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PRIMARY HEALTH CARE ACCESS REFORM: COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

EXAMINING PRIMARY HEALTH CARE ACCESS REFORM, FOCUSING ON COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS

APRIL 30, 2009

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PRIMARY HEALTH CARE ACCESS REFORM: COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS

THURSDAY, APRIL 30, 2009

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

The committee met, pursuant to notice, at 10:00 a.m. in Room SD–430, Dirksen Senate Office Building, Hon. Bernie Sanders presiding.

Present: Senators Sanders, Harkin, Merkley, Hatch, Brown, and Casey.

OPENING STATEMENT OF SENATOR SANDERS

Senator SANDERS. Good morning. I am Senator Bernie Sanders of Vermont. I want to welcome and thank all of our guests for being here. I especially want to thank Congressman Jim Clyburn of South Carolina for joining us today. It's important that he be here because he has been a leader in the House of Representatives on the issues of primary health care and community health care centers in particular.

As I think everybody in this room understands our country faces extraordinary problems in terms of health care. They run the gamut. But I think one area where there is widespread and clear understanding, where we have a major problem, is in terms of primary health care. Some of you may have seen a front page article in the New York Times just a few days ago highlighting that issue.

The reality is a pretty simple one. At the time when 46 million Americans have no health insurance, that is not the total problem. Because even if tomorrow, by some magical circumstance, we were to pass a national health care program and provide an insurance card for every American, we would by no means solve the health care crisis.

We have some 60 million Americans, many with insurance, who can't find a medical home. They can't find a doctor. They can't find a dentist. They can't find mental health counseling. They can't gain access to low cost prescription drugs.

Clearly what all of us understand is that there is not going to be real reform or the bringing of cost effectiveness to our health care system unless we address that issue.

I expect that our witnesses will be focusing on that as well and what primary health care is all about and what community health care centers do to make quality health care and dental care and

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mental health counseling accessible to people of all incomes in their community.

I look forward to hearing what our witnesses have to offer about this. And let me just briefly tell you how this hearing will proceed. Members, I suspect, will be dropping in and out. But we will hear from Congressman Clyburn in a moment. Other members, if they come in, will say a few words. Then we will just go to brief comments, a couple of minutes each, from members of the panel.

What we have found in general is that it is a richer process if we exchange and engage in discussion, rather than us giving you lengthy speeches and you giving us lengthy speeches. So we will have a dialogue. We will have a conversation, informal, and everybody should feel free to pop up and comment whenever they want.

Now in the midst of a lot of bad news in our country, let me give you some very good news. This is the result of the work done by a lot of people, including many of our panelist, people in the House, people in the Senate. Congressman Clyburn played a great role in this.

We have in the stimulus package, taken this country a major, major, major, major step forward in terms of improving primary health care. At a time when community health care centers were receiving about $2.1 billion a year, we basically doubled in that package—doubled—it went from $2.1 to $4 billion, the amount of money going to community health centers.

Many are aware that President Obama, a month or so ago, announced 126 new centers in 1 day, that is extraordinary.

In addition to that we all understand that we are not going to solve the primary health care crisis unless we have far more primary health care physicians and dentists and other medical personnel.

Within that same stimulus package we almost tripled the amount of money for the National Health Service Corps, going from $120 million to $300 million.

So the good news is I think in a very bipartisan manner, people understand the crisis and we are beginning to address it.

Having said that, let me introduce Congressman Clyburn for some opening remarks and then we will just take it to the panel.

Jim.

STATEMENT OF HON. JAMES E. CLYBURN, U.S. REPRESENTATIVE FROM SOUTH CAROLINA

Representative CLYBURN. Let me thank you very much, Senator Sanders, for allowing me to be a part of this hearing today. Thank you so much for your tremendous leadership on this issue that is very, very important to this great country of ours.

I do have a statement and I heard you when you made your opening statement. This PK, this preacher's kid will get on the soap box every now and again, so to resist that temptation I am going to ask that you allow me to put my statement into the record, but let me take a couple of minutes to thank a few people.

I want to thank Ms. Davis for being here. She comes from a county in my congressional district, Marion County, I believe. Ms. Latian Woodard, comes from the county that I was born in. Thank you so much for being here. And I want to say this about Ms.

Davis' county. Marion County today, as we sit here, is situated along what we call the I-95 corridor that many of you have heard referred to in recent weeks as the corridor of shame. Many of you may recall that President Obama, when he spoke to the joint session a few weeks ago, had with him a student from Dillon County, next door to Marion, talking about the educational problems along that corridor. I think that all of us know that a big part of the problem that we have with delivering accessible, affordable, quality health care to all of our citizens has to do with a lack of education on so many fronts, not just what may be garnered from the classroom, but the lack of education on many fronts.

If I might use a personal experience. My wife, about 6 years ago had 5-vessel bypass surgery. On the night that she took ill, we knew from her history, we knew from the symptoms what was happening. And when the emergency room medical staff wanted to send her back home, my daughters said, "No. We are not taking her back home. We know that there is something else wrong. It is not over."

Simply because they were educated to what could happen and would happen with her history, and a few days later, they found three 100 percent blockages, one 90 and one 50. Now what would have happened but for the education about her condition that my daughter's had when they would not take her back home that night? I can think, as I said to the President last week, I can think of no better way for us to put prevention at the center of this problem than through community health centers.

We have got to pass H.R. 1296, as I call on the House side, Senators Sanders has a different number on the Senate side. Whatever it is, they are companion bills. We need to go from 1,100 health centers that we have now to 4,800, which will give us 100 percent coverage, we need to increase the funding up to $9 billion per year over a 5-year period of this new budget that we just approved yesterday, and we need to do it now.

It will create not just the prevention measures that we need, but it would create or adjust the shortages of the deliverance of health care. It would create new employment opportunities for people who we know represent services where we have tremendous shortages.

So I am pleased to be here today and to put this in the record and to say to Senator Sanders how much I appreciate working with him on the bill, and to our staffs, thank you all so much for making us look intelligent on these issues, and thanks to my constituents for being here to help drive this issue home.

Thank you, Senator Sanders.

Senator SANDERS. Thank you very much Congressman Clyburn.

I am just looking at—just as one further word. I concur with everything that the Congressman said, that at the end of the day when we make this $8.5 billion investment, do you know what we are also doing? We are saving money. How's that? We are keeping people well. We are keeping them out of emergency rooms. We are keeping them out of hospitals. And what the studies suggest is we are saving substantial sums of money. This is a win-win-win situation and we are going to go forward and pass this legislation.

OK. Enough from us. My preference would be that people keep their remarks brief so we can engage in a dialogue. Let's begin

with Ms. Bascetta, who is the director of health care for the Government Accountability Office, the GAO. Cynthia, thank you very much for being with us.

STATEMENT OF CYNTHIA A. BASCETTA, DIRECTOR OF HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE (GAO), WASHINGTON, DC

Ms. BASCETTA. Thank you, Senator Sanders and Mr. Clyburn. I am happy to be here today to discuss our work on community health-centered programs, whose mission, as you know, is to increase access to primary health care services for the medically underserved. More than 6,000 health center sites provide comprehensive primary health care services to about 17 million people through preventative, diagnostic, treatment and emergency services, as well as referrals to specialty care. Although our work and the work of others has shown problems in the referral process.

Our work focused on the provision of these services for people who reside in the federally designated medically underserved areas, called MUAs.

People served by health centers are often Medicaid beneficiaries and the uninsured. And because more people in employer-based health insurance may need to rely on health centers in times of growing unemployment, the Recovery Act anticipates a growth in demand for health center services and it includes a significant infusion of funds for HRSA to expand the program.

My remarks today are based on our August 2008 report for which we analyzed data from HRSA's uniform data system, commonly called the UDS.

We compared the location of health care center sites with the locations of MUAs. At the time of our review, the most recent UDS data available was for 2006. We also examined how new access point grants awarded in 2007 changed the distribution of health centers across MUAs.

Because of the UDS lag time, we contacted agency officials this week, who told us that the most recent round of awards did not significantly change our findings, which I am about to report to you today.

We found that almost half of MUAs nationwide, 47 percent, lacked a health center site. We also reported wide variation among the four census regions, and across States and the percentage of MUAs that lacked sites. Specifically 62 percent of MUAs in the Midwest lacked a health center site compared to 32 percent in the West.

The awarding of new access point grants in 2007 was modestly successful in reducing the number of MUAs without a site to 43 percent, however differences between the regions persisted. The West continued to show the lowest percentage of MUAs without health center sites, 31 percent, while 60 percent of MUAs in the Midwest still did not have health center sites.

We have a map in our testimony that shows significant variation among States within those census regions.

The 2007 awards had minimal impact on regional variation largely because more than two-thirds of the nationwide decline in MUAs lacking a health center site occurred in the South census re-

gion. HRSA awarded grants to 40 percent of applicants in the South compared to only 17 percent in the Midwest.

In our report we also recommended that HRSA collect data on the services provided at each site. Currently they only have readily available data at the grantee level, which limits their ability to place new sites where they are most needed.

We continue to believe that this information is essential for HRSA to use in assessing any potential gaps or overlaps in services and that it will more effectively distribute Federal resources to meet primary health care needs, especially in light of the stimulus.

[The prepared statement of Ms. Bascetta follows:]

PREPARED STATEMENT OF CYNTHIA A. BASCETTA

SUMMARY

Why GAO Did This Study

Health centers funded through grants under the Health Center Program—managed by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS)—provide comprehensive primary care services for the medically underserved. The statement GAO is issuing today summarizes an August 2008 report, *Health Resources and Services Administration: Many Underserved Areas Lack a Health Center Site, and the Health Center Program Needs More Oversight* (GAO–08–723). In that report, GAO examined to what extent medically underserved areas (MUA) lacked health center sites in 2006 and 2007. To do this, GAO obtained and analyzed HRSA data and grant applications and interviewed HRSA officials.

What GAO Recommends

In its report, GAO recommended, among other things, that HRSA collect site-specific data on services provided at each health center site. HHS commented that collecting these data would be helpful for many purposes, but would create a burden on grantees and add expense to the program. While GAO acknowledges that effort and cost are involved in program management activities, this information is essential for effective HRSA decisionmaking on placement of new health center sites and for evaluating potential service area overlap in MUAs.

What GAO Found

• In its August 2008 report, which is summarized in this statement, GAO found the following:

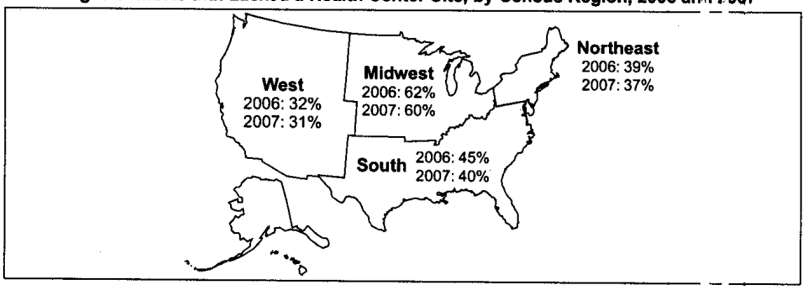
• Grant awards for new health center sites in 2007 reduced the overall percentage of MUAs lacking a health center site from 47 percent in 2006 to 43 percent in 2007.

• There was wide geographic variation in the percentage of MUAs that lacked a health center site in both years. (See figure.)

• Most of the 2007 nationwide decline in the number of MUAs that lacked a health center site occurred in the South census region, in large part because half of all awards made in 2007 for new health center sites were granted to the South census region.

• HRSA lacked readily available data on the services provided at individual health center sites.

Percentages of MUAs that Lacked a Health Center Site, by Census Region, 2006 and 2007



Source: Copyright © Corel Corp. All rights reserved (map); GAO analysis of HRSA and U.S. Census Bureau data.

GAO concluded that from 2006 to 2007, HRSA's grant awards to open new health center sites reduced the number of MUAs that lacked a site by about 7 percent. However, in 2007, 43 percent of MUAs continued to lack a health center site, and the grants for new sites awarded that year had little impact on the wide variation among census regions and States in the percentage of MUAs lacking a health center site. GAO reported that HRSA's grants to open new health center sites increased access to primary health care services for underserved populations in needy areas, including MUAs. However, HRSA's ability to place new health center sites in locations where they are most needed was limited because HRSA does not collect and maintain readily available information on the services provided at individual health center sites. Because each health center site may not provide the full range of comprehensive primary care services, having readily available information on the services provided at each site is important for HRSA's effective consideration of need when distributing Federal resources for new health center sites.

Mr. Chairman and members of the committee, I am pleased to be here today to discuss our work on the extent to which health centers in the Federal Health Center Program are located in areas having a shortage of health care services. Health centers provide comprehensive primary health care services—preventive, diagnostic treatment, and emergency services, as well as referrals to specialty care—to federally designated medically underserved populations (MUP), or those individuals residing in federally designated medically underserved areas (MUA).[1] The people served by health centers include Medicaid beneficiaries, the uninsured, and others who may have difficulty obtaining access to health care. To fulfill the Health Center Program's mission of increasing access to primary health care services for the medically underserved, the Health Resources and Services Administration (HRSA)—the agency within the U.S. Department of Health and Human Services (HHS) that administers the Health Center Program—provides grants to health centers.[2] A health center grantee may provide services at one or more delivery sites—known as health center sites. HRSA does not require all health center sites to provide the full range of comprehensive primary care services; some health center sites may provide only limited services, such as dental or mental health services. In 2006, approximately 1,000 health center grantees operated more than 6,000 health center sites that served more than 15 million people. Additional people may need to rely on health centers for their care during the current economic period.

Beginning in fiscal year 2002, HRSA significantly expanded the Health Center Program under a 5-year effort—the President's Health Centers Initiative—to increase access to comprehensive primary care services for underserved populations, including those in MUAs. Under the initiative, HRSA set a goal of awarding 630 grants to open new health center sites—such grants are known as new access point grants—and 570 grants to expand services at existing health center sites by the end of fiscal year 2006. New access point grants fund one or more new health center

[1] The Health Resources and Services Administration designates MUAs based on a geographic area, such as a county, while MUPs are based on a specific population that demonstrates economic, cultural, or linguistic barriers to primary care services.

[2] In 2006, Health Center Program grants made up about 20 percent of all health center grantees' revenues. Other Federal benefits include enhanced Medicaid and Medicare payment rates and reduced drug pricing.

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sites operated by either new or existing health center grantees. In July 2005, we reported challenges HRSA encountered during this expansion of the Health Center Program.[3] In particular, we found that HRSA's process for awarding new access point grants might not sufficiently target communities with the greatest need for services, although we concluded that changes HRSA had made to its grant award process could help the agency appropriately consider community need when distributing Federal resources. We also reported that HRSA lacked reliable information on the number and location of the sites where health centers provide care, and we recommended, among other things, that HRSA collect this information. In response to our recommendation, HRSA took steps to improve its data collection efforts in 2006 to more reliably account for the number and location of health center sites funded under the Health Center Program.

By the end of fiscal year 2007, HRSA had achieved its grant goals under the original President's Health Centers Initiative and launched a second nationwide effort, the High Poverty County Presidential Initiative. In fiscal year 2007, HRSA held two new access point competitions, one focused on opening new health center sites in up to 200 HRSA-selected counties lacked a health center site—part of the High Poverty County Presidential Initiative—and one that was an open competition.[4]

My statement today is based largely on our August 2008 report entitled *Health Resources and Services Administration: Many Underserved Areas Lack a Health Center Site, and the Health Center Program Needs More Oversight.*[5] In the August 2008 report, we examined, among other things, (1) for 2006, the extent to which MUAs lacked health center sites and the services provided by individual sites in MUAs, and (2) how new access point grants awarded in 2007 changed the extent to which MU lacked health center sites.

In carrying out the work for our August 2008 report examining the extent to which MUAs lacked health center sites and the services provided by individual sites in 2006, we interviewed HRSA officials and obtained health center site data from HRSA's uniform data system (UDS), and then compared the location of health center sites with the location of MUAs by census region and State.[6] We limited our analysis to health center sites operated by grantees that received community health center funding—the type of funding that requires sites to provide services to all residents of the service area regardless of their ability to pay.[7] In addition, because HRSA takes into account the location of federally qualified health center look-alike sites—facilities that operate like health center sites but do not receive HRSA funding[8]—when deciding where to award new access point grants, we obtained from HRSA the location of health center look-alike sites in 2006 and compared them with the location of MUAs. To examine how new access point grants awarded in 2007 changed the extent to which MUAs lacked health center sites nationwide, we obtained data from HRSA and compared the location of proposed and funded new

[3] GAO, *Health Centers: Competition for Grants and Efforts to Measure Performance Have Increased*, GAO–05–645 (Washington, DC: July 13, 2005).

[4] This new access point competition is described as open because applicants were not required to be located in certain geographic areas in order to apply, but were required to demonstrate in the proposal that the health center and its associated sites would serve, in whole or in part, an MUA or MUP.

[5] GAO, *Health Resources and Services Administration: Many Underserved Areas Lack a Health Center Site, and the Health Center Program Needs More Oversight*, GAO–08–723 (Washington, DC: Aug. 8, 2008).

[6] In our report, we considered the District of Columbia a State.

[7] 42 U.S.C. § 254b(a)(1). In contrast, HRSA grantees that operate health center sites targeting migrant farmworkers, public housing residents, and the homeless are not required to serve all residents of their service areas. 42 U.S.C. § 254b(a)(2). Because the UDS does not allow separate identification of individual health center sites for grantees that receive a combination of community health center funding and health center funding to target migrant farmworkers, public housing residents, or the homeless (27 percent of all grantees in 2006), we could not distinguish sites supported exclusively by community health center funding from sites supported exclusively by health center funding for migrant farmworkers, public housing residents, or the homeless. Therefore, we included all sites associated with health center grantees that received, at a minimum, community health center funding (90 percent of all grantees in 2006). As a result, some health center sites included in our analysis are not sites exclusively supported by community health center funding.

[8] Some organizations choose not to apply for funding under the Health Center Program; however, they seek to be recognized by HRSA as federally qualified health center look-alikes, in large part, so that they may become eligible to receive other Federal benefits, such as enhanced Medicare and Medicaid payment rates and reduced drug pricing. For our purposes, federally qualified health center look-alike sites are referred to as health center look-alike sites.

health center sites in 2007 with the location of MUAs in 2007.[9] As with the 2006 analysis, we limited our review to health center sites operated by grantees that requested community health center funding, and we obtained from HRSA the location of health center look-alike sites in 2007 and compared them to the location of MUAs in 2007. We discussed our data sources with knowledgeable agency officials and performed data reliability checks, such as examining the data for missing values and obvious errors, to test the internal consistency and reliability of the data. After taking these steps, we determined that the data were sufficiently reliable for our purposes. We conducted the performance audit for the August 2008 report from 2007 through July 2008, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. A detailed explanation of our methodology is included in our August 2008 report.

In brief, we found that grant awards for new health center sites in 2007 reduced the overall percentage of MUAs lacking a health center site from 47 percent in 2006 to 43 percent in 2007. In addition, we found wide geographic variation in the percentage of MUAs that lacked a health center site in both years. We reported that, for 2006, we could not determine the types of services provided by individual health center sites in MUAs because HRSA does not collect and maintain data on the types of services provided at each site. Because HRSA lacks readily available data on the types of services provided at individual sites, the extent to which individuals in MUAs have access to the full range of comprehensive primary care services is unknown. In reporting on geographic variation, we found that, for 2007, the West and Midwest census regions continued to show the lowest and highest percentages, respectively, of MUAs that lacked health center sites. In addition, three of the four census regions showed a 1 or 2 percentage point decrease since 2006 in MUAs that lacked a health center site, while the South census region showed a 5 percentage point decrease. The minimal impact of the 2007 awards on geographic variation overall was due, in large part, to the fact that the majority of the decline in MUAs that lacked a health center site was concentrated in the South census region, which received the largest proportion of the awards made in 2007. To help improve the agency's ability to measure access to comprehensive primary care services in MUAs, we recommended that HRSA collect and maintain readily available data on the types of services provided at each health center site. In commenting on a draft of our report, HHS raised concerns regarding this recommendation. HHS acknowledged that site-specific information would be helpful for many purposes, but said collecting this information would place a significant burden on grantees and raise the program's administrative expenses.

While we acknowledge that effort and cost are involved in program management activities, we believe that having site-specific information on services provided is essential to help HRSA better measure access to comprehensive primary health care services in MUAs when considering the placement of new health center sites and to facilitate the agency's ability to evaluate service area overlap in MUAs.

ALMOST HALF OF MUAS LACKED A HEALTH CENTER SITE IN 2006, AND TYPES OF SERVICES PROVIDED BY EACH SITE COULD NOT BE DETERMINED

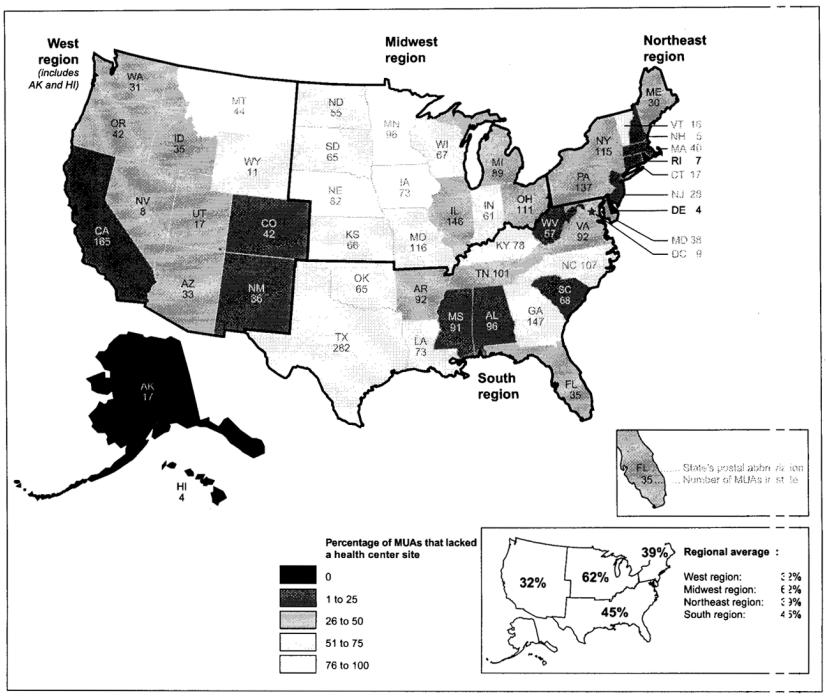
In August 2008, we reported that almost half of MUAs nationwide—47 percent, or 1,600 of 3,421—lacked a health center site in 2006,[10] and there was wide variation among the four census regions and across States in the percentage of MUAs that lacked health center sites. (See fig. 1) The Midwest census region had the most MUAs that lacked a health center site (62 percent), while the West census region had the fewest MUAs that lacked a health center site (32 percent). More than three-quarters of the MUAs in 4 States—Nebraska (91 percent), Iowa (82 percent), Minnesota (77 percent), and Montana (77 percent)—lacked a health center site. (See Appendix I for more detail on the percentage of MUAs in each State and the U.S. territories that lacked a health center site in 2006.) In 2006, among all MUAs, 32 percent contained more than one health center site; among MUAs with at least one

[9] Because the UDS had not been updated for 2007 at the time of our review, we could not determine whether any health center sites that were in operation in 2006 were no longer operating in 2007; therefore, we assumed that all health center sites operating in 2006 were still operating in 2007.

[10] When we included the 294 health center look-alike sites operating in 2006, we found that the percentage of MUAs lacking either a health center site or health center look-alike site in 2006 was 46 percent (or 1,564 MUAs).

health center site, 60 percent contained multiple health center sites, with about half of those containing two or three sites. Almost half of all MUAs in the West census region contained more than one health center site, while less than one-quarter of MUAs in the Midwest contained more than one site. The States with three-quarters or more of their MUAs containing more than one health center site were Alaska. Connecticut, the District of Columbia, Hawaii, New Hampshire, and Rhode Island. In contrast, Nebraska, Iowa, and North Dakota were the States where less than 10 percent of MUAs contained more than one site.

Figure 1: Percentage of MUAs That Lacked a Health Center Site, by Census Region and State, 2006



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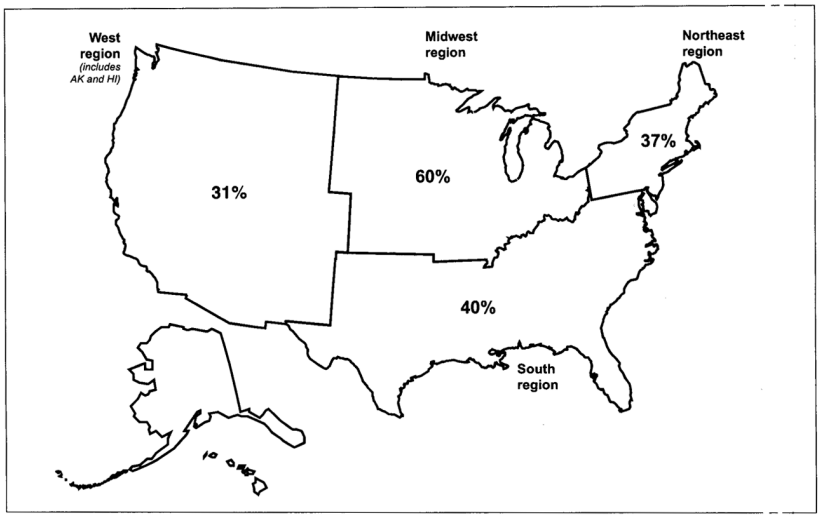
Note: U.S. territories are not included in this map.

We could not determine the types of primary care services provided at individual health center sites because HRSA did not collect and maintain readily available data on the types of services provided at individual sites. While HRSA requests information from applicants in their grant applications on the services each site provides, in order for HRSA to access and analyze individual health center site information on the services provided, HRSA would have to retrieve this information from the grant applications manually. HRSA separately collects data through the UDS from each grantee on the types of services it provides across all of its health center sites, but HRSA does not collect data on services provided at each site. Although each grantee with community health center funding is required to provide the full range of comprehensive primary care services, HRSA does not require each grantee to provide all services at each health center site it operates. HRSA officials told us that some sites provide limited services—such as dental or mental health services. Because HRSA lacks readily available data on the types of services provided at individual sites, it cannot determine the extent to which individuals residing in MUAs have access to the full range of comprehensive primary care services provided by health center grantees. This lack of basic information can limit HRSA's ability to assess the full range of primary care services available in needy areas when considering the placement of new access points and can also limit the agency's ability to evaluate service area overlap in MUAs.

2007 AWARDS REDUCED THE NUMBER OF MUAS THAT LACKED A HEALTH CENTER SITE, BUT WIDE GEOGRAPHIC VARIATION REMAINED

In August 2008, we reported that our analysis of new access point grants awarded in 2007 showed that these awards reduced the number of MUAs that lacked a health center site by about 7 percent. Specifically, 113 fewer MUAs in 2007—or 1,487 MUAs in all—lacked a health center site when compared with the 1,600 MUAs that lacked a health center site in 2006. (See Appendix I) As a result, 43 percent of MUAs nationwide lacked a health center site in 2007.[11] Despite the overall reduction in the percentage of MUAs nationwide that lacked health center sites in 2007, regional variation remained. The West and Midwest census regions continued to show the lowest and highest percentages of MUAs that lacked health center sites, respectively. (See fig. 2) Three of the four census regions showed a 1 or 2 percentage point decrease since 2006 in the percentage of MUAs that lacked a health center site, while the South census region showed a 5 percentage point decrease.

Figure 2: Percentage of MUAs That Lacked a Health Center Site, by Census Region, 2007



Source: Copyright © Corel Corp. All rights reserved (map); GAO analysis of HRSA and U.S. Census Bureau data.

We found that the minimal impact of the 2007 awards on regional variation was due, in large part, to the fact that more than two-thirds of the nationwide decline in the number of MUAs that lacked a health center site—77 out of the 113 MUAs—occurred in the South census region. In contrast, only 24 of the 113 MUAs were located in the Midwest census region, even though the Midwest had nearly as many MUAs that lacked a health center site in 2006 as the South census region. While the number of MUAs that lacked a health center site declined by 12 percent in the South census region, the other census regions experienced declines of about 4 percent. The South census region experienced the greatest decline in the number of MUAs lacking a health center site in 2007 in large part because it was awarded more new access point grants that year than any other region. Specifically, half of all new access point awards made in 2007—from the two separate new access point competitions—went to applicants from the South census region. For example, when we examined the High Poverty County new access point competition, in which 200 counties were targeted by HRSA for new health center sites, we found that 69 percent of those awards were granted to applicants from the South census region. The greater number of awards made to the South census region may be explained by the fact that nearly two-thirds of the 200 counties targeted were located in the South census region. When we examined the open new access point competition, which did not target specific areas, we found that the South census region also re-

[11] When we included the 265 health center look-alike sites operating in 2007, we found that 1,462 MUAs lacked a health center site or health center look-alike site in 2007, which did not change the overall percentage (43 percent) of MUAs in 2007 that lacked a health center site.

