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WHAT CAN CONGRESS DO TO ADDRESS THE SEVERE SHORTAGE OF MINORITY HEALTH CARE PROFESSIONALS AND THE MATERNAL HEALTH CRISIS?

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING WHAT CONGRESS CAN DO TO ADDRESS THE SEVERE SHORTAGE OF MINORITY HEALTH CARE PROFESSIONALS AND THE MATERNAL HEALTH CRISIS

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C O N T E N T S

STATEMENTS

THURSDAY, MAY 2, 2024

WHAT CAN CONGRESS DO TO ADDRESS THE SEVERE SHORTAGE OF MINORITY HEALTH CARE PROFESSIONALS AND THE MATERNAL HEALTH CRISIS?

Thursday, May 2, 2024

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:01 a.m., in room 430, Dirksen Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Casey, Baldwin, Kaine, Hassan, Smith, Hickenlooper, Cassidy, Braun, Marshall, and Tuberville.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIR. All right. The Senate Committee on Health, Education, Labor, and Pensions will come to order.

Today, our Committee is going to focus on two extremely important health care issues that must be addressed. First are the major need for more Black, Latino, and Native American doctors and medical professionals.

Second, the alarming rate of maternal deaths in America that is disproportionately impacting Black, Latino, and Native American women.

In the midst of a health care system that, in my view, is largely broken and dysfunctional, where we spend almost twice as much per capita on health care as the people of any other country, or 85 million Americans today are uninsured or underinsured, and where we don't have enough doctors, nurses, dentists, mental health specialists, or pharmacists, we have another crisis on top of all of that, and that is that problem of lack of medical personnel is extremely, especially acute in Black, Latino, and Native American communities, which is the subject of our hearing today.

Despite making up almost 14 percent of our population, just 5 percent of all doctors in our Country are Black, less than 4 percent of all dentists, and just 6 percent of all nurses in America are African American.

Further, despite making up over 19 percent of our population, just 6 percent of doctors and dentists and just 7 percent of nurses in America are Latino. And, we cannot forget the Native American community, which makes up 1.3 percent of our population, but just

three-tenths of 1 percent of all doctors in our Country are Native American. So why is this an important issue that we have got to address?

Well, the answer is that study after study has shown that when Black, Latino, and Native American patients have access to Black, Latino, and Native American doctors, their health outcomes substantially improve. They are more likely to receive preventative services. They are more satisfied with their care.

They are more likely to live longer and happier lives. In my view, it is unacceptable that life expectancy on average, which is low in America in general, is about 5 years lower for Black Americans and 11 years lower for Native Americans than it is for White Americans.

It is unacceptable that Black Americans are more likely to die of heart disease and have the highest rates of cancer of any other group in America. It is not acceptable that Black Americans are more than twice as likely to have diabetes, an issue that we are dealing with right now.

A major epidemic in America, twice as high in the Black communities than in the white community. And one of the most alarming and troubling health disparities in America is the maternal mortality rate, which is the other major focus that we will be talking about today.

In America today, we have the highest maternal mortality rate and the highest infant mortality rate of any other wealthy country on Earth. In fact, the maternal mortality rate in America is 19 times higher than Norway, 4 times higher than France.

Incredibly, according to the CDC, women in America today are twice as likely to die from childbirth as their—than their mothers. And as bad as this crisis is overall, it is much, much worse for Black women and infants.

In America today, Black women are nearly three times more likely to die from pregnancy related complications than their white counterparts. The crisis is also getting significantly worse for Latina women. Between 2019 and 2020, the Latina maternal mortality rate skyrocketed by 44 percent in just 1 year.

Meanwhile, Black infants in America are almost four times more likely to die from complications due to low birth weight than white infants. So, the question then becomes, given that reality, what are we going to do about it? How are we going to address what is obviously a major health care crisis in America?

That is what we will be discussing this morning. Just a few things that I think we have got to do. We need to substantially increase the class sizes of historically Black colleges and universities, and we will be hearing from representatives of one of them today. We need to pass the Black Maternal Health Momnibus Act, introduced by Senator Booker and Senator Butler.

Senator Butler will be talking about that today. We need to substantially increase funding for the women, infants, and children program. We need to substantially increase funding for the National Health Service Corps.

In my view, we need to cancel student debt and make all public colleges and universities tuition free so that all people, regardless of background and income, will be able to get the education they need, including going to medical school.

In fact, the good news is that making tuition, medical school tuition free, is a growing idea. In fact, four medical schools in America, including the New York University School of Medicine, are currently tuition free, while five others have made tuition temporarily free or offering free tuition to working class students.

We have got a lot to talk about today and I look forward to a serious discussion about a serious issue, and I thank our panelists who are here with us.

Senator Cassidy.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you, Chair Sanders. This Committee has covered the shortages of physicians and other health workers extensively. Shortages hurt the delivery of health care in all communities.

My home State of Louisiana, projected to have the third worst shortage of physicians of any state by 2030. We need more doctors, particularly in the underserved areas lacking sufficient health care resources. My practice as a physician was for 25 years in a hospital serving the uninsured and the poorly insured, which is to say Medicaid.

This is something which I have spent my professional life attempting to address. Today, we are going to look specifically at minority doctors and health professionals underrepresented in our health care system.

For example, African American physicians account for only 8 percent of all physicians, despite comprising 13.6 percent of the population. Now, if you are listening carefully, you will note that my statistics are different than the Chairs'.

His is 5 percent and mine is 8 percent. My data is more—he uses the Association of American Medical Colleges 2019 data, and I am using the Bureau of Labor Statistics, which is 2022 data. That is important. 2019, 2022 Government data. A little bit more up to date, a little bit more valid.

Maybe there is progress being made. And as we look at something which needs to be addressed, we can also say that if we have gone from 5 to 8 percent, there may be progress being made, and that is a good thing.

But it is interesting to note that this disparity is not felt across all minorities. Asian doctors account for 22 percent of all physicians but are only 6.8 percent of the population. And this is an important nuance as we address this situation. It is also important to note, as the Chair notes, that we have a limited number of GME residency slots to train new doctors.

These residency positions are not allocated or dispersed to reflect where underserved communities are. Unfortunately, this topic is under Finance jurisdiction, but it is an important context and

needs to be considered in any conversation about addressing health care workforce shortage.

It is kind of a truism that a physician will practice within 100 miles of whether—where she or he does their residency. If the residency spot is not in an underserved area, it is not going to be within that 100 miles.

But access to opportunity is crucial. I want to highlight and brag on Xavier University, a Historically Black College and University in my State of Louisiana. This week, they announced an agreement with Ochsner Health to open a medical school in New Orleans at Xavier.

Many of the doctors trained at Xavier, which has had a traditional mission to serve the underserved and to provide opportunity for minorities, they will stay in Louisiana and go elsewhere to serve those populations.

I am proud of Xavier, and I look forward to continuing to support their effort. Now, as a doctor, I am so aware and desire to support those nurses who have climbed the career ladder by building credentials over time through upskilling.

Despite from benefiting the individual, it benefits the capabilities of our workforce. It also benefits their family as their child sees the impact of their mother or father seeking through education and delayed gratification, greater opportunity that results in more prosperity.

There is a woman I worked with named Olive, who went from a nurse's assistant to an LPN to an RN to a nurse manager, and the clinic in which she formerly was the NA, she ultimately ended up being the manager of. Incredible story. We will have someone here today with a similar story.

Dr. Jaines Andrades will tell us how she has done that in her career, and that is something that we need to think how to enable. We should also look at other challenges to ensure our health care system meets the need of all, especially the underserved.

Making sure that patients from all walks of life can participate in clinical trials, which oftentimes gives the most advanced—most advanced treatment to those who have the most advanced disease.

As I mentioned from my career, making sure that all have high quality medical treatment is something I am passionate about. One of our witnesses today, Dr. Brian Stone, will tell us how he is trying to address these issues in his community.

The Committee will also discuss maternal mortality, a topic incredibly important that has been a priority of mine in Congress, and it is important to acknowledge that this issue disproportionately affects African Americans.

As a doctor, again, who worked in Louisiana's charity hospital system, I know this community from my practice, and I know that this community is at high risk. That is why I am pleased to have U.S. Representative and Dr. Michael Burgess testifying.

He is an OB-GYN who stayed up many nights delivering medical care to pregnant moms and their babies in an underserved population of Dallas. Now, as a legislator, Dr. Burgess is a leader in addressing racial disparities in health care, and it has been an honor

to work with him on legislation specifically tackling maternal mortality.

We were unaware that we were having a Members of Congress panel until Sunday, so we greatly appreciate him joining us on short notice when actually they were adjourned last night. His participation helps make clear that Congress understands the severity of the issue and is working to address.

I am also proud to have led several bipartisan legislative efforts to improve maternal mortality and reduce health care disparities. In 2022, Congress passed the Maternal Health Quality Improvement Act, which helps address maternal mortality, particularly that disparity within African Americans.

It also supports research examining the best practices to reduce and prevent racial discrimination in the American health care system. The same year, Congress passed my legislation, the John Lewis National Institute in Minority Health and Health Disparities Research Endowment Revitalization Act.

It is a mouthful, but it is a good piece of legislation that provided funding to institutions, including Xavier, to conduct research and address minority health disparities. And last year in this Committee, we passed the Preventing Maternal Deaths Reauthorization Act, the legislation led in the House by Dr. Burgess, and the bill directs the CDC to provide hospitals and other providers information on best practices to prevent maternal mortality.

This reauthorization has not yet become law, but we are pushing for passage this Congress. All this work shows a bipartisan commitment in Congress to addressing health disparities, but there is more to do.

The connected maternal online monitoring systems or the Connected MOM Act, doctor—Senator Butler, I was about to demote you or promote you by calling you doctor, which I introduced with Senator Hassan of New Hampshire of this Committee, promotes Medicaid coverage of remote monitoring technologies for those who are pregnant at higher risk of complications.

The need for moms in underserved urban or rural areas who travel sometimes hours on public transportation to a doctor's office can be a major impediment to care. This legislation allows a physician to remotely monitor her health, watching for indicators of potential complications.

It is bipartisan and improves access to crucial health care for moms, and it prevents maternal deaths. While this bill is in Finance jurisdiction, I look forward to the discussion today on how we can continue to make progress on maternal mortality in the HELP Committee.

Thanks to our witnesses for being here and providing your expertise on how we better address these important issues. With that, I yield.

The CHAIR. Thank you, Senator Cassidy. Our first witness will be Senator Laphonza Butler, a Senator from California.

Senator Butler is a long standing advocate for health care workforce and increasing opportunities for students from underrepresented and disadvantaged backgrounds in the health professions.

She is also a strong advocate for reducing maternal health disparities and combating the Black maternal health crisis. Senator Butler, thanks for being here.

STATEMENT OF HON. LAPHONZA BUTLER, UNITED STATES SENATOR, CA

Senator BUTLER. Thank you, Chairman Sanders and Ranking Member Cassidy for the hearing today. Thank you to other Members of the Committee for joining. Your leadership on this issue is demonstrable.

Thanks for having me. It is an honor, truly, to sit before today's Committee to bring added amplification to the lack of diversity within our Nation's health care system, as you both have outlined so clearly, and in addition, the worsening maternal health crisis.

Before I begin my testimony, I would like to acknowledge those leaders who have been championing this issue prior to my arrival in the U.S. Senate.

It is leaders like Representative Lauren Underwood, our colleague Senator Booker, who introduced the Black Maternal Health Momnibus in the Senate, and Representative Alma Adams, for their leadership in developing the Black Maternal Health Caucus, and the leadership. I also cannot sit here without recognizing Vice President Kamala Harris, who introduced the first version of the Momnibus while serving in the Senate.

She continues to lead the Biden-Harris administration's efforts to improve maternal health outcomes. These are champions that I am proud to stand alongside. I want to also take a brief moment to highlight Dr. Michael Galvez, who is a witness in today's hearing and is also a resident of California and one of my constituents.

Dr. Galvez is a board certified plastic and reconstructive surgeon specializing in pediatric hand surgery in Valley Children's Hospital in Madera, California. He co-created National Latino Physician Day to bring attention to the fact that while Latinos make up 19 percent of the population, they account for only 6 to 7 percent of the physician workforce.

Thank you for being here today, Dr. Galvez. Our health care system and the state of maternal health in this country is at an inflection point that requires the urgent attention of this Committee. The numbers should alarm all of us.

The United States has the highest rate of maternal mortality among high income nations. Within recent years, thousands of women have lost their lives due to pregnancy related causes. And over the past decade, while the birth rate in this country has declined by roughly 20 percent, maternal mortality rates have steadily risen.

The crisis is exacerbated in communities grappling with a lack of access to essential maternal health care. According to a report produced by the March of Dimes, one-third of counties in the United States are considered maternity care deserts, meaning there are no hospitals providing obstetric care, no birth centers, and no obstetric providers.

Think about that. Imagine your loved one preparing to give birth and bring new life into your family and having no choice but to drive hours away from home to seek the care they need. We know from the research and the numbers that this crisis has not been felt equally.

Among Black and native indigenous communities, maternal mortality rates are two to four times higher compared to those of white communities. Two to four times higher are in—Black and Native American women are more likely to die in a pregnancy related death.

While Black and Brown communities experience the highest rates of maternal mortality and morbidity, these populations also remain starkly underrepresented within the health care field. While an estimated 13 percent of our Country's population identifies as Black, only about 5 percent of physicians in the United States are Black.

Research suggests that under the care of Black physicians, the mortality rate for newborns decreases by over 50 percent, which is why I applaud and urge this Committee's continued efforts to not only bolster the health care workforce, but to use every tool to ensure that workforce is diverse and equipped to provide unbiased and culturally competent care.

Only then can we begin to change the course of our Nation's current health care system. And we know that this must not mean focusing exclusively on physicians. For families, mothers, and babies, this means doulas and nurse midwives, nutritionists, and the full spectrum of reproductive health care professionals that contribute to their health, well-being, and birthing experience.

Having access to a comprehensive care team can make the world of difference for families. For example, in my home State of California, the Martin Luther King Community Hospital in Los Angeles has reimagined the birth experience for women serving—within its service community.

When I visited the hospital, I first—I saw firsthand how doulas and nurse midwives were integrated into their overall maternal health care model to ensure that birthing mothers receive the highest quality and most comprehensive care.

The leadership of Dr. Elaine Batchlor has made an indispensable difference. And even as we have existing models and we consider other proposed solutions to this crisis, I implore this Committee to advance the Black Maternal Health Momnibus Act led by Senator Booker.

The Momnibus is comprised of 13 individual bills that would combat the Black maternal health crisis and make historic investments to address comprehensively and deliver—every driver of maternal mortality, morbidity, and disparities in the United States. This legislation is not just about the life and death of Black women.

Its enactment will improve birthing outcomes for all women. The Momnibus includes bills such as the Kiera Johnson Act, which would make necessary investments in community based organiza-

tions that are leading the charge to protect mothers and support culturally competent training within maternity care settings.

This bill is named after Kiera Johnson, a Black mother who in 2016 checked into a hospital with her husband, Charles, to give birth to their second child, Langston. Despite being in excellent health, Kiera died from a hemorrhage in the hours after delivering young Langston. Kiera should be here today.

The lives of her husband and her sons have forever been changed. The Johnson family's tragic experience, and that of so many other families, should be a wakeup call for us to act with urgency to address the need of unbiased, patient centered care. Today's hearing is an important step in the right direction.

I urge this Committee to hold additional sessions focused on the Black maternal health crisis and important legislation that my colleagues and other advocates have introduced and researched.

This Committee, which holds the primary jurisdiction for the Black maternal health Momnibus, and so many other maternal health policy solutions is having a—hasn't had a recent hearing on the topic.

Last month, during Black Maternal Health Week, I convened a roundtable of prominent maternal health leaders and experts for discussion on how we can work together to combat the maternal health crisis.

We discussed the hurdles that lie ahead in advancing the Momnibus and similar legislation. Those advocates shared with me that they believed that they would have to remove the word Black from the title of the Momnibus. They believe that only then the legislation would be likely to gain the necessary support for passage.

After spending some time with my colleagues in the Senate, spending time with many of you, I don't believe that to be true. I know this Committee is filled with Senators, public servants, who represent Black women living in each of their states.

I am here to stand with you and to show every American watching that I stand with leaders on this Committee who together demonstrate our commitment to the Black and Brown women and their families who suffer the most in our health care system.

We have solutions at the ready, and I know that anti-Black sentiment will not serve as a barrier toward progress. While I serve in this chamber, I will continue to stand with all of you loudly and proudly, ensuring that we deliver the investments required to meet this moment for caregivers, health care personnel, the mothers and families in California, and throughout the Nation.

I look forward to working with this Committee and my colleagues in both chambers as we advance comprehensive solutions and utilize every level to prevent maternal deaths in this country. Thank you.

[The prepared statement of Senator Butler follows.]

PREPARED STATEMENT OF SENATOR LAPHONZA BUTLER

Thank you, Chairman Sanders and Ranking Member Cassidy, for inviting me to today's important hearing. It is an honor to sit before the Committee today, to bring critical attention to the lack of diversity within our Nation's health care system, and the worsening maternal health crisis.

Before I begin my testimony—I'd like to submit a statement for the record on behalf of Representative Lauren Underwood who has long worked to champion these issues. I would also like to thank Senator Booker and Representative Alma Adams for their leadership in elevating the devastating Black maternal health crisis.

As leaders of the Black Maternal Health Caucus and the Black Maternal Health Momnibus Act—they have made it their mission to thoughtfully address maternal health disparities. I also want to recognize Vice President Kamala Harris, who introduced the first version of the Momnibus, while serving in the Senate. She continues to lead the Biden-Harris Administration's efforts to improve maternal health outcomes.

Thank you to all of these champions for your unwavering commitment. I am proud to stand alongside each of you in this effort.

I also want to take a moment to highlight Dr. Michael Galvez, who is a witness in today's hearing and is also one of my constituents. Dr. Galvez is a Board-certified plastic and reconstructive surgeon specializing in Pediatric Hand Surgery in Valley Children's Hospital in Madera, California. He co-created National Latino Physician Day to bring attention to the fact that while Latinos make up 19 percent of the population, they account for only 6–7 percent of the physician workforce. Thank you for being here today, Dr. Galvez.

Our health care system and the state of maternal health in this country is at an inflection point that requires the urgent attention of this Committee. The numbers should alarm us all: The United States has the *highest* rate of maternal mortality among high-income nations. Within recent years, thousands of women have lost their lives due to pregnancy-related causes. And over the past decade, while the birth rate in this country has declined by roughly *20 percent*, maternal mortality rates have steadily risen.

This crisis is exacerbated in communities grappling with a lack of access to essential maternal health care. According to a report produced by the March of Dimes, *one-third* of counties in the United States are considered maternity care deserts, meaning there are no hospitals providing obstetric care, no birth centers, and no obstetric providers. Think about that—imagine your loved one preparing to give birth and bring new life into your family, and having no choice but to drive hours away from home to seek care.

We know from the numbers that this crisis that has not been felt equally. Among Black and Native Indigenous communities, maternal mortality rates are two to four times higher compared to those of White communities. Let me repeat that—Black and Native American women are two to four times more likely to die a pregnancy-related death.

While Black and Brown communities experience the highest rates of maternal mortality and morbidity, these populations also remain starkly underrepresented within the health care field. While an estimated 13 percent of our Country's population identifies as Black, only about *6 percent of physicians* in the United States are Black.

Research suggests that under the care of Black physicians, the mortality rate for newborns decreases by *over 50 percent*, which is why I applaud and urge the Committee's continued efforts to not only bolster the health care workforce, but to use every tool to ensure this workforce is diverse and equipped to provide unbiased, culturally competent care. Only then can we begin to change the course of our Nation's current health care system.

This must not mean focusing exclusively on physicians. For families, mothers, and babies, this means doulas, nurse midwives, nutritionists, and the full spectrum of reproductive health care professionals that contribute to their health, well-being, and birthing experience. Having access to a comprehensive care team can make a world of a difference for families. For example, in my home state of California, the Martin Luther King Community Hospital in Los Angeles has reimagined the birthing experience for women within its service community. When I visited the hospital, I saw firsthand how doulas and nurse midwives are integrated into their overall maternal health care model to ensure that birthing mothers receive the highest quality, most comprehensive care. The leadership of Dr. Elaine Batchlor has made an indispensable difference.

Even as we have existing models and as we consider other proposed solutions to these crises, I implore this Committee to advance the Black Maternal Health Momnibus Act led by Sen. Booker. The Momnibus is comprised of 13 individual bills that would combat the Black Maternal Health crisis and make historic investments to comprehensively address every driver of maternal mortality, morbidity, and dis-

parities in the United States. This legislation is not just about the life and death of Black women—it's enactment will improve birthing outcomes for all women.

The Momnibus includes bills such as the Kira Johnson Act, which would make necessary investments in community-based organizations that are leading the charge to protect mothers—and support culturally competent training within maternity care settings. The bill is named after Kira Johnson—a Black mother who, in 2016, checked into a hospital with her husband Charles to give birth to their second child, Langston. Despite being in excellent health, Kira died from a hemorrhage in the hours after delivering Langston. Kira should still be here today. The lives of her husband and sons have been forever changed. The Johnson family's tragic experience, and that of so many other families, should be a wake up call for us to act with urgency to address the need for unbiased patient-centered care.

Today's hearing is an important step in the right direction. I urge this Committee to hold additional sessions—focused on the Black maternal health crisis and the important legislation that my colleagues and other advocates have introduced and researched. This Committee, which holds primary jurisdiction of the Black Maternal Health Momnibus and so many maternal health policy solutions, has not held a recent hearing on the topic.

Last month, during Black Maternal Health Week, I convened a roundtable of prominent maternal health leaders and experts for a discussion on how we can work together to combat the Black Maternal Health crisis. We discussed the hurdles that lie ahead in advancing the Momnibus and similar legislation.

Those advocates shared with me that they believed that they would have to remove the word "Black" from the title of the Momnibus. They believe that only then would the legislation be more likely to gain the necessary support and passage. After spending time with my colleagues in the Senate, spending time with many of you, I don't believe that to be true. I know this Committee is filled with Senators, public servants, who represent Black women living in each of their states. I know that this body is resolved to ensure that the Black women they serve can count on you to hear their experiences and take action to save their lives. I am here to show every American watching that I stand with the leaders on this Committee as we, together, demonstrate our commitment to the Black and Brown women and their families who suffer the most in our health care system.

We have solutions at the ready—and I know that anti-Black sentiment will not continue to serve as a barrier toward progress. While I serve in this chamber, I will continue to stand with all of you—loudly and proudly—ensuring we deliver the investments required to meet this moment for caregivers, health care personnel, and the mothers and families in California and throughout the Nation. I look forward to working with the Committee, and my colleagues in both chambers to advance comprehensive solutions and utilize every lever to prevent maternal deaths in this country.

Thank You.

The CHAIR. Well, thank you very much, Senator Butler. Our next witness will be Congressman Michael Burgess, representative from Texas. I think Senator Cassidy, you wanted to introduce the Congressman.

Senator CASSIDY. Yes. It is a pleasure to introduce a witness and a friend, the honorable Michael Burgess, an OB-GYN, representative for 20 years, the 26th District of Texas in the House of Representatives.

He is the Chair of the Budget Committee, the health care task force. Chair of the Rules Committee. He serves on Energy and Commerce. He has used his wealth of knowledge in maternal health and in building the health care workforce to advance key pieces of legislation addressing these issues.

He has, as you might guess, a unique perspective as both a policymaker and as a practitioner. So, Dr. Burgess, thanks for being here.

STATEMENT OF HON. MICHAEL C. BURGESS, M.D., UNITED STATES CONGRESSMAN, TWENTY SIXTH CONGRESSIONAL DISTRICT, TX

Dr. BURGESS. Thank you, Dr. Cassidy. Chairman Sanders, Members of the Committee, thank you for allowing me the opportunity of testifying here this morning. I do represent the 26th District in the State of Texas.

In the House, we have congressional districts. So that is the area near the Dallas-Fort Worth airport—just to locate it for you. Before coming to Congress, I spent nearly three decades practicing medicine in that area.

Look, I know practicing medicine can be very complex. I chose obstetrics because if there is attention to detail, the results can almost always be satisfactory. I spent time in residency as an OB-GYN at Parkland Hospital.

Statistically, Parkland has some of the best outcomes in the country due to its emphasis on proper care and attention to detail. When I started my residency, I remember Dr. Jack Pritchard, who was the leader of the Department of Obstetrics and Gynecology at the time, pointing out that in practicing OB, you are unique in medicine.

Those privileged enough to continue were going to be charged with taking care of the simultaneous care of two patients with a combined life expectancy of 100 years. Nowhere else in medicine does that occur.

The patient population for Parkland, the Dallas County Hospital District, serves both rural and urban communities in and around Dallas. In my time, the clientele was multi-ethnic, almost completely uninsured or underinsured, but again, they have some of the best statistics in the country.

The lesson for me there always was, it doesn't have to be this way. You can do better. And I would like for us to focus on that with whatever our public policies are going forward. For myself, I have delivered in private practice over 3,000 babies, treated patients who have suffered from miscarriages, ectopic pregnancy, stillbirths, sickle cell, and other life threatening conditions.

Whether my responsibility was to step in and deliver a baby or save a life, I did it without hesitation. For this reason, I have spent my career trying to increase access to quality health care for patients through both my experience as a physician and a legislator.

In 2005, through what I described as the miracle of redistricting, I picked up an area the East side of the city of Fort Worth. It had one of the highest infant mortality rates in the country.

Despite the challenges, it took years of concerted effort, but eventually I was successful in getting a federally qualified health center with a pediatric unit in that part of Fort Worth. A collaboration with a Democratic County Commissioner, Roy Brooks, the Mayor of Fort Worth, Mike Moncrief, who was a prior Democratic State Senator.

It was through that joint effort and the experience and the expertise and the passion that led us to championing those issues. Now

in Congress, I have continued that, as well as other health care issues that are improving the health of the Nation.

The alarming trend of our Country's rate of maternal mortality first came to my attention in September 2018, and my copy of the Green Journal, the Journal of Obstetrics and Gynecology.

The original research cited in the journal stated that the maternal mortality rates increased in Texas between 2011 and 2012. But then a new study found that the number of maternal deaths in Texas in 2012 was actually half than the number previously reported. In other words, there was a mistake in the arithmetic.

Because of that, the focus became on how things were counted rather than how do we prevent these bad things from happening. The study was retracted, but again the discussion became about the numbers, not about the patients, and that was unfortunate.

I personally believe one maternal death is too many, and it is important that we capture these deaths accurately to understand the scope of maternal mortality in the United States and my State of Texas, and that we have a better understanding of how to address them.

In combination, we cannot legislate good practice, but we can provide the tools to be able to come up with the best practices and increase access to maternity care. These critical points have influenced my policy work.

Here are some actual tangible results from that. Because of the Preventing Maternal Deaths Act, which was signed into law in 2018, and increasing the dollars spent on maternal mortality review committees, it actually came to my attention that 53 percent of maternal deaths were occurring 1 week to 1 year after delivery.

I had been focusing on that time actually in hospital, but by broadening the lens out a little bit, more lives can be saved. And as a consequence, now there was an amendment to a state plan amendment available to Medicare—I am sorry, the Medicaid and CHIP programs that has allowed inclusion of postpartum care up to a full year after delivery.

Texas, I am happy to say, enacted that on March 1st of this year, and now new moms in Texas are going to have the benefit of an additional year of postpartum coverage. 3338, which was referenced in Senator Cassidy's opening remarks, has passed the House, and I encourage you to look at that in the Senate.

I think we can do more with what we—our approach that the disciplinary maternal mortality review committees and the causes of maternal deaths. I cannot stress enough the importance of continuing bipartisan work to reduce disparities, improve outcomes.

We can bolster our public health workforce. We can actually start by paying our doctors, so they don't retire early, or never enter the practice of medicine in the first place. That has been a particular concern of mine since coming to Congress.

Repeal of the Sustainable Growth Rate formula and the approach to value based care that followed in its place. Although it is imperfect and we still got a ways to go, these are important parameters that will benefit all Americans.

I have had the good fortune of working with your future colleague, Lisa Blunt Rochester, soon to be Senator from Delaware, in my understanding. I also work with Robin Kelly and Danny Davis, working with Danny Davis to improve the care of the sickle cell patient, which importantly really had not received any new FDA approved therapies in over 40 years until we began to work on that in—right after the Cures Act passed.

I know my time is done, but I just want to stress that there are important things we can work on together, House and Senate, Republican and Democrat, and it is our obligation to those future Americans that we do so.

This generation of doctors is coming up, is going to have tools to alleviate human suffering that no generation of doctors has ever known. It is our job to deliver that to them in a timely fashion. Thank you for your attention this morning. I yield back.

[The prepared statement of Dr. Burgess follows.]

PREPARED STATEMENT OF HON. MICHAEL BURGESS

Chair Sanders, Ranking Member Cassidy, and Members of the Senate Health, Education, Labor, and Pensions Committee, thank you for the opportunity to speak at today's hearing.

I am Representative Michael C. Burgess from Texas' 26th District. Before coming to Congress, I dedicated nearly three decades to practicing medicine in Texas. Between myself, my grandfather, and my father combined we have practiced medicine for nearly the whole of the twentieth century. Practicing medicine can be very complex. However, I chose obstetrics since there is almost always a satisfactory result. I spent time in residency as an OB-GYN at Parkland Memorial Hospital in Dallas, Texas. Statistically, Parkland had some of the best outcomes in the country due to its emphasis on proper care and attention of patients. At the time, I remember the Chairman of the Department of Obstetrics and Gynecology pointed out that the practice of obstetrics is unique in medicine, and those privileged enough to continue were going to be charged with taking care of two patients with a combined life expectancy of 100 years. Nowhere else in medicine does one have the ability to do that.

The patient population near Parkland often came from both rural and urban communities in Dallas. In my time, the clientele was multi-ethnic, largely uninsured, or underinsured. Throughout my career, I have delivered over 3,000 babies and treated patients who had suffered from miscarriages, ectopic pregnancies, stillbirths, sickle cell, and other life-threatening conditions. Whether my responsibility was to step in and deliver a baby, or save a life, it was done without hesitation. For this reason, I've spent my career trying to increase access to quality health care for patients, both through my experience as a physician and as a legislator.

In 2005, I became aware of the rising infant mortality rates in Southeast Fort Worth. Despite the challenges, it took several years of concerted effort, but eventually, I successfully established a federally Qualified Health Center (FQHC) with a maternal unit. Remarkably, the center was opened through a longstanding collaboration with the Democratic County Commissioner and Mayor of Fort Worth. It was my experience, expertise, and passion in maternal health care that led me to championing this issue in Congress as well as other health issues aimed at improving health disparities.

The alarming trend in our Country's rate of maternal mortality first came to my attention in September 2018, when I was reading my copy of the Green Journal. The original research cited in the journal stated that maternal mortality rates increased in Texas between 2011 and 2012.[1] The new study found that the number of maternal deaths in Texas in 2012 was less than half the number previously reported.

The peer-reviewed research, published in the journal *Obstetrics and Gynecology*, determined there were 56 maternal deaths among Texas residents compared with

[1] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5001799/*.

147 reported in national statistics.[2] Later on, it was released that the state overcounted the deaths due to a new method of how Texas was reporting data that was different than other states. This retraction of the study made disputes over the statistics the subject of national news coverage as opposed to the lives that need saving.

I believe that any maternal death is one too many. It is important that we capture these deaths accurately to understand the scope of maternal mortality in the United States and have a better understanding of how to address them. In combination, we cannot legislate good practice, but we can provide the tools to be able to come up with best practices and increase access to maternity care. These critical points have influenced my policy work during my time as a legislator.

Throughout the years, I have worked across the aisle on several pieces of legislation that became law, including H.R. 315 The Improving Access to Maternity Care Act and H.R. 4387 The Maternal Health Quality Improvement Act. Additionally, I am currently a lead sponsor of H.R. 3838 The Preventing Maternal Deaths Reauthorization Act, H.R. 7432 The Sickle Disease Comprehensive Care Act, and H.R. 3226 The PREEMIE Reauthorization Act of 2023. In the past, I have led critical reauthorizations of Title VII Health Professional Education and Training Programs to increase access to health care in underserved areas and diversify the health care workforce. I also worked on H.R. 5395 The Expanding Connectivity for Health Outcomes Act (ECHO) Act, which promoted connection between primary care providers and specialists, increasing access to specialty care for underserved communities.

