Testimony to the Vermont Senate Health and Welfare Committee on Bill H.812 and Bill H.761
Vermont Primary Care: The Path Forward
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Dr. Sharon Fine, Dr. Peter Sher, Dr. Jean Andersonn-Swayzee, Dr. Tim Tanner, Dr. Steve Genereaux

Good morning, my name is Sharon Fine. Thank you for this opportunity to testify today. I am a family physician and have been practicing at the Danville Health Center since I graduated from the UVM residency program in 1997. I benefited from Vermont's recruitment and retention program as I spent a month in Danville during my residency, fell in love with the community, and was given great loan repayment through AHEC which allowed me to stay here. I'm also the Medical Director of Northern Counties Health Care which operates 5 Federally Qualified Health Centers (FQHCs) in the Northeast Kingdom. In this role I hear the anguished voices of my providers and others throughout Vermont who are struggling to remain in primary care. We all love the time with our patients but are being pulled away from this due to administrative tasks that add little to patient care. We have reached a crisis point which will erode our primary care workforce unless something changes quickly. My colleagues and I brainstormed on how to avert this crisis, and decided that our best option is to have a voice in healthcare reform to help shape the future of primary care in Vermont. We are all well aware of the national healthcare crisis and that Vermont is working very hard toward healthcare reform. Vermont is unique as we are a small state with a proven track record of working collaboratively in healthcare. We should be able work together to create (per the challenge from Al Gobeille) the "coolest" healthcare system in the nation by shifting to an alternate payment model that includes payment for quality and global budgeting. This system should be built around primary care as evidence has shown that primary care providers working in a patient centered medical model are the most cost efficient in managing acute and chronic medical conditions.

However, primary care physicians are fearful that the new system will be just as burdensome administratively as the old one unless there are some important changes. We want to be able to do what we do best which is spend quality time with our patients to help them make difficult decisions about their health care, and to help them choose wisely about appropriate tests, procedures and treatment. We relish the opportunity see more patients, but need to decrease the administrative burden in the order to do this. Vermont's goal is to increase access to primary care but this could be very difficult since our primary care work force is diminishing. We have an aging workforce - 35% of our physicians are 60 or older in many Vermont counties.[i] [and ii] Existing physicians are burning out. Many primary care physicians are retiring early or transitioning to other less burdensome or more lucrative types of medicine. We have lost the joy in practicing medicine as we are spending more time on documentation, quality reporting and prior approvals. We need to make primary care in Vermont attractive in order to recruit new physicians to the state and to retain our current work force. My colleagues will be testifying about some basic concepts that we believe will go a long way toward improving

healthcare in Vermont. This will result in increased access for our patients to high quality care and bring joy back to practicing medicine for our providers.

Peter Sher is a family physician at the Hardwick Area Health Center and he will share his experiences with you now.

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I became a family doctor because I value getting to know my patients and their families, because I value the rewards of helping folks more than money, and because I value work-life balance more than typical doctors.

I used to spend about 20% more time in the office than I spent seeing patients. Most of this time was spent going over test results and talking to patients about the results, or speaking with other providers about care of mutual patients.

Over the past few years this administrative time has been steadily increasing and changing. As the administrative burdens have increased, I spend less time talking with my patients outside normal office hours, and like many docs I have become increasingly a part-time employee.

It has become increasingly difficult to tie these tasks to developing a better relationship with my patients or their health. I spend more time in meetings that deliver news about administrative burdens that are supposed to make me buy in, but that I clearly have no control over. I used to love practicing medicine for the rich interactions with patients and the stories they would tell, but now I feel increasingly unable to give them the time and attention they deserve. I periodically fall into burnout-angrily questioning my career choice and feeling overwhelmed. I see other docs who are much more stoic than I also falling into burnout. National studies put the rate of burnout at around 50% and it has gone up by 20% in the past 3 years, while burnout in the general population has remained steady at half that rate. Perhaps more concerning is that 39% of docs screened positive for depression and the rate of docs contemplating suicide doubled during that time. All of these statistics are higher for family docs than other docs. I used to enjoy teaching medical students and used to enthusiastically try to guide them to be family doctors but I don't feel able to anymore.

