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**Statement of L. Allen Dobson, Jr., MD**
Senate Committee on Health, Education, Labor and Pensions
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Chairman Sanders, Senator Burr and members of the committee, it is a great honor to be with you today to discuss health policy issues that are critical to our future, both in terms of access to quality healthcare and the overall strength of our healthcare system and economy.

My name is Allen Dobson. I am a family physician in North Carolina and President and CEO of Community Care of North Carolina (CCNC).

In North Carolina, as in most of the country, there has been a whirlwind of change with new payment structures, new technologies, market consolidation, new regulatory requirements, and a new industry of healthcare "consultants" who tell us they have the latest innovation or technology that will fix it all. **Despite all of this, building and supporting a strong primary care base remains the top priority in healthcare policy.**

Over the last 15 years, North Carolina has built a strong, community-based primary care system. Over 90 percent of North Carolina's primary care workforce participates in CCNC, a Medicaid participation rate far higher than most states. This is the result of North Carolina paying a somewhat higher rate for reimbursements than other states and the support provided to primary care doctors by CCNC. This includes health informatics and low-cost care management platforms that enable the application of population management across CCNC's entire state-wide footprint and improve the quality of care delivered.

This unique public-private infrastructure, which covers all 100 of the state's counties, has helped to give North Carolina the lowest Medicaid growth rate in the country (see Figures 1 and 2, below), making it a national model for quality improvement and cost control. In an independent actuarial study, Community Care was shown to save nearly a billion dollars over a 4 year period in our Medicaid program. CCNC's system works equally well in rural, underserved and urban areas (See Figure 3 for geographic distribution of primary care facilities).

