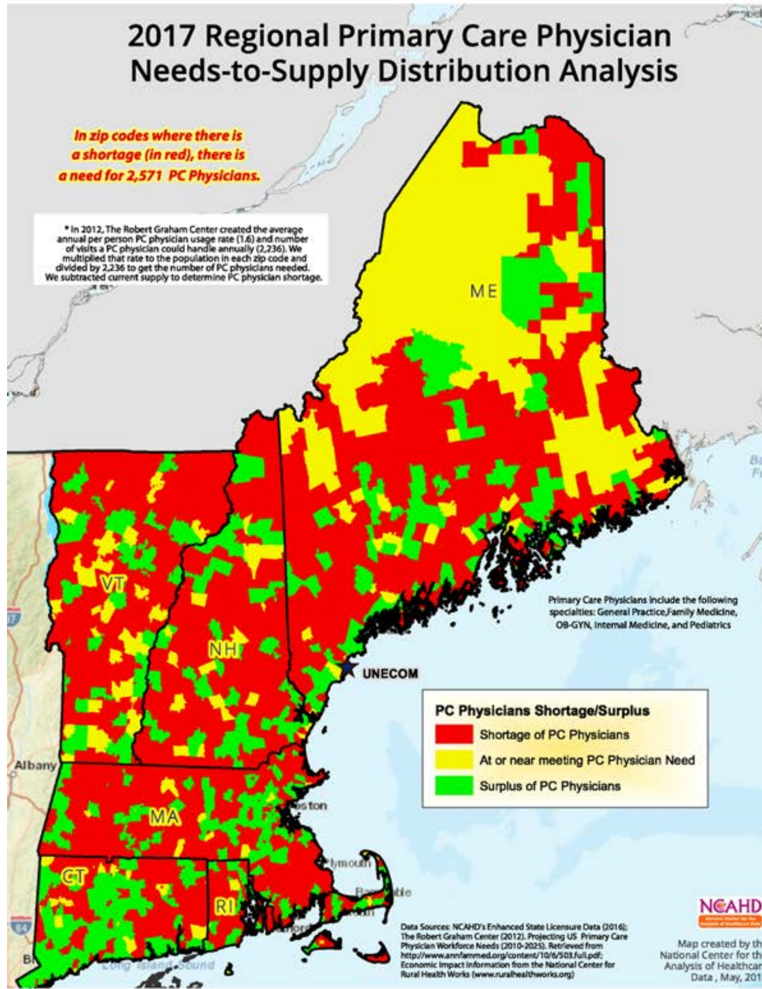
Appendix



The CHAIRMAN. Thank you very much, Dr. Herbert.

I have been impressed that, from the panelists and from the Members here, I think there is a general consensus about what the crisis is and probably the direction that we have to go forward.

I have about 400 questions, but I have time for three or four. Let me start with—Dr. McDougle made an interesting point, which we do not talk about enough, and I would like each of you to tell me whether you think he is right.

We are losing, as I understand it, 50, 60,000 people a year because they do not get to the doctor when they should. But, interestingly enough, when you have more primary care physicians, it not only saves lives, it saves money, as well. That is my impression. So, you get to a doctor when you are sick, you do not end up in the hospital or the emergency room.

Is that a true assertion, that in the long run, having—giving people more access to primary healthcare not only keeps them healthier, probably saves the system more money?

Let's go to everybody. Dr. Skorton, you want to begin?

Dr. SKORTON. Thank you. Permit me 15 seconds to thank and congratulate the other panelists on their very important contributions, not only with the panel today, but in general.

I agree with what you just said, Chairman, but I want to add one thing, and let me just give you my bona fides. I ran a general medical—general medicine division for 5 years at the University of Iowa in which we were a primary care provider, as well as rural health provider. And, so, I could not be more simpatico with the importance of rural health and rural healthcare and changing the calculus.

However, we need clinicians in specialty areas, as well. And it is very, very important that we do not put those two things off sort of butting heads against each other. We need more of a variety of things. And, so, that is one thing that I would comment on.

Then, second, I would say that there is no question that primary care and preventive care go together, just as Dr. McDougle stated. I will be very quick, Mr. Chairman. But, I do want to say that depending on the issue, the idea of interprofessional teams are very, very important. So, we have to think about things beyond the physician workforce.

Overall, we continue to hope that you will help to do things like the Residency Act to have more GME slots in general; duty incentives to bring them to rural areas in primary care, but fill out all the areas that we need.

The CHAIRMAN. Sorry to be rude, but there is not a lot of time and I wanted everybody to comment, and I have some other questions.

Dr. McDougle, do you agree with yourself?

Dr. MCDOUGLE. Yes, I do. And we spoke to geriatrics earlier. I am a geriatrics physician by trade. Most of the patients I see are older, so using the skills that I developed and learned in residency and so forth have allowed me to serve in that role.

The CHAIRMAN. Okay. Ms. Spires.

Ms. SPIRES. Yes, and thank you. I would certainly agree with that comment. I have seen it firsthand and with patients who, if it had not been for the primary care physician and in a setting

such as a federally qualified health center, potentially would not have received the care they needed.

The ongoing idea of the diagnosis would certainly lead to hospitalization. And, so, when you are looking at things such as chronic illnesses, which we face every day, which if it is managed, will decrease expenses as it relates to Medicare and Medicaid, putting people into the hospital.

When you are looking at a primary care physician, who is the individual responsible for managing that chronic illness for that patient, it truly—if we do what we are supposed to do from our standpoint, it does truly decrease the cost from a bigger picture standpoint by being able to provide that care.

The CHAIRMAN. Okay. Dr. Herbert.

Dr. HERBERT. The answer is absolutely yes. There is no question. It is not even up for debate. There is research showing very clearly that those investments in primary care pay.

I would add two quick things. One is primary care involves more than just family practitioners, doctors. It also involves psychiatry, OBGYN, which are desperately needed.

The second thing I would mention are mid-level practitioners, so-called physician extenders, PAs, nurse practitioners, those folks can be critical in meeting unmet needs in rural areas.

The CHAIRMAN. I am running out of time, but one quick question here and I would like all four of you to comment on it.

Explain to me why when primary care physicians often work so hard, crazy hours, why are they paid substantially less than other specialists? Does that make any sense at all?

Dr. Skorton.

Dr. SKORTON. It is going to be hard to answer that question briefly.

The CHAIRMAN. Well, you have to do it briefly. I have got 16 seconds here. Very briefly.

Dr. SKORTON. Okay. It has to do with the way our payment systems are set up, and it is not directly linked to the quality or the importance of care.

The CHAIRMAN. But it does say something about the system that primary care physicians receive substantially less than surgeons, for example?

Dr. SKORTON. That is right.

The CHAIRMAN. Okay. Dr. McDougle.

Dr. MCDOUGLE. We are not a procedure-based specialty. We are a person-focused specialty, and that does not necessarily lead to increased revenue, but an increased cost savings that does not necessarily reflect in pay.

The CHAIRMAN. Ms. Spires.

Ms. SPIRES. Absolutely. Yes, I think that they are certainly underpaid, not just from the standpoint of being a specialty service, but they actually take care of the entire person. I mean, we are looking at a holistic approach. And, so, they are managing multiple issues versus one dedicated issue.

The CHAIRMAN. Dr. Herbert.

Dr. HERBERT. Our payment system is based on procedure and visit codes. That is what you get paid for. If a primary care physician spends 50 minutes counseling a patient on their diet, lifestyle,

exercise, this sort of thing, a patient with chronic disease, they are going to get paid less than if they—they will get paid one-tenth to half what they would get paid if they did an EKG, maybe a catheterization, gave them some medications. It is—the payment system is flawed and it incentivizes the wrong things.

The CHAIRMAN. Thanks very much.

Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

Dr. Herbert, U.S. nursing schools turned away more than 80,000 qualified applicants from baccalaureate and graduate nursing programs in 2019, and faculty shortages were cited as the top reason. So, think about that. Eighty thousand qualified applicants who wanted to be either initial RNs or advanced practice nurses turned away because of a lack of faculty.

How can Congress help with the faculty side of the equation that is creating this bottleneck and contributing to the shortages?

Dr. HERBERT. Thank you, Senator Collins, for the question. It is a challenge with nursing faculty in particular. I would say all of the faculty disciplines, it is a challenge, but nursing in particular. One of the things that many places, UNE being one that we are doing, is training our own now. So, we are standing up a program to train nurse educators who in turn will become our own faculty because there is not enough nurse educators out there.

The second thing, the loan repayment programs are absolutely critical. There are a number of programs out there. I know you have sponsored many of these, and I am deeply grateful for that. I know right now that at least four of my nursing faculty are taking advantage of those programs, and these are individuals who would not have gone into nursing teaching were it not for those programs.

Then, fundamentally, a big challenge is that nurses can simply make more out in practice than we can pay them at universities. And, of course, the easy answer would be, well, just pay them more, right? But, I have to balance my budget, and I have to live within a balanced budget, and if I—I do not want to charge my students higher tuition or to decrease their financial aid, the institutional aid, that we offer them in order to pay them more. So, therein lies the dilemma.

Support on any one of those three initiatives would be phenomenal to help with this problem.

Senator COLLINS. Thank you. I am very intrigued that you are training your own educators. I think that is a very innovative idea.

Dr. McDougle, it is really distressing to hear from you that the number of Black physicians has remained flat for I think you said 80 years. I held what I believe to have been the first hearing in the Senate to look at the racial disparities in the COVID cases. And even as a state with a small Black population like Maine, we see that disparity. I get a report on it each and every day from the Maine CDC.

I had at that hearing Morehouse University testify about what could be done, and they echoed what was said here, that we need to be training more people who look like the community that they are serving. That is clearly true, and it would help overcome the

legacy of mistrust between the Black population and medical professionals that exists in some areas.

But, how can we get more Black Americans, Hispanic Americans, Native Americans to apply to medical school and to see that as a career path?

Dr. MCDOUGLE. Very good question. We need to go to our elementary schools, pre-K through 12th graders.

We have a program at the Ohio State University called Health Sciences Academies where there is a cascading mentorship model involved with partnering with the teachers and parents of students who are in feeder schools into Columbus East High School, which is right across the street from Ohio State East Hospital.

I think those types of initiatives where we have that expertise at the academic health center, at our seven health professions colleges, and we partner with the elementary, middle, and high schools to create that pathway of opportunity. And I think that is one example in addition to the existing HCOP programs and the other pathways funded through HRSA.

Very good question. Thank you.

Senator COLLINS. Thank you for an excellent answer.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Collins.

I have on my list Senator Braun, Senator Kaine, Senator Hassan, Senator Baldwin. Senator Baldwin, are you there, Tammy?

Senator BALDWIN. I am.

The CHAIRMAN. Where are you? I do not see you.

Senator BALDWIN. I am virtual.

The CHAIRMAN. All right. There you are.

Senator BALDWIN. Hello, Mr. Chairman. Thank you for the recognition. And I want to thank our panelists. What an important hearing.

I wanted to focus in on the importance of training in the area of palliative and Hospice care.

Dr. McDougle, you just stated that you are not a procedure-based specialty, your area of practice in geriatrics. You are a person-based specialty. And I would argue the same is true in palliative and Hospice care.

One of the challenges in preparing health professionals for careers in palliative care is the lack of support for trained professionals to serve as faculty and dedicate time to the educational function. There is an urgent need to build our workforce, but we cannot do it without building the workforce training infrastructure.

I have introduced bipartisan legislation with my colleague, Senator Shelley Moore Capito, called the Palliative Care and Hospice Education and Training Act, and we are working to re-introduce it this year, shortly. It would grow and improve the palliative and Hospice care workforce by supporting the full pipeline of physician training in the subspecialty, including through academic career awards and fellowships for providers.

I want to start with a question for Dr. Skorton. How can we better address the need for programs that train health professionals, and how does the idea of training the trainer support our healthcare workforce overall?

Dr. SKORTON. First of all, Senator, we want to thank you. I appreciate your leadership on working to authorize these new Title VII programs to train future physicians in palliative and Hospice care. It is incredibly important.

In these Title VII type programs, including geriatric and mental and behavioral health, have a longstanding history in training health professionals to treat our most vulnerable Americans. So, I would take the—very, very quickly mention that we are supporting an investment of $1.5 billion in Title VII and Title VIII programs and hope that Congress will think carefully about that. Not only about this issue, but many of the things that we are talking about today would develop a great boost by more funding going into HRSA programs, Title VII and Title VIII, and I think that would speak directly to your question.

Thank you for the question and for your creativity in this sphere.

Senator BALDWIN. Thank you.

Dr. McDougle, this will go to you. As many of the witnesses have noted, the current healthcare workforce shortages that we face today are only going to continue to grow, and research projects an impending palliative care workforce crisis over the next 20 years. In the shorter time, by 2030, we could see a ratio of only one palliative care physician for every 26,000 seriously ill patients. Part of why we urgently need to grow the palliative care workforce is to ensure that more Americans and their families have access to this type of care when they need it the most, and it is a matter of healthcare equity in my mind.

Dr. McDougle, can you speak to how support for workforce development programs and provider training works to advance health equity and help us make sure that more Americans have access to the quality care and culturally competent care that meets their needs?

Dr. MCDOUGLE. Another very good question. So, we know from research and data that physicians from underrepresented groups have a concordance with patients that they are caring for in the population, and we have seen where this has led to increased compliance with preventive care, even flu shots. And, so, that is important. And that visibility in the community, becoming a trusted messenger in the community, was also important and continues to be during this pandemic.

In regards to palliative care, I think there is also a need for just broader public education, and I would recommend to the audience a book recently published by Dr. Dan Morhaim entitled Preparing for a Better End. He speaks to the importance of palliative care, and actually, I will read some of this.

It means a practice where a patient suffering a serious illness will not—will have not only a medical team focusing on a cure, but also a team focusing on symptoms, pain, and quality of life.

Many people do not know the difference between Hospice care and palliative care, so I thank you so much for lifting this important topic up because more discussion and education is needed, especially in the community.

Senator BALDWIN. Thank you. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Senator Baldwin.

Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman.

Healthcare has been the thing I have been most interested in since I have been here in the Senate and trying to reform it from the top down. I think it has evolved into a—I do not like to even call it free enterprise because there are so many things that bother me about it.

It has gotten increasingly concentrated with large corporations. You have an urban, rural divide. I am from Indiana. A lot of our rural hospitals are in peril. Sometimes, they have to end up getting bought by an urban chain, and then it seems like it gets even worse.

A lot of—and running a business for 37 years before I got here, you have to have transparency, competition. Things have got to work well. I harp on that all the time.

Here, I would love to hear your comments, Dr. Herbert and Dr. Skorton, about on the workforce side of it. I have a healthcare advisory group that meets three times a year. Doctors and nurses are kind of tiring of the profession almost because it used to be they had a family practice or they had a viable rural hospital to work for. Now, it is working for a huge corporation that seems to have a disproportionate amount of wealth, will not accept transparency and competition. The insurance companies are along with them. They tell me that it has a lot to do with why we are having trouble getting nurses or even doctors. When they want to form their own hospital, cannot do it due to the big guys having regulations in place.

How much of the nature of the industry evolving the way it has do you think has to play into the lack of people wanting to get into the profession when it is some of the highest paid jobs you could have out there?

Dr. SKORTON. Nobody wants to jump in first on this one, but it is a very, very important point that you make. And, I would say that right now is a great time to rethink all of these disincentives. We have an increasing interest in going to medical school across the Country. A lot more people want to go to medical school. Perhaps the work of those who were on the front lines in COVID had a little bit to do with that. Who knows?

