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To: Senate Finance Committee on Chronic Care Reform
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From: Scott D. Richards, PhD, PA-C, DFAAPA
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Re: Input on Chronic Care Reform

For ease of reading and interpretation, the following is divided into two overarching sections: Outline of Recommended Steps and Narrative on Recommended Steps – aligning recommendations to matching Issue Areas.

**OUTLINE OF RECOMMENDED STEPS TO IMPROVE CHRONIC CARE TREATMENT
AND THE FINANCIAL BURDEN OF CHRONIC CARE TREATMENT**

Step 1. Improved access to care for high quality, efficient, and effective medical services

- a. Issue: Nationally Certified and State Licensed advanced practitioners, including Physician Assistants (PAs) and Nurse Practitioners (NPs) are already filling a much needed gap in meeting the Country's medical needs, including, but definitely not limited to, providing medical care for Medicare patients with chronic conditions and comorbidities. However, there exist multiple obstacles for improving access to these providers and permitting these providers to provide the care they are trained, qualified, and experienced to provide.
- b. Solution: Given that the intentions and the educational goals for PAs and NPs are similar, and that both are fully capable of providing high quality, competent, complex, efficient, and effective care, *the national and state legislative rules covering level of autonomy, services they can provide, needed on-site supervision, limitations to care provided, etc. should be equalized.*
- c. Reasoning: Such a change would allow for consistency across the nation, allowing PAs and NPs in all states to provide the same level of care, more effectively fill the gaps in access to care, and, as research has shown, improve patient outcomes, reduce costs, reduce the need for and the duration of hospitalizations, and improve outcomes for underserved patients. Such a change would also encourage physicians and medical organizations/facilities to employ greater numbers of PAs and NPs, decisions that are currently hampered due to confusion over state regulations, obstacle-laden regulations, and misinformation regarding the potential benefit for employing these medical providers.

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Step 2. Improved coordination among primary care providers, specialists, & community resources

- a. Issue: At the heart of good care coordination is the sharing of medical information. Although a vast number of medical providers and medical organization systems are now fully involved in the use of Electronic Health Record systems (EHRs), these systems still do not adequately communicate with one another. Obstacles include flaws in some systems, the inability of systems to communicate with each other, and the cost of purchasing add-on modules that would allow for enhanced and more effective communication among some systems.
- b. Solution: *Incentives to ensure that clinicians and organizations treating Medicaid and Medicare patients utilize Electronic Health Record systems (EHRs) that have proven communication ability with other systems, such that any medical provider could access a system that will provide a full picture of patient history, current treatments, recent and past diagnostic work-up results, and treatment success and failures.*
- c. Reasoning: For the benefit of patients and for reduced costs we need to prevent duplication of care, unnecessary diagnostic work-ups, and initiation of treatments that have no proven benefit for individual patients based on their medical histories. Patients are sometimes, if not often, unable to recall pertinent details of their complex medical histories – and this grows increasingly complex when patients develop chronic medical conditions and comorbidities. Access to such information is of the utmost importance to medical providers, and lack of such access is one of the foundational obstacles to reducing costs, and more importantly to providing adequate and effective care to patients.

Step 3. Improved Interprofessional Education (IPE) experiences

- a. Issue: Coordination of care, particularly for patients with chronic medical conditions, comorbidity, and complex conditions requires timely, effective, and efficient interactions with others, including other medical providers, community resources, allied health providers, and social services. Although many academic health science institutions have missions of collaborative training and experiences, few actually translate this into true student experiences that promote lifelong collaboration. The majority of IPE activities involve group didactic lectures, workshops, and simulation activities, rather than true clinical experiences that would best promote true collaboration in future practice.
- b. Solution: *Evidenced-based, outcome-focused, and validated incentivization programs for IPE, targeting academic medical/health science education programs, could assist at overcoming this major obstacle.*
- c. Reasoning: If medical providers are to be truly invested in and efficient at collaborating with others, with the direct intention of enhancing patient care, promoting better patient outcomes and reducing costs, clinically beneficial and patient-centric IPE experiences must be incorporated within their academic training. To shift cultural value systems and interpersonal habits to be more accepting of and adaptive to collaboration, such educational experiences must start, at a minimum, in graduate training and carry-over to post-graduate residency/fellowship training and future practice. Such training must integrate a team-based approach to medical care involving not only medical providers with different levels of training (e.g., physicians, PAs, NPs & other advanced practice nurses), but also allied health

