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Overview: If we could just focus on our patients it would be easy! Primary care is overburdened by administrative costs in the effort to forward Health Care Reform. The costs associated with these initiatives are high and not sustainable

I plan to address the following three areas:

1. Insurance requirements that require practices to receive prior approval for certain medications and services and limit access to medications not on their formularies.
2. Excessive documentation, panel management, care coordination and quality improvement. These are all required to participate in quality programs such as the Patient Centered Medical Home, Meaningful Use, Accountable Care Organizations, and the Uniformed Data Services (for Federally Qualified Health Centers)
3. Electronic Health Records , the amount of work it takes to use them and the lack of interoperability between systems

I understand you recently heard testimony from Dr Thomas Moseley who also addressed the prior approval process. I am also aware that Dr Allan Ramsay has suggested some changes to this process and I endorse his suggestions. My experience with prior approvals is similar to theirs and is quite frustrating. This is a process that is in place to save the payers money but adds cost to the practices and interferes with patient care.

Measure	Practice			HSA			Statewide		
	Rate Per 1,000	95% LCL	95% UCL	Rate Per 1,000	95% LCL	95% UCL	Rate Per 1,000	95% LCL	95% UCL
Pharmacy Total	$713	$614	$813	$819	$772	$865	$835	$827	$844
Pharmacy Psych Medication	$125	$92	$158	$159	$141	$177	$167	$163	$170

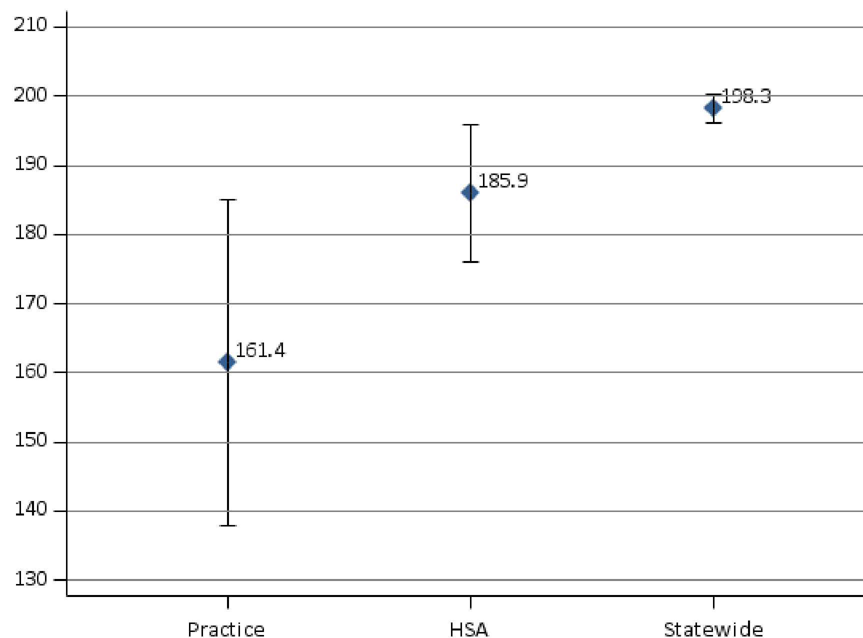
*Blueprint practice profile for 2012

1. Formulary Changes: Each insurance company has their own list of preferred medications which includes: Preferred generic drugs, Non-preferred generic drugs, Preferred brand name drugs and Non-preferred brand name drugs.
    a. The formularies change at least yearly and can be a particular problem when patients change insurance.
    b. Unintended Consequences: Can result in extra office visits, extra labs, always results in additional phone calls or letters at cost to the practice. Also erodes patient physician relationship as insurance company dictates treatment.
    c. Can result in loss of compliance, patient may not fill new prescription.
    d. Can result in loss of control over a previously controlled condition

    i. Asthma example- Well controlled asthmatic deteriorated with change in formulary.

2. Prior Approval for medications at The Danville Health Center
    a. Average 25-30 Prior approval for medications monthly, 30 minutes per PA, 15 hours/ month mostly nursing time but some provider involvement
    b. Example of seizure medication requiring 3 hours
3. Prior Approvals for "advanced" imaging - CT/MRI . Primary care providers understand it is best to avoid radiation when possible and we try to limit radiographic studies. Vermont Radiology recently met with the Green Mountain Care and informed them that VT is already the best in the country for limiting advanced imaging. As the below graph indicates my practice spends significantly less than others in VT on advanced imaging but we still have to go through the same prior approval process.

ADVANCE IMAGING (MRI AND CT SCANS)



Annual risk-adjusted rates and 95% confidence intervals for advanced imaging diagnostic tests (MRI,CT Scans) per 1000 members
*Blueprint practice profile for 2012

Prior Approval for advanced imaging studies at The Danville Health Center
    a. Number varies 1-4 weekly, average 1 hour but sometimes takes 3-4 days to get a response
    b. Examples - Since January have had to send 3 patients to ER for CT scans because they were urgent situations and we could not get a response to our request

The next topic I would like to address is the administrative overhead required for quality programs. This includes extra documentation of quality metrics, panel management, and continuous quality improvement. None of these items are reimbursable based on traditional billing. As part of a Federally Qualified Health Center we emphasize low cost, comprehensive care. The Blue Print for Health has been a natural partner and we are one of the original pilot sites. We endorsed the chronic care model and embraced the transition to the Patient Centered Medical Home and subsequently were one of the first practices in Vermont (and the country) to become officially certified as a Patient Centered Medical Home. In fact, we just completed our third recertification as a level three Patient Center Medical Home. Additional we are certified for Meaningful Use and have been using an Electronic Medical Record for twelve years. This experience has given me an appreciation for quality endeavors and I still support them BUT the documentation and additional non-reimbursable time spent on for these efforts is onerous.

