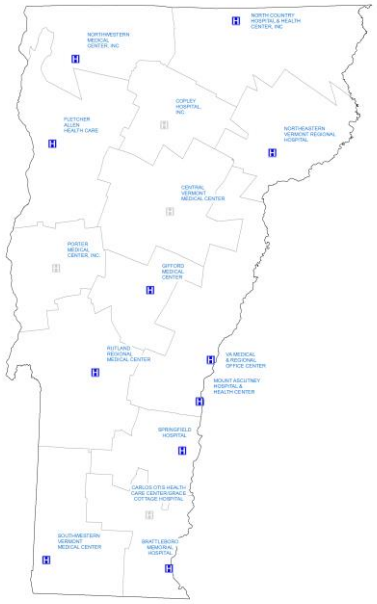
Vermont Senate Economic Development Committee

March 26th, 2014

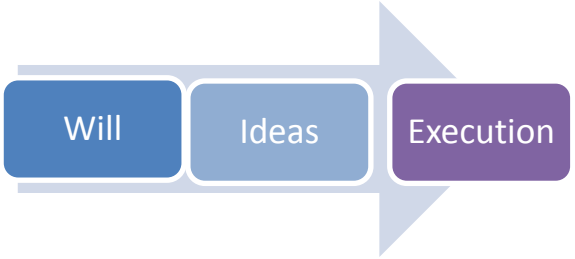
The Green Mountain Care Board and VMS Education and Research Foundation

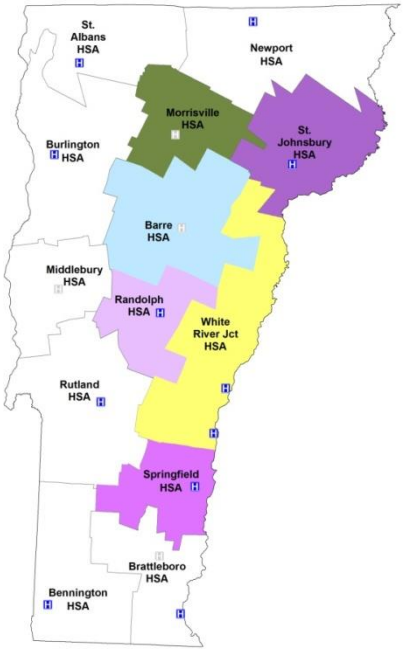
Recommendations for a State-wide Health Resource Allocation Plan



Actualizing reform thru clinician leadership

Better quality, Better health, Lower costs





VMS Education & Research Foundation

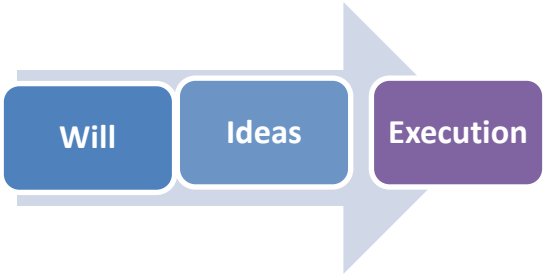
helping physicians help patients & communities

www.vmsfoundation.org

1) Better care, better health, lower costs

How can leaders accelerate innovation?

"You have to have the *will* to improve; You have to have *ideas* about alternatives to the status quo; and then you have to make it real through *execution*. All three have to be arranged by leaders – they are not automatic." – Don Berwick



VT Region Hospitalists – December 5th - GMCB

1. A population-based care plan
2. **Anticipation of workforce needs**
3. Coordination of care across settings
4. Transparency of payment reform
5. Meaningful actionable measurement

Rural Clinician Leaders – December 19th - GMCB

1. Actualize 3 planned levels of care
2. **Make VT a magnet for the workforce**
3. Become the national benchmark for measurement
4. Reduce the gap between practice and policy

Vermont Health Resource Allocation Plan (HRAP)

Qualitative research - Key informant interviews

Interview questions

1. Health resource allocation planning
2. Measurement of health care processes and outcomes
3. Payment policy and payment reform
4. Communication with Board
5. Retention and recruitment of physicians

