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CARING FOR AMERICA:
LEGISLATION TO SUPPORT PATIENTS, CAREGIVERS, AND PROVIDERS
H.R. 1474, THE ALZHEIMER'S CAREGIVER SUPPORT ACT;
H.R. 1667, THE DR. LORNA BREEN HEALTH CARE PROVIDER PROTECTION ACT;
H.R. 3297, THE PUBLIC HEALTH WORKFORCE LOAN REPAYMENT ACT OF 2021;
H.R. 3320, THE ALLIED HEALTH WORKFORCE DIVERSITY ACT OF 2021;
H.R. 5583, THE HELPING ENABLE ACCESS TO LIFESAVING SERVICES ACT, OR THE HEALS ACT;
H.R. 5594, THE ENHANCING COMMUNITY HEALTH WORKFORCE ACT; AND
H.R. 5602, THE BOLSTERING INFECTIOUS OUTBREAKS PREPAREDNESS WORKFORCE ACT OF 2021, OR THE BIO PREPAREDNESS WORKFORCE ACT OF 2021;
TUESDAY, OCTOBER 26, 2021
House of Representatives,
Subcommittee on Health,
Committee on Energy and Commerce,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m., in the John D. Dingell Room, 2123 of Rayburn House Office

Building, Hon. Anna Eshoo [chairwoman of the subcommittee], presiding.

Present: Representatives Eshoo, Butterfield, Matsui, Castor, Sarbanes, Welch, Schrader, Cardenas, Ruiz, Dingell, Kuster, Barragan, Blunt Rochester, Craig, Schrier, Trahan, Fletcher, Pallone (ex officio); Guthrie, Upton, Burgess, Griffith, Bilirakis, Long, Bucshon, Mullin, Hudson, Carter, Dunn, Curtis, Crenshaw, Joyce, and Rodgers (ex officio).

Staff Present: Shana Beavin, Professional Staff Member; Waverly Gordon, Deputy Staff Director and General Counsel; Tiffany Guarascio, Staff Director; Zach Kahan, Deputy Direvtor Outreach and Member Service; Mackenzie Kuhl, Press Assistant; Aisling McDonough, Policy Coordinator; Meghan Mullon, Policy Analyst; Juan Negrete, Junior Professional STaff Member; Tim Robinson, Chief Counsel; Chloe Rodriguez, Clerk; Andrew Souvall, Director of Communications, Outreach, and Member Services; Kimberlee Trzeciak, Chief Health Advisor; Caroline Wood, Staff Assistant; C.J. Young, Deputy Communications Director; Alex Aramanda, Minority Professional Staff Member, Health; Sarah Burke, Minority Deputy Staff Director; Theresa Gambo, Minority Financial and Office Administrator; Seth Gold, Minority Professional Staff Member, Health; Grace Graham, Minority Chief Counsel, Health; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Bijan Koohmaraie, Minority Chief Counsel, O&I Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; Kristin Seum, Minority Counsel, Health; Kristen Shatynski, Minority Professional Staff Member, Health; Olivia Shields, Minority Communications Director; and Michael Taggart, Minority Policy Director.

*Ms. Eshoo. The Subcommittee on Health will now come to order.

Due to COVID-19, today's hearing is being held remotely, as well as in person.

Good morning, colleagues. For members and witnesses taking part in person, we are following the guidance of the CDC and the Office of the Attending Physician. So please wear a mask when you are not speaking. For members and witnesses taking part remotely, microphones will be set on mute to eliminate background noise. Members and witnesses, you will need to unmute your microphone when you wish to speak.

Since members are participating from different locations at today's hearing, recognition of members for questions will be in the order of subcommittee seniority.

Documents for the record should be sent to Meghan Mullon at the email address we have provided to your staff, and all documents will be entered into the record at the conclusion of the hearing.

The chair now recognizes herself for five minutes for an opening statement.

In the first year of the pandemic, over 3,600 U.S. health care workers died fighting COVID-19, and this is according to the Guardian, and Kaiser Health News. And since February 2020, about one in five health care workers have

quit their jobs. For those still on the job, almost all report experiencing stress, and most report being emotionally and physically exhausted.

As a country we have responded, really, with mostly symbolic support: ticker tape parades, health care hero yard signs, and Time Magazine dedicating its cover to frontline health workers. Congress provided Federal aid to support health care institutions through the $175 billion Provider Relief Fund, but it has been difficult to track how much of that aid made it to the workers themselves.

On the West Coast, more than 24,000 nurses and other health care workers have authorized a strike over pay and working conditions as we meet this morning. Public health workers, as well as doctors and nurses, also report being physically threatened. In my district, Dr. Sara Cody, the top Santa Clara County public health official, was stalked and threatened over her decisions to protect public health during the pandemic. And Asian-American health care workers have faced a new wave of racial harassment in the workplace during COVID-19.

This is the urgent backdrop as we meet in this hearing today. We are considering seven bills, five of which are bipartisan, focused on supporting current caregivers, as well as rebuilding the pipeline of future workers. Three of the bills set up loan repayment programs for the health care

workforce, which will directly reward future workers for their important contributions. Two other bills, the Dr. Lorna Breen Health Care Provider Protection Act and the Alzheimer's Caregiver Support Act, recognize that current caregivers need stronger support to help them weather their physically and emotionally draining work.

Our subcommittee is honored to welcome Mr. Corey Feist and Ms. Jennifer Breen Feist. They are the brother-in-law and sister of Dr. Lorna Breen, who died by suicide after experiencing the mass death of the first wave of COVID-19 patients, and then contracting the virus herself. Since their sister's death, they have dedicated themselves to addressing clinician burnout and suicide.

What an honor to have you here with us today.

The Dr. Lorna Breen Health Care Provider Act provides grant funding for suicide prevention, and peer support at health care facilities. It also makes sure that health care professionals can ask for mental help without facing negative consequences in their careers.

We are also honored to welcome back to the Congress Stephanie Monroe, who has served as chief counsel to the Senate Health Committee during her 25-year career on the Hill. Ms. Monroe now serves as the executive director of African Americans Against Alzheimer's, and is the current caregiver for her 84-year old father, who is living with

Alzheimer's. She will testify in support of the Alzheimer's Caregivers Support Act, which provides grants to expand support services for the unpaid caregivers of people living with Alzheimer's and other dementia.

The final two bills being considered today will reauthorize grants and fellowship programs for clinicians in medically-underserved communities -- and we have so many members that represent those communities -- and volunteers for community health centers.

This hearing, I believe, is the first step toward treating our nation's health care workers as heroes. We have called them that, but now we have to act. I look forward to today's expert testimony that will be provided by our witnesses.

We thank you for traveling the distances that you have to be with us, and to moving these important bills through our subcommittee as swiftly as possible. We want this to get to the finish line. We want these bills to get to the finish line, send them to the President for his signature into law, and then the words on the pages will walk into people's lives.

[The prepared statement of Ms. Eshoo follows:]

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

*Ms. Eshoo. The chair now recognizes the ranking member of our subcommittee, Mr. Guthrie, for his five minutes of opening statements.

And it is great to see you, and be with you today.

*Mr. Guthrie. Thank you, Chair Eshoo, it is great to be with you, as well, and thanks for holding this important hearing. And thanks to have all of our witnesses with us here today.

Today we are examining bills that aim to support patients, caregivers, and providers. Now, more than ever, due to the COVID-19 pandemic, our country is facing severe workforce shortages, and the health care industry is no exception.

Since the beginning of the pandemic, health care workers have stepped up to the plate, and have been on the front lines fighting against this terrible virus. I want to take a moment and thank each and every health care worker for their selfless attitude as you continue to go to work and help our nation at a crucial time in our history.

I think we all agree on the importance of increasing recruitment and retention in our nation's health care workers. However, I am concerned, and I want to point out about the impact of President Biden's COVID-19 vaccine mandate on the workforce. Numerous Kentuckians have told me that the anticipated Center for Medicare and Medicaid

Services and Occupational Safety and Health Administration rule is leading to many people to quit their jobs.

This is -- there is confusion. The mandates were announced months ago, but rules have yet to be released. Many questions remain, including how will someone get an exemption, will prior infection count, and is testing an alternative to comply.

Another hurdle in attracting and retaining people to the health care workforce is the high cost of obtaining a medical degree. I continually hear from constituents that the reason for not pursuing a degree or certificate in health care is due to the financial burden of tuition costs. To help alleviate this distress, I introduced the Public Health Workforce Loan Repayment Act, along with Representatives Eshoo, the chair, Burgess, and Crow.

This bill, this bipartisan bill, would establish the Public Health Workforce Loan Repayment Program to promote the recruitment of public health professionals at local, state, and tribal public health agencies. I believe a strong public health infrastructure starts with health professionals at its core.

Additionally, we continue to encourage private entities and states to create innovative solutions in order to tackle staffing shortages in the health care field. For example, one of the most vital health care needs confronting Kentucky

is the shortage of physicians, particularly primary care doctors serving in community settings. I am proud to represent the University of Kentucky's College of Medicine Bowling Green Campus in my district and my hometown, which aims to address this critical need.

Launched in 2018, the Bowling Green Campus has increased the size of the UK College of Medicine by 120 students, a 20 percent increase. The school provides students two opportunities to obtain a combined degree, whether an MD/MPH or an MD/MBA.

Another great example is the Medical College of Georgia 3+ program that Dr. Keel will testify before us today. Arkansas -- I will leave you -- leave that to explain your program yourself, and -- but I will talk about Arkansas, Maryland, and Nebraska have launched new recruitment and retention programs. For example, Arkansas recently created their first graduate registered nurse apprenticeship program, and Nebraska announced new online resources to connect with health care facilities with staffing needs. As co-chair of the Congressional Apprenticeship Caucus, I have been a strong supporter of apprenticeships, and believe they are a great avenue for workers and employees.

Lastly, as we discuss these bills before us today, we need to keep in mind that Congress has already authorized 5.9 trillion in funding to provide COVID assistance and relief

for Americans, including money intended to address workforce shortages in health care. President Biden's $1.9 trillion American Rescue Plan, which was signed into law in March of 2021, provided significant mandatory funding for workforce initiatives, including 7.6 billion for the public health care workforce.

I voted for all the previous, but -- COVID relief. But to make note, and to be fair, I didn't vote for the American Rescue Plan. However, I want to point out that many states, like my home state of Kentucky, have yet to receive much of this funding. We need to ensure the remaining funds that have not been dispersed are being spent effectively, and take stock of that spending.

I want to thank all of the witnesses for being here today, and I look forward to hearing from each of you as -- on ways we can better address and find solutions to current health care workforce shortages.

[The prepared statement of Mr. Guthrie follows:]

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

*Mr. Guthrie. Thank you, and I yield back.

*Ms. Eshoo. The gentleman yields back. The chair is now pleased to recognize the chairman of the full committee, Mr. Pallone, for his five minutes for an opening statement.

*The Chairman. Thank you, Chairwoman Eshoo. Last week we held a legislative hearing to examine bills that would improve the health of children and families. And today this subcommittee needs to discuss a slate of bipartisan bills that seek to strengthen America's health workforce, and support our communities and providers.

The legislation before us now would foster a robust public health workforce, and provide support to those who fought on the front lines of the COVID-19 pandemic. Throughout the pandemic, physicians, nurses, scientists, contact tracers, community health workers, and many others have worked tirelessly to attend to the needs of patients, and to promote the health and well-being of our communities. And it is a tribute to their selfless work over the last 18 months that we are gradually approaching a new normal.

But we are not out of the woods yet. The pandemic has stressed our health care system, with many health care workers suffering from fatigue and burnout. And unfortunately, some workers are leaving the workforce entirely. Historically underserved areas, rural, and tribal communities, in particular, are suffering from a lack of

access to basic public health services, and are experiencing workforce shortages.

And there is also an alarming trend in the mental health of health care professionals. An April survey from the Kaiser Family Foundation and The Washington Post found that a majority of frontline health care workers say that stress related to COVID-19 has had a negative impact on their mental health, and that same survey found that only 12 percent of health care workers receive mental health services. An additional 18 percent reported that, even though they thought they needed care, they did not seek it due to busy schedules, stigma, fear, or financial concerns.

These issues demonstrate the need for broad investments and support for our health care workforce. This includes resources to recruit and retain talented health professionals, and to protect their mental well-being, going forward. And the seven bills before us today recognize the urgency of these issues by addressing the mental health burden faced by frontline workers, creating incentives and novel pathways for services to underserved communities, strengthening workforce capacity so we can meet future public health emergencies head on, and incorporating the needs of caregivers for Alzheimer's patients.

I just wanted to mention the bills H.R. 1667, the Dr. Lorna Breen Health Care Provider Protection Act authorizes

grants for mental and behavioral health training for health care workers. It also authorizes grants for its programs and campaigns to improve the mental health and resiliency of health care providers. This bill was named for Dr. Lorna Breen, the medical director of the emergency department at NewYork-Presbyterian Allen Hospital, whose family is here to provide testimony on the bill. And I would like -- I want to thank them for being here today.

Two of the bills before us aim to build a more diverse and community-based health care workforce. H.R. 5594, the Enhancing Community Health Workforce Act, would improve health outcomes in medically underserved neighborhoods by investing in outreach through community health workers.

And then there is H.R. -- I guess it is 33520 (sic), the Allied Health Workforce Diversity Act, that seeks to increase diversity in the physical, occupational, and respiratory therapies, as well as audiology and speech language pathology professions. And this legislation would accomplish -- would, basically, authorize grants for scholarship stipends and recruitment and retention programs for students from under-represented backgrounds.

We are also considering bills that would provide guidance on how to expand our pandemic response and strengthen workforce resiliency. H.R. 3297, the Public Health Workforce Loan Repayment Act, establishes a student

loan repayment program for public health professionals that complete a period of full-time employment with a state, tribe, or local public health agency for at least three years.

And then there is H.R. 5602, the BIO Preparedness Workforce Act, that helps grow the infectious disease workforce by creating loan repayment programs for healthcare professionals who spend at least half of their time engaged in bio preparedness and response activities. And they will also be eligible if they provide infectious disease care in a shortage designation area, underserved community, or federally-funded facility.

And then the last bill, H.R. 1474, the Alzheimer's Caregiver Support Act, authorizes additional funding to expand training and support services for unpaid caregivers of people living with Alzheimer's disease.

So obviously, these are all important. We would like to move them forward, and I look forward to our discussion and hearing more from the panel, Madam Chair.

[The prepared statement of The Chairman follows:]

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

*The Chairman. Thank you again, Ms. Eshoo.

*Ms. Eshoo. The gentleman yields back. It is a pleasure to recognize the ranking member of the full committee, Congresswoman Cathy McMorris Rodgers, for her five minutes for opening statement. And she is joining us, I believe --

*Mrs. Rodgers. In person.

*Ms. Eshoo. Oh, you are here. Oh, that is great. I am looking up at the screen.

*Mrs. Rodgers. Thank you, Madam Chair. To all Americans who work in health care, thank you. You are all heroes who have been on the front lines at every stage during this pandemic, caring for people who need you. Your sacrifices, especially during these most uncertain times, is why we will not stop our investigation into COVID-19 origins. We must hold China accountable for hiding lifesaving information that could have made your job easier.

I know you are tired. There is great frustration and anxiety. Health care providers from my home state of Washington are sounding the alarm. Our vaccine mandate took effect on October 18th. According to the Washington Hospital Association, they expect to lose up to five percent of their entire workforce. That is up to 7,500 workers whose patients and families are depending upon them.

I hope that the Biden Administration will learn a lesson

from these mandates that have made Washington State a difficult place right now, and I hope that he will abandon -- President Biden, will abandon -- his top-down federal mandate. This approach, these type of mandates, only promote fear and control. And they are making the shortages worse.

Across the country, 11 million jobs remain unfilled. It is more expensive to purchase nearly everything, from food to fuel. It is getting harder to get by. And ultimately, more and more people are facing a choice to either comply with a mandate, or lose their livelihood altogether. I have heard too many heart-wrenching, heartbreaking stories from individuals in eastern Washington in recent weeks. The hard-working men and women of this country, especially our frontline health care workers, our heroes, need solutions, not force and fear that is eroding trust in public health.

I am glad that Mr. Levine is here to discuss what challenges he is facing, and how Congress might be able to help.

I have always been a strong supporter of existing federal incentives to support health provider training and education, including championing the reauthorization of the Teaching Health Center Graduate Medical Education Program. Through the CARES Act, Congress reauthorized the major health workforce programs under title 7 and title 8 of the Public Health Services Act, run by Health Resources and Services

Administration.

CARES also required a strategic plan to better inform Congress on a framework for addressing workforce needs. This plan was given to us last night, a month over -- after it was due. It certainly would have been helpful to have it before last night, but we will look forward to looking at that to better direct our legislative efforts that we are considering today.

In addition to many existing grant programs that support health workforce through CMS payments, the Federal Government has spent roughly $16 billion per year on the health workforce as of 2015. In December 2020, Congress passed legislation that will add 1,000 new GME slots, starting in 2023.

Further, in the American Rescue Plan, Democrats, although they went it alone, they allocated a lot of money on workforce programs, including billions for public health programs, hundreds of billions for more Medical Reserve Corps, National Health Service Corps, Nurse Corps, teaching health centers, and behavioral health workforce. In reconciliation, Democrats are also providing almost 150 million in mandatory funding for an unauthorized program that some are now seeking to authorize through one of the bills before us today.

While I support the intent of this program, this is the

wrong way to legislate. We need to know what is actually working before spending more money, and authorizing more programs.

We should be looking at how states are leading. Governors DeSantis and Baker gave more flexibility with staffing ratios, including the use of personal care attendants to meet requirements. Governor Sununu authorized military service members and emergency medical technicians to obtain temporary licenses as nursing assistants. Governors Hogan, Hutchinson, and Ricketts worked to streamline licensing, by allowing nurses from out of state to practice, waiving application fees for nursing licenses, and removing red tape for license renewals.

States are also funding programs and working with medical schools on long-term strategies to improve retention in underserved areas. Dr. Keel is here today to share how Augusta University is leading to reduce medical debt, and encourage doctors to work in underserved areas in Georgia. I am excited to hear about this, and how maybe it could work in my home state of Washington.

Overall, states regulate the practice of medicine. At the Federal level, we need to support states and share best practices.

The health care workforce plays a key role in our economy, keeps our patients healthy and safe. We owe so much

to our frontline workers, who have been at the forefront of this pandemic. Let's hear from the states. Let's hear from those that are on the front lines. I yield back.

[The prepared statement of Mrs. Rodgers follows:]

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

*Ms. Eshoo. The gentlewoman yields back.

The chair reminds members that, pursuant to committee rules, all members' written opening statements shall be made part of the record, so make sure, members, you get your marvelous remarks in.

I now would like to introduce our witnesses.

First, Mr. Corey Feist. He is the founder of the Dr. Lorna Breen Foundation. He is the brother-in-law of Dr. Breen. And with him, seated behind him, is Jennifer Breen Feist, Dr. Breen's sister.

Thank you for being here today, on behalf of everyone on the committee. We are very grateful to you for being willing to testify.

Next, Ms. Lisa Macon Harrison, she is the president of the National Association of County and City Health Officials. And I would like to call on Mr. Butterfield to enhance her introduction, because she is his constituent.

So are you with us?

*Mr. Butterfield. I am with you. Thank you, and good morning, Madam --

*Ms. Eshoo. There you are.

*Mr. Butterfield. Madam Chair, and --

*Ms. Eshoo. Good morning.

*Mr. Butterfield. Can you hear me?

*Ms. Eshoo. Yes, very well.

*Mr. Butterfield. Okay, thank you.

*Ms. Eshoo. Yes.

*Mr. Butterfield. Good morning, Madam Chair. Good morning to all of my colleagues, and thank you to all of the witnesses for your testimony today. I will be very brief, but I want to introduce to my colleagues Lisa Macon Harrison.

Ms. Harrison is the -- testifying today in her capacity as president of the National Association of County and City Health Officials. But she is also the health director of Vance County, which is in my congressional district, and Granville County, which is in the adjoining area. Ms. Harrison has worked at the intersection of public health research and practice in my great state of North Carolina since 1995. She has a bachelor's degree in public health and public policy, and a master of public health from the Gillings School of Global Public Health at the legendary UNC Chapel Hill.

She has co-authored more than 30 peer-reviewed publications, and is associated with both UNC Chapel Hill and the Duke University School of Nursing. Even though these schools are competitors in sports, they collaborate every day in academics and other endeavors.

So thank you, Ms. Harrison, for coming today.

I will conclude by saying that she serves as a member of the North Carolina Institute of Medicine, and is a past

president of the North Carolina Public Health Association. She is a current president of the National Association of County and City Health Officials, and previously represented five southern states on its board of directors.

As you can see, our witness is well-qualified to testify today.

Thank you very much, Madam Chair. I yield back.

*Ms. Eshoo. Thank you, Mr. Butterfield. Beautiful words about Ms. Harrison, and it is always a reminder to me of what extraordinary Americans we have in their -- whatever their capacity is, they come here, and we are better for it.

Dr. Brooks Keel, he is the president of Augusta University, and I would like to recognize Mr. Carter to introduce his constituent, Dr. Keel.

But a warm welcome to you, Doctor. It is great to see you.

*Mr. Carter. Well, thank you, Madam Chair and Ranking Member Guthrie, for inviting a great witness to testify today from my home state of Georgia, Dr. Brooks Keel.

Dr. Keel is the president of Augusta University. It is the ninth largest medical school in the country. Georgia, as you know -- we often say there are two Georgias, there is Atlanta and everywhere else. And of course, everywhere else is pretty much rural. And Georgia has faced severe physician shortages in rural areas of our state, and Dr. Keel's

leadership has led Augusta University to create a unique solution to this problem to encourage students to open practices in medically underserved areas. I am excited to introduce him today.

Thank you for being here, Dr. Keel, and I know we are all looking forward to hearing more about this innovative program that I think is going to benefit all rural areas of our country, but particularly, in the beginning, the rural areas of Georgia. So thank you very much for being here.

*Ms. Eshoo. Thank you, Mr. Carter.

Dr. Victoria Garcia Wilburn is an assistant professor of occupational therapy at the IUPUI School of Health and Human Sciences.

Welcome to you, a warm welcome. Thank you for being here with us today.

And last, but not least, Alan Levine is the executive chair, president, and CEO of Ballad Health, a health system serving Northeast Tennessee, Southwest Virginia, Northwest North Carolina, and Southeast Kentucky. I would like to recognize Mr. Griffith to introduce Mr. Levine, since he is one of his constituents.

*Mr. Griffith. Thank you.

*Ms. Eshoo. So you are recognized, my friend.

*Mr. Griffith. Thank you very much. I appreciate it, and I would like to welcome Alan Levine here with us today, I

have known him for many years.