Documentation of data is not magical. Every element has to be captured, some more easily than others

1. Some documentation is for clear, discrete data elements such as blood pressure or labs. These can flow from interfaces or manual entry. These are relatively easy to enter although do not happen automatically.
2. Non-discrete data items are more difficult to document and the documentation is usually only helpful for tracking a process.
    a. For example, every time I encourage someone to lose weight I need to click a box that says BMI, F/U plan. This does not indicate what I discussed with the patient so only functions to indicate that it was done. If I don't click the box none of the payers know it was addressed even though my note may discuss it. From a reporting point of view if the box was not checked, the counseling did not happen. There are a lot of similar data elements.
3. The quality initiatives don't always ask for the same data. There is more overlap than there used to be but everyone needs to be on the same page and the amount of data that is being tracked needs to be reduced.
4. The clinical metrics being tracked need to be clinically useful
    a. Example: brief tobacco intervention has data to support its effectiveness but brief obesity or depression intervention does not have data to support this
5. Most of primary care visit spent documenting which has taken away from the joy of practicing medicine.
6. Panel Management is an important aspect of quality care but takes time and staff to run reports, monitor data for accuracy, recall patients as needed and review care to look for opportunities for improvement.
7. Continuous quality improvement is essential however it requires time for office staff including providers to meet on a regular basis. This is not reimbursable time and is either done on our own time or time taken out of patient care time or not done.

Lastly, I wanted to briefly touch on Electronic Medical Records in general and the problems with interfaces.

1. Data goes in, but often data flow is one directional. Capturing the data doesn't mean it is easy to get reports back. We are still having difficulty getting quality data on clinical metrics to improve care.
2. Electronic order entry essentially uses clinicians as clerical workers. We have to type in the order, which takes more time than ordering them verbally or in written form. Most of us don't have the typing skills, entry is time consuming and takes provider time away from the patient.
3. Lack of coordination within different Electronic Medical Records. Most Electronic Medical Records do not talk to each other. This means that we are spending lots of time and money making interfaces to allow the computers to talk to each other.
    a. NCHC example with our Centricity implementation, 3 hospitals requiring different interfaces, VITL not able to help, hiring of a 3rd party vendor as one of the systems does not interface with the VHIE.
4. For practices lacking interfaces someone in the practice then has to look into each system for data and then enter manually it into your own system
    a. NCHC example for a single patient may have to look into FAHC, DHMC, and NVRH. Patients assume that they all "talk" to each other and are frustrated when data is missing (as are we) .
5. Enormous time and expense spent on interfaces. Even if an interface is in place it requires someone to manually touch each data that passes through it.
6. In terms of outcome to the patient, Electronic Medical Records take enormous time and expense that primary care offices are asked to absorb.

Unless something changes our current primary care system is not sustainable. Here are some suggestions to help sustain primary care and move forward with health care reform in Vermont:

- Eliminate prior approvals
- Use radiologists for real time decision support in place of prior approval with the insurers
- Streamline insurance formularies
- Ask payers to cover the additional costs with their prior approval and formulary changes including those "hidden" costs

I believe that the PA process should be waived for those practices that already practice "cost" efficient medicine. I encourage you to endorse Dr Allan Ramsay's suggestions to streamline the PA process, eliminate some PA's and use real time decision support with radiologists to manage the advanced imaging process. I also believe that the insurance companies need to cover the office costs for these prior approvals and formulary change. These should be part of their administrative costs, not passed on to the offices or patients. I encourage you to ask the insurance companies to limit their formularies and to make them transportable - if you get a prior approval for a medication from one insurer it should carry over to the next one.

- Increase Blueprint payments to the primary care practices.

  It costs a lot of money to keep a "tidy" medical home. Much of what we do is not reimbursable in the traditional method. The current money from the Blueprint does not cover the costs associated with the Patient Centered Medical Home. Recent data presented by Dr Craig Jones indicates that our practices are saving payers a significant amount of money. Where is this money going?? This money should be directed back to the practices to support the Patient Centered Medical Home model.

- Consider bundled payment that is not centered on documentation. Move away from the traditional fee for service model. Consider a global budget for primary care instead of the "ACO" model. SIMPLIFY- do not endorse a solution that requires more documentation from primary care!

- Coordinated effort for quality initiatives and clinically appropriate quality metrics.
  Focus only on clinical metrics that are supported by data. Consider using the Choosing Wisely initiative to pick clinical relevant metrics (http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx) Use the Patient Centered Medical Home for quality. This is a rigorous program that more than covers the other initiatives. Limit the number of metrics and ensure the quality initiatives have the same reporting requirements. Make sure there is enough reimbursement for primary care to cover the added expense of the Patient Centered Medical Home.

- Statewide focus on making our EMR's interoperable - this is essential and should not occur at the practice level.

THANK YOU!