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ceived a greater number of awards than any other region under that competition. Specifically, the South census region was granted nearly 40 percent of awards; in contrast, the Midwest received only 17 percent of awards.

CONCLUDING OBSERVATIONS

In our August 2008 report, we noted that awarding new access point grants is central to HRSA's ongoing efforts to increase access to primary health care services in MUAs. From 2006 to 2007, HRSA's new access point awards achieved modest success in reducing the percentage of MUA's that lacked a health center site nationwide. However, in 2007, 43 percent of MUAs continued to lack a health center site, and the new access point awards made in 2007 had little impact on the wide variation among census regions and States in the percentage of MUAs lacking a health center site. The relatively small effect of the 2007 awards on geographic variation may be explained, in part, because the South census region received a greater number of awards than other regions, even though the South was not the region with the highest percentage of MUAs lacking a health center site in 2006.

We reported that HRSA awards new access point grants to open new health center sites, which increase access to primary health care services for underserved populations in needy areas, including MUAs. However, HRSA's ability to target these awards and place new health center sites in locations where they are most needed is limited because HRSA does not collect and maintain readily available information on the services provided at individual health center sites. Having readily available information on the services provided at each site is important for HRSA's effective consideration of need when distributing Federal resources for new health center sites, because each health center site may not provide the full range of comprehensive primary care services. This information could also help HRSA assess any potential overlap of services provided by health center sites in MUAs.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions that you or members of the committee may have.

APPENDIX I

Number and Percentage of Medically Underserved Areas (MUA) Lacking a Health Center Site, 2006 and 2007

	Total no. of MUAs		No. of MUAs lacking a health center site		Percentage of MUAs lacking a health center site	
	2006	2007	2006	2007	2006	2007
Midwest census region	***1,027***	***1,029***	***641***	***617***	***62***	***60***
Illinois	146	143	71	63	49	44
Indiana	61	61	35	34	57	56
Iowa	73	73	60	56	82	77
Kansas	66	71	49	52	74	73
Michigan	89	89	44	43	49	48
Minnesota	96	97	74	75	77	77
Missouri	116	116	62	58	53	50
Nebraska	82	82	75	73	91	89
North Dakota	55	55	40	39	73	71
Ohio	111	110	48	42	43	38
South Dakota	65	65	40	40	62	62
Wisconsin	67	67	43	42	64	63
Northeast census region	***395***	***400***	***153***	***147***	***39***	***37***
Connecticut	17	17	1	1	6	6
Maine	30	32	10	11	33	34
Massachusetts	40	40	10	9	25	23
New Hampshire	5	5	1	1	20	20
New Jersey	28	28	1	1	4	4
New York	115	116	56	53	49	46
Pennsylvania	137	139	63	61	46	44
Rhode Island	7	7	0	0	0	0
Vermont	16	16	11	10	69	63
South census region	***1,435***	***1,441***	***651***	***574***	***45***	***40***
Alabama	96	96	24	19	25	20
Arkansas	92	93	38	33	41	35

Number and Percentage of Medically Underserved Areas (MUA) Lacking a Health Center Site, 2006 and 2007—Continued

	Total no. of MUAs		No. of MUAs lacking a health center site		Percentage of MUAs lacking a health center site	
	2006	2007	2006	2007	2006	2007
Delaware	4	4	0	0	0	0
District of Columbia	9	8	1	1	11	13
Florida	35	35	17	15	49	43
Georgia	147	149	88	78	60	52
Kentucky	78	78	51	45	65	58
Louisiana	73	73	39	33	53	45
Maryland	38	38	11	10	29	26
Mississippi	91	91	18	17	20	19
North Carolina	107	108	59	55	55	51
Oklahoma	65	66	34	30	52	45
South Carolina	68	69	17	15	25	22
Tennessee	101	101	38	35	38	35
Texas	282	283	167	145	59	51
Virginia	92	93	38	34	41	37
West Virginia	57	56	11	9	19	16
West census region	***485***	***487***	***155***	***149***	***32***	***31***
Alaska	17	17	0	0	0	0
Arizona	33	33	13	13	39	39
California	165	167	33	31	20	19
Colorado	42	42	9	9	21	21
Hawaii	4	4	0	0	0	0
Idaho	35	35	15	14	43	40
Montana	44	44	34	33	77	75
Nevada	8	8	4	4	50	50
New Mexico	36	36	5	4	14	11
Oregon	42	42	17	16	40	38
Utah	17	17	7	7	41	41
Washington	31	31	12	12	39	39
Wyoming	11	11	6	6	55	55
U.S. territories	***79***	***79***	***0***	***0***	***0***	***0***
American Samoa	4	4	0	0	0	0
Guam	0	0	n/a	n/a	n/a	n/a
Northern Mariana Islands	0	0	n/a	n/a	n/a	n/a
Puerto Rico	72	72	0	0	0	0
U.S. Virgin Islands	3	3	0	0	0	0

Source: GAO analysis of Health Resources and Services Administration and U.S. Census Bureau data.

Senator SANDERS. Thank you very much. Dan Hawkins is the Senior Vice President with the National Association of Community Health Centers in Bethesda.

Dan, thank you for being here.

STATEMENT OF DANIEL R. HAWKINS, Jr., SENIOR VICE PRESIDENT, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, BETHESDA, MD

Mr. HAWKINS. Thank you, Mr. Chairman. Good morning, Majority Whip, Senator, members of the committee, thank you for the opportunity to speak with you today about the important role of community health centers and health reform.

Senator SANDERS. And if you could pull that mike a little closer, please?

Mr. HAWKINS. Sure. Well, it's an honor to share this panel with many distinguished colleagues, many of whom are on the front lines today delivering quality health care to thousands of Ameri-

cans, as part of the health center family that provides care to more than 18 million Americans across the country today.

Mr. Chairman, I have personally seen the power of some health centers to lift the health and the lives of communities and people all across the country, both as a VISTA volunteer and as director of one of the earliest, vibrant community health care centers back in the 1970's.

The beauty is that this patient-directed model thrives today in more than 7,000 communities across America, and I am honored to share its success story.

What is the secret of the successful health centers? I think there are several key points. No. 1, as was pointed out by my colleague a moment ago, every single health center in every single one of those 7,000 sites is located in a designated underserved area where there are shortages of providers and barriers to access to care that cause millions, to have to forego care, delay care, get sicker and not be able to receive care when it's timely and appropriate.

No. 2, they occupy the most opportune place in the entire health care system, at the entry point, where good quality, preventative and primary health care can not only improve and maintain health, it can reduce the need for later care for illnesses that might otherwise not have been treated, and save the system billions.

Last year we reported together with the Robert Graham Center of the American Academy of Family Physicians that health centers saved the entire health care system $18 billion a year. That is more than twice the total amount of money that they spent.

Senator SANDERS. Say that again.

[Laughter.]

Mr. HAWKINS. I've got even better news for you. Last year, health centers saved the health care system more than $2 for every dollar they spent. If you look at $2 billion in grant funding, they saved $18 billion. That's $9 billion for every dollar that this committee and Congress has invested in them, and more than $2 for every other dollar that they secured from other sources.

That colleague, from the American Academy of Family Physicians, last week noted to another colleague that if every person in America received the care that the health care centers provide, Senator, are you ready for this, more than $500 billion a year could be saved in health care spending today.

Senator SANDERS. That is such an important statistic. Everybody is wrestling with skyrocketing health care costs. Everybody is wrestling with that. We are going to ask you to repeat that fact one more time.

Mr. HAWKINS. I will and I know Senator Hatch has been a long time champion and believer of health centers, and has visited health centers in Ogden and throughout his State of Utah, will enjoy this as well. If every person in America received the care that is provided by health centers, more than $500 billion a year could be saved in health care spending today. Today!

There was an article published just earlier this week that said that health center patients receive less specialty care than patients seen by other providers. The interesting thing—there was a worry that health centers are stinting on care, in fact, though, even the authors of that study said we don't know whether it's because

health center patients have less care than they need or the patients of other providers get much more care than they need.

We think the answer is probably a combination of those two. At any rate, I just want to close by saying that health care centers are eager to be full partners and full participants in health care reform and know that their role will truly be integral because they are the one place in America that can turn the promise of coverage into the reality of high quality, cost-effective care.

[The prepared statement of Mr. Hawkins follows:]

PREPARED STATEMENT OF DANIEL R. HAWKINS, JR.

SUMMARY

Community Health Centers are a 40-plus year unprecedented success story. Health center patients have better health outcomes than patients in other settings, and they receive this care at a lower cost.

• Health centers improve the health and quality of life of their patients through vigorous clinical improvement efforts such as the Health Disparities Collaboratives. These efforts result in documentable improved outcomes.

• Health centers achieve these outcomes at a lower cost. For example, in one study in South Carolina diabetic patients enrolled in the State employees' health plan treated in non-CHC settings were four times more costly than those in the same plan who were treated in a community health center.

• Indeed, literally dozens of studies done over the past 25 years have concluded that health center patients are significantly less likely to use emergency rooms or to be hospitalized for avoidable conditions, resulting in large cost savings. A recent national study done in collaboration with the Robert Graham Center found that people who use health centers as their usual source of care have 41 percent lower health care expenditures than people who get their care elsewhere. As a result, health centers saved the health care system $18 billion last year alone.

Community Health Centers are critical to ensuring access to care.

• As Congress turns its attention to universal health reform, health centers are eager to be full and active participants in a new and improved health care system.

• Community health centers will be integral to ensuring that increased health coverage translates into universal health care *access* for all Americans.

• "Access" means a physical **place to go** to receive high quality health care services. But beyond that, to be truly accessible, care should be culturally competent, affordable, and nearby.

Health centers have identified several key principles for health reform that we believe will help to guarantee universal *access*.

• First, health reform should strive to achieve universal coverage that is both available and affordable to everyone; second, coverage must be comprehensive, including medical, dental, and mental health services, with an emphasis on prevention and primary care; finally, reform must strive to guarantee that everyone has access to a medical or health care home where they can receive high quality, cost-effective care for their health needs.

• Expanding community health centers is a key to making these principles a reality, especially for our most vulnerable populations, most of whom live in medically underserved areas. The Health Care Safety Net which became law last year, thanks to the bipartisan work of this committee, would significantly expand health centers program over the next 5 years.

• S. 486, the Access for All America Act introduced by Senator Sanders would even more rapidly expand the program and NACHC supports that legislation.

In order to make health care reform a true success, we must ensure that access to care is front and center. Community health centers' 40- plus year track record of success demonstrates that we are well-equipped to play a pivotal role in providing this health care access and doing so in a way that will ultimately save the health care system money. We look forward to that opportunity.

Mr. Chairman and members of the committee, my name is Dan Hawkins and I am Senior Vice President for Policy and Programs for the National Association of Community Health Centers. On behalf of America's Health Centers and the more

than 18 million patients they serve, I want to express my gratitude for the opportunity to speak to you today about the importance of the Community Health Centers program to ensuring that all Americans have access to high quality, affordable health care. NACHC and health centers appreciate the unwavering support of this committee over many years, dating back to the original authorizing legislation introduced by Chairman Kennedy and approved by this committee in 1975. The ongoing, bipartisan support from this committee, including through last year's historic reauthorization law, has allowed health centers to carry out their important mission, and we look forward to continuing to work with you both in health reform and in the years to come.

Mr. Chairman, I have personally seen the power of health centers to lift the health and the lives of individuals and families in our most underserved communities. As a VISTA volunteer assigned to south Texas in the 1960s, the residents of our town asked me to work on improving access to health care and clean water in our community. We decided to apply for funds through a relatively new, innovative program—the Migrant Health program. I stayed on and served as executive director of the health center from 1971 to 1977. That health center is still in operation today, and has expanded to serve over 40,000 patients annually. The community empowerment and patient-directed care model thrives today in every health center in America, and I am honored to be here to share this success story and how health centers' 40-plus-year track record makes them uniquely positioned to be important participants in a reformed health care system.

HISTORY AND OVERVIEW OF THE HEALTH CENTERS PROGRAM

Conceived in 1965 as a bold new experiment in the delivery of preventive and primary health care services to our Nation's most vulnerable populations, health centers are an enduring model of primary care delivery for the country. The Health Centers program began in rural Mississippi and inner-city Boston in the mid-1960s to serve rural, migrant, and urban individuals who had little access to health care and no voice in the delivery of health services to their communities. In the 1980s and 1990s, the Health Care for the Homeless and Public Housing health centers were created. In 1996, the Community, Migrant, Public Housing and Health Care for the Homeless programs were consolidated into a single statutory authority within Section 330 of the Public Health Service Act.

Congress established the program as a unique public-private partnership, and has continued to provide direct funding to community organizations for the development and operation of health systems that address pressing local health needs and meet national performance standards. This Federal commitment has had a lasting and profound effect on health centers and the communities and patients they serve in every corner of the country. Now, as in 1965, health centers are designed to empower communities to create locally tailored solutions that improve access to care and the health of the patients they serve.

Federal law requires that every health center be governed by a community board with a patient majority, which means care is truly patient-centered and patient-driven. Health centers are required to be located in a federally designated Medically Underserved Area (MUA), and must provide a package of comprehensive primary care services to anyone who comes in the door, regardless of ability to pay. In last year's reauthorization, this committee strongly endorsed the preservation of these core requirements.

Because of these characteristics, the insurance status of health center patients differs dramatically from other primary care providers. As a result, the role of public dollars is substantial. Federal grant dollars, which make up roughly 22 percent of health centers' operating revenues on average, go toward covering the costs of serving uninsured patients and delivering care effectively to our medically underserved patients. Just over 40 percent of health centers' revenues are from reimbursement through Federal insurance programs, principally Medicare and Medicaid. The balance of revenues come from State and community partnerships, privately insured individuals, and low-income uninsured patient's sliding-fee payments.

Health centers have also been pioneers in improving health care quality, particularly in the area of chronic disease management. The majority of health centers now participate in the Health Resources and Services Administration's (HRSA) Health Disparities Collaboratives. The Collaboratives are delivery system improvement initiatives specifically designed for health centers, focused on improving the performance of clinical staff and strengthened care-giving through the development of extensive patient registries that improve clinicians' ability to monitor the health of patients both individually and as a group, and on effectively educating patients on the self-management of their conditions such as cancer, diabetes, asthma, and cardio-

vascular disease. Health centers participating in the Collaboratives almost unanimously report that health outcomes for their patients have dramatically improved. Published studies have documented these outcomes, including one study on the Diabetes Collaboratives where evidence showed that over a lifetime, the incidence of blindness, kidney failure, and coronary artery disease was reduced.

Health centers not only improve health and save lives, they also cost significantly less money, saving the health system overall. In Yvonne Davis' home State of South Carolina, a study showed that diabetic patients enrolled in the State employees' health plan treated in non-CHC settings were 4 times more costly than those in the same plan who were treated in a community health center. The health center patients also had lower rates of ER use and hospitalization.[1] In fact, literally dozens of studies done over the past 25 years, right up to this past year, have concluded that health center patients are significantly less likely to use hospital emergency rooms or to be hospitalized for ambulatory care-sensitive (that is, avoidable) conditions, and are therefore less expensive to treat than patients treated elsewhere.[2] A recent national study done in collaboration with the Robert Graham Center found that people who use health centers as their usual source of care have 41 percent lower total health care expenditures than people who get most of their care elsewhere.[3] As a result, health centers saved the health care system $18 billion last year alone.

HEALTH CENTERS' ROLE IN ENSURING ACCESS TO CARE

As Congress turns its attention to shaping universal health reform legislation, health centers are eager to be full and active participants in a new and improved health care system. We look forward to sharing our decades of experience caring for millions of Americans in a high quality, cost-effective way. Above all, we know that community health centers will be integral to ensuring that the increased health coverage we all support translates into universal health care *access* for all Americans.

What do we mean by "access"? Well, first, access means a physical **place to go** to receive high quality health care services. However, to be truly accessible, that care should be culturally competent, affordable, nearby, and without barriers to care. We believe that access must be front and center in health reform discussions in order to maximize the value of our investments in expanded coverage.

Health centers have identified several key principles for health reform that we believe will help to guarantee universal *access*. First, health reform should strive to achieve universal coverage that is both available and affordable to everyone, especially low-income individuals and families. Second, coverage must be comprehensive,

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[1] Proser M. "Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care." October–December 2005 *Journal of Ambulatory Care Management* 28(4):321–330.

[2] Rust G., et al. "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties." *Journal of Rural Health*, Winter 2009 25(1):8–16; Dobson D., et al. "The Economic and Clinical Impact of Community Health Centers in Washington State: Analyses of the Contributions to Public Health and Economic Implications and Benefits for the State and Counties." Dec 2008 *Community Health Network of Washington and Washington Association of Community and Migrant Health Centers*; McRae T. and Stampfly R. "An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers (FQHCs) Operating in Michigan." October 2006 Institute for Health Care Studies at Michigan State University. *www.mpca.net*. Falik M., Needleman J., Herbert R., et al. "Comparative Effectiveness of Health Centers as Regular Source of Care." January–March 2006 *Journal of Ambulatory Care Management* 29(1):24–35; Proser M. "Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care." October–December 2005 *Journal of Ambulatory Care Management* 28(4):321–330; Politzer R.M., et al. "The Future Role of Health Centers in Improving National Health." 2003 *Journal of Public Health Policy* 24(3/4):296–306; see also, e.g., Politzer R.M., et al. "Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care." 2001 *Medical Care Research and Review* 58(2):234–248; Falik M., et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." 2001 *Medical Care* 39(6):551–56; Starfield, Barbara, et al., "Costs vs. Quality in Different Types of Primary Care Settings," *Journal of the American Medical Association* 272,24 (December 28, 1994): 1903–1908; Stuart, Mary E., et al., "Improving Medicaid Pediatric Care," *Journal of Public Health Management Practice* 1(2) (Spring, 1995): 31-38; *Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers*, Center for Health Policy Studies (1994); Stuart, Mary E., and Steinwachs, Donald M., (Johns Hopkins Univ. School of Public Health and Hygiene), "Patient-Mix Differences Among Ambulatory Providers and Their Effects on Utilization and Payments for Maryland Medicaid Users," *Medical Care* 34,12 (December 1993): 1119–1137; *Health Services Utilization and Costs to Medicaid of AFDC Recipients in California Served and Not Served by Community Health Centers*, Center for Health Policy Studies/SysteMetrics (1993).

[3] NACHC and the Robert Graham Center. *Access Granted: The Primary Care Payoff*. August 2007. *www.nachc.com/access-reports.cfm*.

including medical, dental, and mental health services, and it should emphasize prevention and primary care. Finally, reform must also strive to guarantee that everyone has access to a medical or health care home where they can receive high quality, cost-effective care for their health needs. Expanding health centers is a key step toward making these principles a reality, especially for our most vulnerable populations, most of whom live in medically underserved areas.

For this reason, we believe that health centers will have an increased and even more important role in a post-health reform environment. Indeed, the Massachusetts experience has born this out: as the percentage of insured residents in the State increased, the number of health center patients increased as well. Yet, at the same time, health centers in that State have also increased the percentage of the State's remaining uninsured who they serve.

PROPOSALS FOR EXPANDING THE HEALTH CENTERS PROGRAM

Thanks in large part to the work of this committee, last year Congress reauthorized the Community Health Centers Program, passing the Health Care Safety Net Act of 2008. This legislation preserved all of the essential elements of the Health Centers program and reaffirmed Congress' support for our successful model. The Health Care Safety Net Act also included significantly increased authorizations of appropriations. If the authorization levels approved in the reauthorization are appropriated, health centers will be on target to meet our goal, contained in our Access for All America plan, of serving 30 million patients by 2015.

However, community health centers know better than anyone that the need right now is greater still. Indeed, a report recently released by our Association, entitled "Primary Care Access, An Essential Building Block of Health Reform" found that there are currently 60 million medically disenfranchised Americans—people who lack access to a regular source of medical care.

Given Congress' intention to dramatically improve and reform our health care system, and the essential role that health centers will play in providing many of the newly insured with access to care, some have proposed to grow the health centers program more rapidly. S. 486—the Access for All America Act introduced by Senator Bernie Sanders and co-sponsored by five members of this committee is one such proposal. NACHC has endorsed this legislation and the strong message that it sends: that growing the Health Centers grant program in conjunction with health reform is the most effective way to guarantee that access grows along with coverage.

What will happen if we increase coverage and do not address access? One of my health center colleagues came up with this illustration. Giving everyone an insurance card without increasing access would be like giving everyone in town a free bus pass but not adding any new buses. That's a lot of people standing on the side of the road. When it comes to people's health, the issue is far more serious and the costs are much higher, both in moral and fiscal terms. We must ensure that health care access is a part of health reform.

THE ROLE OF THE NATIONAL HEALTH SERVICE CORPS

When defining access, I mentioned having a health care home where people can go to receive high quality health care services. However, patients can't receive these health care services without a health professional to provide them. The National Health Service Corps (NHSC), also administered by HRSA, plays an essential role in ensuring that health centers have the health care providers they need to care for their patients.

Back in South Texas as a health center director, our community benefited from the services of one of the first NHSC participants, who was placed there in 1972. I can't express what it meant to our center and our patients to have the services of that additional physician. Today, health centers across the country know what an invaluable tool the NHSC is to recruiting and retaining a primary care workforce in underserved areas. Without it, the impact of the nationwide problem of a diminishing primary care workforce and the maldistribution of providers would be devastating to health centers. The Corps is a vital tool as health centers work to maintain the workforce they need to keep their patients healthy.

Indeed, between the years 2000 and 2007, health centers successfully increased their physician staff by 72 percent, their Nurse Practitioner/Physician Assistant staff by 80 percent, and their dentist staff by 116 percent, well ahead of their overall 68 percent growth in patients during that period. This was accomplished with support, assistance, and encouragement from HRSA, NACHC, and the State and Regional Primary Care Associations. However, to reach their goal of serving 30 million patients, health centers will need an additional 16,000 primary care providers; to reach 60 million people, they will need over 50,000 more primary care providers. Ad-

dressing these deficits will involve more than a continuation of current workforce policy.

As we look toward comprehensive health reform and continued growth of the Health Centers program, expansion of the Corps is critical to ensuring we have a primary care workforce capable of meeting the needs of the 21st century. This committee recognized that health centers and the NHSC go hand in hand when they included a reauthorization and significant expansion of the Corps in the Health Care Safety Net Act. The American Recovery and Reinvestment Act also included a landmark amount of funding for the Corps: $300 million, essentially doubling the program over the next 2 years. We must sustain this investment and grow it further in the years to come. S. 486 would accomplish that goal, growing the program from its current 4,000 clinical field strength to over 21,000 clinicians by 2015.

CONCLUSION

In conclusion, in order to make health care reform a true success, we must ensure that access to care is front and center. Providing every American with access to comprehensive, affordable care is key to achieving a healthier nation. Community health centers' 40-plus-year track record of success demonstrates that we are well equipped to play a pivotal role in providing this health care access and doing so in a way that will ultimately save the health care system money. As you consider the myriad challenges facing our health care system, America's health centers offer a real, proven solution to many of these complex questions. We thank this committee for your years of stalwart, bipartisan support and we look forward to continuing to work with you as partners in improving the health of all Americans.

Senator SANDERS. Thank you very much, Mr. Hawkins. We are pleased to be joined by Senator Merkley, Senator Hatch and Senator Brown, all long time champions of primary health care and community health centers.

Senator HATCH. Mr. Chairman.

Senator SANDERS. Yes.

Senator HATCH. I have to go to another hearing. Could I just make a remark?

Senator SANDERS. You sure can. Please.

STATEMENT OF SENATOR HATCH

Senator HATCH. Very briefly. I am very grateful to all of you for showing up and, as you know, I'm a long supporter of this. We just had major meetings in the Finance Committee about the fact that we don't have enough primary care physicians in this country, and yet we have some of the greatest primary care in the world through community health centers.

So I just want to personally congratulate all of you and I would like to take this opportunity to welcome Ms. Lisa Nichols, the executive director of the Midtown Committee Center in Ogden, UT. We are grateful that you would take the time to come here and participate with us. I want to thank you for being here.

Midtown Community Health Center has done an excellent job providing health care services to residents throughout the Ogden community, which is one of our fastest growing communities in Utah. I am very proud of you. We are proud of all of you. I intend to do whatever I can to help keep community health centers strong and expand them. They have to be an effective part of total health care reform, in my opinion, and I'm just very proud of all of you who work so hard and do so much for so many people in the community health centers. I want to thank you, Mr. Chairman, for allowing me to interrupt, and for having may buddy here, Congressman Clyburn from South Carolina, and actually there are some other buddies here, too.

[Laughter.]

Senator SANDERS. Thank you for your support for community health centers and we look forward to working with you to significantly expand them.

Senator Brown wanted to say a word and then we will go to Senator Merkley and then we will go back to the panel.

STATEMENT OF SENATOR BROWN

Senator BROWN. Mr. Chairman, thank you very much. I am thrilled to see Congressman Clyburn here, who I saw up close for many years in the House do such outstanding work on primary care and especially on community health centers. Thank you panel for all that you do for community health service centers and for primary care. There is no better story of health care in my State than what community health care centers do.

A special mention of Dr. Evans, and what dental—we are pushing in my State, and I know around the country, particularly on primary dental care for children and what a difference it makes in their lives, in terms of their health, in terms of their appearance when they go out job seeking, and just in terms of their going through school; all the kinds of things that good dental care at a young age could mean for our Nation's children. I want to thank you again for all that you do and you make such a difference.

Mr. CHAIRMAN. Thank you, Senator.

Senator Merkley.

STATEMENT OF SENATOR MERKLEY

Senator MERKLEY. Thank you very much, Mr. Chair. I certainly want to say that my State legislative experience there is wide bipartisan support for community health centers in underserved areas, be they urban, be they rural; hugely popular recognition that this is a doorway into the health care system, both providing significant care but also providing a doorway to the other care.

We need a lot more doorways and we need a lot more primary care, and I look forward to hearing and learning additional details, and thank all of you for coming to testify.

Senator SANDERS. Thank you.

Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. Mr. Chairman, thank you very much. I am going to be looking forward to engaging in this discussion. We had an opportunity over the last couple of months to make positive steps forward on health care, in particular with regard to children. We finally got that done, but believe it or not, there's a lot more to do with regard to children. There are still millions who are not covered despite the great work that everyone has done. Senator Sanders has been a real champion of this issue of community health centers and I know the impact that they have had on our State of Pennsylvania, a substantial impact, I am proud to be a co-sponsor of the bill and we are grateful for Senator Sander's leadership and look forward to the discussion.

Thank you.

Senator SANDERS. Thanks very much.

OK. Let's go now to Dr. Fitzhugh Mullan, who is the Murdock Head Professor of Medicine and Health Policy. We appreciate very much your being here. Thank you, Dr. Mullan.

STATEMENT OF FITZHUGH MULLAN, M.D., MURDOCK HEAD PROFESSOR OF MEDICINE AND HEALTH POLICY, WASHINGTON, DC

Dr. MULLAN. Thank you, Senator Sanders, Congressman Clyburn, collaborative colleagues. I am pleased to be able to speak with you today about a sister program that is almost as old as the health center program, the last day of 1970 signed into law by President Nixon, the National Health Service Corps. The Corps has grown from that point, but not as one might like to see it grow and not as the growth is envisioned in Senate bill 486 and House bill 1276. So I am delighted to be able to envision with the committee how that might be.

Just stepping back for a moment, I started my career in medicine as a National Health Service Corps physician in New Mexico following residency. First generation, first year out of the chute, I was privileged to come back and for some years thereafter, run the National Health Service Corps. It was the early years of the scholarship program. We were very excited. We went from 500 to upwards of 2,000 people in the field, this being the late 1970's. And I will argue that it was then a fabulous demonstration program. Its biggest problem is that 30 years later, it's still a demonstration program. We need to move beyond that.

A quick word about how to envision or frame the issue. I took the liberty of putting up a graphic here in back. I am sorry it's—I couldn't figure out where to put it in the room so that everybody could see—but in terms of primary care work force reform, I would suggest three elements to the life cycle of a health worker, a physician in this case: medical school, graduate education, and practice.

The latter, of course is the longest. But the other two are formative—the pipeline. And there are a number of instruments that are in play and others could be put in play to influence that.

Importantly, we need influence in all three. If you fix the pipeline and don't fix practice, or you do something good about practice and upscaling reimbursement, but you don't do anything about the pipeline, you are going to have far less than a satisfactory outcome. So all of this is a framing concept.

A quick word about where we are about the physician work force in general. While we have 280 physicians per 100,000, it puts us about in the middle of the pack for developed nations. Europe has a few more, Canada and the UK have a few less.

