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SUPPORTING TOMORROW'S HEALTH PROVIDERS:

EXAMINING WORKFORCE PROGRAMS UNDER THE

PUBLIC HEALTH SERVICE ACT

THURSDAY, SEPTEMBER 14, 2017

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

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

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

Also Present: Representative Denham.

Staff Present: Adam Buckalew, Professional Staff Member, Health; Paul Edattel, Chief Counsel, Health; Jay Gulshen, Legislative

Clerk, Health; Edward Kim, Senior Health Policy Advisor; Katie McKeogh, Press Assistant; Kristen Shatynski, Professional Staff Member, Health; Waverly Gordon, Minority Health Counsel; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

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

Today's hearing provides us with an opportunity to begin discussion on how to best address provider shortages in our country and how to ensure that today's medical students have the skills and resources to succeed in the 21st century.

As a physician, I have supported programs that improve access to care and enhance patient experience, and the programs that we are examining today seek to accomplish this goal.

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

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

For example, programs like the National Health Service Corps and the Area Health Education Centers, supported by Title VII grants, and Teaching Health Centers, tackle these shortages by connecting young providers with underserved communities. These programs are essential

to addressing the Nation's provider shortage by connecting providers to those that are not served.

Additionally, Title VII and Title VIII programs support opportunities for continuing medication education for the healthcare workforce, which is not only mandatory for many providers to keep their licenses, but it is also essential to providers as they attempt to keep up with evolving issues and treatments.

In an age with modern drugs and the 21st Century Cures Act supporting future innovation, we must ensure that our healthcare workforce is ready for these breakthroughs and prepared for future challenges. This hearing, however, comes at a precarious time for these programs as we seek to reauthorize them and extend their funding.

For Title VII and Title VIII, both of which have expired, yet continue to receive appropriations on a year-by-year basis, a commitment by this subcommittee to reauthorize these programs would ensure longer-term stability, particularly for future generations of providers.

The National Health Service Corps and the Teaching Health Center Graduate Medical Education Program have funding that will expire at the end of the fiscal year, and our subcommittee is working to ensure these programs will continue to operate and serve communities in coming years.

As is the case with all programs with mandatory funding, finding offsets can be challenging, but I am committed, and I know others on the committee are committed, to finding a solution and extending these

programs.

I want to thank each of our witnesses for being here today and providing their unique insights into the problems ahead.

Dr. Adrian Billings, the chief medical officer of Preventive Health Services; Dr. Neil Calman, the president of the American Association of Teaching Health Centers; Dr. Janice Knebl of the University of North Texas Health Science Center; and Dr. Juliann Sebastian, dean of the College of Nursing at the University of Nebraska Medical Center, are each celebrated providers and experts in their respective fields, and I look forward to hearing from each of them.

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

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

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

[The prepared statement of Mr. Burgess follows:]

******** COMMITTEE INSERT ********

Mrs. McMorris Rodgers. Thank you, Mr. Chairman.

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

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

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

Thank you, Chairman.

[The prepared statement of Mrs. McMorris Rodgers follows:]

******** COMMITTEE INSERT ********

Mr. Burgess. The chair thanks the gentlelady.

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

Mr. Green. Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

success of delivery of care.

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

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

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

[The prepared statement of Mr. Green follows:]

******** COMMITTEE INSERT ********

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

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

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

Our Nation's aging population will especially increase the demand on our nursing workforce, and a reauthorization of Title VIII would ensure that critical nursing education programs can continue.

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

[The prepared statement of Ms. Matsui follows:]

******** COMMITTEE INSERT ********

Mr. Green. I yield back my time.

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

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

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

Ms. Schakowsky. Thank you.

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

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

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

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

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

Thank you. And I now yield to Congressman Kennedy.

[The prepared statement of Ms. Schakowsky follows:]

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

By bringing the expertise of all of the witnesses and their experiences to Washington today, you are helping us strengthen the future of our community healthcare system, including Teaching Health Centers and the National Health Service Corps. Thank you for your commitment and thank you for your work.

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

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

Instead of once again asking our local leaders to bear the burden of our inaction, we should address the healthcare shortage today,

starting with these bills, extending the community health centers, and reauthorizing CHIP.

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

Mr. Burgess. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Burgess. Does the gentleman yield back?

Mr. Kennedy. Yes, I yield back.

[The prepared statement of Mr. Kennedy follows:]

******** COMMITTEE INSERT ********

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

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

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

Today, we will hear from Dr. Neil Calman, chief medical officer, Preventive Health Care Services; Dr. Adrian Billings, president of the American Medical Association of Teaching Health Centers; Dr. Janice Knebl, Dallas Southwest Osteopathic Physicians Endowed Chair and professor in geriatrics at the University of North Texas Health Science Center; and Dr. Juliann G. Sebastian, dean and professor, College of Nursing, the University of Nebraska Medical Center.

