NYS Assembly Standing Committees on Health, Labor, & Higher Education
Public Hearing: Impact of COVID-19 on health care workforce
November 17, 2021

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to provide this testimony to the Assembly Committees on Health, Labor, and Higher Education. CHCANYS is the primary care association for all of New York's federally qualified health centers (FQHCs), also known as community health centers (CHCs), which provide comprehensive primary and preventive care to more than 2 million New Yorkers at over 800 sites statewide. In 2020, health centers employed nearly 19,500 full time equivalent (FTE) staff, of which approximately 12,500 were clinical staff and 7,000 were nonclinical staff.

Community health centers are in every corner of the state, serving communities that have been hardest hit by COVID-19. Among our patients, 90% are low income, 68% are people of color, 13% are uninsured, and 59% are enrolled in Medicaid or Child Health Plus. Due to the pervasive structural inequities that our patients regularly encounter, they are at the highest risk for severe negative health consequences resulting, not only from COVID-19, but also from a lack of access to health care services generally. One reason that CHCs are so trusted by their communities is that they hire individuals who live in the communities they serve. The providers, nonclinical staff, and patients patronize the same grocery stores, have children who attend the same school, and ride the same transit lines. As such, health center staff too have been devastatingly impacted by the COVID-19 pandemic. Many CHC staff, as well as patients, have lost family, friends, community members and coworkers throughout the pandemic, and continue to experience unprecedented demands in their professional lives. Moreover, the COVID-19 pandemic has exacerbated existing health care provider shortages across the state.

As an association supporting safety-net healthcare providers and their workforce, CHCANYS is uniquely suited to highlight policy areas where the State can create or continue improvements to maintain and enhance the existing health care workforce.

Importance of telehealth in sustaining workforce and increasing access to care

In response to the COVID-19 pandemic, NYS initiated new flexibilities for providers and patients to deliver and receive care from home via remote visit options. These remote options included both traditional audio-visual telehealth and, for the first time, Medicaid reimbursement for telephonic visits. Both modalities have proven critical to ensuring patients and providers could safely connect amidst an unprecedented health crisis. At one point during the pandemic, more than two-thirds of health center visits were remote. Data from July 2021 indicates that approximately 28% of visits remained remote, and more than half of those were delivered via the telephone with no video-facing component (audio only).

In the fall of 2020, CHCANYS surveyed patients and providers on their acceptance of remote care visit options. Overwhelmingly, providers and patients alike shared that access to remote care increased their ability to receive or deliver care and decreased barriers that would usually inhibit the ability to visit a provider, like lack of transportation, managing childcare issues, or taking time off from work. The ability to receive care within the comfort of one's home resulted in widespread reductions in appointment no-

show rates and, in some cases, increases in the number of patients seen per day. For providers, the ability to deliver care through telehealth modalities was a much-welcomed flexibility.

CHCs continue to report that the ability to offer remote working options to their providers has increased their ability to recruit new providers who, without that option, would not be interested in working for the CHC. We are grateful to the Assembly for ensuring that language in the FY22 budget allowed providers to continue delivering care from home once the pandemic ends. However, continued reimbursement for telephonic and audio-visual care will be necessary to ensure that CHCs and providers can continue to offer remote visit options, which have proven beneficial for healthcare workforce and patients.

Per CHCANYS' interviews, providers overwhelmingly shared their belief that in-person visits, audio-visual telehealth and telephonic visits should be paid at the same rate. Providers noted that CHCs specifically serve a high-risk and high-need population; proper reimbursement is essential to ensure they can keep their doors open as more and more patients require telephonic visits. Providers have reported to CHCANYS that telephonic visits take the same amount of time as audio-visual visits, and often the decision to "see" a patient via audio-only is due to the patient's technological limitations or other barriers preventing their ability to join an audio-visual call. Some examples of individuals that may need or prefer telephonic visits provided by community health centers include: older adults with limited technology proficiency, individuals without access to smartphones or camera devices, individuals with limited English proficiency who cannot obtain video interpreters for their languages, individuals living in rural areas with poor internet connection, individuals with limited data plans, individuals without a private space in which to conduct a video visit (including some unhoused individuals), parents of young children who cannot sit in front of a screen for an extended period of time, some individuals living with Autism spectrum disorder, and individuals for whom seeing their own image on video is uncomfortable, which has been self-reported by some gender-nonconforming individuals. Lower reimbursement for telephonic visits has the potential to exacerbate the health disparities for these and other video-challenged patients, who are often the most isolated and in need of care.

