

CONFERENCES

<p>DEMENTIA & NEUROPSYCHIATRY</p> <p>Sept. 19-20, 2008 Hilton Hotel Burlington, VT</p> <p>For more information call 802-656-2292 or go to the website at http://cme.uvm.edu</p>	<p>VITL SUMMIT '08</p> <p>Sept. 25, 2008 Killington Grand Hotel Killington, VT</p> <p>For more information call Heidi Banks at 802-223-4100, ext. 106 or go to the website at www.vitl.net</p>	<p>VERMONT MEDICAL GROUP MANAGERS ASSOCIATION QUARTERLY MEETING</p> <p>October 7, 2008 The Fireside Inn Lebanon, NH</p> <p>For more information contact Monique Corcoran at: mcorcoran@cvoms.com</p>
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**ACP Vermont Chapter
Fall Meeting**

October 24, 2008
Trapp Family Lodge, Stowe, Vermont

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**Vermont Medical Society
195th Annual Meeting**

October 25, 2008
Topnotch Resort & Spa, Stowe, Vermont

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*"Not for
Ourselves do
we labor"*

VMS motto

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Society**

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BLUEPRINT FOR HEALTH SEEKS TO TRANSFORM HEALTH CARE IN VERMONT

For the past three years, the Vermont Department of Health's Blueprint initiative has been working with a number of communities across Vermont to create and implement a vision, a plan, and a partnership to improve health and the health care system for Vermonters. The Blueprint is focused on providing effective preventative care and control of chronic disease to improve the quality and control the cost of health care in the state. Now the Blueprint is taking a critical step toward a more comprehensive, systems-based change in the way health care is delivered in Vermont by implementing integrated pilots in three communities.

Integrated Pilots Begin

Two pilot sites are becoming operational this year. The integrated pilot in St. Johnsbury began earlier this summer. The second pilot will begin in October in the Burlington area, with a Fletcher Allen practice (FA) and a non-FA practice. A third integrated pilot site will be selected through a RFP process, as were the first two integrated pilots, from among the responding Blueprint communities.

The fundamental structure of the integrated pilots includes the following components:

- Patient-centered medical home
- Local care support
- Health information technology to support those functions: the underlying network, as well as the clinical tracking tools
- Strong emphasis on prevention in the community, linking prevention with care delivery

Patient-centered medical homes

First, the Blueprint will provide help the pilot practices operate as patient-centered medical homes. The goal is to allow the primary care providers to operate their practices in the way they see fit and in alignment with the National Committee for Quality Assurance (NCQA) standards for a patient-centered medical home. To help the practices operate as patient-centered medical homes and to link prevention with care, financial reform is critical. Since the doctors are being asked to practice differently, they need to be paid differently. The insurers in the state have agreed to pay the practices based on how well they are delivering care in accordance with NCQA standards for a patient-centered medical home. Based on their score, the practices will receive an enhanced payment for each of the providers in the practice on a per-person per-month basis. This enhanced payment is in addition to their normal negotiated insurance payments.

Local Care Support Teams

Secondly, the practices will have access to local care support teams for patients who need additional care support; whether that support is social or economic, a better understanding of treatment plans or more close follow-up. Whatever the patient's needed care support may be, the care teams will be available to assist the primary care providers. The cost of the local care teams will be shared across the payers.

BLUEPRINT FOR HEALTH

Continued from Page 1

Each of the integrated pilot sites will design their own community care team. The teams will be multi-disciplinary, including nurse educators, community health workers, social workers and behavioral specialists. Each pilot is designing what it needs to fill in the gaps of what is missing in the community right now.

As part of the community care teams, there will be a prevention specialist in each community. The prevention specialist can work with the community care team and the providers to plan the best prevention strategies that meet the needs of that community, truly linking prevention and care delivery. There is a lot that these teams can do. For example, if the community has high rates of smoking, the team may focus on tobacco cessation and linking the people in the practices, the patients, with tobacco cessation programs. They will be able to focus on their priorities as a prevention effort and will have the health information support needed to get at the data to determine what those needs are. They can do evidence-based planning.