We appreciate your being here today.

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

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

STATEMENT OF NEIL S. CALMAN

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

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

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

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

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

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

Congresswoman Cathy McMorris Rodgers is very familiar with the THC program in Spokane and has been a champion for increasing our health workforce in medically underserved areas, especially in rural America.

We are so grateful to her for introducing bipartisan legislation to reauthorize the program sustainably for 3 years and to fund expansion to help satisfy the pent-up demand throughout the country for new teaching health centers.

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

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

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

Primary care saves lives and saves money, and the Teaching Health Center Graduate Medical Education Program helps solve our primary care crisis. However, it is two weeks away from extinction. We need it reauthorized now and at the level recommended in the HRSA-funded study published last year of $157,000 per resident per year. We need a 3-year

authorization at $116.5 million per year so that centers will not terminate their training programs and continue recruiting new residents.

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

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

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

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

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

[The prepared statement of Dr. Calman follows:]

******** INSERT 1-1 ********

Mr. Burgess. The chair thanks the gentleman.

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

The committee stands in recess.

[Recess.]

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[12:10 p.m.]

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

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

STATEMENT OF ADRIAN BILLINGS

Dr. Billings. Thank you, Chairman.

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

I am also a fellow with the American Academy of Family Physicians, an organization that strongly supports --

Mr. Burgess. Dr. Billings, will your check your microphone to see that it is on.

Dr. Billings. Better, okay.

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

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

I was able to graduate medical school debt free because of the National Health Service Corps. And I have chosen to stay because of

the sense of calling I still feel to be practicing along the Texas-Mexico border. But our community needed more healthcare access, and so did I. So I made the decision to merge my private practice with a federally qualified health center in the neighboring community, Presidio County Health Services.

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

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

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

While I could talk about the impact the Corps has had on me and my community all day long with you, I want to be sure to highlight the importance of preserving the program and the urgency of doing so. Without immediate action from this subcommittee, funding for the Corps

will expire in 2 weeks. This potential lapse in funding will cause an immediate and severe impact in underserved areas across the country such as my own.

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

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

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

[The prepared statement of Dr. Billings follows:]

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Mr. Burgess. The chair thanks the gentleman for his testimony.

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

STATEMENT OF JANICE A. KNEBL

Dr. Knebl. Thank you, Chairman.

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

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

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

Collectively, the GWEPs are leveraging the skills of geriatric

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

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

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

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

out and do falls preventions workshop in senior centers. And we have basically treated -- gone to about 14 of them, touching almost 300 older Texans.

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

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

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

greater.

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

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

This funding offers each of us a platform for making that possible, for demonstrating how attention to core geriatric principles can improve the care we all provide. In just 1 year, according to the Health Resource Service Administration, we have collectively trained almost 19,000 trainees in over 45 professions and disciplines. About 11 percent of our trainees come from disadvantaged backgrounds or underrepresented minorities in their chosen health professions, and we have partnered with almost 400 healthcare delivery sites to provide the trainees with that clinical training experiences in geriatrics. Thanks to our work, over 100,000 faculty and practicing professionals

have experienced nearly 1,200 continuing education programs. No surprise to someone who has worked in the field of geriatrics, about 75 percent of our GWEP graduates receive training in medically underserved communities, and upon completion of the training, are actually going to go back and serve in those communities.

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

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

[The prepared statement of Dr. Knebl follows:]

******** INSERT 2-2 ********

Mr. Burgess. Thank you, Doctor.

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

STATEMENT OF JULIANN G. SEBASTIAN

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

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

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

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

AACN, along with 50 other national nursing organizations, fully

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

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

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

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

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

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

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

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

I thank the subcommittee members for this opportunity to share

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

[The prepared statement of Ms. Sebastian follows:]

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Mr. Guthrie. [Presiding.] Thank you.

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

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

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

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

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

pipeline for people so that you can go into these communities and serve.

Mr. Guthrie. Thank you.

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

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

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

Mr. Guthrie. Okay. Good. This is for you, but I will also let Dr. Sebastian go first, and then anybody else can add to this. But

many of the Title VII and VIII programs has curriculum development and continuing education components. How do your programs help the health professions workforce quickly adapt to the Nation's most pressing healthcare concerns? So how are the continuing education components of these programs addressing you in emerging public health issues? So Dr. Sebastian?

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

Mr. Guthrie. Okay. Thank you.

Dr. Knebl?

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

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

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

Mr. Green. Thank you, Mr. Chairman.

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

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

providers to take care of the patients.

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

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

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

Mr. Green. Thank you.

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

Ms. Sebastian. Yes. Nursing faculty, one of the challenges that we experience is the competition in terms of wages with the clinical practice arena. So that is often a big challenge in terms

of recruiting nursing faculty. We are working very hard and, actually, with the support of the Nurse Faculty Loan Program, to attract more students into faculty roles. And that particular component of Title VIII has been very helpful to attract students who then can, in fact, look towards some relief from their loans as a result of the provisions of the Nurse Faculty Loan Program.