Regardless of visit type, patients and providers should be empowered to decide together which modality of care is best suited for their needs in each instance of care. Payment to support the visit should not be a consideration when developing the optimal plan of care. As health centers are already faced with consequences of lower-paid visits in telephonic care, many are forced to forgo or limit access to telephonic visits for fear of adverse impacts on their payment rates. Decreases in payment rates could cause health centers to have to cut staff or service hours to stay open. Meanwhile, patients are already beginning to miss care due to the rollback of telephonic visits. The concerns are especially stark for behavioral health providers and patients. CHCANYS expresses strong support for the telehealth payment parity bill (A.6256 Woerner/S.5505 Rivera), which would have dual impacts of positively impacting workforce shortages across the state and ensuring access to care for underserved populations. We encourage the Assembly to pass this legislation to improve payment rates for telephonic care.

Continued need for health workforce pipelines in medically underserved communities

Since 2008, the Doctors Across New York (DANY) program has provided loan repayment and practice support funding to improve physician recruitment and retention in locations throughout the State that

lack sufficient capacity to meet community needs. While DANY has helped place physicians in communities across the state, the number of placements has not kept pace with the growing physician shortage. In the years since DANY became law, there have been eight solicitation cycles, with the program historically receiving more applications than award funds can support.

COVID-19 has exacerbated existing workforce strains across the state, especially in the primary care setting. Beyond DANY, NYS must look to expand loan repayment programs specifically for individuals living in medically underserved communities. CHCANYS is pleased to learn that NYS Department of Health (DOH) plans to apply to the Federal Sate Loan Repayment Program in 2022 to grow existing and develop new loan repayment programs across the State. CHCANYS encourages the State to prioritize applicants who serve Health Provider Shortage Areas (HPSAs), like the individuals employed in CHCs. Additionally, the State should consider expanding loan repayment program opportunities for critical workforce beyond physicians, such as behavioral health professionals or nursing students.

As NYS pursues an 1115 waiver from the Federal government, a key component of the state's concept paper[1] has emphasized the need to increase workforce development in medically underserved communities and communities of color, especially in communities with a high number of Medicaid beneficiaries. CHCANYS welcomes the opportunity to expand workforce development initiatives with Medicaid providers like CHCs.

As part of the waiver, DOH has also stated interest in expanding the number of community health workers (CHWs) employed by health care entities and utilizing those CHWs to conduct social needs assessments to better understand patients' health-related social needs. CHCANYS is supportive of an increased emphasis and drive to hire CHWs, however, without sustained or long-term investment in CHWs (i.e., by making those workers eligible for reimbursement by Medicaid), it is unlikely that the CHW model will be sustainable once the 1115 waiver expires.

Special considerations needed for behavioral health workforce

Prior to the pandemic, NYS applied restrictions to the types of CHC providers that could provide visits remotely, despite that provider's ability to be reimbursed for services delivered in-person (i.e. Licensed Clinical Social Workers (LCSWs)). During the pandemic, those restrictions do not apply and no-show rates for LCSW visits have declined, with providers successfully serving patients unable or unwilling to come into the office. To preserve this patient/provider relationship, CHCANYS recommends that NYS continue this practice and allow any CHC provider authorized to bill for in-person services to be authorized to deliver care remotely, and, most importantly, to maintain the ability for critical behavioral health staff to be reimbursed for services delivered remotely.

Additional regulatory issues create artificial barriers to accessing behavioral healthcare at CHCs. For example, Licensed Master Social Workers (LMSWs) are limited in Article 28 clinics from operating independently from a LCSW – they are required to be supervised by an LCSW and in pursuit of their own licensure as an LCSW. All CHCs are licensed under Article 28. Health centers have shared that finding LCSWs to work at an Article 28 facility is extremely difficult, and the process of moving from LMSW to LCSW is long and arduous. Conversely, LMSWs are recognized as billable providers in Article 31 licensed

[1] https://health.ny.gov/health_care/medicaid/redesign/2021/docs/2021-08_1115_waiver_concept_paper.pdf

facilities. Considering the dual problems of an ongoing mental health crisis and extreme behavioral health workforce shortage, CHCANYS requests the state to allow LMSWs in an Article 28 facility to be recognized as billable providers without need for supervision by an LCSW.

Increasing utilization and responsibilities of Medical Assistants

Medical Assistants (MAs) work within their clinical care teams to support patient centered medical homes. Although a national credentialing standard exists for MAs, the NYS Education Department (NYSED) does not recognize this certification. Per NYSED guidance[2], unlicensed persons, including MAs, can only perform tasks after appropriate training and under the supervision of a physician. These tasks include measuring vital signs, secretarial duties, and assisting with collection of laboratory specimens or carrying out tasks that do not require medical judgment. In other states, certified MAs perform tasks such as taking medical histories and administering vaccines. CHCANYS recommends that a certification be made available in NYS so that certified MAs can be added to the list of individuals that, upon taking a state required training, are able to administer vaccinations. Other health care workforce personnel who are not traditionally eligible to initiate injections (e.g., EMTs), have been allowed to vaccinate against COVID-19 and the flu pursuant to Executive Order[3] and have taken the NYS training to become vaccinators during the pandemic. Given that nursing staff are among the most difficult to hire due to shortages, if MAs were able to vaccinate, not only would vaccination efforts improve, but it would also ameliorate strains on the existing nursing workforce.