I now spend an additional 60% of my office hours completing administrative tasks. Others spend much more. That means my colleagues and I are there until 8 or 9 pm. A recent study showed a teaching doctor needs staff spending 15 hours per week on admin, and the average family doc spends 3.9 hours per week on quality measures alone, not counting precertification tasks, entering data in a computer, meetings, and the regular extra time to communicate with other providers and patients.[iii]

Jean Andersonn-Swayzee will now share her experiences.

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What if, as a legislator, every time you had a conversation with a constituent, you had to document it? I have met several legislators, and many did take notes. So maybe that doesn't sound too bad. But imagine these notes are required . . . in order for you to get paid. They are in a format developed by others, not by you. And they take so long to complete that you had to spend most of your meetings looking down at your computer typing. Then imagine it was decided that these documents were a vital source of legislator performance data. Every few months, a few more questions were added that you need to log: "On a scale of 1-10, do you like your school district?" And so on. Then the Feds got involved. They had questions that needed answering too! Is this starting to sound less appealing? Would you see this as the path toward creating a better legislature?

My name is Jean Andersson-Swayze and I am a family doctor in Middlebury, Vermont. I wanted to be a doctor ever since I was a young girl. I went to UVM medical school and did my residency at the UVM Medical Center. I love practicing medicine, and I love primary care. I am here today because the policies of organizations under your oversight, are trying to turn me into a scribe. They are taking away the autonomy that gives my profession meaning and layering on burdens that yield little practical benefit to Vermonters, but endanger the keys to health improvement.

The practice I am with, Middlebury Family Health, loves technology. We implemented an EMR in 2011 and were the first primary care practice in the State to achieve a Meaningful Use designation. The practice I am with is quality focused: we scored 98% on our medical home certification. So if I thought that logging more data in my EMR was the key to improving my patients' health outcomes, I wouldn't be here. But as a clinician, I know that the key to making a difference in patients' lives is not going to be found necessarily in their last A1c. The key is to invest in my relationship with them. I need to know who they are. They need to trust me. We need to look each other in the eyes during our visits. Currently Middlebury Family Health is responsible for reporting on 97 different measures. What that forces us to do is spend more time staring at a computer screen and not engaging with our patients. It challenges providers to try to do both at the same time, a danger that I often liken to 'texting while driving' – it is impossible to do both well, and it is dangerous. Often I try to type while the patient is talking and try to click as many boxes as I can knowing that certain elements of my note are required to be completed before the patient has left the office. Yet I realize that this strategy may miss subtle but important communication clues from the patient. In the end, it is a strategy that leaves us both dissatisfied. Some of my colleagues have even resorted to hiring a third person (a scribe) just to handle the documentation and free the physician up for doing what they are trained to do. Talk about increasing the cost of health care! And to add insult to injury, the notes that we labor to produce are so full of these meaningless metrics that the document that is created in the end is almost unreadable! It is not uncommon for me to receive a report from a patient's encounter in the ER that is between 5-10 pages long, but only has one useful paragraph in it that I have to hunt for – why? Because they are full of data that had to be entered that is of little clinical significance. We need providers who are actually practicing to be making these decisions, not bureaucrats who apparently have little appreciation for the

relevance and impact of the metrics. We need a single set of proven measures that is uniform across entities, and measures that are meaningful and easily extractible – preferably through claims data.

Health Affairs last month found that US physician practices spend more than $15.4 billion annually to report quality measures.[iv] Primary care providers spent on average 3.9 hours per week entering information into an EMR for the purpose of reporting for quality measure. If the 600 primary care providers in Vermont spent this time seeing patients, they could do 60,000 more patient visits per year. And which do you think would yield better health outcomes in VT?

