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**A New Plan to Expand Health Care Access in America for  
People Who Can't Find a Doctor to Care for Them  
National Association of Community Health Centers  
March 12, 2008**

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**DAN HAWKINS:** Good morning to all of you. I'm Dan Hawkins, policy director for the National Association of Community Health Centers. And I want to thank you for joining us today to learn more about our latest report, ACCESS CAPITAL. I want to begin though by, where did Oliver go, by thanking Oliver Kim from Senator Stabenow's for multiple, multiple activities that he has done on behalf of health centers in Michigan and all across the country. Oliver works with Senator Stabenow. He managed to help us get this room today for today's briefing.

Also I should note that Senator Stabenow is the leader of the Stabenow Bond Letter, a letter supporting a \$248 million funding increase for the health centers program in the next fiscal year, which now has better than 40 co-signers on it already. And I might add one other thing. Senator Stabenow is also lead sponsor of legislation here in the Senate, I think it's S. 2270 which would allow health centers to take advantage of a critically important capital infrastructure financing program, the HUD mortgage insurance program. The report that you have, ACCESS CAPITAL, speaks more to that bill and the importance of that issue.

I'd first like to begin by thanking our partners, Capital Link, Allison Coleman here from Capital Link, which is

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a program that assists health centers. And Joe McKelvey in the back who works with Capital Link also, assists health centers to put together their financing packages and do the so-called due diligence that any organization, and especially a private non-profit safety net organization that has very limited resources and operates on a thin margin, absolutely must go through in order to make sure that if they're going to finance any activity such as facility expansion or construction, they've got to be able to pay off the loans that they're going to take out, et cetera. And Capital Link does a fabulous job there. And community health centers, Community Health Ventures, where's Glenda? Okay, in the back of the room. Community Health Ventures is a partner with NACHC which assists health centers in securing capital financing among other things. Each of the two groups, Capital Link and Capital Health Ventures have provided invaluable data analysis and assistance in producing this ground-breaking report that we're releasing today.

But before summarizing the report's highlights I'd like to provide a brief background to you on community health centers and their continuing mission of bringing good health care to people in communities who need it most. Today some 1,100 community health centers provide high quality affordable preventive and primary health care to 17 million people

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nationwide, regardless of their ability to pay, in more than 6,000 communities all across this great land. All who seek the care of the community health center are welcomed equally and all are served with professionalism, excellence, and dignity. This small but mighty band of pioneering health care providers has compiled a remarkable record of achievement in providing care of superior quality with exceptional cost effectiveness and efficiency.

Health centers have just undergone an historic expansion spearheaded by the president with strong bipartisan congressional leadership and support, growing to serve 6 million additional people over the past six years. Even with this modest progress, however, the larger health care system as we all know continues to falter and stumble leaving too many in peril.

Now everyone agrees that the current health care system in America is not working. Too much money continues to be spent while the number of uninsured and underserved people continues to rise. And the quality of care quite frankly that people receive continues to be inadequate. Health care consumed nearly \$2 trillion last year, nearly one fifth of our economy, and yet 47 million people were completely uninsured. Despite widespread agreement that improving insurance coverage must be a top priority, one that we totally support, it is also

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clear that insuring the uninsured alone won't automatically solve America's health care problems.

Many of you will remember the heart breaking story in last year's Washington Post about a 12-year-old boy who died as a result of an untreated tooth infection because the family could not locate a dentist who would care for him. One of the most tragic parts about that story was the fact that the young boy had insurance coverage and yet no one could be found who would accept that child's Medicaid coverage and provide care. That story makes clear, as those who work on the front lines of our country's health care system know all too well, that while every American absolutely needs affordable and adequate health insurance coverage they also need a regular source of primary health care, health care home.

A recent report from NACHC and the American Academy of Family Physicians that we released last year found 56 million people, nearly one in every five Americans who have no or inadequate access to primary health care. Those people are America's medically disenfranchised, people with no health care home or usual source of care even though many of them actually health insurance coverage like young Deamonte Driver. It doesn't have to be that way. A whole arsenal of studies has consistently shown, and by the way, every candidate for president be they Republican or Democrat, has agreed that we

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can provide better health care and lower our costs if every person had a regular source of primary health care. The community health centers serve as living proof that providing high quality continuous care to people in communities without adequate sources of health care not only saves lives and narrows health disparities, it generates significant savings to the health care system documented in over \$18 billion last year alone by health centers, while pumping much needed economic benefits into the very communities that most need it.

America's health centers have developed a framework for change. We call it the Access for All America campaign, designed to reduce the ranks of America's medically disenfranchised by strengthening and expanding the existing and new health centers to reach a total of 30 million patients over the next eight years by the year 2015. Once health centers reach those 30 million patients the cost savings that they will generate to tax payers, private payers, and others for the entire health care system will grow to more than \$40 billion annually while simultaneously bringing more than \$41 billion in annual economic benefits and employment as well to the low income communities they serve.

Now, despite the laudable benefits of a health center expansion, significant investments in infrastructure, buildings, equipment, HIT, electronic health records are

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critical to meet those Access for All Americans goals. Nearly all health centers report a need for capital investment now or in the near future. A need that the report today shows to be up to \$10.5 billion between now and 2015. Let me repeat that number, \$10.5 billion. I think we sit here in the Dirksen building where Senator Ev Dirksen once said a billion here a billion there, pretty soon you're talking real money.