Part of the goal of H.R. 3838 was to establish Maternal Mortality Review Committees (MMRCs). These multidisciplinary committees review the causes of maternal deaths in their state or other localities and make recommendations based on their findings to prevent future deaths and improve maternal health outcomes during pregnancy, childbirth, and the postpartum period. Through my work on this legislation, Maternal Mortality Review Committees were able to discover that 53 percent of pregnancy-related deaths happen between 7 days and 1-year post-partum, leading to the critical extension of the state plan amendment for Medicaid and Children's Health Insurance Program (CHIP) 12-month post-partum coverage.[3] This year, effective March 1st, 2024, Texas extended postpartum coverage to the full 12 months for eligible Medicaid and Children's Health Insurance Program (CHIP) recipients through the Texas Health and Human Services Commission.

I cannot stress enough the importance of continuing bipartisan work to reduce disparities and improve outcomes, as well as bolster our public health workforce. Throughout the years, I've developed great working relationships with Members such as Reps. Lisa Blunt Rochester, Robin Kelly, and Danny Davis. It is through these great partnerships that we influence and expand our understanding of health care policy in the Nation. With that knowledge, it is my belief that Congress should examine the effectiveness of our existing programs and determine what changes may be necessary to achieve these goals.

Congress has an important role, but so do community/physician-led efforts. The work of Congress should be informed by what's happening on the ground. It is our passion and work that define who we are and leave a lasting imprint on Capitol Hill, shaping policies, building relationships, and fostering change that impacts the lives of countless American patients.

Thank you for having me today and for holding this hearing on such important topics. It has been a privilege to discuss my work and experience with you.

The CHAIR. Well, thank you very much, Congressman Burgess. Thank you very much, Senator Butler. We appreciate your testimony and your excellent work. We will now hear from our second panel. Thank you. Let me thank all of our knowledgeable panelists for being with us this morning.

We have five panelists, Dr. Yolanda Lawson, Dr. Samuel Cook, Dr. Michael Galvez, Dr. Jaines—Jaines Andrades, and Dr. Brian Stone. And we thank all of them for being here. Our first witness will be Dr. Yolanda Lawson.

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[2] *https://journals.lww.com/greenjournal/abstract/2018/05000/identifying-maternal-deaths-in-texas-using-an.3.aspx.*

[3] *https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html.*

She is President of the National Medical Association, the largest organization representing Black physicians. Dr. Lawson is an OB-GYN who is committed to addressing health inequities and improving diversity among physicians.

She is also committed to eliminating maternal health disparities. Dr. Lawson, thanks so much for being with us.

STATEMENT OF YOLANDA LAWSON, M.D., PRESIDENT, NATIONAL MEDICAL ASSOCIATION, DALLAS, TX

Dr. LAWSON. Thank you. Good morning——

The CHAIR. Is your mic on? Press the button.

Dr. LAWSON. Okay. Good morning, Chairman Sanders and Ranking Member, Dr. Cassidy, and Members of the Committee.

Thank you for the opportunity to appear before the Committee to discuss this critical issue, addressing the shortage of racial minoritized health care professionals and maternal health disparities.

I am Dr. Yolanda Lawson, and I am testifying today as an OB-GYN practicing in Dallas, Texas, and founder of MadeWell OBGYN and MadeWell Woman, which is a birthing center. I am currently the Executive Medical Director for Maternal Infant Health at Healthcare Services Corporation.

Today, I speak to you primarily in my capacity as the President of the National Medical Association. We are the largest and oldest national organization representing more than 50,000 African American physicians and the patients they serve of all racial and ethnic backgrounds. As a physician, my first duty is to the health of my patients.

As NMA President, my first duty is to fulfill our mission to eliminate health disparities in this country. The sad fact is, African Americans, as well as other people of color, are not as healthy as their white counterparts. African Americans experience the lowest life expectancies across a myriad of health care outcomes compared to White Americans, irrespective of their socioeconomic status.

Research demonstrates that such inequities in health outcomes have existed since Federal recordkeeping began, and they cannot be explained solely by socioeconomic differences, and they are largely preventable through structural interventions and through the implementation of equitable health policy and measures before a prospective patient even enters a traditional medical setting.

In 2020, our Nation watched in horror as Black people died disproportionately in high numbers from COVID–19. That extraordinary moment spotlighted a chronic problem of the ongoing health disparities that exist for Blacks in this country.

Black people are disproportionately affected by virtually every major chronic disease, including diabetes, high blood pressure, and obesity. Even more disturbing are disparities in maternal health. You all know the numbers.

Black women are more than—are 3 to 4 times more likely to die from pregnancy related complications than white women, and maternal health disparities persist as a pressing public health chal-

lenge in the United States despite advances in medical technology and health care delivery.

These disparities are not solely attributable to socioeconomic factors but are deeply rooted in systemic racism and unequal treatment, bias, and inadequate access to quality health care. This is just—this is not just a matter of equity or fairness.

When there are more sick people in our Nation, such an imbalance dynamic creates a bigger burden on our health care system, reduces workforce productivity, increases disability, and raises medical costs that ultimately we all pay for, whether through Medicare, Medicaid, or other high health insurance premiums.

Avoidable health disparities are deeply rooted in the operationalization of structural and systemic racism and discrimination and in the persistence of unequal access to quality health care. Each of these elements erodes a patient's health care experience and diminishes their ability to make the best choices in support of their health today and across their lifetime.

Today, I would like to emphasize a critical piece of the American health care puzzle, the shortage of Black physicians. Research consistently demonstrates that patients from racial and ethnic minority backgrounds experience better outcomes when treated by health care providers who share their racial ethnic backgrounds.

In short, patients can have better health outcomes when their doctors look like them. Yet Black doctors remain vastly underrepresented. Representation is critical, and Black physicians and health care providers are more likely to understand the unique challenges that Black patients—that affect Black patients' health.

Black patients are more likely to trust and comply with the recommendations of a Black physician. This country has a legacy of distrust among African American—among American health care institutions, rather well or perceived, and this is rooted in historical abuses of power.

70 percent of all Black physicians in the U.S. today attended HBCUs. In the 20th—in the early 20th century, we know that number was reduced after the Flexner Report was released. Instead of addressing those concerns about the quality of education at HBCU medical schools, the AMA allowed them to close.

We know that likely the number of Black physicians in this country today would be more proportionate to the Black population if those institutions had remained open. The NMA believes we must create pathway programs to address inequities in the education system.

We must address financial constraints. For many Black students, medical school is a financial impossibility. We support programs such as the National Health Service Corps. And as for resources, for the HBCU medical schools to address education and infrastructure, medical schools must adopt more holistic admission processes.

We must address the higher attrition rates among medical—Black medical students and residents. We advocate, in regard to maternal health, a companion bill from the Senate to the Black Maternal Momnibus Act to focus on preventable maternal mortality.

Finally, we must take steps to reduce the bias in our health care system by establishing regional centers of excellence to address implicit bias and cultural competency in health professions settings like Senator Durbin and Robin—Representative Robin Kelly's Care for Moms Act.

I believe we are at a turning point in my lifetime. Two major events have significantly exposed the disparities between the health of Black people compared to those of our white counterparts, the COVID–19 pandemic and Hurricane Katrina.

Both catastrophic events revealed the glaring health inequities that are present in our Country. There is much work to do, but we also have a historic opportunity to change the story. Thank you, Senator.

[The prepared statement of Dr. Lawson follows.]

PREPARED STATEMENT OF YOLANDA LAWSON

Greetings Chairman Sanders, Ranking Member Bill Cassidy, M.D., and Members of the Committee.

Thank you for the opportunity to appear before the Committee to discuss this critical issue: addressing the shortage of minority healthcare professionals.

My name is Yolanda Lawson, M.D. I am testifying today as an OB-GYN practicing in Dallas, Texas, and as the President of the National Medical Association, the largest and oldest national organization representing the interests of more than 50,000 African American physicians and the patients they serve.

I am the founder of MadeWell OBGYN in Dallas and MadeWell Woman, a birthing center. I am currently the Executive Medical Director, Maternal Infant Health at HealthCare Services Corp.

As a physician, my first duty is to the health of my patients. As NMA president, my first priority is to represent the needs of Black physicians and Black communities in this country.

The sad fact is: Patients who are African American, as well as other people of color, are not as healthy as their white (non-minority counterparts.) And these disparities have existed since Federal recordkeeping began.

The COVID–19 pandemic brought this issue to the forefront. In 2020, the entire nation watched in horror as members of the Black community accounted for a disproportionate number of COVID–19 deaths.

That was an extraordinary situation but reflected a chronic issue. Black people are disproportionately affected by every major chronic disease (excluding those with a genetic basis). They are 2.2 more likely to have diabetes. According to the CDC Black infants 2.4 times the mortality of White infants. African-Americans have the highest mortality rates of any racial or ethnic group for all cancers combined and most major cancers. Black people are more likely to die of heart disease than any other group. Black women are 60 percent more likely to have high blood pressure compared to White women.

Other disparities include "higher uninsured rates, being more likely to go without care due to cost, and worse reported health status. The life expectancy of Black people is nearly 5 years shorter compared to White people (72.8 years vs. 77.5 years)."

Even more disturbing are disparities in maternal health. Black women continue to experience disproportionately high rates of maternal morbidity and mortality compared to white counterparts. The Centers for Disease Control and Prevention (CDC) reports that Black women are three to four times more likely to die from pregnancy-related complications than white women.

MATERNAL HEALTH DISPARITIES: A PERSISTENT CHALLENGE

Maternal health disparities persist as a pressing public health challenge in the United States. Despite advances in medical technology and healthcare delivery, Black women continue to experience disproportionately high rates of maternal morbidity and mortality compared to their white counterparts. The Centers for Disease Control and Prevention (CDC) reports that Black women are three to four times more likely to die from pregnancy-related complications than white women. These

disparities are not solely attributable to socioeconomic factors but are deeply rooted in systemic racism, implicit bias, and unequal access to quality healthcare.

This is not just a matter of equity. The commitment to safe birthing processes and positive health outcomes affects everyone, not just mothers. When there are more sick people, that creates a bigger burden on our healthcare system, less productivity for the affected workforce, and higher medical costs that ultimately, we all pay for, whether through higher health insurance premiums or tax dollars for Medicare and Medicaid. In 2019, it was noted that the impacts of maternal morbidity cost the United States $32.3 billion.

To address this problem, we must understand why it's happening. These disparities are not attributable solely to socioeconomic factors. Nor is there a genetic or biologic basis. They are deeply rooted in a myriad of factors that include systemic racism, implicit bias, and unequal access to quality healthcare. But one key factor, which I'd like to address in depth, is the shortage of Black physicians.

MORE BLACK PROVIDERS

Research consistently demonstrates that patients from racial and ethnic minority backgrounds experience better health outcomes when treated by healthcare providers who share their racial and ethnic backgrounds. In short, patients can have better outcomes when their doctors look like them.

Yet Black doctors remain vastly underrepresented relative to their proportion of the U.S. population. Despite long-standing efforts to increase minority representation in our physician workforce, gains have been minimal. African American and Black people represent only 5.7 percent of physicians—which means they are grossly underrepresented relative to the roughly 13.6 percent of Americans who are Black.

Physicians, of course, are only part of the healthcare workforce. Recently, the NMA's Annual Colloquium convened the presidents of all the major organizations of Black healthcare providers, including Black nurses, Black pharmacists, Black registered dieticians, and Black physical therapists, Black Dentists and Black Psychologists. We all agreed: Ensuring the future of a diverse workforce is critical to ending healthcare disparities.

Why is representation so important? Why do Black patients seem to do better when they see Black physicians?

One reason is that Black physicians and healthcare providers are more likely to understand the unique challenges that influence Black patients' health outcomes. Also, Black patients are more likely to trust the advice of a Black physician or provider and comply with the physician's recommendations. Sociocultural understanding and improved communication can lead to better quality of care. Studies indicate that Black infants are 3 times more likely to die than non-Hispanic white infants, however that number decreases by half when they are seen by a Black doctor. Similarly, cardiovascular deaths in Black men are reduced by 19 percent when they are seen by a Black physician.

Trust is critical in creating positive health outcomes and there is a legacy of distrust in our community. This history of distrust is understandable given the history of healthcare delivery and research in the United States. The Tuskegee syphilis study is widely recognized as one key reason for this mistrust. However, studies suggest that the history of medical and research abuse of African Americans goes well beyond Tuskegee.

Distrust has so many repercussions and costs. Despite mandates by the Federal Government to ensure inclusion of women and minorities in all federally funded research, African Americans continue to participate less frequently than Whites. Lower participation rates among African Americans have been reported across various study types (e.g., controlled clinical treatment trials, intervention trials, as well as studies on various disease conditions, including AIDS, Alzheimer's disease, prostate cancer and other malignancies, stroke, and cardiovascular disease). Black people don't enroll in research studies because of that legacy of distrust. The presence of more Black physicians could begin to repair some of that distrust.

Black physicians and healthcare providers can advocate for equitable healthcare policies and practices within the healthcare system.

UNDERSTANDING BARRIERS

Several challenges persist for young Black people who aspire to become physicians:

Structural barriers—including limited access to medical school education, financial constraints, pervasive discrimination within academic and healthcare settings—all hinder the recruitment, retention and advancement of Black medical students, residents and practitioners.

It is important to note the role of historically Black colleges and universities (HBCUs), which have represented an important piece in the pipeline. Nearly three-quarters—70 percent—of all Black physicians in the U.S. attended HBCU medical schools.

At one time, there were seven HBCU medical schools. However, five of those seven were shuttered after the 1910 release of the Flexner Report, commissioned by Carnegie Corporation and the American Medical Association's (AMA)'s Council on Medical Education. In 1910, Flexner published his report with devastating consequences for the numbers of Black doctors. He recommended shuttering five of the seven historically Black medical schools that trained the vast majority of Black physicians. Within 2 years of the Flexner Report, three Black medical schools closed, and by 1924, only two such schools remained.

Flexner claimed the Black medical schools were substandard. His biased thinking suggested that Black medical schools existed primarily to keep Black citizens from spreading contagious disease to the white population. The U.S. has yet to fully recover from this loss as there are now only four HBCU medical schools.

More critically, instead of providing assistance to help raise the quality of education at these schools, the AMA allowed them to close. Had they remained open, likely the number of Black physicians in this country today would be comparable to the size of the Black population, and more importantly, the tragic health disparities I've described would be much less.

HERE ARE SOME STEPS THAT NMA BELIEVES MUST BE TAKEN TO BEGIN TO ADDRESS THE SHORTAGE OF BLACK PHYSICIANS

(1). Address barriers and inequities in the education system that prevent talented Black students from getting to medical schools, beginning with early childhood, through elementary and secondary school and pre-medical education at the undergraduate level.

(a). Black, Hispanic and Native American students are more likely to have parents without a college degree and more likely to attend a low-resourced college.

(b). Not only does that affect their ability to compete in the admissions process . . . these factors trickle down to social networks, limiting opportunities that affect their ability to succeed as medical students.

(c). For example, one study found that students of color were less likely to have shadowed a physician—an experience that can burnish a med school application.

(d). Pathway programs should offer early interventions and exposure to medical disciplines.

(2). Address financial constraints through scholarship opportunities and additional funding for low-income students. A student who is the first in their family to attend college, or who works 20 hours a week to pay expenses while attending college, faces an uphill battle. It's much more difficult for those students to earn the same GPA and MCAT scores as a student who doesn't have those constraints. NMA has established a Million Dollar Scholarship Challenge to help address that need—but it's just a start. The burden of student debt disproportionately affects Black physicians, further exacerbating existing socioeconomic disparities.

(3). Ensure that guidance counselors at the high school level, and pre-med advisors at the undergraduate level, encourage and support Black students who aspire to medical careers. Black students are more likely to face discouragement from advisers when applying to medical school compared to their white counterparts. Instead of discouragement, they need support and resources.

(4). Create a more holistic admission process for medical school. Medical schools must expand their recruitment targets to include "added values" that underrepresented and racially minoritized individuals can bring to a training program or a department. Admission tests and grades don't tell the whole story. To quote the American Medical Association (AMA)—"Scoring highly on the Medical College Admissions Test (MCAT)—one of the primary

measurements used in consideration of medical student admission by medical schools—doesn't mean you'll become a great, or even a good, doctor." The AMA report adds: "Overreliance on just one measure of performance, such as the MCAT, risks missing a pool of candidates with other valuable attributes to contribute to the health care system." Aspiring Black medical school candidates have valuable attributes to contribute. They relate to Black patients and they contribute to better health outcomes. An admission process that overlooks that potential could exclude some of our best future doctors.

(5). Increase the number of residency positions.

(6). Address the issue of higher attrition rates among Black medical students and residents. These are students who managed to overcome barriers to get into medical school and on to residency. We need to understand what's keeping them from meeting these final hurdles and how we can better support them.

(7). Address the especially severe shortage of Black men in medicine through continued support of funding for graduate medical education. Black men make up less than 3 percent of the overall physician population. This disturbing numbers stems from a history economic disadvantages and systemic racism.

(8). Continue and enhance programs in medical schools aimed at improving diversity. We've seen a backlash of late against DEI programs in medical schools. We cannot repeat the mistakes of the Flexner report. As HBCUs produce 70 percent of Black doctors, it is paramount that we continue to support these institutions and support increases in graduate medical education funding.

CLOSING COMMENTS

I believe we are at a turning point. In our lifetime, we have experienced two major life events that have significantly exposed the disparities between the health of Black people compared to those of our white counterparts: the COVID–19 pandemic and Hurricane Katrina. Both catastrophic events revealed the glaring health inequities that are present in our Country. I believe we have the awareness and the political will to begin to create change.

As I said before, this is more than a matter of equity. It's not just about representation and fairness. It's about life and death. It's about the health of millions of Black Americans.

There is much work to do, but there is also an opportunity to change the story.

[SUMMARY STATEMENT OF YOLANDA LAWSON]

The healthcare workforce and reproductive justice are not only key policy foci of the NMA but of myself personally. Representing the needs of Black communities is paramount in a time where we face some of the worst health outcomes in the country. Black people are disproportionately affected by every major chronic disease and have a much higher likelihood of maternal mortality. Additionally, distrust in the healthcare system has a longstanding history amongst Black Americans, which creates additional barriers in receiving quality care. Sociocultural understanding and improved communication have been proven to lead to increased patient adherence to healthcare guidelines and higher patient satisfaction, which results in better health outcomes. Research continues to show that racial concordant care is key to improved health outcomes for minority communities, however, due to a history of racial and systemic barriers, the number of Black doctors in the United States is staggeringly low. The United States has been facing a physician shortage for several years, but especially with Black doctors, who represent only 5.7 percent of doctors in the country. The COVID–19 pandemic further exasperated these shortages and brought them to the forefront. The shortage has resulted in lack of access to receiving care, especially in rural and low-income communities, extraordinarily long wait times to receive care, a lack of a diverse workforce, and lack of healthcare workforce retention. It is important to focus on providing resources to increase support for Black students seeking graduate medical education. 70 percent of the Black physicians in the United States attended Historically Black Colleges and Universities (HBCUs) and the existence and support of these institutions is critical to the pathway of increasing the number of Black doctors. The Flexner report severely impacted the number of HBCUs in our Country and we have yet to recover. By ad-

dressing barriers that contribute to the lack of Black physicians in the United States, we can begin to dismantle the systems that continue to impact the health outcomes of our community.

The CHAIR. Dr. Lawson, thank you very much. Our next witness will be Dr. Samuel Cook, a resident physician at Morehouse School of Medicine. Dr. Cook received his medical degree from Drexel University and is an advocate for improving diversity of the physician workforce. Dr. Cook, thanks very much for being here.

STATEMENT OF SAMUEL COOK, M.D., RESIDENT, MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA

Dr. COOK. Thank you, sir. Senator and Chairman Sanders, Senators of the HELP Committee, my fellow panelists and guests, thank you so much for having me here today. I am Dr. Samuel David Cook and a PGY–3 internal medicine resident at Morehouse School of Medicine.

I was born and raised in the Bronx, New York, by my two loving parents, Ronald Cook and Ambassador Susan Johnson Cook, who instilled in me a deep love of God and the impetus to serve those among us who are most in need.

Though all of us in this room today are red blooded Americans, my journey to this platform has been anything but traditional. The doctors I saw as a child never looked like me, so I made it my life's mission to be the change I sought in medicine.

During my undergraduate studies at Johns Hopkins University, I was told by my medical school admissions counselor that my above average GPA at one of our Nation's top ten universities was not strong enough to make medicine a reality.

Nevertheless, I persisted and entered a post-baccalaureate pipeline program for underrepresented minorities at Drexel University's College of Medicine. In this Drexel pathway to medical school program, I thrived in the specialized and supportive environment and quickly excelled.

I then graduated to become a medical student at Drexel, where I earned top academic awards above my peers of all races and published my medical research, even authoring a paper with decorated physicians at Harvard's medical school.

As the things go, you can't judge a book by its cover, and it takes a village to raise a child. It is a fact, not an opinion, that historically Black colleges and universities have been instrumental in creating their own pipelines to medical schools.

Between 2009 and 2019, HBCUs have seen the most Black graduates to them. Last year, HBCU medical schools produced 10 percent of our Nation's Black doctors, while only accounting for 2 percent of all medical colleges.

Assuming we beat an educational system that is stacked against us, many Black students are then faced with hundreds of thousands of dollars in student loan debt. For me, the current sum of medical student loan debt plus accrued interest stands just shy of $400,000.

Though the costs are the same, no matter the student's race, the financial impact it will have on their families is not. Racially biased and systemic wealth inequity is an undeniable truth in our Nation, and one that has barred far too many students of color from becoming the doctors they were qualified to be.

Thus, we call on you to increase funding for HBCUs to reduce the cost of producing high quality physicians of color. This is with the understanding that these institutions have a proven track record of incubating some of our Nation's brightest minds, those nearly snuffed out by the waves of racial bias and injustice.

How does having a Black doctor better serve Black patients or save them from undue harm? I wrote in my testimony about a Black woman who was nearly committed and chemically and physically restrained, all because her medical team didn't know that hitting your head to scratch an itchy scalp doesn't make you crazy. It simply means you don't want to mess up your hair.

How it was the presence of a Black psychiatrist that saved them and that hospital from what would have been justifiable malpractice lawsuits. So, this is not just an issue for Black American, Senators. This is an issue for all Americans.

What is more, a 2016 study found that half of white medical trainees surveyed, 50 percent believe such myths as Black people have thicker skin or less sensitive nerve endings than white people.

They continued, participants who endorsed these beliefs rated the Black patients pain as lower and made less accurate treatment recommendations. In this population of white medical students, we see evidence that negative racial biases are currently and have long been harming America's Black patients.

Senators, I humbly come before you today as nothing more than a mouthpiece for our collective struggles. We serve tirelessly, Senators. We, resident physicians and medical students of color sacrifice our physical, mental, spiritual, and financial well-being to be the change in the medical field we so desperately seek.

Now we ardently advocate for the reintroduction of legislation which would specifically fund and protect the growth of HBCU medical schools like that proposed by Chairman Sanders in 2023.

This is what the sentiment that we make these vital pipelines more affordable, because the financial manacles of medical schooling are the greatest impediments in recruiting Black and Brown doctors to our workforce.

It frightens me to think that after today, nothing will change to render our physician workforce more representative of the racial and ethnic makeup of our great nation. Therefore, I am challenging you, Senators, calling upon you to each assure the American public and your constituents that you will vote to support our HBCUs and empower future generations of Black and Brown physicians.

The time to act is never tomorrow, Senators. It has been and always will be today. Thank you.

[The prepared statement of Dr. Cook follows.]

PREPARED STATEMENT OF SAMUEL COOK

Senator and Chairman Sanders, Senators of the HELP Committee, my fellow esteemed panelists, and guests.

Thank you so much for having me here today to speak on one of the most critical issues in the U.S. Healthcare system as it currently stands.

I am Dr. Samuel David Cook, a PGY–3 Internal Medicine Resident Physician at The Morehouse School of Medicine. I was born and raised in the Bronx, NY, by my two loving parents, Ronald Cook and Ambassador Suzan Johnson Cook, who instilled in me a deep love of God, and the impetus to serve those among us who are most in need.

We come here today for an awesomely important purpose: to recognize the shortage of Black doctors currently in the American workforce, to understand why it is an issue, and to identify actionable steps that you may take as Congress to rectify this gap.

Though all of us in this room today are red-blooded Americans, my journey to this platform has been anything but traditional. I grew up in a neighborhood that was inherently sick, underserved from the most critical healthcare needs. The doctors I saw as a child never looked like me, so I made it my life's mission to be the change I sought in medicine. During my undergraduate studies at Johns Hopkins University, I was told by my medical school admissions counselor that my above-average GPA at one of our Nation's top ten universities was not strong enough to make medicine a reality. Nevertheless, I persisted and entered a post-baccalaureate pipeline program for under-represented minorities at Drexel University College of Medicine. In this Drexel Pathway to Medical School Program (DPMS), I thrived in the specialized and supportive environment, and quickly excelled. I then graduated to become a medical student at Drexel, where I earned top academic awards above my peers of all races, and published my medical research, even authoring a paper with decorated physicians at Harvard Medical School. As the sayings go, "You can't judge a book by its cover," and "it takes a village to raise a child."

While I do not have as many years of experience as my colleagues testifying today, I do possess the benefit of recency in pursuing a medical career.

What is the true measure of a physician? Is it how well they score on a standardized exam, or is it the care and poise with which they utilize such knowledge? I submit to you today that high-quality medical care necessitates qualified, yet compassionate and culturally competent physicians.

Historically Black Colleges and Universities (HBCUs) have been instrumental in creating pipelines to medical schools. Between 2009 and 2019, HBCUs sent the most Black graduates to medical schools. According to the Association of American Medical Colleges (AAMC), "Howard and Morehouse graduated more than 400 each over this time period, while no predominantly white institution graduated as many as 300." Of the three undergraduate institutions supplying medical colleges with the most Black entrants in 2023, "two were HBCUs—Howard (first) and Xavier (third)." Additionally, HBCU Medical Schools produced 10 percent of our Nation's Black doctors last year while only accounting for 2 percent of all medical colleges.

Assuming we beat an educational system that is stacked against us, Black medical students have one of the most difficult and potentially injurious decisions facing them: Should I assume hundreds of thousands of dollars in student-loan debt without any guarantee I will actually become a practicing physician? For me, the current sum of medical student loan debt and accrued interest stands just shy of $400,000. Though the costs are the same no matter the student's race, the financial impact it will have on their family is not. Racially based and systemic wealth inequity is an undeniable truth in our Nation, and one that has barred too many students of color from becoming the doctors they were qualified to be.

Acceptance into medical school and matriculation through residency are crucial pain points when looking at the employment gap, but retention and support are, nevertheless, equally as important. We are often bound by our debts to work in hospitals in which we may not be equally supported, or worse, face reprimand at unjustly higher rates than our peers. One 2020 study published in JAMA Surgery found that over 70 percent of Black surgical residents who were surveyed faced discrimination during their residency. Another showed that "Black trainees accounted for only 5 percent of all residents in 2016 but 20 percent of those who were dismissed from a residency program." Thus, we call on you to increase funding for HBCUs to reduce the cost of producing high-quality physicians of color. This is with the understanding that these institutions have a proven track record of incubating

some of our Nation's brightest minds, those nearly snuffed out by the waves of racial bias and injustice.

How does a black doctor better serve Black patients, or save them from undo harm? I will give an especially poignant example. I was informed of the particularly harrowing story of a Black patient at one of our area's hospitals. She was seen furiously hitting her head, to the degree that her medical staff were alarmed, insisting that the patient be placed under a psychiatric hold as they judged she was a direct harm to herself. When the Black female Psychiatrist went to the bedside to see this patient, she immediately indicated to the rest of the medical team that the patient was, in fact, not harming herself, but simply patting her head because that is how you scratch an itchy scalp without messing up your hair. Had a Black physician not intervened in this instance, that patient was on a pathway to being chemically or physically restrained, and that hospital and staff would have justifiably faced a malpractice lawsuit. So, this is not just an issue for Black Americans, it is an issue for all Americans.

Senators, cultural competence directly saves our patients' lives and well-being. It protects them from the perils of physicians who have sheltered in their own cultural bubbles without true understanding of the diverse communities they serve.

What's more, a 2016 study published in the Proceedings of the National Academy of Sciences (PNAS) found that "Half of white medical trainees [surveyed] believe such myths as Black people have thicker skin or less sensitive nerve endings than white people." They continue, "participants who endorsed these beliefs rated the Black (vs. white) patient's pain as lower and made less accurate treatment recommendations." In this population of white medical students, we see evidence that negative racial biases are currently, and have long been, harming America's Black patients.

To support our efforts further, I ardently advocate for the re-introduction of legislation which would specifically fund and protect the growth of HBCU medical schools, similar to that proposed by Chairman Sanders in 2023.

Senators, though I have faced my own substantial tribulations on the path to becoming a physician, I humbly come before you today as nothing more than a voice for our collective troubles. We serve, tirelessly, Senators. We resident physicians and medical students of color sacrifice our physical, mental, spiritual, and financial well-being to be the change in the medical field we so desperately seek. We physicians, residents, and medical students of color humbly ask that you increase spending on medical education at HBCU medical colleges, because the financial manacles of medical schooling are the greatest impediments in recruiting Black and Brown doctors to our workforce. Americans need us in these roles to provide the high-quality, culturally competent care they require. So let's work together to fund the new wave of Black and Brown physicians our Country, including you all, will need in the future. The time to act is never tomorrow, Senators; it has been, and always will be, today.

Samuel D. Cook, M.D.

PGY–3 Internal Medicine Resident Physician.

Morehouse School of Medicine

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[SUMMARY STATEMENT OF SAMUEL COOK]

Growing up in the Bronx, NY, my parents instilled in me a deep sense of duty to help those in need, casting my journey into medicine. Nevertheless, I have encountered and overcome numerous challenges on my path to serving others. Despite facing recurrent discouragement, particularly during my undergraduate education, I remained steadfast in my commitment to advocating for underserved communities and healing other families as if they were my own.

Through programs like the Drexel Pathway to Medical School (DPMS) Program, I have been blessed to educationally excel, and recognize the crucial role of Historically Black Colleges and Universities (HBCUs) in nurturing diverse talent within the medical field. However, I have directly witnessed the disproportionate impact of student loan debt on medical students of color, hindering their access to and progression within medicine. Nevertheless, my journey is just one among many. I believe that, by working together, we can overcome these obstacles and create a brighter future for healthcare in America.

As an Internal Medicine Resident Physician at Morehouse School of Medicine, my experiences have led me to recognize the urgent need for change in the medical field. Despite the progress we have made thus far, there is much work to be done. Moreover, there are still far too many barriers preventing individuals of underrepresented backgrounds from pursuing and thriving in healthcare careers.

In light of these challenges, I humbly urge Congress to expand support for HBCU medical schools, and establish a fund to directly increase their available resources. By amplifying support for HBCUs and implementing targeted initiatives, we can empower the next generation of diverse medical professionals and ensure equitable access to quality care for all. These steps are essential to addressing systemic barriers in medicine, ensuring a more inclusive healthcare landscape where all patients receive culturally competent care.

In advocating for change, I am not just speaking for myself, but for countless others who have faced similar struggles. Together, we can work toward a healthcare system that reflects the rich diversity of our Nation and meets the needs of every patient, regardless of their background or circumstance. It is time, Senators, to acknowledge the shortcomings of our current healthcare system, and turn our collective focus to the action needed to revive it.

The CHAIR. Thank you very much, Dr. Cook. Our next witness will be Dr. Michael Galvez, who specializes in pediatric reconstructive hand surgery in Madero, California. Dr. Galvez co-created the National Latino Physician Day, and the phrase 6 percent is not enough, to bring attention to the need to diversify the physician workforce. Dr. Galvez, thanks so much for being with us.