I think we are in a zone of sufficiency. And folks who are yelling about we need more physicians, we need more nurse practitioners and more physicians assistants to make more use and better use of what we have in the way of a very excellent physician work force, but I think roughly we are in a pretty good zone in terms of what we are producing.

We do have enormous distribution problems. And that's where health centers, aided by the National Health Service Corps have

shown the way thus far, but it's no where near the way that it might be shown in the future.

Let me talk just briefly about the Corps and where it sits, emphasizing I am not a representative of the program, but I've been a fan of it and a participant in it over the years, and I did a little homework coming in.

The essence of the physician distribution problem, is shortage areas, which are some combination of local economics and local geography that are not sufficiently incentivized to get physicians to go there.

This is a problem throughout the world. Every country has it. There is a gradient, docs like well-to-do communities, and they like urban areas. So how do we get them to go where they don't want to go? That's what democratic incentive programs are about and that's what the Corps is.

In closing, let me just say quickly that one could envision under this bill what I've called in the past the muscular Samaritan. The Corps is a samaritan—but there are many ways it could be developed and more fully impact the country's health centers, build them out as we build health centers. There is prison health. There is urban health. There is public health. There are many ways this instrument could benefit the country.

And finally the Corps, itself, needs some modest changes. It's a great formula. Education for service for things like better flexibility in terms of where people serve, teaching health centers where there is much more education that goes on in health centers, for recruitment purposes, many things could be done. The bills proposed would allow that to happen, a real revolution in health workforce of the country.

[The prepared statement of Dr. Mullan follows:]

PREPARED STATEMENT OF FITZHUGH MULLAN, M.D.

SUMMARY

• Improving access to health care in the United States will require modifications in the U.S. health care workforce, the foremost of which will be the construction of a strong primary care base.

• Two-thirds of the U.S. physician workforce practice as specialists and the number of young physicians entering primary care is declining.

• The distribution of health care providers in the United States heavily favors urban areas. Metropolitan areas have 2–5 times as many physicians as non-metropolitan areas and economically disadvantaged areas have significant health care access problems.

• Today's physician-to-population ratio is in the zone of adequacy and should be maintained with growth in the number of physicians trained to parallel growth in the population. Increased requirements for patient care due to the aging of the population or the inclusion of more Americans in a universal care plan should be met by more strategic distribution of physicians, both geographically and across the primary care—specialty spectrum, and the expanded use of physician assistants and nurse practitioners.

STRATEGIES

• Medical Schools.—Medical schools are currently expanding, and title VII legislation needs to be re-invigorated and up-funded to augment primary care training.

• Graduate Medical Education.—The current number of Medicare funded slots is sufficient to maintain workforce numbers. However, reforms need to be made in current legislation to prioritize and incentivize community-based and primary care training. Serious consideration also needs to be given to aligning Medicare GME

with the workforce needs of the country. This would entail designing a new GME allocation system.

• Medical Practice.—Primary care payment reform, support for new practice organizations such as primary care medical homes, and investment in health information technology are all important reforms that will promote a strong primary care practice base in the country.

• National Health Service Corps.—The NHSC is a proven program that delivers primary care clinicians to needy communities in return for student debt reduction. It is a brilliant and successful strategy that has always been under-funded. It is time to radically increase its budget toward the end of fully staffing Community Health Centers and addressing the oncoming needs for clinical service in the United States.

• Teaching Health Centers.—Establishing stable funding for both undergraduate and graduate medical education in health centers will promote a workforce prepared with skills needed for practice and improve recruitment and retention for health centers, which are critical providers of health care to underserved communities.

• Data and leadership in the field of U.S. health workforce development is insufficient. A National Health Workforce Commission would be an important asset at the Federal level in managing health care workforce reform.

INTRODUCTION

Thank you, Mr. Chairman, for this opportunity to testify today. During the 40 years since I graduated from medical school, I have practiced medicine as a member of the National Health Service Corps in New Mexico; I have directed workforce programs including the National Health Service Corps; and I have been a student of and commentator on U.S. workforce policy in my current role as a Professor of Health Policy at The George Washington University.

Therefore, it is with experience as a practitioner, administrator, and scholar that I come before you this morning.

Current health care access and the expansion of access to all Americans are necessarily reliant on both the number and make-up of the workforce available to provide care. In my remarks, I will briefly review the history, demographics, trends, and problems associated with the U.S. health professions workforce. I will focus on the physician workforce, which is large, at the center of the delivery system, and closely associated with the costs of the health care system. I will also talk about nurse practitioners and physician assistants who make major contributions to clinical care delivery in the country. I will discuss the current and potential future role of the National Health Service Corps. Much of my commentary will reference the challenge of providing a strong and efficient base to the U.S. health care system—the sector of practice termed primary care. I will propose a number of areas in which legislative action would, in my judgment, support and augment the training and practice of primary care providers, thereby improving the availability, efficiency and effectiveness of the overall health delivery system.

HEALTH CARE ACCESS AND THE HEALTH CARE WORKFORCE

Increasing health care access in the United States is necessarily dependant upon the current and future status of the health care workforce—in absolute numbers, specialty make-up, and geographic distribution. Health care reform in Massachusetts provides one instructive example of achieving health care reform without concurrently addressing the health care workforce. In 2006, Massachusetts enacted universal health care measures, increasing the number of insured by 340,000. However, within 2 years, reports of access problems due to an insufficiency of primary care providers emerged, causing the State legislature to scramble to enact primary care legislation.

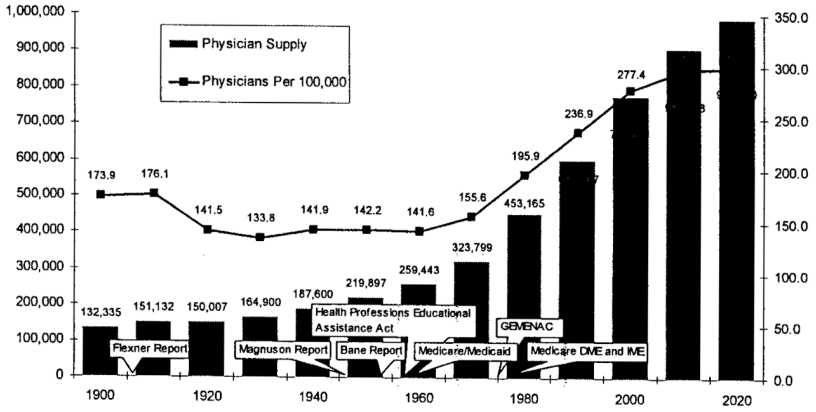
In addition to the Massachusetts example, many organizations are indicating increasing concern over the primary care workforce. The National Association of Community Health Centers (NACHC) reports health centers currently have a shortage of over 1,800 primary care providers. Further, if health centers are to increase their services and access, they will need an additional 15,585 primary care providers to reach 30 million patients by 2015 or an additional 51,299 primary care providers to reach 69 million patients.[1]

Both the Massachusetts experience and the NACHC report remind us coverage does not equal access. In order to increase access, we must build a high quality, cost-effective, well distributed workforce.

THE DEMOGRAPHICS OF THE WORKFORCE

Today, there are over 800,000 practicing physicians in the United States. This number represents a steady increase over the last 50 years in both the number of physicians and the physician-to-population ratio (see Figure 1). The current density of physicians is 272 per 100,000. However, the distribution of physicians in the United States trends heavily towards urban and well-to-do areas. Less than 10 percent of physicians practice in rural areas while 20 percent of the country's population resides in these areas. Metropolitan areas have a primary care physician-to-population ratio of 93 doctors per 100,000 people compared to 55 primary care doctors per 100,000 people in non-metropolitan areas. Specialists are even more concentrated, with greater than three times the density of specialists in metropolitan areas versus non-metropolitan areas.

Figure 1: Physician Supply 1900 Projected to 2020



Sources: 1900, 1920: US Census occupations; 1910: Schofield (1984); 1930,1940: Stewart WH (1960).
1950-2020: Data provided by the Bureau of Health Professions

American Medicine is highly specialized. Currently, there are 142 Accreditation Council on Graduate Medical Education (ACGME) recognized specialties and combined subspecialties as well as multiple additional unrecognized subspecialties. Physicians reporting that they practice primarily as specialists comprise 63 percent of practitioners whereas those working in the primary care specialties (family medicine, general internal medicine and general pediatrics) comprise only 37 percent of doctors in practice. This figure is markedly different than it was 50 years ago when 50 percent of America's physicians were generalists. In Canada today, by contrast, 51 percent of physicians are currently family physicians and GPs.

The situation in primary care, however, is more problematic than the numbers might suggest. Hard work, low pay, and "lifestyle" expectations of medical graduates today have resulted in dramatic reductions in interest in primary care in U.S. medical graduates (see Figures 2 and 3). Between the mid-1990s and today, the number of training positions in family medicine has declined 20 percent and the percentage of the family medicine residency positions being selected by U.S. graduates has fallen from 72 percent to 44 percent. The majority of family medicine positions are now filled by international medical graduates.

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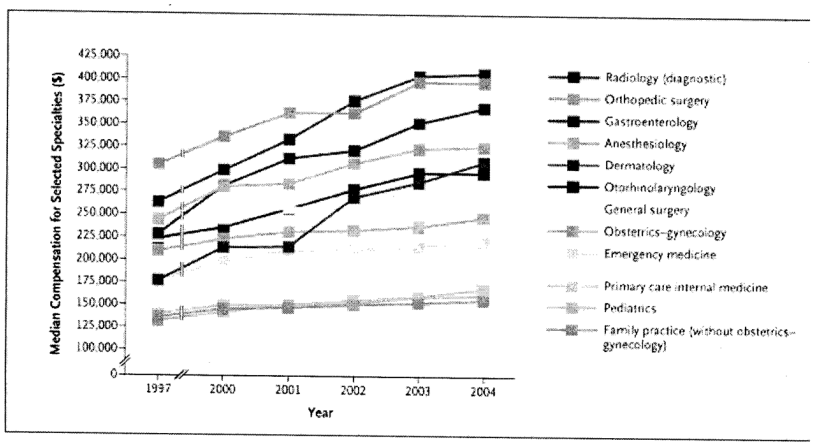
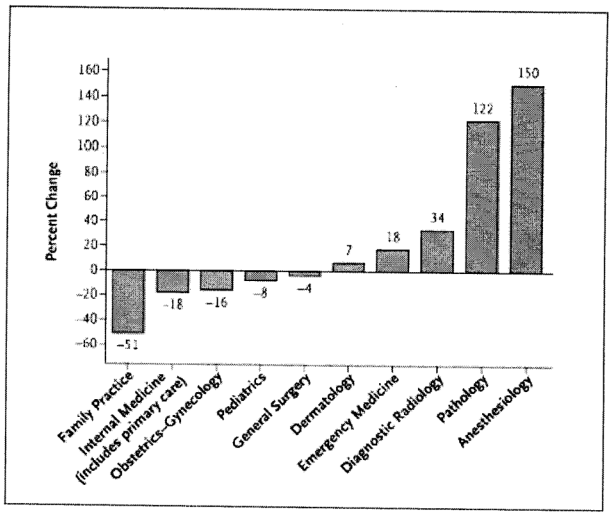
Figure 2: Median Compensation for Selected Medical Specialties



Source: Medical Group Management Association Physician Compensation and Production Survey, 1998 and 2005. From: Woo: N Engl J Med, Volume 355(9).August 31, 2006.864-866.

Figure 3: Percent Change between 1998 and 2006 in the Percentage of U.S. Medical School Graduates Filling Residency Positions in Various Specialties.



Source: Medical Group Management Association Physician Compensation and Production Survey, 1998 and 2005. From: Woo: N Engl J Med, Volume 355(9).August 31, 2006.864-866.

A recent questionnaire of senior medical students considering careers in internal medicine showed that only 2 percent of them wanted to be general internists.[2] These trends have implications for the future—a future that will require more primary care services for our aging population. A recent study projects that we will be short approximately 40,000 primary care doctors in 15 years[3]—and that doesn't take into account the millions of Americans who will seek primary care when universal coverage is implemented.

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PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

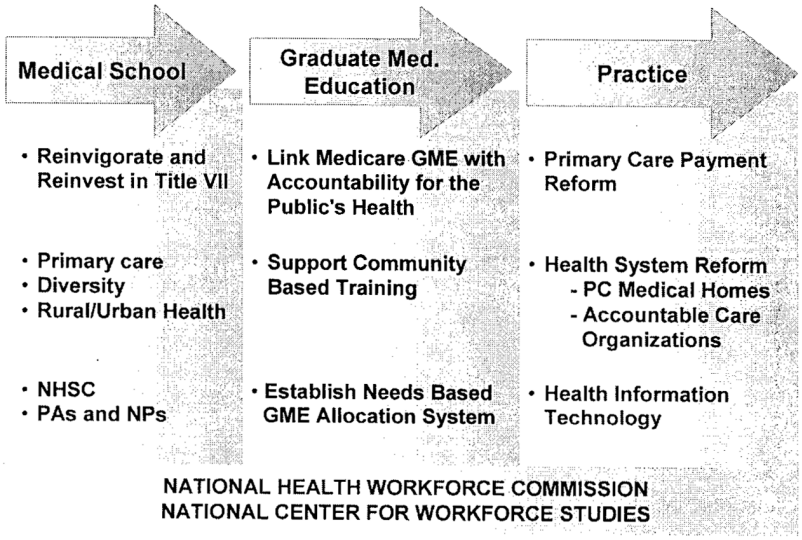
The United States is a global pioneer in the creation of new categories of health professionals who contribute to the delivery of clinical services. Separate pilot programs in the 1960s introduced the world to the idea of the nurse practitioner (NP) and the physician assistant (PA). Since those early programs, both professions have grown enormously in size, stature and public acceptance. Approximately 125,000 nurse practitioners have been trained in the United States, the majority of whom are engaged in clinical practice. There are almost 70,000 certified physician assistants in the United States and more than 100 training programs.

Both of these professions are associated with primary care and practice in rural and underserved areas. About 25 percent of all nurse practitioners are located in non-metropolitan areas and an estimated 85 percent of them practice primary care. Physician assistants are active across the spectrum of medical specialties with more than one-third of them working in primary care practices and approximately one-fifth of them working in rural areas.

THE CAREER LIFECYCLE OF A PHYSICIAN

Before considering questions of the sufficiency of the workforce or policy options to modify its direction, I would like to suggest a framework for considering physician careers. I call this the career lifecycle of a physician. It has three phases—one of which is educational, one of which is transitional and the final one of which is vocational (see Figure 4). The phases are medical school, graduate medical education, and practice. The first two might be considered "pipeline phases" since they determine the quantity and nature of physicians prepared for practice. The final phase is the "payout" phase when the physicians are actually providing health care to the Nation.

Figure 4: Primary Care Workforce Reform



This framework allows us to consider capacity, cost and performance in three separate but interlinked longitudinal phases of the career path of physicians.

One further clarification is necessary to understand the dynamics of the physician lifecycle. The governing sector in the lifecycle is graduate medical education (GME). Contrary to popular belief, it is not medical schools that determine the ultimate size and specialty composition of the physician workforce of the country. Rather it is residency programs, taken as a whole, that serve as the final pathway into practice and largely govern the numbers and specialty distribution of the physicians in practice. In order to practice medicine in the United States, one needs a license from a State. All States require 1 to 3 years of residency in order to obtain a license.

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It is also important to recognize that a significant proportion of practicing physicians did not attend U.S. (allopathic) medical schools. Of the current first year residents, for instance, 64 percent graduated from U.S. allopathic (M.D.) medical schools, 7 percent from U.S. osteopathic (D.O.) medical schools, and 29 percent from medical schools abroad (International Medical Graduates or IMGs).[4] Almost all of these physicians will complete residency and enter practice in the United States. Thus, it is the size and specialty offerings of the aggregated residency programs of the country that really determine the future of the U.S. physician workforce.

SUFFICIENCY

As we examine the Nation's health care system and as we consider options to increase coverage, fairness, quality, and affordability, we must wrestle with the question of how many physicians we need. This is a central question, not only because it involves the physician production process but also because it has important implications for training requirements for other health professionals (i.e., nurse practitioners and physician assistants). It also has ramifications for prospective spending in a number of areas including hospital beds, diagnostic testing, medication usage and locations of practice.

Many policy scholars and analysts have written on this topic with strikingly different conclusions. Some have suggested that we are training too many physicians while others issue predictions that we are entering into a period of dramatic physician shortage. These projections are largely dependent on the assumptions made about the health care system of the future. If one assumes that the health care system will be highly coordinated with the well-organized use of physician services, such as is the case in prepaid managed care plans like Kaiser Permanente, the case can be made that we might well have a surplus of physicians. If one assumes the continuation of a minimally organized, specialty dominated, predominantly fee-for-service system that is an extrapolation of today's circumstances, one can make the case for a perpetually escalating need for physicians. Both cases have been argued eloquently.

My view is that the density of physicians (the physician-to-population ratio) that we have at the moment is reasonable and the role of public policy (financing and regulation at the Federal and State levels) should be to maintain a physician workforce of approximately the current size. This strategy should take into account projected growth in the size of the U.S. population (which is projected at 1 percent per year) so that the absolute number of physicians would grow in a modest but consistent fashion.

This strategy would be challenged by critics who would raise objections in the following areas:

1. The American population is aging, and by all measures, older citizens require more health care;
2. Physician practice patterns have changed and physicians don't work as many hours as they used to;
3. Technology is advancing and we will need more specialists to deliver the fruits of new technologies to the population:
4. Don't bet on better organization of the health care system.

These observations are all valid. A response to these concerns could certainly be placement of greatly increased numbers of physicians into practice—whether from U.S. medical schools or from physicians trained abroad at the expense of other nations. However, all evidence indicates this would be a very costly response since physicians are expensive to train and to compensate in practice. Additionally, excellent evidence shows an association of more physicians and, especially, more specialist physicians with higher health care costs. This is the case because more physicians and, particularly, more specialty physicians are associated with higher hospital utilization and increasingly costly patterns of practice. Importantly, this evidence also shows no benefit in care from this higher intensity of physician practice.

Reforming physician workforce policies in a way that promotes quality and constrains costs requires a different strategy. The essential elements of that strategy are three:

1. The revitalization of a primary care workforce that will be able to staff an organized system of national primary care delivery that needs to be created by reforms in the delivery system. Whether services are delivered in primary care medical homes, accountable care organizations (ACOs), prepaid group practices, or community health centers, the size and skills of the primary care workforce need to be robust.
2. The physician education pipeline needs to produce enhanced numbers of primary care physicians prepared to work in hard pressed inner city and economically

challenged communities, cities and rural areas as well as in economically comfortable urban and suburban settings.

3. To the degree that the clinical care workforce as a whole needs more providers to address the changing needs of the population, a strong strategy of support for nurse practitioners and physician assistants should be adopted. The increased use of PAs and NPs should not be limited to the primary care sector. Both professions have demonstrated excellent functionality as team members in all aspects of medical practice from the pediatric office to the operating room. Nurse practitioners and physician assistants are trained more quickly, at less expense than physicians, cost less in practice, and are not, on their own, drivers of ancillary clinical tests and services. Moreover, they represent a highly flexible workforce—an important asset generally lacking in the physician workforce. In contrast, physicians (especially specialty physicians), invest enormous amounts of time, money and deferred income in establishing their capabilities and credentials. Training, retraining, and/or redirecting them is not easily done. Physician assistants and nurse practitioners are, comparatively speaking, "stem cells" and more able as individuals and as professions to focus on areas of emerging or urgent need. NPs and PAs provide a well-proven quality, clinical workforce that can interdigitate with all aspects of physician practice and whose pipeline can be turned up or down as needed to assist in addressing emerging or changing clinical needs.

No discussion of the physician workforce would be complete without reference to international medical graduates (IMGs) who constitute approximately 25 percent of physicians in practice and 29 percent of physicians in residency training. No American policy body—certainly not the U.S. Congress—has ever advocated that we "offshore" one quarter of our medical training or design a system in which our medical schools are only capable of training three-quarters of the physicians we need. Yet that is what we have done.

We can be proud that the appeal of our way of life and the prowess of our medical institutions that have made the United States a magnet for physicians from around the world for the last 50 years. Most have arrived under educational visas and, in overwhelming numbers, have remained in the United States following residency training. This has been an enormous gift to the United States. In steadily escalating numbers, these hard working, smart, and ambitious men and women from all over the world have staffed our health system. They have also allowed us to be casual in our medical education policy. There is no need for planning or precision nor, even, adequate funding for medical schools since large numbers of foreign graduates are always available to fill in the gaps in residency programs and in specialties that are out of favor with American graduates. Sixty percent of international medical graduates come from poor countries—largely the Indian subcontinent, Africa and the Caribbean. In many small countries the physician "brain drain" is the largest and most destabilizing aspect of their health sector. We are not the only country to rely on foreign trained physicians, of course. At one point, Nelson Mandela personally appealed to Tony Blair to stop "poaching" South Africa's doctors. Recently, global attention has turned to the question of health system strengthening to fight AIDS and end poverty, and yet everywhere one turns the brain drain of doctors and nurses stands as an impediment to improved health in developing countries. Some have called it "reverse foreign aid."

Heavy reliance on international medical graduates to fill residency positions and undergird the Nation's physician workforce is neither good domestic policy nor good foreign policy. Going forward, public policy makers and medical educators should work toward self sufficiency in medical education. This boils down to a single simple principle: U.S. medical schools should graduate approximately the number of students required to fill the first year residency positions offered in the country.

In that regard, the current initiation of new medical schools and expansion of class sizes at existing schools is a positive development. These new U.S. students will undoubtedly find residency positions upon graduation, decreasing our need to draw on the rest of the world to meet our medical needs. This will be an asset in our efforts to promote the United States as a good global citizen and also provide an overdue opportunity for more U.S. students to go to medical school in the United States.

REFORM IN THE THREE SECTORS OF THE PHYSICIAN WORKFORCE

MEDICAL SCHOOLS

The principal Federal legislation impacting medical schools since 1963 has been the series of programs authorized under Title VII of the Public Health Service Act. From 1963 to 1976 the principal investments were designed to increase the number

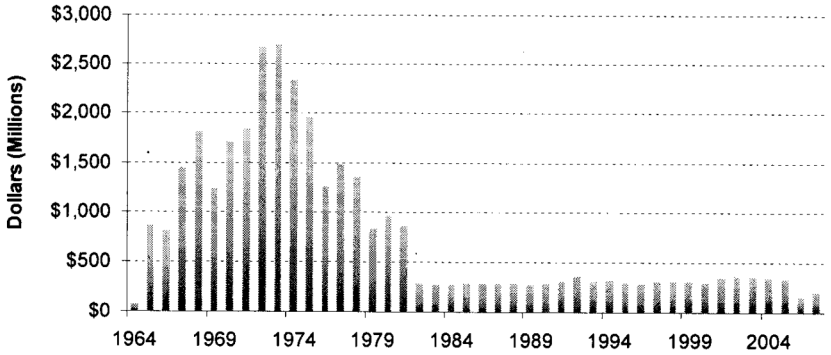
of medical schools and medical school graduates. Construction grants, capitation funds, and student loans were all used as stimuli for medical schools. The result was more than a doubling of the Nation's annual medical school graduating class from approximately 7,500 students a year in 1960 to 16,000 students a year in 1980. This was an extraordinary achievement of public policy and medical education.

The problems with medical education, however, that concerned policymakers even in those early years went beyond absolute numbers. It was growingly clear that physicians were not equally distributed in the country nor were medical students reflective of the diversity of the population of the United States. The term "primary care" was first used in the 1960s to focus on yet another problem with medical graduates—the increasing specialization of physicians such that many parts of the country had little access to generalist care.

The result was a new growing set of programs authorized under Title VII of the Public Health Service Act to promote community practice, rural practice, primary care, and opportunities for minorities and disadvantaged students. These included the Area Health Education programs, support for family medicine, general internal medicine, and general pediatrics, the Health Careers Opportunity Program and funding for physician assistants. During this same period, funding for nursing and, particularly, new nurse practitioner programs was similarly increased under Title VIII of the Public Health Service Act.

In the early 1970s, the funding for title VII programs reached over $2.5 billion (2009 dollars) (see Figure 5). In the mid-1970s, the consensus changed with the belief that we were training enough (some thought too many) physicians and title VII authorizations and appropriations were throttled back. The title VII programs have functioned in the very modest $200–300 million/year range from that time until the present.

Figure 5: Title VII Funding, 2008 Dollars



Source: Health Resources and Services Administration

In the latter years of the Bush administration, serious efforts were made to eliminate all title VII funding including support for primary care, minorities in medicine, rural placements and workforce tracking. During the same period, medical school revenues from NIH research funding have risen from $2.4 billion in 1970 to $16.3 billion in 2004 (all 2009 dollars), creating a robust culture of research at medical schools that dominates medical school finances, faculty values and school culture (see Figure 6).

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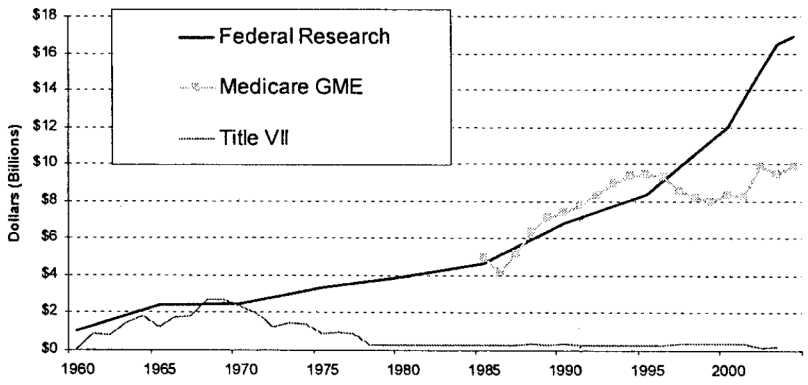
Figure 6: U.S. Medical School Revenue, 2008 Dollars



Source: AAMC Data Book, Centers for Medicare and Medicaid Services, Health Resources and Services Administration

Any serious proposal to reform medical practice in the United States must start with reinventing and reinvigorating title VII funding to medical schools for the purpose of creating incentives and educational pathways that will select and train students for primary care, rural health, diversity, and social mission. Parallel support for nurse practitioners and physician assistants is important as well.

In the past, critics of title VII have proposed high standards of measurement, asking, "how do we know title VII funds make a difference?" This is a difficult problem for programs with small funding streams that function within large institutions with many contrary incentives. Nonetheless, an impressive series of studies have shown that title VII funds affect physician careers positively in regard to primary care, rural placement and minority opportunities. There are many ways in which title VII could be augmented and strengthened. One of those would be an initiative which provides incentives for the creation of "teaching community health centers"—creating funded linkages between medical schools and Federally Qualified Health Centers (FQHCs) for the purpose of training. Another area in which title VII needs strengthening is in the ability to collect important data and produce useful policy analyses on the workforce. A national center for workforce studies should be given serious consideration in augmenting title VII authorities and funds.

Funding for the education of physician assistants and nurse practitioners should be continued and augmented to help provide the build-up of flexible clinicians for health reform.

While the National Health Service Corps (NHSC) it is not an educational program, it is a brilliant but underfunded asset available to redistribute health professionals—physicians, NPs, PAs and others. I say brilliant, since it matches the needs of individual health science students/professionals with national needs for practitioners in underserved areas. The program has been "tested" since 1971 and works to the benefit of clinicians and communities. Many clinicians have remained in their assigned communities for long periods or full careers. At times, however, the NHSC has received criticism for not having as high "retention rates" as some would like. There are American communities that for reasons of geography or economy have never been able to retain physicians. To the degree that the NHSC can meet service needs with serial placements in these communities, the program is a success. The principal problem with the NHSC is its size. There are many more communities eager for NHSC help and many more clinicians interested in scholarships or loan repayment opportunities than can be met given the program's budget. Major investment in the NHSC would do a great deal to increase access to health services in some of our poorest and most rural communities.

A word should also be said about Community Health Centers which are not teaching institutions but have a stellar record of providing learning sites and supervision

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for clinical students—often without recompense. Good data now shows that in many communities CHCs are struggling to find sufficient primary care providers to meet their staffing needs. Expansion of the NHSC and support through title VII and Medicare GME for CHC-based teaching activities will be essential to allow them to expand to meet the growing needs of the uninsured and underinsured populations of our country.

GRADUATE MEDICAL EDUCATION

Graduate medical education (GME) grew significantly through the 1980s and early 1990s and leveled off at about 100,000 residents and fellows a year in GME from the late 1990s to the early 2000s. In recent years there has been a small increase in the total number of residents and fellows. Residency programs are unevenly distributed throughout the country, with history playing an important role. The locations of the earliest residency programs 100 years ago are the areas of the largest residency concentrations today including Boston, New York City, Philadelphia and Washington, DC. In general, the resident physician-to-population ratio is highest in cities in the Northeast, lower in Southern and Western States, and lowest in rural areas.