Despite the laudable benefits of a health center expansion, significant investments in infrastructure are needed. Unfortunately current programs for capital financing provide a patchwork of options to finance expansion. And getting their help is often difficult, costly, and time consuming. To meet these significant needs a new paradigm of capital financing is needed today. This new paradigm involves three straightforward steps, all detailed in the report, that could give health centers streamlined access to tax-exempt bond and tax credit markets and it would all more than half of all health centers to finance their capital projects immediately at a cost that is more than offset by the overall health care savings that a health center expansion would produce.

Now the Access for All America plan offers a path for meeting escalating health care needs and establishing a system of care that would be crucial to the success of any potential national health reform initiative. America now has the chance

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to make a real investment that will pay off now and in the future. An expansion of health centers would quickly address the needs of the underserved across our nation and constitute a critical first step in transforming our health care system, generating substantial benefits for patients, communities, insurers, governments and tax payers, indeed for all of America.

And now I'd like to introduce three stellar health center leaders from across the country, from the east coast to the gulf coast to the west coast, who will discuss their specific capital financing needs and the challenges that they face and will continue to face in attempting to meet their goals. With us today are Dr. Gary Wiltz, a physician, a national health service scholar and alumnus, who is also the medical and executive director of Teche, that's T-E-C-H-E, Teche Action Clinic, he'll tell you what Teche stands for, a health center serving the rural bayou communities in Louisiana.

Ms. Anita Monoian who is the head of Yakima Neighborhood Health Services in the city of Yakima, Washington, part of apple country, and Jim Luisi who is CEO of the North End Community Health Center in Boston. Let me turn it over now to Dr. Wiltz. Gary?

**GARY WILTZ, M.D.:** Thank you, Dan. Good morning and I bring you greetings from way down south as Dan just mentioned

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to you. Teche Action Clinic is located in Franklin, Louisiana. We're about five or six miles from the Gulf of Mexico so we really are way down south. The word teche is a Native American word that means snake and it was named after the bayou that traverses the community that we serve. Our middle name, as always struck me when I first arrived at our center and in 1982 is a National Service Corps obligee. And I soon found out what the middle name stood for, Teche Action Clinic. And as I was coming here today I was reflecting on the growth that we've experienced and putting this into a perspective of how far we've actually come in the last, in our case over 40 years at our center, as a new movement with the National Association of Community Health Centers.

When you look at what we're about to present to you today to kick off this Access for All America, we termed it in committee when we were discussing this plan as a bodacious plan. You know, really stepping out there looking at the landscape as it is, 56 million disenfranchised people in America right now, not to mention in that subgroup of the uninsured. But 56 million people in this country, a lot of them who have insurance cards, if you will, who lack access to regular primary care. Do not have a primary care clinician to serve them on a regular basis or do not have a medical home that they can call their place of seeking and receiving health

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care. We're talking about adding or serving 30 million people by the year 2015. When I look back, and you look back at the numbers over the last seven years, we've gone from serving 11 million people in this country to over 17 million people.

But we're not content as our middle name says in our clinic, Action, we're not content to what I call run in place. So what do we do? We look at the landscape and we've put together a plan and a roadmap to try and - and let me state unequivocally right from the beginning - we're not billing this as the panacea to solve the whole health care problem. But we do realize and we know from our experience that we are a large part of the solution. We've been at this for over 40 years now. We have a proven track record of providing high quality comprehensive primary preventive care with all the cost savings that Dan has alluded to, that you will find in the report that is being published today.

Louisiana is known for a lot of things as I'm sure those of you who are familiar with our state. Unfortunately we have been at the bottom of the United Health Care Foundation's ranking for the last 10 years. We've been either 49th or 50th. It used to be the same thing going for Mississippi and Louisiana, but we kind of traded places. The one great thing that Louisiana did this last year was that our state legislature appropriated \$41.5 million specifically to

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community health centers for capital improvement. Now we're leveraging that money with new market tax credits and we'll be able to generate over \$88 million worth of capital improvements. Now, what does that mean? That means that over the next three years we're going to be able to serve an additional 186,000 in our centers.

Almost every Parish in the State of Louisiana is underserved and I know all of you are familiar with the tragedies that happened with Hurricanes Katrina and Rita, the forgotten one. The good news is that we realized that we had a problem before Katrina and Rita. So we took due diligence and put out a statewide strategic plan just as most of the states, or all of the states have put together that figured out how much shortages were out there and how much capacity we would need to solve that problem. And that's what this national plan is all about.

When I started out in 1982 at my center we had a staff of about 10, an operating budget of about \$300,000. Right now we have a staff that's close to 100. Our operating budget is close to \$9 million with a payroll of over \$3 million. We're serving almost four times as many people as we once did. Right now we're almost at 20,000 people. But the point is we are now at capacity. We are at the breaking point. We have our next available appointments are almost a month away. We've now gone

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to extended hours. We're opening on Saturdays. We're entertaining even opening on Sundays to try to meet the demand that's out there. Right now we have three major capital projects that are going to be helped to be funded by the initiative that the legislature did. And this is not unique to Louisiana. This is a national problem and once again, if you read the report the critical part is to build that infrastructure. We are the medical homes right now to over 17 million people. And let me tell you, as a practicing physician that has made a tremendous difference in the lives of the communities that we serve. I'm now, I used to say the expression I'm getting old, but now I am old. I'm treating the children of some of my 80- and 90-year-old patients right now and I'm seeing the great benefit that we've had in my lifetime on the communities that we represent.

