The Perspective

A Publication of the Vermont Academy of Family Physicians

"To promote excellence of the health care provided to all the people of Vermont."

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In This Issue:

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President's Report

As this is my first article for our newsletter, I would like to thank Rob Penney for his leadership as the VT Academy president over the past two years. He has worked tirelessly for all of us on advocacy issues in the state, and he will continue to work in those roles as we move forward. I know it must be very hard to run an independent practice and find the time to advocate for us and it is much appreciated.

Carol Blackwood and I met this past summer to put together our ideas for the next four years – where we see the Academy can be most beneficial to our state and members. The members have responded that advocacy is of prime importance and we will do our best to further that goal. To that end, I have initiated the following:

Contact with the legislature – Mary Dill and I sat down to discuss a program that has been initiated in Oregon called Key Contact. It encourages all of our members to reach out to one legislator and take them to lunch/coffee to let them know what we do as family medicine doctors. Also to encourage them to get in touch with us to discuss our views on various bills that may be in the Legislature. I know we are a diverse group and can't possibly have the same views on all of the issues that we may be asked to comment upon. However, I do know that each of us can advocate for Family Medicine and for what we do for our patients and the community. Mary has agreed to take the lead in trying to organize this effort – more to come.

Contact with medical students interested in Family Medicine and Family Medicine residents – I met with the Family Medicine Interest Group at UVMCOM and there is a lot of interest in our group and what we do. Vanessa Patten (a fourth year) joined us for our last Board meeting and will be writing a column in the newsletter. There are several other medical students who will be attending our June meeting. Our hope is to be mentors for the students as they navigate medical school.

There is also interest in the residency program. Julia Hunter is meeting with Stephanie to discuss advocacy and the role that residents can play. Again, we are hoping to involve the residents in our Academy as well in hopes that they will remain aciive in their state chapters in the future.

Outreach to members around the state – it is my hope to travel to many of your practices over the next two years to speak with you about what the Academy can do to help you, what you should expect from the academy, and any ideas that you have to help us be a more valuable organization for you and your practices in these changing health care times. Please let Stephanie know if this is of interest and what the best times would be for a short visit.

I have been reaching out to other small state chapters to discuss what they are doing for members and to see if there are ideas we can utilize in Vermont. Stephanie attended the leadership conference this April in Kansas City. She had a chance to meet with other executive directors and brought back ideas to implement in our chapter. We have two delegates, Carol Blackwood and Andy Regan, who will be attending the National Congress of Delegates this September. In this role they will have a chance to speak with others around the country and compare notes. These encounters should prove to be a wonderful exchange of information.

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Vermonters will always have choice in health care

By Allan Ramsay, M.D.

On April 3, 2013 several Vermont physicians participated in a press conference at the Statehouse. They were there to express their concern about the Green Mountain Care Board's (GMCB) authority to set all payer provider compensation rates, a provision of Act 48. Their message was that the GMCB should not be able to set payment rates because "it infringes on the economic freedoms of doctors." One physician commented that this would allow the State to "manipulate the clinical decision making of doctors." If this authority is not removed there was a suggestion that legal action would be brought against the Shumlin administration and GMCB.

The truth is that our current fragmented health system has infringed on our economic freedom for over thirty years. Any health care professional who participates in Medicare, Medicaid, or contracts with health insurers has already had their payment regulated for a long time. In addition, the current payment system is not rational or fair. This variation in how we get paid to provide health care totally undermines any attempts at making payment more transparent for those who seek care.

For example, the way each health insurance company pays health professionals and hospitals can vary widely. Those with the most bargaining power get the best payment. Because Medicare and Medicaid pay less than the actual cost of some services, insurance companies (or those with no health insurance) have had to make up the difference, leading to the "cost shift".

In 1982 Medicare began paying hospitals a fixed payment based originally on 467 diagnosis-related groups, which were then divided into diagnostic categories. In addition Medicare sets the fee schedules for all Medicare outpatient procedures done at hospitals. The Relative Value Scale Update Committee (RUC) is a private group of mostly specialist physicians who make highly influential recommendations on how to value a physician's work which leads to how they get paid. The RUC meetings are closed to the public and have no regulatory oversight.