The most important financial policy and educational instrument in graduate medical education is Medicare GME. While Medicare has paid for a portion of GME since its inception, the current system was established in 1983 as part of the prospective payment reforms of Medicare. The current system reimburses hospitals that train residents for two costs:

1. Direct costs (DGME) associated with residents, such as salaries, teaching time of faculty, administrative costs; and
2. Indirect costs (IME), which are intended to subsidize the higher cost of patient care in teaching hospitals related to both higher patient care acuity and the presence of residents in the hospital.

The calculation for direct and indirect payments is different, but both are based on the number of residents at a given teaching hospital and, as such, are a form of capitation payment—the more residents, the higher the payment. In 2006, direct GME payments totaled $2.8 billion and indirect GME payments totaled $5.8 billion, a total of $8.6 billion. This total amount represents only 2 percent of Medicare's expenditures in 2006 and, perhaps, receives less public debate than it might. On the other hand, $8.6 billion is far and away the largest Federal expenditure related in any way to medical education.

As part of Medicare, these funds function as an entitlement and are allocated based on established formulas. Medicare legislation requires no community or regional physician needs assessment to qualify a hospital for GME payments, sets no targets for the number or type of resident physicians that a hospital trains and requires no accountability for the type or sufficiency of physicians in the hospital's city, county or State. Concerned with the cost of the program and its potential to escalate, Congress capped the number of federally funded residents in the Balanced Budget Act of 1997. In the last 5 years, the total number of residents in the country has grown slowly presumably due to the addition of "off-cap" residents and the selection of specialties with longer training periods.

While Medicare GME in its current form has provided a large and stable source of income for teaching hospitals that is understandably of enormous value to those important institutions, it is effectively a Federal payment without a deliverable—a subsidy. The resident compliment of any given hospital is determined by the staffing needs of that particular hospital with, presumably, the input of the chiefs of the clinical services. There is no requirement that the particular hospital or the medical school with which it is affiliated make any judgments about the workforce needs of their community, region or State. The result is that the annual graduates of the over 9,000 residency programs at nearly 1,100 teaching hospitals in the United States comprise the workforce of the country with no regard to specialty selection, practice location or regional needs.

Effectively, we are addressing the health care needs of the country with a physician staffing pattern based on hospital needs. This is a core problem for workforce reform. There are many ways in which Medicare GME could be reconceptualized and redirected. For the purpose of this testimony, let me suggest two levels of reform that might be considered. The first I will entitle "modest" and the second "major".

Modest reforms to current Medicare GME would entail modifications in the rules governing the use of GME funds. Currently, there are a variety of financial disincentives to offsite training. Hospitals stand to lose GME payments, both DGME and IME, for residents who spend time offsite (for instance in Community Health

Centers, office-based practices, or local public health departments.) The sites, in turn, face either complicated negotiations to obtain GME pass-through funds or the prospect of training residents without receiving the benefit of GME financing.

There is much that could be done to make Medicare GME more user-friendly to primary care and community-oriented training. Reforms in this area would be helpful but would do little to change the basic problem of hospital staffing patterns dictating the Nation's physician workforce.

A major reform would require reconstituting the current policy thinking that governs Medicare GME. Rather than seeing GME as a convenient vehicle for teaching hospital support, Medicare GME should be seen as the principal instrument to shape the physician workforce of the country. This perspective would require teaching hospitals to undertake community or regionally oriented analyses of physician workforce needs and make application for training positions based on a fiduciary responsibility to train a complement of residents that corresponds to agreed upon regional needs. This approach might also call for rebalancing regional and sectional allocations of GME funding and therefore physicians to provide a more balanced landscape of GME training.

One problem with envisioning a system of this sort is that many teaching hospitals who are current recipients of GME funding are not large and do not have a large number of teaching programs. In fact, many larger hospitals have specific foci such as cancer or children or surgery that do not equip them to address regional needs. An answer to this problem is the formation of independent consortia of teaching institutions that would, when working together, represent training capacity that could address regional needs in a much more comprehensive fashion. A variant approach would be State-based GME organizations that might (or might not) have a link to State government. In either case, the consortium would be able to represent regional needs and work with the Center for Medicare and Medicaid Services (CMS) on residency training targets and GME funding.

A consortium system would require the establishment of many new arrangements within the medical teaching sector. It might also mean that teaching hospitals would have to modify their complement of residency programs in ways that might not be popular with the chiefs of service or the hospital administration. Strong political objection would predictably be mounted against any such reform, but if this most crucial link in the construction of the physician workforce in the United States—graduate medical education—is to be modified to meet the needs of an efficient and effective health system in the future, changes will need to be made in the way the Federal Government does business with the teaching hospitals of the country.

MEDICAL PRACTICE

Re-incentivizing and re-directing primary care in the pipeline (medical schools and GME) will amount to little if parallel reforms are not achieved in support for primary care practice. Physicians are smart and ambitious enough that, if the current reimbursement inequities and structural disincentives to primary care practice remain in place, many will abandon primary care during their practice years despite excellent primary care education and support for primary care in their training years. The key areas in the practice environment that will help are practice reimbursement, practice organization, and health information technology.

Primary care physician average annual incomes are currently less than half those of their specialty colleagues. Given high medical school debt, late entry into an economically productive life and demands of the job, it is not hard to understand why primary care careers are severely disadvantaged in comparison to more lucrative specialty options that often have more controlled lifestyles. While physicians receive payment from many sources, the Medicare fee schedule is the primary determinant of physician reimbursement and is a candidate for major restructuring.

The organization of primary care practice is another area of major reform potential. The preponderance of primary care providers still work in solo practice or small groups. This minimizes the opportunity to develop a full-service primary care team benefiting from new information technologies or relating in an effective way to specialty consultants. Larger team-based practices with excellent information systems such as medical homes or accountable care organizations offer the promise of a new platform for health care delivery. Incentivizing and supporting these forms of practice stands to do a great deal to improve the overall health system, particularly promoting primary care, whose currency is patient well-being over time linked to episodes of care provided by other practitioners. Health IT will organize and empower the primary care practitioner in ways that will make the practice of primary care much more effective. Investments in these areas are crucial.

ACTION ITEMS

In closing, I want to emphasize three areas for legislative action that would move the healthcare workforce of the United States in the direction needed to provide universal coverage built on a strong primary care base. The areas are the following:

1. The 1 percent National Health Service Corps

Increase investments in NHSC scholarships and loan repayment such that there are 8,000 physicians and others in the field by 2012—something approaching 1 percent of the physicians currently practicing in America. A field strength of this size would help staff the expanding network of community health centers and other community sites and begin to address the medical needs of many newly insured Americans. Additionally, modifications will need to be made in the current NHSC law to allow NHSC clinicians to engage in teaching and medical leadership functions.

2. Teaching Health Centers

A reform effort focused on all three sectors of the physician workforce is the Teaching Health Center. Patient care in the United States increasingly occurs in ambulatory settings. Yet medical education (both undergraduate and graduate) is overwhelmingly based in hospitals—creating a mismatch between the skills obtained during training and those needed in practice, promoting specialization over primary care careers and inhibiting recruitment and retention in ambulatory sites, particularly those serving rural and underserved communities. Establishing Teaching Health Centers would address all of these by augmenting the current training system with increased training directed by and occurring in health centers (including FQHCs, FQHC look-alikes and public health department). While education does currently occur in these settings, current laws and regulations are prohibitive. Legislation to support the Teaching Health Center could include:

- Medicare GME funding paid directly to health centers to support these training programs.
- Title VII and title VIII grants to support faculty and curriculum development.
- Section 330 grants to support facility expansion and faculty time costs.
- Changes in National Health Service Corps to support a teaching role within the NHSC service obligation.

3. A National Health Workforce Commission

Underlying reform efforts in all three sectors of the physician workforce is the need for national level analyses and guidelines for workforce policies. Policy changes aimed at reforming the three sectors to address the health care needs of the Nation can not be successful without clear workforce objectives, which require the ability to collect important data and produce useful policy analyses on the workforce. A National Health Workforce Commission, established as an independent congressional agency, could serve in this function and advise Congress and the Secretary on the alignment of Federal programs including Medicare GME with national health workforce goals. Also recognizing the complexities of data collection and the varying geographic needs at the local level, State Level Health Workforce Councils could support the National Commission—collecting and analyzing State level data and implementing national level policies at the local level.

CONCLUSION

In order to reform the delivery of health care in the United States in a way that is more effective and constrains costs, a number of changes need to be made in the workforce since the workforce is an essential governing component of the functionality, quality and cost of the system as a whole.

The number of physicians entering practice in the United States currently is in a zone of adequacy. Many of these physicians are trained abroad and measures should be taken to increase U.S. medical school output so as to decrease our dependence on foreign-trained physicians. The training and use of nurse practitioners and physician assistants should be augmented to absorb increased demand in the system due to an aging population.

The current system heavily favors fragmented specialty care, making it inefficient and expensive. Moreover, it is unevenly distributed, raising serious concerns of access and equity. Major investments in the pipeline at the medical school and GME level will be essential to rebalancing the system. At the GME level, in particular, where a large investment already exists, modifications need to be made in the system. In the practice sector, primary care is currently severely disadvantaged and reforms in payment systems and practice support will be needed to re-incentivize and restructure the practice of primary care across the country.

It goes without saying that this is an important moment in the history of health care in the United States. The Congress has an unprecedented opportunity to lead in the reform of the system for the benefit of all Americans. I very much appreciate the opportunity to testify before you and I remain available to provide assistance in whatever way I can.

Thank you.

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Senator SANDERS. Thank you very much, Dr. Mullan. When we talk about health care, sometimes we forget dental care, which is a huge problem in my State of Vermont. We are very pleased to have Caswell A. Evans, Jr., who is the Associate Dean for Prevention & Public Health Sciences, University of Illinois, at Chicago College of Dentistry.

Dr. Evans, thanks very much for being here with us.

STATEMENT OF CASWELL A. EVANS, Jr., D.D.S, M.P.H., ASSOCIATE DEAN FOR PREVENTION & PUBLIC HEALTH SCIENCES, UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF DENTISTRY, CHICAGO, IL

Mr. EVANS. Senator Sanders, thank you very much for having me and Senator Brown, very nice to see you again and I appreciate your comments, and our other distinguish elected leaders. It is a pleasure to be here with you.

I am here this morning representing the American Dental Education Association, which represents the dental education network and 58 dental schools in the United States, all its faculty and residency programs and other training programs.

It's important to point out and I want to echo your comments, Senator, that we often overlook the fact that oral health is inextricably linked to general health and the jaw bone is connected to the toe bone. It's a connection we unfortunately miss, and infections that occur in the jaw bone, in effect, eventually will affect the toe bone and all in between.

I want to point out that academic dental institutions are significant safety net providers in their communities. They provide care to populations that unfortunately do not have access otherwise to the health system, with the exception of our community health centers. And we know these populations well. They are low income, racially and ethnically diverse, disabled, institutionalized patients, HIV/AIDS patients, and a long list of those who did not have access to care.

We know that vulnerable populations are more at risk for unmet oral health needs compared to other populations and the same populations that, again, make up the service community and recipients of services at community health centers, also seek care in our schools of dentistry.

One of the issues facing dentistry is its lack of diversity of the workforce. While we take African-Americans and Hispanics collectively, they represent approximately 25 percent currently of the U.S. population. Only 3 percent of dentists are Hispanic and only 3 percent of dentists are African-American. So we look at that as a potential barrier to access to care, much less the issue of role modeling in terms of profession and recruiting individuals into the profession.

I want to take just a moment to illustrate some of the things we are doing at the University of Illinois at Chicago College of Dentistry, because I think they are illustrative to this particular issue.

In a course that is requisite and for credit and for all of our senior students, we have 64 students per class. All senior students now spend between 60 and 80 days in community centers, in terms of gaining their clinical experience. We have a group of specifically selected students, 16 in all, who spend half of their senior year in community-based sites. These sites include community health centers, FQHCs, Federally Qualified Health Centers in both rural and urban environments. They also include philanthropically supported health centers, a clinic serving the developmentally disabled only, local health departments, a union run clinic, Veterans Administration Hospital, and other hospitals.

These clinical rotations are intended to provide an experience in terms of access to care and health disparities for these students and we find that they are resonating well to that and many of them are seeking employment in community health centers and we think that's a very significant model for training and sensitizing our dental student cadre.

Thank you.

[The prepared statement of Dr. Evans follows:]

PREPARED STATEMENT OF CASWELL A. EVANS, JR., D.D.S, M.P.H.

SUMMARY

Good morning, Mr. Chairman and members of the committee. I am Dr. Caswell Evans, Associate Dean for Prevention and Public Health Sciences, at the University of Illinois at Chicago College of Dentistry.

The American Dental Education Association represents all 58 dental schools in the United States, in addition to more than 700 dental residency training programs and nearly 600 allied dental programs, as well as more than 12,000 faculty who educate and train the nearly 50,000 students and residents attending these institutions.

Academic Dental Institutions as safety net providers. Academic dental institutions are the dental home to a broad array of vulnerable and underserved low-income patient populations including racially and ethnically diverse patients, elderly and homebound individuals; migrants; mentally, medically or physically disabled individuals; institutionalized individuals; HIV/AIDS patients; Medicaid and State Children's Health Insurance Program (SCHIP) children and uninsured individuals. These dental clinics serve as key referral resources for specialty dental services not generally accessible to Medicaid, SCHIP, and other low-income uninsured patients. ADIs provide care at reduced fees and millions of dollars of uncompensated care is provided each year.

Vulnerable populations are more at risk for unmet oral health needs. The same people that make up the largest proportion of Community Health Center patients, namely low-income families, members of racial and ethnic minority groups, the uninsured and rural residents, experience more unmet oral health care needs than other groups and suffer greater losses to their overall health and quality of life as a result.

Multiple approaches are needed to improve access to dental care, including improving access to community health centers. Evolution in dental edu-

cation to involve a more diverse student body, greater attention to public health, and collaboration with other oral health providers as well as primary care providers will help improve access to oral health care in the long term.

Health centers are important providers of oral health care to vulnerable populations who otherwise would go without. In 2005, 73 percent of existing federally funded health centers provided oral health services onsite and all new federally funded health centers are now required to assure the availability and accessibility of oral health care services. About half of all NHSC providers are at community health center sites. In order to meet the medical staffing needs of underserved communities, including hundreds of vacancies at community health centers, the NHSC must be expanded. Scholarship and loan repayment programs ease provider shortages with approximately 20 percent of loan repayment awards currently going to dentists.*

University of Illinois at Chicago College of Dentistry. The University of Illinois at Chicago College of Dentistry (UIC COD) has made an unwavering commitment to community-based service-learning as a fundamental element of its curriculum. The average class size is approximately 64 students. In the context of a requisite and for-credit course structure, all fourth-year (senior) students spend at least 60 days in community sites providing care. A specifically selected group of 16 students gain half of their clinical education and training experience in community settings. The community sites include FQHC's (Federally Qualified Health Centers) in urban and rural locations, philanthropically supported health centers, a clinic serving the needs of developmentally disabled patients only, local health departments, a union-run health clinic, a Veterans Administration hospital and other local hospital-based clinics. These clinical rotation experiences are intended to expose students to issues of access to care, health disparities, practice models beyond private practice, and the "real world" of health care delivery and the related challenges. The didactic aspect of the course provides an opportunity to explore these issues in a scholastic manner as well. These educational experiences have also proven to be an opportunity as more students, upon graduation, have sought to initiate their careers in community health centers, the Indian Health Services, or through the National Health Service Corps supported positions.

In conclusion, Mr. Chairman, I thank the committee for considering the American Dental Education Association's recommendations regarding Primary Care Access Reform. A sustained Federal commitment is needed to meet the challenges oral disease poses to our Nation's citizens including children, the vulnerable and disadvantaged. Congress must address the growing needs in educating and training the oral health care and health professions workforce to meet the growing and diverse needs of the future. ADEA stands ready to partner with you to develop and implement a national oral health plan that guarantees access to dental care for everyone, eliminates oral health disparities, bolsters the Nation's oral health infrastructure, eliminates academic and dental workforce shortages, and ensures continued dental health research.

Good morning, Mr. Chairman and members of the committee. I am Dr. Caswell Evans, Associate Dean for Prevention and Public Health Sciences, at the University of Illinois at Chicago College of Dentistry. I currently serve on the Legislative Advisory Committee of the American Dental Education Association (ADEA) on whose behalf I am honored to appear before you to offer recommendations with regard to primary health care access reform.

The American Dental Education Association represents all 58 dental schools in the United States, in addition to more than 700 dental residency training programs and nearly 600 allied dental programs, as well as more than 12,000 faculty who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge, where the majority of dental research is conducted, and where significant dental care is provided. ADEA member institutions serve as dental homes for a broad array of racially and ethnically diverse patients, many who are uninsured, underinsured, or reliant on public programs such as Medicaid and the Children's Health Insurance Program for their health care.

U.S. academic dental institutions (ADI) are the fundamental underpinning of the Nation's oral health. As educational institutions, dental schools, allied dental education, and advanced dental education programs are the source of a qualified work-

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*Ruddy G "Health Centers" Role in Addressing the Oral Health Needs of the Medically Underserved. "Report" National Association of Community Health Centers, Washington, DC, August 2007.

force, influencing both the number and type of oral health providers. Academic dental institutions play an essential role in conducting research, educating and training the future oral health workforce. All U.S. dental schools operate dental clinics and most have affiliated satellite clinics where preventative and comprehensive oral health care is provided as part of the educational mission. All dental residency training programs provide care to patients through dental school clinics or hospital-based clinics. Additionally, all dental hygiene programs operate on-campus dental clinics where classic preventive oral health care (cleaning, radiographs, fluoride, sealants, nutritional and oral health instruction) can be provided 4 to 5 days per week under the supervision of a dentist. All care provided is supervised by licensed dentists as is required by State practice acts. All dental hygiene programs have established relationships with practicing dentists in the community for referral of patients.

As safety net providers, academic dental institutions are the dental home to a broad array of vulnerable and underserved low-income patient populations including racially and ethnically diverse patients, elderly and homebound individuals; migrants; mentally, medically or physically disabled individuals; institutionalized individuals; HIV/AIDS patients; Medicaid and State Children's Health Insurance Program (SCHIP) children and uninsured individuals. These dental clinics serve as key referral resources for specialty dental services not generally accessible to Medicaid, SCHIP, and other low-income uninsured patients. ADIs provide care at reduced fees and millions of dollars of uncompensated care is provided each year.

DENTAL ACCESS

Access to oral health care is a growing challenge in the United States. As many as 130 million American adults and children lack dental insurance, nearly three times as many as lack medical insurance. Now more than ever, academic dental institutions are a critical source of oral health services to those with the highest burden of disease and unmet need. The disparities in oral health care are stark: 100 million Americans lack adequate fluoridated drinking water and only 10 percent of the highest risk children have dental sealants. Yet, fluoridation and sealants have been shown to prevent dental disease and reduce health care costs over time. Dental caries remains the single most common disease among children in America, with five times as many sufferers as asthma. Half of all children have untreated tooth decay by age 9 and 70 percent have at least one cavity by 18. Thirty percent of Americans over the age of 65 have no teeth. In the face of these alarming realities, academic dental institutions are working to reduce the burden of oral health disease.[1]

Many Americans do not have access to dental services given a lack of dental providers in their areas, or a lack of dentists who are willing to accept insurance. Over 2,000 counties or partial counties have been designated dental Health Professions Shortage Areas (D–HPSA), where individuals suffer from an absolute lack of dental providers. Less than half of these are served by safety net providers. Many dentists do not accept patients insured by public insurance, such as Medicaid.[2] This was the case of a 12-year-old Maryland boy whose untreated infected tooth resulted in his death. His death could have been avoided by simply removing his tooth, a procedure costing about $80. Though covered by Medicaid, the boy's family was unable to find a dentist willing to take new Medicaid patients. The implications of not having access to oral health care can be severe and even fatal.

Currently a number of dental schools are taking it upon themselves to address dental workforce issues around the lack of diversity and lack of providers for underserved communities. The Arizona School of Dentistry and Oral Health at A.T. Still University is a new school with a focus toward social responsibility. Students spend their fourth year in a residency at a health center, Indian Health Service site, or Veterans Affairs facility.[3] The school was founded to help meet the staggering need for dental care in Arizona and to avert a significant shortage of dentists—given that

[1] Ruddy G "Health Centers" Role in Addressing the Oral Health Needs of the Medically Underserved. "Report" National Association of Community Health Centers, Washington, DC, August 2007.

[2] Ruddy G "Health Centers" Role in Addressing the Oral Health Needs of the Medically Underserved. "Report" National Association of Community Health Centers, Washington, DC, August 2007.

[3] 3 Krause B. "State Efforts to Improve Children's Oral Health," Issue Brief, Center for Best Practices, National Governor's Association, Washington, DC, November 20, 2002.

2,000 more dentists are retiring each year than entering practice in the State.[4] Some 200 applicants vie for 62 spots each year. The dental school graduated its first class in 2007. Graduates are specifically trained to be culturally competent, community-responsive general dentists who are able and willing to serve as a resource in their community for dental public health issues.

Additionally, other dental schools in California, Kentucky, Missouri, New Mexico, and Oklahoma are exposing students during their training to patients covered by Medicaid or the State Children's Health Insurance Program (SCHIP). The Illinois at Chicago College of Dentistry, the University of Michigan School of Dentistry and the College of Dental Medicine Columbia University go further and link students to underserved communities in an effort to encourage subsequent work with low-income and other vulnerable populations.[5]

Pipeline, Profession and Practice is a 3-year-old program funded by the Robert Wood Johnson Foundation that now involves 27 percent of U.S. dental schools. Each school is slated to establish a community-based clinical education program and develop recruitment and retention programs directed at underrepresented minorities and those from low-income backgrounds. Even before graduation, students are in a position to improve access to oral health care.

DENTAL WORKFORCE

The representation of minorities in the health care workforce has not increased in over a decade. Black, Hispanics and American Indians represent more than 25 percent of the U.S. population, yet comprise less than: 9 percent of nurses, 6 percent of physicians and 5 percent of dentists. The U.S. Bureau of Labor Statistics (BLS), which placed the number of *practicing* dentists at 161,000 in 2006,[6] projects a 9 percent growth in the number of dentists through 2016. This rate would bring the total number of practicing dentists to 176,000.

About 80 percent of dentists are solo practitioners in primary care general dentistry while the remaining dentists practice one of nine recognized specialty areas: (1) endodontics; (2) oral and maxillofacial surgery; (3) oral pathology; (4) oral and maxillofacial radiology; (5) orthodontics; (6) pediatric dentistry; (7) periodontics; (8) prosthodontics; and (9) public health dentistry.

The vast majority of the 176,634 professionally active dentists in the United States are White non-Hispanic. At the present time the U.S. population is 303,375,763.[7] At the time of the last census, when there were 22 million fewer people, the largest segment of the U.S. population was White (75 percent), but an increasing percentage was minority with 35.3 million (13 percent) Latino, and 34.6 million (12 percent) Black or African-Americans.

The allied dental workforce, comprised of dental hygienists, dental assistants and dental laboratory technologists, is central to meeting increasing needs and demands for dental care. About 167,000[8] dental hygienists, 280,000[9] dental assistants and 53,000[10] dental laboratory technologists were in the U.S. workforce in 2006. Both dental hygiene and dental assisting are among the fastest growing occupations in the country with expected growth of 30 percent and 29 percent respectively through 2016, bringing the total numbers of dental hygienists to about 217,000 and dental assistants to 361,000. Only about 2,000 dental laboratory technologists will be added to the workforce by 2016. The ability to increase the number is limited. At the present time there are only 21 accredited training programs.

We must acknowledge that the current dental workforce is unable to meet present day demand and need for dental care. If every man, woman and child were to have a dental home and were covered by dental insurance, the Nation would clearly have an insufficient number of dentists to care for the population. We are not close to

[4] Ruddy G "Health Centers" Role in Addressing the Oral Health Needs of the Medically Underserved. "Report" National Association of Community Health Centers, Washington, DC, August 2007.

[5] Ryan J. *Improving Oral Health: Promises and Prospects.* National Health Policy Forum Background Paper. Washington, DC, June 2003.

[6] U.S. Bureau of Labor Statistics, *http://www.bls.gov/oco/content/ocos072.stm*, accessed February 5, 2008.

[7] U.S. Bureau of the Census, *http://www.census.gov/population/www/popclockus.html*, accessed February 5, 2008.

[8] U.S. Bureau of Labor Statistics, *http://www.bls.gov/oco/pdf/ocos097.pdf*, accessed February 5, 2008.

[9] U.S. Bureau of Labor Statistics, *http://www.bls.gov/oco/ocos163.htm*, accessed February 5, 2008.

[10] U.S. Bureau of Labor Statistics, *http://www.bls.gov/oco/ocos238.htm*, accessed February 5, 2008.

being at this point but we aspire to get there as quickly as possible so everyone who needs and wants dental care is able to achieve optimal oral health.

The need and demand for dental services continues to increase; in large measure this is due to the population explosion. Also, Baby Boomers as well as the geriatric population, are retaining more teeth and there is a growing focus on increasing access and preventative dental care.

Each year academic dental institutions (dental schools, allied dental programs and postdoctoral/advanced dental education programs) graduate thousands of new practitioners to join the dental workforce. About 4,500 predoctoral dental students graduate annually. About half of these new graduates immediately sit for a State licensure exam before beginning private practice as general dentists, or they join the military, the U.S. Public Health Service, or advance their education in a dental specialty. Approximately 2,800 graduates along with hundreds of practicing dentists apply to residency training programs. Nearly 23,000 allied dental health professionals graduate from ADIs each year and join the dental workforce. Approximately 14,000 dental hygiene students, 8,000 dental assistants, and 800 dental laboratory technologists graduate annually.

According to the U.S. Surgeon General, the ratio of dentists to the total population has been steadily declining for the past 20 years, and at that rate, by 2021, there will not be enough active dentists to care for the population. The number of Dental Health Professions Shortage Areas (D-HPSAs) designated by the U.S. Health Resources and Services Administration (HRSA) has grown from 792 in 1993 to 4,048 in 2008. In 1993, HRSA estimated 1,400 dentists were needed in these areas; by 2008, the number grew to 9,432. Nearly 48 million people live in D–HPSAs across the country. Although it is unknown how many of these areas can financially support a dentist or attract a dentist by virtue of their infrastructure or location, it is clear that more dentists are needed in these areas.

ORAL HEALTH AND COMMUNITY HEALTH CENTERS

Over 2,000 counties or partial counties have been designated dental Health Professions Shortage Areas where individuals suffer from an absolute lack of providers in addition to all of the other barriers facing the uninsured and publicly insured. Less than half (875) of these dental HPSAs are served by federally qualified health centers (837), FQHC look-alikes (6), or rural health clinics (32). Many counties eligible for dental HPSA status have not applied for the designation, whether because of the administrative burden or for other reasons.

There are over 7,000 community health centers (CHC); 52.8 percent are in rural communities.[11] In calendar year 2007 16 million patients were served. The CHC dental workforce includes 6,899 oral health professionals: 2,107 dentists, 806 hygienists and 3,986 assistants.[12]

Currently, community health centers are providing dental services to over 2.3 million patients, a growth of 77 percent since 2000. Most new dental care patients are likely to be those who lacked access to care prior to seeking it at a health center, therefore more likely to suffer from caries and periodontal disease and require more intensive services than simple preventive care. The people who make up the largest proportion of community health center patients, namely low-income families, members of racial and ethnic minority groups, the uninsured and rural residents, experience more unmet oral health care needs than other groups, and suffer greater losses to their overall health and quality of life as a result. Research shows that the provision of preventive dental care is cost-effective.[13]

Of existing community health centers 73 percent provide oral health services and all new community health centers are now required to provide comprehensive oral health care. But challenges persist as these centers continue to expand their capacity to better meet the oral health needs of their patients. Community health centers cannot bridge the gap between the supply and demand for oral health care alone. They will continue to depend on the important contributions of the large, private dentistry workforce as they work to provide dental care for the medically underserved.

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[11] Health Resource Service Administration. Accessed May 2007.

[12] Uniform Data System, 2007 Data.

[13] Ruddy G "Health Centers" Role in Addressing the Oral Health Needs of the Medically Underserved. "Report" National Association of Community Health Centers, Washington, DC, August 2007.

CHC STATE-BY-STATE ANALYSIS

Appendices A, B, and C provide state-by-state data on the proportion of community health centers providing oral health services, community health center dental staff, and related patients and visits in 2005. As Appendix A demonstrates, 100 percent of community health centers in **Vermont** and **Nevada** provide all four major dental service categories—preventive, restorative, emergency, and rehabilitative, and 100 percent of the community health centers in three other States (**Delaware**, **Missouri**, and **New Mexico**) provide three out of the four services (preventive, restorative, and emergency).