Whatever it is, it is a very positive trend. There is a lot of enthusiasm. Young people who want to go out there and do the right thing. Leaders like my fellow panelists today who are showing the right way to point to specific areas that need to be done. So, I think there is a great wave of optimism and desire to do things in the public interest.

Through your wisdom, in consultation with us, we think, in the private sector, as well, as Dr. Herbert mentioned, we need to talk over these specific areas that are disincentives and see how we can focus on those specific areas. Throwing the whole system out, while it might be tempting in some ways, would be chaotic in a Country as large as ours.

But, through your wisdom and our experience, I think we could work together to find those areas that cause disincentives for the profession in general. And we would be glad offline to talk with you and your staff about that if it would be of interest.

Over to you, Dr. Herbert.

Dr. HERBERT. Thank you. This is a big problem and I do not pretend to have all the answers. I will mention a couple of things.

The payment structure issue that we just mentioned creates incentives for doing certain kinds of procedures that is not as well aligned. I think that is part of the burnout issue. I mentioned before that there are actually compelling data that the interprofessional training model can actually reduce provider burnout.

The other thing I would say is with some of these rural hospitals is that we need the—to help them develop GME so that they can become teaching hospitals. There are many rural hospitals out there that would like to do that. The problem is the investment, the upfront costs, to develop a GME program in a virgin, a so-called virgin hospital that has never had GME. The price tag just to begin the process, to get it through ACGME, the accreditation body, is between 1.5 and $3.5 million. And, that is not taking into account the first few years of having a residency program when the CMS payments are not going to be as high as they will be once it is at full steam.

There is—and it may not sound like a lot of money in the grand scheme of things, but if you are a small, rural hospital, three million bucks is a lot of money. But, that small investment could be just enough to develop a GME program, to develop a new residency program. Suddenly, now there is new energy. It brings a cultural change in many positive ways to these hospitals.

There is a way that I think the Federal Government could help substantially, just getting us over that hump. We are partnering right now with a hospital in Maine trying to do exactly this. But, three million bucks is a lot of money, so——

Senator BRAUN. Thank you for that. And I think for this to really be solved holistically before we get more government involved with it, the industry has obviously in itself evolved in a way that I do not think is good.

Transparency, transparency, transparency. Let the consumer see things. Get the hidden veil that insurance companies, and especially hospitals have out there that frustrate nurses, doctors, and especially stakeholders like myself where I have wrestled with it in my own business prior to coming here. It does work. When you do those things, engage your healthcare employee, make them into a consumer, a lot of these other things start to fall in place.

Thank you.

The CHAIRMAN. Senator Kaine.

Senator KAINE. Thank you, Mr. Chairman and Senator Collins. What a wonderful hearing.

Dr. Skorton, the AAMC did a report that came out last June, I believe, that predicted a shortage of 139,000 physicians by 2033. A report dated June 2020 was probably done a few months before and probably did not even take into account the pandemic effect. I understand that you are looking at an update of that report.

My prediction, before I read the update, is that number will not have decreased because a pandemic that has now infected more than 30 million Americans with COVID, and 10 to 20 percent are claiming to have long-term effects after COVID. I am one of those 10 to 20 percent. And, then, there has been a mental health impact

of COVID, which has also been significant, very significant. I doubt that the number of the shortage is going to go down.

Recruiting people in is important. You have addressed strategies on that. I really want to focus on keeping people in the profession once they are in.

Dr. Skorton, I appreciate your testimony today focusing on the Lorna Breen Act that I have introduced with Dr. Cassidy and other colleagues. The problem of keeping our healers healthy, the mental health, the frontline health providers is so important.

Lorna Breen was a New York emergency room physician with family in Virginia, who died by suicide in April, in the early days of the pandemic, as she was, just facing an onslaught of sickness and death. And, then, she got COVID herself, and, then, tried to get back to work but was worried about seeking mental health counseling because she felt like there would be a stigma, she might lose her license, she might lose her practice, ability to practice.

We have to do things to break down any stigma about seeking mental health training among our professionals, and we have to come up with novel strategies so that we can keep our healers healthy.

I have even, Mr. Chairman, started a rankle when I hear people talking about our healthcare workers as heroes because sometimes heroes are people we put up on a pedestal, and that might make it even harder for somebody to seek help. They are healers. That is a good enough word, and we have got to keep our healers healthy.

Chairman Murray has noted the Lorna Breen Act for action in our next Committee markup. It is very widely supported on both sides of the aisle. And I hope my colleagues will join me in doing something really important for the healthcare of our healers.

A mental health issue I want to ask each of you about is this. As we are talking about shortage of healthcare workers, let's talk about mental health workers. The National Council for Behavioral Health reported, also in a 2020 report that was done before COVID, that 77 percent of the counties in the United States are experiencing a severe shortage of mental health providers. The Virginia Healthcare Foundation indicates that much of Virginia is essentially a mental health professional desert, a shortage area. And these were before COVID.

The after effects of COVID, people having lost loved ones, people having lost income, lost their jobs, seen so much suffering, these mental health needs are not going down.

Many in Virginia who were participating in substance use group therapy sessions or other modes of treatment to try to deal with substance use issues saw those treatments become more difficult. Zoom sessions are not as good as in-person sessions, et cetera.

If we had a 77 percent shortage of mental health providers pre-COVID, or 77 percent of counties were sort of short of mental health providers pre-COVID, it is going to be more after COVID. What can we do to make sure that the Nation has the mental health workforce that we need? And I would offer that to any of the witnesses.

Dr. SKORTON. First of all, let me thank you for the Lorna Breen Act. It is very important. She was at Allen Hospital—rest in

peace—which is part of the New York Presbyterian world where I practiced, saw patients, and taught up to about 2 years ago. So, I very much appreciate what you have done.

In terms of long COVID, we are working on research to understand what is going on. Please stay tuned and stay of good cheer because we are going to figure this out like we have figured everything else about COVID.

This mental health issue is dramatic and getting worse. There is no question about it. I think two Members of the Subcommittee who have developed the Opioid Workforce Act, which is incredibly, incredibly important because, as the Ranking Member mentioned—and thank you, Senator Hassan, for that, as well—we are really suffering with all of those things related to substance abuse throughout America, urban, rural areas, you name it.

But, to focus specifically on stigma, which is probably the biggest single issue, I am afraid to say that healthcare workers, like many other people, are afraid to come forward and say, I need help. Very afraid to do that. Afraid for the stigma, afraid perhaps even to be limited in their practice prerogatives.

This is something the profession itself really has to work on. This is not something we can unload on Congress. We have to develop ways to reduce that stigma and to make sure that coming forward does not result in something that will limit someone's professional choices. And I have had some experience with that, friends and personally, and would be glad to talk to you offline.

But, we thank you or the Lorna Breen Act. I hope that comes to completion and that we can do all of these things together, and the Opioid Workforce Act. Those things, I believe, would come together, both the providers and to reduce stigma.

Thank you for all you are doing.

Senator KAINE. I yield back, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you.

Senator Hassan.

Senator HASSAN. I want to thank the Chairman and Ranking Member for holding this hearing. And to all of the panelists, thank you for being here. Thank you for your work.

I want to start with a question to Dr. McDougle. I have heard heartbreaking firsthand accounts from K through 12 students in New Hampshire about their own struggles with mental health during the pandemic or their worries about their friends.

Maybe the silver lining here, to follow-up on what Dr. Skorton was just saying, is that last week in a meeting with them in person, I was tiptoeing around the issue. I was not sure fifth graders and high school students would want to talk to me about mental health. They had no inhibitions about talking to me about mental health. They are worried about it for themselves, for their friends, and the pandemic has really obviously exacerbated it.

In 2020, mental health related emergency department visits for children increased dramatically. And we know because of the pandemic, it has been harder for them to get in to see their primary care docs or to get to school in person to have the kind of mental health supports that school might provide. So, we have to do better for our kids.

Dr. McDougle, what steps can Congress take to ensure that pediatricians and primary care providers are prepared to respond to the pediatric mental health crisis we are experiencing as a result of the pandemic? And what can we do in Congress to improve access to mental health services for kids through their communities, including their schools?

Dr. MCDOUGLE. Very good question. As primary care physicians, we many times are the first persons who are talked to about the mental health concerns. In some cases, we are able to manage the mental health concerns. That being said, typically it may involve referral to a psychologist or a licensed social worker to work in concert with us.

Someone mentioned earlier about the importance of telehealth. Congress has to continue funding of telehealth. That has to continue. And we need to also prioritize training of licensed social workers, psychologists, and psychiatrists.

A strong message needs to be sent to our medical schools, our health professions schools, that this is a national crisis that we all need to step up to.

Those are my initial thoughts.

Senator HASSAN. Thank you very much for those initial thoughts. They are great ones.

I want to—I am just going to comment quickly that I thank all of the panelists for the support that you have all expressed for boosting the behavioral workforce and the workforce to treat substance use disorder. And I am pleased and honored to work with Senator Collins on the Opioid Workforce Act and we will continue to push that through.

Dr. Herbert, under the American Rescue Plan, Congress increased Federal funding for home-and community-based services to help more people access the care they need in the setting that best suits their needs.

But, this funding increase is temporary. Congress needs to make long-term, sustainable investments in the home health and community-based workforce that is going to ensure access to quality, comprehensive health services for older adults and individuals with disabilities who choose to remain in their homes.

Doctor, can you speak to the role that home health workers play in improving care for older adults and individuals with disabilities? And how will additional sustained investments in home-and community-based health workers strengthen our healthcare system?

Dr. HERBERT. I think you nailed it. We need additional funding to support—it is absolutely critical, the home healthcare workforce, in terms of maintaining the health, especially of our older populations.

If I—so, I would simply support your assertion that funding needs to continue post-COVID.

Could I add something about——

Senator HASSAN. Sure.

Dr. HERBERT [continuing]. Behavioral health——

Senator HASSAN. Yes.

Dr. HERBERT [continuing]. Since you brought that up?

As a clinical psychologist by training, I could go on for hours on this topic, but I will try to just keep it very brief.

It is absolutely critical that we train more behavioral health professionals, there is no question, at all levels; not just doctoral level trained people, but masters level counselors, social workers.

At the same time, what we also need to do is—and this gets back to that interprofessional model I was talking about. We need to train all healthcare professionals——

Senator HASSAN. Right.

Dr. HERBERT [continuing]. Including dentists, to recognize—and OBGYNs, for example——

Senator HASSAN. Yes.

Dr. HERBERT [continuing]. To recognize and diagnose behavioral health problems. And there are behavioral health interventions that those non-expert providers can also learn to provide.

Also, I would add that we have made tremendous progress over the past 30 years in non-pharmacological treatments that in many cases have longer lasting effects, but they are still not widely practiced.

Senator HASSAN. Right.

Dr. HERBERT. Because it is much easier to just give somebody a pill.

Senator HASSAN. Okay.

Dr. HERBERT. I am not suggesting there are not appropriate places for pharmacological intervention.

Senator HASSAN. Sure. No, I understand that. I appreciate that.

I realize I am out of time. I am just going to say I am going to submit a question for the record to the panel because, Mr. Chairman, one of the things I think we really also need to focus on is a partnership between our primary care docs and community health workers to help address the social determinants of health. Because it is so critical if people—docs who are treating, can actually get the nutrition assistance or housing that they need. That can be a big step forward, too.

Thank you.

The CHAIRMAN. Thank you.

Senator Rosen.

Senator ROSEN. Well, thank you, Chairman Sanders, Ranking Member Collins. I really appreciate this hearing. It is just so important. And the witnesses for your work, your compassion, and caring. I really appreciate that.

The entire State of Nevada has shortages of healthcare providers. It is especially true for our rural areas; of course, of rural areas probably across this Country. We desperately need more doctors and nurses. We have to support our existing medical providers who choose to care for those patients in rural and underserved areas so that they stay in those communities.

One of the things my office has heard from Nevada primary care physicians, that they could use more support from specialists to meet the needs of their patients. That is why I introduced the bipartisan Improving Access to Healthcare in Rural and Underserved Areas with Senator Murkowski. It is going to provide additional support for primary care providers in community health centers or rural health clinics through specialist support and accredited continuing medical education.

Ms. Spires, as the leader of a large community health center, could you please speak a little bit about the challenges patients have accessing the center, specialty care, and how having the option for concurrent visits with both their primary care and a specialist might really improve those patient outcomes that of course we all want? And what kind of Federal support would you like to see going forward to potentiate positive outcomes for patients? That is what we all want; right?

Ms. SPIRES. Absolutely. I would certainly be glad to address that.

As far as being in a community health center and access available to our patients, we do have the barrier of resources, special—subspecialties, if you will.

One of the things that we try to do is integrate interdisciplinary teams into our organization as much as possible. So, we have included in that podiatry, optometry, and some of those things that—thinking particularly about a diabetic population, when you look at them and you start looking at foot exams and retinal exams and things like that, indicative of the holistic care of that diabetic patient.

One of the things we also started was when we were looking at endocrinology, which is kind of connected with that, as well, and having limited resources. And, so, we continue to face that challenge.

Transportation is an issue as we, all know, as well. So, when I have remote areas, such as 40 miles away, it is how do we get those patients in to be seen?

I think funding that would support some opportunity for collaboration and partnerships with some of the subspecialties, if you will. One of the things we have done is actually we have corroborated with our local hospital to see what some of those specialties that they have hired, how do we take our mobile units on the road and go to some of these rural areas. And I do primary care and then they handle specialty care, just so that we can continue to control cost. Because if we can get out there and see them, when you are looking at the issue of finances available, then that is going to ultimately save the tax dollars money, as well.

We are continuing to work on that. But, I think one suggestion would be is to continue to have inside conversations with those individuals and organizations that do have good partnerships and relationships and decide how can we address this issue. But, I would love to see that happen. That would be great for our patients.

Senator ROSEN. Thank you. I appreciate what you are doing.

I will tell you, I am also so proud that, of course, Dr. Skorton, UNLV graduated its very first medical school class. Ninety-five percent of the graduates were from Nevada; twenty-six percent first generation college students.

We passed bipartisan legislation to support 1,000 new Medicare-funded Graduate Medical Education residency positions. Of course, really important because we have got to address the workforce shortage so we can use things like mobile units, collaborative care, comprehensive care. And, so, we have to work on these GME slots, especially maybe redistributing some of those unused slots.

Dr. Skorton, in this short time I have left, even though we did increase the GME slots by 1,000, some of them are not always a

match. And, so, there soon will be qualified medical school graduates. How can we utilize these while they may be perhaps on a gap year waiting for a residency, to potentiate some of our rural and underserved areas? What options do you think we might use?

Dr. SKORTON. Well, first I want to tell you that I had the honor of giving the commencement speech at UNLV—it was recorded about 2 weeks ago—to congratulate them on their first class, as well as UNR. And they are doing a lot of very interesting, important things.

The idea of volunteerism and other things that people can do while they are awaiting the next step in their careers is one that our medical schools themselves are working on.

By the way, in the State of Nevada, both in Reno and in Las Vegas, there is a lot of very innovative things happening to connect the medical school itself with the community.

I would like to get back with you offline, Senator, with some ideas about that business of the gap year. There are some of our schools in other states that are also thinking about that. And if it is acceptable, I would like to get back to you on that.