He is chairman, president, and chief executive officer of Ballad Health, which, as you heard, serves a big chunk of area in Appalachia. Ballad Health operates 13 hospitals in Tennessee, 7 in my district in Southwest Virginia, including the Lee County Community Hospital, which opened earlier this year in Pennington Gap.

And I say opened, because it had closed and, working with the community, they reopened it. They were able to get it reopened about four or five years after it had originally closed. That is fairly unusual for hospitals in rural areas that close, particularly in rural Appalachia. So we are very pleased about that.

Ballad employs 14,000 individuals, including 800 physicians, many of whom serve in very rural areas. His wife, Laura, is a nurse, and they have two grown children, who also have careers in health care.

So, we are very glad to have him with us today, and appreciate him taking his time. Even though he couldn't be here live with us in the room, he will be participating on the video.

*Ms. Eshoo. The gentleman yields back?

Thank you.

Ms. Stephanie Monroe, she is the director of equity and access of UsAgainstAlzheimer's, and executive director of

AfricanAmericansAgainstAlzheimer's.

Thank you for being with us today. It is wonderful to see you, and thank you for your extraordinary leadership.

Dr. Jeanne Marrazzo is a board member of the Infectious Disease Society of America and Infectious Disease Division Chief of the University of Alabama at Birmingham.

Thank you, Dr. Marrazzo, to you, as we welcome and acknowledge not only all of the brilliance that you each bring to the hearing today, but for your life's work. You have made our country better, and you do every day.

So thank you, each one, for joining us. We look forward to your testimony. You are probably -- I don't know if you are familiar with the lights in front of you. Green, just go for it. Yellow, warning. And you know what red is.

So we will start with Mr. Feist for your five minutes of testimony. And again, thank you for being with us.

STATEMENT OF COREY FEIST, FOUNDER, DR. LORNA BREEN FOUNDATION; LISA MACON HARRISON, M.P.H., PRESIDENT, NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS (NACCHO); BROOKS A. KEEL, PH.D., PRESIDENT, AUGUSTA UNIVERSITY; VICTORIA GARCIA WILBURN, D.H.SC., O.T.R., F.A.O.T.A. ASSISTANT PROFESSOR, OCCUPATIONAL THERAPY, IUPUI SCHOOL OF HEALTH & HUMAN SCIENCES; ALAN LEVINE, EXECUTIVE CHAIRMAN, PRESIDENT, AND CEO, BALLAD HEALTH; STEPHANIE MONROE, J.D., DIRECTOR, EQUITY AND ACCESS, USAGAINSTALZHEIMER'S, EXECUTIVE DIRECTOR, AFRICANAMERICANSAGAINSTALZHEIMER'S; AND JEANNE MARRAZZO, M.D., BOARD MEMBER, INFECTIOUS DISEASE SOCIETY OF AMERICA (IDSA), INFECTIOUS DISEASE DIVISION CHIEF, UNIVERSITY OF ALABAMA AT BIRMINGHAM

STATEMENT OF COREY FEIST

*Mr. Feist. Thank you for having me today. My name is Corey Feist. As you heard, I am the president and co-founder of the Dr. Lorna Breen Health -- Heroes Foundation. I am also the chief executive officer of the University of Virginia Physicians Group, which employs all of the physicians and most of the nurse practitioners and advanced practice professionals at the University of Virginia Health System in Charlottesville.

I am also the proud husband of Jennifer Breen Feist, who

is sitting over my shoulder, who is here with me today, and is also welcome to answer any questions that you might have of her. Jennifer co-founded the Dr. Lorna Breen Heroes Foundation with me in June of 2020, and she is the sister of Dr. Lorna Breen.

I want to start by thanking the chair and ranking member of the -- for the opportunity to address the committee today. Unfortunately, the thousands of health care professionals who take such incredibly amazing care of us, particularly during this pandemic, cannot access mental health support, and it is critical that this changes.

On behalf of the thousands of health care professionals, I am here to encourage you to immediately consider passing H.R. 1667, the Dr. Lorna Breen Health Care Provider Protection Act, which aims to reduce and prevent suicide, burnout, and mental and behavioral health conditions among health care professionals. The companion legislation to this bill, S.610, unanimously passed the Senate on August 6th.

I would like to extend a special thank you to Representatives Wild, McKinley, Krishnamoorthi, and Chu, along with Senators Kaine, Reed, Cassidy, and Young for championing this first-of-its-kind legislation.

Let me start by sharing a little bit about my sister-in-law, Dr. Lorna Breen. This picture in front of me was taken on March 10th, 2020, while on a Montana ski trip with our

family. That is my daughter, Charlotte, with us.

As Jennifer has said, this was the last week of normal for our family, and for many of us across this country.

Dr. Breen was the medical director of the emergency department at NewYork-Presbyterian's hospital, and left our Montana ski trip to return home to take care of patients. In the three weeks that followed, Dr. Breen treated confirmed COVID patients, contracted COVID herself, and returned to an overwhelming, relentless number of incredibly sick patients.

After 12-hour shifts, she and her co-workers would stay, because the influx of patients never slowed. Yet she kept going back until she, literally, could no longer stand. Despite these overwhelming challenges, she pushed on, and tried to push through.

Sharing that the entire time she was concerned that her inability to keep up was going to end her career, by April 9th Lorna hit her breaking point. She couldn't get out of her chair. She called Jennifer on the phone. She was nearly catatonic, and needed immediate help.

Lorna answered the call for her city, for her country. But when she needed to take care of herself, she was concerned about her job, fearing she would lose her license, or be ostracized by her colleagues. She died by suicide April 26, 2020, 47 days after this picture was taken.

When Lorna died, we were all looking around, saying,

"Why, how did this happen? When did it? Why did it happen?'' We were in the news all over the world. And then something that we found completely unbelievable happened: people started reaching out. The families of doctors and nurses and other health care providers told us their own stories about their loved ones who had died by suicide. All total strangers.

Many doctors and nurses continue to suffer in silence with mental health challenges, due to both cultural and regulatory hurdles, which reinforce and often prevent them from obtaining help, the same help that we can all get in this room.

Prior to the pandemic, the suicide rate among physicians and nurses was twice the national average in this country. In fact, prior to the pandemic, 400 physicians died by suicide each and every year.

Early after Dr. Breen's death we heard about a phrase coined the "parallel pandemic,'' which refers to the mental health crisis in medicine. Lorna kept telling us she was going to lose her license, lose her job, all because she required mental health care for the first time in her career. She was mortified, fearing her colleagues would never want to work with her again. We promised her she wasn't right. And after she died, we learned that she was.

This is not okay. This is not normal. This is not

right. We believe Lorna died because she was a physician.

Consider the following statistics before the pandemic: 96 percent of medical professionals agree that burnout was an issue; 42 percent were reluctant to seek mental health treatment; 50 -- and then after the pandemic, 55 percent of professionals agree that burnout is an issue; 60 percent say that stress has harmed their mental health.

On top of these statistics, Dr. Breen's case, nearly all of the health care professionals -- nearly half of those professionals won't obtain treatment. This is like sending the entire health care workforce to war, and not supporting them when they come back.

Thank you for consideration of the Dr. Lorna Breen Health Care Provider Protection Act, and your support of our health care heroes.

[The prepared statement of Mr. Feist follows:]

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

*Ms. Eshoo. Thank you very much, Mr. Feist.

I also would like to acknowledge that there are two members that are cosponsors of that legislation on the committee, Mr. Upton and Mr. Griffith, and we thank you for your fine work. Thank you for your testimony.

Ms. Harrison, you are recognized for five minutes.

STATEMENT OF LISA MACON HARRISON

*Ms. Harrison. Good morning, Chairwoman Eshoo, Congressman Guthrie, and members of the subcommittee. My name is Lisa Macon Harrison, and I am president of the National Association of County and City Health Officials, also known as NACCHO. This is the association that represents our nation's nearly 3,000 local health departments.

I am also the local health director of Granville-Vance Public Health in North Carolina, serving a rural population of approximately 100,000.

Thank you for the opportunity to speak to you today about the critical importance of the nation's public health workforce, and legislative opportunities to support them.

My colleagues across the country in local health departments have been the tip of the spear in the pandemic response. They have been the voices over the phones, the hands in the gloves, the faces behind the masks, the arms in the gowns, and the fingers typing away on data updates daily for local communities to help others understand how we are getting through this pandemic, community by community.

In my district alone, our 12 public health nurses have delivered over 40,000 vaccines, which is over half of the COVID-19 vaccines delivered in our counties. While we are

still in the background, contact tracing, still testing, still educating the public, still consulting with local schools and courthouses and businesses, so that people can feel safe.

No other health care partners have the same breadth of responsibilities for communicable disease control and health-related policy decisions the same way public health is. Our workforce is our most critical asset. However, a decade of disinvestment leading up to the pandemic meant that health departments were understaffed and overworked long before this crisis hit. Local health departments started the pandemic 20 percent down in workforce capacity, and the pandemic really stretched thin our already lean workforce. Preliminary findings from NACCHO's 2020 Forces of Change survey show that over 80 percent of local health departments reassigned existing staff from regular duties to the agency's COVID-19 response. That was certainly true in my district.

The response is taking a toll. Turnover is up across communities, and some health department staff have actually shrunk again during the pandemic. For some, it is the intense polarization and threats that drive them away. Others are lured away by better paying opportunities in hospitals or the private sector, while still others are leaving due to the response's effect on mental health. In fact, this past spring, CDC found out that over half of

public health workers were experiencing symptoms of PTSD.

We expect this migration out of governmental public health to be more acute when the pandemic ends, as many of my colleagues have stated they are committed to staying the course during the crisis, but will leave as soon as the threat is abated. I have seen firsthand the turnover rate increase at my local health department before the pandemic. Our annual turnover was between 2 and 5 percent, annually; right now it is closer to 12 percent. In rural areas like mine it can take months to fill vacant positions. The public health workforce crisis needs our attention, both now and in the future.

In order to build the public health workforce for the 21st century, we have to focus on three different factors: retaining the current hardworking, skilled, and experienced staff we have; recruiting top new talent; and expanding the workforce with more predictable, sustainable funding. That is why we are so appreciative that you are considering bipartisan legislation that would make a meaningful impact in these efforts, H.R. 3297, the Public Health Workforce Loan Repayment Act. Thank you.

This bill would create a loan repayment program for public health professionals who work at local, state, or tribal health departments for at least three years. It is modeled after the successful National Health Service Corps,

with support from clinical health care workforce, and would be the first dedicated program to help recruit and retain top talent into public health departments, where they are so desperately needed.

Public health loan repayment has support from health departments large and small, as well as from over 100 public health medical, academic, labor, and consumer stakeholder groups. We hope it will have your support, as well.

While the Public Health Loan Repayment bill will help recruit new staff, we must also invest in public health infrastructure to provide predictable, sustained, and disease-agnostic funding to bring back the positions we have lost, and support optimal staffing levels.

Moreover, we must do better to increase salaries and benefits for public health department staff, and offer those already in the pipeline a career ladder to stay in the field long-term. Federal policy plays a role here, as well, as jobs tied to specific Federal programs at the local level often pay so much less than a living wage.

The challenges facing the public health workforce are incredible, but with your help we can make a meaningful impact to support them while they support our communities. Thank you for your attention to these issues. I am happy to answer any questions.

[The prepared statement of Ms. Harrison follows:]

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

*Ms. Eshoo. Thank you very much. Excellent testimony.

Dr. Garcia Wilburn, you are recognized for -- oh, I am sorry.

Dr. Keel -- I didn't do that on purpose, Dr. Keel. It is my eyesight. You are recognized for your five minutes, and welcome again. Lovely to have you.

STATEMENT OF BROOKS A. KEEL

*Dr. Keel. Chairwoman Eshoo, Ranking Member Guthrie, and members of the Subcommittee on Health, thank you very much for the opportunity to speak with you today.

And thank you, Representative Carter, for your introduction, and for the continuing service to our great state and to this country.

My name is Brooks Keel. I am the president of Augusta University. AU is one of four public research intensive universities in the State of Georgia, and the home of the Medical College of Georgia, or MCG, which is the thirteenth oldest and ninth largest medical school in the country. We are the only public medical school and the only public academic health center in the state.

It is no secret that the entire country is facing a physician shortage. Where primary care physicians are in short supply everywhere, the lack of providers in rural settings is especially acute. Georgia has a severe shortage of physicians, ranking forty-first in the country in physicians per capita. Currently, eight counties in Georgia have no practicing physician at all.

One contributor to the physician shortage is the staggering amount of debt incurred while pursuing a medical degree. While MCG offers scholarships to the neediest of

students, more than 80 percent of MCG students graduate with debt, sometimes exceeding $130,000. This debt can discourage future physicians from practicing in the very areas where their need -- where the need is the greatest, and may also dissuade medical students from choosing a career path in primary care, as specialty fields often prove to be more financially lucrative.

Today I want to share with you the details on a program created at the Medical College of Georgia termed MCG 3+, which aims to eliminate medical school tuition debt and reduce disparities, by increasing access to care in rural and underserved areas across the state, and begins to tackle the extreme physician shortage that we are experiencing in one of the top 10 most populous states in the country.

First, by employing a unique and novel curriculum, the 3+ program shortens medical school from four years to three years. Right away, this reduces medical school debt by 25 percent.

Second, we are asking first-year medical students who have a passion for primary care, and a propensity for practicing in rural Georgia, to commit to primary care residency in the State of Georgia. This alone will significantly enhance the chance that these students will continue to stay in practice in the state once they complete their training.

And in this context, I am referring to primary care in the broadest of terms, to include family medicine, internal medicine, pediatrics, but also psychiatry, obstetrics, gynecology, emergency medicine, and general surgery.

Third, if these motivated students will commit to establishing their clinical practice in an underserved rural area in Georgia, and will agree to practice in these areas for at least three years after completing their residency training, we will waive their medical school tuition. In other words, free medical school in return for a year-for-year clinical service commitment in rural Georgia.

I should point out that, while the primary impetus for the 3+ program was to incentivize physicians to establish a clinical practice in rural and underserved Georgia, this overall approach should also lead itself to tackle other vital needs the state may have. For example, we are exploring whether the 3+ program will allow us to address a critical shortage of medical examiners and forensic pathologists in the state.

Additionally, as I mentioned earlier, psychiatry is one of the seven primary care pathways identified in MCG's 3+ program. We are, therefore, excited about how the reauthorization of H.R. 5583, Helping Enable Access to Lifesaving Services Act, might indeed play a role in our 3+ program.

The 3+ was implemented in the fall of 2021, and MCG has contracted with 9 first-year medical students to join this program. We hope to add another 10 next year. We recently received a $5.2 million gift from Peach State Health Plan, a subsidiary of Centene Corporation, in support of the 3+ rural program. This was matched by another $5.2 million from the State of Georgia, allowing us to establish the $10.4 million endowment to cover the cost of tuition for these physicians.

We are aggressively seeking additional public and private philanthropic opportunities that will allow us to support additional students who desire to take advantage of this program. Our goal is to create a continuing pipeline of physicians who are dedicated to meeting the health care needs of the state, both now and well into the future.

We believe that leveraging the combined efficiencies of the accelerated three-year M.D. curriculum, coupled with tuition-free medical education and an in-state primary care residency experience, MCG will dramatically enhance our contribution to Georgia's physician workforce, and significantly impact the health and economic prosperity of all Georgians, especially those living in our rural and underserved areas.

Madam Chairwoman and Ranking Member Guthrie, thank you once again for your interest in Augusta University and the Medical College of Georgia, and for allowing me to be here

today. I will be happy to answer the questions you or the committee may have.

[The prepared statement of Dr. Keel follows:]

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

*Ms. Eshoo. Thank you very much, Dr. Keel. That is helpful. It is not only helpful, it is hopeful, and we all need hope.

Dr. Wilburn, it is indeed your time for your testimony.

*Dr. Wilburn. Thank you.

*Ms. Eshoo. Welcome again.

STATEMENT OF VICTORIA GARCIA WILBURN

*Dr. Wilburn. Chairwoman Eshoo, Ranking Member Guthrie, and members of the Health Subcommittee, thank you for inviting me to speak to you today in strong support of H.R. 3320, the Allied Health Workforce Diversity Act.

This legislation is crucial, as our nation looks to recover from the pandemic and have an allied health workforce that mirrors the makeup of our nation.

I want to thank Representatives Rush and Mullin for their leadership on this bill.

I also want to thank Ranking Member McMorris Rodgers, who has been such a champion for this bill since it was first introduced in the 116th Congress, passing unanimously out of the House of Representatives as part of the larger title 7 workforce program's reauthorization package.

When reflecting on this legislation, I think about how different my life would have been if the Allied Health Workforce Diversity Program had existed when I was on my trajectory to becoming an occupational therapist. I would have been provided a distinct pathway to my career, instead of spending countless hours navigating potential college majors as a first-generation student. I would have had improved mental health, and perhaps my academic achievement would have been greater with more support.

After my parents moved to Chicago -- after my parents married, they moved to Chicago for the booming industry jobs. My father was in construction for 30 years, and my mother, who didn't finish the eighth grade, worked in a factory at night, while my four older siblings slept. When we were old enough, she enrolled in cosmetology school. Her cosmetology diploma was the first degree to ever hang in our home.

My parents strongly believed education equaled opportunity. But as the youngest of five, my parents' ability to provide financial support was limited. Financial support from Boston University and Federal student loans allowed me to afford a bachelor's degree in occupational therapy. But it is because of the network of mentors and career counselors who became like family at BU that I speak to you today, as a licensed occupational therapist and member of the board of directors of the American Occupational Therapy Association.

The Allied Health Workforce Diversity Act would provide thousands of future students of respiratory therapy, occupational therapy, physical therapy, speech language pathology, and audiology with access to additional, targeted supports beyond what I received, like mentorship and tutoring. Students who are disadvantaged and from under-represented communities bring a unique perspective to our health care system, and improve health outcomes. If we, as a

nation, want to improve patient care and reduce health disparities, we must increase our efforts to recruit, train, and support these students.

The Allied Health Workforce Diversity Act creates a grant program in title 7 of the Public Health Service Act, administered by the Health Resources and Services Administration. Grants would be awarded to accredited higher education programs of respiratory therapy, occupational therapy, physical therapy, speech language pathology, and audiology to support efforts to increase the opportunities of students from under-represented and disadvantaged backgrounds.

The funding the grant provides would support efforts by the program to attract, recruit, and retain individuals under-represented in these professions. It will fund community outreach efforts, mentoring and tutoring program creation or expansion, and financial support directly to the students in the form of scholarship and stipends.

The program is modeled after a similar successful program, the Nursing Workforce Diversity Act. According to the Bureau of Labor Statistics data, since its creation in 1998, the Workforce Diversity Program has doubled the percentage of nurses from a diverse background. H.R. 3320 seeks to duplicate the success of the nursing program, while providing HRSA with the flexibility to continuously define

which communities are considered under-represented, to grow with an ever-changing health care workforce.

While the bill cites people from ethnic or racial minorities, or those with a disability as an example for an individual under-represented in the profession, HRSA would have the authority to fund programs seeking to increase the share of students from other backgrounds, such as those from rural, military, or agricultural communities.

A study published in JAMA in March, 2021 stated, "Fostering a diverse, inclusive workforce is critical to increasing access to care and improving aspects of health care quality.''

The research shows two important findings. First, health professionals from under-represented and minority backgrounds are more likely to practice in medically underserved areas. Patients who receive care from health care professionals of their own cultural background tend to have better outcomes.

The same study shows the higher education pipeline of the allied health professionals are less diverse than the current workforce findings, which match an analysis of the national college progression rates by the National Student Clearinghouse Research Center. Between 2019 and 2020, the national college enrollment rate fell 9.4 percent for students from high minority high schools.

I thank the committee for the opportunity to come here today and discuss this important issue. The Allied Health Workforce Diversity Act as an opportunity to move our nation along the path to recovery.

I look forward to working with you, and I am happy to answer any questions you might have.

[The prepared statement of Dr. Wilburn follows:]

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

*Ms. Eshoo. Well, bravo. Let it be noted that the baby the family came and testified before the Congress of the United States of America. Bravo to you, bravo.

Next, Mr. Levine, who is the chair of the board and chief executive officer of Ballad Health, welcome to you, and thank you for your testimony to the committee this morning.

STATEMENT OF ALAN LEVINE

*Mr. Levine. Thank you, Madam Chair, and thank you, members.

Before I begin, I would like to say that, in my opinion, I do not believe that we, as a nation, have shown enough respect for the nurses and frontline caregivers in a manner worthy of the sacrifice and labor they have given us. And I am grateful to you and to your committee for affording us the opportunity to embark upon correcting this, and providing them with the support they deserve, and I agree with the advocacy you have heard from my colleagues on your panel.

My name is Alan Levine, and I have the honor of serving as the chairman of Ballad Health, which is an integrated health improvement organization serving the incredible Appalachian Highlands, a non-urban and rural region of about 29 counties the size of New Hampshire. Proudly, also the twenty-ninth best employer for diversity in America, according to Forbes Magazine in 2020.

The Appalachian Highlands is unique for its beauty, low cost of living, and friendly culture. But it is not unique, however, when it comes to an emerging national crisis. And that crisis is the supply and resiliency of our nation's health care workforce. In particular, our nursing professions.

As some of the legislation before you today thankfully recognizes, this challenge to our workforce has a disproportionate impact on our nation's non-urban and rural communities, which make up 85 percent of America's landmass. Despite the financial headwinds brought on by the combination of the pandemic and the major investments necessary in wages due to the shortages, Ballad Health yesterday announced a major partnership with East Tennessee State University, making a $10 million commitment to create what we hope will be a nationally-recognized Center for Nursing Advancement, focused on studying and acting on the issue of nursing resiliency and supply.

As the data in my written testimony supports, the nursing shortage was a crisis before the pandemic. But the pandemic has now revealed the problem of resiliency and the major mental health and behavioral aspects of the last two years. Consider that, since 2016, the average American hospital has turned over about 83 percent of its nursing staff. Twenty-four percent of registered nurse turnover is occurring in the first year, which points to the issue of resiliency. And for the first time now, retirement is one of the top three reasons given for nursing turnover, which is a frightening fact.

The cost of this, in terms of quality of care and sustainability, is enormous. And as I detail in my written

testimony, Ballad Health, an important system operating on a slim two percent margin prior to the pandemic, has now invested, this year alone, a recurring $100 million into mitigating the turnover issue. Once the very generous federal pandemic support is gone, I do fear this could have a lasting impact on our sustainability, as a rural health system.

With 180 rural hospitals already having closed nationally, it is an obvious worry, especially given that we are now paying fourfold for contract labor, with rates as high as $140 per hour for med-surg nurses. Most rural health systems can't afford to do this for very long, and in our case we have nowhere to turn. Seventy percent of our payer mix is government-established payment, while only twenty-one percent is commercially market-based insured. Government payment is not and cannot keep up with the inflation we are seeing in the market right now, and it is further harmed by the arcane and frustrating Medicare Area Wage Index.