STATEMENT OF MICHAEL GALVEZ, M.D., VALLEY CHILDREN'S HOSPITAL; CO-CREATOR OF NATIONAL LATINO PHYSICIAN DAY, MADERA, CA

Dr. GALVEZ. Buenos Dias, Chairman Sanders and Ranking Member Cassidy. Thank you for having me here today. My name is Dr. Michael Galvez, and I stand before you as a husband, father, son

of Peruvian immigrants, a surgeon, and an advocate for Mi Comunidad, My Latino Community.

I am honored to serve as a pediatric hand surgeon to help children with complex hand conditions at Valley Children's Hospital in the Central Valley of California, a region with significant disparity and need for high quality care. Hablo Espanol todo los dias. I speak Spanish every day with my patients.

In my practice of medicine, I have come to recognize that my language and culture are as valuable as my training at prestigious universities. There is nothing like seeing a face of a Latino child's mother when I come through a clinic door and begin speaking Spanish, alleviating fear as their first encounter with a physician that speaks el idioma, the language.

I see complex problems, and having the superpower of language proficiency and understanding the culture adds clarity and connection. After working at medical institutions across the United States, I have asked myself constantly, why don't I see more students and faculty like myself?

For that reason, I helped co-found National Latino Physician Day, celebrated on October 1st, along with Stanford Obstetric Anesthesiologist Dr. Cesar Padilla, to spotlight the underrepresentation of Latinos and Latinas in medicine.

This effort has rapidly evolved into a movement supported by the National Hispanic Medical Association, the Latino Medical Student Association, and nearly every medical organization in this country and multiple hospital systems across the country.

We rally behind the motto, 6 percent is not enough, in recognition of the public health crisis affecting our community. Despite being the largest minority group in the United States, Latinos represent only 6.9 percent of the physician workforce, which is a big contrast to almost 20 percent representation in the Nation's population and nearly 40 percent in the States of California and Texas.

There are not enough physicians to provide high quality care to communities that are the backbone to our economy—and overrepresented in difficult professions such as agriculture and construction. Latinos in the U.S. have the fifth largest gross domestic product in the world, GDP.

However, limited access to health care, face language, and cultural barriers experience poorer cancer and maternal health outcomes and had increased COVID–19 mortality during the pandemic. This deeply burdens the Nation's social safety nets, more missed school days for children, and lower productivity, which really stunts the potential of our Country.

Our hospitals, our institutions, medical schools, and indeed, Congress have the ethical responsibility to address the underrepresentation of Latino physicians to meet the needs of a growing Latino population, which is estimated to comprise one-third of the population by 2050. But the journey to medicine is full of socioeconomic barriers, especially for Latino and minority students.

In my journey, community college education was key to my success, but it can really just be the—it is really the only educational option for some students. To expand the percentage of Latino phy-

sicians and minority physicians in general, it is critical to meet them where they are, and that is in our Nation's community colleges.

The commercialization of medical school admissions and the reliance on standardized tests, such as the MCAT, overlooks the potential of a compassionate and capable physician candidate. Having helped excellent students navigate these waters, I am in disbelief when they are not recruited, despite our physician shortage.

The National Latino Physician Day highlights the persistent shortage of Latino physicians, which underscores the need for change and opportunities for action that Congress can take. First, expand funding for pathway programs and new medical school programs.

We can increase the minority physician workforce by recognizing the value of lived experience of Latino identified individuals through pathway programs that begin at community colleges, earlier exposures to medicine, and advocate for holistic medical school admissions.

We need a bilingual and bicultural medical school anchored in a Hispanic serving institution, partnered with local hospitals. We can start with regional satellites of medical schools in predominantly Latino areas of California.

We also should not be ignoring language. Language proficiency by physicians is a proven strategy for improving patient outcomes demonstrated by the UCLA Latino Policy and Politics Institute, which has shown that concordant language enhances compliance with treatment plans and medication adherence.

Mandating medical schools to value bilingual skills and community college background by tying medical school funding and NIH grants to admission practices that prioritize these elements.

This will drive medical schools to align more closely to their local, underserved areas. For example, the University of California could be mandated to recruit, accept, and retain these qualified students to take care of those underserved populations.

Finally, funding loan repayment programs. In California, I am grateful to be the recipient of a Cal Healthcare's loan repayment to serve patients on Medi-Cal. But federally, the National Health Service Corps is essential to attract and retain physicians in underserved areas, ensuring equitable health care access.

We can no longer allow the status quo from our medical schools. As the Latino population increases, we must confront this public health crisis head on. Necesitamos mas, we need more. Thank you so much.

[The prepared statement of Dr. Galvez follows.]

PREPARED STATEMENT OF MICHAEL GALVEZ

"Buenos días!" Chairman Sanders and Ranking Member Cassidy.

My name is Dr. Michael Galvez. I stand before you as a husband, father, son of Peruvian immigrants, surgeon, and advocate for "*mi comunidad*" (my Latino community).

I am honored to serve as a Pediatric Hand surgeon to help children with complex hand conditions at Valley Children's Hospital in the Central Valley of California—a region with significant disparity and need for high-quality care.

"Hablo espãol todos los días" (I speak Spanish every day) with my patients. In my practice of medicine, I've come to recognize that my language and culture are as valuable as my training at prestigious universities. There is nothing like seeing the face of a Latino child's mother when I come through a clinic door and begin speaking Spanish—immediately alleviating fear as their first encounter with a physician that speaks "el idioma" (the language). As a specialist, I see complex problems and having the "superpower" of language proficiency and understanding the culture adds clarity and connection.

After working at medical institutions across the United States, I've asked myself constantly, "why don't I see more students and faculty like myself?"

For that reason I helped co-found National Latino Physician Day celebrated on October 1st, along with Stanford Obstetric Anesthesiologist Dr. Cesar Padilla, to spotlight the underrepresentation of Latinos and Latinas in medicine. This effort has rapidly evolved into a movement, supported by the National Hispanic Medical Association, the Latino Medical Student Association and nearly every medical organization across the country.

We rally behind the motto "6 percent is not enough!" in recognition of the public health crisis affecting our community. Despite being the largest minority group in the U.S., Latinos represent only 6.9 percent of the physician workforce, a contrast to our almost 20 percent representation of the Nation's population and nearly 40 percent in the States of California and Texas. There are not enough physicians to provide high-quality care to communities that are the backbone of our economy and overrepresented in difficult professions including agricultural and construction work. Latinos in the U.S. have the fifth-largest Gross Domestic Product *(GDP) in the world, however we have limited access to healthcare, face language and cultural barriers, experience poorer cancer and maternal health outcomes, and had increased COVID–19 mortality during the pandemic. This deeply burdens the Nation's social safety nets, more missed school days for children, and lower productivity. In a real way, it stunts the development and potential of our Country.

Our institutions, hospitals, medical schools, and indeed, Congress, have an ethical responsibility to address the underrepresentation of Latino physicians to meet the needs of a growing Latino population which will comprise one-third of the population by 2050. But the journey to medicine is full of socioeconomic barriers, especially for Latino students and other underrepresented backgrounds.

In my journey, community college education was key to my success, but sometimes can be the only educational option available. To expand the percentage of Latino physicians, and minority physicians in general, it is critical to meet them where they are at—in our Nation's community colleges. The commercialization of medical school admissions and reliance on standardized tests often overlooks the potential of compassionate and capable physician candidates. Having helped excellent students navigate these waters, I am dumbfounded when they are not recruited despite our physician shortage.

Programs to improve physician access, such as CalHealthCares a California loan repayment program, alleviates loan burden to help physicians root down in underserved areas.

The persistent shortage of Latino physicians underscores the need for change and opportunities for actions Congress can take:

(1). **Expand Funding for Pathway Programs and New Medical School Programs**. We can increase the minority physician workforce by recognizing and valuing the lived experiences of Latino identified individuals through pathway programs that start at community colleges, early exposures to medicine, and advocate for holistic medical school admissions. We need a Bilingual and Bicultural Medical School anchored in a Hispanic Serving Institution partnered with local hospitals. We can start with regional satellites of medical schools in predominantly Latino areas of California.

(2). **Not Ignore Language**. Language proficiency by physicians is a proven strategy for improving patient outcomes demonstrated by the UCLA Latino Policy and Politics Institute, as research has shown that concordant language enhances compliance with treatment plans and medication adherence.

(3). **Mandating Medical Schools to Value Bilingual Skills and Community College Background**. By tying medical school funding and NIH grants to admission practices that prioritize these elements. This will drive medical schools to align more closely with underserved areas. For example,

the University of California could be mandated to recruit, accept, and retain these qualified students for the betterment of severely underserved areas.

(4). **Funding Loan Repayment Programs**. Including the National Health Service Corp, is essential to attract and retain physicians in underserved areas, ensuring equitable healthcare access.

We can no longer allow the status quo from our medical schools, as the Latino population increases. We must confront this public health crisis head-on.

"Necesitamos más!" We need more.

Thank you.

[SUMMARY STATEMENT OF MICHAEL GALVEZ]

Good morning, Chairman Sanders and Ranking Member Cassidy.

My name is Dr. Michael Galvez, a proud husband, father, and Pediatric Hand surgeon. As a son of Peruvian immigrants and an advocate for my Latino community, I am privileged to work at Valley Children's Hospital in California's Central Valley, a region that faces significant health disparities.

I communicate daily in Spanish, the native language of many of my patients, allowing me to connect with them. This linguistic ability, paired with an understanding of my culture, proves as invaluable as my academic qualifications from prestigious institutions. The relief visible on the faces of Latino families when they interact with a Spanish-speaking doctor highlights the profound impact of language and culture.

Despite my experiences across various U.S. medical institutions, I frequently reflect on the scarcity of Latino faculty and students in medicine. This observation led me to co-found National Latino Physician Day on October 1st, along with Dr. Cesar Padilla from Stanford. This initiative, now supported by key medical associations nationwide, focuses on the underrepresentation of Latinos in the medical field. We rally around the slogan "6 percent is not enough!" acknowledging a public health crisis within our community. Latinos constitute the largest minority group in the U.S., yet make up just 6.9 percent of the physician workforce. This discrepancy is stark, considering Latinos represent nearly 20 percent of the U.S. population and significantly more in States like California and Texas. The shortage of Latino physicians exacerbates the lack of access to quality healthcare in our communities, which form an essential part of the national economy. Our community's economic contribution is immense, being the fifth-largest GDP globally if considered independently. Yet, we face limited healthcare access, language barriers, and poorer outcomes in conditions like cancer and maternal health. It is not just a matter of healthcare but of national productivity and potential. Medical institutions, along with Congress, hold an ethical obligation to address this imbalance to support the growing Latino population, projected to reach one-third of the U.S. by 2050.

The path to increasing Latino representation in medicine is hindered by socioeconomic barriers. Community colleges, often the only higher education avenue available to many, were instrumental in my own medical journey.

Several actions are crucial for Congress to consider:

(1). **Expand Funding for Pathway Programs and New Medical School Programs**. We can increase the minority physician workforce by recognizing and valuing the lived experiences of Latino identified individuals through pathway programs that start at community colleges, early exposures to medicine, and advocate for holistic medical school admissions. We need a Bilingual and Bicultural Medical School anchored in a Hispanic Serving Institution partnered with local hospitals. We can start with regional satellites of medical schools in predominantly Latino areas of California.

(2). **Not Ignore Language**. Language proficiency by physicians is a proven strategy for improving patient outcomes demonstrated by the UCLA Latino Policy and Politics Institute, as research has shown that concordant language enhances compliance with treatment plans and medication adherence.

(3). **Mandating Medical Schools to Value Bilingual Skills and Community College Background**. By tying medical school funding and NIH grants to admission practices that prioritize these elements. This will drive medical schools to align more closely with underserved areas. For example, the University of California could be mandated to recruit, accept, and retain these qualified students for the betterment of severely underserved areas.

(4). **Funding Loan Repayment Programs**. Including the National Health Service Corp, is essential to attract and retain physicians in underserved areas, ensuring equitable healthcare access.

We need more dedicated professionals who reflect the communities they serve. Thank you for your attention to this public health crisis.

The CHAIR. Thank you very much, Dr. Galvez. Senator Cassidy, do you want to introduce your panelists?

Senator CASSIDY. Yes. My pleasure to introduce doctor—I am sorry. Dr. Jaines Andrades, who is a certified Nurse Practitioner who completed her doctor—nurse practitioner at Elms College 2020 and her Bachelor of Science in Nursing from Elms College in 2014.

She is a native of Springfield, Massachusetts, dedicated her professional career to caring for vulnerable populations with addiction, mental illness, and chronic disease. She credits her pre-nursing experiences in the hospital setting as a catalyst to pursuing a career in health care.

Her clinical experience as a registered nurse began as a correctional nurse for the Hampton County Sheriff's Department, where she conducted mental health evaluations and incorporated a multidisciplinary approach to care.

Later joined the Baystate Mason Square Neighborhood Clinic, providing drug and alcohol abuse nursing care. She enhanced her clinical skills as an inpatient staff nurse and joined Baystate Medical Center team as a trauma surgery nurse practitioner in September 2020.

Her commitment to be a voice for the disenfranchised has allowed her to be a change agent and a role model for others. Dr. Andrades, thank you for being here.

STATEMENT OF JAINES ANDRADES, DNP, AGACNP-BC, NURSE PRACTITIONER, BAYSTATE HEALTH, SPRINGFIELD, MA

Ms. ANDRADES. Chairman Sanders and Ranking Member, Dr. Cassidy, I am Jaines Andrades, a nurse practitioner in trauma surgery at Baystate Medical Center in Springfield, Massachusetts.

It is an honor to present my testimony before you today, and I thank you for the opportunity and your attention to addressing the shortage of minority health care professionals.

I want to tell you a bit of my experience and offer you some insight into ways I believe Congress can help increase the number of minority health care workers in the future. I went to high school in Springfield, Massachusetts, at Putnam High School, an urban vocational school.

I was enrolled in the cosmetology program but had dreams of becoming a lawyer. At that time, I struggled to figure out how to make this dream come true, coming from a single parent home where my mother didn't have the means to save for college or law school.

I was fortunate, though she did have the drive to instill a strong work ethic and the foresight to encourage me to contemplate my talents and choose a career which would offer economic stability.

One day at a medical appointment with my mom, a nurse started talking to me about the opportunities her nursing could offer. I was intrigued. To get a better sense of how I would fare on the path to becoming a nurse, I started taking courses at Holyoke Community College.

I took prerequisites for the nursing program and eventually enrolled to Elms College to earn my Bachelor's of Nursing. While I was going to school, I wanted to support myself and thought taking a job at a hospital to get my foot in the door and learn more about health care would benefit me in the long run.

I began working in environmental services as a custodian at Baystate Medical Center. I worked to keep surgery and procedure rooms clean. This allowed me to see firsthand what nurses did, what I would need to know moving ahead in the health care environment, and to get advice on how to proceed in my career.

My colleagues offered incredible insight into ways I could fund my education. They pointed me toward resources like the Western Mass Community Foundation, where I had access to scholarships and interest free loans. Without my colleagues, I would not have been able to find these resources, which I believe were instrumental to my education. These resources need to be made more visible and accessible to students.

I proceeded through my nursing school and stayed at BC Medical Center in Environmental Services. Eventually, I was hired as a nurse, once I graduated, in a community health center, Mason Square.

There again, with the support of my colleagues, I was encouraged to earn my Doctorate of Nursing Practice. I did this at the height of the COVID–19 pandemic, which was not easy, and eventually I was able to come full circle and take a job as a nurse practitioner in trauma surgery again at Baystate Medical Center.

Looking back on my experience, if I could make suggestions to lawmakers on how to improve the shortage of minority health care providers, I would offer a few thoughts. First, I would say robust college and career planning is very critical.

Many students at all schools, most especially those in lower income areas aware of health care as an attainable career opportunity would go so far. Letting these students know it is within their reach, and that there are resources available to them to embark on their journey to higher education is key.

At Baystate Medical Center, we have a program called the Baystate Springfield Educational Partnership, or BSEP. This is a program for the youth in Springfield, which helps connect them with hospital based learning and opportunities to learn about different professions within the health care system.

It allows students to engage with professionals and learn from them, like I did while being a custodian. But in this program, they are still in high school, and this option helps them evaluate what health care career they could select.

I did not go through this program myself, but I would recommend supporting similar opportunities for minority youth for early professional mentorship. There are a number of physicians,

physician assistants, and nurse practitioners like myself who entered BSEP as high school students and now work for Baystate.

Many of the BSEP students also fill other roles in Baystate while advancing their education. I believe Federal support for programs like this could lead to many more minority students embarking on prosperous careers in health care.

Another way to make this journey more accessible is tuition free community college. This would allow students to begin their education without taking on a financial burden. This opportunity to begin to pursue the education needed to become a professional health care provider at a community college should not be underestimated.

Additionally, state and Federal grants to reduce loan costs would make their career paths a more appealing option. Helping fund the education of minority students interested in becoming professional health care providers is a wise investment.

It fills in demand jobs in the health care field and connects people with practical careers, which will allow them economic stability to support themselves and their families. Thank you again for the opportunity to testify and share my experience with you. I appreciate your consideration of my recommendations.

[The prepared statement of Ms. Andrades follows.]

PREPARED STATEMENT OF JAINES ANDRADES

Chairman Sanders and Ranking Member, Dr. Cassidy, I am Jaines Andrades, a nurse practitioner at Baystate Medical Center in Springfield, Massachusetts. It is an honor to present my testimony before this Committee today. I thank you for the opportunity and your attention to addressing the shortage of minority health care professionals.

I want to tell you a little bit about my experience and offer you some insight into ways I believe Congress could help increase the number of minority health care professionals in the future.

Currently, I work as a nurse practitioner in the trauma and surgery unit at Baystate Medical Center. That is not exactly where my journey in health care began—but in some ways, it is close.

I went to high school in Springfield, Massachusetts, at Putnam High School, an urban vocational high school that frequently failed to meet state standards. I was enrolled in the cosmetology program but had dreams of becoming a lawyer. As time passed, I struggled to figure out how to make that dream come true, coming from a single-parent home, where my mother didn't have the means to save for college or law school. I was fortunate, though, that she did have the drive to instill a strong work ethic and the foresight to encourage me to contemplate my talents and career which would offer economic stability. Not every kid has that behind them.

One day, I was at a medical appointment with my mom, and a nurse started talking to me about the opportunities nursing offered. I was intrigued.

To get a better sense of how I would fare on the path to becoming a nurse, I started taking courses at Holyoke Community College. I took prerequisites for programs to become a registered nurse, eventually enrolling at Elms College to earn my BSN.

While I was going to school, I wanted to work to support myself, and thought taking a job at a hospital, to get my foot in the door and learn more about health care, would only benefit me in the long run.

I began working in "environmental services," as a custodian, at Baystate Medical Center. I worked to keep surgery and procedure rooms clean. This allowed me to see, first-hand, what nurses did, what I would need to know to move ahead in a health care environment, and to get advice on how to proceed in my career. My colleagues also offered incredible insight into ways I hadn't thought of to fund my education. They pointed me toward resources like the Western Mass Community Foundation, where I had access to scholarships and interest-free loans. Without my colleagues, I would not have been able to find such resources, which I believe were

instrumental to my education. These resources need to be made more visible and accessible to students.

I proceeded through nursing school and stayed at Baystate in environmental services for quite some time, waiting for a nursing opportunity. Eventually, I was hired as a nurse at one of our community health centers. There, again with the support of my colleagues, I was encouraged to earn my doctor of nursing practice degree.

I did that at the height of the COVID–19 pandemic, which was not easy. I eventually came "full circle" and took a job as a nurse practitioner in trauma and surgery back at Baystate Medical Center.

Looking back on my own experience, if I could make suggestions to lawmakers on how to improve the shortage of minority health care providers, I would offer a few thoughts.

First, I would say robust college and career planning is very critical. Making students at all schools, most especially those in lower-income areas, aware of health care as an attainable career opportunity would go far. Letting these students know it is within their reach and that there are resources available to them as they embark on the journey to higher education is key.

At Baystate, we have a program called the Baystate Springfield Educational Partnership, or BSEP. This is a program for youth in Springfield, which helps connect them with hospital-based learning and opportunities to learn about different professions within the health care system. It allows students to engage with professionals, and learn from them, like I did working alongside them as a custodian, but while they are still in high school and evaluating their options. I did not go through this program myself, but I would recommend supporting similar opportunities for minority youth for early professional mentorship. There are a number of physicians, physician's assistants, and nurse practitioners who entered the program as high school students and now work for Baystate Health. Many of them also fill other roles in the Baystate system while advancing their education. I believe Federal support for programs like this could lead to many more minority students embarking on prosperous careers in health care.

Another way to make this journey more accessible is tuition-free community college. This would allow students to begin their education without taking on a financial burden. The opportunity to begin to pursue the education needed to become a professional health care provider at a community college should not be underestimated.

Additionally, state and Federal grants to reduce loan costs would make these career paths a more appealing option. Helping fund the education of minority students interested in becoming professional health care providers is a wise investment; it fills in-demand jobs in the health care field and connects people with practical careers which will allow them economic stability to support themselves and their families.

Thank you again for this opportunity to testify and share my experience and insight with you. I appreciate your consideration of my recommendations and thank you in advance for your questions.

[SUMMARY STATEMENT OF JAINES ANDRADES]

Chairman Sanders and Ranking Member, Dr. Cassidy, I am Jaines Andrades, a nurse practitioner at Baystate Medical Center in Springfield, Massachusetts. I thank you for the opportunity and your attention to addressing the shortage of minority health care professionals.

Currently, I work as a nurse practitioner in the trauma and surgery unit at Baystate Medical Center.

I went to high school in Springfield, Massachusetts, at Putnam High School, an urban vocational high school that frequently failed to meet state standards. I had dreams of becoming a lawyer but eventually it became clear this was not realistic financially.

I was inspired by a nurse I met at a medical appointment and started taking the prerequisites to becoming an RN at Holyoke Community College, eventually enrolling at Elms College to earn my BSN.

While I was going to school, I took a job as a custodian at Baystate Medical Center to support myself and work alongside nurses. My colleagues pointed me toward resources to help fund my education like the Western Mass Community Foundation,

where I had access to scholarships and interest-free loans. These resources need to be made more visible and accessible to students.

I proceeded through nursing school and was hired as a nurse at one of our community health centers. There, again with the support of my colleagues, I was encouraged to earn my doctor of nursing practice degree.

I eventually took a job as a nurse practitioner in trauma and surgery back at Baystate Medical Center.

If I could make suggestions to lawmakers on how to improve the shortage of minority health care providers, I would offer a few thoughts.

First, I would say robust college and career planning is very critical.

At Baystate, we have a program called the Baystate Springfield Educational Partnership. This is a program for youth in Springfield, which helps connect them with hospital-based learning. I did not go through this program myself, but I would recommend supporting similar opportunities for minority youth for early professional mentorship.

Another way to make this journey more accessible is tuition-free community college.

Additionally, state and Federal grants to reduce loan costs would make these career paths a more appealing option. Helping fund the education of minority students interested in becoming professional health care providers is a wise investment; it fills in-demand jobs in the health care field and connects people with practical careers which will allow them economic stability to support themselves and their families.

The CHAIR. Senator Cassidy, you want to introduce your last witness?

Senator CASSIDY. I will let my Senator from Alabama introduce the doctor from Alabama.

Senator TUBERVILLE. Thank you, Senator Cassidy. Welcome to all of you. It is my honor to introduce today Dr. Brian Stone of Jasper, Alabama.

Dr. Stone grew up in Birmingham and received his undergrad degree from Rutgers. He went on to earn his medical degree from the University of Alabama, Birmingham. He was identified as a top urologist in New York and New Jersey, in his years of tenure at Columbia University's College of Physicians and Surgeons.

He has received so many awards for his success, it is hard to count them all, but he has been honored by the NAACP, the Morehouse School of Medicine, the American Cancer Society, and the American Urology—Urological Association.

Because of his leadership on issues like health disparities and prostate cancer, he has served in many capacities as a consultant and scientific advisor. He has served in advisory positions on the local, national, and international level over the years.

He also worked in partnership with pastors and different denominations in Jefferson County, and the Jefferson County Department of Health to educate and recruit Black patients to participate in the clinical trials process.

He serves on the Committee for Underrepresented Minorities at the University of Alabama, Birmingham School of Medicine, in conjunction with School of Medicine's National Alumni Association. He created a medical scholarship program for deserving male students of color from Alabama who have been accepted into the UAB School of Medicine.

The goal is to increase the number of minority physicians who are from Alabama and are willing to practice medicine in the state. He has also worked to increase STEM exposure to K–12 students in the city of Birmingham, in partnership with the Boys and Girls Club.

Dr. Stone is currently the President and Chief Medical Staff of Walker Baptist Regional Medical Center, and the President of Jasper Urology Associates. I couldn't be more proud to have him here today, and we all look forward to his testimony. Thank you, Dr. Stone.

STATEMENT OF BRIAN STONE, M.D., FACS, PRESIDENT, JASPER UROLOGY ASSOCIATES, JASPER, AL

Dr. STONE. There we go. Good morning. I would like to thank Chairman Sanders, Ranking Member Cassidy, Senator Tuberville, and Members of the HELP Committee for having me present to speak today.

My background is a urologist. I think I am the old guy on this Committee. I graduated in 1985. I have had a breadth of experience working in the inner city, having trained in the Bronx, having worked at Harlem Hospital, which was connected to Columbia University. And I am now in a rural setting, and I see the similarities between the health problems that we see in the inner city as well as in rural America.

When I think of America, I think of the saying that you can't choose your family, but you got to love them anyway. Our diverse people make our Country the greatest country in the world. But our greatness cannot be maintained if we can't keep our people healthy.

Currently, we have about 71,000 physicians retiring per year over the past few years, and we are only graduating 21,000 medical students per year. And if you follow the mathematics, you see where we are going to end up.

We are going to need some very creative ideas to get us out of this situation. The impact of under—the low numbers of physicians has downstream impact on the number of specialists. And we feel that at our hospital now with our inability to recruit physicians in various specialties. An unhealthy nation is a less productive nation.

Certain segments of American population are less healthy than others, as other speakers have spoken about. Black Americans have the highest death rate from all causes in our Country. These higher rates of disease and death have economic consequences, and that is why this is important for us to address.

I grew up in a segregated Birmingham, where every Black, regardless of his socioeconomic status, lived in the same neighborhood. This had benefits because I had the opportunity to grow up with role models like Dr. James Montgomery, Dr. Clarence Hickson, Dr. Herschel Hamilton.

My uncle, Dr. Warner Meadows was one of the first Black surgeons in Atlanta. These role models made me know that I could be whatever I wanted to be, but that is not the case for a lot of kids in America today.

Unfortunately, technology has almost become an impediment to educating our children, and America appears to be at a major inflection point in how we educate our children, because this is the pool from which physicians are recruited.

America and the Black community have a serious challenge in addressing the STEM gap that exists between white and Black students. Richard Coley and Barton noted that progress was being made in recruitment of African Americans to medical school, but this peaked in 1994.

A 2018 Pew Research study showed that the poor foundation of STEM education in K–12 was the root cause of the recruitment problem for medical schools of medical students. There is a wealth of data showing better health outcomes when Black patients have Black physicians, and this applies across different cultures.

This is because when you have cultural connectivity, you have better communication, you have shared experiences, and you can overcome the mistrust that has developed over the decades. Alabama has a population of 4.8 million people, 25.8 percent of whom are Black.

Yet we only have 7 percent of the physician workforce that is Black. We are dealing with some serious health care issues in our state, particularly with limited access to health care in many of our rural areas. We have had closure of many of our rural hospitals and clinics, particularly in the Black belt of the state, and we got to come up with some real solutions.

Most of our physicians tend to be concentrated in the major metropolitan areas of the state, leaving our rural areas at risk. It is no wonder that Alabama always ranks at the lowest as far as health amongst states in the area and it is—not only is the overall health of Alabamians comport—poor compared to residents of other states, but the health disparities between African Americans and Whites are very considerable.

What are some of the potential solutions? Enhancing K–12 STEM education. Incorporating mentors early. Creating a health focused fast track—to fast track students into medicine.

Reducing the financial burden of medical education. Increasing the size of medical school classes. Increasing the size of residency training programs. The problem cannot be corrected overnight, but the crisis is real, and I think we need to start thinking out of the box. Thank you very much.

[The prepared statement of Dr. Stone follows.]

PREPARED STATEMENT OF BRIAN STONE

Increasing Diversity in the Healthcare Workforce

The U.S. will see a shortage of almost 139,000 physicians by 2032 as the demand for physicians grow faster than the supply according to data published by the Association of American Medical Colleges. This physician deficit has many downstream affects and translates into shortages in both primary care and specialty care. Among specialists, the data project a shortage of up to 12,100 medical specialists, 23,400 surgical specialists, 39,100 other specialists such as pathologists, neurologists, radiologists, and psychiatrists. 2032 is only 8 years away!

America's strength is in its diverse population. Our grand experiment in democracy, which is a byproduct of the sacrifice and toil of religious refugees, slavery, immigrants, and native Americans has resulted in the most powerful country in the

world. However, we are only as good as our health. An unhealthy nation is a less productive nation. Certain segments of the American population are much less healthy than others. Black American's have the highest mortality rate of all causes in the U.S. These high rates of disease and death have economic consequences. Increasing diversity in the healthcare workforce is one of the solutions in reducing the historic differences in health outcomes. The problems are complex, and the potential solutions complicated.

Background

America and the black community have a serious challenge in addressing the **STEMM** (**S**cience **T**echnology **E**ngineering **M**athematics **M**edicine) education gap between white and Black students. Furthermore, African Americans represent 4 percent of U.S. physicians but approximately 14 percent of the population. This chasm widens further when you include the under representation of Hispanics who represent 18.3 percent of the U.S. population and only 5 percent of the Nation's physicians. Richard Coley and Paul Barton note that progress was being made in recruitment of African Americans into medical school and peaked in 1994. However, there has been a precipitous decline in recruitment since that time creating a critical shortage in diversity in the physician workforce which adversely affects the care provided to underserved communities.

According to 2023 data from the Association of American Medical Colleges, it is estimated that there are over 989,000 physicians in the U.S., but only approximately 46,000, were Black or African American. Forty-four percent of African American physicians are between the ages of 55 and 64 while another 35 percent are 65 or older. Among younger (< 34 years old) African American physicians, the overwhelming majority (67 percent) are women, reflecting the dearth of young African American men entering the practice of medicine. The inequities in access to healthcare, participation in medical research, and current treatments can be mitigated by the presence of physicians that have been recruited from the communities that they treat. The COVID–19 pandemic has made evident the chasm between access to care in communities of color compared to white communities.

Coley and Barton and multiple studies have consistently confirmed that Black and Hispanic physicians are "significantly more likely to practice in underserved areas comprised largely of minority and poor populations". The devastating, asymmetric impact of COVID–19 on communities of color and the racial inequities of the vaccine rollout highlighted the need for Black and Hispanic physicians. There is a wealth of data confirming better health outcomes in Black patients who have Black physicians. Dr. Karey Sutton, Ph.D. (Director of Health Equity Research; Medstar Health Research Institute) oversaw a systematic review of over **3000 studies** on the impact of physician and patient race. The conclusion was that Black patients had better outcomes in the care of Black physicians because the care was better. Cultural connectivity is important, particularly in the context of historical mistrust. The negative impacts of outright racism (both individual and structural) on patient care like healthcare workers minimizing the pain of Black patients' complaints of pain and encounters of racism in emergency departments have been well documented. The bottom line is that racial concordance studies have illuminated the ways in which race affects how patients and doctors communicate and make decisions, regardless of either person's intent. Physicians and patients bring subconscious racial perceptions to their conversations. These problems can be mitigated by having a healthcare workforce that reflects the community that it serves.