Advantages

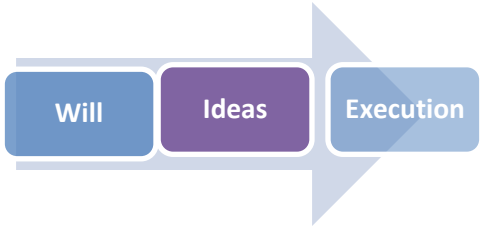
- Candid/in-depth
- Detailed rich data
- Nuanced and actionable
- Trust/sensitive topics
- Motivation and beliefs
- Raise interest/enthusiasm
- Build/strengthen relationships
- Stay connected/clarify issues

Interviewees

- People who know what's going on in their community
- Insight on the nature of problems and recommend solutions

Disadvantages

- Difficult to select the "right" informants
- Diversity? Bias?
- Difficult to schedule
- Difficult to generalize unless many involved



Vermont Region Hospitalist Community

Aida Avdic MD, Brattleboro Memorial Hospital
Director of Hospitalist Medicine BMH

Amy Gadowski MD, Brattleboro Memorial Hospital
Hospitalist BMH

Steve Grant MD, Fletcher Allen Health Care
Associate Director of Hospital Medicine, FAHC/UVM College of Medicine

Rick Hildebrandt MD, Rutland Regional Med Center
Hospitalist RRMC

Martin Johns MD, Gifford Medical Center
Director of Hospitalist Medicine GMC

Bill Palmer MD, Mt Ascutney Hospital/Health Cntr
Hospitalist MAHHC

Mark Pasanen MD, Fletcher Allen Health Care
Director of Hospital Medicine, FAHC and UVM College of Medicine

Joe Perras MD, Mt Ascutney Hospital/Health Cntr
Director, Hospitalist Services MAHHC and former Director of Hospitalist Services at Dartmouth Hitchcock Medical Center

Jim Poole MD, Southwestern VT Medical Center
Hospitalist Dartmouth Hitchcock Putnam, SVMC; Director of Hospitalist Medicine SVMC; and Medical Director of Medical Affairs SVMC

.

Mary Ready MD, Northeastern VT Regional Hosp
Hospitalist NVRH

Allen Repp MD Fletcher Allen Health Care
Health Care Service Leader & Division Chief, Primary Care Internal Medicine, FAHC/ UVM College of Medicine

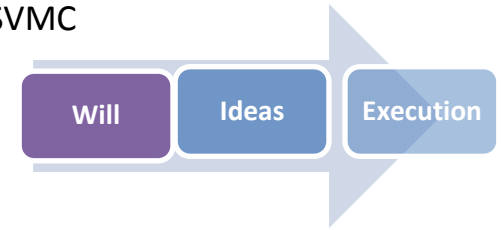
Chris Rickman MD, North Country Hospital
Director of Hospitalist Medicine N**CH**

Mike Rousse MD, Northeastern Vermont Regional Hospital
Director of Hospitalist Medicine NVRH

David Shea MD, North Western Vermont Medical Center
Director of Hospitalist Medicine NMC

Heather Smith MD, Rutland Regional Medical Center
Medical Director of the RRMC Hospitalist Program

William Tock MD, Southwestern Vermont Medical Center
Hospitalist Dartmouth Hitchcock Putnam, SVMC



Vermont Rural Physician Leaders Community

Phil Brown MD, Berlin
CVMC - Chief Medical Officer
Internal medicine, Emergency medicine

Kevin Buchanan MD, Randolph
Clara Martin Center - Medical director
Psychiatry

Ovleto Ciccarelli MD, Randolph
Gifford Health Care - Surgical Chairperson
General Surgery

David Coddaire MD, Morrisville
Community Health Services of Lamoille Valley
Medical director, Family practice

Mark Crane MD, Berlin
CVMC - General Surgery

Lou DiNicola MD, Randolph
Gifford Health Care - Pediatrics

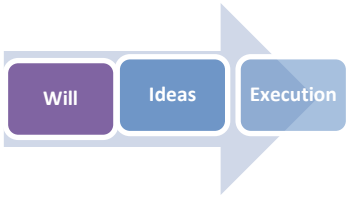
Jeremiah Eckhaus MD, Montpelier
CVMC - Family practice

Sharon Fine MD, Danville
Northern Counties Health Care - Medic al director
Family practice

Steve Genereaux MD, Wells River
Little Rivers Health Center - Medical director
Family practice

Nikki Gewirz PA-C, Randolph
Gifford Health Care - General Surgery

Mark Heitzman MD, Berlin
CVMC - Cardiology



Sarah Kemble MD MPH, Springfield
Springfield Medical Care Services - Medical director
Internal medicine, Preventive medicine, Public health