Rural health systems like Ballad Health are critical to the health and overall well-being of the communities we serve. Not only are we serving the current disproportionately high chronic health needs of our population and the demands of COVID-19, but as leading providers of preventive services, health education, social care navigation, and employment, community-led hospitals and

health systems are important catalysts for overall community health improvement.

In Ballad Health's case, our programs aimed at helping pregnant women combat addiction, and focusing on the needs of pregnant women whose newborns are likely to experience trauma, childhood trauma, rely heavily upon a skilled workforce, including community health workers, something I hope to expand upon during the Q&A session.

I have included numerous citations in my written testimony, but Linda Shepherd, the chief nursing officer at our Johnston Memorial Hospital in Abingdon, Virginia, and president of the Virginia Nurses Association, summed up our current situation best: "Our nurses'' -- and I quote -- "Our nurses are mentally depleted, exhausted, and traumatized, experiencing pandemic-related PTSD with little or no time to seek mental health services. Suicide among nurses and other members of the medical community is also on the rise.''

Clearly, many of the provisions you are considering here today are intended to get to the heart of this problem. Ballad Health was proud to support, for instance, the introduction of the Dr. Lorna Breen Health Care Provider Protection Act, which should help improve health care providers' mental health, and reduce burnout. And while not on today's agenda, Ballad Health has also been working with Congress, including many of you on this committee, to gain

passage of the Save Rural Hospitals Act to establish a permanent national minimum Area Wage Index to ensure our health care manpower is compensated fairly.

I would like to thank you, Madam Chair and the ranking member, for the invitation to participate in today's hearing, and I especially want to thank Congressman Griffith for his unwavering advocacy for our region.

I would be happy to discuss Ballad Health's initiatives or any other legislative or administrative proposals impacting rural hospitals during the upcoming Q&A portion of this hearing. Thank you.

[The prepared statement of Mr. Levine follows:]

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

*Ms. Eshoo. Thank you, Mr. Levine.

Next, Ms. Monroe, you have five minutes for your testimony. And welcome again, and we are all grateful to you.

*Ms. Monroe. I will put myself on talk.

*Ms. Eshoo. That is it. Now we can hear.

STATEMENT OF STEPHANIE MONROE

*Ms. Monroe. Good morning, Chairman Eshoo, Ranking Member Guthrie, and members of the committee. I really appreciate being able to be here to share a little bit about my story, but also the things I think this committee is doing excellently, and ways that you can continue to support Alzheimer's families and their caregivers.

So, as I mentioned -- as was mentioned previously, I am a Capitol Hill veteran of about 25 years. I am a former assistant secretary for civil rights at the Department of Education. I have had a lot of honors and privileges in my lifetime. This, I would say, is the best job I have ever had. I was working in the U.S. Senate for all of that time.

Despite that fact, and being knowledgeable, as I thought I was, about health care and the needs of very vulnerable communities, and the fact that my brother is a physician at Vanderbilt University, and that my sister is a trained professional educator in Baltimore, Maryland, we were all completely blindsided when, eight years ago, my father received a diagnosis of Alzheimer's.

Now, we shouldn't have been surprised, I guess, because seven years before he started displaying certain symptoms. It took us that long to get a doctor to actually tell us what was going on. And that was lost time that we can't ever get

back, and it was unfortunate, and it was unnecessary.

So we received the diagnosis, we were given a prescription, we were given the name of a doctor to go to see who was a neurologist. And we were basically sent along our merry way in a daze.

This is something that you are just not prepared to hear, no matter how extensive your -- you think your knowledge is. This is your father. This is the man who did everything in your household, all the electrical, the painting, even if he didn't know how to do it, it got done by him.

So we left there, and we were like, you know, where do you start? You know, you are given medications. What do you expect? How do you manage this condition? What does it mean, in terms of long and short term? What are the financial realities of this?

My parents were working class people. They didn't have long-term care insurance. What are we going to do, as a family? We knew we were going to come together and make this work, but what do we really do?

You are not given any support, you are not given -- connected to any resources that might be able to help you along this journey, just a script and a "good luck.''

You don't even know what questions to ask, because you don't know what you don't know. You don't know what

resources exist, or whether they would even be helpful to you. You don't seek caregiver support because, like a parent doesn't consider him or herself to be a child care provider, you don't consider yourself to be a caregiver. You are the mother, daughter, sister, spouse of a loved one, of a father, of a mother. So you are just lost in that moment.

So I am here today, and I know I am just one person, but I want to let you know that I represent the 6.2 million Americans living with Alzheimer's. The scary thing is that number is expected to double by 2060. Thirteen percent of Americans in the U.S. are African American. Twenty percent of persons living with Alzheimer's are African American. Yet, unfortunately, only three percent of African Americans are included in clinical trials to find better treatments for everyone. So I would say we have got a real problem on our hands that we have to address.

So I am here today to urge consideration of the bills on the agenda as a lifeline for caregivers who, unfortunately, are forced often to deny their own health and well-being while caring for others. Too often this results in physical and emotional deprivation, sometimes resulting in the caregiver becoming sicker and dying sooner than the loved one that they are taking care of.

The Alzheimer's Caregivers Support Act authorizes the Secretary of HHS to award grants to public or private

nonprofits to expand and offer training and support services for families.

And at UsAgainstAlzheimer's, we have done surveys of caregivers and their families to understand exactly what mattered most to them. We found that the majority of caregivers reported that their own health care provider knows that they are caregivers, but 74 percent report that the doctor hasn't mentioned anything about resources that might be available to that person. For those who actually did receive training, about 50 percent said they did not receive it at the appropriate time, and fewer than half felt it addressed the situations that they actually faced.

So I would like to thank Representative Waters and Smith for their leadership, and introducing this important piece of legislation, and working to improve it.

I know that I am out of time, but I just have a little bit more to say, just for a few seconds, if that would be okay.

I first want to associate myself with all of the comments that were made by Dr. Wilburn. Having a qualified, well-trained, diverse workforce will be essential to all that we do in this space, as the United States continues to brown and age. We will be the new majority, and we already are in seven different states in this country.

Finally, I just might like to thank and mention a couple

of other bills that are before the committee, and a policy that I hope all of you will support.

The CHANGE Act sits before the committee. That will help ensure that we have early and accurate diagnosis for people like my dad, where we didn't have to waste seven years.

The ARPA-H legislation that the chairman has graciously introduced will help us understand and make sure that we have innovation and research that we can hopefully prevent and treat this disease, with critical innovations that are necessary.

And then the paid leave, which currently is pending before Congress, is absolutely a lifeline for America's caregivers. I am grateful that I live in a position -- I have a position where I am able to access paid leave, but only 77 percent -- 77 percent of American workers do not have that. So I really feel like that is an important lifeline in the strategy that we need that will allow people to be able to take the time that they need to care for themselves, and to make sure that their loved ones with Alzheimer's get the support and the care that they need. Thank you.

[The prepared statement of Ms. Monroe follows:]

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

*Ms. Eshoo. Thank you, Ms. Monroe, very powerful testimony, both professionally and personally. Thank you.

And I think if -- the top criticism of the chairwoman of the subcommittee is allowing both members and those that testify to go over time, but everyone has such good things to say that it is hard for me to lower the gavel on them. So mea culpa.

Dr. Marrazzo, you are now recognized for five minutes, and thank you again for being with us, and your willingness to testify.

STATEMENT OF JEANNE MARRAZZO

*Dr. Marrazzo. Thank you, Chair Eshoo, Ranking Member Guthrie, and members of the subcommittee. Thanks for the opportunity to testify. I am Dr. Jeannie Marrazzo, I am the director of the division of infectious diseases at the University of Alabama at Birmingham. I am also the treasurer of the Infectious Disease Society of America, and I have served on the governor of Alabama's COVID task force.

On behalf of IDSA, I am pleased to support the bill that we are here considering today, the Bolstering Infectious Outbreaks, BIO, Preparedness Workforce Act, and to speak about why this bill is needed.

I also offer support for the Public Health Workforce Loan Repayment Act and the Dr. Lorna Breen Health Care Provider Protection Act.

Addressing bio preparedness and ID workforce shortages is important to me, because I have seen firsthand the devastating effects of COVID-19, with disproportionate impacts on our most vulnerable Alabama residents. The pandemic and recent natural disasters have exposed insufficient bio preparedness and ID workforce capacity at health care facilities across the country.

More than 80 percent of U.S. counties lack an infectious disease physician. In Alabama, our smaller and more rural

communities have little or no access to ID care. During the pandemic, nearly everyone who required intensive care had to go to regional medical centers, which quickly became overwhelmed. Most hospitals in Alabama have limited ID expertise, and rely on informal telephone consultation with regional experts, such as myself.

During the pandemic, I personally received phone calls from physicians caring for people with COVID in rural hospitals, with questions ranging from indications for monoclonal antibody treatment, to antiviral therapy in pregnant women, to management of antimicrobial resistance secondary infections acquired during prolonged hospital stays for COVID.

UAB also serves as a critical hub for HIV and hepatitis care for over 25 counties. While telehealth is an option for many, many Alabama residents do not have reliable internet access. ID workforce shortages limit our ability to prevent and treat HIV and viral hepatitis, and infections associated with opioid and other substance use. A study of the HIV workforce in 14 southern states, including Alabama, found that more than 80 percent of those states' counties have no experienced HIV clinicians, with disparities greatest in rural areas.

Despite the urgent need for a robust bio preparedness and ID workforce, the pipeline for ID physicians lags behind

all other specialties. In 2020, only 75 percent of our ID training programs were able to fill, while many other specialties did so. The average salaries for ID physicians are below nearly all other medical specialties, and below general internal medicine, although ID specialization requires an additional two to three years of training. With average medical student debt of $200,000, the ID specialty is not financially feasible for many.

Of great concern as we work to improve our workforce diversity, individuals from populations under-represented in medicine are more likely to have educational debt, making financial concerns a barrier for them to enter ID, as well. This Workforce Act will address this problem by providing loan repayment for these professionals, with an explicit goal of workforce diversification.

Every community needs a strong workforce to mount rapid, effective responses to ID threats. Trained staff develop and update surge capacity plans, train health care personnel, purchase and manage protective equipment, optimally manage patient flow, perform infection prevention, and oversee antimicrobial stewardship to ensure that ID treatments are used appropriately.

For example, the availability of new COVID-19 therapeutics was often limited, and their administration often complex. Antimicrobial stewardship teams were critical

to determine the most effective ways to deploy these tools to fight COVID.

This workforce was also instrumental in conducting COVID-19 clinical trials. Nearly all the patients that we enrolled at UAB into these trials were from the Birmingham metropolitan area. These patients thus have the advantage of early access to new treatments under study. A larger and more diverse workforce statewide that is more distributed appropriately through our state would expand access to clinical trials, and ensure that these trials reflect the populations that we serve.

In addition to pandemics, bio preparedness and ID professionals are critical in responding to natural disasters like hurricanes and wildfires. Skin infections frequently complicate common wounds. Overcrowding in shelters increases spread of infection. Gastrointestinal infections occur when sewage systems or access to clean drinking water is compromised. And waterborne and vectorborne infections also increase after floods.

Finally, ID physicians are essential in caring for patients receiving transplants or cancer chemotherapy. Early intervention by an ID physician for patients hospitalized with serious infections is associated with significantly lower mortality and readmission, shorter hospital and ICU length of stay, and lower Medicare costs.

In conclusion, the bipartisan BIO Preparedness Workforce Act will help ensure an adequate supply of bio preparedness and ID professionals by providing loan repayment. We are deeply grateful to Representatives Trahan and McKinley for their leadership on this legislation.

We are also pleased to see the Public Health Workforce Loan Repayment Act, as well as the Dr. Lorna Breen Health Care Provider Protection Act that has been introduced.

Thank you very much for this hearing. We welcome the chance to advance these critical pieces of legislation to ensure we have the workforce we need for the future.

[The prepared statement of Dr. Marrazzo follows:]

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

*Ms. Eshoo. Thank you very much, Dr. Marrazzo.

Excellent testimony across the board. Okay, we will now move to member questions, and the chair recognizes herself for five minutes to do so.

To Mr. Feist, the American Rescue Plan provided $140 million to address burnout among health care professionals. How does this legislation, in your view, work in conjunction with that law to address the mental health crisis that you so aptly described?

*Mr. Feist. Thank you for your question, Chairwoman Eshoo. This is an excellent question.

The Dr. Lorna Breen Health Care Provider Protection Act provides the policy language that directs the distribution of those funds from the American Rescue Plan. And in fact, this summer, when HRSA was allocating through the grant process, those funds, I heard from hospitals across the country, chief wellness officers from across the country, who were interested in applying for those funds.

It is clear to me that those funds are going to be used soon. They will be allocated in the next 30 to 45 days, from what I understand, and they will go a long way towards impacting the well-being of the health care workforce, current as well as the future.

*Ms. Eshoo. Well, that is highly instructive to us. Thank you very much.

To Ms. Macon Harrison, I am proud, along with Congressman Crow, Ranking Member Guthrie, and Dr. Burgess, to put forward the Public Health Workforce Loan Repayment Act. Obviously, it establishes a student loan repayment program for public health professionals, and everything that you outlined shows that, I think, if that fund were in place now, there would be a run on the money, because the needs are so great.

How do you currently recruit new local public health staff, especially in rural areas? I mean, can you actually recruit?

*Ms. Harrison. Yes, ma'am, thank you for the question. I appreciate that.

It is definitely one of the main challenges of my role, as a local health director, to -- excuse me -- to recruit against a lot of the larger systems that are just an hour away.

*Ms. Eshoo. Right.

*Ms. Harrison. So often, across the United States, you see individuals who are well trained and experienced in their work travel to larger areas, where the pay is greater, and the benefits might also be.

So recruitment is one of the issues that this loan repayment program really will help us with, and it directs some of that funding also to local health departments.

*Ms. Eshoo. Good.

*Ms. Harrison. Often times we see public health sort of connected together to lots of health care workforce, and we certainly share the responsibility with lots of health care partners. But local health departments really need the help with this in rural areas, as you mentioned. It is very difficult to do that recruitment well.

*Ms. Eshoo. Thank you very much.

The first 10 years of my elected public service was on a board of supervisors, and I chaired our county hospital's board of directors. I must have spent 80, 85 percent of my legislative time on health care, working with the public health department, with -- overall, the health department in the county. So I know those operations well, and it is very sad to me that they have been left behind.

So I think that there is an important Federal role to play, and I think, as we ramp that up, that it sends a real message to county governments, local governments, and those that are responsible for them, that they need to jack up those budgets, as well.

Mr. Levine, I am going to enter into the -- this into the record, but I am curious how North Carolina's and Tennessee's refusal to expand Medicaid has affected your system's financials.

I mean, in my view, surely, avoiding uncompensated care

would help. And there is really trusted statistics on that -- on this, that being in a Medicaid expansion state decreases by 62 percent the likelihood of a rural hospital closing. And conversely, being in a non-expansion state makes it more likely that a rural hospital will close.

Do you care to comment?

*Mr. Levine. Well, Madam Chair, thank you. We, Ballad Health, did support the expansion of coverage for the poor and low-income populations. In Virginia they did do that, and we saw that it did assist us with our programs for the low-income populations.

In the absence of expansion, we began the Appalachian Highland Care Network, providing coordinated delivery for patients that are uninsured, and who suffer from diseases like diabetes and other things to reduce --

*Ms. Eshoo. But I asked you what this has done, relative to your financials and hospital closures.

*Mr. Levine. Well, certainly --

*Ms. Eshoo. I am not so sure about your answer.

*Mr. Levine. Well, certainly, I believe that providing more coverage to people who currently do not have coverage would help rural hospitals with their financial situation. That is -- clearly, that is part of why we were able to reopen a rural hospital in Southwest Virginia.

*Ms. Eshoo. Thank you. My time has expired.

The chair now is pleased again to recognize the wonderful ranking member of our subcommittee, Mr. Guthrie, for your five minutes of questions.

*Mr. Guthrie. Thank you very much, and thanks for everybody being here, and particularly those sharing personal stories, putting a name to an issue, and faces to issues that we have here and you have talked about. It moves Congress from what we all know we should do to what we absolutely need to do and get done. So thanks for sharing that.

I actually want to direct a couple of my questions to Dr. Keel, because, similar to you, we have major cities in Kentucky, but we also have a lot of rural area, and I know we -- I wish that we could have our discussion we had yesterday when you came by the office in public, because it is concerning.

We are trying to do things in Kentucky. The University of Kentucky has put a medical campus in Bowling Green, where I live, a growing town, but it is the surrounding counties and other counties we are most worried about. And so innovation is kind of -- we are moving forward.

And going from, I guess -- medical schools have been four years since -- I am 57 years old. I can't remember when it wasn't. And I know when they went to internships and direct residencies, that was a big controversy.

So what did you face, and how important are public-

private partnerships?

And then what barriers when you say, "We are going to go to a three-year medical school?''

And then how did you ensure that people are adequately trained?

And what barriers did you say to say, "We can still train these people in three years, and get them to where they need to go''?

So you just share your story a little bit.

*Dr. Keel. No, that is a great question. And, as you would imagine, that is one of the first questions I get asked. When you say we are going to be reducing medical school from four years to three years, it gives the impression that we are short-cutting, or we are short-changing the physician training, and nothing could be further from the truth.

Most traditional, four-year medical schools, including ours just a couple of years ago, that fourth year is used almost entirely for electives that the students choose. And a lot of it is used for preparation for interviews for residency programs throughout the state, and throughout the country. The vast majority of the actual core, the curriculum core that prepares the physician, is -- it takes place in those first three years, even in traditional environments.

What we have done, then, is removed the summer experience that a lot of those students have, so they go through the summer. That gives us several months to be able to continue this education in the three-year period of time.

We are using small-group sessions, which provide students with a greater opportunity to have interaction with faculty to learn the material.

We are putting them in the clinics at a much earlier stage. The first-year medical students actually -- not just standardized patients, which provides good training, but they get their hands on real patients at a very early stage in their career, and that helps them matriculate what they learn in the textbooks, and apply it directly to that.

Now, for those students that want to go on to a more specific residency program, like dermatology or neurology or orthopedic surgery, they can use that fourth year to get additional training, going to those residencies. But an individual that wants to go into primary care can go straight from that third year straight into a residency program.

*Mr. Guthrie. Great. Well, I know innovation does come up from the states, and we appreciate that.

Mr. Levine, I am really interested in value-based agreements, and how we enter those into -- and how we pay for health care. In the context of hospitals, instead of fee-for-service, how would supporting value-based agreements

instead of fee-for-service with health care providers encourage a stronger workforce?

*Mr. Levine. Well, that is actually a great question, sir. We have put that to practice.

We began doing these value-based arrangements three years ago. And since then, we have reduced the number of avoidable hospital admissions by 16,000 per year, which, number one, has saved taxpayers and payers and employers about $200 million a year in reduced health care costs. But imagine if we had 16,000 more admissions to our hospitals that we had to contend with during the pandemic. We couldn't have staffed for it.

So the combination of the value-based arrangements, and the partnerships we have with the primary care physician workforce has really helped better manage patients and reduce the cost of health care, taking the burden off of our team members.

So we encourage, and Ballad Health will certainly continue to lead the way in trying to lean into these risk-based and value-based --

*Mr. Guthrie. Okay, thank you.

And I have a question, Mr. Monroe. I am concerned, as you say, that we don't get enough minorities in our studies, in our tests. And I know that I went to a Pfizer study in Bardstown, Kentucky, and one of the people who set up the

test -- I understand, and I believe that, setting up the tests, we absolutely have to focus on that as we set up the test -- and they were trying to get more minorities into the testing, and had a substantial minority population in that area. They just were having trouble recruiting and getting people to come to the test.

So I know we have to set them up and recruit minorities to get into the test. But how do you -- what do we need to do to get more minorities to be more acceptable to come into the testing?

*Ms. Monroe. Well, one of the things that has been interesting to me, I have traveled to 27 cities, talking about recruitment, and mentoring different sites about how to employ strategies. When we have surveyed over 30,000 people, about 80 percent of minorities said that they had never been asked. And so that is the first step, is to ask.

*Mr. Guthrie. Absolutely, I agree with you.

*Ms. Monroe. Not be embarrassed about past things that may have happened, or your fear that they are going to say no. Give them the opportunity.

But I think the workforce issues are important, too. If you go into a place that you don't know, you don't necessarily feel welcome, there is no one who looks like you there, you speak Spanish, no one there speaks Spanish, those are things that put a barrier before you even get to the

place where you are ready to roll up your arms and take a test.

But the National Institutes of Health, I was privileged to serve on their strategy for recruitment and inclusion, and they came up with wonderful suggestions, in terms of what sites can actually do to bring more minorities to the door.

*Mr. Guthrie. And you saw success in that?

*Ms. Monroe. If implemented, we would see success. But we also need -- we need, I think, a series of carrots and sticks. Right now we just have sort of the goodwill of entities wanting to get higher numbers.

But again, if you are coming in at three or four percent, and that drug is allowed to go to market to everyone, without a label that discloses the lower percentage points, I think that is a challenge. And I think we should be looking to see if FDA would make some kind of an allowance when that happens, or require a commitment for a phase four trial that will be really focused on getting minorities engaged.

*Mr. Guthrie. Thank you. I have expired my time.

Thanks for being indulgent, and I appreciate it.

That is a great answer. I appreciate it. Thank you.

*Ms. Eshoo. The gentleman's time has expired. The chair now recognizes -- Mr. Pallone is not here -- Mr. Butterfield of North Carolina, the gentleman from North

Carolina, for your five minutes.

*Mr. Butterfield. Thank you, Madam Chair. Again, thank you so much for this important and informative hearing today. I have listened to all of the witnesses, and they are so resourceful. I thank all of you for your testimony. Let me begin with Ms. Harrison.

Ms. Harrison, you shared with us that public health departments across the country have been hemorrhaging employees, and that it has been difficult to retain and actually hire new staff. My staff is informed that your department here, in North Carolina, has a turnover rate of some 10 to 12 percent for the past 2 years. I don't know if that is accurate or not. You can correct the record, if it is not.

But could you discuss some of the unique challenges that rural public health departments face in attracting and retaining employees?

*Ms. Harrison. Yes, sir, thank you for the question, and thank you for that kind introduction, it is always nice to see you.

I, unfortunately, have experienced about a 12 -- even over the last few weeks that has increased a little bit more -- percentage of turnover that really rarely happens in local communities that are rural. We are fortunate that we do have a lot of staff from our local area, and they are incredible.

I think the challenges we face are low salaries, and salary bands that are not updated frequently at the state level.

