

Testimony of Dennis Freeman, Ph.D.
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United States Senate Committee on Health, Education, Labor and Pensions
Hearing on “Access to Care: Health Centers and Providers in Underserved Communities”
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Chairman Alexander, Ranking Member Murray and Members of the Committee,

It is an honor to be asked to share my views on the Federally Qualified Health Center Program (Health Centers) and the National Health Service Corps (NHSC) with you today. I am Dennis Freeman, a psychologist and Chief Executive Officer of Cherokee Health Systems, a Health Center in Tennessee. In 2018 Cherokee served 70,000 patients in 23 clinics located in 14 Tennessee counties.



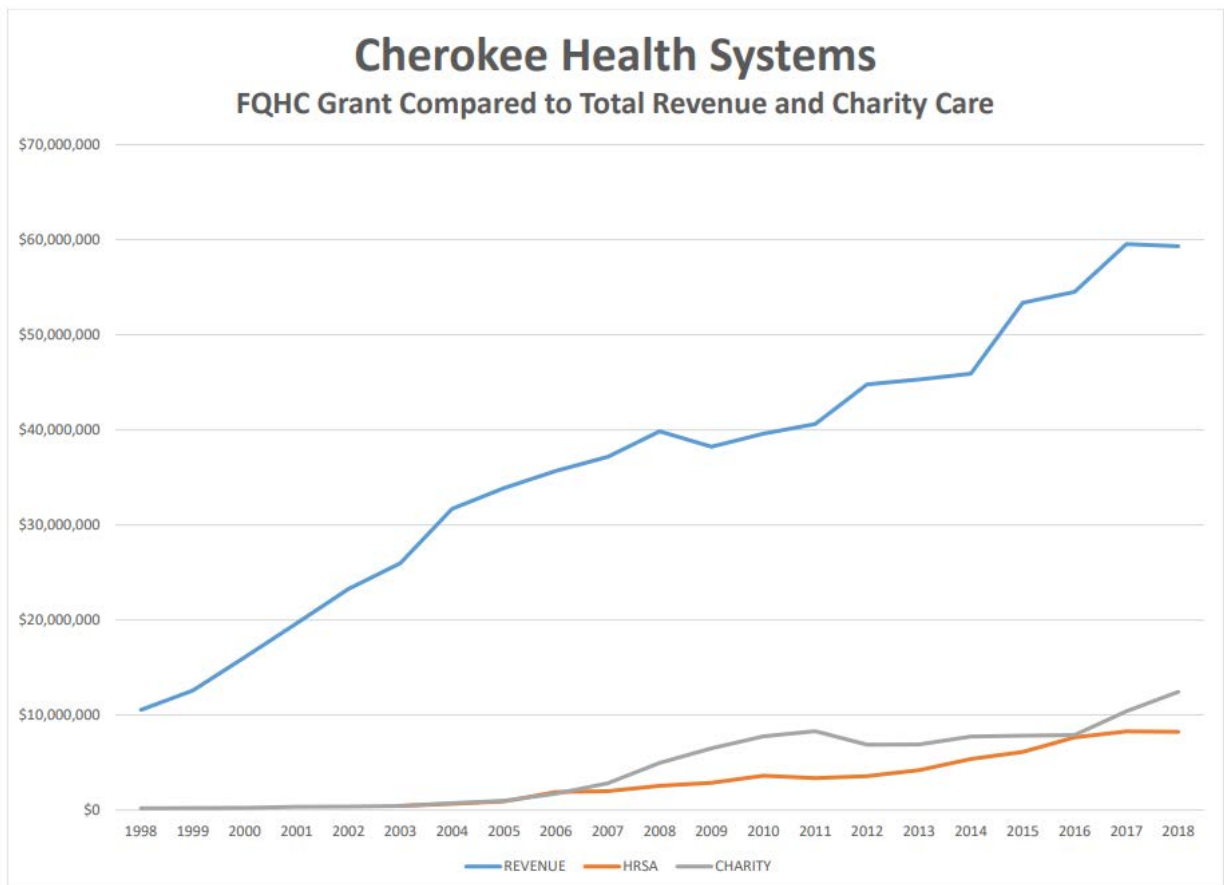
Cherokee operates clinics in isolated, rural mountain hamlets, mid-size east Tennessee communities and inner city Memphis, Knoxville and Chattanooga. Our staff outreaches into area schools, public housing complexes, homeless shelters, hospital emergency departments and patient’s homes. Thirty percent of our patients are uninsured and forty percent are on Medicaid.

