The Green Mountain Care Board
And
The Vermont Medical Society Education and Research Foundation

A Qualitative Research Project

Optimizing hospital based care in the Vermont region:

Better care, better health and lower costs

VMS Foundation White Paper

This report is the second in a series of reports from the VMS Foundation providing the views of Vermont physicians and other leaders on topics critical to the future of our state’s health care system
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Preamble

This white paper is the result of a partnership between the Green Mountain Care Board (the Board) and the Vermont Medical Society’s Education and Research Foundation (the Foundation), a public-benefit corporation whose purpose is to advance the public good by supporting educational and research activities in the field of health. The Foundation has been fortunate to receive core capacity funding for the past two years from The Physicians Foundation of Cambridge, Massachusetts.

In April of 2013 conversations began between members and staff of the Board and the Foundation exploring approaches to involve practicing physicians in a collaborative process among themselves and with the Board to rationalize care delivery, improve quality, reduce variation and shift the principal focus of reform to health improvement. The discussants shared the opinion that the sum of these issues is the epicenter of health system transformation in both Vermont and in the country; everything else should aim to support this work, or any effort to control costs and improve quality will be fleeting.

The Board having responsibility for a number of areas of health care regulation, strongly desired input from the practicing physician community on how they should change and reform regulatory processes to further the health care reform goals of the state:

1. Reduce health care costs and cost growth;
2. Assure that all Vermonters have access to coverage for high-quality health care;
3. Support improvements in the health of Vermont’s population; and
4. Assure greater fairness and equity in how we pay for health care.

The result of these conversations was a qualitative research effort managed by the Foundation and co-funded by both the Foundation and the Board. The focus of the research is to elicit physician opinion on three topics directly relevant to current Board activities:

- Health resource allocation planning;
- Measurement of health care processes and outcomes; and
- Payment policy and payment reform

The research effort has generated two white papers. Both white papers are based on structured interviews with practicing physicians. One group of physicians consists of the lead physicians for inpatient care at the majority of the region’s hospitals. The second group of physicians includes mostly primary care physicians practicing in contiguous communities in the central eastern part of our state; two general surgeons, an obstetrician gynecologist, two pediatricians and two psychiatrists also participated in the section research effort.

Both sets of physicians were asked 10 similar questions. The answers provided by the inpatient physicians focused for the most part on inpatient care; the responses from the group of physicians in the second group referred to broader community wide needs. There was a great
deal of similarity between the responses in both sets of interviews; and the reader of both white papers will find reference to many of the same issues across the two groups.

The document you are currently reading is the product of research focused on inpatient services, and represents the aggregation of structured interviews during the summer and fall of 2013 with 17 Vermont physicians who are responsible for the hospital care of Vermonters. Interviewees included the lead physician at eleven Vermont hospitals and the former lead physician for the Dartmouth Hitchcock hospitalist service. Physicians from all sizes of Vermont hospitals are included: critical access hospitals, community hospitals and Fletcher Allen Health Care in Burlington. The only hospitals not included in the interviews were Copley Hospital in Morrisville, Porter Hospital in Middlebury, Grace Cottage Hospital in Townsend and Central Vermont Medical Center in Berlin. Grace Cottage does not have a hospital medicine service; the other three hospitals did not participate due to time constraints on behalf of their physician staff.

Each physician was asked to respond to questions about what core inpatient clinical services should be available to Vermonters, and how health resources should be allocated across the region. Physicians were asked how to best measure the quality of inpatient care and how payment reform could best support good care. The interview also included questions about physician hopes and fears about the future of care in the state, specifically how to keep Vermont an attractive place for physicians to practice.

The Executive Summary is structured to highlight recommendations to the Board on issues of mutual interest. Recommendations were chosen in an attempt to balance the importance of the issue with the likelihood that the Board would be able to actualize the promise of their efforts.

Each recommendation is referenced to one or more of the supporting six sections that comprise the body of the document. Not every section lines up with a specific recommendation, though some do; rather the sections follow more closely the questions asked in each interview. The sections contain quoted material from the interviews. The reader is encouraged to read the sections to gain a fuller understanding of the opinions of the physician leaders who contributed to this effort.
The Green Mountain Care Board and the VMS Foundation are grateful for the contributions of the following professionals who contributed to this report:

Aida Avdic MD, Brattleboro Memorial Hospital
- Director of Hospitalist Medicine BMH

Amy Gadowski MD, Brattleboro Memorial Hospital
- Hospitalist BMH

Steve Grant MD, Fletcher Allen Health Care
- Associate Director of Hospital Medicine, FAHC and UVM College of Medicine

Rick Hildebrandt MD, Rutland Regional Medical Center
- Hospitalist RRMC

Martin Johns MD, Gifford Medical Center
- Director of Hospitalist Medicine GMC

Bill Palmer MD, Mt Ascutney Hospital and Health Center
- Hospitalist and former Acting Director of Hospitalist Services MAHHC

Mark Pasanen MD, Fletcher Allen Health Care
- Director of Hospital Medicine, FAHC and UVM College of Medicine

Joe Perras MD, Mt Ascutney Hospital and Health Center
- Director, Hospitalist Services MAHHC and former Director of Hospitalist Services at Dartmouth Hitchcock Medical Center

Jim Poole MD, Southwestern Vermont Medical Center
- Hospitalist Dartmouth Hitchcock Putnam, SVMC; Director of Hospitalist Medicine SVMC; and Medical Director of Medical Affairs SVMC

Mary Ready MD, Northeastern Vermont Regional Hospital
- Hospitalist NVRH

Allen Repp MD Fletcher Allen Health Care
- Health Care Service Leader & Division Chief, Primary Care Internal Medicine, Fletcher Allen Health Care & Univ of Vermont College of Medicine

Chris Rickman MD, North Country Hospital
- Director of Hospitalist Medicine NCH

Mike Rousse MD, Northeastern Vermont Regional Hospital
- Director of Hospitalist Medicine NVRH

David Shea MD, North Western Vermont Medical Center
- Director of Hospitalist Medicine NMC

Heather Smith MD, Rutland Regional Medical Center
- Medical Director of the RRMC Hospitalist Program

William Tock MD, Southwestern Vermont Medical Center
- Hospitalist Dartmouth Hitchcock Putnam, SVMC
Executive Summary

This executive summary highlights recommendations for optimizing hospital care in Vermont from physician leaders responsible for the majority of the in-hospital care in the region. The recommendations are made in the spirit of helping the Board succeed in their enormously important work to design a Vermont health system for the 21st century. The summary is followed by six sections each of which voice physician opinion on topics of mutual importance to their patients and to the Board, both in its role as a regulatory body and as a catalyst for change. The physicians involved in the process all express interest in continuing to work with the Board in efforts to develop additional specificity to the recommendations and partner with the Board to actualize the promise of health care reform in the state.

1. Construct a health resource allocation plan for the state population as a whole

The chief determinant of allocating capacity and location of inpatient resources should be the overall medical needs of the state’s population. The state should leave behind planning constructs that consider each community separately. The state should discourage each community health system going it alone and competing with each other in a costly arms race for patients needing profitable services. The Board has statutorily established responsibility for the Vermont Health Resource Allocation Plan. The Board should not allow resource distribution on a community by community basis, but insist that the Resource Allocation Plan makes sense from the perspective of the population as a whole. We know how many people live in Vermont. We know where they live. We know what the burden of illness the population bears. We can reliably predict what the medical needs of the population will be from year to year. We can reliably predict where the patients in need live. Section 2 - Health resource allocation plan offers the reader more detail about physician opinion on a rational health resource allocation plan for the state based on the state’s population as the key planning metric.

2. Weight heavily patient centric considerations

The Health Resource Allocation Plan should guarantee equal access for all Vermonters; equal access not necessarily meaning equal distance to care. Equal access can be achieved in remote areas of the state through enhanced transport capability and enhanced telecommunication among care levels. Core clinical services should be readily available to all Vermonters regardless of where they live. In their considerations on allocating health resources across the state, the Board should weigh heavily issues of equity and patient centeredness. Consideration should be given to pushing services out into the more rural parts of the state rather than consolidating all resources in the more populous areas. Why shouldn’t services travel to patients rather than patients traveling to services? Section 2 - Health resource allocation plan has additional detail on the importance of recognizing patients’ perspectives on
3. Plan three levels of hospital resources

The Board should establish three levels of inpatient care as building blocks for a statewide system of care in the Resource Allocation Plan:

- a. Community based care;
- b. Regional centers of excellence; and

The three care levels should be defined in terms of the severity and complexity of patient illness that can be appropriately cared for at each level. Subsequent determinations on appropriate expenditures for physical plants and technology can be made based on the clinical needs of typical patients at each level of care. Patient need would drive allocation of technology and other capital expenses. The location of the three levels of care should be determined by the overall needs of the state’s population and the overall financial solvency of a statewide system of community based care.

a. Community based care

The inpatient services included in this level of care are: adult general internal medicine; and general surgery. This inpatient capacity must be closely coupled with: a) an emergency department; b) an emergency medical service able to safely transport critically ill patients; and c) formal arrangements for constant immediate support from distant specialty services.

Adult Medicine

Patients appropriately cared for at this foundational level of care will have needs typical of the majority of the current medical inpatient population in the state. Typical patients would be those in need of palliative and end of life care, treatment for common acute community acquired conditions, treatment for patients with chronic conditions needing brief inpatient interventions, and subacute rehabilitative care.

General Surgery

Providing general surgery at all community hospitals is already a challenge due to national trend in less physicians being interested in general surgery as a career and the aging current workforce. Vermont has not been spared this hardship. Potential solutions include cross coverage across institutions, enhanced telecommunication ability to support around the clock general surgery consultation and close working relationships between/across community based level hospitals and strategically located regionalized centers of general surgery excellence.

Not all community based care hospitals necessarily need to have the capacity to support inpatient surgery; rather the surgical procedure and immediate post op care could be done at a strategically located regional center of general surgery, but patients not likely to need repeat surgery could be transferred back to their community based level of care for recovery. Outpatient general surgery could be more widely available and sited at smaller hospitals. It is unrealistic to expect that general surgeons will be present 24/7 at every hospital. Rather than having individual physicians on call, a statewide surgical system should be on call for emergencies with strategically located acute care surgical emergency capability.

b. Regional Centers of Excellence

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Both the scope and the intensity of inpatient services will be expanded in the proposed regional centers of excellence in comparison to that present at the community based hospital care level. The location of these expanded resources should again be based on the needs and location of the entire state population. Market forces over the past few decades have already somewhat paired facility size and clinical capacity to the needs of the immediate population, but not necessarily with a result that benefits the entire population. Consideration should be given to locating these centers in community based care level facilities for economies of scale related to supporting a full time operating room to ensure efficient and timely access to general surgery and obstetrics. Many hospitals are currently supporting maternity care at cost, and thoughtful earnest discussions are needed towards developing a rational equitable and affordable system of obstetric care across the state.

Medical and surgical specialty care
These regional centers of excellence will have the workforce and resource capacity to care for patients too ill to be cared for at the community based care level. Centers of excellence will be developed for those medical and surgical conditions that require specialty expertise and expensive technology that cannot be justified either in terms of population need or cost at the community based level of care. Surgery examples include urology, orthopedics, obstetrics, gynecology and otolaryngology. Medical examples include cardiology, neurology and gastroenterology. Surgical centers of excellence will necessarily have fully functioning operating rooms; medical centers of excellence will have expanded ICU capacity and capabilities.

It is possible that all hospitals would offer both community based care and at least one center of excellence, e.g. obstetrics, orthopedics, cardiology, laboratory or radiology capacity. Decisions regarding the location of both community based care and centers of excellence would be principally driven by the overall medical needs of the state’s population, but would also consider the financial viability of hospitals, their economic importance in their communities and maintaining rural practice as an appealing option to young physicians. Physicians do not like to be isolated. Clinical medicine by its nature involves uncertainty and unpredictability; peer support is essential if one is to remain in practice. If the state expects adequate physician presence in our rural settings, attention needs to be paid to ensuring that these rural physicians are supported locally and regionally by their peers and clinical teammates.

c. Tertiary Care
Fletcher Allen and Dartmouth Hitchcock should continue to serve the state’s tertiary care needs. However, the two institutions need to work together more to maximize the safety, effectiveness, efficiency, timeliness, equity and patient-centeredness of tertiary care in the region.

Duplication of tertiary services
There is duplication of clinical services and their associated technology resources between the two institutions. Just as this document recommends a Vermont Health Resource Allocation Plan that is population based and demands coordination of resources within the state, it is also the recommendation of the contributing physicians that there be an identical purposeful plan for location and coordination of tertiary care across the region; and that our local tertiary care resources are coordinated with the national referral centers in southern New England and New York state.

That being said, both Fletcher Allen Health Care and Dartmouth Hitchcock Medical Center have another very important role in regards to the future of the delivery system in the state in that they are the two regional academic medical centers. As teaching institutions they host
Vermont’s educational and training programs for the state’s future health care providers. Their role in maintaining quality professional workforce needs to be recognized when developing a plan for coordination of tertiary care across the region. In order to maintain a curriculum meeting the requirements for students, residents, or fellows, there may need to be certain clinical services offered in both locations. Duplication of services may be needed for educational purposes.

The reader interested in learning more about physician opinion about constructing a health resource allocation plan around the concept of purposeful stratification and coordination of hospital services across the region will find more detail in Section 2 - Health resource allocation plan.

4. Care for patients at the right level of care through coordination of resources
One of the principal collective challenges to the current inpatient capacity in the region is the need for more tertiary care capacity. An everyday challenge across the region is freeing up beds at the two tertiary care centers for new critically ill patients. At any time there are typically 10 patients waiting for a bed at Dartmouth Hitchcock, but finding acute care beds in outlying hospitals that can safely accept stable patients who no longer need tertiary care is difficult. The gap between the severity and complexity of illness of inpatients at the tertiary care centers and what can be safely cared for at the outlying institutions has widened in the past decade due to a variety of factors including advances in technology at the tertiary center and changes in the professional workforce, practice patterns and institutional capacity at the outlying hospitals. Section 2 - Health resource allocation plan offers the reader more information about this key recommendation.

5. View the direct care workforce as the key resource
The professional healthcare workforce that directly interacts with patients is the paramount resource in health care, and the Vermont Health Resource Allocation Plan should recognize the immediate and future challenges to ensuring an adequate healthcare workforce in Vermont.

Teamwork
The workforce consists of discretely identified professions such as nursing, physicians, mid-level practitioners and allied health professionals. However, the provision of good care is the result of teamwork and coordinated supportive interaction among all the professionals. Policy makers should recognize the interdependence of professionals in their consideration of workforce needs. Patient care is enormously more complex than it was just a single decade ago; no individual practitioner can provide good care alone. Advances in medical science, particularly technologic advances, have resulted in many new diagnostic and treatment modalities. Patients are able to live longer, but the burden of caring for them safely and to meet their individual needs has increased exponentially. The interdependence of all the members of the professional team was highlighted by recent events at one Vermont hospital where the dominant influence on patient care and physician practice in years was a significant reduction in the nursing workforce.

The physician centric comments in this document should not be interpreted as diminishing the importance of teamwork and the interdependence across all the professions; the importance of teamwork was mentioned just as frequently as specific physician workforce issues. All of the interviewees were physicians. Issues regarding the physician workforce came up in every interview and in response to almost every question. Section 6 - Retention and recruitment of physicians offers more information about retention and recruitment of physicians.
6. **Push hard for a seamless integrated information technology**
The most common initial response from interviewees to any question about measurement, reporting or what information would be most useful was the need for a seamless integrated clinical information system both within their own institution and across institutions in the region.

The Board has regulatory authority over the Vermont Health Information Technology Plan. The consensus of those physicians interviewed is that insisting on improvements in information technology particularly the interoperability of systems should be one of the Board’s highest priorities in their efforts to redesign the current system of care. **Section 3 – Accountability and measurement** highlights the pervasive need to address the dysfunction of the current health information technology system in the state.