I do believe that these loan repayment program opportunities will help us with recruitment, because they are better targeted to local public health, in particular. And as you know, it is sometimes assumed at the Federal level that all the money that you all approve gets to the local level. But that is not always the case.

*Mr. Butterfield. So you are --

*Ms. Harrison. There are state budgets that don't always pass --

*Mr. Butterfield. So you are supportive of loan forgiveness programs, is that right?

*Ms. Harrison. Yes, sir.

*Mr. Butterfield. All right. Let me move over to Dr. Marrazzo.

Thank you so much for your testimony, as well. Duke University Medical Center -- which is in North Carolina, we all know that -- operates two infection prevention and antibiotic stewardship networks. These are designed to help community hospitals prevent superbugs and hospital-acquired infections.

Most of participating hospitals do not have an infectious disease-trained clinician on their own. This

shortage was a problem before the pandemic, but COVID and the strains it placed on the -- on community hospitals simply laid bare the problems that can occur without this type of expertise, with inappropriate antibiotic use and increased hospital infections. Experts in North Carolina are concerned that hospitals not connected to networks like Duke's are faring even worse.

And so, Doctor, are the challenges that physicians in North Carolina experience, are they similar to the challenges that you face in Alabama?

And how will the BIO Preparedness Workforce Act helps smaller hospitals address infectious diseases?

*Dr. Marrazzo. Mr. Butterfield, thank you very much for that excellent question. You describe a very, very similar situation to what we are experiencing in Alabama.

And indeed, we have some smaller programs that are able to do that, but nothing that really can meet the need of the state. So very much echoing, I think, what -- your experience and what many states across the country are experiencing.

The BIO Preparedness Workforce Act will help by expanding the necessary bio preparedness and ID workforce, and incentivizing these providers to work in these underserved communities, so you can actually make it worth their while to get out there and do the service in the places

that really need it.

*Mr. Butterfield. Thank you. Let me move over to Dr. Monroe.

Thank you as well for your testimony. In waiting my turn to ask questions, I researched your bio, and you have impeccable credentials. And just thank you for your years of service.

Dr. Monroe, 10,000 Americans turn 65 every day. Seventy percent of these individuals will need long-term care. However, since March of 2020, senior living facilities have lost over 380,000 caregivers, and 96 percent of assisted living communities currently face shortages. And so do you think the legislation before us goes far enough to address the caregiving shortages in long-term settings, such as memory care and assisted living?

If not, what additional efforts should we consider?

*Ms. Monroe. Well, that is a great question. I think we need to do much more than we are doing. I am not sure exactly what it will take, but certainly these are extremely hard-working individuals. They are not necessarily well-trained. Many of them are just receiving minimum wage, and that is a challenge.

In fact, I can tell you, from personal experience, even as of last week, at the independent/assisted living facility that my parents reside in, my mom has had to, on a weekly

basis, turn away the professional caregivers that come in, because they are unvaccinated.

*Mr. Butterfield. Thank you. It looks like --

*Ms. Monroe. And there has not been a --

*Mr. Butterfield. Thank you, Ms. Monroe, thank you. The patient -- the chair has been very patient with us, but I think we had better yield back.

Before yielding back, Madam Chair, let me ask unanimous consent to enter a statement into the record from a new health care organization, qualified health center organization, called Advocates for Community Health. I would like to get that into the record, and my staff will send it over to you. Thank you, I yield back.

*Ms. Eshoo. So ordered, Mr. Butterfield, thank you.

[The information follows:]

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

*Mr. Butterfield. Thank you.

*Ms. Eshoo. A pleasure to -- and he yields back -- to recognize the ranking member of the full committee, Mrs. McMorris Rodgers, for your five minutes of questions.

*Mrs. Rodgers. Thank you, Madam Chair. I too want to thank all the witnesses for being here and sharing your insights. I especially want to recognize Mr. Feist, and appreciate you sharing the story of Dr. Lorna Breen. It highlighted, I thought, what you said about the parallel pandemic of mental health and suicide, which is so important for us to be focusing on, also.

Dr. Keel, I wanted to thank you for being here, and sharing about your innovative novel curriculum that is improving the pipeline of practicing primary care physicians in Georgia. I wanted to ask, do you think that this is a model that could be replicated in other states, an accelerated three-year curriculum?

And what else can we be doing, as policymakers, to streamline career training for health providers to help reduce that debt burden?

*Dr. Keel. No, that is a -- and thank you for the question.

I certainly believe this is a model that any state in the Union could take advantage of, not only from reducing medical school from four years to three years, which takes

quite a bit of work, as you might imagine. There are some 20, from what I am told, medical schools across the country already that have some form of an accelerated MD program, although I don't believe it is that the scale at which we are doing it, not the entire incoming class that we are doing, but certainly that would be one aspect of it.

But this is the problem, or putting physicians in rural health -- this -- what we are doing is not -- that is not going -- that is not the silver bullet that is going to completely solve everything. We know that. It is going to take support from the individual states, just like we were able to match a major a contribution towards this program by state funds. That the state appropriated it in order to do that certainly will -- goes towards that.

But I think the states themselves are going to have to step up, and the local communities themselves are going to have to step up, as well, to try to participate in this. It is not just eliminating the debt, but it is also finding ways to cover the cost of setting up a practice in a rural area that -- I think that gets to the more local aspects of what might take place.

So this can clearly be implemented in any state, and we will be happy to talk with anyone about what we are doing, and how we are doing it. But it is going to be a program that is going to require a tremendous amount of work across

the board.

*Mrs. Rodgers. Thank you, thank you.

Mr. Levine, CMS provided flexibilities during the global pandemic related to staffing through the 1135 waivers. Some flexibilities help expand access to an array of skilled nurse aides for nursing homes. Some helped waive requirements from NTALA to ensure flexibility in screening and delivery of care while hospitals were overwhelmed during surges, while others helped ensure access to lifesaving telehealth, so our doctors could more easily meet the needs of their patients during the worst of the pandemic.

I think that we should be looking also at the impact on patient safety, and if there is any flexibilities that should remain in place during -- or after that pandemic. And would you speak to the ways that the pandemic flexibilities helped Ballad Health, and then which ones should be considered for permanency after the public health emergency ends?

*Mr. Levine. Well, thank you, Representative. First of all, what I would start with, going back to something you said in your opening comments, you are 100 percent right, that states really did lean into this at the state level, and the flexibility that started with the states by deploying the National Guard, and some of the other things they did to assist us, were extremely helpful.

One of the things I think CMS did that I think

particularly helped us was the expansion of the use of telemedicine. Here, in a rural or non-urban region of the country, the use of telemedicine is important if you are going to bring services, particularly children who suffer from health issues, and -- as well as adult addiction. So the flexibilities with telemedicine, particularly if we can get broadband deployment in non-urban communities in America, that will help.

And I do think some of the flexibilities with staffing, particularly -- and something that was said earlier -- as the pandemic subsides, when we get in the rearview mirror, we are going to see a lot more turnover. And, as we see more turnover amongst our staff, we need the flexibility of other health care professionals, like paramedics, EMTs, nursing assistants in ways that perhaps in the past we haven't used them before --

*Mrs. Rodgers. Yes.

*Mr. Levine. -- flexibilities would help.

*Mrs. Rodgers. Thank you. As a -- I also wanted to note that in your testimony you discussed the increases in the diseases of despair, such as substance abuse disorders and suicides. Can you further elaborate on what you think maybe are some strategies that we can be using to help address the diseases of despair?

*Mr. Levine. You know, I will speak first to the non-

urban and rural parts of America, which, of course, is 85 percent of our land mass. And, you know, they are facing economic challenges.

You look at the -- pre-pandemic, you look at the unemployment rate, and then you look at the workforce participation rates, and you really have to recognize that there is a lot of despair in our region of the country, where we have lost the coal industry, and nothing has replaced it. And so economic despair is one of the big drivers for -- poverty and economic despair are the drivers for those types of behavioral -- and so I would lean very heavily on economic growth, and find ways to help these regions expand and grow their local economy and, therefore, workforce opportunity.

*Mrs. Rodgers. Okay, thank you. Thank you, everyone. I yield back.

*Ms. Eshoo. The gentlewoman yields back. The chair is pleased to recognize the gentlewoman from California, Ms. Matsui, for her five minutes of questions.

*Ms. Matsui. Thank you very much, Madam Chair, for convening this very important hearing, and I want to thank the witnesses for being with us today.

Today's discussion around health care workforce needs is particularly timely, as the pandemic has exacerbated mental health challenges for people of all ages, especially our nation's youth.

As with COVID-19 and other health conditions, when it comes to behavioral health we know that people of color, including children, face disparities in vulnerability and access to care. Coming out of the pandemic, we have an opportunity to save lives by bolstering Federal resources that support community mental health and substance use services. That is why I encourage this committee to consider my legislation that extends and expands the CCBAC Medicaid demonstration program.

My bill supports clinics that hire and train more staff that make it possible for people to receive timely and high-quality care under a comprehensive primary and behavioral health treatment model.

Moreover, we know that we need to take a multifaceted approach to responding to the growing and unique needs of our communities.

I am deeply concerned about the shortage of over four million behavioral health service providers we have seen across the country, so I am pleased that we are discussing legislation today that would extend funding for critical provider education and training programs.

Dr. Keel, I would appreciate your perspective on the need for and benefits of these programs, particularly as you share that psychiatry is one of the seven primary care pathways in your program that aims to address provider

shortages.

Dr. Keel, you note in your testimony that the behavioral health workforce education and -- program is particularly important to students at your public academic medical center. How does this program assist in your students' field placement clinical experience?

*Dr. Keel. And thank you very much for the question. We have not had an opportunity to study the -- that particular legislation well enough to be able to comment on that at this time. We most certainly will do that.

But if I can speak to the issue of mental health, especially as it relates to campuses, we are seeing an extraordinary increase in the need for mental health services on our university campuses. I know this won't be a big surprise to you, as well.

*Ms. Matsui. Right.

*Dr. Keel. And clearly, anything that can be aimed towards not only providing educational opportunities for students to understand that, if they are having issues, they need to reach out to get those services, but also how we, as universities and as -- and how we, as health systems, can provide those sort of services to the individuals that need it the most, whether it is our student population, who are very vulnerable, or whether it is to the rural and underserved areas, and also the minority populations of our

community, who also find themselves in a position where they just don't have access to that.

*Ms. Matsui. Dr. Keel, I want to ask you about another program that you highlighted, a pilot program that enables medical residents and fellows to practice psychiatry in underserved community primary care settings.

In your experience, do integrated services like those made possible by training demonstrations and the CCBAC help strengthen the state's mental and behavioral health service capacity?

*Dr. Keel. Absolutely. And as you may recall from my testimony, one of the residency programs that we are -- one of the specialties that we are emphasizing in this 3+ program is psychiatry.

I am told that, of the 159 counties in Georgia, nearly half of those do not have a psychiatrist in that particular county.

*Ms. Matsui. Right.

*Dr. Keel. It provides an incredible lack of access, again, especially in the rural and underserved areas, for an incredibly much-needed service. So we are certainly hoping that some of the legislation has been proposed that would emphasize not only behavioral health counselors and that sort of thing, but also would emphasize the training of psychiatrists, we can incentivize those individuals to go to

the areas in which they need it the most, as well.

*Ms. Matsui. Certainly. Thank you very much, Dr. Keel. I am going to talk about workforce diversity. My colleagues and I have been working on numerous proposals to help diversify the health care workforce, and I am pleased we are considering several of these today.

In fact, many of the proposals in our package, the Build Back Better legislation, would also help to increase diversity in the provider pipeline, including proposals related to perinatal and maternal workforce development, health professionals opportunities grants, and graduate medical education.

Dr. Wilburn, the Allied Health Workforce Diversity Act would allow HHS to continuously define which communities are considered under-represented. Why is this important when it comes to training new health professionals?

*Dr. Wilburn. Thank you so much, I am happy to elaborate on that.

It is important for the community to match the community in which it serves. So in some areas of our country, under-represented includes racial minority groups. And for others of our country that might be rural and military families. We all know that we have better health outcomes when our providers match the demographics of their community.

*Ms. Matsui. Well, thank you very much, Dr. Wilburn.

I yield back, Madam Chair.

*Ms. Eshoo. The gentlewoman yields back. The gentleman from Virginia, Mr. Griffith.

*Mr. Griffith. Thank you very --

*Ms. Eshoo. For five minutes.

*Mr. Griffith. -- much, Madam Chair.

Mr. Feist and your wife, I am so sorry for your loss. I don't have any questions, but I was appalled at the conditions, and we are going to do our best, which is why I was proud to be an original cosponsor of the bill. So thank you very much for being here.

Dr. Keel, I want to talk to you on another date. I have some crazy ideas about residency reform, as well, but I love the 3+ program. I think that that is a step in the right direction, and I appreciate your innovation there. All right, now I am going to go to Alan Levine from down my way.

As I mentioned in my introduction, Ballad recently was able to reopen a hospital in Lee County, Virginia. The community had gone -- and I shortened it up, because when you are dealing with it, sometimes time goes. It was actually eight years that it was closed. And when the hospital originally closed down in 2013, it cited two reasons: reimbursement and recruitment challenges.

So, Mr. Levine, recruitment challenges predate the pandemic, don't they?

*Mr. Levine. Yes. Yes, sir, they do. And they absolutely did, and it is worse now.

*Mr. Griffith. Yes. And at this point in time, Ballad has not imposed a vaccine mandate on its staff. I am correct in that, am I not?

*Mr. Levine. Yes, sir, that is correct.

*Mr. Griffith. And my estimate -- you tell me if you agree or disagree, or have some number, but my estimate is that you could lose as many as 15 percent of your health care workers if you implemented a vaccine mandate. Am I pretty close to the mark?

*Mr. Levine. We have had some concern about that. And, you know, 63 percent of our team members and 90 percent of our physicians are vaccinated. But, you know, a lot has been said here about the cultural differences in the delivery of health care. And cultural differences don't --

[Audio malfunction.]

*Mr. Levine. We are in a part of the country where, for a lot of various different reasons, people have differing viewpoints on vaccines. And so we have tried very hard to lean heavily into educating people, being a resource, a source of truth for the community on it. And we are going to continue to lean into doing that.

Of course, with the mandates that may be coming down from Medicare, that certainly will change our perspective,

because we certainly, with 70 percent of our --

[Audio malfunction.]

*Mr. Levine. -- government, we can't afford to lose that reimbursement.

*Mr. Griffith. Right. And the problem is, if you get a mandate from Washington, D.C. -- and sometimes in our area -- and people don't realize it -- and you mentioned the cultural differences -- we actually see some of these things coming out of Washington to be kind of cultural colonialism by Washington, D.C. And there is a resistance to the Federal Government, no matter what, in our area.

I am often reminded of the song, Rocky Top, which is actually the anthem of one of the colleges there, in Tennessee, where it says once two strangers went up Rocky Top, looking for a moonshine still. Strangers ain't been seen again, guess they never will. I paraphrased that a little bit, but that is -- you know, there is just a resistance to the folks coming in from outside trying to tell everybody what to do.

And I am concerned that there will be a lot of people, a lot of health care professionals, who will just say, "Forget it, I will go do something else.'' And in this time, where we have -- we still have a lot of unemployment in some sections, particularly in the coal fields, but in other sections of where you serve, there is an employee shortage.

Isn't that also true, for all kinds of things, not just health care?

*Mr. Levine. That is correct, sir. And I think the concern we have -- again, a one-size-fits-all approach doesn't always work. The difficulty in recruiting -- if a team member leaves -- and we, right now, have openings for 700 nurses -- if a team member leaves, getting a new one to replace him is very difficult in a rural region. And so we have been a bit hesitant to impose a mandate, while we continue to try to work with and educate our team members.

We certainly are for them getting vaccinated. But the issue --

*Mr. Griffith. Yes.

*Mr. Levine. -- of a mandate pushing them away is -- obviously, has been a concern for us.

*Mr. Griffith. Well, I think my attitude reflects it. I am vaccinated, but it reflects the area that I represent. I will never vote for a mandate, because that is just going to make more resistance to the vaccine, and more distrust of the Federal Government.

How much has Ballad relied in the past on traveling nurses, and how much are you relying on them now?

*Mr. Levine. It is -- you know, I have served as a secretary of health in two states through hurricanes, the pandemic, H1N1, and the oil spill in Louisiana. And you

know, I know attorneys general, generally, will prosecute and go after organizations that gouge consumers in the aftermath of a disaster, like supplies or gas.

Here we sit, where we are now paying $140 an hour for contract nurses. I have got a nurse at one of my hospitals in Johnson City from Vanderbilt --

[Audio malfunction.]

*Mr. Levine. -- nurses here, four hours away, is because they could get three times more money from contract agencies.

And so we are getting -- right now we have 400 contract nurses in our system. That is helping to offset the 700 need that we have. But I think this is going to get worse --

[Audio malfunction.]

*Mr. Levine. -- after this. And I am very concerned about the impact -- the incremental cost and the impact on quality an over-reliance on contract agencies has, and I do hope somebody can look --

[Audio malfunction.]

*Mr. Griffith. I appreciate it. My time is up, and I yield back.

*Ms. Eshoo. The gentleman, well, yields his time.

I would just like to state a factoid here. At Tyson Foods, 96 percent are vaccinated, 60,000 people vaccinated, thanks to their requirement.

I don't know if -- I have to tell you, if I went to Stanford University Hospital, which is a couple of miles away from me, as a patient, I wouldn't want any doctor, any nurse, anyone coming near me that was not vaccinated. I don't go to the hospital to become infected, so I just -- I wish that we were all on the same page, because I think this back-and-forth on vaccinations, it is -- at the end of the day, I think it is holding us back. Honestly, it is hurting us in our country.

If we were all one, we would march forward, and put this pandemic behind us. Instead, we are going back and forth, back and forth, back and forth, and it is -- we are here, we are doing all this wonderful work with these bills, and yet we can't be sensible enough to listen to those that know what they are talking about.

We want to train more of them. We want to train more of them. We want more in the pipeline, and then we are going the other way.

So excuse my two cents here, but I guess you get to do this every once in a while, as -- chairing the committee.

I am pleased to recognize the gentlewoman from Florida, Ms. Castor, for her five minutes of questions.

*Ms. Castor. Well, thank you, Madam Chair, and I agree with you. We have a safe and effective vaccine, and we are so fortunate that -- to live in America, where we have been

able to distribute it widely. And it is an unnecessary debate, that has cost lives.

But I want to thank our witnesses, especially, for sharing your expertise here today. The frontline health care workers, the doctors, the nurses, the therapists have been nothing less than heroic throughout the pandemic. And the burnout in the stress is very real, though.

I -- one of my best friends, back home in Tampa, is a long-time nurse at Tampa General Hospital. She has worked there for about 30 years. And it was the first -- this summer was the first time I ever heard her say she didn't want to go to work. And then, when we had our very preventable COVID surge this summer, in August, September, when Florida led the nation in the COVID death rate, she just shared she was so tired of seeing people die unnecessarily.

And then I was heartened, though, because another very good friend, who is a mental health therapist, said, "You know, Tampa General has just hired me to go in and talk to the health care workers, and be there for them, and counsel them.'' And I think this was even before the HRSA money out of the American Rescue Plan was distributed. So what a godsend to those frontline heroes.

So, Corey and Jennifer, thank you very much for your testimony, and turning your grief into action that will help other health care heroes on the front lines. During your

advocacy work in speaking to frontline providers about the need for better mental health recognition and services, what do you hear most often from them?

What are the common barriers you hear from those frontline workers on seeking health care, mental health care service?

*Mr. Feist. Excellent question. This answer requires a look at regulatory barriers, as well as just the culture of medicine and the operations.

On September 9th we published an article in U.S. News and World Report that summarized 6 of the barriers that we had heard for the last 18 months from the health -- mental health -- sorry, the health care workforce around some of the things that prevent them from getting mental health treatment: those we -- those are state licensure questions that go above the Americans with Disabilities Act, hospital credentialing application questions, commercial insurance questions, malpractice application questions, medical plan design, or hospitals that require their mental health treatment for patients to come to their own hospitals.

And then, something that completely boggled my mind, which is that physicians' mental health medical records can be subpoenaed in a malpractice lawsuit in many states, and those are not protected from disclosure during a malpractice lawsuit. So those are just six of the areas. But this is a

-- this is something that is so incredibly pervasive across the industry.

You know, Dr. Breen was convinced she was going to lose her license to practice medicine in New York, but she was incorrect. The licensure law in New York doesn't even ask questions about mental health past. She was incorrect, but that thought is pervasive across the health care industry, which is why one of the things that we did this year, in honor of National Physician Suicide Awareness Day, on September 17th, was to ask every hospital in this country to publish for their own workforce just what the what the facts are in their own institution and in their own state. Those that one group of regulatory barriers that I just identified for you need to be all knocked down.

In addition, we have got tons of cultural issues about just health care workforce looking out for themselves and their colleagues, because they go into the business looking out for patients first.

*Ms. Castor. That is kind of unbelievable to me, that there are so many barriers. So did Dr. Breen -- did you -- would you say that again, that she may not have sought help because she was afraid of something involved with her license?

*Mr. Feist. Absolutely. Not only that, though, but once she received help for the first time ever in her career,

after she was discharged from the inpatient unit at the University of Virginia, she was convinced beyond any doubt that she was going to lose her license to practice medicine, and she ultimately took her life only a handful of days later. And she -- and New York State doesn't even ask that question. But the thought of loss of licensure is incredibly pervasive.

I will give you one other example. Every year, new residents come out of medical school and they start their residency in the summer. We have heard from many residents across the country that, as soon as they start their residency, they stop taking their anti-depressants. They stop taking medications. They stop going to see a therapist. They will pay in cash. They will use a pseudonym, all because of this stigma and these regulatory issues.

And I will give you one last example. We heard from a physician in Oregon who received mental health treatment for the first time in her career because she had a reaction to an allergy medicine that created a mental health condition for her. It took her 10 years of fighting to get her license back after that one issue.

This is just incredibly widespread. Now that we have spoken about this issue, others are coming out, and they are talking about it all over the place.

*Ms. Castor. Thank you very much. I yield back.

*Ms. Eshoo. The gentlewoman yields back. The chair recognizes the gentleman from Florida, Mr. Bilirakis, for his five minutes of questions.

*Mr. Bilirakis. Thank you so much, Madam Chair. I appreciate it. And thanks to the witnesses for their testimonies today.

While I appreciate the intent of this hearing to focus on workforce issues within our health care systems and, in particular, the inclusion of a bill that I have cosponsored, the Dr. Lorna Breen Health Care Provider Protection Act, I do want to speak to some of the broader significant challenges we have been seeing during the pandemic amongst our hospital systems, nursing homes, assisted living facilities, and other providers.

