How Primary Care Affects Healthcare Costs and Outcomes

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Thank you, Chairman Alexander, Ranking Member Murray, the members of this committee, and their staff for giving me the opportunity to be here today to discuss the role of primary care in shaping our health care and controlling costs as we head into the future. As a primary care physician for the last 17 years, I have had the privilege of sharing in the lives of thousands of patients and helping them navigate a complicated health care system that fails to meet the needs of too many Americans.

I have had the opportunity to work in a variety of health care settings over the years. I attended medical school at Emory University School of Medicine and completed much of my training at Grady Memorial hospital, which is the largest safety-net hospital in the state of Georgia. I had the privilege of serving our veterans at the Atlanta VA hospital, and worked in the hospital and clinics of Emory University. Through my work in a private primary care clinic in a rural town outside of Atlanta, I witnessed the challenges in accessing specialty care services for patients in a timely manner. These delays placed patients at risk of serious medical consequences. These experiences allowed me to learn about the challenges of health care delivery that transcend socioeconomic classes and affect the cost of health care for all of us. Since 2007, I have been on faculty at Vanderbilt University Medical Center and have been involved in teaching undergraduates, medical students, and residents as they embark on their careers in medicine. I have seen them choose their fellowships in subspecialties rather than a career in primary care in order to avoid the onerous burdens that force primary care doctors to spend more time with documentation and administrative tasks than direct patient care and often lead to physician burnout.

I would like to share a patient story that is all too familiar in our clinics. Jane is a 27-year-old woman who has diabetes, hypertension, seizure disorder and bipolar disorder and due to the severity of her mental condition, has not been able to work in years. She is morbidly obese and has a BMI of 45. She cannot afford healthy food and she often stops taking her insulin and other medications when she runs out of money. Due to her seizure disorder and mental health issues, she is socially isolated. Despite all this, she is interested in making healthier choices and taking better care of herself. She calls the office daily with concerns about her blood sugar level or blood pressure. She is seen by me in clinic every 1-2 weeks. Despite these frequent contacts, she visits the walk-in clinic 1-2 times a week and goes to the emergency department 2-3 times a month for various ailments.

How does our current system provide support and assistance for patients like Jane?

How do we control the overwhelming cost of caring for someone like her?

As primary care physicians, we are the front line in promoting the health and wellness of our patients. We help them understand the nuances of their individual health plan and the meaning of terms such as co-pay, co-insurance, deductible and out of/in-network charges. We often personally pick up the phone to speak with administrators of health companies who deny necessary services, so our patients can get the care they need, and we serve to bridge the gap in services that may have limited availability, such as mental health. We educate patients and families about their diseases and counsel them about prevention, vaccines and wellness We provide them with advice when they see a new medication on TV, hear about a fad diet, or want to try alternative therapies. We help to coordinate visits with subspecialists and make sure they are keeping up with follow up appointments. In this way, the primary care doctor is the “quarterback” who makes sure all the players in the health care team (including the patient) are following the outlined plan. This vital, albeit time-consuming, role in medicine is essential in improving the quality of health care and lowering cost. In short, primary care matters!

Unfortunately, primary care is undervalued in the U.S. Reimbursements are more robust for the treatment of disease with expensive regimens rather than for prevention. Time spent in educating and counseling about lifestyle modifications is not well reimbursed, and there is little investment in ancillary services by CMS or most insurers. Primary care is the front line for addressing mental health issues and obesity, yet reimbursement is poor for these services. Dietician services are still not covered for people with obesity until they develop diabetes, and insurers will often cover bariatric surgery to treat obesity but will not pay for treatments that target lifestyle and behavioral change.

Health care spending in the U.S. continues to grow. In 2017, we spent an estimated 3.5 billion dollars on health care, which amounts to $10,739 for every man, woman and child in the U.S. This represents 17.9% of our GDP which far exceeds the amount spent in other

developed countries. This excess spending has not resulted in improved health outcomes compared to other countries. This problem is multifactorial and there will not be a singular solution. There are numerous ways in which investments in primary care can improve health outcomes in a cost-effective way. My testimony will focus on innovation, reducing spending, and investing in the primary care work force.