7. **Encourage more meaningful and efficient accountability measurement**
Beyond the disappointment and frustration with the current state of health information technology, the overall sense about measurement, reporting and available health care information among the region's hospitalists is that there is little information available to them that they feel is meaningful or useful. There is significant interest among hospitalists to have access to reports and measurement that is clinically meaningful and could facilitate benchmarking and improvement.

That being said, no interviewees want more measurement just for measurement sake. Rather their desire is for meaningful, actionable measurement that aligns with other ongoing federal and state level measurement programs and metrics.

In contrast to their colleagues working in the primary care outpatient setting, the inpatient physicians do not feel overburdened by documentation and reporting demands. The majority of the documentation and reporting burden in the inpatient setting is born by the hospital’s administrative and nursing staff. Several mentioned the irony in the contrast between the inpatient and outpatient settings; outpatient practitioners with little administrative resources are being asked to document excessively in order to support a robust set of measures, whereas the hospitalists with ready access to administrative support and responsible for the highest cost patients are wanting meaningful actionable information and measurement.

**Suggestions for Information that would be more meaningful**
The most frequent responses from physicians about how measurement could be made more valuable or the process could be more efficient are grouped in the following categories:

- Comparative measures across institutions;
- More detail to existing measures;
- Patient satisfaction data;
- Individual service and physician level performance data;
- Measurement need to be based on scientific evidence;
- More transparent value to patient care
- Overall population health measures
- Consistency of measures across payers, regulators and others that are trying to “help”
- Feedback from the tertiary care centers
- Local professional interactions
- Time and resources to address shortcomings
Section 3 – Accountability and measurement contains further information supporting this recommendation.

8. Align payment logically and transparently with good care
A common hope for payment reform is that the new models will be aligned with good care as opposed to the current fee for service model so dominant at present. Everyone expressed hope that new models would develop and mature principally to support good and efficient care and replace the current backward system where decisions about care are made frequently to comply with payment rules and regulation.

A common sentiment is new models need to be transparent to both patients and practitioners so they understand why the new models are both in their interest and in the interest of the greater good. Payment reform should be designed to support best care; practitioners and patients should not have to make contorted care decisions to comply with unaligned payment policies.

Section 4 – Payment reform offers the reader more information on these issues.

9. Include direct care givers in policy discussions
Many physicians and other members of the care team are concerned that reform is moving forward fast, but they are not being asked to be part of the conversation. For some, reforms imply a loss of autonomy or a loss of income. There has been talk of caregivers leaving the state rather than tolerate intrusion into their autonomy or income. These issues need to be taken seriously and addressed aggressively. Specialty societies need to be integrally involved in all conversations. Individuals need to be informed and offered a chance to give their input as much as possible. Transparency within the reform process needs to be paramount. Resources specifically designated to maintain provider involvement and education about the reform process will be essential to the successful implementation of any reforms. Communication is the key. Lack of communication is poisonous.

“My biggest fear is the risk of a negative effect of the state’s reform initiative on the physician workforce, the risk of Vermont getting tagged as an unattractive location to set up practice and as a work environment with an inordinate administrative burden for practitioners” - Tertiary center physician

“Health care reform is a double edged sword in terms of attracting new physicians and its effect on those currently here. Until there are more details and physicians have more sense of what they can expect the future work climate to be in the state, the prospect of reform can cut both ways” - Community hospital physician

Section 5 – Communication around policy that matters offers more insight on physician interests and concerns on being involved in policy discussions as well as some initial thoughts about how to actualize physician involvement in policy that matters to them and their patients.

Concluding remarks
The executive summary is structured to highlight recommendations on issues of mutual interest to both the Board and the participating physicians. As mentioned in the Preamble each recommendation is referenced to one or more of the supporting six sections that comprise the body of the document. Not every section lines up with a specific recommendation, though some do. Sections are organized to follow more closely the questions asked in each interview. The
document is written to carefully link each recommendation with the supporting physician responses.

The six sections comprising the body of the document contain quoted material from the interviews. The reader is encouraged to read the sections to gain a fuller understanding of the opinions of the physician leaders who contributed to this effort. Though these physicians are principally responsible for the care of inpatients, many of their comments refer to issues relevant across all care settings. Comments in this white paper touch on delivery system issues that are highlighted in the companion document based on interviews principally with physicians who work in outpatient settings.

All the recommendations address extremely challenging issues and the participating physicians appreciate the steep climb the Board faces in redesigning the delivery system. The physicians involved in the thoughtful work supporting this document would like to offer their continued help to the Board in efforts to develop additional specific actionable recommendations to assist with delivery system redesign; and to partner with the Board to actualize the promise of health care reform in the state.
Section 1

Fears and hopes for the future of care

What are your biggest fears and hopes for the future of care in the state?

The paramount concern expressed by the majority of interviewees in response to this chapter’s question had to do with physician retention and recruitment. The issues of physician retention and recruitment are among the most prevalent themes heard during the interviews and were mentioned by many in their responses to questions not intended to illicit responses about workforce issues such as the questions about core clinical services and payment reform. Interestingly, physician workforce issues were even mentioned in terms of the questions about measurement as the burden of documentation is an enormous problem for primary care outpatient practitioners and frequently the burden of measurement was mentioned as a reason for practitioners considering leaving practice.

Section 6 – Physician retention and recruitment is focused solely on the issues of physician retention and recruitment. This chapter includes other hopes and concerns that interviewees expressed.

Concerns for the future

Global Uncertainty
There is a general sense of anxiety and worry among practicing physicians. Many physicians do not feel adequately informed about the direction or pace of state reform and the lack of information is causing worry.

“A lot of the concern on the part of the physicians is fueled by the lack of information they have access to. Will the Board dictate that all Vermonters need to get their care in Vermont? What will that mean to DHMC where 40% of the patient volume comes from Vermont?” - Tertiary center physician

“Most physicians feel anxious about the coming payment changes; they feel caught between the fee for service (FFS) world that is driven by volume and procedures and the portent of complete capitation for a given population as represented by the ACO pilots. Part of the anxiety is a result of knowing very little about the ACO model. The primary care physicians seem to be better informed about the coming payment pilots than those of us who work in the hospitals” - Community hospital physician

Concern about state reform efforts is compounded by concomitant federal reform activities and the widespread financial stress in all aspects of the health care industry. Many physicians are of the opinion that reform is moving forward more rapidly than is the case, and they feel that they are not being asked to be part of the conversation.
“This is an extremely stressful time for our hospital. We’re in the process of significant personnel layoffs. Physicians per se have not been laid off, but the effect on staff morale is being felt by all of us. The downsizing effort is a strategic corporate initiative to prepare us for anticipated less inpatient volume—a trend that is being seen locally as well as nationally. The organization is looking under every stone for waste and inefficiencies. The physician staff understands, but nevertheless, it is very stressful for all of us.” - Community hospital physician

“There is so much change. What is going to happen when there is a political change like a new governor? Will we just have to start all over again? Will the Board stay? What happens to the patients? There are lots of anxious physicians. What is it going to look like in 5 years? Physicians are even beginning to worry about job security” - Community hospital physician

“As hospitalists who are not paid on incentives, payment reform is not immediate clinical concern. That being said, we all spend a lot of time fretting about what will happen. Just a short time ago, the ACO model was being touted as the end all of plans, but now we’re hearing just about all the short comings of the model and that many early adopters are turning their backs on the model. The concept of a budget to keep a defined population healthy is very appealing, but how will it work? What are the details? It would be wonderful to both us and the patients to get rid of all the hoops we have to jump through to get things done in the current system, but will it really happen? Everyone is skeptical” - Community hospital physician

Fall in the quality of care
Some physicians mentioned concern about reform leading to worse care. Some physicians had very specific concerns about restriction in treatment options and wrap around services.

“The biggest overarching concern among physicians is how we are going to continue to provide high quality care. Our current environment is that we are being asked to do more with less pay and less resources. The challenge of recruiting and retaining well trained professionals is getting more difficult. What we hear about the future is very nebulous; it is difficult to have confidence in all the expected change when we don’t understand the big picture of payment reform, let alone the details that will affect our everyday work life and our ability to care for our community” - Community hospital physician

“Other risks of reform (other than the effect on the physician workforce) are that it will result in an overly restricted formulary, overly restrictive rules about treatment options and low physician reimbursement. I fear that reform could result in less access to patients to core services like mental health and key wrap around resources like case management as the provider organizations react to less revenue” - Tertiary center physician

“Physicians are concerned about the reduction in nursing and case management resources that will be available” - Community hospital physician

Hopes for the future
Not everyone was ready to hang crepe on Vermont’s delivery system, reform being the cause of its demise. Physician anxiety and fears were somewhat balanced by hope. Not a single physician was of the opinion that we did not need to change and reform the system. Some of the more common hopes were that reform would result in a more logical delivery system, a system that made sense to both patients and practitioners and that was guided by an overall transparent logical plan.

Logical system of care
“We are cautiously optimistic about reform, but it needs to be done on many, many levels. Our biggest hope is that we will end up with a logical system of care based on the needs of our region’s population and applied medical science. The patchwork payment system needs to be replaced. Volume of services has to be removed as the major incentive” - Tertiary center physician
“Hopefully, we can build a system of care that is the best way to care for the population in our region. If that could be done, physicians would flock to the region. Those of us already here, would stay. But the logic of the system needs to be clear. Physicians need to understand why they are being required to do things particularly if they intrude on patient care. Reform has to be a complete redesign; the outcome cannot be just more of the same in another package” - Tertiary center physician

“Financial returns, our income is not the primary concern. If a new system is going to require lots of time away from patient care it needs to make sense to us. Measurement needs to be meaningful. Length of stay in itself is a meaningless number; what would be more meaningful to a physician is what percentage of the length of stay was necessary. That would be worth the extra hassle of documentation. Administrative inefficiencies need to be removed; for example, the CMS regulation for 72 hours of acute inpatient care before a beneficiary is eligible for a SNF placement is ridiculous. We have to spend unnecessary funds and take up needed acute care beds just to work around a CMS rule that is not transparent to any of us” - Tertiary center physician

Single Formulary
Though some physicians mentioned concern that reform would limit treatment options for their patients, mention was also made of the need to make the formulary of medications uniform across payers; and that the choice of what was included in the formulary be guided by best care and not solely on cost savings.

“Relatedly, having a single medication list would be a huge boon to the safety and efficiency of the system. This issue is compounded in our community in that we have lots of part time residents who go south in the cold months, we border on two other states and our patients get specialty care at multiple other centers. Many issues would benefit from a single national medication list - prescription drug abuse, prescription error and redundancy, safer inpatient stays “- Community hospital physician

Health Information Technology Interoperability
Without any doubt, the most common and passionate complaint about the current delivery system was directed at the inefficiencies and inadequacies of the recent introduction of information technology into care settings, particularly the lack of interoperability across systems. Many physicians feel that the introduction of information technology has negatively affected patient care. Most physicians are of the opinion that the net effect of information technology to date has been detrimental to care; that too many immature systems have been bought. Nearly all physicians feel that information technology offers huge potential to improve care and reduce costs, but that it has been prematurely foisted on everyone, and as a result everyone has suffered. That being said, many physicians hope that reform will somehow help with all the problems.

“Maybe the biggest issue we struggle with and needs the most attention is issue of the inability of the various HIT systems to interact with each other. The lack of continuity in the flow of information is a constant drain on resources and negatively affects care and professional morale. Ironically, if the issue could be solved, it would also be one of the most significant improvements that could help us move beyond the status quo” - Tertiary center physician

“The EMR has been an enormous disappointment. Our medical records have suffered as has patient care. There are so many simultaneous changes that both the number and the speed of changes compound physician dissatisfaction and concerns” - Tertiary center physician

“The single most needed intervention is for all the various EMR systems to be the same or be seamlessly interfaced. We have three separate EMR systems in our institution alone, none of which interact well with the other systems. We do not have a practical interface with either of the tertiary centers; it can take as much as 3 weeks for a discharge summary to arrive on a transferred patient and once received it is cumbersome and confusingly organized” - Community hospital physician
Redirect time spent maximizing payment to caring for patients
Every physician knows that they spend less time with patients as a result of both intrusions from third parties like payers and regulators as well as the enormous inefficiency of the primitive EMRs that everyone has been forced to use. All physicians hope that reform will result in more time with patients and less time with intrusions and system inefficiencies. The irony in it not lost on any physicians that most of the recent efforts to improve care through quality efforts and information technology has decreased their ability to offer good patient care.

“There’s been this constant drift away from allocating work away from time spent with patients toward documentation and optimizing productivity in terms of dollars per hour or patient” - Community hospital physician

Survival of a strategic system of community hospitals
Nearly all physicians in the state are here for the lifestyle and the opportunity to live in the unique communities in this rural state. “No one is here for the money,” was said innumerable times. Probably 100% of Vermont physicians trained in a large urban or regional medical center; those that chose to practice in our rural communities associated with one of our rural community hospitals made that choice purposefully as opposed to settling in a more populous community or practicing in a large referral or teaching institution. But physicians do not want to be isolated from their peers. They need peers to help with the work load; they need peers to help them with the frequent uncertainties and decision making challenges that are so much a part of clinical medicine. There is a critical mass of professionals and a critical scope of practice that physicians need to be attracted to a community and certainly to stay in that community. As will be restated in the Section 6 – Physician retention and recruitment, a logically planned system of community hospitals is essential to continue to attract a high quality physician workforce to the state; and a high quality physician workforce in rural communities is necessary for good and equitable care for Vermonters.

“Vermont is a rural state, and ensuring that all Vermonters in every community have equal access to all services will be an ongoing challenge as the cost of healthcare rises and the call for efficiencies increase. However, people in this community for the most part want to get their care locally. They want to continue to have a choice about where they get their care and who they get their care from. If this community hospital is gobbled up by the tertiary care center because of corporate leverage in a market that favors consolidation, the community will suffer; they will not have choice; they will have lost control of their care” - Community hospital physician

“Professional isolation and too much patient demand are issues. One has to set limits – there is an endless demand for our professional time” - Community hospital physician

“The appeal of Vermont is the lifestyle that one can lead and still practice rewarding and interesting medicine” - Community hospital physician

Physicians as a group interact well across the various levels of care in the state and across communities. However, physicians do not think that management and administrators work together well or often.

“In contrast to the excellent supportive collegial relationship the local physicians have with the medical staff at the nearby tertiary care center, there is a sense in the community, both among the medical staff and hospital leadership, that the tertiary care center has a strategic business plan to consume us. I think this is coming from the corporate leadership of the tertiary care center and not from the medical staff” - Community hospital physician
"A role for the Board should be to ensure that market forces and corporate hospital interests do not allow the reduction of choice to those on our community about where and how they get their care. The role of the Board with their expansive authority to determine health resource allocations across the state should be to ensure that Vermonters can continue to access medical care that is appropriate at a community level; this will entail regulating the current trend of consolidating all levels of care at the tertiary care centers" - Community hospital physician

“The case of providing dialysis services across the state illustrates the need for resource allocation rules and regulations that serve the public in the most efficient manner but still recognize the importance of patient choice. It may be that the system as a whole would be more efficient and certainly more equitable, timely and patient centered if inpatient dialysis was available more broadly across the state, but that would necessitate supplemental support for the service at the outlying community hospitals that could not support the service on the local revenue alone; some sort of cross subsidy process would be needed” - Community hospital physician
Section 2

Vermont health resource allocation plan

What are the core inpatient clinical services that need to be available locally?

Are these core services all currently available? What’s missing?

Are core services adequately resourced? Is there mal-distribution of resources?

How often is there a mismatch between appropriate level of care and the patient location (community based vs. tertiary center)?

An updated Health Resource Allocation Plan regarding inpatient care in the state for Vermont should reflect four foundational constructs: 1) the aggregate needs of the state’s population be the underlying planning metric; 2) the amount of resources are logically stratified across hospitals; 3) resource utilization be coordinated in real-time across levels of care; and 4) the professional workforce be recognized as the paramount resource.

