Testimony to House Health Care Committee on H.762
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COMPLIANCE

The requirements for medical homes are worded too broadly, and the definition of "primary care" in Section 1901g is breathtakingly broad. This will make it very difficult for clinicians and regulatory enforcers alike to interpret.

COSTS

No provision is made for the costs of setting up the systems to be used by patients to access their personal medical information; the costs of administering the ACE questionnaire; or the costs of setting up internal systems to monitor compliance. No provision is made to pay clinicians for the time it takes to meet as part of community health teams. No provision is made for the costs of enforcement. Excepting the latter, presumably these costs will be borne by medical practices and passed onto patients.

Primary care doctors spend 3.5 hours a week and 3 weeks each year interacting with third party payers. The figure for specialty surgeons is 2.1 hours a week. Clerical staff spend 7.2 hours per doctor per day on these tasks; RNs, MAs, and LPNs spend 19.1 hours per physician per week. This costs $68,274 per physician per year. (*Health Affairs*, 2009, reported in the ACP Advocate Blog, 5/18/09.)

The above underestimates the total administrative burden borne by physicians and passed onto patients--there are many administrative requirements that do not relate directly to third party payers. H.762 adds to this crushing administrative burden. Another cost unaccounted for is the reduction in face to face time for patient and doctor as the doctor's time is consumed with administrative requirements.

INFORMED CONSENT

Making Medicaid reimbursement completely contingent upon the use of the ACE questionnaire is extremely coercive. Medical home designation does not put the entire reimbursement at risk, so it is somewhat less coercive.

H.762 makes no provision for patients to refuse to complete the questionnaire without financial penalty. The bill does not spell out how the information will be used. The ethical principle of informed consent requires that patients be informed in advance how information will be used and to whom it will be disclosed. Informed consent also means

the patient can say “no” without penalty. This law as written violates the ethical principle of informed consent for treatment.

If the state plans to use the data collected for research, then this law violates the ethical principle of informed consent for research.

CONFIDENTIALITY

The information in the ACE questionnaire is extremely sensitive. H.762 makes no provision to segregate this information from the rest of the record. Presumably this information is destined someday for the state’s central patient database envisioned in the State of Vermont’s Health Information Technology Plan, and eventually the federal patient database envisioned in PPACA.

HIPAA and HITECH enable 2.2 million entities to gain access to patient information without the patient’s prior authorization (Institute for health Freedom, *Health Freedom Watch*, September 2010).

The ethical principle of confidentiality means that the patient has the final say about how his or her medical information will be used, no matter what the reason. H.762 as it stands now violates the ethical principle of confidentiality.

SCIENTIFIC EVIDENCE

I am not aware of any scientific evidence that the application of the ACE questionnaire on a wide scale will improve clinical outcomes. The ACE study on which this bill is based makes no such claim. Clinicians generally do not do things that do not benefit patients, especially when clinical time is limited. Clinicians also tend not to collect data when there is no clear clinical use for the data, as is the case here.

CLINICAL JUDGMENT

How to interview patients and when to use standardized questionnaires are clinical judgments. The kind of information contained in the ACE is the kind of information best obtained in a sensitive and nuanced clinical interview. The bill makes no provision for which member of the doctor’s staff will administer the questionnaire; the task will likely fall upon members of staff other than the doctor, which cuts the doctor out of this sensitive discussion. Speaking as a medical professional who specializes in the treatment of individuals who have experienced adverse childhood experiences, I would never use this questionnaire routinely in my practice, because routine use is apt to do more harm than good. Moreover, I would encourage my patients to participate in this questionnaire only if they choose to, and I would counsel them about the risks of disclosure to electronic databases that do not meet my standards for security.