So as you read the report and I know we'll have a question and answer session afterwards, I just want you to realize that we have the ability to pull this off. And we are excited about this. We are looking forward to it. We are ready to meet this challenge. I want to just caution you, as Dan alluded to earlier, the fact that you have an insurance card does not always buy you access to care. And I can't emphasize that enough. He illustrated the point with the child who died last year with the dental abscess. Well we take

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Medicaid at our center, our dentists take Medicaid. We take everyone without the ability, regardless of their ability to pay. But we are the patient navigators. We are the ones, when they come in we are the ones to figure out how to get the services that people need. And that's extremely important. So in this health care debate, this whole idea that insurance coverage buys access to care, is not true. We deal with it on a daily basis and I can't emphasize that enough. Now, I'm going to end my remarks from the Gulf Coast and we'll bring it to the west coast and Anita Monoian. Thank you.

**ANITA MONOIAN:** Thank you. I'm Anita Monoian and I'm the CEO at Yakima Neighborhood Health Services in Yakima, Washington. We have three sites in the Yakima valley where last year we served 16,000 individuals providing medical, dental, mental health, pharmacy, home health care, and public health services. Of these 16,000 people, nearly 80 percent were from families whose incomes were less than 100 percent of the federal poverty level, and 1,853 of our patients last year were homeless. Our largest and smallest sites are in the metropolitan city of Yakima with a population of roughly 100,000. Our third site, located in Sunnyside, is a more rural community of about 15,000 people and about 35 minutes south of Yakima. Both communities are supported largely by agriculture; thing about those beautiful red Washington apples, the good

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ones come from Yakima [laughter], and by the service industry. In fact in Yakima County only 13 percent of full time jobs pay above the minimum wage. We're not very proud of that.

As you've heard from others there is a tremendous need to expand the availability of primary care across this nation. In fact I can tell you that in Yakima and the surrounding communities we could be doing more to help people in need. Long before the movie we had said, and it has proven to be true, if we build it they will come. And they stand in line and they wait for appointments. The medically disenfranchised are alive but not well in the Yakima valley. However, it takes so much more than just knowing the need is there. My point today is to go through what it takes to expand our operations given the current availability of capital for health centers.

I'm going to start by going over what the national picture is and then I would like to give you a couple of examples from my own center. First, first and foremost, we cannot possibly we cannot reach the 30 million goal of Access for All America initiative without the infrastructure to get there, of which capital financing is a crucial component. Health centers are falling severely short in meeting their financing needs for new and renovated buildings and for health information technology. Most of our health centers operate in buildings more than 20 years old, but many with some as old as

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110 years. Nearly all, 94 percent, of the health centers surveyed report they must rebuild or renovate their facility either to continue or to expand services in the next five years alone. In order to achieve the Access for All America goals, health centers will need to invest, and you heard it from Dan already, \$10.5 billion in facilities and equipment between now and 2015, \$10.5 billion. And the way this year is going, 2015 will be here before we know it.

But what we're facing at this point is capital support available to health centers today is simply not enough. It is fragmented, it is limited. It is difficult to access. It is costly and time and staff consuming. Health centers are currently relying on government funds, foundation grants, and capital campaigns. And if anybody in this room has ever run a capital campaign, and I don't care if it's in a small community or in a very large community, that is a time and a half job and then when you're through with that at the end of the day, you do your regular job. Capital campaigns produce resources that are scarce and insufficient to produce the necessary amount of equity to allow health centers to move ahead.

In the report we are releasing today, and there's a pile of them over there, there are several examples of health centers that have faced these very issues and how they diligently made it through. But not every health center can do

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that. Even the ones that do, have to spend time, money, and effort, time that could have been spent on caring for the people who need our services.

A couple of examples from my current center in Yakima, back in 2000 we saw the need to expand care at our Yakima site. Buildings that were started from two little houses built in the 1930s. Now, we are not the biggest health center in our world, and we don't have the ability to issue tax exempt bonds, but fortunately for us the State of Washington had established a tax exempt bond pool through our health care authority. And in collaboration with four other community health centers around our state we had access to this capital at a lower interest rate than we could have achieved alone. The building addition cost \$3.9 million and we were able to use the State's bond authority to finance 80 percent of that. It was a pretty sweet deal.

Now fast forward to 2008. We're adding dental care at our Sunnyside office. It's about a \$490,000 - well, it's exactly a \$493,000 project, just right at a half a million. But the bond pool is no longer an option for this project. We don't qualify for any of the federal loan guarantees and new market tax credits just aren't an option for a project this small. So we're left with the private market and our local banks. Now, please, please don't get me wrong. We have not

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just a good relationship, but we have a great relationship with our local banks and they've been as helpful as they can be given our size and the scope of this project. But the terms just can't be as good as they could be if we could join together in a national effort and develop a comprehensive strategy on health care financing. Out of curiosity a few days ago while I was preparing these remarks, I asked my accounting staff to add up interest paid on mortgage payments since our first major capital construction back in 1994. It added up to a whopping \$1.6 million in interest, most of it financed through the private market. That could have supported a lot of health care.

The new national campaign structure is exactly what we'll need to do to reach the 30 million patients by 2015. We'll need what we call a new paradigm of capital financing. As for what it should include, there are three components that are absolutely necessary.

Number one, a federal credit enhancement program that can be married with tax exempt bonds. Number two, dedicated tax credits that make health center financing economical, and number three, a single national entity to provide streamlined access to the tax exempt bond market. These three things together on top of technical assistance will allow the majority

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of health centers to finance their capital projects immediately with the rest close behind.

