Senate Health, Education, Labor and Pensions Committee

Sub Committee for Primary Health & Retirement Security

Hearing on A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce

Testimony of:

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Chairman Sanders, Ranking Member Collins, and Members of the Committee.

Thank you for inviting me to speak to you today on this very important topic. My name is Shelley Spires, I am here today on behalf of the Association of Clinicians for the Underserved – the ACU - as a member of its Board of Directors. The ACU is a non-profit, transdisciplinary organization of clinicians, advocates and health care organizations united in a common mission to improve the health of America's underserved populations and to enhance the development and support of the health care clinicians serving these populations. I am also the Chief Executive Officer of Albany Area Primary Health Care, Inc., a rural Federally Qualified Health Center serving over 45,000 patients in Albany, Georgia. Prior to serving as CEO, I spent most of my career in human resources at the same institution. My professional experience has made me an expert at delivering care to the underserved and recruiting and retaining the workforce to support these efforts.

To begin, I'd like to share three important things that are foundational to my experience serving the underserved:

The people who do this work are committed, mission driven and dedicated.
The patients they care for are resilient, smart, and inspiring.
Federal support for all of these people is critical and pays huge dividends.

Let me give you a little more detail about each of these.

The people who do this work are committed, mission driven and dedicated. In my experience working at the health center, I've witnessed this more times than I can count, but most recently with the pandemic. While the Albany area had numerous private outpatient practices close their doors due to the risk of the pandemic, AAPHC kept our doors open to continue serving patients. One of the critical resources that enabled us to continue to do that successfully is our providers. Our providers understand what it means to address a situation head on instead of running from it. They were troopers and were standing strong on the front lines of this pandemic battle we were fighting and continue to fight to this day.

When I tell you that the people who do this work are committed, mission driven and dedicated, it may be helpful for me share a more about the realities of working in and with underserved populations. Many patients live with chronic conditions, sometimes long untreated or neglected, making their initial care more intensive and their ongoing care more complex. High numbers of our patients are low income or living in poverty. Nationally more than 91% of health center patients are at or below 200% of the federal poverty level. Most of our patients are members of ethnic and racial minority groups. This, along with many other factors, makes culturally competent care absolutely vital to understanding and effectively caring for their specific needs. In my own community, we witness these and other realities on a daily basis. In fact, during a vicious COVID outbreak early on in the pandemic, our community faced incredible hardship. People were dying every day, we had an employee and spouses of employees die, and yet we stood strong. My team pulled together to eliminate barriers, use innovative ideas to continue caring for our patients, and made sure that the quality of care never deteriorated. At the end of the day, it was our team, our model of patient centered care, and our commitment to our collective mission to care for those in need that carried us through one of the worst challenges we have faced.

Working in systems that support high quality, patient-centered work – surrounded by a network of colleagues with shared ideals and goals – has defined the Association of Clinicians for the Underserved since its inception. This is part of what drew me to join the Board of ACU and it is

these shared ideas and goals have driven ACU to lead and spearhead advocacy for the National Health Service Corps (NHSC), to support workforce retention and recruitment. The NHSC has always been an invaluable tool for recruitment and retention of clinicians to underserved areas. However, it is worth noting that as the health care system has evolved, so too have the demands placed on clinicians. These demands are evident in the needs of the patients and the requirements in the way that they provide care.

The term “burnout” among healthcare providers was a huge topic of discussion prior to COVID. It did not go away during the pandemic. While health care providers may have forced the burnout that existed prior to COVID into the background as the pandemic provided a big shot of adrenaline, the longstanding burnout problem lingered, and the new demands placed on providers as a result of the pandemic exacerbated the impact of burnout. While the light at the end of the tunnel *may* be in sight for COVID, the pandemic of provider burnout continues and is likely to strike our health care workforce with a vengeance. We are already seeing this and in fact, burnout is now a bona fide medical diagnosis. The World Health Organization has noted that the syndrome of burnout is characterized by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one’s job, or feelings of negativism or cynicism related to one’s job; and 3) reduced professional efficacy.

Burnout has an impact on patient care: it not only produces less engaged employees, but also is linked to reduced patient satisfaction, reduced quality and value of care that is delivered – and it increases the risk for a healthcare error or mistake. Burnout costs our healthcare system millions of dollars, a cost that is well beyond the loss of organizational knowledge that results from employee change. We need serious efforts to measure – and perhaps mitigate – burnout recognizing all of these impacts. Patients are also beginning to demand that the problem be addressed. They simply want safe more engaged care, delivered by more empathetic care teams, something all of us should want.