Senator ROSEN. I would love to have that conversation because I—we have such a shortage of medical resources across the spectrum and across the Country. We have to do everything we can to promote, protect, and enhance our collaborative models for patient care. So, I look forward to that.

My time is expired. Thank you.

The CHAIRMAN. Thank you, Senator Rosen.

Let me conclude by thanking all of the Senators for their questioning. I perceive that there really is a general consensus. We may not agree on every detail, but I think there is a general understanding that we have a crisis. I think we have a pretty good understanding of where we want to go and have to go.

This is a solvable problem. I mean, this is the wealthiest country. Yes, we can have enough doctors, and we can have doctors and nurses in the places that we need them. I think we can do this. And I think the Congress and the medical profession have got to be working together on this. So, I just look forward to working with my colleagues here.

I want to thank the panelists for their great testimony, Senator Collins for her help on this.

I would ask unanimous consent to put into the record letters from nine different healthcare organizations who are interested in this issue.

[The following information can be found on page 48 in Additional Material]

Okay. Well, thank you all very much. This was, I think, a great hearing, and let's go forward together on this.

Thank you all.

ADDITIONAL MATERIAL

May 20, 2021

The Honorable Bernie Sanders
Chairman
Subcommittee on Primary Health and Retirement Security
Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, D.C. 20510

The Honorable Susan Collins
Ranking Member
Subcommittee on Primary Health and Retirement Security
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, D.C. 20510

Dear Chairman Sanders and Ranking Member Collins,

On behalf of the American Academy of Family Physicians (AAFP) and the 133,500 family physicians and medical students we represent, I applaud the committee for its continued focus on the health care workforce. I write in response to the hearing: "A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce" to share the family physician perspective and the AAFP's policy recommendations for ensuring that we have a robust primary care workforce to address current and future needs.

Primary care is unique in health care in that it is designed for everyone to use throughout their lives - from healthy children to older adults with multiple comorbidities and people with disabilities. Family physicians also play critical role in mitigating health inequity, including systemic racism, by collaborating with community stakeholders to affect positive change for the populations they serve. However, the United States is facing a significant shortage of primary care physicians. We will need up to 55,200 additional primary care physicians by 2033 in order to meet the health care needs of our growing and aging population.[1]

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. Despite these benefits and primary care accounting for 35 percent of health care visits, **only about 5 percent of overall health care expenditures is invested in primary care.**[2] The COVID-19 pandemic has also highlighted the urgency of building and financing a robust, well-trained, and accessible primary care system in our country.

The AAFP urges the committee to consider the recommendations below to ensure that our nation has a robust primary care workforce that is equipped to address our population health needs and facilitate access to health care, improve patient outcomes, and reduce health care costs.

Recommendations

- Permanently Authorize the Teaching Health Center GME Program — Today's 59 Teaching Health Centers play a vital role in training the next generation of primary care physicians and addressing the physician shortage. To date, the Teaching Health Center Graduate Medical Education (THCGME) program has trained more than 1,148 primary care physicians and dentists, 65 percent of whom are family physicians. THCGME graduates are more likely to continue practicing primary care medicine and serving in medically underserved communities

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than those in Medicare GME-supported programs. **Congress should permanently authorize the Teaching Health Center GME program.**

- Provide an adequate number of primary care residency positions - Effective health care systems have a physician workforce comprised of roughly 50 percent primary care and 50 percent subspecialty. The current U.S. physician workforce is 33 percent primary care, and only 13 percent of medical school graduates match into family medicine residency programs.[3] To achieve the goal of 50 percent primary care, it is imperative that at least 25 percent of U.S. medical school graduates choose family medicine by 2030. **Congress should establish accountability for federal GME payments to correct the historical maldistribution of federal GME financing by ensuring new positions are allocated to mitigate geographic and specialty imbalances to reduce health professional shortage and medically underserved areas.**

- Strengthen the family physician pipeline by investing in federal programs that reduce medical student debt - The average student loan debt for four years of medical school, undergraduate studies and higher education was $200,000 in 2019, according to the Association of American Medical Colleges.[4] Research has shown that loan forgiveness or repayment programs directly influence physician practice choice. **Congress should expand funding for federal programs, including the National Health Service Corps Program, that target primary care, support the deferment of interest and principal payments on medical student loans until after completion of postgraduate training, and we recommend that the interest on medical student loans be deductible on federal tax returns.**

- Student loan forgiveness for frontline physicians - Family physicians are on the frontlines of the COVID-19 pandemic screening, diagnosing, triaging, and treating patients who are fighting the virus while continuing to provide comprehensive care to their patients with ongoing health care needs, including management of chronic conditions. Family physicians conduct one in five office visits in the nation - totaling 195 million visits annually. They are keeping patients healthy and keeping them out of the hospital and emergency room while many of them have also provided surge staffing when hospitals have been overwhelmed. **Congress should pass the Student Loan Forgiveness for Frontline Health Workers Act (H.R. 2418), which would forgive the outstanding student loan debt of frontline physicians, medical students, and health care workers who are treating patients with coronavirus.**

- Medicaid Parity - Recent data show that Medicaid enrollment has increased by more than 7 million since the start of the COVID-19 pandemic, and trends suggest that enrollment will continue to increase a result of pandemic-related job losses.[5] The demand for primary care physicians in the Medicaid program is more acute than ever. Inadequate Medicaid payment threatens access to primary care services in areas hardest hit by COVID-19, and without proper support during this public health emergency and beyond, family physician practices could be forced to close. **Congress should ensure Medicaid beneficiaries have timely access to primary care by raising Medicaid payments to at least Medicare payment levels.**

- Ensure financial stability and delivery system support for physicians serving rural communities to eliminate health disparities and improve access for all populations - Almost a quarter of the U.S. population lives in a rural area. And disparities between health outcomes and rural residents continue to increase. Americans living in rural areas are more likely to die from the five leading causes than their urban counterparts according to a study by the

Centers for Disease Control and Prevention.[6] About 17 percent of AAFP's members practice in rural communities, which is the highest percentage of any medical specialty. Many rural family physicians provide obstetrical care and emergency medical services under some of the most challenging conditions possible. Recognizing the challenges in rural health, the AAFP launched Rural Health Matters, an Academy-wide strategic initiative to improve health care in rural communities.

Congress can improve these health outcomes with targeted investments in rural health infrastructure by expanding teaching and residency training opportunities in rural communities, supporting stable funding for rural and critical access hospitals, and expanding access to broadband and telemedicine services.

- Address the current family physician shortage by increasing the number of visas for international medical graduates (IMGs). Research verifies that IMGs are twice as likely to practice primary care as their U.S. counterparts.[7] They also serve a vital role in providing health care in rural and underserved areas.[8] **Congress should pass the Healthcare Workforce Resilience Act (S. 1024), which would recapture unused immigrant visas Congress authorized in previous years and reallocate them, with 15,000 for physicians.** This is especially critical to strengthening our health systems' capacity as we continue to deal with the COVID-19 pandemic.

- Mental Health of Physicians - Even prior to the pandemic, burnout among health providers was a pervasive public health concern, with some studies reporting burnout in more than 50 percent of clinicians. According to the American Board of Family Medicine, primary care physicians have experienced the highest rate of death (26.9%) among health provider specialties during COVID-19.[9] Physician burn out during the COVID-19 pandemic has become worse, negatively impacting happiness, relationships, career satisfaction, and patient care. A January 2021 report showed that 47 percent of family physicians are burnt out, and 20 percent of all physicians are clinically depressed.[10] **Congress should invest in the mental health needs of our nation's doctors, particularly during the pandemic, and fight the stigma around seeking necessary treatment by passing the Dr. Lorna Breen Health Care Provider Protection Act (S. 610).**

Thank you in advance for consideration of our recommendations. The AAFP looks forward to working with the committee to develop and implement policies to strengthen the primary care workforce. Should you have any questions, please contact John Aguilar, Manager of Legislative Affairs at jaguilar@aafp.org.

Sincerely,

Gary L. LeRoy, MD, FAAFP
Board Chair
American Academy of Family Physicians

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May 20, 2021

The Honorable Bernie Sanders
Chair
Senate HELP Subcommittee on Primary
Health and Retirement Security
332 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Susan Collins
Ranking Member
Senate HELP Subcommittee on Primary
Health and Retirement Security
413 Dirksen Senate Office Building
Washington, DC 20510

RE: Palliative Care and Hospice Workforce Shortages

Dear Chairman Sanders and Ranking Member Collins:

On behalf of the 5,300 members of the American Academy of Hospice and Palliative Medicine (AAHPM), I write in reference to today's hearing titled "A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce." With the workforce shortage in hospice and palliative care well documented, and further spotlighted by the COVID-19 pandemic, we welcome your attention to these critical issues and stand ready to help advance sound policy that ensures our nation has the workforce necessary to provide high-quality serious illness care for all Americans.

AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for patients facing serious illness, as well as their families and caregivers. We applaud the Subcommittee's leadership in examining the need to support and expand workforce training programs, and **we respectfully request consideration of the *Palliative Care and Hospice Education and Training Act* (PCHETA)** which soon will be reintroduced by Senators Baldwin (D-WI) and Capito (R-WV).

PCHETA recognizes the importance of a well-trained, interprofessional healthcare team to ensuring high-quality, coordinated, person-centered care. This bipartisan legislation would expand opportunities for interdisciplinary education and training in palliative care, including through new education centers and career incentive awards for physicians, nurses, physician assistants, social workers and other health professionals. In helping to address the long-standing shortage of healthcare providers with the knowledge and skills to provide optimal care to the growing number of Americans experiencing serious illness or multiple chronic conditions – ever more important in the wake of the COVID-19 pandemic – **PCHETA would help build a healthcare workforce more closely aligned with the nation's evolving healthcare needs and improve care and quality of life for millions of Americans facing serious illness.**

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Transforming Care of People with Serious Illness

Many of the problems of our healthcare system – high costs, overutilization, lack of coordination, preventable transitions between healthcare institutions, and poor quality – become particularly evident during extended chronic and serious illness. We believe palliative care offers the solution. **A growing body of medical research has documented the benefits of high-quality palliative and hospice care for patients and families, for hospitals and payers, and for the healthcare system as a whole.** Palliative care is associated with enhanced quality of life for patients, higher rates of patient and family satisfaction with medical care, reduced hospital expenditures and lengths of stay, and other positive outcomes – including longer patient survival time. Hospice care has also been associated with lower costs of care, better outcomes (such as relief of pain), and even longer life, despite its focus on comfort rather than treatment aimed at cure.

Palliative care is patient- and family- centered—it focuses on matching treatment to achievable patient goals and supporting patients and their families/caregivers during and after treatment to maximize quality of life. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences; expert assessment and management of physical, psychological, and other sources of suffering; and coordination of care across the multiple settings (e.g., hospital, post-acute care, ambulatory clinics, home) that patients can traverse throughout the course of a serious illness. Palliative care can be offered alongside life-prolonging and curative therapies for individuals living with serious, complex, and eventually terminal illness and includes hospice care.

While AAHPM members care for our nation's sickest and most vulnerable patients, there just are not enough specialists to meet the needs of the increasing number of Americans with serious illness who stand to benefit from palliative care. And not only will the pressure of serious illness and multiple chronic conditions mount as the U.S. population ages, but the public health emergency created by COVID-19 has exacerbated the need — highlighting the current palliative care workforce shortage as well as the importance of providing better training to all healthcare providers who will be called upon to care for the seriously ill. Simply put: **Despite the growing need for palliative care, the U.S. is unable to meet patient and health system demand because of a significant shortage of trained providers.**

Even before the emergence of the coronavirus pandemic, researchers at Duke University, the University of Alabama at Birmingham, and the Mayo Clinic projected an impending palliative care workforce crisis. They estimate an absolute growth rate of no more than 1% in palliative care physicians over the next 20 years, with the number of persons eligible for palliative care growing by over 20% during that same period, resulting in a ratio of only one physician for every 26,000 patients by 2030. Similarly, the George Washington University Health Workforce Institute found that current training capacity for Hospice and Palliative Medicine is insufficient to provide hospital-based care and keep pace with growth in the population of adults over 65 years old. These shortages are exacerbated when considering the current rapid expansion of community-based palliative care, such as in outpatient and home-based settings.

This need for trained providers is borne out by other major institutions working to provide evidence-based policy recommendations. The Institute of Medicine reported that "major gains have been made in the knowledge base of palliative care" but noted that "these knowledge gains have not necessarily been matched by the transfer of knowledge to most clinicians caring for people with

advanced serious illnesses." A National Academies of Sciences, Engineering and Medicine workshop to examine these issues similarly found that "to provide high-quality care to people of all ages living with serious illness, it is critical that the nation develop an adequately trained and prepared workforce consisting of a range of professionals, including physicians, nurses, social workers, direct care workers, and chaplains."

Meeting the Nation's Evolving Healthcare Needs

We believe enacting PCHETA will go a long way in helping our nation meet current health workforce challenges as well as those of the future, including future pandemics. With the Commonwealth Fund having characterized palliative care as a vital component of COVID-19 care – and palliative care and hospice teams stretched thin in the wake of this public health emergency – addressing the critical shortage of health professionals with knowledge and skills in palliative care is even more urgent, particularly as the United Nations predicts future pandemics are likely to be more frequent and more deadly.

PCHETA would provide an infrastructure to educate and train all members of the interdisciplinary care team. At the same time, the bill is designed to build the evidence base for the field, by directing existing funds toward palliative care research to strengthen clinical practice and healthcare delivery. Finally, PCHETA would allow the Secretary of Health and Human Services to implement an awareness campaign, to inform patients and healthcare providers about the benefits of palliative care and hospice and the services available to support individuals with serious illness, including infectious diseases such as COVID-19.

AAHPM is not alone in championing PCHETA. It has enjoyed strong bipartisan support in Congress (and previously passed the House twice), as well as broad support from more than 50 national and 35 state organizations. We urge you to consider this legislation as you consider workforce proposals and to ultimately advance PCHETA in the Senate to ensure our nation has the robust, well-trained workforce necessary to ensure access to high-quality, equitable care for the expanding and diverse population of patients with serious illness, as well as their families and caregivers.

*****

Thank you again for your commitment to address workforce shortages. We appreciate your consideration of PCHETA and welcome the opportunity to discuss other ways to address workforce needs of the healthcare sector, including as relates to the COVID-19 pandemic. Please direct questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,

Nathan E. Goldstein, MD FAAHPM
AAHPM President

CC: Members, Senate HELP Subcommittee on Primary Health and Retirement Security

Statement for the Record
American College of Physicians
To the United States Senate Committee on Health, Education, Labor and Pensions
Subcommittee on Primary Health and Retirement Security
On
"A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce"
May 20, 2021

The American College of Physicians (ACP) is pleased to submit this statement and offer our views regarding the ongoing and growing health care workforce shortage, including a shortage of physicians, in the United States. We greatly appreciate that Chairman Sanders, Ranking Member Collins, and the Subcommittee on Primary Health and Retirement Security have convened this hearing, "A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce," held on May 20, 2021. Thank you for your commitment to ensuring that clinicians have the opportunity to share their views about the health care workforce shortage in this country, especially as it applies to physicians. ACP believes that immediate action is necessary to address the existing and growing physician workforce shortage through expansion of federal programs such as Medicare supported graduate medical education (GME), the National Health Service Corps (NHSC), and the Public Service Loan Forgiveness (PSLF) program, in addition to other programs and legislation outlined below that Congress can enact now.

ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The COVID-19 global pandemic continues to take a toll on virtually all aspects of the U.S. economy and health care system including on physicians. Internal medicine specialists in particular have been and continue to be on the frontlines of patient care during the pandemic. Many physicians were asked to come out of retirement to provide care, and there continues to be an increasing reliance on medical graduates, both U.S. and international, to serve on the frontlines in this fight against COVID-19 and deliver primary care.

ACP encourages efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide primary care to patients. Primary care physicians, including internal medicine specialists, continue to serve on the frontlines of patient care during this pandemic with increasing demands placed on them. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health

care professionals providing care for all communities, including for racial and ethnic communities historically underserved and disenfranchised.[1] According to the Association of American Medical Colleges (AAMC), before the Coronavirus crisis, estimates were that there would be a shortage of 21,400 to 55,200 primary care physicians by 2033. A recent report by the National Academy of Sciences, Engineering and Medicine calls on policymakers to increase our investment in primary care as evidence shows that it is critical for achieving health care's quadruple aim (enhancing patient experience, improving population, reducing costs, and improving the health care team experience. Now, with the closure of many physician practices and near-retirement physicians not returning to the workforce due to COVID-19, it is even more imperative to assist those clinicians serving on the frontlines and increasing the number of future physicians in the pipeline.

For example, many residents and medical students are playing a critical role in responding to the COVID-19 crisis all while they carry an average debt of over $200,000. In addition, international medical graduates (IMGs) are currently serving on the frontlines of the U.S. health care system, both under J-1 training and H-1B work visas and in other forms. These physicians serve an integral role in the delivery of health care in the United States. IMGs help to meet a critical workforce need by providing health care for underserved populations in the United States. They are often more willing than their U.S. medical graduate counterparts to practice in remote, rural areas and in poor underserved urban areas. More must be done to support their vital role in health care delivery in the United States.

Pass Legislation to Support the Primary Care Physician Workforce

ACP supports several pieces of legislation from the 116th Congress that should be reintroduced, as well as legislation introduced this session that should be passed in the current 117th Congress to assist medical graduates and the overall physician workforce as well as address the mental and behavioral health needs of physicians themselves.

- *The Resident Education Deferred Interest Act* (H.R. 1554, 116th Congress) would make it possible for residents to defer interest on their loans.
- *The Conrad State 30 and Physician Access Reauthorization Act* (S. 948, 116th Congress) and *the Healthcare Workforce Resilience Act* (S. 3599, 116th Congress), would help with medical student loan forgiveness and support IMGs and their families by temporarily easing immigration-related restrictions so IMGs and other critical health care workers can enter the U.S. to train in internal medicine residency programs, assist in the fight against COVID-19, and provide a pathway to permanent residency status.
- *The Student Loan Forgiveness for Frontline Health Workers Act* (H.R. 2418, 117th Congress) would assist frontline clinicians as they provide care during the pandemic.
- *The Dr. Lorna Breen Health Care Provider Protection Act* (H.R. 1667/S. 610, 117th Congress) is an important proposal because it aims to prevent and reduce incidences of suicide, mental health conditions, substance use disorders, and long-term stress, sometimes referred to as "burnout" among physicians themselves. Through grants, education, and awareness campaigns, the legislation will help reduce stigma and identify resources for health care clinicians seeking assistance. The legislation also supports research on health care professional mental and behavioral health, including the effect of the COVID-19 pandemic. View ACP's letter of support to the House and Senate for H.R. 1667 and S. 610.

Fix and Reform the Public Service Loan Forgiveness (PSLF) Program
As referenced above, ACP is greatly concerned by the already high and ever-increasing cost of obtaining a medical education and the impact those expenses have on the number of medical students and residents opting to enter careers in primary care. The Public Service Loan Forgiveness (PSLF) program was established with the goal of boosting the number of individuals choosing a career pathway in public service or a specific or high-need profession that promotes the overall public good. Borrowers of federal student loans, such as Direct Subsidized Loans and Direct Unsubsidized Loans, including Direct PLUS loans for graduate students, are eligible for the PSLF program across a range of professions, including medicine.

Unfortunately, several issues emerged, especially in the initial years of PSLF program availability that started in 2007, which made the PSLF program difficult to access. These issues resulted in a high percentage of PSLF applications being outright denied and an astonishingly low number of applicants actually getting their loans forgiven after the required 120 payments (usually 10 years) beginning in 2017. There have been reports of servicers failing to place borrowers in the right service plans, qualifying payments being miscounted, employment certification being improperly disqualified, misinformation by loan servicers, and a general lack of education and awareness by applicants due to inadequate outreach and guidance.

ACP feels strongly that the federal government should create incentives for medical students to pursue careers in primary care and practice in areas of the nation with greatest need by developing or expanding programs that eliminate student debt for these individuals—linked to a reasonable service obligation in the field and creating incentives for these physicians to remain in underserved areas after completing their service obligation. Therefore, ACP was pleased by several changes to the PSLF program made by the *What You Can Do For Your Country Act*, (H.R. 2441/S. 1203, 116th Congress), introduced in the previous 116th Congress that would hopefully help extend the program to future physicians and encourage them to choose career paths in public service and nonprofits that help serve the overall public health, especially in primary care and underserved areas. The bill would make all types of federal student loans qualify for the PSLF program, including Federal Family Education Loan (FFEL) loans that were previously left out—and permit consolidation to a Direct Loan without losing previously made payments counting towards the overall required PSLF payments. Confusion about which repayment plans were eligible for the PSLF program led to the denial of PSLF applications. Accordingly, the legislation would also permit all federal repayment plans to qualify for the PSLF program. The Act would also enable borrowers to receive loan forgiveness at a 50 percent level after five years of the required payments instead of waiting for full forgiveness after 10 years of payments. The measure would attempt to remedy the education and awareness deficit surrounding the PSLF program by improving resources with accurate information, helping applicants determine whether they qualify for the PSLF program, making it possible for borrowers to check on their payment status, and being able to effectively dispute payment issues. ACP calls on Congress to reintroduce and pass the *What You Can Do For Your Country Act* in the 117th Congress.

Expand Medicare Supported Graduate Medical Education (GME)
ACP was encouraged that bipartisan congressional leaders worked together last year to provide 1,000 new Medicare-supported Graduate Medical Education (GME) positions in the *Consolidated Appropriations Act, 2021* (H.R. 133)—the first increase of its kind in nearly 25 years—and that some of those new slots will be prioritized for hospitals that serve Health Professional Shortage Areas (HPSAs). The training and costs associated with becoming a medical or osteopathic doctor (M.D. or D.O) are significant. A student who chooses medicine as a career can expect to spend four years in medical school, followed by three to nine years of graduate medical education (GME), depending on the choice of specialty. GME is the process by which graduated medical students progress to become competent practitioners in a particular field of medicine. These programs, referred to as residencies and fellowships, allow trainees to develop the knowledge and skills needed for independent practice. GME plays a major role in addressing the nation's workforce needs, as GME is the ultimate determinant of the output of physicians. With an aging population with higher incidences of chronic diseases, it is especially important that patients have access to physicians trained in comprehensive primary and team-based care for adults—a hallmark of internal medicine GME training. It is worth noting that the federal government is the largest explicit provider of GME funding (over $15 billion annually), with most of the support coming from Medicare.

- ACP now calls on Congress to pass the *Resident Physician Reduction Shortage Act of 2021* (H.R. 2256/S. 834, 117th Congress) which would provide 14,000 new GME positions over seven years, or 2,000 per year to build on the 1,000 new GME slots mentioned above.
- Congress should also pass the *Opioid Workforce Act of 2021* (S. 1483, 117th Congress). This bill would provide Medicare funding for 1,000 more GME positions over five years in hospitals that already have established, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.

Continue Increased Funding for the National Health Service Corps (NHSC) and Teaching Health Centers Graduate Medical Education (THCGME)
ACP also supports other physician and clinician workforce programs and we strongly supported providing $800 million for the National Health Service Corps (NHSC) and $330 million to expand the number of Teaching Health Centers (THC) Graduate Medical Education (GME) sites nationwide and increase the per resident allocation that were enacted in the American Rescue Plan (ARP) Act, H.R. 1319.

In FY2021, the NHSC received $120 million in discretionary funding to expand and improve access to quality opioid and substance use disorder treatment in underserved areas, in addition to $310 million in mandatory funds which have been extended through FY2023. The NHSC awards scholarships and loan repayment to health care professionals to help expand the country's primary care workforce and meet the health care needs of underserved communities across the country. In FY2020, with a projected field strength of over 14,000 primary care clinicians, NHSC members are providing culturally competent care to a target of almost 15 million patients at a targeted 18,000 NHSC-approved health care sites in urban, rural, and frontier areas. These funds would help maintain NHSC's field strength helping to address the health professionals' workforce shortage and growing maldistribution. There is overwhelming interest and demand for NHSC programs, and with more funding, the NHSC could fill

more primary care clinician needs. In FY2016, there were 2,275 applications for the scholarship program, yet only 205 new awards were made. There were only 150 scholarship awards in FY2020. There were 7,203 applications for loan repayment and only 3,079 new awards in FY2016. Accordingly, ACP urges the doubling of the NHSC's overall program funding to $860 million to meet this need and to sustain the American Rescue Plan Act's $800 million for the NHSC for when the pandemic subsides.

Indeed, a recent study appearing in the *Annals of Internal Medicine* showed that in counties with fewer primary care physicians (PCP) per population, increases in PCP density would be expected to substantially improve life expectancy.[2] Accordingly, Congress should enact policies that will not only increase the overall number of PCPs, but also ensure that these additional PCPs are located in the communities where they are most needed in order to furnish primary care. Enhanced investments in programs such as the NHSC and THCGME that increase the physician workforce should be sustained after the pandemic caused by COVID-19 has come to an end.

Expand Primary Care and Training Enhancement (PCTE)

Another federally-funded program, the Title VII Health Professions, is also instrumental in training physicians in primary care, specifically in the fields of general internal medicine, general pediatrics, and family medicine. While the College appreciates the $10 million increase to the Primary Care and Training Enhancement (PCTE) program in FY2018, ACP urges more funding because the PCTE program is the only program of its kind. Therefore, PCTE funding is critical to the future pipeline of primary care physicians in the workforce. The Title VII Health Professions Training in Primary Care and Training Enhancement (PCTE) received $48.92 million in in federal funding for FY2021. General internists, who have long been at the frontline of patient care, have benefitted from the program's training models emphasizing interdisciplinary training or from primary care training specifically in rural and underserved areas that have helped prepare them for a career in primary care.

Conclusion

We commend you and your colleagues for working in a bipartisan fashion to examine the health care workforce shortage to develop legislative proposals to address this issue. We wish to assist the subcommittee's efforts in this area by offering our input and suggestions about ways that Congress can intervene through evidence-based policies to increase the number of physicians providing primary care across the country. Thank you for consideration of our recommendations that are offered in the spirit of ensuring that the nation's health care workforce needs are met. Please contact Jared Frost, Senior Associate, Legislative Affairs, by phone at (202) 261-4526 or via email at jfrost@acponline.org with any further questions or if you need additional information.

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https://www.acponline.org/acp_policy/policies/understanding_discrimination_affecting_health_and_health_care_persons_populations_highest_risk_2021.pdf

[2] Sanjay Basu, MD, PhD; Russell S. Phillips, MD; Seth A. Berkowitz, MD, MPH. Estimated Effect on Life Expectancy of Alleviating Primary Care Shortages in the United States. Ann Intern Med. 2021. https://www.acpjournals.org/doi/pdf/10.7326/M20-7381

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May 19, 2021

The Honorable Bernie Sanders
Chairman
Subcommittee on Primary Health and Retirement Security
Senate Committee on Health, Education, Labor & Pensions
332 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Susan Collins
Ranking Member
Subcommittee on Primary Health and Retirement Security
Senate Committee on Health, Education, Labor & Pensions
413 Dirksen Senate Office Building
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Dear Chairman Sanders, Ranking Member Collins, and Members of the Subcommittee on Primary Health and Retirement Security:

On behalf of the more than 82,000 members of the American College of Surgeons (ACS), thank you for your leadership and interest in addressing health care workforce shortages. The ACS has serious concerns with the growing crisis in surgical workforce shortages and the impacts that these shortages have on patients. We urge you to consider the need for additional data as well as the importance of designating general surgical shortage areas as you examine these issues.

Background

General surgery is an essential element in the care of a community or region. In areas without general surgeons or with an insufficient surgical workforce, patients in need of care must travel to a place with surgical capabilities, leading to delays in care and potentially suboptimal outcomes. In both rural and urban areas, the availability of general surgical care facilitates the treatment of an expanded spectrum of a local population's health care needs, because a general surgeon cares for patients with a broad range of surgical needs.[1] This obviates the need for transfer, time away from employment, travel, and associated costs.

In addition to improving care and outcomes for patients, a general surgeon contributes substantially to the local economy, both in terms of hospital revenue and creation of jobs, which are critical to the hospital and the community they serve.[2] Loss of surgical services and their associated revenues can contribute to hospital closures which can be catastrophic to the local community.[3] The loss of surgical services and hospital closures is felt acutely as over 100 rural hospitals

[1] https://www.facs.org/education/resources/residency-search/specialties/general
[2] https://digitalprairie.ok.gov/digital/collection/stgovpub/id/24192
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closed from January 2013 – February 2020.[4] A recent report from the Center for Healthcare Quality and Payment Reform found the COVID-19 pandemic has increased the number of rural hospitals at immediate risk of closure to 500 with an additional 300 also at heightened risk of closure in the near future.[5] Rural hospital closures further impede access to surgical care.

A shortage of general surgeons is a key component of the crisis in the health care workforce and patient access to health care services because surgeons are the only physicians who are uniquely trained and qualified to provide certain necessary, lifesaving procedures.

A Congressionally mandated 2020 report conducted by the Health Resources Services Administration (HRSA) detailed potential surgical shortages, especially as it relates to geographic location (i.e., rural, urban, and suburban).[6] Specifically, the report found a maldistribution of the surgical workforce, with widespread and critical shortages of general surgeons particularly in rural areas. Additionally, a 2020 report released by the Association of American Medical Colleges projects shortages of between 17,100 and 28,700 surgeons by 2033.[7]

Support Health Care Workforce Data Collection

ACS strongly believes that building a solid foundation of accurate and actionable data is critically necessary to better understand the physician workforce and begin to identify and define general surgery shortage areas.

At present, our health care system is in dire need of accurate data. ACS believes the periodic, repetitive collection and analysis of workforce data on both a regional and national basis should be a top priority. This data collection should be undertaken in consultation with relevant stakeholders to ensure accuracy of both the data collected and its subsequent analysis. Data collection is necessary in order to better understand the health care workforce supply and distribution and to project workforce demands for the future.