1) Investment in innovative models of health care delivery.

This includes coverage for alternative models of care such as home telehealth, which allows patients to receive care in their own home. Advantages include the ability for medical personnel to thoroughly review medications (including over the counter medicines) that patients take at home, but frequently forget to bring to their doctor's visits, which can help prevent drug interactions, duplication, and other medication errors. Telehealth can enhance the patient history by allowing family members in the home to participate in the visit, when they may not have been able to attend a face-to-face visit. It allows the physician to gain insight into home conditions which may affect the safety or health of the patient. In our clinic, we are preparing to pilot a telehealth program for urgent care needs, but the potential for telehealth in managing chronic diseases such as diabetes, hypertension or behavioral health needs is promising. Imagine the time and cost saved for the patients and the system if the patient and physician could coordinate a time to "log-in" and conduct a visit without the administrative burden, time, cost and inconvenience of an office visit. Telehealth may also increase access to primary care and certain limited-supply resources such as mental health, dermatology, and other subspecialties. Currently, in the state of Tennessee, telehealth visits are only covered by Medicare and Medicaid when patients present to specific rural health care sites. Some commercial insurers will pay for telehealth if the patient presents to a remote health care site, but not from home. This eliminates the numerous advantages and convenience of an at-home visit. I encourage the committee to support coverage of at-home tele-visits so that Tennesseans and all Medicare beneficiaries can more easily access the health care they need. Although telehealth will not be appropriate for all situations, I believe primary care doctors would embrace it as an option to enhance patient care.

Another opportunity to improve access is the Shared Medical Appointment (SMA) which is a clinical encounter that allows patients to receive counseling, education, and individualized interventions in group setting. This is a visit in which physicians and facilitators can simultaneously address disease-specific concerns and issues with 8-12 patients in a group setting. In 2017, with the help of our social worker and office staff, I implemented a Shared Medical Appointment program with my diabetic patient population. We conducted monthly visits with this group to set goals, share experiences and provide diabetes-specific education. We later expanded the program in 2018 with a new group of patients who were interested in improving physical activity, called "Healthy Steps." Through collaborative efforts with the Dayani Wellness center at Vanderbilt and a small

institutional grant with which we purchased pedometers and supplies, the “Healthy Steps” program has been very successful. A quote from a patient sums it up well…

“Thank you for the opportunity to join the excellent Healthy Steps meetings. The information was very valuable. Without the boost of this program I would not have disciplined myself to get more serious about exercising. “

With appropriate patient selection, consent forms that address HIPAA policies, and advanced planning, this is a highly successful and innovative way to deliver care and has an additional advantage of creating a support structure for patients who are isolated or feel alone in their disease. Studies have shown potential for enhancement of quality and consistency of care provided as well as improvement in self-management with reduction in cost through use of SMAs. Advantages for patients include reduction in sense of isolation which can improve self-efficacy in managing their chronic illness. Patients learn vicariously about disease management by hearing the perspective of others facing similar challenges in managing their illness. SMAs bring patients together so that those who are managing well can help encourage those who may be struggling.

One memorable moment in a recent shared medical appointment was when a patient-participant provided information to others in the group about the pharmacies that provided the lowest prices on metformin, statins, and blood pressure medications, and which online coupons saved her the most money on her medications. Many of the people in the group were taking the same medications and were delighted to learn how to reduce their monthly medication costs.

The SMA also has advantages for physicians due in part to the ability allocate a longer amount of time with the group than they typically have with patients in a traditional one-on-one model. Typical SMAs last 90-120 minutes (as opposed to 10-15 min for a traditional visit) which allows for a more in-depth exchange of information, allows patients to feel more supported, and can help combat the fatigue that physicians experience as they dash from one room to the next.

By encouraging the implementation of newer methods of delivering primary care, we can improve access and reduce physician burn out while providing cost-saving, high-value care.

2) **Reduction of excess spending in our health care system**.

This committee has heard the statistic on many occasions that as much as 1 out of every 3 healthcare dollars is “wasted.” It is thought that much of this waste is attributable to excessive or unnecessary testing but defining inappropriate care can be challenging.