Mike Kilcullen MD, Woodstock
Ottauquechee Health Center – Pediatrics

Dina Levin MD, Randolph
Gifford Health Care - Obstetrics and Gynecology

John Matthew MD, Plainfield
The Health Center – Executive and Medical director
Internal medicine, Family practice

Josh Plavin MD MPH, Randolph
Gifford Health Care - Medical Director
Internal medicine, Pediatrics, Pubic health

Deborah Richter MD, Montpelier
Family practice, Addiction medicine

Joel Silverstein MD, Morrisville
Copley Hospital – Chief Medical Officer
Internal medicine, Gastroenterology

Peter Thomashow MD, Berlin
CVMC – Psychiatry Chairperson
Psychiatry

Sean Uiterwyk MD, White River Junction
White River Family Practice – Independent practice
Family practice

Mark Yorra MD, Barre
CVMC - Internal Medicine

2) Global Uncertainty

"The biggest overarching concern among physicians is how we are going to continue to provide high quality care. Our current environment is that we are being asked to do more with less pay and less resources. The challenge of recruiting and retaining well trained professionals is getting more difficult. What we hear about the future is very nebulous; it is difficult to have confidence in all the expected change when we don't understand the big picture of payment reform, let alone the details that will affect our everyday work life and our ability to care for our community - Community hospital physician

What are your biggest fears and hopes for the future of care in the state?

The paramount concern expressed by the majority of interviewees in response to this chapter's question had to do with physician retention and recruitment. The issues of physician retention and recruitment are among the most prevalent themes heard during the interviews and were mentioned by many in their responses to questions not intended to illicit responses about workforce issues such as the questions about core clinical services and payment reform.

Physician workforce issues were even mentioned in terms of the questions about measurement as the burden of documentation is an enormous problem for primary care outpatient practitioners and frequently the burden of measurement was mentioned as a reason for practitioners considering leaving practice.

Anxiety

There is a general sense of anxiety and worry among practicing physicians. Many physicians do not feel adequately informed about the direction or pace of state reform and the lack of information is causing worry

Compounded by anxiety over federal reform

Concern about state reform efforts is compounded by concomitant federal reform activities and the widespread financial stress in all aspects of the health care industry. Many physicians are of the opinion that reform is moving forward more rapidly than is the case, and they feel that they are not being asked to be part of the conversation

3) Compensation
Wages

Vermont wages are relatively low

Physician incomes in Vermont are less than in other parts of the country and lower than some other northeast states. Physicians would like to Board to address the comparatively low salaries for Vermont physicians. Hospitals have an ever present problem with recruitment and retention of physicians. All of the current hospitalists in Vermont know that they can get significantly more income just by working across the Massachusetts, New York or New Hampshire borders. Hospitalists are constantly barraged by requests from both instate and out of state recruiters. It is not uncommon for a physician to get ten such requests in a single day, some offering $60,000 signing bonuses.

That being said nearly all physicians mentioned that they are not in Vermont to make a high income. They are principally here because of the lifestyle or family ties.

Difficult to Compete with other states

"Physician and nursing salaries are low in Vermont. The northeast region in general has the lowest salaries in the country and Vermont is at the low end of the spectrum in the northeast. As hospitalists our incomes are about $50,000 less than national averages. We've been recruiting for a third hospitalist for 4 years without any interest from outside. We recently increased the salary range and have just hired and additional MD. We have also established with DHMC a rotation in community hospital medicine but have had no inquiries as yet" - Community hospital physician

"The pay scale in Vermont is very low compared to other states, particularly in primary care. I have a family member who can make twice the average Vermont PCP salary in another attractive state. Vermont salaries in primary care are about 30% lower other states" – specialty physician

Compensation

Income Discrepancies Among Specialties

"There is a very significant problem when the incomes of certain highly reimbursed specialties are compared to the incomes of primary care practitioners. This fact drives medical students choice of specialty" – hospital chief medical officer

"Payment reform should address the disparity between the incomes of specialist physicians and primary care physicians" - Community hospital physician

"Pediatricians are very concerned that the very good pediatric delivery system that they have worked to create in the state over the past four decades is in danger of being undone; that the focus of the state's health care reform efforts is solely focused on present cost and that the long term investment in children's health will be short charged and suffer as a result" - Employed pediatrician