1. Base the plan on the entire state population

The chief determinant of allocation decisions should be the overall medical needs of the state’s population. The Allocation Plan should not allow resource distribution on a community by community basis, but insist that the Plan makes sense from the perspective of the population as a single unit. The capacity and location of inpatient resources should be continually monitored and evaluated

“Medical specialty and surgical resources should be distributed based on the needs of the whole state population rather than through a community versus community marketing process; need determinations should also be aligned with what resources are needed to support best medical practices at different levels of care intensity” - Critical access hospital hospitalist

“So much of what we see on the inpatient service is related to heart disease, lung disease and diabetes. In terms of how resources are being distributed, one approach would be to look at need in terms of underlying disease burden in the state and ensure that resource planning be cognizant of potential disease burden” – Community hospital hospitalist

“There is so much pressure to close hospital and skilled nursing facility beds; does this make sense in the face of an aging population?” - Critical access hospital hospitalist

“In the outlying communities there is a mix of both inadequate core services and in some cases an excess of specialist services given the local need” - Tertiary center physician
The Allocation Plan should guarantee equal access for all Vermonters; equal access not necessarily meaning equal distance to care. Equal access can be achieved in remote areas of the state through enhanced transport capability and enhanced telecommunication among care levels.

“In general, looking at all services for all groups of patients, there is a strong case for consolidation of services across the region. Public reaction to having travel increased distances will have to be addressed, but that challenge should not dissuade us from having these difficult conversations” - Tertiary center physician

“The promise of telemedicine resources being available through DHMC to our ER is very exciting and should augment the local care in terms of quality, timeliness and efficiency. The telemedicine support will focus on psychiatry, stroke and trauma” - Critical access physician

The Allocation Plan should consider both consolidation of certain inpatient resources as well as expansion and dispersion of resources into outlying communities.

“We are relatively close to the tertiary center; as a result the two institutions compete for primary care patients particularly those with private insurance. The tertiary center recently placed an obstetric outpatient site in our community and we’re beginning to lose low risk obstetric patients to them. They’ve also increased marketing for elective orthopedic surgery and routine medical procedures like colonoscopies” - Critical access physician

“We have a shortage of specialty services both surgical and medical. We have general surgical coverage from 8 to 5 five days a week; all other times any acute surgical patient needs to be sent to the tertiary care center” - Critical access physician

“It will be controversial, but consideration should be given to having less outlying hospitals, but with the remaining institutions having a larger array of services available” - Tertiary care physician

2. Plan purposeful resource stratification
The Allocation Plan should recognize three levels of inpatient care as building blocks for a statewide system of care:

- a. Community based care;
- b. Regional centers of excellence; and

The three care levels should be defined in terms of the severity and complexity of patient illness that can be appropriately cared for at each level. Determinations on appropriate expenditures on physical plants and technology can then be made based on the clinical needs of typical patients at each level of care. Physical plant and technology allocation determinations should be made in conjunction with human resource allocation. Human resources are the key resource in health care – it’s all about people, both as patients and as professional care givers.

“The system would have three levels of care acuity similar to what now exists in the skilled nursing facilities. Patients would be cared for at the appropriate level, preferably but not necessarily in their own community. There seems to be an assumption in the public debate that there is less need for hospital beds and these bed reductions should come from the community facilities. Thought should be given to an alternative approach that would keep more patients in the outlying less costly community facilities and not increase the number of beds in the most costly tertiary settings” - Critical access physician
“If all the institutions could work together and develop a protocol driven allocation of patients based on best practices that would place patients in the most appropriate level of care, then it is possible that the system as a whole would be more efficient as well as more satisfying to patients and providers. A system wide approach could reduce the cost of technologies and specialized services by locating them dependent on the needs of the patients at the various levels of care rather than the current arms war approach of every hospital needing everything” - Critical access physician

**a. Community based care**

The inpatient services included in this level of care are: adult general internal medicine; and general surgery. This inpatient capacity must be closely coupled with: a) an emergency department; b) an emergency medical service able to safely transport critically ill patients; and c) formal arrangements for constant immediate support from distant specialty services.

“A critical aspect of our inpatient service is our partnership with our Emergency Department which acts a filter allowing appropriate admissions to stay in the community while more complex and severely ill patients are referred to the nearby tertiary care center. Most of the community members that need hospitalization are appropriately admitted here; however, there are always patients needing care not locally available” - Community hospital physician

“We are very sensitive to the appropriateness of admitting someone here; depending on the availability of medical specialty or surgical services at the time, we often have to send patients to a tertiary center rather than try to care for them here” - Community hospital physician

**Adult Medicine Service**

Patients appropriately cared for at this foundational level of care will have needs typical of the majority of the current medical inpatient population in the state. Typical patients would be those in need of palliative and end of life care, treatment for common acute community acquired conditions, treatment for patients with chronic conditions needing brief inpatient interventions, and subacute rehabilitative care.

“In general, patients with terminal illnesses such as cancer and end stage cardiac disease should be cared for in their community rather than at the tertiary care centers “ - Critical access physician

The severity of illness of patients will include patients needing short term ventilator support. Hospitals will necessarily require small but safe ICUs and requisite anesthesiology, nursing, respiratory therapy, laboratory and diagnostic radiology resources.

“We do not have a local pulmonologist which can be a problem for the hospitalists when we are managing patients on ventilators. We end up transferring particularly challenging patients and patients that need long term ventilator support” - Critical access physician

Medical specialty consultation will need to be readily available. As a result of the current reduction in the number of medical specialists located in rural communities, the scope of required skills and depth of clinical knowledge for hospitalists will continue to increase. Local teaching institutions and the organized professional medical community will need to recognize this transition and offer appropriate post graduate and continuing medical education.

“We are a small hospital and can’t be all things to all people” - Critical access physician

Attending physicians will be hospitalists, community based physicians or a combination of both. To address the present workforce shortage of physicians interested in hospital medicine, a
formal process should be created facilitating cross coverage of inpatients by hospitalists in different hospitals.

“Our community is very adamant about having a local community hospital with inpatient capacity; that being the case, we need a hospitalist service. The PCPs are no longer willing to cover both inpatient and outpatient services” - Critical access physician

General Surgery
Providing general surgery at all critical community hospitals is already a challenge due to national trend in less physicians being interested in general surgery as a career and the aging current workforce in the state. Potential solutions include cross coverage across institutions, enhanced telecommunication ability to support around the clock general surgery consultation and strategic location and close working relationships between community based level of care hospitals and regionalized centers of excellence for general surgery that can support co-management of surgical inpatients by the medical service.

Not all community based level of care hospitals necessarily need to have the capacity to support inpatient surgery, rather the surgical procedure and immediate post op care could be done at a regional center of general surgery, but patients not likely to need repeat surgery be transferred to the community based level of care for recovery. Outpatient general surgery could be more widely available and sited at smaller hospitals.

“General surgery presence doesn’t not have to be 24/7 and would probably be satisfactory is done through regular and predictable consultant visits. Subspecialty surgery services should be available through consultation. A possible exception is orthopedics which might be justifiable present 24/7” - Critical access physician

b. Regional Centers of Excellence
Both the scope and the intensity of inpatient services will be expanded in the proposed regional centers of excellence in comparison to the community based care level. The location of these expanded resources should again be based on the needs and location of the entire state population. Market forces over the past few decades have already somewhat paired facility size and clinical capacity to the needs of the immediate population. However, consideration should also be given to locating these centers in community based level of care facilities for economies of scale related to supporting a full time operating room to ensure efficient and timely access to general surgery.

Advanced medical and surgical care
These regional centers of excellence will have the workforce and resource capacity to care for patients too ill to be cared for at the community based care level. Centers of excellence will be developed for those medical and surgical conditions that require specialty expertise and expensive technology that cannot be justified either in terms of population need or cost at the community based level of care. Surgery examples include urology, orthopedics, obstetrics, gynecology and otolaryngology. Medical examples include cardiology, neurology and gastroenterology. Surgical centers of excellence will necessarily have fully functioning operating rooms; medical centers of excellence will have expanded ICU capacity and capabilities.

Increased access to specialty care and advanced technology
A common current scenario in outlying hospitals is a patient in need of an interventional radiology procedure that is not provided by their radiology staff. Examples of situations include
the need for placement of a drain in a deep abscess or endovascular access to a internal organ. Not only is it a big inconvenience for the patient to be transferred to one of the two tertiary centers, the situation can present a financial problem for the community hospital. It is not uncommon for the cost of the procedure and the transfer itself to be billed back to the community facility – the cost sometimes being more than the total allowable charges that the community hospital can bill to the patient’s insurance. Wider distribution of some technology rich services may make sense in terms of patient centeredness, clinical appropriateness and the overall system’s financial cost.

“We still ship a fair number of patients to the tertiary care centers, all of which are out of state. Frequent appropriate clinical needs include neurosurgery, multi-trauma patients, and interventional cardiology. However, another reason for transfer is the need for interventional radiology for biopsies, endovascular procedures and drainage of deep abscesses; other than the procedure there is often no need for the patient to stay at the tertiary center” - Community hospital physician

“Other services that we need include interventional radiology, gastroenterology including ERCP. One possible solution would be to have a dependable system of outsourcing from larger centers for these services “- Critical access physician

“Cardiology coverage is adequate; we have a consultant cardiologist on site two days a week; echocardiograms are read distantly from the tertiary center. We have access to most other medical specialists by phone or videoconferencing technology; this is satisfactory in terms of professional support and patient outcomes. Presently, we have very good and dependable general surgery and obstetrics coverage, but if one of these physicians leave and we cannot quickly recruit a replacement we will have a sudden large problem” - Community hospital physician

Ease the burden on tertiary care and keeping health care dollars in state
In addition to the issue of decreasing availability of tertiary care beds, an important consideration for the Green Mountain Care Board is how important the existing hospitals are to each community in terms of the local economy. In many communities the hospitals are the major employers and a key engine for local commerce. As mentioned above, purposeful distribution of specialty services across the state is an approach worthy of consideration in terms of the state’s overall economic health

“We are presently looking at a regional arrangement with a slightly larger community hospital out of state to take some of our inpatients who are too sick for our current ability but do not need tertiary care. Hopefully this will help us find beds for our patients; our tertiary center is perennially at full capacity and frequently is unable to take our referrals. We estimate that about half of the patients that we now feel uncomfortable or unable to admit can be taken care of at a non tertiary setting. With more beds and nursing capacity, most of these patients could in fact be kept locally” - Community hospital physician

“Dartmouth is one of our principal referral destinations. They have a very small ICU capacity and that affects us as well as other community facilities in not being able to transfer critically ill patients to units staffed and stocked with the needed technology. Recently, we admitted an elderly man with severe heart failure as a transfer from a critical access hospital. The referring hospital had called five other hospitals before they called us including all the tertiary centers. We accepted the transfer because we still have a small ICU and could offer the patient more than the CAH could” - Community hospital physician

It is possible that all hospitals would offer both community based care level and at least one center of excellence, e.g. obstetrics, orthopedics, cardiology, laboratory or radiology capacity. Decisions regarding the location of both community based level of care institutions and centers of excellence would be principally driven by the overall medical needs of the state’s population,
but would also consider the financial viability of hospitals and their economic importance in their communities.

“Some patients who are referred to a tertiary center for a procedure, like ERCP, end up staying at that institution for recuperation or subsequent treatment that could be done here at the community hospital. This has two negative effects: 1) the tertiary center beds fill up with less acute patients; and 2) we lose the revenue opportunity to offer treatment or convalescent care that we are capable of. This is particularly frustrating in the context of our institution currently laying off staff in anticipation of an even larger decrease in inpatient demand while at the same time the tertiary care centers are at times refusing to accept critically ill transfers from us due to lack of beds” - Community hospital physician

Help with the availability of general surgery
A possible approach to ensure general surgery is available in a timely safe manner across the state is to design enough distribution of specialty surgical centers of excellence among hospitals to ensure a safe minimal overall volume of surgery and an economy of scale at each institution supporting an operating room. Examples of specialty surgical centers of excellence could be obstetrics, gynecology, orthopedics, and other subspecialty surgical procedures.

“In contrast to the situation where a routine general surgical patient has to be sent to the tertiary care center because they presented at night or on a weekend, we not infrequently find ourselves having to care for a very ill patient because the tertiary care center is full” - Critical access physician

c. Tertiary Care
Fletcher Allen and Dartmouth Hitchcock should continue to serve the state’s population tertiary care needs. However, the two institutions need to work together more to maximize the safety, effectiveness efficiency, timeliness, equity and patient-centeredness of tertiary care in the region.

“It is not uncommon for New Hampshire patients in need of tertiary care to have to travel to FAHC because DHMC is full and vice versa. Patients and families can be very frustrated” - Tertiary center physician

“There hasn’t been the track record of cooperation between the two tertiary care institutions – it’s sort of like the cold war between the Soviet Union and the USA. The competition isn’t so much between the physicians as it is the corporate aspects of the institutions. What is needed is a physician led assessment of the need across the shared population and appropriate shared resource allocation between the two centers” - Tertiary center physician

Duplication of tertiary services
There is duplication of clinical services and their associated technology resources between the two institutions. Just as this document recommends an Allocation Plan for the state that is population based and demands coordination of resources within the state, it is also the recommendation of the contributing physicians that there be an identical purposeful plan for coordination of tertiary care across the region; and that our local tertiary care resources are coordinated with the national referral centers in southern New England and New York state.

“There needs to be more coordination of regional specialty services between DHMC and FAHC. Hopefully, the new joint venture with the CMS Shared Savings Program ACO will begin that dialogue. Physicians in the two institutions interact well with each other; however, there is a competitive relationship between the two organizations at the management and corporate leadership level that seems to interfere with the need for regional collaboration. The state can’t afford duplication of services. Two obvious examples of redundancy and potentially subsequent reduction in the quality of care are the pediatric
subspecialties and some areas of advanced medical care for complicated uncommon illnesses” - Tertiary center physician

“There are clinical services that we do not offer, for example, heart, lung and liver transplants and some sophisticated surgical subspecialty procedures, but that is entirely appropriate given the low volume of those situations. There is a good case for DHMC and FAHC working together on the challenge of offering low volume services on a regional level in coordination with the national referral centers to the south” - Tertiary center physician

3. Insist on real-time coordination of resources

One of the principal collective challenges to the current inpatient capacity in the region is the need for more tertiary care capacity. An everyday challenge across the region is freeing up beds at the two tertiary care centers for patients with recent onset critical conditions. At any time there are typically 10 patients waiting for a bed at Dartmouth Hitchcock, but finding acute care beds in outlying hospitals that can safely accept more stable patients who still need more than community based level of care is difficult. The gap between the severity and complexity of illness of inpatients at the tertiary care centers and what can be safely cared for at the outlying institutions has widened in the past decade due to a variety of factors including advances in technology at the tertiary center and changes in the professional workforce, practice patterns and institutional capacity at the outlying hospitals.

