A new GMCB Public Comment has been received.

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Topic: Community Engagement: Hospital Sustainability and Act 167

Comment: I write as a physician living in Vermont but currently working in New Hampshire within the Dartmouth Health system. I was, though, involved with the Oliver Wyman consultant engagement and was interviewed while I was in my former role as the Chief Medical Officer at Porter Medical Center. I am deeply aware of the suffering within the system- patients, families and healthcare workers and I have listened to many in our community that have barriers to healthcare or are frustrated with the current state of healthcare delivery. Regardless of my individual perspectives on what the report gets correct, I am most concerned about what comes next and how. Having been involved with the GMCB proceedings and now reading about them, I have deep reservations about the manner in which the Board interacts with hospitals and health systems. If we are to be successful as a state, GMCB and hospitals must find a new way of working together; the adversarial relationships have not advanced healthcare quality or improved affordability and have eroded trust both in the hospitals and the regulatory body. I am concerned that the GMCB will take immediate actions that further threaten the financial stability of hospitals across Vermont without first addressing conditions for success; acknowledging that many of these actions are outside of the scope of the board. Namely: reducing administrative burdens (like prior authorizations), increasing housing, improving regional EMS and transportation services, expanding bed capacity in some areas prior to shuttering others. Working on sharing resources across sites (whether it is physicians or administrative professionals or contracted services) is good practice but it will take both time and support for hospitals to work together in these ways. It will be incredibly detrimental to progress if commercial rates are capped prior to addressing the above conditions. Clinically, there are a multitude of recommendations in the report that bring up concern for me and I will highlight several: 1. Increasing Provider Productivity. Focus on provider productivity (whether Primary Care or Specialists) is important as it relates to access to care. However, wRVUs do not capture all the work performed by providers or their value to the system. The amount of administrative tasks that are uncompensated and done outside of clinical encounters is massive. Additionally, if we are to provide specialties other than primary care in communities, we balance offering appropriate services locally including 24/7 coverage for emergencies. Use of wRVU productivity targets has been linked to increased stress and rates of burnout. It would be better to focus on access, schedule utilization (both in office and OR), and panel management as optimizing these will also lead to improved productivity. Our healthcare workforce is fragile; it's been a challenge to recruit to Vermont- blaming physicians for not being "productive" without addressing and removing administrative burdens is divisive and harmful. 2. Creation of Rural Emergency Hospitals. While some hospitals have very few inpatient admissions, those people are likely well-cared for and benefit from family support while they are treated in their home community. Family support is critical in the healing process as well as necessary for effective discharge planning. Many families in rural areas do not have time or money to travel for >1 hour to another hospital to visit with loved ones and participate in family meetings. There are pitfalls in relying on outbound transfers as there are often a shortage of Medical Surgical beds in Vermont. Moreover, until we can also increase affordable options for extended subacute rehab and long-term care, our state will continue to be constrained by lack of available appropriate acute care beds. (Please see second message)

Comment: (2nd portion of comments) 3. Birthing Centers. To suggest that patients would be served better by independent Birthing Centers rather than at a hospital-based OB unit demonstrates a lack of understanding of Obstetrical care. From a safety perspective, a low-volume birth center in a remote area will not be better for patients. Obstetrical emergencies are unpredictable, rapid, and have a high degree of morbidity. Birthing centers should be in reasonable proximity to a hospital that can care for pregnant people and their newborns. Placing them as an alternative to a hospital-based unit will increase patient risk. I am not opposed to Birthing Centers, but they are not a viable alternative in a rural area when there is not an appropriate facility within 30 minutes for transfer. While OB units are not directly profitable to hospitals, they are often feeders for other services (Pediatrics, Primary and Specialty Care). Moreover, small communities have a challenge in expanding their population when there is not a safe and viable place to give birth as childbearing people are less likely to choose to move there without that access. 4. Replacing ED physicians with Advanced Practice Providers: I believe that Advanced Practice Providers are competent clinicians who provide excellent care to our patients in all settings, including the Emergency Department. However, while there is a financial advantage, they are not a substitute for physician-led care. Especially in a low-volume, low-resource setting- the experience and training of a physician is necessary to treat the most severe emergencies- even if they are rare. This will certainly increase our risk of severe morbidity and mortality in those areas. 5. Hospitals at Home. I think the move towards more home-based care is both the right thing clinically and financially for both healthcare organizations and many patients. I believe, though, there is much more to learn about how to do this well in rural settings. Even in the Middlebury HSA, which is relatively well-educated and well-resourced, I have encountered many patients who would not be able to manage this- whether it is poor home infrastructure or lack of family support (or family at all). 6. Changing people's jobs. On slide 56, the heading states "Hospital staff from Inpatient units can easily be redeployed at healthcare facilities within the community". This lacks understanding of the differences in scope of practice and professional interests. I believe this has potential for further constraining our healthcare workforce; when people's jobs are eliminated, they often seek the opportunity to do the same job elsewhere. The changes listed are not equivalent work and I would be concerned about outmigration of healthcare workers. Finally, the report fails to address major costs to the system, specifically the ballooning costs of technology, supplies, and pharmaceuticals. Labor costs are increasing rapidly and will continue to as demand for professionals (nursing, technical, support) outpaces supply. I want to reiterate my understanding of the imperative. Our system is unaffordable and unsustainable. In order to transform, though, we first need to repair relationships between those providing care and those regulating it. Our communities deserve better. This work will only be successful if all parties can come together in a collaborative way. This will likely require additional oversight and the creation of clear expectations for scope and responsibilities as well as emphasis on transparent and collegial interactions.

Post Comment: Yes