Family Doctor

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FEATURE ARTICLES:

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From the Executive Vice President

By Vito Grasso, MPA, CAE

The enormous and growing burden of complying with various administrative requirements of health insurance plans and regulations imposed by government, have severely impaired the ability of physicians to be independent and effective clinicians focused on the needs of their patients.

The Academy has been a leading advocate of reform in both the administrative environment imposed by plans and the regulatory environment created by government. While we have had some success, the interference of plans and government has persisted and the net effect continues to be adverse for the medical profession, for our health care system and for patients.

In 2024 the AMA conducted a survey to assess the impact of prior authorization. Included among the findings:

Prior authorization is costly:

- Physicians and their staff spend more than 13 hours/week (nearly two business days) on prior authorizations.
- Physicians complete an average of 39 prior authorizations per week.
- 88% of physicians report that prior authorization has led to higher overall use of health care resources.
- 89% of physicians report that prior authorization somewhat or significantly increases physician burnout.

Restrictions on physician collective bargaining have made it impossible for the medical profession to work directly with payers to address the burden of prior authorization and other administrative and financial requirements imposed by payers. Consequently, physicians and their advocacy organizations have had to resort to legislation. NYSAFP has been vocal and persistent in advocating for limitations on the use of prior authorization as well as wholesale reform of our healthcare system through single payer to eliminate many administrative requirements and to allow physicians to collectively bargain with the single payer to prevent administrative burden from occurring in this environment.

We are currently engaged in advocacy which we believe will relieve some of the administrative burden which our members and the broader medical community must confront every day. Among the legislation we are engaged with are:

A.3789 (Weprin)

This legislation would enact several principles outlined in a comprehensive 2017 report by the American Medical Association, the American Academy of Family Physicians and over one hundred state and national health and patient advocacy associations titled *"Prior Authorization and Utilization Management Reform Principles."* This legislation would:

- Assure that utilization review criteria are evidence-based and peer reviewed;
- Require utilization review determinations involving health care services which require pre-authorization to be provided within 72 hours or 24 hours in an emergency (currently determinations are required to be provided within 3 business days); and
- Assure that once a prior authorization is received it will not need to be repeated and is valid for the duration of treatment.

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... regulations imposed by government, have severely impaired the ability of physicians to be independent and effective clinicians focused on the needs of their patients.

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A.2526 (Paulin)

This legislation would allow physicians to collectively negotiate contracts with health plans. Physicians are one of the few professions where practitioners are prohibited from joining together to negotiate contract provisions and payments with managed care and other health insurance plans. This bill corrects this inequity to restore fairness to physician negotiations and enable physicians to better advocate on behalf of the patients that they serve.

A.1466 (Paulin)/S.3425 (Rivera)

NYSAFP was the first medical society to endorse the NY Health Act more than 25 years ago. This legislation would address a myriad of health system deficiencies by creating a single publicly financed and managed health care system. Under *New York Health's* single payer system, every New Yorker regardless of age, income, wealth, employment or other status will qualify for comprehensive health insurance. New York Health would be publicly funded and paid for by assessments based on ability to pay, through a progressively graduated payroll tax, and a surcharge on other taxable income. Federal funds now received for Medicare, Medicaid, Family Health and Child Health plus would be pooled to establish a New York Health Trust Fund. Health care providers would be paid in full by this one payer, New York Health, without any fees for the patients. A single payer system will eliminate the varying administrative practices of multiple health insurance plans which add costs and frustration to providers and patients and serve primarily to delay or deny coverage for care. Such day-to-day interference in medical practice compromises patient care. In a field where time is of the essence, it is essential that people have immediate access to the care they need when they need it.

A. 6773 (Paulin)

This legislation would eliminate the requirement that consent for payment of services must occur after treatment has been provided. The law currently requires separate patient consent for treatment and for payment and stipulates that consent for payment cannot occur until after treatment has been provided.

S. 6375 (Rivera)

This legislation would create a single patient financial liability form to use in providing patients with a good faith estimate of what they will pay for services provided.

We will continue to advocate for specific reforms and have made progress in securing some relief. Our focus on single payer, however, remains the best hope we have of achieving system reform and an infrastructure that will empower physicians to negotiate collectively to protect the interests of patients and to assure that their own costs are considered when defining the administrative environment within which essential services are provided.

Upcoming Events

2025

May 10
Congress of Delegates
Opening Day
Virtual

May 17-18
Congress of Delegates
Reconvenes
Albany

Aug 2-3
Summer Cluster
Long Island

President's Post

By Rachelle Brilliant, DO, FAAFP

I will start by saying what an honor it was to serve as your president this past year. You can read a full accounting of my activities as president in our Congress of Delegates Handbook. Highlights include a great summer cluster at the Arts Center of the Capital District where some of those serving on our commissions participated in salsa or painting classes, and at AAFP's Congress of Delegates in Phoenix, AZ where the AAFP elected our own past-president, Dr. Sarah Nosal, as president-elect! I look forward to attending Congress in Anaheim, CA next October to see her installed as AAFP president.

Another highlight was our biggest ever Lobby Day in Albany, with over 60 doctors and medical students talking to our elected officials to discuss the things that matter most to us. Topics included; expanding NYSIIS to include all adult vaccines; requiring insurance companies to increase primary care spending; preventing restructuring of the Excess Medical Malpractice Program; continuing funding for the Doctors Across New York program and the Area Health Education Center system; training our future abortion providers; protecting reproductive health care and gender-affirming care; and supporting the Medical Aid in Dying bill. Advocacy and lobby day brought me into NYSAFP and I am happy to see so many members coming to Albany to meet with their elected officials. Hopefully even more of you will come next year, however if you cannot, please remember that our elected officials spend just as much time at home in their districts as they do in Albany. Using the links below you can look up your State Senator and Assemblyperson and the phone number and address of their district offices.

https://www.nysenate.gov/find-my-senator and https://nyassembly.gov/mem/search/.

This year has had some unhappy events as well. We all mourn the death of our past-president Dr. James Mumford. His humor will be missed at our upcoming Congress of Delegates. He was always ready to tell jokes and stories when there was down time during our meetings.

We all have noticed the increase in prices everywhere, and our Academy is not exempt. These increased costs have now made printing this journal and mailing it to every member too expensive for our Academy to sustain. More and more of us now read articles online - sitting down and reading a journal cover to cover is a rare occurrence for many of us. In this vein this will be our first online only journal issue. I was proud to serve as one of the first editors for our Family Doctor Journal and look forward to its continuation.

We serve many functions for our members. We advocate with payers and government. We educate our students, residents, and attendings by providing CME and leadership training, all of which cost money. Our organization primarily runs on dues. To try to keep costs down we will be exploring and experimenting with new (and old) form of sponsorships. We will be taking your reviews of events very seriously so please fill out the surveys sent to you after an event. In the meantime, we owe it you, our members to try to balance the budget so anticipate a number of changes for the foreseeable future. Please be patient with us as we try new things.

In this issue we focus on healthcare regulation. Very few of us have a business education. Most of us studied sciences or humanities in college and very few medical schools provide more than a lecture or two about running a medical office. Most of what we learn is in the trenches. This edition focuses on issues we should be aware of even if we are employed physicians including coding, value-based payment programs, Medicaid programs, and administration. It has been my honor serving as your president this past year and working for all of you to continue the great work our Academy does.

Thank you,

Rachelle Brilliant, DO, FAAFP

Please share your comments regarding our online only journal with Penny at penny@nysafp.org

Albany Report

By Reid, McNally & Savage

Successful 2025 NYSAFP Advocacy Day

We would like to recognize the over sixty family physicians, residents and students who joined us at the State Capitol in Albany on Monday, February 24th for NYSAFP's annual Advocacy Day. Led by President Dr. Brilliant, President-elect Dr. Doucet, Advocacy Chair Dr. Faso, and CEO Vito Grasso, ten regional teams met with nearly seventy legislative offices, as arranged by our firm, to advocate for the 2025 budget and legislative priorities of NYSAFP. Special thanks to Donna Denley, Director of Finance for NYSAFP for her assistance with planning and executing the Advocacy Day as well.

During the day, members discussed budget and legislative priorities as outlined below, some of which were included in Governor Hochul's Executive Budget that was released on January 21st, to promote high quality primary care for New Yorkers. NYSAFP also submitted testimony for the February 11th Health/Medicaid Joint Legislative Budget hearing to make lawmakers aware of the Academy's budget priorities.

- Supporting the Governor's proposal to include $50 million from the proceeds of the MCO Tax to fund an increase in the Medicaid physician fee schedule as well as legislation (S.1634, Rivera/A.1915A, Paulin) requiring health care plans to spend a minimum of 12.5% of their overall healthcare spending on primary care services
- Supporting funding for Doctors Across NY (DANY) and Area Health Education Center workforce programs while urging expanded support under DANY for private practicing physicians
- Opposing problematic Executive Budget proposals that would eliminate physician supervision of PAs, cut funding to the State Excess Medical Malpractice program and require participating physicians to pay 50% of the cost, and transfer oversight of physicians, PAs, and special assistants to the Department of Health from the State Education Department
- Supporting various abortion access investments in the Governor's budget and expanding abortion access & residency training opportunities; NYSAFP is asking that $2 million be specifically allocated in the final state budget to clinicians providing uncompensated telemedicine abortion care and $10 million be included to support the New York State Abortion Clinical Training Program Act

- Furthering Legal Protections for Reproductive Health Care and Gender-Affirming Care by preventing state engagement with hostile actors and building on professional discipline and medical malpractice protections in New York's shield laws
- Authorizing Medical Aid in Dying
- Adult Vaccine Reporting to the statewide and city immunization registries similar to pediatric vaccines
- Universal healthcare coverage through a single payer health system and much-needed insurance standardization/simplification

As a key member of the coalition advocating for establishing the abortion clinical training program, several NYSAFP members also participated in a press conference advocating for this legislation that took place on February 24th. Dr. Paladine, Immediate Past President, was one of the main speakers at the event. For more details, please see the press release issued by Senator Krueger.

State Budget Update – One House Budget Bills Released

On March 11th, the Senate and Assembly released their own one-house budget bills in response to what the Governor proposed and with their own priorities. Below, please see their budget actions related to Academy priorities.

The Senate and Assembly accepted DANY and AHEC funding levels and included funding with modifications for physician fee schedule increases from proceeds from the managed care organization (MCO) tax. The Senate added $10 million to support expanding DANY to include dentists, $500,000 in support of AHECs, and $50 million for physician fee schedules. The Assembly kept the Executive's funding level for DANY and AHEC and reduced the physician fee investment by $7.5 million to account for spending associated with not including the elimination of the specialty physician independent dispute resolution (IDR) process.

Additionally, both houses rejected PA independent practice and the proposed oversight of physicians, PAs, and special assistants from the State Education Department to the Department of Health. They also both rejected the Excess Medical Malpractice Program restructuring and funding cut and proposed to extend the program through June 30th, 2026, as NYSAFP requested. Further, we were happy to see that they both included language to create the NYS Abortion Clinical Training Program with the Senate providing $5 million to support this and the Assembly requesting that $2 million from the Executive's proposed abortion access funding be allocated to support the program. To advocate for this to be included in the final state budget, RMS secured a meeting in late March with key staff in the Governor's office on behalf of the coalition in support of this proposal. Dr. Paladine and Dr. Faso were able to join and provide key perspectives on the need for resources and training for residents and providers and the impact this has/could have in the future on access to abortion and other reproductive care.

New proposals from the Senate one-house budget bill include **language to require all health plans and payers to spend a minimum of 12.5% of their total expenditures on primary care services** (as provided by S.1634/A.1915 which NYSAFP has been strongly in support of) and language to modernize pregnancy loss reporting to protect patient privacy and reduce burdens on providers (per S.3173/A.4023). Both houses also included a permanent carve-out of school-based health centers from Medicaid managed care.

Positively, neither house included wrongful death legislation which the Governor has now vetoed three years in a row. NYSAFP will remain active on this issue, as the 2025 bill reintroduced by Senator Hoylman-Sigal and Assemblymember Lunsford (S.4423/A.6063) has advanced to the Senate calendar to be eventually taken up for a vote. The Senate also included positive language to reform the Office of the Medicaid Inspector General's (OMIG) audit processes which the Academy supported via joint letters and a memo in support.

Overall, the Legislature provided substantive support in their one house proposals for many NYSAFP priorities thanks to the critical advocacy efforts of Academy members. For more information comparing the Executive Budget to the Senate/Assembly One-House Budget Bills in the health/mental hygiene sectors, please review our comprehensive HMH Budget Update.

With this step in the budget process completed, three-way negotiations are now ongoing between the Governor and Legislature – all of the items mentioned above are tentative and being discussed. Several issues are highly contentious such as changes to criminal discovery laws, outstanding unemployment insurance debt from the COVID-19 pandemic, how to handle federal funding cuts, and limits on wearing masks in public areas, and negotiations are in some ways at a standstill. NYSAFP issued a statement to the media on March 27th urging Governor Hochul and lawmakers to not include anti-mask legislation in the state budget as the Academy is dedicated to immunocompromised patients and supporting the right of people who want to wear masks for health and safety concerns.

The SFY 2025-26 final state budget deadline already passed on April 1st and has been extended in an effort to reach and pass a final budget agreement before the 2-week Passover/Easter break. At this point, we are keeping the pressure on to advocate for inclusion of NYSAFP's priorities this year in the budget.

NYSAFP will provide a member update on the final state budget outcomes related to priority areas once the final deal comes together and the budget is passed. Following the budget's enactment, NYSAFP will continue to advocate for the advancement of its legislative priorities during the remainder of the session which is scheduled to end in June 2025.

We thank all members for your interest and participation in NYSAFP advocacy efforts on behalf of members and your patients. We encourage all to be involved through the COD, annual Advocacy Day and NYSAFP Action Alerts throughout the year, and to reach out to your state legislators to ask for their support of family medicine!

Family Physicians and Nurse Practitioners – A Collaborative Arrangement

By Colleen T. Fogarty, MD, MSc, FAAFP; Luzann C. Ampadu DNP, MS, FNP-BC and Carissa Singh, DNP

Introduction

The increasing complexity of primary care combined with an aging population and more prevalent chronic conditions has affected primary healthcare access across the United States. Nurse practitioners (NPs) have long been viewed as key professionals in team-based care to expand the capacity of the primary care system, which is largely provided by family physicians. Nurse practitioners' additional training after securing the RN credential, allows NPs to assess, diagnose, and treat patients, thus adding to the capacity of family medicine practices to care for patients. Of the approximate 25,407 nurse practitioners practicing in New York State in 2018, 38% practiced in primary care outpatient settings.[1]

The number of nurse practitioners continues to rise, and many new graduates are entering practice. This paper will outline the training, certification, registration process for nurse practitioners, review the scope of practice for NPs in New York State, discuss common issues faced by new NP grads in family medicine practice, and provide "best practice" suggestions for collaborating with new NPs in practice.

Nurse Practitioner Training

Nurse practitioners must have completed training as a registered nurse (RN) and then a master's, post master's, or doctoral program in nursing including advanced clinical training beyond the RN scope.

Accredited nurse practitioner programs must adhere to The Essentials, Core Competency for Professional Nursing, established by the American Association of Colleges of Nursing, which outlines ten domains or areas of focus. See Table 1.[2]

All nurse practitioners complete core coursework in advanced physical assessment, advanced pharmacology, and advanced pathophysiology, and diagnostic and clinical reasoning.[3] Master's programs train NPs in sixteen focused tracks including family practice, adult health, women's health, acute care, gerontology, pediatric/child health, and mental/behavioral health.[1]

Along with didactic education, NP programs must include a minimum of 500 hours of supervised clinical training. Additional instruction and clinical hours may be required based on the NP specialty, for example, family nurse practitioner programs require additional didactic and clinical training across the lifespan, which includes, pediatric and adolescent health and women's health topics as well as additional clinical hours- approximatively 200-220 along with the required minimum 500 supervised hours. Following graduation, nurse practitioners must be licensed as a registered professional nurse and pass one of the national nurse practitioner certification exams in their chosen specialty to become fully licensed NPs to practice.[4,5]

For family nurse practitioners (FNPs) to obtain a NY state licensure and meet certification eligibility through organizations such as the American Academy of Nurse Practitioners Certification Board (AANPCB) or the American Nurses Credentialing Center (ANCC), they must receive a minimum of 500 supervised clinical hours. To maintain licensure and certification, FNPs must provide evidence of continuing education.[4,6]

Certification and Registration for Nurse Practitioners in NYS

The New York State Education Department (NYSED) requires NPs to hold certification and registration to practice. Criteria for certification and registration include current NYS registration and licensure as a registered professional nurse; good moral character; and completed required NP education (including clinical experience).[7] Two national certifying organizations for family nurse practitioners exist in the US- The American Academy of Nurse Practitioner (AANP) and the American Nurse Credentialing Center (ANCC). Both certification organizations require successful passage of an exam that assesses FNP knowledge on clinical assessment, diagnoses, plan, and evaluation. Certifications must be renewed every five years, demonstrating proof of clinical practice and continuing education.[4,6]

Scope of NP Practice in NYS

Under the New York State Board of Nursing Laws, NPs have full practice authority which permits them to evaluate and diagnose patients, order and interpret diagnostic tests, and initiate and manage treatments including prescription medication.[8] NPs with fewer than 3,600 hours of clinical experience (approximately 2 years of full-time practice) must have a written practice agreement with a collaborating physician. The written practice agreement should include information regarding

patient referral and consultation; coverage for emergency absences for both the NP and physician; resolution of disagreements between the NP and physician regarding diagnosis and treatment; written practice protocols the NP will use; and any additional provisions agreed upon by the NP and collaborating physician. The collaborating physician must also complete quarterly chart reviews for the NP.[7] Once a NP has completed 3,600 hours of clinical practice, they can practice independently without physician supervision.

Common Concerns Facing New Nurse Practitioners in Family Medicine Practice

Transitioning from a student nurse practitioner role to a practicing nurse practitioner is challenging and can be stressful. Many new NP graduates report feelings of anxiety and inadequacy during their transition to clinical practice. New NPs experience lack of confidence and question their skills and competency. Imposter syndrome is commonly experienced.[9-11] These stressors facing new NP graduates, unaddressed, may lead to burnout, and NP turnover.

An expanding literature base explores NP specific concerns and strategies to support new graduate NPs entering clinical practice. One recent study of new primary care graduate NPs identified 6 key gaps in their transition to practice:[11]

1) professional care development
2) credentialing and licensure
3) billing reimbursement, and insurance
4) pharmacology and medication management
5) radiology diagnostics
6) laboratory diagnosis and interpretation.

Newly graduated nurse practitioners also experience a key role transition, from a registered nurse (RN) to nurse practitioner. RNs function under clinician orders, while NPs are among the clinicians who direct treatment and develop orders for patient care.

NP training is a stand-alone program, with certification and licensing following exam passage. Unlike physician colleagues who complete a residency, new NPs are not required to complete post-master's clinical training prior to entry to practice. Post-graduate NP clinical training programs, named "residency" or "fellowship" have developed over the last fifteen years to address these gaps. Program evaluations find that such training programs coupled with effective interprofessional education (IPE) can help address many of the stressors identified by new NP graduates as they transition to practice. While not every NP can complete a post-graduate clinical training program for reasons as varied as financial, availability, and geography, every new graduate NP deserves to be supported during the transition from graduation to practice.

Current research supports the implementation of post graduate NP training programs.[9,10,12] Our own experience developing and implementing a postgraduate NP residency in an existing family medicine residency program, has been viewed as highly successful to all stakeholders. Our new NP trainees and graduates reported significant satisfaction with their training. NP residents responded positively to program evaluations. Several key comments are:

"[I] feel we are better prepared compared to a NP graduate with no residency experience. [The program] helps with first job entry. Not sure I would be fully prepared without the residency."