Medicaid is jointly funded by the federal government and the state so payment rates are partially set based the state's ability to pay. States are allowed to develop their payment rates based on the costs of providing the service, a review of what local commercial insurers pay, and a percentage of what Medicare pays for equivalent services. Under Medicaid managed care arrangements, states contract with organizations to deliver care through networks and providers get paid a fixed monthly amount.

The GMCB will take a new approach to determining how health care providers are paid. It has contracted for a study of price and payment variation. The GMCB will use this research to identify policy approaches that support fair payment for all providers by all payers and moderate the shifting of costs from one payer to another. The GMCB has significant discretion in how it sets payment rates for different groups of health care professionals and need not set rates for everyone who provides health services. Setting a payment rate is a very complicated process, requiring analysis of historical trends, payment reform pilots, workforce issues, and utilization projections. The GMCB's policy decisions related to provider compensation will occur in open Board meetings and we will encourage public input in the process.

The GMCB's initial goal will be to bring more fairness, transparency, and support for high quality care to the payment system. Our priority is to improve payment methods for services paid for by insurance, and not to regulate transactions outside the insurance system. Even the most highly regulated health care systems in the world do not limit the ability of those with financial resources to purchase medical services outside the basic medical benefits provided to all their citizens. When asked about regulating physicians who want to independently contract with patients at a recent Joint Health Committee hearing, GMCB Chair, Anya Rader Wallack said, "This will not be our focus."

As a physician member of the Green Mountain Care Board I realize that some of my colleagues who practice independently have concerns about the transition to a well regulated, fully integrated Vermont health system. I know primary care best, having practiced family medicine in Vermont for many years. Many primary care physicians in Vermont are still independent but most are employed by Federally Qualified Health Centers or hospital organizations. I am on record as supporting all models of practice in Vermont, including those who wish to remain independent. Whatever type of practice, there will be increased accountability for us to demonstrate increased value and better health care outcomes. I do not believe Vermont physicians have ever made clinical decisions based on how they get paid, even though they have had minimal control over their payment models for many years. The GMCB's ability to set fair compensation for health care professionals and relieve them of the administrative burdens in the current system is critical to the survival of us all.

I joined the Green Mountain Care Board in the hopes that Vermont could overcome some of the barriers that exist to health care reform. I knew that Vermont needed to be sure every citizen was covered with a set of health care benefits, at a cost we could afford. Most other health care systems that are able to provide basic benefits to all citizens rely on regulating prices and payment, whether physicians contract independently or not. The authority of the GMCB to improve the payment system will not change how doctors make clinical decisions or how they share them with their patients. All Vermonters will continue to have choice in their health care professionals, they will get high quality health care, and they will no longer fear the crushing effect of health care costs.

An Update on the UVM College of Medicine Family Medicine Interest Group (FMIG)

By Vanessa Patten, MD Candidate Class of 2014

The UVM College of Medicine Family Medicine Interest Group (FMIG) entered the 2012-2013 school year with more energy and enthusiasm than ever. The group is a student-run organization that provides a forum where medical students of all four classes interested in pursuing a career in family medicine can learn about and integrate themselves into the specialty. The group has sponsored several well-received events this year, including an injection clinic, vital signs and suturing clinic and the upcoming casting clinic in May. These events are open to members of all classes to learn from each other and share skills. They provide an opportunity to connect with local family medicine physician and resident mentors.

The group also sponsors lectures during Primary Care Week in the fall, which is well-attended by the student body. The lectures expose students to the variety of scopes of practice within the field of family medicine. Additional speakers are sponsored by the FMIG to speak during lunch meetings, furthering medical student exposure to the many aspects of family medicine.