Unfortunately, these data do not tell us if the supply of all surgical specialists nationwide is adequate to provide access to the surgical services demanded by the population. This is largely because there is no agreed upon definition of what constitutes a shortage of general surgeons for a given population. Since there is no federally accepted definition of a surgical shortage, projections reset each year and

[4] https://www.gao.gov/products/gao-21-93
[5] https://revcycleintelligence.com/news/covid-19-increases-rural-hospital-closure-risk-care-access-concern
[6] https://www.facs.org/-/media/files/advocacy/federal/hrsa-general-surgeon-projection-report-to-appropriations.ashx
[7] https://www.aamc.org/media/45976/download

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assume that the then current ratio of surgeons to population is the appropriate baseline rather than tracking the decline and growing shortage over time. The data simply tell us that year after year we are falling behind, with a shrinking proportion of general surgeons to population. **In order to prepare for future surgical workforce demands, Congress should support the comprehensive, impartial research and high-quality data needed to form dynamic projections of the health care workforce.**

Create Optimal Surgical Access

Congress cannot consider reforms to strengthen the healthcare workforce without also considering the disparities that exist in access to surgical care. Access to surgical care is impacted by socioeconomic status, age, gender, level of education, race, ethnicity, health care availability, and geographic distance. Timely access to surgical care is necessary for optimal outcomes. Efforts to increase surgical presence and availability are crucial to providing the right care, at the right time, in the right place.

Optimal quality, the centerpiece of the mission of the ACS, is not achievable without optimal access. A new study finds that older cancer patients are less likely to have optimal results following their cancer operation if they live in an area highly affected by social challenges, especially if they are racial-ethnic minorities.[8] Another recent study of liver transplant centers confirms that non-Hispanic, white patients get placed on liver transplant waitlists at disproportionately higher rates than non-Hispanic, Black patients.[9] The ACS motto is, "To serve all with skill and fidelity." One key step to live up to this motto and provide high quality care to all is eliminating racial disparities in access to care as there can be no quality without access.

Designate Formal Surgical Shortage Areas

Unlike other key providers of the community-based health care system, HRSA does not maintain a geographic shortage area designation for surgery. ACS believes that increasing evidence highlights the urgent need to establish a surgical shortage designation. Determining what constitutes a surgical shortage and designating areas where patients lack access to surgical services will provide HRSA with a valuable new tool for increasing access to the full spectrum of high-quality health care services. Identifying communities with workforce shortages is a

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[8] High social vulnerability is associated with a decreased chance to achieve a "textbook outcome" following cancer surgery. *Journal of the American College of Surgeons.* DOI: /10.1016/j.jamcollsurg.2020.11.024.
[9] Racial Disparities in Liver Transplantation Listing. *Journal of the American College of Surgeons*, 2021. DOI: https://doi.org/10.1016/j.jamcollsurg.2020.12.021

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critical first step in guaranteeing all patients, regardless of geographic location, have access to quality surgical care. Only then can necessary actions be taken to address these shortages and disparities in access to care.

Concluding Remarks

To build upon existing data and plan for the future, ACS urges the subcommittee to consider the *Ensuring Access to General Surgery Act of 2021* (S. 1593), introduced by Senators Brian Schatz (D-HI) and John Barrasso, MD (R-WY). The legislation would direct the Secretary of HHS, through the HRSA, to study and define general surgery workforce shortage areas and collect data on the adequacy of access to surgical services. Additionally, the legislation would grant the Secretary of HHS with the authority to designate general surgery shortage areas.

ACS appreciates the opportunity to weigh in on health care workforce concerns faced by surgeons and their patients and urges you to authorize the collection of data on general surgery shortage areas, which would provide the same opportunity to ensure access to care for all surgical patients, regardless of geographic location. Additionally, establishing a surgical shortage designation will allow for better resource allocation and incentives to practice in areas where we know there are not enough general surgeons.

ACS remains dedicated to working with Congress to further address the physician workforce issues facing our nation. Please contact Carrie Zlatos in the ACS Division of Advocacy and Health Policy at czlatos@facs.org if you have any questions or need additional information.

Sincerely,

David B. Hoyt, MD, FACS
Executive Director

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Addressing Shortfalls Within The Long Term Care Workforce Critical To Strengthening Nursing Homes

Today, the U.S. Senate Committee on Health, Education Labor & Pensions is holding a hearing on workforce shortages in healthcare, a critically important focus for long term care providers across the country. The American Health Care Association/National Center for Assisted Living (AHCA/NCAL), which is the largest association in the United States representing long term and post-acute care providers, commends the Committee for addressing this topic, including issues related to workforce recruitment and retention.

A recent report in Axios sounded the alarm that health care employment is on the decline, with the nursing home industry in immediate danger. The article highlighted "a drop of about 19,500 nursing and residential care facility jobs, according to the latest labor report." This rapid decline in employment underscores the urgent need to invest in the long term care workforce to help attract and retain dedicated workers. This is especially important given our rapidly-growing elderly population and the anticipated increase in demand for long term care services.

Workforce recruitment and retention has been a persistent challenge for long term care providers for years. There is an ongoing shortage of trained caregivers for a variety of critical roles. Although nurses and nurse aides are among the fastest growing occupations, supply is not keeping up with demand. As members of Congress hold long overdue conversations about ways to strengthen the overall health care workforce, AHCA and LeadingAge have released a comprehensive reform proposal, the Care for Our Seniors Act, that offers several solutions to help build a strong long term care workforce. Solutions include:

Financial assistance:

- Provide student loan forgiveness for licensed health care professionals who are new graduates and work in long term care.
- Develop assistance programs for caregivers like affordable housing, housing down payments, and childcare.
- Provide career ladder scholarships that would encourage staff to advance their career by becoming a registered nurse (RN) or other positions in aging services.
- Funding for universities who have shown graduation rates with direct correlation to long term care hires with retention of two years or more.

Regulatory solutions:

- Create a pathway (including training and testing) for temporary nurse aides allowed by the current Public Health Emergency to become certified nurse aides.
- Ensure the Nurse Licensure Compact is available in every state to be able to "share" RNs across state borders.
- Expedite the progression in licensed practical nurse to RN bridge programs to increase the number of RNs.
- Pass common-sense immigration reform that increases opportunities for foreign-born individuals to work in the long term care profession. Expand the ability for international nurses to come to the United States.

The long term care industry looks forward to working with lawmakers to strengthen the health care workforce to ensure every nursing home, assisted living, and intermediate care facility for individuals with intellectual or developmental disability provider has the staff they need to provide the highest level of care to all residents.

Sound Policy. Quality Care.

May 19, 2021

The Honorable Bernie Sanders
Chair,
Senate Health, Education, Labor & Pensions
Subcommittee on Primary Health
and Retirement Security
332 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Susan Collins
Ranking Member,
Senate Health, Education, Labor & Pensions
Subcommittee on Primary Health
and Retirement Security
413 Dirksen Senate Office Building
Washington, DC 20510

RE: Subcommittee Hearing, "A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce"

Dear Chairman Sanders and Ranking Member Collins:

As the Alliance of Specialty Medicine (Alliance), our mission is to advocate for sound federal health care policy that fosters patient access to the highest quality specialty care. We noted with interest the upcoming subcommittee hearing entitled, "**Subcommittee Hearing, "A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce"** and applaud your efforts to examine the healthcare workforce shortage. The specialty physician workforce shortage is equally as dire as it is for primary care providers and the Alliance would like to add its voice to the conversation.

According to the Association of American Medical Colleges (AAMC), the United States will face an overall shortage of up to 139,000 physicians by 2033. While the Alliance acknowledges the need to increase the number of available primary care providers, we note that specialty shortages will be particularly large, including neurosurgeons, urologists, cardiologists, gastroenterologists, plastic and reconstructive surgeons, orthopaedic surgeons, and general surgeons. Unlike primary care physicians whose residency training is only three years, specialty physicians require up to seven years of post-graduate residency training. Given the increased demand created for their services by an aging population and expanded insurance coverage, we need to take steps now to ensure a fully trained specialty physician workforce for the future.

The Alliance supports H.R. 944, which would improve access to specialty care in rural America through a student loan forgiveness program. According to a 2019 statement from the Health Resources and Services Administration (HRSA), 252 counties in the rural United States are without a single healthcare provider[i]. Further, a specialty such as urology can only be found in 38 percent of all U.S. counties, and the number of gastroenterologists per 100,000 people varies between rural (.39) and urban (2.55) counties as well. This variation highlights the access barriers that exist for colorectal cancer screenings and the

increased colorectal cancer mortality rates in rural counties. With one-fifth of Americans living in a non-urban region and only 11 percent of physicians practicing in those same areas, access to preventive measures and lifesaving treatments is severely limited for millions of U.S. citizens.

In addition, the Alliance is appreciative of the 1,000 Graduate Medical Education (GME) residency positions that Congress included in the *Consolidated Appropriations, 2021* and **urges passage of *S. 834, the Resident Physician Shortage Reduction Act*,** which would provide an additional 2,000 residency positions each year for seven years to tackle the severe primary care and specialty physician manpower shortage.

Thank you for raising awareness and examining issues related to healthcare workforce shortages. We appreciate your consideration of specialty physicians' views on the issue as the subcommittee considers legislative efforts to alleviate the problem in the future.

Sincerely,

American Academy of Facial Plastic & Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists

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[i] [i]Health Resources and Services Adminstration. (2019, February 21). *Rural Health Disparities to the Fore*. Retrieved October 03, 2019, from Health Resources and Services Administration: https://www.hrsa.gov/enews/past-issues/2019/february-21/rural-health-disparities

May 20, 2021

Submitted electronically

Senator Bernie Sanders, Chair
U.S. Senate Committee on Health, Education, Labor and Pensions
Subcommittee on Primary Health and Retirement Security
428 Dirksen Senate Office Building
Washington DC, 20510

Senator Susan Collins, Ranking Member
U.S. Senate Committee on Health, Education, Labor and Pensions
Subcommittee on Primary Health and Retirement Security
428 Dirksen Senate Office Building
Washington DC, 20510

Re: A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce

Dear Chair Sanders, Ranking Member Collins, and members of the subcommittee,

We, the undersigned associations, submit the following comments for the Senate Health, Education, Labor and Pensions (HELP) Subcommittee on Primary Health and Retirement Security hearing on the growing shortages in the health care workforce.

The ongoing public health crisis due to COVID-19 is a challenge in two parts and therefore recovery must continue two-fold. First: treatment and immediate care. Second: recovery in the long term. We urge Congress to focus its efforts on ensuring our nation can meet both aspects of this crisis in part by working to promote a workforce adequate to meet the needs of the country, and one that reflects the diverse communities it serves. The Allied Health professions are well positioned to assist with both the immediate care and long-term recovery and rehabilitation of those affected by COVID-19 and diversifying this workforce will help better enable these health care professionals to meet the current and future needs of this population.

The Allied Health professions play a crucial role in recovery from COVID-19 infections, as well as treatment of the effects of "Post-Acute Sequelae of SARS-CoV-2 infection," (PASC[i]), often self-described as "long-haulers" or "long-COVID". Issue 13 of The Exchange, an information sharing publication produced by the Office of the Assistant Secretary for Preparedness and Response (ASPR) in the Department of Health and Human Services, entitled *The Work of Hospital Allied and Supportive Care Providers During COVID-19* states, "The articles in this section illustrate the work performed by physical, respiratory, and occupational therapists to ensure patient comfort and assist COVID-19 patients through the recovery process.[ii]"

It is vital to anticipate what is required to promote a thriving, diverse health workforce. Health workforce diversity was important prior to the pandemic, as the Institute of Medicine raised concerns about

the diversity of the health care workforce in its 2004 study: *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*.[iii] The report found that racial and ethnic minorities receive a lower quality of healthcare than non-minorities.[iv]

Overall, increasing diversity will lead to improved access to care, greater patient choice and satisfaction, and better education experience for health professions students, among many other benefits.[v] In particular, a diverse health care workforce can help to both address preexisting health disparities among the population, as well as those disparities exacerbated by the COVID-19 pandemic.

In addition to these reasons, a more diverse healthcare workforce is important because:

- Patients who receive care from members of their own racial and ethnic background tend to have better outcomes;[vi]
- Health professionals from underrepresented and minority backgrounds are more likely to practice in medically underserved areas;[vii]
- Minority groups disproportionately live in areas with provider shortages.[viii]

We appreciate the support of HELP Committee members Senators Casey and Murkowski, who have been strong champions for diversifying the allied health professions by introducing the Allied Health Workforce Diversity Act (S. 1679), which would create a workforce development program for rehabilitation therapy providers and audiologists to increase the percentage of individuals from underrepresented communities in these professions. We urge you to build on their efforts to create this new program to support better representation in the professions of audiology, physical therapy, occupational therapy, respiratory therapy, and speech-language pathology.

Solving the diversity gap in our nation's health systems will need a multistep approach. The step presented in this letter includes the creation of a workforce development program for rehabilitation therapy providers. The potential program under the Health Resources and Services Administration (HRSA) would be the modeled after the Title VIII Nursing Workforce Diversity program that has successfully increased the percentage of racial and ethnic minorities pursuing careers in nursing. This new program would help strengthen and expand the comprehensive use of evidence-based strategies shown to increase the recruitment, enrollment, retention, and graduation of students from underrepresented and disadvantaged backgrounds for the professions of audiology, physical therapy, occupational therapy, respiratory therapy, and speech-language pathology. The result would be better care for individuals who live in areas with provider shortages.

Thank you for the opportunity to provide input on solving the nation's health care workforce challenges. We stand ready to provide any additional information you need, as well as collaborate on any efforts in this area. Please contact Abe Saffer at asaffer@aota.org or 202-450-8068 if you have questions or need additional information.

Sincerely,

American Academy of Audiology
American Association for Respiratory Care
American Occupational Therapy Association
American Physical Therapy Association

* * * * *

CC:
Senator Patty Murray, Chair, Senate Committee on Health, Education, Labor and Pensions
Senator Richard Burr, Ranking Member, Senate Committee on Health, Education, Labor and Pensions

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[i] https://www.usatoday.com/story/news/health/2021/02/24/covid-19-long-haulers-fauci-announces-launch-nationwide-initiative/4572768001/ viewed March 4, 2021
[ii] U.S. Department of Health & Human Services. (2021). The work of hospital allied and supportive care providers during COVID-19. The Exchange, 13. https://files.asprtracie.hhs.gov/documents/aspr-tracie-the-exchange-issue-13.pdf
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[iv] Institute of Medicine. (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: National Academy Press.
[v] Institute of Medicine. (2004). In the nation's compelling interest: Ensuring diversity in the health care workforce. Washington, DC: National Academy Press.
[vi] Institute of Medicine. (2004). In the nation's compelling interest: Ensuring diversity in the health care workforce. Washington, DC: National Academy Press.
[vii] Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race, gender, and partnership in the patient-physician relationship. JAMA, 282, 583–589.
[viii] Reyes-Akinbileje, B. (2008, February 7). Title VII health professions education and training: Issues in reauthorization. Washington, DC: U.S. Congressional Research Service.

May 19, 2021

Senator Bernie Sanders
Health, Education, Labor & Pensions Committee
Chairman, Subcommittee on Primary
Health & Retirement Security
Washington, DC

Senator Susan Collins
Health, Education, Labor & Pensions Committee
Ranking Member, Subcommittee on Primary
Health & Retirement Security
Washington, DC

Dear Chairman Sanders and Ranking Member Collins:

On behalf of the Infectious Diseases Society of America (IDSA) and its affiliated HIV Medicine Association (HIVMA), thank you for scheduling a hearing titled "A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce." The COVID-19 pandemic exposed gaps and weaknesses in our nation's preparedness for public health emergencies related to infectious disease outbreaks, including insufficient preparedness and response workforce capacity at health care facilities. Infectious diseases (ID) physicians are integral to health care facility preparedness and often lead the response teams. We must invest in the future of this workforce to ensure equitable access to infectious diseases care. A June 2020 study in the *Annals of Internal Medicine* found that 208 million Americans live in areas with little or no access to an ID physician, and rural areas are particularly underserved. We greatly appreciate your leadership in addressing critical health care workforce shortages and look forward to working with you.