Another respondent commented "[The residency is] great, well-organized, physicians are collaborative and open. Program is very supportive. Program is good training for NPs going into practice."[12]

General Guidance for Physicians on "Best Practices"

A theoretical framework, the Interprofessional Teamwork for Health and Social Care Framework, outlines four domains thought to improve interprofessional teamwork: Relational, Organizational, Processual, and Contextual. See Table 2.[13]

A mixed methods study of practicing NPs in Massachusetts published in 2017 using this framework found that the key factors for NP practice were NP-physician and NP-administration relationships; organizational support and governance; time and space for teamwork; and regulations and economic impact.[14]

Using this framework as a model for best practices, we suggest the following:

Relationship – Ensure that there is an identified physician or physicians in the practice who serve as a collaborating physician for new NPs who have not had 3,600 hours of practice. Establish a regular time – we suggest at least 30 minutes monthly – for the collaborating physician and NP to meet to review clinical cases. Allow the NP to set the agenda and review cases that will promote their clinical growth. Use the state required chart review process as a vehicle for learning, especially regarding level of service for billing, which is often new knowledge for new clinicians. While not required by law, this collaboration should extend through the duration of the NPs practice to provide support as needed. Ideally, a physician and NP can become a practice duo, consulting each other to review patient care in the service of improved patient outcomes and quality of care, as reflected by a participant in the Poghosyan study.[14] Consider the importance of same discipline mentoring. When possible, connect the new NP in the practice to an experienced NP colleague in the same practice or within the community. This allows the new NP to share experiences and ideally, normalize the feelings associated with entering practice.

Organizational – Given the often-overlapping work of family physicians and family nurse practitioners, ensure that the practice provides comparable resources for NPs to successfully complete their duties and maximize their scope of practice. This includes, but is not limited to, adequate clinical and clerical assistant staff and nursing or technician support. Ensure that NPs have representation in applicable committees and meetings. Ensure that practice administrators understand the scope and practice of NPs to ensure that NPs get adequate practice support.

Process – Perhaps the most challenging in modern busy family practices – ensure adequate time and space for collaborating. Often an NP and physician may work on opposite days to ensure clinical coverage; if this is the case, consider having one-half or one day of overlapping practice, to ensure communication. Consider using the electronic record for short questions or "FYI" communication. Similarly, space is often a concern. Provide comparable clinical space and clinical administrative resources (computer, desk, office space) for comparable expectations of clinical productivity.

Contextual – Larger social and regulatory factors can feel out of our individual control. However, it's incumbent upon physicians,

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whether in community practice or employed practice, to understand the NP scope of practice, and ensure patients and staff understand, respect and value the NP role on the team.

Conclusion

Nurse practitioners are highly trained clinicians who can help improve access to all aspects of primary care. New York State law allows independent practice after 3,600 hours of post-graduate practice; NPs and physicians benefit from establishing collaborative practices. Incorporating nurse practitioners into family medicine practice requires attention to relationships and ensuring that NPs have the interpersonal and systems/organizational support to provide outstanding family medicine care.

Table 1. Essential Core Competencies for Professional Nursing[4]

Knowledge for Nursing Practice
Person-Centered Care
Population Health,
Scholarship for Nursing Discipline
Quality and Safety
Interprofessional Partnerships
System-Based Practice
Informatics and Healthcare Technologies
Professionalism
Personal, Professional, and Leadership Development

Table 2. Interprofessional Teamwork for Health and Social Care Framework[13]

Domain	Definition
Relational	Relates to the professional relationships, including power, hierarchy, respect among the team members
Organizational	Relates to factors in the local organization
Processual	Relates to process factors, like workspace and time allocation
Contextual	Relates to broader social, political, and economic landscape in which the practice functions

Endnotes

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Colleen T. Fogarty, MD, M.Sc., FAAFP *has practiced family medicine in urban and rural practices, collaborating with nurse practitioners since her first practice out of residency at the Highland Hospital/University of Rochester Medical Center FM Residency Program. In 2019 she became the William Rocktaschel Professor and Chair, Department of Family Medicine (DFM), University of Rochester School of Medicine and Dentistry. She leads the multiple missions of the Department, including education and training, of which the Nurse Practitioner Residency Program is one. She practices at the Highland Family Medicine Center (HFM), the urban training practice for the Highland Hospital/University of Rochester DFM.*

Carissa Singh, DNP, FNP-C *is a doctoral-prepared family nurse practitioner (FNP) with five years of clinical experience at HFM, where she completed the FNP residency in 2019. In addition to her practice, she serves as the Clinical Director for the Highland Family Medicine NP Residency Program, working closely with new NP grads who are doing a one-year residency. Carissa is adjunct faculty at St. John Fisher College's FNP Program, where she earned her Doctoral degree in Nursing Practice.*

Luzann C. Ampadu DNP, MS, FNP-BC *is a doctoral-prepared family nurse practitioner with over a decade of clinical practice in family health and in a pediatric practice. In addition to her clinical practice at HFM, she serves as the Academic Director for the Highland Family Medicine NP Residency Program. Since 2022, she has been an adjunct lecturer and clinical instructor in the FNP at State University of New York – Brockport, where she earned her Doctoral degree in Nursing Practice.*

Editorial Note: *This issue's 'Two Views' columns are in response to "Family Physicians and Nurse Practitioners: A Collaborative Arrangement" on page 8.*

TWO VIEWS: Family Medicine and Nurse Practitioners

VIEW ONE

LET THE FACTS SPEAK FOR THEMSELVES

By Ani Bodoutchian, MD, MBA FAAFP, DABOM, CPE

The Nurse Practitioner Modernization Act (NPMA) permits nurse practitioners (NPs) to be independently responsible for the care of their patients without physician supervision.[1] This has set the stage for NPs to assume the responsibilities of physicians without having completed medical school or undergoing similar rigorous clinical training.

As aptly stated by Shakespeare, "the miserable have no other medicine, but only hope." Medical care should not be relegated to hope alone, which is a significant concern when patient care is left unilaterally in the hands of NPs.

Unlike the positive experiences expressed in the other view by my esteemed colleague, my experience is not so optimistic. The facts speak for themselves - there is simply no comparison to the education, training and experience that a physician obtains, even on an entry level, to that of a NP.

On the path to becoming a physician, the Accreditation Council of Graduate Medical Education (ACGME) sets standards to assure the public that any graduate will deliver safe, appropriate and high-quality medical care. United States (US) educated physicians complete a 4-years of medical school plus 3 - 7 years of residency and/or fellowship before being permitted to treat patients independently. Foreign graduates have additional years in medical school as college and medical school are combined. Residency and fellowship are the same number of years as this training must be completed in the US even if they have practiced for years abroad.

Additionally, all physicians must pass simulated patient encounters, numerous tests and a minimum of 2 to 3 national exams before taking their specialty and/or subspecialty exams. This demanding training is not for the faint of heart. There is a reason for these requirements as patients' lives are at stake.

Medical school preclinical curriculum consists of anatomy, physiology, biochemistry, microbiology, and pharmacology which all culminate into a cohesive and required medical foundation, which forms the basis for additional and necessary clinical training. This is interwoven with further education and several years of clinical skills in hospital and clinic settings, followed by many years of clinical training and supervised patient care as a resident and/or fellow. This is all completed before rigorous national exams and finally board certification(s) and re-certification(s).

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VIEW TWO

THE ENDURING CONNECTION BETWEEN DOCTORS AND NURSES

By Louis Verardo, MD, FAAFP

Throughout my 40-year clinical career, I have taught and worked alongside a variety of individuals classified together as "physician extenders." Primarily, though, my greatest exposure has been to a group of nurse practitioners who have come from an extensive background in nursing representative of multiple areas of nursing practice. Let me tell you about some of them...

My first such clinical student was Camille, a young nurse with excellent clinical skills who I believe was in the vanguard of experienced RNs wishing to elevate their role in patient care by obtaining advanced credentials. Our interactions were professional and demonstrated a shared outlook on pragmatic care management. When she finished her training at my hospital site, I followed up on her career. I found out that Camille was running an ambulatory hypertension clinic in Brooklyn and had achieved remarkable success in terms of patient compliance with treatment and meeting blood pressure goals.

Another student was Judy, an RN who served a several-month clinical experience with me; she was interested in eventually working as an advanced practice nurse within the cardio-pulmonary department at her hospital. Judy integrated herself smoothly into the rhythm of my office practice, demonstrating strong assessment skills and an easy demeanor with patients. We collaborated on a variety of conditions seen daily, with an attempt to focus her experience on those patients with active heart and lung conditions. A few years after the conclusion of her time with me, I was happy to learn that she had indeed obtained a position preparing patients for complicated surgical procedures and was uniquely appreciated by the surgical staff for what she brought to the job.

While medical director of a clinic affiliated with a Long Island hospital, I worked alongside an amazing NP who had obtained dual certifications, in both adult medicine and women's health. Mary Beth and I collaborated frequently on selected patients, settling into a co-management relationship which matched what I had read occurred between Dr. Paul Frame and his NP while both practiced in an Upstate New York community. Shortly before I left that position, I had the unique opportunity to honor her professional practice with a special award unique to our institution, an award dedicated to the memory of the clinic's deceased founding director of nursing.

In an isolated rural Rhode Island community where I worked in solo practice, I took on an NP student named Kathy for a summer

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Regardless of where one is trained, medical school, residency and fellowship are grueling on every level and entail financial, physical and emotional commitment and dedication.

The table below is from the Medical Society of the State of New York's (MSSNY) legislative program in 2021. At a bare minimum, a family medicine trained physician has a minimum of 20,700 - 21,700 hours of training.

MEDICAL/PROFESSIONAL SCHOOL AND RESIDENCY/POST-GRADUATE HOURS FOR COMPLETION

	Lecture hours (pre-clinical years)	Study hours (pre-clinical years)	Combined hours (clinical years)	Residency hours	**TOTAL HOURS**
Family physician	2,700	3,000**	6,000	9,000 – 10,000	**20,700 – 21,700**
Doctorate of Nursing Practice	800 – 1,600	1,500 – 2,250**	500 – 1,500	0	**2,800 – 5,350**
Difference between FP and NP hours of professional training	1,100 – 1,900 more for FPs	750 – 1,500 more for FPs	4,500 – 5,500 more for FPs	9,000 – 10,000 more for FPs	**15,350 – 18,900 more for FPs**

* While a standard 4-year degree, preferably a BSN, is recommended, alternate pathways exist for an RN without a bachelor's degree to enter some master's programs.

** Estimate based on 750 hours of study dedicated by a student per year.

Sources: Vanderbilt University Family Nurse Practitioner Program information, http://www.nursing.vanderbilt.edu/msn/fnp_plan.html, and the Vanderbilt University School of Nursing Handbook 2009-2010, http://www.nursing.vanderbilt.edu/current/handbook.pdf.

American Academy of Family Physicians, Primary Health Care Professionals: A Comparison, http://www.aafp.org/online/en/home/media/kits/fp-np.html.

Contrast that with the total hours required for a doctorate of nursing practice, keeping in mind that the NPMA granted NPs, with only 3,600 hours of experience, the ability to practice without a formal relationship with a physician. Their formal education is 4 years of nursing school and 2 years of NP school. Once they pass their NP certification exam, the recertification process is to meet the necessary continuing education requirements or retake their exam.[2] In contrast, the American Board of Family Medicine requires 50 continuing medical education credits annually and board recertification every 5 years.[3]

A NP simply is not qualified to replace a licensed physician for independent and unsupervised patient care and treatment, especially in complex cases.[4]

I do not disagree with my colleague that nurse practitioners are valued members of the medical team. The key word here is team. Supervised NPs play a vital role as part of the care management of the patient. They are front and center during emergent situations and are very resourceful and meaningfully contributing to patient care as team members. However, permitting them to function as solo-practitioners, is not the answer to address the shortage of primary care providers in the US.[4]

I train and have trained nurse practitioners for over a decade. As part of the getting to know process for my students, I often inquire what drew them to this particular career path. Many times, they come to us with no clear direction. They are often unaware of the demands of meeting the metrics as stipulated by the Centers for Medicare & Medicaid Services (CMS), and have limited knowledge of the demands of the patient centered medical home or accounts receivable versus payable, billing, and coding. Not all NPs are receptive to constructive critical evaluations, yet others are and make positive changes. Unfortunately, for some, the potential financial benefits of this career path appear to be their primary focus.

I have also heard other distressing responses. How they "always wanted to go to medical school" and for whatever reason they could not. Instead, they went into nursing and now the NP route is their "easier way to practice medicine." When probing why they do not apply to medical school now, the most common responses are "it's too long" and "I don't want to spend that kind of time or money."

I have had the opportunity to work with a nurse practitioner in my office. No sooner did she pass her exam that the following day she came to work, and stated "we are equals now." The reality is she had no understanding just how far from the truth that was or the potential harm that could result from holding this belief.

Patient care is a responsibility and a privilege. While nursing training and NP education are valuable, the two-year NP program in no shape or form can prepare you to become a diagnostician. Again, I am not blind to the shortage of primary care physicians now and in the future. However, unsupervised NPs are not the answer.

Endnotes

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clinical experience required by her degree-granting program. We focused on assessment skills she'd need as a practitioner seeing patients, either alone or in collaborative practice, with an expectation of formulating a *medical* diagnosis, different from the *nursing* diagnosis process with which she was likely familiar. By the end of several months, she had grasped the significant differentiation between the two, reflective of the distinct roles nurses and physicians played within the healthcare system as traditionally constituted.

What do these personal anecdotes which I have recounted say to the questions raised in this exchange of opinion? For one, none of these NPs with whom I interacted had a desire to become a physician "on the cheap." To a person, they all recognized the significant training needed to become the sole and unique contact person tasked to evaluate, assess, and treat untriaged and first-contact patients in a variety of settings. Rather, all of them wished to expand on their accumulated and verifiable clinical experience as registered nurses, which for all of them was considerable, and move onto the next level of recognizing familiar patterns of illness in select type of patients, which would then allow them to follow validated practice protocols and initiate treatment regimens. To me, this seems the logical next step for an experienced nurse to take in their professional development.

While I do appreciate the objections raised as to the number of training hours currently listed as sufficient to fulfill graduation requirements from a nurse practitioner program, my response would be that an experienced nurse brings an impressive number of clinical hours to the equation from their work in various hospital, ambulatory office, SNF, and other healthcare locations; there needs to be recognition that such practical work must be able to count towards the expanded clinical role envisioned by an RN moving into an NP position. And while nursing has become a field with increasingly open opportunities for more than the traditional pool of women applicants, it would certainly be collegial of medicine to be supportive of those nurses who both care for their patients on 12-hour shifts and also manage their own families on a 24/7 basis, often while continuing the coursework needed to obtain not just a BSN, but those advanced practice credentials to which they aspire. I will speak only for myself when I tell you that when I first entered the hospital space, the person who was the kindest in helping me learn my craft was a nurse.

It is time to repay the favor.

Louis Verardo, MD, FAAFP *is a 1978 graduate of the University of Bologna, Italy, and a 1981 graduate of the Family Practice Residency Program at Glen Cove Hospital. He has worked for many years, primarily on Long Island, in numerous facets of family medicine including clinical practice, research and teaching students and residents. Dr. Verardo has held numerous leadership roles throughout his career and since his retirement from clinical practice in 2019 has maintained professional involvement with Stony Brook's Office of Continuing Medical Education. He is an active member of the NYSAFP, serving in numerous capacities over the years.*

2025 Coding Updates and Billing Tips Relevant to the Family Physician

By Cean Mahmud, MD, MBA, CPC, FAAFP

As the clock struck midnight on January 1st, many family physicians may still have been enjoying the revelry that comes with traditional New Years celebrations. What may not have been realized were the coding changes brought into effect by the 2025 Medicare Physician Fee Schedule (PFS). One dark cloud that continues to adversely impact physicians is the yearly reimbursement cut to the CMS conversion factor. For 2025, the conversion factor of $32.35 represents a decrease of $0.94 from 2024, a roughly 3% cut.[1] While this does represent a negative financial impact on private practices and those employed physicians compensated on net collections payment models, there have been no changes made to the wRVU valuations of CPT/HCPCS codes in 2025 for those dependent on wRVU based productivity. A silver lining does exist when it comes to the services that family physicians provide in primary care. Many of the key changes made to the PFS in 2025 favor family physicians being able to capture services already being performed and to bill for the work that better reflects the complex and comprehensive care provided.

New 2025 Coding Changes Pertinent to Family Physicians

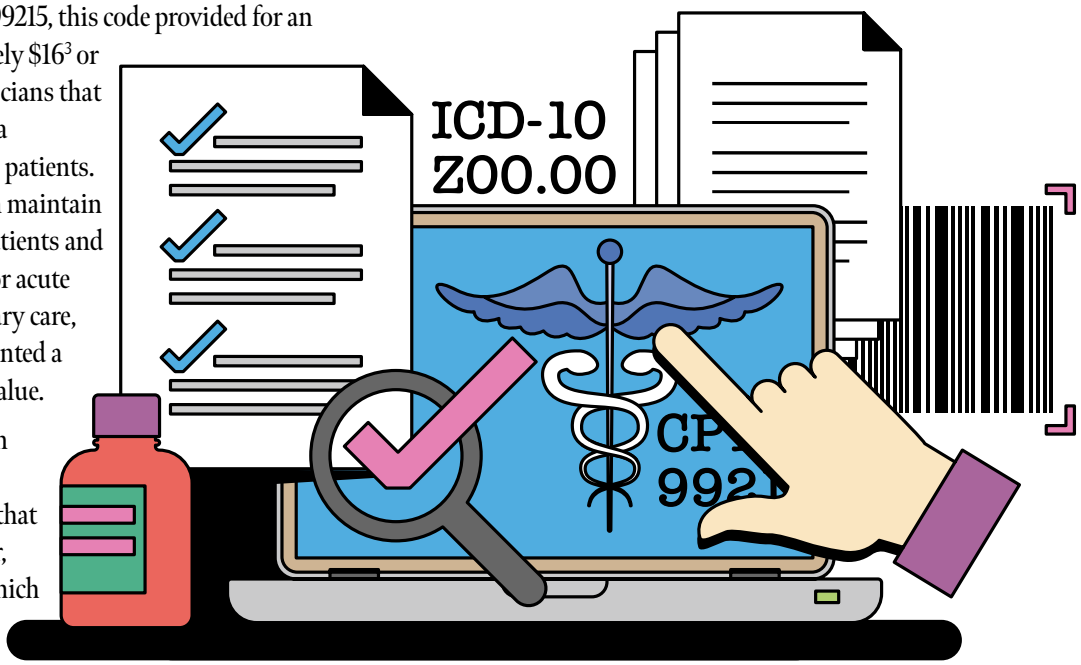
Expansion of G2211 Utilization

2024 represented a landmark shift in billing and coding opportunities for family physicians with the implementation of the long-awaited office and outpatient (O/O) evaluation and management visit complexity add-on code G2211.[2] In addition to the payment provided for office and outpatient (O/O) evaluation and management (E/M) codes 99202-99215, this code provided for an additional payment of approximately $16[3] or an additional 0.33 wRVU[4] for clinicians that served as a focal point of care with a longitudinal care relationship with patients. As family physicians by profession maintain a longitudinal relationship with patients and often serve as focal points of care for acute and/or chronic conditions in primary care, the ability to utilize this code presented a potential 15-20% uplift in billing value.