We need data, but we are failing to weigh the costs of these documentation burdens and failing to involve the physician community in jointly determining meaningful measures of patient health and provider efficacy. I ask you to take action.

Thank you. I would like to introduce Tim Tanner who is an internal medicine/pediatrician practicing at the Danville Health Center.

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I will briefly describe some documentation issues that add to primary care providers' administrative burden, decrease our professional quality of life and add to burnout, and end with a request for your assistance to facilitate a change.

As this committee undoubtedly has heard before, reducing unnecessary, low value medical care is an important means of controlling medical spending. Just as there are medical tests and treatments of low value, there are documentation requirements of low value, particularly in relation to the monitoring and treatment of chronic conditions. The documentation of a medical encounter should first and foremost impart to the reader what the clinician thinks is the patient's problem(s), and the plan for any evaluation and treatment. Over the past 3-4 decades, and particularly in the past 10 years, additional purposes have been added: billing/reimbursement, quality assessment, and research. The advent of the EHR has facilitated the expanded roles of medical documentation, unfortunately, at the expense of efficiency and clinical utility. To satisfy all of the end-users' needs (billing, meaningful use, quality metrics, registry management and population research), documenting a medical encounter now involves multiple interruptions and diversions of the providers' stream of thought so that specific elements of information are captured in the necessary data fields of the EHR—the hated check boxes and forced template fields. The output of many such "template", check-boxed notes are syntactical swamps, overgrown with information of no clinical value and which suck up time trying to find the important information that will help with the ongoing care of the patient.

Under the current fee-for-service (FFS) reimbursement system, there are incentives to expand the documentation, sometimes with information of limited or no bearing on the current problems, in order to justify the billing level. This additional documentation is textual noise to the reader, and provides little or no value to the care provided.

There are explicit documentation requirements under FFS reimbursement for billing that are better suited for episodic, acute care, but not well suited for the management of chronic conditions. If there is a shift from the FFS system of reimbursement to a more value-based reimbursement system with a global budget, it is conceivable that the documentation requirements for chronic care management can be changed to allow more concise and germane documentation. Any such change has the potential to improve the quality of medical communication. Given that the current documentation guidelines have been issued by CMS, a change may require a waiver from CMS. As the state moves from the present FFS payment system to a value-based model, we ask that revisions to the current documentation requirements be included in the change.

Thank you for the chance to come testify. Steve Genereaux will now present about his experiences with prior approvals.

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I will share examples of how the Prior Authorization process pulls us away from direct patient care.
By way of introduction, I am Steve Genereaux, a Family Physician in Wells River since 1994. I serve as the Medical Director of Little Rivers Health Care, an FQHC that provides primary care to parts of Orange and Caledonia Counties. In 2015, we cared for over 6,000 Vermonters or about 1% of the state population.

I trained at the UVM Family Medicine residency with rotations in Milton, Winooski, Rutland, Chelsea and the VA Medical Center in WRJ. State and Federal financial support for those training sites means there is considerable taxpayer investment in my skills and knowledge. One could think of me and my fellow Primary Care Providers (PCP's) as publicly funded infrastructure. We could be considered human capital meant for the community's benefit; much like our roads, cell towers and bridges. Consistent with this significant investment, the State's healthcare policies should clearly support and sustain the State's PCP resource. State healthcare policy should maximize our time with patients and reinforce our efforts to provide the optimal cost effective care for our fellow Vermonters.

One way to do so is to reduce or remove Prior Authorization (PA) tasks.

Prior Authorization means getting the approval of a third-party to prescribe certain medications or order certain tests. In some instances, merely a form needs to be completed and faxed. Other times it requires faxing actual patient notes. In some cases, it requires a phone call by me to an out-of-State call center where I wait for an operator to connect me to an administrative physician whom I then try to convince of my patient's need for the medication or test. All of these efforts soak up hours of staff or provider time and in the end our requests commonly are approved. We spend time and energy to get the 'yes' answer. This added cost to the system yields no benefit to our patients. And every minute I spend seeking a PA is one less minute for patient care.