Appendix B provides for each State information on patients who rely on community health center dental services. Not surprisingly, these centers in eight large States (**California**, **Florida**, **Massachusetts**, **Michigan**, **New York**, **Pennsylvania**, **Texas**, and **Washington**) account for half of all community health center dental patients. While nationally 17 percent of all health center patients use health center dental services, more than 25 percent of health center patients in six States (**Connecticut**, **Michigan**, **Missouri**, **Nebraska**, **Vermont**, and **Washington**) receive health center dental services.

Last, Appendix C provides a close look at community health center dental services staffing and visits per dentist and dental hygienist by State. Although nationally the average dentist provided 2,719.5 visits last year, health centers in three States (**California**, **Florida**, and **Wyoming**) provided over 3,000. In addition, the average dental hygienist in four States (**Connecticut**, **Maryland**, **Michigan**, and **Oregon**) and **Puerto Rico** provided over 1,600 visits, compared to the national average of 1,279.8.

ORAL HEALTH AND THE NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps (NHSC) has been important to the oral health of the underserved for more than 26 years as it positively addresses two public health concerns:

(1) enabling underserved populations to access qualified, high-skilled health care practitioners; and

(2) facilitating continued interest in serving these special populations after participants have left NHSC. It is more important than ever that the NHSC embrace a bold proactive health agenda. Due to the increased focus on children's oral health, the findings reported in the *U.S. Surgeon General's Report on Oral Health*, and increasing research data linking oral health to systemic health, the NHSC is of paramount importance.

The National Health Service Corps dispatches clinicians to urban and rural communities with severe shortages of health care providers. Currently, more than 4,000 NHSC clinicians, including dentists, physicians, nurse practitioners, physician assistants, nurse midwives, and behavioral health professionals, provide health care services to nearly 5 million Americans. About half of all NHSC providers are at community health center sites. In order to meet the medical staffing needs of underserved communities, including hundreds of vacancies at community health centers, the NHSC must be expanded. Scholarship and loan repayment programs ease provider shortages with approximately 20 percent of loan repayment awards currently going to dentists.[14]

There are several straightforward steps that Congress can take to immediately address the challenges we face. The answer lies in prioritizing resources both in terms of manpower and funding to tackle these challenges. Some are fairly simple and pragmatic while others, admittedly, will require coordination among multiple interested parties and compromise. The American Dental Education Association stands ready to work with Congress and our colleagues in the dental community to ameliorate the access to dental care problems the Nation faces and to meet the needs of the future dental workforce. Specifically, we recommend:

- Evolution in dental education to involve a more diverse, representative student body, greater attention to public health, and collaboration with dental hygienists as well as primary care providers will help improve access to oral health care in the long term;
- Financial, administrative and clinical support incentives will increase the likelihood that dentists at both ends of their careers will choose to care for the under-

[14] Ruddy G "Health Centers" Role in Addressing the Oral Health Needs of the Medically Underserved. "Report" National Association of Community Health Centers, Washington, DC, August 2007.

served. Reimbursement and remuneration may also need to more closely reflect those in the private sector if more dentists are to choose to care for the underserved;

• Innovative programs involving public-private partnerships in several States have improved dentist participation in Medicaid and increased take-up by eligible persons. These programs provide templates for other States to devise solutions to challenges around use;

• Maintain Support and restore adequate funding for Title VII General and Pediatric Dentistry Residency Training programs;

• Strengthen and Improve Medicaid;

• Prioritize Dental Access in Rural Health Clinics;

• Bolster Prevention to Eradicate Dental Caries; and

• Establish Dental Homes for Everyone.

CONCLUSION

In conclusion, the American Dental Education Association thanks the committee for considering our recommendations with regard to addressing access and dental workforce issues. A sustained Federal commitment is needed to meet the challenges oral disease poses to our Nation's citizens including children, the vulnerable and disadvantaged. Congress must address the growing needs in educating and training the oral health care and health professions workforce to meet the growing and diverse needs of the future. ADEA stands ready to partner with you to develop and implement a national oral health plan that guarantees access to dental care for everyone, eliminates oral health disparities, bolsters the Nation's oral health infrastructure, eliminates academic and dental workforce shortages, and ensures continued dental health research.

APPENDIX A.—PERCENT OF COMMUNITY HEALTH CENTER GRANTEES PROVIDING DENTAL SERVICES ONSITE* BY STATE, 2005

State	# Health center grantees	Dental preventive onsite [percent]	Dental restorative onsite [percent]	Dental emergency onsite [percent]	Dental rehabilitative onsite [percent]
Alabama	15	73.3	73.3	66.7	40.0
Alaska	24	66.7	58.3	58.3	25.0
Arizona	14	92.9	85.7	100.0	64.3
Arkansas	12	75.0	75.0	75.0	50.0
California	97	74.2	72.2	72.2	44.3
Colorado	15	80.0	80.0	80.0	73.3
Connecticut	10	90.0	90.0	90.0	70.0
Delaware	3	100.0	100.0	100.0	33.3
District of Columbia	3	66.7	33.3	33.3	33.3
Florida	36	69.4	66.7	69.4	47.2
Georgia	23	65.2	52.2	52.2	34.8
Hawaii	11	54.5	54.5	54.5	27.3
Idaho	10	70.0	70.0	70.0	60.0
Illinois	33	75.8	66.7	69.7	45.5
Indiana	13	61.5	61.5	53.8	53.8
Iowa	9	77.8	77.8	77.8	66.7
Kansas	9	55.6	33.3	44.4	33.3
Kentucky	14	64.3	64.3	57.1	28.6
Louisiana	18	66.7	66.7	55.6	44.4
Maine	16	75.0	62.5	62.5	50.0
Maryland	13	76.9	69.2	69.2	46.2
Massachusetts	33	72.7	69.7	66.7	51.5
Michigan	26	76.9	73.1	73.1	61.5
Minnesota	12	66.7	66.7	66.7	33.3
Mississippi	19	84.2	78.9	84.2	36.8
Missouri	17	100.0	100.0	100.0	82.4
Montana	12	75.0	66.7	58.3	41.7
Nebraska	5	80.0	80.0	80.0	20.0
Nevada	2	100.0	100.0	100.0	100.0
New Hampshire	8	62.5	62.5	50.0	50.0
New Jersey	17	76.5	70.6	70.6	64.7

State	# Health center grantees	Dental preventive onsite [percent]	Dental restorative onsite [percent]	Dental emergency onsite [percent]	Dental rehabilitative onsite [percent]
New Mexico	14	100.0	100.0	100.0	78.6
New York	47	91.5	89.4	85.1	63.8
North Carolina	24	75.0	75.0	75.0	37.5
Oregon	21	61.9	52.4	57.1	28.6
Pennsylvania	29	86.2	79.3	82.8	62.1
Rhode Island	7	100.0	100.0	85.7	42.9
South Carolina	21	33.3	28.6	33.3	28.6
South Dakota	7	57.1	42.9	42.9	28.6
Tennessee	22	50.0	45.5	50.0	27.3
Texas	43	88.4	86.0	88.4	48.8
Utah	11	90.9	72.7	72.7	63.6
Vermont	3	100.0	100.0	100.0	100.0
Virginia	21	57.1	47.6	57.1	28.6
Washington	23	95.7	95.7	87.0	52.2
West Virginia	27	44.4	37.0	37.0	22.2
Wisconsin	15	80.0	73.3	73.3	73.3
Wyoming	5	80.0	20.0	20.0	0.0
United States**	952	73.4	68.7	68.8	46.4
North Dakota	4	25.0	25.0	25.0	0.0
Ohio	23	73.9	69.6	73.9	56.5
Oklahoma	9	44.4	44.4	44.4	22.2

*''Onsite'' includes services rendered by salaried employees, contracted providers, National Health Service Corps Staff, volunteers, and others such as out-stationed eligibility workers who render services in the health center's name. Grantees may also provide these services through formal referral arrangements.

**U.S. totals include American Samoa, Fed. States of Micronesia, Guam, Marshall Islands, Virgin Islands, and Palau.

Note: Includes only federally-funded health centers, and therefore may underreport the volume of health care delivered by health centers.

Source: Bureau of Primary Health Care, HRSA, DHHS, 2005 Uniform Data System.

Appendix B.—Community Health Center Dental Services Patients, Visits per Patient, and Percent of Total Patients by State, 2005

State	Total dental services patients	Average dental visits per dental patient	Total patients using dental services [percent]
Alabama	42,057	1.6	15
Alaska	16,243	1.9	21
Arizona	40,353	2.2	14
Arkansas	18,565	1.7	15
California	285,460	2.8	14
Colorado	65,018	1.9	16
Connecticut	58,046	1.7	29
Delaware	3,874	2.1	18
District of Columbia	13,851	1.9	18
Florida	102,464	1.9	16
Georgia	24,137	1.4	10
Hawaii	13,480	2.1	16
Idaho	13,599	2.0	15
Illinois	66,582	1.9	9
Indiana	22,089	1.8	14
Iowa	16,715	2.0	18
Kansas	4,689	1.5	8
Kentucky	21,424	1.7	11
Louisiana	27,780	1.7	22
Maine	20,604	1.5	16
Maryland	27,574	1.6	16
Massachusetts	86,305	2.4	20
Michigan	113,385	1.5	27
Minnesota	29,804	1.9	24

State	Total dental services patients	Average dental visits per dental patient	Total patients using dental services [percent]
Mississippi	41,031	1.7	15
Missouri	71,510	2.1	24
Montana	18,287	1.5	24
Nebraska	5,989	2.2	17
Nevada	Data Unavailable	Data Unavailable	Data Unavailable
New Hampshire	4,550	1.1	8
New Jersey	57,914	2.0	22
New Mexico	53,839	2.1	24
New York	196,811	2.1	18
North Carolina	52,196	1.9	17
North Dakota	3,726	1.8	17
Ohio	53,171	1.9	17
Oklahoma	10,184	1.9	12
Oregon	41,620	1.8	21
Pennsylvania	72,543	2.1	16
Puerto Rico	27,699	1.7	7
Rhode Island	19,724	1.7	21
South Carolina	11,319	1.6	4
South Dakota	7,353	2.0	15
Tennessee	29,648	1.7	12
Texas	117,025	1.9	18
Utah	13,169	1.8	16
Vermont	10,526	1.6	30
Virginia	21,803	1.8	11
Washington	174,972	2.2	30
West Virginia	23,653	1.5	8
Wisconsin	37,513	1.9	24
Wyoming	4,779	1.6	25
United States*	2,340,710	2.4	17

* U.S. totals include American Samoa, States of Micronesia, Guam, Marshall Islands, Virgin Islands, and Palau.
Note: Includes only federally-funded health centers, and therefore may underreport the volume of health care delivered by health centers.
Source: Bureau of Primary Health Care, HRSA, DHHS, 2005 Uniform Data System.

Appendix C.—Community Health Center Dental Services Staffing and Visits by State, 2005

State	Dentist visits	Visits per FTE dentist	Dental hygienist visits	Visits per FTE hygienist	Dental support staff* FTE	Total dental services FTE	Total dental services visits
Alabama	67,204	2,941.1	19,945	1,360.5	36.8	74.3	87,149
Alaska	31,210	2,100.3	3,429	546.0	29.2	50.3	34,639
Arizona	88,994	2,604.4	21,737	1,232.3	96.5	148.3	110,731
Arkansas	31,030	2,800.5	5,486	1,284.8	24.3	39.7	36,516
California	808,672	3,239.2	28,780	1,100.6	497.6	773.4	837,452
Colorado	122,860	2,642.7	22,624	1,147.3	102.9	169.1	145,484
Connecticut	100,335	2,837.5	45,555	1,867.0	58.6	118.4	145,890
Delaware	8,278	1,851.9	1,646	1,266.2	5.7	11.5	9,924
District of Columbia.	25,756	2,846.0	0	0.0	11.8	20.8	25,756
Florida	195,566	3,177.9	34,402	1,284.1	126.2	214.5	229,968
Georgia	34,186	2,387.3	8,682	1,205.8	22.2	43.7	42,868
Hawaii	28,702	1,807.4	2,122	742.0	28.0	46.8	30,824
Idaho	26,655	469.2	5,342	1,077.0	19.2	35.4	31,997
Illinois	128,316	3,050.1	12,073	1,223.2	73.0	124.9	140,389
Indiana	39,730	2,579.9	11,668	1,511.4	29.0	52.1	51,398
Iowa	34,056	2,742.0	5,985	1,031.9	31.5	46.7	40,041
Kansas	7,177	2,648.3	1,866	790.7	6.0	11.1	9,043
Kentucky	37,280	2,782.1	9,184	1,111.9	24.6	46.2	46,464
Louisiana	48,409	2,384.7	2,746	888.7	30.4	53.8	51,155

State	Dentist visits	Visits per FTE dentist	Dental hygienist visits	Visits per FTE hygienist	Dental support staff* FTE	Total dental services FTE	Total dental services visits
Maine	31,140	2,077.4	25,309	1,202.3	30.4	66.4	56,449
Maryland	45,259	2,935.1	5,994	1,927.3	24.3	42.9	51,253
Massachusetts.	205,754	2,870.1	37,419	1,514.3	94.8	191.2	243,173
Michigan	174,784	2,703.5	79,163	1,663.1	114.1	226.4	253,947
Minnesota	56,932	2,564.5	14,316	944.3	28.6	66.0	71,248
Mississippi	68,943	2,496.1	7,991	1,225.6	40.9	75.1	76,934
Missouri	148,374	2,582.2	20,709	1,320.7	108.0	181.1	169,083
Montana	27,351	2,811.0	7,146	1,791.0	16.5	30.2	34,497
Nebraska	13,359	2,515.8	1,332	672.7	11.7	19.0	14,691
Nevada	Data Unavailable.	Data Unavailable.	Data Unavailable.	Data Unavailable.	Data Unavailable.	Data Unavailable.	Data Unavailable
New Hampshire.	5,145	2,198.7	3,969	1,160.5	2.5	8.3	9,114
New Jersey	116,724	2,824.2	6,497	1,486.7	65.6	111.3	123,221
New Mexico	110,404	2,455.1	28,684	1,221.6	92.2	160.7	139,088
New York	408,533	2,468.0	78,776	1,558.1	251.2	467.3	487,309
North Carolina.	96,581	2,530.3	18,872	1,217.5	71.2	124.8	115,453
North Dakota	6,777	2,823.8	1,337	568.9	5.6	10.3	8,114
Ohio	103,027	2,762.9	15,728	1,012.7	72.4	125.3	118,755
Oklahoma	19,325	2,049.3	3,233	829.0	15.9	29.2	22,558
Oregon	73,311	2,260.6	24,353	1,742.	63.4	109.8	97,664
Pennsylvania	154,850	2,517.5	33,388	1,239.8	97.1	185.5	188,238
Rhode Island	32,567	2,649.9	19,375	1,490.4	31.4	56.7	51,942
South Carolina.	18,227	2,112.1	4,494	1,129.1	13.6	26.2	22,721
South Dakota	14,358	2,033.7	3,845	1,248.4	14.7	24.8	18,203
Tennessee	49,224	2,507.6	4,359	736.3	26.4	51.9	53,583
Texas	224,858	2,543.6	46,622	1,185.4	186.1	313.8	271,480
Utah	23,232	2,242.5	3,176	1,549.3	17.8	30.2	26,408
Vermont	16,881	2,718.4	10,030	1,297.5	12.1	26.1	26,911
Virginia	40,317	2,599.4	2,660	537.4	33.4	53.9	42,977
Washington	391,782	2,893.3	30,543	1,000.4	333.3	499.2	422,325
West Virginia	36,623	2,886.0	10,689	1,138.3	26.9	49.0	47,312
Wisconsin	72,454	2,575.7	17,672	979.1	57.3	103.5	90,126
Wyoming	7,779	3,758.0	4,065	2,032.5	4.1	8.2	11,844
Puerto Rico	45,797	2,346.2	5,382	2,152.8	28.3	50.3	51,179
United States*.	4,728,590	2,719.5	834,042	1,297.8	3,268.2	5,649.6	5,562,632

FTE = Full-time employed.
* Includes Dental Assistants, Aids, and Technicians.
** U.S. totals include American Samoa, States of Micronesia, Guam, Marshall Islands, Virgin Islands, and Palau.
Note: Includes only federally-funded health centers, and therefore may underreport the volume of health care delivered by health centers.
Source: Bureau of Primary Health Care, HRSA, DHHS, 2005 Uniform Data System.

Senator SANDERS. Dr. Evans, thank you very much. Yvonne Davis is a board member with the Community Health Center in Florence, SC. And one of the interesting aspects about federally qualified community health centers is they are run by the community, itself, and Ms. Davis, thank you so much for being with us.

STATEMENT OF YVONNE DAVIS, COMMUNITY HEALTH CENTER BOARD MEMBER, FLORENCE, SC

Ms. DAVIS. Thank you, Mr. Chairman. To my own Congressman Clyburn, and members of the committee as well, for the invitation to speak to you today. This is a topic that I care deeply about and I appreciate the chance to share my thoughts with you.

My name is Yvonne Davis, I'm from Florence, SC. I have been employed at Francis Marion University as a Resource and Acquisitions Coordinator for about 28 years. Today I am here as a community health center patient, advocate and consumer board member. I have been a part of the community health center movement for about 18 years now, as both a health center patient and a community board member at Health Care Partners of South Carolina, Incorporated.

I have never been more excited for the world to witness and hear what our community health center is and to learn what it is all about.

I come from Marion, SC. It's my home, which is a very small town about 45 miles north of Myrtle Beach. Communities there are close knit, and of course, gatherings there are still alive and well. My home town, at one time, was booming with many jobs, and life was good. Then as years passed, they all seemed to just disappear; no jobs, no insurance, no unemployment benefits means no health care.

Having the health center in our community has made it possible for people who have lost their jobs to still receive access to quality care, purchase medicine at a reduced price, and be educated about preventive measures they can take to live a normal and productive life.

The story I would like to share with you is about my brother, Dwayne. After being laid off from his job of 20-plus years, and suffering a series of personal tragedies, as if he had no reason to live, Dwayne went into a state of depression. One day I went to visit him and found him in a condition I couldn't believe.

I took him to our community health center for a complete examination. The doctor called me and informed me that my brother had suffered a heart attack. What a shocker. Luckily, he survived.

Now my brother receives health care at the health center and is sharing the information about the center with his friends who are in need as well. And he says to me quite often, "Thank you."

Since that time I have vowed to advocate for community health centers. We are truly blessed to have access to a place like Health Care Partners in our community and receive the comprehensive care that they provide.

Now, my role as a community health center board member. Consumer board members in my center go out to church services, civic meetings, and town functions and share information about the services provided by our health center. We don't want anyone to go without care simply because they're not aware of our health center.

I am thinking about an instance I am particularly proud of, and that is when we worked with one of our local high schools there—we housed a school-based plan and saw their numbers of teenage pregnancy, STD's, and other conditions decrease. That pride turned to disappointment when we could no longer provide the services due to limited funds.

There is an emergency call from the community for us to return. So we must find a way to answer their call.

I have witnessed the power of community health centers firsthand, and I know that all across the country America's health centers are ready to lead the way in health reform by providing high

quality, affordable, accessible primary and preventive care to anyone in need. Thank you.

[The prepared statement of Ms. Davis follows:]

PREPARED STATEMENT OF YVONNE DAVIS

SUMMARY

I'm here as a community health center patient, advocate and community board member.

• I've been a part of the community health center movement about 18 years now, as both a health center patient for 16 years and a community board member for 18 years at Health Care Partners of South Carolina, Inc.

• I come from a very small town about 45 miles north of Myrtle Beach, SC. My hometown at one time was booming with many jobs for the citizens of Marion as well as the connecting counties, and life was good. Then as years passed they all just seem to have disappeared; no jobs, no insurance, no unemployment benefits, means no health care.

Having the health center is critically important to our community and it has been to me personally.

• I've had allergy problems since I was a kid. It was our physician at the community health center who taught me how to live a more comfortable life during the high allergy season. I no longer felt like it was a waste of time to seek a physician's help when my eyes were always running and red all the time and I spent little or no time outside.

• My brother Dwayne was very ill and actually suffered a heart attack after years of not seeing a doctor. His experience motivated me to advocate for community health centers because there are many more cases just like my brother's: people who, if they had access to the right care at the right time, could avoid the pain and cost of hospitalization.

As a board member, I make it a priority to get out in the community and spread the word on health centers.

• Volunteer consumer board members at my center make it a point to get out to church services, civic meetings and town functions and share information about the services provided by our community health center.

• We don't want anyone to go without care simply because they aren't aware of the health center.

• Funding constraints have limited our ability to advertise, but the good news is that there is no better advertisement than recommendations coming from community leaders that are now patients of the center.

• Because of the recession we're facing serious problems with providing coverage for the higher demand. Patients are constantly calling asking for more office hours.

I have witnessed the power of community health centers first hand as a patient and board member. I know that all across the country, America's Health Centers are ready to lead the way in health reform, providing high-quality, affordable, accessible primary and preventive care to anyone in need.

Good morning. Thank you, Mr. Chairman and members of the committee, for the invitation to speak to you today. This is a topic that I care deeply about, and I appreciate the chance to share my thoughts with you.

My name is Yvonne G. Davis of Florence, SC. I've been a State employee for 28 years at Francis Marion University as the Resource & Acquisitions Coordinator for the library.

Today I'm here as a community health center patient, advocate and community board member. I've been a part of the community health center movement about 18 years now, as both a health center patient for 16 years and a community board member for 18 years at Health Care Partners of South Carolina, Inc. I have never been more excited for the world to witness and hear what community health centers are all about.

I come from a very small town about 45 miles north of Myrtle Beach, SC. Communities there are close knit and family gatherings are still alive and well. My hometown at one time was booming with many jobs for the citizens of Marion as well as the connecting counties, and life was good. Then as years passed they all just

seem to have disappeared; no jobs, no insurance, no unemployment benefits, means no health care.

Having the health center in our community has made it possible for people who have lost their jobs to still receive access to quality care, purchase medicine at a reduced price, and be educated about preventive measures they can take to live a normal and productive life.

You see, I've had allergy problems since I was a kid, and if any of you suffer from them, then you know where I'm coming from. It was our physician at the community health center who taught me how to live a more comfortable life during the high allergy season. I no longer felt like it was a waste of time to seek a physician's help when my eyes were always running and red all the time and I spent little or no time outside. What a difference it makes when your doctor makes you feel as if he or she really cares. The service at my health center is excellent and I would recommend the center to any of my family members. My mother who at the time lived in St. Petersburg, FL had a serious stroke and could no longer take care of herself; once we relocated her to the Carolina's, we immediately registered her as a patient at the health center.

She was diagnosed with several serious conditions: hypertension, renal failure, diabetes, congestive heart failure, etc. This was a big adjustment for my family and we really didn't know what to expect. It was the assistance of the center's staff and other specialists that made life a little easier for us and we're so grateful. The quality of care she received was just unreal. If you can please my mother, then you must be doing something right.

But the real story is about my brother Dwayne. I remember so clearly the day when Dwayne, who is just 11 months older than me, was laid off from his job of 20+ years. Not only did he lose his job, but within a 16-month timeframe, his only son was killed in a car accident, our oldest brother who was a disabled veteran died of medical problems, our mother had a stroke, and Dwayne's wife was diagnosed with a lung disease then later died. It was if he had no reason to live. Dwayne went into a state of depression like never before, and it was like we had lost another family member.

In August 2007, I attended the National Association of Community Health Center's (NACHC) annual Community Health Institute conference in Dallas, TX and had invited my brother Dwayne to travel with me just to get him away. For a lifelong Dallas Cowboy fan to quickly turn me down was shocking. I immediately went to visit him and found him in a condition I couldn't believe. I promised myself and him that he was my candidate for take a love one to the doctor day, and I did just that.

After a complete examination and several tests the Doctor called me in and informed me that he thought my brother suffered a heart attack and the ambulance was on its way. What a shocker. I saw the look on his face from the news and knew that he was afraid. He was afraid for several reasons, one, because he didn't have any insurance and wasn't sure what would happen because he had no money. After completing applications for public assistance, patient care services, etc., he was finally admitted to the hospital then immediately put into the intensive care unit. A quadruple bypass operation was recommended after a series of tests. He had 96.5 percent blockage.

After spending about 14 days in the hospital, we all know who ended up paying for that bill: yes, taxpayers. His excuse for not seeing a doctor earlier was after paying his utility and other bills he just didn't have the money. My brother is now sharing the information about the community health center with his friends that may be in the same shape he was in, and says to me, thank you. "That Health Center is alright with me," I didn't know they had it like that.

Since that time I have vowed to advocate for Community Health Centers because there are many more cases just like my brother's: people who, if they had access to the right care at the right time, could avoid the pain and cost of hospitalization. We truly are blessed to have access to a place like Health Care Partners in our community, and to receive the comprehensive care they provide, regardless of the ability to pay.

I would also like to speak a little about my role as a community board member. Volunteer consumer board members at my center make it a point to get out to church services, civic meetings and town functions and share information about the services provided by our community health center. We don't want anyone to go without care simply because they aren't aware of the health center. Funding constraints have limited our ability to advertise, but the good news is that there is no better advertisement than recommendations coming from community leaders that are now patients of the center. Because of the recession we're facing serious problems with providing coverage for the higher demand. Patients are constantly calling asking for

more office hours. With your help we can make that happen. The need of our people is why we're here.

In thinking about an instance I am particularly proud of, I think one example is when one of the local high schools where we housed a school-based clinic saw their numbers of teenage pregnancy, STDs, and other conditions decrease during the time we were on campus. That time of being proud turned to disappointment when we could no longer provide these services within the school. There is an emergency call from the community for us to return, so we must.

I have witnessed the power of community health centers first hand as a patient and board member. I know that all across the country, America's Health Centers are ready to lead the way in health reform, providing high-quality, affordable, accessible primary and preventive care to anyone in need.

Senator SANDERS. Thank you very much, Ms. Davis.

John Matthew is a physician and the director of the health center in Plainfield, VT. In Vermont, we have gone, in the last 6 years, from two community health centers, FQHCs, to eight. And John, at Plainfield, is doing an outstanding job. Dr. Matthews, thank you very much for being here.

STATEMENT OF JOHN D. MATTHEW, M.D., THE HEALTH CENTER, PLAINFIELD, VT

Dr. MATTHEW. Thank you, Senator Sanders, Representative Clyburn and members of the committee. Thank you for having us here today.

I have been practicing primary care medicine in rural Vermont for 36 years. When good, accessible primary care is available, it still is most costly when provided in a multispecialty setting. It's almost as expensive in the hands of internal medicine physicians, and is much less costly in family medicine practices. The care is most economical, with equal outcomes, in community health centers, just published in *Health Affairs*, this very week, same as it was a decade ago. When care is unavailable, those who lack access pay the price and society pays the bill.

Rural communities, suburbs and city neighborhoods, all would do well to have accessible good health care through FQHCs. These services, I want to emphasize, are not only for the poor, the uninsured or the Medicaid population. FQHCs provide care to all persons, regardless of their ability or inability to pay. We do not discriminate against those who are insured.

At our health center, we have a motto, we do "Health Care the Way it Ought to Be," everyday for every one.

Our organization, The Health Center in Plainfield, functioned for years as a freestanding nonprofit rural health center. It was a struggle to keep the organization afloat. We had to scrimp and save all the time to break even at each year's end. We were always restrained by very tight finances.

Since becoming an FQHC 2 years ago, we've been able to expand the number of uninsured persons we see, and our active patient population has increased from 7,800 to 9,400 persons. By this fall, our staff will have grown from 34 full-time and 19 part-time employees to 47 full-time and 30 part-time employees. We anticipate that we will be able to take care of 1,200 to 1,800 more medical patients, 2,000 more dental patients and 2,400 kids and adolescents around the State with a mobile dental program. We have consolidated our fiscal position and are poised to do more in behavioral

health, mental health, dental health, access to 340b pharmacy and physical therapy, which is now in-house.

It is an enormous relief as head of the agency to be on a more solid financial footing. And as a physician, it's extremely gratifying to be able to provide a broader scope of services and to care for all of our patients, and to offer more sliding scale and nominal charge care to the unfortunate, the downtrodden and the marginalized, and now with the newly unemployed and uninsured who are suffering in the current great recession.

Many of these improvements and our ability to address our community's needs would be impossible without our having become a FQHC. Others would have occurred only slowly and incrementally because tight finances would constrain innovation and the starting of new or expanded services, despite these being badly needed by the population.

Expansion of funding for FQHCs and for the National Health Service Corps has the potential to help reverse the decline of primary care and bring excellent, accessible care to all in all of our communities.

This is the essence of health care reform. This is what America needs, not just for the poor and uninsured, but for all of us. Health care for all.