The 2025 PFS pushed ahead with expansion of G2211 utilization by removing many of the restrictions that limited full use of the code last year, including the use of modifier 25, which is when a significant, separately identifiable evaluation and management (E/M) service above and beyond that associated with another procedure or service is reported by the same physician or other qualified health care professional (QHP) on the same date, prevented the billing of G2211.[5] One major instance requiring the use of modifier 25 included billing the E/M codes 99202-99215 along with vaccine administration (90471/90472). This often forced PCPs to forgo the additional revenue of G2211 when providing the benefits of vaccines during office visits.

With the removal of the modifier 25 restriction, family physicians should be able to code for the appropriate level E/M services, along with G2211, vaccine administration as well as any of the other listed Medicare Part B preventative services performed on the same date of service. Some commonly billed preventative services include but are not limited to:

- G0296 - counseling visit to discuss need for lung cancer screening using LDCT
- G0444 - annual depression screening, 5 to 15 minutes
- G0442 - annual alcohol misuse screening, 5 to 15 minutes
- 99406-99407 - time-based smoking and tobacco cessation counseling



Sample List of Additional Medicare Part B Preventive Services Commonly Used by Family Physicians	
Part B Preventative Service Codes	Description
90471-90474	Immunization administration
99406	Smoking/tobacco cessation counsel 3-10 min
99407	Smoking/tobacco cessation counsel >10 min
G0101	Pelvic/breast exam cancer screen
G0102	Digital rectal exam prostate cancer screen
G0296	Visit to determine low dose CT lung cancer screen eligibility
G0442	Annual alcohol misuse screening 5-15 min
G0444	Annual depression screening 5-15 min
G0136	Administration of SDOH risk assessment tool 5-15 min

New Cardiovascular Risk Assessment and Management Codes

Two new codes introduced in the 2025 Physician Fee Schedule coincide with CMS's increased focus on the primary prevention of atherosclerotic cardiovascular disease (ASCVD) and the integral role primary care plays in this endeavor. These new codes reflect the work undertaken with CMS Innovation Center's Million Hearts model test. Under this model, payments were coupled with the risk assessment and management of a patient's cardiovascular risk which subsequently reduced strokes and heart attacks.[6]

With the introduction of HCPCS codes G0537 and G0538, Medicare is now paying for the work that many family physicians are already undertaking as part of their existing workflow. The two codes and their definitions are listed below.

G0537: Administration of a standardized, evidence-based atherosclerotic cardiovascular disease risk (ASCVD) assessment for patients with ASCVD risk factors, 5-15 minutes, not more often than every 12 months per practitioner

G0538: Atherosclerotic cardiovascular disease risk management services with the following required elements: patient is without a current diagnosis of ASCVD, but is determined to be at intermediate, medium or high-risk for cardiovascular disease as previously determined by the ASCVD risk assessment; ASCVD-specific care plan established, implemented, revised or monitored that addresses risk factors and risk enhancers and must incorporate shared decision-making between practitioner and patient; clinical staff time directed by physician or other qualified health care professional; per calendar month.

To bill G0537, physicians must utilize a validated ASCVD risk assessment tool such as but not limited to the AHA's Predicting Risk of Cardiovascular Disease EVENTs (PREVENT) or the ACC ASCVD Risk Estimator Plus. This service is only intended for those patients without a history of stroke or heart disease but do have risk factors to the development of these conditions including but not limited to obesity, diabetes, hypertension or a family history of heart disease. Due to the time requirements of the code, a minimum of 5 minutes must be spent on the administration and discussion of the tool and its results during a preventative or problem oriented E/M visit. The wRVU valuation for this service is 0.18, or approximately $18.44.[7] No modifier 25 is required to the E/M service to utilize this code.

To bill G0538, a plan of care must be established, implemented and be monitored to address the elements of risk that contribute to the patient's ASCVD determined intermediate, medium or high risk. This service represents the shared decision making between patient and the physician, along with the clinical staff time overseen by the physician or other QHP.[8] The management of these risk elements can include but is not limited to promotion of preventive services, tobacco cessation counseling and diabetes self-management training, medication management such as the use of aspirin or statin therapy to decrease cardiovascular risk, ongoing communication and care coordination via electronic health record technology along with the ability to offer synchronous non face to face communication.[8] This code can be billed monthly with wRVU valuation for this service is 0.18, or approximately $18.44. No modifier 25 is required to an E/M service when used with this code. This code may be subject to cost sharing and as such, patients should consent to this monthly service being performed.

Dual Coding and Billing of Preventive with Problem Oriented Visits

Although not new to 2025, it is important to recognize the challenges that family physicians encounter in the exam room in capturing the work of a preventative service such as Medicare's annual wellness visit along with E/M services provided on the same date. Oftentimes, patients may view the annual preventative visit as an opportunity to present a long list of complaints or concerns requiring additional evaluation and medical decision making above and beyond the scope of the preventative service. Alternatively, if during a preventative examination, a new undiagnosed problem is uncovered such as a breast lump that requires additional diagnostic work up and medical decision making, it would be appropriate to code for both the preventive service along with the appropriate level E/M. Failing to code for such scenarios represents a lost revenue opportunity to obtain credit for the work being performed.

The important element to differentiate the appropriateness of dual billing a preventative and problem oriented E/M service on the same date will be the medical necessity of the new problem being significant enough to address at the time of the preventative visit. If a patient known to have hypertension or diabetes presents for their annual physical or Medicare wellness visit and mentions no complaints about their chronic conditions and similarly no

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separately identifiable problem warrants additional medical decision making, it would only be appropriate to bill for the preventive service. However, should that same patient present for a preventive service and have an uncontrolled blood pressure of 160/100 and the family physician was to perform the entire preventative service along with appropriate medical decision making regarding the hypertension such as modification of prescription medication therapy to control the condition, it would be appropriate to dual bill the E/M service with the use of modifier 25.

Modifier 25, when appended to an E/M service, indicates a significant separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.[9] In the scenario listed above with an established patient presenting for an annual physical but noted to have uncontrolled hypertension requiring additional moderate level decision making to be performed on the same date of service as the physical, it would be appropriate to bill 99214-25 (representing modifier 25 appended) being linked to ICD10: I10 for hypertension. The remaining bill for the established patient preventative code would be in the range of 99391-99397 based on age of the patient and linked to ICD10: Z00.00 for annual physical exam. If this patient was a Medicare patient presenting for their annual wellness visit, billing codes such as G0402, G0438 or G0439 should be billed when that specific service is performed. If this patient had a longitudinal continuity relationship with the family physician, it would also be appropriate to bill G2211 also linked to the ICD10: I10 for hypertension.

It is important to note that CMS acknowledges and deems it appropriate to dual bill preventative and problem-oriented encounters when medically necessary with the utilization of modifier 25.[10] However, it is imperative that each payor's unique policies be consulted to ensure payment for both preventative and E/M codes are allowable and avoid performing unpaid non reimbursable services. In such scenarios where payors are known to not pay for dual visits, it may be beneficial to discuss with the patient which type of service should be performed based on the situation, either preventative or problem oriented.

Take Aways

Despite the many complexities that exist in the world of coding of office visits, having a baseline knowledge will only help family physicians get compensated for the excellent care provided to their patients, and achieve greater financial success for work performed in 2025 and beyond.

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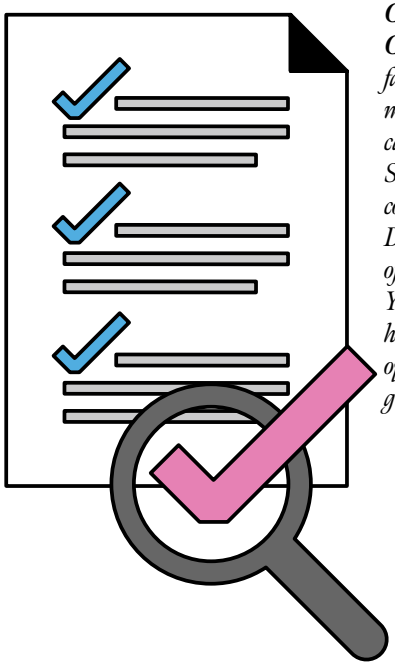

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Lung Cancer Screening:
Making it the New Norm for Early Detection and Improved Survival

By Susan P. Opar MD, FAAFP; Heather Dacus, DO, MPH; Mary Reid BSN, MSPH, PhD and Whitney Mendel, MSW, PhD

A 62-year-old white female with a 40-year history of smoking an average of one pack per day, comes in for a routine primary care visit. Lung cancer screening has been offered over the past several years and she continues to decline stating, "if it's going to happen, it's going to happen." She declines again during today's visit. She has no current signs or symptoms of lung cancer. She currently takes a medication for cholesterol and is otherwise healthy.

As family medicine providers, you may experience similar encounters in your clinic. Why is counseling for lung cancer screening important? What are the guidelines? What are the risks and how well are we doing across New York State (NYS) to screen those at high risk for lung cancer? This article provides insights for us to consider as family medicine providers.

Lung Cancer Burden in the United States and New York State

Lung cancer is the leading cause of cancer death and causes more deaths than colon, breast, and prostate cancers combined (refer to Figure 1).[1] In 2024, an estimated 125,070 people in the United States (US) and approximately 6,100 people in NYS died of lung cancer.[2]

Lung cancer incidence rates are lower in New York City (NYC) and surrounding areas compared to Upstate NY and mortality from lung cancer follows a similar pattern.[3] In 2021, the incidence of lung cancer in NYC was 40.4/100,000 compared to 57.6/100,000 in NYS excluding NYC and the mortality from lung cancer was 18.1/100,000 in NYC and 29.4/100,000 in NYS excluding NYC.[4] Refer to Figure 2 for county-specific incidence and mortality rates.

Lung Cancer Causes

Approximately 1.6 million New Yorkers smoke. This represents approximately 11.3% of the NYS population.[5] From 1997 to 2022, smoking rates in the US decreased by 53%.[5] However, cigarette smoking remains the leading cause of preventable death and disease in the US and is the cause of 80% to 90% of lung cancer deaths.[6,7] People who smoke are 15 to 30 times more likely to be diagnosed with lung cancer and die from lung cancer compared to those without a smoking history.[7] People without a smoking history have a 20 to 30% higher chance of developing lung cancer if they are exposed to secondhand smoke.[8] Radon is responsible for approximately 3-14% of lung cancer cases and is the second leading cause of lung cancer among individuals with a smoking history and the leading cause of lung cancer in people who do not smoke.[9] Occupational exposures (asbestos, arsenic, diesel exhaust, chromium), outdoor air pollution, a personal or family history of lung cancer, a history of radiation to the chest, and non-cancer lung disease such as chronic obstructive pulmonary disease and pulmonary fibrosis also increase the risk of lung cancer.[7]

Screening for Lung Cancer and the Supporting Research

Several randomized trials have demonstrated the benefit of lung cancer screening. The **National Lung Cancer Screening Trial (NLST)**, sponsored by the National Cancer Institute and the American College of Radiology, enrolled 53,454 participants, and found a **20% reduction** in lung cancer-specific mortality in the lung cancer screening cohort using low-dose computed tomography (LDCT).[10] Lung cancer screening was associated with a 6.7% reduction in all-cause mortality due to the detection of other health conditions found on screening. In the trial, 70% of cases of lung cancers were diagnosed at an early stage among those screened compared to 34% of cases in the unscreened population.

The **Multicentric Italian Lung Detection (MILD)** study included 4,099 high risk participants randomized to either annual

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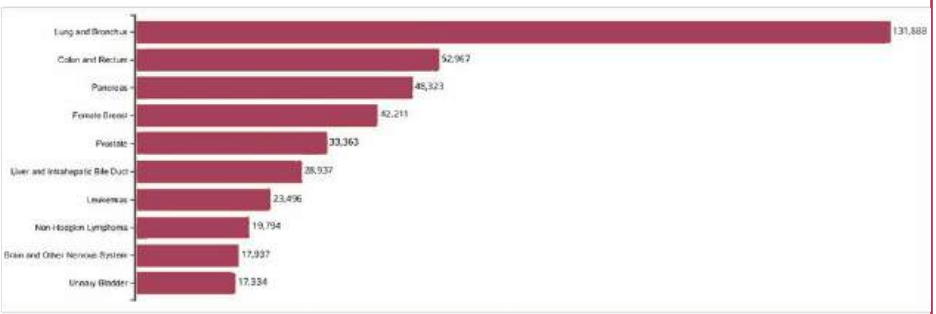
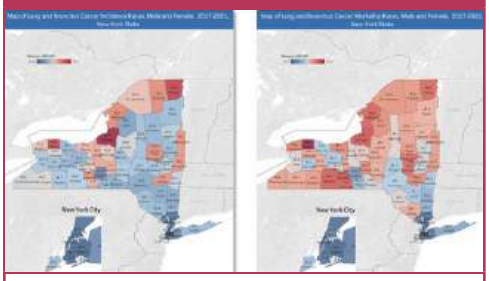
Figure 1. Top 10 cancers by number of cancer deaths United States, 2022



Source https://www.cdc.gov/cancer/dataviz, released in June 2024.

Figure 2. Incidence and mortality of lung cancer in New York State by county



Source: https://www.health.ny.gov/statistics/cancer/registry/ratebyCounty.htm

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lung cancer screening with LDCT, biennial LDCT, or no screening. An **overall 39% reduction** in lung cancer-specific mortality was found for patients who received lung cancer screening.[11] When annual screening continued past five years, lung cancer-specific mortality reduced by **58%**.[11]

In the **NELSON Trial**, LDCT was compared to unscreened, high-risk patients in 15,789 participants. A **25% reduction** in lung cancer-specific mortality occurred in the screened population.[12]

Studies have shown the number of people who need to be screened to save one life with lung cancer screening is 208 compared to mammography screening for breast cancer which ranges from 377 to 1,904 based on age, and for colorectal cancer screening, flexible sigmoidoscopy is noted to be 850, and fecal occult blood testing at 1,000.[13,14,15]

Lung Cancer Screening Recommendations

The United States Preventive Services Task Force (USPSTF) recommends with a "B" rating (i.e., with moderate certainty) annual lung cancer screening with LDCT in persons at high risk of lung cancer. High-risk eligibility for screening includes persons ages 50 to 80 years with at least a 20 pack-year smoking history who currently smoke or have quit smoking within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.[16] A pack-year calculator can be found at https://www.lungcheck.org/providers#calculator.

Figure 3. USPSTF lung cancer screening qualifications

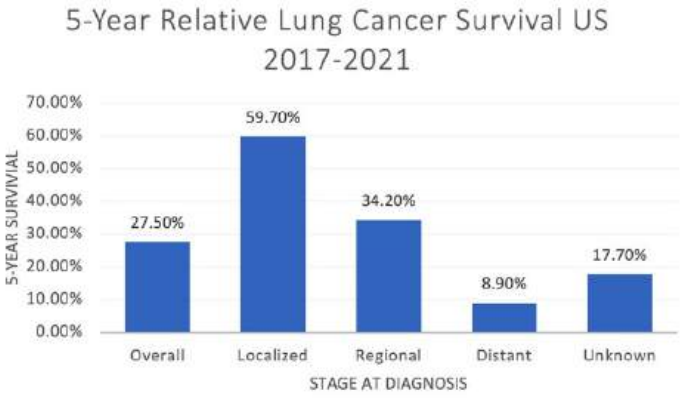
Age 50-80	≥20 pack years	Smoked within past 15 years/Currently smoking

In March 2021, the American Academy of Family Physicians updated their recommendations in support of the USPSTF recommendation for lung cancer screening.[17] Many professional organizations recommend annual LDCT screening for individuals at high risk for lung cancer based on their age and smoking history. These include the National Comprehensive Cancer Network (NCCN), the American College of Radiology, the American Cancer Society, and the American Lung Association. Some organizations' recommendations differ from the USPSTF recommendation. For example, the National Comprehensive Cancer Network guideline for lung cancer screening does not place a cut off above 15 years since quitting smoking and includes individuals who have smoked for 20+ years, not just a 20 pack-year history.[18]

Screening Benefits/Survival

Early detection and diagnosis through lung cancer screening is an important tool that can allow treatment to begin when lung cancer is most curable. The current survival rate for all stages of lung cancer in the US is poor at 27.5%.[19] The 5-year survival rate is 33.9% in NYS, higher than the national rate.[20] From 2017 to 2021, early-stage diagnosis accounted for only 28.1% of cases in the US.[19] Unfortunately, almost 45% of patients continue to be diagnosed at a late stage, when, as shown in Figure 4, only 8.9% of these patients will be alive at 5 years.[19] When patients present with lung cancer symptoms such as digital clubbing, weight loss, hemoptysis, persistent cough, chest pain, a hoarse voice, worsening shortness of breath, and recurrent pneumonia or bronchitis, lung cancer treatment success is greatly reduced.[21] The goal of screening is to find lung cancer before it can become difficult to treat and when it is associated with higher survival rates. One study showed a five-year survival rate of 92% for patients who were diagnosed with stage 1 lung cancer and underwent surgical resection within one month.[22] In NYS, over the past five years, the early diagnosis rate has improved by 10% and the survival rate has improved by 32%.[20] Increasing screening awareness and education and supporting patient access and follow up to quality lung cancer screening is needed to continue to improve these rates.

Figure 4. Lung cancer survival at 5 years based on cancer location



Source: www.cdc.gov/united-states-cancer-statistics/publications/lung-cancer-stat-bite.html

Lung Cancer Screening Shared Decision-Making

A shared decision process for lung cancer screening is recommended prior to patients pursuing LDCT.[23] Shared decision-making should include:

- Determining a patient's eligibility.
- Using one or more decision aids to explain lung cancer screening, for example: https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/lung-cancer-screening-patient-decision-aid.pdf.
- Discussing with the patient the importance of annual screening, reviewing the impact of comorbidities, and discussing the patient's ability and willingness to pursue diagnosis and treatment if a screening test identifies anything abnormal.
- Understanding a patient may not be appropriate for screening if they have multiple and serious comorbid conditions, especially if they are close to the upper limit for screening age.
- Emphasizing the importance of remaining nonsmoking if the patient formerly used tobacco products and offering smoking cessation for individuals living with tobacco use disorder.

Other examples of shared decision-making tools are available including this one recommended by the National Comprehensive Cancer Network: https://shouldiscreen.com/English/home.

Patients may feel shame and guilt when discussing lung cancer screening. Primary care providers should use appropriate language to reduce stigma and allow patients to feel comfortable pursuing screening. One way to actively prevent stigmatizing individuals is in the words we use when discussing tobacco use and lung cancer screening. Language guides are available to assist and can be found at https://www.iaslc.org/IASLCLanguageGuide. For example, using "a person with active tobacco use" instead of "a smoker" identifies the patient as a person and not as a disorder. More information on reducing stigma can be found at https://cancercontroltap.org/news/lung-cancer-awareness-month-campaign/#best-practices-for-communicating-about-lung-cancer.