Before I share my perspective on today’s topic, I briefly want to acknowledge and recognize the depth of support that has been shown by this Committee, on a bipartisan basis, for the three programs we will discuss today. Thanks to that support, 1,400 health center organizations now serve 28 million patients in over 11,000 communities nationwide. The investments you’ve made have had a profound impact on the patients and communities we serve, not to mention the healthcare system as a whole, and for that we are truly grateful.

Cherokee Health Systems---A Federally Qualified Health Center

Cherokee Health Systems began providing services as a Community Mental Health Center in 1960. As was customary for Mental Health Centers in those days we did outreach into other parts of the healthcare delivery and social services sectors. Through our outreach into primary care we quickly saw primary care was the most common access point for people seeking help for behavioral health concerns. Our clinicians began circuit riding to area primary clinics on a regularly scheduled basis so we could increase access to behavioral health services to residents in our service area. After a few years we recognized that many portions of our service regions had a critical shortage of primary care providers so we began opening primary clinics with behavioral health professionals working in close collaboration with their primary care colleagues. When an opportunity to apply for a grant to become a Health Center presented itself in 2002, we seized upon it. Thankfully, our application was successful and we have been proud and contented member of the Health Center community ever since.

The graph below shows clearly how Cherokee's growth has been buoyed, but not totally dependent upon, our annual Health Center grant. Our overall revenue has grown at a faster pace over time than our federal Health center grant has. As expected, our trend line of patients in care parallels our growth in revenue. The graph shows that our grant has covered a good share of the amount of sliding fee discounts we offer our low income patients in many years. During economic hard times people lose employment, employers stop providing insurance and more people show up on our doorstep needing healthcare they can afford. As you can see, our grant has not covered our charity care the last two years and the widening gap is worrisome.



The increases in our grant over the years have been for expansions into new geographic areas or for new programs. The increases have allowed us to open new offices in underserved areas and expand or start new programs. For example, we have opened a clinic to serve homeless residents in Knoxville. We have opened services near public housing complexes. We have opened specialized services to treat patients addicted to opiates. Most of these grants fueled program expansions that decreased the percentage of our patients who had any healthcare coverage to pay for their care.

At Cherokee we act on our expansion strategy of going where the grass is browner. The program expansions cited above are fully in line with that development strategy. Typically, the increases in our grant are a critical piece but do not fully fund these expansions. We make the program work financially by being frugal and efficient. Our reward is reaching many of our neighbors who are in desperate need of care.

I expect a member of Congress will look at the graph above and feel good about the government's investment. Our grant is a relatively small percent of our financing (currently 13.5%) but it spurs the growth, and helps sustain the operation, of an effective and efficient healthcare system. I'm quite sure the Cherokee picture is not unique but is replicated by the community of Health Centers who are extending primary care access into many, but by no means all, underserved areas of our country. Additional investment in Health Centers is needed in order to reach populations and communities not yet served by a Health Center.

Cherokee's Clinical Model

At Cherokee we have blended behavioral health services into our primary care clinical model and embedded behavioral health professionals in our primary care teams for many years. This approach to care is known, of course, as integrated care. This model of care is rapidly gaining traction across the country, especially among Health Centers. Without question, access to appropriate and timely care is the greatest challenge facing the mental health and substance misuse treatment sectors of the nation's healthcare system. In our experience providing access to behavioral health assessment and intervention within primary care goes a long way toward reducing the access barrier to behavioral healthcare so prevalent across the country.

Primary care is the front door to the health care system. It's the primary access point for all healthcare concerns and medical conditions, including behavioral health issues. In addition to the frequent presentation of psychiatric conditions and substance use disorders in primary care, the personality and the lifestyle of the patient are always factors in a patient's healthcare outcomes. Personal health habits; a history of trauma; and resiliency in response to stress all influence the etiology, the response to treatment and the prognosis of all medical conditions that are presented in primary care. The patient's behavioral health is a factor in every primary care patient visit. This is especially true for patients coping with chronic medical conditions. Encouraging these patients to adopt appropriate health behaviors is the key to the medical management of complex and chronic conditions. The presence of behavioral health professionals within the primary care setting brings a clearer focus on the psychosocial factors which influence health status. The integrated care strategy has broadened the scope of primary care and enhanced the effectiveness and efficiency of primary care practice.

Over the past few years the Patient-Centered Medical Home (PCMH) model has come to be considered the best practice when it comes to primary care delivery. At Cherokee we have embraced this model

and have enhanced it in a number of ways. We embed uniquely skilled behavioral health professionals, referred to as Behavioral Health Consultants (BHC), in the primary care team. BHCs are available to their primary care colleagues for consultation at the point of care. They provide assessment and intervention with patients during their primary care visit. Community Health Coordinators are available to help patients negotiate social determinates of health. In effect, they extend the exam room into the community. When indicated, psychiatric consultation is also available, in real time, to the primary care team. Psychiatric consultation is one of the telehealth services Cherokee makes available across its network of clinics. All providers on the team share an electronic health record, treatment planning and the responsibility for the overall care of all the patients on the panel.

