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Testimony Submitted:
Behalf of the National Association of Community Health Centers
To the Subcommittee on Primary Health and Aging
"Successful Primary Care Programs: Creating the Workforce We Need"

Introduction

Chairman Sanders, Ranking Member Burr, and Distinguished Members of the Subcommittee:

My name is Dan Hawkins, and I am the Senior Vice President for Public Policy and Research at the National Association of Community Health Centers. On behalf of the American health center community, including the more than 22 million patients served nationwide by health centers, the 131,660 full-time health center staff, and countless volunteer board members who serve our centers as well as the National Association of Community Health Centers, we thank you for this Subcommittee's strong bipartisan support of health centers. I also wish to thank you for the opportunity to testimony for the committee as you continue to discuss the primary care workforce challenges facing our country.

Health Centers- General Background

Community Health Centers (CHCs) are community-owned non-profit entities providing primary medical, dental, and behavioral health care as well as pharmacy and a variety of enabling and support services. To date, there are over 1,200 CHCs located at more than 9,000 urban and rural locations nationwide serving as health care homes for more than 22 million patients.

By statute and mission, CHCs are located in medically underserved areas or serve a medically underserved population. CHCs see patients regardless of their ability to pay or insurance status and offer services based on a sliding fee discount.

CHCs are also directed by patient -majority boards; this unique model ensures care is locally-controlled and responsive to each individual community's needs, while also reducing barriers to accessing health care though our various services.

The nation’s health centers have experienced significant growth over the last decade and received strong bipartisan support thanks to their cost-effective model which brings access to care and improved health to communities nationwide. The health center infrastructure is projected to continue to grow with the expansion of CHCs contained within the Affordable Care Act (ACA). Through the ACA's Health Center Fund, CHCs were allocated $9.5 billion dollars over 5 years for operational expansions including the opening of new sites as well as expansions of medical and other services. This capacity expansion was designed to allow health centers to meet the needs of the newly insured, many of whom are expected to seek care at our nation's health centers, beginning in 2014. That expansion has been slowed significantly due to a sizeable reduction to health center funding in FY2011, but growth has resumed in the last two fiscal years.

With this operational growth, however, will come an additional strain on health centers that already face challenges in recruiting sufficient numbers of clinicians from a limited supply of primary care providers nationally. Many CHCs face challenges in filling provider vacancies across provider types including physicians, nurse practitioners, physician assistants, certified nurse midwives and nurses, pharmacists, dentists, and other clinical staff. In order to address the challenges of developing a sufficient primary care workforce for underserved communities, CHCs have embraced a strategy we like to call "grown our own," by stepping up and training health professionals right in our health centers.

Health centers have a long history of training the full complement of primary care providers, but for the purposes of this hearing I am going to focus largely on physician training.

Health Centers and Residency Training

Health Centers have a long history training medical residents in our centers at a variety of levels. Some centers may have residents rotate through for a short few weeks, others for longer periods of time, and still others serve as the primary ambulatory care site (or "continuity clinic") for the resident's training experience. These programs have proven to be beneficial to the health centers in which they are located, to the residents, to the partnering institutions, and the medical colleges or hospitals. Through these partnerships, health centers are able to provide additional care for patients and recruit providers and residents who are more inclined to work in underserved areas after their exposure to these unique training opportunities.

To date, we know of at least 57 health center engaged in significant residency training activity. Many of these health centers are engaged in residency training at the continuity clinic level, beyond offering elective rotation experience.

Each health center residency program is unique to the community in which it is located and there are many variations on the arrangements health centers have with their partnering institutions. However, there are many universal benefits and challenges these programs face.

Residency training in health centers has proven to be a successful way for health centers to recruit providers and to them practicing in medically underserved areas. In fact, health center trained residents are four times more likely to work in health centers. In addition, more than two thirds of health center-trained residents reported working in underserved settings following graduation - nearly double the rate of non-health center-trained graduates. These training benefits are particularly significant in rural areas of the country where access to academic medical centers are limited.[i]

Yet, a lack of dedicated and reliable funding for this community-based training at the continuity level prevents many interested health centers from pursuing it. Even for those engaged in these activities, funding is often tenuous and many programs result in a financial loss for the health center. Partnering institutions often do not provide enough reimbursement and patient revenue does not generate enough funding to offset the direct and indirect costs faced by health centers engaging in this training. Some financing to cover the costs of training is provided by Medicare and Medicaid reimbursement from patients whose care is supervised by physician preceptors and resident billing for patients seen, but unreimbursed indirect costs are particularly significant. Many residency programs cover some of the direct costs incurred by CHCs, but such funding is often unreliable and CHCs generally do not receive adequate resources to support their indirect costs such as additional space, supplies and staff time commitments that residency training requires. [ii]

The Teaching Health Center Program

Until health reform, efforts to coordinate and fund residency training in community based settings such as CHCs had been accomplished on a very limited scale. Efforts within the Affordable Care Act focused on unique ways to foster and more reliably fund primary care training in community-based settings.