Potential Risks of Lung Cancer Screening

In high-risk patients, the potential benefit of screening outweighs the potential risks.[24] When providers accurately identify appropriate candidates for screening and when radiologists use lung nodule reporting systems such as the American College of Radiology's Lung-RADS (https://www.acr.org/Clinical-Resources/Clinical-Tools-and-Reference/Reporting-and-Data-Systems/Lung-RADS) to categorize and communicate findings, these risks can be reduced.[25] Proper education and risk assessment are essential to reduce the risks associated with lung cancer screening. Potential risks of lung cancer screening include:[18,26]

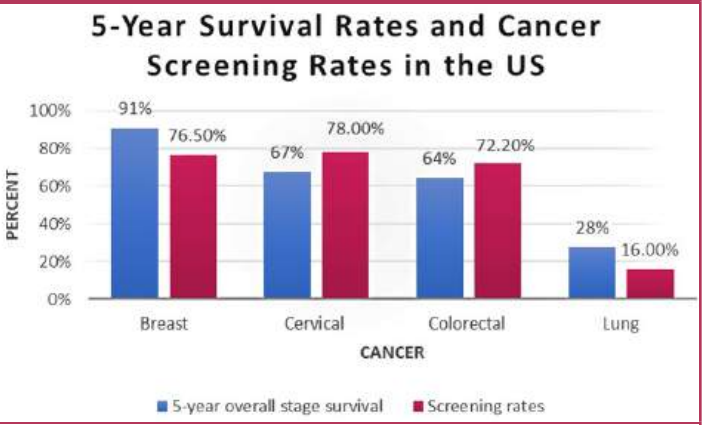
- False positives, approximately 12-14% of LDCTs, and reduces with subsequent screening
- Following slow-growing, indolent disease that may never cause symptoms or death
- Incidental findings which may need further evaluation, estimated at 6% of LDCTs
- Diagnostic procedure complications
- Radiation exposure, although one LDCT scan is equal to approximately six months of natural background radiation by living on Earth, and slightly higher than a mammogram
- Increased anxiety while awaiting testing and results
- Financial costs

Screening Uptake

National survey data from the Behavioral Risk Factor Surveillance System (BRFSS) 2022 estimates 13.6 million people in the US are eligible for lung cancer screening per USPSTF criteria.[27] New York State has the sixth largest population of eligible lung cancer screening candidates in the nation, estimated to be nearly 700,000 adults.[27] Even though lung cancer screening is a USPSTF recommendation, there has been very low uptake. Across the US, 8 out of 10 eligible people are not screened.[27] New York State ranks 11th in lung cancer screening rates among all states.[20] In NYS, it is estimated only **19.3%** of high-risk persons have been screened, demonstrating the need for more family medicine providers to identify patients who are eligible to be screened, engage them in a shared-decision making conversation, and recommend annual lung cancer screening.[20] There is also a need for improving lung cancer screening public education and access to screening.

Figure 5 shows how lung cancer five-year survival rates and lung cancer screening prevalence compare to other cancers in the US.[20, 28,29] Lung cancer screening rates are lagging far behind those of breast, cervical, and colorectal cancer screening. If we are not screening for lung cancer, we will not see a decrease in mortality and we will continue to see advanced-stage lung cancers where cure can be limited. With an increase in screening, the expectation is to see a shift to lower stage cancers and an improvement in mortality rates.

Figure 5. Survival rate and screening rate comparison



Source: https://gis.cdc.gov/Cancer/USCS/#/Survival/ and https://progressreport.cancer.gov/detection

Disparities in Lung Cancer Screening Outcomes

Unfortunately, in NYS, as in many locations across the country, compared to White New Yorkers, Black New Yorkers have a lower 5-year lung cancer survival rate, a lower rate of diagnosis at an early stage, a lower rate of pursuing surgery, and a higher rate of not receiving treatment.[20] The Latino community also suffers from disparities regarding lower rates of surgery and diagnosis at an early stage.[20] To avoid widening health disparities, tailored and responsive counseling strategies should be implemented. Some examples to improve access to and acceptance of lung cancer screening include deploying mobile radiology units to ease transportation burdens; finding low-cost, efficient transportation for patients; setting up screening sites in community clinics with high rates of lung cancer and smoking; using motivational interviewing strategies to make the screening discussion patient-focused; learning about cultural values of minority groups in your community; utilizing community leaders and events to increase education about screening; providing educational materials in the languages of your patient population; and utilizing translation services.[25,30]

Coverage and Quality Measurement

The USPSTF 'B' recommendation for lung cancer screening requires coverage under the Affordable Care Act for individuals determined to be at high risk.[31] The Centers for Medicare and Medicaid Services reimburses for annual LDCT for high-risk individuals up through age 77 years if providers engage these individuals in a shared decision-making process.[23] New York State Medicaid fee-for-service programs also cover annual lung cancer screening. Some cost sharing for procedures and follow up care may exist. Legislation is in the NYS Legislature to remove cost-sharing

continued on page 20

continued from page 19

and require mandatory health insurance coverage for follow up diagnostic services after an abnormal LDCT screening exam.[32]

According to the National Committee for Quality Assurance, quality measure development for lung cancer screening is underway and expected to be released sometime in 2026.[27,33] The Healthcare Effectiveness Data and Information Set, or HEDIS, is a tool utilized by more than 90% of US health plans to measure quality and performance aspects of health care and services focusing on prevention, screening, and chronic disease management.[34] Measurement data is used to identify how often insurers are providing evidence-based care, monitor quality improvement, and allow comparison with other plans.[35] More than 235 million people in the US are enrolled in health plans reporting quality results using HEDIS.[34] **With lung cancer screening anticipated to become a HEDIS measure in 2026**, primary care will need to be comfortable adding lung cancer screening to their care plans and into clinical workflows for appropriate patients. Primary care practices that want to build screening into patient care can find screening clinical workflow models at https://hcp.go2.org/workflow-models/. Lung cancer screening billing assistance can be found at https://www.lung.org/getmedia/bd0af1bf-1cd8-4fd0-9f8f-47e55c783448/ala-lung-cancer-screening-billing-guide-final and includes CPT, ICD 10, and procedure codes to use for shared decision making, documenting smoking history and smoking cessation interventions.

The New York State Lung Cancer Screening Action Team

To combat the devastating effects of lung cancer in NYS, the NYS Cancer Consortium formed the Lung Cancer Screening Action Team (LCSAT). The LCSAT is taking the lead on mobilizing multi-level resources and statewide partnerships aimed at increasing lung cancer screening using guideline-driven, evidence-based strategies. The LCSAT has already worked to establish a NY Lung Cancer Screening locator (https://www.nylungcancerscreening.com/) and is currently partnering with the NYS Quitline to counsel high-risk individuals about the importance of lung cancer screening. Family medicine providers can be a voice on this Action Team and are encouraged to become a part of it by visiting: https://sites.google.com/view/nys-lcsat-public/home.

Lung cancer screening resources jointly developed by the NYS Quitline and LCSAT can be found at https://www.nysmokefree.com/print-materials/.

Conclusions

- Lung cancer is the leading cause of cancer mortality with a low 5-year survival rate. Family medicine physicians must generate an urgency for lung cancer screening. Alongside breast, colorectal, and cervical cancer screening, lung cancer screening must become a new norm.
- Lung cancer screening can find cancers early and increase survival. Current low screening rates highlight the need for improvement in lung cancer screening awareness and utilization.
- When family medicine physicians discuss yearly lung cancer screening with their patients, they can raise awareness, offer screening to appropriate patients, address tobacco cessation, and save lives.

Resources

Comprehensive Cancer Control resource listing: https://cccnationalpartners.org/wp-content/uploads/2024/10/CCCNP-LuCaS-Resource-List-10.01.2024.pdf

NYS Quitline: 1-866-NY-QUITS (1-866-697-8487), text QUITNOW to 333888, or visit nysmokefree.com

American Cancer Society: https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/lung-cancer-screening-patient-decision-aid.pdf

GO2 For Lung Cancer patient education video: English: https://youtu.be/i0tvWY22gGc Spanish: Spanish: https://vimeo.com/901685865

Blueprint for lung cancer screening programs: *elcn-lung-cancer-screening-taskforce-blueprint-march-2024.pdf

American Lung Association quiz and information for patients: www.lung.org/lung-health-diseases/lung-disease-lookup/lung-cancer/saved-by-the-scan

NY Lung Cancer Screening locator: https://www.nylungcancerscreening.com/

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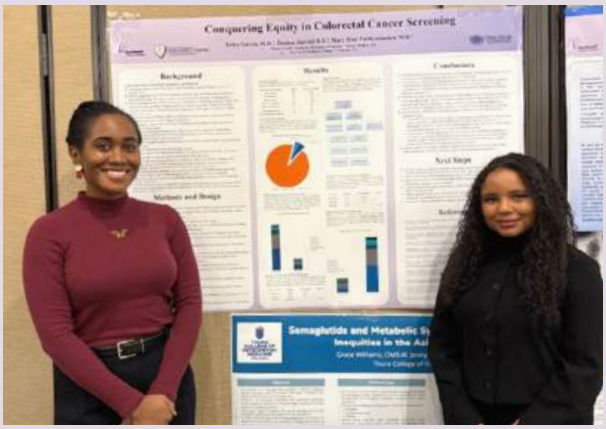
IN THE SPOTLIGHT

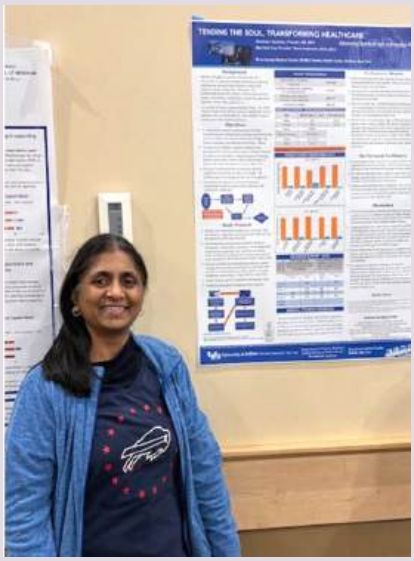
Congratulations to our Winter Weekend 2025 Poster Winners!



First Place: Conquering Equity in Colorectal Cancer Screening

By Erica Garcia, MD; Denisse Janvier, BS and Mary Rose Puthyamadan, MD

Barriers to colon cancer screening heavily impact minority populations leading to poor outcomes. Colorectal cancer is one of the major causes of cancer related mortality in the US. Currently African Americans and Hispanics have higher mortality rates due to colon cancer indicating that these communities are disproportionately impacted. Income, health insurance and access to healthcare affect one's ability to obtain colorectal cancer screening. This QI project aims to identify barriers to colon cancer screening at a FQHC in Sleepy Hollow, NY. Data was obtained from our FQHC to measure our rates of colon cancer screening. Our data demonstrated that 43% of patients due for CRC screening in the FQHC have completed screening. 7,662 patients have not completed colon cancer screening. Within this sample 70% of patients were Hispanic and 18% were African American. Patients were contacted to determine what barriers exist for CRC screening in African American and Hispanic patients. The responses were categorized as provider, education or navigation barrier. This research is imperative to identify the barriers that exist in underserved communities so that measures can be taken to close the gap in screening and improve outcomes.



Second Place: Tending the Soul, Transforming Healthcare

By Sushama Thandla, MD, MPH

Spiritual struggle is common for people who are chronically ill, interventions attending to spiritual suffering increases levels of peace, along with patient & family satisfaction. Spiritual care is interdisciplinary care-each member of the interdisciplinary team provides spiritual care, including a spiritual care expert. The ECMC Family Health Center (FHC) cares for a significant load of patients with complex medical needs, who are chronically ill, and at risk of spiritual distress.

Study Objectives

1. To implement a clinician – spiritual care provider interprofessional collaboration for creating a practice-based model to address the spiritual dimension of high-risk stratified patients with chronic illness.

2. To implement a billable outpatient advance care planning (ACP) protocol where spiritual care providers integrate issues of meaning, purpose, spirituality, and life values in advance directive, healthcare proxy, & MOLST planning.
3. To assess facilitating factors and barriers during integration of spiritual care into care of high risk stratified patients needing chronic care management.
4. To evaluate the impact of an Interprofessional collaborative model on clinical team wellness and compassion satisfaction.

Results:

46% of urban patients with complex chronic illness at risk of spiritual distress were positive when screened by the clinician using two questions.

59% of the cohort needed advance care planning and were referred to the team spiritual care professional.

62 % of the high risk- stratified patients received spiritual care intervention during a complex care management office visit.

Overall, there was extremely high (> 88%) attainment of greater peace, clarity, coping with illness, meaning and purpose among patients who were seen by spiritual care provider. Over 90% stated they found MD referral beneficial & would recommend it others. Over 80% high risk patients felt cared for, emotionally unburdened, felt renewed hope and deepened spirituality after spiritual care visits

Third Place: Using Artificial Intelligence to Improve Diabetes Education

By Dynell Pinder, MD; Christopher Anghel, MD; and Nichole Delgado-Salisbury, EdD

Diabetes management in family medicine often requires thorough and culturally sensitive patient education. This study explores the use of ChatGPT, an AI language model, to enhance diabetes education and improve resident communication confidence at Saint Joseph's Medical Center in Yonkers, NY. A pre-and post-survey design was implemented, measuring resident comfort and confidence in using ChatGPT as an educational tool for diabetes management. Post-intervention surveys revealed residents' increased comfort in explaining complex medical concepts, rising from 66.7% pre-intervention to 84.62% post-intervention.

While comfort levels improved, no ChatGPT use was documented in patient charts, indicating a gap in practical application. ChatGPT was shown to ease physician workload by supporting pre-visit planning, real-time education, and follow-up instructions, yet challenges in integration remain. ChatGPT demonstrates significant potential to enhance patient understanding and adherence, supporting family doctors in providing clear and patient-centered diabetes education. Future research will explore long-term patient retention, privacy considerations, and the tool's specific benefits in diabetes management. This study highlights AI's role in complementing human interaction and enriching the healthcare experience for both providers and patients.

Equity Focused QI Transformation

By Mary Rose Puthiyamadam, MD; Samantha Williams, MD; Erica Garcia, MD and Denisse Janvier

Introduction

Quality improvement (QI) initiatives in healthcare generally focus on the standardization of processes across patients, clinicians, and systems.[1] The tools used to ensure these improvements, such as order sets, templates, and checklists, have been successful in addressing gaps in care, particularly for preventive services like mammograms and colorectal cancer screenings.[2] While these improvements have benefited many patients, they have also inadvertently exacerbated disparities.[3] More resource-rich patients have been able to complete these services, while those with fewer resources have faced significant barriers.

In response to this issue, healthcare systems have increasingly turned to interventions like patient navigation and self-management support, which have proven to be beneficial in improving access to care for underserved populations. This targeted approach has underscored the importance of providing individualized care, addressing the specific needs of diverse patient groups, and considering the complex factors that contribute to health disparities.

However, achieving equity requires a multifaceted approach that addresses barriers at both the patient and physician levels. Patient-centered interventions – such as reducing structural barriers which limit access to healthcare – can mitigate patient-level challenges. Physician- centered strategies, which include team-based care, are equally critical to addressing disparities in care delivery. In addition, recognizing the role of implicit bias in clinical decision-making is essential. Implicit bias refers to unconscious attitudes and stereotypes that can shape physician interactions with patients, often in ways that perpetuate health disparities. Integrating implicit bias training and standardized screening protocols into broader QI efforts can help mitigate these biases and ensure equitable access to care. As we examine strategies to overcome barriers to cancer screening, these dual approaches – patient-centered and physician-centered – emerge as vital components of equity-focused QI transformation.

Equity Support in Breast Cancer Screening

Disparities in breast cancer screening have been extensively researched, showing that Black and Latina women are disproportionately impacted by barriers to screening and often experience poorer outcomes.[4] Previous QI efforts have shown that interventions targeting physicians have led to significant increases in screening rates, but targeted approaches are still underutilized.[5] These targeted approaches are crucial to addressing the nuanced vulnerabilities within populations and ensuring more specific interventions that improve care and outcomes.

Recent studies have highlighted the importance of patient-centered approaches in understanding barriers to screening adherence. These barriers can be categorized as physician-driven, system-driven, or patient-driven. Addressing these barriers requires targeted interventions acknowledging unique barriers to care and improving screening adherence. It has been demonstrated that inadequate medical system navigation was a significant barrier for federally qualified health center (FQHC) patients who experienced delays in mammography screening.[6] A targeted intervention that included personalized follow-up and navigation support resulted in a significant increase in screening completion rates.[7] This shows that providing individualized support tailored to specific patient needs, such as navigation assistance, is more effective than standardized reminders alone.

Along with addressing logistical barriers, equity-focused research emphasizes the importance of patient empowerment and physician partnership. These shifts encourage physicians to engage with patients in ways that are collaborative and empowering, making decisions with insight into cultural background or preference. Acknowledging and addressing factors like fear or distrust in the medical system, which are often rooted in historical and cultural contexts, can help build stronger patient-physician relationships and increase adherence to preventive services like breast cancer screening. The importance of addressing these cultural and psychological factors is vital, as they significantly impact health outcomes and are often overlooked in traditional models of care.[8]

Moreover, subgroups within broader racial/ethnic categories, such as Black and Hispanic women, encounter additional challenges accessing healthcare,

highlighting the importance of including subgroups within broader racial/ethnic categories when designing interventions. Notably, Black Hispanic women were less likely to complete mammogram screenings–an alarming finding given their higher genetic predisposition for poorer breast cancer outcomes based on African ancestry.[9] This underscores the importance of developing a deeper understanding of the cultural and historical factors that influence healthcare decisions in these populations.

Physician Barriers in Colorectal Cancer Screening

Colorectal cancer is one of the leading causes of cancer-related death in the US. Early screening is critical for detecting colorectal cancer at its earliest and most treatable stages. Similar to disparities found in breast cancer screening, colorectal cancer screening also faces challenges in terms of patient access and physician barriers, particularly in underserved communities. Socioeconomic status, lack of health insurance, and limited access to healthcare services contribute to these disparities.[10]

In our clinic, our study found that physicians did not routinely offer colorectal cancer screening to eligible patients. Physician bias, language barriers, and systemic issues within the healthcare delivery system may contribute to this disparity. When screening was ordered, many patients were unaware of how to complete the screening process or where to return the required tests, highlighting a significant gap in both patient education and healthcare system coordination.[11,12]

Although standardized order sets can facilitate screening orders, it is equally important that care is individualized to meet the unique needs of each patient. Individualizing care in this manner is a growth and development opportunity for physicians. Physicians have an influential role in leading the team and advocating for their patients and eliminating barriers.[13] Urgent health concerns have been shown to reduce the likelihood of discussing CRC screening.[14] Since health inequities exist across all types of cancer, implementing evidence-based strategies along with physician-centered and patient-centered approaches can help reduce health disparities.[15] These approaches can also improve screening uptake, particularly among historically excluded populations.

Physician-Centered Approaches

1. **Clinician Reminders and EHR Tools**
   At the physician level, integrating reminders into electronic health records (EHR) is an effective strategy to ensure timely screening. Tools such as patient chart flags, automated alerts, and physician-specific screening lists have been shown to improve screening rates. For instance, a cluster randomized controlled trial (RCT) in FQHCs found that clinics using EHR-embedded reminders achieved higher screening participation compared to usual care.[16]
2. **Physician Education and Training**
   Educating physicians on CRC screening guidelines and communication strategies is an additional tool in mitigating inequities in CRC screening. Training in motivational interviewing (MI) can help clinicians engage in patient-centered discussions, address patient concerns, and support personal and professional behavior change. Health systems like the Veterans Affairs (VA) have successfully increased CRC screening through comprehensive physician training, audit feedback, and coordination between primary care physicians and specialists.[17]
3. **Addressing Implicit Bias**
   Implicit bias – unconscious attitudes and stereotypes – can influence clinical decision- making and contribute to health disparities. Research shows that physicians may be less likely to offer preventive care, including CRC screening, to patients from racially and ethnically minoritized backgrounds.[18] Intentional efforts to address implicit bias includes:
   - **Implicit Bias Training:** Programs that raise awareness of unconscious biases and their impact on patient care can help physicians adopt more equitable practices.
   - **Standardized Screening Protocols:** Implementing uniform guidelines for offering recommended cancer screenings ensures that all eligible patients receive equitable care, reducing the influence of individual biases.[19]
   - **Data Monitoring and Feedback:** Regularly reviewing screening data disaggregated by race, ethnicity, and other demographic factors allows health systems to identify disparities and address gaps in care.[20]

By recognizing and mitigating implicit bias, physicians can foster more equitable screening practices and improve health outcomes for all patient populations.