And while burnout is important overall, with a real impact on staff retention, the other side of the human capital coin – recruitment – is also difficult in the underserved setting. Recruiting staff to work in underserved areas is, in a word: tough! This goes for all staff, with a particular focus on our clinical staff. New graduate family practice, internal medicine or pediatric physicians, many with an average of 125,000 dollars in debt, can work in a hospital and make 30-40 thousand dollars a year more compared to what we can offer in a community health center. Market forces, in general, don’t lift up the underserved.

I can speak to the challenges of recruitment and retention, both in my current capacity as CEO and in my experience in my former position with HR. Challenges that come with rural areas include the geographic location, a lack of many services and amenities that new, younger providers are looking for, the burden of student debt, and the need to understand our population. I make a conscious effort to pay attention to my providers and what they are telling me about “burnout”. I have spent time over the last couple of years trying to develop systems that allow us to work smarter and not harder. Trying to research ways to make patient care, patient flow, and the clinic environment a place that my staff enjoy coming to work. There is a lot of stress associated with the underserved population – high risk patients, managing multiple chronic illnesses with limited resources, and documenting in an Electronic Medical Record.

The good news is that we have existing, functional programs that can help with recruitment, retention, and workforce shortages, but these systems need additional investment.

Among the programs that can always benefit from more investment and can provide a substantial return on that investment are the National Health Service Corps (NHSC) and Nurse Corps programs. Since its inception in 1972, the NHSC has expanded not only in numbers of clinicians but also in types of clinicians. Notably, the Corps – which initially counted physicians as its dominant workforce component - now counts behavioral health clinicians as its largest workforce component. In 2009, a majority of the Corps was physicians (35%); in 2017, behavioral health providers made up the majority of clinicians in the NHSC (30%), with nurse practitioners taking second place at 23% and physician participation down to 20%. The NHSC continues to adapt to the needs of the U.S. healthcare system and reflects that in its workforce.

Over the past several years the program has expanded to respond to national crises such as the Zika outbreak (in 2017) and the substance abuse disorder crisis (in 2019). What began as one program – a scholarship program – now encompasses six complementary but distinct opportunities to serve under the NHSC: The scholarship program and multiple loan repayment programs including the students to service program.

While there are countless examples within the NHSC that can be cited to highlight its long-standing record of success in addressing workforce shortages in medically underserved areas, it's vital to recognize that health equity and health equality are key components of federal health policy. To this end, the NHSC is an important vehicle to achieve these goals: both by delivering services to underserved areas, and through the workforce that delivers these services. A study by the Robert Graham Center documenting the impact that the NHSC has had on health equality during its first 30 years showed that the NHSC has assigned its resources preferentially - and delivered its most consistent service - to counties with large minority populations.

Ensuring greater racial and ethnic diversity of the health care workforce is essential for increasing access to culturally competent care for all of our nation's communities. A more diverse workforce delivers better results in many settings, including healthcare settings, and is better suited to meeting the overall needs of our nation's diverse population, particularly in the most underserved areas. Historically and currently, many racial and ethnic and minority groups are underrepresented nationally within the major health professions. As a result, the NHSC is a success story and is deliberate in continuing its work to increase the number of minority clinicians.

To provide greater context to the present statistics on clinical workforce diversity, the latest data available shows that African Americans make up 13% of the U.S. population but they comprise only 6.9% of U.S. advanced practice nurses (nurse practitioners and nurse midwives) and 4% of U.S. physicians. Of actively practicing advanced practice nurses in the US in 2018, 81.8% were white, 7.9% were Asian and 0.2% were American Indian or Alaska Native. Data on practicing physicians in the United States in 2013 showed that 48.9% were white, 11.7% were Asian, 4.4% were Hispanic or Latinx, and 0.4% were American Indian or Alaska Native. These statistics are in contrast to the composition of the NHSC: 13% are African American, 10% are Hispanic, 7% are Asian or Pacific Islander, and 2% are American Indian or Alaska Native.