Student members have participated locally in Vermont Academy of Family Physicians (VT AAFP) board meetings, regionally at the Society of Teachers of Family Medicine (STFM) meetings, and nationally at the AAFP's National Conference of Family Medicine Residents and Medical Students (NCFMR/S). Currently, members of the group are preparing to attend the AAFP's National Conference this coming August as well as the 2013 Family Medicine Education Consortium (FMEC) Northeast Region Meeting in November, where members will submit posters summarizing their research. One FMIG member spoke of her experience at the 2012 FMEC conference by saying, "I left feeling like I belonged to something bigger than myself, and felt motivated to work hard in school so I could be like the great people I got to know at the conference. "

Members of the Family Medicine Interest Group are currently brainstorming new community service initiatives to take part in as a group to further their connection with the Burlington Community. By identifying needs within the community and searching for avenues to address them, students will develop skills that they will utilize as future family physicians in whatever community they serve. The FMIG is looking forward to expanding their involvement beyond the medical school, and will continue to seek out opportunities to learn about and promote family medicine.

Vermont Academy of Family Physiicans

2013 Annual Meeting

Saturday, November 2, 2013

Capitol Plaza Hotel
Montpelier, VT

Save the Date!

VERMONT ACADEMY OF FAMILY PHYSICIANS

Leadership

Allyson Bolduc, M.D.
President/Delegate

Carol Blackwood, M.D.
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Mary Dill, M.D.
Member-At-Large

Mark Lichtenstein, M.D.
Member-At-Large

Andrea Regan, M.D.
Member-At-Large
Alternate Delegate

Stephanie Winters
Executive Director

Majestic Mountains, Fabulous Food, A Diverse Population And Amazing Illnesses

By Mark Lichtenstein, M.D. & Cynthia West

A path leads down the hill, perhaps to a favorite neighborhood restaurant, or on to other villages. Paths are the main routes of travel.

BAYALPATA, Nepal — Namaste - greetings - to our community from Bayalpata, in far western Nepal. This evening, we walked 10 minutes down the hill from the room we are renting, to our favorite neighborhood restaurant. Nirpa Bahadur Kadayat, the owner, is saidto be the best cook in town. The food is fabulous. Eating here is like eating in someone's home and we are always the center of attention. We communicate by practicing our Nepali while they try out their English. Several people always stop by either to get a look at us or to try to help.

As many of you may remember, we are in the Achham province of far western Nepal to volunteer at Bayalpata Hospital and the local school until mid-April. Nyaya Health is partnered with the government to bring health care to the more than 200,000 people in this district.

Each morning, we walk about 30 minutes from our village to Bayalpata Hospital. The surrounding terraced hillsides have a backdrop of majestic mountains, from 3,000 to 4,000 foot hills nearby to 20,000 foot snowcapped Himalayan peaks. We find the view breathtaking. We are struck by the amazing panoply of visual delights that fill the landscape of our everyday lives. A small boy holding and caressing his pet chicken while walking to his destination, an elderly woman balancing a few armloads of fire wood on her head, slowly walking, and using her only free hand to greet us and say "Namaste." At the road's edge, women scrubbing down children from head to toe, while they yell at the top of their lungs at the completely frigid experience.

The diversities are dramatic, everyone with slightly different facial features since there are many ethnic nationalities, over 70 languages and several castes. We see well-dressed townspeople walking to a job who knows where, lanky teens trying to be cool in jeans listening to their cell phones or MP3 players, goat and cow herders with the animals, wide-eyed children laughing and then suddenly stopping and staring at us. Sometimes, one of the children has the courage to yell out "hello" or some other English phrase and everyone giggles.

At the hospital, Mark sits with a doctor in the outpatient room and offers mentoring when the doctor reviews the case and asks for advice. The illnesses that come through the door are amazing: many people with active TB; a 16-year-old with severe rheumatic heart disease; women with traumatized pelvic organs from a traditional healer placing a stick in the uterus and leaving it there to produce sterility or induce an abortion. There are many fractures of arms, legs, and wounds that resist healing.

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A young mother uses a handful of twigs to brush off the ground as her young child looks up. They live in Bayalpata in far western Nepal.