IDSA represents more than 12,000 infectious diseases physicians, scientists and other public health and health care professionals specializing in infectious diseases. Our members care for patients with serious infectious diseases, including COVID-19, HIV, viral hepatitis, infections caused by antimicrobial resistant pathogens and infections associated with the opioid epidemic. We are on the front lines of the COVID-19 pandemic response, designing and updating infection prevention, diagnostic testing and patient management protocols; collaborating with state and local health departments on communications and mitigation efforts; leading health care facility responses; and conducting research to develop new tools for the prevention, diagnosis and treatment of COVID-19.

Workforce Challenges

The COVID-19 pandemic has severely strained the health care workforce, particularly those most focused on bio-preparedness and response, such as ID physicians. Prolonged, significant additional work (both direct patient care and programmatic response activities) in an environment of health risks, uncertainty and overwhelming loss of patient lives has contributed to severe burnout.

The ID physician workforce was under serious strain even before the pandemic. The number of applicants to ID fellowship training programs declined by 21.6% from 2011-2016. The following years saw only modest improvements that quickly plateaued. In 2020, only 75% of infectious diseases training programs were able to fill all their slots, while many other internal medicine subspecialties (cardiology, rheumatology, gastroenterology, hematology, oncology, pulmonology and critical care) were able to fill

from 96% to 100% of their training programs. Initial 2021 data indicate increased interest in medical careers, likely due to the pandemic, but experts warn that this interest may wane, and we are unlikely to effectively address longstanding workforce challenges without addressing medical student debt and physician compensation. Financial concerns are a chief barrier to pursuing a career in ID. Data published by Medscape in 2021 indicate that average annual salaries for ID physicians are below all other medical specialties except pediatrics, family medicine, endocrinology and public health, and even below the average salary for general internal medicine, although ID training and certification requires an additional two to three years of study and training. Given that the average medical student debt is $200,000, the ID specialty is a financially infeasible choice for many.

Value of Bio-preparedness and Infectious Diseases Workforce

The value of a strong bio-preparedness workforce that can mount rapid, effective responses cannot be understated. Trained staff in health care facilities are needed to develop and update response and surge capacity plans and protocols; collaborate with state and local health departments; train health care facility personnel; purchase and manage equipment (such as PPE) to prevent infections; execute readiness assessments; repurpose areas of a health care facility to manage patient influx; communicate with the public; perform infection prevention and control; and conduct antimicrobial stewardship to ensure that treatments for infectious diseases are used appropriately to achieve optimal patient outcomes.

Infectious diseases physicians provide high value care, particularly for the most seriously ill patients. Studies have indicated that infectious diseases physician care of patients with serious infections is associated with improved patient outcomes. Early intervention by an ID physician for hospitalized patients with serious infections is associated with significantly improved survival and reduced readmission rates, shorter hospital and ICU length of stay and lower Medicare costs. ID physicians are essential components of teams caring for patients receiving transplants or cancer chemotherapy. Antibiotic stewardship programs led by ID physicians and implemented by multidisciplinary teams have been found to improve cure rates, reduce adverse events, lower health care costs and decrease inappropriate antibiotic use that drives antibiotic resistance. Antibiotic resistance further compromises our preparedness by diminishing our arsenal of treatments for secondary infections that typically complicate pandemics and other mass casualty events.

The infectious diseases workforce is central to preventing, treating and eventually stopping ongoing public health threats, including HIV, viral hepatitis and bacterial and fungal infections that are on the rise due to the opioid use and other substance use epidemics. Workforce shortages are limiting our ability to control these persistent epidemics. A study of the HIV workforce conducted in 14 southern states found that more than 80% of those states' counties had no experienced HIV clinicians, with the disparities greatest in rural areas. A robust HIV workforce is critical to ending the HIV epidemic in the United States, which is for the first time an achievable and realistic goal. In addition, expanding clinical workforce capacity for viral hepatitis was recently identified as a key element of the Department of Health and Human Services *Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination 2021 - 2025*.

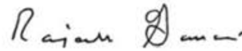
Recommendation

As the Subcommittee considers strategies to address workforce shortages, we recommend that Congress establish a bio-preparedness and infectious diseases workforce loan repayment program to help ensure the workforce needed to meet patient and public health needs. A new loan repayment program would have two categories of eligibility:

1. Health care professionals who spend at least 50% of their time engaged in bio-preparedness and response activities; or
2. Health care professionals who spend at least 50% of their time providing infectious diseases care in a shortage designation area or federally funded facility.

We look forward to working with you to solve the crisis in the health care workforce. Please feel free to contact Amanda Jezek, IDSA Senior Vice President of Public Policy & Government Relations, at ajezek@idsociety.org or Andrea Weddle, HIVMA Executive Director, at aweddle@hivma.org, if we may be of any assistance.

Sincerely,



Barbara D. Alexander, M.D., MHS, FIDSA
President, IDSA

Rajesh T. Gandhi, M.D., FIDSA
Chair, HIVMA

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Statement for the Record
Submitted to
U.S. Senate Committee on Health, Education, Labor & Pensions
Subcommittee on Primary Health and Retirement Security
"A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce"
May 20, 2021

The Physician Assistant Education Association (PAEA), representing the 275 accredited physician assistant (PA) programs in the United States, welcomes the opportunity to submit a statement for the record regarding the issue of growing health workforce shortages.

Throughout the history of the profession, PAs have played a critical role in addressing gaps in the health workforce. In response to a significant shortage of primary care physicians in the 1960s, the PA profession was created to rapidly and effectively train and deploy graduates to the communities in greatest need. The generalist training that all PA students receive through clinical rotations in family medicine, internal medicine, emergency medicine, surgery, pediatrics, women's health, and behavioral health, in addition to electives, uniquely prepares PA graduates to fill a variety of different workforce deficits, as demand shifts over time, given their flexibility to easily change specialties as needed.

The critical importance of a sufficient supply of well-trained health care providers has been widely recognized once again due to the COVID-19 pandemic. While COVID-19 has drawn renewed attention to the implications of workforce shortages, this issue will persist in the absence of significant congressional intervention. As of March 31, 2021, the Health Resources

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EX OFFICIO MEMBER

and Services Administration (HRSA) has designated more than 7,300 primary care health professional shortage areas with a combined population of more than 83 million people.[1] To remove these designations, HRSA projects that 15,275 primary care clinicians would be needed, an estimate that is expected to grow under existing law.[1]

While the PA profession holds unique promise to address growing workforce shortages, COVID-19 has presented considerable challenges to PA education as programs across the country work to prepare the next generation of providers. According to a recent survey of PA programs, more than 85% of respondents indicated that their clinical training sites are now taking fewer students than prior to the pandemic.[2] Beyond clinical sites now accepting fewer students, programs are also encountering challenges in securing new rotations, particularly in specialties with the most acute provider shortages. For example, nearly 70% of programs report that it is now either harder or much harder to secure clinical rotations for students in obstetrics/gynecology/women's health, with 50% indicating this is the case for family medicine rotations. **This reduction in clinical education capacity is the single most important factor constricting the expansion of PA programs as workforce shortages continue to grow.**

Beyond the particularly acute issue of clinical training site shortages, the racial and ethnic health disparities exacerbated by the pandemic illustrate the need to prioritize workforce diversity in any legislative solution to the issue of broader workforce shortages. Throughout health professions education, underrepresented minority students have historically faced considerable socioeconomic barriers to matriculation. According to PAEA's most recent Student Report, only 3.9% of first-year PA students identified as Black or African American and 9.1% identified as Hispanic or Latino as of 2019.[3] **To ensure patients are able to access the culturally competent care they deserve, creating a strong pipeline of students representative of the communities they serve must be a priority.**

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[1] Health Resources and Services Administration. (2021). *Second Quarter of Fiscal Year 2021 Designated HPSA Quarterly Summary*. https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport
[2] Physician Assistant Education Association. (2021). *COVID-19 Rapid Response Report 3*. https://paea.edcast.com/insights/ECL-c621408d-c82a-43f5-a067-75a03494d8be.
[3] Physician Assistant Education Association. (2020). *By the Numbers: Student Report 4: Data from the 2019 Matriculating Student and End of Program Surveys*. https://paeaonline.org/wp-content/uploads/imported-files/student-report-4-updated-20201201.pdf.

As legislative solutions to the issue of health workforce shortages are considered, PAEA urges the subcommittee to advance the following Senate-introduced legislation and to integrate the following House-introduced bill into broader workforce legislation:

The Rural MOMS Act (S. 1491)

The Rural MOMS Act, recently reintroduced on a bipartisan basis by Sen. Tina Smith and Sen. Lisa Murkowski, is intended to address long-standing and persistent workforce shortages in rural areas by facilitating training opportunities for students in these communities with the goal of promoting long-term retention. Specifically, this bill would authorize $5 million over five years to support interprofessional clinical training opportunities in obstetrics/gynecology/women's health for PA and other health professions students in rural areas.

The Perinatal Workforce Act (S. 287)

In response to disproportionate rates of maternal mortality among Black women, Sen. Tammy Baldwin and Sen. Jeff Merkley introduced the Perinatal Workforce Act in February 2021 to improve the capacity of providers to render culturally competent care. Specifically, this critical legislation would authorize $15 million annually over five years to support PA and other programs training maternal health providers in their efforts to recruit and retain diverse cohorts of students intending to specialize in obstetrics/gynecology/women's health.

The Physician Assistant Higher Education Modernization Act (H.R. 2274)

Under the Higher Education Act, existing sources of aid to support minority-serving institutions explicitly prioritize the development of programs for certain named high-demand professions, not including the PA profession. Rep. Karen Bass and Rep. David Trone recently reintroduced the Physician Assistant Higher Education Modernization Act, which would explicitly prioritize PA program development at minority-serving institutions, such as historically Black colleges and universities, and Hispanic-serving institutions to create a sustainable pipeline of diverse PA students to the health workforce.

PAEA appreciates the opportunity to provide the Association's perspective on effective solutions to combat health workforce shortages and looks forward to the opportunity to serve

as a resource to the subcommittee. Should you require additional information or have questions, please contact Tyler Smith, Director of Government Relations, at tsmith@PAEAonline.org or 703-667-4356.

QUESTIONS AND ANSWERS

RESPONSE BY DR. JAMES HERBERT TO QUESTIONS OF SENATOR CASEY

SENATOR CASEY

Question 1. The primary care physician shortage is particularly acute in rural areas such as the one you serve. Access to mental health care is also severely challenged and has been called a crisis, particularly for the underserved. Increasingly, primary care providers, if properly trained, have been seen as part of the remedy to help address mental health needs. You spoke to the importance of considering not only physicians as part of our primary care workforce, but the necessity and benefits of an interprofessional approach. Please elaborate on the roles of nurses and other providers to extend primary and mental health care. How might we best increase the capacity of rural providers, including physicians, nurses and others to meet our Nation's mental health and social care needs?

Answer 1. I completely concur regarding the problem of access to behavioral healthcare. As with the healthcare workforce more broadly, this is reflected by an undersupply of mental health professionals and maldistribution of the workforce. The National Center for Health Workforce Analysis projected that by 2025 there will be a nationwide shortage of at least 10,000 FTEs in each of six categories of behavioral health practitioners (e.g., psychiatrists, psychologists, social workers, counselors, etc.). In addition, most practitioners are concentrated in urban areas, leaving large rural areas without access. According to a 2020 report by the Health Resources and Services Administration, 119 million Americans currently live in behavioral health care professional shortage areas. The problem of access to behavioral healthcare in rural areas is compounded by higher rates of uninsured or underinsured populations in these areas. And experts predict that the behavioral health care workforce shortage will be exacerbated in the aftermath of the COVID-19 pandemic (Bryant, 2020).

Early identification, assessment, and treatment of mental health problems is critical to reducing morbidity. Most mental health problems do not remit without treatment and many progress with respect to morbidity and functional impairments. Efforts are needed to train more behavioral health practitioners and to incentivize clinicians to practice in underserved areas, for example through loan repayment programs. But it is unlikely that these efforts alone will solve the problem. An alternative model of health care education that stresses collaborative, cross-disciplinary training and practice has the potential to help address our country's unmet behavioral health needs.

The collaborative, team-based approach to healthcare education known as Interprofessional education (IPE) can help address the behavioral health workforce crisis. At its core, IPE is an education model designed to bring students from various health care disciplines together to learn with, from, and about each other with the goal of improving patient care (Rubin, Cohen Konrad, Nimmagadda, Scheyett, & Dunn, 2017). Collaborative training includes reviewing roles and responsibilities of various disciplines, shared didactics, shadowing professionals from diverse disciplines, participating in cross-disciplinary clinical simulations and other experiential learning activities with peers and professionals. In addition to classroom and simulation experiences, students participate in collaborative experiences in actual healthcare settings.

Especially when paired with telehealth, interprofessional training has the potential to positively impact gaps in behavioral health workforce. One model is behavioral health integration, in which a mental health professional is embedded within a primary care practice, allowing for early assessment and intervention and referral to more specialized or long-term care as needed (Talley et al., 2021). Whereas this model can work well, it is not always possible to place a behavioral health specialist in all settings, especially in the most remote, rural areas. Another model is to train primary care practitioners themselves, including family practice physicians and mid-level practitioners (physician assistants, nurse practitioners), to screen for and mental disorders and even offer basic interventions in partnership with specialist clinicians located remotely from the primary care provider.

This expanded scope of practice is made possible by telehealth and related digital tools. Primary care clinicians can use videoconferencing tools to consult with psychiatrists, psychologists, and other behavioral health experts located in distant universities and medical centers. Using secure videoconferencing tools, these practitioners can introduce patients to distant therapists, help socialize them to telehealth interventions, and then the therapist can provide expert care remotely. The local clini-

cian and remote therapists can then coordinate ongoing care with the former periodically seeing the patient in person to encourage ongoing engagement with treatment and to provide in-person assessments.

Finally, primary care practitioners can themselves learn not only to screen and assess for psychological problems, but also to provide certain interventions themselves. In addition to psychotropic medications, certain forms of brief, semi-structured cognitive behavioral psychotherapy lend themselves to provision by non-specialists (Weisberg & Magidson, 2014). For example, a treatment known as behavioral activation can be highly effective in treating mild to moderate depression, which is one of the most common conditions seen in primary care. Another example is ″SBIRT″ (Screening, Brief Intervention, and Referral for Treatment), an evidence-based program targeting substance abuse. These interventions, and many others like them, can be successfully provided by physicians, nurses, and other primary care practitioners who are appropriately trained and who practice in an interprofessional model, thereby greatly extending the reach of behavioral health services.

The University of New England (UNE) is Maine's largest private university and home to Maine's only medical school, only physician assistant program, Northern New England's only dental school, Maine's largest nursing program, and many other health care programs. The University is Maine's largest provider of health care professionals. UNE is known nationally for its innovations in interprofessional education, and is currently expanding programming to further integrate telehealth into our interprofessional training to address behavioral health programs.

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Senate Health, Education, Labor, and Pensions Committee
Subcommittee on Primary Health and Retirement Security Hearing:
A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce
May 20, 2021
Questions for the Record for Leon McDougle, MD, MPH

From Senator Hassan:
The past year highlighted the critical role that community health workers play in addressing health disparities. Not only can community health workers help patients navigate complex health care systems, but they can also work to connect individuals in need with nutrition-assistance programs, job training services, and housing.