In other words it will result in rapid expansion of health centers throughout the country at very little cost. Once this rapid expansion is achieved the number and percent of medically disenfranchised will fall. And the entire economy will benefit in savings and returns on investment into local and poor communities. One of the things I think is frequently overlooked is what these community health centers put into the local economy and particularly into poor neighborhoods. And at Yakima Neighborhood Health Services a very modest size clinic, we put roughly \$19 million a year into the local economy.

In closing let me thank you for letting me go through the capital financing needs of health centers nationally and to tell you a little bit about what we're experiencing in my community. I know Dr. Wiltz has outlined our large expansion initiative to serve the millions in need today and Jim Luisi is going to go through our comprehensive legislative agenda, but I just want to make a point in saying the current financing available for community health centers today will take longer, cost more, and delay our expansion unnecessarily. The NACHC report, in conjunction with Capital Link and Community Health Ventures outlines the issue very well. And I encourage each

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and every one of you to take a copy from the table over there and see what we will do with the right resources.

Thank you again. And now I'd like to introduce Jim Luisi to talk to you about our legislative agenda.

**JAMES LUISI:** Thank you, Anita. Good morning. I'm Jim Luisi. I'm CEO of the North End Community Health Center in Boston, Massachusetts. Since opening in 1972 we have grown to serve more than 10,000 patients. This Italian-American community has the highest concentration of low income seniors in Massachusetts. Our health center is committed to seniors remaining in the community for their entire lives and receiving their health care from the same medical home. To accomplish this we have built our own nursing home and low income senior housing facility. As the largest employer in the area with 400 employees, we are the community's economic engine, pouring more than \$30 million into the local economy each year. Our success has been through hard work at the local level in partnership with our state and federal governments. As chair of NACHC's legislative committee I would like to present our legislative agenda to you today.

Health centers have undergone an historic expansion in the past few years. Congress has expanded funding, reconfirmed our Medicaid payment structure, and enabled health centers to serve an additional six million people nationwide in the past

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seven years. However, as Dan pointed earlier there is much more that we need to do, both in the communities we currently serve as well as creating access for those who still lack health care. With that in mind our Access for All America initiative has several legislative components that I'd like to discuss and urge Congress to enact.

First and foremost we'd ask that Congress reconfirm and reauthorize the health centers program through 2012. This will give our centers the long-term stability they need to really look to the future. Included in that reauthorization we urge Congress to include specific funding targets for growth that reflect our access plan and also clearly reconfirms the core principles of the health centers programs as mentioned by Dan earlier. Fortunately just such legislation already exists. HES 901, sponsored by Senators Kennedy and Hatch, accomplishes all these goals and has passed the Senate Health Committee late last year. We would urge the Senate to pass this bill as soon as possible. Also the House has legislation, HR-1343 that also does the same thing and it has over 230 co-sponsors already. We would like to see this bill pass as quickly as possible.

In addition to the reauthorization we'd ask Congress to pass funding levels for health centers reflecting the access initiative. We're asking Congress to expand funding so that we can strengthen existing centers and also expand to serve more

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than 1.5 million more people next year. For fiscal year '09 this would mean a funding increase of \$248 million. Letters are currently circulating in the House and Senate supporting this expansion. We'd ask that every member of the House and Senate sign either the Stabenow Bond Letter or the Palone Deal Letter in support of health center funding.

Both the reauthorization and appropriation will reconfirm and revitalize the health centers program, but we also need staff for our centers, and as Dan mentioned before this is becoming more and more difficult in underserved areas. To that end we'd ask that Congress reauthorize and expand the National Health Service Corps and also strengthen the health professions training programs under Titles Seven and Eight of the Public Health Service Act. Health centers very much rely on a diverse primary care workforce and these programs are critical to our continued success. Notice that the next report will come out in the summer of this year on workforce. Look for that.

Under capital financing, in addition to the workforce needed at health centers and as this latest report clearly indicates, we also need help financing our capital campaigns. Anita did a terrific job outlining the current issues each health center faces at the local level. And our latest report goes into additional detail. But in order to meet the

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expansion needs of health centers, we'd ask Congress to pass legislation that makes it easier for health centers to access capital financing. Specifically we need legislation to allow a national capital campaign for health centers through the use of our existing federal funding and also existing loan guarantees.

We'd ask that the new market tax credit program be expanded, that Congress authorize a national insurer of tax exempt bonds for health centers. Senators Stabenow and Cochrane have legislation expanding a key type program for health centers, and Senator Rockefeller has legislation that would allow us to once again use our existing federal funds for construction purposes. Both of these bills are important, but we also need Congress to help in more ways in as outlined in our report.

And finally, we cannot overlook the fact that millions of people remain uninsured in our country and that expanding the availability of insurance and access to care through health centers will truly improve the health of our country. We stand ready to work with Congress to expand access to insurance as we also expand access to care through health centers. We clearly have an ambitious agenda, or as Dr. Wiltz called it, a bodacious plan [laughter] that we look forward to working with all our elected leaders to achieve. There are many moving parts, but there are millions in need and there really is no

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time to waste. We stand ready to work with each member, each committee, and each chamber to enact legislation that will advance the Access for All America agenda. And I'm happy to answer any questions that anyone has. Thank you.