(Cont'd from pg. 4) The inpatient ward is mostly women with severe end stage emphysema from breathing smoke during cooking. The hospital can do plain x-rays and very simple chemistries and diagnose TB sputum samples. Anything more complicated requires referral to bigger facilities that are 6 to 20 hours away by jeep.

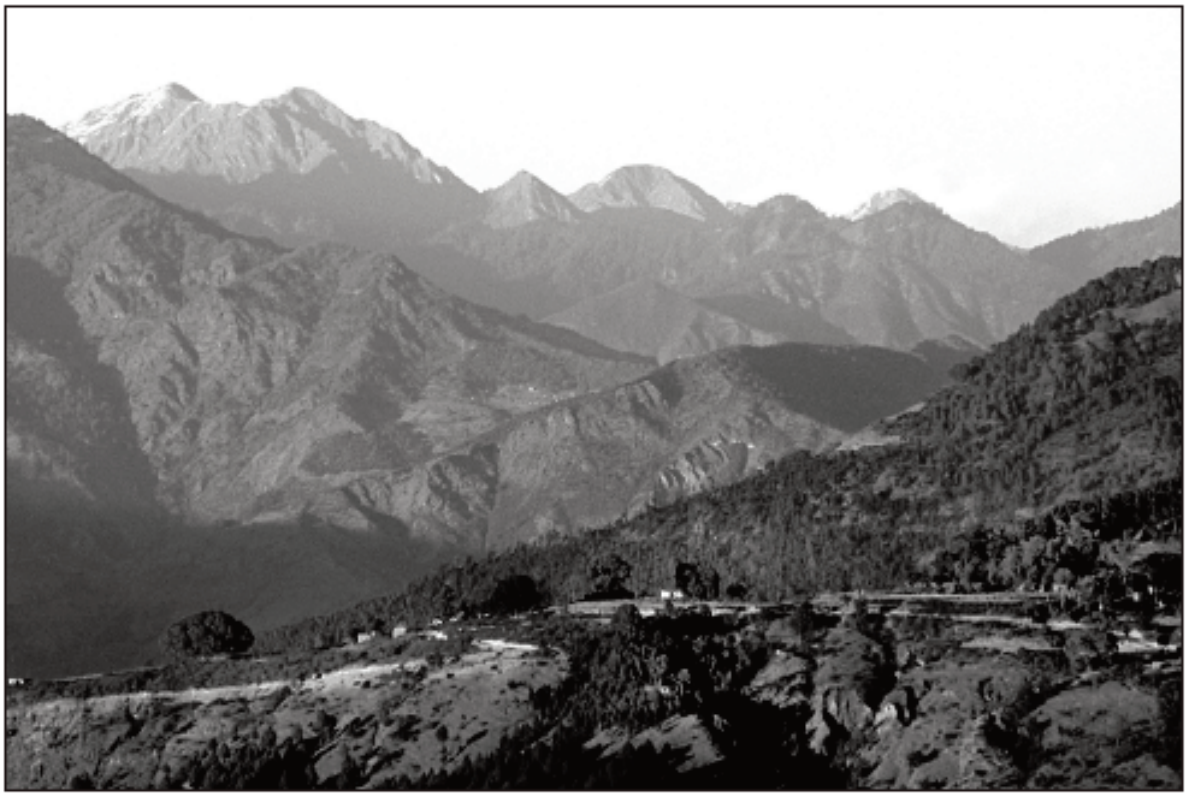
One of the local high school English teachers has brought Cynthia into his classrooms for observation and evaluation of his classes . They will collaborate to bring some new methodologies for ESL into practice. She has also begun some tutorial work at the hospital with some of the employees.

Most towns are accessible only by foot. People walk on footpaths. It is not uncommon for students at the local high school to walk one or more hours to begin their classes at 7 a.m. The drivable roads are narrow and often sparsely paved. Mud and rockslides are frequent. We had a memorable eight hour ride from the nearest city, Dhangadi, to go about 100 miles. We traveled over several 3,000-foot hills with non-stop switchbacks both up and down.