**Figure 1**

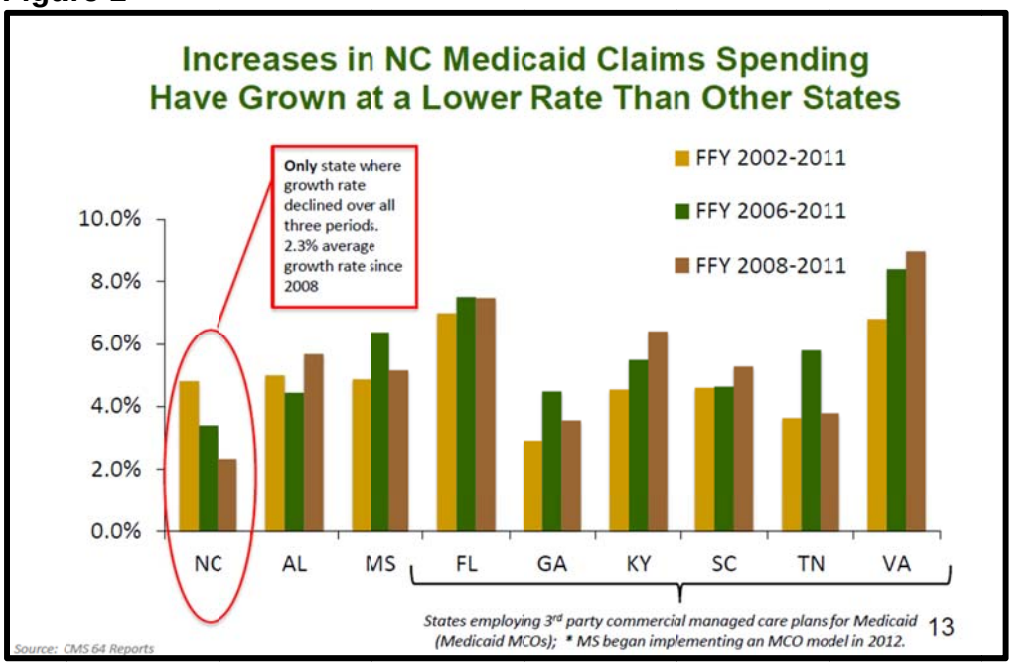



**Figure 2**

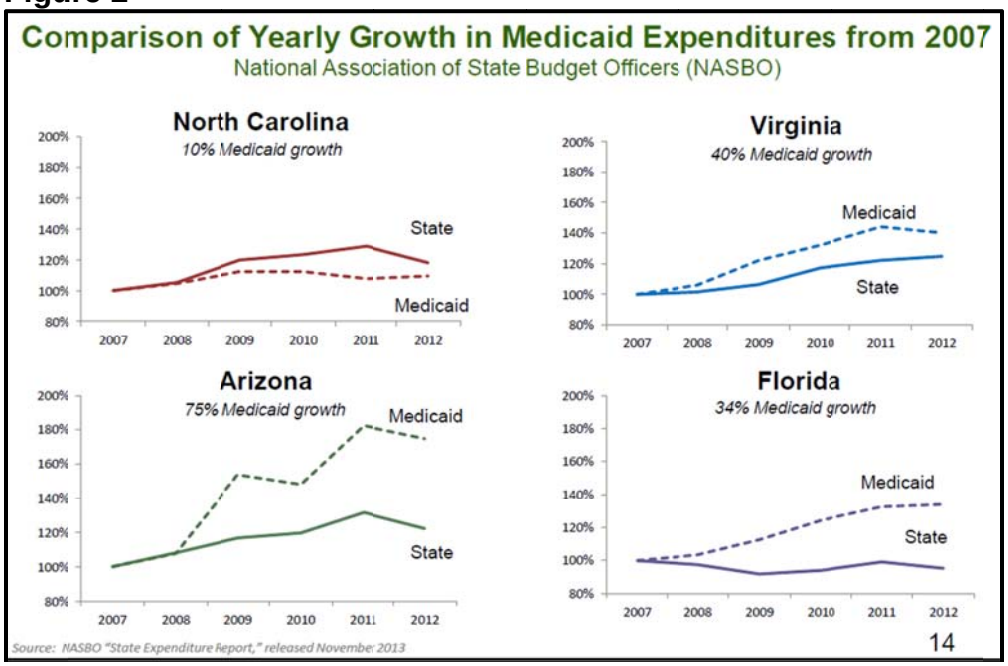
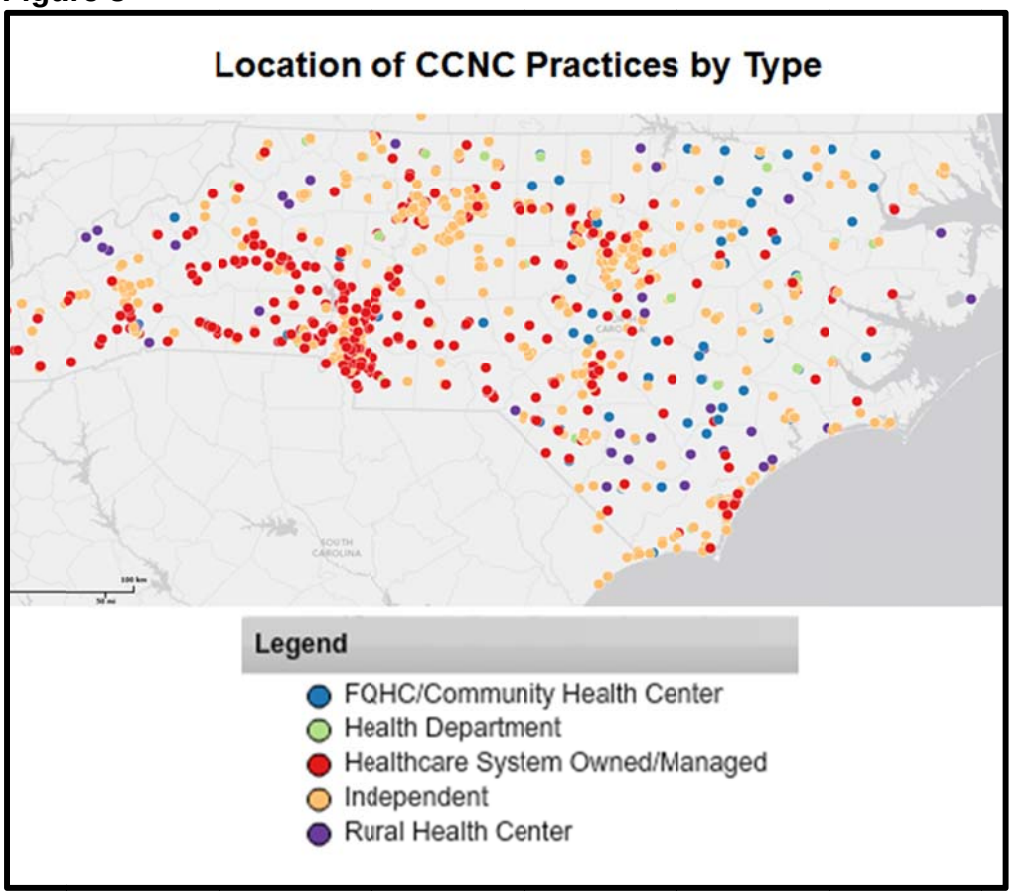