1) How can we help facilitate the connection between physicians and community health workers to better address social determinants of health?

This is a timely and very important question. Please see recommendations below:

1. Provide incentives such as increasing Scholarships for Disadvantaged Students funding and GME positions for medical schools and Graduate Medical Education (GME) programs, respectively, to include experiences working with community health workers (CHWs) within respective inter-professional education curriculums. https://www.hrsa.gov/grants/find-funding/hrsa-20-006

   CHWs may need financial support to participate in these experiences so they can afford the time to participate

2. Fund development of training programs to assist healthcare practices in using CHWs, including onsite technical assistance and support.

3. Provide CMS incentives to embed community health workers directly into the clinical location with clinicians to allow direct relationship/trust building and warm patient transfers from clinician to CHW.

4. Make available CHW start up grants to healthcare practices that commit to a serious use of CHWs to help cover the cost of the CHW for one year and associated costs with incorporating the CHW into the practice.

5. Explore ways to remove employment requirement barriers to use of CHWs. Some CHWs may face the same employment challenge that peer support workers in the addiction/behavioral world face, having a criminal record that prevents them from being considered by employers.

6. Encourage CMS to identify and implement mechanisms for involvement of CHWs in existing or future value-based payment models - consider incentivizing use via additional payments or ability to obtain full payments through incorporation of CHWs. (National recommendation)

7. Develop and implement mechanisms that would allow payers to cover CHWs as part of HUB pathways model (state level recommendation) to address chronic conditions (not

just infant mortality). At the national level, the work would be done on creating HUB pathways more broadly across the U.S.

8. Encourage CMS to clarify wording so state Medicaid plans know they can reimburse for CHWs to address SDOH. This would be a director's letter from CMS - not policy change per se.

Another important program that employs CHWs is the Pathways Community HUB program both the CHW concept and program were developed by Drs. Sarah and Mark Redding (Mansfield, Ohio) "Pathways Community HUB Model: A Whole Person Approach to Improving Outcomes" - Sarah Redding, MD, MPH and Mark Redding MD.

The Pathways HUB model differs from other social determinants models on at least two fronts:

First, it manages its clients with community health workers who come from the same neighborhoods as the people they serve.

And second, the model's financial framework is premised on a monetary incentive that is realized by care coordination agencies—that is, the community health workers' employers (like PrimaryOne Health/FQHC)—when HUB clients/patients achieve measurable, positive outcomes in a host of factors, both large and small.

This is a pay for performance or achievement model of care utilized with the Pathways Community HUB certified model. (see T.R. Goldman, HEALTH AFFAIRSVOL. 37, NO. 12: Charting A Pathway To Better Health). The Pathways Community HUB program has been featured by ARHQ - Pathways Community HUB Manual: A Guide To Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes, initially published in 2010 by the Agency for Healthcare Research and Quality (AHRQ).

"The HUB relies on community care coordinators (CCCs)—community health workers, nurses, social workers, and others—who reach out to at-risk individuals through home visits and community-based work. Once an at-risk individual is engaged, the CCC completes a comprehensive assessment of health, social, behavioral health, economic, and other issues that place the individual at increased risk.

Each identified risk factor is tracked as a standardized Pathway that confirms the risk is addressed through connection to evidence-based and best practice interventions. The Pathway is a tool for confirming that the intervention has been received and that the risk factor has been successfully addressed. The Pathway also serves as the quality assurance and payment tool, and it is used by the CCC to ensure that each risk factor is addressed and that outcomes have improved. When this model is deployed across multiple agencies within a community, the centralized HUB helps agencies and CCCs avoid duplication of effort. The HUB serves as a communitywide networking strategy that helps isolated ("siloed") programs become a quality-focused team to identify those at risk and connect them to care.

The HUB model was first developed by the Community Health Access Project (CHAP) in Mansfield, Ohio, with leadership from Drs. Sarah and Mark Redding. The model involves working across organizational silos within a community (CHAP worked with multiple

stakeholders in three counties) to reach at-risk individuals and connect them to health and social services that yield positive health outcomes. The model is now part of a national network of community-based initiatives working under a common set of national standards and certification developed by the Pathways Community HUB Institute."

1. From a curriculum standpoint in regard to CHW training there is a real need to get CHWs more in clinic rotation experience and clinical documentation training. They are great in the community setting but some may struggle a bit with the expectations of clinical workflows, documentation, etc.

2. One big barrier that must be overcome requires the creation of a login type for CHWs. This allows them to properly document in EPIC and share their work/notes with the care teams. So full EMR capability for CHW workflows is a consideration systems need to explore.

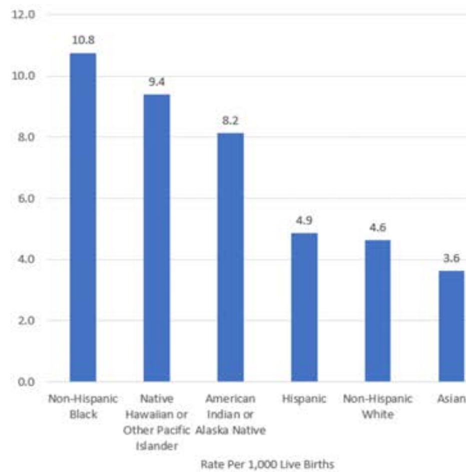
From Senator Casey:

Dr. McDougle, you spoke of the need for increased diversity in the health care workforce, particularly in primary care, and the evidence that increased diversity results in improved patient outcomes, including access to care and adherence to preventive medicine recommendations. Yet, for decades, we have failed to make significant gains in medical school enrollment diversity. You and others have stressed the need to start priming the pipeline earlier, preparing school children for careers in medicine. Our education system is not equitable. Promising minority and low income children are less likely to take challenging AP science courses, for example, than their white and higher income peers. To remedy the disparities, how early do we need to start? Is it even **before** elementary school? Further, what are the concrete steps we can take to increase the number of children who will chose health care professions, and in particular, the proportion of children of color who will become doctors?

How early do we need to start?

These are very important questions that address the essence of effective interventions. Interventions must facilitate both an interest in medical careers and the educational pathways that will successfully guide diverse youth to overcome the systemic barriers that they too often face, including social determinants, poverty and lack of mentorship, to provide the inspiration and support needed to not be lost from educational pathways to careers in medicine and STEMM. To begin; we must support initiatives that improve birth outcomes and lower infant mortality rate such as the Moms2B program established in Franklin, County Ohio in 2011. Moms2B provides weekly education and support sessions to promote healthy lifestyle choices and link Moms with support services. Education topics focus on: breastfeeding, child development, family planning, goal setting, labor and delivery, maternal-infant health, positive parenting, reproductive health, safe sleep and more.[1] More recently, DADS2B was established to educate fathers on maternal, positive family structure and infant health.[2]

U.S. Infant Mortality Rates by Race and Ethnicity, 2018[3]



The foundational skills of reading, writing and math and the ability to read by end of 3rd grade are essential for all career pursuits.[4]

In addition, we must support initiatives that improve the social determinants of health and quality of neighborhoods that children experience daily across the United States. Developed by the Kirwan Institute of Race and Ethnicity, the Child Opportunity Index 2.0 (COI 2.0) includes 29 indicators that measure neighborhood-based opportunities for children including but not limited to access and quality of early childhood education (ECE), high-quality schools, green space, healthy food, toxin-free environments, socioeconomic resources and more.[5]

For example, when comparing metropolitan Columbus, Ohio, most Black children live in neighborhoods with a very low or low Child Opportunity Index. Substantially more White children live in neighborhoods with a very high or high Child Opportunity Index.[5]

Neighborhood opportunity levels Very low Low Moderate High Very high

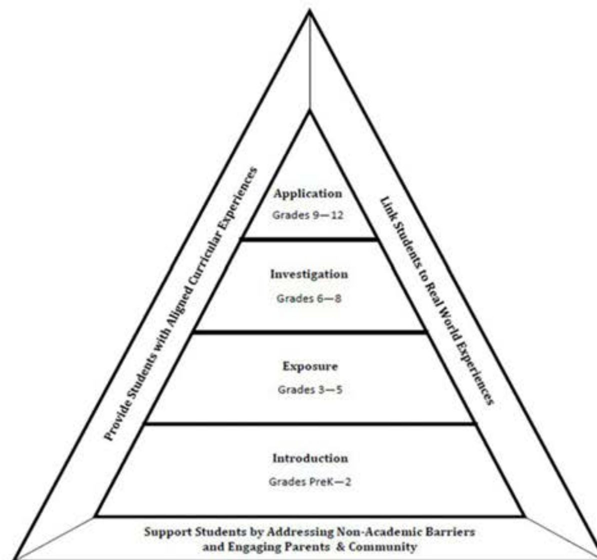
Neighborhood opportunity levels Very low Low Moderate High Very high

"Further, what are the concrete steps we can take to increase the number of children who will choose health care professions, and in particular, the proportion of children of color who will become doctors?"

Columbus City Schools (CCS) and Partners Achieving Community Transformation (PACT), leveraging The Ohio State University and Wexner Medical Center, partnered to launch the PreK - 12th Grade **Health Sciences Academies** (HSA) on August 26, 2015. HSA exists to foster successful outcomes for the children and families and to transform the Near East Side community into an education destination of choice.

The HSA are designed to be a college preparatory curriculum aligned to the State of Ohio Academic Standards. *Health Sciences Academies include: East High School; Champion Middle School; Trevitt and Beatty Elementary Schools; Ohio Avenue Elementary School; and Eastgate Elementary School.*

Health Sciences Academies Framework
&
Career Interdisciplinary Unit Studies by Grade Level



Pre-Kindergarten	Kindergarten	First Grade	Second Grade
Staying Safe and Healthy • Dental Hygienist • EMT/paramedics • Physician	*A Whole Healthy Me* • Medical assistant • Exercise coach • Mental health professional • Audiologist	*Our Needs and Our Health* • Veterinarian • Food scientist • Wellness coach • Gastroenterologist	*Our Physical Health* • Dentist • Physical therapist • Occupational therapist • ER/Trauma Doctor
Third Grade	**Fourth Grade**	**Fifth Grade**	**Sixth Grade**
Health in My Community • Dance therapist • Urban and regional planner • Public health inspector	*Investigating Medicine: Past and Present* • Nurse • Respiratory therapist • Environmental health technician • Medical investigator	*Light and Sound in Medicine Healthy Eating* • Dietician/nutritionist • Audiologist • Hydroponic gardener • Optometrist/ophthalmologist	*Cellular Medicine* • Phlebotomist • Organic farmer • Microbiologist • Cytotechnologist • Pathologist
Seventh Grade	**Eighth Grade**	**Ninth Grade**	**Tenth Grade**
Energy in Medicine • Radiologist • Oncologist • Pharmacist • Epidemiologist • X-ray technician • ENT doctor	*Reproductive Science/ Force and Motion in Medicine* • Geneticist • Fertility specialist • Forensic anthropologist • Orthotist/prosthetist	*Physical Science* • Anesthesiologist • Pharmacologist • Kinesiologist • Cardiac sonographer • Physical therapist • Athletic trainer • Nuclear medical technician • Ultrasound technician	*Biology* • Immunologist • Virologist • Bioethicist • Medical researcher • Biostatistician • Biochemist

Exposure to science and health in elementary school can ignite career interests in medicine and other health professions. HRSA Title VII Health Career Opportunity Programs (HCOP) and Center of Excellence (COE) programs funded by the federal government have shown that engaging students as early as elementary school can help to increase diversity of the health professions workforce. Examples include: *An Urban School District-University-Industry Partnership to Increase Diversity in the Health Professions: Lesson Learned from the University of Kansas Health Science Academy*[6] and the Department of Health Career Opportunity Programs at UConn Health involving the Aetna Health Professions Partnership Initiative (Aetna HPPI), a formal education consortium offering a comprehensive program of educational enrichment and support activities for underrepresented and first-generation students.[7]

There are several steps:

a. Increase funding of Historically Black Colleges and Universities (HBCUs), Tribal Colleges and Universities (TCUs), and institutions such as Hispanic-serving institutions, Asian American and Native American Pacific Islander-serving institutions, and other minority-serving institutions (MSIs). For example, according to a National Science Foundation report, while 8.5% of Black undergraduates attended an HBCU, nearly 18% of Black students who earned STEM bachelor degrees attended an HBCU. In addition, among the top eight undergraduate institutions producing Black graduates who go on to earn doctorate degrees, seven are HBCUs. Furthermore, among all Black students who earned a doctorate degree, one-third earned their undergraduate degree at an HBCU.[8]
b. Facilitate improved resources for academic advising and career development in public middle and high schools.
c. Support efforts to increase number of qualified, and diverse teachers in public schools.

d. Increase funding for teacher professional development, especially to focus on equity in public schools.
e. Improve the quality of public education for all, including reexamining funding streams for schools and exploring a requirement for periodic continuing education certification to help ascertain maintenance of teaching knowledge and skills.
f. Expand government sponsored youth summer employment programs like the New York City Department of Youth and Community Development Summer Youth Employment Program (SYEP) to provide young people meaningful employment within health care settings, like hospitals, clinics and public health facilities that will increase their exposure to health careers.
g. As the students matriculate to under-grad we need to ensure that they are employed and their education is paid so that they can continue their educational and career journey to completion (i.e., Emergency Medical Technician – Research Laboratory Technician – Dental Tech Certification – Associate Degree – Hygienist – Dentist etc. – each step of the way they can continue their education while being employed).
h. Enhance access to higher education via financial aid to include increase in availability of Pell Grants and scholarships for students from Health Professional Shortage Areas and Medically Underserved Areas.
i. Grow support for Title VII HCOP and COE programs and Area Health Education Centers.
j. Provide funding for place-based programs focused on health careers in communities, schools, and 2 and 4 year colleges and universities that are serving students with low family incomes, and Black/African American, Latino, American Indian and Alaska Native, and Native Hawaiian and Other Pacific Islander students.
k. Pass legislation to enact the Biden American Families Plan. Provisions within the proposed **American Families Plan** are aligned with goals of increasing number of physicians who Black, Indigenous and People of Color.

The American Families Plan calls for an additional four years of free, public education for our nation's children. Specifically, President Biden is calling for $200 billion for free universal pre-school for all three- and four-year-olds and $109 billion for two years of free community college so that every student has the ability to obtain a degree or certificate. In addition, the plan includes approximately $85 billion investment in Pell Grants, which would help students seeking a certificate or a two- or four-year degree. Recognizing that access to postsecondary education is not enough, the American Families Plan includes $62 billion to invest in evidence-based strategies to strengthen completion and retention rates at community colleges and institutions that serve students from our most disadvantaged communities. This is alongside a $46 billion investment in HBCUs, TCUs, and MSIs. President Biden is also calling for $9 billion to train, equip and diversify American teachers in order to ensure that our high school graduates are ready for success.