An outdoor kitchen provides many delightful and delicious dishes.

As we sat down to dinner with Nirpa tonight, we savored a local curried fish dish along with a rice pilaf and two special chutneys — which made it a very special meal for the weekly day of rest, Saturday. Along with that were curried vegetables, tarkaree, braised greens, called saag and last but not least, the lentil soup/sauce, dahl, often a blend of legumes such as black, yellow and green lentils. This is generously scooped onto the rice to moisten and add flavor. The Nepalese eat with their hands, but we always get a spoon.

Tomorrow we will wake up to our neighbor's rooster crowing and will look forward to the adventures that unfold as we begin our second week here in Bayalpata, Nepal.



The Achham province of far western Nepal has many terraced hillsides, 3,000 to 4,000 foot hills and a backdrop of 20,000 foot snow-capped Himalayan peaks.

Read more about Nyaya Health's work at Bayalpata Hospital here: *nyayahealth.org or blog.nyayahealth.org.*

This article first appeared in the Hardwich Gazette on Wednesday, February 9, 2011.

2013 Legislative Wrap-Up

H. 522 – Requires Prescribers to Register and Query the Vermont Prescription Monitoring System (VPMS)
H. 522, a bill designed to respond to opioid addiction and methamphetamine abuse passed the House and Senate. The final version of the bill requires prescribers to check the VPMS data base in four circumstances: (1) at least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance; (2) when starting a patient on a Schedule II, III, or IV controlled substance for non-palliative long-term pain therapy of 90 days or more; (3) the first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat chronic pain; and (4) prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance pursuant to section 4290 of this title.

Log-in information is available at http://healthvermont.gov/adap/VPMS_prescribers.aspx#register. Prescribers may assign the responsibility to check the VPMS to delegates, who are registered with the VPMS.

The bill requires all prescribers to register with the VPMS on or before Nov.15, 2013. The bill does not require the VPMS registration process to be linked to the physician licensing process, but it is believed that the Vermont Board of Medical Practice (VBMP) and the Department of Health intend to integrate the two databases in an effort to streamline the registration process.

Prior to adopting rules, the Commissioner of Health will consult with the Unified Pain Management System Advisory Council (Council), an interdisciplinary group of clinicians that includes clinicians with expertise in pain management and addiction. The Council has 25 members and includes clinicians representing the VMS, BiState Primary Care Association, the American College of Emergency physicians – Vermont Chapter, the American Academy of Family Physicians – Vermont Chapter, the UVM College of Medicine – academic detailing, the UVM College of Medicine – addiction or pain management, the Board of Medical Practice, and the Board of Osteopathic Physicians.

S.77 -- Allows physicians to prescribe lethal doses of medication to terminally ill patients
On the day before adjournment, the Vermont legislature approved S.77 – a bill that would allow physicians to prescribe lethal doses of medication to terminally ill patients in order for the patient to end their lives. By a 75-65 vote, the House concurred with a Senate version of the bill that passed 17-13. The legislation largely mirrors a similar law in Oregon law for first three years and then shifts to a system with less government monitoring. However, there's widespread expectation that lawmakers may push to eliminate the changes set to take effect in 2016, leaving an Oregon-style law in place.

The legislation creates a new chapter 113 in Title 18 of Vermont Statutes Annotated entitled "Patient Choice at End of Life." The two key provisions of the bill are found in section 5283 that establishes the fifteen requirements for legal immunity if a physician prescribes lethal doses of medication for a patient to self-administer, and in section 5285 that states a physician shall not be under any duty, by law or contract, to participate in the provision of a lethal dose of medication to a patient. These provisions go into effect once the bill has been signed into law by the Governor.

Under section 5283, a physician would not be subject to any civil or criminal liability or professional disciplinary action if the physician prescribes to a patient with a terminal condition medication to be self-administered for the purpose of hastening the patient's death and the physician affirms by documenting in the patient's medical record that all of the following fifteen requirements occurred.