Given the role health centers play across the country in training various health professionals, health centers were uniquely positioned to help meet what we believe is an important goal of health reform to "flip the pyramid" and move our nation toward a broader base of primary care instead of the inverse specialty care driven system we have today.

To that end, we were very pleased when the Teaching Health Centers Graduate Medical Education (THCGME) program was created within ACA. This represented Congress' first direct investment in primary care training in the community, where the vast majority of primary care providers will actually practice upon completion of their training. The ACA authorized and appropriated $230 million in total funding for a five-year (Fiscal Year 2011-2015) payment program to support accredited primary care residency training programs operated by community-based entities, including health centers.

The THCGME statute also authorized but did not appropriate $125 million in developmental grants for developing THCs. The goal of these grants was to help defray the cost of establishing

a THC, including curriculum development, recruitment, training and retention of residents and faculty, accreditation, faculty salaries, and technical assistance.

Currently, our estimates are that there are over 300 residency slots at nearly 40 THCGME-funded programs across the country. Eligible training programs are accredited graduate medical education residency training programs in: family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.

While the program is still in its early stages, it is already starting to change the paradigm of residency training by putting community-based entities in the driver's seat for the first time.

Current Challenges for the Teaching Health Center GME Program

The $230 million in ACA funding allocated for the THCGME program expires in FY2015 at the end of the program's five-year authorization. However, current grantees are facing a more immediate threat to their programs.

The traditional residency year begins July 1, and while varying by discipline, most residencies run at least three years. Grantees will be recruiting this summer and fall for the class that will start July 1, 2014 and will be in the midst of their residency training when THC funding expires. Absent some certainty by this summer or fall, these programs will face the untenable situation of recruiting a resident class for which they may have no funding to support completion of those residents' training. Instead, many have indicated they will not recruit a next class absent the assurance of continued funding. For those programs that were created specifically with THCGME funding, in particular, this could mean their programs enter a "death spiral." If no new class is recruited, faculty may leave and existing residents may also want to do so, but in an environment where most hospital-based programs are at their GME cap, these residents could be orphaned.

For this reason, and to ensure this innovative new program is not extinguished before it has even had the opportunity to make its mark on the way our nation trains it primary care providers, we urge this committee to promptly reauthorize this program for five additional years and to fully fund it through that period.

Issues for consideration

The THC program, as designated by the ACA, is essentially a capped entitlement, providing a fixed "direct" or mandatory appropriation for operating teaching health centers. Due to this construction, HRSA is obligated, as long as funds are available, to fund all programs that apply and meet the program requirements. As such, HRSA must continue to fund all programs meeting the requirements of the program for as many qualifying programs as requested as long as funding is available.

Absent an annual limitation on funding, a surge in interest in the program could deplete the program's total funding in a very short timeframe, possibly even a single year, making an annual funding cap prudent and likely essential for long-term sustainability. With an annual cap in place, we believe it is equally important that there be some mechanism, such as a minimum per resident amount, in place to ensure that there is reliability for those operating the programs. In effect, we propose a ceiling be established for annual program funding, which make necessary the construction of a floor in terms of a minimum per-resident amount.

The National Health Service Corps and Health Centers

While the Teaching Health Center GME Program aims to address the critical issue of the supply of primary care providers in medically underserved communities, another vital program, the National Health Service Corps (NHSC) has since 1970 been an essential program in addressing provider distribution disparities that affect the underserved and provider-short communities where health centers and other key health care systems are located.

With my colleague Rebecca Spitzgo here with me today, I will not cover the full landscape of how critically important the NHSC is. However, I would be remiss if I failed to note that the NHSC serves as a vital partner to the Health Centers program. According to the most recent numbers I have seen, approximately half of the approximately 10,000 health professionals currently placed by the NHSC are working at CHCs – and those providers make up almost one-fifth of the health center clinician staff nationally.