A 2018 Pew Research Center review described the poor foundation of STEMM education in K–12th grade as the root of the recruitment problem of Black students into medical school. The declining quality of public education, shrinking education budgets, loss of programs in the arts and music, greater emphasis on athletics and the increasing societal distractions (electronic gaming, social media, cell phones, etc.) have made educating our youth much more challenging. The shift to virtual learning due to the pandemic has had an additionally devastating impact on learning, particularly among African American males. A U.S. Department of Education's study of students beginning college as early as 1989 –1990 found that African American men were less likely to major in science than white males and females or African American women. Only 2.6 percent of African American males were science majors in their first year of college, representing only 1/3 of the proportion of 1st-year white males majoring in science during the same year. Coley and Barton concluded that this alarming trend supports the observation that African American men are steering away from majoring in science, leaving only a small pool of African American male science majors for medical schools (and STEMM entities) to recruit from.

African American women, while performing better than the males, are being negatively impacted as well. I would dare say that at the current rate of decline in the recruitment of Blacks into medicine that there may come a day that Black physicians are rarely seen, especially Black men!

The impact of structural and systemic racism continues to hinder entry of Black students into STEMM career fields in 2021. In 2019, we saw the lowest representation of African Americans in the incoming medical school classes of the country's medical schools since 1978! Even more alarming is the fact that most Blacks entering graduate medical education programs are female. This trend of declining Black male representation in medical school began in 1988–89 when the percentage of Black female medical school graduates became the majority at 51–52 percent. In 2018, Q. M. Capers and L. Clinchot concluded that Black gender disparity rapidly accelerated to 35 percent male versus 65 percent female medical school graduates in 2015.

Health Disparities in Alabama

My home state of Alabama has a population of 4,833,722 and is faced with some serious healthcare challenges, particularly with limited access to healthcare in many of its rural areas. Many of our small rural hospitals have closed. The "Black Belt" of the state, with some of its poorest areas, has suffered the most. We are experiencing significant healthcare workforce shortages.

Per 2023 AAMC Data: Alabama's Physician Race/Ethnicity
White 69%
Black 7%
Hispanic 3%
Asian 10.5%
American Indian/ Alaska Native 0.3%
Unknown 8.4%

Per the 2020 U.S. Census Data: Alabama's Race & Ethnicity Composition
White alone 64.1%
Black alone 25.8%
Hispanic 5.3%
Asian alone 1.5%
American Indian/ Alaska Native alone 0.7%
Native Hawaiian/ Other Pacific Islander alone 0.1%
Some Other Race alone 2.7%
Two or More Races 5.1%

The "Alabama Health Disparities Status Report 2010" confirmed the startling tragedy of minority healthcare in Alabama, which consistently ranks as one of the least healthy states (46th out of 50) in the Nation. Similarly, Alabama ranks 37th in health care access, 39th in health care quality and 47th in public health. Not only is the overall health of Alabamians poor compared to that of residents of other states, but health disparities between African Americans and Whites are considerable. African Americans comprise approximately 82.75 percent of the non-white population in Alabama. These health disparities in both access to care and the delivery of care to minorities in the state. African Americans in Alabama had higher rates of all chronic diseases, injury, premature death and disability. The consequences of these disparities include shorter life expectancy, diminished quality of life, loss of economic opportunities and socioeconomic inequality.

There are significant racial disparities in cardiovascular disease, diabetes, obesity, kidney disease, cancer, infant mortality, chronic lung diseases, stroke, and complications (and severity) of the COVID–19 infection. It is a moral imperative that we actively seek to increase the numbers of physician healthcare providers in the State of Alabama and ensure that there is appropriate representation of African American physicians. Studies have shown that Black patients are more likely to feel comfortable with physicians with a similar cultural framework and more likely to adhere to preventative medical recommendations offered by Black physicians. Cultural competency is the key to improving patient compliance and trust. The COVID–19 vaccine rollout has confirmed that the Black community continues to distrust majority health institutions, reflected in the "PTSD" of the "Tuskegee Experiment" and

the legacy of physicians like James Marion Sims (the "father of modern gynecology") who performed unethical surgical procedures on enslaved Black women. In addition to these landmark research abuses, there is both a long legacy and, in some settings, an ongoing pattern of racial bias experienced by African Americans seeking care. It is for these reasons that we must provide early introduction to STEMM education, mentor, prepare and recruit more African American students into medicine. The presence of diversity in medicine enhances African American (Hispanic, Asian, and Native American) cultural competency by increasing empathy and cultural sensitivity in the entire medical community.

The Lack of a Pipeline

Coley and Barton write that a college graduate's educational choices directly affect the size of the pool of candidates available to apply to medical school. This talent pool is deeply deficient in the U.S. and even more so in Alabama. Multiple factors, early in the lives of young Alabamians, hinder growth of the pool of qualified students applying to STEMM graduate programs. The "molding" of talent starts at the birth of the child and extends to care provided in early formative years. This process continues through the K–12 education system as the students potentially lack rigorous academic curricula and subsequently don't graduate from high school or attend college. Even among those Alabamians who do attend college, many, lacking early stimulation of their interests in science and math, do not choose a STEMM major or even succeed in graduating.

Multiple sources including Parker and Funk as well as Shamard Charles recognize that the overwhelming challenge is to enhance the educational process, introduce the students at an early educational age to STEMM, "steer" their education choices toward STEMM and reduce the attrition rate. Enlarging the pool of qualified African American students who realistically have a choice of a higher education pathway to medicine requires increasing their academic proficiency during the period from middle school to high school. The success of increasing the pool of academically qualified Black students from Alabama for acceptance into the medical school requires a dual approach of developing and exposing students early in their academic journey to a STEMM curriculum and exposing them to Black STEMM role models. Controlling the attrition rate will require reinforcing this exposure through continuous contact with Black STEMM mentors. The more "African American success" they see, the more confidence they will have that they too can "succeed" in STEMM. The goal should not be to lower academic standards but to enhance student education and preparation.

Economic Impediments to Medical Education

It is no secret that there is a significant economic gap between white communities and communities of color in the U.S. Many aspiring students and their families struggle just to provide financial support for a college education. The cost of collegiate and graduate education has increased significantly over the years which represents a greater barrier to entry for students of color. Graduate school can be a financial "Mount Everest" for most qualified students of color. On average medical school tuition, fees, and health insurance during the 2019–2020 academic year ranged from $37,556 (in-state, public) to $62,194 (out of state, public). Additionally, among persons entering medical school in 2018, African Americans were more likely than other racial and ethnic subgroups to owe > $50K dollars even before accumulating any additional medical school debt. It is imperative that financial support be readily available to those students who successfully navigate the academic rigors of a collegiate pre-medical program and are accepted into a medical school program.

What Are the Solutions?

The ideal goal should be to create a healthcare workforce that is representative of the population that it serves (preferably staffed by members from that community). This means setting recruitment goals based on the ethnic make-up of the state or community.

K–12 STEMM Education—Building the talent pool of kids interested in undergraduate education in the sciences and ultimately pre-medical education.

Completely Changing the K–12 Education Paradigm—Moving away from the educational structure of the past and shortening the pathway into medicine. Developing health academies in high schools in partnership with a state's undergraduate universities and medical schools creating curriculums that "fast track" qualified students into medical careers.

Reducing the Financial Burden—The cost of an average 4-year undergraduate education at a public institution is approximately $120,000 (out-of-state $180,000). Combine that with the average medical school cost of $300—400,000 and a student pursuing a career in medicine is looking at shouldering over $500,000 in debt! This is outlandish and has a negative impact on diversity in the healthcare workforce.

Increasing Medical School Class Sizes—U.S. medical schools graduated 28,700 students in 2022. The training of new doctors must keep tract with the physician retirement rate. The challenge facing our Nation is the substantial number of "baby boomer" physicians, like me, who will be leaving the workforce in the coming 5–10 years that will create the projected shortfall of 139,000 physicians by 2033!

Increasing the Number of Residency Training Positions—As medical school enrollment is increased the concern is the lack of residency programs and clinical training sites for the graduates. According to an AAMC annual survey, the number of residency training positions has not kept pace with the increasing number of medical students. This dilemma threatens to exacerbate the Nation's physician shortage.

Conclusions

(1). Our country has faced daunting challenges before. This is not a Democrat or Republican problem; it is an American problem.

(2). Heart disease, diabetes and cancer don't care about political party affiliation or race. The health of "all" of our population must be our No. 1 priority. Our people are our greatest strength and our treasure and should be treated as such.

(3). Assembly of talented people who have different experiences and perspectives empowers the necessary cultural translation when people need assistance facing challenges that have the complexity and intimacy of healthcare.

(4). Diversity improves cultural competence for the collective body of the healthcare workforce. Better cultural competence facilitates better engagement with patients which leads to better understanding, better shared decision-making, better compliance with treatment plans, and, ultimately, to improved patient outcomes.

(5). Furthermore, as we consider the wholistic approach of improving the health of the population, cultural differences not only affect engagement with people who have clinical needs but also influences how different peoples ingest information to consider participation in clinical research.

(6). A healthcare workforce that reflects the heterogeneous population of the U.S. increases patient "trust" which is necessary to achieve greater participation in clinical research and achieve better clinical outcomes to improve the health of the entire U.S. population. To optimize effectiveness for healthcare outcomes we must confront the reality that communication and trust are essential to be most effective, as we focus on the opportunity to help those who need the most help.

The CHAIR. Well, let me thank all of the panelists. Every one of you made extremely important issues, and I hope very much that this Committee will act on some of your thoughts. Let me start with, and I must confess that until fairly recently, I did not appreciate this issue.

Until a couple of years ago, we had some, young people from Howard University coming into the office, and they were chiming in. And one young one was saying, talking about the experience her mom had of going to a physician's office and not being taken seriously and so forth. And I know all of you in various ways have raised the issue.

Let me ask, I think many Americans would say, hey, this as a physician, what difference does it make white, Black, Latino, who cares, as long as they are a good doctor. What difference does it make for having—going to a physician who kind of understands your life maybe comes from your community. What difference does it make? Dr. Lawson, you want to start? We will go right down the line.

Dr. LAWSON. Absolutely. It makes a huge difference. Me, myself, in practice, many times the trust, when I build trust, my patients really do respect and comply with therapy.

It is not uncommon for me to experience many of my patients may go to, a physician of a different race or ethnicity and question, right, the treatments that they are prescribed or have given me or provided personal experiences where they weren't respected within the system, or they were provided treatments that were inadequate or substandard, or not even given options—especially being an OB-GYN.

I don't have to tell you that historically, so many women, Black women and Latino women, underwent hysterectomies unnecessarily. The options of childbirth were taken away from them. And so, these are everyday experiences.

The CHAIR. Thank you very much. Please be brief. I want to hear from everybody. Dr. Cook.

Dr. COOK. Yes, sir. Thank you so much, Chairman Sanders. It is really an issue of cultural competence. You don't understand the perspectives and the concerns of people from other races as well as they do for themselves.

We grow up in similar situations. We know very similar circumstances that happen to all of our families. And, as Dr. Lawson alluded to, there is an inherent mistrust. We saw that even with COVID vaccinations and the inability to get Black Americans to even take those vaccinations. So it is a widespread problem, and it will only improve with more representation.

The CHAIR. Thank you very much. Dr. Galvez—the microphone, yes.

Dr. GALVEZ. Thank you. For the Latino population the patient physician concordance is so important to have that cultural competency, to decrease miscommunication. And the language component for Latinos in particular is very important because things can get lost in translation.

A story I can think of is a patient comes in, their child needs a surgery, has a congenital hand difference, and everything gets discussed in the visit, but the family is more worried about general anesthesia.

That question doesn't get asked or doesn't get fully addressed. And so, they leave the visit. They maybe booked the surgery because someone said just, we are ready to do the surgery. You got to fix this problem.

They book the surgery but then the patient just cancels because they are so concerned, and they didn't get their questions answered. And so that miscommunication results in delays in care.

The CHAIR. Dr. Andrades.

Ms. ANDRADES. I think for patients, especially in my field of trauma surgery, I meet patients on their worst day. I am of Puerto Rican descent, so in being able to speak to someone who just went through a terrible car accident or some trauma, I think gives them a breath of fresh air.

Again, as the other panelists have alluded to, it is the trust that you have someone that speaks your language and looks like you at the forefront of your medical care. And I think that really makes a difference in patient satisfaction and patients trusting the health care system.

The CHAIR. Thank you. Dr. Stone.

Dr. STONE. I deal with it daily when it comes to, say, prostate cancer, the difference between a Black male and how he communicates than a white male. The concerns they may have, the trust factor. All of that plays into the relationship and patient compliance.

The CHAIR. My last question, briefly. I am running out of time now. Dr. Cook mentioned that he graduated medical school for $400,000, and that I have talked to doctors who graduated with more debt. Nurses, graduating with a lot of debt.

Generally speaking, Black, Latino, Native American communities are poorer than White communities. What does the financial constrictions mean to young people in minority communities who want to pursue a career in medicine? Dr. Lawson, briefly.

Dr. LAWSON. Absolutely. The financial implications can almost make it impossible to pursue the degree or be very discouraging to individuals.

I myself am working on scholarships for students, but I encourage anything that we can do. I myself participated in many disadvantaged programs to fund my medical education. But, I was told that I couldn't do it literally because my family did not have the resources.

The CHAIR. If people could go to medical school without having to worry about tuition or student debt, would that make a difference in your communities, Dr. Cook?

Dr. COOK. Of course. The price tag in itself is a barrier. Think for 1 second if you took out $400,000 in debt and you got sick in your first year of residency, you will have no way to repay that. You will be forever in debt.

The CHAIR. Dr. Galvez.

Dr. GALVEZ. Those socioeconomic differences make a big difference. And the difference for Latinos in particular is the need to work. And so, when you have to take on all this debt, it really is something you are deciding for your family.

The other difference that happens frequently is you have a student who has to work and do classes at the same time, and pay for tuition, versus a student who is in a more affluent community and has an office space to study and dedicated time. That is where these disparities begin.

The CHAIR. Dr. Andrades.

Ms. ANDRADES. It gives students a chance to be able to even start to feel that a health care career is in their realm of possibilities because, finances and the financial burden, as again the other panelists have alluded to, really is a huge deterrent for minority students.

The CHAIR. Dr. Stone.

Dr. STONE. I mentor a lot of kids that are bright and could be physicians, but they are deterred by the cost. So, if there was a way to offset the costs, we could increase the numbers.

The CHAIR. Good. All right. Thank you, panelists.

Senator Cassidy.

Senator CASSIDY. I thank you all. Dr. Stone, my wife is a 1983 graduate of UAB.

Dr. STONE. Okay.

Senator CASSIDY. I kind of hide that fact in Louisiana, but that is okay. And I will note, Dr. Galvez, you don't respect our Spanish. If you are interpreting, this is—I am telling you why you should do it.

[Laughter.]

Senator CASSIDY. Thank you all. Dr. Stone, African Americans have a, as we both know, as you particularly know, much higher incidence of prostate cancer. And there is a certain kind of, I don't know, cultural kind of reticence to have it address sometimes. I am a gastroenterologist.

Dr. STONE. Yes.

Senator CASSIDY. Same sort of thing. And I see that you have partnered with communities of faith by which to, I assume, allay concern and spread the word. So, will you comment on that?

Dr. STONE. Yes. One of my particular concerns has been the lack of inclusion in clinical trials and the fact that most therapeutics, as matter of fact, all therapeutics that are developed in the U.S. are developed based on data from white patients.

The Human Genome Project has shown that the way drugs are metabolized is different between cultural groups. So, I am concerned that the dosing, when doses are established and the FDA approves it, that it may not be appropriate for different cultural groups.

I am trying to increase participation in clinical trials by engaging the faith-based community, through which we can recruit and try to get more patients to participate, because the trust bridge is already established in the church.

Senator CASSIDY. I am totally with you on that. I used to do clinical research and treated a lot of hepatitis, and my population was 60 percent African American. I ended up being the lead recruiter for African Americans because I had worked for two decades in the hospital and there was a trust there.

Dr. STONE. Yes.

Senator CASSIDY. The first time they were invited in was not to participate in a trial. The first time they were invited in was to see me. And then I saw them for 10 years before speaking about a trial.

Dr. STONE. Absolutely.

Senator CASSIDY. I congratulate you on that because as we both know it can bring great benefit.

Dr. STONE. Thank you.

Senator CASSIDY. To the individual and to the patient. So, Dr. Andrades—for some reason my Rs are not rolling today. I am so impressed with how you were kind of what is the word, inspired to pursue health care, and move from cosmetology into doing that environmental services work, etcetera. How do we light that same flame in others?

Ms. ANDRADES. I think as I said in my testimony, I think, again, it is making the financial burden on students of minority less.

Senator CASSIDY. Yes, but I am not speaking about—it has to first have that spark of interest. And the next is, how do you reduce the barrier. But the first is a spark of interest. So how do you spark that interest?

Ms. ANDRADES. I think sitting here today is one way to spark that interest so that other minority students can see that this is a reasonable idea for them, and they can see someone that looks like them in a space where typically you don't see minorities.

Senator CASSIDY. I accept that because people see a role model. My daughter is an air traffic controller, whatever, because she saw a YouTube of a female air traffic controller. So that makes sense to me that you would do that. And then what inspired you to continue to upskill, if you will, to become that nurse practitioner?

Because it is obviously what—I went to med-tech, and she had already taken all the pre-med courses. She was med tech, and then she advanced her skills and became an MD. So just to point that out, that works, right? So, your thoughts on that.

Ms. ANDRADES. I was inspired to continue my education to become a nurse practitioner by actually an African American nurse, Gloria Wilson, who worked with me at Mason Square. She was in her 60's at the time, and she was going to school for her master's degree.

She kept kind of saying, but you can do it. Like, you can do it. And I just said, Okay, well, I will apply. If I get in, then I will continue my education. So, my inspiration to continue was this African American nurse who is in her 60's and still searching and looking for opportunities for her own education.

Senator CASSIDY. A role model and a mentor.

Ms. ANDRADES. Again, a role model, yes.

Senator CASSIDY. Dr. Galvez, you had mentioned increasing the Latino workforce by having some sort of Federal funding tie that would require someone to have a second language in order to advance.

But frankly, that would discriminate against like African Americans or against others who might—a Native American who may not have a second language. And so, square that circle for me. It seems like we are creating another barrier to require a second language.

Dr. GALVEZ. It is a great question and thank you so much for it. It really is, as I mentioned as well in my testimony, language has frequently been ignored.

Yes, it is challenging. I didn't want to—like my parents forced me to speak Spanish at home. That is how I learned it. And yes,

I am privileged that I was able to learn it at home and very grateful because it is my superpower, like I mentioned.

But it is something that I believe should be encouraged, especially if you have a medical school that, for example, in California, by 2050 it is going to be almost 50 percent Latino.

Those considerations of language will improve efficiency in your clinic, right. If you have a 15 minute visit——

Senator CASSIDY. I accept that. We are almost out of time—we are.

Dr. GALVEZ. Oh, sorry. Yes.

Senator CASSIDY. But maybe as a question for the record, we have to see we don't create other barriers for a future Dr. Cook.

Dr. GALVEZ. Yes.

Senator CASSIDY. Let me just finish by saying this. As a physician, I thank you all for still seeing patients. So, thank you. I yield.

The CHAIR. Senator Casey.

Senator CASEY. Let me start by thanking you, Mr. Chairman, and the Ranking Member, for having a hearing on this range of critically important issues, whether it is the diversity of the workforce or whether it is health disparities or maternal health or maternal mortality.

I believe that in order to nurture a future generation of Black and Brown health care workers, or in order to close gaps between outcomes for white and Black mothers, we have to start in childhood.

That means that the Congress of the United States has to get into the game in a way that we haven't ever really. I believe it comes down to at least five basic freedoms that every child should have a right to enjoy, and we should invest in those freedoms, not just talk about them like their platitudes.

The freedom to be healthy, the freedom to learn, the freedom to have economic security, which means giving children the opportunity—their families, the opportunity to save at a very young age for their future.

The fourth freedom would be the freedom from hunger. And the fifth freedom would be the freedom to be safe from harm. Every child has those five, health, the opportunity to learn, economic security, freedom from hunger, and to be safe. We will have a much different outcome on all these issues we are here to talk about. But the Federal Government hasn't done that.

I think it requires a maximum commitment to our children. I will start with Dr. Lawson, you had talked about the improved outcomes patients have when they are able to see health care providers that look like them, a very important point to make in this hearing and beyond.

In the context of maternity care, what has your experience been with both midwives and doulas, and what role can they play in reducing health disparities?

Dr. LAWSON. Absolutely. Thank you, Senator. I have had a 22 year history with experience in OB-GYN. My entire career I have

worked with midwives and doulas. I even owned a birth center myself and employed midwives. Very impactful.

No. 1, I believe women should have a choice with what type of provider they want, and that is what midwives can do. I think that doulas are an excellent support for women. They were an extension of me.

I could send the doula to the house, help a woman in early labor, postpartum checks, mood disorders. Sometimes they would share things with the doula they may not want to share with me. So very important aspect and add on support for women during pregnancy and childbirth.

Senator CASEY. Well, thank you. We are all trying to do more to invest in programs that would support doulas and midwives. Dr. Galvez, you mentioned the role of community colleges in helping to develop the pipeline of health care workers and for diversifying the workforce. Community colleges are the most diverse sector of higher education.

I know that just from representing Pennsylvania. We have got 15 community colleges, and I am amazed at the sophistication of the curriculum and how well-prepared young people are coming out of those community colleges. How can we better use the opportunities that community colleges offer to help grow and diversify the health care workforce?

Dr. GALVEZ. It really was, at least for me—I didn't know how to study. I did poorly in high school. It wasn't until community college that I learned how to study, and I learned those skills—I used those skills at Stanford for medical school, the same study skills.

I do think, as I mentioned, I think it is an untapped resource. I think recruiting early and encouraging students to consider a career in medicine and other health care fields is a good source, just like you said. It is a very diverse pool.

Better use them and include them. It is to create pathway programs where we have—in California, we have the California Medical Scholars Program, which is in development, where they are linking community college.

But it really is—it is providing mentorship and guiding them, but it is not guaranteed acceptance. And that is where I think taking it a step further and guaranteeing these students, and creating even a quota for medical schools so that they can better reflect their community is a strategy for this—for diversifying the workforce.

Senator CASEY. Doctor, thanks very much. And before I conclude, I want to commend Dr. Cook for your telling your story here today. The fact that you attended Drexel helps in my estimation. But it is a great American story and I know you worked hard to achieve it. So, thanks for being here today and providing that testimony. Thanks, Mr. Chairman.

The CHAIR. Thank you. Senator Marshall.

Senator MARSHALL. All right. Thank you, Chairman. This is obviously an issue very near and dear to my heart. It is an issue that I have dedicated my life to solving. And before I go on with my re-

marks, I want to make sure everybody knows that one maternal death is too many.

Yes, we need more minority doctors, nurses, the whole gamut, Okay. I totally acknowledge that. Mr. Chairman, I would suggest that the work we have done with community health centers will do more to impact this than all the other ideas we are hearing about.

That our vision of these community health centers would have prenatal clinics in them and then help take care of the woman after the baby is delivered, something as an obstetrician that maybe I didn't do the best job after we got to about 6 weeks.

The other thing that would impact this more is stopping the illegal crossings on our border and the fentanyl poisoning that is just—it is accumulating problems for my moms as well. My story—I think you have to hear my story. And I am sorry, but I am a first generation college student too.

I went to a community college. My wife went to a community college, a community college nurse. 90 percent of nurses in our hospital are community college nurses. Went to a residency program in Saint Pete, Tampa. Very busy.

Eight residents, 5,000 deliveries a year. So, in 20,000 moms that we delivered, do you know how many maternal deaths we had? Zero. And how so? The answer is how come? Two things. One, we had incredible committed doctors and nurses and ultrasound techs. But No. 2 is I set up a prenatal clinic.

When I got there, a fourth, maybe half of our moms were not getting any prenatal care. I went to a church on the wrong side of town, and said, we will use your basement to set up a prenatal clinic and made sure that every mom had prenatal care before they ever got to the hospital.

That probably, how many lives that saved. But that was one simple solution. And then in my private practice, half of my moms, we delivered—I delivered over 5,000 babies personally, and half of my moms drove more than 60 miles to see me. By the way, the only thing worse than no prenatal care is bad prenatal care.

It scares me to death when people think that they should be delivering babies in facilities that have one delivery a week or one a month. That is a scary situation as well. But again, zero deaths. Why? Because—and I am going to—half the babies we delivered in residency were minority.

Half the babies we delivered in my private practice were minorities, half of which were on Medicaid or had no money. So, it wasn't like it was this perfect group of people that had everything in life. Half of my patients spoke Spanish that I delivered.

Those were challenges, but no deaths is because we gave prenatal care and I was obsessed with prenatal care, and my nurses were obsessed with giving good prenatal care.

Ask the panel, how many women died in 2023, maternal deaths were there in 2023? Does anybody know the answer to that? Okay, it was 684. In 2021, it was 1,205. So, we dropped from 1,200 to 684.

First of all, I want to thank all the hard working nurses and doctors and the people out there, community health centers that are

making a difference. Next, what is the most common cause of maternal death now? Does anyone in the panel know that? Go ahead.

Dr. LAWSON. In Black women, cardiovascular disease. In Native American men and women, and in Caucasian women, we sometimes see mental health and substance use disorders.

Senator MARSHALL. Yes. I wish that was the case, but the most common cause of maternal death now is suicide and drug overdosing and fentanyl poisoning, Okay. That is the No. 1 cause. What percentage of these deaths occur more than a week after delivery?

Dr. LAWSON. Over half—around 52 percent.

Senator MARSHALL. Yes, 52, 53 percent. So, half of these deaths are occurring after—a week after delivery. It is why these community health centers are so important, is to follow-up on the mental health aspect, let alone the addiction issues as well, Okay.

That is the solution to the postpartum issues. Inter-partum, No. 1 cause is now hemorrhage, heart disease, stroke PE, cardiomyopathy infection, and hypertension. Those are the ones that we can impact with prenatal care and intra-partum care as well.

I think we have to also acknowledge why is heart disease spiking right now from a maternal M and M situation as well? Well, it is several reasons. One is our moms are older.

No. 2 is they are heavier. And No. 3 is diabetes. I mean, the amount of diabetics, type 2 diabetics that I saw in my clinic doubled or tripled over my 25 year career. So again, we go back to our community health centers with nutrition as a component, with mental health as a component, that we hopefully have healthier moms before they get pregnant. That is what is going to impact all these.

We don't need to form committees and pray about it. We know the solutions. I think our community health center is the best thing I see out there that is going to touch all people, and just look forward to continue the great work the Chairman and Ranking Member have done in these issues.

Thank you so much. I yield back.

The CHAIR. Let me just inject. What Senator Marshall was talking about is fairly comprehensive legislation that left this Committee. And Senator Marshall and Senator Braun, among others, Senator Murkowski played an important role in that. And I hope we can get that legislation moving again.

Senator Kaine.

Senator KAINE. Thank you, Chair Sanders. And thanks to the panel. What a great panel. So, you all in your professional lives have some pinnacle days that really make it worth doing. And I just wanted to reflect as I think about the work we do here, we may not have as many as you, but we have some.

Three times in the 11 years I have been here, we passed meaningful legislation or taken meaningful action on the floor of the Senate by one vote. And on those days, it makes me think, wow, what if I hadn't run.

In August 2017, we saved the Affordable Care Act in the U.S. Senate by one vote, and 30 million people did not lose health insur-

ance, and tens of millions of people did not lose the ability to be protected against discrimination because they had a preexisting condition.

In 2022, we passed the Inflation Reduction Act by one vote, capping prescription drug prices, out-of-pocket costs, negotiating for prescription drugs under Medicare passed it by one vote. The third one voter is not generally thought of as a health bill. It is the American Rescue Plan in March 2021.

But it had within it something really important. Prior to the American Rescue Plan, Medicaid would cover a mom after birth for 60 days. In the American Rescue Plan and then subsequently in appropriations bills, we extended that option.

States could choose that a mom would be covered post-delivery for a year by Medicaid. It is interesting it was a state option, but it was enormously popular. 46 states have embraced this option, 3 are in the process of embracing it, and only 1 has not pursued it.

What is this likely to mean playing out over time that Medicaid will now cover moms, not just the kids, but will cover moms for a year after delivery? Please, Dr. Lawson.

Dr. LAWSON. Sir, thank you. Thank you for that comment and I appreciate your work. The one state that has not adopted legislation is Arkansas and that is originally where I am from, where over 50 percent of moms here are on Medicaid that deliver.

This has huge impacts. And I extend to you that it is beyond even maternal care. When you look at the five top causes of infant mortality in this country, two of those five are due to either maternal complications or low birth weight babies, really due to preterm birth. So, you are talking about lifelong impact, because we know that infant health also is an important marker of the overall health of society.

When you talk about how impactful this is, major impactful. Again, I am in Texas. We are excited. I remember and certain my colleagues that have done OB-GYN as a rotation, even as a student, know that we would try to compact all of a woman's health care in those 6 weeks where she had Medicaid coverage. So, we thank you for the work that you all have done for this.

Senator KAINE. Yes, the ability not to have to cram it into 6 weeks, but to have it for a year. I mean, it is—I think we will start seeing statistics and I would suspect the statistics because of who Medicaid covers, are not just likely to be a reduction in maternal mortality, but it should start to eat away at some of the disparities that we are seeing in maternal mortality.

I am really interested in following this. It is still relatively recently implemented. I think Virginia might have been the first state that embraced it. We happen to have a doctor as Governor when this got passed, the American Rescue Plan, so he was fast out of the starting gate.

But the fact that now every state has either done it or in the process of doing it save one. We seldom do things that are so popular here where states say we want to be part of this, and I am excited that we are.

I want to just—my colleague, Senator Casey, asked the question about community colleges, and I don't need to go into it as much. But I mean, it is interesting to note that of our five panel, I think both Dr. Galvez and Dr. Andrades were community—began in community college, and it is really important.

Community college students—just who is a community college student? The average community college student is older than 25, receives a Pell Grant, attends part time, and is a woman. And is more likely than the population norm to be a person of color. That is our community college population.

Many fantastic health care professionals start there, and we just need to do more really to recognize our community colleges as great beginning places, accelerators, on ramps, right, on ramps to success in many ways, but including in health care professions. And so, I think it is just interesting.

In the randomness of who are our five witnesses. We have two who began in community college, and I appreciate that. The last thing I will say, it is not really a question, but we have to get a hold of it.

We have been using a set of maternal mortality statistics to compare to other nations and also to look at disparities. And there has been some recent churn about whether the statistics that we have been using are accurate.

I am kind of a data geek, and I really hope that we can work together with the CDC to arrest any confusion about the statistics. I think measured accurately, we are still going to find we are an outlier with other nations, and we are still going to find these significant disparities.

But to the extent there has been a little bit of controversy about them, I think—I hope we can work together to improve the data and how we report it. Thank you, Mr. Chair.

The CHAIR. Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman. In my home State of Indiana, we have the third highest maternal mortality rate at 44 deaths per 100,000 births in 2022. That is sad. Regarding this sad state of affairs, local news article said that nothing has changed in 10 years. That needs to change.

That lack of improvement is disappointing state by state. That is why I have been vocal on health care in general here. And we did pass out of this Committee the Preemie Act reauthorization, which renews resources for HHS to promote healthy pregnancies.

The Improving Access to Maternal Health for Military and Dependent Moms Act, that is being reviewed. Hopefully we get that through this Committee. And the Standing with Moms Act, which would increase the availability of pregnancy related resources to expectant mothers. Another bill.

We are drawing attention to it. My question is for Dr. Lawson, in your home State of Texas, what have you seen there? Have they been improving? There is a lot more agility at the state level to address things. Tell me what has been happening there.

Dr. LAWSON. Thank you for the question. So, over the—up until 2021, we have not improved. Some new data—I know that our

MMRC is working on the biennial report. We will hopefully have that this summer to see where we are for 2022 and thus far.

But overall, Texas has one of the worst rates of maternal morbidity and mortality. We are very excited that the postpartum Medicaid extension was made, but of course, we are a state that does not have Medicaid expansion.

What we are also concerned about from a workforce perspective is some—having enough physicians, right, for the population and enough physicians that actually take Medicaid coverage for those populations.

We have some strong county hospital networks there. But of course, we have not seen the reduction in numbers that we would like to see ideally.