**DAN HAWKINS:** Thank you, Jim, and Anita and Gary. We appreciate your, not only your poignant testimony here and words of wisdom, but also the daily work that you do back home in your communities to make the promise of health care a reality for millions of Americans.

As we open it up for questions, I'd like to point out to folks that the three reports that we have issued over the last year in this series, Access Denied, which documented the 56 million medically disenfranchised Americans and identified exactly where they live, in which states and et cetera and who they are, in conjunction with the American Academy of Family Physicians; Access Granted, the primary care pay off which documented the 41 percent lower costs for people who receive care from health care centers than for people who receive health care from other sources. This is what translated into the \$18 billion in savings against \$8 billion in expenditures, costs, that health centers expended last year. The latest report, ACCESS CAPITAL, which identified the \$10.5 billion in needed capital infrastructure financing and called for a new paradigm in financing that and ultimately coming soon this

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summer the Access Workforce report which will identify the workforce needs of health centers, are all available on our website, [www.NACHC.Com](http://www.NACHC.Com). And I think you click on Issues and Advocacy, Amy? And then click on the Access Initiative and you can access the full copies of those reports for download, for printing out, for I don't know, paper weights on your desk or whatever purposes you might have.

I want to last of all welcome Mitch Dell who has joined us this morning. Mitch is a member of the public policy and advocacy group and also working with our partner, Community Health Ventures. He and Allison Coleman are the architects of the new paradigm that we discussed this morning and know so much more than any of us ever will about the intricacies and the arcaneness of capital financing mechanisms, and are here also to answer any technical questions that anybody may have.

Let me open it up now for questions and comments. I'm going to repeat the questions. Turn to any of our folks or I may bring Allison or Mitch up to answer the questions depending on their nature. Comments? Questions? Yes.

**FEMALE SPEAKER:** Actually my question is directed towards Dr. Wiltz. You touched upon this briefly but I was wondering if you could expand on the state of primary care in Louisiana post Katrina.

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**GARY WILTZ, M.D.:** The question is the state of primary care in Louisiana post-Katrina. Unfortunately we had a major shortage prior to Katrina. We don't have counties in Louisiana, as you know we have parishes, that's to pray as well as to document geography, but almost every parish in Louisiana, there's 64 are designated as medically underserved areas, some more so than others throughout the state. Katrina knocked out I guess just in the New Orleans area alone over 5,000 providers that have not come back. Several have gotten dispersed and scattered throughout the state. We were hoping that one of the bright sides of this tragedy was that they would relocate and stay in the state. Unfortunately that did not happen.

Right now in our community we have on our waiting list - we have been trying to recruit a psychiatrist for the last three years. There's only one psychiatrist right now that's serving a seven parish area. And more recently we just lost our psychiatric nurse practitioner to the private sector because they offered him twice as much as we could pay in a community health center setting. Mental health is an extremely difficult area to deal with and it's been very difficult to deal with that. And I think the report that's going to come out will outline the tremendous need across the board for workforce development piece. There are less and less students choosing primary care as a career, that has a lot to do with

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the fact that it's not reimbursed. Students come out with large amounts of debt. That's why the National Service Corps piece, that's how I went through Tulane Medical School was through that scholarship. And part of our strategy is to increase the National Service Corps expenditures, both on the loan as well as the scholarship repayment, over the next several years to try to attract and make every community health center eligible to receive those type of providers. So I hope that...

**DAN HAWKINS:** Gary, one thing you might want to mention though is the devastation of Charity and LSU Medical Centers, two of the mainstay inpatient care institutions, but then the State's decision to not try to rebuild the specialty inpatient care infrastructure but to focus on primary care.

**GARY WILTZ, M.D.:** Well, Louisiana has been unique in that we have a charity hospital system that was viewed as the primary safety net provider for the state. Historically, community health centers have been on their own, as I say, for 40 years, but a lot of the emphasis was on the inpatient side as Dan alluded to. Now the thinking is, which is what we've trying to promote all along and I think it's taken hold, the best way to solve these problems is to have local care for local people at the local level, of course using federal dollars; that's why we're up here trying to get those moneys.

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But the point is that the most effective efficient way to provide that primary preventive care, and that when we talked about his whole medical home concept that you hear coming about, we've been doing this for 40 years. We've been doing comprehensive care not only providing medical care but dental care, mental health care, pharmacy. We do all the wraparound services. That's why it was so enlightening to me coming out of the charity system where I was born and trained to come to a community health center. You could see the impact that that team approach and those comprehensive services can make on a community. So you're absolutely correct that the paradigm has shifted. I think people recognize the work that has been documented and proven, so we're excited about expanding this nationwide.

**DAN HAWKINS:** Great. Next question. Jim?

**JIM:** Yes, what is the future of patient-centered medical home? You said it's shifting back. Where do you see the future of it and where do you see it fitting in when a new administration takes over?

**GARY WILTZ, M.D.:** The question was, where do we see the medical home concept going forward? Well, if you look at the literature there are many people using different terms about this. Some people are using patient-centered medical home, primary care medical home, I'd like to step out and be

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bodacious enough to say that we should take the ownership of this whole concept because other people have come around to what we already had in place historically. And it always tickles me when I'm in meetings and I see people saying, you know what would be a great system? What if you had a place where all these elements are in place? Where you had the quality, you had the documentation, and all the things that we have in place and have had in place historically? People forget that we've had to have accounting and reporting requirements that from our funding source, from HER and from the bureaus historically. Most of our centers are joint are joint commission accredited which is a very high burden to meet. So we've had the quality issue, the medical home, the regular source of care in the documentation to prove that we've been cost effective as well as having those impacts that I talked about earlier.