**Figure 3**




Our model has improved care by building capacity at the provider and community level and linking providers together through a statewide infrastructure that links providers together. We provide support for practices seeking recognition as a Patient Centered Medical Home (PCMH) support and other needed help in collaboration with the NC Office of Rural Health, NC Area Health Education Centers (AHEC), NC Division of Medical Assistance and others.

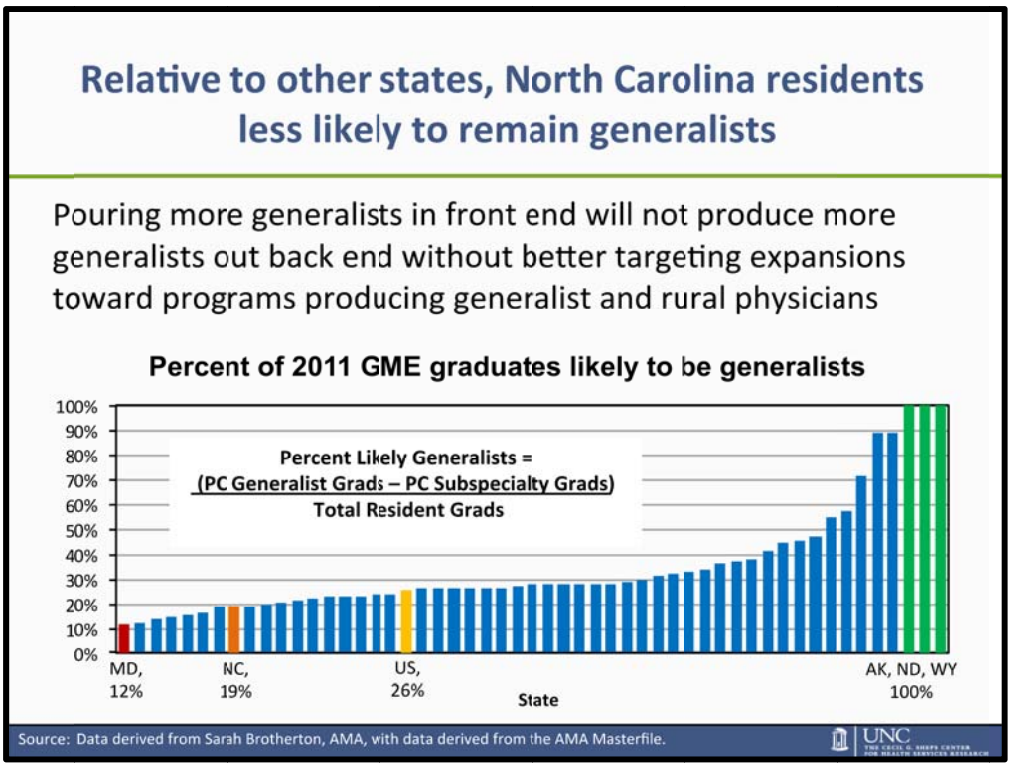
We have thrived on innovation, fostering change, and establishing a culture of collaboration with all our partners around a common goal, improving the care delivered to our most vulnerable citizens.

**Upheaval in the healthcare landscape, however, has accelerated rapidly over the last 2-3 years and our doctors are reeling. Our primary care medical homes are under stress and this will have a significant impact on the future primary care workforce and access to quality healthcare for our citizens.**

If you are a primary care physician in NC:

- You have probably just bought and implemented an electronic medical record and are now figuring out how to meet meaningful use requirements. You may be with vendors who have promised a Ferrari and delivered a Yugo. Many EHRs still are not capable of providing needed reports or communicating with other systems effectively.
- Despite buying into technology, doctors are inundated with paperwork and clerical tasks often turning physicians into data entry clerks. A recent national survey demonstrated doctors spend 22 percent of their time on paperwork; that is equivalent to 1 day a week of work.
- You may have been promised enhanced reimbursement for becoming an accredited Patient Centered Medical Home and may have invested $30,000 to $40,000 and hundreds of staff hours and have yet to recoup your investment. Promised payment reforms have been slow to come, leaving primary care doctors a volume-based payment system while being told they need to must prove their value before payment changes can be considered.
- Physicians now have to decide whether to join (or become) an Accountable Care Organization. A recent national survey of emerging ACOs put the price tag for start-up costs at $4M to $10M. The decision of independent physicians to join larger ACOs may be based on money rather than performance.
- There is rapid consolidation of our hospital systems, leaving independent physicians little choice but to take on salaried positions with large health systems. The number of independent hospitals has dropped from 142 to 24. From personal communications I have had with the North Carolina Medical Society and North Carolina Hospital Association, it appears that the number of independent cardiology practices in North Carolina has dropped from 196 to 4 in just the last two years.
- While some notable integrated delivery systems have increased healthcare value for purchasers, consolidation also decreases competition and may actually decrease local collaboration and innovation as the systems becomes more competitive and proprietary.
- There has also been rapid growth in healthcare technology platforms that promise to activate patients, provide remote monitoring, and control costs. Our state legislators and NC Department of Health and Human Services staff are inundated with information from vendors promoting the latest app or care management solution and promises of savings and return-on-investment. Without a state infrastructure or larger reform plan, more fragmentation will occur.
- Unfortunately, this chaos is also having an impact on recruiting medical students and residents into primary care. While we have increased the number of medical student slots in NC, only 19 percent are choosing primary care specialties (See Figure 4, below).

**Figure 4**



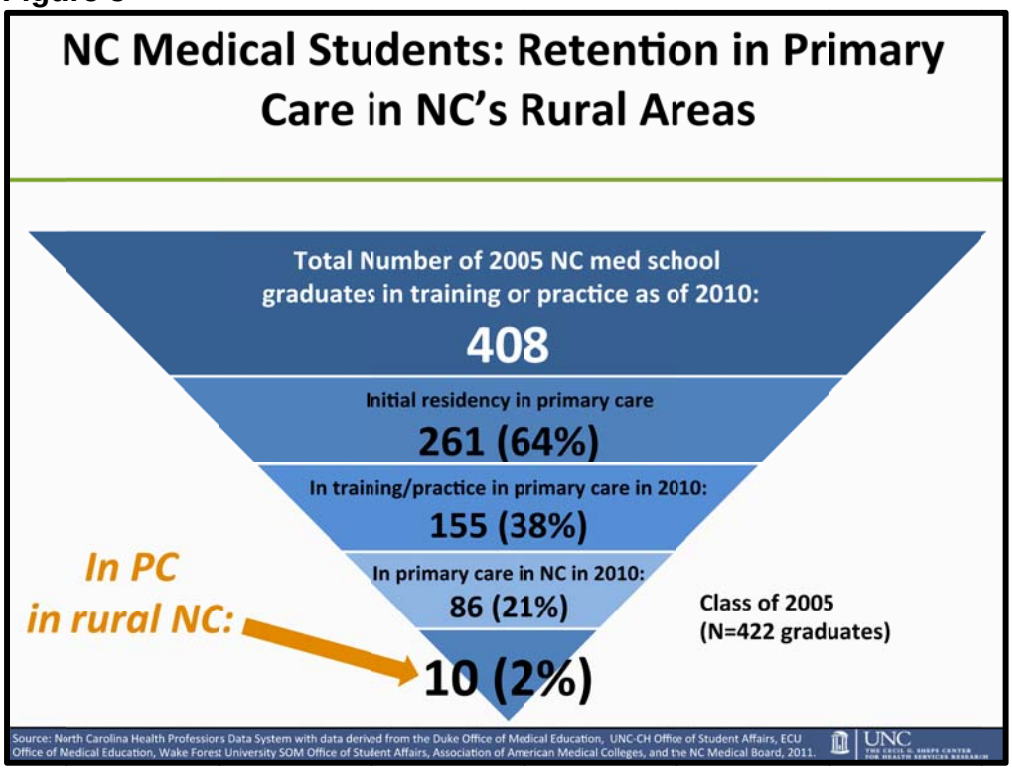

**I believe that policy options that strengthen primary care are the most important element to a successful national healthcare reform effort. Primary care is essential for delivering preventive care, providing a significant portion of a healthcare needs in a low-cost setting and effectively coordinating care of patients with multiple chronic diseases.**

Here are three recommendations from our experience in NC that may be helpful:

1. **Create an effective primary care pipeline.** We need a continuous and coordinated medical education strategy with both undergraduate and graduate medical education policies that increase the supply of primary care doctors in rural areas.