And I wonder if we are missing a real opportunity to do more to address these challenges. For example, the Florida Hospital Association and Safety Net Hospital Alliance of Florida recently commissioned a report with projections from the health care workforce in my home state of Florida, which found that, if the current trends hold up, by 2035 the state will be short of supply by more than 65,000 registered nurses and 26,000 licensed practical nurses. And that was using the 2019 -- actually, year 2019 as a baseline, not counting the potential worsening effects of COVID-19, the pandemic.

Even now, one of my local Tampa-area hospital systems,

Advent Health's West Florida Division, has told me that they currently have 1,022 RN openings, and it is not getting any better.

Unfortunately, it is not unique to the hospitals alone, as other providers are also seeing their demand pushed, while their supply is stretched extremely thin. In the mental health space, SAMHSA has estimated an over four million-provider shortage of behavioral health services across the country. Very unfortunate.

Amongst our nursing homes, 94 percent nationwide are currently facing staffing shortages, and the problem is only being exacerbated, as you know, by the pandemic.

We must continue to do what we can to ensure we are supporting clinical education and training, increasing facility faculty, of course, and clinical sites for nursing programs, and allowing for additional flexibilities in our current workforce incentive programs across the system. I believe this is all a non-partisan issue. We all agree on this.

In that vein, I was very glad to see Governor DeSantis sign legislation this summer that created a personal care attendants program, with new entry-level position opportunities for these types of caregivers to count towards nursing assistant requirements in long-term care facilities, along with a path towards certified nursing assistant

careers.

This is thinking outside the box. This is what we need, flexibility. We need innovative ideas such as this to ease the burden to our industry by making it attractive for individuals to enter into the workforce with a robust support system to grow our labor supply.

Another way we can ease this burden is by reducing the demand. So I have a question to my friend from this -- well, originally from the State of Florida, and did an outstanding job as the Department of Health head under Governor Bush, very innovative ideas, and we did a lot together. I served for eight years in the legislature, while he was there doing an outstanding job on behalf of the great people of the State of Florida.

So Alan, Mr. Levine, you mentioned in your testimony the importance of deliberately working towards admitting fewer patients and lowering inpatient hospital admissions by moving towards outcomes-based care at Ballad Health. I could not agree more that we should be promoting value-based care centered on outcomes, which is what Medicare Advantage does so well.

Can you tell us more about the ways you think we can not only increase the supply of the workforce, but also specifically reduce the demand for these services?

*Mr. Levine. Well, I -- Congressman, it is great to see

you again, my friend, and I want to go back to one quick thing that Congressman Griffith said earlier. He was referencing Rocky Top. I do want to point out I am a Florida Gator.

So -- but your question is right on target. All of these movements towards value-based, risk-based payment to our health systems incentivizes us to provide a lower-cost way of delivering care. For instance, Ballad Health was just approved for our new Hospital at Home program that we are going to trial with CMS, because we learned during the pandemic, if we were able to take care of people at home, based on certain criteria, we kept them out of the hospital, and this took the burden off the nurses at the hospital. And that happens with telemedicine and the use of technology. We are going to be moving in that direction.

So anything we can do to avoid going to a hospital is helpful in reducing the burden on nursing staff in the bedside setting. It doesn't diminish the need for health care and health care settings, but it does diversify the health care manpower --

*Mr. Bilirakis. Very good. Thank you. And it is great to be a Florida Gator. I appreciate that, and I think we have a shot against Georgia this weekend. I know it is a stretch, but I am always confident. I am the eternal optimist.

With that, I will yield back. Thank you.

*Ms. Eshoo. You always are, Mr. Bilirakis. Okay, the chairman of the full committee, Mr. Pallone, you are recognized for five minutes for your questions.

*The Chairman. Thank you, Chairwoman Eshoo. I wanted to start out with some questions of Ms. Harrison.

I know your members are local health departments who are often the first and last resort for our local communities. You know, they are on the ground, setting up the vaccination clinics, and all the things that are so important.

The Public Health Workforce Loan Repayment Act is designed to make a significant impact in repairing the public health workforce -- well, and I would say in repairing a broken health care system, you know, trying to help with the workforce, capture new talent who might not have pursued these careers before the pandemic. So I wanted to ask some questions about that legislation to you in that vein.

We have heard today from witnesses on the shortages of providers in several specialties. There are two workforce areas which we know are expecting workforce gaps, due to burnout or leaving for higher-paid positions in the private sector. So -- and if you could tell me, just in a yes-or-no response, would the Public Health Workforce Loan Repayment Act be helpful to address public health nursing shortages, yes or no?

And then what about computer science, or IT professional shortages? Yes or no, because I have more questions of you.

*Ms. Harrison. Yes, sir. On both counts, yes.

*The Chairman. Okay. So let me ask this. There are differences in the authorization levels between the House and Senate versions of this bill. So, in your view, what is the appropriate authorization level needed to have a successful program?

*Ms. Harrison. Thank you for that question --

*The Chairman. That is not a yes or no.

*Ms. Harrison. Thank you, yes, sir.

So the House bill, in my understanding, authorizes 100 million for the first year, and then 75 million after that, whereas the Senate bill authorizes a full 200 million. And so, I think, you know, speaking on behalf of nearly 3,000 local health departments across the United States, in this case more is more, and each dollar goes toward supporting new opportunities to have recruited high-level staff in local health departments.

And so, you know, even with that $200 million, that would support approximately 6,000 staff at the local level. That is just two people, or approximately two people for most local or state health departments. That would not even do the trick, but close.

*The Chairman. So we, obviously, have to go for the

higher amount, at a minimum, is what you are saying.

*Ms. Harrison. More is more. Yes, sir.

*The Chairman. Okay. So then the last question I have of you -- and then I want to ask another question of Mr. Feist -- we have heard from some that investments made in the American Rescue Plan should be sufficient to address public health workforce concerns. So how would the -- and I am not saying I agree with that, but how would the Public Health Workforce Loan Repayment Act complement the one-time workforce-directed funding that was provided by this committee in the American Rescue Plan?

*Ms. Harrison. Yes, sir. Thank you for that.

The difference is long-term versus short-term funding. So when we have the shorter-term funding that comes down in American Rescue Plan Act, it is very prescriptive, once it gets to the local level, about what we may and may not use that funding for. And it is also very short-term. So it doesn't make a lot of practical sense for us to hire new individuals into our agencies, if we know that money is going to run out.

And I think the more sustainable infrastructure building workforce supportive approach is this loan repayment plan, which is more long-lasting.

*The Chairman. All right, thank you. Now I want to go to Mr. Feist.

In the -- again, going to the American Rescue Plan, in the American Rescue Plan Congress provided funding to support key areas included in the Dr. Lorna Breen Health Care Provider Protection Act. So some view the ARP, the Rescue Plan funding, as sufficient in addressing the mental health needs of the provider community, and I view the Lorna Breen Act as the roadmap for sustained investments to ensure the success of these endeavors.

So sort of the same question. In your view, why is this legislation even needed, even with the investments that we made from the Rescue Plan?

*Mr. Feist. We are thrilled that the American Rescue Plan included the monetary provisions of the Lorna Breen Act. But as you just said, sir, the Lorna Breen Act will not only create the policy for the distribution and allocation of those funds, but it will also create a future roadmap for us, with a comprehensive study provision that really addresses the root cause of these issues, and it creates a road map of this -- to take care of the health care workforce, now and in the future.

*The Chairman. All right, thank you so much.

Thank you, Madam Chair.

*Ms. Eshoo. The gentleman yields back. The chair is pleased to recognize the gentleman from Indiana, Dr. Bucshon, for five minutes of questions.

*Mr. Bucshon. Thank you, Madam Chairwoman. While I support many of the proposals we are discussing today, I must ask one important question: Where is the support for physician providers right now?

My friends in the majority are planning to spend trillions of dollars, yet nowhere in their spending package is their help for our providers facing looming reimbursement cuts in the Medicare physician fee schedule set to take effect at the start of next year, as well as sequester cuts and PAYGO cuts that could result in up to a 10 percent reimbursement cut -- and decreased access to care, by the way.

Just last month, here in this committee, I offered an amendment during the reconciliation markup that would have alleviated most of these looming cuts for one year to provide our heroes on the front lines with some relief, as we work in Congress to find a long-term solution to better value their work. However, the amendment was rejected.

So I ask: If not today, when is the right time?

This hearing is focused on supporting providers, which I am all in favor of, providers across the spectrum. How are we not focusing on one of the key issues facing doctors at this time, an issue that will force more early retirements, and continue the trend of our best and brightest students choosing other professions with more financial promise, all

of which is leading to physician shortages, especially in rural America?

We all keep hearing from our providers that this will have grave consequences, and directly threaten access to care. To my friends and colleagues, let's work together to make this a priority for this committee -- this subcommittee, also -- so we can better support our providers.

Also, I want to voice my strong opposition to the HHS rule on surprise billing, and my disappointment that there is not strong opposition from the majority committee leadership. The rule, in my view, does not reflect congressional intent, and may, in fact, violate the law. I urge all of my colleagues to stand up on behalf of Congress and our ability to write the laws and a two-year bipartisan process.

So now, switching gears, Dr. Keel, I want to applaud the work you are doing at the Medical College of Georgia with the accelerated three-year medical school program. I was a cardiovascular surgeon, so I did four, and four, and seven years of residency for primary care -- critical shortages in rural Indiana, of course. I know firsthand that the length of medical school and the student loan debt students leave is a major factor for why our best and brightest students are choosing different professions. In fact, my three adult kids aren't doctors, and my wife and I both are.

In your experience, do you think more colleges can offer

accelerated medical programs like you are doing at yours?

And have you looked at accelerated programs like this for other medical specialties, as well, including surgeons?

*Dr. Keel. Absolutely. As I mentioned earlier, I think this program that we have put together in Georgia can be implemented in just about any state in the Union that is willing to take the time and effort to change their curriculum. And I think that is certainly something that should be considered.

I think to try to eliminate that debt for the reasons that you pointed out just a few moments ago is critical, because -- to encourage these individuals to go into the primary care disciplines because of the reasons that you just alluded to --

*Mr. Bucshon. Yes.

*Dr. Keel. -- in terms of the opportunity to really earn an income and help pay off that particular debt.

We have used the term "primary care'' very broadly, to include not only the things that you would recognize right away, the members would recognize right away: family medicine, internal medicine, pediatrics. But we have also included OB/GYN, emergency medicine, psychiatry, and general surgery.

We have right now a rotation that physicians -- in some of the more rural parts of our state -- take a surgery

rotation in those areas, so they can understand what it is like to be a surgeon, a general surgeon, in some of those greatest -- areas of greatest need.

So yes, I think this can be applied broadly, and we certainly hope to be able to expand it to many other areas, based on what the need is --

*Mr. Bucshon. Right.

*Dr. Keel. -- in a particular area of the state.

*Mr. Bucshon. Right.

*Dr. Keel. Thank you, sir.

*Mr. Bucshon. Personally, I support a six-year medical program, and working with colleges to combine the medical school and college education that eliminates unnecessary, duplicative courses, which -- I love -- I was a chemistry major. I love biochemistry, but I didn't need to take it twice. And genetics, the same thing. So other countries can do this. The question of whether or not people are properly trained really wouldn't be a problem.

Mr. Levine, I have a question for you to finish up here. Has any staff infected a patient at Ballad Health, that you are aware of, with COVID-19?

*Mr. Levine. No, sir, not to my knowledge. Our staff are required to wear universal precautions. Whether you are vaccinated or not, you are wearing PPE, and you are doing everything you can to protect our patients.

*Mr. Bucshon. Great, thank you. I yield back.

*Ms. Eshoo. The gentleman yields back. The gentleman from Vermont, Mr. Welch, is recognized for his five minutes.

*Mr. Welch. Thank you very much, Madam Chair.

Senator Sanders and I -- Senator Sanders convened a workforce roundtable with the leaders in our health care system in Vermont, including the University of Vermont Medical Center, which is our largest. And just to recite the incredible challenges we have in our small rural state, 3,900 nursing-related job vacancies; 70 primary care provider vacancies; 571 long-term care facility vacancies; 386 home health nursing vacancies, and a big turnover, about 28 percent.

The cost of this is brutal. You know, we are a small state, but traveling nurses, which has been the go-to place, is $50 million at the University of Vermont. In a small community, Rutland, which is a really vibrant, but not rich community, $25 million.

And a concern I have is actually -- I don't know who owns these nursing -- traveling nurse agencies, but it is like now a business model, where there is incredible profiteering, and it creates the dynamic where nurses who are, for instance, on staff at the University of Vermont go on a per diem, and then go down 90 miles the road to Dartmouth-Hitchcock as a traveling nurse, and make a lot more

money, and there is no benefit to the community. And I would really welcome thoughts on how to deal with that.

But Mr. Levine, I want to ask you, because in your testimony you discussed how extensive the nursing workforce shortage is, especially aggravated with COVID. And the faculty issue is a real challenge, particularly with the pay gap. So can you be very specific as to the steps we can take -- and this is bipartisan -- to bolster our dwindling nursing force?

And how can Congress help get at the root cause of the dynamic for long-term and sustainable change for our patients?

*Mr. Levine. Well, thank you, sir. I would start by agreeing with the advocacy for the Lorna Breen Act, because nursing resiliency is one of the most critical issues we are facing right now. And the reality is, you know, the East Tennessee State University Center for Nursing Advancement that we just created yesterday, they are going to be an eager applicant for those grant funds to study what causes these issues, and how do we intervene before we end up losing a nurse from the bedside.

The second thing is -- you said it when -- you just said that --

[Audio malfunction.]

*Mr. Levine. We -- our nurse -- the data that I have

seen in 2019, I believe, tens of thousands, as many as 80,000 applicants for nursing school were turned away because there is not enough space in the nursing programs.

I think we have got to lean in to create programs to identify high school students with a propensity towards being successful in the sciences, and get them exposed to nursing as a career where systems like ours would gladly employ them as unlicensed workers, so they could get a -- they could graduate high school with some kind of a certification, and then go into a nursing program and come out with a job.

There are --

*Mr. Welch. Okay, thank you. I am almost out of time, but thank you very much for that.

I would like to ask Ms. Harrison about this incredible challenge of the traveling nurses. How can we deal with that?

How can we make -- I mean, part of it is making the nursing profession more financially competitive, but we can't compete with the traveling nurse, where, essentially, it is a stickup, and a lot of that extra charge goes to, probably, hedge funds. Ms. Harrison?

*Ms. Harrison. Yes, sir. I wish I had a good answer. I think this is a struggle across private-versus-public opportunities to do healthcare delivery. It -- they are very different models, and it is a real struggle to work against

that, for sure.

*Mr. Welch. So nothing to say about that?

*Ms. Harrison. I don't have a good answer for how to eliminate that sense of loss from the public sector to the traveling nurse --

*Mr. Welch. You know, the dynamic with the traveling nurse is this. You have got hospitals, some of them non-profit, some for-profit. But essentially, their ability to serve people is based on taxpayer contributions for Medicare and Medicaid employers, who are employer-sponsored health care. And there is a captive market.

And then the hedge funds, essentially, create this dynamic, where it is incredibly attractive to a nurse, understandably, to go from Burlington down to Hanover, New Hampshire. But we can't sustain that cost.

I mean, is that a topic of concern among your community?

*Ms. Harrison. Well, in rural areas we don't experience that as much. And you know, we have such a short bench, not many opportunities for hiring and retaining nurses, whether it is a local hospital or a health department, in a rural area. So we don't have that dynamic as much as they have in larger metropolitan areas.

*Mr. Welch. All right, thank you.

*Ms. Eshoo. The gentleman yields back. It is a pleasure to recognize the gentleman from Pennsylvania, and

that he is, Dr. Joyce.

*Mr. Joyce. Thank you for yielding, Chair Eshoo, and Ranking Member Guthrie, and our incredibly distinguished panel of witnesses today.

Even before the onset of COVID-19, we were facing multiple crises in our rural health systems, especially in my district in South Central and Southwestern Pennsylvania. Shortages of physicians, nurses, physical therapists, occupational therapists, other health professionals limited what services were available, and often would force patients to travel to Pittsburgh, or even to Philadelphia for care.

COVID-19 has only further stressed a workforce that was already in crisis. Burnout has contributed to an uptick in retirements and providers leading the field -- leaving the field. These have had negative impacts, negative impacts on staffing, and especially in these rural communities.

In my community at health facilities like Windber Hospital and Excela Health, they have been forced to contract with nursing agencies that sometimes double, even quadruple the cost for hourly rates, just to stay operational and staffed to be able to take care of post-op patients.

A misguided vaccine mandate that makes no attempt to account for natural immunity is also driving more and more long and committed professionals out of their fields. This path that we are on is not sustainable, and will not result

in better patient outcomes for the long term.

In order to address parts of this crisis, I worked to introduce the Enhancing Community Health Workforce Act that would reauthorize funding for community health workers to help improve the care coordination in underserved communities.

Mr. Levine, and then Ms. Harrison, what impact do you think a bill like this could have, especially in rural settings?

And I will ask Mr. Levine to answer first.

*Mr. Levine. Well, we -- thank you, sir. We are actively using community health workers now in several programs that we have implemented throughout the region, as a health improvement organization.

One of the things that we are focused on is, as I mentioned earlier, avoiding hospitalization. So we identified social determinant issues. It could be anything from somebody who is homeless, or can't afford their medications. We deploy our community health workers out to assist them. So anything that is done to enhance and solidify their role in the system, I think, would be very positive, and we would strongly support it.

And I applaud you on your statement about the contract nursing agencies. What they are doing is not only financially destroying some of these hospitals, but they are

also distorting the market for nurses, and it is not helpful, what they are doing.

*Mr. Joyce. Thank you for your answer.

Ms. Harrison, would you please address the same?

*Ms. Harrison. Thank you. Yes, sir. So I am not as familiar with the particular program, but recognize the importance of any bill that gets more opportunities to work with community health workers at the local level, especially in rural areas. We do work with local community health workers, and they have been wonderful, especially these last few months.

I think it is important to note that the intent of the grants do seem really helpful, in that they are disease agnostic. So much of the funding that comes to us is very specific. And so I can appreciate what I understand is true about that level of flexibility to address health care needs that might vary community by community. Certainly, COVID funds are critical to address COVID, and there are also many other public health issues that still will need to be addressed, moving forward.

So hopefully, you know, one program will not be accountable to the other. I think we need them all.

*Mr. Joyce. And do community health care workers provide that ubiquitous care that is so necessary?

*Ms. Harrison. Yes. And originally, also, public

health workers were our original community health workers. We definitely need both.

*Mr. Joyce. Thank you.

Mr. Levine, in your testimony you spoke at length regarding workforce shortage issues, and I have heard from several people who run health systems in my district of the challenges of maintaining a workforce, especially in this economic climate.

What should we be doing, as policy-makers, to ensure that rural health care workers want to stay in these critical roles?

*Mr. Levine. Well, one of the first things that really has disadvantaged rural hospitals and non-urban hospitals throughout America has been the Medicare Area Wage Index. The Save Rural Hospitals Act that has been filed, I think, would help solve that.

When 80-plus percent of the counties in the country are below the index of -- clearly, there is an imbalance. And that imbalance keeps rural hospitals from being able to compensate their nurses in a competitive way, with the larger neighboring counties, where the wage index is higher. To me, that is the first thing that ought to be done.

*Mr. Joyce. Thank you for illuminating that imbalance, because we certainly see that throughout my district in Pennsylvania.

Madam Chair, thank you, and I yield the balance of my time.

*Ms. Eshoo. The gentleman yields back. The chair is pleased to recognize the gentleman from California, Mr. Cardenas, for his five minutes of questions.

*Mr. Cardenas. Thank you very much, Madam Chair, and also Ranking Member Guthrie, for having this important hearing on these very important topics.

I want to start with H.R. 1474, Alzheimer's Caregiver Support Act. Alzheimer's disease and other forms of dementia are truly disabling, as patients eventually are no longer able to eat, sleep, or care for themselves. There are more than five-and-a-half -- approximately five-and-a-half million Alzheimer's disease patients in the U.S., and approximately 600,000 of those are in California.

Family caregivers suffer terribly trying to care for loved ones who no longer recognize them, and the role is often like that of a full-time parent doing a hard and thankless task out of love. This legislation would help train and support family members and other important, but unpaid, caregivers in their often unrecognized work caring for Alzheimer's patients.

Ms. Monroe, can you help explain what this legislation would do to help the situation?

*Ms. Monroe. Yes, thank you for that question.

Absolutely. This legislation would help caregivers who are trying to do what is best for their loved ones to be able to access resources as they need them in their community.

There is not a sole source that you can currently go to to find out what exists. We do have some agencies like area agencies on aging, and sometimes -- although we hear now it is only about 30 percent of doctors that are connected to community resources. But families absolutely need that. That is a prescription for their health, and their well-being over the long haul.

When I, for example, have to take my dad to the doctor, I have to do that because I am his voice. So it is important for me to have access to that information, so I can make sure that he does, as well.

As I mentioned earlier, we see caregivers who not only need linkages of services for their loved one, but they themselves may need mental health supports, and respite, and other health care supports for themselves, as this is a daunting, often very physical issue. And --

*Mr. Cardenas. Thank you.

*Ms. Monroe. -- find that caregivers are getting sicker and dying before the people that they are actually taking care of, because --

*Mr. Cardenas. Thank you.

*Ms. Monroe. -- you are making a choice sometimes

between work --

*Mr. Cardenas. Thank you. Thank you, Ms. Monroe.

*Ms. Monroe. Thank you.

*Mr. Cardenas. Thank you very much. In the interest of time, I would like to ask a question regarding H.R. 3297, Public Health Workforce Loan Repayment Act.

The COVID-19 pandemic has really shined the light on what a shortage we have in this country of health care workers, even though the ones that we do have have been heroes, always, not just during this pandemic.

This bipartisan legislation helps ensure we have professionals in place to keep us safe, so we are prepared for future pandemics and the everyday life of caregiving.

Ms. Harrison, what was the public health workforce capacity and infrastructure like before the pandemic?

And with COVID-19, what have been the effects?

And also, how would this legislation help?

*Ms. Harrison. Thank you so much for the question. The -- over time, the recessions and the dips in funding that has come to public health really crippled the workforce capacity, even prior to the pandemic. So we were already at a deficit. And then the pandemic hit, and we were expected to, of course, make sure we could continue to do more and more.

This Loan Repayment Act will help tremendously, with at least being able to recruit and retain over the long haul for

the public health infrastructure, and make up for some of those losses.

The de Beaumont Foundation and the Public Health Innovations Committee has actually done a research study that requests 80,000 new full-time equivalents to public health at state and local levels; 54,000 of those need to come to the local level to just shore up regular functions and capabilities of public health, community-to-community. And so I believe this loan repayment program is a start to fill that gap.

