Community HealthCare Association of the Dakotas

House Appropriations Committee Human Services Division

Testimony by:

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Community HealthCare Association of the Dakotas

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Good afternoon, Chairman Nelson and Members of the Committee. My name is Shelly Ten Napel, and I am the CEO with the Community HealthCare Association of the Dakotas (CHAD). Thank you for the opportunity to be here today to speak in support of House Bill 1142.

As you may know, CHAD is a non-profit membership organization that serves as the Primary Care Association for North Dakota and South Dakota, supporting community health centers across both states in their efforts to provide health care to underserved and low-income populations.

Community health centers are non-profit, community-driven primary care clinics that provide high-quality primary and preventive care to all individuals, regardless of their insurance status or ability to pay. Health centers are located in health professional shortage areas (HPSA), including both rural and urban areas across North Dakota. In rural communities, health centers support a community's ability to retain local health care, supporting access to health care where rural North Dakotans live and work.

North Dakota is home to five community health center organizations that provide comprehensive, integrated care to more than 40,000 individuals at 21 delivery sites in 19 communities across the state. In 2019, over 12,000 of those individuals were uninsured; 53 percent earned below 100 percent of the federal poverty level (FPL); and 81 percent earned below 200 percent of FPL.

Community health centers practice a model of care that focuses on treating the entire patient – a holistic approach to health care. Our integrated care model includes primary care, mental health and substance use treatment, dental care, pharmacy services, and a range of case management services that can include help with transportation, finding social services, or assistance with insurance and financial enrollments. As a result, health centers employ a range of health professionals. Because we work in communities that are, by definition, underserved by the health care system, recruitment and retention of good staff is both challenging and critical to our ability to fulfill our mission of access to high quality health care for ALL North Dakotans. In fact, our members have shared with me that support with meeting their workforce needs is their number one need.

I'd like to open my comments by expressing our strong support for the work of the North Dakota Area Health Education Center (AHEC). As you know, the program supports training experiences for students in rural and underserved settings. We often find that once students are exposed to rural and underserved settings, they are more likely to choose them as a place to work.

I'd also like to take a few minutes to share our view that the educational experiences obtained through AHEC-sponsored training are strengthened by being aligned with loan repayment programs. These programs offer repayment of student debt in return for years of service in an underserved community. As community-based non-profits, CHCs are typically not able to afford large signing bonuses or the highest salary levels, but our ability to offer help with loan repayment can be a deciding factor for a health professional who is considering starting their career in an underserved rural or urban setting.

Loan repayment programs are a great investment. A study by the American Medical Association makes the case that each physician generates an average of $1.8 million in total economic output and $47,655 annually in state and local tax revenue per physician.[1] We know that nurse practitioners, physicians' assistants, dentists and behavioral health providers can have similar economic impacts. Access to local health care is also a key part of making rural areas great places to live and work and to recruiting new businesses and residents to those communities.

Similar to the AHEC program, federal funds are available to match a state investment in loan repayment, and North Dakota is currently failing to maximize the opportunity for federal funds. The federal matching program is called the State Loan Repayment Program or SLRP. It matches state investment 1:1, potentially up to $1 million. Currently, communities are being asked to provide the 1:1 match. The community match requirement has put this program out of reach for CHCs. If the state were to help support the matching requirements for CHCs, we could use that to leverage federal match as a recruiting tool. According to the Department of Health, of the 35 contracts that were completed between 2013 and 2019, 95% of those providers remain in North Dakota. We can share a fact sheet on the program in you are interested.

It is important for the legislature to act this year to increase state investment in SLRP because 2022 will be a year in which North Dakota would be allowed to request additional resources in order to take advantage of the full $1 million that is available to states.

In conclusion, we want to strongly emphasize the importance workforce programs to CHCs – including training experiences in underserved communities and loan repayment to those serving in health professional shortage areas. Our mission as health centers is to provide care to populations and communities that otherwise could be left behind, but we cannot meet that mission without qualified health professionals willing to serve in those communities. We encourage the committee to support full funding for the AHEC program, and we ask that you consider amending this bill or finding another appropriate vehicle to also make a strong investment in state loan repayment programs, both the SLRP program and those currently funded with state dollars. We would love to work with you on ways to ensure all loan repayment programs are working for communities and maximizing the value of state investment. I am happy to take any questions.

[1] American Medical Association (2018). https://www.physicianseconomicimpact.org/pdf/northdakota.pdf