Chair Patterson and members of Senate Healthcare Committee,

My name is Tony Germann. I am an active rural family medicine doctor practicing in Silverton and Woodburn communities concurrently serving as clinic director of a primary care community health center where we serve over 16,000 community members.

I submit testimony in support of SB609. Thank you for the opportunity to share the critical need for advancing and augmenting primary care payment reform. We need increased investments in primary care.

Chronic underfunding has left primary care at a significant disadvantage and we continue to see the erosion of this fundamental bedrock of an ideal health system that provides an equitable delivery of health care outcomes. The state of Oregon is moving towards a goal of spending on primary care of 12%. However, the reality of the current spending is likely much lower than that presently. In comparison, around the globe the Organisation for Economic Co-operation and Development (OECD) countries average 14% spending on primary care.

Due to this underfunding, we see the consequences.

Workforce Shortages and Maldistribution: Oregon is projected to need an additional 1,174 primary care physicians by 2030, a 38% increase from current levels, due to aging, population growth, and increased insurance coverage. Rural areas are disproportionately affected, with many designated as Health Professional Shortage Areas (HPSAs).

Burnout and Administrative Burden: Many PCPs report burnout due to excessive administrative tasks, misaligned payment models, and inadequate support. This has led to physicians reducing hours or leaving the field entirely.

Nurse Practitioner (NP) Gap: While NPs could help fill the gap, only about 25% of Oregon's NP workforce focuses on primary care. Many are not located in accessible settings or spend limited time on primary care services.

Ask yourself on this committee, how long does it take to get into your primary care provider?

Payment reform is not the only solution to the failings of our primary care system. However, we know that recruitment and retention for this frontline workforce is dependent on our ability to ensure parity compared to spending in other sectors of our health system.

What do we get in return? Evidence for investing in primary care is well documented. When we promote preventative care and improve access to a patient centered medical home we reduce cost to our system overall and deliver on quality of care. This augmentation in funding will improve clinical outcomes, avoid emergency room visits, avoid preventable testing, hospitalizations, and referrals as patients can obtain the treatment in advance of disease progression.

Primary care interventions lead to fewer heart disease and cancer deaths, but also decrease rates of low birthweight and infant mortality.

With the adoption of a value based payment system we also have observed a dramatic change in administrative burdens for practices. These payment models require a significant amount of support staff and resources for capital investments, analytic tools, utilization of technological platforms and the ability to share data. This burden has fallen predominantly on primary care practices. Consequently, practices report they are not able to keep up with this transition predicated on former payment levels and schemes of the past. SB609 will move our state forward.

I urge this committee to be considerate of SB609 and continue to press forward with the crucial adjustment we need for primary care spending in our state.

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