Acknowledgements for contributions to these responses for the record:

Shari Bolen, MD, MPH, Director, Center for Health Care Research and Policy, CWRU at MetroHealth System
Aaron D. Clark, DO, Physician Lead, Population Health, Medical Director/Quality Assurance & Improvement Officer, Ohio State Health, Inc. ACO
Patricia Gabbe, MD, Moms2B Founder and former Director

William D. Hayes, PhD, Director of Health Policy, External Relations & Advocacy
The Ohio State University Wexner Medical Center and Health Science Colleges
Vivian W. Pinn, MD, Past President of the National Medical Association, Former Director (Retired), Office of Research on Women's Health, NIH
Norma Poll-Hunter, PhD, Senior Director, Equity, Diversity and Inclusion at Association of American Medical Colleges (AAMC)
Demicha D. Rankin, MD, Associate Dean of Admissions, The Ohio State University College of Medicine
Candy Rinehart, DNP, APRN-CNP, FAANP, CEO/Director, The Ohio State University College of Nursing Total Health and Wellness
Twinkle Schottke, Program Director, Moms2B, The Ohio State University
Tei Street, Educational liaison for Partners Achieving Community Transformation (PACT) to the Health Sciences Academies
Charleta B. Tavares, Chief Executive Officer, PrimaryOne Health (FQHC)
Randell K Wexler, MD, MPH, Academic Vice Chair, Department of Family Medicine at The Ohio State University Wexner Medical Center
Yolanda Zepeda. Assistant Vice Provost, Office for Diversity and Inclusion, The Ohio State University

Thanks again for providing me the opportunity to offer my thoughts and suggestions to improve the health care crisis in this country so that all of our communities can benefit from accessible and empathetic health care. The National Medical Association stands ready to assist you in any way that we can to achieve this goal.

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RESPONSE BY DR. DAVID SKORTON TO QUESTIONS OF SENATOR CASEY

SENATOR CASEY

Question 1. Dr. Skorton, you shared data predicting a substantial 10 to 12 year physician shortage, ranging from over 50,000 to nearly 140,000. Even today there is a shortage in rural and other underserved areas. The *AAMC report* accounts for the 45 percent growth of our U.S. population over age 65 years, in the face of an also aging physician workforce. However, it does not fully account for equal health care access and utilization by underserved populations, highlighting that removal of barriers for these populations would mean nearly a doubling of the predicted shortage. As health care access improves health outcomes, we will want to remove barriers for the underserved. The report suggests several steps to mitigate the predicted shortage. Focusing on disparity reduction for the underserved, what additional steps are necessary to reduce health inequity, to increase not just the number of physicians, but the number of physicians who will serve the underserved?

Answer 1. The 2021 version of the *AAMC report* includes estimates that if marginalized minority populations, people living in rural communities, and people without health insurance had the same health care use patterns as populations with fewer barriers to access, an additional 102,400 to 180,400 physicians would be needed now.[1] COVID-19 has put a spotlight on disparities in health and access to care among underserved populations, and this analysis underscores the systematic differences in health care services by insured and uninsured individuals, individuals in urban and rural locations, and individuals of differing races and ethnicities. These estimates, which are separate from the shortage projection ranges, help illuminate the magnitude of current barriers to care and provide an additional reference point when gauging the adequacy of physician workforce supply.

Even before the COVID-19 pandemic, physician shortages were being felt by patients across the country. In 2019, the U.S. Health Resources & Services Administration estimated that an additional 13,758 primary care physicians and 6,100 psychiatrists would have been needed to remove Health Professional Shortage Area designations for areas with primary care and mental health shortages. According to public opinion research conducted by the AAMC in 2019, 35% of survey respondents said they or someone they knew had trouble finding a doctor in the past year or two. This is a 10-point increase from when the question was asked in 2015.

At the end of 2020, Congress took an important step to address the physician shortage by adding 1,000 new Medicare-supported graduate medical education (GME) positions—200 per year for five years—targeted at underserved rural and urban communities and other teaching hospitals nationwide, ending a nearly 25-year freeze on Medicare support for GME. Bipartisan legislation recently introduced in both the U.S. House of Representatives and the Senate, the Resident Physician Shortage Reduction Act of 2021, would build upon this historic investment and help expand the physician workforce by adding 2,000 federally supported medical residency positions annually for seven years.

In addition to increasing the number of physicians to reduce workforce shortages and access barriers, AAMC supports several federal programs to help shape the physician workforce and target underserved communities. In particular, the Health Resources and Service Administration (HRSA) Title VII pipeline programs (discussed in greater detail in response to question (2) play an important role in improving the diversity of the health workforce. Studies show that students from underserved communities are more likely to serve patients from similar communities in practice.[2]

Additionally, students and physicians who train in underserved areas are more likely to practice in those communities. Regional medical campuses, teaching health center graduate medical education (THCGME), and rural training tracks help expose students and residents to underserved communities. AAMC supports investing in these training opportunities as part of a multi-pronged approach to addressing physician workforce shortages. As Congress considers improving the Nation's health infrastructure, AAMC supports the Expanding Medical Education Act (H.R. 801),

[1] The 2020 version of the AAMC report estimated 74,100 to 145,500 physicians would be need now to address health care utilization equity scenario.

[2] Stewart, K., Brown, S. L., Wrensford, G., & Hurley, M. M. (2020). Creating a Comprehensive Approach to Exposing Underrepresented Pre-health Professions Students to Clinical Medicine and Health Research. Journal of the National Medical Association, 112(1), 36-43. doi:10.1016/j.jnma.2019.12.003.

which would authorize grants to enhance current and establish new regional medical campuses (RMCs).

Finally, public service loan repayment programs offered by HRSA, the Department of Education, the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are effective, targeted incentives for recruiting physicians and other health professionals to serve specific vulnerable populations. Increasing federal investment in these programs is a proven way to increase the supply of health professionals serving HPSAs, nonprofit facilities, and other underserved communities.

For example, the Public Service Loan Forgiveness (PSLF) program administered by the Department of Education encourages physicians to pursue careers that benefit communities in need. In an annual AAMC survey of graduating medical students, over one-third of 2020 medical school graduates indicate an interest in pursuing PSLF.[3] The AAMC supports preserving physician eligibility for PSLF to help vulnerable patients and nonprofit medical facilities that use the program as a provider recruitment incentive.

The NHSC in particular has played a significant role in recruiting primary care physicians to federally designated HPSAs through scholarship and loan repayment options. With a field strength of 13,053 in 2019, including 2,418 physicians, more than 13 million patients relied on NHSC providers for health care.[4] Despite the NHSC's success, it still falls far short of fulfilling the health care needs of all HPSAs due to growing demand for health professionals across the country. We are pleased Congress recognized the vital role the NHSC has in caring for our nation's most vulnerable patients by providing the program with $800 million in supplemental funding in the American Rescue Plan. The AAMC supports continued growth for the NHSC in FY 2022 appropriations, and we urge Congress to provide a level of funding for the NHSC that would fulfill the needs of all current HPSAs.

Similar to the NHSC, the State Conrad 30 J-1 visa waiver program has been a highly successful program for underserved communities to recruit both primary care and specialty physicians. Conrad 30 allows physicians to remain in the U.S. in an underserved community after completing medical residency on a J-1 "exchange visitor" visa (the most common nonimmigrant visa for GME), which otherwise requires physicians to return to their home country for at least 2 years. Over the last 15 years, the Conrad 30 program has brought more than 15,000 physicians to underserved areas—comparable to (if not more than) the NHSC, at no cost to the federal government.

As the 117th Congress considers immigration reform, the AAMC endorses the bipartisan Conrad State 30 and Physician Access Reauthorization Act (S.1810, H.R. 3541), which among other improvements would allow Conrad 30 to expand beyond 30 slots per state if certain nationwide thresholds are met. We applaud this bipartisan reauthorization proposal for recognizing immigrating physicians as a critical element of our Nation's health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied growth of the physician workforce.

Question 2. Continuing to focus on the goal of improving care through equitable health care, increased diversity of the physician workforce has been strongly recommended, not only as an end in and of itself, but because minority physicians are more likely to choose primary care and to serve the underserved. African Americans are not proportionally represented among the profession nor its training programs. Rectifying that will likely require complementary solutions. Would you please speak to how we can increase the pipeline to assure that more minority students apply to medical school? What steps are needed? Who is responsible to make the change? What role do American medical schools play now and how will they expand that role?

Answer 2. Over the past year, the COVID-19 pandemic has laid bare the existing health inequities harming our Nation's racial and ethnic minority communities, exposing the structures, systems, and policies that create social and economic conditions that lead to health disparities, poor health outcomes, and lower life expectancy. Your questions importantly highlight these persistent challenges and the need for academic medicine's ongoing work with communities to eliminate health dispari-

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[3] Medical School Graduation Questionnaire: 2020 All Schools Summary Report (Rep.). (2020). *https://www.aamc.org/media/46851/download*.

[4] Health Resources and Services Administration. Department of Health and Human Services Fiscal Year 2021 Justification of Estimates for Appropriations Committees. *hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf*. Accessed Feb. 10, 2020.

ties. A diverse and inclusive health workforce contributes to culturally responsive care, helps to mitigate bias, and improves access and quality of care to reduce health disparities, such as those seen during COVID-19. Improving diversity of our workforce requires both private and public ownership of the problems and contributions to the solutions.

The AAMC is committed to increasing significantly the number of diverse medical school applicants and matriculants, and last year launched a new strategic plan that will take a multitiered approach with sustained investment, collaboration, and attention over time to significantly increase the diversity of medical students. Our goal is to keep increasing the number of students from underrepresented groups until they are no longer underrepresented in medicine.

According to the AAMC Medical School Enrollment Survey,[5] virtually all medical schools have specific programs or policies designed to recruit a more diverse student body. The majority of respondents to that survey had established or expected to establish programs/policies geared toward minorities underrepresented in medicine, students from disadvantaged backgrounds, and students from underserved communities. Schools also reported a variety of approaches, with a focus on outreach at high schools and local four-year colleges and admission strategies such as holistic review. Holistic Review refers to mission-aligned admissions or selection processes that take into consideration applicants' experiences, attributes, and academic metrics as well as the value an applicant would contribute to learning, practice, and teaching. In addition to these efforts, AAMC believes earlier and greater intervention prior to the medical school admissions process is necessary to diversify the physician workforce.

In particular, pipeline programs play an important role in improving the diversity of the health workforce and connecting unrepresented students to health careers by enhancing recruitment, education, training, and mentorship opportunities. Inclusive and diverse education and training experiences also expose students and providers to backgrounds and perspectives other than their own and heighten cultural awareness in health care, resulting in benefits for all patients and providers. One example is the Summer Health Professions Education Program (SHPEP), a free summer enrichment program focused on improving access to information and resources for college students interested in the health professions. SHPEP is a national program funded by the Robert Wood Johnson Foundation with direction and technical assistance provided by the Association of American Medical Colleges (AAMC) and the American Dental Education Association (ADEA). SHPEP's goal is to strengthen the academic proficiency and career development of students underrepresented in the health professions and prepare them for a successful application and matriculation to health professions schools.

Likewise, the federal HRSA Title VII health professions diversity programs help support medical schools and students:

- Health Careers Opportunity Program (HCOP), which invests in K-16 health outreach and education programs through partnerships between health professions schools and local community-based organizations;
- Centers of Excellence (COE) program, which provides grants for higher education mentorship and training programs for underrepresented health professions students and faculty;
- Faculty Loan Repayment, which provides loan repayment awards to retain minority health professions faculty in academic settings to serve as mentors to the next generation of providers; and
- Scholarships for Disadvantaged Students (SDS), which grants scholarships for health professions students from minority and/or socioeconomically disadvantaged backgrounds.

Studies have demonstrated the effectiveness of such pipeline programs in strengthening students' academic records, improving test scores, and helping racial and ethnic minority and students who are economically disadvantaged pursue careers in the health professions.[6] Title VII diversity pipeline programs reached over 10,000 students in the 2018-2019 academic year (AY), with HCOP reaching more than 4,000 disadvantaged trainees, SDS graduating nearly 1,400 students and COE

[5] Results of the AAMC Medical School Enrollment Survey: 2017, May 2018. *https://www.aamc.org/media/8276/download*.

[6] Ojo, K. (2020). Preparing Minority Students For Careers in Health: A Case Study Investigation of a Health Careers Opportunity Program (HCOP) (Temple University Press). Temple University. *doi:https://scholarshare.temple.edu/handle/20.500.12613/287*.

reaching more than 5,600 health professionals; 56% of whom were located in medically underserved communities.[7] This success is even more impressive considering that only 20 schools have HCOP grants and only 17 have COE grants—down from 80 HCOP programs and 34 COE programs in 2005 before the programs' funding was cut substantially.

The AAMC appreciates that Congress reauthorized the HRSA Title VII and Title VIII programs in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136). However, increased funding is necessary for these programs to reach their full potential. For FY 2022, AAMC joined an alliance of over 90 national organizations, the Health Professions and Nursing Education Coalition (HPNEC), in recommending $1.51 billion for Title VII and Title VIII, which includes doubling funding for the HRSA diversity pipeline programs.

In addition to pipeline programs, the AAMC works continuously with the academic medicine community to advance equity, diversity, and inclusion. We would be happy to discuss any of the following AAMC led or supported initiatives in greater detail:

- **Action Collaborative for Black Men in Medicine** - The Action Collaborative will be a network community that will focus on systemic solutions to increase the representation and success of Black men interested in medicine sponsored by the AAMC and the National Medical Association (NMA).
- CDC **Cooperative Agreement** - The Centers for Disease Control and Prevention's Academic Partnerships to Improve Health focuses on improving the health of individuals and communities through alliances among academic associations, universities, and CDC.
- **Health Equity Research and Policy** - Funding and training opportunities, case studies and best practices, and solutions-focused research initiatives for AAMC member institutions to move their communities—and the Nation—toward health equity.
- **Improving Sexual and Gender Minority Health** - These resources help promote the health of people who are lesbian, gay, bisexual, transgender (LGBT), gender nonconforming (GNC), and/or born with differences of sex development (DSD).
- **Medical Career Fairs** - Medical career fairs offer workshops on medical school admissions, opportunities to meet admissions officers and current medical students, as well as hands-on activities.
- **Population Health Education** -The AAMC seeks to improve the integration of public health concepts into medical education and enhance and expand a diverse and culturally prepared health workforce.
- **Promising Practices to Improve Hispanic Health** - This webinar series is designed to increase awareness, foster discussion, and catalyze further research among health professions faculty on how to best advance Hispanic health.
- **Sexual and Gender Harassment** - These AAMC resources contain key terms, findings, recommendations, and general information from the National Academies of Science, Engineering, and Medicine (NASEM) report Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine.
- **Unconscious Bias** - At medical schools and teaching hospitals, unconscious biases can compromise diversity and inclusion efforts across the board. The AAMC provides resources and trainings to help members address unconscious biases.
- **Urban Universities for HEALTH** - Urban Universities for HEALTH (Health Equity through Alignment, Leadership, and Transformation of the Health Workforce) aims to enhance and expand a culturally sensitive, diverse, and prepared health workforce that improves health in urban communities.

Thank you again for your questions and leadership on the important topic of physician workforce shortages and the challenges the country faces. We believe there must be a private-public, multipronged approach to bolstering the physician work-

[7] Health Resources and Services Administration. Department of Health and Human Services Fiscal Year 2021 Justification of Estimates for Appropriations Committees. *hrsa.gov/ sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf*. Accessed Feb. 10, 2020.

force and the diversity of the physician workforce. Academic medicine is committed to working to address the challenges and has made significant investment in both these areas. At the same time, we believe there must be a corresponding increase in the federal government's investments for a variety of federal programs that are already working. The cost of inaction today will result in higher costs and a less healthy population tomorrow. We look forward to continuing to work with you and the Senate HELP Committee to achieve this goal. If you have any further questions please contact Matthew Shick, Senior Director, AAMC Government Relations.

[Whereupon, the hearing was concluded at 11:58 a.m.]