But certainly, our workforce is tired, and we are losing them to burnout. Their cups are empty after 20 months of this level of intense and protracted work during the pandemic. So we need to make sure that we are addressing our appreciation --

*Mr. Cardenas. Thank you.

*Ms. Harrison. -- for the current workforce, and recruiting new ones. This will help.

*Mr. Cardenas. Thank you so much. Thank you.

I would like to, with the remaining time, just say thank you for all of us who are supporting 1667, the Dr. Lorna Breen Health Care Provider Protection Act.

And to Mr. Feist and your family, thank you so much for putting your time and energy into making sure that such a tragedy does not come upon other individuals and caregivers

and their families. So thank you so much for being here with us, and thank you for all that you do.

With that, I yield back.

*Ms. Eshoo. I thank the gentleman for his beautiful words, and he yields back. The chair is pleased to recognize the gentleman from Utah, Mr. Curtis, for your five minutes of questions, the patient Mr. Curtis.

*Mr. Curtis. Thank you, Madam Chair and Ranking Member Guthrie, not only for this hearing and for hearing my bill today, but for putting these hearings together in a tough environment, with COVID, with votes, and all of our other responsibilities. And so thank you for your patience, which we don't always recognize.

The Helping Enable Access to Lifesaving Services Act, or the HEALS Act, is my bill, and I am very proud of it. It reauthorizes the grant program established by the 21st Century Cures Act, something that happened before I came here to Congress.

Funding within the grant would be used to help eligible groups to recruit, educate, and provide learning opportunities for behavioral health care students, including substance use disorders, specialties, psychiatrists, psychologists, and social workers, just to name a few.

The HEALS Act is especially important to me, because Utah, unfortunately, has seen significant increase in demand

for behavioral health care services throughout the COVID-19 pandemic, not unlike our nation. As a matter of fact, the nation has seen an overdose rate increase by 30 percent, year over year.

Dr. Keel, I don't have a question for you, but perhaps a comment and -- to you and some of the other panelists. I have watched over the last few years my son, who is now practicing psychiatry, go through medical school. And you might all enjoy that I visited him once, while he was going through medical school, and he had his water heater turned off, and he was trying to save money to lower his student debt, right, when he came out the other side.

And I know firsthand the difficulty and the sacrifices these health care workers make. My wife is a physical therapist, and does home health care visits. Dr. Wilburn, you are smiling behind the mask, and I have seen the impact on her firsthand, as well.

So thank you for your testimonies today, and for all that you are doing.

Mr. Levine, I am curious how your doctors have been dealing with the increase in demand for behavioral health care services since the beginning of the pandemic.

*Mr. Levine. Well, it has obviously been a huge concern for us. Right now we have expanded our Employee Assistance Program. We are leaning in to every hospital. We have 21

hospitals, we are leaning in every hospital to make it available. And based on what has been said here, I agree, convincing people that it is not only necessary to seek help when you have it, it is a sign of strength, not weakness.

*Mr. Curtis. Right.

*Mr. Levine. And we are doing a lot of education to try to get our physicians and our frontline caregivers with the physicians to take advantage of these opportunities.

*Mr. Curtis. If you are familiar with the HEALS Act, are you able to comment on how that would help your situation?

*Mr. Levine. I am not familiar with all of the relevant details of the HEALS Act, but I can tell you that we would definitely be among those that would apply for these brands because we think, incrementally, it can help us link further in with our physicians.

*Mr. Curtis. You will smile when I say that my district is about 80 percent rural. A lot of you here will understand what that means. Although I do like to tease my colleagues here from the East Coast. I think we have different definitions of rural, and we are really rural out in Utah.

It won't surprise you that telehealth was really critical before the pandemic, and has been even more important during the pandemic.

And Dr. Levine, again, as it relates to audio-only

telehealth services, can you share how Ballad Health, specifically, has been dealing with that, in context to behavioral health?

*Mr. Levine. It has been a huge opportunity for us. Right now we are -- six schools throughout our rural region. Many areas are very, very rural, and so we have got several behavioral programs that we deploy that way, and the audio is really important.

Obviously, we would like to have bandwidth to be able to do full video. And frankly, during the pandemic, some of our largest physician practices, our very large cardiology group, were able to keep up with the patients, purely because of the telemedicine and because of audio.

So I absolutely agree that that opportunity is something we would want to continue to expand and take advantage of.

*Mr. Curtis. Do you have any suggestions for Congress, as we think about the long-term cost benefits of expanding the audio-only telehealth behavioral services with Medicare patients and others that promote this reliable access to quality care?

*Mr. Levine. I think the payment mechanisms that could institutionalize that would be helpful in making them more permanent and predictable. I think that it would help create more investment into the growth of those mechanisms. And certainly, I would always advocate for more broadband to help

with getting beyond audio.

*Mr. Curtis. Yes, broadband is clearly an issue for rural districts.

I have got just a few seconds left. I don't know if anyone else wanted to comment.

Yes, Ms. Harrison, in just a few seconds, please.

*Ms. Harrison. Thank you. I just want to mention that my brother is a nurse in rural Utah --

*Mr. Curtis. Oh, great.

*Ms. Harrison. -- and works in a school system. So I would just add to the importance of including schools in your bill for mental health, behavioral health services, and telemedicine.

*Mr. Curtis. Thank you for the exclamation point on my comments.

Madam Chair, I am out of time. I yield back to you.

*Ms. Eshoo. The gentleman yields back. I especially appreciate your sharing the story about your son training to become a physician, what your wife does. I think it is so important for the American people to hear that we, too, are very human. So thank you.

The chair now is very pleased to recognize the gentlewoman from California, Ms. Barragan. Five minutes.

*Ms. Barragan. Thank you, Madam Chairwoman Eshoo, for holding this important hearing today. I want to thank all of

our witnesses for their testimony, and my colleagues who have shared.

You know, the investments in our caregivers are personal to me, to my constituents, and the American people. My mother is 80 years old, has Alzheimer's, and it has been a struggle, not just in understanding the disease and what to expect, but in finding reliable caregivers for her.

So, you know, we come from a Latino culture background, where we never spoke about this, and we really didn't know where to go for help. So it has been incredibly challenging. And so to hear the stories here today is something I can relate to. But it is something that the American people, especially low-income Americans, maybe those who have cultural differences, have, you know, certainly a hard time navigating our system.

I -- just this week I had to take a red-eye here, to Washington, D.C., to help make sure I was there to provide care overnight. And so it is not easy, and I have to continue to educate myself, and navigate my way through our fragmented health and caregiving system to understand what resources are available.

One of them, of course, is the in-home care program that we are trying to expand under reconciliation, and make sure people can stay in their homes.

And when you hear about the stories of the more than 16

million people who serve as unpaid caregivers, I know firsthand, whether I am one of them, whether I have other family members that are, it does take an enormous toll, and it is -- you know, it takes time, and emotionally is hard, as well.

So I am supportive of the legislation before us today to provide that grant money and availability for that. You know, we need to show compassion to those in need, and invest in our public health workforce and care economy. And so I support the bills today.

Ms. Monroe, I found your testimony to be so powerful, you know, particularly on the lack of culturally appropriate resources for dementia diagnosis. We need to use every available resource available to fight this disease.

We also need to continue to work on getting treatments for Alzheimer's as soon as possible, and I hope we can continue to support the accelerated approval path for medicines to treat serious or life-threatening conditions.

There is a lot of important legislation out there, but what would you say is the most important thing that Congress can do to help advance the fight against Alzheimer's?

*Ms. Monroe. Excellent question. Gosh, I wish I could come up with just one. I think there are probably, I would say, two.

The first would be to make sure that we have timely,

accurate, early diagnosis of this disease that will give people the ability to plan, and take better care of their loved ones.

I would also like to see us adopt a national prevention strategy, because we know that 40 percent of Alzheimer's could be prevented by us addressing a lot of the comorbidities that go along with it. And we have been writing letters, and hope to have that national strategy implemented with some teeth to it.

But, you know, recruiting all communities into clinical research will be really important to make sure that we know that all the medicines and the therapies work well for all people. I think that is a great priority for us because, as we become a majority-minority country, we will be serving the new majority when we do that, and we have just a few years under our belt to get ready to do that.

*Ms. Barragan. Well, thank you for that, and thank you again for all your work.

Mr. Keel, in your testimony you spoke about the need for future physicians to practice in rural and underserved communities. Can you speak to the importance of community health centers, and how your program encourages graduates to practice in these types of care environments?

*Dr. Keel. No, actually, I am afraid I can't comment on that at this time. We rely mostly on academic centers,

health centers within our community-based campuses to help us implement that.

*Ms. Barragan. Okay, got it.

Ms. Macon Harrison, putting your local public health official hat on for a second, what role do you -- do community health workers play in local health districts, such as yours in Granville, North Carolina?

*Ms. Harrison. Thank you for that question. In Granville and Vance Counties, we do have one local federally-qualified health center. It is called Rural Health Group, and we work collaboratively with them. We have enough need for the safety net for primary care services that half of the local health departments in North Carolina do full-scale primary care to complement those federally-qualified health centers and community health centers that do exist that are so critical across rural North Carolina.

*Ms. Barragan. Well, thank you all again for your work and your testimony.

Madam Chairwoman, I yield back.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Texas, Dr. Burgess, for five minutes.

*Mr. Burgess. I thank the chair, and I apologize for being in and out of the hearing today. Trying to stop a friend from writing a $5 trillion bad check, and it has just

not been easy.

Let me just address something with you all, and this has concerned me for a long time, and that is the repetitive provider cuts that are coming the way of our physicians. It happened last December 31st, it almost happened with the last -- we kept them from going over the falls. The same thing is happening this year. It is an almost 10 percent aggregate cut.

And I know people say we will fix it before the end of the year, but it is a risky strategy. Because if you don't, then the very people that we have all been describing as our heroes, and the people that we have depended upon to deliver the care in the worst possible situations, they are going to get hit with this.

And kind of off to the side, we have the agency working on a very, very bad interpretation of our surprise billing rule, which is going to render doctors almost powerless against the big insurance companies.

So there is a lot on the plate of the practicing physician right now, and we have not had a single hearing about how to deal with that, how to deal with these cuts. It is a misguided -- in my opinion, it is a misguided approach.

Now, in an effort to be bipartisan, Bobby Rush and I have a temporary solution that is H.R. 5613, for anyone keeping score at home, that would waive the budget neutrality

requirement from the physician's fee schedule, and then we can offset with unobligated funds that still remain in the provider relief fund.

But again, I would just stress it is so risky to wait until the last minute, because if something distracts us -- and you may have noticed that there are a lot of things that can distract us -- then the provider cuts go into effect.

And this is not a partisan issue. The basis of -- for hearings on that, I think, could and should be bipartisan.

Let me pose a question for Mr. Levine. And again, bearing in mind what I just said about the end of this year, the provider cuts in Medicare reimbursement, there are solutions we can consider that will ensure providers are paid a reasonable amount, such as the bill I just referenced, 5612, that would waive the budget neutrality adjustments under the physician fee schedule.

But do you have in mind what else we could do to ensure that our docs and nurses, their health care providers' pay is competitive, in order to recruit and retain health care professionals, and not burden them so severely?

*Mr. Levine. Yes, Dr. Burgess, these cuts couldn't happen at a worse time, because they are happening right at the same time we are facing the major pressure --

*Voice. Alan?

*Mr. Levine. -- the major market pressure on nursing

salaries. These cuts to the physician community, particularly in rural and non-urban America, are devastating. And for those who are concerned about more vertical integration in terms of antitrust, this is going to lead to more vertical integration.

These physicians, particularly in rural areas, if they get cut, they are coming to the hospitals, and it is going to be -- and that is going to happen more and more, which a lot of people are concerned about, rightly so, as are we. So I think that is issue number one.

Of course, the Area Wage Index that I referenced earlier severely harms the majority of America's hospitals.

I think those two things can help, though, both with nursing salaries, as well as with physician pay.

*Mr. Burgess. Well, thank you for that, and I agree with you, the private equity folks are waiting on the sidelines, and are eager to pounce when our providers despair, and are driven into the arms of someone else.

Let me just ask you a question of your health center. You don't have a mandate for the vaccine there. It is my opinion that the vaccine is a miracle, but mandates are toxic, and drive oppositional behavior. How are you handling that?

*Mr. Levine. Our position up to this point has been to promote vaccines, educate our team members. We have got

about 60 percent of our team members that are vaccinated, 90-plus percent of our doctors. We have started -- actually, I have had some resignations already, just in anticipation of the Medicare mandate that is coming down. So our position has been not to do the mandate, but to educate.

Obviously, that position will likely change with the impending Medicare rule that is being --

*Mr. Burgess. Yes, I think that would be a big mistake. But thank you, everyone, for your participation this morning. It has been a very informative hearing.

I will yield back.

*Ms. Eshoo. The gentleman yields back. It is a pleasure to recognize the gentlewoman from New Hampshire, Ms. Kuster, for her five minutes of questions.

*Ms. Kuster. Thank you so much, Madam Chair. The discussion we are having today on health care workforce and caregiver support is critically important in New Hampshire, where we are experiencing a COVID surge right now.

I am consistently hearing from health care providers in my district about the current workforce crisis. Even before the pandemic, New Hampshire was experiencing an urgent health care workforce shortage, especially in the rural communities in my district. The pandemic has exacerbated this issues -- these issues, and there simply are not enough clinicians to meet current demands.

One hospital leader told me recently they are facing a clinical crisis. Cases of COVID are rapidly increasing and overwhelming medical providers. Hospital staff are stretched thin, and patient care is suffering. So I agree that we must examine and support ways to grow, diversify, and strengthen the clinical care and health workforce.

But we also need to think about ways we can immediately support the providers who cannot meet the current labor demands necessary to care for our communities, especially underserved areas. Our frontline providers have experienced relentless physical and emotional strain over the last 20 months, and they need immediate assistance.

Dr. Keel, in addition to investing in provider mental health and wellness, can you go into more detail about what Congress can do to sustain the health care workforce now and mitigate the immediate ramification of the existing provider shortage?

I am sorry, that was addressed to Dr Keel.

*Dr. Keel. Yes, okay. Could you repeat that question for me real quick? Sorry, I couldn't hear that.

*Ms. Kuster. Oh, I am sorry. In addition to investing in provider mental health and wellness, can you go into more detail about Congress -- what Congress can do to sustain the health care workforce now, and mitigate the immediate ramifications of the existing provider shortage?

And if you would address telehealth, if that is one of the solutions?

*Dr. Keel. Yes. No, I think you have hit on an excellent potential solution. We have been utilizing telehealth extensively for the last several years -- in fact, more than a decade -- dealing primarily with stroke. Initially, we had a telehealth stroke program, a hub and spoke program, where we are attached through telehealth to some 12 or 13 hospitals in some of the more rural areas of our state, and it allows us to be able to address that very serious issue on an immediate case.

One thing COVID has taught us, though, is that the use of telehealth is now more important than ever. And some of the roadblocks that have been in place in past years I think are now coming down. We need to make sure that those roadblocks stay down, so that we can begin to implement telehealth on a more widespread case.

This allows us to -- especially in the rural hospitals, it allows us to keep the patients in the rural hospitals if they don't need to be transferred to a more tertiary care or quaternary care unit like we have. And the telehealth certainly does allow us to do that. It provides the opportunity for the patient to stay in the hospital. That is financially advantageous for the local hospital, certainly, but it also is advantageous because that is where the

families are located, and it contributes greatly to the overall care that the patients receive.

So I am fully convinced that we will see more and more telehealth. And I think the more that we can do to try to make telehealth more readily available and easier to do, and more cost effective to do, it is going to help address the rural health problems we have in this country.

*Ms. Kuster. Great, thank you.

Now, Mr. Feist, from your work on the Dr. Lorna Breen Health Care Provider Protection Act, have you learned of any unique challenges or experiences faced by providers working in predominantly rural or underserved communities?

*Mr. Feist. Apologies, bio break after a three-hour tour.

[Laughter.]

*Ms. Kuster. No problem.

*Mr. Feist. Would you mind repeating that very quickly?

*Ms. Kuster. Did you hear that, Mr. Feist? I am asking about whether you have learned about unique challenges or experiences faced by workers in predominantly rural or underserved communities.

*Mr. Feist. Absolutely, absolutely.

*Ms. Kuster. And what would you recommend we do?

*Mr. Feist. Absolutely. The Dr. Lorna Breen Health Care Provider Protection Act provides funding for the current

workforce, as well as the future workforce, irrespective of where they are, rural or urban.

The issues that we have on the workforce are ubiquitous, regardless of where you are in medicine. And so we need to bring programs right now to the workforce to support their well-being, whether those be peer support programs, or that is redesigning that health care delivery system so that it doesn't burn out the workforce in the process.

If we have heard from one physician or nurse, we have heard from a thousand, "Don't just give me another meditation app. I need you to help me redesign the health care delivery process so that I am not burnt out in the process.''

*Ms. Kuster. Right. Regretfully, my time is up. I didn't get to discuss Alzheimer's, which is near and dear to my heart, but I will follow up with the committee. Thank you.

I yield back.

*Ms. Eshoo. The gentlewoman yields back. The chair recognizes the gentleman from Oklahoma, Mr. Mullin, for his five minutes of questions.

*Mr. Mullin. Thank you, Madam Chair, and thank you for holding this hearing today.

Dr. Wilburn, I would like to start with you. Can you provide just specifics on how the grant program that allowed health workers -- Allied Health Worker -- Health Workforce

Diversity Act would further benefit American Indians and Alaska Native communities?

*Dr. Wilburn. Thank you so much for that question, Representative Mullin. This is such an important point, since American Indian and Alaska Native communities have been hit so hard by COVID.

The Indian Health Services faced a severe health workforce shortage prior to the pandemic, a problem that has only gotten worse. This legislation would provide an opportunity for Northeastern State University, where 20 percent of its student body is American Indian/Alaskan Native, to apply for grant funding to support efforts to recruit more individuals from the community into all of the higher education programs for all of the professions in this bill.

According to the Post-Secondary National Policy Institute, only 17 percent of American Indian/Alaskan Native high school students continue on to higher education, compared to the 60 percent in the U.S. population.

*Mr. Mullin. Thank you. Based on the projected increase for the need for health care professionals, obviously, there is going to be an increased need on that, and we all know that, moving forward. How important is it to understand the under-represented individuals that we need to recruit? And then how do we retain those?

*Dr. Wilburn. Thank you again for that question. Recruitment and retention is really synonymous, and so the best thing for us to do is to be able to support individuals by affinity groups, academic counseling, tutoring, and pipeline programs.

*Mr. Mullin. So when you start talking about recruiting those individuals, is there a program that we have put out there yet that we are thinking about a tool to help recruit them?

I know, for instance, Oklahoma State University, they have paired with Cherokee Nation to have a program designed to go into high schools, and specifically start recruiting people as early as freshmen to say, "Hey, do you want to enter the health care profession? How do we start working with you?''

And then they actually opened a medical hospital, and -- partners with Cherokee Nation in Tahlequah, which is, obviously, an underserved area that is represented by, you know, a large population of Native Americans.

*Dr. Wilburn. So that is an excellent point, and I agree that recruitment begins, really, in middle school.

This program would allow individuals to see themselves in those professions already. Financial implications can seem insurmountable. So what this program would do is really come alongside individuals, and give them a pipeline for

financial support, which we know is often the biggest barrier to academic achievement.

*Mr. Mullin. Well, thank you for that.

In closing, Madam Chair, I would like to echo the concerns among many of my colleagues that said -- regarding the Biden Administration's vaccine mandates. As this committee knows, and as you know, all the last year, through the beginning of the pandemic, my son was in a clinic for traumatic brain injuries. And the individuals that worked with him every day, they showed up understanding the protocols that they had to follow, understanding the work that needed to be done with individuals that had to have rehab to be able to continue to function on their daily life. And they did it in a safe manner.

We have had a workforce that we depended on with our frontline health care workers that we depended on every day, that we cheered them, and we thanked them for what they were doing. And they were good enough to take care of it in the heart of the pandemic. Why are we forcing these individuals now, that worked all last year without a vaccine? Now we are saying that wasn't good enough, even though you were safe, and you protected your patients, now we are going to say that you have got to have the vaccine, when we already are running a shortage, or we are already running short on health care providers and medical professionals, as we are, as it

currently stands.

And so I would like to echo my colleagues and say why are we doing this? I think this committee has the opportunity to make a strong ask to the Administration to relook at this mandate, because they are running out good people when we shouldn't be losing anybody right now.

With that, I yield back.

*Ms. Eshoo. The gentleman yields back. I appreciate your comments. Just a very quick reflection. You -- we all prayed for your son, knowing the condition that he was in, and thank God. You know, it is a good news story.

We didn't know about Delta a long time ago. It is called the novel coronavirus because that it is. We keep learning about this virus. Remember when they told us, "Don't touch your face''? We don't hear that anymore.

So -- and over 700,000 American souls have been lost, over 700,000. So this is about saving lives, not losing lives. And I don't find this -- I just don't think it is menacing. But you know what? There are people that don't agree with me, so they don't agree. But I would place myself in the company of those that know so much more than I do, the very people who we want more to come into the system, those that have studied for a decade or more, to take care of us. They know what they are talking about, in my view, I think they know what they are talking about.

Thank God we have the vaccines. And, you know, as I said to a constituent, do you think that, if I had polio, that I have the right to infect you? I don't think so. Okay.

The chair recognizes the gentlewoman from Delaware, Ms. Blunt Rochester, for her five minutes of questions.

*Ms. Blunt Rochester. Thank you, Madam Chairwoman, and thank you so much to you and the witnesses for this very important hearing on some very vital bills. And particularly, I want to thank the families for their testimony today, as well, as you honor your family members.

Investing in our infectious disease workforce is not only a matter of pandemic preparedness, but a matter of health equity. Today there are 1.2 million people living with HIV in the U.S., and racial and ethnic minorities make up the majority of new HIV diagnoses, people living with HIV disease and deaths among people with HIV.

Furthermore, a large proportion of new HIV diagnoses occur in the South, as well as other rural areas, often in places where there has either been a disinvestment in health care or natural attrition of providers due to other factors. Given that Black and Latinx Americans account for nearly 70 percent of new HIV diagnoses in the U.S., I am particularly concerned about ensuring that there is a diverse and culturally competent infectious disease and HIV workforce

that reflects the populations most impacted.

My bipartisan bill, H.R. 2295, the HIV Epidemic Loan-Repayment Program, otherwise known as the HELP Act, which I am leading with Congresswoman Barbara Lee, would address that issue head on, by helping to make it possible for HIV professionals to live and work in underserved communities. I am really proud of the fact that this was led by our late friend and colleague, Congressman John Lewis, and we are proud to carry on his legacy.

