Dear Members of the Green Mountain Care Board:

I am a primary care internal medicine physician who has practiced in Barre, VT for more than 20 years. I am also the Governor of the Vermont Chapter of the American College of Physicians (ACP). ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students, including more than 300 Vermont members. These comments are in response to the Act 167 Community engagement Report: Recommendations by OliverWyman.

The report raises very serious concerns about the sustainability of Vermont's health care system. Rising costs and shifting demographics are serious problems and should raise alarm. ACP Vermont is eager to be a part of the solution to issues the report raises. However, many of the assumptions of the report seem flawed, and I am concerned that if implemented many of the report's recommendations will further weaken Vermont's health care delivery system. It is essential that those charged with decisions about our health care system carefully consider all changes and their potential repercussions; not doing so may have dire consequences for Vermont residents, particularly those who are disadvantaged and/or live in more remote areas.

Differences in health outcomes between urban and rural areas are well documented.

According to the US Centers for Disease Control (from https://www.cdc.gov/rural-health/php/about/index.html):

"Several demographic, environmental, economic, and social factors may put rural residents at higher risk of death than people who live in urban areas. This is especially true for the top five leading causes of death: Heart Disease, Cancer, Unintentional Injury, Chronic Lower Respiratory Disease, Stroke."

"People who live in rural areas in the United States tend to be older and sicker than people living in urban areas. Rural residents have higher rates of cigarette smoking, high blood pressure, and obesity. They also have higher rates of poverty, less access to healthcare, and are less likely to have health insurance. Unintentional injury deaths are more common in rural areas than in urban areas. This is partially due to motor vehicle crashes and opioid overdoses."

Hospital closures impact patient access to care. The U.S. Government Accountability Office (GAO) examined over 100 rural hospital closures from January 2013 to February 2023 in its report **Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services** (from https://www.gao.gov/products/gao-21-93)

"GAO found that when rural hospitals closed, residents living in the closed hospitals' service areas would have to travel substantially farther to access certain health care services. Specifically, for residents living in these service areas, GAO's analysis shows that the median distance to access some of the more

common health care services increased about 20 miles from 2012 to 2018. For example, the median distance to access general inpatient services was 3.4 miles in 2012, compared to 23.9 miles in 2018—an increase of 20.5 miles. For some of the less common services that were offered by a few of the hospitals that closed, this median distance increased much more. For example, among residents in the service areas of the 11 closed hospitals that offered treatment services for alcohol or drug abuse, the median distance was 5.5 miles in 2012, compared to 44.6 miles in 2018—an increase of 39.1 miles to access these services.

"GAO also found that the availability of health care providers in counties with rural hospital closures generally was lower and declined more over time, compared to those without closures. Specifically, counties with closures generally had fewer health care professionals per 100,000 residents in 2012 than did counties without closures. The disparities in the availability of health care professionals in these counties grew from 2012 to 2017. For example, over this time period, the availability of physicians declined more among counties with closures—dropping from a median of 71.2 to 59.7 per 100,000 residents—compared to counties without closures—which dropped from 87.5 to 86.3 per 100,000 residents."

It is striking to me that while the Act 167 Community Engagement Report seeks to improve health equity and access, it puts forward many recommendations that would undermine it.

As someone who has practiced primary care internal medicine in the state of Vermont since 2003, I have witnessed extraordinary changes in health care delivery, as well as the increasing complexity of medicine and the patients I care for. To suggest that we can solve health care professional shortages by asking primary care physicians, specialist physicians, or advance practice clinicians to simply see patients faster is ridiculous. Likewise, measuring our systems by the number of patients seen (as opposed to the numbers and complexities of the patients cared for and the value of care provided) seems short sighted. If the goal is to provide the type of comprehensive, preventive primary care that will keep complex and vulnerable patients from needing emergency or hospital services, we will not realize that goal by asking physicians and advance practice clinicians to work at double speed.

We all deserve access to timely and thorough care. Attempting to force physicians and advance practice clinicians to see more patients will undermine the ability to recruit and retain health care professionals in Vermont. We are already facing a crisis of burnout among health professionals. It is increasingly difficult to recruit physicians to rural areas and it is essential that the GMCB not take actions that will worsen this problem.

Vermont needs to do better than a two-tiered system of health care delivery -- one that would allow access to hospitals, emergency departments, obstetrics services, and surgical care in population centers, but deprive those in more remote areas of timely access to primary, emergency care, and specialty care services. It's one thing to draw arrows on a map, but an entirely different thing to take care of vulnerable patients. As a primary care physician, I continually witness tremendous variation in my patients' abilities to self-advocate. When systems are disrupted or removed, patients fall through those cracks and it is the more vulnerable patients who are impacted the most. Losses in access to hospital

services, birthing units, and outpatient physicians in rural areas will result in worsened health outcomes and increased deaths, particularly amongst the most vulnerable Vermont residents.

I also strongly reject the suggestion that UVM Medical Center should step away from research and education. These missions are part of the pipeline that brings students, trainees, and attending physicians to Vermont. I myself came to Vermont to train and stayed here. Any attempts to change this will undermine physician recruitment and retention in Vermont. UVM's continuing medical education programs (and the participation of UVM faculty in other local programs) play a critical role in ensuring that Vermont's physicians and advance practice clinicians have ongoing access to high quality educational programs.

The state of Vermont needs to do more to ensure that our hospitals and medical practices are stabilized. We cannot cost-cut our way out of providing high quality medical care or ignore the challenges facing medical practice in Vermont today. Now is the time to act to stabilize our primary care, specialty, and hospital services, not undermine them.

Thank you for your consideration, and I would welcome the opportunity to provide additional input on behalf of Vermont ACP as the Board considers its next steps.

Sincerely,

Priscilla Carr MD, FACP (she/her)

Governor, Vermont Chapter, American College of Physicians

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