Senator BRAUN. Have any states, from your observation, found best practices that are doing a good job? Do you keep track of that? Because you think among the 50, that someone would actually be doing a decent job with it. Have you noticed anything to that effect?

Dr. LAWSON. There are some states that I think—I can point to California, the California Perinatal Quality Collaborative. They are doing some really great work. And especially when you think about that population.

Also, New York is doing some really great work. I think, again, in collaboration with the MMRCs, the data piece is very important. That drives a lot of policy from a public health perspective and for hospital quality improvement projects.

Senator BRAUN. This is such an important area, along with getting more doctors and professionals paying attention to it, especially among minorities as well. We should be throwing everything in the kitchen sink at this, both federally and by state.

I want to segue to one other issue that I bring up always, is the broken nature of our health care system that is increasingly being run by large corporate entities that I don't know that have any interest in prevention and wellness—mostly in expensive remediation.

Until we get that fixed, we are going to keep, I think, avoiding what we all know makes more sense, prevention and wellness. And that is going to take a cultural change within health care itself.

Probably the biggest thing would be how do you lower costs among insurance companies and hospitals? I can tell you what has been happening has been the opposite. It has alienated even a lot of physicians and nurses from getting into the business, because their dream wasn't to be working for huge corporations that don't have practitioners in mind and the patient.

That has got to change in terms of what we can do state by state, and here as well. Senator Sanders and I introduced a bill, and it is already got a lot of bipartisan support. Senator Smith, Hickenlooper, Grassley, Coons, Hassan, Ernst, and Baldwin.

This would be transformational. It is a bill that is going to force corporate health care to accept transparency and competition, not to have barriers to entry for people to get into the health care business or try to corner the market with high costs along the way.

I would urge all of you to make sure in a grassroots way you get behind it. And until we break that grip to where that is in control, we are never going to address this, or many other issues related to health care. Thank you for being here today.

The CHAIR. Well, let me just thank Senator Braun for his work and mention to him, this whole issue of corporate and private equity control over our health care system is exploding. You are right, young doctors don't want to be corporate employees. It is an issue we will deal with.

Senator Hickenlooper.

Senator HICKENLOOPER. Thank you, Mr. Chair. And thank all of you for being here, but also for your service. You could all be making more money doing other things and appreciate your commitment.

I am from Colorado, and we have been working a lot on apprenticeships. And I think on a broader scale, they can help address the shortage of minority health care professionals.

Colorado Public Health Works is one of the first of its kind that connects AmeriCorps volunteers with a registered apprenticeship program run by a Trailhead Institute. Their goal is to recruit a more diverse workforce.

Allows the apprentices to get valuable on the job apprenticeship experience while we make progress in our public health needs. So, I will start with Dr. Galvez and Dr. Andrades.

How are apprenticeship models and other on the job training models particularly helpful in terms of the recruitment and retention of diverse healthcare forces? And then follow that up with additional Federal support for apprenticeship programs, which we have worked on this Committee. Would that be helpful also in terms of recruiting students of color?

Dr. GALVEZ. Thank you for that question, Senator. The apprenticeship model is fantastic. And I think of it from the medical side, we frequently shadow.

Shadowing a physician is where you learn what you potentially could be, what you are getting into, right. And so, there are some shadowing experiences that aren't great, like at an ER where you are passing out juice and blankets. That is not really learning about how the ER functions.

But when you are in an ER where you are taking care of patients or helping to translate, and seeing what a physician is doing, that buy-in, that spark that was mentioned, that is what really gets people hooked, right, that they want to proceed and go into that model.

I think that is a good format, and it likely would reduce attrition. Because there are—like an example is you have someone who goes to an Ivy League school, right. They want to be a doctor.

Yes, they will get some research experience, but they don't they—and yes, they will be shadowing in a clinical setting. But it is—you see a high attrition rate in people interested in entering medicine who didn't really get a great initial experience. And so, apprenticeships I think are a fantastic model.

Senator HICKENLOOPER. Dr. Andrades.

Ms. ANDRADES. I also believe that apprenticeship model is probably the best way to help minority students.

As I mentioned in my testimony, BSEP, the Baystate Springfield—educational partnership is really a mentorship program between the city of Springfield Public Schools and Baystate Medical Center to provide underserved students with the opportunity to work alongside different health care professionals.

I think one of the major benefits there is that maybe a student may go into it saying, well I want to be a radiology tech, but—or I may want to be a nurse, but students have followed me, and I work very closely with surgical residents and surgeons.

Maybe that exposure to another level in the health care field is integral in them making the decision, Okay, I don't just have to be, let's say—I don't have to be in this position. I can be the surgeon.

I can be the nurse practitioner. And again, that program really offers them an opportunity that they wouldn't have otherwise.

Senator HICKENLOOPER. Thank you. I appreciate that. And Dr. Braun—or Dr. Braun—Senator Braun and I have worked on this and had a lot of support on the Committee. We are making progress.

Dr. Lawson, as you noted in your testimony, CDC reports of Black women are tragically two, three, four times more likely to die. And we also just heard, a lot of that is due to mental health issues. Colorado has a 2023 maternal mortality report based on 4 years, 2016 to 2020.

They found that basically a third of all deaths were attributed to suicide or accidental overdose, which is staggering. What do you think we can best—how do we best address this mental health, substance use disorder epidemic that we have?

Dr. LAWSON. That brings up one of our focus areas as an organization. There are certain specialties we are worried about the workforce and availability.

I have not been to one state during my presidency during this past term where they do not have a shortage of behavioral health care providers. I myself practice in Dallas. I am not in Podunk, but we still don't have an availability of behavioral health care providers.

There needs to be investments on how we can give scholarships for those students, medical students to get them interested in that career. Second, thinking about psychologists and other specialties, right, that support those services.

Also, when you think about women, about 55 percent of women, even if they had Medicaid, there is a coverage gap. So, we got to also think about coverage. Many of my psychiatry colleagues do not accept commercial insurance because of low reimbursement.

Really the root cause of this is reimbursement for behavioral health care services and showing value on that.

Senator HICKENLOOPER. Great. Thank you all. I am out of time. I yield back to the Chair. Thank you.

The CHAIR. Senator Marshall, did you want to stay——

Senator MARSHALL. Well, I just want to again, thank all of our witnesses for coming. Thank you for your dedication to the health of women and pregnancies and deliveries, and all the other aspects of health care. Thank you so much.

The CHAIR. I just want to echo Senator Marshall. Thank you all. This is without exception, excellent testimony, and we look forward to continue to work with you to implement many of the very important suggestions that you made. So, thank you all. And with that, let me just say that the hearing is over.

For any Senators who wish to ask additional questions, questions for the record will be due in 10 business days, May 16th at 5.00 p.m.. Finally, I ask unanimous consent to enter into the record 12 statements from stakeholder groups.

[The following information can be found on page 55 in Additional Material:]

The CHAIR. The Committee stands adjourned. Thank you, again.

ADDITIONAL MATERIAL

May 2, 2024

The Honorable Bernie Sanders
Chair
Senate HELP Committee
428 Senate Dirksen Office
Building Washington, DC

The Honorable Bill Cassidy
Ranking Member
Senate HELP Committee
428 Senate Dirksen Office
Building Washington, DC

RE: "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

Dear Chairman Sanders, Ranking Member Cassidy, and members of the HELP Committee,

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association appreciates the opportunity to submit comments for the hearing "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

"The Economic Value of Physical Therapy in the United States," a recently released APTA report, showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. The report compares physical therapy with alternative care across a suite of health conditions commonly seen within the U.S. health care system. The report underscores and reinforces the importance of including physical therapists and physical therapist assistants as part of multidisciplinary teams focused on improving patient outcomes and decreasing downstream costs, including expanding access to physical therapist services for maternal and pelvic health services.

Recommendation

One key tool to help address the maternal health crisis is expanding access to pelvic health physical therapy, which is a vital part of recovery in the postpartum period. It can aid in muscle control, tissue repair, and help heal internal portions of cesarean section scars. However, many mothers lack access to and awareness of the benefits of pelvic health physical therapy. Even some health care providers may not understand the importance of pelvic health physical therapy in the postpartum period.

Legislation has been introduced in the House by Rep. Lisa Blunt Rochester, D-Del., and Rep. Don Bacon, R-Neb., titled the Optimizing Postpartum Outcomes Act (H.R. 2480). This bipartisan legislation is designed to address knowledge and access gaps head-on. It would require the Centers for Medicare & Medicaid Services to, within one year of enactment, issue guidance on coverage under Medicaid and the Childrens Health Insurance Program for pelvic health services performed during the postpartum or

neonatal period (six months from the termination of the pregnancy or the end of lactation, whichever is later). This guidance would include best practices; recommendations for available financing options; technical assistance to state agencies regarding flexibilities relating to and incentives for screenings, referrals, and access to covered services; and suggested terminology and diagnosis codes.

The legislation also would instruct the Government Accountability Office to conduct a study on pelvic health programs and submit a report to Congress. This report would address gaps in coverage for covered pelvic health services and other services postpartum women received during their pregnancies.

Additionally, H.R. 2480 would obligate the Secretary of the Department of Health and Human Services to carry out a program to educate and train health professionals on the benefits of pelvic health physical therapy. The program also would educate postpartum women on the importance of pelvic floor examinations and pelvic health physical therapy, and on how to obtain these services.

The Optimizing Postpartum Outcomes *Act* would arm providers with awareness of pelvic health physical therapy's importance and provide Congress with critical information on how to close gaps in access to this much-needed postpartum care. The American Physical Therapy Association urges the Committee to consider H.R. 2480, and other related legislation, as it addresses the critical issue of access to maternal care.

Conclusion

APTA appreciates the opportunity to share our perspective and recommendations to the committee. Should you have any questions, please contact Brian Allen at brianallen@apta.org. Thank you for your time and consideration.

Sincerely,

Roger Herr, PT, MPA

President, American Physical Therapy Association

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement

of the

American Hospital Association

for the

Committee on Health, Education, Labor & Pensions

of the

U.S. Senate

"What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

May 2, 2024

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comments on ways to increase diversity in the health care workforce and improve maternal health care.

Hospitals and health systems are currently facing a national staffing emergency that could jeopardize access to high-quality, equitable care for patients and the communities they serve. In 2017, the majority of the nursing workforce was close to retirement yet nursing schools had to turn away nearly 66,000 qualified applications in 2023 due to a lack of faculty and training sites. Hospitals face similar challenges with physicians, with data indicating that one-third of practicing physicians will reach retirement age over the next decade.

The result of these mounting pressures on the health care workforce has created a workforce crisis complete with short-term staffing shortages and a long-range picture of an unfulfilled talent pipeline. Significant projected shortages of physicians and allied health and behavioral health care providers will likely be felt even more strongly in

underserved communities. We urge Congress to address these challenges to help create a strong, sustainable, and diverse health care workforce.

INCREASING WORKFORCE DIVERSITY

The AHA believes that a talented, qualified, engaged and diverse health care workforce is indispensable to our nation's health care infrastructure. A diverse workforce recognizes that understanding the cultures, issues and needs of local patient populations can result in better decision-making about how to serve those communities and positively impact patient experience, safety and quality. Yet today, people of color are vastly underrepresented across the health professions.

For example, in 2022, 18.8% of active physicians identified as Asian; 6.3% as Hispanic, Latino, or of Spanish Origin; 5.2% as Black or African American; and less than 1.5% identified as Multiracial (non-Hispanic; 1.3%), Other (1.1%), American Indian or Alaska Native (0.3%), or Native Hawaiian or Other Pacific Islander (0.1%), according to the Association of American Medical Colleges.

The AHA urges Congress to help create a more diverse health care workforce by strengthening the nation's capacity to educate and train students from underrepresented groups.

Funding for Graduate Medical Education

The nationwide shortage of physicians continues to jeopardize access to timely, quality care. The AHA supports the bipartisan, bicameral Resident Physician Shortage Reduction Act of 2023 (S. 1302/H.R. 2389), which would increase the existing cap on the number of Medicare-funded residency slots. Importantly, section three of the legislation would require the Government Accountability Office (GAO) to study and report to Congress with recommendations on strategies for increasing the diversity of the health care professional workforce.

Additional Workforce Programs

The AHA supports robustly funding the following federal programs to increase the diversity of the health care workforce.

- **Nursing Workforce Development programs** support nursing education and seek to diversify the nursing profession and improve access in rural and underserved communities.

- **Title VII programs** play an essential role in diversifying the health care workforce and promoting health careers by supporting recruitment, education, training and

mentorship opportunities. Inclusive and diverse education and training experiences expose providers to backgrounds and experiences other than their own and heighten cultural awareness, resulting in benefits for all patients, as well as the providers who serve them. Evidence shows that concordance between patients and providers results in better health outcomes.

- **The National Health Service Corps** awards scholarships to health professions students and assists graduates of health professions programs with loan repayment in return for their providing services in underserved rural and urban areas. We support mandatory funding as a necessary investment in this critical program, which boosts clinical diversity.

- **The Centers of Excellence and the Health Careers Opportunity Programs** focus on recruiting and retaining students of color into the health professions to build a more diverse workforce. Centers of Excellence grants to accredited allopathic schools of medicine, osteopathic medicine, dentistry, pharmacy, and graduate programs in behavioral or mental health strengthen the nation's capacity to train students from underrepresented groups and help increase providers' understanding of the social determinants of health and health issues disproportionately affecting people of color. The Health Careers Opportunity Program aids students from disadvantaged backgrounds in entering and completing education in health profession schools through tailored enrichment programs, and it provides opportunities for community-based experiential health professions training.

Health Care Workforce Retention

In addition to addressing workforce shortages and increasing diversity, we urge Congress to take the following steps to help retain the current health care workforce and reduce factors that lead to burnout.

- Ensure a safe environment for health care workers to deliver care by protecting them from assault and intimidation while working. The AHA supports the Safety from Violence for Healthcare Employees Act (S. 2768), which would make it a federal crime to assault a hospital worker. It also would direct the GAO to study the effect these laws have on violence against health care workers so we can continue to adapt, refine and strengthen protections for our caregivers.

- Reduce onerous administrative burdens like prior authorization that delay access to care and contribute to provider burnout. The AHA supports The Improving Seniors' Timely Access to Care Act, which would streamline prior authorization requirements under Medicare Advantage plans by making them simpler and uniform, and eliminating the wide variation in prior authorization methods that frustrate patients and providers.

- Continue to address health care worker well-being by supporting the Dr. Lorna Breen Health Care Provider Protection Reauthorization Act (S. 3679/H.R. 7153), which would provide grants to help health care organizations offer behavioral health services to prevent burnout and suicide for health care workers through 2029.

IMPROVING MATERNAL HEALTH

The AHA and its hospitals and health systems are dedicated to eliminating maternal mortality and reducing maternal morbidity to provide moms and babies with the opportunity to lead healthy and productive lives. Last year, we released a comprehensive set of federal public policy and legislative solutions for improving maternal health, including:

- Support for Medicaid expansion in those states that have not yet done so.
- Support all states opting for one year of postpartum coverage for their Medicaid populations. To date, 46 states, including the District of Colombia, have expanded coverage.
- Maintain health care coverage for children and pregnant women during the Medicaid unwinding process.
- Continue to support ACA health insurance subsidies for lower- and middle-income individuals and families.

Additionally, the AHA urges the Senate to pass the Preventing Maternal Deaths Reauthorization Act (S.2415), bipartisan legislation that would reauthorize federal support for state-based maternal mortality review committees, which review pregnancy-related deaths to identify causes and make recommendations to prevent future mortalities. We appreciate that the Senate HELP Committee favorably reported this bill out of committee in October and that the House passed its companion legislation last month.

Maternal Health Workforce

The AHA also requests Congressional support for a maternal health workforce that reflects the communities they serve. Recent studies have shown that Black patients cared for by Black primary care providers live longer, and Black newborns cared for by Black physicians have better outcomes.[1,2]

Additional providers are needed at every level along the care continuum in all aspects of maternal care (prenatal/surgical assist in obstetrics/postpartum), including midwives and nurse practitioners (NPs). In particular, NPs' strong medical backgrounds make them

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[1] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2803898
[2] https://www.pnas.org/doi/10.1073/pnas.1913405117

very suitable to provide routine care and address other issues, such as expediting subspecialty consults, which can be difficult to achieve in a timely manner.

The AHA appreciates that Congress provided funding for several initiatives to increase diversity in the health care workforce and improve maternal health in its Fiscal Year 2024 Labor-HHS Appropriations bill, including:

- Maternity Care Target Areas: $8,000,000, an increase of $3,000,000, to support loan repayment and scholarships for maternity care services in health professional shortage areas.
- Scholarships for Disadvantaged Students:
    - Midwife Training: $5,000,000 to support grants to educate midwives to address the national shortage of maternity care providers.
    - Certified Nurse Midwives: $8,000,000 to grow and diversify the maternal and perinatal nursing workforce by increasing and diversifying the number of Certified Nurse Midwives with a focus on practitioners working in rural and underserved communities.
- Rural Residency Planning and Development: $2,000,000 for family medicine/obstetrics training programs in states with high infant morbidity and mortality rates.

CONCLUSION

Thank you again for your interest in exploring ways to increase diversity in the health care workforce and improve maternal health care. We look forward to working with you to support these important issues.

STATEMENT

of the

American Medical Association

to the

U.S. Senate

Committee on Health, Education, Labor and Pensions

Re: "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

May 2, 2024

Division of Legislative Counsel

Statement

of the

American Medical Association
to the

U.S. Senate
Committee on Health, Education, Labor and Pensions

Re: "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

May 2, 2024

The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP) as part of the hearing entitled, "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?" In order to support state and federal policy development and initiatives and make significant progress in this space, the AMA has worked collaboratively over the last year with a variety of members of the Federation of Medicine, including relevant specialty societies, key state medical societies, and physicians from rural parts of the U.S. As a result of these efforts, the AMA has cultivated the following recommendations and advocacy materials.

The AMA commends the Committee for focusing on this critically important issue, which disproportionately affects Black and American Indian/Alaska Native (AI/AN) pregnant and postpartum individuals. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is committed to working with all interested parties, especially Members of Congress, to support efforts to reduce and prevent the rising rates of maternal mortality and serious or near-fatal maternal morbidity and believes that, with additional funding from Congress and the implementation of the recommendations discussed below, maternal health across the country can be significantly improved.

GROW AND RETAIN THE PHYSICIAN WORKFORCE TO PROVIDE COMPLEX CARE TO HIGHER-RISK PREGNANT, BIRTHING, AND POSTPARTUM PATIENTS

Recommendation 1a: Address physician workforce needs in maternity care.

Access to physician practices, clinics, and hospitals that provide maternal and infant care services is critical to providing high-quality care; yet, in 2023, only about 43,500 Obstetrician-Gynecologists (OBGYNs) were in practice across the entirety of the U.S. and its territories. According to the latest March of Dimes report, almost 7 million women live in maternal care

deserts. Moreover, 36 percent of counties nationwide, largely in the South and Midwest, have no obstetric hospitals, birth centers, or physicians who provide obstetric care. As such, a greater emphasis is needed on increasing and retaining the number of physicians in the maternal and infant care space to decrease maternal care deserts and improve health outcomes. Therefore, in order to increase the number of maternal care providers and help with the retention of physicians who provide maternal care Congress should:

The Physician Residency Cap and Training

- Work to help remove the cap on physician residency slots. If this is not possible, Congress should work to increase the cap on physician residency slots and ensure that the cap is not stagnant—i.e., the cap is increased as needed. Moreover, the cap-building period for new residency programs should be increased.
- Expand maternal care education and training, especially to those physicians likely to have to administer care to pregnant or postpartum individuals but are not OBGYNs or maternal-fetal medicine specialists.

National Health Service Corps

- Increase funding for the National Health Service Corps (NHSC) and ensure that a higher percentage of physicians are accepted to the NHSC Loan Repayment Programs and Scholarship Programs.
- Ensure that further information about the Maternity Care Target Area (MCTA) addition to the NHSC is provided to the public and grant more funding for the MCTA addition so that an adequate number of maternity care physicians—including OBGYNs, family physicians with an emphasis on maternal care, emergency medicine physicians, and maternal-fetal medicine specialists—can be placed in Health Professional Shortage Areas (HPSAs) through the NHSC.

Indian Health Service

- The Indian Health Service (IHS) should establish an Office of Academic Affiliations responsible for coordinating partnerships with the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, accredited medical schools, and residency programs accredited by the Accreditation Council for Graduate Medical Education. Furthermore, to support these partnerships, funding streams should be developed to promote rotations and learning opportunities at IHS, Tribal, and Urban Indian Health Programs.
- The IHS loan repayment program should be strengthened. The payments received through the IHS loan repayment program are taxable. In order to align this loan repayment program with other similar programs the loan repayments received should be tax free.
- Compensation for IHS physicians should be increased to a level competitive with other Federal agencies and additional funding should be provided to the IHS loan repayment program to increase the number of physicians who can be supported, especially in the maternal care space.

- Additional funding should be provided for the IHS Maternal Child Health (MCH) program. The IHS MCH should ensure that the funds it receives are used to increase access to OBGYNs and maternal-fetal medicine specialists for AI/AN pregnant individuals.
- The Centers for Disease Control and Prevention should increase its engagement in the following ongoing initiatives (this list is not exhaustive): develop awards to fund support for MMRCs for AI Tribes, expand materials on the Hear Her Campaign website for AI Tribes, and continued support for the Healthy Native Babies Project (HNBP) to assist local programs in addressing safe infant sleep in AI/AN communities.

Teaching Health Center Graduate Medical Education

- Increase funding for Teaching Health Center Graduate Medical Education (THCGME) Programs. Since 2010 this program has helped 21 OBGYNs complete their residency and enter the workforce. Though this is an excellent start, additional funding, and support for this program, and in particular OGBYNs in the THCGME Program, is needed.

Residency

Additional specific training tracks for maternal and infant care should be created and expanded. Rural track programs (RTP) already exist and are designed to encourage the training of residents in rural areas. Specifically, the Maternal Health and Obstetrics Pathway within the Rural Residency Planning and Development (RRPD) Program is available for both OBGYN rural residency programs and family medicine rural residency programs that have enhanced obstetrical training. The RRPD is a vital path that helps draw more physicians into rural practice. Therefore, **the AMA supports the Rural Residency Planning and Development Act of 2024 (H.R. 7855),** which would codify the RRPD program. This legislation is a great example of some of the permanent and meaningful fixes that Congress can make to help provide additional training pathways for physicians who want to provide much needed care in rural communities.

While the Maternal Health and Obstetrics Pathway within the RRPD is an important first step, it needs to be expanded so that additional maternal health pathways can be created. For example, additional training tracks should be created that allow for both rural and urban training for OBGYNs, maternal-fetal medicine specialists, family physicians, and other physicians who will likely have to provide maternal care. These training programs could be modeled off existing programs that are already accredited by ACGME such as the family medicine RTP programs which exist in the "1-2 format"—meaning the resident's first year is at a core family medicine program and the second and third years are at another site. Since there are already provisions of law and regulations that allow urban hospitals to create multiple RTPs and receive adjustments to their caps for newly established RTPs, it would be possible to create an educational format that allows for residents to train in urban and rural settings in maternal care thereby enabling physicians who will ultimately practice in rural areas to do rotations in hospitals with a high volume of deliveries so they can receive ongoing training and experience with cesarean sections and pregnancy-related complications. As such, **more funding should be provided for the Maternal Health and Obstetrics Pathway and programs with similar goals should be**

created. Moreover, additional funding for rural clinics and hospitals should be provided to enable them to offer rotations for medical students and residents in rural obstetric care.

Recommendation 1b: Utilize new payment models to prevent maternal deaths.

More than one-third of the rural hospitals that still have labor and delivery services are losing money on patient services overall, putting their ability to continue delivering maternity care at risk. Moreover, the number of health care professionals who are needed to maintain labor and delivery units, such as physicians, nurses, and anesthesiologists, are costly. "As a result, payments per birth that are adequate at a large hospital are not enough to support maternity care at small rural hospitals with far fewer births." This lack of funding often results from the fact that the prenatal, perinatal, and postpartum care provided by physicians is paid for through a fixed "global" code, regardless of the complexity of the patient receiving the care. This fixed fee fails to support the additional services that are necessary to provide high-quality care for pregnant individuals who have chronic conditions, undergo a high-risk pregnancy, or who experience health-related social needs. Therefore, it is imperative that additional payments are provided in the maternal health space.

FUND PATIENT-SAFETY BUNDLES, ACCESS TO SUBSTANCE USE DISORDER TREATMENT, AND MEDICAL-LEGAL PARTNERSHIPS TO ADDRESS THE LEADING CAUSES OF MATERNAL MORTALITY AND MORBIDITY

Recommendation 2a: Ensure feasibility and implementation of Core AIM Patient Safety Bundles and checklists.

The AMA strongly supports the Alliance for Innovation on Maternal Health (AIM) patient safety bundles, and we are encouraged that they are included in both the White House Blueprint and the new Transforming Maternal Health (TMaH) program. However, it is important for states and the federal government to recognize that the biggest barrier to implementing these bundles is a lack of resources and that additional funding, beyond what has already been invested, is needed to adequately implement the AIM bundles, especially in smaller institutions and institutions that do not have vast resources. **Therefore, the AMA strongly recommends that Congress provide the financial resources necessary for implementation of the Core AIM bundles and seek input from physicians providing obstetrical services about the barriers to implementing the AIM patient safety bundles.**

AIM: Simulation Training

Multiple AIM bundles include requirements to "[c]onduct interprofessional and interdepartmental team-based drills with timely debriefs that include the use of simulated patients." The American College of Obstetricians and Gynecologists (ACOG Simulations Working Group) has already created multiple simulation resources including obstetric surgical skills, emergencies in clinical obstetrics, uterine atony, and cerclage. However, the cost of implementing simulations is always a concern, especially for smaller practices, practices located in historically minoritized areas, and rural practices. As such, it is vital that **funding be provided**

for consistent, up to date, holistic simulations that can improve maternal health. Moreover, these simulations should be available for every physician, and physician led team, who engages in maternal care, including OBGYNs, maternal-fetal medicine specialists, family physicians, and emergency medicine physicians.

Recommendation 2b: Expand evidence-based programs for pregnant and postpartum people with substance use disorder.

From 2018 to 2021, the mortality ratio more than tripled among pregnant and postpartum women aged 35 to 44 years. Increasing access to holistic care for pregnant and postpartum women with substance use disorder (SUD) is vitally important, and one of the issues addressed in the core AIM bundles. As such, **we recommend that the AIM bundles be built out to cover additional care concerns connected with SUD and maternal health and to incorporate some additional best care practices.**

Increase access to evidence-based treatment to help patients access medications for opioid use disorder

The AMA commends the HELP Committee for advancing the Modernizing Opioid Treatment Access Act (M-OTAA)—policy that would greatly expand access to care for methadone in the community rather than limiting it to only federally authorized opioid treatment programs. This legislation would increase access to methadone if prescribed by board-certified addiction medicine physicians or addiction psychiatrists—among the highest trained specialists to treat substance use disorders in the nation. As such, **the AMA and more than 70 local, state and national organizations, support this important piece of legislation and urge Congress for its passage.**

Provide the Department of Labor with the authority to levy civil monetary penalties for violations of the Mental Health Parity and Addiction Equity Act (MHPAEA)

Congress should provide the U.S. Department of Labor (DOL) with the authority to assess civil monetary penalties for parity violations. After 15 years of health plans consistently failing to comply with MHPAEA—as detailed in the 2022 and 2023 Reports to Congress from the DOL, Department of Health and Human Services and Department of the Treasury—the AMA urges Congress to provide the DOL the necessary resources and authority to finally hold health plans accountable for their failures. Insurers' actions have made clear for nearly 15 years that they will not comply with MHPAEA unless forced to do so.

Increase the addiction medicine, addiction psychiatry, and pain medicine workforce

Congress should pass the Substance Use Disorder Workforce Act of 2024 (H.R. 7050). Only 102 Accreditation Council for Graduate Medical Education (ACGME) -accredited addiction medicine fellowship programs exist nationwide, falling short of the goal of 125 fellowships by 2022 set by the President's Commission on Combating Drug Abuse and the Opioid Epidemic in 2017. These fellowships, available to a wide range of physicians, including those in family medicine, internal medicine, psychiatry, pediatrics, and emergency medicine, offer vital training

in evidence-based SUD care. If enacted, H.R. 7050 would provide Medicare support for an additional 1,000 new graduate medical education positions over five years in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine and their prerequisite programs. More physicians in these specialties must be trained to meet the needs of patients with a mental illness or an SUD.

Require states to comply with federal law protecting access to medications for opioid use disorder as a condition of their prison systems receiving federal dollars

Despite positive efforts from some states and the U.S. Department of Justice to ensure access to medications for opioid use disorder (MOUD) in jails and prisons for individuals, denial of MOUD in jails and prisons continues, including for individuals who are pregnant and postpartum. Denying access to MOUD violates the Americans with Disabilities Act, and federal court decisions protecting the right to receive MOUD in carceral settings, jails, and prisons. **The AMA encourages the federal government to help ensure pregnant people in jails and prisons have access to their rights under the law, including access to MOUD during pregnancy and postpartum periods, per federal law.**

Urge the U.S. Food and Drug Administration (FDA) to take steps to revise the outdated buprenorphine drug label limiting access to this life saving drug in the era of illicit fentanyl

There is widespread evidence that supports buprenorphine as an evidence-based medication to treat opioid use disorder (OUD). In the age of illicit fentanyl killing tens of thousands of Americans, buprenorphine doses greater than 24mg are showing effective in some cases. The current FDA label is based on old studies that did not include fentanyl—and that label is used by health insurance companies and other payers to deny access to higher dose buprenorphine. **AMA advocacy has for years called for removing all barriers to buprenorphine for the treatment of OUD—including prior authorization reforms, the x-waiver, telehealth restrictions, and dosage caps.** Congress has taken several of these steps. Removing the outdated 24mg threshold is the next important step to save lives from illicit fentanyl.

Recommendation 2c: Address Social Determinants of Health within the pregnant and postpartum population by enhancing medical-legal partnerships.

"Perinatal medical–legal partnerships share responsibility across a diverse team, integrate legal care as needed, and leverage law and policies to help manage vulnerabilities that are exacerbated by an advancing pregnancy…. Encouraging the use of medical–legal partnership in more perinatal settings is warranted as obstetric visits offer an advantageous moment for the types of interventions offered." Moreover, some very successful medical-legal partnerships (MLPs) have been established across the country such as the Georgetown University Health Justice Alliance's Perinatal Legal Assistance and Well-being (LAW) Project – one of the first MLPs to focus specifically on perinatal needs. These MLPs show a reproduceable pathway to helping patients navigate the health care system. As such, **the AMA urges Congress to work together to provide funding to expand MLPs across the U.S. so that every birthing person can have access to the benefits they are entitled to ensure a healthy pregnancy.**

LEVERAGE DIGITAL HEALTH TO ADDRESS THE LEADING CAUSES OF MATERNAL MORTALITY AND MORBIDITY

Recommendation 3a: Promote telehealth and home monitoring during pregnancy and the postpartum period and address barriers to providing remote patient care.

Infrastructure for Remote Patient Care

While the Centers for Medicare & Medicaid Services (CMS) created the State Medicaid & Children's Health Insurance Program (CHIP) Telehealth Toolkit as well as a Supplement to facilitate state implementation of telehealth policies and promote greater provision of telehealth services in the maternal health space, in order to guarantee that remote maternal care can be offered, it is vital to first ensure that the infrastructure for remote care services is in place. Accordingly, **it is imperative that there are reliable broadband connections at both the site of the physician and the patient to ensure that consistent, reliable, maternal care can be provided virtually. Thus, the federal government should build out, and make permanent, initiatives like the Connected Care Pilot Program** which provides funding for "eligible costs of broadband connectivity, network equipment, and information services...." Moreover, it is exceptionally important that these initiatives focus on rural areas that tend to have the worst broadband access. Consequently, **programs like the Rural Health Care Program and the Rural Telehealth Initiative Task Force should be provided with additional support**, potentially through the Internet for All Initiative, so that broadband access can be provided to these communities as quickly as possible. Moreover, it is important to ensure that programs that increase access to the internet so patients can receive remote care (e.g., the Affordable Connectivity Program) are provided with the funding needed to continue.