However, we do know that patients who have primary care doctors have fewer preventable ED visits which reduces cost. Data have shown that primary care doctors overall use fewer tests, spend less money and provide more high-value care, such as cancer screening, blood pressure testing, diabetes care and counseling on weight loss, smoking cessation and exercise. In lower income populations, primary care use is associated with improved immunization rates, better dental health, lower mortality and higher self-reported quality of life.

Primary care encourages the “right care, right time, right setting” model in which patients can be directed to the most appropriate facility that meets their health care needs. Too often, our emergency departments are filled with patients who present with symptoms that could have been managed in an outpatient clinic. We should seek to divert common non-emergent health care needs to a setting that is better matched economically than the ED. Efforts to identify high health care utilizers and intervene before they seek care can help to reduce the overall cost of health care.

No conversation about healthcare cost is complete without mentioning prescription drugs and the soaring prices of essential medications that lead to significant burden on patients and insurers. This leads to frustrating changes in drug coverage as insurers seek the best deals on medications within a class of drugs. Higher costs lead to higher copays for patients, some of whom must choose between food and rent or their life-saving medications. Medication non-adherence leads to more healthcare costs when that patient ends up in the hospital from poorly controlled hypertension that results in a stroke or other adverse outcomes. We must find a way to control prescription costs so that patients can consistently afford them and avoid higher downstream medical spending.

3) **Invest in the primary care work force**

As the baby-boomer generation continues to age and more Medicare beneficiaries are accessing healthcare, there continues to be growing shortage of primary care doctors nationwide. As a lead physician in my clinic, I have seen new PCPs join our practice and quickly fill their schedules with patients who have been waiting to find a doctor. Within a few weeks, the wait time to see a new provider can quickly climb to several months. This issue is even more prevalent in rural areas which struggle to regularly attract new physicians. While high demand may be good for business, it is not optimal for the patient whose doctor has retired, and refills expire before they can see a doctor. It doesn’t help the older patient who cannot get in to see a new doctor after declining health has required her to move in with her daughter. It certainly does not benefit the countless Americans who are unable to find a doctor who accepts new Medicare patients. It is estimated that the United States will face a shortage of between 42,600 and 121,300 physicians by 2030. The declining number of medical students and residents who enter primary care will further aggravate this shortage. Many physicians are discouraged from pursuing primary care due

to the relatively low compensation compared to specialists. They recognize the “half the pay, twice the work” penalty of primary care, and with burgeoning educational debts, decide to pursue more lucrative careers. The solution lies in recognizing that primary care is unique from other medical specialties. The emphasis is on disease prevention rather than disease treatment. Primary care physicians, like myself, enter this career in order to develop relationships with patients and families over many years. We share in their joys, sorrow, losses and successes and learn to modify our treatment strategy to meet the unique needs of each individual patient. We thrive in cultivating and nurturing these relationships and in helping patients realize a healthy future.

Unfortunately, federal regulations such as meaningful use and onerous documentation requirements have been burdensome on primary care doctors, without enhancing the quality of the care provided. Electronic health records have the capability to aid in the identification of deficiencies in care but are not aligned with the work flow of physicians and slow the pace of care in clinic. For every hour of face-to-face patient encounters, we must spend an additional 1-2 hours completing documentation and administrative tasks. This is unsustainable and leads many primary care doctors to leave the work force. I hope this committee looks to alleviate this burden so that physicians can spend more time engaging with patients and providing high value care, and less time facing a computer.

In returning to our patient, Jane, several interventions have proven helpful. She has attended our Shared Medical Appointment for diabetes and has enjoyed the personal interactions and advice from other patients who have been in her situation. She is contacted weekly by the primary care nurse to review her medications. These interventions have reduced the number of ED and urgent care visits she makes. She has successfully lost 50 lbs. and is checking her glucose and blood pressure several times a week. She would be a great candidate for regular telehealth visits, exercise and diet coaching, and medication adherence counseling, if these services were covered by Medicare. Although she has a long road ahead, I believe assistance for patients like Jane could significantly change her health trajectory. I hope future investments in primary care will help us take better care of patients like Jane and many others.

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