"One of my biggest fears is that reform will not address the income differences between primary care and specialty care. Primary care is undervalued, yet all the public debate promotes it as the core of care. Payment reform should pay us for what we do. We fill out an inordinate amount prior authorization forms – we have to fill out an authorization form for diabetic supplies for the insurers, in spite of the pharmacies not requiring the documentation. We spend lots of time with phone calls, referrals and care coordination but are never compensated for that effort" – Federally qualified health center medical director

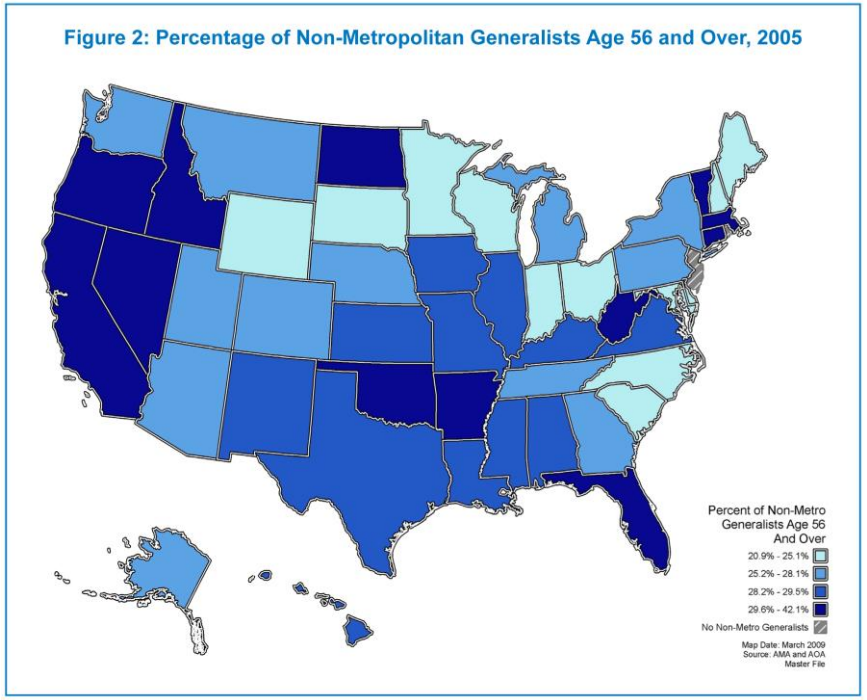
"The most critical core service is primary care; however, the demand for mental health and substance abuse treatment far exceeds our resources and puts an additional strain on the primary care workforce" - Federally qualified health center medical director

4) Aging Workforce
Core Community Practices

"PCPs are aging; there is an impending disaster if the state cannot come up with a strategy for replacement. Many have already closed their practices to new patients" - Community hospital physician

"We've seen a fall off in the quality of the physicians in our primary care community as replacements come for retiring physicians. Salary is most certainly playing a role in this phenomenon" - Community hospital physician

"We need to do some basic workforce calculations to judge the need for the core PCP, psychiatric and hospitalist services for the state's population and figure out a way to pay for it. Relatedly, we need to address the issue that a major barrier to recruiting physicians to the state particularly in these three high need core services is the relatively low salaries Vermont physicians can expect compared to other state settings" - Community hospital physician



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5) Retention and Recruitment

Primary care and Hospital medicine

"Primary care is just not an attractive practice setting anymore. They are being asked to do too much without enough support. The younger physicians are also not willing to be as accessible as physicians were in the past. Come 5 PM and they're gone. This dynamic is changing primary care; it may be helping to sustain the workforce, but there is a price being paid in terms of continuity which compounds the difficulty of the challenges of primary care itself" – Federally qualified health center medical director

"The new reality is that for a hospital to exist, it needs a hospitalist service, but this has come at the cost of both the primary care workforce as the pay and hours are more appealing" - Community hospital chief medical officer

Statewide strategy

"Physician recruitment should be done in a collaborative fashion across all hospitals rather than having each hospital compete with all the others. If Vermont was perceived as having a statewide approach to the physician workforce; one that was based on the needs of the population and capitalized appropriately, the state could be unique and attractive to physicians. This will take strong community support, strong medical staff support and strong physician leadership" - Community hospital physician

"Vermont should recognize that physicians with family ties to Vermont are the most likely to locate in the state. The Medical College should offer preferential status to Vermont residents who are applicants to either the undergraduate medical school or the post graduate residency and fellowship positions" - Community hospital physician

6) Loan repayment and income security

Medical undergraduates, many of whom are carrying $200,000 to $400,000 education loan debts are less attracted to primary care careers because of the large wage discrepancies between primary care physicians and specialist physicians and their subsequent ability to pay off their education loans.