   In North Carolina, as in many parts of the country, there is not just a doctor shortage; there is a misdistribution of primary care doctors (along with general surgeons and psychiatrists). While the focus has been on adding more medical school positions (we have added 177 slots in the past 2 years), there is likely to be little impact on the other end of the pipeline unless we tie GME funding to outcomes. In 2005, out of 408 medical students in North Carolina, only 21 percent went into primary care and just two percent went on to practice primary care in a rural area. (See Figure 5.)

**Figure 5**




However, instate training and community based GME programs will increase the primary care physician supply:

a. Students who both went to school in North Carolina and completed residency in North Carolina, were more likely to practice in North Carolina (69 percent vs. 42 percent)
b. Residents who trained in community based AHECs were more likely to practice in North Carolina compared with those trained in conventional GME settings (46 percent vs. 31 percent) and more likely to practice primary care (53 percent vs. 31 percent).
c. We now have two teaching health centers based out of FQHCs in North Carolina and a CCNC practice site; we believe this to be an effective workforce strategy. Residents trained in an FQHC are 3.4 times more likely to choose a job in a community health center.
d. CCNC works with all NC primary care residency programs and North Carolina AHEC
e. CCNC involved practice are more likely to be involved in education.

We must support and build capacity in primary care in order to improve access in rural areas and control costs. The evidence base around population health is teaching us that physician-led medical homes, supported with care management and effective population health strategies and infrastructure can help control costs and improve outcomes.

However, medical homes cannot function under a reimbursement model where physicians must see patients every 10-12 minutes. Payment structures that incentivize team based care, population management, quality data reporting, and accountable care are a start; but we are finding that our independent practices are struggling to participate in these new models.

One of our pediatricians said "I met with my office manager and my accountant, and we figured out that it costs me $87 an hour to be involved in quality work. I'm not rewarded for it. Doing quality work actually costs me at this point. None of my partners are particularly interested in doing it and they take home more than I do. I do it because it is right and because I see it coming. I also get ulcers when things are not running efficiently and doing quality work has really improved our ability to not let patients fall through the cracks. Some things that used to keep me up at night don't anymore since we have these processes in place. We are delivering better care – no doubt."

2. **Payment reform is needed now and on a larger scale**. It should focus on incentives that allow primary care doctors – especially those in independent practices and FQHCs – to form continuous relationships that engage and activate patients to change behaviors and allow physicians to manage at risk populations. The Direct Primary Care model where some or all primary care services are capitated with a flat fee is one example that shows promise.

3. **States need structures to support and build capacity in rural areas and for independent practices.** In the CCNC program, two-thirds of our Medicaid population is cared for in approximately 900 independent practices. In fact, despite the consolidation of the last few years, over 60 percent of the Medicaid population is still cared for by independent physicians and FQHCs, the majority in the rural areas of NC. Our independent practices, like FQHCs, take care of a complex case mix and are our higher performers in total cost of care, hospitalization rates and readmission rates. With the exploding costs of "practice overhead," we need lower cost utilities for practices to subscribe to that will allow them to participate in value-based care.

   In NC, we have built a statewide informatics infrastructure that supports our practices and has enabled our practices to identify ED super utilizers, patients who are not getting their medications filled, and those with chronic disease who are missing needed tests like hemoglobin A1Cs. Our platform also allows them to compare their clinical quality data with that of their peers and motivates local clinical management entities to improve population health.

We are now working with our partners including FQHCs to knit together a statewide health information exchange that will allow practices to report quality data and identify populations that need more intensive care management and will allow physicians to use healthcare resources more efficiently.

**In summary:** In North Carolina, we have found that supporting primary care and residency training in local settings has led to local collaboration and care improvement – and ultimately improved quality and cost control. We look to policy makers to help enable community-based infrastructures such as health informatics and care management supporting primary care that will further improve population health outcomes. Highly functional integrated health systems play an important role, but there will be a need for state-based “utilities” to support rural and independent practices to achieve lasting and widespread reform of our healthcare system.

Thank you for the opportunity to testify before this committee.