professionals (e.g., physical therapists, occupational therapists), pharmacists and pharmacologists, nurses, medical assistants, social workers, psychologists and counselors, etc. And, such training must incorporate both didactic and clinical training such that theory is applied to clinical practice with actual patients in actual clinical environments as opposed to just simulated patients in simulated environments.

Step 4. Improved clinical training placement in rural & underserved areas

- a. Issue: The gap between access to quality care and need for care by underserved persons (e.g., rural geographic locations, impoverished patients, underinsured patients) continues to widen. The country continues to have an insufficient number of students graduating from health science programs, including medical schools and PA programs, who opt to pursue primary care practice positions. This is in part due to several factors:
 - i. Negative cost-benefit ratios between employment salaries and educational debt
 - ii. Decreased desire to work in rural locations – not only because of geographic and social factors but also because of the complexity of care (due to limited specialization availability) needed by underserved patients in rural communities
 - iii. Misinformation about life and work in rural communities founded on lack of experience in such areas throughout clinical training.
- b. Solution 1: *The federal and state governments would significantly benefit from enhancing funding and support for the National Health Service Corps, Public Health Service, state programs, and academic institutions such that loan repayment or educational debt forgiveness can be offered to a wider band of medical/health science students and providers with greater consistency and frequency.* Expanding the National Health Service Scholarship and Loan Repayment programs and the Commissioned Officer Student Extern Programs, both of which I participated in during my training, would encourage and entice greater numbers of students to train in and subsequently seek out careers at inner-city and rural FQHCs, the Indian Health Service, the Federal Bureau of Prisons and the Public Health Service. I am a living model of this process, having remained in serving the underserved at FQHCs throughout my clinical career and now focusing my medical education teaching on primary care for the underserved.
- c. Solution 2: *Incentivization programs for institutions and health science programs to train students at practices and institutions serving the underserved (e.g., community health centers, correctional institutions, free clinics, rural practices, Veterans Administration hospitals and clinics).* Medical providers in such locations are often reticent to precept medical/health science students (e.g., medical students, PA students, NP students, PT students, OT students). The most common issue I have experienced in placing students at such practices is economic – preceptors are ever challenged with productivity issues that weigh mostly on patient volume. Precepting a student can reduce the preceptor’s patient-care volume resulting in lower financial gain to the preceptor and the health clinic/institution. Assisting training programs with a proven focus on serving the underserved by providing stipends to such providers and practices would open-up clerkship training opportunities in practices serving the underserved, including practices serving Medicare and

Thirdly, in order to best receive and understand my thoughts, I will divide the following statements into several of the matching issue areas for which you are seeking input, specifically issues 3 (reforms regarding incentivization of medical providers); 4 (effective use, coordination and cost of prescription drugs); 6 (addressing chronic care treatment in rural and frontier areas).

Issue Area 3. Reforms to Medicare's current fee-for-service program that incentivizes providers to coordinate care for patients living with chronic conditions