[The prepared statement of Dr. Matthew follows:]

PREPARED STATEMENT OF JOHN D. MATTHEW, M.D.

SUMMARY

Good, accessible primary care is the essential foundation of all health care and for any hope of constraining the costs of health care for the Nation. But primary care is, and has been for a decade or more, in precipitous decline, with some 60 million Americans now unable to find a personal physician. Arresting and reversing this decline must be a matter of the highest priority.

When primary care is available, it is most costly when provided in multi-specialty settings. It is almost as expensive in the hands of Internal Medicine physicians, and it is much less costly in Family Medicine practices. But care is most economical, with equal outcomes, in Community Health Centers (Federally Qualified Health Centers or FQHCs).

When care is unavailable, those who lack access pay the price and society pays the bill.

Rural communities, suburbs, and city neighborhoods, to have accessible care for all, need to have an FQHC in their area. These services are not only for the poor, the uninsured, or the medicaid population. FQHCs provide care to all persons regardless of their inability—or ability—to pay. We do not discriminate against those who are insured or economically better off.

We do "Health Care the Way it Ought to Be" every day, for everyone.

Our organization, The Health Center in Plainfield, VT, functioned for years as a freestanding nonprofit Rural Health Clinic. It was a struggle to keep the organization afloat, We had to scrimp and save all we could to break even at each year's end. We were always restrained by very tight finances.

Since becoming an FQHC 2 years ago, we have been able to expand the number of uninsured persons we serve on sliding scale and our active patient population has increased from 7,800 persons to 9,400 persons. By this fall our staff will have grown from 34 full-time and 19 part-time employees to 47 full-time and 30 part-time staff members. We are consolidating our fiscal position and are poised to do much more, with more medical, dental, and behavioral health patients and more persons accessing our 340b pharmacy program, all with sliding scale discounts for uninsured persons with incomes below 200 percent of the federally determined level of poverty.

To accommodate the unmet need, we will add a physician and a physicians assistant this summer. We anticipate taking care of about 1,200 to 1,800 more medical patients with this summer's staff additions, with eventual growth to 12,000 patients. Adding two dentists this fall and another in December will allow our staffing a dental care mobile in six locations around the State and will allow our caring for

about 2,000 more patients in the dental service of the center. We will also see substantial growth in our behavioral health and 340b pharmacy services.

It is an enormous relief as head of the agency to be on a more solid financial footing. And as a physician it is extremely gratifying to be able to provide a broader scope of services and care to all our patients and to offer more sliding scale and nominal charge care for the unfortunate, the downtrodden, and the marginallized—and now for the newly unemployed and uninsured who are suffering in the current great recession.

Many of these improvements in our ability to address our community's needs would be impossible without our having become an FQHC. Others would only occur slowly and incrementally, because tight finances would constrain innovation and the starting of new or expanded services, despite those being badly needed by the population.

Expansion of funding for FQHCs and for the NHSC has the potential to help reverse the decline of primary care and to bring excellent, accessible care to all—in all of our communities.

This is the essence of health care reform.
This is what America needs.
Not just for the poor or the uninsured—but for all of us.
Health Care for All.

THE COMING CRISIS IN PRIMARY CARE IS SOON UPON US

Vermonters were pleased recently to have been told we live in the healthiest State in the Nation. The State launched the new Catamount health plan, an ambitious effort to reduce the number of persons without health insurance in the State. The UVM School of Medicine was rated very highly for its education of primary care physicians. The past 2 years have seen the expansion in Vermont of Federally Qualified Health Centers chartered to serve all persons in their geographic area, regardless of their ability to pay.

But these recognitions, innovations, ratings, and successes have occurred in circumstances that, beneath the radar of most of the public and many policymakers, threaten to undermine our collective efforts to make health care available to all, especially in rural areas. In fact, the very structure of our health care system, if it should be called a system, is threatened by the coming collapse of primary care, which is the foundation of quality and any hope of economy in this realm.

There is a substantial and worsening lack of physicians and dentists to work in primary care nationwide, with rural areas suffering disproportionate shortages. While our need for these essential professionals is projected to grow by as much as 40 percent in the coming decade, the number of medical students moving on to primary care residencies after graduation has fallen by about 50 percent in the last 10 or 12 years. Our cadre of primary care providers, both medical and dental, is aging and not being replaced. If this trend continues—and it appears to be accelerating—we will find ourselves in a circumstance with 50 percent of our present supply trying to provide care for 140 percent of our present demand. This may understate the problem, since the aging population, in little more than 20 years, will need about seven times the present number of geriatric physicians, a group already available at half of current need.

About half of the estimated 56 million Americans who now have no primary care doctor have health insurance but still can find no source of primary care. We are already seeing many practices in Vermont closed to new patients and the professionals working longer hours to take care of those enrolled in their practices. In Vermont, and across the Nation, increasing numbers of patients are being seen and experiencing worsening delays in our emergency rooms. This trend has been aggravated in other States by the closure of many ERs by for-profit hospitals which have discovered that these services lose money, particularly as they attract the uninsured and the down and out. The care that people without a regular source of primary care receive, if they do receive care, is almost certain to be much more costly, in both the short and the longer run, in financial and in human terms.

Primary care is one of the most challenging disciplines in medicine, requiring broad scientific knowledge and exceptional interpersonal "soft" skills. It is also one of the most rewarding, involving long-term relationships with individuals and families which many other specialties do not offer. It is also the most cost-effective component of our system. But primary care is in trouble.

Many primary care physicians, feeling under appreciated and under reimbursed compared to their professional colleagues in other fields, report diminished satisfaction with their professional work. After working more and more un-reimbursed hours contending with Medicare pharmacy program companies and an unending

stream of prior approval forms, changing formularies, and barriers to care, some are getting out of practice. They are not recommending similar careers to their children or others, and increasingly report feeling undervalued, overworked, and taken for granted.

There are many disincentives to choosing primary care that devolve from our medical education system, including what sort of person is chosen to be admitted to medical school, how they are influenced by the role models and practice organizations in academic medical centers, and the great costs they confront to get through college, medical school, and residency training before starting practice. Medical students graduate with substantial debt after 4 years of college and 4 years of medical school, so they are apt to opt for specialties that provide higher incomes after residency training. For the same time in training and no less work, primary care incomes are often half or a third of what other specialists earn.

We not only have half as many graduating doctors choosing primary care postgraduate training but also find that half of the new residents in family medicine programs are graduates of foreign medical schools, half of whom are foreign nationals. We do not seem to be able to manage to attract and educate enough of our own bright young people to take care of our own population.

Unlike attorneys, physicians can not bill for telephone work or most paperwork, so roughly 35 percent of the regular working hours of primary care physicians are not reimbursed. The average family physician, prior to the extra hours demanded by managed care and pharmacy benefits management companies, worked a 54-hour week, not including the hours on call with a beeper on their belt or a phone on the bedside table. More and more "free" work is the result of companies, often for profit companies, requiring physicians and their staff to complete forms, answer questionnaires, or make telephone calls to justify their decisions in order to have their patients receive care.

The private physicians still attempting to survive in unsubsidized situations are trying to make ends meet with increasing numbers of persons in the expanded Medicaid program, which nickels and dimes providers at every turn. Medicaid also has its own formulary program, which adds to the difficulty of caring for these patients. Quite a number of these physicians are limiting or ceasing enrollment of Medicaid patents in their practices, because of the poor reimbursement.

One of the great ironies of our present circumstance is that State government, the State colleges, and some of our leading and more successful companies reduce their operating costs by insuring with Cigna, which, when patient management fees are taken into account, pays primary care providers in the fee-for-service sector less than Medicaid pays. The State and some employers often appear to be surprised and even mystified by the shrinking supply of doctors for their beneficiaries and employees, but some simple accounting would solve the mystery. (It's the reimbursement, stupid.)

The public, where primary care is still available, seems unaware of the accelerating crisis in access that faces all of our citizens. If they knew the true situation, there might be a clamor for solutions, but any of these, when adopted, will take years to change the supply of doctors for the population. Things are virtually certain to get much worse before getting better, if that is going to happen. The primary care system, with dwindling numbers of providers contending with increasing patient loads and expanding mandates, dictates, expectations and demands, including those of such laudable quality initiatives as the Vermont Blue Print for Health, is much closer to breaking down than most people realize.

Those leading the march to health care reform run the risk of turning around to discover that there are no primary care physicians and dentists behind them in the parade. Those who do continue in the work—some would say the calling—of taking care of the sick will all be entirely too busy with patients who are aging and have more complex illnesses, while trying to get pharmaceuticals and tests approved by companies which increase their profits—or non-profit insurers which must try to compete with those companies—by reducing access to care.

Also missing from the parade will be the numerous Physician's Assistants and Nurse Practitioners who are essential and capable components in our primary care efforts. They too will be overwhelmed as more and more need confronts our shrinking numbers, physicians and "physician extenders" alike.

There will be increasing numbers of foreign medical graduates filling out the ranks of America's primary care providers, but leaving their native lands with even less care in a global brain drain to the more affluent United States. Hospitals will increasingly employ primary care providers, subsidizing their practices by shifting income from imaging and surgery services to attract and retain primary care doctors, whose value is not as obvious until they are not available in their communities.

President Bush may be proven to have been inadvertently prescient when he stated recently that all Americans have access to health care because they can go to the emergency room. More and more, this will be the health care entry point of necessity: crowded, expensive, and poorly suited to attend to the tasks of primary care. It is a chaotic and worrisome picture to contemplate.

Mr. Chairman, members of the committee, my name is John Matthew. I am a primary care physician. I have been practicing primary care medicine in rural Vermont for the past 36 years. I appreciate the opportunity to offer to you my insights and opinions concerning the crisis in primary care access and the potential that Community Health Centers and The National Health Service Corps offer to address this core challenge in our present circumstances and to any health care reform program the Nation may undertake.

Good, accessible primary care is the essential foundation of all care and for any hope of constraining the costs of health care for the Nation. But primary care is, and has been for a decade or more, in precipitous decline, with some 60 million Americans now unable to find a personal physician. The causes and consequences of this situation are multiple and complex. I addressed some of these last year in the appended article, "The Coming Crisis in Primary Care is Soon Upon Us," which provides some detail concerning the dynamics of this accelerating calamity.

Arresting and reversing this decline must be a matter of the highest priority. Without an adequate supply of primary care providers, located and organized to make accessible, high quality care available to all residents in all of our communities, good health care is in jeopardy. Care will not just be less and less available, it will, when accessed, be of lower quality and of much greater cost, in human and in economic terms. Without primary care the population delays care, visits emergency rooms as sources of basic care, and often uses medical sub-specialists in lieu of those trained to provide primary care.

When primary care is available, it is most costly when provided in multi-specialty settings. It is almost as expensive in the hands of Internal Medicine physicians, much less costly in Family Medicine practices, and most economical, with equal outcomes, in Community Health Centers (Federally Qualified Health Centers or FQHCs). There are also short- and long-term impacts on health and on health care costs that devolve from primary care quality and availability, or the lack of these, played out in other settings and for years to come. Early intervention, preventive medicine, and risk factor control are key parts of good primary care. Those who lack access pay the price and society pays the bill.

The days of physicians setting up shop in small communities and suburbs, even if we did train a sufficient number to care for the population, are going fast, if not gone. No primary care physician has set up a private practice in Central Vermont in many years. Most physicians now are not entrepreneurs: they seek employment in which they can practice on a salary and without investing in buildings, equipment, and staff. Rural communities, suburbs, and city neighborhoods, if they are to have accessible care would do very well to have an FQHC in their area, providing an organizational structure, economies of scale, economies of scope, efficient use of providers organized in teams of physicians and mid-level practitioners, integration of behavioral health services, well-equipped dental units, community outreach and social services, and access to less costly prescription medications. With a community board of directors in charge, the program of each FQHC can be tailored to the needs of its particular community. These services are not only for the poor, the uninsured, or the medicaid population. FQHCs provide care to all persons regardless of their inability—or ability—to pay. We do not discriminate against the insured or better off in our population. We take pride in providing care as good as or better than that which insured persons might find anywhere else to everyone, whatever their insurance status.

Just as all politics is local, so is all health care, whether in an exam room or in the community. Every community is different in some way. We need flexible, locally controlled institutions such as FQHCs to organize and operate the structures which can tailor their programs to meet local needs. These established agencies can then better attract professionals to provide the primary health services—medical, dental, mental health, and medications—needed in every community, rural or otherwise. FQHCs are the prototypical patient-centered medical homes, committed to patient participation in their care and viewing health care as far more than a series of episodic or periodic office visits. Informing and empowering people are key concepts of the community health center movement.

Our organization's evolution and the value of our becoming a Federally Qualified Health Center to the people whom we serve is illustrative. At the start we estab-

lished The Health Center as a non-profit corporation, which employs the staff and owns the practice. We have always had a board of directors made up of community members and it has always been our mission to provide care for everyone from our area who wants to come to the center, whatever their insurance status. We functioned for years as a freestanding Rural Health Clinic (RHC). The RHC caps for cost-based reimbursement were always too low. We lost money on every Medicare and Medicaid office visit and it was a struggle to keep the organization afloat, though we always did. Our sliding scale was self-funded, in the sense that we had no outside monies to support the un-reimbursed care we provided for the less fortunate. We had to know where every nickel was and to scrimp and save all we could to pay our staff and operating costs and still break even at each year's end. We were always constrained by very tight finances. But for a very dedicated core staff putting in extraordinary hours, we might well have floundered and folded up shop. We did good work, but in a very crowded facility, and our margin was far too tight for comfort. I spent as many sleepless nights concerned about our finances as I did up admitting patients to the hospital and taking after hours calls.

When we became an FQHC—after once having our application receive a grade of "95" but not be funded—higher reimbursement caps provided more income than we had received as an RHC for the very same work. We reduced our losses on Medicare visits, though the caps still cause us to receive less than our costs, and were able to recoup our costs for Medicaid visits. Our 330 grant has allowed us to have community resources persons on staff, to expand the hours of our operations manager to coordinate fund raising for and construction of an expanded facility, to have the luxury of time free for program development, and to expand the number of uninsured persons we serve on a sliding scale. We are enabled to provide not just one-on-one care in a series of office calls and hospital visits, but also to innovate, to collaborate, and to reach out to our community and to other agencies and local systems that compliment the provision of these services.

In the past 2 calender years our active patient population has increased from 7,800 persons to 9,400 persons. By this fall our staff will have grown from 34 full-time and 19 part-time employees to 47 full-time and 30 part-time staff members. We are consolidating our fiscal position and are poised to do more, with more medical, dental, and behavioral health patients and more persons accessing our 340b pharmacy program, all with sliding scale discounts for uninsured persons with incomes below 200 percent of the federally determined level of poverty.

We are expanding our medical and our dental staff to meet the unmet medical and dental needs in the area. All of the local medical practices, other than the Health Center, have been closed to new patients for most of the past few years. And no local dental practice accepts medicaid patients except on a very limited basis. Our medical practice has about 45 percent medicare and medicaid patients. Our dental practice does 65 percent or more of total work for medicaid patients. There is a region-wide need for more dental care for medicaid and uninsured patients.

To accommodate the unmet need, we will add a physician and a physicians assistant this summer. We anticipate taking care of about 1,200 to 1,800 more medical patients with this summer's staff additions, with eventual growth to 12,000 patients, or 20 percent of the county population as we find another physician and another PA or nurse practitioner.

We have moved from five to nine dental chairs and are now going to add four more. We are expanding our in-house dental program and cooperating with other FQHCs in an innovative mobile dental program for rural kids and youth. Adding two dentists this fall and another in December will allow our staffing the dental care mobile in six locations around the State and will allow our caring for about 2,000 more patients in the dental service of the center.

Our "mental health" staff, with added counseling, PTSD treatment, behavioral neurology, rehabilitation, and onsite psychiatric skills is growing to meet a large unmet need. We have teamed with other FQHCs to set up a tele-psychiatry link for consultations with the University of Vermont child and adolescent psychiatrists. We have submitted a request for a Change of Scope to allow our contracting for child and adolescent, general, and geriactric psychiatric consultations for our medicaid and uninsured patients who otherwise have substantial problems receiving this care.

We have been able to bring 340b pharmacy services to our patients in a collaborative effort with four other FQHCs, including an automated dispensing unit—effectively a branch of the pharmacy—in our center.

We have brought two staff members on to expand our outreach and case management efforts. We are taking on more medical students for teaching in the practice, improving continuing education for our professionals, and strengthening our community health education efforts.

This fall we will, through a cooperative agreement with the local transportation agency, start to offer transportation to patients who do not have reliable private transportation. We are already open 60 hours a week. We will add another evening medical clinic and more evening dental hours this fall.

It is an enormous relief as head of the agency to be on a more solid financial footing and to have more adequate support staff in the business and operations components of the center, necessary to our addressing the needs of those whom we serve.

It is an equal relief as a physician to be able to provide more sliding scale and nominal charge care for the unfortunate, downtrodden, and marginallized—and now for the newly unemployed and uninsured who are suffering in the current great recession. We wish that we could provide a sliding scale fee schedule to persons or families with incomes under 300 percent of FLP, as we did when we were a Rural Health Clinic.

It is heartening to be able to expand our dental program. We have become the *de facto* dental practice for those seen in our local emergency room with dental pain. We draw dental patients from a large geographic region. This includes many persons who have medicaid dental coverage but no other practice which will see them. We have always understood dental care to be an integral part of the promise of good heath care. To be able to deliver on this promise is very heartening.

We have always been very comfortable and capable, nearly unique amongst practices in our region, caring for behavioral heath problems in our practice, but we have always recognized the need for other skills in this domain. We are very pleased to have been able to offer more services on site, where they are more accessible and affordable for our patients.

And it is a very substantial benefit to providers and patients alike to have access to more affordable medications through the collaborative 340b program. For some patients the postal delivery of these medications is about as helpful as the lower prices, since getting to the drug store, often several times a month due to PBM restrictions, and waiting for overworked pharmacists has been a burden and a barrier that we did not recognize before we had the 340b option in house and by mail.

And, I am sleeping better, concerned with service delivery rather than with survival.

Many of these improvements in our ability to address our community's needs would be impossible without our having become an FQHC. Others would only occur slowly and incrementally, because tight finances would constrain innovation and the starting of new or expanded services, despite these being badly needed by the population.

To staff the FQHCs that we envision being established across the Nation, as well as other primary care settings in every corner of the country, we will need to attract a very much larger proportion of the graduates of our medical schools to work in primary care. Slowing and then reversing the trend to fewer and fewer graduates entering primary care will require a multifaceted and multi-year effort. One important step will be to relieve physicians who undertake primary care training of some of the substantial debt that they accumulate as they pursue their professional education and post graduate studies. It is telling that our community, with most practices closed to new patients and having lost three primary care doctors in the past year, has been unable to recruit replacements. The last primary care M.D. brought to our area by the local hospital and the new physician who will join our organization this summer are both veterans with years of practice and experience, not the 30-year-olds fresh out of residency training. These veterans will not practice forever, nor will my physician colleagues at The Health Center, nor will I, as much as we enjoy most aspects of our practice lives. The same limits apply to the very fine Physicians Assistants and nurses who work with us every day.

Expansion of the National Health Service Corps will be one mechanism to address the need to replace the Nation's aging cadre of primary care medical and dental providers. Knowing that NHSC loan forgiveness or scholarships are available will help attract students to primary care. Having the NHSC professionals located in various communities will provide professional staffing for the interval of the professional's commitment. And some will remain to dedicate their professional lives to the communities which they get to know as NHSC members.

Expansion of funding for FQHCs and for the NHSC has the potential to help reverse the decline of primary care and to bring excellent, accessible care to all—not just the poor or uninsured—in all of our communities. This is the essence of health care reform. This is what America needs. Not just the poor or the uninsured—all of us. All Americans.

Senator SANDERS. Dr. Matthew, thank you very much.

Lisa Nichols, who is the Executive Director of Midtown Community Center, Ogden, UT. Ms. Nichols, thanks very much for being with us.

STATEMENT OF LISA NICHOLS, EXECUTIVE DIRECTOR, MIDTOWN COMMUNITY CENTER, OGDEN, UT

Ms. NICHOLS. Thank you. Thank you for having us here today. I'm very proud to be part of the community health center movement and to tell you all about our health center and health centers in general.

My name is Lisa Nichols. I am the Executive Director of Midtown Community Health Center, and a board member of the Association for Utah Community Health.

Midtown serves underserved community residents from Weaver, Morgan and Davis counties located in northern Utah. Midtown has experienced tremendous growth fueled by community need, Federal funding opportunities and private partnerships.

In 1999, Midtown served 6,500 patients from a single site. Services were limited to comprehensive primary care. Oral health care services and mental health services were not provided. We now operate from six sites in four different cities, providing comprehensive primary, oral and mental health services to nearly 26,000 patients.

The most dramatic growth has come over the past 3 years. Midtown relocated its Ogden site to a new facility in 2006. This $3.2 million facility was funded through Federal funds and private dollars, with $2.9 million raised from our community.

The new facility is more than twice the size and should have allowed for 5 years of growth. We were turning an average of 20 patients away because demand exceeded resources daily. The patient population has grown by over 11,000, and we still turn an average of 20 patients away daily.

Midtown received new Federal access point funding in 2007 to open a site in Davis County. Over 1,000 residents from Davis County were traveling to Midtown's Ogden site to receive subsidized services. We opened in 2007 with a goal of adding 4,300 users by 2010. Over 5,800 patients are served and the need continues to grow.

One of Midtown's most successful partnerships is with Weaver State University's Oral Hygiene Program. Midtown provides a dentist to supervise the students, while providing dental services to Midtown patients. The University provides space, equipment and students to care for the oral hygiene needs of patients. This arrangement allows 2,500 individuals to receive care annually at an average cost of $62 compared to the national benchmark of $139.

Federal funding to Midtown has grown by 685,000 since 2006, allowing for $62 per user. This is a cost-effective model, giving that the average cost of serving a patient in other settings ranges upwards to $700.

Midtown, along with other community health centers, decreases overall health care costs. Midtown's work with InterMountain Health Care, our local hospital, to transfer uninsured patients seeking non-emergent care through the emergency department to a community health center. A decrease from an average of six visits per patient to less than one per year has been realized.

Midtown's largest challenge is in medical provider staffing. It is difficult to compete with the generous wage and benefits packages of larger organizations. The National Health Service Corps' loan repayment program has been vital to our success. We have retained medical providers hired in 1994 through this program.

Community needs continue to grow beyond our resources to meet it. An additional 37,000 individuals in Weaver, Morgan and Davis counties have limited health care access. We will strive to meet this need through new Federal funds and new community partnerships. Thank you.

[The prepared statement of Ms. Nichols follows:]

PREPARED STATEMENT OF LISA NICHOLS

SUMMARY

The following written statement contains an overview of community health centers in Utah. It includes a profile of each of the 11 federally qualified health centers along with their 2008 data, as reported in the Federal Bureau of Primary Health Care Uniform Data System. My remarks to the committee will focus primarily on specifics related to the Midtown Community Health Center (MTCHC), of which I am the executive director.

MTCHC has operated in northern Utah since 1970 serving underserved community residents from Weber, Morgan and Davis Counties. MTCHC has experienced tremendous growth fueled by community need, Federal funding opportunities and private partnerships over the past 10 years. In 1999, MTCHC served 6,504 patients from a single site located in Ogden, UT. Currently, MTCHC operates from six sites in four different cities, providing comprehensive primary health care, oral health care services and mental health services to 25,969 individuals.

Midtown relocated its Ogden site to a new facility in the spring of 2006. This facility, at a cost of $3.2 million, was funded through a combination of Federal funds and private dollars. *Nearly $2.9 million was raised from the residents of northern Utah.* The new facility is more than twice the size of the former facility. It was anticipated that the site would allow for 5 years of growth. Midtown added a pharmacy and radiology services along with additional medical providers. The patient population has grown by over 11,000 and we still turn an average of 20 patients away daily.

Sixty-eight percent of the patients served by MTCHC are uninsured. This is in contrast to the national benchmarks for urban health centers of 41 percent. Only 31 percent of Midtown's funding comes from the Bureau of Primary Health Care. Midtown is able to serve such a large uninsured population and manage tremendous growth by managing resources cost-effectively and developing community partnerships.

Midtown's largest challenge in meeting the on-going needs of the underserved is in finding adequate medical provider staffing. Midtown competes with larger health care facilities in recruiting efforts. It is through the National Health Service Corps loan repayment program that Midtown is able to keep the clinic fully staffed. Midtown has retained medical providers hired in 1994 through this program. It is vital to our success.

Community need continues to grow despite MTCHC's efforts to meet it. It is estimated that an additional 37,000 individuals in Weber, Morgan and Davis Counties have limited health care access. MTCHC will strive to meet this need through new Federal funds and new community partnerships.

Mr. Chairman and members of the committee, my name is Lisa Nichols. I am the executive director of the Midtown Community Health Center in Ogden, UT and a board member of the Association for Utah Community Health (AUCH). On behalf of Utah's 11 not-for-profit community health center corporations (CHCs), we appreciate the opportunity to demonstrate the cost-effective provision of comprehensive primary and preventive medical, dental, and mental health services being offered at 29 health care home delivery sites in Utah. While the National Association of Community Health Centers (NACHC) speaks to the contribution of the Nation's CHCs providing service in more than 7,000 communities nationwide, AUCH will present information on Utah CHCs. The CHC response to Utah health care reform efforts is also included.

COMMUNITY HEALTH CENTERS IN UTAH

The first health center established in Utah was the Wayne Community Health Center in the rural town of Bicknell (January 1978), followed by the Salt Lake Community Health Center in 1979. The contrast in the two locations is striking—one, a relatively isolated rural setting and the other within the large metropolitan area of the State. Fourteen of Utah's counties are classified as "Sparsely Populated/Frontier," with less than six persons per square mile. There are 14 health center delivery sites within these counties. Approximately 89 percent of Utah residents live in metropolitan areas where 15 health center delivery sites are located. ***The diverse nature of the populations/locations served by CHCs in Utah is a testimony to the versatility and suitability of the model to successfully provide comprehensive, high quality primary care in a reformed health care system.*** Appended to this document are profiles of Utah's CHCs together with 2008 data as reported to the Federal Bureau of Primary Health Care (BPHC). Important in describing CHCs in Utah is the comprehensive nature of the services provided to over 100,000 individuals, which include the following:

- Pediatric, adult and family medicine, including chronic disease management;
- Obstetrics/gynecology;
- Dental care;
- Supporting social services;
- Specialty referrals;
- Immunizations;
- School-based health locations;
- Laboratory services;
- Mental health/substance abuse counseling;
- In-patient care;
- Pharmacy (including access to 340B pricing);
- Smoking cessation and prevention; and
- Public health programs.

Additionally, CHCs in Utah are connected through video technology, helping to mitigate the considerable geographic distances between the 29 sites. This capacity allows for educational/informational presentations for both CHC providers and patients from a variety of sources, e.g., Moran Eye Center and other University of Utah departments, the Utah Department of Health, Utah Women's Information Center, private providers. Teleophthalmology services for diabetic retinopathy screenings are provided collaboratively between all Utah CHCs and contracted screening providers. Teleradiology services are in place for most Utah CHCs, as well.

Utah CHCs have quantified the economic impact on the communities they serve. A 2006 report by Capital Link and AUCH found that the CHCs had an overall impact of $71.1M and supported more than 846 jobs during the 2005 study period. The impact included $42.6M in operational expenditures injected into local economies and $28.5M in indirect and induced economic activity. Additionally, the report estimated that the economic output on Utah's CHCs included $39.2M in aggregate gain of household incomes within the communities that CHCs served.

Staffing of CHCs with adequate numbers of primary care providers remains a challenge, however. Currently, there are 10 CHC-posted vacancies in Utah with the National Health Service Corps, a primary recruitment source.

COMMUNITY HEALTH CENTER ROLE IN A REFORMED HEALTH CARE DELIVERY SYSTEM

Utah's CHC presented the following response to a United Way's Financial Stability Council Straw Man Reform Proposal in 2008. The response includes a number of cost-effective CHC practices that highlight the appropriateness of community health centers as centerpieces within health care reform efforts.