Administrative barriers

“Recently, as hospitalists at the tertiary care center we get the sense that some of the outlying hospitals feel that we are inappropriately refusing transfers. This is a relatively new phenomenon. Often we find ourselves full not because of the acuity of the patients in our beds, but rather because of payment issues. We are frequently told by our case managers that patients cannot return to their referring community hospital because it would negatively affect our payment” - Tertiary center physician

“As one of the two tertiary centers, we would like to always say yes to appropriate transfer requests from outlying facilities; unfortunately, we just can’t always do that anymore. One of the reasons for our higher inpatient census recently is that patients are sicker than in previous year. They are either local residents or too sick to be transferred back to their local hospital. However, administrative barriers are more common; the above mentioned financial obstacle is not infrequent “- Tertiary center physician

Patients are sicker

“In order to free up beds at our tertiary center for the most critically ill patients, the level of acuity of illness of the patients being transferred back out is constantly increasing. It is an everyday challenge to find the appropriate discharge setting” – Tertiary center physician

“As a regional referral center, we have the appropriate capacity to provide tertiary and quaternary care. The biggest challenge for us is transferring patients back to outlying institutions after the need for advanced care passes. There is always at least a waiting list of ten patients needing transfer into our institution for advanced medical or surgical care. Every day we’re trying to transfer less acute patients out to appropriate care settings. Patient through-put is a daily struggle – it’s like traffic control “- Tertiary center physician

Mismatch between patients and level of care

“On a typical day there are patients in the critical access and community hospitals that need to be transferred to our tertiary care center for advanced care, but the we’re is full because there are no beds available in the outlying facilities to transfer out stable but still demanding patient” - Tertiary center physician
“The net result of both the consequences of our nursing downsizing and the increased efforts by the tertiary center to market their services in our community is that mismatches of care location are becoming more frequent. Much of the care that is capable of being done locally is now being done at the tertiary center. The bed census at tertiary center is constantly full; and some of these patients do not need tertiary care. As a result critically ill and complex patients that do need tertiary care are often kept at our community facility inappropriately” - Critical access physician

“There could be much better coordination among hospitals on how to maximize bed use. The tertiary center is full most of the time and we run near capacity for a CAH. However, it’s not uncommon for us to have to care for someone critically ill here when the tertiary center has beds being occupied by our patients who could be transferred back as their need for tertiary care has passed” - Critical access physician

“We are in the process of working with the tertiary care centers on protocols for determining if patients can be transported by ambulance accompanied by a nurse, have the needed procedure or consultation and return here versus needing to be admitted to the remote facility” - Community hospital physician

Another more subtle but significant untoward consequence of patients unnecessarily getting their care at tertiary centers not located in their own community is that post hospitalization follow up often ends up being done at the tertiary center. The result is not only a mismatch in appropriate care setting, but the resultant discontinuity of care becomes a problem for both patients and practitioners.

Real time communication system across the region on bed availability
“Which we need is a constantly updated map of what beds are free where and what the capacity of the staff is who are attending these beds… There needs to be a system in place that allows freer movement of patients across the region and between varieties of care levels” - Tertiary center physician

“There needs to be much better communication between all the hospitals so we can optimize the use of the limited beds and professional skills that remain in the region” - Critical access physician

“…most critically ill patients are appropriately transferred for tertiary care. There are times when we are full and have to refuse patients. There are opportunities for improvement for communication across all institutions at these times to optimize the use of acute care beds” - Tertiary center physician

Wider distribution of clinical excellence
A major theme in this document is providing relief to the tertiary care bed shortage through a combination of consolidation and expansion of clinical services in the outlying institutions. An example of consolidation that could ease the demand for beds at the tertiary care center is the afore mentioned creation of regional centers of surgical excellence allowing elective surgery in relatively healthy patients to be done at places other than the tertiary care center.

“The referral center needs to know where a patient who has had their advanced surgical procedure can be sent for their convalescence and still receive appropriate care” - Tertiary center physician

“….or the patient whose critical pulmonary illness has been stabilized, but will need an extended period of care involving physicians, nurses and respiratory therapist who are familiar and competent with the care still needed “ - Tertiary center physician

“There is an opportunity for patients who initially need the technology and professional resources of the tertiary care centers to be discharged to the lower intensity and less costly beds at the community hospitals. A recent example took place here, where a patient with a rare viral CNS infection needed long
term inpatient treatment but no longer needed the high cost technology rich support at the tertiary center”
- Community hospital physician

Wider distribution of inpatient dialysis
The capacity for outpatient dialysis is distributed across the state, but not the capacity for inpatient treatment. A common current scenario in all hospitals other than FAHC is a patient whose is being treated for end stage renal disease with outpatient dialysis in their home community and comes down with a community acquired pneumonia or some other medical or surgical illness that could be treated in their local hospital were it not for their need for dialysis while they are an inpatient. In spite of being able to receive local dialysis treatment as an outpatient, because of licensing restrictions, they cannot be dialyzed while an inpatient except at one of the two tertiary care centers. The result is that patients with relatively minor illness occupy beds at the tertiary care facilities that then are no longer available for a patient with a more severe or complex illness who then has to be treated in less than ideal circumstances at an outlying facility until a bed opens up at the referral center.

“A group of patients that end up in the tertiary center possibly unnecessarily are patients who are receiving chronic dialysis who have a minor medical illness like a pneumonia that could appropriately be treated locally. However, because we are the only source of dialysis, these patients are admitted here until their minor illness resolves and they can resume receiving their dialysis as an outpatient” - Tertiary center physician

Patient perceptions and End of Life care
Two patient driven aspects warrant mentioning in regards to the use of tertiary beds: 1) often patients and families resist be transferred back to their community facility because of concern that they will get a lower quality of care in an outlying institution; and 2) patients and families not uncommonly do not want to accept a terminal diagnosis and the futility of further aggressive treatment only available at a tertiary center.

“Some patients elect not to return to their community facility because of lack of confidence in the care back home” - Tertiary center physician

It is possible that patients concerns over variation in quality of care will be eased if they perceive better coordination of care across institutions and community facilities offering solely critical community care embrace this new mission and strive for excellence in those aspects of care most relevant to their patient population – relationships, trust, continuity, patient centeredness and safety. A role for the Green Mountain Care Board to consider is promoting to the public at large the use of less costly inpatient beds for less resource intense care; obviously coupled with accountability metrics regarding the quality of care that support this position.

The issue of excessive care in the last months of our lives is a national cultural challenge. The lead organization in the state working on the challenge is the Vermont Ethics Network. It behooves all professionals in all clinical settings to become more engaged in this challenge. Perhaps a more coordinated consistent statewide approach involving all provider organizations would be helpful and possibly appropriate to include in the state’s Health Resource Allocation Plan.

“Patients receiving end of life care are probably better served at their local community hospital than here at the referral center. This is a frequently complex issue. We try not to accept patients whose needs can be met locally, but sometimes families are insistent and are not ready to accept end of life care. Sometimes the local medical professional isn’t comfortable with his or her assessment and wants additional input from specialty services” - Tertiary center physician
Skilled Nursing Facilities (SNF)
On a typical day in Vermont there are patients being cared for in an acute care facility only because there is no place for them at a skilled nursing facility (SNF). Their need for acute care admission has either resolved or never existed in the first place as they were admitted to the acute care facility only to facilitate their placement in a SNF – the result of providers and patients needing to comply with federal rules and payment issues. The inappropriate use of the most expensive beds in the system is common at all levels of hospital care - critical access, community and tertiary hospitals. The Board should investigate the possibility of getting CMS to waive this requirement. Health systems in Maine have done so.

“We recently had a patient who was extremely obese who came here from out of state for a minor surgical need. Though clinically ready for discharge to a SNF in a short amount of time, he stayed in our tertiary care center for a year and actually died here” - Tertiary center physician

“We typically have a ‘non-teaching” service of 10 to 15 patients that are not acutely ill, but rather just waiting placement in a SNF. Sometimes this census can reach 20. One of our staff who recently moved from Utah and had worked at Inter-Mountain Health Care was shocked; her experience in that more integrated system was that there was no delay with SNF or rehab placement once the need for acute care resolved “ - Tertiary center physician

“The skilled nursing facilities hold all the cards. We cannot refuse to take their patients, but there is no similar mandate that they have to take the patients back. This is particularly common in patients whose ability to pay for the SNF care is limited by no insurance or public insurance. Other reasons for difficulty in placing patients in SNFs include MRSA (an antibiotic resistant infection) and expensive treatment regimens that decrease or erase any profit margin for the SNF” - Community hospital physician

“There is a trend to use the acute care hospital as holding station for patients whose real need is SNF placement. We can’t refuse patients who are too sick to care for themselves, aren’t really sick enough to warrant an acute care admission, but there are no SNF bed available. We end up being the place of last resort. These patients can end up staying as inpatients for very long times” - Community hospital physician

“A constant very significant problem is the difficulty getting patients transferred from our acute care facility to a SNF… The PACE\(^1\) system was great! As this wasn’t as big an issue, it was an issue, but less so” - Community hospital physician

“Critical access and community hospitals need to actively support the tertiary care centers so patients waiting for SNF placement and palliative and end of life care patients can be cared for nearer to their home and free up the tertiary care center beds for more appropriate patient’s” - Critical access physician

Observation beds
The concept of observing patients before determining the appropriate level of care and placement is complicated by current CMS rules. These rules tie the hands of the acute care hospitals in appropriately providing the correct level of care at the correct time. The Green Mountain Care Board needs to consider obtaining a waiver from CMS regarding the Observation Bed rules to allow for the appropriate care of the patient be determined by their clinical need and not the payment mechanism

\(^1\) The Program of All-inclusive Care for the Elderly (PACE) model is centered around the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. [http://www.npaonline.org/website/article.asp?id=4&title=Home](http://www.npaonline.org/website/article.asp?id=4&title=Home)
"A related issue is the CMS rule that patients cannot be transferred from an observation bed directly to a SNF; rather the patient needs to be admitted to the acute care facility for 72 hours before they are eligible for SNF admission and subsequent CMS payment" - Community hospital physician

Inpatient Psychiatry
The capacity of Vermont’s inpatient facilities to adequately provide appropriate care settings for those of us with severe acute and persistent mental illness was one of the first issues brought up in every interview with every physician in every hospital in every community in the state and at Dartmouth Hitchcock Medical Center. For example, the following are opening remarks from several interviewed physicians:

“There are two paramount needs regarding the inpatient bed capacity in the region: 1) is the need for a regional information system designed expressly to coordinate and optimize the use of health care beds…; and 2) the related need for an efficient and sufficiently resourced system to assist with placement for patients with combined complex medical and psychiatric illnesses. At present there is insufficient capacity for these patients in the region, both in Vermont and in New Hampshire. Vermont Medicaid used to be very helpful in placing these patients; more so than NH. However, recently, Vermont has become less helpful with these tasks” - Tertiary center physician

“Our present offering of clinical services in our community functions well. The one glaring need is inpatient psychiatry. Not only do we frequently have patients with severe persistent mental illness admitted from our community; a situation that has become much worse since the closing of the state hospital; but we serve as the medical and surgical acute care hospital for one of the new replacement facilities for the state hospital. As a result we are sent their inpatients if they develop medical or surgical issues, but do not get any help from the designated state facility managing the very severe underlying mental health issues these patients– an ironic situation to say the least” - Community hospital physician

“The biggest need we have is beds for severely mentally ill patients. These beds are not available here or elsewhere in the state and the issue has become much worse since the closing of the state hospital. The current situation is a nightmare and a half” - Critical access physician

“The major deficiency (in clinical services in our community) is related to persons with severe mental illness – without a state hospital these patients are being hospitalized in our hospital for up to 3 weeks at a time. Our institution and staff are not prepared for these patients; it has negatively affected staff moral particularly among the nursing staff. It has negatively affected the care of other patients and general patient safety “ - Community hospital physician

“There has been a perennial significant problem with inpatient placement for patients with severe mental illnesses. The problem has been much worse since the closing of the state hospital” - Community hospital physician

The Green Mountain Care Board should include considerations about the number, nature and location of inpatient psychiatric beds in the state when deliberating the needs of the state’s population as a whole. Inpatient psychiatry resources are critically under-resourced presently and the effect is influencing all inpatient and emergency room care across the region.

4. Recognize the workforce as the key resource
The professional healthcare workforce that directly interacts with patients is the paramount resource in health care, and the Vermont Health Resource Allocation Plan should recognize the immediate and future challenges to ensuring an adequate healthcare workforce in Vermont.

Teamwork
The workforce consists of discretely identified professions such as nursing, physicians, mid-level practitioners and allied health professionals. However, the provision of good care is the result of teamwork and coordinated supportive interaction among all the professionals. Policy makers should recognize the interdependence of professionals in their consideration of workforce needs. Patient care is enormously more complex than it was two decades ago; no individual practitioner can provide good care alone. Advances in medical science, particularly technologic advances, have resulted in many new diagnostic and treatment modalities. Patients are able to live longer, but the burden of caring for them safely and to meet their individual needs.

Nursing
An example of the interrelatedness of all the professionals that comprise the clinical care team was mentioned by two physicians at a rural hospital. In their opinion the dominant influence on patient care and physician practice in years was a significant reduction in the nursing workforce.

“The most significant recent event that has affected the quality and capacity of care in our institution is a downsizing of our inpatient nursing staff. The nursing reduction has caused us to reconfigure our inpatient space…reducing a 5 bed dedicated ICU to 2 beds in a standard room…our 6 step-down beds are now scattered” - Critical access physician

“Because we are fortunate in still having a solid general surgery workforce, other community hospitals had been referring both elective and emergency general surgery patients here…Our surgeons are less comfortable accepting many of these patients as in the past - particularly those whose recoveries would entail complex long term inpatient nursing care. This has the potential to create a patient safety issue regionally as our role has been to stabilize surgical patients until a tertiary care bed becomes available” - Critical access physician

“Our pediatricians have become less willing to hospitalize locally as a result of the loss of nurses comfortable caring for kids “ - Critical access physician

Allied health professionals
Another example of the interdependence of the different team members relates to patients requiring long term ventilator support but who are otherwise clinically stable. An everyday challenge across the region is freeing up beds in the two tertiary care centers for new critically ill patients.

“There is an ever present mismatch of patient needs and patient location. Some institutions are always full, while others always seem to be under their capacity. The underlying issues are complex and not limited just to whether there is an empty acute care bed; it involves the clinical capacity of the staffing at the outlying institutions. And it is broader than just the clinical expertise of the physician and nursing staff; it includes ancillary services as well. A good example is whether there is adequate respiratory therapy staff available, allowing outlying hospitals to take back patients from the tertiary care center while they still have ongoing respiratory care needs” - Tertiary center physician

Workforce issues specific to physicians
The following paragraphs focus on the physician workforce. Issues regarding the physician workforce came up in every interview. The physician centric comments should not be interpreted as diminishing the importance of teamwork and the interdependence across all the professions; the importance of teamwork was mentioned just as frequently as specific physician workforce issues. All but one interviewee was a physician.
The most pressing challenges to the current physician workforce in all Vermont counties are outpatient primary care physicians, hospitalists and psychiatric physicians. Inpatient psychiatric care is in disarray since the closing of the state hospital in Waterbury.

"Chittenden County has the highest per capita rate of primary care physicians, but there is still a need for more. As is the case across the state there is a significant problem with access to psychiatry" - Tertiary center physician

“Our biggest need is adult psychiatry and primary care. One of the dynamics we are experiencing presently is that we have older primary care physicians who are practicing very limited hours and days per week. It makes it hard for the community to recruit and justify recruiting new primary care physicians when so many patients still identify with the older physicians who are not able to meet their patient demands any more. It also creates problems for the other physicians in the community when they are trying to ensure that a transition of care from the hospital to another community setting is seamless and well orchestrated” - Community hospital physician

Additional physician workforce needs vary across communities; however there are a few overarching trends. There is a recent trend of out migration of urologists from the state. There are fewer general surgeons consistent with a national trend. Maintaining an obstetrics service is becoming both a workforce and a financial challenge in smaller communities. There are less medical specialists outside Chittenden County. Pediatric admissions beyond the newborn period are infrequent and comfort with hospitalized children is waning among all workforce team members including pediatricians.

Primary Care Physicians
Though the interviews that support this document were focused on inpatient services, the shortage of primary care physicians came up as a major influence on the quality of overall care in every community. The primary care workforce shortage is a complex issue and has many aspects. In the context of these interviews focused on inpatient care, the aspect of the shortage most mentioned was related to discharge planning and post hospital care. Specific problems that exist from the perspective of the inpatient services include: 1) not being able to contact the designated primary care physician because of reduced number of work days or hours, the growing number of part time PCP positions and older physicians with reduced work hours; 2) lack of timeliness of response from outpatient physicians due to their increased work load; and 4) needing to discuss discharge planning with a physician rather than a mid-level provider due to the complexity of patient illness.