In order to be fully eligible for legal immunity following the writing of a lethal prescription, physicians also need to be familiar with the bill's definitions found in section 5281.

The bill also contains a "compromise" that would sunset the above fifteen requirements of section 5283 on July 1, 2016, and replace them with a new set of five more limited requirements as found in section 5289 of the bill. However, it is likely that the statute will be further amended prior to July 1, 2016, and the fifteen requirements will be maintained.

To read the text of S.77, as passed, please go to:
http://www.leg.state.vt.us/database/status/summary.cfm?Bill=S.0077&Session=2014

H. 530 Three Percent Medicaid Reimbursement Increase
The three percent Medicaid reimbursement increase was included the FY 2014 budget, although the implementation of the increase was delayed one month – from October to November 2013. The Senate added language requiring the administration to develop consistent measures to be accountable for the results of cost shift investments. The language will require the Green

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The Residents Corner:

FM Journal Club Bottom Line: Beta-blocker use and clinical outcomes in stable outpatients with and without coronary artery disease

Clinical question: **Which patients should be placed/kept on beta-blocker therapy?**

Bottom Line Answer:

- Randomized control trials show beta-blockers benefit patients with systolic congestive heart failure and for the first three years after a patient has a MI.
- Beta-blocker use may not be associated with lower event rates of CV death, non-fatal MI, stroke of hospitalization in patients even with prior history of MI after 3 years.
- Level 2b evidence: Recent longitudinal study followed 3 cohorts of patients for 44 months with and without beta-blocker use: 1) prior MI 2) CAD no prior MI 3) risk factors for CAD only.
- There were no significant differences in primary outcomes of cardiovascular death, non-fatal MI or non-fatal stroke in the known MI or CAD without prior MI cohorts
- In patients with no known CAD history (only risk factors), betablocker use may be associated with increased risk of CV death, non-fatal MI and stroke (HR 1.18, p = 0.02)
- Secondary outcomes of hospitalization for atheroembolic event and revascularization procedures were increased in patients using beta-blockers who had known CAD but no prior MI and CAD risk factors only.
- Results were not specified for type or dose of betablocker

Case: 62 year old man who is 5 yrs s/p stent for known MI presents wanting to minimize his medications. Currently taking statin, asa, betablocker, ACEI, metformin. BP 116/72 HgA1c 6.4. Should he stop his betablocker?

Background and Supporting Evidence:

- AHA 2011 guidelines now recommend betablocker therapy for heart failure patients and MI or ACS patient for 3 years after MI (as class I recommendation)
- AHA guidelines recently changed its recommendation for longterm betablocker therapy from class IIa to class IIb
- European Society of Cardiology now recommends longterm betablocker therapy only for patients with left ventricular s systolic dysfunction

References: *http://www.ncbi.nlm.nih.gov/pubmed/23032550*

Elena Simon, M.D. Family Medicine Third Year Resident

President's Report

(Cont'd from 1) We now have representation on several state committees to be sure we have a voice at the table. It has been very instructive especially all of the work that is happening at the state level on our behalf. We will disseminate this information in our newsletters – but more frequently as needed. This includes monthly meetings with the Pediatric Council, the VDH/VTAAP/VTAFP/OBGYN, the VMS among others.

The exchange of ideas at our quarterly meetings has been very helpful in shaping what directions we take in the future and the best ways to accomplish our goals. Special thanks go to Fay, Mark, David, Tom, Stuart, Andy, Carol, Mike, Rob and Stephanie for their help. Anyone is welcome to call in or come join us. At our last meeting we heard from Jon Porter and had a chance to speak directly with one of our legislators,.

I hope to see many of you on Vermont Day this June. Please take some time to speak with me during the conference. We are having a board meeting on Wednesday night in Burlington if you would like to join us – let us know. And please put our annual Academy CME meeting to be held on Saturday, November 2nd this year on your calendars.