So I'd like for us to move forward, but the fact that we are providing that medical home right now and then have other people look at what we've done, when you look at the Institute of Medicine when it did the report, Crossing the Quality Chasm, it outlined the elements of what good care is about. And we've been specifically cited among community health centers as being the providers of that care. So I'm glad to see that everyone's kind of coming around to the way

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that we've been doing things and we look forward to expanding the model. We just don't have enough of us and that's what this is all about; getting the capital to do that. We have four parishes right now on the drawing board that we're ready to step into in the next six months with the capital that we finally got from the state legislature. But if you look at the national map it's not only unique to Louisiana is the point I'm trying to make. It's in Washington, it's in Massachusetts, it's all over the country and we have the capacity to know how to do this.

**DAN HAWKINS:** Jim, let me just add a couple of points. We recognize the leadership of the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, the internists, and the American Osteopathic Association in having come forth with the primary medical care home and concept and definition. We embrace it fully. We have endorsed the primary care medical home concept and the patient-centered primary care collaborative. And as Gary says, we believe that we, as much as any private practice or primary care physician group embody and in many cases even more importantly embody more broadly, the concept of the medical home in fact because health centers typically provide medical care, dental care, and mental health care all under one roof.

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We tend to think of health centers as medical and health care homes and that's how we refer to ourselves. But this is not a competition. Those 56 million people who are medically disenfranchised were identified by us in collaboration with the American Academy of Family Physicians. These are people who don't have a family physician. They don't have a pediatrician. They don't have an osteopathic physician. They don't have a health center. They simply don't have a place where they can get regular, continuous, high quality, patient-centered and committed and committed to fulfilling their health care needs, preventive and primary health care.

So we have wholeheartedly endorsed it in concept and I think what Gary said, we want to be among the leaders along with AAFP and the other organizations in advancing this concept up here on Capitol Hill because taking the step of guaranteeing every person living in America today with a family doctor and medical and health care home is the surest way we can rein in costs, eliminate disparities, and improve health care quality and outcomes.

**GARY WILTZ, M.D.:** Let me just follow up and say that, and I prefaced my comments that we were not the panacea, and the work that the AAFP has done has been outstanding and they've been on the leading edge as Dan alluded to in recognizing that whole, and that's, if I had to use a term

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that's the term I would use, patient-centered health care home because that really is all-encompassing. You put the patient in the middle when it's surrounded with all the services that they need and I agree with that.

**DAN HAWKINS:** Matt, you had a question?

**MATT:** Yes, I'm curious to know is there a cause and effect between the current economic instability and how community health centers can access capital that's outside the federal government? And even, you know, does a recession or a potential recession lead to an increase in patients? I'm just curious.

**DAN HAWKINS:** Alright, the question relates to the impact of the current economic downturn, and its impact on health centers both in terms of what's coming to them and their ability to access private market financing. Allison, come on up here because we're going to need your help on this one. [laughter] I will just say with regard to the patient impact or the impact in communities, and I'll ask very quickly, Gary, Anita and Jim to talk about what you've seen over the last 6 to 12 months in the number of people coming to your doors, many for the first time seeking care. I know it's been up all over the country.

**JAMES LUISI:** I know I can talk about Massachusetts. we had health care reform where everyone received an insurance

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card. Thousands and thousands of people actually got coverage. The problem is access. Where did they go when they got their insurance cards? Health centers. We did not have large enough buildings to accommodate all these patients. We didn't have the workforce we needed. All of these things to put this in place, but they wanted to come to the health centers. At the health centers they had 200 people at the front door when it opened, all people looking for their health care. It took as many patients as it could, but where did they send the rest? To the emergency rooms where the cost is three times as much as at a health center, where they got fragmented care, no medical home, and they eventually tried to send them back to the health centers. So we actually do need this capital financing to build bigger facilities, better facilities, expansions, and also we'll talk about the workforce needs at the health centers also.

**ALLISON COLEMAN:** To the question of the capital financing environment and the current impact, I would say over the last probably five or six years we've been in a relatively good credit environment. And it's still been challenging for health centers to access debt financing. So now in the midst of the subprime mortgage crisis where credit is drying up for everybody, interest rates are going up, and the credit enhancers, the major banks and the bond insurers are in

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financial trouble, it's going to make it considerably more difficult than it has been over the last five to six years at a time when health centers need the funds to expand. So we are concerned about the very significant capital, the credit challenges out there. It's partly why we're recommending the need for a federal credit enhancement that can be used with tax exempt bonds. As Anita said, you spend, what is it, \$1.6 million in interest expense? As interest rates go up then your ability to finance facilities goes down. You can buy in certain ways less health center for the same, you know, you're just paying higher amounts of money in interest rates. Tax exempt bonds offer a lower cost of capital but health centers don't have access to the credit enhancement you need in order to issue tax exempt bonds.

So having a federal credit enhancement would make a very important difference in accessing capital. Frankly, even in a good credit market and we're not heading into a good credit market. The other reason that the suggestion of making tax credits more available to health centers, tax credits, act as really a form of mirror equity. They're not quite grants but they provide a significant subsidy to projects.

So again, in more difficult economic times the importance of that subsidy - it becomes more important because I think it's very likely that as the uninsured rates rise more

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people show up at health centers. They serve all comers regardless of ability to pay. That means that they're operating margins get increasingly squeezed and they have less cash to put into facilities. So the combination of lower interest rates and this form of equity through tax credits is important even in good economic times, but it just becomes more important as the economy weakens and there are more people trying to obtain care in health centers.