Another aspect of changes in the primary care workforce that is influencing inpatient care is the perceived loss of comfort on the part of outpatient based physicians with complex medical patients and a loss of professional skills as they no longer round on patients in the hospital and are involved with the complex decision making required to manage severely ill patients.

Hospitalists
Retention and recruitment of hospitalists is a challenge in every institution in Vermont and at Dartmouth Hitchcock Medical Center.

“The biggest issue for us is the hospitalist workforce. We have been recruiting PCPs from our community – one full time, one half time and several about 25% time. The PCPs are very supportive of the program and would not want to go back to covering inpatients in addition to their outpatient responsibilities. However, we’ve recently been recruiting from outside our community with little success; the barriers are both salary level and life-style including number of required hours of work. In contrast the pay for
hospitalists is higher than what the PCPs are able to make doing outpatient work” - Critical access physician

The role of the hospitalist is new and evolving; a great deal of what they do for patients formerly was done by community based physicians. In some ways hospitalists have assumed part of the patient care responsibilities that were traditionally included in the primary care physicians’ scope of practice. The traditional role of the primary care physician has been partitioned. The results of the transition have been mixed. Some aspects of care have been improved, e.g. hospitalists being up to date with critical care issues, but other areas of care are potentially more vulnerable to error and less patient satisfaction due to the partitioning of care which necessarily creates more handoffs and more opportunity for miscommunication resulting in discontinuity of care and even error.

“We've had a hospitalist program for approximately 2 and ½ years now. Initially, we contracted with a national firm to put the program in place and staff it. The result was that no full time hospitalists could be recruited; the service was staffed by locum tenens physicians. The program was very costly and patients, nursing and local physicians were dissatisfied with the care; hospital length of stays (LOS) increased and quality suffered. A subsequent effort that consisted of a hospital employed physician and locum tenens was also unsatisfactory…

“Currently, the local physicians staff the hospitalist service, each of us working approximately one week every 2 months covering 24 hours five days a week. Tertiary center trainees are contracted to cover the weekends. Local physicians help out with morning rounds on their own patients. The present system is much less costly and patient, nursing and physician satisfaction are improved; LOS’s have decreased as well. Though presently, physicians are enjoying the system, it is not sustainable. Ultimately, we would like to employ a hospitalist to cover about 50% of the days; the other days will be covered by local physicians and tertiary center trainees”- Critical access physician

Inpatient mid-level practitioners
Nurse practitioners and physician assistants are employed in some hospitals to help with inpatient care; mid-levels are becoming more common, however, there are mixed opinions of their impact on easing the work load and how their skills can best be utilized.

“We do not have any mid-levels on the inpatient service; there are several in the community in outpatient settings. The Green Mountain Care Board needs to be aware that mid-levels cannot be expected to be as effective and practice independently like a board certified physician in the inpatient setting. There needs to be accessible physician backup and a dependable protocol that all involved can trust including the patients. As mid-levels gain work experience they become much more competent. They aren’t exposed to as many clinic hours of training as physicians, so when they come out of their formal training they still need readily available support until they are more accustomed to recognizing the level of patient need and severity of illness. This is particularly the case in primary care and on the hospitalist service where anything and everything might come their way as opposed to a specialty setting which sees a much more constricted array of clinical problems” - Community hospital physician

Special Inpatient workforce Issues
The following areas justify special mention due to their immediate importance in the discussion of an informed Health Resource Allocation Plan for the state’s health care system.

  a) Psychiatry
Mental health and substance abuse needs of the Vermont population are the most frequently mentioned needs according to physicians who work in the inpatient settings. The prevalence of need is increasing as is the severity of the illnesses. The capacity for caring for those Vermonters needing inpatient care was under stress before the closing of the Vermont State
Hospital in 2011, but has increased to a dangerous level since that event. The present situation presents safety issues not just to the Vermonters in need of psychiatric care, but to caregivers and other non-psychiatric patients in our community hospitals and tertiary care centers. Many of the effects of this change in the mental health system’s capacity have been documented elsewhere; however, some additional dimensions and comments on the severity of the issues are captured in the following quotes from physicians practicing in Vermont’s hospitals.

“Given the current disarray of the state’s mental health system, a very core services is psychiatry with expertise in very ill patients with severe persistent mental illness. We have several of these patients constantly and it creates stress on everyone including the other patients” - Community hospital physician

“We have a very big hole when it comes to psychiatry. This has been acerbated recently with the state wide crisis due the closing of the state hospital. There are always patients either in the ED or on the floor in psychiatric crisis and neither setting is ideal for these patients as they are waiting to be transferred for appropriate treatment. A tremendous amount of resources are needed to ensure these patients are safe while awaiting transfer, which has been as long as 5 days. We are in the process of creating two “safe rooms” in the ER just for these patients. We have the sense that once these patients are admitted to our community hospital, the effort on the part of the state to transfer them to more appropriate care falls off. As a result we are hesitant to admit these patients “- Community hospital physician

“Our present offering of clinical services functions well. The one glaring need is inpatient psychiatry. Not only do we frequently have patients with severe persistent mental illness admitted from our community; a situation that has become much worse since the closing of the state hospital; but we serve as the medical and surgical acute care hospital for one of the new replacement facilities for the state hospital. As a result we are sent their inpatients if they develop medical or surgical issues, but do not get any help from the designated state facility managing the very severe underlying mental health issues these patients– an ironic situation to say the least” - Community hospital physician

Hospitalists mentioned not only the shortage of inpatient psychiatric expertise, but that the lack of access to mental health resources in the outpatient setting was directly affecting hospital inpatient utilization as well:

“…there is a big deficiency in outpatient mental health resources and even bigger hole related to substance abuse. The outpatient problem affects our inpatient service, because there is a lot of recidivism particularly in the community population that are struggling with substance abuse. We see a lot of the same patients over and over again for detoxification, send them out knowing that there’s not much help out there and are not surprised when we get a call from the ER that they are back again….

“It’s discouraging to community oriented physicians. We know we do a good job on the inpatient service with detoxification, while at the same time we know that as a community we are not penetrating the problem” - Community hospital physician

“The local community mental health center has psychiatric staffing, but they do not see patients when they are inpatients” - Community hospital physician

b) Maternity Care
Continuing to provide maternity care at Vermont’s community hospitals is in question. The costs associated with both the wages required by the medical professionals and the cost of maintaining a birthing center that includes immediate access to an operating room for Cesarean section are becoming more than the revenue that the service can produce. Many of the state’s community hospital birthing centers are operating in the red. Hospital administration and boards are struggling to justify continuing to offer maternity care in spite of it being central to the
historical mission of these community institutions. A regional approach to maternity care based again on the entire population should be considered.

"It's hard to imagine a community hospital not defining obstetrics and gynecology as a core clinical service, but the volume is ever decreasing and the cost of offering the service is substantial" - Community hospital physician

“We currently have obstetric and gynecologic physicians, but this is borne at a loss to the hospital. It may be time for regionalization of obstetric and gynecologic care particularly as the birth rate continues to decrease" - Critical access physician

c) Urology
There has been a recent out-migration from the state of urologists. The reasons for leaving are varied. None of them have retired, rather they have left for family related reasons, higher wages, concern over Vermont’s health care reform efforts and more appealing working conditions in terms professional growth, work schedule and hospital support. Urology is another care need that may need a regional approach to meet the aims of a 21st century health care system. There is concern in the physician community that access to care and the quality of care are being affected by the reduction in the urology physician workforce.

A recruitment challenge specific to urology is the provision of robotic surgery technology. Recent trainees are for the most part being trained to use robotic surgical techniques which may be difficult for a low volume hospital to justify as a capital investment. Robotic surgery is an example of the interplay between capital resource allocation and workforce; and how the advent of new costly technology makes achieving equity, efficiency and safety of care statewide so challenging.

“Urology has become a difficult issue. We are currently understaffed and in the process of recruiting physicians. One of the issues with the younger physicians who might be interested in coming is that our facility does not have robotic surgery technology. The younger physicians are being trained to use this technology extensively. There has been some talk about leasing the technology possibly in conjunction with other hospitals, much like we did with MRIs when that technology was first becoming available" - Community hospital physician

d) Pediatrics
Pediatric admissions outside of the newborn period have become uncommon across the region and the state. Not unexpectedly, both physicians and nursing staff are becoming less comfortable with pediatric admission to the community hospitals. Vermont children currently has access to a children’s’ hospital located in each of the two tertiary care centers serving Vermont; the majority of the pediatric admissions now appropriately occur at these two institutions. There may be potential efficiencies to be gained if these two institutions were to offer pediatric subspecialty resources in a formal coordinated regional approach.

“Pediatrics is a good example of the challenge a lot of community hospitals have to ensure that physician and nursing skills are maintained at a high level; it’s difficult when the volume of patients is low. The same challenge can be an issue with certain adult patient needs” - Community hospital physician

“Availability of inpatient pediatric services is problematic. The volume of pediatric patients in each institution excluding newborns is very low. We need a pediatric hospital in the state, how much capacity we need in each outlying hospital is not clear, but the volumes are low enough to give concern as to the quality of care” - Tertiary center physician
e) Subspecialty Medical Consultation

The majority of medical subspecialties are becoming less present in outlying facilities. The reasons are several and include retirement and professional isolation. Many physicians value close interaction and support of their specialty peers and prefer work arrangements that provide this support. Some are willing to travel and staff satellite clinical sites; this has become a more common and a satisfactory practice arrangement in the past decade for the specialist, the outlying institution and patients.

“Subspecialty consultations can be a challenge either because we have no local sub specialist or because of vacations and other work schedule issues. Over the past several years as we lose subspecialists, we’ve had to adapt to no longer being able to get immediate subspecialty consultations” - Community hospital physician

“There is a general sense that we one subspecialist away from a crisis” - Community hospital physician

The medical specialty most depended on in the outlying hospitals is cardiology, and there is the most access to cardiologists either resident or remotely located but with formal arrangements with the outlying hospitals. Advanced imaging and testing technologies are commonplace in modern cardiology. There is a wide variety among institutions of the degree of technology that is present on site. Many institutions have arrangements with cardiology services elsewhere to interpret test results done locally.

“We have 3 general surgeons, a robust orthopedic service, ob/gyn, diagnostic cardiology and a local GI specialist who does GI procedures here which is very helpful to both the other physicians and patients as it avoids a lot of referrals away for routine procedures done safely here” - Community hospital physician

Access to gastroenterologists across the state is in transition. There are fewer practitioners located in the outlying communities. The dynamics for this transition are similar to other specialties that have resulted in a consolidation of specialists at the higher volume institutions. One consequence specific to gastroenterology is the contraction in the availability to ERCP, a complex inpatient endoscopic procedure for liver, gallbladder and pancreatic problems. Patients requiring the procedure are frequently transferred to tertiary centers and remain in those institutions for either convalescence or subsequent routine surgery that could be performed in their local hospital closer to home. Transfer of patient between facilities can cause financial difficulties for both the referring and receiving hospitals as mentioned previously.

“Gastroenterology could be available through regular consultation visits and these visits could include routine uncomplicated procedures otherwise available only at the tertiary centers” – Critical access physician

Few outlying hospitals have intensivists or pulmonologists who care for inpatients. Some communities have pulmonary clinics for outpatients. No hospitals other than the tertiary care centers have nephrologists. There is only one infectious disease specialist not at a tertiary care center. There are a decreasing number of neurologists in the outlying communities, though neurology conditions such as stroke, seizures, syncope, TIAs and altered mental status are common causes of hospitalization everywhere. Endocrinology is exclusively a tertiary care center resource. Access to dermatology is very limited everywhere, the specialty being mostly based in the larger communities.

“We have one pulmonologist who is a big asset for our ICU patients. We do have patients on ventilators. The ICU is covered by the hospitalist service; we do not have an intensivist. The bar for the capability of
the hospitalist service keeps rising as the attrition in local specialists continues” - Community hospital physician

“Neurology is another area where we are soon going to be having a problem. Our current physician is older and soon will be retiring. We have a big need as hospitalists for neurology support: lots of patients are admitting with primary neurological diagnoses - stroke, seizures, TIA's, syncope and altered mental status” - Community hospital physician
Section 3
Measurement and Information

What information/reports about care would be most useful to you?

How could utilization and quality measurement be more efficient?

Two questions were directed at measurement issues. The Board has a number of areas of responsibility - payment reform, price transparency, hospital budgets and insurer rate review — that could incorporate quality measurement. The Board’s payment reform efforts, in particular, include quality measurement - a provider only benefits financially from the payment methodology if they meet quality standards. The Board wants physician input on how they can assure that measures are meaningful to the providers on the ground. The Board is interested in practitioner opinion on the usefulness of the 33 ACO measures being used in the Medicare Shared Saving Accountable Care Organization pilots. The Board needs to know if the measures are not meaningful to practitioners, what do they need to do to track a more meaningful set of measures

Seamless integrated health information system
The most common initial response from interviewees to both questions was the need for a seamless integrated clinical information system both within their own institution and across institutions in the region.

“Without any doubt the single most needed improvement in terms of information flow is the need for a truly integrated seamless medical record across our entire institution and that can effectively interface with the HIT in other facilities” - Tertiary center physician

“I have no trust in any data point that comes from our EMRs both inpatient or outpatient systems – it will be a long time before we can get reliable actionable information from these early primitive IT systems” - Community hospital physician

“We desperately need true errorless exchange of core information such as labs, radiology and prescriptions; as well as baseline documentation of patient status” - Tertiary center physician

“An enormous problem is the lack of compatibility between the hospital information system and the EMR in the local health center where about 85% of the community receives its primary care. We need accurate bi-directional flow between the two systems. Outside physicians don’t have access to all the content of the inpatient system, so even if they go out of the shell of their clinic EMR they can’t get the information they need by connecting into the hospital's system” - Community hospital physician

“The lack of compatibility between the IT systems can cause tension between the inpatient physicians and the outpatient physicians themselves, let alone comprise care and add to the inefficiencies of the system” – Community hospital physician
“Information technology will certainly play a role in capturing and sharing important clinical information, but to date this has not been the case. The federal Meaningful Use effort is a good example. Before Meaningful Use, we had a dependable medication reconciliation process embedded in our outpatient medical record that everyone across the system had access to. Because of the federal requirements for the hospital, we now have a duplicate, non-communicating reconciliation process in our inpatient record: We no longer communicate directly with our primary care colleagues; practices have had to add staff to transfer hospital data into the outpatient EMR. The result is not only loss of time, but decrease in quality and safety as a result of the creation of another care handoff prone to error” - Community hospital physician

“So far, we have seen no on the ground positive impact from VITL or other state HIT efforts. We have 5 EMR systems within our small organization. None of them interface with each other and there has been no response from the state or VITL in terms of our requests for help” - Community hospital physician

**Little useful information available**

Beyond the disappointment and frustration with the current state of health information technology, the overall sense about measurement, reporting and available health care information among the region’s hospitalists is that there is little information available to them that is meaningful or useful. However, there is significant interest among hospitalists to have access to more reporting and measurement that is meaningful and could facilitate benchmarking and improvement.

In contrast to their colleagues working in the primary care outpatient setting, the inpatient physicians do not feel overburdened by documentation and reporting demands. The majority of the documentation and reporting burden in the inpatient setting is born by the hospital’s administrative and nursing staff. Several mentioned the irony in the contrast between the inpatient and outpatient settings; outpatient practitioners with little administrative resources are being asked to document excessively in order to support a robust set of measures, whereas the hospitalists with ready access to administrative support and responsible for the highest cost patients are wanting more information and measurement.