In the Corps' physician workforce, in 2016, African American physicians accounted for 17.2% and Hispanic or Latino physicians 18.2%. Unfortunately, there are no currently available workforce data on national estimates of LGBTQ+ or other under-represented minority groups. Historically there has been insufficient funding to support all clinicians interested in participating in the NHSC. In recent years an average of just ~10% of Scholarship Program applicants ~40% of Loan Repayment Program applicants have been funded. There remains a large gap in terms demand versus opportunity. The result is that with large numbers of applicants not being

funded, thousands of positions needed to provide clinical care to America's neediest communities remain unfilled. In 2018, there were nearly 5,000 open NHSC-approved positions in Health Profession Shortage Areas across the country that remained unfilled due to inadequate field strength – this has been a persistent problem each year since.

While the current field strength of the NHSC is greater than 16,000, which serves more than 16 million people, severe workforce shortages persist in every corner of the nation. The most recent Designated Health Profession Shortage Area Statistics indicate that nearly 33,000 additional clinicians across disciplines are needed to care for hundreds of millions of people who reside in health profession shortage areas. While we are incredibly grateful for the infusion of funding invested into the NHSC through the American Recovery Act, much more needs to be done to truly address the clinical workforce shortages that remain.

In addition to the NHSC, there are other programs worth considering as a part of the solution in addressing workforce shortage issues across the nation. For example, the Federal Government also oversees graduate physician training – so called Graduate Medical Education, or GME. A Government Accountability Office report in 2017 showed that training of residents remains concentrated in urban areas, which continued to account for 99% of residents, despite some growth in rural areas from, 2005 through 2015. Given that many residents stay in the same communities where they train, investment of GME dollars both for rural hospitals, but also for primary care training, is critical. But investing in hospital-based training programs – where many hospitals train residents in traditionally primary care specialties like internal medicine or pediatrics – is not a complete solution to this problem. Most of these residents go on to specialize, and hospitals are not required to track and report on career paths of graduates who work in primary care or underserved settings.

Another component needed to create a workforce dedicated to the underserved is further investment in teaching health centers (THCs). Initially supported under the ACA, the Teaching Health Centers program began development and evaluation in 2011, and now exist in a majority of states and train close to 1,000 residents a year.

THC programs are located in community-based ambulatory care settings and serve a large number of Medicaid patients. From a workforce perspective, those who train in these underserved areas are likely to remain in practice in the same or similar settings, with location of residency training often predicting practice style regarding quality and cost. If additional Medicare GME funding was unavailable, reallocating approximately 5% of the current $6.5 billion per year that funds Centers for Medicaid and Medicare Services indirect medical education would achieve budget neutrality to expand THCs significantly. There is a real opportunity to impact CMS deciding on GME slots that benefit the national need, and not just slots that generate higher incomes for academic medical centers.

I would also call to your attention to some state laws that provide barriers to care, especially behavioral health care, at a time in our nation when the behavioral health crisis is worsening every day. In many states, laws or regulations require organizations to employ a psychiatrist to oversee behavioral health programs. This needs to change and no longer be a requirement in any state. While it is true that all behavioral health clinics would benefit from psychiatrist oversight, recruiting one and retaining one even for several hours a week is a barrier to care. We have seen, during the COVID public health emergency, that overdoses have increased, and mental health has worsened. There is a national psychiatric prescriber shortage. When these providers can – and often do – make $200 an hour in private practice, it is all but impossible for a community health center to recruit a psychiatrist even with a starting salary of $250,000 and loan repayment opportunities. The result is that there are no behavioral health programs at

many institutions that need them, effectively restricting access to care for thousands upon thousands of high need individuals.

This issue is one that is very real to Albany Area Primary Health Care. The conversation around Behavioral Health and the needs in our area and our country is continuous. Most Federally Qualified Health Centers and Rural Health Centers are not financially sound enough to take on a salary for a Psychiatrist. This salary is very hard to offset when you are serving underserved, uninsured, and underinsured populations. These are the people who need it most and we struggle to meet the needs. I have had at least four Psychiatrists interview and ultimately decline an offer due to the salary. I can get them to interview because of their interest in the mission of our organization, but the salary is always insufficient to keep them. I and my colleagues across the country continue to try and be innovative and creative with trying to meet these needs through collaborations and partnerships because we believe persistence pays off. However, my goal is to hire a psychiatrist to be a part of our team and the challenges in doing so remain significant and unrelenting.