**DAN HAWKINS:** We have another question over here?

**MALE SPEAKER:** Yes. Following up on my able colleague's comment about your growth rates, actually your patient growth rates. Maybe Dr. Wiltz you can talk about that given your institutional knowledge. And Ms. Monoian maybe you can talk a little bit about the average age of some of your health centers. I don't know if you can add to that nationally, you know, how old they are and how much they need to be refurbished? The brick and mortar stuff.

**GARY WILTZ, M.D.:** Well, in regards to the growth rate what I alluded to was on the last seven years we went from serving 11 million people to over 17 million people. And that we've done that, that was the president's initiative and we've done that very successfully, but we did that with the same capital structures that we have. Historically we receive operational monies to carry out those objectives and that's

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what we've done. But we're now to a point where we're beyond capacity and we just can't physically see any more people because we don't have enough space and as well as the newer communities that we want to go into, to go into those new communities. We're not going to make the same, I'm not going to say the same mistake, but we're not going to go into a new community and get a 100-year-old building that was formerly a church or a house, like the center I started at was a house. It was a house we converted. And that's the story of most of the community health centers. They started off with very humble beginnings and we made it work.

But now when we're talking about expanding and providing comprehensive care the way that we do and the model that we use, you can't piecemeal this thing. I think the best way to do it is to say when we get that capital that we need to build the type of structures that can accommodate the capacity that we're trying to serve. And that's been well documented. And by taking this bodacious step of saying not only are we going to service the people that we're serving to date, but over the next eight years, we can almost double what we're doing. That's the only that we can achieve that goal is to have that access to capital to expand.

**DAN HAWKINS:** Allison?

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**ALLISON COLEMAN:** In terms of the age of health center facilities that more than half of health centers have buildings that are upwards of 20 years old. And some are in facilities as old as 101, I think, or 110 I think was the oldest facility. So you definitely have an aging infrastructure for many of the health centers. On the other end I think that, and this sort of speaks to where a lot of health centers start out, because there have been a number of new start health centers and new sites that have been funded via the last growth of health centers, many of them start out in small kind of storefront operations or in, you know, borrowed and rented space that as they develop capacity then they need to be able to expand. So you really have challenges on both ends of aging facilities as well as newer health centers that need to be able to expand.

**MALE SPEAKER:** Okay, just a quick follow-up, how many total in the U.S.?

**ALLISON COLEMAN:** Sites? There are like 6,300 sites.

**DAN HAWKINS:** Do we have - yes?

**DR. RHODES:** My name is Dr. Rhodes. If you, I believe Anita mentioned that you have a psychiatrist was it that decided to go to the private sector because they offered him more? How much of an effect will this, you know, investment of capital, you know, change people like this decision to invest

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in you guys, to invest his time. I mean, it will have some impact upon the [inaudible]?

**GARY WILTZ, M.D.:** Well it was a psychiatric nurse practitioner and this was in the aftermath of Katrina. We lost over a hundred inpatient beds in the New Orleans area. The need was there before it became exacerbated. We are on the waiting list right now. We have two potential candidates with the National Service Corps who are obligated to serve an underserved area, so it's going to be a challenge. Historically we've been able to meet the challenge. We have used every device you can imagine to try to attract and retain folks. We were able to broker a deal with this guy to gives us one and a half days per week with the extended hours, so we did retain part of his services. But no, it's a challenge, but I don't think given the proven track record that we have and the comprehensiveness of what we're trying to do as far as a team that it's going to impact that. The best proof I can say is that the State of Louisiana had enough confidence in what we're doing to put \$41.5 million into this capital project and that was historic. We have previously not received any money from the state legislature at all. So I think they recognize the work that we do and that was a vote of confidence as far as we were concerned.

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**DAN HAWKINS:** Let me add one more thing here because I think it helps put things in context. I talked about the fact that health centers offer medical and dental and mental health services. I'm proud to say that more than a quarter of all 80 million visits to health centers last year were for preventive purposes, immunizations, child development, prenatal care, mammograms, pap smears, colorectal, HIV screenings, et cetera. But in terms of diagnostics, reasons that people come to a health center when they're ill, diabetes is the most common reason for a visit to a health center followed by hypertension and other cardiovascular issues. The third most common reason, illness reason, for a visit to a health center is mental health. Now, we are not seeing schizophrenics hallucinating. We are not seeing the serious psychoses.

What health centers are seeing, and these three can tell you, is all the stress, anxiety and depression that goes along with trying to keep a roof over the family's head and put food on the table when you're making seven or eight bucks an hour. It's all that primary care mental health needs that family practitioners were trained to deal with but it takes time. It's time consuming whether it's a physician or a nurse practitioner to do that or a psychologist, a clinical social worker, a quality nurse practitioner. You've got Louisiana which, you know, after Katrina I'm sure is a whole community

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just like what we're seeing coming back from Iraq and Afghanistan, post-traumatic stress and all the anxiety in an elevated way, but every day in every community across America people are feeling that stress and anxiety, and never more so than now with the economic downturn because they live at the very margins of our society economically. Paul?

**PAUL:** Just quickly, these are laudatory goals it sounds like and these are lean times and so forth. And I just wonder, it just sounds to me like you want Congress and government to take three actions. What benefit is there, what's the bottom line cost benefit to the federal government? Is this another large government program? I'm not quite sure the dollar numbers.