“It would be great to get quality of care scorecards that weren’t just internally generated to satisfy CMS like the Core Measures and the frequency of Never Events. Moving from nothing to something would be positive’ - Tertiary center physician

“Outpatient measurement is far ahead of inpatient measurement in both good and bad ways – good in that the outpatient teams are beginning to become more efficient at both gathering and acting on measurement, whereas, in the inpatient setting the team concept is very inchoate. On the other hand the outpatient setting is being asked to do much more documentation and measurement, not all of which has been shown to be of use or even valid” - Tertiary center physician

“Not a few physicians who are practicing as hospitalists were formerly outpatient practitioners who left because of the documentation and administrative demands that are now present in the outpatient setting. The measurement burden is critical in the outpatient setting” - Community hospital physician

“As hospitalists we are not bombarded by the constant demand for external measurements and reporting as much as in the outpatient setting. That being said, we would greatly value more meaningful measurement, particularly comparative reports on clinical processes and outcomes among all Vermont hospitals” - Community hospital physician

“The burden of measurement has increased, but it’s not as big an issue for the hospitalist service as it is for the outpatient physicians. The hospital has the resources to build a lot of the documentation into the work flow, so it’s less of a burden. It’s in the patients best interest and financial interest of the hospital for
example to build the CMS core measure set into our workflow and put in place systems for the required documentation to be done easily” - Community hospital physician

Suggestions for more meaningful information
The most frequent responses from physicians about how measurement could be made more valuable or the process could be more efficient are grouped in the following categories:

- Comparative measures across institutions;
- More detail to existing measures;
- Patient satisfaction data;
- Individual service and physician level performance data;
- Measurement based on scientific evidence;
- Transparent contribution to improved patient care
- Overall population health measures
- Consistency of measures across payers, regulators and others that are trying to “help”
- Feedback from the tertiary care centers
- Local professional interactions
- Time and resources to address shortcomings

Comparative data across institutions
Nearly every physician mentioned interest in being able to compare their own performance and that of their institution to other institutions in the region. There were many comments about the lack of performance benchmarks at any level of aggregation. Specifically, there were many requests for information on clinical and financial effectiveness and efficiency such as clinical process and outcomes measurements, overall utilization of services, utilization of services per admission, overall costs and cost per admission.

“With the GMCB now having authority over hospital budgets and certificate of need requests it would make sense for the Board to demand accountability from the hospitals in terms of quality of care and utilization rates. A focus on value at both small and large Vermont hospitals will be key in reforming the system and improving the level of care and control of costs” - Tertiary center physician

“All the quality and utilization information available on the inpatient side is internally generated; there is no external stream of like information coming in. One pertinent example is the lack of quality or utilization reports coming from Vermont Medicaid. The inpatient service would like to know how others perceive the value of their services and if there are areas in which they fall short of expectations” – Tertiary center physician

“In contrast to the outpatient setting where there can be too much information being directed at care providers and certainly too much being asked of them in terms of documentation, there is inadequate information available to the inpatient settings, particularly in regards to quality and utilization information from external sources” - Tertiary center physician

“We would love more information about our patient outcomes, both pertaining to the course of their care as inpatients and their subsequent clinical course post discharge” - Tertiary center physician

“There is an excessive reliance on the state’s Blueprint for Health program to solve both individual and population health needs. The Blueprint outcomes are all about reducing services to people in an effort to reduce short term costs. The accomplishments of the Blueprint are very limited to date” - Community hospital physician
“Comparative data across institutions on cost, efficiency, patient and process outcomes would be very welcome particularly if the new reports would replace existing valueless reports and not in addition to them” - Community hospital physician

“We would love to know how we compare to others in terms of utilization of services, patient outcomes and efficiencies” - Community hospital physician

“Comparative data across like institutions on quality, utilization and efficiency metrics would be very welcome, e.g. LOS, cost per DRG, utilization of resources per episode of care, patient satisfaction” - Community hospital physician

“Even physician specific information would be welcome in the spirit of identifying best practices and quality improvement” - Community hospital physician

More detail to existing measures
A second common request was for more detailed information linked to existing reports. A common example was the desire for more detail on the CMS Core Measures. The general sentiment was that readmissions rates were not helpful, and that these measures needed to include data that offered insight into why the patients were being readmitted, e.g. length of time to outpatient follow up, inability to obtain medications, inability to understand or adhere to treatment recommendations or lack of social support.

“As hospitalists we like to see data on readmissions, but the data that we currently get is too general and not detailed enough to help us understand why the patient is being readmitted. What went wrong, if anything, post discharge? Was there too long a time before the patient was seen as an outpatient? Did they find themselves unable to get their prescribed medications? Did we make the wrong diagnosis? We need more granular data to design and carry out process improvement efforts so we can get better” - Community hospital physician

“The current measurements, CMS’s Core Measures for example, aren’t clinically meaningful; they don’t tell us anything about the quality of care being delivered, rather they are simply punitive and need to be met to ensure the hospital’s financial viability” - Community hospital physician

“There is too much emphasis on readmission rates. For us, and probably for most Vermont hospitals, all of whom have low hospital admission rates and low readmission rates, the patients that are most frequently readmitted are those at the end of the lives. For Vermont to address readmissions most effectively, we should address head-on our views as a society on end of life issues” - Community hospital physician

“Readmissions rates in themselves are too crude to be very useful, and most of the reasons for readmission are not in the control of the acute care facility. Our fragmented system of care is not capable of the communication and coordination necessary to keep people from falling between the cracks during transitions of care” - Community hospital physician

“A patient with terminal cancer who is expected to have multiple admissions is very different from the congestive heart failure patient who was readmitted because they were discharged on inadequate diuretic treatment” - Community hospital physician

“The presence of a hospitalist service assists the institution and its medical staff in complying with federal and state quality metric and performance programs. The hospitalists’ role creates a structure that enables changing the community practice norms more quickly and more thoroughly - Community hospital physician” - Community hospital physician
“More detailed information about cause of readmissions would be very welcome. We’d like to know how to make care better, either what we do while patients are here or in terms of arranging post discharge care that is needed to avoid people having to return to us” - Community hospital physician

“We get little information on how we compare to others from external sources, and when we do, it is often not credible. For instance the mortality from stroke in our service area is more than the number of stroke patients we see. Supporting detail to the reports would help with their credibility. It is possible that some of these stroke patients came from our community but died elsewhere, but without the details, the reports lack both credibility and any utility in terms of quality improvement” - Community hospital physician

Relatedly, physicians are of the opinion that the amount of resources that their institutions are forced to dedicate towards the collection of the existing crude opaque measures diverts scarce quality improvement resources from quality and safety shortcomings that do need attention.

“The current federal measurement requirements such as the Core Measures, HCAP and Meaningful Use are not inappropriate. That being said a consequence of the need to comply with the data collection and performance expectations of these programs is intense and results in this institution not being able address other quality and safety issues that may be more pressing than the areas that the federal monitoring focuses on” - Community hospital physician

Meaningful patient satisfaction reports
Specific mention was made to the need for patient satisfaction measures. Mention was made to the need for not only more sophisticated measures, but also distribution of aggregate institutional measures by service sector and individual physicians. Mention was made that inpatient physicians had no sense of ownership to the institutional patient satisfaction reports, particularly in large institutions when multiple services attend to any given patient.

“Of particular interest is meaningful patient satisfaction information. Patient satisfaction measurement is very new in the inpatient setting in terms of physician involvement as opposed to nursing or institutional involvement. The science is emerging and as a result we are just beginning to learn how to measure and how to react. We need to develop a sense of ownership for patient satisfaction as an inpatient team. It is commonplace currently for everyone to disclaim ownership of patient satisfaction” - Community hospital physician

“Our hospital is not yet patient centric. It is typical for patients to wait hours in the ED while unbeknownst to them, the various clinical services are squabbling about whose service the patient should be admitted to. Physicians do not as a group feel ownership for the patient experience. A hospital executive once told me that physicians were so easy to manage because they were so unorganized as a group, but ironically, the organization ultimately needs physicians to be organized around the patient experience or else the corporate interests of management will dominate decisions; they will not necessarily be in the interest of optimizing patient experience and clinical care” - Tertiary center physician

Individual service and physician level performance data, but done efficiently
Disaggregation and attribution of institutional measures to the level of specific services and individual physicians and teams of practitioners was mentioned frequently. Many of the physicians interviewed had previously had access to patient panel and individual patient level data in previous employment in the outpatient settings; they were very conscious of the contrast between the amount of useful and specific data between the two settings. However, it should also be noted that many hospitalist physicians had made decisions to change from the outpatient setting to the inpatient setting because of the excessive burden of documentation that was required by them as practitioners to support the amount of available measurement in the outpatient arena. The hospitalists want more measurement, but they do not want to adopt the same inefficient data collection methods that they fled from in the outpatient setting.
“Many physicians have not been exposed to measurement of their effectiveness; we are at the beginning of a cultural shift. Physicians typically feel that their patients are different from others; physicians do not like to follow protocols, let alone protocols designed to address measurement deficiencies” – Tertiary center physician

“We are eager for detailed information about those patients in our own practice panel so we can begin to identify high utilizers by either category or by individual so we can begin to wrap around ancillary services and case management to address unmet needs and keep patients out of the hospital” - Community hospital physician

“We also need information on the individual practitioner level so we can assess our needs and behaviors. This will be a particular challenge for us as we share so many patients across so many services. How do I compare to my peers or current practice in treating my patients with CHF or pneumonia? We need this granular level of information in order to improve” - Community hospital physician

Measurement based on scientific evidence
A unanimous opinion was few of current measures were based on solid medical science; this is particularly the case in terms of the clinical process and outcome measures.

“Part of the resistance to measurement by physicians is previous bad experiences. Many of the initial process and outcome measures proved to not be based on evidence, some of the processes that even the federal government or national quality organizations insisted they we document to evidence that care was of high quality have in fact proved to be detrimental to care” - Tertiary center physician

“Reporting and measurement need to be evidence based. There is presently very little evidence about how measure helps care” - Community hospital physician

“Care needs to be taken in choosing quality metrics; they need to be evidence based and there needs to be physician input in the conversation. There is the potential for chosen metrics to be detrimental to reform if they selection process is not done well resulting in metrics that are cumbersome to collect during the work flow, not evidenced based and not perceived by physicians are being beneficial to patient care” - Tertiary center physician

“Another aspect of measurement is the return on investment. If the measure isn’t particularly meaningful to the patient care or the physicians work flow and responsibilities, there will be justifiable resistance. As measurement becomes more widespread, those selecting the measures need to be absolutely certain of the evidence base of the measure and the clinical relevance to patient care” - Tertiary center physician

“We are now very familiar with the CMS Core Measurement set, but for a critical access hospital few of these measures are applicable either because of our low bed count or the lower severity of illness of our patients. What is needed is more research on the evidence base of these measures before we are all forced to bear additional measurement burden. Several of the CMS measures have been discontinued as evidence accumulated about their lack of validity or inconsistency with the evidence base” - Community hospital physician

“Measurement should be evidence-based; most of the federal and state measures look at metrics that have not been shown to actually improve care nor decrease utilization over the long term” - Community hospital physician

“On the outpatient side, little of the Blue Print’s quality measurements are of much value or evidence based and though we dedicate significant resources to data collection, there is little local evidence that all the resources committed have improved patient outcomes” - Community hospital physician
“Measures that look at short term costs are less useful than measures that track adherence to best practices and that are evidence based” - Community hospital physician

More transparent value to patient care
An issue closely related to the need to ensure that measures be based on science is the need for the value of the measure be transparent to clinicians particularly if they are distracted from patient care to ensure that the needed data is documented. Several interviewees mentioned that the perceived burden of documentation required to support measures would seem less intrusive if the return on the invested time and effort was obvious in terms of its affect on patient care.

“Too much of the documentation and coding requirements are irrelevant to clinicians. The link between the need for the measurement and documentation and the clinical care of the patients needs to be transparent, needs to have real value to patient care either immediate or long term is less important than real and transparent” - Community hospital physician

Overall population health measures
Mention was made that though hospitalists work on the inpatient side of the delivery system, they would like to know more about the overall population health measures for their community; they feel that they are part of the larger medical community and that the health of their community is a shared responsibility. Hospitalists are part of the continuum of primary care. In fact for many community members at the end of their lives or with severe illness requiring repeated hospitalization, the hospitalist service assumes the de facto primary care role because of the difficulty maintaining good communication with the outpatient workforce due to any of a variety of problems in every community relating to: the lack of primary care practitioners particularly those with the knowledge and confidence to manage complex patients; the increase in part-time practitioners; and barriers due to the lack of interoperability of IT systems.

“We are eagerly anticipating the availability of population based reports on all patients in our service area or who use our referral services. At present we do not have easily accessible information on the distribution of diagnoses or treatments across all our center’s patients” - Community hospital physician

“We need population based information that stratifies our community by need and resources to do successful outreach to those in need, but not in care” - Community hospital physician

Measures should be consistent across payers
Measures should be consistent across payers. Each payer seems to use slightly different definitions for their measures which cause undue waste for little if any gain. There is skepticism on the value of reports and measured gleaned from medical billing claims. Community hospital based physicians desire reporting and information from clinically relevant documentation.

“The claims based data that the ACOs are promising us, will be of little use” - Community hospital physician

Feedback from the tertiary care centers
Several physicians mentioned the desire to know more about how their patients fare once they are transferred to a higher level of care; they are particularly interested feedback on the quality of the care they gave prior to the transfer.

“It would be very helpful to get feedback from the tertiary care centers on patients that we transfer out – did we care for them appropriately? Could they have stayed here?” - Community hospital physician
“We need ongoing feedback. In order for all of us to create a more integrated system of care, we need to know how each of us is doing relative to one another in order to accept our professional responsibility to do the best we can and correct our deficiencies” - Community hospital physician

Community hospital physicians also mentioned their interest in using specific cases that were transferred as learning opportunities for them on how to best manage common clinical situations.

“Case review would be very helpful as well – are we caring for the patients that stay as well as we should? Could we have our deaths and bad outcomes reviewed?” - Community hospital physician

“We need to open the lines of communication between the outlying institutions and the tertiary care centers” - Tertiary center physician

**Local professional interaction and peer feedback**

As patient care has become more partitioned and practitioners have reduced opportunities to interact professionally with each other, one of the traditionally most important modes of quality measurement and valuable professional feedback has been lost. When discussions of health care measurement occur, the focus immediately focuses on measurement to assess utilization, crude clinical processes and outcomes or cost and efficiency. A dimension of measurement and information feedback extremely relevant to clinicians is more related to immediate and nuanced feedback from peers about the care given. Clinicians often responded to questions about measurement and useful information in terms of their interest in the affect of their own immediate actions. As health resources become ever more constrained attention should be given to balance resources dedicated to measurement and reporting for cost accountability and resources supporting peer oversight and feedback on direct patient care.

“Not being anonymous and being accountable to the other community physicians is very important in maintaining the quality of care in our community. A lot of aspects of health care delivery have suffered as care has become more fragmented, outpatient physicians no longer making daily rounds and more part time work arrangements. Immediate peer reaction and input about specific patient challenges used to be so much of what kept us all learning and kept the medical ethic so high in the state” - Community hospital physician

**Time and resources to address shortcomings**

Hospitalists mentioned the need for time and resources to address areas in need of improvement and change. There is a sense of frustration among some hospitalists that when they do receive meaningful information, they are shorted resources to act on its implications.

“We need time and resources to address our shortcomings that are exposed by measurement with process improvement initiatives. We recently focused on patients needing expensive admission to the ICU after elective joint replacements to find that the underlying issue was post operative fluid management. The investment made in the process improvement work will pay for itself many times over. We need more resources directed at developing more meaningful measures and subsequently to improving our performance when needed” - Community hospital physician

“Given the limited human resources of the physician workforce, measurement needs to be prioritized. It is much more important for the physician to document the medication list correctly and reconcile it with other lists than it is for him or her to enter the additional specific wording necessary for CMS to allow payment for an observational stay” - Community hospital physician
Section 4
Payment Policy and Payment Reform

How can payment policies better support good care?

What are your hopes or concerns about proposed new models of payment?

The Green Mountain Care Board has the authority to establish payment methodologies across all payers. The Board would like to engage practicing physicians in the discussions around how should payments to physicians, hospitals and other providers be changed and restructured to encourage system efficiency, quality and improved health of Vermonters. This fourth chapter aggregates physician responses to questions about payment reform and its affect on the delivery system.