Towards this same end, we need HRSA to change how it makes program awards. At present, awards are made on an annual basis. This is convenient for the government but does not address the real world of provider recruitment in the field. You see, when I try to hire new graduate doctors, perhaps I can offer $30,000 in loan repayment, IF they apply AFTER I hire them and IF that loan gets granted 6 months down the road. My competition for that newly minted doctor is the local hospital, which can guarantee prior to signing an extra $30,000 loan repayment, and a higher salary. This is all done in an age where 20-somethings can get whatever they want delivered to their doorstep in a day. The competition has changed. We need systems to change to support this.

Again, to give you a personal example of the reality of what this challenge looks like in practice, I have had a couple of physicians that declined our offer due to the competition offering a sign on bonus (which would equate to loan repayment), pay off their loans to relieve the interest, and commit to a five-year contract. FQHC's just do not have that kind of money, so the idea of creating more than one application cycle would be a fabulous way to market our organization and clinicians wouldn't have to wait for the reward and can prevent the interest from accruing while awaiting the award.

I'd like to leave you with some concrete suggestions of actions that Congress can take to make a noticeable, needed, and meaningful impact to address the nation's workforce shortage and to support people in underserved areas:

1. Increase funding for the national health service corps and nurse service corps. We estimate total annual program cost for the NHSC to be $1.5 billion. Taking into account funding already in place for the NHSC, $310 million in mandatory funding and $800 million via the American Recovery Act, a minimum of $400 million in FY22 annual appropriations is needed in order to address existing need within health profession shortage areas.
2. Support the creation of state loan repayment programs in all states and territories with dedicated funding to enhance workforce recruitment and retention on a state-by-state basis.
3. Increase funding, or reappropriate funding, for Teaching Health Centers to at least double the size of the program and corresponding funding in the coming year.
4. Congress passed a historic increase to the Medicare graduate medical education (GME) program at the close of last year — the first increase to the program in nearly 25 years. The expansion was part of the year-end Consolidated Appropriations Act, 2021. The

legislation includes 1,000 new Medicare-supported GME positions. Congress should direct future expansions to enhancing the primary care and behavioral health workforce.

5. Allow providers working in an FQHC the ability to waive DEA fees – this could be modeled from the present Veteran's Administration (VA) system.
6. Similarly, consider expanding the VA approach and policy to redeploy workforce to areas of need via telemedicine, apply the same concept to support areas of higher need for the underserved. Unfortunately, cross-state licensure as well as payer reimbursement prohibits this at present.
7. Allow federally qualified health centers to participate in government supported insurance programs. Many health centers that serve the underserved are smaller organizations and are forced to spend a significant amount of operational dollars on health insurance. Allowing FQHCs the opportunity to participate in government support insurance programs would enable these health centers to invest a greater percentage of their operating revenue in salaries for recruitment and retention.

Conclusion

As a nation we are facing an urgent and critical issue with clinical workforce shortages, one that is predicted to worsen in the coming years. The Association of American Medical Colleges predicts that we will see a shortage of up to 55,000 primary care clinicians within the next ten years – this is to say nothing of the damages and additional strain placed on primary care workforce as a result of the pandemic and chronic burnout faced by countless numbers of providers. Today, more than 16,000 NHSC clinicians serve 16 million people across the country. I stand before you as someone who has personally witnessed the incredible impact, value and effectiveness of this program. We are hopeful that we can strengthen and grow the National Health Service Corps and other key programs to help address the urgent need of millions of people who need access to primary health care services.

Let us all take a moment to remember that these people have faces and names, they have families and children, and they have hopes and dreams. These are the people and patients we care for every day at Albany Area Primary Health Care. They are our neighbors. They are your constituents. They are the babies that our team welcomes to this world, they are the hands we hold as they manage their chronic illnesses and persevere, and they are the faces we hold in our hearts as they make their final transition from this life. The NHSC program has proven time and time again to be an effective program. I can assure you as someone working in an underserved community to care for those in need, in my opinion, the NHSC is one of the best programs this country has devised to incentivize primary care medical providers to be able to choose primary care and to serve in underserved communities. I appreciate the opportunity to testify before you today. We thank you for recognizing the urgent need to do more to address the nation's clinical workforce shortages and making the National Health Service Corps a priority as we work collectively to solve this critical issue. I would be glad to answer any questions you may have.