Frank J Landry MD, MPH, FACP
Internal Medicine
43 Timber Lane
South Burlington VT 05403
802-860-3940 drlandry@mdvip.com

To: Green Mountain Care Board
Re: Primary Care in Vermont
From: Frank J Landry MD, MPH, FACP

Bruce Hamory's recommendation to the Green Mountain Care Board to reduce doctors' time with patients is completely off base. I have been practicing General Internal Medicine for 37 years and in Vermont for 28 years. During this time, I have seen the complexity of my patients increase, demands of the doctor increase, making it less likely that decreasing the time with patients to be a successful model or solution. It will fail. We do not have enough Primary Care physicians in Vermont despite what his data might support. We are now seeing doctors retire younger, or reducing their clinical time due to burnout, or physician assistants and nurse practitioners choosing subspecialty positions over primary care due to the burden and stress that is put upon the primary care provider. Recruitment of new physicians to Vermont is becoming more difficult as there are better opportunities elsewhere. Primary Care in Vermont is in trouble and I think attracting any new physicians, primary or subspecialty care, is going to be a challenge in Vermont, and this will further stress our healthcare system.

When we look at national data, we see trouble ahead. A Harvard study predicted that the U.S. will have a shortage of primary care physicians ranging from 21,000-55,000 by the year 2033. The American Medical College reports that more than 40% of active physicians in the U.S. will be 65 or older within the next decade and notes that 29% of physicians retire between the ages of 60 and 65, and 12% now are retiring before the age of 60. This will further compound the shortage of clinic physicians providing care to our patients.

In regards to Vermont, the 2020 physician census from the Vermont Department of Health showed that there were 566 physicians providing mostly primary care and this showed a steady decrease from studies from 2016 and 2018. Specifically, for internal medicine physicians, in 2004, there were 177 primary care internal medicine doctors and in 2020 there were 127. Twelve percent in 2004 over the age of 60 and in 2020 that number was 33%. This report also showed time in the office diminished over time, likely due to the increased strains put upon the physician in their practices. Physician burnout is real. Doctors are retiring earlier or seeking employment away from direct patient care. This trend will likely continue, especially as more jobs for physicians are available in non-clinical positions like administration and industry, pharmaceuticals especially.

I can speak about Internal Medicine physicians, but my comments most likely represent those of Family Medicine doctors, PAs and NPs in Primary Care. We chose this profession, rather than subspecialty medicine, because we like continuity of care with our patients---getting to know them, keeping them healthy, diagnosing diseases when they are sick, coordinating their

care, and caring for them at the end of their lives. Time with the patient is needed to do this well, and short of that, we lose the satisfaction of the profession we chose.

I would like each member of the Board to think that "rushed care," as is proposed, is what they would want for themselves or for their family members. I do not think so. Here is a description of one day in my clinic, and if you think a doctor could handle this in a 20-minute visit, please have them come see me to discuss. Here are just a few patients I saw a day last week:

1. 80-year-old hospital follow up with an abdominal abscess, psoas abscess, Alzheimer's dementia, now on hospice and family came to discuss hospital follow-up and a home care plan
2. 89-year-old with ischemic bowel, post resection, high blood pressure, lives alone. Fall risk needing review and care plan.
3. 91-year-old with recent COVID, a fall, chronic kidney disease, a husband with dementia, now moving to assisted living. Care provider comes with her to visit.
4. 80-year-old with cancer who a two-month hospitalization for a life-threatening medical complication after a procedure and survived.
5. 72-year-old patient for annual exam with new shortness of breath, abnormal EKG who needs a nuclear stress test. CIGNA requested records for Prior Auth and denied the procedure requiring a peer-to-peer review (doctor to doctor---they would not accept the information from my skilled nurse). When the time came for the Peer to Peer, the CIGNA doctor did not call. I had to call again and get another doctor (had to miss 2 office visits as total time was nearly 50 minutes with CIGNA). Finally, the CIGNA cardiologist gets on and says "I have reviewed the records and I agree with you that he needs a nuclear stress test so here is the authorization number." Obviously, this was a complete waste of time, but this happens all too frequently and takes us away from patient care.

So, I ask the Board, how would one provide this type of care in a 10- or 20-minute visit?? How would you like to be treated, and how would you like your family to be treated when they are faced with serious medical conditions? Keep in mind, the population is aging in Vermont, people are living longer, and medical care has become more complex than ever as new therapies extend life. Simply put, doctors need more time with patients, not less, and primary care providers' panel sizes will need to be smaller, not larger, going forward.

I served as the Vermont Governor of the American College of Physicians from 2003-2007. During this time, I spent time in Montpelier lobbying for reforms in Primary Care which I had been doing since my arrival in Vermont in 1996. No one listened. After managing a UVM primary care practice for 3 years, I opened a private practice in 2000, and by 2011 I was caring for 2800 patients. I saw no changes in how primary care doctors were paid. I witnessed as the complexity of care increased. I experienced the burdens the health care system was placing on the doctors (prior authorizations for scans and medications, the implementation of electronic records, the demands for certification as a medical home to name a few). I realized that I was going to put my patients in jeopardy as "rushed care" could lead to medical errors that I was unwilling to accept. I took it upon myself to invest my own money and open a preventative health care model with MDVIP. This reduced my patient panel to 600, provides comprehensive exams yearly to all patients, offers same day or next day appointments, 24/7 access to me by

phone---the quintessential medical home. As a physician, age 64, I feel I have been able to extend out my career, provide excellent care, reducing unnecessary ER visits and hospitalizations for my patients. I have established excellent patient loyalty, as well as exceptional satisfaction ratings. I know there is a shortage of such care as daily we receive 2-4 requests from patients asking for such care but unfortunately, I have had a full practice for over 4 years. There is a real shortage of comprehensive Internal Medicine Care in Vermont.