Guiding principles	Health center alignment
Contain Costs:	
We must make difficult choices that will make health care more affordable and equitable, stem rapidly rising health care costs, simplify administration and encourage the implementation of health information technology. Incentives in the system must be realigned to focus on quality, value, best practices, and personal responsibility.	An emphasis on preventive care, such as immunizations, disease screenings, and health education provides for screening and early identification of conditions that are considerably more expensive to treat if not addressed early. Evidence-based chronic disease maintenance and monitoring slow the progression of conditions such as diabetes and heart disease, and minimize the need for costly hospitalization for these conditions. For example, if everyone with diabetes were screened for eye disease and received the recommended care and treatment, a savings of $470 million could be created for the health care system nationally.[1] Utah's health centers currently provide retinal screenings for their diabetic patients. Many of Utah's health centers provide primary care services using Nurse Practitioners or Physician Assistants, which is a cost-effective method of care delivery that has proven results. The total medical care services cost per medical encounter in Utah health centers averages $110. This compares with the average encounter charge in an emergency department for a medical condition which could more appropriately have been treated in a primary care setting of $347–$572,[2] depending on the degree of delay by the patient and subsequent severity. Following Federal health information technology best practice guidelines, health centers in Utah monitor health outcomes and track key measures. CHCs are adopting integrated electronic medical records technology, and many sites have also implemented telehealth technology.
Shared Responsibility:	
Individuals, employers, providers, insurers, State government and the Federal Government share responsibility to make high-quality, cost-effective health care available to everyone. Within this framework, Utahns should decide what health care solutions work best for them.	The model of health centers has always been based on shared responsibility. The clinics do not provide charity or free care, but provide a reasonable fee schedule that is based on an individual's ability to pay for the services. In 2006, $4.4 million was collected directly from health center patients for care rendered.[3] In addition to patient revenue, the health center model leverages a combination of contract and grant funding from Federal, State, local, and private sources to ensure adequate access to high-quality care for all health center patients. Shared responsibility is inherent in the diverse funding sources that are brought together to serve each community in which health centers operate.
Support For Market-Based Solutions:	
Effective and fair competition in a responsibly regulated free-market system will deliver greater value for both employers and individuals. Competition should be focused on effectiveness, outcomes, efficiency, and overall quality and value. Consumers should have the information and incentive to choose health care options based on value.	CHCs are full participants in the existing health care market. Patients are rigorously screened for insurance eligibility. Health centers participate in all available health plans. Insurers, including Medicare and Medicaid, are billed according to established methodologies. The quality of care at CHCs is assured by the rigorous standards required to annually maintain their Federal designation and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) ambulatory care accreditation.
Endorse Wellness and Prevention:	

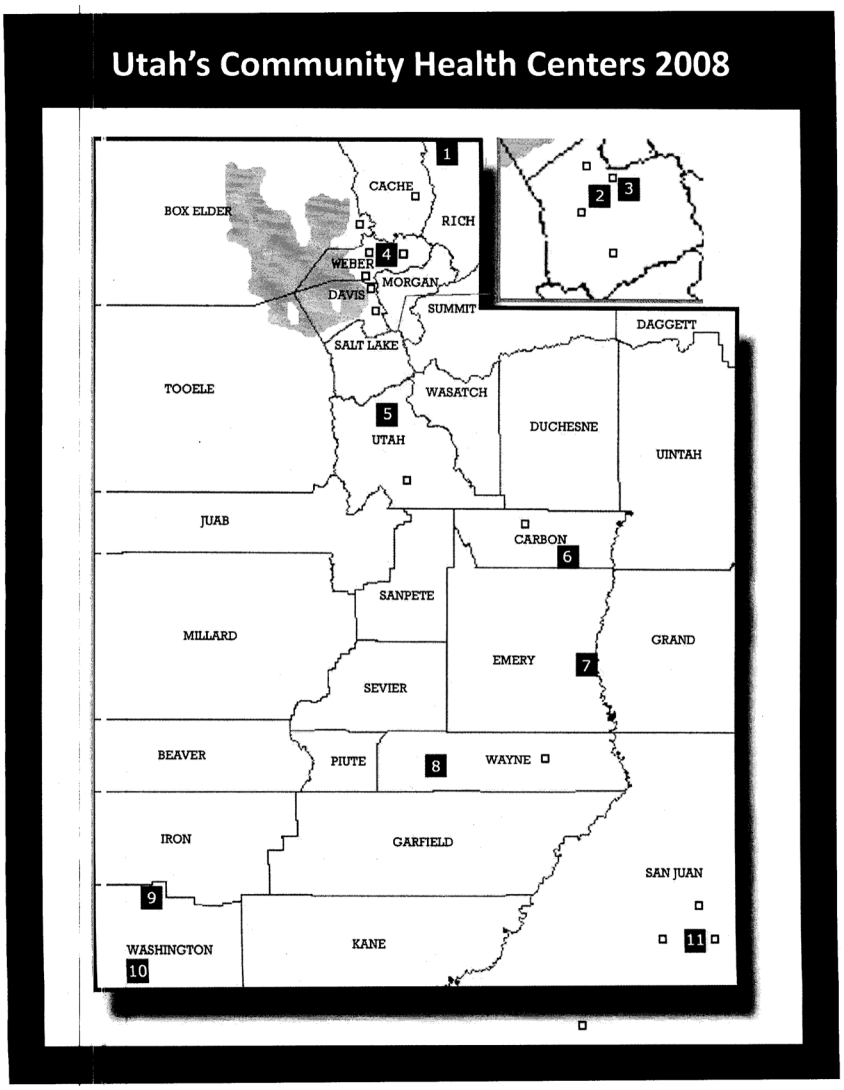
Guiding principles	Health center alignment
Healthy lifestyles and preventive care form the cornerstone of good health. Individuals must take responsibility for their health and be provided with incentives that reward responsible behavior.	Health centers receive significant UDOH funding ($348,000) to engage in preventive care activities, including funding from Heart Disease and Stroke Prevention, Immunization, and Tobacco Control to implement programs in their patient base. Health centers adhere to national quality measures in the treatment of individuals with chronic conditions such as diabetes and heart disease. Health centers leverage funding sources to improve access for preventive screening technology, such as the use of a shared retinal camera for diabetic screenings. Health centers continue to emphasize wellness practices as an essential component of good health care. Services offered may include health education, parenting education, and lifestyle change practices. Through the services offered by health centers, patients gain an understanding of the impact that current decisions have on their subsequent health status.
Be Compassionate: Society must devote appropriate resources to care for the most needy in our community. In addition, population-specific differences in the presence of disease, health outcomes and access to health care should be eliminated.	Health centers in Utah and nationally have continued to follow a vision that places the patient first, regardless of their economic, insurance, or geographic situations. As an example, Utah's health centers provided care to over 53,000 uninsured Utahns in 2006 (61 percent of the total patient base, and 17.6 percent of the total uninsured in the State). Utah's health centers also provided care to over 83,000 individuals living at or below 200 percent of the poverty level. (94.4 percent of total patient base)[4] Access to health center services is designed to accommodate any person in need of health care services. The use of a sliding fee scale based on income provides one indication of the commitment to access that health centers share. Significant resources are expended in health centers to assist patients.

[1] National Association of Chronic Disease Directors, An Urgent Reality: The Need to Prevent and Control Chronic Diseases, undated.

[2] Utah Office of Health Care Statistics, Utah Department of Health. Primary Care Sensitive Emergency Department Visits in Utah, 2001. April, 2004. ***http://health.utah.gov/hda/Reports/Primary_Care_ERvisits_Utah2001.pdf***.

[3] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, Uniform. Data System Calendar Year 2006 Utah Rollup Report, available on request. AUCH Health Care Reform Action Plan—April 2008.

[4] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, Uniform. Data System Calendar Year 2006 Utah Rollup Report, available on request.


Utah's Community Health Centers 2008
BOX ELDER
CACHE
RICH
WEBER
MORGAN
DAVIS
SUMMIT
SALT LAKE
DAGGETT
TOOELE
WASATCH
UTAH
DUCHESNE
UINTAH
JUAB
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~ Utah's Community Health Centers ~

The following list includes Community Health Center sites that were supported by HRSA Bureau of Primary Health Care grants in 2008. For more details about each community health center organization, visit www.auch.org.

1. Bear Lake Community Health Center, Inc. Clinics: Bear Lake CHC (Garden City) Cache Valley CHC (Logan)	**LaVal Jensen, Executive Director** **DJ Ballingham PA-C, Medical Director**	**435-946-3660**
2. Community Health Centers, Inc. Clinics: Copperview CHC (Midvale) Oquirrh View CHC (Taylorsville) Central City CHC (Downtown SLC) Stephen D. Ratcliffe CHC (Rose Park) Clinica de Buena Salud/Utah Farm Worker Health Program (Brigham City/mobile services statewide)	**Dexter Pearce, Executive Director** **Keith Horwood MD, Medical Director**	**801-412-6920**
3. Wasatch Homeless Health Care, Inc. Clinic: Fourth Street Clinic (Downtown SLC) Open Door and Outreach Services (SLC)	**Allan D. Ainsworth PhD, Executive Director** **Christina Gallop MD, Medical Director**	**801-364-0058**
4. Midtown Community Health Center Clinics: Midtown CHC (Ogden) Weber Midtown Dental Clinic (Ogden) Davis County Medical Clinic (Farmington) Davis County Dental Clinic (Layton) Children's Clinic (Ogden) James Madison Elementary Health Center (Ogden)	**Lisa Nichols, Executive Director** **Richard Gregoire MD, Medical Director**	**801-393-5355**
5. Mountainlands Community Health Center Clinics: Mountainlands CHC (Provo) Payson Family Health Center (Payson)	**Todd Bailey, Executive Director** **Bruce Grover MD, Medical Director**	**801-374-9660**
6. Carbon Medical Services Association, Inc. Clinics: Carbon Medical SA (East Carbon) The Helper Clinic (Helper)	**Yvonne Jensen, Executive Director** **Virginia Wheeler FNP-C, Medical Director**	**435-888-4411**
7. Green River Medical Center Clinic: Green River MC (Green River)	**Mary Winters, Executive Director** **Kim McFarlane PA-C, Medical Director**	**435-564-3434**
8. Wayne Community Health Centers, Inc. Clinics: Wayne CHC (Bicknell) Wayne CHC (Hanksville)	**Gina Flanagan, Executive Director** **Jeffrey Chappell MD, Medical Director**	**435-425-3744**
9. Enterprise Valley Medical Clinic Clinic: Enterprise Valley MC (Enterprise)	**Rydel Reber, Executive Director** **Curt Niederhauser PA-C, Medical Director**	**435-878-2281**
10. Southwest Utah Community Health Center Clinic: Southwest Utah CHC (St. George)	**Nancy Neff, Executive Director** **David Grygla DO, Medical Director**	**435-986-2565**
11. Utah Navajo Health System, Inc. Clinics: Monument Valley CHC (Mon. Valley) Blanding Family Practice (Blanding) Montezuma Creek CHC (Montezuma Creek) Navajo Mountain CHC (Tonalea, AZ)	**Donna Singer, Executive Director** **L. Val Jones MD, Medical Director**	**435-651-3291**

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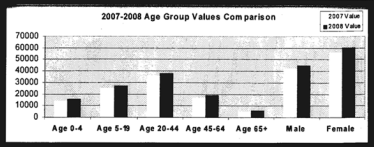
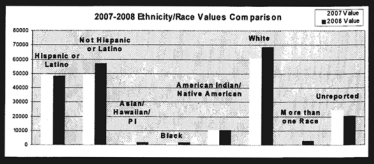
2008 Utah Community Health Centers Preliminary Demographic Rollup

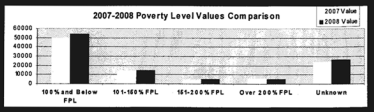
Age Groups	2007 Value	2007 %	2008 Value	2008 %
Age 0-4	14,463	14.7%	15,559	14.7%
Age 5-19	25,075	25.5%	27,005	25.6%
Age 20-44	36,342	37.0%	38,077	36.1%
Age 45-64	16,855	17.1%	18,997	18.0%
Age 65+	5,596	5.7%	5,913	5.6%
Total	98,331		105,551	
Male	42,112	42.8%	44,974	42.6%
Female	56,219	57.2%	60,577	57.4%



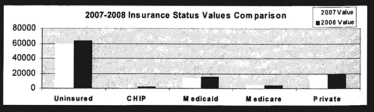
Ethnicity/Race	2007 Value	2007 %	2008 Value	2008 %
Hispanic or Latino	49,215	50.1%	48,400	45.9%
Not Hispanic or Latino	49,116	49.9%	57,151	54.1%
Asian/Hawaiian/PI	1,511	1.5%	1,528	1.4%
Black	932	0.9%	1,471	1.4%
American Indian/AN	10,270	10.4%	10,647	10.1%
White	60,872	61.9%	68,630	65.0%
More than one Race	136	0.1%	2,940	2.8%
Unreported	24,610	25.0%	20,335	19.3%
Total Patients	98,331		105,551	
Language Other than English	39,429	40.1%	40,188	38.1%



Poverty Levels	2007 Value	2007 %	2008 Value	2008 %
100% and Below FPL	49,389	50.2%	54,251	51.4%
101-150% FPL	14,484	14.7%	14,622	13.9%
151-200% FPL	4,419	4.5%	5,248	5.0%
Over 200% FPL	6,091	6.2%	4,800	4.5%
Unknown	23,948	24.4%	26,630	25.2%



	2007 Value	2007 %	2008 Value	2008 %
Uninsured	59,708	60.7%	63,419	60.1%
CHIP	1,208	1.2%	1,968	1.9%
Medicaid	14,620	14.9%	15,661	14.8%
Medicare	4,648	4.7%	4,569	4.3%
PCN/Other Public	20	0.0%	23	0.0%
Private	18,127	18.4%	19,911	18.9%
Total	98,331		105,551	



The following information includes a brief profile of each health center organization in Utah.

BEAR LAKE COMMUNITY HEALTH CENTER, INC.

The mission of BLCHC is to provide access to quality primary and urgent health care for the residents and visitors of the Bear Lake Valley and surrounding communities on an ability-to-pay basis. The center takes a holistic approach to maintaining a healthy community through education, prevention, and a community networking system.

In 2008, the clinics of BLCHC served 5,138 individual patients, and provided 15,819 patient visits during the year while supporting 28 full-time equivalent positions in its clinic communities.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 33	100 percent or < FPL: 10	Age 0–4: 11	Hispanic/Latino: 7
CHIP: 0	101–150 percent FPL: 2	Age 5–19: 25	Not Hispanic/Latino: 93
Medicaid: 9	151–200 percent FPL: 1	Age 20–44: 38	Asian/PI: < 1
Medicare: 6	> 200 percent FPL: < 1	Age 45–64: 19	Black: < 1
PCN/Other: 0	Unknown: 87	Age 65+: 7	NA/AI: < 1
Private: 52			White: 92
			> One race: 7
			Unreported: < 1

FPL = Federal Poverty Level

CARBON MEDICAL SERVICES ASSOCIATION, INC.

Carbon Medical Services Association, Inc. (CMSA) was originally founded in 1952 to serve the needs of the local coal miners and their families. Since 1992, CMSA has been operating as a Federally Qualified Health Center. CMSA operates two clinic sites, and serves Carbon County and the northeast region of Emery County.

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In 2008, the clinics of CMSA served 3,058 individual patients, and provided 9,651 patient visits during the year while supporting over 19 full-time equivalent positions in its clinic communities.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 33	100 percent or < FPL: 33	Age 0–4: 5	Hispanic/Latino: 15
CHIP: 1	101–150 percent FPL: 11	Age 5–19: 14	Not Hispanic/Latino: 85
Medicaid: 12	151–200 percent FPL: 3	Age 20–44: 37	Asian/PI: < 1
Medicare: 18	> 200 percent FPL: 2	Age 45–64: 30	Black: <
PCN/Other: 0	Unknown: 51	Age 65+: 14	NA/AI: < 1
Private: 36			White: 92
			> One Race: 0
			Unreported: 7

FPL = Federal Poverty Level

COMMUNITY HEALTH CENTERS, INC.

The mission of CHC, Inc. is to provide quality patient-centered primary health care services to individuals regardless of their ability to pay. It is CHC's vision that culturally relevant primary health care is available, affordable, appropriate, adequate and acceptable to all community members, particularly for individuals, families and groups who are vulnerable and underserved.

In 2008, the clinics of CHC, Inc. served 31,096 individual patients, and provided 99,432 visits during the year while supporting 152 full-time equivalent positions in its clinic communities.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 63	100 percent or < FPL: 61	Age 0–4: 20	Hispanic/Latino: 73
CHIP: 2	101–150 percent FPL: 18	Age 5–19: 32	Not Hispanic/Latino: 27
Medicaid: 18	151–200 percent FPL: 5	Age 20–44: 33	Asian/PI: 3
Medicare: 2	> 200 percent FPL: 1	Age 45–64: 12	Black: < 1
PCN/Other: 0	Unknown: 15	Age 65+: 3	NA/AI: 3
Private: 15			> One Race: < 1
			Unreported: 5

FPL = Federal Poverty Level

UTAH FARM WORKER HEALTH PROGRAM

In 1990, Community Health Centers, Inc. (CHC) received Federal funding to provide health services to Utah's migrant and seasonal farm workers and their families. CHC provides medical, dental, health education, and outreach services through the Utah Farm Worker Health Program (UFWH). UFWH also refers patients to other existing health care providers and resources.

In 2008, UFWH served 5,531 individual patients, and provided 7,088 patient visits during the year through the Brigham City clinic site (Clinica de Buena Salud) and mobile van services.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 92	100 percent or < FPL: 92	Age 0–4: 13	Hispanic/Latino: 98
CHIP: 1	101–150 percent FPL: 5	Age 5–19: 78	Not Hispanic/Latino: 2
Medicaid: 4	151–200 percent FPL: 1	Age 20–44: 6	Asian/PI: 2
Medicare: < 1	> 200 percent FPL: < 1	Age 45–64: 2	Black: 1
PCN/Other: 0	Unknown: 2	Age 65+: < 1	NA/AI: 1
Private: 3			> One Race: 0
			Unreported: 11

FPL = Federal Poverty Level

ENTERPRISE VALLEY MEDICAL CLINIC

The Enterprise Valley Medical Clinic (EVMC), established in 1983, provides primary and preventive care to a service area spanning a 40-mile radius in rural southwest Utah. EVMC serves individuals living in the Washington County towns of Enterprise, Central, Brookside, and Veyo and the Iron County towns of Beryl, New Castle, Modena, and Lund.

In 2008, the EVMC served 2,465 individual patients, and provided 6,619 visits during the year while supporting over nine full-time equivalent positions in its clinic community.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 45	100 percent or < FPL: 29	Age 0–4: 11	Hispanic/Latino: 14
CHIP: 2	101–150 percent FPL: 17	Age 5–19: 29	Not Hispanic/Latino: 86
Medicaid: 10	151–200 percent FPL: 100	Age 20–44: 29	Asian/PI: < 1
Medicare: 9	> 200 percent FPL: 37	Age 45–64: 19	Black: < 1
PCN/Other: 1	Unknown: 7	Age 65+: 12	NA/AI: 1
Private: 33			White: 89
			> One Race: 0
			Unreported: 9

FPL = Federal Poverty Level

GREEN RIVER MEDICAL CENTER

The Green River Medical Center (GRMC) provides a full range of healthcare services to eastern Emery and northern Grand counties in southeastern Utah. GRMC not only provides care to the local residents but also provides the bulk of emergency medical services for those individuals traveling on the isolated stretch of Interstate 70 running through central Utah.

In 2008, GRMC served 1,527 individual patients, and provided 4,804 patient visits during the year while supporting almost seven full-time equivalent positions in its clinic community.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 38	100 percent or < FPL: 41	Age 0–4: 6	Hispanic/Latino: 17
CHIP: 2	101–150 percent FPL: 11	Age 5–19: 26	Not Hispanic/Latino: 83
Medicaid: 14	151–200 percent FPL: 3	Age 20–44: 33	Asian/PI: < 1
Medicare: 13	> 200 percent FPL: 3	Age 45–64: 22	Black: < 1
PCN/Other: 0	Unknown: 42	Age 65+: 14	NA/AI: 22
Private: 33			White: 75
			> One Race: 0
			Unreported: 1

FPL = Federal Poverty Level

MIDTOWN COMMUNITY HEALTH CENTER

Midtown Community Health Center's (MTCHC) mission is to provide excellent and safe health care to the residents of northern Utah, especially those with economic, geographic, cultural, and language barriers. MTCHC is recognized for its high level of cultural competency and ability to provide affordable, quality health care.

In 2008, the clinics of MTCHC served 25,969 individual patients, and provided 60,060 visits during the year while supporting over 76 full-time equivalent positions in its clinic communities.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race (2007) [percent]
Uninsured: 68	100 percent or < FPL: 36	Age 0–4: 16	Hispanic/Latino: 60

2008 Key Demographics—Continued

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race (2007) [percent]
CHIP: 2	101–150 percent FPL: 12	Age 5–19: 26	Not Hispanic/Latino: 40
Medicaid: 13	151–200 percent FPL: 3	Age 20–44: 38	Asian/PI: <1
Medicare: 3	>200 percent FPL: <1	Age 45–64: 16	Black: 1
PCN/Other: 0	Unknown: 48	Age 65+: 4	NA/AI: <1
Private: 15			White: 35
			>One Race: <1
			Unreported: 62

FPL = Federal Poverty Level

MOUNTAINLANDS COMMUNITY HEALTH CENTER

The mission of MCHC is "Health professionals providing and collaborating with other partners to assure high-quality health care for everyone in our community." MCHC is the only provider in Utah County that offers comprehensive primary medical, dental, and mental health services on a sliding fee scale.

In 2008, MCHC served 10,111 individual patients, and provided 32,397 patient visits during the year while supporting almost 51 full-time equivalent positions in its clinic communities.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 75	100 percent or <FPL: 64	Age 0–4: 14	Hispanic/Latino: 78
CHIP: 2	101–150 percent FPL: 20	Age 5–19: 19	Not Hispanic/Latino: 22
Medicaid: 11	151–200 percent FPL: 3	Age 20–44: 46	Asian/PI: 1
Medicare: 3	>200 percent FPL: 1	Age 45–64: 16	Black: 3
PCN/Other: 0	Unknown: 11	Age 65+: 5	NA/AI: <1
Private: 9			>One Race: 0
			Unreported: <1

FPL = Federal Poverty Level

SOUTHWEST UTAH COMMUNITY HEALTH CENTER

The mission of the SWUCHC is to make lives better in southwest Utah by providing accessible, quality health care, regardless of financial, language, or cultural barriers. SWUCHC serves a five-county area in southwestern Utah, and is the only provider of care in the St. George area that offers medical, dental, and mental services on a sliding fee scale.

In 2008, the SWUCHC served 4,805 individual patients, and provided 13,585 visits during the year while supporting over 18 full-time equivalent positions in its clinic community.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 57	100 percent or <FPL: 64	Age 0–4: 17	Hispanic/Latino: 66
CHIP: 2	101–150 percent FPL: 18	Age 5–19: 17	Not Hispanic/Latino: 34
Medicaid: 24	151–200 percent FPL: 5	Age 20–44: 44	Asian/PI: 1
Medicare: 4	>200 percent FPL: 3	Age 45–64: 18	Black: 1
PCN/Other: 0	Unknown: 11	Age 65+: 5	NA/AI: 2
Private: 13			White: 48
			>One Race: 51
			Unreported: <1

FPL = Federal Poverty Level

WAYNE COMMUNITY HEALTH CENTERS, INC.

WCHC has been offering full-time primary health care services in Wayne County since 1978. Deep canyons and high mountains separate this service area from any

other primary or emergency care provider for 60 to 120 miles. WCHC has built a strong reputation for delivery of high quality services to this economically depressed and isolated area.

In 2008, WCHC served 3,899 individual patients, and provided 15,068 patient visits during the year while supporting almost 26 full-time equivalent positions in its clinic communities.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 42	100 percent or < FPL: 29	Age 0–4: 8	Hispanic/Latino: 2
CHIP: 7	101–150 percent FPL: 13	Age 5–19: 29	Not Hispanic/Latino: 98
Medicaid: 5	151–200 percent FPL: 10	Age 20–44: 27	Asian/PI: < 1
Medicare: 7	> 200 percent FPL: 39	Age 45–64: 22	Black: < 1
PCN/Other: 0	Unknown: 9	Age 65+: 14	NA/AI: < 1
Private: 39			White: 96
			> One Race: 0
			Unreported: 2

FPL = Federal Poverty Level

WASATCH HOMELESS HEALTH CARE, INC. FOURTH STREET CLINIC

The Fourth Street Clinic helps homeless Utahns improve their health and quality of life by providing high-quality health care and support services. WHHC principles include the fact that good health is necessary for maintaining a job and stable housing; that affordable health care and housing are basic human rights; that compassionate and respectful health care is delivered to all Fourth Street Clinic patients; and that ensuring affordable health care, housing and other basic life necessities will break and prevent the cycle of homelessness.

In 2008, the Fourth Street Clinic provided health care to 5,723 individuals.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 84	100 percent or < FPL: 93	Age 0–4: 4	Hispanic/Latino: 19
CHIP: < 1	101–150 percent FPL: 1	Age 5–19: 6	Not Hispanic/Latino: 81
Medicaid: 13	151–200 percent FPL: < 1	Age 20–44: 50	Asian/PI: 1
Medicare: 3	> 200 percent FPL: < 1	Age 45–64: 39	Black: 8
PCN/Other: 0	Unknown: 5	Age 65+: 2	NA/AI: 4
Private: < 1			White: 70
			> One Race: 0
			Unreported: 17

FPL = Federal Poverty Level

UTAH NAVAJO HEALTH SYSTEM, INC.

The mission of UNHS is to make a difference in the quality of life for all community members by providing high quality, comprehensive primary and preventive health care in a culturally and linguistically competent manner while maintaining fiscal viability. UNHS operates clinics in San Juan County, Utah and Tonalea, AZ, and is a major provider of health care to Navajo Tribal members living in southeast Utah and adjacent "Four Corners" locations.

In 2008, UNHS served 11,760 individual patients, and provided 53,660 visits during the year while supporting over 129 full-time equivalent positions in its clinic communities.

2008 Key Demographics

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Uninsured: 44	100 percent or < FPL: 62	Age 0–4: 12	Hispanic/Latino: < 1
CHIP: 1	101–150 percent FPL: 11	Age 5–19: 28	Not Hispanic/Latino: 99
Medicaid: 20	151–200 percent FPL: 12	Age 20–44: 26	Asian/PI: < 1

2008 Key Demographics—Continued

Insurance [percent]	Poverty level [percent]	Age groups [percent]	Ethnicity/Race [percent]
Medicare: 8	>200 percent FPL: 13	Age 45–64: 24	Black: <1
PCN/Other: 0	Unknown: 2	Age 65+: 9	NA/AI: 76
Private: 28			White: 24
			>One Race: 0
			Unreported: <1

FPL = Federal Poverty Level

Senator SANDERS. Ms. Nichols, thank you very much.

We have been joined by Senator Harkin of Iowa, and I want him to say a few words because he has perhaps, more than anybody else in the Senate over the years, been the leading exponent for disease prevention and primary health care. Welcome, Senator Harkin.

Senator HARKIN. Thank you very much, Mr. Chairman.

Senator SANDERS. Do you want to say a few words?

Senator HARKIN. No. I don't want to interrupt. I am sorry I am late. I had a previous engagement. I wanted to be here. This is so important.

Senator SANDERS. Let's just begin the discussion. Let's all take a deep breath and we will do it informally. We're among friends here.

[Laughter.]

Let me start off. I want to go to Dan Hawkins for a minute because he made a very profound statement a few moments ago. He talked about the potential of the saving of hundreds of billions of dollars through the expansion of community health centers as we keep our people well. People are healthier. The system spends less money. It's kind of a no-brainer in terms of wanting to go forward. Dan, why would we save so much money by, if Representative Clyburn and I are successful, putting a community health center in every underserved area in America? Where does the savings occur?

Mr. HAWKINS. Senator, where they occur most profoundly is in the quality management of the care and the health of each individual patient that they serve. Health centers, No. 1, emphasize prevention, both for children, childhood check-ups, immunizations, for women who are pregnant, good, quality prenatal care, they have lower low-birth weight rates and lower infant mortality rates. Studies have shown that rates are 40 percent lower in communities that have a health center than they are in similarly situated communities that do not have a health center.

And perhaps most importantly in this day and age, when chronic illness is such a major cause of health care spending, health centers have learned to engage the people they serve. I don't like the word patient because it implies dependency. It's really a co-dependency in a collaborative relationship between a provider of care and the individual receiving care. The individual receiving care has to understand their condition, has to take charge of that condition, embrace it, and understand if they have diabetes or high blood pressure, congestive heart failure, they may well have—now HIV and many forms of cancer, which instead of being a fatal diagnosis now are more likely to be a lifelong condition diagnosis. Take

charge, embrace that condition, understand how to manage it, to self-manage their care. Health centers provide glucometers to diabetics, blood pressure cuffs to hypertensives, tell them to go home and measure your particular indicators, call us every day, provide that information, and come back for regular planned visits and group visits. Actually, I think that John Matthew and Lisa could probably speak more profoundly to this from the real world, but this is what we know health centers do. By doing that, they avoid the need for much of the specialty care and repeat services that are needed. They avoid the need for in-patient hospitalization and they take people out of the emergency room, which is the absolute worst place for people to receive primary or preventive care, most costly and least effective.