"Loan repayment is very important and not well advertised. The state should invest in more advertisement and more amounts of repayment. Loan repayment could certainly be the deciding factor in choosing to locate in Vermont" - Tertiary center physician

"Nearly all physicians come to Vermont because they are attracted by the lifestyle, the community and the high level of professional ethic in the medical community itself. Financial gain is not their highest priority. That being said, if Vermont physicians were able to be given some security in their future, it might greatly add to the appeal of the state and the appeal of staying in the state. The loan repayment system is an example that attracts physicians, possibly if there were incentives to stay such as aid to children's education or appealing retirement programs, it would stem the tide of departures and help with retention" – hospital chief medical officer

"Young physicians with large debt to pay off will not be able to locate in Vermont as primary care physicians. They will not be able to retire their debt given the income they can expect to earn" - pediatrician

"The GMCB needs to pay close attention to physician salaries in Vermont compared to other states in the region. We recently needed to recruit another hospitalist. The recruiting firms actually laughed at us when they heard our salary offering. They said it was non-competitive, and it wasn't even worth their time to post the job opening. After we were able to raise the salary range, we were able to get someone right out of a UVM residency program which we're very excited about. Vermont salaries are the lowest in the region. Most Vermont physicians did not come here to make a lot of money, but with loans and family obligations, the low Vermont wages can become an issue for those of us here and anyone interested in locating here" - Community hospital physician

7) Team-based Care

Nursing and Case Management

"Payment reform should address the wages of nursing and ancillary health professionals not just physicians" - Community hospital physician

"Physicians are concerned about the reduction in nursing and case management resources that will be available" - Community hospital physician

Allied Health Professionals

"There is an ever present mismatch of patient needs and patient location. Some institutions are always full, while others always seem to be under their capacity. The underlying issues are complex and not limited just to whether there is an empty acute care bed; it involves the clinical capacity of the staffing at the outlying institutions. And it is broader than just the clinical expertise of the physician and nursing staff; it includes ancillary services as well." - Tertiary center physician