The reader will note that physician hopes for payment reform touch on many of the same themes that are dominant in other sections, such as workforce, administrative burdens, lack of coordination of care among various care settings, addressing their disappointments and frustrations with information technology, and lack of a logical construct for delivery system design.

It is also noteworthy that the majority of responses expressed cautious optimism about reform rather than concern.

Hospitalists are paid in various ways; some are salaried while others have performance incentives. The method in which hospitalists are paid influences their answers about the current payment system versus new proposed models. Typically, those interviewees that are salaried physicians were not as informed about new payment models. That being said, regardless of the manner that they were paid, every physician was frustrated with the current payment system and has hopes that payment reform would be better than the status quo.

1 - Hopes
The initial paragraphs of this section combine responses to both the question about how payment policies can better support good care and hopeful responses to the sister question about new proposed payment models. A subsequent shorter part of this section compiles responses that reflect general and specific concerns about payment reform and the specific new payment models endorsed by the federal government and the state.

Logical alignment of payment with good care
A common hope for payment reform is that the new models will be aligned with good care as opposed to the current fee for service model so dominant at present. Everyone expressed hope that the new models would develop and mature principally to support good and efficient care
and replace the current backward system where decisions about care are made frequently to comply with payment rules and regulation.

“Payment reform needs to go hand in hand with delivery system redesign. Payment reform needs to address aligning incentives with good care” - Community hospital physician

“Incentives need to be aligned with good care. We cannot rely on physicians just to do the right thing based on goodwill and professionalism. Incentives need to support more seamless care, more teamwork. Incentives have to be obviously transparent, fair and aligned with best care” - Tertiary center physician

“CMS rules seem to be oriented towards denying payment rather than addressing the patient’s clinical needs. Obviously, we need to be accountable for how we spend resources, but the system that we work in needs be redesigned in a logical manner” - Community hospital physician

“As hospitalists, we generally are not concerned about payment issues. Whatever, systems become the norm, we don’t care as long as they are supportive and consistent with being able to deliver good medical care” - Community hospital physician

“The current situation where the viability of the hospital is dependent on the income from specialty surgical practices like orthopedics is absolutely absurd. That is not to detract from the orthopedists and the important role they play in our community, but rather that core clinical services like inpatient medicine and general surgery are dependent on the higher profit margin of specialty surgical procedures. It’s ridiculous that if orthopedics goes, we all go. It’s an unfortunate reality in the present payment system that the money-making services are more attractive at a time when money is tight” - Community hospital physician

Transparency
Another common sentiment is the new models need to be transparent to both patients and practitioners so they understand why the new models are both in their interest and in the interest of the greater good. Payment reform should be designed to support best care; practitioners and patients should not have to make contorted care decisions to comply with unaligned payment policies.

“The reasons for the extra work for documentation need to be apparent and incentivized. If we want a highly efficient health system, payment policies need to be designed to that end – every system is perfectly designed to produce the results it produces” - Community hospital physician

“Reform should be designed around best practices and protocols. The goal of reform should be high quality care, not short term cost reduction. Reform should encourage early intervention rather than encouraging delay of care in an attempt to avoid short term costs while increasing the possibility of greater long term costs. Reform should not penalize for hospitalization or ER use if it is appropriate for the level of care needed” - Community hospital physician

More patient centric care
Care that is more patient centered was among one of the most mentioned hopes among interviewees for payment reform affects. While “patient centered care” has become a much overused buzz word, and examples of achieving it are so rare since its introduction in 2001 as a key aim for a 21st century delivery system, the interviewed physicians feel it is too important and too central to take off the table. Patient centeredness needs to be highlighted if not made paramount among the other five aims for improved care - safety, timeliness, effectiveness, efficiency and equity2.

2 Crossing the Quality Chasm – a New Health System for the 21st Century - the Institute of Medicine
“As a community health care organization we sell relationships, trust and familiarity; we sell “I know you”. The tertiary care center sells technology. Reform needs to support patients getting what they need where it can best be delivered. Healthcare needs a more fluid ecology; it’s too fragmented now. Having providers spend time at all levels of care might be helpful” - Community hospital physician

“As a community hospital receiving CMS payment under the PPS conditions of payment, we frequently find ourselves in a scenario where the most patient centered care rubs up against the hospital’s financial interests. When we have inpatients in need of a procedure not available locally, interventional radiology for example, the patient is transferred to a tertiary care center. The most patient centric plan is often that the patient be transferred by ambulance accompanied by a nurse, have the procedure elsewhere and then return close to their home and family. What usually happens however is that the patient is completely transferred to the other institution; has the procedure; but remains at the referral center until ready for discharge. The reason for this is that if the patient were to return to our community facility, we would bear the cost of the procedure which often is more than we can get paid for the entire admission by CMS” - Community hospital physician

“There are not infrequent times when CMS denies us payment for our hospital days even when we transfer the patient to the referral setting; it seems to depend on the length of stay prior to transfer; a shorter LOS is more likely to get reimbursed than if the patient is here for several days before being transferred. So we play this game all the time to ensure hospital revenue, and sometimes ignoring what is best for the patient” - Community hospital physician

“Partitioning of care is eroding the trust and familiarity and ultimately will cost more. People ask what ever happened to the house call – we’re not too far from “whatever happened to my doctor” - Community hospital physician

“Patients should be able have some choice in what they want and what they need; they should not be forced to go to the tertiary care center because that is all that reform will support. Reform should empower patients to choose who their providers are and where they will be” - Community hospital physician

Population based care - ACOs

There is widespread interest in the potential of population based payment methodology like the accountable care organization (ACO) model being promoted by both the federal government and the state. Physicians were not as familiar with the other payment model pilots - bundled care or pay for performance.

“One huge service the GMCB could do for all of us is to encourage ways that all the funds available come from a single pot, rather than portioned separately in these various silos who are not accountable to each other and no one is accountable for the entire system as a unit” - Community hospital physician

“If we were to move to a completely capitated system, where we would be held accountable for the care of a given population within a given budget, most of the waste and irritation would disappear. Possibly there should be a variety of sub-capitated designs for discreet populations such as rehabilitation or strictly acute inpatient care” - Community hospital physician

“The ACO model is the most promising approach to payment reform and aligning incentives with good outcomes. I’m less convinced of the utility of P4P; possibly P4P could have some use if the performance metrics were valid quality outcomes. The key will be paying for quality; value should be the driving force. Vermont is much farther along this path than NH” - Tertiary center physician

“The medical staff is cautiously optimistic about the prospects of the ACO model for improving care and seem to separate this new payment model from their concern over a single payer system run by the state” - Community hospital physician

“The medical staff sees the ACO approach, i.e. a population based approach to paying for care, as an opportunity to improve the system, particularly in this institution where both the administration and medical staff are open to be flexible and change the status quo” - Community hospital physician

**Direct care provider input on policy decisions**

There is widespread distrust of persons removed from direct patient care being able to make good decisions about how to restructure the payment system. There is concern that if payment models are created and implemented without input from direct care providers that the result will suffer from many unintended consequences and new barriers to patients getting what they need.

“As the delivery system becomes more integrated and decisions become more centralized, those responsible for making the decisions need to listen more and talk less to those of us out in the trenches doing the work and living with the unanticipated consequences of potentially uninformed centralized and bureaucratic decisions” - Community hospital physician

“All members of the care team need to be listened to, not just the doctors; nursing and all the ancillary health professionals are part of the team and have important perspectives on issues that matter to patients” - Community hospital physician

“Because of recent experience, we are concerned that decisions on how the system should be redesigned will be left to administrators and bureaucrats without input from direct care providers. Input from direct care providers is necessary to ensure that the result is a truly integrated system that supports appropriate transfer of information and coordination and efficiencies of care” - Community hospital physician

**Burden and meaningfulness of measurement**

Physicians understand, invite and anticipate more and better measurement of the value of services rendered. However, this specific policy area came up in many interviews as an area in need of much improvement and physician hope that payment reform would lead to a better more meaningful system of measurement.

“If the intent of reform is for us to accomplish more for less, then we need to be able to focus more on patient care and be less distracting by checking boxes. We want that and so do the patients” - Community hospital physician

“Our experience in the outpatient setting with quality measurement and expectations of care is that they often lag best practice and current medical knowledge because of both the bureaucratic manner in which they are proliferated, but also because of the lack of input from practicing physicians” - Community hospital physician

“The perception by each individual group with their specific interest that the demands of their reporting requirement will only add a minute or two to each patient encounter, but with so many interest groups, and so little time to see patients already, the reporting and documentation requirements become distracting and unsafe to patient care” - Community hospital physician

“Pressure to “teach to the test” will worsen the already intolerable situation of primary care physicians just becoming “box checkers” and not being able to see the entire patient and determine the priority health needs” - Community hospital physician
Medical Records
The quote below captures a concern shared by many about how the clinical value of the medical record has been corrupted by the fee for service payment system and amplified in recent years by encoding the drive to maximize reimbursement into the new EMR systems.

“Another insidious, but potential harmful effect of the current system of fee for service is in the area of the medical records. What is put in the medical records now is heavily influenced by what will be paid for both in terms of codes that reflect higher expenses and codes that represent allowable services; all so the hospital can maximize its revenue. But at this happens at the expense of the accuracy and utility of the medical record; which in the worst case scenario has the potential to harm patients, particularly because transitions of care between settings and providers are so common place now” - Community hospital physician

The Elderly
The importance of our aging population was an aspect that physicians felt strongly about needing to be recognized and addressed by new payment models.

“Payment reform and delivery system design reform need to address the needs of the elderly foremost among our population. We have one of the oldest populations in the US, second only to Maine, and we’re aging. But we are not allocating enough resources for the elderly. This is both a humane issue and a financial issue. There are not enough SNF beds or other non acute care settings available, The acute care facility becomes the only place available for many elderly who clinically do not need an acute care bed, rather their issues are related to not being able to meet the needs of living independently: shopping, self care, food preparation and transportation for example. Because of the lack of alternatives, they end up admitted to the most expensive setting in the community and often end up staying for long periods of time until a less expensive and more appropriate arrangement can be put together for them” - Community hospital physician

“Even when the area agency for aging is involved from the very beginning it can take 1 to 2 weeks before a placement is identified. We are lacking a community safety net for our most commonly in need population; as part of health care reform, we need to address this unmet need and cause of unnecessary spending of acute care dollars and resources” - Community hospital physician

End of life care
Another specific issue that physicians hope payment reform will address is care at the end of life.

“As a society we need to address the unnecessary expense of care at the end of people’s lives. We waste so many resources needlessly; knowing full well that death is unavoidable” - Community hospital physician

Coordination across levels of care
The need for more coordination of care across levels of care was another common issue that physicians hope will be recognized and addressed in new payment models.

“On a micro level here in our institution, the hospitalist service is not well integrated in the Department of Medicine in which is nominally resides. The payment policies need to encourage breaking down all the silos. We have silos within our own Department; we have silos between Departments, between the two tertiary care centers, between the tertiary care centers and the community facilities, between all the hospitals and the SNFs. Our hope is the Green Mountain Care Board can use their authority to make us all a team, a truly integrated delivery system” - Tertiary center physician
“A significant issue that needs to be addressed is the frequent situation where an inpatient at our institution needs a procedure only available at the tertiary center. The need for placement of a drain in an abscess using interventional radiology, patients in need of a restricted chemotherapy regimen or in need of a PET scan are common examples. The patient is transferred to the tertiary care center, but the cost for the treatment and associated resources is billed back to us, the referring community hospital. My understanding is that the tertiary center cannot bill CMS directly for the procedure. The result is that it puts an extra strain on the already tight revenues” - Community hospital physician

“Presently, there are too many silos. There is no seamless continuum of care that traces from tertiary care, community based acute care, rehab, SNF or home health. There are administrative and financial barriers between all these settings. The result is an enormous waste of time and inappropriate care for patients” - Community hospital physician

“Another area of concern is getting appropriate payment for patients in rehab and swing beds which we do a lot of to ease the census at the tertiary center” - Community hospital physician

**Workforce**

There is a lot of concern among hospitalist physicians that the burden of payment reform will fall on them along with the outpatient primary care workforce including the psychiatrists.

“The role of hospitalists is very similar to the role of PCPs in the current system. As resources are diminished due to the need to control and reduce costs, hospitalists and PCPs are the ones who will suffer the most in terms of pay while at the same time being asked to accept a bigger work load with less wrap around and support services” - Community hospital physician

“As hospitalists in a community experiencing attrition in local subspecialists, we are being asked to do more and more, but for less and less salary” - Community hospital physician

“We’re presently caught in this viscous cycle that if hospitalists and PCPs decrease the use of the hospital’s lab services, the hospital experiences less revenue and typically tries to decrease its expenses in their biggest cost centers, which are the hospitalists and PCPs themselves and their equally important peers, the psychiatrists” - Community hospital physician

“We need to salary the interventional physicians, so that FFS volume doesn’t drive care instead of clinical indications and best practices. The current perverse incentives of FFS result in higher costs and poorer quality as each procedure carries with it some risk to the patient” - Community hospital physician

“Payment reform should address the wages of nursing and ancillary health professionals not just physicians” - Community hospital physician

“Payment reform should address the disparity between the incomes of specialist physicians and primary care physicians” - Community hospital physician

“We are very supportive of the changes being made at the federal and state level; however, we have several concerns, the most important of which relates to the workforce. Workforce issues are crucial to maintaining the safety and quality of care in our state and in our community; but policy makers need to understand that all the various workforce categories are interdependent on each other. The healthcare workforce is not merely a sum of the number of nurses, allied health professionals and physicians. The workforce is a team, and all the components are inter-related. The reduction in nursing workforce at our institution was a decision made by administration with no physician input. The negative results of the decision has had the single most impact on physician, nursing and patient satisfaction of any recent event in our community; physicians are less comfortable with our ability to offer safe and high quality care” - Community hospital physician

**Admission to skilled nursing facilities (SNF)**
Several physicians mentioned their interest in the Board pursuing a waiver from CMS so that patients do not need to be hospitalized in an acute care facility before CMS will pay for that person being placed in a skilled nursing facility. It was mentioned by one physician that such a waiver had been granted to one health system in Maine.

“In general the allocation of patients to bed type and institution is driven by financial interests rather than by the patient’s clinical needs. A typical example is an elderly 92 y/o who can’t care for herself at home any more, but can’t be sent directly to a SNF because of CMS regulations, so she gets admitted unnecessarily to the acute care facility where she may end of staying for long term because she is not a financially appealing patient for a SNF.” - Community hospital physician

“The other patient population whose care is adversely affected by the current payment system are those patients that no longer need acute inpatient care, but end up waiting for SNF or rehab placement for weeks. The potential receiving institutions are unwilling to take these patients in a timely manner because of their concern about insurance coverage and what the marginal profit will be on the patient. The overall system ends up paying the high cost of unnecessary acute care, and access to appropriate level of care and inpatient beds across the system is reduced” - Community hospital physician

Equitable funding for all levels of care
Both physicians from community hospitals and their peers in the tertiary care center expressed concern about the financial viability of some of the outlying hospitals. Two common reasons for this concern was the need for the outlying hospitals to take the pressure off the referral centers in terms of beds as well as the importance of the role that stable community institutions could play in keeping Vermont as appealing location for physicians interested in practicing in a rural setting as opposed to the larger referral and academic institutions.

“The GMCB can ensure that the tertiary care centers support the entire system including the outlying institutions. All the most profitable services are being consolidated at the tertiary care centers in the current market environment. The GMCB should ensure: 1) services are either distributed in satellite centers of excellence or more diffusely in keeping with best medical practices; or 2) ensure that the revenue from those services appropriately centralized be shared to support the outlying but no less important community facilities and the less profitable services provided there” - Tertiary center physician

Observation Bed Status
The concept of observing patient before determining the appropriate level of care and placement is complicated by current CMS rules. These rules tie the hands of the acute and tertiary care centers in appropriately providing the correct level of care at the correct time.