Patient-Centered Approaches

1. **Patient Reminders and Outreach**
   Patient reminders – delivered via phone calls, text messages, secure emails, and mailed letters – are highly effective in increasing screening participation. RCTs show that patients receiving text reminders are more likely to complete screening than those receiving usual care.[21] Health systems like the VA have successfully increased screening rates by combining patient outreach with comprehensive follow-up processes.[22]
2. **Reducing Structural Barriers**
   Structural interventions help reduce logistical challenges that prevent patients from accessing screening. Strategies include:
   - **Extended Clinic Hours:** Offering non-standard clinic hours increases accessibility for patients who face scheduling conflicts during typical business hours.[23]
   - **Direct Mailing of Testing Kits:** Mailing FIT kits directly to patients reduces the need for in-person visits and improves screening completion. Healthcare systems like Kaiser Permanente have achieved screening rates exceeding 75% in their Medicare population by employing a combination of direct mail and systematic follow-up for abnormal results.[24]

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3. **Peer Coaching and Patient Navigation**
   Peer coaching – where patients who have previously undergone a colonoscopy provide guidance and encouragement – has been shown to improve colonoscopy completion. Peer coaches use motivational interviewing techniques to address practical concerns such as preparation, discomfort, and embarrassment. Compared to informational brochures, peer coaching is more effective at increasing screening uptake.[25]

   Patient navigation provides personalized support to help patients schedule, complete, and follow through with screening. Navigators also act as a safety net, helping to connect patients with appropriate care if screenings reveal acute concerns.[26]

4. **Community Engagement**
   Community-based interventions address sociocultural and systemic barriers to screening through tailored education and outreach. Programs like the Achieving Cancer Equity through Identification, Testing, and Screening (ACE-ITS) use a multilevel framework to engage communities through:
   - Mobile health education sessions
   - Genetic risk assessment and counseling
   - Automated text reminders and patient navigation[27]

By partnering with community organizations, these programs improve screening access and participation among underserved populations.

Future Directions

To further advance equity-focused quality improvement (QI), healthcare systems must prioritize culturally responsive strategies tailored to the unique needs of diverse patient populations. This includes:

1. **Developing Culturally Tailored Interventions:** Future QI efforts should prioritize interventions that address the cultural, linguistic, and social contexts of the populations they serve. This includes offering materials in multiple languages, employing community health workers from the target communities, and engaging patients in the design of care initiatives to ensure cultural relevance.
2. **Expanding Data Disaggregation and Equity Audits:** Regularly collecting and analyzing data by race, ethnicity, language, and other social determinants of health will enable healthcare systems to identify disparities, track progress, and refine interventions to close equity gaps.
3. **Sustained Implicit Bias Education:** Incorporating ongoing, evidence-based implicit bias training into the professional development of clinicians and staff can foster continuous self-reflection and mitigate the impact of unconscious biases on care delivery.
4. **Community Partnerships:** Forming collaborative partnerships with local organizations allows healthcare systems to extend care beyond clinical settings. Future efforts should focus on integrating trusted community voices into QI processes, which can improve patient engagement and outcomes.
5. **Policy Advocacy for Structural Change:** Addressing health inequities requires system-level policy changes, including improved insurance access, sustainable funding for navigation programs, and policies that reduce social barriers to care. Future work should engage policymakers to ensure that equity remains central to healthcare reform efforts.

By embedding these culturally responsive and structural strategies within QI frameworks, healthcare systems can move beyond incremental change and work toward sustainable equity. This commitment to ongoing improvement is essential to ensuring all patients receive equitable, high-quality care.

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Prior Authorization:
A Growing Plague for Patients and Providers

By Jacob Castiglia, MD

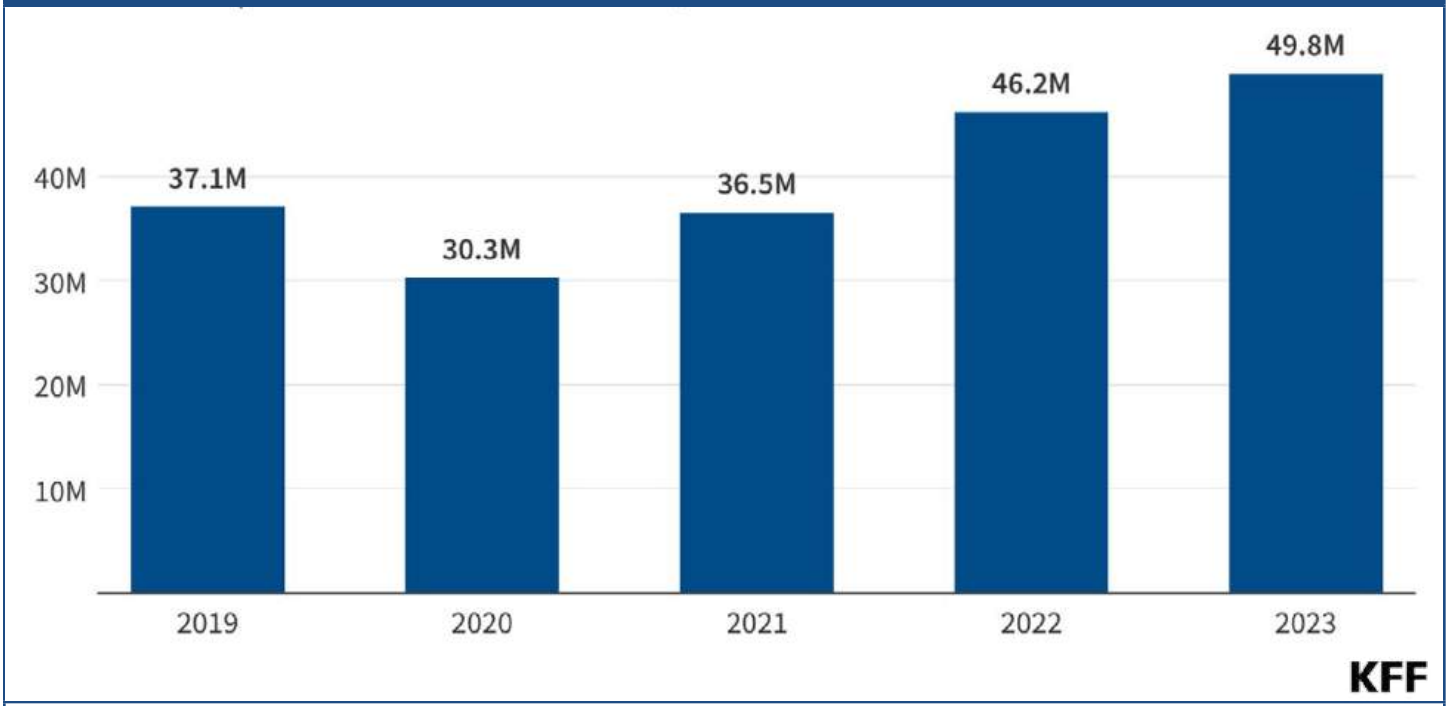
Rates of prior authorization requests from health insurance companies are on the rise in the United States. This trend is unlikely to be a surprise to any family physician. Private insurers do not publish data on their prior authorization (PA) rates or practices. Medicare Advantage plans (i.e. Medicare benefits administered through private insurers), must report prior authorization data to the Centers for Medicare & Medicaid Services (CMS). Medicare Advantage plans thus provide a window into the troubling growth of PA requests and its impact on our health care system.

In 2020, the total number of PA determinations among Medicare Advantage insurers was 30.3 million, which represented a modest decrease from 37.1 million in 2019. The Covid-19 pandemic likely resulted in decreased utilization of health services by patients and increased pressure on insurers to adjust their prior authorization requirements.[1] Since 2020, PA requests have risen dramatically from 30.3 to 49.8 million in 2023. (Figure 1) The increase in the total number of PA requests is largely due to a proportional increase in the number of Medicare Advantage enrollees, which increased from 22 million people in 2019 to 31 million in 2023.[1] Prior authorizations per MA enrollee returned to its pre-pandemic level at 1.7 in 2022 and rose slightly to 1.8 in 2023. Additional key takeaways for Medicare Advantage PA data in 2023 are as follows:[1]

- Of the 49.8 million PA determinations in 2023, 6.4% (3.2 million) were denied
- Of the 3.2 million PA denials, only 11.7% were appealed to MA insurers
- Most appealed prior authorizations (81.7%) were overturned
- Humana & Anthem require the most PAs per Medicare Advantage beneficiary at 3.1
- Centene denies the highest percentage of PA requests at 13.6% (Figure 2)

It is particularly striking to learn that very few PA denials are appealed, and of those that are, 8 in 10 are approved. Such a high rate of reversal begs the question of whether it was necessary to initially

Figure 1. Total number of prior authorization determinations, 2019- 2023



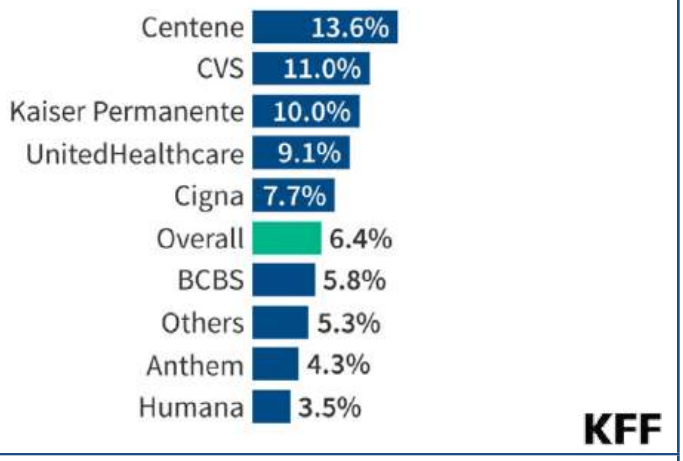
Note: Excludes requests that were withdrawn or dismissed.

Source: Medicare Limited Data Set, Contract Years (CY) 2022 - 2023 Part C and D Reporting Requirements and Public Use file Contract Years 2019-2021 Part C and D Reporting Requirements

deny coverage. Regardless of outcome, nearly all prior authorizations represent a delay in patient care. In 2023, 94% of physicians surveyed by the AMA reported that the PA process led to delays in necessary patient care.[2] 78% of physicians reported that prior authorizations at least sometimes led to treatment abandonment by patients, with 22% of physicians reporting this occurring often.[2] The consequences of these delays or resignation of care can range from harmless to severe. 24% of physicians surveyed reported that prior authorization led to a serious adverse event for a patient under their care, such as hospitalization or a life-threatening event.[2] Among both Medicare Advantage and private insurers, there is no standardization of prior authorization criteria, which makes the process exceedingly challenging for patients and providers alike.[3] Patients are often faced with complicated paperwork to navigate, and providers have limited time to handle both the high volume of PA requests and the significant variability in requirements between plans. Physicians surveyed by the AMA reported rarely submitting appeals due to lack of time and inability of patients to wait for treatments to be approved.[2] What may have started as a system of checks and balances, has grown into a form of weaponized bureaucracy on behalf of insurers, as evidenced by an astoundingly low rate of appeal.

In October 2024, the United States Senate Permanent Subcommittee on Investigations (PSI) released a detailed report on the prior authorization practices of the country's largest Medicare Advantage Insurers: UnitedHealthcare, Humana, and CVS. These companies comprise nearly 60 percent of all Medicare Advantage enrollees. The report details a deliberate and years long effort to deny a costly, yet critical service to older adults: post-acute care following hospitalization. These include facilities such as skilled nursing rehabilitation and long-term acute care hospitals. Documents obtained showed that post-acute care services for MA enrollees were denied at considerably higher rates than other medical services.[4] In 2022, UnitedHealthcare and CVS denied PAs for post-acute care at a rate of three times higher than their overall average denial rates, while Humana's stood at a staggering 16 times higher.[4] Rates of denial for these services have been increasing over time as well, with UnitedHealthcare denying 8.7% of post-acute care PAs in 2019, a rate that nearly tripled to 22.7% in 2022.[4]

Figure 2. Adverse and partially favorable determinations as a share of all prior authorization determinations in 2023



Note: Denied requests include determinations that were partially favorable or adverse. Data for Anthem BCBS is not included because of data quality issues.

Source: Limited Data Set, Contract Year (CY) 2023 Part C and D Reporting Requirements Data

What is driving this stark contrast in post-acute care denials? The commonality between these insurers is a dedicated effort to identify the highest areas of potential savings (i.e. PA determinations of post-acute care) along with the development of automated and artificial intelligence systems to increase the probability of denials being upheld. Most uses of AI are meant to simplify and streamline processes, however, a March 2022 meeting at CVS regarding PA automation detailed the decision to not pursue a plan to reduce the overall volume of prior authorizations as the impact on lost savings was "too large to move forward."[4] As CVS began to roll out its post-acute care initiatives in in 2021, it estimated cost savings of $4 million per year, but later updated this figure to $77 million over the proceeding 3 years. At UnitedHealthcare, meetings focused on how machine learning could "identify cases which may result in an appeal" as well as "identify what is driving those trends . . . to change the outcome of the appeal."[4] In March 2021, UnitedHealthcare moved its post-acute care services to naviHealth, which uses an AI-driven algorithm to handle PA determinations. From 2020 to 2022, the first full year in which UnitedHealthcare utilized naviHealth, the rate of initial adverse determinations for skilled nursing facilities increased by 207%.[4] Insurers knew that these systems increased the share of denied requests, which is likely due in part to the bias introduced from a pre-determined outcome before it is passed to a human reviewer. While public statements by UnitedHealthcare emphasize that living, breathing reviewers alone make the final determinations, various media reports detail pressure from the company for reviewers to meet their performance goals by strictly adhering to algorithm conclusions.[4,5]

At Humana, in addition to AI algorithms, greater focus was dedicated to training physician reviewers to uphold PA denials and suggest alternative forms of care. Between 2020 and 2021, Humana held multiple conferences specifically for handling long-term acute care hospital admissions. Outside of standard materials providing guidance for reviewers to explain denials to providers, templates included references to suggesting hospice as an alternative for patients requesting post-acute care. A PowerPoint presentation even urged reviewers to ask a patient's provider if a "goals of care discussion" had been performed, noting that the "surprise

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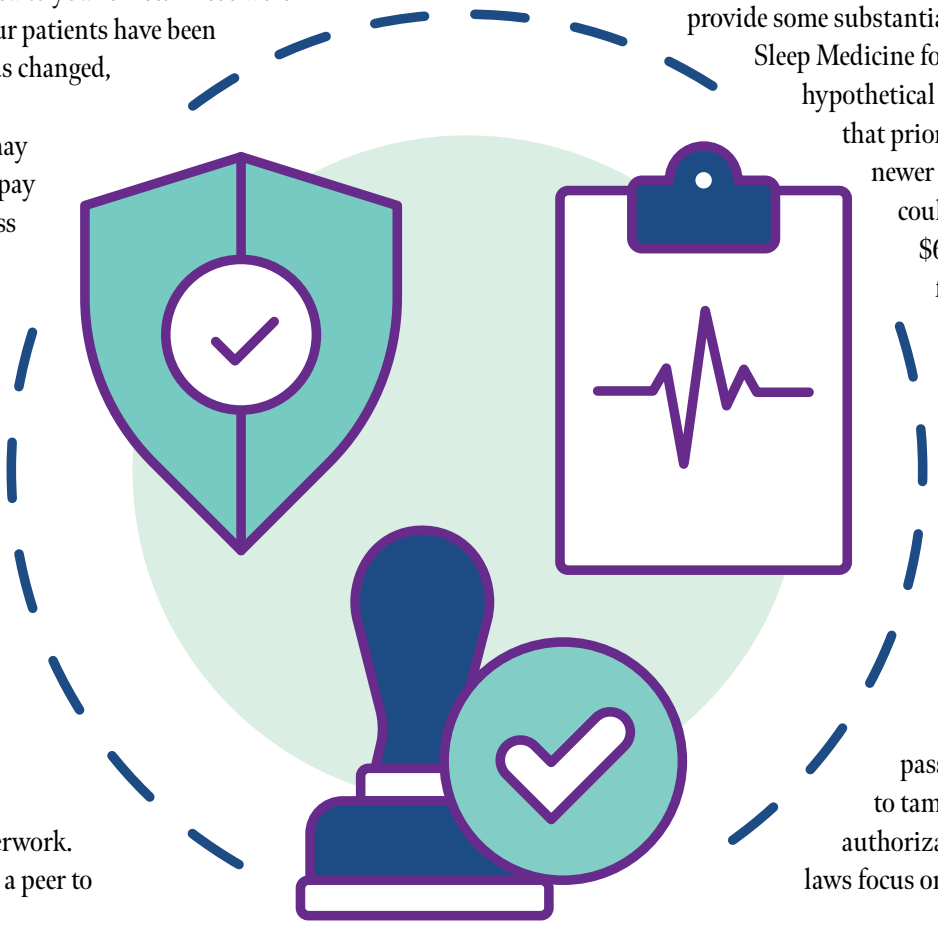
question" acted as a "gut check" to test the provider's resolve.[4] To be clear, hospice care is not covered under Medicare Advantage plans, making this line of questioning even more unsettling. Work group members at these conferences repeatedly voiced concerns about the potential insensitivity of this discussion. Despite this, Humana's training materials continued to emphasize the high cost of post-acute care and to postulate hospice as an alternative.[4]

As troubling prior authorization practices among insurers grow, so does the impact on family physicians. Prior authorizations increase the administrative burden on providers, often consuming what little time they have between other clinical responsibilities. 2023 data from the AMA estimate that practices complete 43 PAs per physician per week and physicians and their staff spend an average of 12 hours each week completing PAs. One-third of practices employ staff that exclusively work on prior authorizations.[2] Nearly all physicians (95%) surveyed by the AMA reported that prior authorizations somewhat or significantly contributed to burnout. Family medicine ranks fourth among medical specialties in the highest reported burnout with a rate of 51%.[6]

Let us go through the day of a typical family physician. You see an average of 16 patients per day, and of those 16 patients, four prior authorizations were generated for treatments or tests you ordered. While you were working, another three prior authorizations were faxed to your office. These were for medications that your patients have been on for years. Nothing has changed, they are stable on these medications, but they may soon run out or need to pay out of pocket costs unless this authorization is completed promptly. Between finishing your notes, managing patient messages and lab results, completing your other paperwork, you wonder when you will have time to manage these PAs. For some of these authorizations, they are denied. You appeal by submitting further paperwork. Insurance then requests a peer to peer with a physician at their company. You spend time on the phone to schedule this discussion, which may need to be in the middle of seeing patients or scheduled for another day. You discuss your rationale for treatment with the insurer's physician and provide any additional information needed. More than likely, the physician reviewer you speak with is not truly a "peer" in the strictest sense. They are likely not a family physician nor currently in clinical practice. Physicians surveyed by the AMA reported that their peer reviewer had the appropriate qualifications only 15% of the time.[2] The entirety of this process represents the current reality of primary care for many providers. It is a resource draining threat to provider autonomy, and therefore, understandable that nearly all family physicians report that prior authorizations contribute to their feelings of burnout.