Removing artificial barriers to patients accessing healthcare delivered by Nurse Practitioners (NPs)

CHCs are a critical access point for underserved New Yorkers and rely heavily on NPs to increase access to care, especially in regions where other provider types are difficult to recruit or retain. NPs in health centers conduct physical examinations, order tests, diagnose patients, prescribe medications, and immunize all in compliance with current practice laws. Nurse practitioners have always played an especially important role in the CHC workforce, particularly during the COVID-19 pandemic. The care that NPs provide in a primary care setting has allowed patients in communities most adversely impacted by the pandemic to continue to have access to care. Nurse practitioners are a cornerstone of the primary care medical home and it is important for the state to allow NPs to practice at the top of their license.

Flexibilities afforded by executive orders issued during the COVID-19 pandemic relaxed administrative obligations for NPs without having any effect on patient care. It would be unnecessarily burdensome to reimpose those administrative obligations in the post-pandemic period. Consistent with prior executive orders and those recently issued by Governor Hochul, A.1535 (Gottfried)/S.3056 (Rivera) eliminates the statutory mandate for NPs with at least 3,600 practice hours to maintain a regulated collaborative relationship with a physician or hospital. Nurse practitioners with less than 3,600 practice hours would be required to enter into a written practice agreement, but instead of being limited to a physician or hospital, that agreement could be with a physician, hospital, or senior NP. Nurse practitioners, especially those working in CHCs, employ team-based care and work collaboratively with all medical professionals

[2] http://www.op.nysed.gov/prof/med/medmedicalassistants.htm
[3] https://www.governor.ny.gov/executive-order/no-41-continuing-declaration-statewide-disaster-emergency-due-healthcare-staffing

to provide the best patient-centered care. Physicians, specialists, and allied professionals together develop the patient's care plan and work in concert to ensure the best possible outcomes. These are not actions that need to be dictated by statute or identified through burdensome and potentially costly paperwork.

CHCANYS strongly supports A.1535 (Gottfried)/S.3056 (Rivera), which would ensure that New Yorkers continue to have access to the high-quality care provided by NPs, all while making important amendments to the Education Law to improve upon the Nurse Practitioner Modernization Act, that was passed in 2014, without a fiscal impact to the State.

Expanding scope of practice for Registered Nurses (RNs)

In 2000, legislation was enacted to allow the administration of immunizations and anti-anaphylactic agents by RNs without the need for a patient specific order. Purified protein derivative (PPD) tests, Hepatitis C testing, and human immunodeficiency virus (HIV) tests were later added to the law by the legislature, and during the COVID-19 pandemic, RNs have been able to provide COVID-19 vaccines and order COVID-19 tests through standing orders via Executive Order. NYSED has historically interpreted that these standing orders are not appropriate to dictate nursing care because "there is no existence of a relationship between the patient and an authorized provider."

However, CHCANYS asserts that there are instances where nurses are operating within a broader care team (i.e., in a patient-centered medical home (PCMH)), where a patient has an ongoing relationship between a primary care provider and an entire care team, inclusive of RNs. In these instances, non-patient specific standing orders that allow for nurses to order testing related to evidence-based preventative care and chronic disease management would alleviate strains on providers and potentially strengthen the relationship between RN and patient. For example, at present an RN may not initiate an order for mammograms, A1C screens, or colonoscopies, even in instances where it is a reasonable next step for clinical case management and can be identified as necessary through automated clinical decision support and care pathways. In these instances, the RN must communicate with the provider to have the physician initiate the order, causing strains on physician workflows and potential delays for the patient. CHCANYS encourages the legislature to create a pathway to allow PCMH-recognized organizations to issue non-patient specific standing orders for certain preventative care and chronic conditions (as approved by that organization's Medical Director). This would enhance RN capacity and responsibilities within team-based care and alleviate strains on physicians to order or initiate routine evidence-based preventative care and chronic disease management.

Conclusion

CHCANYS is grateful for the ability to submit this testimony, and for the Committees on Health, Labor, and Higher Education to recognize that these workforce shortage issues cross many programs and legislative areas and that a resolution requires a joint effort by the respective Committees here today. CHCANYS is hopeful that this is only the start of further discussions around bolstering and protecting health care workforce in underserved communities. With questions or follow up, please contact Marie Mongeon, Senior Director of Policy, mmongeon@chcanys.org.