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After decades of federal and state healthcare reform efforts, each with its own catch phrase, acronyms and political perspective, there is one area of profound agreement. If we want to increase quality and decrease cost, we must provide more primary care. Data shows that patients with a primary care provider (PCP) have better health and lower health care costs. That is even more true when patients can work with a heath care team, get care close to home, and get appointments when they need them. As a family physician in rural Vermont for 32 years, I know this is true. But it's not just my opinion; there is research to back it up. One study shows that for every dollar spent on primary care, $13 is saved in overall health care spending. If we want to decrease the cost of health care, a critical part of the strategy has to be shifting more of our spending into primary care.

But changing how much we spend in primary care needs to be accompanied by a change in the way we pay for it. Our current system, with a fee charged for each service, pushes practices to keep every slot in their schedules full just to keep the doors open. As a result, most primary care providers in Vermont have productivity expectations from their employers, and need to move patients quickly in and out of their offices. That leaves no time to see patients when they need care promptly, and leads to an increase in emergency room visits and referrals to specialists.

A bill on the Senate floor this week, S.197, proposes to change how we pay for primary care. This system would expand on our existing Blueprint for Health program to provide a fixed monthly amount per patient to primary care practices. This type of "per-member-per-month" payment allows flexibility in scheduling and gives PCPs time to see our sickest patients when they need it. This will decrease emergency room visits and lessen the delays patients currently face in accessing specialty care. Monthly payments can be designed to support the things that matter most to our patients; a broad scope of care available close to home, from a provider who knows them. It can give providers the breathing room for more effective communication with specialists, home health and mental health agencies. A per-member-per-month payment could allow for initiatives that bring care to patients in diverse settings, such as school clinics, or mobile vans for substance use treatment and home visits.

The proposed system would also allow practices to invest in health care teams to support complex patient care. A health care team can have many facets, such as on-site counseling, dental care, regular contact with nurses to reinforce self-care at home, and

care coordinators who connect patients with insurance coverage and other services, such as fuel assistance or transportation.

PCPs spend 50% of their time on administrative tasks. That is shocking, sad, and unfortunately, accurate. This decreases access for patients and causes burnout for physicians. The payment system proposed in this legislation would simplify billing, coding and other administrative tasks, allowing PCPs to spend more of their time caring for their patients instead of their computers.

A few weeks ago, I saw a patient who rarely comes in for care. He was booked in a short appointment for a diabetes check. But he also has heart disease, hypertension, and depression. I would normally see a patient like him every three months, but he has difficulty getting to the office because he doesn't drive, and he struggles with motivation due to depression and anxiety. It was easy enough to add the hypertension visit on top of the diabetes visit, but we also discovered that he had not returned to his cardiologist after his heart attack last year, and was still taking a medication which should have been discontinued. We spent time talking about his depression and how it makes it difficult for him to prioritize self-care. He agreed to see a counselor who works in our office. That felt like a big win; it has been many years since he has been willing to do that. As the visit was winding down, he mentioned several new problems which we had not known about. He brought up balance problems, dizziness, falls, abdominal pain, nausea and vomiting. So we had to do a quick pivot for brief neurologic and gastroenterological workups to determine how serious the problems were and decide on next steps. Finally, as I had my hand on the doorknob, he asked, “does anyone have time to cut my toenails today? I can't see them and I can't reach them, and I can't get a ride to the podiatrist.” So we did.

*That* is primary care at its best. In that appointment, we did endocrinology, cardiology, psychology, neurology, gastroenterology, and podiatry. That is the kind of care that we are trained to do and that we love to do, but there is nothing in our current payment system which makes it possible in a usual office day. That’s what makes S. 197 so important and so deserving of support.