Patients appreciate the comprehensiveness of the integrated care model. Our primary care providers are enthralled with the support the behavioral health and community-based staff provide them. The integrated care team lightens the individual burden on primary care providers and enhances their satisfaction with their work. Insurance companies are pleased because the overall cost of care declines. Best of all, patient outcomes improve.

The integrated Patient-Centered Medical Home is the best practice model for treating patients with chronic conditions. Patient with a chronic condition rarely present with only one chronic condition. This is especially true with persons suffering a psychiatric or substance use disorder. In our experience more than two-thirds of these patients have one or more co-existing medical problems that need treatment. The recent national attention on opioid addiction has illuminated the need to identify effective treatment models and has brought additional focus on integrated primary care as an effective treatment approach.

Treatment of Opioid Addiction in Context

The opioid epidemic has garnered the nation's attention for a number of very good reasons. Few if any families have been spared the devastating impact of a family member addicted to opioids. Healthcare, law enforcement, the courts, social services—every sector of our society has felt the impact. Death rates from opiate overdoses have skyrocketed, medical providers have been indicted for over prescribing and state Attorneys General are suing pharmaceutical companies for misleading marketing and advertising strategies. Obviously, bringing the opioid epidemic under control will require a multi-faceted approach beginning with more public awareness of the dangerous, addictive potential of these drug and much broader availability of effective treatment for those who become addicted.

It is tempting to isolate on opiate addiction as a singular problem and formulate overly simplistic treatment and financing strategies to address the problem. This has led to some targeted funding streams narrowly restricting providers in how grant funds may be use and how third party payers reimburse for services. Some grants will only support the treatment of patients with a specific diagnosis of opiate addiction; some grants require that certain medications which block the effect of opioids be part of the treatment; and some grants and payers limit reimbursement to those clinical activities that take place in the exam room.

Successful treatment of addiction, including treatment of those addicted to opiates, requires a more comprehensive approach. Most patients who present with opiate addiction are abusing other substances as well. Many have co-occurring psychiatric conditions that need treatment. Most have serious co-morbid medical conditions that need immediate attention, conditions that are the direct

result of their substance abuse or an outcome of their unhealthy lifestyle. Many with addictions have alienated their families and are without positive social support. Addiction is a complex condition. The words of Cherokee's Director of Addiction Medicine, Dr. Mark McGrail, are instructive, "cross addiction is a real phenomenon and patients who suffer from addiction will find something to fill the void if we "just take the opioids away".

At Cherokee we have adapted our integrated medical home model to treat patients presenting with opioid addiction. We provide accelerated, walk-in access because we know this is critically important for some patients. We use medication assisted treatment as appropriate. Patients participate in group treatment and receive additional individual behavioral health services when indicated. Most patients participate in an Intensive Outpatient Program which meets several times a week for several hours at each session. We've had a 30-day retention in treatment of 68% for these patients compared with national data cited in the professional literature in the 35-40% range. We have teams to care for women who are pregnant and abusing drugs and/or alcohol. We're beginning to incorporate pediatric care into the model in order to provide concurrent care for mother and infant after delivery. We always seek to become the healthcare home for these patients, just as we are for patients living with other serious chronic conditions. In 2018 Cherokee saw 6571 patients with a Substance Use Disorder, including 2003 with a diagnosis of Opioid Use Disorder. The integrated medical home has proven effective for the care of our patients with addictions, including those abusing or addicted to opiates.

The National Health Service Corps

Payment of educational debt by the National Health Service Corps is life changing for clinicians who receive it. I frequently hear heart-warming stories from a Cherokee staff member who speak passionately about how being relieved of their debt allowed them to see their way clear to follow their heart and work with their population of choice. Concerns about purchasing a home and starting a family are eased. The prospect of a financially secure future seems possible. At any point in time Cherokee has a couple dozen clinicians who are receiving loan repayment. Currently, seven clinicians are in the process of applying. The majority stay on after their loans are paid and many envision long careers at Cherokee. Cherokee has benefitted greatly from the service of clinicians who have received scholarships or have had educational loans repaid by the NHSC.

Despite the success of the program, as an employer we are reluctant to use the NHSC as a recruiting tool when funding for the program remains uncertain. While the possibility for the payment of educational debt is there for a prospective hire, to dangle the NHSC before them is to ask them to make a leap of faith. In the black and white world of personal finance that would be unfair to the applicant. Every year there are many more applicants for NHSC slots than the program is able to pay for at the current funding level. We should be doing more to help support the recruitment of these applicants who have the will to practice in medically underserved communities. In order to maximize the effectiveness of the program we need to see long term, stable investment in the program as well as the opportunity for growth so more providers can be accepted into the program. It would be enormously beneficial if Health Centers had designated NHSC slots they could use as actual tools in recruiting clinicians.