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

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

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

But the other opportunities that are provided by the advanced nurse education workforce, which is a slightly new program this year,

help us get more students into graduate programs, who then may be interested in the future in faculty careers.

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

Mr. Burgess. [Presiding.] The chair thanks the gentleman. The gentleman yields back.

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

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

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

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

education. And so we are doing that collaboration with those programs and actually assisting them with some funding to expand the reach.

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

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

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

GWEP that I am very excited about.

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

Dr. Knebl. You should.

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

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

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

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

Mr. Bilirakis. Okay. Thank you.

A question for Dr. Billings. You and your colleagues are

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

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

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

The other huge need is, of course, we need -- we have about 10,000 field strengths within the National Health Service Corps every year. To meet the need of the patients, the health centers, the critical

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

Mr. Bilirakis. Okay. Thank you.

I yield back, Mr. Chairman.

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

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

Ms. Eshoo. Thank you, Mr. Chairman.

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

I am really privileged to represent Lucile Packard Children's Hospital, Stanford University Medical Center, and, of course, the school. All of these issues are interwoven into my congressional district, as well as a community health center in one of -- most people don't think that there are poor people in Silicon Valley, but there

are, there are. There are really underserved people that now are being served so much better because of the new community health center in East Palo Alto, which has always been a poor community.

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

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

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

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

we are meeting in a current comprehensive primary care need of expanding that.

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

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

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

Dr. Calman. Yeah, I guess that is for me. So the Teaching Health Center Graduate Medical Education program was originally funded, as you said, at a level of $150,000 per resident per year. So that was based on a historical analysis of what it costs to train a resident.

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

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

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

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

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

Dr. Calman. Totally.

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

Dr. Calman. Thank you very much.

Ms. Eshoo. -- and what you have chosen to do with your lives. You really are great Americans. Thank you.

Dr. Calman. Thank you.

Ms. Eshoo. God bless you. Thank you.

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

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

Mrs. McMorris Rodgers. Thank you.

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

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

Dr. Calman. So it is not really possible. I mean, the community health centers that are the sponsors of the vast majority of the Teaching Health Center slots really don't have excess income. And so,

you know, what we have really seen is a loss of program slots. You really can't sustain the program on inadequate funding. We lost 170 positions since the start of this program just a few years ago with the reduction in the funding that came with the last inadequate reauthorization. These are 170 doctors that would have been out practicing in needy communities that can't be replaced at this point.

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

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

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

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

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

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

Dr. Calman. So we tract outcomes. This is an outcome-based program, like all grant programs. And so we can tell you that the percentage of regular graduates that go into primary care is normally 23 percent. Eighty-two percent of the Teaching Health Center graduates stay in primary care. There are twice as many that stay in underserved areas. There are four times as many that stay in rural areas, and 18 times as many graduates of teaching health center programs go into community health centers, federally qualified community health centers, than come out of the normal GME program. So we are responsible for outcomes.

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

programs around the country.

Mrs. McMorris Rodgers. Thank you, Dr. Calman.

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

And with that, I yield back.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

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

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

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

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

Dr. Calman. Thank you.

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

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

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

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

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

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

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

Mr. Engel. Well, thank you. And H.R. 3394 also contains additional funding for expansion of the program. So let me ask you again, Dr. Calman, is there currently demand for new teaching health centers and new residency slots in the program?

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

or a problem maintaining an adequate workforce.

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

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

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

So I want to commend the chairman for having today's discussion, but obviously, we cannot have it take place in a vacuum. Congress must

enact a long-term, well-funded extension of the community health center program without delay, and the health of all of our constituents is at stake.

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

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

I recognize myself for questions.

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

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

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

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

to train in OB/GYN, and they have to be able to train in train across a broad range of areas.

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

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

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

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

RPTR FORADORI

EDTR CRYSTAL

[1:08 p.m.]

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

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

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

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

Mr. Burgess. Great.

Dr. Billings.

Dr. Billings. Healthcare is delivered by a team. It is not the

physician. It is not a midlevel provider. It is truly a team. And the Title VII and Title VIII dovetail very well with the National Health Service Corps and with regards to the training of the students that are entering into service in the National Health Service Corps. The Area Health Education Programs that are funded through these programs help to place students in underserved areas for their training. So it is just vital. We are a team.

Mr. Burgess. Thank you.

And, Dr. Sebastian.

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

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

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

Mr. Burgess. Very well. Thank you.

I want to thank all of you for being here today. And I apologize that we had the interruption for votes in the middle of the hearing.

It is an important hearing, quite clearly.

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

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

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

[The information follows:]

******** COMMITTEE INSERT ********

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

Without objection then, the subcommittee stands adjourned.

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