From a healthcare system perspective, there is evidence to suggest that prior authorizations have the opposite effect from insurers' goal of cost savings. Due to disruptions in care or abandonment of treatments, the downstream effects of rampant prior authorization can lead to increased healthcare utilization by patients and thus higher medical costs. 87% of physicians reported that prior authorization increased their patients' health care usage, whether that be increased frequency of office visits, or urgent care & hospitalization.[2] To date, there have been no comprehensive cost analyses on prior authorizations for the United States a whole, but studies on singular medication classes provide some substantiation. The Journal of Sleep Medicine found using a hypothetical managed-care plan, that prior authorization for newer insomnia medications could result in a loss of $600-700,000 annually for the health plan when accounting for administrative costs.[7] Further and more comprehensive analyses on prior authorizations using real data are needed to inform future reform efforts.



Ten states in 2024 passed legislation aiming to tamper down on prior authorization practices. The laws focus on reducing prior

authorization volume, reducing care delays, and increasing transparency by expanding the data that insurers must publicly report. New York, unfortunately, is not one of these states, and has yet to pass any legislation in this area since 2020. In Minnesota and Vermont, new legislation tackles PAs for chronic conditions, citing that if the treatment for a patient's condition such as diabetes or rheumatoid arthritis does not change, they no longer will be subjected to periodic authorizations every six to twelve months. This is a monumental win for both patients and family physicians in these states.[8] In the final report for the US Senate Permanent Subcommittee, recommendations are made for what measures are needed to more effectively regulate Medicare Advantage insurers. These include collecting prior authorization data from insurers broken down by service category, conducting targeted audits of insurers if data shows a dramatic increase in adverse determination rates, and to expand regulations to prevent predictive technologies from significantly influencing human reviewers.[4]

The New York State Senate introduced a bill in 2023 that seeks to amend prior public health law to reduce turnaround time for prior authorizations and mandate that insurers are using evidence-based criteria for their PA policies.[9] This bill has not yet been passed, but it also does not go far enough in addressing the needs of patients and providers. New York must join the handful of states that passed more sweeping legislation in 2024 that directly targets harmful prior authorization practices that continue to plague our health care system. Additional advocacy is also required to ensure that the regulating power of the Centers for Medicare and Medicaid Services is expanded to meet the recommendations outlined by investigative committees.

Family physicians serve as leaders in our respective communities and carry significant weight behind our calls for reform. Tangible steps we can take include contacting our state representatives to advocate for advancement of prior authorization legislation. The American Medical Association has also compiled many helpful resources for family physicians to utilize. The AMA has written a model bill to present to lawmakers that addresses many of the concerns outlined in this review.[10] Lastly, the AMA has created a grassroots campaign resource that providers can access at fixpriorauth.org, where you can share stories and keep up to date on ways to take action.

To put all this into perspective, compared to the 49.8 million prior authorization reviews conducted by Medicare Advantage insurers in 2023, traditional Medicare completed just under 400,000 in the same year.[1] That is 125 times more volume, even though patients on MA plans only make up 54% of eligible beneficiaries. This is a bureaucratic cancer on our health care system that shows no signs of slowing down. In the United States, we have a system that is primarily driven by the pursuit of profits over patient care. This should not come as a surprise when insurers are beholden to their investors, who are expecting growth every financial quarter. Insurers have determined that prior authorizations and denial of critical, yet costly areas of medical care are the best paths to boosting profits. They have dedicated considerable resources to denying medical care, rather than creating systems that enable more accurate and evidence-based determinations. Family physicians in New York State and across the country have the power to advocate for a better path forward, one that puts the needs of patients over the greed of company shareholders.

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How Insurance Changed Medicine

By Thomas C. Rosenthal, MD

Health insurance coverage is confusing. It fuels anger from both patients and physicians and impacts the doctor/patient relationship by making all things seem possible while being unable to deliver.[1]

In the 1930s, only 9% of the population had health insurance. By the end of the wage and price controls of World War II, nearly 23% gained employer sponsored health insurance. Coverage rose to 70% of workers by 1960; then rose to 83% in 1975. But, the cost of health care ballooned in the early seventies and coverage rates declined, until rising to 95% with passage of the Affordable Care Act in 2010.[2]

The federal government's first step into health care dates to 1798. President John Adams signed a law that assessed every American seaman $0.20 per month to establish the Marine Hospital Service for sick and disabled sailors. Congress paid little attention to health care until 1854, when it passed the Benefit of the Indigent Insane legislation. It proposed establishing asylums for the mentally ill, blind and deaf, according to a model Dorothea Dix had experienced in England. However, the bill was vetoed by President Franklin Pierce, who argued that social welfare was the responsibility of the states. Both Union and Confederate armies suffered storms of debate as eclectic theories of medicine battled each other during the Civil War. Following the war, restoration legislation established the Freedmen's Bureau to care for sick and dying former slaves. Forty hospitals were constructed, and, except the hospital in Washington, D.C. that became part of Howard University, all closed within five years.

After the Civil War, the Odd Fellows fraternal organization introduced a package of health and life insurance for their members. It was consistent with their mission to: "Visit the sick, relieve the distressed, bury the dead and educate the orphan." Their insurance packages proved so popular that, along with their sorority affiliate (the Daughters of Rebekah), the Odd Fellows became America's largest fraternal order. British actuarial tables were used to determine premiums, but it was soon revealed that the rugged and durable American was a myth, forcing premiums to rise. The Odd Fellows joined with the American Medical Association to advance public health, sanitation, birth/death registration, and the licensing of doctors.[3]

As commercial companies pursued the Odd Fellows' model, physicians were suddenly being paid to conduct pre-enrollment exams to find disease that had no symptoms, and render opinions about behavioral or intemperate habits that might affect future health. It was a dramatic change from seeing patients only when they were sick, but doctors liked it because insurance companies reliably paid their charges. The arrangement did raise questions about whether doctors represented the patient or the company.[3]

Doctor fees had been kept low because technology was rudimentary and neighborhood botanical healers and homeopaths offered nearly similar results. Also, charity had been a tradition since the beginning of time. Even as nineteenth-century hospitals opened, they were seldom expected to generate profits. They survived on a mixture of paying patients and philanthropic support from local elites.[4]

Things changed in the last quarter of the nineteenth-century. Medical education not only improved, but became more expensive as science and technology advanced, and licensing restricted a better-defined medical profession. Starting with anesthesia, antisepsis, and the germ theory, medicine's ability to heal began a century of doubling every twenty years. As treatments made dramatic inroads, optimism reigned while few predicted the cost of ever decreasing increments of lifespan could be so expensive. By the 1950s, every decade has seen a 100% increase in U.S. healthcare expenditures. A larger and older American population and inflation account for roughly half of the increase. Improved technology and pharmaceuticals account for about 25%. But, in the United States, there is no accounting for just under 25% of the increased expenditures. It is a gap that is unique to the American medical system.[5] Insurance company overhead, executive salaries, physician billing costs, and malpractice overhead are often blamed. For most of Europe, physicians make roughly three times the country's median salary. In the United States, primary care physicians make about three times the median salary, but many specialists make far more. (https://worldpopulationreview.com/country-rankings/doctor-pay-by-country?form=MG0AV3)

By the first decade of the twentieth-century, hospitals were feeling squeezed. They became more vigilant about "charity abuse," introduced means-testing, and advertised for paying patients. New York City maintained eighteen municipal hospitals with open-door policies, but many communities made no such provisions.[4]

Flexner's 1910 recommendations for improving medical schools further increased the cost of a medical education. Rising student debt raised expectations for income. The same year (1910), the railroad industry offered generous health insurance plans to recruit and retain employees.[6] Feeling these same pressures, the United Kingdom responded by passing the National Insurance Act in 1911 to guarantee workers' medical care. But the United States Constitution omits any mention of health care and the tenth amendment (in the Bill of Rights) delegated all things not mentioned in the Constitution to individual states. The constitution did not stop Theodore Roosevelt from campaigning for universal coverage in 1912, but his proposal was opposed by the American Medical Association, and Roosevelt lost the election.

In 1929, Dallas school teachers assessed themselves $6 a year to cover member hospital bills. Hospitals liked the plan because it guaranteed payment. Soon, plans emerged to cover working people in

other communities. Only rarely did these plans cover families, but their expansion was enough to persuade state governments against implementing more universally available coverage. Employment-based health coverage continued to expand during World War II when wage controls made fringe benefits the only way to attract workers and the Internal Revenue Service declared health insurance benefits tax exempt. When President Truman proposed universal health coverage in 1945, congress balked. Truman's plan was defeated because of the huge lingering war debts and the AMA labeled universal plans "socialized medicine," evoking the communism feared by Americans.[6]

Rising costs continued as the first intensive care units opened in 1959. Even the most dedicated constitutional constructionist feared community hospital bankruptcies would hobble their districts. It was this threat of hospital closures that pressured congress to pass the Medicare and Medicaid Act of 1965. But the new federal dollars focused on shoring up hospitals, increasing the number of doctors, and paying for hospital-based specialty graduate medical education. By intent, Medicare and Medicaid concentrated on covering society's most expensive groups, those over 65 and the disabled. In 1982, the states were given more flexibility to operate Medicaid programs, provide emergency treatment for immigrants and include pregnant women. When Medicaid was unlinked from welfare in 1996, states could enact more restrictions, but the focus remained on increasing physician supply and supporting hospitals. Neither state nor federal governments were willing to take responsibility for improving models of care delivery.[4] The Affordable Care Act of 2010 defined a minimal comprehensive coverage plan and expanded Medicaid, but its drain on the federal government was worsened when the individual mandate was repealed in 2019.

To increase profits, health insurance companies can raise premiums or deny payments, and hassling high-cost patients encourages patients to find another company.[7] Despite all their complaints, many Americans fear government control of a single payer system, though the single payer Veterans Administration delivers more preventive health care and meets established standards of care at a lower overall cost than traditional Medicare.[8] Also, single payer Medicare has been the most popular federal government program in history. It is just that Americans have grown accustomed to the fragmentation and hassles of employer based, third party health insurance. A 2023 Gallop poll found that 57% of U.S. adults believe the federal government should guarantee coverage for all Americans, but they want it provided through private insurance carriers. Again, Medicare has such a model, it is called Advantage Care.[9] No single model is best in all circumstances, but there are proven, cheaper and more efficient models that deliver more care, most of the time.

As intended, American insurance programs have given us more doctors, more technology, and more hospital and specialty services, but at a tremendous expense with diminishing returns. There are ways out of this conundrum. First, providers (hospitals and physicians) should be forced to advertise their fees. Fee comparison is capitalism's greatest weapon and, where attempted, prices have decreased modestly. Second, malpractice reform can be addressed simply by adopting the English rule for litigation whereby the loser pays the expenses of both sides.[5] Third, we must minimize the use of low value care. To quote the famed cardiologist Bernard Lown, heart disease can be ruled out in 50% of chest pain patients by a good history and physical alone. And fourth, we need to recognize that there is no cure for old age.[10]

But foremost, Americans must take better advantage of what Atul Gawande calls the incremental continuity care model delivered by well-trained family doctors.[11] Primary care visits with a personal physician are most likely to discover the correct management with fewer unnecessary interventions and lower costs.

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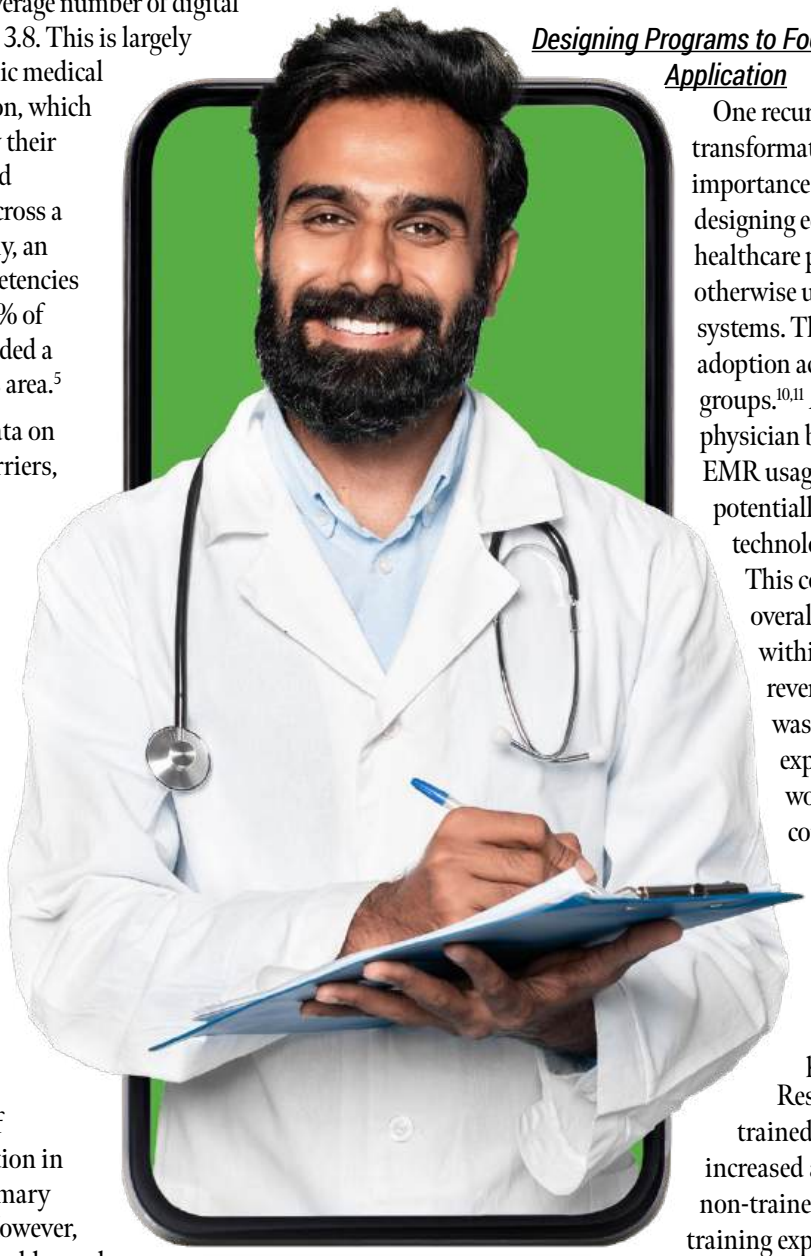
Assessing Physician Perceptions of Digital Transformation Tools

By Aditya Bissoonauth, MPH, MBA; Saad Amar, MPH; Sara Siddiqui; Hamnah Khan; Lillian Cargill, MHA; Jenna Laguerre; Aldo Alleva, MD; Keasha Guerrier, MD; Neubert Philippe, MD; Barbara Keber, MD and Tochi Iroku-Malize, MD, MPH, MBA

Introduction

Digital transformation refers to an ongoing change process rooted in digital technologies.[1,2] In healthcare, this includes telehealth appointments, cybersecurity, and remote patient monitoring to enhance outcomes and efficiency.[3] The American Medical Association (AMA) surveyed 1,300 physicians on digital health utilization, which revealed an increase in tele-visits from 14% in 2016 to 80% in 2022, and the average number of digital tools doubled in use from 2.2 to 3.8. This is largely attributed to the rise in electronic medical record (EMR) system utilization, which allows patients to securely view their personal health information and streamlines communications across a patient's care team.[4] Additionally, an analysis on digital health competencies in primary care showed that 54% of the articles reviewed recommended a need for updated studies in this area.[5]

This study aims to gather data on perceived readiness, utility, barriers, attitudes, and gaps regarding utilization and integration of digital transformation across primary care, aiming to pinpoint weaknesses and improve training and implementation plans for digital health systems. The goals of this study are to (1) identify ways to implement digital transformation tools into primary care, (2) investigate gaps related to digital transformation, and (3) identify digital transformation's role in medical education and training. Existing literature highlights potential benefits of integrating digital transformation in various settings, including primary care and medical education.[6] However, this emerging field is not fully addressed in medical education and training programs.[7]



Perceived Usefulness

Perceived usefulness refers to whether users believe technologies can improve performance. One study showed physician use of mobile health (mHealth) facilitates client and community engagement. Perceptions of mHealth can be influenced by factors tied to cost, user, technology, the health system and society, and poor network or electricity access.[8,9]

Designing Programs to Focus on Tools and Application

One recurring theme in the digital transformation literature is the importance of training programs or designing educational interventions for healthcare professionals who are otherwise unfamiliar with these systems. This is seen as a barrier to adoption across professions and age groups.[10,11] Another study assessed physician burnout and the influence of EMR usage to identify new and potentially burdensome EMR technology as possible stressors. This contributed to reported low overall satisfaction with EMR within that study. However, reverting to paper documentation was not a viable alternative, exposing a knowledge and workflow gap in the system that could be rectified with proper training.[12]

Other recent works assessed the association between evidence-based training and clinician proficiency in EMR use. Results showed that clinicians trained in EMR systems sustained increased appointments compared to non-trained clinicians, supporting training expansion as a strategy for bringing more patients into practices.[13]

Areas of Improvement

To fully leverage digital health technologies, a primary healthcare system needs a digitally literate workforce.[5] Current literature discusses the challenges of medical education training and attempted implementation into residency curriculums, encouraging many residency programs to increase required telemedicine visits and digital transformation training for certification within their residency programs.[3] This will better equip the emerging workforce to navigate such integrated technologies in the coming years.

The effect of digital transformation on healthcare workers also poses challenges. Some studies show it can increase the burden of practice inefficiencies.[12] Thus, it is imperative to address any "fixes that fail" effects, such as increased clinician burnout or staff overwhelm.[14] Financial burden is also taken on in increasing digital transformation, including costs relating to startup and implementation, such as equipment, software, technological support needs, or personnel.[13,15]

Methods

Participants

A cross-sectional online survey was developed to assess primary care physician attitudes and practices toward digital transformation in healthcare. The population of this study involves family medicine residents, physicians, and faculty at Northwell Health, a large healthcare organization based in New York (n = 642). Participants are aged 18+ and employed by Northwell Health. They were informed that this survey was for research purposes, responses were anonymous, and participation would not impact employment status (See Table 1).

Survey

The 17-question survey is comprised of multiple-choice questions, Likert scale questions, and check-all-that-apply questions regarding demographics, familiarity with digital transformation, and perceived gaps, attitudes, and readiness (See Appendix A).

Institutional Review Board Review

This study was approved by the Northwell Institutional Review Board (IRB) on November 16, 2022. It was deemed an exempt study that posed minimal risk to participants.

Procedure

Participants were surveyed via REDCap, a secure HIPAA-compliant platform, about their knowledge and attitudes toward digital transformation in medical education and research gaps. They were contacted via email, with responses kept anonymous. A follow-up email was sent weekly for four weeks. Data were analyzed using IBM SPSS, leading to results interpretation and recommendations for next steps and best practice.

Results

A total of 51 respondents completed the survey including 4 family medicine resident physicians (7.8%), 15 family medicine attending physicians (29.4%), and 32 faculty members of academic medical programs (62.8%). Tables 1 and 2 present the data grouped by respondents' answers.

33.3% of respondents indicated they were familiar with what digital transformation is and how it's used in their environment. EMR and telehealth were most used on-site with 94.1% of respondents using EMR and 76.5% conducting telehealth appointments. Artificial intelligence and machine learning medical devices were least used, with 5.9% and 2% of respondents noting use. 53.1% of participants noted that digital transformation usage is "high" or "somewhat high," demonstrating utility in the current context. 37.3% of participants view integration of digital transformation in medical education curricula as "very useful." Lack of interoperability was the most significant perceived barrier to digital transformation at 43.1%. Other perceived barriers include fear of change, insufficient resources, and technology choice. The most frequently reported research gaps included effects on business logistics (11.8%) and efficiency resource management (72.5%). When considering perceived levels of readiness, 53% of participants are at least "somewhat ready" for increased digital transformation integration and future usage.