Dr. Marrazzo, can you share more about how the BIO Preparedness Workforce Act will help to recruit diverse clinicians to the ID HIV field, and how this bill will advance health equity?

*Dr. Marrazzo. Well, thank you very much for that excellent question, which is near and dear to my heart, as an ID physician based in Alabama, which continues to experience very high rates of HIV incidence, as you are aware.

I agree with you, that having a workforce that reflects the populations most heavily affected by HIV and other infectious diseases has to be a top priority. We are able to reach the patients who are affected because we look like them, and we really care about them, and that is really important.

The bill, I think, is going to be able to help address health disparities by reducing some of the financial barriers

that I mentioned before to the populations that are most under-represented in medicine, particularly when you factor in the challenge that many of these individuals have with paying some of the considerable loan balances that have already been mentioned. Hopefully, that will really incentivize people not only to do HIV and ID, but to work in these underserved communities.

*Ms. Blunt Rochester. Thanks. And just as a follow-up, I know we have had a lot of conversation about attracting people to rural areas. Can you talk about how this bill would help to ensure that more providers go into HIV care, where they are most needed in these rural areas?

*Dr. Marrazzo. So again, I think part of the challenge with going into rural areas for people doing specialty care is feeling isolated, feeling like they don't really have a community not just to support their work, but who even recognize their expertise.

Again, this bill would support the creation of a network of people, and a network of interdisciplinary team providers, which you know, especially for HIV, is really critical. You need everything from dentists, to social workers, to infection prevention people. So creating this kind of interdisciplinary opportunity for people to go into this field could really make a big difference in making people feel welcome in these communities, and like they really want

to be there and provide the care we need for the populations who most need it.

*Ms. Blunt Rochester. All right, thank you so much. And I just want to shift to the nursing shortage, and especially during the COVID-19 pandemic.

We know that hospital-based nursing programs provide a desperately-needed pipeline of highly-skilled nurses to hospitals, nursing homes, and community settings. Hospital-based nursing schools act as both an employer and educator, delivering successful student outcomes, and nurses who are ready to enter the professional health care workforce because of the experiential education they receive and that they provide. Yet these programs are facing drastic cuts because of the technical glitch and oversight from CMS that will lead to a recoupment of millions of dollars.

My bipartisan legislation, H.R. 4407, the TRAIN Act, would fix this administrative error, and prevent Medicare payment cuts to these critical nursing education programs.

Mr. Levine, I am going to have to ask if you would follow up with me afterwards, because my time has expired, but I would love to hear you speak to the impact of these cuts to nursing programs.

*Mr. Levine. Yes, will do so.

*Ms. Blunt Rochester. Okay, thank you so much.

And Madam Chair, I yield back.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Georgia, Mr. Carter, for his five minutes of questions.

*Mr. Carter. Thank you, Madam Chair, and thank all of you for being here. I know it has been a long hearing, and we appreciate your diligence in staying here.

Dr. Keel, I want to ask you. I am very proud that you are here today, very proud of what we are doing and what you are doing, specifically, in the State of Georgia, in the sense of your 3+ program that shortened medical school from 4 years to 3 years. I know -- as you know, I am a pharmacist, and I have a Bachelor of Pharmacy degree, and it was a three-year degree after our prerequisites were met.

And we always -- we were always concerned that we only got a bachelor's degree, even though it took us three years, as opposed to other people, two years. So what they do, they added on a year, and gave us a doctor of pharmacy degree that took four years. But you are doing just the opposite, and this is good. I just want to ask you about it, and to elaborate upon it.

So let me -- how do you condense it? Did you condense anything that -- exactly how does it work?

*Dr. Keel. That is a great question. One of the things most traditional four-year medical schools do is that that fourth year is aimed at providing students with electives and

opportunities to interview for residency programs in the disciplines that are not considered primary care. That is really -- they are so competitive to get into dermatology, ophthalmology, neurology, those sorts of things.

We have compressed the program, the core curriculum, into three years by eliminating the summers that the students would typically have off, and focusing on the core curriculum at that point in time. For those students that need that fourth year for the electives, they can certainly do that. But for those students who really are aimed at trying to serve in rural and underserved Georgia, they get to go right into their fourth year, and start their residency in the primary care at that point in time.

So we are not shortchanging the education of these students a bit. We are just accelerating the opportunity for them to get out and get to practice.

*Mr. Carter. In medical school, before you can become licensed, you still have to pass the boards. So it is not as if you are not as qualified as someone else. I mean, you still got to -- I know we had to pass the pharmacy boards, as well, after -- even if you got a degree. We had some people who had a degree that didn't have a license, because they couldn't pass boards.

*Dr. Keel. Absolutely. And these students really haven't been in the program long enough to really have any

hard data to show you, but these students in the three-year program are every bit as successful passing boards as those in the four-year program. And we certainly will -- we are going to keep a close eye on that.

There have been other programs in the country that have exercised accelerated programs, and they have shown that the opportunities to pass boards are not diminished at all.

*Mr. Carter. As you and I know also well, we struggle in the rural parts of our state, in rural parts of our country, and in South Georgia, in particular, with attracting physicians to our communities. And this is a way that -- I understand the financing for it is a way that we can get some of the students to locate to some of these rural areas that are underserved.

*Dr. Keel. Absolutely. It eliminates the debt before they ever accumulate it, and that gives them opportunities to really focus on staying in the state, and practicing in those rural and underserved areas, without being strapped with upwards of $130,000 in debt.

*Mr. Carter. Right. And it is such an important part of the rural community because, you know, when people look to go to a community -- and businesses, especially -- you know, they want to know about the education, they want to know about health care. And that gives these communities the opportunity to address those issues there.

*Dr. Keel. Absolutely. One of the things we have -- and rightly so -- focused on today is the need for health care in those rural areas, and the need to put physicians there so that they can provide that health care.

But one -- the other important aspect about this is there is a huge economic development contribution that this program and other programs like it are going to have, as well, for the reasons that you just mentioned. This is an industry, when they choose to locate in an area, regardless of whether it is rural or not, they want to know how is the education system, the K through 12 system, and how readily accessed is health care to their employees.

And so providing physicians incentives to practice in these rural and underserved areas is not only going to help the health disparities that we see, but it is also going to help the economic prosperity.

*Mr. Carter. What disciplines does it cover? Because, as you know, we are really struggling with primary care physicians, we are really struggling with psychiatry, and a number of different disciplines to try to get to the rural areas, right?

*Dr. Keel. And we are focusing on what the greatest needs are in our state, not only the more classical primary care disciplines, the family medicine, the internal medicine, pediatrics, but we are also offering this to emergency

medicine, psychiatry, OB/GYN, and general surgery, as well, because it is not just the need for a physician; some of these counties have very specific needs for specialties, and this is going to help address that, as well.

*Mr. Carter. Just very quickly, what about financing? How are you handling this, as far as scholarships or whatever go?

*Dr. Keel. Right. We were fortunate to get a $5.2 million gift from Peach State Health Plan, a subsidiary of Centene. That was matched by the State of Georgia to give us an endowment that will serve -- serves as the basis for these scholarships, and we hope to raise more money that can also be matched by the state to adjust this, as well.

The communities are going to be -- have a great need to chip into this process, too, because it is in their best interest.

*Mr. Carter. Absolutely. Thank you very much, and I yield back.

*Dr. Keel. Thank you, sir.

*Ms. Eshoo. The gentleman yields back. The chair is pleased to recognize the gentlewoman from Washington State, Dr. Schrier, for her five minutes of questions.

*Ms. Schrier. Thank you, Madam Chair, and thank you the witnesses for testifying at this really important hearing today.

This pandemic has stressed and maxed out our health care system in ways we have not seen before, in ways that we will see even after the pandemic is behind us.

Mr. Feist, first, thank you for coming today and sharing the story of your sister-in-law. I am so, so sorry for your and your family's loss, and I want to also thank you for sharing those harrowing facts about provider burnout, and mental health strains, and physician suicide, and how many physicians are thinking about leaving their profession that they trained so hard for years to enter.

In my state of Washington, 19 months into COVID, our providers are exhausted. I heard from a provider at Central Washington Hospital in my district that COVID rates are still high. The average approximately -- this is a rural hospital -- approximately 40 COVID patients each day, about 28 percent of their overall census. At any given time, 10 to 15 of those are in the ICU. And the nurses, the respiratory therapists, the doctors are tired, and they are also demoralized, especially since most of these hospitalizations could have been prevented with a simple vaccine.

They have about 150 open nursing positions throughout Confluence Health, which is almost a 20 percent vacancy rate. And this prolonged high-intensity work, combined with understaffing, can take a huge toll on mental health.

Mr. Feist, you mentioned in your testimony that Dr.

Breen expressed concern about losing her license if she sought psychiatric care, and it is absolutely devastating. As a physician, I absolutely relate to that sentiment. We are trained to put ourselves on the back burner, to work 36-hour shifts, don't ever show weakness, know everything, postpone relationships, don't even think about having a family. And so it is no surprise to me at all that Dr. Breen felt that way.

And I want to just say here on the record for all my fellow providers in Washington State and elsewhere that seeking help should not put your career at risk.

I am proud that the Washington Medical Commission in my state encourages any practitioner in need to seek help, and to develop a support plan to address any needs they may have, because nothing about seeking mental health treatment or other medical treatment risks the license of a Washington physician or PA.

Mr. Feist, in a perfect world there would be no stigma. But in the meantime, do you know of any physician-led or provider-led efforts to create a more supportive environment for providers who are going through what Dr. Breen went through?

*Mr. Feist. It is an excellent question. What we have heard from the health care community through nationwide surveys, particularly because of this stigma, is the number

one-thing that the health care workforce wants right now are scalable peer support programs. The military has used these type of programs in the past, battle buddy programs or peer support programs. Physicians, like others, nurses, like others, want to speak to someone who has walked the walk a mile in their shoes, and those are the things that we have heard repeatedly from the workforce themselves.

And what we have also heard are there are health systems in this country that are stepping up, and they are delivering those services to the workforce. They are not delivering them fast enough, but those are just one significant thing that the health care workforce is stepping up to do to support them.

The other big piece of this, though, as I mentioned previously, is that we -- is that there are systems that are also working on trying to figure out how to redesign health care delivery so that it doesn't burn out the workforce in the process. And there are systems. Probably not enough, certainly not enough right now that are making inroads to redesign the health care delivery so that it doesn't burn out the workforce in the process.

*Ms. Schrier. I appreciate those comments. You know, sometimes it is -- it just helps to know that you are not the only one. And so those peer programs sound phenomenal.

I just want to add to your list that Washington

Physicians Health Program is one program that provides behavioral health support to physicians in Washington State.

I have very few seconds remaining. I just wanted to turn to Ms. Harrison.

Thank you for coming today. Can you talk a little bit about the pay of public health providers who simply don't get paid enough?

We need to have the ability to surge public health needs if another pandemic or some other thing comes along. I was wondering if you had some ideas about how we can boost salaries and incentivize students to join the field.

*Ms. Harrison. Thank you for that question. And salary is one of the most pressing issues that we deal with in recruitment and retention. The last two people I have lost out of my health department have been pulled away for similar jobs at more than $10,000 a year of an increase in their salary, and we just don't have the budget to compete with that.

I do think that these loan repayment programs will help alleviate a little bit of that to give an alternate benefit for individuals to come to a local health department. But I do think we need to do a better job addressing salary bands and ranges across the board for public servants that are dedicating so much of their time and energy pre-pandemic, and certainly even more during the pandemic. Thank you for that

question.

*Ms. Schrier. Thank you. I yield back.

*Ms. Eshoo. The gentlewoman yields back. I am pleased to recognize the gentleman from Texas, Mr. Crenshaw, for his five minutes of questions.

*Mr. Crenshaw. Thank you, Chairwoman Eshoo, and thank you, Ranking Member Guthrie, for holding this hearing. Thank you all for being here. It is an important topic, and I want to echo many of my colleagues in thanking the tremendous work done by our health care workforce over the course of this pandemic. It has been a hard strain on them, to be sure.

But also, it is worth noting that the shortage of physicians has been occurring for quite some time now, and there is a lot of factors involved in that, which we are talking about today. I think some of these bills are an excellent start to dealing with some of those problems. But a lot of them don't get really quite at the core of the issues, and one of which was just mentioned.

People need basic incentives to be able to deal with the work that they are doing. One of those incentives is, of course, pay, pay that is proportional to the hardship that they are enduring. And the other is workforce environment. Are they dealing with endless amounts of red tape and regulations that make their daily job just insufferable? And these are things that maybe we could affect, here in the

Congress.

One I want to dive into specifically, which is the ever-changing cuts to reimbursement that comes down from CMS. Any time that we might be trying to save money in Medicare, we often make cuts to physician reimbursement. And that, of course, is a strain on the workforce.

This question is for Mr. Levine. If we simply continue adding more benefits and requirements on a system that is indeed antiquated without adding structural changes, how will that impact a health system like yours, which is beholden to this centrally-planned set of fee schedules and payment systems?

*Mr. Levine. Well, that is the core of the problem, Representative. A good example is, as fast as wages are rising with -- for nurses and other health care professionals right now, 70 percent of our payer mix is Medicare, Medicaid, and uninsured. The payment system is not keeping up with the market.

So, on the one hand, we have a government pricing model downstream, where we are trying to go deal with the free market in employment -- we are dealing with two competing systems. One does not support the other. And so my advocacy would be to, again, deal with the Medicare Area Wage Index issue, and move more towards a market-based model, where the market can keep up with the labor costs.

And I am telling you, this is going to be a massive crisis for rural and non-urban hospitals, because the Medicare payment system cannot keep up with how fast the market is moving, in terms of the cost of labor.

*Mr. Crenshaw. Do you anticipate losses and -- in physicians in this country?

I mean, do you anticipate -- and what does that look like? I mean, can you paint a picture for us?

*Mr. Levine. Yes, sir --

*Mr. Crenshaw. A little bit more specific?

*Mr. Levine. Yes, it is already happening. The expected cuts to physicians that is forthcoming, I have already got physicians coming in saying either I employ them, or they have to leave, which would be devastating to our rural region.

And listen, I mean, if you look at just two years ago, I paid -- for the third quarter that just ended, contract labor cost -- the quarter that just ended, $23 million for contract labor. And we put $100 million into wage adjustments in the last year. We only generate a two percent operating margin. So that is almost triple our operating income that we put into wage adjustments this year that the Medicare system is not keeping up with.

*Mr. Crenshaw. So in Houston we are seeing more and more physicians flock to the direct primary care model of

medicine, so that they can see less patients for longer, and actually do what they got into medicine to do, which is treat patients.

I love this model, it keeps patients out of the emergency room, gets doctors back to that direct relationship with patients. It is affordable for patients. I mean, we are talking between 50 and $100 a month for this, what is total access to a primary care physician. It doesn't solve the insurance problem, but it sure helps us solve the insurance problem.

Do you imagine that a program like direct primary -- or model like direct primary care, or other models of direct contracting could increase the number of physicians in the workforce, especially in the primary care area, where we really see a shortage?

*Mr. Levine. Yes, sir. I could tell you, with the move to value-based models, for the first time we are seeing primary care doctors, pediatricians, and OB/GYNs who are earning more money, because it has moved to a market-based model, where, if they are able to reduce avoidable admissions, they share in the savings of that.

So five years ago, a pediatrician might make -- might have made $150,000 a year. Some pediatricians now can make as much as $300,000 or $400,000 a year, and it actually cost the system less, because they are now are now partnering with

us in reducing wasted inpatient utilization and other high-cost types of care.

So yes, I think those are the right models.

*Mr. Crenshaw. I appreciate that. I am out of time. I yield back, Madam Chairwoman.

*Ms. Eshoo. The gentleman yields back. The chair is pleased to recognize the gentleman from Maryland, Mr. Sarbanes, for his five minutes of questions.

*Mr. Sarbanes. Thank you very much, Madam Chair. Thanks for this hearing today.

As has been testified to today, we know that a well-trained workforce is absolutely critical to supporting high-quality health care delivery, and every other dimension of our health care system. These issues have, obviously, only become more important over the past year-and-a-half during the pandemic. It has added some pressures. It has laid bare and given transparency to pressures and challenges that were already there, of course.

And we have heard a lot of important testimony today about, particularly, the toll that the pandemic has taken on our health care system and our health care heroes, as we have come to call them. We have got to make sure that we put more than just phrases behind their efforts, that we put real work and resources behind them, as well.

These are issues, the health care workforce issues, that

I have been privileged to be working on for a number of years. I was able to work into the Affordable Care Act the establishment of a National Health Care Workforce Commission. We are still working on getting the funding in place to support that, but the idea was to evaluate these workforce needs across the country, and then be a resource for us, as policymakers in Congress, in making some decisions about how to address the shortages.

And we know how important it is to do that. It is estimated there will be a shortage of between 18,000 and almost 50,000 primary care physicians by 2034, and a shortage of between 20 and 75,000 physicians in non-primary care specialties.

Dr. Keel, can you speak to what the value of a national perspective on addressing these health care shortages, health workforce shortages could be, in terms of evaluating where we are, and making sure -- because I know, for example, during the pandemic we saw this situation of health care workers traveling the country to meet shortages. And at some point there was a kind of robbing Peter to pay Paul dimension to this.

So speak to the value you think, if you do believe it offers value, bringing a kind of national perspective, and getting that kind of a commission in place.

*Dr. Keel. Well, I -- it is really hard to place a

value on the importance of providing local health care in some of our most rural and neediest parts of the state. These -- we have eight counties in the State of Georgia that has no physician, whatsoever. I am told that, up until this past year, we had three counties in the State of Georgia that had no EMS service, and that is a very sobering statistic.

So the -- we aren't going to be able to address this issue of health care disparities, especially in rural parts of the state, until we can tackle the problem of how we incentivize physicians to go there and practice, to start off with, which is what our 3+ program is really intended to try to do.

As I mentioned previously, the economic prosperity of these areas is also critically dependent upon the availability of quality health care, whether it is a regional or local hospital, or whether it is a --

[Audio malfunction.]

*Dr. Keel. -- what it means to this country for us to finally get a hold on this issue of providing health care at the local level.

*Mr. Sarbanes. I appreciate it very much. Obviously, figuring out how we design the pipeline so they get to the places that need these health care workers the most is absolutely critical. And I imagine, as well, thinking about, in particular -- in moments of particular need, how you

triage the workforce, and bring it to bear with certain intensity in key places that have that need.

Mr. Feist, real quickly, comment, if you would -- I have got a bill I have worked on for years called the Primary Care Physician Reentry Act, which is to get retired physicians to come back into the practice of medicine to help us with these workforce needs.

Could you speak to how incentivizing that, to bring those physicians back in the workforce, could help with the burnout and some of the mental health challenges that you have been talking about today?

*Mr. Feist. Sure. Briefly, we have a workforce shortage right now in health care across all fields and all specialties. And so the more workforce that we can bring to take care of the patients that we have, the better.

What we also need to do, at the same time, is we need to redesign the health care delivery at the same time, not just throw more people at the problem, if you will. But that would be a significant step towards helping this workforce right now get out of this pandemic.

*Mr. Sarbanes. Thank you very much. I yield back, Madam Chair.

*Ms. Eshoo. The gentleman yields back.

Next we will -- I will recognize the gentlewoman from Massachusetts, Mrs. Trahan, for five minutes for your

questions.

*Mrs. Trahan. Well, thank you, Madam Chair. Thank you to the families and the witnesses for giving us their time and their expertise today. Also, I just want to thank Chairman Pallone and Chairwoman Eshoo for holding this important hearing.

This hearing is so timely, as the COVID-19 pandemic has exacerbated workforce issues that were already present, pre-pandemic, across the health care continuum. You know, I am pleased this committee recognizes that, and is highlighting legislation that aims to address these issues, including my bipartisan bill, the Bolstering Infectious Outbreaks Preparedness Workforce Act, or the BIO Preparedness Workforce Act, which I introduced with Congressman McKinley.

Madam Chair, I would love to offer a stakeholder letter of support for the BIO Preparedness Workforce Act for the record.

*Ms. Eshoo. Ordered.

[The information follows:]

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

*Mrs. Trahan. Thank you. As many of my colleagues have expressed today, COVID-19 has highlighted longstanding health disparities in the U.S.

In addition to COVID-19, other infectious diseases like HIV also disproportionately impact people of color, and people of color face greater barriers in access to health care. At the same time, Black, Latinx, indigenous, and other communities of color are under-represented in medical professions.

The BIO Preparedness Workforce Act authorizes HHS to consider geographic equity, and ensure that contracts help to increase the number of under-represented minority individuals serving as bio preparedness health professionals or infectious disease health professionals.

I am concerned about the disproportionate impact of COVID-19 and other infectious diseases on underserved populations, including our communities of color, and it is important to increase access to culturally competent health care, particularly during a pandemic or another public health emergency.

Dr. Marrazzo, you mentioned to my colleague, Congresswoman Blunt Rochester, how you believe the BIO Preparedness Workforce Act would help diversify the bio preparedness and infectious disease workforce. But could you elaborate on why a more diverse infectious disease workforce

is important to advancing health equity?

*Dr. Marrazzo. Yes, thank you so much for that question, Mrs. Trahan, and I am really grateful that the bill that you are sponsoring specifically gives the Secretary of HHS discretion to award loan repayment contracts in a way that increases the diversity of our workforce.

As I mentioned before, financial challenges probably pose an even greater barrier for individuals from underserved communities to pursue careers in infectious diseases and in bio preparedness. A more diverse workforce really addresses the need for a culturally competent workforce.

We know, as I mentioned before, that we do better, we resonate stronger with providers and people who look like us and who understand our specific health challenges. So getting a more equitable distribution of ID professionals, not just geographically, but also across these different strata of society, is really going to be critical to reach the patients that we need to reach.

*Mrs. Trahan. Thank you for that. And in addition to physicians, many other health professionals are critical to bio preparedness and infectious disease care. I mean, many of these professionals, including our clinical lab professionals, our advanced practice nurses, and others are also struggling with workforce shortages and burnout.

Dr. Marrazzo, can you also elaborate on the types of bio

preparedness and ID health care professionals, including their roles, their recruitment challenges, and how the BIO Preparedness Workforce Act would help them?

*Dr. Marrazzo. Absolutely. I don't think anything has illustrated the need for a team approach more than this pandemic. We have all felt it very, very urgently.

So in addition to physicians, you need a team of health care professionals, and those include clinical laboratory professionals, infection preventionists, ID-trained pharmacists, advanced practice nurses, and physician's assistants. All of these folks are really critical to staff the sort of workforce that we need to deal with these things. And very importantly, all of these professionals are included in the BIO Preparedness Workforce Act.

These people are already in short supply. Twenty-five percent of health care facilities have a vacancy for an infection preventionist position, with more than half of long-term care facilities, which have experienced incredible COVID challenges, as we know, having experienced a loss of an infection preventionist in the last 24 months. These shortages are likely to grow more in the future, as 40 percent of the infection preventionist workforce is expected to retire in the next 10 years.