**DAN HAWKINS:** No, Paul, the question is, you know, and especially in these lean times with budget deficits and growing pressures to spend more money overseas as well as here in America on a whole lot of needs dealing with the current economic downturn, et cetera, is are we just asking for another handout is basically I think your question?

**PAUL:** Well, not that.

**DAN HAWKINS:** And the answer is no. We're asking for Congress and the public to invest. Invest in health centers and get a great return on that investment. Number one, the growth of health centers to serve 30 million people by the year

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2015 will take funding for health centers from the \$2 billion they receive today to \$5 billion in the year 2015. You do the math; \$5 billion, 30 million patients. That's what the cost is. It is barely over \$100 per patient per year.

Now that's not the only funding that health centers receive. They also bill and collect from Medicaid, Medicare, private insurance, et cetera. Today health center total budgets are \$80 billion, of which \$2 billion is the federal share. So in 2015 federal health center budgets will be slightly over \$20 billion of which \$5 billion will be the federal share. That \$20 billion, for 30 million people now, or about \$650 per person per year, will return more than \$40 billion in health system savings, overall savings to the health care system, half of which is financed by the federal government. So they'll get \$20 billion back in federal savings alone for the \$5 billion that are invested in health centers in that year, a 4 to 1 return.

Now, I'm not, who's the Berkshire Hathaway guy, I can't think of his name now. Oh, Warren Buffet. I am no Warren Buffet but I think Warren Buffet would see that as a damn good investment that would produce a phenomenal return. Nobody's asking for a handout here, Paul. Folks are asking for the commitment, the kind of commitment that the State of Louisiana had, the confidence that the State of Louisiana showed in

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health centers to produce both good health care and a return on investment. This is exactly what we're looking for. Yes, let's make this the final question.

**MALE SPEAKER:** I just need to be clear about something on the [inaudible]. So basically what you're saying over there is that there is trouble filling these positions sometimes, I mean you're missing or you have doctors that aren't employed, I mean you have slots to fill at the centers. Now an investment in capital is that going to create more slots per se, more jobs more career opportunities. My question is, if it creates those where you already have a problem filling them, is that going to mean more empty slots and what do you put in to get a good return?

**GARY WILTZ, M.D.:** No, I think the two have to be married together, if you build them they will come and then you will need the workforce to address that. I think the next piece that – we've done the research on this. we can go into great detail about that. We have a workforce committee that's dedicated to coming up with strategies to solve that problem. Part of that's going to be a commitment from the federal government. When I was in medical school as I alluded to earlier, when I went to the bank to get money to go to medical school it was based on dreams. Well, guess what? They don't loan you money on dreams.

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So thank God for the National Service Corps because that scholarship enabled me to go through as well as countless people are going through the National Service Corps is in place. We need more funding for that. We need more loan repayment. We need all the incentives that are going to get people into the reasons that they were originally going to go into health care.

So I think we have a strategy going forward to solve the workforce issue, but it has to be in tandem with the capital development. There's no question to me. We're not sitting back and seeing this whole thing unfold and saying, "Whoa, what are we going to do?" We have a plan. It's a well-thought out plan and it goes to the whole process. Every piece of the puzzle's been thought about and we have a strategy to move forward with that.

**DAN HAWKINS:** Two things that I'd like to say in response, too. I think that because you might be getting the impression that, okay, first we're going to ask for capital financing. Then if we go ahead and do that are they going to come back and ask for financing for workforce? The answer is partly yes, but let me say a couple of things about that. The American Association of Medical Colleges, the nations' medical colleges, has indicated that they are on a path to grow medical education, the medical student body in this country by 30

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percent over the next eight years. The same time frame as we're talking about the Access for All America Initiative. That means by the year 2015 America's medical schools will be producing 25,000 more medical students than they are today. They're not necessarily asking for more money. They're going to grow and charge tuition.

There is going to be a need, however, if you want to achieve three things in the next several years, Congress needs to get involved to number one, make sure that that 30 percent increase doesn't just produce a huge increase in, not emergency, electives surgery, cosmetic surgeons for America. We need to have more primary care physicians coming out of that pipeline. And right now less than 1 in 5 medical school graduates goes into primary care. Congress has a way to influence that outcome by, in its financing of medical education, by prioritizing those institutions that produce more primary care physicians.

Number two, we do not have a health care workforce today that looks like America itself. We need more diversity in the workforce. We need more people of color going through that training, not only at the medical level but at the nurse practitioner and physician assistant training, dental training, clinical social work and psychological training. All of that needs to produce a more diverse workforce. Again, Congress can

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influence that by insisting and supporting those institutions produce a more diverse workforce body.

And finally to Gary's point, once you've produced a greater primary care, more diverse workforce, how are you going to get them into underserved communities? That's where programs like the National Health Service Corps and the exceptional financial needs student disadvantaged loan programs come in. Those programs need to be supported at increased levels to ensure, whether they go to a health center or open up their own private practice, that they go to the very communities that need them the most. Those are the three goals you and the rest of the Congress needs to focus on when talking about not just whether, but how we're going to finance and revitalize health professions training. It needs to be done. It will be done. The question is will it be done right? And those are the three steps that need to be taken.

I want to thank everybody here for staying with us for this period. Thank you for your attention to this matter and we look forward to working with you as we go forward. Take care.  
[applause]

[END RECORDING]

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