Coverage of Telehealth

While maternity care is covered without cost-sharing by private plans and Medicaid expansion program under the Affordable Care Act, there are no federal requirements for coverage or reimbursement of telehealth care provided during or after pregnancy. However, due to the increased reliance on telemedicine over the past few years, Medicaid programs have begun to permanently expand coverage of telemedicine as a modality to provide health care services, although maternal and postpartum virtual care is not always included in these policies. **The AMA believes that telehealth and remote patient monitoring are a critical part of the future of effective, efficient, and equitable delivery of health care in the United States and encourages the federal government to help ensure comprehensive Medicaid coverage of virtual maternal health care services.**

Monitoring of Hypertension During Pregnancy and Postpartum

Over the last decade, the AMA has developed and disseminated an evidence-based quality improvement program, AMA MAP™ hypertension (HTN), that has demonstrated improvement in blood pressure (BP) control for adult patients with hypertension in primary care settings. In addition the AMA has collaborated with other interested groups to increase access to tools, resources and services to improve the clinical management of hypertension, including clinical

services and home devices for self-measured blood pressure (SMBP), specifically increasing Medicaid coverage. SMBP is an evidence-based strategy for BP control that is incorporated into AMA MAP HTN and other AMA solutions.

The AMA is convening clinical subject matter experts to identify effective strategies and best practices to improve care of patients with Hypertensive Disorders of Pregnancy (HDP). Expected deliverables include clinical resources, issue briefs/commentaries, and peer-reviewed publications for national dissemination. The AMA collaborates regularly with organizations and leaders in maternal health who are national experts on HDP to build upon the AMA work to develop an SMBP postpartum strategy.

Improving Care for Patients with Hypertensive Disorders of Pregnancy

HDPs are one of the leading causes of pregnancy-related deaths that occur in the first six weeks postpartum. The rate of patients entering pregnancy with chronic HTN and the overall rate of HDPs have risen considerably in recent years. The use of SMBP has been shown to increase compliance with ACOG recommendations for BP monitoring, increase patient satisfaction, and decrease readmissions for HDPs. SMBP has also shown promise in reducing inequities in the monitoring and treatment of BP in postpartum patients. Multiple barriers prevent the widespread adoption and use of SMBP for which there are potential solutions. These include coverage and access, clinical infrastructure, clinical quality improvement, federal legislation related to remote patient monitoring, and teleconsultation which are discussed below.

Coverage and access

Medicaid covers 42 percent of all births in the U.S. Coverage varies by states including the inclusion of an extra appropriately size cuff, often needed to ensure clinical accuracy. This variation and others are barriers to scaling SMBP. Even when coverage exists there are still access issues. Some states prohibit shipping a covered device directly to the patients or require patients to go to a specific durable medical equipment supplier rather than a more convenient location. For SMBP coverage to be clinically impactful it necessitates that patients have coverage and access to devices that are appropriately sized and clinically validated. **Therefore, we recommend policies that support increased coverage and access to SMBP devices clinically validated for pregnancy and appropriate cuff sizing options.**

Clinical infrastructure

SMBP requires investments in clinical personnel and technology integration into clinical practice. Therefore, we recommend policies that support:

- **Improved interoperability of apps/platforms to support the transfer of BP measurement data from patients to clinical teams.**
- **Increased reimbursement for physician-led team-based care in order to increase patient access to programs that improve care for patients with HDP.**

Clinical quality improvement

Clinical teams require access to data to drive and measure quality improvement programs as well as research efforts. Dedicated funding to scale promising interventions nationally and measure the impact on outcomes is also needed to identify the most effective solutions and strategies. Therefore, we recommend policies that support:

- **Increased availability of standardized clinical and billing data for use in quality improvement.**
- **Increased funding for clinical, dissemination and implementation research on HTN and cardiovascular diseases during pregnancy and postpartum in order to identify and measure effective interventions to improve quality of care and health outcomes.**

Additional factors that may impact the use of SMBP are the availability of maternity care, the status of policies related to caregiving (e.g., parental leave) and the status of health insurance coverage availability (e.g., Medicaid expansion).

Federal Legislation Related to Remote Patient Monitoring

Improving maternal and infant health outcomes for pregnant and postpartum women with the support of telehealth and remote patient monitoring solutions. Telehealth and technology enabled devices have proven to be key assets in the physician's toolbox for prevention and improved health outcomes for a number of conditions. The AMA recognizes the same technology is critical to addressing maternal mortality and morbidity by helping screen new mothers for high blood pressure and related treatable and preventable conditions, such as preeclampsia, that lead to unnecessary and avoidable maternal deaths and adverse health outcomes.

To help improve maternal health outcomes, **the AMA strongly supports S. 712, the "Connected Maternal Online Monitoring (Connected MOM) Act."** This bill would require CMS to send a report to Congress identifying barriers to coverage of remote physiologic devices (e.g., pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under state Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women. This bipartisan legislation would also require CMS to update state resources, such as state Medicaid telehealth toolkits, to align with evidence-based recommendations to help decrease maternal mortality and morbidity.

Teleconsultation

In many rural and underserved areas that lack regular and reliable access to physician specialists and subspecialists, such as maternal-fetal medicine physicians and fetal cardiologists, primary care physicians routinely manage pregnancy care. These primary care physicians need access to specialist consultations to help address complex clinical challenges that may arise over the course of pregnancy or delivery. One way to support multidisciplinary peer collaboration is through a telehealth hub-and-spoke model in which one large "hub" hospital provides additional support and training for smaller "spoke" facilities. This model, introduced through Project ECHO, enables physicians in rural areas to connect with specialists in facilities with capacity to

provide higher levels of maternal care via telehealth. **These models should continue to be supported, and provided with additional funding, to enable patients to access higher levels and more specialized care without having to leave their communities.**

Recommendation 3b: Ensure the acquisition of the right type of data.

Advancing Interoperability for Maternal Health

Standardization is the first step in forming robust research datasets and is especially important for studies on maternal health. One of the first improvements that must be made in the collection and usage of maternal health data is ensuring that the data are complete. For example, maternal health and child health are inextricably linked, but relevant data are often held in separate, unconnected health records. In order to address this issue, models are being developed to support data exchange for predictive analysis, risk assessment, and retrospective maternal health research. One such project is HL7's Longitudinal Maternal & Infant Health Information for Research. **This project, and projects like it, should be supported and provided with additional funding so that the necessary data linkage between individuals and their infant's health can be made and a holistic picture of the maternal mortality crisis can be achieved.**

To further aid in creating this holistic picture of maternal and infant health, Medicaid eligibility and claims data should be used, in conjunction with vital statistics and data from the Pregnancy Risk Assessment Monitoring System (PRAMS), to help review maternal and infant health data points that could indicate trends in care across Medicaid and CHIP. Moreover, **federal policies should support the expansion of the Pregnancy Mortality Surveillance System (PMSS)**. To aid in this, standards are needed to support physician collection of patient-identified race and ethnicity information to better detect inequities because better electronic health record (EHR) data in clinical settings and standardization across health systems is essential for meaningful and unbiased research.

Conclusion

The issues surrounding maternal health are deep-seated, multicultural, and systemically ingrained. The AMA believes it will require a holistic approach to ensure that birthing individuals and their children receive the care they need and deserve. While our recommendations, if implemented, will have a significant positive impact on maternal health across the nation, we remain committed to seeking solutions to broader SDOH issues that impact maternal health.

The AMA thanks the Committee for this hearing and for the careful consideration of solutions to improve maternal health outcomes across this country. We look forward to working with the Committee and Congress to help ensure that birthing individuals experience healthy pregnancies.

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

May 2, 2024

The Honorable Bernie Sanders
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC

The Honorable Bill Cassidy
Ranking Member
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to thank you both for your bipartisan leadership in addressing issues impacting family physicians and their patients through today's hearing entitled "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

The lack of a diverse physician workforce has significant implications for public health, including maternal health outcomes. Physicians who understand their patients and the larger context of culture, gender, religious beliefs, sexual orientation, and socioeconomic conditions are better equipped to address the needs of specific populations and the health disparities among them. Studies show that racial, ethnic, and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[i,ii] However, our current health care workforce does not accurately resemble our nation's diversity. For example, Black and Hispanic Americans account for nearly one-third of the U.S. population but just eleven percent of physicians.[iii,iv]

While physicians from racial and ethnic minorities are more likely to practice primary care, there is still significant work needed to develop a health care workforce that reflects the communities it serves. The AAFP believes that achieving a more diverse family medicine workforce is essential to improve patient outcomes and society's overall health, and it is with this in mind that we offer the following feedback to inform today's conversation.

Address the Maternal Health Crisis

The United States has one of the highest maternal mortality rates in the developed world. Recent studies have shown that U.S. maternal mortality rates have stagnated or even worsened over time, while rates around the globe continue to fall.[v] According to the World Health Organization, maternal mortality globally declined nearly 38% between 2000 and 2017.[vi] During roughly the same period, maternal mortality in the United States increased by over 26%. In the U.S., approximately 700 women a year die as a result of pregnancy or related complications, yet

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the vast majority (84%) are preventable.[vii]

Significant disparities exist when these rates are broken down across demographic groups, with higher rates of mortality occurring among Black women, low-income women, and those living in rural areas.[viii] The AAP believes family physicians can play a significant part in addressing the disparities in maternal morbidity and mortality because they are trained to provide comprehensive care across the life course, including prenatal, perinatal, and postpartum care for people in the communities where they live. More than one in ten family physicians (13%) reported they delivered babies in 2022.

The factors driving these disparities are complex and multi-faceted. They include but are not limited to access to and affordability of care, the intersection of demographic factors, and structural and systemic bias and discrimination. For example, the closure of rural hospitals and obstetrics programs has led to enormous gaps in access to prenatal and perinatal services for pregnant people living in rural communities. Between 2011 and early 2023, 217 hospital obstetric units closed, creating many maternity care deserts across the nation.[ix] In addition to the loss of facilities, there are compounding factors such as lack of transportation, increased poverty, increased rate of chronic diseases, and difficulty recruiting and retaining physicians to live and work in rural communities.

The AAFP has two courses to provide education and build skills focused on recognizing obstetrical emergencies. Advanced Life Support in Obstetrics (ALSO®) is a program that equips the entire maternity care team with skills to effectively manage obstetrical emergencies. Basic Life Support in Obstetrics (BLSO®) is designed to improve the management of normal deliveries, as well as obstetrical emergencies, by standardizing the skills of first responders, emergency personnel, and maternity care providers.

To further address this issue, the AAFP recommends that Congress pass the Rural Obstetrics Readiness Act (S. 4079), which would establish training programs to help non-specialists respond to obstetric emergencies. The bill would also provide grants for rural facilities to provide better equipment to train for and handle these emergencies and develop a pilot program for teleconsultation services so a maternal care expert can provide consulting services in an emergency.

Gaps in insurance coverage and availability of affordable care also increase the risk of morbidity and mortality, particularly during the postpartum period. We appreciate that Congress permanently extended the voluntary option for states to provide postpartum Medicaid coverage for up to a year in the Consolidated Appropriations Act of 2022. However, a permanent solution across all states is needed to ensure access to continuous care for pregnant people throughout the full, one-year postpartum period.

Current law only requires states to provide Medicaid coverage based on pregnancy status up to 60 days postpartum. As the largest single payer of maternity care in the U.S., covering 41 percent of births nationwide, Medicaid has a critical role to play in ensuring healthy moms and babies.[x] According to the Centers for Disease Control and Prevention, more than half (53%) of pregnancy-related deaths occur between one week and one year postpartum, during which time many postpartum individuals lose Medicaid coverage.[xi] The AAFP therefore continues to

advocate for requiring one year of postpartum Medicaid coverage as an important way to address the disparities in maternal health and improve outcomes. Specifically, **Congress should pass the Healthy Maternal and Obstetric Medicine (Healthy MOM) Act (S.3509 / H.R. 6716) to create a special enrollment period for marketplace plans for pregnant people and require states to offer Medicaid coverage to pregnant people up to 12-months postpartum.**

Further, the AAFP recognizes that the root causes of racial and ethnic disparities in maternal morbidity and mortality include institutional racism in the health care and social service delivery system and social and economic inequities. Implicit bias is pervasive among all health care professionals and has deleterious effects on patient health.[xii] It reduces trust, self-efficacy, understanding, and satisfaction between a patient and their physician, affecting a patient's ability to manage their health and adhere to treatment. For physicians, implicit bias limits their level of cultural proficiency, patient-centeredness, and job satisfaction.

Formal medical education and training curricula often lack content that provides a framework for identifying and mitigating implicit biases in clinical practice. Faculty who seek to incorporate this topic in training are often faced with barriers, such as the limited number of subject matter experts who can provide instruction, a lack of opportunities for participants to observe and demonstrate mitigation strategies in practice, and a lack of opportunities to engage with patients who can share experiences of encountering implicit bias in the delivery of prenatal care.

The implicit biases of health care professionals toward people of color, particularly Black women, have been shown to be a contributing factor to racial and ethnic disparities in adverse maternal health outcomes. For example, studies have demonstrated that implicit bias of health care professionals affects rates of racial and ethnic disparities in contraception use,[xiii] access to and quality of prenatal care,[xiv,xv] and clinical decision-making[xvi] in the intrapartum and postpartum periods.

Diversifying the Health Care Workforce

We know that a physician's background and upbringing influences where and how they practice. Evidence has shown that students from backgrounds currently underrepresented in medicine are more likely to care for underserved populations in their careers and are more likely to practice primary care.[xvii] We have also seen that these two factors compound, leading to more minority primary care physicians practicing in underserved communities. For example, Black, Native American, and Hispanic groups have higher proportions practicing in Health Professional Shortage Areas (HPSA), Medically Underserved Areas/Populations (MUA/P), and rural areas compared with White and Asian primary care physicians, who have smaller proportions practicing in these areas.[xviii]

Importantly, research has shown that patient satisfaction and health outcomes are improved when health care clinicians and their patients have concordance in their racial, ethnic, and language backgrounds.[xix] However, while primary care specialties lead other specialties in the representation of racial and ethnic minorities in the workforce, all of medicine lags significantly behind the racial and ethnic diversity of the U.S. population.[xx] It is critically important that federal policymakers prioritize opportunities to invest in and diversify our health care workforce to ensure better, more culturally component care for patients.

One federal program that has been successful at embedding physicians into underserved communities is the Teaching Health Center Graduate Medical Education (THCGME) program. THCGME is the only federal program that trains physicians and dentists in community-based settings focusing specifically on rural and underserved communities. It has trained more than 2,027 primary care physicians and dentists, 61% of whom are family physicians. However, the THCGME program's authorization expires at the end of this year, which further jeopardizes the stability of this program for its current and future residents as well as the patients they serve. Historically, the program has received piece-meal, short-term reauthorizations from Congress. This fails to consider the fact that family medicine residencies are three-year programs, meaning many medical students are dissuaded from applying to THC residencies because they have no certainty that the program will even be around long enough for them to complete their training. We have unfortunately seen this instability result in some THCGME programs accepting fewer or no new residents for next year or closing their program entirely.

For these reasons, the AAFP strongly cautions against a short-term extension. **Instead, the AAFP recommends that Congress pass the Doctors of Community (DOC) Act (H.R. 2569) to permanently authorize the THCGME program.** Absent a permanent solution, we urge Congress to, at a minimum, provide a multi-year reauthorization that provides sufficient funding levels to support the true per-resident costs to each program.

We also urge Congress to increase investment in Community Health Centers (CHCs), including a long-term authorization, to meet the health workforce needs of the underserved and to increase access to comprehensive primary care in our most vulnerable communities. CHCs, including Federally Qualified Health Centers and Rural Health Clinics, provide comprehensive primary care and preventive services to some of the most vulnerable and underserved Americans. Family physicians are the most common type of clinician (46%) practicing in CHCs and thus are well-positioned to ensure accessible and affordable primary care and reduce racial, ethnic, and income-based health disparities.[xxi] Research also shows that CHC-trained family physicians are more than twice as likely to work in underserved settings than their non-CHC-trained counterparts.[xxii]

Medical student loan debt remains one of the biggest barriers to diversifying our health care workforce. The average student loan debt for four years of medical school, undergraduate studies, and higher education is, on average, between $200,000 and $250,000 and will continue to increase as the cost of medical school continues to rise. That price tag alone can deter students from applying. For example, one report found that 18.2% of black high-school sophomores said they aspired to apply to medical school, but only 6.7% applied. For Hispanic high-school sophomores, 24.4% said they wanted to go to medical school but only 6.8% applied.[xxiii] Research has also shown that loan forgiveness or repayment programs directly influence physician's choices about whether to choose primary care specialties. While we appreciate Congress' recent efforts to help address health workforce shortages, additional action is needed to comprehensively address the current and projected primary care workforce shortages.

The Academy urges Congress to pass the bipartisan Resident Education Deferred Interest (REDI) Act (S. 704 / H.R. 1202), which would allow physicians and dentists to defer their loan payments interest-free through residency. After medical school, physicians

undergo several years of residency with very low pay (averaging around $60,000 in recent years), making it difficult for them to begin repaying loans immediately. The REDI Act would not forgive existing student loan debt. Rather, it is a very incremental but crucial first step to help address the financial burden that has dissuaded many individuals from pursuing careers in medicine or dentistry.

Additionally, the AAFP supports the National Health Service Corps (NHSC), which incentivizes physicians from diverse backgrounds to practice in underserved areas by providing scholarships and loan repayment. Nationwide, nearly 19 million patients are cared for by NHSC providers.[xxiv] We thank Congress for extending the authorization of the NHSC through the end of the year but urge for additional action. Specifically, **the AAFP encourages Congress to pass the Restoring America's Health Care Workforce and Readiness Act (S. 862), which includes a three-year reauthorization that would double the mandatory funding for the NHSC.** We have also supported proposals to allocate a set percent of NHSC funding for racial and ethnic minorities and students from low-income urban and rural areas.

Finally, we also ask Congress to move forward policies that would support international medical graduates (IMGs) practicing in the United States. IMGs play a vital role in caring for some of the most vulnerable populations in the U.S. as they are more likely to practice in rural, low socio-economic status, and non-white communities.[xxv] However, resident physicians from other countries working in the U.S. on J-1 visa waivers are currently required to return to their home country after their residency has ended for two years before they can apply for another visa or green card. The Conrad 30 Waiver Program allows these IMGs to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. **Congress must pass the Conrad State 30 & Physician Access Act (S. 665), which extends authorization for the Conrad 30 Waiver program for three years, improves the visa process, and allows for an increase beyond 30 waivers per state if states need additional doctors.**

We also support the Healthcare Workforce Resilience Act (S. 3211 / H.R. 6205), which would increase the number of visas available to physicians. Specifically, it would recapture 15,000 unused employment-based physician immigrant visas from prior years, thus enabling more IMGs to practice in communities across the country and ensuring more patients have access to the care they need.

It is imperative that Congress take steps to combat the maternal health crisis and support minority physicians. The AAFP looks forward to working with you and your colleagues to advance policies that will improve outcomes and address disparities by investing in a more diverse health care workforce. Should you have any questions, please contact Anna Waldman, Associate of Legislative Affairs, at awaldman@aafp.org.

Sincerely,

May 2, 2024

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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Statement for the Record Submitted by the Association of American Medical Colleges before the Senate Health, Education, Labor, and Pensions Committee hearing, titled "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"
May 2, 2024

The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit this statement for the record for the Senate Health, Education, Labor, and Pensions Committee's May 2, 2024, hearing, "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?" The AAMC appreciates the Committee's focus on increasing diversity in the health care workforce and addressing the maternal health crisis in the United States.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, 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, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

The United States is an increasingly diverse country that deserves a diverse workforce. The AAMC believes that diversity in medical education and training is an important component to helping ensure that all physicians are prepared to serve our diverse nation regardless of their race, ethnicity, socioeconomic status, or where they live. According to the AAMC Medical School Enrollment Survey, virtually all medical schools have specific programs or policies designed to recruit a more diverse student body.[1] The majority of respondents to that survey had established or expected to establish programs/policies geared toward students who are 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. In addition to these efforts, AAMC believes earlier, and greater intervention is necessary to diversify the physician workforce.

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

For myriad reasons, there has been limited progress in increasing the number of physicians from diverse perspectives and experiences including racial, ethnic, education, veteran status, and other 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 inconsistent access to quality education, beginning with pre-K, negatively affect diversity in the health care workforce. We must explore socioeconomic and geographic barriers that impede the pathway to medicine. We must also design bolder interventions to address the insufficient number of Black men and the near invisibility of American Indians and Alaska Natives in medical school and the physician workforce.

The AAMC is committed to significantly increasing the number of diverse medical school applicants and matriculants, and recently launched a new strategic plan that will take a multi-tiered approach with sustained investment, collaboration, and attention over time to significantly increase the diversity of medical students. Our goal is to continue 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 the 2023-2024 medical school class enrollees we saw:

- The number of American Indian or Alaska Native matriculants rose 14.7% and Hispanic, Latino, or of Spanish Origin matriculants increased 4.5% since 2022-23.
- Matriculants with a parent whose highest level of education was less than a bachelor's degree or any degree with an occupation categorized as "service, clerical, skilled, and unskilled" increased slightly (0.2%) over 2022-23, from 4,887 to 4,897.
- The number of first-generation matriculants increased 2.5% over last year, from 2,543 to 2,606.
- 171 matriculants are military veterans, an 11% increase over 2022-23.[2]

While these statistics are promising, the number of Black or African American matriculants remained stable, falling slightly by 0.1%, and Native Hawaiian or Other Pacific Islander matriculants fell 6.9% since last year. Black or African American students made up 10.0% of total matriculants in 2023-24, a slight decrease from 10.2% in 2022-23 but up from 8.4% in 2016-17. The AAMC is committed to using these data to inform our work to further diversify the physician workforce.

[2] 2023 Fall Applicant, Matriculant, and Enrollment Data Tables.
https://www.aamc.org/media/71336/download?attachment

For example, the AAMC has focused on finding solutions to addressing the dearth of Black men in medicine. In its 2015 report, Altering the Course: Black Males in Medicine, the AAMC found that the number of Black male medical students had actually declined over the previous four decades – from 542 in 1978 to just 515 in 2014. This was the first report to bring to light the decline in Black male applicants and matriculants. Recognizing that systemic change and collaboration across the education continuum are key to diversifying the physician workforce and improving health everywhere, the AAMC and the National Medical Association (NMA) created the Action Collaborative for Black Men in Medicine to address persistent barriers that Black men face.

We recognize that early interventions are needed and will focus our efforts on areas of the continuum where the AAMC and the NMA may have the greatest impact, which is from the last two years of high school through the first two years of medical school. The Action Collaborative recently partnered with Blue Cross Blue Shield of Illinois to create the Illinois Black Men in Medicine Innovation Grant, to fund up to five grants that are specifically allocated for projects focused on addressing systemic barriers that influence physician diversity and health equity in Illinois. The aim is to examine the root causes, such as institutional structures, policies, and cultural conventions, that impact the distribution of resources and opportunities.

The AAMC remains committed to the full scope of science, health care, social service, diversity, and preparing future generations to enter health professions. In 1989, we launched the Summer Health Professions Education Program (SHPEP), which is a free summer program for students to explore their interest in medicine, dentistry, nursing, optometry, pharmacy, physical therapy, public health, and more. The program is jointly funded by the Robert Wood Johnson Foundation, takes place at 12 partner institutions, and offers students a chance to develop competencies for becoming successful applicants to health profession programs, plan academic journeys, get clinical exposure, and network. Since its inception, SHPEP has had more than 30,000 alums and assisted 990 scholars being accepted into various medical programs; of those, 564 scholars qualified for a Federal Pell Grant, and 73.74% of scholars are from underrepresented backgrounds.

Ensuring a diverse and representative health care workforce can improve patient experiences and outcomes, address health disparities, and advance health equity. For example, some recent research shows that greater representation of Black physicians is associated with longer life expectancy and lower all-cause mortality among Black patients[3]. This is particularly true for pregnant patients, who face unique challenges and barriers to accessing timely and culturally informed care. These challenges are reflected in the statistics – the U.S. reports unacceptably high rates of maternal injury and death compared to its peer nations. The burden of our maternal health crisis is disproportionately borne by Black, American Indian, and Alaska Native women,

[3] Snyder, John E.; Upton, Rachel D.; Hassett, Thomas C.; Lee, Hyunjung; Nouri, Zakia; & Michael Dill. 2023. Black representation in the primary care physician workforce and its association with population life expectancy and mortality rates in the US. JAMA Network Open. 2023; 6(4):e236687. DOI:10.1001/jamanetworkopen.2023.6687.

who are more likely to die from pregnancy-related causes than their white counterparts, even after controlling for individual-level characteristics such as age, education, and socioeconomic status. To help address this crisis, we must cultivate a diverse and culturally competent maternity care workforce. In addition, we must address systemic barriers to care, including the ever-increasing prevalence of maternity care deserts in rural and underserved communities.

The AAMC believes that Congress can take the following actions to diversify the health care workforce and address the maternal health crisis:

- Significantly Increase Funding for HRSA Title VII and Title VIII Workforce Development Programs
- Protect the Existing Workforce
- Address Medical Education Debt and Promote Public Service
- Support Pathway to Practice
- Expand Graduate Medical Education
- Bolster the Maternity Care System
- Ensure Access to Coverage and Care
- Promote Whole-Person Health
- Foster Cross-Sector Partnerships
- Ensure Financial Support for Teaching Health Systems and Hospitals
- Support the Role of Medical Schools and Teaching Health Systems and Hospitals in Educating the Physician Workforce

Significantly Increase Funding for HRSA Title VII and Title VIII Workforce Development Programs

We recognize the value of diversity in health care and the health workforce, and we realize that diversity may take many different forms. The HRSA Title VII health professions and Title VIII nursing programs play an important role in connecting students to health careers by enhancing recruitment, education, training, and mentorship opportunities. Inclusive 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 communities.[4]

[4] 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.
Goodfellow A, Ulloa JG, Dowling PT, Talamantes E, Chheda S, Bone C, Moreno G. Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review. Acad Med. 2016 Sep;91(9):1313-21. doi: 10.1097/ACM.0000000000001203. PMID: 27119328; PMCID: PMC5007145.

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 pathway 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.[5] Title VII diversity pipeline programs reached over 22,998 students in the 2022-2023 academic year (AY), with HCOP reaching more than 4,805 disadvantaged trainees, SDS graduating nearly 2,613 students and COE reaching more than 4,512 health professionals – 77%, are also underrepresented minorities.[6] This success is even more impressive considering that only 21 schools have HCOP grants and only 26 have COE grants — down from 80 HCOP programs and 34 COE programs in 2005 before the programs' funding was cut substantially. One way for Congress to positively impact workforce diversity would be to provide additional funding for HCOP and COE health workforce programs.

There is broad agreement that there is a shortage of health providers in rural, frontier, and island or non-contiguous communities. Important to addressing shortages across the spectrum of health providers in these areas is conducting education and training in these communities and drawing on members of these areas to enter health professions. Medical students who grow up in rural communities are much more likely to return to these areas to practice medicine, including primary care. Many medical schools aim to identify potential candidates from rural communities and encourage them to pursue a career in medicine.[7] The HRSA Title VII Area Health Education Centers (AHECs) specifically focus on recruiting and training future physicians in rural areas, as

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[5] 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

[6] Health Resources and Services Administration. Department of Health and Human Services Fiscal Year 2025 Justification of Estimates for Appropriations Committees. budget-justification-fy2025.pdf (hrsa.gov) Accessed April 28, 2023.

[7] Attracting the next generation of physicians to rural medicine, Peter Jaret, Special to AAMCNews, Feb. 2020.

well as providing interdisciplinary health care delivery sites. Additionally, the HRSA Title VII Primary Care Training and Enhancement (PCTE) and Medical Student Education programs support education and training programs for future primary care physicians. The PCTEP funds new awards to support training for primary care physician assistants, and medical students' rotations in rural and underserved areas, that also integrate behavioral health conditions into primary care. Additionally, the MSEP provides grants to prepare and encourage medical students who are training in the most underserved states, to choose residencies and careers in primary care that serve rural communities, tribal communities, and/or medically underserved communities after graduation. Though we have seen progress toward diversifying the future physician workforce across the spectrum of our AAMC-member institutions, there is more work to be done.

The AAMC encourages increasing federal investment in minority-serving institutions (MSIs), including Historically Black Colleges and Universities (HBCUs), Predominantly Black Institutions (PBIs), Hispanic Serving Institutions, and Tribal Colleges and Universities. AAMC also supports the Expanding Medical Education Act (S. 3175/ H.R. 4985), which would authorize HRSA grants to establish or expand medical schools, including regional branch campuses, and would prioritize HBCUs and MSIs or those institutions that propose to establish or expand schools in medically underserved communities or areas with shortages of health professionals where no such schools exist.

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 2022-2023, the program trained 2,033 nursing students enrolled in degree programs or academic support programs, and 65% of the 2021-2022 graduates worked or trained in medically underserved communities one year later.[8]

For FY 2025, the AAMC leads an alliance of national organizations, the Health Professions and Nursing Education Coalition, in recommending $1.51 billion for FY 2025 for Title VII ($980 million) and Title VIII ($530 million), which would nearly double funding for the programs and would help HRSA address pressing health challenges, health inequities, and patients' evolving needs across America.

Protect the Existing Workforce

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

[8] *Id.*

nearly a third of medical faculty face one or more symptoms of burnout.[9] 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.

To that end, we ask Congress to reauthorize the HRSA Title VII Preventing Burnout in the Health Workforce program authorized by the Dr. Lorna Breen Health Care Provider Protection Act (P.L. 117-105). This historic bipartisan legislation, the Lorna Breen Health Care Provider Reauthorization Act (S. 3679, H.R. 7153), aims to reduce and prevent suicide, burnout, and mental and behavioral health conditions among healthcare workers. We must reauthorize this bill to ensure we are continuing to do what we can to prevent burnout and protect the well-being of our health care workforce.

The AAMC urges Congress to take action to protect health care workers by passing the bipartisan Safety from Violence for Healthcare Employees (SAVE) Act (S. 2768/ H.R. 2584). Violence should have no place in the health care setting. Recent studies reveal that health care workers are five times more likely to experience physical attacks on the job compared to other workers.[10] Moreover, 44% of nurses have reported experiencing physical violence and 68% reported verbal abuse in the workplace.[11] These incidents of violence have far-reaching consequences, including disrupting and delaying care in hospitals, demoralizing staff, and complicating efforts to attract and retain health care workers. This situation strains health care systems, particularly in regions already facing worker shortages, such as rural and other underserved communities, by increasing delays, workloads, and operational costs.

The SAVE Act would address the aforementioned crises by providing federal-level protections for health care workers subjected to workplace violence like those protections afforded to airline and airport workers. This includes criminalizing assault and intimidation against health care workers under federal law, creating a safer work environment by deterring violent behavior, and ensuring that offenders face appropriate consequences. Enacting this legislation is pivotal for protecting health care workers, who have selflessly cared for patients throughout the COVID-19 pandemic and beyond.

Address Medical Education Debt and Promote Public Service

The AAMC continues to support a variety of federal programs aimed at easing the impact of medical education debt and urges Congress to provide robust support for these programs.

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[9] Dandar, V. M., Grigsby, R. K., & Bunton, S. A. (2019). Burnout Among U.S. Medical School Faculty. AAMC Analysis in Brief. Retrieved from:
https://www.aamc.org/system/files/reports/1/february2019burnoutamongusmedicalschoolfaculty.pdf

[10] U.S. Bureau of Labor Statistics. Fatality data are from the Census of Fatal Occupational Injuries. Nonfatal injury and illness data are from the Survey of Occupational Injuries and Illnesses.
https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm

[11] Byon HD, Sagherian K, Kim Y, Lipscomb J, Crandall M, Steege L. Nurses' Experience With Type II Workplace Violence and Underreporting During the COVID-19 Pandemic. *Workplace Health & Safety*. 2022;70(9):412-420. doi:10.1177/21650799211031233

Medical education costs can also be a significant deterrent and burden for individuals interested in medicine, and the AAMC is deeply concerned about the impact these costs may have on the physician pathway.[12] Medical school leaders across the country are committed to serving the interests of medical students and reducing this burden. Some institutions have increased institutional aid, while a few have committed to eliminating debt or tuition altogether in the hopes of attracting diverse candidates and increasing interest in primary care.[13] In the 117th Congress, the AAMC endorsed the National Medical Corps Act (H.R. 9105) scholarship program to help address the financial debt burden for students who are underrepresented in medicine.