Sincerely,

Allyson Bolduc. MD

Legislative Wrap-Up

(Cont'd from pg. 6) Mountain Care Board (GMCB) to maintain and report on its dashboard of key indicators "a comparison of the difference between Medicaid and Medicare provider reimbursement rates and additional measures as determined to create standard transparent measurement of a reduced cost shift."

H.107 Prior Authorization
Timeframe for non-urgent prior authorization - H. 107 shortened the time for health plans to respond to requests for non-urgent requests for prior authorization from 120 hours to two business days. A law passed last year requires insurers to respond to urgent requests for prior authorization in 48 hours.

Step Therapy - The bill prohibits health insurers that use step therapy from requiring patients to fail on the same medication more than once. Health insurers may continue to use tiered co-payments when drugs are not subject to a step-therapy protocol. The provision also requires health insurers to limit step-therapy to drugs that are indicated by the FDA for the diagnosed condition, and does not permit insurers to require use of off-label drugs as part of step therapy.

Prior Authorization Pilot Program - After hearing testimony, the House Health Care Committee added a prior authorization pilot program to the bill. The pilot program will measure changes in system costs within primary care associated with eliminating prior authorization requirements. It will also examine the effect of eliminating prior authorization on provider satisfaction and on the number of requests for and expenditures on imaging, medical procedures, prescription drugs, and home care.

Standardized Claim Edits and Payment Rules - The bill requires the Green Mountain Care Board (GMCB), in consultation with the Department of Vermont Health Access (DVHA) to develop a complete set of standardized edits and payment rules. Insurers will be required to begin using the standardized edits and payment rules on Jan. 1, 2015. Medicaid will be required to begin using the standardized edits and payment rules on Jan. 1, 2017. DVHA and the GMCB will report to the legislature on progress made toward developing a complete set of standardized edits and payment rules.

Adding "APRN" to Laws that refer to "physicians" or "doctors"
The bill adding "APRN" to all statutory references to "physician" or "doctor" will not be taken up this year. VMS will work with the licensing boards, professional associations and other interested stakeholders to review this proposal before the next legislative session. This proposal touches a very broad range of issues, for example: disability certification, mental health (involuntary treatment), guardianship, education (ability to attend school), public health, regulated drugs, sterilization reports, motor vehicles (handicap tags, school bus drivers), municipalities, corrections, and child abuse. Please let VMS know if you would be willing to help with this proposal.

Naturopaths' Authority to Prescribe Drugs
Last year, the Office of Professional Regulation (OPR), in consultation with the Commissioner of Health was authorized to adopt rules that would permit naturopaths to prescribe prescription medicines. OPR filed proposed rules in early May. There will be a public hearing on the rules on June 18, 2013 at 10:30 a.m. at 32 College Street, Shulmaier Hall, in Montpelier. Written comments may be submitted to OPR until June 26, 2013 at the link. Comments may be emailed or mailed. Link to proposed rules: http://vtprofessionals.org/opr1/naturopaths/rules/Administrative_Rules.pdf

To obtain the license endorsement, the proposed rules require naturopaths to take and pass the examination(s) given in the Medical Pharmacology course taught within the Department of Pharmacology through Continuing Medical Education at the University of Vermont's College or Medicine, or a substantially equivalent course approved by the Director of OPR.
The proposed rules require that the first 100 prescriptions written by a naturopath after receiving the license endorsement must be reviewed by a supervising physician. The supervision and prescription review process must be performed by a medical or osteopathic doctor. The naturopath must have a formal agreement with an allopathic or osteopathic physician who agrees to participate in the supervision and prescription review process and agrees to advise, mentor and consult with the naturopath concerning the naturopaths' ability to safely prescribe and administer drugs within his or her scope of practice and in compliance with federal and state statutes and the rules of the Vermont Board of Pharmacy.

The rules authorize naturopaths to prescribe medications off-label in conformance with generally accepted standards of practice, including safety and efficacy, for both allopathic and naturopathic physicians. For naturopaths who go through the steps in the rules to obtain an endorsement to prescribe drugs, the rules do not limit the drugs or classes of drugs that they may prescribe, on or off label, or on the routes of administration.