“The Green Mountain Care Board and or the State needs to consider obtaining waiver from CMS regarding the Observation Bed rules to allow for the appropriate care of the patient be determined by their clinical need and not the payment mechanism” - Tertiary center physician

“The decision whether to hospitalize someone or place them on observation status is a constant enigma. The process for deciding should be simplified. The care that is delivered is not any different, but the amount of administrative resource and the consequences of how much the patient and family are financially at risk is very significant” - Community hospital physician

2 – Concerns about new payment models
The second part of this section compiles responses that reflect general and specific concerns about payment reform and the specific new payment models endorsed by the federal government and the state.

Single payer
“The prospect of a single payer system in 2017 is very concerning to many of the physicians particularly those whose practices are procedure oriented. However, there are some that anticipate that their work environment and patient outcomes will improve” - Community hospital physician

**Double duty**

“The GMCB should maintain an inexorable march toward payment reform. A single payer outcome would be very welcome among physicians. That being said, the GMCB should be careful not to punish institutions for their efforts to adapt themselves to a more capitated future. This transitional time will consume lots of resources as institutions continue to heed the present FFS master and prepare for their future capitated master. The GMCB needs to recognize institutions needed to do double duty. However, both the GMCB and the providers need to keep their eyes on the long view of realigning financial incentives towards better health outcomes. State government needs to be strong, supportive and unambivalent” - Tertiary center physician

“Presently, compensation at DHMC is based on productivity in terms of RVUs. RVUs keep the lights on. There is a lot of work going on retooling the organization to be prepared for a future with more capitation, but the FFS is still the driver when it comes to present revenues. Having the two world views operating at the same time creates concern and tension” - Tertiary center physician

**State border issues**

“As a ‘border’ town most of our tertiary care referrals are out of state, and any Vermont centered payment reform system needs to take this into account and be prepared to deal with most costly care (procedure intense care) to be delivered out of state” - Community hospital physician

“Our geographic situation is such that all our referrals go out of state, we are interested in how that will affect Vermont’s payment reform efforts; and inversely, many of our patients come from other states. How is the GMCB going to address these two issues?” - Community hospital physician

**Accountable care organizations, bundled care and pay for performance**

When asked about concerns and hopes in terms of the three new payment models being proposed by both the federal government and the state, respondents were much more aware of the ACO model than either bundled care or pay for performance. The hospitalists that were salaried tended to be less informed about new payment models.

“I’m not very familiar with either the P4P or bundled care models that the state and CMS have endorsed; all the conversation has been about the ACO model” - Community hospital physician

“From a 100,000 foot level, the ACO is a lovely concept, but the way in which it is evolving is concerning. From the viewpoint of a community hospital, all the financial reward seems to stay at the top of the pyramid at the tertiary centers at the expense of the smaller settings. Ironically, most of the waste in the system is not at the outlying institutions but in the larger referral centers” - Community hospital physician

“The ACO as it is currently being designed has a goal for reducing hospital admissions by 25%. On the surface this is appealing, but it is possible that the total cost of care will rise because of delays in appropriate level of care; and though there may be fewer admissions; those patients that are admitted are admitted after inappropriate delays in appropriate level of care and the total costs accrued are greater” - Community hospital physician

“The ACO needs to be less concerned with short term cost savings and more concerned with being proactive about the needs of the population that they are accountable for. The drivers for the ACO should be quality and safety metrics not measures of short term utilization of the ED or inpatient beds” - Community hospital physician

“The concept of population based care underlying the ACO model is appealing in theory, but we’ve seen nothing that makes us trust the model or those responsible for implementing it to date. Recent past
experience with changes invoked without practitioner input have made us wary” - Community hospital physician
Section 5

Policy input and communication with the board

How can practitioners and the GMCB best communicate on critical issues?

Hospitalist physicians feel isolated from state level health policy debates and decisions. Few mentioned any satisfaction with their attempts at locating information from state sources. There is a general sense that decisions are being made, but physicians are not being informed nor was there a convenient or reliable source of information they could query.

“Physicians have gotten little information directly from the Green Mountain Care Board or any other state agency. If the hospital administration is receiving information, little if any gets relayed to the medical staff, even to me in my role as the lead for inpatient services” - Tertiary center physician

“At this point everything seems very vague in terms of state health care reform. It’s hard to find any information either about the payment pilots or care delivery reform. The GMCB’s website isn’t very informative” - Community hospital physician

“There is little information available to the direct care providers at our tertiary center about health care reform in Vermont; a specific example is the status of the OneCare ACO endeavor. Very little information trickles down to the boots on the ground physicians. Physicians are worried” - Tertiary center physician

Green Mountain Care Board Technical Advisory Groups
Those physicians that were aware of the Green Mountain Care Board’s Technical Advisory Groups (TAG) were not impressed with their effectiveness.

“We do have local physicians on the GMEB’s clinical TAG, but there is no routine reporting out from them local” - Community hospital physician

Interviewed physicians did suggest possible solutions:

• Face to face meetings
• Periodic email or hardcopy updates
• Designated regional physician delegates

“Face to face meetings between the local medical community and the GMCE would be best. Periodic email or hardcopy updates geared for the physician community would be a good complement, but face to face meetings would be optimal” - Community hospital physician

“Another potential approach would be for the Board to designate regional physicians who we could use as conduits for information both to and from the Board” - Community hospital physician

“Targeted emails with 1-3 questions and opportunity for open comments would be the best way to reach us. Large TAGs are a difficult forum to get meaningful input from professionals” - Tertiary center physician
Section 6

Physician retention and recruitment

How can Vermont remain attractive to physicians?

Complementing the comments on the physician workforce in Chapter 2 about core clinical services and the related physician workforce issues, answers to the specific question about physician retention and recruitment emphasized concerns about the three vulnerable and most needed physician groups - outpatient primary care, hospitalists and psychiatrists.

Retention

General anxiety about change
Hospitalists share the anxiety of all physicians about what health care reform will mean to them personally as well as for patients. All the interviewees endorse reform, but there is a general sense of unease because so little has been defined for them.

“Establishing ACO type structures and regionalizing care are good goals and the GMCB should continue in this direction; but it makes physicians nervous, particularly those offering specialty services; they are worried about still having jobs as care is consolidated” - Tertiary center physician

“The hospitalist service has been fortunate to have a very stable group of physicians. This is not been the case for other services. We’re just coming out of about 10 years of churning in the obstetric and pediatric staffs. There is a lot of anxiety among the medical staff; there is concern that if one or two leave, many others will follow” - Community hospital physician

Primary care, hospitalists and psychiatry
As mentioned above there is widespread concern in every community including Chittenden County about the need for more primary care physicians and psychiatrists.

“There is a big deficit in terms of psychiatry, both in terms of access to appropriate safe inpatient beds for people in crisis and in terms of access to physician level psychiatric consultation and expertise. We recently had to transfer a patient out of state for an inpatient psychiatric consultation; the cost of all was then charged back to our critical access hospital” - Community hospital physician

“PCPs are aging; there is an impending disaster if the state cannot come up with a strategy for replacement. Many have already closed their practices to new patients” - Community hospital physician

“Reform has to address the inadequate resources currently being directed at PCPs, psychiatry and hospitalists if it is to be successful” - Community hospital physician

“Recruitment and retention of physicians is an issue in both Vermont and New Hampshire. Salaries are lower in both states compared to the rest of the Northeast and particularly lower in comparison to other more distant parts of the country. DHMC salaries are lower than even some surrounding community
institutions particularly in primary care and hospital medicine. There are always 2-3 and sometimes as many as 5 vacancies in primary care and hospital medicine. It’s tough to recruit; the difficulty is a combination of earning potential, finding jobs for spouses and not an appealing social environment for unmarried candidates” - Tertiary center physician

“We need to do some basic workforce calculations to judge the need for the core PCP, psychiatric and hospitalist services for the state’s population and figure out a way to pay for it. Relatedly, we need to address the issue that a major barrier to recruiting physicians to the state particularly in these three high need core services is the relatively low salaries Vermont physicians can expect compared to other state settings” - Community hospital physician

Recruitment
Health care reform is a double edged sword in terms of attracting new physicians and its effect on those currently here. Until there are more details and physicians have more sense of what they can expect the future work climate to be in the state, the prospect of reform cuts both ways. One of the biggest fears physicians have is the risk of a negative effect of the state’s reform initiative on the physician workforce - the risk of Vermont getting tagged as an unattractive location to set up practice and as a work environment with an inordinate administrative burden for practitioners.

Decrease the administrative burden
If the Board can find ways to decrease the administrative burden, physicians would likely view Vermont as an appealing place to practice.

“Reform could help if it removes intrusions into their work flow; so far the experience has been that reform has meant just more intrusion by third parties resulting in PCPS being less productive in the past” - Community hospital physician

“The currently intolerable and ever increasing burden of documentation in primary care is a huge burden. ICD- 10 will make this exponentially worse” - Community hospital physician

“Both of us trained and initially practiced as primary care physicians, but the consequences of the increased burden of reporting, productivity pressures that exceeded what good care required, and the increased fragmentation of care led to both of us becoming hospitalists. The fragmentation of care has decreased both patient and physician satisfaction. Patient care has suffered as a consequence of the lack of continuity. The PCPs have become less comfortable with severely ill patients, referring anyone who has the remote possibility needing immediate care to the ER. The cost of care due to excessive diagnostic testing and treatments has risen because of lack of familiarity and trust between patients and providers. If Vermont was able to make itself a truly appealing setting to practice primary care it could become very attractive to physicians. What may seem as a little addition to an administrator or bureaucrat can be crippling to the clinician” - Community hospital physician

“If Vermont can prove that health care reform can work and result in higher quality of care to patients and a less intrusive work environment in terms of third party presence, reform itself could attract physicians. They will probably come from other New England states because of the similarity in wages and not from a high wage area of the country. Vermont should pay attention to what pond they are fishing in, in terms of attracting new physicians” - Tertiary center physician

Wages and salaries
Physician incomes in Vermont are less than in other parts of the country and lower than some other northeast states. Physicians would like to Board to address the comparatively low salaries for Vermont physicians. Hospitals have an ever present problem with recruitment and retention of physicians. All of the current hospitalists in Vermont know that they can get significantly more income just by working across the Massachusetts, New York or New
Hampshire borders. Hospitalists are constantly barraged by requests from both instate and out of state recruiters. It is not uncommon for a physician to get ten such requests in a single day, some offering $60,000 signing bonuses.

That being said nearly all physicians mentioned that they are not in Vermont to make a high income. They are principally here because of the lifestyle or family ties.

“We’ve seen a fall off in the quality of the physicians in our primary care community as replacements come for retiring physicians. Salary is most certainly playing a role in this phenomenon” - Community hospital physician

“The GMCB needs to pay close attention to physician salaries in Vermont compared to other states in the region. We recently needed to recruit another hospitalist. The recruiting firms actually laughed at us when they heard our salary offering. They said it was non-competitive, and it wasn’t even worth their time to post the job opening. After we were able to raise the salary range, we were able to get someone right out of a UVM residency program which we’re very excited about. Vermont salaries are the lowest in the region. Most Vermont physicians did not come here to make a lot of money, but with loans and family obligations, the low Vermont wages can become an issue for those of us here and anyone interested in locating here” - Community hospital physician

“Physician and nursing salaries are low in Vermont. The northeast region in general has the lowest salaries in the country and Vermont is at the low end of the spectrum in the northeast. As hospitalists our incomes are about $50,000 less than national averages. We’ve been recruiting for a third hospitalist for 4 years without any interest from outside. We recently increased the salary range and have just hired and additional MD. We have also established with DHMC a rotation in community hospital medicine but have had no inquiries as yet” - Community hospital physician

“It would be much better for physicians, employers and patients if hospitalists could be paid on a salary basis rather than based on RVUs as we are presently. We do track hours and RVUs to monitor the sharing of the workload among our group, but the nature of our work is very much determined by the volume of inpatients and their severity of illness, neither of which is under our control” - Community hospital physician

“A lot of what we do is not captured by an RVU based system for pay; we do a lot of coverage of other services for which we can’t bill for example, we take call for a lot of the outpatient services, hospice and many inpatients who aren’t on our service per se” - Community hospital physician

“We hope payment reform will allow physicians to be paid on the basis of the quality and efficiency of care they offer rather than the current FFS system that seems to reward quantity of care with little regard to quality” - Community hospital physician

“We are concerned that if the GMCB struggles to slow the rise in the cost of care, will physician reimbursement be reduced, particularly to those physicians at the low end of the salary scale who are most in need: PCPs , hospitalists and psychiatry”- Community hospital physician

Midlevel practitioners
A common comment about mid level practitioners is that as the ratio of mid level practitioners to physicians increases in many communities, a critical problem is developing because of a lack of access to the physicians for the mid levels for complex clinical issues. The problem is multiplied by the ever increasing complexity of patients as medical science and technology advances and treatment and diagnostic interventions multiply.

“The sometimes mentioned solution to the shortage of primary care in the state is to promote an increase in mid level providers to replace the diminishing number of physicians. We are already at the point in our community where this is a mismatch in the number of mid levels compared to the number of physicians
available for consultation. The result is excessive referrals to the ED, increase in the cost and discontinuity of care as well as an decrease in convenience for patients” - Community hospital physician

**Hopes about the future workforce**

As anxious as the interviewed physicians are about reform, nearly all of them offered some optimism about Vermont becoming a relatively attractive place for physicians to practice even though their income potential is greater elsewhere.

“Other the other hand, reform could make Vermont a very attractive place for physicians if it is done right; if reform has the opposite of my fears. Reform should increase reimbursement for things that matter to patients and physicians. Reform presents an enormous opportunity to reduce the administrative burden on practitioners. Reform presents the opportunity to have a single sensible formulary across all payers. Reform presents the opportunity to diminish the current disincentives for the cognitive based services and increase the incentives to spend more time with each patient rather than less. Reform presents the opportunity to spend more time discussing end of life issues with patients and the risks and benefits of procedures as opposed to the current incentives just to do more even in the context of a terminally ill patient” - Tertiary center physician

“A key to recruitment and retention of physicians is their interest in practicing in a rural environment and a good fit between their expectations and the reality. Rural practice can be appealing and satisfying to physicians, but not to all physicians. Rural physicians need to be comfortable with assuming responsibility for a broader scope of practice. They cannot depend on 24/7 access to whatever specialist they were accustomed to in their training environment or a more urban setting” - Community hospital physician

“Vermont should recognize that physicians with family ties to Vermont are the most likely to locate in the state. The Medical College should offer preferential status to Vermont residents who are applicants to either the undergraduate medical school or the post graduate residency and fellowship positions” - Community hospital physician

“The most attractive aspect of Vermont is being able to practice in a community where you know the patients and they know you; to be able to live someplace where people won’t sue you at the drop of a hat. It is nice to be in a community institution with its own medical staff, community board and independent governance system rather than be a satellite of a tertiary care center and having all the decisions being made elsewhere about your practice and your patients. There is camaraderie among the physicians in the community. We have a great nursing staff. The community feel of everything is the biggest asset” - Community hospital physician

**Loan repayment**

Loan repayment was mentioned frequently particularly by the younger physicians as a good lever to make Vermont an attractive location for physicians, particularly those interested in practicing primary care, hospital medicine or psychiatry.

“Loan repayment is very important and not well advertised. The state should invest in more advertisement and more amounts of repayment. Loan repayment could certainly be the deciding factor in choosing to locate in Vermont” - Tertiary center physician

**Collaborative recruiting across the state**

Finally, some physicians mentioned that if all the physician employers pooled resources in a statewide recruitment effort it would be an improvement from the status quo as institutions within the state compete for physicians at present. New York was mentioned as a state that has such a program.

“Physician recruitment should be done in a collaborative fashion across all hospitals rather than having each hospital compete with all the others. If Vermont was perceived as having a statewide approach to the physician workforce; one that was based on the needs of the population and capitalized appropriately,
the state could be unique and attractive to physicians. This will take strong community support, strong medical staff support and strong physician leadership” - Community hospital physician