GraceCottage HOSPITAL

Good Day to You All-

My name is Bob Backus.

I am a graduate of the University of Vermont College and Medicine Class of 1976.

I am a residency-trained board certified family physician with additional qualifications in geriatric medicine.

I have been in rural family medical care since 1978 in the West River Valley of Townshend, Vermont.

I was in private practice until 1995 when I joined the Grace Cottage Hospital to start a hospital-based family practice unit, where I have remained since that time.

I will be retiring on March the 9th of this year.

I greatly appreciate you allowing me to come here to plead a case for our patients medical welfare, and for our beloved small hospitals in Vermont, and the wonderful staff who care for them there.

I am going to tell you four separate stories and will add a bit of commentary.

The first/second story is about the electronic medical record. The electronic medical record was conceived and dedicated to the idea that we could communicate more legibly, more accountably, and potentially we would be able to integrate care across the country and around the globe with this electronic tool.

In Vermont, Dr. Lawrence Weed, an internist at the University of Vermont College of Medicine, and the originator of the problem oriented medical record, had an electronic medical record fully functioning in the obstetrical and gynecologic unit at UVM in 1972.

If you were a patient you entered your own history on a computer with the assistance of the medical student when you came to the hospital for your surgery.

The medical student and/or the residents put in your physical exam and pertinent labs.

The operative notes, the progress notes, the discharge notes were all electronically entered and when you left the hospital you, the patient, had a printout of everything that had happened during your admission; this was in 1972.

Fast forward to Santarem a town on the Amazon River.

Place yourself in the local slum in a clinic.

You walk in the door in 2004 a little red light flashes and said "Welcome Dr. Backus."

You sit down in front of the computer and there is a list of the patients for the day, the ones who are already there are in green, the ones who are not are in red. Beside each patient is the presenting complaint or concern.

You take the patient in, you take your history, you do your exam, you type it into the computer, you put in a diagnosis, you hit printer out comes the patient educational materials and the prescription, which the patients then take with them to the pharmacy 2 doors down.

This system was designed for under 3,000 dollars and it worked flawlessly.

Fast forward to Grace Cottage Hospital several years back. The hospital purchased a system for $2,300,000 that was reportedly a turnkey system, which means that you turned it on and it worked because it had been used by multiple professionals previously and was found to function flawlessly.

In effect it was a beta system.

The people sent to us to teach us were only 1 page ahead of us in their learning curve.

It has taken years to take this system to functionality, however, it cannot communicate with any other system that we have in Vermont.

It is unlikely to be able to do so in the immediate future.

Then contemplate the VA's electronic medical record.

The VA can communicate with a key touch anywhere in the world with their medical record. Your records can be sent to Kabul in seconds. It was a tried and a true system and had been in operation for over 25 years.

My question, why did we not use this throughout the United States when we rolled out the electronic medical record?

It is now estimated that the average physician using an electronic system in the United States spends up to 50% of their working day putting information into the system, taking information out of the system and/or responding to over 1500 insurance companies and numerous pharmaceutical companies on a daily basis trying to get patients the healthcare they need and that they deserve in an efficient manner.

This is 50% of the time taken away from you the patients so that we can meet "meaningful use" criteria, which generally generate meaningless data.

Your doctors now practice as scribes 50% of the time, unless you work for one of the large hospitals where a whole new layer of expense has evolved, 'professional scribes' who sit at your side and put in all the info into the EMR.

And who pays for these scribes?

You pay for them via the cost shifting that goes on each time we layer the bureaucratic cake.

Story # 3: Primary Care Primacy.

It is said that primary care is the driver of the system, it is the hope of the future, it is what we should be all about.

Now if you were the average student of medicine and had their current debt load, would you opt to work for $164,000 a year, 7 days a week for very long hours as a family physician or a general internist or a pediatrician or $500,000 a year as a specialist working 9-4 with minimal call and no weekend duty?

Why do other countries have many more people in the primary care networks, because they have more equity, many have no debt for their students as they come out or certainly a lot less debt and a lot more support from well-disciplined national healthcare systems.

Story 4: Let us move on to Vermont Hospitals.

When I started at Grace Cottage Hospital there was no EMR, the medical records were contained on small white cards and sometimes on that card the entire obstetrical history of a woman lived writ small.

There were no CT scanners. The laboratory tests were rudimentary, but the network of caregivers was not burdened with multiple challenges from insurance companies, pharmacies, governments, and other such influences.

The doctors and nurses took daily care of people with their hands and their full attention.

They listened, they worked for the benefit of the patients and their loved ones.

Come now to Grace Cottage, look at the regulatory burdens that come every meeting on every day in waves from multiple areas of the healthcare industrial complex. We are drowning in paperwork.

We are drowning in rules, often one conflicting with the other.

The current healthcare system is obviously in disarray.

Much of the control valves for how the system is to work are not in the hands of you folks, they are in the hands of the power brokers on K Street.

Let's talk about some of the new things that are being proposed.

Because we do not have a common core of healthcare benefits for all and a system, which is simple with only one form, not 1500 insurance forms, we do not appreciate the benefits of healthcare benefits for all through a national healthcare type system.

In my 38 years of practice, I have witnessed the failures of the private healthcare industrial complex from CHP to the touted yet chronically unsuccessful ACOS that attempt mightily to "control costs and add meaningful use and improve care".

Often these experiments take place in areas like Vermont, which has very low costs, and where our care is valued in the top tier of the USA.

Witness the struggles of the 2 ACO drivers in our region now.

The highly respected Dartmouth Hitchcock Medical Center and the UVM Medical Center.

At the moment they are trying to squeeze out savings from a very lean system, while they add on a fresh layer of bureaucracy on top of our sui generis Green Mountain Care Board.

The new ACO is reportedly going to have a multimillion dollar budget and management structure that includes a high 6 figure salary for its CEO.

Where will the cost savings go if there are any savings?

You know where they are going to go, this will be paid for by taxes on our hospital and our healthcare providers.

This does not favorably impress a rural family physician, who at the top of his career earned $165,000 a year, which was 8 times less than his plumber.

Early in the 1960s, I wrote a paper in support of a national healthcare system funded by a non-regressive tax on income collected by the Feds and proportioned out to the states to be administered by the best minds at the state level from the insurance industries, from the healthcare industries, and from business.

The cost savings tool, the axis around which the wheel would turn, would be a well-thought out common benefits package for all that covered all of basic necessary care to improve health and treat illness for all of our people.

There would be no frills just the solid basics.

For care beyond the basics supplemental insurance plans or private financing would foot the bill. But if you had a cancer and you needed treatment for it, that would be covered under this program as it is throughout the developed world.

Please think of the enormous financial and practical benefits to our society from such a system.

Our current system does not look first rate when it comes to healthcare outcomes worldwide.

If you look at the healthcare outcomes worldwide and compare them with ours, those that are at the top of heap have a national healthcare system that provides healthcare for all, which costs far less than our current system.

How hard would it be to take Medicare, Medicaid, and the Military Coverage, merge them giving similar quality care to the remaining 30 some odd percent of the population. These systems could be easily universally connected to the VA's electronic type medical record, and we could have that dream that Dr. Lawrence Weed hoped we could have of communication throughout the system electronically using a problem oriented medical record.

I appreciate you allowing me to come here.

I want to thank the members of the House, the Senate and our Capital staff for giving their time and energy to keep real New England democracy alive in these political times.

I dearly appreciate what you do.

I am very proud of what you do.

I am thankful that I live in this State and that you are here.

If you have questions I would be happy to answer them.