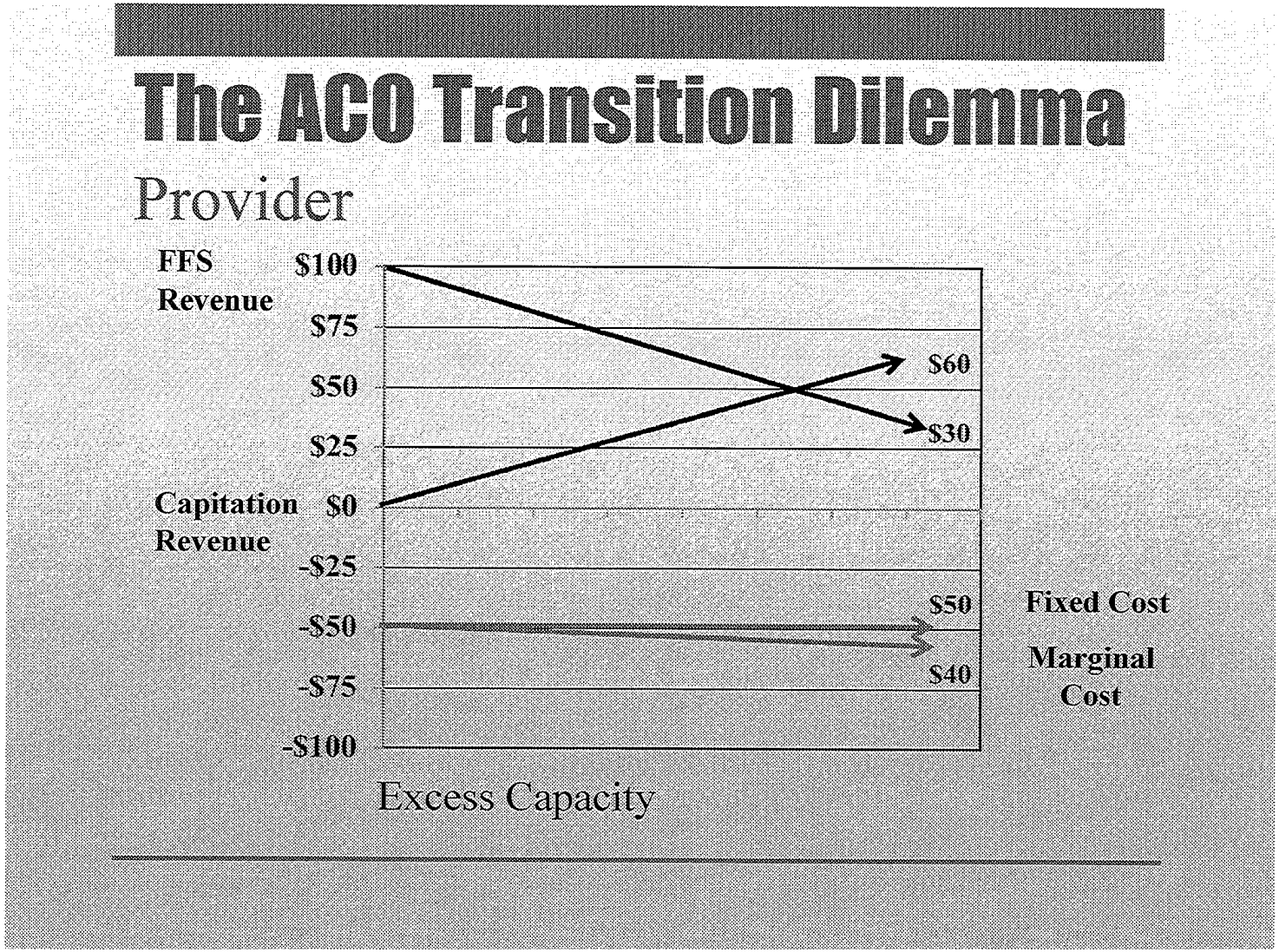
Hospital staffing

"This is an extremely stressful time for our hospital. We're in the process of significant personnel layoffs. Physicians per se have not been laid off, but the effect on staff morale is being felt by all of us. The downsizing effort is a strategic corporate initiative to prepare us for anticipated less inpatient volume –a trend that is being seen locally as well as nationally. The organization is looking under every stone for waste and inefficiencies. The physician staff understands, but nevertheless, it is very stressful for all of us"- Community hospital physician

Non-physician Clinicians

"A growing problem that has us all concerned is the limitation of the current primary care workforce to meet the primary care needs of our community. We have enough mid-level practitioners, but they don't enough access to physician level primary care practitioners. We have a growing number of complex medical patients that are not appropriate for mid-levels to manage. This is a growing concern for both mid-levels and physicians - Federally qualified health center medical director

Staffing – “discretionary cost”



8) Loss of Human Capital

"Our current clinical capabilities are such that we never lose a life because we are missing capacity when a life threatening situation presents itself; but we are all really stressed " – Federally qualified health center medical director

Some rural communities may be able to recruit specialists to come to their small community, but interviewees predict that they won't stay long unless there are unique circumstances. And if such a situation does happen, there is a risk to the quality of care with a specialty physician practicing in isolation from peer support and review. In the current period of transition, communities are trying to continue to offer a wide array of specialty services as older physicians leave or retire by using locum tenems; this is very costly and probably not sustainable. In contrast, having specialty physicians located together in a central location, and including outreach and travel to smaller communities as part of their workload is an attractive and sustainable model in terms of recruiting and retaining physicians.

