

Testimony to House Health Care Committee, January 29, 2019

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Little Rivers Health Care

I'd like to tell you first about DeeDee, a young woman I first got to know when she was a cute high-schooler on my daughter's soccer team. After high school, like so many kids in her generation, she got involved in opiates. She got pregnant, spent time in jail. Recently, some years later, she came back to my office for her second pregnancy. During a visit, she disclosed to me that she was in an abusive relationship and wanted to leave. The stress had started her craving opiates again (she has been clean for 2 years) and she was using massive amounts of an herbal supplement that mimics opiate effects. She was sure she was going to use again, and asked to be in a MAT program. At that same visit, she was able to meet with one of our MAT team counselors, and was started on Suboxone a few days later. She gets individual and group addiction counseling with us. Our Care Coordinator was able to help her apply for VT Medicaid (she'd been living with her boyfriend nearby in NH), helped her apply for fuel assistance when she moved in with her mother, where finances were tight. Her older daughter, who has behavior problems, gets counseling at her school from one of our mental health counselors. We have computers for our MAT patients to use so they can work on their resumes, look for work or housing. Today, she's stable in our MAT program and working full time at a hotel. Without our FQHC, she might not have gotten prenatal care at all --the next nearest OB provider is 30 minutes away. And without FQHC status, we could never have offered the scope of services that have had such an impact on and her children's lives.

I'd also like to tell you about Jack, a middle aged patient with COPD. He went to the emergency room with shortness of breath recently. ERs are algorithm-driven. If you come in with shortness of breath, you immediately get put on a heart monitor and oxygen, get an EKG, chest X-ray, and lab work to look for heart attack and blood clots. In many ERs, this happens automatically, even before you are assessed by a physician. I've known Jack for 20 years, and know that he has trouble affording his inhalers. He is supposed to use two of them every day, but they cost nearly \$200/month *each*. I know that he sometimes limits his use of them to save money, and even lets his wife use them at times when hers have run out. In my office, he would have had a simple visit: vital signs, a brief exam, and a conversation with me. At the ER, he was advised to quit smoking, but at my office, he would have seen a Care Coordinator, who can provide group and individual smoking cessation assistance, including free nicotine patches. The cost of the visit at my office: \$165. The ER visit – I'm guessing – but around \$5,000.

You may be surprised to know the scope of services available through our FQHC: OB care, including delivery and C/section by our Family Physicians, hospital care by your own primary care doctor, avoiding the fragmentation that can happen with the more common hospitalist model, colposcopy (a procedure to investigate abnormal Paps), joint injections, skin biopsies, abscess drainage, suturing of lacerations, spirometry (assessment of lung function), and soon, in-office ultrasounds. Our Mental Health team provides Accu-detox (a form of acupuncture that shows promise in treating addiction), Tai Chi and yoga classes for people with addiction and chronic pain, Reiki, EMDR (a "non-talk therapy" for

PTSD that involves reprocessing of traumatic memories) . In our town of 350 people, we now have 5 full time mental health counselors, several of whom go out to 4 nearby schools to provide on-site counseling. We provide topical fluoride treatment for children, and soon will offer on-site dental cleanings and screenings. Our Care Coordinator can link people to state programs, housing options, help write a resume, connect people to job training programs, provide access to computers, transportation to appointments, free medication through pharmaceutical companies, classes for managing diabetes, chronic pain, smoking cessation and healthy living.

**What we need:** the ability to further redesign our practices to meet community needs. In a fee-for-service environment, it is difficult to leave appointments open to help keep people out of the ER, or to spend adequate time with someone who shows up in crisis. We need more of us. At our clinic, 3 of the 4 providers are older than 57. We need to decrease the administrative burden that has hijacked the doctor-patient relationship in recent years.

Bistate can provide specific suggestions to achieve these goals: practice redesign, decreased reliance on emergency and specialist care, attracting and producing more Family Physicians in VT, decreasing administrative burden, and improving meaningfulness of quality measures. I will also mention that I am on the board of the VT Academy of Family Physicians, and am on the Primary Care Advisory Group of the Green Mountain Care Board. All of these groups have remarkably similar goals and ideas on how to support and strengthen primary care, and are also available resources to you.

**What we don't need:** We don't need more money spent on health care. We spend plenty, even excessive amounts already. We do need to rethink *how* we spend it, and build a system that supports broad spectrum primary care, available to everyone, and available in every community.