Discussion

Results revealed many participants were unfamiliar with digital transformation, suggesting a need for improved digital competencies through professional development. Not all work facilities utilized EMR or telehealth, presenting opportunities for advancement. Future research could assess the benefits of broader implementation. Over half of participants use digital transformation in their daily work ("somewhat high" or "high"), and 64.8% believe it would benefit trainees.

Fear of change, insufficient resources, and technology choice were noted as significant barriers to implementation at approximately 20% to 30% each. Lack of interoperability between platforms and systems was the largest perceived barrier, emphasizing the importance of technological support, input from clinical personnel, and software updates. Resource management was the most prevalent research gap reported by 72.5% of respondents, supporting the need for future investigations centered on how organizations communicate, share, and develop resources. Only 37.3% of respondents feel that their perceived readiness is "somewhat high," demonstrating that nearly 66% of the sample are still not confident in navigating technology.

The primary limitation in this study was the response rate. Out of 642 participants, only 51 (8%) responded. Future ways to strengthen data collection include increased advertising, incentivization, and a longer collection period. Future studies should target the lack of interoperability, the expansion of digital transformation into medical education curricula, and an exploration of resource management.

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Table 1: Participant Demographics			
Measure	**Item**	**Count**	**Percentage (%)**
Gender	Male	27	52.9
	Female	24	47.1
	Other	0	0
Age	18-29	1	2
	30-44	15	29.4
	45-59	12	23.5
	60-74	21	41.2
	75+	2	3.9
Ethnicity	American Indian/Alaska Native	0	0
	Asian	7	13.7
	Native Hawaiian/Other Pacific Islander	0	0
	Black or African American	5	9.8
	White	32	62.7
	Latino	3	5.9
	More than One Race/Mixed Race	0	0
	Other	4	7.8
Highest Level of Education	No Schooling Complete	0	0
	High School Graduate	0	0
	Some College Credit, No Degree	0	0
	Associate's Degree	0	0
	Bachelor's Degree	0	0
	Master's Degree	0	0
	Professional Degree	15	29.4
	Doctorate Degree	36	70.6
Identification	Resident	4	7.8
	Faculty Member	32	62.7
	Other (Physician)	15	29.4
Family Medicine Residency Program Affiliation	Glen Cove FMRP	1	25
	Peconic Bay FMRP	2	50
	Phelps FMRP	1	25
	Plainview FMRP	0	0
Post-Graduate Year Status (Residents only)	PGY-1	1	25
	PGY-2	1	25
	PGY-3	2	50
	Other	0	0

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Table 2: Responses of Survey Participants

Measure	Item	Count	Percentage (%)
How familiar are you with Digital Transformation?	Very Familiar	6	11.8
	Familiar	17	33.3
	Neutral	5	9.8
	Somewhat Familiar	15	29.4
	Not Familiar	8	15.7
Which Aspects of Digital Transformation are most common in the facility you work in?	Electronic Medical Records	48	94.1
	Telehealth	39	76.5
	Smart Devices	25	49
	Research Databases	13	25.5
	Cybersecurity	14	27.5
	Artificial Intelligence	3	5.9
	Virtual Reality Software	0	0
	Wireless Medical Devices	14	27.5
	Mobile Medical Applications	19	37.3
	Medical Device Software	6	11.8
	Machine Learning Medical Devices	1	2

On a scale from 1-5, how much Digital Transformation aspects are being used on-site? (1=low usage & 5=high usage)			
	1	4	8.2
	2	7	14.3
	3	12	24.5
	4	17	34.7
	5	9	18.4

On a scale from 1-5, how useful would Digital Transformation be if it was embedded into medical education curriculums. (1=not useful & 5= very useful)			
	1	5	9.8
	2	2	3.9
	3	11	21.6
	4	14	27.5
	5	19	37.3

What barriers are perceived to exist regarding embracing Digital Transformation?			
	Poor Communication	6	11.8
	Insufficient Resources	12	23.5
	Inadequate Executive Support	4	7.8
	Fear of Change	15	29.4
	Technology Choice	10	19.6
	Other	4	7.8

What is the most difficult about transitioning to advanced medical technology in your practice?			
	Learning New Technology	8	15.7
	Training Staff in New Technology	6	11.8
	Lack of Interoperability	22	43.1
	Increased Cost	6	11.8
	Technical Issues	6	11.8
	Other	3	5.9

What are some gaps in Digital Transformation Research that you would like to see studied?			
	A lack of present-day studies on Digital Transformation	3	5.9
	Implementation of Digital Transformation into Residency Curriculums	2	3.9
	Effects on Business Logistics and Efficiency	6	11.8
	Security and Privacy Concerns	3	5.9
	Resource Management	37	72.5
	Other	0	0

What is your Current Perceived Personal Readiness in terms of Digital Transformation Implementation? (1= low readiness & 5= high readiness)			
	1	6	11.8
	2	3	5.9
	3	15	29.4
	4	19	37.3
	5	8	15.7

Appendix A: REDCap Survey

Northwell Health®
Family Medicine

The Family Medicine Service Line is collecting data to assess physician knowledge, skills, and attitudes towards digital transformation and its implementation in practice, medical education, and research.

The objectives of this research study are to (1) Identify ways to implement digital transformation tools into the primary care workspace and provide medical education on tools in a digital environment, to (2) investigate research gaps related to digital transformation (3) Identify digital transformations role in medical education and training.

This questionnaire is voluntary, and your decision on whether to participate will have no effect on your affiliation with Northwell Health. By taking this survey you are participating in a research study that is being conducted by Dr. Tochi Iroku-Malize. **This survey should take about five minutes to complete.**

If you agree to participate, please complete the survey. Your responses are anonymous; **do not put your name or other identifying information in this survey**. We ask that you try to answer all questions. However, if there are any questions that you would prefer to skip, simply leave the answer blank.

This research has been reviewed by the Northwell Health Institutional Review Board (IRB). If you have any questions about your rights as a participant, or if you feel that your rights have been violated, please contact the IRB at 516-465-1910.

Principal Investigator Information:
Name: Dr. Tochi Iroku-Malize
Title: SVP, Professor, and Chair of Family Medicine
Dept: Family Medicine, Northwell Health
Phone: 631-665-0305
Email: tmalize@northwell.edu

1. **Which gender do you identify as?**
   A. Male
   B. Female
   C. Other: _____

2. **What is your age?**
   A. 18-29
   B. 30-44
   C. 45-59
   D. 60-74
   E. 75+

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Northwell Health
Family Medicine

3. **What is your ethnicity?**
   A. American Indian/ Alaska Native
   B. Asian
   C. Native Hawaiian or Other Pacific Islander
   D. Black or African American
   E. White
   F. Latino
   G. More than One Race/ Mixed race
   H. Other: _____

4. **What is your Highest level of Education?**
   A. No Schooling complete
   B. High School Graduate, diploma or equivalent (ex: GED)
   C. Some college credit, no degree
   D. Associate Degree
   E. Bachelor's Degree
   F. Master's Degree
   G. Professional Degree
   H. Doctorate Degree

5. **Are you a Resident, Faculty, or Other?**
   A. Resident
   B. Faculty
   C. Other: _____

6. **If Resident, Which Family Medicine Residency Program are you affiliated with?**
   A. Glen Cove FMRP
   B. Peconic Bay FMRP
   C. Phelps FMRP
   D. Plainview FMRP

7. **Post-Graduate Year Status?**
   A. PGY-1
   B. PGY-2
   C. PGY-3
   D. Other: _____

8. **If Faculty/Other, which Hospital/FMRP/Other location are you affiliated with?**
   _____

9. **If Faculty/Other, how many years have you been in practice post-residency?**
   A. 0-5 years
   B. 6-10 years
   C. 11-15 years
   D. 16-20 years
   E. 21+ years

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10. **How familiar are you with Digital Transformation?** (*Digital Transformation: The process of using digital technologies to create new — or modify existing — business processes, culture, and customer experiences to meet changing business and market requirements*)
    A. Very Familiar
    B. Familiar
    C. Neutral
    D. Somewhat Familiar
    E. Not familiar

11. **Which aspects of Digital Transformation are most common in the facility you work in? (Choose all that apply)**
    A. Electronic Medical Records
    B. Telehealth
    C. Smart Devices
    D. Research Databases
    E. Cybersecurity
    F. Artificial Intelligence
    G. Virtual Reality Software
    H. Wireless Medical Devices
    I. Mobile Medical Applications
    J. Medical Device Software
    K. Machine Learning Medical Devices

12. **On a scale from 1-5, how much Digital Transformation aspects are being used on-site? (1=low usage & 5=high usage)**
    1 2 3 4 5

13. **On a scale from 1-5, how useful would Digital Transformation be if it was embedded into medical education curriculums. (1=not useful & 5= very useful)**
    1 2 3 4 5

14. **What barriers are perceived to exist regarding embracing Digital Transformation?**
    A. Poor Communication
    B. Insufficient Resources
    C. Inadequate Executive Support
    D. Fear of Change
    E. Technology Choice
    F. Other: _____

15. **What is most difficult about transitioning to advanced medical technology in your practice?**
    A. Learning new Technology
    B. Training staff in new technology

Achieving Equity and Quality: The Role of Value-Based Care

By Tai L. Li, MD; Yura Kim, DO and Ruchi Mathur, MD, MPH

Introduction

The healthcare landscape is shifting, and value-based care (VBC) is now at the forefront of this transformation. As family physicians, we have a unique opportunity to lead this change – from a system that rewards the sheer volume of services to one that truly values quality, efficiency, and equity. VBC is not just a buzzword. It represents a model that leverages our clinical expertise to improve patient outcomes, lower costs, and increase provider satisfaction. Notably, the Centers for Medicare & Medicaid Services (CMS) has set an ambitious goal: to have all Medicare beneficiaries and nearly all Medicaid beneficiaries enrolled in payment models that account for quality and outcomes by 2030.[1] This national initiative underscores the urgency and relevance of adopting VBC models, emphasizing the importance of proactive, patient-centered care. In our everyday practice, this means moving beyond the constraints of fee-for-service models and embracing an approach that is personalized, continuous, and coordinated. For us in New York State, where our diverse communities face complex challenges, VBC offers a promising pathway to bridge healthcare gaps and create a more sustainable, patient-centered system.

New York State presents a distinct mix of challenges and opportunities that force us to reconsider healthcare delivery. Our population is incredibly diverse, with marked racial, socioeconomic, and geographic disparities that directly affect health outcomes.[2] According to recent data, approximately 24.9% of New Yorkers experience food insecurity, and over 50% of renters spend more than 30% of their income on housing, contributing to housing instability.[3,4] In rural upstate communities, transportation barriers and limited healthcare access exacerbate chronic disease prevalence. These social determinants – housing instability, food insecurity, and transportation challenges – significantly influence healthcare disparities and highlight the urgent need for solutions that address these non-clinical factors alongside traditional medical interventions.[5]

For decades, our healthcare system has been anchored in fee-for-service models that prioritize quantity over quality, leaving primary care underfunded and undervalued. This fragmented approach drives costs higher and hampers our ability to provide the proactive, comprehensive care our patients need.[6] In stark contrast, VBC is driven by four aims: improving patient outcomes, enhancing the patient experience, reducing costs, and promoting provider well-being. When supported by innovative primary care models and modern payment strategies, these actionable goals can fundamentally reshape our practices.[7]

Key Components of Value-Based Care

At its core, VBC emphasizes quality over quantity. Rather than simply increasing the number of billable services, our focus shifts to the meaningful impact of each patient interaction. For example, instead of scheduling more visits for a patient with diabetes, comprehensive care plans can be tailored to include regular follow-up calls, patient education, and coordinated medication management. This proactive, hands-on approach not only reduces hospital admissions, but also improves long-term outcomes.[8]

Cost efficiency is another fundamental pillar of VBC. By embracing alternative payment models (APMs), resources can be reallocated more effectively toward preventive care and early intervention.[9] In practice, investing in robust care coordination and patient education not only enhances patient health but also helps curb unnecessary expenses.[10] It's a win-win situation that enables us to focus on quality rather than being trapped in the cycle of high service volume.

Equity and sensitivity to the social determinants of health are equally central to the model. Factors, such as housing stability, food security, and reliable transportation can profoundly influence patient outcomes. Modern VBC payment models increasingly account for these social complexities.[11-13] For instance, when managing a patient burdened by multiple chronic conditions and economic challenges, a payment adjustment that factors in social risk can provide the additional resources needed to offer holistic support, including establishing partnerships with community services that address non-medical needs.[12-14]

Prevention and proactive management complete the core tenets of VBC. Early screenings, timely interventions, and consistent chronic disease management allow us to identify and address health issues before they spiral into costly emergencies. By prioritizing the prevention of complications rather than reacting after the fact, we achieve improved patient outcomes and overall cost reductions.[15]

Current Landscape of Value-Based Care

On a national level, several APMs have emerged gradually to align financial incentives with patient outcomes, as shown on Table 1.[16] The transition toward value-based care can be understood as a stepwise progression. At the most basic level, the traditional fee-for-service (FFS) model reimburses physicians for each individual service provided. While simple and familiar, this approach inherently encourages a higher volume of visits and procedures rather than focusing on the quality of care delivered. Recognizing the need to incorporate incentives for better patient outcomes, the second level, FFS linked to quality, was introduced. Under this model, financial rewards were tied to specific quality benchmarks, such as reducing hospital readmissions or improving preventive care measures. However, the reliance on volume remains a challenge, leading to the development of more sophisticated APMs which emphasize VBC.

The third level of APMs introduces shared savings programs and bundled payments, which provide stronger financial incentives for providers to invest in preventive care and care coordination. In a shared savings arrangement, healthcare organizations that successfully lower costs while maintaining or improving quality receive a portion of the savings.[17-19] Similarly, bundled payments allocate a single, comprehensive payment for all services related to a specific episode of care, such as managing a diabetic patient over a 90-day period – routine visits, lab tests, medication management, and patient education would all be included under one bundled payment.[20] This encourages our care teams to collaborate closely, streamlining processes and preventing complications through coordinated efforts.

Finally, under a population-based payment model, a practice or organization receives a fixed per-member-per-month payment, also known as capitation. This approach shifts the financial focus from service volume to patient health outcomes, offering the strongest incentive for preventive care and chronic disease management. By decoupling reimbursement from the number of visits or procedures performed, it lets us focus on keeping patients healthy over time, rather than being driven solely by fee-for-service incentives.

Implementation of VBC in New York State

Across New York State, the implementation of VBC is a multifaceted endeavor that draws on innovative frameworks designed to address the unique challenges of a diverse population. In our region, models such as Patient-Centered Medical Homes (PCMHs), Accountable Care Organizations (ACOs), and Managed Care Organizations (MCOs) serve as the building blocks of a system designed to promote coordinated, patient-focused care.

The PCMH model has emerged as a powerful tool in our everyday practice. This model positions primary care at the center of the patient experience, where a dedicated team, including physicians, nurses, care managers, and support staff, works collaboratively to deliver continuous, comprehensive care.[21] In a PCMH, the focus is on building long-term relationships that enable proactive management of chronic conditions, resulting in improved treatment adherence and reduced hospitalizations.[22] By fostering an environment of trust and continuity, PCMHs allow us to address not just the clinical but also the personal needs of our patients.

ACOs bring together networks of healthcare providers who share responsibility for managing the health of a defined patient population. ACOs operate under VBC arrangements like shared savings programs, where if collective care efforts lead to cost savings while maintaining high quality, the savings are shared among the providers.[17,23] For example, imagine several community practices forming an ACO to launch a coordinated program for managing congestive heart failure. By pooling resources and data-driven insights, they can significantly reduce emergency department visits and hospital readmissions, generating meaningful savings and enhancing patient care.

Medicaid MCOs offer another critical avenue for implementing VBC. MCOs function as integrated health plans that use capitated payment models to manage care across a tightly coordinated network of providers.[24,25] By receiving a fixed fee per member, MCOs incentivize efficiency and proactive management. Their centralized structure often enables more streamlined and consistent care compared to the more decentralized approach of ACOs, yet both ultimately share the common goal of improving outcomes and controlling costs.

A significant policy shift under a new New York State Medicaid amendment, effective January 2025, introduces Social Care Networks (SCNs) to expand access to health-related social needs for qualifying Medicaid members.[26] SCNs utilize the capitated model and receive per-member-per-month payments to advance health equity by providing enhanced services in nutrition, housing, social care management, and transportation. This development marks a critical advancement for VBC. Previously, any ACOs or independent physicians in NYS who wished to participate in payment models analogous to Level 3 or 4 (Table 1) with Medicaid were required to address social needs directly at their own expense, which deterred some due to additional administrative and operational burdens.[27] With the formation of SCNs, this responsibility is shifted, allowing physicians to focus on delivering high-value care while the SCNs manage social care interventions. This development signifies New York State's Medicaid program's commitment to aligning value, quality, and equity while facilitating broader adoption of VBC by removing potential hurdles.

The convergence of these diverse frameworks – PCMHs, ACOs, and MCOs – integrated with innovative payment strategies, illustrates a robust VBC system in New York State. This holistic approach not only enhances patient care and satisfaction but also creates a more sustainable financial model for our practices. As we see these initiatives in action, the pressing question becomes: can we, as family physicians, fully harness the strengths of these models

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to build a truly seamless, high-quality, and cost-effective healthcare system for all New Yorkers?

The Role of Family Physicians in Advancing VBC

Family physicians are the true cornerstone of VBC, serving as the "quarterbacks" who coordinate and drive comprehensive care in our communities. In our daily practice, we understand that primary care is not simply about treating illness but about nurturing long-lasting relationships and delivering care that sees the whole person. This very principle is why VBC rests so firmly on the foundation of primary care. Our unique blend of clinical expertise and deep, personal insight into our patients' lives puts us in an exceptional position to lead this transformation.

Family physicians are uniquely positioned to lead VBC due to our emphasis on preventive care, expertise in managing complex patients, and efficiency in resource utilization. Our proactive focus on prevention aligns directly with VBC's goals of reducing hospitalizations and costly interventions. Additionally, our ability to coordinate care across multiple specialties ensures that patients receive well-integrated, high-quality treatment. Finally, 90% of the national $4.5 trillion annual health care expenditures are attributable to chronic diseases.[28] Strong primary care systems, led by family physicians, have been shown to lower overall healthcare costs by prioritizing outpatient care and chronic disease management, making our role indispensable in driving the success of VBC models.[29] We often see firsthand how factors, such as housing instability, food insecurity, and limited access to transportation can complicate the management of chronic disease. By weaving these social complexities into our care strategies, we are not only treating medical conditions; we're connecting patients with community resources and social services that can change lives. Our sensitivity to identifying SDOH as family medicine physicians enables us to leverage programs, such as the recently established SCNs in NYS for Medicaid patients, which provide extended resources and services to address these needs.

Policy and legislative initiatives have also played a transformative role in the evolution of VBC. At the forefront of this movement is the advocacy work of organizations, such as the American Academy of Family Physicians, which consistently champions payment reforms that recognize the central role of family physicians.[30,31] Additionally, the New York State Academy of Family Physicians continues to advocate before the New York State Assembly for increased investment in the primary care workforce, emphasizing the need for sustainable funding.[32] These efforts have not only emphasized our unique position within the healthcare system but have also secured critical incentives that empower us to innovate and lead in delivering high-quality, patient-centered care.