The other area is laboratory personnel. There is a very high total vacancy rate for clinical microbiologists, just

over 10 percent. And also, that is a field that is aging. Probably about 17 percent of them are going to retire in the next 5 years.

And then finally, pharmacists. We work very closely with ID pharmacists to make sure people are safely treated with many infectious disease agents, and they are very much in short supply. A 2018 survey of the acute care U.S. stewardship workforce found that pharmacists and physician staffing ratios, particularly in places in the country like ours, are well below recommended levels for stewardship to be optimal.

*Mrs. Trahan. Thank you so much for that detailed response, and I yield back. Thank you.

*Ms. Eshoo. The gentlewoman yields back. The chair is pleased to recognize the gentlewoman from Texas, Mrs. Fletcher, for your five minutes of questions.

*Mrs. Fletcher. Thank you so much, Chairwoman Eshoo, and thank you for holding this hearing, of course.

Thank you to our witnesses for joining us today. We appreciate all of you taking time from your practice, classrooms, and family rooms to join us and share the insightful testimony that you have today.

Certainly, as many of my colleagues have noted throughout the hearing today, the last year-and-a-half of this pandemic has really inspired a renewed sense of

gratitude to our health care workforce, and the possibility of a normal post-pandemic reality could not be realized without the tireless work of all of the health care heroes across our country. And I am proud to represent so many of them, so many health care providers living and working in my district in Houston, in and around the Texas Medical Center. We are so fortunate to have just this incredible care in our community coming from Houston, which is the most diverse city in the country.

We also know that -- and as your testimony highlights, Dr. Wilburn -- that our health care workforce is lacking in diversity, and studies have highlighted the alarming under-representation of people of color, mostly Black, Hispanic, and Native American, in the health care field. Obviously, we just talked about this in the context of Congresswoman Trahan's questions, and I think it matters, you know, across the spectrum, in terms of provision of health care.

So, in light of those disparities, in infection that we have seen over the last year-and-a-half, the health outcomes that we have learned more about, and seeing, as well as, you know, longstanding disparities in chronic illnesses, this issue is just so, so important.

So Dr. Wilburn, I wanted to ask if you could describe the lack of diversity in allied health professions in terms of what groups are most under-represented, and in what

fields, and then maybe follow up with talking a little bit about what the barriers that students of under-represented backgrounds face in their pursuit of a career in the health care workforce.

*Dr. Wilburn. Absolutely. Well, as I stated in my testimony, the JAMA results were not promising for the allied health professions. Disparity is large among all of our allied health professions. As a reminder, that includes physical therapy, occupational therapy, speech language pathology, respiratory therapy, and audiology.

And so what this does is that, when under-represented groups are not represented in health care, we really miss the mark, and we are not able to provide culturally competent or culturally humble care. And when that occurs, it is a devastating effect, not at the individual level, but at the community level, as well. So this could really have great devastation among many areas.

For example, during COVID, urban areas were hit hard, very large, and those areas are a very large representation of minority groups. So passing this legislation would be key. It would give us a pipeline. It would provide supports. It would give first-generation students like myself an opportunity to see a pathway for a clear trajectory in health care.

Also, thank you, coming from the great State of Texas.

My parents retired there.

*Mrs. Fletcher. Oh, terrific. Well, I have to say that very recently I have been working with -- in my own family situation, a lot of folks in occupational therapy, and it is so incredible to see the quality of care, and the patience, and the dedication of our health care workforce. It really is incredible, what you all are able to do, able to accomplish, all of our health care professionals, and it is so important to the patients and to the families.

And so I was hoping, with the little bit of time that I have left, that maybe you could just -- I appreciated the thoughts that you shared in your testimony, and how your path to occupational therapy would perhaps have been different if this bill, H.R. 3320, would have -- when you were starting your career. And so, with that in mind, I would just like, with the time we have left, maybe you could talk about a little bit more from your professional perspective now, what benefits are associated with an increase in the diversity of the allied health care workforce for prospective students and patients.

*Dr. Wilburn. Sure. So what I could imagine is, really, a spark of innovation. Under-represented groups largely go back to the communities in which they came from to serve. So that -- we know those communities best, and we live in those communities, we grew up in those communities.

And what we can offer are perhaps areas of innovation that, you know, non-majority populations that serve us, or majority populations that serve us, haven't thought of yet.

So really, I see this as an opportunity for a pipeline of talent that has not yet gone noticed. This would really improve health outcomes. We know, when our providers look like us, when they come from the same cultural backgrounds as we do, we have improved attendance rate, we have improved compliance with interventions, and we are an essential part of the inter-professional and inter-collaborative teams.

*Mrs. Fletcher. Terrific. Well, thank you so much for that.

I am out of time, but very grateful, Madam Chair, for hosting this hearing. And with that, I will yield back.

*Ms. Eshoo. The gentlewoman yields back.

You know, with each member that speaks and asks the questions, it is a reminder all over again what an extraordinary subcommittee this is. And you can see what our attendance -- I mean, you have been here since 10:30 this morning. But to -- the attendance of all of the members, and their diligence, their work, what they care about is all on display, as your testimony is. So I just wanted to say that.

And we now have members that would like to question that are not members of the subcommittee, they are members of the full committee. And so they are waiving on, and we welcome

them.

And the chair recognizes the gentleman from Ohio, and that he is, very much a gentleman. His father served in the Congress, as well.

Mr. Latta, you have five minutes. Welcome to the subcommittee.

*Mr. Latta. Well, Madam Chair, thank you very much for allowing me to waive on, and I always appreciated the time that I spent on this subcommittee.

And again, I want to thank the witnesses for you being here today, for your testimony, because it is so important for us to hear from you, because the only way we can enact good legislation is by hearing from you all.

You know, over the last year-and-a-half, the COVID pandemic has tragically taken the lives of hundreds of thousands of Americans, and fundamentally changed the way we view the world. In the beginning, millions of Americans closed their businesses and paused their lives in an attempt to slow the spread of the virus. Through it all, our frontline health care workers, even with PPE shortages and no vaccine, stepped up to the plate to serve.

Prior to the public health emergency, our country was already facing a shortage of qualified labor and industries across the entire economy. The pandemic has only exacerbated this labor crisis, with burnt-out workers and early

retirements. I don't know how the situation can get any worse.

But unfortunately, when the President announced his vaccine mandate -- which I believe is unconstitutional -- for all Federal workers and 17 million health care workers.

I have seen this across my district, as I have traveled across it during the pandemic. I heard from staff in numerous hospitals and from other health care facilities about their concerns with being short-staffed, and it is a great concern. I was told at several hospitals that, due to the state vaccine mandates in other states, their employees from these other states were coming into Ohio, because there were no mandates. One health care provider stated that it could lose almost 30 percent of their staff to the vaccine mandates. If this is true, there is no doubt that patient care and access will suffer, and possibly result in up to 50,000 patients in need of finding other facilities.

And that is why I introduced the Health Care Workforce Protection from Mandates Act. While -- the legislation would prohibit the HHS Secretary from forcing the mandatory COVID-19 vaccination of workers employed by participating entities in the Medicare program, unless the Secretary certifies in writing that this mandate would not result in staffing shortages.

Mr. Levine, if I could start my questioning, we

acknowledge the importance of educating our employees about the vaccine with real-world data and de-politicized science. Given this, isn't it true that hundreds of your staff, including critical frontline nurses, could or would lose their -- leave their positions or be fired if you have to enact the COVID-19 mandate?

*Mr. Levine. Sir, I haven't yet seen the rule come out of Medicare, but my presumption is that that could be the case, be vaccinated or be fired. I suspect that there would be some loss of some of our frontline employees.

*Mr. Latta. Now, just out of curiosity, because, again, as I -- what we saw from -- happening in Ohio, with individuals coming in from Michigan to Ohio, especially because my district borders the southern boundary of Michigan, that we did see people crossing the state line to work in Ohio.

You know, when you would look at the -- you know, you haven't really -- you said they haven't really looked at the specific numbers, but have you had any people that have come to you saying that they might even leave the health care profession?

*Mr. Levine. I have, and I have had some resignations, just from the fact that we are even considering the mandate. We had a very public resignation last week.

We are -- and I just want to be clear, I know you have

got limited time, but no organization has been more invested in trying to educate people on why it is important to be vaccinated than Ballad Health has. And we think everyone should be vaccinated.

But we also have an obligation to take care of people who have heart attacks and strokes who come into our hospitals. In a rural region, everybody we lose, it is, right now, very difficult to replace them.

*Mr. Latta. Well, you know, you bring up a point, because I know that, you know, as I go through my facilities and hospitals in my district, and also the different colleges and universities that I have, you know, we have got -- we are trying to get more and more individuals engaged in the health care profession. We already knew we were going to have a shortage because, even before the pandemic, especially when we were thinking about individuals out there who are Baby Boomers, as we all age, that we are going to need more folks out there, not less.

But, you know, in your opinion, are the mandates the appropriate route for the Federal Government to approach this right now?

*Mr. Levine. You know, we mandate MMR, we mandate polio, we mandate other types of vaccines for team members. I do think at some point, when there is more certainty and more data and -- about the longevity of the vaccine, there

would be an appropriate time to mandate it.

Right now we believe, right now, that we are leaning towards education and being examples. I will say if Medicare mandates as a condition of participation, we certainly have no choice but to comply with the Medicare mandate.

*Mr. Latta. Well, thank you very much.

Madam Chair, my time has expired. And again, I want to thank my friend for allowing me to waive on today.

*Ms. Eshoo. It is wonderful to have you at the subcommittee.

I can't help but think that, if someone is unvaccinated, that they are highly susceptible to contracting the virus. They contract the virus, and they are unvaccinated and working in a hospital, they can pass it on to the patients. So this is -- I just don't get this.

Anyway, the gentleman from Illinois, Mr. Rush, is recognized for five minutes.

And it is wonderful to have you waive on. I keep having to look around the hearing room, but remember to look at the screen.

Is Mr. Rush with us?

If not, then we will go to recognize Mr. Pence, the gentleman from Indiana, for your five minutes. Welcome to the subcommittee.

*Mr. Pence. Well, thank you very much, Chairman Eshoo

and Ranking Member Guthrie. Thanks for letting me come on today, and thank the witnesses today for being here.

You know, I am encouraged that this committee is taking steps to address health care workforce shortages affecting Hoosiers and all Americans. The pandemic highlighted that our nation's overburdened health care system is on an unsustainable spending path, leading to higher costs and less care, particularly in rural America.

While the bipartisan bills before us today are approaches to address workforce challenges, I am concerned that we are not conducting the necessary oversight to figure out the root causes of this systemic problem. Across Indiana's 6th district, the workforce shortage in our hospitals and critical care facilities is leaving patients with fewer options and longer wait times. Hospitals are struggling to meet the financial obligations necessary to adequately staff their facilities.

In Indianapolis, St. Vincent needed to bring in the Indiana National Guard. At King's Daughters' Health in Madison, nurses are making double, sometimes triple what they were making in 2020, as well as in my hometown hospital, Columbus Regional in Columbus, Indiana. Some directors of nursing have reported to me personally that their nurses are either burnt out from battling the pandemic, or finding new employment as much higher traveling nurses (sic).

Meanwhile, vaccine mandates from the Administration are compounding this problem, pushing even more nurses out of the industry, as told to me by these directors of nursing. Unfortunately for rural patients in my district, this trend is disrupting available care and treatment.

Dr. Keel, this August, Governor Eric Holcomb put together a commission to look at the State of Indiana's health infrastructure, including the nurse and workforce shortage. Like your state of Georgia, Indiana faces challenges in maintaining health systems in rural areas.

In your experience dealing with nursing workforce shortages, what will be the long-term impact on rural hospitals if this shortage and incredible growing cost continues?

Because, as I have talked to hospitals, their revenues are now projected to be 50 percent down, simply because of payroll costs in the next rolling 12 months. And that is unsustainable, even for the profitable hospitals.

Sir?

*Dr. Keel. Thank you very much for that question. And yes, it is a great concern for our health system. We are facing the exact same shortages that you have alluded to, and those shortages are due almost entirely to an increase in payroll costs. The -- and a lot of that is due to having to pay travel nurses.

Yes, nurses are leaving other positions and coming to our system as a travel nurse. We have nurses from hospitals that are, literally, across the street from us that are quitting their positions there, only to fill the travel -- the nurse shortage that we have in our facility due to travel nurses. So it is a great concern.

One of the -- but beyond that, the concern that I have is what are we going to do down the road? We cannot sustain the cost of the travel nurses at this current rate, and we are certainly not going to be able to sustain this once we get beyond COVID.

*Mr. Pence. And Dr. Keel, I also serve on a community college that -- we have a nursing program. Just last week I was told that two of the professors that teach the reduced applicant student body have just left to become traveling nurses. Because, if you do the math, at $150, $190 an hour that the traveling nurses are getting paid in Indiana, that is $300,000 or $400,000 a year. What can we possibly do? I guess we are going to have to pay nurses $300,000 or $400,000 a year.

*Dr. Keel. I -- that is not sustainable.

*Mr. Pence. No, sir.

*Dr. Keel. I know you would appreciate that. You know, we have had a nursing shortage that goes back well before the pandemic.

And to your point, the primary reason for the nursing shortage is, at least from my perspective, is not a lack of classroom space, or lack of positions, or an enrollment cap. Quite the opposite. It is having the ability to hire nurse faculty, when they can go into private sectors and make a lot --

*Mr. Pence. Yes, and if I may, as I -- as in my opening remarks, I am very concerned. We really need to get a handle on -- you know, you got -- you can't fix a problem until you identify a problem, and I think we have really got to figure out what we need to do to have nurses, because rural hospitals, without nurses, the doctors can't get anything done.

And thank you for letting me on. I yield back.

*Ms. Eshoo. You are always welcome to waive on. I understand that Mr. Rush is going to join us.

Are you there, the gentleman from Illinois, Mr. Rush?

*Mr. Rush. Madam Chair?

*Ms. Eshoo. Four, three, two --

*Voice. I hear a voice.

*Ms. Eshoo. Where are you? Yes --

*Mr. Rush. Can you hear --

*Ms. Eshoo. I can -- I can't see you, and I -- your voice is not very loud.

*Mr. Rush. Can you hear me, Madam Chair?

*Ms. Eshoo. Just -- you need to turn the volume up, because we can't hear you very well.

[Pause.]

*Ms. Eshoo. He is not on camera. Does he have to be on camera?

*Mr. Rush. I am on camera.

*Mr. Butterfield. He is on camera.

*Ms. Eshoo. All right, the gentleman is recognized. We don't see you on our screen, but I believe you are on -- oh, there you are. Okay.

*Mr. Rush. Can you hear me?

*Ms. Eshoo. Yes, and we can see you.

*Mr. Rush. All right, wonderful.

*Ms. Eshoo. Begin.

*Mr. Rush. Hey, technology has come through, once again.

I want to thank you, Madam Chair, for allowing me to participate in today's very important hearing, and I am grateful that you chose to include my bill, H.R. 3320, the Allied Health Workforce Diversity Act, which I introduced in this Congress with Representative Markwayne Mullin, and the last Congress with the ranking member of the full committee, Congresswoman McMorris Rodgers.

The lack of diversity in the fields of physical therapy, occupational therapy, respiratory therapy, speech and

language pathology, and audiology is very troubling to me and to others. Many of these professions, Madam Chair, have been pivotal in helping individuals recover from COVID-19, which makes our legislation needed now, more than ever.

Even prior to COVID-19, this lack of diversity was extremely problematic. Research shows that this lack of diversity leads to less access to these specialists in underserved in rural areas, and worse outcomes are attended to every -- these patients. That is why I was compelled to introduce the Allied Health Workforce Diversity Act, H.R. 3320.

This bipartisan piece of legislation would authorize funding to, in fact, recruit and retain students who are racial or ethnic minorities, or who are from disadvantaged backgrounds to enter and complete programs in these professions.

And I want to thank you, Dr. Garcia Wilburn, for your appearing before the committee today. Your story is inspiring, and I hope that you and your family are very proud of what you have accomplished and will continue to accomplish.

As you know, Dr. Garcia Wilburn, the Allied Workforce Diversity Act is based on the highly-successful Title VIII workforce development program. Can you explain why that program was so successful?

What best practices or lessons should allied health professionals take from the Title VIII program?

*Dr. Wilburn. Thank you so much, Representative Rush. I really appreciate your question, and giving me the opportunity to answer your question.

First, the funding provided higher education program support to focus on recruitment and retention, which we have talked about numerous times today for individuals from under-represented groups. By funding community outreach programs, higher education programs were able to show that these under-represented communities -- that the profession has a realistic option and pipeline to those health care professions. It showed that communities -- the program would be partners to these individuals, with both moral and financial support, as they pursued their degree, which is key.

Second, the success of the Nursing Workforce Development Act -- although cliche, success breeds success. And I know we have some hurdles to currently overcome in the nursing profession, but we cannot negate the fact that the nursing profession is more diverse than ever. As programs were able to see more people from under-represented communities graduate and go back to their communities to practice, the idea of pursuing nursing as a career became more mainstream at all degree levels, from associate to doctorate.

These programs were used to fund the grant programs, to build resources within the programs to help future classes of students, in time to see the real benefits of diversity to the profession. High school students, middle school students, beyond saw people with a similar culture, racial group, ethnicity from their own background in a respected profession, inspiring those communities long beyond grant funding.

So this is what led to the Nursing Workforce Diversity Act, and its program has nearly doubled in diversity since then, and we are hoping to see the same success among the allied health professional programs.

*Mr. Rush. Thank you.

Madam Chair, my time has expired. I yield back the balance of it.

*Ms. Eshoo. The gentleman yields back, and we want you to know you are always welcome at our subcommittee, Mr. Rush.

*Mr. Rush. Thank you.

*Ms. Eshoo. Thank you.

The chair now recognizes another member, last but not least, who is waiving on, the gentlewoman from Illinois, Ms. Schakowsky, for your five minutes of questions. And I think that will be it.

*Ms. Schakowsky. Well, thank you so very much, once again, for allowing me to waive on to this wonderful

subcommittee, and the great job that you are doing, Madam Chair.

I want to say, as the co-chair of the House Democratic Caucus on Aging and Families, that the importance of caring for America's seniors is, you know, right at the top of my list.

We know that two-thirds of unpaid family caregivers are women. And one in three caregivers are themselves senior citizens. And we also know that one in four Americans are in the sandwich generation, meaning they are taking care of children, as well as elderly parents, so they are very busy as caretakers.

My -- but most disturbing is that, according to a 2020 report from the Center for Disease Control and Prevention, nearly 31 percent of family caregivers feel alone in their caregiving, and report serious consideration of suicide. I mean, this is a real mental health challenge that we have right now, and that is because family caregivers continue to be left on their own, just trying to figure out how to address this.

We have never had a real long-term care policy in this country, so I wanted to ask Ms. Monroe -- are you here, still, Witness?

*Ms. Monroe. Yes, I am here.

*Ms. Schakowsky. Okay, there you are. Okay. I wanted

to ask you this. I found your testimony so incredibly compelling, and really disturbing, that you were somehow completely blindsided, that -- the seven years to get your father diagnosed, that the basic message that she got was -- that you got was "good luck.'' And here you are, as you described yourself, as someone who is so credentialed, so informed.

So really, what I need to know from you, how -- can you shed light on exactly what type of guidance and training has to be built-in right away, that people have to understand that they are going to get the information, and that the help that they need?

And as Bobby Rush was talking about, you know, there is disparate results, as well, especially communities and people of -- in low-income communities are really, really on their own. So what do we need to do?

*Ms. Monroe. Well, I would say one of the biggest, I think, helps would have been -- so my mom lives with my dad full-time, and she is 88, and he is 84. So having us understand --

*Ms. Schakowsky. Does she also have Alzheimer's, or no?

*Ms. Monroe. No, she does not, at least not diagnosed. But, you know, we are having to support her, one who is there 24/7 with him, which is a lot of a different feeling than we have, from -- I am an hour away, my brother is about -- you

know, he is down in Nashville, and my sister is about 15 minutes away. So we are trying to do a construct, where we have 3 siblings working together to try to be a caregiver, but my mom is there 27/7.

And the stress on her, and her not really understanding the disease, thinking that, you know, we -- she knows it is a disease, but a lot of times she thinks he is just "crazy'' -- and not being able to get help -- help, right now, for my parents -- and I hate to use an anecdote -- would be for my dad probably to be in assisted living. But there is no room at the inn. And caregivers are not being -- you know, are not reliable, in terms of being there.

So we will often get a call, very last minute, saying, "The caregivers didn't show up this morning, I can't get your dad dressed.'' One of us has got to get in the car and drive to do those kinds of tasks. So, you know, reliable services that can be there, having facilities that have built-in care structures, even on an emergency basis, that you can call upon because you are, you know, paying 5,000 or $6,000 a month for the purpose of being -- having access to these services.

Helping my family, my siblings and I, plan, come up with a timetable, a work plan for how we are going to manage what this looks like, who is going to be in charge of the medication, who is going to be in charge of the meals, who is

going to take the parents to the doctors' visits, just someone to really help us do a work plan for what that looks like.

And how do you determine at what point you need to step up care, and then where do you go for that?

*Ms. Schakowsky. All right. Thank you so much for that.

And I also know that, even in your opening statement, you talked about the legislation that is being considered. And I am very proud to be a cosponsor of the Alzheimer's Caregiver Support Act. And all the other bills that you talked about is something we need to do. So thank you very much for your testimony, for being such an incredible witness.

And thank you to all the witnesses, and I yield back. Thank you.

*Ms. Eshoo. The gentlewoman's time has expired.

This concludes our hearing today. On behalf of all of the members of the committee, to each one of you that have testified, you have our lasting gratitude. You have been highly instructive on the bills that are before us, and given us a -- well, you have given us very direct answers to our questions, which really enhances our understanding of each of the issues that are before us. So thank you. And to those that had to travel, you took on an additional burden to be

here, and we thank you.

Now, members, as you know, have 10 business days to submit additional questions for the record. And witnesses, your work is not done, because, as members put their questions together and submit them to you, we ask that you, as promptly as possible, answer those questions. And we know that you will.

So at this time I request unanimous consent to enter the following documents into the record. There are 27 of them, and I would love to have the ranking member --

*Mr. Guthrie. We have reviewed the list, and we accept the list, as you presented it.

*Ms. Eshoo. That is wonderful. So, with that consent, we will enter into the record the 27 documents that we have received on the bills.

[The information follows:]

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

*Ms. Eshoo. And with that, I think we can adjourn the subcommittee. Thank you, everyone.

[Whereupon, at 2:31 p.m., the subcommittee was adjourned.]