I have first-hand experience with incentivization programs in clinical practice. I can say that I am not supportive of plans that incentivize medical providers for number of patients seen. I have not seen such plans benefit patients – even though such plans have often been implemented under the guise of improving access to care. Most often, in organizations where such plans were implemented, I saw one frequent result, providers were discharging or referring complicated patients to accomplish two things: (a) increase their ability to see more patients within any given time period; (b) reduce the number of patients who, due to their comorbidity, disease/condition severity, or life circumstances were unable to attain or maintain a level of treatment adherence to guarantee 'good' outcome measurements. Further, improving access to care should accomplish several things: improving access for all patients in any given geographic area; improving access not only to healthcare, but to high quality, efficient, and effective healthcare (here, 'effective' is defined by including both medical provider and patient definitions – what is determined effective by one, is not always seen as effective by another – let alone by an outside entity); improving access that enables patients to continue necessary day to day activities (e.g., employment, child care); ensuring access is timely (a one week or one month wait is not timely; a six hour wait in an ER is not timely, etc.); ensuring access as defined by patient needs. Incentivizing medical providers based on patient volume, in my experience, results in shorter patient visits, more misdiagnosis, and greater risk of failure to meet patient needs.

Additionally, incentivization based on condition outcomes is also not without fault. Approved outcome measurement is most often based on evidenced based treatment response indicators. Such indicators may include blood pressure levels, blood glucose or glycohemoglobin levels, rating on mood disorder or depression questionnaires, rating on pain management scales, etc. In the United States, it is my experience that such evidenced based outcome most often rely on laboratory based evidence rather than naturalistic studies. Such laboratory based research often excludes patients with comorbidities or conditions that are of such severity as to fall outside of the research participant selection criteria (whereas, naturalistic based studies attempt to see if the laboratory based studies correlate with real world scenarios in which no patients, conditions, or severity of conditions are excluded from the data collection and interpretation processes). In my many years of medical practice, it was a rarity for me to ever see a patient with one condition. My average patients had 6 or more conditions and were most often on more than 10 medications to treat those conditions (even when they presented as new patients to my practice). These patients, I would argue, make up the average Medicare patient and, as such, such narrowly based outcome measures do not well measure the needed outcomes we should be examining. What I do not see on required or requested outcome measurements, are quality of life indicators.

Research (e.g. Rothrock et al., 2010) supports that chronic diseases are associated with poorer health-related quality of life. In order to get a more accurate picture of success, I would recommend we begin measuring both outcomes – condition/disease specific outcomes and quality of life indicators – as a measurement of success for coordinating care for patients with chronic conditions. After all, my main

practice goal, for all patients, was to reduce suffering and improve their quality of life – this was the measurement I used to assess my own effectiveness in medical practice.

Issue Area 4. The effective use, coordination, and cost of prescription drugs

Even greater than the challenges of burdensome, inefficient, and time-prolonging electronic health systems use, navigating the world of medication formularies – particularly for Medicare – has been not only daunting and frustrating but, on many occasions, utterly confusing and nearly impossible to overcome. In order to establish a system that helps ensure the effective use, coordination, and cost of prescription medications, we first need systems that are stable, predictable, and logical. When the Medicare prescription plans first came into existence for all Medicare patients, my patients and I were overwhelmed with the number of plans, the vast differences in formularies, and the frequently changing formularies. Not even the community pharmacists could keep up and stay ahead of the changes. Over the last decade, I was able to treat the majority of my patients' conditions and diseases with generic medications – with great success. However, I found that many systems changed their formularies every 1-3 months to achieve the lowest cost for medications based on negotiations with pharmaceutical companies and supplies. Sometimes I was literally prohibited from prescribing the cheaper and equipotent generic medication as a particular formulary had made a deal for a brand name medication to undercut the previous cost of the generic medication. I would often have to change prescriptions every 1-3 months for a large number of my patients. Not only did patients respond differently to some of these medication changes, requiring more frequent need for medical evaluation, laboratory evaluation, and follow-up, but uncovering what medication was 'now' covered took a great deal of time – prolonging my day not in patient care – but insurance formulary management. To help ensure the effective use, coordination and cost of prescription drugs, I would strongly recommend that the commission look into practices that may save money at the insurance end, but cost more at the patient-medical provider end. Additionally, if one goal of the commission is to help encourage new graduates to see Medicare and Medicaid patients, and present medical providers to retain their panel of Medicaid and Medicare patients, I would strongly recommend that the commission look into reducing one of the most frustrating aspects of medical practice – insurance formulary changes based on short-term cost savings with long term deleterious consequences.