Medical Specialists

"There is a general sense that we one subspecialist away from a crisis" - Community hospital physician

General Surgery

"General surgery is becoming very difficult to maintain in the community. We currently pay $1400 per day to locum tenens surgeons willing to be on call which is not sustainable for the hospital on a long term basis" – Hospital chief medical officer

Obstetrics and Gynecology

"We currently have obstetric and gynecologic physicians, but this is borne at a loss to the hospital. It may be time for regionalization of obstetric and gynecologic care particularly as the birth rate continues to decrease" - Critical access physician

"We see about 200 deliveries a year, but that is not enough to support the cost of the service. It is also a fair question whether the quality of care can be maintained with such a low volume service" - Obstetrician

9) Loss of Social Capital
Professional Isolation

General Surgery

"The state should move away from the concept of individuals being on call; the system should be on call; a system that is integrated across levels of care, that is team based including mid-levels; and a system supported with a functional EMR" – General surgeon

"One shouldn't isolate the various components of professional and personal opportunity and lifestyle in Vermont – recruitment should emphasis the sum of all the components. Vermont could have enough surgeons if the total package was appealing. Income is certainly a factor, but so is the practice setting including support, work hours, professional enrichment and lifestyle" - General surgeon

Psychiatry

"It is difficult to recruit and retain psychiatrists to Vermont. The pay is relatively low; practice opportunities are isolating; and because of the current scarcity of practitioners, the call schedule and practice demands are unappealing" - Psychiatrist

Obstetrics and Gynecology

"The Green Mountain Care Board should recognize that practicing in a rural Vermont community is not appealing to the majority of practicing obstetricians. Salary is part of the issue in attracting obstetrician, but the greater obstacle is the nature of practicing in a rural setting and the professional isolation of my current practice arrangement. What would be really appealing is a practice setting where I could sit down at the end of the day with colleagues and talk about what we did; it would help us grow as professionals; it would help us learn and help us think…

"I fear for rural communities in regards to the type of physicians who they will be able to recruit. My concern is that they will be stuck with physicians who cannot get along with others, who are loners and don't play well in the sandbox either with their colleagues or with their patients. Vermont should do what the New York hospitals have done – they have single website where a physician can go and find all the work opportunities in the entire state in one place" - Obstetrician

10) Driving?...try practicing medicine while texting…

The Disappointment of HIT

*"**A truly functional and interoperable medical record system would be an attraction to young physicians. The dysfunction of HIT is a national issue, not just a Vermont issue"*** - Primary care physician

EMR's per se

"The EMR has been an enormous disappointment. Our medical records have suffered as has patient care. There are so many simultaneous changes that both the number and the speed of changes compound physician dissatisfaction and concerns" - Tertiary center physician

"Our clinic recently acquired a new EMR; it has made me much less efficient. I spend 90% of my time focused on data entry rather than direct patient interaction. The introduction of the EMR has been the most discouraging and disappointing element of practice in all 34 years that I have been working… since its introduction I no longer talk to patients and families on the phone – I have no time to do so. I just don't have the time that I had in the past; it's been eaten up in little chunks making sure I've checked all the little boxes" – Pediatrician

Interoperability between systems

"Maybe the biggest issue we struggle with and needs the most attention is issue of the inability of the various HIT systems to interact with each other. The lack of continuity in the flow of information is a constant drain on resources and negatively affects care and professional morale. Ironically, if the issue could be solved, it would also be one of the most significant improvements that could help us move beyond the status quo" - Tertiary center physician

"We spend so much time managing the system now rather than caring for patients. Its much worse for the physicians that care for adults. It is so difficult for the internal medicine physician in my practice to access information in the DHMC medical record, that he's given up trying" - Pediatrician

11) Hassle Factors

"Financial returns - our income - is not the primary concern. If a new system is going to require lots of time away from patient care it needs to make sense to us. Measurement needs to be meaningful to be worth the extra hassle of documentation" - Tertiary center physician

Ruining the appeal of VT for Primary Care

"I've practiced primary care in several other parts of the country; Vermont is the best place for primary care that I've been; that being said, if the administrative burden continues to increase, the good intentions underlying the documentation requirements and other administrative burdens will ruin the appeal of Vermont for primary care" – Younger physician in a federally qualified health center

A monster

"Measurement has become a monster in primary care. Primary care is overwhelmed with data; there is very little to squeeze out of primary care in terms of improved care as a result of measurement and reporting. It's gotten to the point where more measurement is not going to make things better; and in fact the current burden is interfering with patient care let alone our capacity to act on the reports" - Federally qualified health center medical director

Disconnect between policy and practice

"There is a disconnect between of the realities of the front line of care and that envisioned by policy makers and public and private officials and bureaucrats" – Primary care physician

Even the patients are complaining

"Physicians and other direct care practitioners are being forced to spend inordinate amounts of time documenting aspects of care that are not directly relevant to the immediate needs of patients - I get it – there is a need to be accountable and justify the wrap around resources being supported, but it shouldn't interfere with care. Even the patients are complaining" - Federally qualified health center medical director

Administrative burden

"Payment reform should be salary neutral for PCPs – the issue of pay is much less important than addressing the issue of administrative burden. We just can't jump through any more hoops" - Primary care physician

12) Link malpractice reform to payment reform

A few interviewed physicians commented on the need for tort reform if they were going to be asked to assume more risk in an effort to reduce the cost of medical care. These physicians are adamant that defensive medicine is very real and very much drives up the cost of care citing they do not have confidence in of the policy literature that states otherwise.