Cherokee's Teaching Mission

At Cherokee Health Systems we consider training the next generation of healthcare providers a core part of our mission. We want professionals-in-training to have a good experience working in underserved areas and providing care to a needy population. We know most who enter the health professions do so with the motivation to help others. Given a positive experience of working alongside highly competent professional mentors who are committed to this work, many will make a commitment to follow suit. We partner with area academic institutions to train psychologists, nurses, nurse practitioners, social workers, pharmacists and primary care physicians.

Cherokee does not participate in HRSA's Teaching Health Center program, though we have been a wistful observer of the program and wished that it had the size and the stability of funding to make the impact needed in the Health Center community. At this point in time it would be hard to find a Health Center that doesn't have available positions for physicians.

Shortages in the workforce of Health Centers extends to other professions besides physicians. Dentists, pharmacists and behavioral health professionals are especially difficult to recruit for most Health Centers. Dentists willing to work with underserved populations seem to be in short supply. As we all know, professionals tend to stay in the environments where they trained. I'm not aware of many health centers who are training dentists and pharmacists. Heretofore, most behavioral health professionals trained in behavioral health settings and upon graduation went to work in behavioral health organizations. These new graduates had neither the vision nor the skills to contemplate a career in a Health Center working as a member of a primary care team.

Fortunately, the education of healthcare professionals is changing. More training is occurring in team-based models and, when that is the case, the setting is usually in primary care. Health Centers are active in these training opportunities. A couple of small but visionary federal programs, the **Graduate Psychology Education program (GPE)** and the **Area Health Education Center's program (AHEC)**, are leading the team-based training agenda and provide support for training of health professionals in settings serving underserved populations.

The Area Health Education Center program (AHEC) was developed by Congress in 1971 to recruit, train and retain a health professions workforce committed to underserved populations. The AHEC program helps bring the resources of academic medicine to address local community health needs. The mission of AHEC is to enhance access to quality healthcare, particularly primary and preventive care, by improving the distribution of healthcare professionals via strategic partnerships between academic programs and community organizations. Recently, the national AHEC program has intensified its focus on multidisciplinary training. In September 2007 Cherokee Health Systems entered into a partnership with Meharry Medical College to serve as the east Tennessee Area Health Education Center. In 2017 Cherokee expanded its role with Meharry and is now the regional center for both east and west Tennessee.

The GPE program prepares doctoral level psychologists to provide behavioral healthcare, including substance abuse prevention and treatment services, in settings that provide integrated primary and behavioral health services to underserved and/or rural populations. This program supports the inter-professional training of doctoral level psychology interns and postdoctoral fellows while also providing behavioral health services to underserved populations such as older adults, rural populations, children,

those suffering from chronic medical conditions, veterans, victims of trauma and victims of abuse. Grants are provided to accredited psychology internships and fellowships. Cherokee’s training of psychologists is partially supported by a GPE grant.

Cherokee began an internship for psychologists in 2003 and started accepting psychology postdoctoral fellows in 2013. To date we have graduated 55 interns and 20 fellows with nine more currently in training. More than a third of the interns have stayed with us upon completion of their internship year. Nearly two thirds chose to work in safety net organizations. Most of the fellows accepted staff positions at Cherokee and the few who left all went to work with underserved populations. We have demonstrated, as has been shown many times over in many settings, training providers is the best recruitment strategy.

<i>Cherokee Health Systems Training Psychologists to Work with Underserved Populations</i>		
	<u>Internship</u>	<u>Postdoctoral Fellowship</u>
Current Trainees	5	4
Graduates	55	20
Stayed with Cherokee following graduation	35%	85%
Working with Underserved Populations	65%	100%
Received NHSC Loan Repayment	20%	35%

Conclusion

I commend the Committee for their review of the Teaching Health Centers, the National Health Service Corps and the Health Center program. These vital programs, and the synergy among them, have an important impact on the health of the nation and a profound impact on isolated, remote and disadvantaged communities. Without these programs many of our fellow citizens would not have access to timely and affordable health care.

I’m grateful to learn legislation was introduced and supported by members of this Committee, including Chairman Alexander, to assure the federal funding base of these critical programs for an additional five years. If secured, this will enable us to continue to thrive and remain a trusted partner of the federal government to address the nation’s healthcare challenges.

I encourage you to continue to build upon the prior investments you have made in these programs and assure the benefits they bring to the communities we serve. Your continued support is vital.