Issue Area 6. Addressing chronic care coordination in rural and frontier areas

I am a staunch advocate of the primary care model. In the first half of my medical career, as a rural primary care practitioner in Northern California, I gained firsthand experience in not only managing underserved patients of all ages and with all conditions and condition severities, but also managing patients without local specialty resources. The nearest specialists that would accept a Medicaid or Medicare patient were 90 minutes away – and, my patients most often could not afford the gas to access specialty care services. I and my partners successfully managed even the most complex patients. We did this by assuming responsibility for patients and accountability for the services we did and did not provide, provided comprehensive patient support – meeting patients at their 'level', and had stellar relationships with specialist that were out of the region. We did this by developing relationships with specialists early on in our practices – even spending time with these specialists at their locations to receive extra training (when first beginning my practice, I accompanied patients to their specialist visits so that I could not only meet the medical providers but gain from their wisdom and experience how to better manage my patients).

In order to be successful, meeting patient needs, reducing costs to both patients, our facility, and local and governmental agencies (reduced costs better enabled us to serve more patients), and having successful outcomes, I quickly discovered that I needed to work collaboratively with many different

- Medicaid patients. Additionally, easing the administrative process for accepting students in training would enable increased placement of students at such sites.
- d. Reasoning: Although I am a NHSC Ambassador, and frequently present on the benefits of the NHSC, it is a rarity for my students, even those who are interested, to be able to participate in the NHSC due to severe funding limitations and inconsistencies from state to state. I am presently overseeing the development of a moderate size PA program in Southwest Virginia with a mission to promote primary care and service to the underserved. I previously oversaw the largest civilian PA programs in the United States located in the Northeast; and, although my curriculum emphasized primary care service and care for the underserved, an extremely small percentage of my students could or would even consider pursuing primary care practices or relocating to rural areas to practice. In exploring the reasons why my students were not selecting such practice opportunities, two issues emerged: (a) they could not afford the lower salary offered by practice serving the underserved; (b) they did not have enough clinical training within FQHCs to experience, first-hand, the benefit of working within FQHCs. Students who do not have clerkship experiences in FQHCs are highly unlikely to seek out employment at such agencies following graduation. Students who have clerkship experiences within FQHCs are more likely to be offered and seek out employment within FQHC practices.

**NARRATIVE ON RECOMMENDED STEPS TO IMPROVE CHRONIC CARE TREATMENT
AND THE FINANCIAL BURDEN OF CHRONIC CARE TREATMENT**

Firstly, I feel it important to state what an honor it is to be a participant in this process. Ever since I graduated from Hahnemann University's Physician Assistant program in 1994, I have been devoted to medical care reform. Since beginning as a medical provider, my practice emphasis has always been on family and behavioral medicine, specifically within federally qualified health centers (FQHCs). My intention of becoming a physician assistant (PA) and my career since that time, has been to serve the underserved. My practice panels, throughout my career, were made up almost entirely of Medicaid and Medicare patients. By developing and remaining devoted to providing care for patients with limited resources, high levels of comorbidities, severely complex diseases and conditions, and patient life circumstances that often resulted in significant obstacles to treatment adherence, I believe I can be of value as a firsthand witness to the dismal state of chronic care treatment in this country, and funding issues intimately intertwined with providing medical care for patients with chronic comorbid conditions.

Secondly, a bit more background may be of benefit to help provide support and validity to my statements. I am not only a nationally certified and state licensed PA who also developed and implemented volunteer free clinics, I also have my PhD in clinical psychology, having integrated behavioral medicine within my family practices. I am also a medical educator, having taught in a variety of health science programs, including PA, psychology and social work programs, and medical school. I have directed PA programs and have been an associate dean overseeing the largest civilian PA programs in the country. Presently, I proudly serve as the founding chair and program director for Emory & Henry's College developing PA program – a program that is squarely focused on improving access for all patients to appropriate and high-quality medical care and serving the underserved, including rural, impoverished, inadequately insured, and uninsured patients. My practice experience provides me with an intimate knowledge of the Medicaid and Medicare systems and the patients receiving care within those systems.