The NHSC has been an incredibly successful recruitment tool for health centers seeking to attract providers to our safety-net settings. According to NHSC clinician retention surveys, many NHSC providers stay at their service site, another NHSC site, or in an underserved area after completing their service obligation. A 2012 HRSA NHSC retention survey found that 82 percent of NHSC clinicians who completed their service commitment in the Corps continued to practice in underserved communities up to one year after their service completion and 55 percent of National Health Service Corps clinicians continue to practice in underserved areas 10 years after completing their service commitment.[iii]

The NHSC was expanded in the ACA, with $1.5 billion in mandatory funds provided over 5 years, enough to train and place some 17,000 health professionals by 2015. Due to a FY2011 reduction however, that expansion has been significantly scaled back. In addition, starting in FY 2011 and continuing through the present, the NHSC's entire budget has been tied solely to the ACA mandatory fund and, like the Teaching Health Center Program, and the Health Centers program, for that matter, it also faces a funding cliff in FY 2016.

The NHSC has been, and remains, a key partner, particularly for CHCs, in the expansion of care prior to the coming coverage expansions under the ACA. We want to work with you in the years ahead to ensure that it remains strong and intact now and post-2015.

True Innovation in Primary Care Training: A.T. Still University Partnership with CHCs

I would also like to briefly touch on an incredibly innovative program that is at the forefront of training primary care practitioners. The A.T. Still University (ATSU) has long had a commitment to providing medical care for those most in need that started with its founder. Doctor Andrew Taylor Still followed in his father's footsteps by bringing care to the most isolated, vulnerable and needy - regardless of their ability to pay.

Today, ATSU has four campuses with the School of Osteopathic Medicine (SOMA) and dental school located in Mesa, Arizona. From its inception, ATSU has focused on community-based care and educating the next generation of osteopathic physicians in the communities that those campuses serve. This made for a natural partnership with health centers. Recognizing the need to increase the number of primary care providers, my organization, NACHC, partnered with ATSU more than 11 years ago to establish a health-center focused osteopathic dental school – and then 5 years later, partnered again to open one of America's newest medical schools – that are each not only growing the next generation of health center providers, but also challenging the notion of how medical training is structured.

Today, ATSU's partnership with NACHC continues through Contextual Learning Campuses at health centers throughout the country. In this first-of-its-kind model, students begin their clinical observations in health centers at the start of their second year instead of waiting until the third year as in most traditional programs. Third- and fourth-year students complete their clinical rotations at health centers and in Community Campus associated hospitals, as well as with affiliated healthcare providers and at select healthcare institutions.

ATSU's work with health centers is already making impressive strides towards improving the number of community-based care providers. To date, our partnership has produced more than 300 practicing dentists, one-half of whom are working at health centers today, with more than 30 of those graduates serving as health center dental directors. Moreover, there are 315 medical students whose education is currently embedded in a health center. ATSU has 200 health center affiliated clinical agreements and over 1,500 CHC shadowing or clinical rotations per year.

This very successful partnership is providing osteopathic dental and medical students with significant exposure to the unique challenges of working in an underserved setting and making them better providers along the way.

Conclusion

Today, 60 million Americans lack regular access to primary care, even as the nation is preparing to provide health coverage for as many as 30 million newly-insured Americans. Health centers stand ready to do our part to meet these enormous challenges of providing a health care home for these individuals.

We believe – and indeed we know from experience – that training residents in health centers offers the opportunity to both improve the supply of primary care providers in our nation and to better distribute those providers to meet the needs and demands of medically underserved communities.

Common-sense programs like the THCGME program and the National Health Service Corps are essential to these efforts- addressing both the supply and distribution issues currently vexing our primary care workforce.

We know that growing our primary care workforce and expanding primary care access is the only way we will achieve true health care reform that provides American the right care, in the right place, at the right time.

We look forward to working with you and the other members of this Subcommittee to accomplishing this shared goal. We simply cannot afford to fail.

Thank you, Mr. Chairman and Members of the Subcommittee.

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[i] Morris, C, Kim. S, Chen, F. *Training Family Physicians in Community Health Centers: A Health Workforce Solution, Health Services Research*. 2008; 40 (4): 271-275

[ii] National Association of Community Health Centers. *Health Centers' Contributions to Training Tomorrow's Physicians: Case Studies of FQHC-Based Residency Programs and Policy Recommendations for the Implementation of the Teaching Health Centers Program*. August 2010. http://www.nachc.com/client/THCReport.pdf

[iii] Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. NHSC Clinician Retention: A Story of Dedication and Commitment. December 2012. http://nhsc.hrsa.gov/currentmembers/membersites/retainproviders/retentionbrief.pdf