Senator SANDERS. OK. Why don't we stay on this issue.

Ms. BASCETTA. I have a comment.

Senator SANDERS. Yes.

Ms. BASCETTA. I want to make three comments. One is that there was a study done a few years ago that noted that while health centers provide care that is equivalent to other providers across the country, that in some situations in chronic care, they weren't performing as well as some integrated systems such as the VA, and the hypothesis was that better health IT at the health centers would enable them to perform better because that was the competitive advantage that the VA has. So I would like to note that the stimulus does provide money for IT. It's not a panacea, necessarily, but it's a very important piece for measuring outcomes across the course of a chronic disease.

The second thing I want to mention is that, and I sort of hesitate to say this, but prevention—everybody wants to do prevention. It's absolutely what you want to do. You do want to avert the cost of failing to take care of people early in the disease, but from a system perspective, overall, most of the studies show that when you prevent certain diseases, people eventually will live to develop something else. So it doesn't necessarily control costs in the long run.

Senator SANDERS. We all hope at 100 to develop something else. I don't know if that's a criticism?

[Laughter.]

Ms. BASCETTA. No, it's not. I just want to point it out. The other thing that I would point out is that on the cost-saving issue, it's correct that many of the studies show important costs from things like emergency room diversion. We have some concerns that the more that health centers expand, the more Medicaid costs will increase. Now that's a good thing, because it means people are getting care. So rather than think only about the cost savings over all to the system, I would prefer thinking about the importance of building on the infrastructure that community centers have established to be a vehicle for using the public insurance that we have, Medicaid and Medicare.

Senator SANDERS. Thanks very much. Further discussion?

John.

Dr. MATTHEW. Senator, I would make the point that I have been around in medicine long enough to see preventive medicine work. We now have a radically reduced rate of strokes and a radically re-

duced rate of coronary heart disease, heart attacks because of risk factor control. It's not a short term phenomenon. It is years of good blood pressure control, good cholesterol control, and salt control in the diet. The American Heart Association says if everybody ate a no-added salt diet in the whole Nation, we'd have 25 percent less cardiovascular disease and stroke. If everybody ate fish twice a week or fish oil every day, we would have 20 percent additional reduction in cardiovascular disease and stroke. Middle-aged men who ate two grams of fish oil a day reduced their risk of sudden death to one-sixth of what it would be. Men with highest levels of vitamin D who have prostate cancer, have one-sixth the chance of dying from that cancer compared to men who have the lowest levels. There is a lot of room to do preventive medicine.

Senator SANDERS. And you feel that community health centers are in a position to do that?

Dr. MATTHEW. Absolutely.

Mr. EVANS. Senator, may I add an oral health point here? It is somewhat indirect but it is rather pertinent.

Senator SANDERS. Yes.

Mr. EVANS. A recent study in California, indicated that in California emergency rooms, there were over 200,000 dentally related emergency visits. The cost translation to that emergency room system of California hospitals was in the multimillions of dollars. Again, were there are better points of access, that would be a major cost savings.

I would also like to point out that that study indicates that there are 51 million school days lost by children for dentally related issues in our system and 146 workdays lost by workers in the United States over dentally related issues. Were there more access points in the system, many of those being provided by community health centers, those statistics also represent major savings in the United States, and in terms of the workforce, increase the productivity of that workforce.

Senator SANDERS. Representative Clyburn.

Representative CLYBURN. Thank you very much, Senator. I would like to make two quick points before I go back to the other side. I don't want to wear out my welcome over here.

[Laughter.]

Two things. First of all is this. I am a former public school teacher. I started out my career as a public school teacher and I know dental care is something that we have to be very concerned about. There is something we never talk about, but that I have seen a profound impact on students being able to do well in school. It's called vision care, and I think we never talk about it. If you talk to any public school teacher, especially first or second grades, they will tell you that a lot of time students fall behind and never catch up simply because they don't know that they can't see or don't see well. So I want us to start a discussion, and community health centers would be great with that.

Second, on yesterday, I met with my hospital association, and I was shocked when they told me how much they are supporting our efforts here, Senator Sanders. And they tell me the main reason is because Federal law currently dictates that their emergency centers must provide primary care for those who can't afford it. And

they said to me that is the worst possible thing to take place. And they would love to get these people out of the emergency rooms and out into the community health centers. So my hospital association told me they are ready for us to get these bills passed. Thank you, Mr. Chairman.

Senator SANDERS. Other discussion?

Yes, Dr. Mullan.

Dr. MULLAN. If I could say just say a word about the future that we might envision with these bills passing. The relationship between training and careers in community health centers in the past has been a little shaky. For a long time the National Health Service Corps and community health centers ran on totally separate tracks. It's only been more recently where there has been a vigorous effort to use the National Health Service Corps to staff health centers.

The notion that we had far more National Health Service Corps people in health centers, and that in fact, training could take place in health centers, so it becomes not just something that you do to pay off a loan, it's something that is seen as a career, as a culture of medicine, not as a side bar, but as a main line activity, is very, very important. And I think running it at very low levels—National Health Service Corps, as I mentioned before, I've always called it a pilot program even though it is 40 years old. There are today 4,000 people in the field serving in that National Health Service Corps, about half of those are physicians.

There are 800,000 physicians in America. So right now, one-quarter of 1 percent of physicians are in the National Health Service Corps. That is a pilot. That is a demonstration, and that's after 40 years of proven effectiveness.

So what you envision in taking this out of the nice experiment into the main line, with teaching, with residency programs, with careers, with leadership training, really is revolutionary and terribly important. I commend you for it, and if we can get it, it would be terrific.

Senator SANDERS. Thank you. Let me tell you a funny story. Senator Harkin, you will be interested in this.

David Reynolds, who is sitting behind me, founded the first federally qualified community health center in Vermont, and is now on my staff. He and I went to Dartmouth Medical School a few weeks ago, and our purpose was to explain to the medical school that we tripled the funding for the National Health Service Corps, and we would like them to do everything they could to advertise that fact to their students to get them involved in primary health care.

What we learned from some of the young students, medical students was, they said that when they told their fellow students that they were going into primary health care, their fellow students looked at them in shock and assumed that they were dummies doing bad on their tests. They could not understand why would you go into primary health care and earn substantially less money than those who were going into specialties?

That's where we are today. The most important work is disparaged. So I did want to mention that and certainly agree with you,

Dr. Mullan, we've got to get out of the pilot project phase, which has now gone on for 40 years.

I would be remiss in not mentioning, obviously that the founder of the whole concept of community health centers is not with us today, but is the Chairman of this committee, Senator Kennedy. His work is so greatly appreciated.

So getting physicians and getting dentists, of course, out into areas where we need them is a major priority that many of us are working on.

Senator Harkin.

STATEMENT OF SENATOR HARKIN

Senator HARKIN. Thank you very much, Mr. Chairman. And thank you for calling this hearing. As we have discussed many times, this is an intense area of interest of mine. As we are looking ahead to having a health care reform bill this year, if you could draft—not the whole bill perhaps—but if you could draft a part that would be for prevention and wellness, which is what I am doing with the working group, how would you fit in these two elements: federally qualified community health care centers and the National Health Service Corps? How would they fit? How would they be structured so they could continue to not only get operational money, but expansion money?

That's always been a battle, as you know, the money we provide—if it's for new construction, then we don't put enough money in there for the operational requirements for existing centers. So how do we structure that to make sure that we can grow federally qualified community health care centers, and also keep the operational structure intact and supporting those that are there? The ones that are there are going to need increases every year, not just cost-of-living, but a lot of them now need to expand their services to dental and a lot of other things that they did not have in the past. That's one element.

The second is just what we just touched on, and that's the National Health Service Corps. How do you structure that in health care reform?

I think that these are just two elements which we've got to address. We are wrestling with it right now, on exactly how we structure it.

So you are the experts. How would you structure it?

Dan.

Mr. HAWKINS. Thank you, Senator. I have to say I know you struggle every year, but I marvel at your success, in managing to produce additional resources to grow these and many other vital public health programs across the board, so my hat's off to you, and the hard work that you do.

First of all, I think an important way to look at this, and this in the context of health reform, is we are talking about investments that produce a return. I mentioned earlier that health centers last year saved the health care system $18 billion. I did point out that their expenditures at that point were $8 billion. That's still a two-for-one return on investment.

And by the way, more than a third of that was Medicaid spending, that Ms. Bascetta mentioned, of which health centers pulled

down $3 billion in Medicaid revenues last year, and sent back to Medicaid through State agencies and to the Federal Government more than $6.5 billion. Again, a two-for-one return on the payments that Medicaid agencies made for care provided.

We have to think about this. Our centers provide personal health care. National Health Service Corps clinicians, by and large, provide personal health care. But as I know you both know, Senators Sanders and Harkin, and everyone at the table, it's got to be about more than personal health. It's community health. It's population health.

Right now, the first confirmed case of swine origin flu was—a confirmed case now—was identified at a health center. But I know my own health center in Brownsville, TX is sitting on 30 cases of suspected flu. They are linked at the hip with the local health department down there, ensuring that the community is going to get preventive measures that they need to avoid spreading that contagion further than it has already spread, to track and contain it. You have to be about population health.

One of the most important things Jack Geiger, one of the founders of community health centers, said was, "Yes, it's care patient by patient, but it is so much broader than that. It's got to be about the whole community." There are resources you have to put in, Senator, but what you also look at is the return you get.

Senator HARKIN. I want to ask Dr. Mullan about this too, the National Health Service Corps, and anyone else who has a thought on this. We are going to have a national health program. We are obviously going to have a lot of price plans out there and whether there is a connector or not, like the Massachusetts system, we don't know. But it's been my thinking that we must insist that any plan that anyone might want to get that comes into this system must provide that they can exercise that plan at a community health center.

Mr. HAWKINS. Oh, absolutely.

Senator HARKIN. And that services are fully reimbursable at any community health center—as it is now. As you know, anyone can go to a federally qualified community health center now, under a private plan, or whatever, and they will pay for that. But we have to insist that somehow that's part of every plan that is allowed into the system.

Mr. HAWKINS. You are absolutely right. I mean I suspect that reform would have network adequacy standards. And one of the worst things that could be allowed in the absence of those strict standards, is that some plans may choose not to contract with community health centers as a way of redlining the very people we are working——

Senator HARKIN. You see, that's why we have got to have that.

Mr. HAWKINS. That's right. We can't allow that to happen. It's a form of discrimination that occurs too much today in the private insurance system. With insurers looking for young healthy folks and avoiding in every way they can, folks who are sicker and in need of greater care. That's one of the things that we've got to do, and as you said, full participation and adequate payment. Folks have got to recognize the kinds of services health centers provide—I know John's center does, Lisa's center does, Yvonne's center does—

services like outreach into the community, health and nutrition education. I am talking about making the medical care they get effective. Making it work. For a pregnant woman, understanding how to take care of herself during pregnancy, in order to ensure a positive outcome. That costs money. That's care management, it's patient management, but oftentimes insurers, especially private insurers, won't reimburse it.

So full participation is required and adequate payment, that is vitally important. The only programs that do that today, Senator, in response to your point about a public plan, the only payers today that recognize the unique needs of the people that health centers serve, and provide benefits accordingly, and the only payers that recognize the unique safety net role that health centers play and reimburse them accordingly, are Medicare, Medicaid, and SCHIP, public programs.

To me, and to all of us, there is great value.

Senator HARKIN. Dan and Mr. Chairman, I would like to work with you, to work together to make sure that in this health reform it is adequately reimbursed, for any plan that comes in has to have that in its plan.

I want to get into the National Health Service Corps. That's another part.

Yes, Dr. Matthew.

Dr. MATTHEW. I would make the point that you have to invest in efforts of community education. I put up on the dias behind you sir—we have a newsletter, we have a series of the public classes on topics of importance to the public. We have people on our staff called community resources. We have always had a dietician. You can not do all of the medical care on a one-on-one encounter in an exam room or the one person who is in the hospital. We have an effort by the staff to get people a ride, to be sure they are signed up for their insurance. That sort of thing. But on the other side, the public education and patient education are terribly important.

Senator HARKIN. Of course, I have another idea for that that I am thinking of incorporating. And that is that we should have a federally qualified community health center establish an outreach program at every public school within its region. But that's for another time. I hate to take any more time, but the National Health Service Corps, how do we incorporate them in this health care reform bill?

Mr. MULLAN. The question is a good one because standard medical education, as we all know, and dental education, is fairly narrow and it tends less to the issues of prevention, population health, and community health, both at the medical school level and in residency. What the opportunity of an enhanced National Health Service Corps, community health center initiative affords is really impacting that education system in several ways.

One is that traditionally it's been hard for the National Health Service Corps to work with the people it gives awards to until they actually come on site. But going back into the pipeline, and doing a lot more power education where there would be summer clerkships, and there would be residency opportunities for people who are headed to health centers even along the way.

The building of teaching community health centers where population health would be part of what they learn, would be essential to creating the kinds of doctors that we need.

And this finally gets to this whole notion of changing the culture of medicine. This is the specialty, community health, and this puts air under the wings of the idea that we would really have a major part of health education in medicine, dentistry, and nursing in this country, focusing on prevention, outreach, population health for folks who are headed into that practice setting with prestige. This gives you the opportunity to really put a brand on what they're doing and not at something, again, that they did just to pay the bills—it's something they did because that's where they want to serve.

Senator HARKIN. A cardiologist friend of mine said just recently, "Look, we really need more primary care doctors. And the only way we are going to get them is you have got to pay them more."

There are two ways of payment, there's back-end payment and front-end payment. We can control and we can do something about the front-end payment. And that is, if you want more primary care doctors, why don't we just pay for their education? Pay for the whole thing? Pay for everything. That's front-end payment.

That, I think is something else I would like to see incorporated, but my time is up.

Senator SANDERS. Senator Merkley.

Senator MERKLEY. Thank you very much, Mr. Chairman. I wanted to explore a couple other points.

One is how the health care centers serve as a gateway to more complicated medical treatment that might involve specialists. Ms. Davis, your story may provide an example of this. Your brother had a heart attack, if I understood correctly?

Ms. DAVIS. Yes.

Senator MERKLEY. So he got care for that heart attack. I'm imagining he did not have insurance. If that's the case, how did the health center work with heart specialists to ensure that he got the treatment that he needed, and how did the finances around that work?

Ms. DAVIS. Actually, what happened was, when my brother was diagnosed that he had had a heart attack, I immediately went to the emergency room. I knew, he knew that he was uninsured. We had no idea what was about to happen. I went there and asked for the patient assistance program, and we had to sign documents and complete the paperwork because they didn't want to dismiss him. Well, actually, I was not going to take him home—let him go home. And it turns out that he had a quadruple bypass. He had a 96.7 percent blockage. The doctors told them he would have lasted about 48 hours, but when they told him what surgery he had to have, family members came in because we knew he was only eligible for a certain amount of patient assistance.

So instead of having to mortgage his home, his siblings—we in turn—had to borrow money to help. But the rest of it, more or less, was paid for by taxpayers because, unfortunately he was in the intensive care unit for 6 days, and then in the hospital for an additional 5 days. But that was the way—we had no other choice. We had to put our necks on the line in order to make the payment.

Senator MERKLEY. Yes, I want to broaden the discussion to the issue of how—thank you very much for your personal example. I think it really helps illuminate the issues that we face and to broaden the question to other folks who would like to comment on how this works, how it should work, how it can work, how it does work currently?

Ms. DAVIS. I would also like to add that when he was discharged from the hospital, the community health center made arrangements for him to see a local internal physician, and then he himself had a personal connection with a cardiologist, and then they got it set up so that he could be treated by him as well.

So it was this ongoing effort by the community health center that helped him get what was locally available to him in Marion. Because Marion County is without a lot of specialists, so we had to do what we had to do to make it happen.

Ms. NICHOLS. We provide comprehensive primary care, but as you might imagine, we often detect people who need specialty care services. Our community has been enormously generous. We have 370 specialty care providers in a volunteer provider network who have each agreed to donate one to three visits monthly and donate about $2 million in care annually. That's wonderful, but that generosity can only go so far. For example, we have an orthopedic surgeon, who spends 2 days a month in our office and another 2 days of surgery donated by the hospital, donated by him. We still have to pay his malpractice insurance. It's a great benefit for the community, but we would love to see services somehow expanded to include FTCA for specialty care providers. That would just help us enormously.

Senator MERKLEY. The health care center plays a huge role in facilitating donated services, and an individual, a poor individual, would have no chance of knowing how to reach that gateway, if you will, to access care for a complicated medical circumstance.

Ms. NICHOLS. Exactly. We have case managers who do that. We have to have them placed in the emergency department and in the local school system.

Senator MERKLEY. Now, Ms. Nichols, I think you mentioned that you had to turn away patients. How do you make decisions as a health care center, who you provide services to, and who you do not provide services to, when the demand exceeds the capacity?

Ms. NICHOLS. It's very difficult. We have created some priority groups. We always take children under the age of 19, pregnant women, individuals with HIV/AIDS, individuals with mental health issues. We are pleased that in August, because of the stimulus funding, that we will be able to open our doors again. We hope! We don't know how soon we will be turning patients away again, but we will be opening our doors again.

Senator MERKLEY. You are completely closed down right now?

Ms. NICHOLS. Other than those groups that I mentioned.

Senator MERKLEY. He means opening the door to new people?

Ms. NICHOLS. Oh, I am sorry. Yes. Yes, we are not closed down. We accept those patient populations that I described. Other than that, we are referring them elsewhere.

Mr. EVANS. I would like to offer an example, if I may, Senator?

Senator MERKLEY. Please.

Mr. EVANS. Health care centers also provide a unique opportunity for physician-dentist interaction. Take, for example, a diabetic patient, we know that there are associations between periodontal diseases and diabetes, for example. That diabetes exacerbates periodontal diseases, and periodontal disease, in turn exacerbates diabetes in terms of glycemic control. And that's understandable, as I said previously, the jaw bone is connected to the toe bone. If you think about it forming an infection anywhere in the body, that will, in fact, exacerbate the effects of diabetes.

Health centers have the option of working with their diabetic patients in terms of that referral and the results of that referral, and that interaction is better control of diabetic conditions, and consequently it is not only lifesaving, it's morbidity saving as well, and cost saving, as a further example. That interaction is also an important one, I think, at the community health centers.

Senator SANDERS. If I could just pick up on a point that Congressman Clyburn raised and Dr. Evans raised a moment ago, and that is getting primary health care to young people in schools, school-based health.

I will tell you a personal experience. We started a dental clinic in a low-income school in the city of Burlington, which is now treating kids all over the city and has been hugely successful. We have one in Bennington. We are expanding one in the northern part of our State as well.

Does bringing health care and dental care to the kids at school, so they do not miss the days that you were talking about—stay home because of dental problems—is that something that is worth exploring?

Ms. Davis, do you want to address that?

Ms. DAVIS. Yes. As I spoke about it earlier, school-based clinics, when I was on the PTA at the high school in Marion. One of the things that we're experiencing now is that, after we met with the local hospital, we found that they are getting a high number of teenaged pregnant students that go to the hospital that are now almost in their fifth trimester, where they've had no prenatal care. When we were in the high school there, we educated the young girls and we talked about it. Congressman Clyburn spoke about the vision care, we had all means of expertise to come in with us.

Senator SANDERS. This was an opportunity for a physician or a medical person to come in and talk to young women about sexuality and so forth.

Ms. DAVIS. Yes, and as a PTA person, we had the parents to come in and they witnessed how the numbers dwindled as to the success of the school-based clinic.

Senator SANDERS. Excellent. Let's wait on that one.

Ms. Nichols.

Ms. NICHOLS. We actually just opened a school-based clinic on April 6. We did that in conjunction with our local hospital, Intermountain Health Care, who funded it because they recognized that so many children were coming to the emergency department for nonemergent needs. So we don't yet have a lot of experience, but we are working closely with the school case managers and counselors. Whenever a child misses school, we will be on the phone

with them scheduling an appointment and we hope to have excellent outcomes.

Senator SANDERS. John, you have a relationship with Cabot High School, don't you?

Dr. MATTHEW. Yes, we have a school-based clinic and have for about 16 or 18 years in Cabot for the school kids, but also for anybody in the community that wants to come. So that puts us out about 15 miles further into the hills.

I also want to point out that we are going to be the base for a dental van, it's called the Care Mobile, that will go around to other FQHC areas in our State to take care of kids and teens who don't have dental care. In one of our rural towns, about an hour from us, there are 1,200 kids with a Medicaid card, good for all the dental care they need through the age of 21 in Vermont, and no dentist to see them. So we are going to be, quarterly, back in town, for about a month each time.

Senator SANDERS. Any additional thoughts on school-based clinics?

Senator Merkley.

Senator MERKLEY. I wanted to take the conversation to a different area.

Dr. Mullan, I believe you mentioned that we have enough physicians, it's the challenge of re-deploying them. Did I hear that correctly?

Dr. MULLAN. Yes.

Senator MERKLEY. I wanted to turn to the issue of recruiting providers, and I understand that the loan repayment program and scholarship program, under NHSC, there are currently a large number of vacancies for certified nurse midwives, 62, nearly 1,000 vacancies for nurse practitioners, 64 vacancies for psychiatric nurse specialists. Are these vacancies a result of a lack of funding for scholarships or lack of applicants because we are under supplied?

Dr. MULLAN. I did take the opportunity, as I mentioned, to do some homework yesterday, talking to people in the program, and they told me the following: in the last round of scholarship and loan repayment awards, there were roughly 1,000 applicants—this is across disciplines—for scholarships and they were able to award 100. And in loan repayment, there were about 2,800 applications, they were able to award about 800. There is an eagerness, and this is an environment which many students know that there is relatively little chance they are going to get an award. If there was a sense that there are awards available, one suspects that the application numbers would go way up.

Senator MERKLEY. In exchange for the loan repayment and the scholarships, there is a service commitment. Could you describe or elaborate on those types of commitment?

Dr. MULLAN. On the scholarship, the law has been since the beginning, it is a year for a year, with a minimum of 2 years. You incur a year of obligation for every year of award. So typically, if it's a 2-year award, you serve for 2 years, although the evidence is that the majority of people placed by the scholarship or loan repayment stay in the community longer, sometimes for careers, and other times work at other health centers or other underserved areas. So it's been quite positive in terms of the movement of peo-

ple from areas that are higher density to ones that are lower density in general.

Senator MERKLEY. So this is a program we should really look at trying to fund at higher levels?

Dr. MULLAN. It would be, I think, critical both to the success of the community health movement, and Dan could speak to this better, but even at the current level, there are very substantial vacancies in health centers for physicians, dentists, nurses, and others, and at the expanded levels, unless we have an instrument that will move personnel along with building health centers, you are going to have great buildings that are empty.

Senator MERKLEY. Thank you.

Senator SANDERS. Well, Senator Merkley, I mentioned, as I said earlier, in the stimulus package, we tripled funding for the National Health Service Corps and the legislation that we are discussing this morning we would increase it by 10 times.

Yes, Ms. Nichols.

Ms. NICHOLS. I know there is discussion of changing the deadline dates of the National Health Service Corps. At this point you can apply once a year, and that certainly has been a barrier for us because those medical providers don't always look for jobs just once a year.

Senator SANDERS. That has changed. The reason for that is they didn't have enough money to accommodate the applicants, but right now I believe they will be around every 2 months. It will be a rolling period. So I think you are going to be able to apply at any time. Because now, they have the money to begin to provide the debt forgiveness and the scholarships.

Mr. EVANS. May I suggest that recruitment and the promotion of those opportunities be very, very early because, per the example you provided earlier, Senator, late in the educational career is really too late. It has to be done day one, and it should be done minus day one.

Senator SANDERS. Absolutely. We're thinking of trying to get the information out to college students who are thinking of going to medical school or dental school.

Yes, Dr. Mullan.

Dr. MULLAN. One other affiliated point. There are numerous studies in medicine and in some of the other health professions that show that students enter with high levels of idealism and we beat it out of them.

[Laughter]

Senator SANDERS. What a process.

Dr. MULLAN. This goes in medicine, through medical school and in through residency. I mean the low point of cynicism is probably residency years and then it goes along wounded, and late in the career you see the optimism and the positive attitude that come up a little bit. That is a little bit of a phenomena and careers and mortgages and all that, but a lot of it is what we do, in the absence of opportunities to express positive careers.

We see right now across the health professions an explosion of interest in global health. People are sort of scratching their heads, what is it? The globe has always been out there. The illnesses have always been out there. The missionary spirit has always been out

there. I think that for a variety of reasons, the seriousness of the HIV world, and what we see in images coming back, it is picking of off the idealism.

But one of the reasons is, frankly, students don't see the opportunities here. And what this double set of up-funding promises is building, once again, a sense of, "I can do this in America." We have an unfinished mission and doing primary care community health can make a huge difference. I don't need to go to Botswana. I can do it in northern Vermont, etc. It's a little bit of smarmi pictures, but I think it's very real.

Senator SANDERS. One of the absurdities of the current situation appropriately related to what you said, Dr. Mullan, in terms of nursing. You talked about globalization. Do you know where we get many of our nurses from right now? We get them from the Philippines. So we are depleting struggling Third World systems, taking their professionals into our country, because we are not producing the doctors, the dentists, the nurses that we need. So it's a reverse globalization, if you like.

Mr. HAWKINS. Senator, I also wanted to add, especially in light of your point about what you heard from the students at Dartmouth, and Senator Harkin's point about the question of how do we re-elevate the value and the position of primary care within our health care system? You talked about the 2,000 or 4,000 clinicians in the Corps today, but really if you think about it in terms of medical school and residency fits, it's not just one-quarter of one percent, but it might be less than 2 percent of residents across the country are actually on loan repayment or scholarship.

But if you can grow the National Health Service Corps to the size, Senator, that your bill portends, a much higher proportion of—now they are going into medical schools. They are going to go into medical schools and offer loan repayment to those who didn't take scholarships before they begin their residency, to pick them up in their third or fourth year of medical school. What you will see is a much greater proportion of medical students going into primary care as a residency and career choice, and as you do that, Senator Harkin, yes, we've got to improve the payment for primary care because it is well below what it should be, just to be appropriate, but it won't be a king's ransom that has to be paid. You will have more folks coming out of the training pipeline, ready to go into primary care. Several years ago we partnered with an osteopathic medical school to create the first community health center-focused dental school in America, in Arizona, that is now pumping out over 60 dentists every year, the vast majority going into practice at a health center in oral health.

Two years after that, we partnered with the same school to create one of the most recent osteopathic medical schools in America, with more than 100 students who spend 3 of their 4 years of medical education in a community health care center-based setting. Although it hasn't graduated its first class, and as a result its students didn't qualify for help from the National Health Service Corps, it will next year. And more than 100 medical students every year will be coming out, going into residency and we believe the vast preponderance, going into practice in community health centers.

This is what we need to do, target the support that is going to be provided as the National Health Service Corps does, on two things: primary care; service in underserved communities. Those are the two great needs.

Senator SANDERS. Dr. Matthew.

Dr. MATTHEW. Senator, I make the point that we have got to get at medical students very early on. Our doctors are all on the faculty of the University of Vermont and I'm on the faculty of Dartmouth. We get first-year students out for a thing called "Doctoring in Vermont." They are obliged to come about six times and then three times towards the end of the year. Some of them come every week. We really try to track them and make them feel welcome and include them in our medical staff, so to speak. We also teach third and fourth year students, usually for about 3½ weeks at a time, but I think that's a bit late in the game. I think we need them early on so they get oriented to this and know that there can be excellent practice in the periphery. It's not all public health. It's having the individual physician to be, recognize that can be good work, done well, and that you don't have to be in an academic institution to do that.

Senator SANDERS. I think we are going to wind down, Senator Harkin, do you have any last thoughts you want to share?

Senator HARKIN. I want to thank everyone here. As we are working on this health care reform we need your best suggestions on how we structure this to accomplish the ends that we've all talked about and that Senator Sanders has taken the lead on. We don't want to miss this boat. This ship is moving and we want to get onboard. We want to make sure that we restructure it properly.

Senator SANDERS. Let me just concur with Senator Harkin and say this, I think because of the work that all of you have done, and many thousands more around this country, there is a growing understanding and we are seeing it manifested in the funding levels here in Congress, that we need nothing less than a revolution in primary health care. That it's absurd that 60 million Americans have no health care home, that even more lack a dentist, that there is so much unnecessary human suffering because of the crisis of primary health care, and then to add insult to injury, we are wasting hundreds of billions of dollars because we are not keeping people healthy, and giving them access to primary health care. So I think we are beginning to change the paradigm and as Senator Harkin indicated, we need your continued help and support to move the ball forward. I think this has been a productive hearing.

Senator Harkin, thank you very much for all of your contributions, and all of the members of the panel, thank you so much for being here.

Thank you.

[Whereupon, at 11:31 a.m., the hearing was adjourned.]

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