Public service loan repayment programs offered by HRSA, the National Institutes of Health, 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 Health Professional Shortage Areas (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. 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 National Health Service Corps (NHSC) in particular has played a significant role in recruiting primary care physicians to federally-designated HPSAs through scholarships and loan repayment options. Despite the NHSC's success, it still falls far short of fulfilling the wide-ranging health care needs of all HPSAs due to the growing demand for health professionals across the country. Congress provided a historic $800 million supplemental NHSC funding under the American Rescue Plan, and we believe this will have a positive impact. Nevertheless, additional funding for the NHSC is needed.

Immigration must be mentioned as we consider health workforce shortages, as the US health workforce has been bolstered by individuals who have come from other countries to our nation. Over the last 15 years, the State Conrad 30 J-1 visa waiver 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. The AAMC-supported bipartisan Conrad State 30 and Physician Access Reauthorization Act (S. 665/H.R. 4942) would allow Conrad 30 to expand beyond 30 waivers 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 the growth of the physician workforce.

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[12] Physician Education Debt and the Cost to Attend Medical School: 2020 Update.
[13] Will free medical school lead to more primary care physicians? Ken Budd, Special to AAMCNews, Dec. 2019.

Support Pathway to Practice

The AAMC supports a proposal championed by House Ways and Means Committee Ranking Member Rep. Richie Neal (D-MA) in the 117th Congress, the Pathway to Practice Program. This new program would enable medical and postbaccalaureate students from rural and other disadvantaged communities who are underrepresented in the physician workforce to receive support earlier in the medical education pathway and throughout residency training. It would provide scholarships for tuition and other fees to underrepresented and economically disadvantaged students planning to attend medical school, or students participating in postbaccalaureate programs with the intention of applying to medical school. As terms of participating in the scholarship program, a student would be required to practice a year in a medically underserved area after residency for each year they receive the scholarship. Scholarship recipients who complete their residency at teaching hospitals with recognition by the Accreditation Council for Graduate Medical Education for certain training activities related to health equity would be exempt from the teaching hospital's graduate medical education (GME) cap. Importantly, the Pathway to Practice program prioritizes students who attended HBCUs, MSIs, or who participated in HRSA diversity pathway programs.

Expand Graduate Medical Education

The AAMC continues to project that physician demand will grow faster than supply (primarily driven by a growing, aging U.S. population) leading to a projected total physician shortage of up to 86,000 physicians by 2036. Make no mistake – these shortages in the physician supply will have real impact on patients, particularly those living in rural, frontier, island or non-contiguous settings, and other already underserved communities. Additionally, the AAMC's "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 U.S. would need an additional 117,100 to 202,800 physicians just to meet *current* demand.[14]

Addressing the nation's physician workforce shortages in both primary care and among needed specialists requires a multipronged, innovative, public-private approach beyond just increasing the overall number of physicians, such as implementing team-based care and better use of technology. We are open to and in fact, ask for, innovative solutions to address health workforce shortages. Since the academic year 2002-2003, total medical school enrollment has grown by more than 38% as medical schools have expanded class sizes and more than 32 new medical schools have opened. While this increase is encouraging, additional action is needed to address the physician shortage.

Growth in GME or residency training is also needed to address projected physician shortages. Dating back to 1997, Congress placed a cap on the number of GME positions Medicare supports at each teaching hospital.[15] According to an analysis of FY 2021 Medicare Cost Report data,

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[14] The Complexities of Physician Supply and Demand: Projections From 2021 to 2036, Prepared for the AAMC by IHS Markit Ltd., March 2024.
[15] P.L. 105-33.

there are approximately 125,238 medical trainees in GME positions. Medicare provides support for only 93,885 of those medical trainees at or below the direct GME (DGME) cap established in 1997. According to the same cost report analysis, the average actual cost per medical trainee for a facility was $184,313, while the average actual Medicare DGME payment per resident was only $53,823.[16] The majority of the difference in the cost to train and the Medicare DGME payment must be shouldered by the clinical revenue at a teaching hospital and given the financial solvency issues facing many of these facilities, funding to train residents is another challenge.

One key element of addressing the physician shortage and diversifying the workforce is increasing Medicare support for GME, which will help boost access to high-quality care, particularly for rural and other underserved populations. The AAMC strongly supports the Resident Physician Shortage Reduction Act of 2023 (S. 1302/H.R. 2389), which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new positions. These new GME positions would target teaching hospitals with varied 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 residents in excess of their Medicare caps. The legislation has broad stakeholder support and has been endorsed by over seventy members of the GME Advocacy Coalition, which represents a broad range of disciplines. Additionally, this bipartisan legislation directs the Comptroller General of the United States to conduct a study and issue a report on strategies for increasing the diversity of the health professional workforce.

GME programs administered by HRSA, including Children's Hospitals GME and Teaching Health Centers, are important complements to Medicare GME that help to increase the number of residents training in children's hospitals and community health centers, respectively. To facilitate new rural residency programs, the HRSA Office of Rural Health Policy provides technical assistance and start-up funding to rural hospitals under the Rural Residency Planning and Development programs. Funding for these programs at HRSA specifically targeting GME at children's hospitals and teaching health centers, and rural areas will have an impact on the physician workforce shortage in those settings.

The AAMC also recommends that Congress pass the Rural Residency Planning and Development Act of 2024 (H.R. 7855). While additional physician training programs and increased Medicare support for graduate medical education are fundamental to addressing the physician shortage, we believe that it is imperative to provide teaching hospitals with the resources that they need to develop more rural training programs. Sponsoring and supporting physician training is a barrier unto itself, but starting new residency programs is also particularly difficult due to obstacles associated with recruiting and developing faculty, recruiting and training residents, securing and maintaining accreditation, and developing curriculum. The Rural

[16] AAMC Analysis of FY2021 Medicare Cost Report data, July 2023 Hospital Cost Reporting Information System (HCRIS) release. If FY2021 data is not available, FY2020 data is used.

Residency Planning and Development Act of 2024 codifies an existing, effective federal grant program that provides funding for the startup costs associated with residency programs in rural areas. From 2019 to 2023, the program funded the development of 39 new accredited rural residency or rural track programs across 36 states.[17] This translates to 521 new residency positions in rural areas. Not only are these positions already producing physicians, but as part of the program, the Health Resources and Services Administration has provided key technical assistance to teaching hospitals to aid in the development of new residency programs. While no Senate bill has yet been introduced, the AAMC recommends that the Committee consider introduction and passage of this legislation.

In addition to diversifying the health care workforce, we encourage the committee to consider the following recommendations to address the maternal health crisis:

Bolster the Maternity Care System

Nationally, over 98% of live births occur in a hospital setting, and therefore, hospital financial challenges and related closures significantly contribute to the maternal health crisis.[18] Mounting financial difficulties stemming from insufficient reimbursement, workforce shortages, and rising costs have forced many hospitals across the country to shutter their maternity care units, or else close entirely. These closures seriously endanger the health and safety of pregnant patients, especially those living in rural and underserved communities. According to the American Hospital Association, between 2015 and 2019, there were at least 89 obstetric unit closures at U.S. rural hospitals, forcing patients to travel further distances to receive medically necessary prenatal and postpartum care.[19] Additionally, research shows that obstetric unit closures disproportionately harm Black patients, who already face an elevated risk of injury and death in giving birth.[20]

The closure of hospital-based maternity wards has contributed to the emergence of "maternity care deserts," defined as counties without a hospital or birth center offering obstetric care. In 2022, over 2.2 million women of childbearing age lived in a maternity care desert, and this challenge is expected to worsen in the coming years due to the profound financial pressures facing hospitals.[21] To address this challenge and ensure continued access to care for pregnant patients, Congress must provide adequate financial support for the maternity care system,

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[17] Rural Residency Planning and Development Program. Health Resources and Services Administration. https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd

[18] MacDorman, Marian F., and Eugene Declercq. "Trends and state variations in out-of-hospital births in the United States, 2004–2017." Birth 46, no. 2 (2019): 279–288.

[19] https://www.aha.org/system/files/media/file/2022/04/Infographic-rural-health-obstetrics-15ap22.pdf

[20] McGregor AJ, Hung P, Garman D, Amutah-Onukagha N, Cooper JA. Obstetrical unit closures and racial and ethnic differences in severe maternal morbidity in the state of New Jersey. Am J Obstet Gynecol MFM. 2021 Nov;3(6):100480. doi: 10.1016/j.ajogmf.2021.100480. Epub 2021 Sep 5. PMID: 34496307.

[21] Brigance, C., Lucas R., Jones, E., Davis, A., Oinuma, M., Mishkin, K. and Henderson, Z. (2022). Nowhere to Go: Maternity Care Deserts Across the U.S. (Report No. 3). March of Dimes. https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx

including both hospitals and community-based providers. To this end, we urge Congress to reject harmful and misguided cuts to hospital outpatient departments, preserve and strengthen the 340B Drug Pricing Program, eliminate scheduled reductions to the Medicaid Disproportionate Share Hospital Program, and update hospital payments to account for inflation. Together, these critical programs help to ensure the long-term financial sustainability of teaching health systems and hospitals, thereby allowing these providers to continue to serve pregnant patients and their families.

Ensure Access to Coverage and Care

The AAMC supports policies to expand access to robust and affordable insurance coverage for parents, families, and infants. Medicaid, which finances over 40 percent of all births in the U.S., plays a critical role in supporting the health of pregnant patients.[22] The Affordable Care Act (ACA) has dramatically expanded access to coverage by incentivizing states to extend Medicaid eligibility to additional individuals. Research shows that Medicaid expansion is associated with improved health outcomes for both parents and infants, including lower rates of maternal and infant mortality, reduced risk of pre-term birth and low birth weight, and fewer hospitalizations during the early postpartum period. Unfortunately, in the remaining states that have failed to adopt Medicaid expansion, nearly 2 million people fall into the "coverage gap," meaning that their income is above the state's Medicaid eligibility threshold but below the poverty line, making them ineligible for subsidies in the ACA Marketplaces.[23] To address this challenge, the AAMC supports policies that incentivize states to adopt Medicaid expansion, including continued access to enhanced federal matching funds for new expansion states.

The one-year postpartum period is an especially risky time for patients, who may develop serious health complications, such as cardiovascular disease or behavioral health conditions. Despite these risks, a shocking percentage of postpartum patients report that they do not receive recommended care. Access to coverage is a key predictor of a patient's likelihood of receiving postpartum care. Although current federal statute requires that states provide just 60 days of postpartum Medicaid coverage, Congress and the administration recently provided states with the permanent option to extend coverage to 12 months postpartum. To date, 46 states and the District of Columbia have chosen to extend postpartum coverage.[24] While the AAMC applauds this progress, we urge Congress and the administration to continue to build on this momentum and advance policies that promote universal access to coverage. This includes maintaining

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[22] Osterman, Michelle J. K., et al. "Births: Final Data for 2020." National Vital Statistics Reports 70, no. 17 (2022). https://stacks.cdc.gov/view/cdc/112078.

[23] Rudowitz, Robin, et al. "How Many Uninsured Are in the Coverage Gap and How Many Could Be Eligible If All States Adopted the Medicaid Expansion?" Kaiser Family Foundation, March 31, 2023. https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-manycould-be-eligible-if-all-states-adopted-the-medicaid-expansion/.

[24] "Medicaid Postpartum Coverage Extension Tracker." Kaiser Family Foundation, January 17, 2024. https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/ 14 Jaffery, Jonathan. Advancing Interoperability and Improving Prior Authorization Processes [CMS-0057P]. Letter. Washington, DC: Association of American Medical Colleges (AAMC), 2023. https://www.aamc.org/media/65416/download.

coverage gains made during the COVID-19 pandemic by permanently extending enhanced premium subsidies provided by the American Rescue Plan Act of 2021 (P.L. 117-2), which are due to expire at the end of this year. These policies are critical to ensuring access to affordable coverage for pregnant patients, especially given the profound economic stress facing patients and families.

The AAMC also recognizes that coverage alone does not guarantee access to care for pregnant patients. Barriers imposed by insurers, including administratively burdensome prior authorization requirements, can reduce patients' access to care and contribute to provider burnout. This is particularly concerning in the context of maternity care, as prior authorization requirements can limit patients' access to time-sensitive diagnostic and treatment procedures, such as genetic testing. To address this challenge, the AAMC has urged Congress to scrutinize prior authorization practices and CMS to prohibit prior authorization for maternal care during the prenatal and one-year postpartum period.[25] To support continuity of care during this critical window, the AAMC also recommends requiring payers to honor prior authorization approvals issued by a previous payer during pregnancy and for one year postpartum. This policy would ensure that pregnant and postpartum patients have continued access to medically necessary care, regardless of whether their source of coverage has changed.

Promote Whole-Person Health

Perinatal behavioral health conditions, including depression and anxiety, are the most common complications of pregnancy and childbirth. An estimated one in five women experience these conditions, but few receive treatment.[26] Left untreated, perinatal behavioral health conditions can be deadly: suicide and overdose are the leading causes of pregnancy-related death in the one-year postpartum period.[27] The AAMC is committed to raising awareness of this troubling problem and empowering our members to expand access to mental and behavioral health services for pregnant patients and their families. We are proud to be part of Mind the Gap, a national coalition convened by Postpartum Support International that aims to increase screening, diagnosis, and treatment of maternal mental health conditions.

Through our strategic plan, the AAMC works to accelerate the coordination and integration of physical and behavioral health care. Integrated behavioral health (IBH) models involve a multi-disciplinary team of medical and behavioral health providers working together to address the

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[25] Jaffery, Jonathan. Advancing Interoperability and Improving Prior Authorization Processes [CMS-0057P]. Letter. Washington, DC: Association of American Medical Colleges (AAMC), 2023. https://www.aamc.org/media/65416/download.

[26] "Launch of the WHO guide for integration of perinatal mental health in maternal and child health services." World Health Organization, September 19, 2022. https://www.who.int/news/item/19-09-2022launch-of-the-who-guide-for-integration-of-perinatal-mentalhealth#:~:text=Almost%201%20in%205%20women,undertake%20acts%20of%20self%2Dharm.

[27] Trost SL, Beauregard J, Njie F, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017-2019. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2022.

medical, behavioral, and social factors that affect a patient's health and well-being. These models, which can be embedded into both primary and specialty care settings, are a proven strategy to reduce the stigma surrounding mental health services and expand access to care, particularly for historically under-resourced patients. The AAMC believes that behavioral health integration is an effective strategy to improve pregnant and postpartum patients' access to mental health and substance use disorder services. To promote the adoption of these care models, the AAMC urges Congress and the administration to invest in sustainable financing mechanisms that incentivize same-day care and ensure the long-term financial viability of behavioral health integration.[28]

Foster Cross-Sector Partnerships

The AAMC recognizes that non-clinical factors, including access to safe and affordable housing, reliable transportation, nutritious food, and a healthy environment, play an important role in a person's health. As anchor institutions in their communities, academic medical centers are well-positioned to forge federal, state, and local community partnerships to address these social determinants of health. Every day, our members collaborate with communities to ensure that all people have the opportunity to reach their full health potential — a state of health equity.

To address this challenge, the AAMC supported the bipartisan Social Determinants Accelerator Act in the 117th Congress. This legislation would authorize an interagency technical advisory panel on the social determinants of health (SDOH) and create planning grants for state, local, and tribal governments to establish accelerator programs addressing SDOH. We encourage the reintroduction and swift enactment of this legislation as a first step in addressing the social drivers of maternal and child health inequities.

The AAMC understands that the availability of robust and comprehensive sociodemographic data is critical to identifying and addressing maternal health inequities. Per the AAMC Center for Health Justice's Principles of Trustworthiness, we believe that peoples' lived experiences with pregnancy and childbirth are integral to the research process, and therefore, data collection, analysis, and dissemination should be undertaken in partnership with the individuals and communities most impacted by maternal health inequities. For data to be useful and meaningful to these communities, researchers should strive to share their findings with pregnant patients, community members, and other relevant stakeholders. Transparent, comprehensive, and inclusive data can help researchers, providers, and policymakers understand who is most susceptible to maternal injury and death.

Maternal mortality review committees (MMRCs) are a powerful tool for understanding the root causes of pregnancy-related deaths. The committees, which are comprised of representatives from public health, medicine, and the community, analyze available data to identify and characterize pregnancy-related deaths, as well as recommend prevention measures. MMRCs help

[28] Focusing on Mental and Behavioral Health Care. Washington, DC: Association of American Medical Colleges (AAMC), 2022. https://www.aamc.org/media/61651/download

researchers, policymakers, and communities understand and address the key drivers of maternal deaths and disparities. To support these life-saving efforts, the AAMC endorses the Preventing Maternal Deaths Reauthorization Act of 2023 (H.R. 3838/S. 2415), which would reauthorize federal support for state-based MMRCs through fiscal year 2028. Absent congressional action, authorization for these programs is set to expire at the end of the current fiscal year 2024.

The AAMC also endorses the Data to Save Moms Act (S. 1599), which would expand data collection and research on maternal morbidity and mortality among communities of color. Under the legislation, the Secretary of the Department of Health and Human Services may furnish grants to MMRCs to support engagement with local communities, such as by inviting and supporting committee participation by community members with under-represented perspectives and experiences.

Ensure Financial Support for Teaching Health Systems and Hospitals

The AAMC remains committed to working with the HELP Committee and Congress to enhance and diversify the health care workforce. We continue to support efforts to increase the number of health care providers to address projected shortages and look forward to ongoing work with Congress to this end. However, we must also urge the Committee to avoid counterproductive proposals that would jeopardize patient access to care, drastically cut payments to teaching health systems and hospitals, weaken the nation's public health infrastructure, and ultimately harm the patients and communities our members serve.

Support the Role of Medical Schools and Teaching Health Systems and Hospitals in Educating the Physician Workforce

Each medical school is responsible for establishing a medical education program that is aligned with its mission and is designed to achieve its stated educational objectives within the framework of the accreditation standards of the Liaison Committee on Medical Education (LCME). Among the standards that LCME outlines is an expectation that "the medical curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine." In accordance with this expectation and in light of the dynamic health care environment, the content of a medical education program is continually revised to reflect scientific advancements, medical breakthroughs, changes in health care delivery systems, and other issues affecting patients' health. For example, as scientific knowledge increases, many diseases that were once acute conditions are now chronic illnesses that can be managed over time. Accordingly, medical education is evolving to reflect these shifts. Similarly, while maintaining and augmenting a sound fundamental basic science and clinical curriculum, the faculty of LCME-accredited medical education programs have incorporated topics and themes such as geriatrics, pain management, palliative care, disease prevention and health promotion, population health, addiction, communication skills, social determinants of health, emergency preparedness, and medical informatics in their medical education programs. The LCME, which is recognized by the U.S. Department of Education as the reliable authority for the accreditation of medical education

programs leading to the M.D. degree in the United States, is the appropriate body to set and assess standards with respect to the medical education curriculum. The LCME standards are carefully designed and regularly updated to ensure that the graduates of all LCME-accredited programs possess the general professional competencies required for proficient medical care.

Congress should reject any efforts to legislate the content, structure, and administration of medical education programs, and instead should support the medical and educational expertise that has developed a medical education system and physician workforce that is the world's gold standard.

Conclusion

The AAMC remains committed to working with Congress to increase the diversity of the physician workforce and improve maternal health. If you have any further questions, please contact AAMC Chief Public Policy Officer Danielle Turnipseed, at dturnipseed@aamc.org, or AAMC Senior Director of Government Relations and Legislative Advocacy Len Marquez at lmarquez@aamc.org.

Written Testimony

Of

The American College of Obstetricians and Gynecologists

Before the

U.S. Senate Committee on Health, Education, Labor, and Pensions

Regarding

What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?

May 2, 2024

Chair Sanders, Ranking Member Cassidy, and distinguished members of the Senate Committee on Health, Education, Labor, and Pensions, thank you for the opportunity to provide this statement for the record on behalf of the American College of Obstetricians and Gynecologists (ACOG). ACOG is the foremost professional membership organization for obstetrician-gynecologists, representing more than 60,000 physicians and partners dedicated to advancing women's health. Addressing the ongoing maternal health crisis, including through a diversified obstetrician-gynecologist workforce, is core to our mission at ACOG. We appreciate the Committee's attention to the interconnected issues of maternal health and increasing minority representation among the health care workforce during today's hearing.

The maternal mortality rate in the United States is the highest among wealthy nations and continues to rise. In 2021, there were 32.9 maternal deaths per 100,000 live births, up from 23.8 in 2020 and 20.1 in 2019.[i] Black women and Indigenous women are two to three times more likely to die from pregnancy-related causes than non-Hispanic white women.[ii] Additionally, for every maternal mortality there are an estimated 20-30 cases of severe maternal morbidity, which the Centers for Disease Control and Prevention describes as "unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health."[iii,iv] Examples of conditions classified as severe maternal morbidity when occurring during or shortly after pregnancy include hemorrhage, eclampsia, heart attack, heart failure, kidney failure, sepsis, aneurysm, and a host of other serious and life-threatening conditions.[v]

At ACOG, our work is driven above all by a commitment to eliminating preventable maternal mortality and severe maternal morbidity among our patients. This is a multifactorial crisis that requires multifactorial solutions. Given the racial inequities in maternal health outcomes described above, meaningfully addressing maternal mortality and morbidity

necessitates obstetrician-gynecologists reckoning with the racial inequities present in our field, including the history of racism in the founding of obstetric and gynecologic practice and persistent social drivers of health creating barriers to care. In 2022, ACOG developed a framework referred to as the Collective Action Against Racism that includes a commitment to increase organization membership and leadership from historically marginalized communities and increase representation and inclusion at all levels of the professional journey for obstetrics and gynecology.[vi] Among all practicing physicians, only 5.2% are Black or African American, 6.3% are Hispanic, and 0.3% are American Indian or Alaska Native (AI/AN).[vii] Between 2014 and 2019, the proportion of new obstetrics and gynecology residents identifying as Black declined from 10.2% to 7.9%, while new Hispanic and AI/AN residents remained consistently low, changing from 9.6% to 10.1% and 0.2% to 0.1%, respectively.[viii] Studies suggest that among Black patients, communication, satisfaction, trust, and adherence to medical advice may be improved if there is racial concordance with the physician.[ix] Promoting an obstetrician-gynecologist workforce reflective of the population at large is pivotal to addressing the maternal health crisis and will require a coordinated effort between the medical community and governmental institutions.

ACOG has been encouraged by recent Congressional actions aimed at diversifying the maternal health workforce. For example, the **Perinatal Workforce Act (S. 1710)**, introduced by Senators Tammy Baldwin and Jeff Merkley and part of the **Black Maternal Health Momnibus Act (S. 1606)**, would make important investments in programs to expand and diversify the maternal health workforce, study the benefits of culturally congruent care, and study the barriers that prevent women from underserved communities from pursuing careers in maternal health. Other proposals that would incentivize individuals from marginalized backgrounds to become

physicians, such as the **Resident Education Deferred Interest (REDI) Act (S. 704)** to allow interest-free loan deferrals for medical residents, should also be considered.

At the same time, we are discouraged by actions we consider antithetical to the goal of improving maternal health through a diversified health care workforce. A recent bill introduced in the U.S. Senate would penalize medical schools that implement diversity, equity, and inclusion (DEI) policies and programs, which would not only suppress enrollment of medical students from diverse backgrounds but deny all future physicians the opportunity to be the best clinicians they can be through a culture of equitable, culturally competent care. ACOG was similarly discouraged by the June 2023 Supreme Court decision disallowing affirmative action programs in higher education. As with misguided efforts to eliminate DEI from medical school curriculum, erecting new barriers to medical school for racial minorities has the potential to reduce the future quality of care for our nation's most marginalized patients, including women of color who suffer disproportionately from maternal mortality and severe maternal morbidity. It is ACOG's sincere hope that proposals attacking DEI are rejected in favor of proactive efforts to sustain a robust pipeline of physicians from a wide range of backgrounds.

ACOG also encourages the Committee to examine barriers to established obstetrician-gynecologists maintaining their practices, particularly in rural and underserved areas. Insufficient reimbursements for obstetric services, particularly under state Medicaid programs, contribute to obstetrician-gynecologist practices closing and hospitals eliminating labor and delivery units. Repeated cuts to the Medicare Physician Fee Schedule conversion factor have downstream impacts on state Medicaid programs that use Medicare rates as benchmarks and typically only reimburse at a fraction of Medicare. ACOG appreciates that Congress partially mitigated cuts to Medicare physician reimbursements each of the past several years, but strongly supports

legislation to tie reimbursements to the Medicare Economic Index going forward, as proposed by the **Strengthening Medicare for Patients and Providers Act (H.R. 2474)** in the U.S. House of Representatives.

If the costs of providing obstetric services continue to exceed the reimbursements for such services, maternity care deserts, which already comprise an estimated 36% of U.S. counties, will continue to expand.[x] Nearly half of counties do not have a single practicing obstetrician-gynecologist and more than 200 rural hospitals stopped providing obstetric services during the past decade.[xi,xii] In rural areas, loss of hospital based obstetric services is associated with higher rates of out-of-hospital births and preterm births and lower use of prenatal care services.[xiii] Deliveries and management of life-threatening obstetric complications may occur in rural settings without dedicated obstetric units, health care professionals trained in obstetrics, or the necessary equipment. Rural residents most deeply impacted by inaccessible obstetric care include racial minorities, who make up nearly one-quarter of rural residents as of the 2020 Census.[xiv] Ensuring rural, non-obstetric care settings are prepared to manage obstetric emergencies is an important piece of a comprehensive strategy to improve maternal health outcomes in the United States. ACOG is an enthusiastic supporter of the **Rural Obstetrics Readiness Act (S. 4079)**, introduced by Senators Maggie Hassan, Susan Collins, Katie Britt and Tina Smith, to provide training and resources to non-obstetric clinicians and facilities for this purpose. Of note, a 2016 study found that obstetrician-gynecologists from underrepresented minorities in medicine, which include physicians identifying as Black, Hispanic, Native American, Alaska Native, or Pacific Islander, were more likely to practice in underserved areas and areas with poverty rates greater than 20%.[xv] This finding suggests that successful efforts to

increase the number of physicians from underrepresented backgrounds could help alleviate obstetrician-gynecologist shortages in rural areas.

The assaults on evidence-based medicine following the decision in *Dobbs v. Jackson Women's Health Organization* underscore the maternal health and obstetrician-gynecologist workforce crises. It is ACOG's firm position that access to the full spectrum of medical care, including abortion, is essential for people's health, safety, and well-being. State laws that ban or severely restrict access to abortion put the health and lives of pregnant patients at risk and influence decisions about where to practice medicine. Areas of the country that already have the least access to obstetrician-gynecologists and the highest rates of maternal mortality often overlap with the areas with the most stringent abortion restrictions.[xvi,xvii,xviii] We urge Congress not to interfere in the practice of medicine, and instead seek opportunities to increase access to obstetric and gynecologic care for all who may need it.

Thank you, again, for the opportunity to provide ACOG's perspective on these important topics. We look forward to serving as a partner and resource on future efforts to improve maternal health, promote minority representation in the health care workforce, and increase access to obstetrician-gynecologists nationwide.

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[xii] Addressing the crisis in rural maternity care. Center for Healthcare Quality & Payment Reform. Accessed May 1, 2024. https://chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf

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BlueCross BlueShield Association

750 9th Street NW
Washington, D.C. 20001-4524
202.626.4800
www.BCBS.com

Statement for the Record
Submitted to U.S. Senate Committee on Health, Education, Labor and Pension
"What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"
May 2, 2024
By: David Merritt, Senior Vice President of Policy and Advocacy

The Blue Cross Blue Shield Association (BCBSA) believes everyone should have access to affordable, high-quality health care, and we are committed to changing the trajectory of health disparities and building a more equitable health care system — for everyone. We commend Chairman Bernie Sanders (I-VT) and Ranking Member Bill Cassidy, M.D. (R-LA) for holding this important hearing to explore opportunities to expand our workforce and improve maternal health care.

BCBSA is a national federation of independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans). Our Plans collectively cover, serve and support 1 in 3 Americans in every ZIP code across all 50 states, Puerto Rico and Washington, D.C. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer or purchase coverage on their own.

The overall maternal death rate in the U.S. is worse than any other comparable country and is substantially worse for Black women, who are three times more likely than white women to die from pregnancy-related complications. That is a travesty. And this disparity exists regardless of education level, socioeconomic status, age, geography and type of health care coverage.[1] These indefensible outcomes point to deep-seated challenges, like underlying chronic conditions, racial inequities and bias within the health care system, that must be addressed systemically and across a woman's life.

The lack of diversity in the health care workforce is a key contributor to health care disparities, in both rural and urban communities. There is substantial evidence showing that the current health care workforce does not reflect the diverse communities that it serves. Patients are more likely to seek care

[1] "Working Together to Reduce Black Maternal Mortality." Centers for Disease Control and Prevention, April 8, 2024. https://www.cdc.gov/healthequity/features/maternal-mortality/index.html.

and feel more comfortable when they have access to health care professionals who reflect their racial, ethnic and cultural characteristics.[2] Cultural awareness and sensitivity in the workforce impact the effectiveness of communications and interactions with patients and among health care professionals, which in turn can improve patient outcomes.[3]

Training and education are key to expanding and diversifying our health professional workforce. These are genuine opportunities for fulfilling, inspiring and impactful work. However, the training landscape — its standards, curricula and infrastructure — must be better developed, standardized and resourced to ensure equitable training and schooling. We must consider how to help a more diverse group of students find access to high-quality training so they can meet the full scope of our workforce needs. Specifically, Congress should take the following actions:

- **Fund and support K-12 STEM education pipeline programs**. These could include the federally funded Health Career Opportunities Program, academic readiness programs to support students going on to college or postgraduate programs and ensuring multiple educational pathways exist to help individuals from minority and underrepresented populations enter health care professions.
- **Incentivize post-secondary school partnerships.** Congress should support incentives for community colleges, universities and graduate medical schools to partner with under-resourced urban and rural school systems to establish K-12 health sciences academies.

These opportunities can expand access and enhance availability of racially and ethnically concordant care, but so, too, can the expanded use of non-physician providers across the medical and behavioral health spectrum.[4] The non-physician workforce is diverse across gender, race and ethnicity, immigrant status, parental status and level of education. Research also has shown that care from non-physician practitioners benefits patient outcomes and plays a valuable role in optimizing health care services.[5] To expand this workforce, Congress and the administration should establish grants and scholarships for accredited education programs aimed at increasing diversity among the non-physician workforce, including community health workers, patient navigators, home health aides, physician assistants, advanced practice registered nurses and physical/occupational/respiratory/speech therapists.
In addition, BCBSA and BCBS Plans continue to advocate for passage of the following bills targeted at improving the maternal health workforce and health outcomes for mothers and babies:

- **S.2415/H.R. 3838, *the Preventing Maternal Deaths Reauthorization*,** introduced by Senators Shelley Moore Capito (R-WV) and Raphael Warnock (D-GA), would support states in preserving

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[2] Junko Takeshita, MD. "Racial/Ethnic and Gender Concordance between Patients and Physicians and Patient Experience Ratings." JAMA Network Open, November 9, 2020. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772682.
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[5] Kurtzman, Ellen T., and Burt S. Barnow, "A Comparison of Nurse Practitioners, Physician Assistants, and Primary Care Physicians' Patterns of Practice and Quality of Care in Health Centers," Medical Care (June 2017).

maternal health throughout pregnancy, childbirth and postpartum, addressing disparities in maternal health outcomes and finding solutions to enhance health care quality and outcomes for mothers.