Challenges and Barriers to VBC Adoption

Despite its immense promise, the transition to VBC is not without challenges. Many of us can envision or have experienced firsthand the financial and administrative hurdles that accompany such a transformative shift. Upfront costs – whether investing in cutting-edge technology, overhauling our practice infrastructure, or recruiting extra care management staff – can feel downright intimidating. These investments, though essential for long-term success, often mean navigating a maze of increased administrative burdens as we transition away from FFS models toward ones that reward quality and efficiency.[33] Moreover, there is the thorny issue of data management and interoperability. Integrating our electronic health records (EHRs) with a myriad of payer systems is rarely straightforward; it is similar to piecing together a complex puzzle without having all the pieces. The task of collecting, analyzing, and reporting performance metrics can easily become overwhelming. Without seamless, interoperable systems, the potential of real-time data to drive meaningful improvements in patient care remains unreachable.[34]

Adding to the complexity is the challenge of payer alignment. Many practices work with multiple payers, each imposing its own set of requirements and expectations. Managing these disparate payment models concurrently can lead to fragmented processes, diluting the overall impact of our VBC strategies.[33] Additionally, we must consider the cultural and operational challenges. Shifting from a long-established fee-for-service mindset to one that genuinely embraces VBC is not just a technical change – it is a profound cultural transformation. Resistance is natural, whether it comes from colleagues clinging to familiar routines or from support staff wary of overhauling their workflows. Successfully engaging our entire team and fostering a culture of continuous improvement demands not only strong, empathetic leadership but also a shared willingness to step outside our comfort zones and try new approaches.

Where to Go from Here?

The road to adopting VBC is not always straightforward, but there are strategies that can make the journey more manageable. Empanelment, for example, is the ongoing process of maintaining an up-to-date roster of patients assigned to a provider.[35] It may sound simple, but having that accurate list ensures every patient receives proactive, personalized care. Pair that with effective risk stratification through hierarchical condition category (HCC) coding – a system that classifies patient diagnoses to predict future healthcare costs – and we can more accurately identify high-risk individuals, directing resources where they will make the greatest impact.[36] Robust panel management follows, allowing us to keep a close eye on patient outcomes and adjust care plans in real-time. The importance of team-based care is vital. When physicians, care coordinators, nurses, and support staff work seamlessly together at the top of their licenses, comprehensive and coordinated care stops being a goal and becomes the norm.[35]

Technology is an indispensable partner in this transformation. Modern EHRs, telemedicine platforms, and advanced data analytics tools help us track clinical outcomes more efficiently and manage care more thoughtfully.[37] Even emerging technologies like artificial intelligence hold exciting promise. Imagine being able to refine risk stratification models and predictive analytics to a point where interventions are not just timely – they are anticipatory.

For New York's richly diverse populations, the potential benefits of VBC are profound. Shifting our collective focus from the quantity of services delivered to the quality of care provided and addressing social determinants of health head-on can foster a more

equitable and effective healthcare system. However, achieving this vision requires more than just clinical innovation. It demands structural support. Advocating for payment models that truly align financial incentives with patient-centered care is key. Programs like Primary Care First and the Making Care Primary Model, variants of VBC with different requirements mandated by Medicare and/or Medicaid, act as excellent examples of promising frameworks that encourage high-quality, cost-effective care while respecting the complexities of practice management.[38,39]

At its core, family medicine stands uniquely poised to lead this transformation. Our specialty is rooted in comprehensive, coordinated, and compassionate care – values that are perfectly aligned with the goals of VBC. The opportunity before us is not just to improve quality metrics or reduce costs; it is to make a lasting, tangible difference in the lives of our patients and the health of our communities. Now is the moment for action. Policymakers, healthcare organizations, and fellow family physicians – we all have a role to play. By embracing these innovative strategies and remaining steadfast in our commitment to quality, equity, and efficiency, we can transform VBC from a well-intentioned concept into a lived reality. Together, we can build a future where value-based care is not just a healthcare buzzword – it is the standard that elevates primary care for every New Yorker.

Table 1. Provider Payment Types, Adapted From Health Care Payment Learning and Action Network[16]

Payment Types	Description	Examples
Level 1: Legacy Payments	Traditional fee-for-service (FFS) payments without a link to quality or performance adjustments	
Level 2: FFS Linked to Quality	FFS payments that are adjusted based on quality incentives, infrastructure investments, or reporting requirements	**Pay-for-Performance:** Adjustments or bonuses based on meeting quality metrics
Level 3: APMs Built on FFS Architecture	Payments that are structured on a FFS foundation but incorporate financial risk and quality performance measures	**Shared Savings:** Traditional or utilization-based shared savings where providers share in savings if they meet cost and quality targets **Bundled Payments:** Procedure-based bundled or episode payments where a single payment covers all services for an episode of care
Level 4: Population-Based Payments	Fixed, prospective payments made on a per-member-per-month basis to cover a defined scope of care for a patient population	**Capitated Payments:** Full or percent-of-premium payments, condition-specific population-based payments

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NEW YORK STATE ACADEMY *of* FAMILY PHYSICIANS

The following was developed by the members of the NYSAFP's Public Health Commission's Payment Models Subcommittee. With special thanks to Dr. Tanya Kapka, Dr. Aerial Petty, Dr. Scott Hartman and Gabriela Miletsky

Value-Based Care Frequently Asked Questions	
1. What is Medicaid?	Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.
2. What is Medicare?	Medicare is a federal health insurance program administered by the Centers for Medicare and Medicaid (CMS) for people aged 65+ and younger individuals who meet certain qualifications such as disability. Medicare has 4 parts: Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage plans), and Part D (prescription drug coverage). It is possible for people to have coverage from both Medicaid and Medicare, typically based on income and disability.
3. What is value based payment?	Value-based payment is a model where providers are reimbursed based on patient outcomes, rather than the number of services provided. Payments, typically made monthly or quarterly, are tied to metrics like care quality and patient engagement. There are different models that can be used to provide value-based payment that involve different levels of financial risk to healthcare delivery systems and health plans. Value based-payment rewards upstream care and patient engagement.
4. How does value based payment affect family physicians in New York?	Value based payment (VBP) is an increasing proportion of both publicly funded and commercially funded payment models targeted at primary care on a population level. CMS has committed to increasing the proportion of payment to value based payment (particularly Medicare) over time. This requires reorganizing care provided to reduce cost and utilization and improve upstream care, particularly primary care, while building systems to improve health outcomes and quality.
5. How does VBC affect patients in New York?	VBC provides primary care access and an infrastructure for improving quality of services, with coordination required, and reporting processes to ensure contract goals are met for cost, utilization, and quality. Health systems that participate in VBC tend to have measurably better health outcomes.
6. How does this affect family physicians who don't accept Medicaid/Medicare?	Given the age and demographics of our population, it will be challenging to provide care to patients outside of the VBC model. Value based payment is already an increasingly mandated model through Medicare, and Medicaid isn't far behind. Commercial payers are also starting to move in this direction.
7. What is the current state of affairs for value based care?	Nationally, Medicare is committing an increasing proportion of payments to value-based models, particularly via Medicare Advantage and Accountable Care Organizations (ACOs). As Medicaid is very specific to each state, it also has more variable adoption of VBC state by state. Note: many states have already passed legislation requiring a certain percentage of healthcare dollars to go to primary care. Some of those states have already demonstrated improved population outcomes and equity. NY has proposed legislation but it is still pending. Current national spending on primary care is 4.5%; New York is 4.1%. States that have passed this legislation vary from 11% to 13% requirement. New York's proposal has a 12.5% target.

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Value-Based Care Frequently Asked Questions, continued	
8. What is the 1115 Waiver? How does it change existing systems?	The 1115 waiver provides an infrastructure to deliver more coordinated services for the most vulnerable patients on Medicaid, which includes social support. Section 1115 demonstration waivers grant flexibility to states for innovative projects that advance the objectives of the Medicaid program. Typically, 1115 waivers are approved for 3-5 years. Authorized under Section 1115 of the Social Security Act, these waivers: • Give the Secretary of Health and Human Services the authority to waive certain provisions and regulations for Medicaid programs, and • Allow Medicaid funds to be used in ways that are not otherwise allowed under federal rules.
9. What is a health equity regional organization (HERO)?	A HERO is an independent statewide entity that convenes and collaborates with a diverse and comprehensive range of stakeholders to inform the state's plan to advance health equity across the state. Components include: • Data aggregation • Regional needs assessment & planning • Value based payment design & development • Program evaluation
10. What do these changes mean for family physicians?	The structure provides enhanced monthly payments for all Patient-Centered Medical Home (PCMH) primary care practices for their Medicaid Managed Care members over the next two years. In subsequent years, payments will transition to a bonus payment structure, linking payments to quality and efficiency, and then to a value-based payment (VBP) model to align with the Medicare Making Care Primary (MCP) model. These enhanced payments are in addition to the monthly PCMH payments that PCMH-recognized practices currently receive. These existing payments will not transition to a bonus payment structure or VBP model along with the enhanced payments. Family physicians should learn as much as possible about these "new" models and seek a seat at the table in organizations or entities administering the plans.
11. What do these changes mean for patients in New York?	For patients, it means moving to a population model, where those who have the most needs will be surfaced more easily by data informed practices that match them with the services they need. This provides an opportunity to improve outcomes with more appropriate "dose" of services based on needs across a region rather than per system.
12. What are the barriers to implementing value based care?	Data systems and platform interoperability is an exceedingly challenging issue in New York. Value based care is predicated on improved interoperability, thus there are significant barriers to fully integrating it into our health systems.
13. What is the timeline for value based care in New York?	The 1115 waiver is one step in the value based payment roadmap for Medicaid. However, CMS has an overall value based payment roadmap, where they are committed to having all Medicare based entities on a value based payment system by 2030. Because of this, they intend to have Medicaid follow. This is only one step in the process of moving to a value based payment system.
14. Are there currently any primary care bills in the New York legislature?	There is currently a proposed Assembly bill and Senate bill regarding value based care. Assembly Bill A8592 requires that health care plans and payers spend a minimum of 12.05% of their total annual physical and mental health expenditures on primary care services.
15. Helpful Links	Medicaid Medicare Value Based Payment in New York 1115 Waiver HERO Share of Medicaid Population Covered Under Different Delivery Systems

SUPPORTING VALUE BASED CARE IN NEW YORK

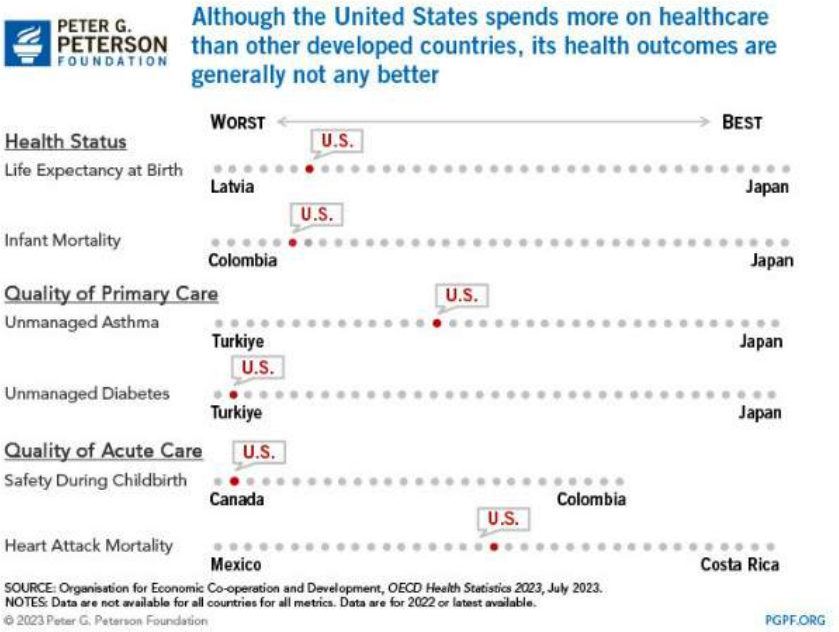
New York State Academy of Family Physicians

BACKGROUND

Nationally, primary care accounts for approximately 35% of all health care visits each year – yet only about 5 to 7 percent of all health care expenditures are for primary care. Primary care is a cornerstone of vibrant, thriving communities and helps keep families healthy, children ready to learn, and adults able to pursue education and participate in the workforce. Primary care also saves lives, improves individual and community health, and regular access to primary care is consistently associated with positive health outcomes. Access to primary care has not only been shown to reduce overall health care costs but is the only part of the health system that has been proven to lengthen lives and reduce inequities at the population level.

PROBLEM

15% of New York residents reported not having a usual source of care or regular health care provider in 2021. In 2022, 20.5% of Hispanic/Latinx residents reported avoiding care due to cost in the past year, 3 times that of white residents. From 2018-2020, the potentially preventable hospitalization rate among Black residents was 2X higher than white residents. In 2021, preventable emergency department visit rates for adults with employer-sponsored insurance was 134 per 1,000 and 136.6 per 1,000 among Medicare beneficiaries (ages 65 and older). In 2020, among those ages 6-17, the preventable hospitalization rate was 97.7 per 100,000.



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SUPPORTING VALUE BASED CARE IN NEW YORK

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SOLUTION

Value-based payment (VBP) is reimbursement based on patient outcomes, rather than the number of services or visits provided. Payments are tied to metrics like care quality and patient engagement. There are different models of providing value-based payment with varying financial risk to healthcare delivery systems and health plans. VBP rewards upstream care, reduction in high cost services, prevention, and patient engagement. This value based payment structure provides enhanced monthly payments for Patient-Centered Medical Home (PCMH) primary care practices for Medicaid Managed Care members over two years.

In subsequent years, payments will transition to a bonus payment structure, linking payments to quality and efficiency, and then to a VBP model to align with the Medicare Making Care Primary (MCP) model. These enhanced payments are in addition to the monthly PCMH payments that PCMH-recognized practices currently receive. These existing payments will not transition to a bonus payment structure or VBP model along with the enhanced payments.

THE 1115 WAIVER

The 1115 waiver is one step in the VBP payment roadmap for Medicaid. However, CMS has an overall VBP roadmap, including commitment to all Medicare based entities in a VBP model by 2030. The intention is for Medicaid to follow. This is only one step in the process of moving to a value based payment system. There is currently a proposed Assembly bill and Senate bill regarding value based care. Assembly Bill A8592 requires that health care plans and payers spend a minimum of 12.05% of their total annual physical and mental health expenditures on primary care services.

The HERO (Health Equity Regional Organization)

Almost ⅓ of New Yorkers rely on Medicaid for coverage. A HERO is an independent regional entity in NY state that convenes and collaborates with a diverse and comprehensive range of stakeholders to inform the state's plan to advance health equity across the state. Components include:

- Data aggregation
- Regional needs assessment & planning
- Value based payment design & development
- Program evaluation

Increasing the Diversity of Administrative Healthcare Leaders in Family Medicine

By Callyn Iwuala, MD

As family medicine physicians, we are privileged to be able to care for all persons at all ages, "from the cradle to the grave," touching the lives of generations of families. As primary care physicians, we are the frontline for most, the initial or only point of medical contact. As we engage with our patients, collaborate on shared decision management plans and maintain continuity, an invisible contract is signed and we make the commitment to ensure that we provide quality care, to the best of our abilities.

In New York, as of 2024, the population included 68.5% White Americans, 17.7% African-Americans, 19.8% Hispanic or Latinos, 9.7% Asians, 1.1% American Indian and Alaskan native.[1] New York has the second highest population of African- Americans and the highest population of Puerto Ricans in the United States.[1] The importance of a diverse workforce in medicine has been expounded upon in many scholarly publications. In summation, diversity in the medical workforce, cultural competency and acknowledgement of existing health disparities strengthen the patient-provider relationship, ultimately improving patient care outcomes, reducing health disparities and increasing the use of preventative health services.[2]

The diversification of the workforce at the level of healthcare administration is equally as important. In rooms where decisions affecting healthcare systems, specific populations and local communities are made, it is paramount that there is a diversified administrative team of qualified leaders who will be tasked to make decisions that will have resounding effects in local and neighboring communities.

In a cross-sectional observational study completed in 2022, utilizing the Association of American Medical Colleges roster, the proportion of chairs who identified as being underrepresented minorities in medicine was compared across specialties. The proportion of chairs who were underrepresented minorities was found to be highest in family medicine at 16.7%, compared to other specialties.[3] The proportions of Black, Asian and Native American family medicine chairs were comparable to that of the United States population.[3] However, the proportion of Hispanic or Latino family medicine chairs was not comparable to the United states population, lagging behind.[3]

In New York State, where almost 20% of the population is Hispanic or Latino, increasing the proportion of Hispanic or Latino family medicine chairs would be paramount. According to the AAMC, matriculants from historically underrepresented groups in medicine declined, with Hispanic matriculants declining by 10.8% and African-American matriculants declining by 11.6%.[4]

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Historically, the percentages of matriculants underrepresented in medicine foreshadow the percentages of administrative leaders who are underrepresented minorities in medicine.

Beyond ensuring the diversification of the chairs of family medicine nationwide, we should aim to ensure the diversification of administrative teams in healthcare in New York State, including the boardroom, within large hospital systems and in local clinics. When issues predominantly seen in specific communities or populations emerge, in an effort to ideate sound considerate solutions, it would be most appropriate for diverse administrative teams to do so. Mentorship, considered recruitment of qualified underrepresented faculty physicians and continued leadership development programs can help to increase representation in administrative leadership.

What systems or programs exist for qualified resident physicians who are underrepresented in medicine and interested in healthcare administrative roles ?

To ensure the diversification of family medicine chairs and other health administrative roles allotted for physicians, it is important to address the beginning of that process – the matriculation into medical school. As mentioned, there has been a decline in the number of college students, who are from traditionally minority populations, who have matriculated into medical school.[4]

Health profession oriented pipeline programs typically target underrepresented students from elementary school through college, with the aim of providing mentorship, increasing exposure to the medical field and providing academic resources.[5] Pipeline programs that focus on supporting and guiding students from minority populations on their journey to medical schools would benefit from increased advertisement, increased funding and subsequent expansion.

As one who has been a participant of health oriented pipeline programs since elementary school , starting at a science club, then joining a STEM oriented pipeline program for middle school students through high school, the pivot from the sciences into the world of medicine can be difficult without guidance. I joined a national summer medical and dental program that had 12 sites nationally for college students interested in matriculating into medical and dental school. Visually seeing physicians who looked like me, being surrounded by students with identical visions and being exposed to the medical field made the pivot into medical school much easier.[5]

To address the decline of underrepresented students into medical school, it would be best to target students at the elementary and middle school level.[6] While there are a handful of pipeline programs starting at the elementary level in New York, they would benefit from increased advertisement throughout the state. It would be beneficial and feasible to identify the pipeline programs that already exist and to amplify them verbally and financially.

According to AAMC, 149 pathway programs were identified in US medical schools from the years 2019-2020.[7] Currently, 154 pathway programs exist nationally, presumably 1 pathway program at each medical school. There has been a steep decline in the number of middle school and high school pipeline programs, with 71 middle school pipeline programs from 2021-2022 declining to 64 programs in 2022-2023 and 129 high school pipeline programs from 2021-2022 declining to 120 programs in 2022-2023.[7]

New York boasts the highest number of medical schools in the United States at 18. In light of the overall decline described above, the need to amplify or create more middle school and high school pipeline programs in New York could contribute to increased diversification of the medical professional body and subsequently the diversification of health care leaders in New York.

While national leadership development programs exist for residents who are underrepresented in medicine, New York medical bodies should also amplify informal or formal leadership development programs for resident physicians in an effort to increase the diversity of administrative leaders in family medicine. The importance of a diverse workforce especially at the administrative level is critical for New York where we serve many diverse populations.

Endnotes

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