September 23, 2024

Green Mountain Care Board
144 State St
Montpelier VT

Dear Board Members,

I'm writing to give my perspective as a retired primary care internist, and now a patient of North Country Health Systems, on the Oliver Wyman Life Sciences report pursuant to ACT 167.

My career at North Country Hospital began nearly forty years ago as a primary care provider in Island Pond with what was supposed to be a temporary stint as a National Health Service Corps assignment. Much changed throughout my years in practice, but what did not were the challenges of providing care to an aging, isolated population with few self-supporting resources and the limited support tools in this very rural area at my disposal to help them. I made frequent house calls throughout my career for the elderly and disabled, traveling the bumpy backroads, after my usual clinic hours- anathema in our age of expediency and efficiency in healthcare. But the poor and the isolated elderly can't conform to our expectations.

I know you are well aware of our demographics: that North Country Hospital serves the two most sparsely populated countries in the State, Orleans and Essex Counties; that those counties have the lowest median household income in the State; and that we serve a disproportionate share of Medicare and Medicaid patients, and specifically those who are duel eligible. With low population density and a lot of dirt roads off the main county roads transportation can be difficult, especially in winter and mud season. Many of our isolated elderly live in these far flung areas. Home services are limited. Crises are common.

I am aware from one of my colleague's communication with Dr. Hamory that his recommendations for NCH focus on the inpatient unit as 'unsustainable'. It is true that NCH has done a commendable job transitioning much of what used to be provided inpatient to the outpatient setting as medical care has evolved. Higher level care that I used to provide in the ICU and other specialty care are referred directly to tertiary settings as medical standards have improved and acute transportation has evolved. Our average inpatient census now averages around fifteen patients a day. But those remaining inpatients are those very people I referred to above- the old, sick and in crisis. Their and their families resources are few. Transportation is a challenge. Compliance and trust can be poor. Knowledge of the system and how to navigate it is low. They are our most vulnerable patients. On every given day several of those patients are in one of our transitional care beds receiving skilled level services and awaiting a nursing home bed. They survived their crisis but are no longer able to manage safely at home. It's an old story for the Northeast Kingdom.

We also know that closing inpatient units, while seemingly expedient, has negative trickle down effects by: decreasing hospital revenue; adversely affecting other services such as general, orthopedic and GYN surgery, and labor and delivery that all require access to inpatient services; and risks the retention of our high quality medical providers. The negative revenue effects spiral and a hospital effectively ceases to be a community resource. And we know from data that rural hospital closures increase patient mortality. If you've ever tried to drive down Route 91 over Sheffield Heights in a winter storm that will make perfect sense.

Act 167 directs the GMCB to 'take into account Vermont's rural nature' and the areas of the State that are 'remote and sparsely populated. It also mentions making meaningful impacts on health equity, specifically inequities of access, quality and outcomes. North Country Hospital, and our patients, deserve support managing payment reform, not threats that limit access.

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