- **S.1573/ H.R. 3226, *the PREEMIE Reauthorization Act of 2023*,** introduced by Senators Michael Bennet (D-CO) and John Bozeman (R-AR), would reauthorize programs to promote healthy pregnancies and prevent preterm birth. These programs include comprehensive data collection to investigate emerging issues in the reproductive health space and grants to educate providers and the public on the risk factors for preterm labor and delivery.
- **S.2231/H.R. 4581, the Maternal and Child Health Stillbirth Prevention Act,** introduced by Senators Jeff Merkley (D-OR) and Bill Cassidy (R-LA), would expand the scope of Maternal and Child Services Block Grant to include research and activities to precent stillbirths.
- **S.712, the Connected MOM Act,** introduced by Senators Bill Cassidy (R-LA) and Maggie Hassan (D-NH)**,** would require CMS to report and provide resources for states for the coverage of physiologic devices and related services under Medicare to improve maternal and child health outcomes for pregnant and postpartum women.
- **S.1710/H.R. 3523, *the Perinatal Workforce Act***, introduced by Senators Tammy Baldwin (D-WI), would require HHS to issue guidance to promote the recruitment and retention of racially, ethically and professionally diverse maternity care teams that provide respectful, culturally congruent care.
- **S.1594/H.R. 3322, *the Social Determinants for Moms Act*,** introduced by Senator Richard Blumenthal (D-CT), would establish a task force and a grant program to target the nonclinical social determinants of maternal health — like affordable housing and transportation to (and childcare during) health care appointments.
- **S.1602/H.R. 3312, *the Moms Matter Act*,** introduced by Senators Kirstin Gillibrand (D-NY) and Chris Murphy (D-CT), would establish two grant programs to address maternal mental health conditions and substance use disorders.
- **S.1699/H.R. 5066, *the Tech to Save Moms Act*,** introduced by Senators Bob Menendez (D-NJ) Chris Murphy (D-CT) and Dan Sullivan (R-AK), would permit CMMI to test telehealth models to screen and treat common pregnancy-related complications for Medicaid enrollees and establishes two grant programs that leverage technology to address maternal health outcomes.
- **S.964, *the Mothers and Newborns Success Act,*** introduced by Senators Tim Kaine (D-VA) and Lisa Murkowski (R-AK), would promote maternal health by identifying workforce needs and reducing racial inequities in maternal and infant mortality by strengthening support for women during and after pregnancy, expanding maternal health research and data collection, and ensuring women are better matched with birthing facilities that meet their specific needs.

We are committed to driving these solutions. Just last month, BCBSA released a policy platform, "Creating a More Equitable System for the Health of America," a comprehensive set of solutions across four foundational pillars to address health disparities[6]:

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[6] Becoming a culturally competent health care organization. Accessed May 1, 2024. https://www.aha.org/system/files/hpoe/Reports-HPOE/becoming-culturally-competent-health-care-organization.PDF.

1. Improving access and affordability.
2. Mitigating the impacts of social drivers of health.
3. Building an equitable health care workforce.
4. Harnessing and standardizing health equity data.

This builds on our Top Ten Maternal Health Equity Actions that organizations and policymakers can adopt to reduce – and ultimately eliminate – maternal health disparities. [7] We have also taken action to address disparities and disparate outcomes within the communities we serve. We continue to improve our Blue Distinction® Centers for Maternity Care program by enhancing its quality and measurement standards with the goal of recognizing higher-quality facilities that have taken action to improve maternal health outcomes while reducing racial and ethnic disparities.[8]

BCBSA and BCBS Plans will remain strongly committed to improving maternal health outcomes and diversifying the health care workforce. We appreciate your leadership and partnership on this important issue. If you have any questions or would like additional information, please contact me or Keysha Brooks-Coley, vice president of advocacy, at Keysha.Brooks-Coley@bcbsa.com.

David Merritt

Senior Vice President, Policy & Advocacy

Blue Cross Blue Shield Association

[7] Becoming a culturally competent health care organization. Accessed May 1, 2024. https://www.aha.org/system/files/hpoe/Reports-HPOE/becoming-culturally-competent-health-care-organization.PDF.
[8] "Blue Distinction Centers Promote Healthy Equity to Reduce Racial and Ethnic Disparities and Improve Patient Outcomes," 2024. Blue Cross Blue Shield Association. https://www.bcbs.com/press-releases/blue-distinctionr-centers-promote-health-equity-reduce-racial-and-ethnic-disparities.

May 2, 2024

The Honorable Bernie Sanders
Chair
Senate Health, Education, Labor and Pensions Committee
430 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Bill Cassidy, M.D.
Ranking Member
Senate Health, Education, Labor, and Pensions Committee
430 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Senate HELP Committee Hearing, "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of our respective associaions representing providers specializing in occupational therapy, physical therapy, respiratory therapy, audiology, and speech-language pathology, we respectfulluy submit the following comments in advance of the Senate Health, Education, Labor, and Pensions (HELP) Committee's hearing on May 2nd, titled "'What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

As the HELP Committee reviews proposals to increase the number of healthcare providers, especially those in underrepresented demographics and residing in medically underserved areas, we urge the Committee to consider legislation to fund and bolster the Allied Health Workforce Diversity (AHWD) Program. This program, enacted into law in late 2022 as part of the PREVENT Pandemics Act and included in the Consolidated Appropriations Act of 2023, aims to provide increased educational opportunities to minority students who are currently underrepresented in our professions. Under the AHWD program, the Health Resources Services Administration (HRSA) can authorize scholarships and stipends to accredited higher education programs to recruit qualified individuals from underrepresented backgrounds, including persons with disabilities, students from economically disadvantaged backgrounds, and racial and ethnic minorities.

However, although Congress authorized the AHWD program, no appropriations have yet to be approved for it to become operational. To address this issue and generally provide much needed additional resources to the healthcare workforce, Sen. Casey recently introduced the Long-Term Care Workforce Support Act (S. 4120) which already has the support of 26 Senators and 50 healthcare associations. Among other items, the bill would ensure that the AHWD program would be provided with five years of funding at $10 million per year.

Supporting the implementation and funding of the AHWD program will help strengthen and expand the comprehensive use of evidence-based strategies shown to increase the recruitment, enrollment, retention, and graduation of students from underrepresented backgrounds. These strategies include outreach to the community, creating or expanding mentorship and tutoring programs, and providing scholarships and stipends to students. The health care workforce is facing significant stresses, and the need to boost recruitment is critical now more than ever to improve access to high-quality care for medically underserved populations and increase the number of minorities as healthcare professionals.

Policy Recommendation

We urge Congress to pass S. 4120 and provide the AHWD program with the necessary resources for its implementation. This will help to recruit, retain, and further develop the healthcare workforce to address provider shortages – notably in the areas that need it the most. While these shortages are felt in many areas, it is especially dire in rural and medically underserved regions. This program will provide expanded resources to minority populations to facilitate their entry into healthcare provider training and education. We appreciate the opportunity to share our views and policy recommendation on this issue. If you have any questions, please contact Steve Kline at the American Physical Therapy Association at stevekline@apta.org

Thank you for your time and consideration.

Sincerely,

American Academy of Audiology

American Association for Respiratory Care

American Occupational Therapy Association

American Physical Therapy Association

American Speech-Language-Hearing Association

National Rural Health Association

Senate HELP Full Committee Hearing

"What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

May 2, 2024

Testimony

Congresswoman Lauren Underwood (D-IL-14)

Chairman Sanders and Ranking Member Cassidy, thank you for convening the full Senate HELP Committee to examine the severe shortage of minority health care professionals and the tragic reality of the maternal health crisis in our nation.

As co-founder and co-chair of the Black Maternal Health Caucus, I know that the matter of maternal health is as important as it is urgent. The United States has the highest pregnancy-related death rate of any high-income country,[1,2] and the crisis is only getting worse: over the past three decades, maternal mortality rates more than *doubled*[3,4], and disparities worsened.[5] Even in my own state of Illinois, maternal mortality rates are on the rise with Black women facing the highest risk of pregnancy-related death.[6]

These statistics are devastating, but for many of us, this crisis isn't just about data – it's personal. Too many friends and families have lost loved ones unnecessarily to this devastating crisis. In January 2017, I lost my friend, Dr. Shalon Irving, to pregnancy-related complications just three weeks after she gave birth to her first child, a beautiful daughter named Soleil. As I have done this work, so many people have shared their own stories with me – losses and near misses, tragedies that could have been prevented. The maternal health crisis touches every community in our nation—urban, suburban, and rural. Moms from all demographics are impacted.

In the House of Representatives, I am the lead sponsor of the "Momnibus"—a comprehensive legislative solution to our nation's maternal health crisis. I am grateful for Senator Booker who leads the legislation in the Senate and has worked closely with myself and Congresswoman Adams on this effort. The Momnibus is made up of 13 bills that address every driver of maternal mortality and morbidity including the workforce and diversity issues the committee is confronting today. The Momnibus is not a band-aid to our nation's maternal health crisis. It is a real, comprehensive solution and Congress should pass it now.

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[1] U.S. Maternal Mortality vs. 10 Countries | Commonwealth Fund
[2] Women in U.S. More Likely to Die Pregnancy Childbirth Postpartum | Commonwealth Fund
[3] https://jamanetwork.com/journals/jama/article-abstract/2806661?resultClick=1
[4] https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm
[5] https://jamanetwork.com/journals/jama/fullarticle/2803272
[6] https://dph.illinois.gov/content/dam/soi/en/web/idph/publications/idph/topics-and-services/life-stages-populations/maternal-child-family-health-services/maternal-health/mmmr/maternal-morbidity-mortality-report2023.pdf

As we continue our work to address this crisis, strengthening the maternal health workforce is critical. Currently, more than 1,000 American counties are "maternity care deserts," with no hospitals offering obstetric care and zero obstetric providers, and more than 2.2 million women of childbearing age live in maternity care deserts.[7] Women in maternity care deserts are more likely to have asthma and hypertension than women in counties with full access to maternity care,[8] putting them at greater risk for pregnancy complications and pregnancy-related death.[9] This dire need for maternal health providers is why the Momnibus includes the Perinatal Workforce Act as one of its thirteen evidence-based bills to comprehensively address the maternal health crisis.

The Perinatal Workforce Act would require the Department of Health and Human Services to issue guidance to promote the recruitment of racially, ethnically, and professionally diverse teams; provide funding to establish and scale programs that grow and diversify the maternal health clinical and non-clinical workforce; and commission a GAO study on the barriers that prevent individuals from pursuing careers as maternity care providers. Across all these efforts, the Perinatal Workforce Act aims to promote the growth of all types of providers within the maternal health workforce – physician assistants, nurse practitioners, midwives -- because mother should have a choice in their providers.

The Momnibus also bolsters the maternal mental health workforce through the inclusion of the Moms Matter Act, which provides funding for programs to grow and diversify the maternal mental and behavioral health care workforce to expand access to high-quality maternal mental health care and substance use disorder services. This legislation is crucial as maternal mortality review committees (MMRCs) that examine pregnancy-related deaths have found that "mental health conditions are one of the leading causes of pregnancy-related death.[10]" Likewise, substance use disorder is becoming a significant contributing factor to maternal deaths with some studies identifying a 190 percent increase in pregnancy associated deaths because of drug use between 2010 and 2019.[11]

For these reasons and more, addressing the shortage of maternal health providers is paramount to solving this crisis. The Perinatal Workforce Act and the Moms Matter Act, within the Momnibus, can deliver on this matter and have already been scored as part of the Build Back Better Act.[12]

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[7] 2022_Maternity_Care_Report.pdf (marchofdimes.org)
[8] Ibid
[9] Hypertensive Disorders in Pregnancy and Mortality at Delivery Hospitalization — United States, 2017–2019 | MMWR (cdc.gov)
[10] https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf
[11] https://journals.lww.com/greenjournal/abstract/2022/02000/pregnancy_associated_deaths_due_to_drugs,_suicide,.5.aspx
[12] https://www.cbo.gov/publication/57673

Moreover, to address the alarming consequences of implicit bias in the delivery of maternal care, the Momnibus includes the Kira Johnson Act.[13] This Act establishes a grant program to implement trainings on bias, racism, and discrimination and to promote respectful, culturally congruent, trauma-informed maternity care. Such trainings would apply to all employees in a birth setting, from health care providers to front desk employees; be offered periodically, rather than one-time; and include a focus on anti-racism and cultural humility. Through this Act and the rest of the Momnibus, we hope to prevent deaths like those of Kira Johnson, an entrepreneur, world traveler, mother of one, who tragically passed after delivering her second child and for whom, this bill is named after.

And while today's hearing is focused on workforce challenges and its intersection with the maternal health crisis, it would be remiss for me to not highlight the multi-faceted causes of this crisis. Social determinants of health such as disproportionate exposure to air pollution and heat[14]; limited access to nutritious foods and maternal vaccinations[15]; and lack of investment in community programming, digital tools, data collection,[16] and public health emergency preparedness create an environment that endangers and fails mothers. This flawed environment can also exacerbate the heightened risks faced by acutely vulnerable populations like pregnant veterans[17] and incarcerated individuals[18].

It is time for Congress to act. We know how to end this crisis: the solutions are out there, and the Momnibus invests in those solutions. The thirteen bills that make up the Momnibus provide significant investments in growing and diversifying the perinatal workforce; improvements in maternal health data collection; funding for community-based organizations; programs to improve maternal mental health and address social determinants of health like transportation, nutrition, and climate change; and protections for women veterans and incarcerated pregnant people.

Mothers in this country deserve our best. Thank you again, Chairman Sanders and Ranking Member Cassidy, for the light that this hearing is shining on maternal health in the United States and thank you to all the stakeholder partners, some represented on today's Panel, for your commitment to this cause.

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[13] https://www.liebertpub.com/doi/10.1089/jwh.2020.8874
[14] Association of Air Pollution and Heat Exposure With Preterm Birth, Low Birth Weight, and Stillbirth in the US: A Systematic Review | Environmental Health | JAMA Network Open | JAMA Network
[15] Maternal Immunization | ACOG
[16] Maternal-Health-Blueprint.pdf (whitehouse.gov)
[17] Women Veterans and Pregnancy Complications - Office of Health Equity (va.gov)
[18] Pregnancy Outcomes in US Prisons, 2016–2017 | AJPH | Vol. 109 Issue 5 (aphapublications.org)

Statement for the Record Submitted by

Stacey Y. Brayboy

Senior Vice President, Government Affairs

Hearing of

The Senate Health, Education, Labor, and Pensions Committee

"What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

10 AM; May 2nd, 2024

March of Dimes began our fight for moms and babies 86 years ago as an organization dedicated to eradicating polio in the U.S., a goal that we achieved. We continue that fight today as we work to address some of the biggest threats to moms and babies, such as premature birth and maternal mortality, through research, education, programs and advocacy.

March of Dimes' ongoing work to improve maternal and infant health is more important than ever as our nation continues to face a dire maternal and infant health crisis. The U.S. is one of the most dangerous places to give birth in the developed world. Additionally, rates of preterm birth and stillbirth continue to unacceptably grow in the U.S.

There are unacceptable disparities in maternal and birth outcomes for women and infants of color compared to their white peers. Maternal mortality rates have nearly doubled since 2018, increasing from 17.4 deaths per 100,000 births to 32.9 (1,205 deaths) in 2021. This is an increase of nearly 89% in the maternal mortality rate since 2018.[1] Additionally, the maternal mortality rate for Black mothers was 2.6 times higher than white mothers. [2]

Where you live matters when considering access to maternity care. The March of Dimes' 2023 Maternity Care Desert Report shows that over 5.6 million women of childbearing age live in counties with limited access or no access to maternity care. Each year, nearly 150,000 babies are born to mothers living in maternity care deserts and an additional 300,000 were born in counties with limited maternity care access.[3] Two in three maternity care deserts are rural counties (61.5%). The proportion of women living in counties below the national median household income is twice as high for maternity care deserts as it is in full access counties (90.1% and 45.2%, respectively). Counties with low access to telehealth were 30 percent more likely to be maternity care deserts.[4] Maternal mortality is also significantly higher in rural areas, where obstetrical providers may not be available and delivery in rural hospitals is associated with higher rates of postpartum hemorrhage.[5] Furthermore, while the infant mortality rate has held steady at 5.4 infant deaths per 10,000 births, nearly 20,000 babies born in 2021 did not survive to see their first birthday.

Since 2008, March of Dimes released our Report Card to educate and advocate for better mom and baby outcomes across the U.S., Washington D.C., and Puerto Rico. One thing that has remained constant is an alarmingly high preterm birth rate. In 2022, over 380,000 babies were born preterm—10.4% of all births. Infants born to Black moms were 62% more likely to be born premature and are twice as likely to die than those born to white moms. Despite a 1% overall improvement nationally compared to 2021, 14 states saw an increase in their preterm birth rates. [6]

These statistics are a reflection of the major healthcare worker shortage we are currently experiencing. Many of these families living in these underserved communities have to rely on whatever healthcare options are available to them, which should include the use of midwives and doulas. Maternal care workforce shortages are also intertwined with maternity ward closures and lead to barriers such as longer distances to travel and longer wait times for care, and are associated with increased out of

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[1] https://www.marchofdimes.org/report-card
[2] https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm
[3] https://www.marchofdimes.org/where-you-live-matters-maternity-care-deserts-and-crisis-access-and-equity
[4] https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4851580/
[6] https://www.marchofdimes.org/report-card

hospital births and preterm births. In 2019, nearly half of U.S. counties (47.9%) did not have an OB, over half did not have a Certified Nurse Midwife (CNM) (55.1%), and 39.8 percent of counties lacked a single OB or CNM.[7]

Given the shortage of obstetricians in many counties, the increased utilization of midwives in underserved areas can help improve access to maternity care, reduce interventions that contribute to risk of maternal mortality and morbidity, lower costs, and improve the health of mothers and babies. In particular, the capacity for midwives in rural areas has potentially been underutilized and expanding access to midwifery care has the potential to reduce disparities in health outcomes for women of color.[8]

Studies suggest increased access to doula care, especially in under-resourced communities, are associated with an improvement of health outcomes for mothers and babies including lowering healthcare costs, reducing c-sections, decreasing maternal anxiety and depression, and helping to improve communication between low-income, racially/ethnically diverse pregnant women and their healthcare providers.[9] Unfortunately, cost is often a barrier to working with a doula, as their services are not often covered by public or private health insurance. To date, only 12 states--California, Florida, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, Nevada, Oklahoma, Oregon, Rhode Island, Virginia, Florida--and the District of Columbia, have passed legislation to reimburse doulas through Medicaid.[10]

In addition to the diversity in workforce training and disciplines, the healthcare workforce must reflect the race and ethnicities of pregnant people.[11] In the U.S., 14% of pregnant people identify as Black, but only 11% of obstetricians/gynecologists and 6.3% of CNMs identify as Black. The high costs of healthcare workforce training, the low reimbursement rates, and institutional racism within training programs creates barriers for people of color who want to enter the workforce. This lack of diversity has led to the mistreatment and abuse that Black pregnant people experience in the healthcare system.[12]

As this Committee considers possible legislation addressing the healthcare workforce shortage, March of Dimes strongly recommends inclusion of policies promoting the following:

- Expand access to and improv integration of the midwifery model of care in all states. This can help improve access to equitable and culturally informed maternity care in under-resourced areas, promote a diverse perinatal workforce, lower costs, reduce unnecessary medical interventions that contribute to risks of maternal mortality and morbidity in initial and subsequent pregnancies, and improve the health of all moms and babies.
- Provide federal incentives to train nurses to provide care in rural communities in states with extended postpartum Medicaid coverage, and provide federal assistance to rural hospitals to prevent closures in states with extended postpartum Medicaid coverage. We also strongly encourage authorization of federal grants to medical and educational institutions with rural health programs in states with extended postpartum Medicaid coverage.

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[7] https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf
[8] https://www.commonwealthfund.org/publications/2021/sep/restoring-access-maternity-care-rural-america
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4720857/pdf/JPE_Vol024-001_A03_008-015.pdf
[10] https://healthlaw.org/doulamedicaidproject/
[11] https://www.commonwealthfund.org/publications/fund-reports/2021/nov/policies-reducing-maternal-morbidity-mortality-enhancing-equity
[12] https://www.pcori.org/blog/promising-evidence-telehealth-strategies-delivery-maternal-health-care

- Expand equitable access to doula services through reimbursement and workforce development. Doula support is associated with improvements in birth outcomes and may reduce maternal morbidity and mortality among women of color. In some states, coverage of doula services is provided under private and public insurance programs, including Medicaid, the Children's Health Insurance Program (CHIP) and TRICARE. Payment levels should be sufficient to support the care provided. Efforts should be made to make the doula profession more accessible to birthing people.
- Diversify the perinatal workforce to ensure that birthing people have access to culturally competent care.[11]
- Provide coverage for evidence-based telehealth maternal health services and support alignment of telehealth reimbursement approaches across payers. In many parts of the country, families cannot access telehealth fully because they don't have access to the necessary bandwidth to access these capabilities. We must ensure all communities have access to high-speed broadband to utilize telehealth services. A robust body of evidence shows largely positive outcomes associated with telehealth services in maternity care.[13]

March of Dimes appreciates the opportunity to provide testimony to the Senate Committee on Heath, Education, Labor, and Pensions. If we can provide further information or otherwise be of assistance, please direct any follow-up questions to KJ Hertz, Senior Director Federal Affairs, at khertz@marchofdimes.org.

[13] https://www.pcori.org/blog/promising-evidence-telehealth-strategies-delivery-maternal-health-care

ADVOCATES FOR COMMUNITY HEALTH

Prepared Statement for the Record of
Amanda Pears Kelly
Chief Executive Officer, Advocates for Community Health

Senate Committee on Health, Education, Labor and Pensions (HELP)
hearing on
"What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?

May 2, 2024
10:00 AM ET
Senate Dirksen Office Building Room 430

Advocates for Community Health (ACH) is a member organization of community health centers (CHCs) focused on advocacy initiatives to affect positive change for CHCs, the patients they serve, and the entire nation's health care system. Our members spearhead forward-thinking federal policies and drive change to advance and achieve health equity through comprehensive, integrated primary care. CHCs and their workforce provide equitable health care, particularly in maternal health, among minority, rural, and underserved communities.

Federally Qualified Health Centers (FQHCs) play a critical role in providing care throughout the continuum of maternal health. As defined by Section 330 of the Federal Public Service Act, health centers are required to provide primary health services to medically underserved populations who often face significant barriers to health care access, including geographic, economic, and cultural factors. Required primary health services include prenatal and perinatal services, preventive screenings, emergency medical services, well-child visits, and voluntary family planning services. Additionally, CHCs screen for health-related social needs, including food insecurity and transportation access for patients.

In 2022 CHCs served 30.5 million patients, of which over 9.6 million were rural residents, 90% of patients were at or below the poverty level, and 63% of patients identified as racial/ethnic minorities. CHCs provided essential prenatal services to 560,000 patients and supported 171,000 deliveries, often in communities at higher risk of pregnancy-related deaths. About 403,000 patients had their first prenatal care visit within the first trimester, ensuring quality care throughout pregnancy and after birth.

Most importantly, CHCs provide quality care and have improved many clinical quality measures, including reducing the rate of low birth weight. In fact, health centers exceeded national quality benchmarks in this measure as well as for dental sealants for children, hypertension control, and the inverse measure of uncontrolled diabetes.

Health centers also focus on special maternal populations. About 1 in 5 pregnant or postpartum women have depression or anxiety disorders, especially among non-Hispanic American Indian/Alaskan Native, Asian/Pacific Islander, and Black women. The Health Resources and Services Administration funds the

Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD) program which helps providers to identify and address mental health concerns during and after pregnancy. The program trains providers in equitable and culturally responsive care.

CHCs are integral parts of the White House Blueprint for Addressing the Maternal Health Crisis. ACH strongly supports the Administration's recommendations and goals, including the integration of behavioral health support in community settings such as community health centers and community-based organizations.

Diverse Health Center Workforce and Related Programs

The workforce at health centers often consists of individuals from the communities they serve, enabling them to act as representatives and advocates for these communities. They have a deep understanding of the people they serve. This kind of representation increases patient trust, health literacy, health care quality, and health outcomes.

ACH strives for health centers to be the centerpiece in an abundant pipeline of skilled professionals who have the infrastructure necessary to provide exceptional care to patients. As a professional home for this skilled and diverse workforce, access to professional development and mental health services, systems to maintain a sustainable workload, and pathways for growth must be in place. Training and exposure to diverse populations prepare health care providers to understand better and manage the unique challenges faced by these communities.

Training programs based at FQHCs are successful. The Teaching Health Centers Graduate Medical Education program has trained nearly 1,500 new primary care physicians and dentists, a majority of whom are now providers in underserved areas. The grants support the work of building a program, developing a training curriculum, recruiting clinical faculty, retooling workflow to integrate residents, and getting accredited, all of which are time-consuming and require resources and staffing. The program is valuable and has produced measurable results. About 62% of clinical training sites are medically underserved communities.
As the program reports:

- Approximately 20% of residents reported coming from a financially or educationally disadvantaged background, while 19% reported coming from a rural background.
- The program produced 296 new primary care physicians and dentists.
- Approximately 62% reported intentions to practice in a primary care setting and 48% intended to practice in a medically underserved community (MUC) and/or rural area.
- Of those residents who completed their programs, 34% reported disadvantaged and/or rural backgrounds and 20% comprised underrepresented minorities.
- Current graduates reported that 55% remained in the state of their residency to practice. Of the 266 prior year program completers with available employment data, most currently practice in a primary care setting (64%) and/or in a MUC or rural area (56%).
- Approximately 23% of prior year completers are currently practicing in Federally Qualified Health Centers (FQHCs) or look-alikes, 7% are practicing in Critical Access Hospitals, and 4% are practicing in rural health clinics.

The National Health Service Corps (NHSC) also supports attracting and retaining health care professionals for areas in need of primary care, dental, and behavioral health services. NHSC participants serve at more than 84000 CHC sites. By providing scholarships and loan repayment

programs, the NHSC incentivizes talented practitioners, including obstetricians, midwives, and nurse practitioners. This program not only helps alleviate healthcare provider shortages but also supports a workforce that is more representative of the population it serves. A diverse healthcare workforce is crucial for cultural competence, which improves patient-provider communication, increases patient satisfaction, and ultimately leads to better maternal health outcomes.

Recent data show that minority women, especially Black women, are disproportionately affected by adverse maternal health outcomes, including higher rates of complications like hypertension and diabetes. These disparities underscore the need for targeted efforts to improve healthcare delivery and accessibility. FQHCs and NHSC members are often on the front lines, providing culturally sensitive care that addresses these complex needs.

ACH Member Innovation

Our CHC members implement creative ways to diversify the CHC workforce and address the maternal health crisis. Many of our CHCs use mobile units to reach patients who would otherwise not receive necessary care. Others, like Mariposa Community Health Center, provide home visitation services for pregnant women and mothers with children under the age of two. Additionally, our centers often expand their range of services such as telehealth, remote patient monitoring, prenatal classes, dental care, care coordination, nutritional counseling, and more. Most importantly, CHC interdisciplinary teams empower patients to be part of their health care plans.

Yakima Valley Farm Workers Clinic has providers specialized in minimally invasive gynecologic surgery, women's pelvic health, fertility and breast health, and high-risk pregnancies. As the health center states, they support "families outside of the exam room". Yakima and other CHCs go beyond just medical treatment; they help patients navigate the broader health and social care systems by connecting patients and families to vital programs like Women, Infants, and Children (WIC) services.

Lowell Health Center in Massachusetts is committed to community health education. They run a board-approved training center that prepares community health workers and medical interpreters and provides other comprehensive training sessions through diverse learning formats—online, in-person, and hybrid. Their efforts include innovative training in LGBTQ-inclusive practices to ensure the cultural and inclusive competence of the workforce. The health center also emphasizes recruitment from within the community, ensuring that the workforce not only grows in size but also reflects the cultural and demographic characteristics of the population it serves.

Our members are also located in states that received recent funding from the State Maternal Health Innovation (MHI) Program. These awards support the White House Blueprint to combat maternal mortality and improve maternal and infant health, particularly in underserved communities. Specifically, these funds help states establish maternal health task forces, expand mental health screening, increase access and community linkages for basic health and social services, and foster innovative projects that address maternal and infant morbidity and mortality. Evara Health, formerly the Community Health Centers of Pinellas, received $2 million to address the Black maternal health crisis and was the sole awardee in Florida. Their team also received training in trauma-informed care and adverse childhood experiences to foster a supportive and safe environment for their patients and maternal health journey. As Representative Kathy Castor stated in the press release, "Evara Health has been on the forefront of

working together to ensure that moms and babies across Tampa Bay get the care they need, improve health outcomes, confront racial disparities in maternal care and make sure children and their mothers are healthy and have every opportunity to thrive. This significant grant funding will support Evara's innovative work in improving the lives of many of our neighbors."

Conclusion

We support health centers in their crucial and ongoing efforts to reduce health care disparities, diversify the health care workforce, and improve maternal health outcomes in minority and underserved populations. ACH urges the committee to consider increased funding and support for these programs, recognizing their essential role in building a healthier, more equitable society.

We appreciate your continued commitment to bolstering the minority workforce and improving maternal health and look forward to working with the Committee on these critical issues.

For more information, please contact me at apearskelly@advocatesforcommunityhealth.org and Stephanie Krenrich, our Senior Vice President of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org.

PA EDUCATION ASSOCIATION
655 K Street NW, Ste. 700, Washington, DC 20001
PAEAonline.org • 703-548-5538

Statement for the Record
Submitted to
U.S. Senate Committee on Health, Education, Labor and Pensions
Hearing entitled, "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"
May 2, 2024

The PA Education Association (PAEA), representing the 309 accredited PA programs in the United States, welcomes the opportunity to submit a statement for the record concerning policy steps Congress can take to strengthen health workforce diversity and improve maternal health outcomes.

This hearing comes at a time of unprecedented challenges in ensuring access to high-quality maternal health care for patients. According to recent data from the Centers for Disease Control and Prevention, the United States continues to grapple with an unacceptable maternal mortality rate of 32.9 deaths per 100,000 live births with a significant discrepancy evident between non-Hispanic Black women and their white counterparts. As of 2021, the maternal mortality rate for non-Hispanic Black women stands at 2.6 times higher, underscoring the urgent need for targeted interventions to rectify this disparity.[1] While the roots of this crisis are multifactorial, a significant contributor is inadequate access to timely, culturally sensitive care, the result of a shortage of maternal health providers who mirror the diversity of the populations they serve.

To begin reversing maternal health disparities, it is critical for Congress to take decisive action to break down barriers to health professions education for students from underrepresented

[1] Centers for Disease Control and Prevention. (2023). *Maternal Mortality Rates in the United States, 2021.* https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm.

communities. PAEA strongly supports both S. 1606 – the Black Maternal Health Momnibus Act – and its component legislation - S. 1710 – the Perinatal Workforce Act. These bills would provide significant resources to support both student scholarships and PA program operations, allowing institutions across the country to contribute to diversifying the future health workforce while ensuring high-quality OB/GYN training for students. By ensuring the enactment of this legislation, Congress can take substantial strides to ensure the availability of culturally competent care for patients in need.

In addition to legislation aimed at increasing the supply of maternity care providers, PAEA also supports additional policy steps to ensure that both institutions and students can meaningfully contribute to achieving the broader goal of a representative health workforce. Congress must increase the amount of available funding for health professions programs at historically Black colleges and university, Hispanic-serving institutions, and other minority-serving institutions to promote the creation of a durable pipeline of providers who reflect the communities they will go on to serve. PAEA further supports increased funding for Title VII programs such as the Health Careers Opportunity Program and Scholarships for Disadvantaged Students, both of which have a long track record in supporting pathways to the health professions for students from marginalized communities. Through these comprehensive steps, Congress can demonstrate its commitment to ensuring high-quality, equitable care for all patients.

PAEA welcomes the opportunity to continue engaging with members and staff on this critical work. Should you require additional information or have questions, please contact Tyler Smith, Senior Director of Government Relations, at tsmith@PAEAonline.org or 703-667-4356.

[Whereupon, at 11:50 a.m., the hearing was adjourned.]

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