Health Information Technology

Thirdly, there will be health information support. The Blueprint is offering practices a clinical tracking system called DocSite. This is an enhanced registry that is designed to work right at the point of care. It works for normal health maintenance, regular visits and routine check-ups, and it also provides care support for the major chronic conditions and the major chronic diseases. It provides a visit planner when a patient walks in. When a staff member is taking vital signs, that information can be put in the system and it will generate an individualized visit planner based on the patient's diagnosis. If a patient happens to have hypertension and asthma, it will create a visit planner for hypertension and asthma and health maintenance information for the patient. If the patient is just coming in for an annual visit, it will create an appropriate age and gender visit planner for whatever the particular individual conditions are.

DocSite also does population reporting, so both the practices and community care teams can pull up reports. For instance, at the beginning of the week, they can pull up a report for all people who have a cardiovascular risk greater than 20%, 10-year cardiovascular risk and who haven't had an appointment in 6 months. They can

then begin calling those people and scheduling them to come in for a reevaluation of their cardiovascular risk. The community care team and the practices will be able to do population management, as well as individual care.

For DocSite to work it needs to be fed information. The Blueprint is also building a health information exchange that will supply the information to the DocSite tracking system: the feeds from the laboratory sources at the hospitals, the feeds from electronic medical records if they are in place, the feeds from practice management systems, the feeds needed to give this system the information it needs to be useful in clinical practice. In those sites that have electronic medical records, (in St. J all pilot sites have electronic medical records), the practices will be using their electronic medical records when they are seeing patients like they normally do. However, their information will be fed out of the electronic medical record to DocSite.

The Blueprint is giving these practices the infrastructure they need to change their operations: financial reform, local care support, and health information technology. "This is real systems-based change", said Dr. Craig Jones, Blueprint Director. "It is oriented towards health maintenance and towards prevention, as opposed to reactive, acute and episodic care."

While the Blueprint is focused on improving quality of care and reducing cost, it may have another benefit according to Dr. Jones – attracting providers. "Imagine that you are a resident coming out of your primary care training, and you see practices in the community where the providers are paid for doing a great job, exactly what we are doing in the integrated pilots, and the enhanced payments are substantial enough to make it competitive and even beyond competitive with what you are looking at in other places in the country", he said. "You see a health information infrastructure that really can help you in your practice and you see local care support services. You see this environment for practicing and financial reimbursement that is different. I think that is going to be a lure to providers to want to practice in that environment."

For more information about the Blueprint for Health, go to: <http://healthvermont.gov/blueprint.aspx>.



INVESTMENT IN DISEASE PREVENTION COULD SAVE VERMONT \$43 MILLION IN FIVE YEARS

According to a report released in July by the Trust for America's Health (TFAH), Vermont could save \$43 million dollars over a five-year period by making a small strategic investment in disease prevention. In its report, entitled Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities, TFAH finds that an investment of \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could produce a return on investment (ROI) of 7 to 1 for Vermont: \$7.00 saved for every \$1.00 spent. The report suggests that Maine could save \$98 million (ROI of 7.5 to 1) and New Hampshire could save \$76 million (ROI of 5.9 to 1). Nationally the savings are projected to be more than \$16 billion (ROI of 5.6 to 1).

"Health care costs are crippling the U.S. economy. Keeping Americans healthier is one of the most important, but overlooked ways we could reduce these costs," said Jeff Levi, PhD, Executive Director of TFAH. "This study shows that with a strategic investment in effective, evidence-based disease prevention programs, we could see tremendous returns in less than five years- sparing millions of people from serious diseases and saving billions of dollars."

Out of the \$16 billion in national savings, Medicare could save more than \$5 billion, Medicaid could save more than \$1.9 billion, and private payers could save more than \$9 billion.