Prior authorization is appropriate for rarely prescribed expensive medications such as Harvoni for Hep C, chemotherapy, and HIV medications. On the other hand, it is inappropriate to require me to get permission for a common clinical situation: to double dose acid reducing agents for GERD. Or to get permission to prescribe a smoker who is trying to quit more than 16 weeks of nicotine replacement patches or gum.

Another example is the Buprenorphine Prior Authorization Form which I must fill in and submit to start a patient on buprenorphine. It asks me to confirm that the patient meets routine criteria. These criteria are fully a part of the protocols produced by VT Department of Health and Office-based Opioid Treatment (OBOT) trainers which are used statewide. This renders the form as predominantly for reporting data, and not one that improves the quality of patient care.

Lastly, DHVA Rule 7405 mandates we seek approval for imaging studies. Examples abound of our frustrating phone calls to out-of-state reviewers trying to get permission to image the L-S spine, knee or shoulder of patients with significant worrisome findings on physical exam. Such phone calls need to occur during business hours. As a result, we are pulled away from direct patient care during clinic hours. We want to see and care for our patients, not be on the phone.

You could help us achieve that goal with a healthcare policy change: First, involve PCP's in the scope and clinical reasoning behind pharmacy PA's. And second, discontinue PA's for imaging tests.
Specifically, we suggest that policy change to either exempt those PCP's whose test ordering frequency falls within the statewide norm or, better yet, exempt all Vermont PCP's until an individual is proven to be over ordering; he or she could then be subject to review. Make us innocent until proven guilty, rather than the other way around.

Sharon will now wrap up the testimony.

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As you have heard from my colleagues, primary care is in crisis. We touched on a few changes that will reduce the administrative burden in primary care:

1. Coordinate clinical quality measures and focus them on clinical outcomes instead of processes.
2. Streamline the documentation process so that documentation of a clinical visit serves the purpose of communicating important clinical elements, and is not the vehicle for billing.
3. Eliminate or exempt prior approvals.

We recognize there are details that need to be worked out and that this is not an exhaustive list. Therefore, we would like you to have the Green Mountain Care Board create a Primary Care Council which will be tasked to review and approve changes to healthcare reform impacting primary care.

We ask for you to add language to Bill H.812 and Bill H.761 to require the Green Mountain Care Board to form and staff a Primary Care Council. This group should be composed of 75% practicing primary care physicians with representation apportioned based on attributed lives, and appropriate geographic and practice type composition (private, hospital-owned, FQHC). There will need to be funding to cover lost office revenue to allow these practicing physicians to attend meetings. The Primary Care Council's main charge will be to provide input and approve any healthcare reform that affects primary care. The goal is to shift the primary care work flow/task emphasis from computer based documentation, to face-to-face direct patient care, and to align appropriate quality measures. This will protect and expand the time primary care providers have to truly deliver health are to our communities.

We created some draft language for this Primary Care Council which I will share with you now.

Thank you for taking the time to listen to us today!

[i] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, "The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand," Bureau of Health Professions website, December 2008 available at http://bhpr.hrsa.gov/healthworkforce/reports/physwfissues.pdf

[ii] Vermont Department of Health, "2014 Physician Census Summary Report," VDH website, February 2016 available at http://healthvermont.gov/research/HlthCarePrvSrvys/documents/phys14ppt.pdf

[iii] Dike Drummond, MD, "Physician Burnout Rates Top 50 Percent (And That's Not the Worst Finding)," Huffington Post online, December 15, 2015 available at http://www.huffingtonpost.com/dike-drummond/physician-burnout-rates-top-50-percent-and-thats-not-the-worst-finding_b_8795006.html

[iv] Mike Miliard, "Quality reporting costs doctors more than $15.4 billion a year, Health Affairs says," *Healthcare IT News online*, March 8, 2016 available at http://www.healthcareitnews.com/news/quality-reporting-costs-doctors-more-154-billion-year-health-affairs-says