I will outline some of my thoughts for someone to consider:

1. We need to be able to **recruit** new physicians to Vermont, both Specialty and Primary Care (Internal Medicine Physicians and Family Medicine—also NPs and PAs) and other professionals.
    a. All aspects of Vt Government and Hospitals need to work with local planning commissions and allow more single-family housing to be built. In South Burlington, there have been residents who proclaim "NIMBY" attitude and have blocked single family housing in the SE quadrant—a place close to the hospital where there is sewer, and public water infrastructure. We need to inform the public that such actions are going to affect their healthcare in the future as our failure to recruit will harm the hospital and community. Although apartment buildings across from the University Mall might satisfy medical students and medical residents, I do not think a young doctor or other professional and his or her family would expect to live in an apartment when choosing to practice in Vermont. They no longer can afford large properties in Charlotte or Shelburne but just want a house with small yard. I am sure we are seeing similar issues in other parts of the State. We need to understand that professionals often choose Vermont for what it offers but given high taxes and lack of houses (not housing), professionals are finding better opportunities elsewhere.

2. We need to **expand outpatient radiologic and other services**, specifically CT. Imagine if you were driving a new car and brought it to a mechanic whose only tool was a wrench? The mechanic says to you *"to diagnose this problem will require a computer analysis and I will need to call General Motors to get prior authorization. This will take a few days as I will need to do a "Peer to Peer" with the GM mechanic. Once I get the approval, I will then schedule the computer analysis but they are backed up 4-6 weeks as these machines are controlled by the Green Mountain Automotive Board and thus are limited as new machines require a certificate of need. So, we should know what is actually wrong with your car, if I get the approval, in about 4 weeks, and then we will need to schedule the repair which could take another 2 weeks to 4 months depending on what specialty it takes to fix it. The alternative is to take to the GM emergency room today where the wait is about 12 hours but they can do the testing they want and fixing right there for about 10 times the cost".* We need diagnostic tools such as CT, MRI, Echocardiograms, and without prior authorization, readily available to make diagnosis and treatment decisions. Doctors do not over utilize tests because they are available. In 2024, patients are aware of the technologies that should be available and expect to have appropriate care when they need it. We need the tools to practice our trade in 2024. Let the hospital coordinate or centralize scheduling of scans or allow private business to

establish sites for CTs, ultrasound, dexa scans and more. The Green Mountain Surgical Center and OPEN MRI of Vermont are two examples where there is efficient and lower cost care being provided.

3. We need to **unburden the physician with over administration**. *Let them practice their profession.* a) <u>eliminate prior authorization</u> of CT, MRI and cardiac diagnostic studies---in 30 years of practice I have never been denied a study I needed. Unfortunately, the fight and time to get them approved is not just frustrating but takes away for patient care. b) For primary care, be open to *physician run models* and *embrace different models of care*. Back in 1996, about 60 percent of primary care physicians were in private practice. They had "*skin in the game*". They owned their practice and were less likely to abandon their practices or shift location. Hospitals could partner with doctors and help establish care out in the communities. This would be less centralized and more convenient for patients—like it once was! Hospital-run clinics should have less non-physician administrators and return to the past where doctor leaders where in charge as these physicians have more on the ground knowledge of what works for their doctors and patients. Accept that there are *alternative models in primary care* and that some patients want by these types of care. These include direct primary care and models like MDVIP. We need **<u>all models</u>** to care of our population and we need to get away for "one size fits all".

4. **Support the physicians and providers that we have** as we *cannot afford to lose a single one*, Primary care or Specialty. Our ability to recruit is threatened by our state economics---lower physician salaries than elsewhere, high real estate and property tax costs, lack of availability of single-family homes---thus we need to hold on to what we have. We need to be attentive to needs of the providers---*flexible work hours* and *extending their careers as clinical providers*. The physicians at *UVM Medical Center* are critical to the mission of our academic medical center—*excellence in clinical medicine, education and research.* The solution to the physician shortage is <u>*not*</u> to disrupt this balance by converting their important non-clinical work for more clinical hours. These academic opportunities are what *attracts excellent physicians* to our medical center. Let us not lose this talent. We also need to remember that there are so many opportunities to take any physician out of *clinical* work—consultation with industry, internet, administration, early retirement. Once a physician does not see patients for a year or more, it is unlikely they will go back to clinical medicine. Retirement of doctors in the early 60's is now common. They still have a lot to offer as clinicians with their knowledge, skill, leadership and teaching abilities. We need to continue to find opportunities to extend their clinical careers, hold on to them and not push them out of clinical medicine.

Primary care in Vermont is on life support. Recruiting young talent, specialty and primary care physicians is a challenge. Increasing panel size and diminishing time with patients is no solution. I hope the community, hospital administrators and patients recognize the great challenges we have in health care in general but we really should be worried about what is happening in Vermont. The system does not run well without physicians. It seems wise to

assemble a work group of physicians from across the state to advise the Agency of Human Services as they seek to implement Bruce Hamory's recommendations.

Sincerely,
Frank J Landry MD
Frank J Landry MD MPH FACP
802-860-3940 or 802-233-9524 cell
drlandry@mdvip.com