"Related to the FFS incentives that cause unnecessary testing, medical malpractice needs to be addressed. If we are going to be asked to do less for less; they've got to give us a break when it comes to liability exposure. If they want us to deliver the goods, they need to get us off the hook. If we are going to be asked to do less, the system will need to accept some uncertainty. I'm ok with uncertainty, but this system needs to be redesigned in such a way as to support me when I take a risk on the behalf of the system's solvency" - Medical specialist

"Another example of how the system encourages cost is that nearly all surgeons require an abdominal CT scan for children suspected of having appendicitis, yet a recent study at UVM showed that 9 out of 10 times that imaging was unnecessary and did not alter the clinical course or choice of treatment" - Pediatrician

"Medical malpractice is a business; a very big business. Adjudication of claims needs to be taken out of the public civil trial arena; some extra judicial or special judiciary system needs to be set up" - Medical specialist

14) Hopes for the future

"My biggest hope is that reform will work, but my biggest fear is that it will not. There needs to be physician buy in. There needs to be a critical mass of engaged supportive physicians "– Employed primary care physician

Not everyone was ready to hang crepe on Vermont's delivery system, reform being the cause of its demise. Physician anxiety and fears were somewhat balanced by hope. Not a single physician was of the opinion that we did not need to change and reform the system. Some of the more common hopes were that reform would result in a more logical delivery system, a system that made sense to both patients and practitioners and that was guided by an overall transparent logical plan

"We are cautiously optimistic about reform, but it needs to be done on many, many levels. Our biggest hope is that we will end up with a logical system of care based on the needs of our region's population and applied medical science. The patchwork payment system needs to be replaced. Volume of services has to be removed as the major incentive" - Tertiary center physician

"Hopefully, we can build a system of care that is the best way to care for the population in our region. If that could be done, physicians would flock to the region. Those of us already here, would stay. But the logic of the system needs to be clear. Physicians need to understand why they are being required to do things particularly if they intrude on patient care. Reform has to be a complete redesign; the outcome cannot be just more of the same in another package" - Tertiary center physician

"Everyone knows that salaries are lower here. Vermont is attractive because it has a proven record of good health outcomes, the quality of life is high, family ties are important and the supportive physician culture in the state is a draw" - Federally qualified health center medical director

Hopes for the future

***"Everything will work out fine in the long run, but there obviously will be and needs to be lots of change in how we fund medicine. There is a good community of physicians and other health care practitioners in the state; they all are committed to good patient care – that dedication and orientation will ultimately hold its place among all the change around it. The medical ethic is very high in this state; patients will always come* first** "– Employed medical specialist

"If Vermont can prove that health care reform can work and result in higher quality of care to patients and a less intrusive work environment in terms of third party presence, reform itself could attract physicians. They will probably come from other New England states because of the similarity in wages and not from a high wage area of the country. Vermont should pay attention to what pond they are fishing in, in terms of attracting new physicians" - Tertiary center physician

"The state needs to find out what physicians want; and it is not all about the money. Establishing a culture of improvement would be very attractive. A cultural of novel payment strategies like bundles of care and population based capitation would be attractive. No one works in Vermont to make a lot of money "- Primary care physician

VMS Education & Research Foundation
helping physicians help patients & communities

15) Saturday January 25th, 2014

Vermont Academy of Family Physicians

VERMONT DEPARTMENT OF HEALTH

Actualizing reform thru clinician leadership

Better quality, Better health, Lower costs

1. **Core community based and planned regionalized clinical services**
2. **Integrating social and community services with clinical services**
3. **Measuring things that matter to patients, practices and policymakers**

April 3rd – GMCB

- **Community-based dually eligible payment pilot**
- **A Proposal to regionalize General Surgery**
- **Recommendations for Team-based Care in VT**