In May, 2012, the Office of Continuing Medical Education surveyed medical practitioners in our area. The survey collected information which may be helpful to you as you determine barriers for your event.

10. Have you witnessed or experienced any barriers that have hindered improvement to your office/practice and/or patient care?

Coding/Insurance

- Coding and Health care cost. Small rural hospital trying to keep afloat
- Computer systems, insurance issues
- Ability to use new information- at times insurance won't cover new medications or procedures we learn about. Also time to learn about new techniques- procedures.
- Insurance limits on med use.
- Dealing with prior-auth and insurance issues takes up a lot of our time. Very few options for opioid addiction treatment
- Handling Insurance issues.
- Insurance (6)
- Insurance Frequent Credentialing documentation
- Insurance barriers (ordering tests, prescribing medications)
- Insurance companies and lack of time (due to the insurance companies) - really - too much paperwork and not enough time per patient in the office due to low reimbursement per patient. In addition, I feel that EMR's have not necessarily been the help they said they would be and I find them often unwieldy and time consuming. This means there is less time to keep up on CME reading which dumbs us down.
- Insurance mandates limiting use of certain medications
- Lack of insurance (2)
- Third party payors

Communications

- Communications
- Difficulty communicating with The University of Vermont Medical Center. Receive specialist notes randomly and are often not useful-- no clear assessment and plan. There are exceptions. Not sure how to improve communication-- this may not be the correct survey for this but not sure where The University of Vermont Medical Center stops and UVM starts.
- Scheduling. Sometimes overbooking. Some communication issues between office staff.

EHR / PRISM

- Bureaucratic inertia - complexity of EHR
- Electronic health records and poor standardization for quality measurement, poor interoperability
- Electronic Medical Record is too time consuming
- EMR is not functional enough. I spend hours.
- EMR needs and time takes away from patient care
- Integration of decision support into EHR's
- Introduction of the EMR is stressful, not well thought out [at least in our facility] and does cause delays in seeing patients on time and also is very discordinated with having records here there and everywhere!
- IT systems that help support our new learning - they are often not designed in a way that is easy to do this.

- Lack of medical records and the coordination between the hospitals.
- Long hours spent documenting office care on EMR leaving little time and energy left to initiate and support QI.
- My private office does not qualify for any financial assistance for EHR. Due to the financial impact of an EHR on my office we have not yet implemented one
- Non- interactive computer systems- unable to access info without asking for faxes, trying to get into multiple EMRs etc.
- PRISM - excessive documentation, information overload such that the important points are missed Having to work at a computer which faces away from a patient
- EMR is time consuming and a distraction from the bedside care.

Expertise/Education

- A major barrier is for the CME pharmacist currently conduct is not backed by CME through UVM because of cost. The pharmacy dept. at The University of Vermont Medical Center claims the fees for UVM CME are too expensive. Consequently, all the excellent CME provided by the dept. of pharmacy does not allow providers as Nurse Practitioners to earn CME in a cost effective manner. National board re-certification now mandates a minimum of 15 hours of Pharmacy related CME for NPs. If UVM & The University of Vermont Medical Center would work together on the cost, everyone would benefit.
- Implementation of prism without enough teaching.
- Updates in other fields not communicated to my field Limited access to guidelines in Oncology because I am not a member of that organization (e.g. NCCN)

Financial

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- Canadian Health Care system is always hampered by lack of adequate funding
- Cost, efficiency
- Costly mandates.
- Finances
- Financial - the rapidly rising tuition costs
- Financial barriers- not being able to afford more space for our practice
- Financial constraints of patients lack of social service availability for high risk follow-up of pts. Price of medications for pts. to purchase.
- financial constraints, technology and the older worker
- Cost of CME
- Inability to pay
- Inadequate payment in psychiatry. Horrendous and frustrating managed care barriers.
- Insufficient funds for our unit
- Lack of payment for services. Government regulations.
- Limited funds-decreasing reimbursement is somewhat a problem – however, we continue to expand especially outside the hospital
- Money - Physical plant in need of updating
- Money and time! (What's new?) Continuing ed really is the most important factor, for me, to improve my practice and patient care. Always a shot in the arm after every in-service, conference or web-based learning! Offerings during school hours are a bust for most school nurses, as it is VERY difficult to find substitutes. Grand Rounds, after school hours, are very much appreciated, as are occasional weekend
- Not enough funding for continuing education

- Patients who cannot afford co-pays/ payment. Patients who no-show frequently but cannot be billed
- Politicians do not believe primary care is struggling- financially, regulations, more and more senseless paperwork, formularies that change at a whim
- Relentless lowering of reimbursements
- Space is expensive, so it is often difficult to add ancillary treatment professionals into a medical setting
- The cost of medication
- Bringing up improvement issues does not generate more revenue and in some cases might reduce it. Also bringing up marginally performing MDs is punished
- Financial barriers to hiring appropriate number and properly trained staff

Habits

- The natural tendency towards inertia (change resistance)
- Unwillingness to change- co-workers stuck in their ways.
- Mainly management and staff unwilling to make changes to procedures that have been in place for years despite obvious problems with efficiency and quality of patient care.
- Professionals who are resistant to change and prefer to work independent rather than team oriented.

