Testimony of Aida Avdic, MD

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VMS member and VMS Board member, Windham County representative

Regarding S.190 – An act relating to the hospital outsourcing of clinical care.

Members of the Senate Health and Welfare Committee, thank you for the opportunity to testify today.

My name is Aida Avdic, practicing hospitalist physician at Brattleboro Memorial Hospital and Chief Medical Officer at BMH. I am here today to express my concern regarding S.190 bill relating to the proposed regulation of hospital outsourcing of clinical care. While this bill is well intentioned, it will unintentionally harm rural hospitals' ability to secure adequate and high-quality staff for critical 24/7 clinical services.

Rural and community hospitals face significant challenges in recruitment and retention of adequate clinical staffing to maintain essential 24/7 clinical services. Covid-19 pandemic has significantly impacted clinical workforce, particularly in rural areas. Aging workforce, including aging physician and APC workforce in Vermont, means that hospitals and health care systems are competing for limited resources and small rural hospitals tend to be less competitive and attractive to new employees. Housing costs and limited housing availability continue to be limiting step in recruitment of this skilled workforce. Practice pattern changes of today's clinicians looking to structure their practice in such ways that leads to less call time in particular impact rural staffing models, where inherently there is a higher need for call coverage compared to more urban/high volume areas where 24/7 coverage can be spread across larger group of clinicians. This leads rural health systems to seek innovative ways of staffing 24/7 services and reliance on several types of partnerships to fulfill this need.

Community hospitals need to maintain agility and flexibility to provide adequate and high-quality staffing to maintain 24/7 clinical services and preserve high-quality, cost-effective care.

Here at BMH we have relied on this agility for many years now in various areas of clinical services, including pathology, radiology, anesthesia and emergency medicine.

We have partnered with UVM pathology to provide high quality pathology services, allowing for more flexible, high-quality 24/7 pathology services. For BMH and its patients this provides access to high quality services. Additionally, this was more cost-effective than direct employment of at least 2-3 pathologists to maintain adequate service staffing, as well as specialized equipment needed to process medical specimens.

BMH has also partnered with DHMC for Radiology services support, in order to increase access, provide adequate staffing for 24/7 needed service and enhance quality of radiology reads, by expanding the pool of radiology staff available to provide quality and reliable imaging services across multiple modalities. Again, this strategy is more cost -effective than direct hiring of four radiologists to staff a 24/7 service.

In the midst of Covid-19 pandemic, local independent small anesthesia group which partnered with BMH to provide perioperative services, including emergency 24/7 coverage for OB and surgical cases, rapidly dissolved after a sudden death of its leader. BMH had to pivot rapidly and find a new partner to provide this essential service. We were able to partner with an independent CRNA group to maintain this essential service for our patients and our community.

S. 190 bill would significantly jeopardize small community hospital ability to maintain and restore essential clinical services in similar situations. It leaves community hospitals to struggle with direct recruitment which takes time (at least 9+ months for any clinical role), reliance on locums staff (which are significantly more expensive and often come at the expense of low engagement and quality of care), or partnering with national groups which are significantly more expensive than independent physician groups.

BMH has also had a long-term partnership (over a decade long) with DHMC/Cheshire to provide 24/7 ED physician and APC coverage. In the fall of 2024, we were notified that this partnership would end by the summer of 2025. BMH had to pivot and look for a different partner. Independent recruitment and employment of multiple physicians and APCs would have been impossible for BMH in such a short period.

We have entered into a partnership with Blue Water Health, an independent physician-led emergency medicine group. This partnership is already benefiting our community and patients. We have improved emergency room access by decreasing the rate of ‘Left without being seen’ patients, by improving quality and patient safety metrics and we are seeing greater engagement and investment of clinical staff in successful operation of the emergency department.

Additionally, this partnership is drawing a new group of clinicians and their families to Brattleboro area and the region and thus strengthening our communities.

S.190 would significantly impair small community hospitals’ ability to efficiently manage their workforce and staff critical 24/7 services and will force hospitals to have prolonged periods of often fruitless recruitment efforts, reliance on locum providers or large staffing groups. Reliance on locums and prolonged staffing insecurity leads to limitations in patient

access, compromises quality and safety of the care delivered and increases costs to health system.

Community hospitals do not make these decisions lightly and look for independent groups who will align with the hospital values, culture, emphasis on patient safety and quality of care as well as attention to the cost containment and fiscal alignment.

Individual physicians get the benefit of preserving practice autonomy, benefits of group practice and expertise in terms of skills and knowledge advancement, collaborative governance and reasonable work/life and compensation balance, and innovative care models.

Additional regulatory burden which S.190 would impose on the independent physician groups, including requirements for inclusion in the hospital budgets, subject to operating expense limits, and rate-setting, would eliminate the fiscal stability and operational independence required for these groups to function. It increases regulatory and reporting burden, which many of these practices cannot support and therefore will likely exit Vermont, leaving community hospitals to continue to scramble for coverage for these services. Vermont has already addressed surprise bills in a different piece of legislation in addition to the national bill. A group, like BlueWater, as part of our approach to the partnership has already aligned their practices to match hospital's financial aid policies.

In conclusion, S.190 would eliminate and limit partnerships that Vermont hospitals need and rely on for 24/7 coverage of services, such as emergency medicine and anesthesia and other services.

This bill with its current language, will lead to fewer physicians choosing to practice in Vermont, fewer staffing options for hospitals, fever choices for patients, and higher long-term costs for health systems.

I respectfully ask the Committee to reconsider or change S.190.

Thank you for the opportunity to testify.