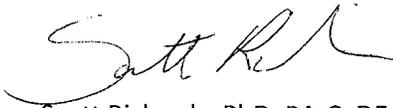
individuals and groups. Specifically, I needed to develop excellent working relationships with other medical providers, local pharmacists, allied health providers, psychologists, counselors and social workers, community resource groups, and many others. Generating a medical team model for all patients – where each individual was equally important to the team, resulted in the best patient care and outcomes. Over my career, having worked for different practices in different settings, having worked in medical education, and, not to leave out, actually being a patient, I have come to realize that the medical team model – despite many agencies declaring to support such a model – is often not well defined, inclusive, effective, or patient-centered. My primary goal as a medical provider was and remains to reduce suffering for my patients by utilizing the safest, most effective and beneficial, and most cost effective treatment regimens and interventions. At their core, my treatment plans are developed first by creating an environment in which the patient intentions and goals and the medical provider intentions and goals are transparently discussed and addressed. Mindful practices focusing on reduction of suffering and examining effectiveness by patient outcomes – based as much on patient quality of life as nationally accepted treatment and disease/condition-specific outcomes – must be introduced to students before they begin practice. Such practices naturally incorporate all players involved in each patient’s care and strive to uncover patients’ worldviews, needs, limitations, obstacles to treatment adherence, and ultimate goals. Additionally, such practices strive to truly understand patients and patient situations. For me, this involved performing home visits on my patients with chronic conditions and patients with apparent treatment adherence issues. It was not uncommon for me to solve a treatment adherence issue following a home visit when the obstacle became grossly apparent. It is an absolute necessity that medical team models include not only the primary care providers but also allied health practitioners, nurses, social workers, and members of local community resources when needed. Further, it is of absolute necessity that medical/health science students be trained in such models throughout their didactic and clinical curricula and experiences such that establishing and participating on medical teams is second nature and of such normality that it would seem abnormal not to have such teams in place when moving from medical training to medical practice.

Lastly, let me add that Emory & Henry College, a Southwestern Virginian college with regional and national recognition for stellar academic training, changing lives of students, service throughout Appalachia to some of the Nation’s most underserved communities, and a proven and deeply embedded mission to serve others, and the College’s School of Health Sciences are uniquely suited to be of help in researching and implementing best practices for the treatment of patients with chronic conditions, monitoring outcomes to such practices, and training the next and future generations of medical and allied health providers in such practices. Our new School of Health Sciences, with a Physical Therapy program, an Athletic Training program, and a developing Physician Assistant program, Occupational Therapy program, and state of the art medical research facility are in a position to not only develop and implement proposals and projects for research and practice, but to do so from the ground up – incorporating such activities from our first day of training. Already, we have developed and are in the process of developing interprofessional education training involving medical residents, PT students, PA students, and OT students to improve care and coordination of care to patients with chronic conditions in the region. We look forward to integrating our health science training to include other medical and allied health and patient care professions students, social service providers and agencies, and local community resources to enhance access to and quality of care for all individuals.

Combined with our greatly regarded Appalachian Center for Civic Life, with a goal of equipping students to be agents of social change in our region, our Nation, and the world, the School of Health Sciences is extremely well suited – both in physical resources and know-how, manpower, and intention to serve our community, region and Nation - to explore ways to improve medical care for patients with chronic

conditions/diseases, investigate practices that improve patient care and outcomes, access to quality care, and reduction in Medicare costs for providing such care.

With great respect and the mindful intention to maximize medical care for underserved patients, benefit all patients, and enhance our Nation's ability to provide care for all patients,

A handwritten signature in black ink, appearing to read "Scott Richards". The signature is fluid and cursive, with the first name "Scott" written in a larger, more prominent script than the last name "Richards".

Scott Richards, PhD, PA-C, DFAAPA