Patient

- During pregnancy: lack of fathers in the pregnancy continuum.
- Problems with engagement in treatment and follow-through.
- Scheduling issues and frequent no-shows by patients

Quality Improvement/Assurance

- Difficulty organizing and executing quality improvement projects
- Poorly informed nonclinical bureaucrats, Both governmental and hospital administration, insert their opinions on how to improve safety not realizing they themselves are making healthcare less safe by stopping clinical practitioners from performing traditional safety practices in order to carry out their mandates and demands

Resources

- Ability to use new information- at times insurance won't cover new medications or procedures we learn about.
- Accessibility of resources/specialists for patients
- Access to new equipment
- Availability of community services for individuals and families with psychosocial stressors which may or may not include mental illness
- Demand vs. supply
- Difficulty in accessing specialty care
- Few outside referrals for psychiatry
- Inaccessibility of mental health care in Chittenden County. Too long to get patients into specialty practices
- Insufficient space and insufficient support staff for our unit
- It's difficult re: changes in government, and reimbursement-we are required to do more w/ less staff, any help re: process stream-line in the primary care practice is always helpful.
- Lack of access to a psychiatrist that I can consult with
- Lack of mental health providers with flexible hours
- Lack of psychiatry resources. Patients not receptive to change. Adolescents opposed to counseling. Families with psychiatric illness with the child as the "presenting problem".
- Lack of services in our area

- Lack of staffing prevents efficient treatment and billing issues for DME Kinesio taping
- Limited access to specialists requiring care of pts. in the outpatient setting that would be better managed by specialists.
- Long wait times for specialists
- Need referral and transfer process to happen more quickly. Are there any thoughts being given to a "one-phone'-call" process? Spend too much time on our end tracking down the right physician specialty, means of transportation, etc.
- There is a shortage of PCPs, counselors that specialize in addiction and co-occurring MH

Time/Workload

- Time, Money & Expertise (not enough of each)
- Time to learn about new techniques- procedures.
- Difficulty collaborating with other physicians because of time constraints and/or office management in the context of a high patient to physician ratio.
- finding time to do the process
- Time for CME
- Having enough time to spend with patients and having office staff who care to help
- In this stressed economy, there is a push to see more and more patients. I feel this diminishes our quality of care as there is less time to spend with patients and families.
- Lack of time to attend conferences
- Lack of time to devote to patient/family education and counseling.
- Lack of time to discuss as colleagues, lack of institutional support for meetings/planning/follow-up
- Lack of time to see patients, need to address multiple issues in one visit, difficulty getting patients into specialty practice in a reasonable time frame
- Largest barrier is time
- Workload at peak times
- Time available to me. Perhaps if I knew about web based CME I could use it.
- Not enough time and/or contact with presenters
- Time away from patient care. Weekend conferences are very helpful. Limited funds for CME are a concern, so cost is an issue.
- TIME to attend programs
- Time. Inefficient EHRs. Poorly trained practice managers.
- Too little time (6)
- The hurry up mentality. The lack of focus by all providers on the patient. Administrations near-complete disconnect with what is happening at the patient-provider interface.
- The spare time to think about and organize changes.
- Conflict between patients wanting more time for visits and administration wanting more visits per day!
- Time is the biggest barrier. We are very busy clinically.

Staffing:

- Low pay for CMAs leads to poor work ethic in staff members, and constant turnover.
- Staff who are uninvested in process improvement - either the process or the specific content; lack of administrative oversight of clinical and/or nonclinical staff who are active in patient care activities
- Sure, it is a large academic center that moves like the Titanic. The nearly 100 Vice Presidents do not wish to listen. Increase patients without increasing resources
- Staff turnover, insufficient communication/buy-in, lack of awareness, etc.
- The cuts made in genetic counselor and administrative support in my division
- Employee burnout, poor people skills, etc

General

- How to send electronic info while maintaining privacy for patient
- Inefficient OR
- Lack of low cost organized physical activities for non-athletes. WIC giving out juice
- Local and national regulation of medical practice
- Transport issues when transfer needed
- Cumbersome documentation and paperwork required of primary care physicians
- Physician buy in and educating staff of services available
- Physician needs /wants overriding pt. care
- Poor understanding of NP practice by compliance people
- Psychiatric medications are not as effective as people think they are.
- Rules regarding hiring The University of Vermont Medical Center employees when another The University of Vermont Medical Center employee leaves a position. Patient throughput hindered by lack of available space and medical office assistants.
- Paperwork/computer nightmares, now that we have some of both going on.
- The lack of institutional support
- Lack of responsiveness by Adult Protective Services (or a lack of a timely response), this results in lost evidence and re-call for someone who has been severely traumatized. This is not fixed, and frankly too many people are buying into the information provided by a very well-spoken Commissioner who is micro-managing her staff and presenting information to the Legislature that is inaccurate.
- Things you guys really can't help with--administration ineptitude, ignorance, refusal to learn, and reimbursement problems.

CME Process

- Initial UVM contact and planning of symposia is almost obstructionist until UVM CME decides that it wants/has to work with a specific program. UVM is probably the most expensive CME credit program I have encountered in the US over the last few years and we need more UVM CME directed grants to make education affordable and doable.
- Lack of ability of UVM to accept industry funding has limited the availability of nationally known speakers.