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Testimony on Health Care Workforce before House Committee on Health Care

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Mr. Chairperson, Members of the Committee, thank you for holding these hearings on the health care workforce crisis in Vermont and the opportunity for me to provide the perspective of Bi-State members on the issue.

Bi-State Primary Care Association is nonprofit organization established in 1986 to advance access to comprehensive primary care and preventive services for anyone regardless of insurance status or ability to pay. Today, Bi-State represents 28 member organizations across both Vermont and New Hampshire. Our members include Federally Qualified Health Centers (FQHCs), Vermont Free and Referral Clinics, Area Health Education Center programs, and Planned Parenthood of Northern New England.

You have heard from many witnesses that workforce issues, especially in primary care, were in crisis prior to the pandemic with more of our primary care providers nearing retirement or finding employment elsewhere. Now two years later, those issues remain, but we have added burnout from the stress of the pandemic and expanded COVID and public health services such as testing and vaccination clinics. To use a sports analogy, our members are struggling to field a full team, there is no one on bench to sub in, and we are in over-time. They are exhausted.

While I appreciate the focus on nurses – this profession has been in short supply for far too long – I also want to call attention to the workforce needs across the spectrum of health care positions. For example, even when a practice can hire a physician, an advanced practice provider, or a nurse… if the front office is not sufficiently staffed to take calls, schedule appointments, and work with patients; if the business office is not staffed to handle billing, process claims, and manage finances; if the medical assistants are not available to update medical records, measure vital signs, and draw blood samples or administer medicine – the provider and practice are severely limited in the services and access they can provide, the remaining staff pull double duty, and burnout becomes the norm. As one member described it, "imagine showing up at the airport and there is a plane and a pilot, but no check-in staff, baggage handlers, mechanics, or flight attendants."

<u>Workforce issues are affecting access and cost of care.</u>

First, I want to call out some examples from our members of how workforce is affecting access to care.

- Due to lack of registered nurses and medical assistants in some clinics, doctors have been rooming their own patients. This practice impacts the number of patients they can see and therefore patient access to care.
- Counseling staff have been needed to support clinic employees in dealing with burnout and the stress of their personal and work lives. This necessary support, however, reduces the counselors' time to work with patients.
- One organization was on the brink of temporarily closing a clinic because the sole nurse at that clinic was out for medical reasons and coverage was not readily available.
- Primary care physicians are aging. In one organization, two physicians are over the age of 70 and retiring this year. The clinic is still figuring out how they will continue to provide services to those 2000+ patients.

- High turnover rates mean disruptions in understanding a patient's history and medical care. One health center is requiring that when a new provider sees a patient for the first time, even if that patient has been with the practice for years, they schedule the longer "new patient" appointment. While this helps with patient care, it means that the newer providers cannot see as many patients for some time, which impacts overall appointment availability at the clinic.
- To cover workforce shortages, many members are redeploying their staff in different roles, such as using department managers and administrative staff to perform COVID testing, administer vaccination, and provide monoclonal antibody treatments (RN managers). This means they are not doing the job they were hired to do. While this arrangement can meet short term emergency needs, it is not sustainable and contributes to burnout throughout the organization.
- Workforce shortages also impact Free and Referral clinics, which depend on volunteer providers, including physicians and dentists, to donate their time and services.
- Free and Referral Clinical work closely with FQHC and specialists to connect patients with longer term care. When workforce shortages back up these referral pathways, this effect is felt by Free Clinics, who must continue to work with a higher caseload and increased cost to the clinic.
- Free and Referral Clinics also struggle to fill nursing positions – they cannot compete with larger organizations who can offer more substantial benefit packages. The grant funding these clinics receive has stayed level for the last 4 years.

Second, workforce shortages add to the increasing the cost of care.

- The cost of recruiting and retaining providers and staff is outpacing the funding coming into health centers. Some organizations have provided a 5% increase in salaries simply to keep their providers on staff. Meanwhile grant funding has stayed level and Medicaid reimbursement increased only 1.4%.
- Recent physician graduates are expecting salaries of $225,000 or more. To date, the average primary care physician salary in Vermont is around $170,000 to $180,000. Health centers cannot keep pace with this cost.
- One member reported that medical students doing a primary care rotation in their office provide great feedback about their experience. However, few end up choosing primary care. The debt from medical school tuition is enormous, and these graduates worry that a lower paying primary care position will not allow them to repay their loans, so they go into higher paying specialty positions.

<u>The remedy needs to be both immediate and long-term.</u>

- Loan forgiveness, housing, transportation, and childcare offer some short-term recruitment and retention tactics.
- Increased primary care reimbursement would support Federally Qualified Health Centers with longer term recruitment and retention strategies. Of note, FQHCs were not included in the primary rate increases in the Budget Adjustment Act or the FY2023 Budget proposal.
- Education and pipeline development is key for long-term solutions.
    - Nursing education needs *much more* funding to create the infrastructure to train more nurses.
    - The medical education system needs to focus on recruiting more students from rural backgrounds and on conducting more medical education in primary care settings.
    - Medical and health care education needs more primary care residency and preceptorship training positions, particularly in rural settings.
    - Additional funding is needed to support health care-focused curriculum for grades five through undergraduate level.
- Credentialing requirements for nurse educators should be adjusted so that excellent experienced nurses are deemed qualified to teach nursing students.

Thank you again for the opportunity to testify on behalf of Bi-State's members and share their experiences with the workforce crisis. I am happy to answer any questions.