The economic findings are based on a model developed by researchers at the Urban Institute and a review of evidence-based studies conducted by the New York Academy of Medicine. They found that many effective prevention programs cost less than \$10 per person, and that these programs have delivered results in lowering rates of disease that are related to physical activity, nutrition, and smoking. The evidence shows that implementing these programs in communities reduced rates of type 2 diabetes and high blood pressure by 5 percent within 2 years; reduces heart disease, kidney disease, and stroke by 5 percent within 5 years; and reduces some forms of cancer, arthritis, and chronic pulmonary disease by 2.5 percent within 10 – 20 years.

The report focused on disease prevention programs that do not require medical care and target communities or at-risk segments of communities. Examples of these programs include providing increased access to affordable nutritious foods, increasing sidewalks and parks in communities, and raising tobacco tax rates. The savings estimates in the report represent medical cost savings only and do not include the significant gains that could be achieved in worker productivity and enhanced quality of life.

"While public and private insurers focus on managing high costs to improve outcomes and save money, this report shows the equally crucial need for the significant investment in community-based prevention to keep people healthier longer and generate... much greater cost savings," said Jo Ivey Boufford, President of the New York Academy of Medicine.

The report was supported by grants from the Robert Wood Johnson Foundation and The California Endowment. The full report, is available on TFAH's website: www.healthyamericans.org.

2008 Vermont Health Care Quality Report

VPQHC is pleased to announce the completion of the 2008 Vermont Health Care Quality Report. The report is available at <http://www.vpqhc.org/2008QR/index.htm>.

New features to the Report this year include:

- Designed for use via the web (with PDF formats available)
- Primary analysis of nationally-recognized quality measures
- Highlights of emerging issues, reflective of current interest for policy makers, consumers, and healthcare professionals. Topics include drug-resistant infections and end-of-life care in Vermont
- Highlights of areas requiring additional analysis; opportunities for focused quality improvement; as well as areas in which the quality of care in Vermont is excellent.

For more information, contact VPQ at 229-2152 or mail@vpqhc.org.

FORMER VMS PHYSICIAN OF THE YEAR RECEIVES UVM MEDICINE AND COMMUNITY SERVICE AWARD



Burlington-based psychiatrist Suzanne Parker, M.D., a 1973 graduate of the University of Vermont College of Medicine, received the UVM Medical Alumni Association's Service to Medicine and Community Award at a reunion awards ceremony held on June 6. The Service to Medicine and Community Award is presented to alumni who have maintained a high standard of medical service and who have achieved an outstanding record of community service or assumed other significant responsibilities not directly related to medical practice.

Dr. Parker, a leader in the field of addiction medicine, is a founder and past medical director of the Vermont Medical Society's Vermont Practitioner Health Program, which is designed to assist in the identification, treatment and rehabilitation of health care providers at risk of impairment because of drug or alcohol addiction. She helped launch a practitioner wellness program at the UVM College of Medicine and is a founding member and co-chair of Fletcher Allen Health Care's Wellness Committee. Dr. Parker is also a founding member of the youth substance abuse prevention organization, Connecting Youth.



DR. TONY WILLIAMS RECEIVES NATIONAL RECOGNITION FOR QUALITY DIABETES CARE

The National Committee for Quality Assurance (NCQA) and the American Diabetes Association (ADA) recently announced that Tony Williams, MD, FACP has received recognition from the Diabetes Physician Recognition Program for providing quality care to his patients with diabetes.

Dr. Williams has an Internal Medicine practice in Berlin on the CVMC campus and is currently President of the Medical Staff at Central Vermont Medical Center.

The recognition program was designed to improve the quality of care that patients receive by recognizing physicians who deliver quality diabetes care, and by motivating other physicians to document and improve their delivery.

To receive recognition, which is valid for three years, Dr. Williams submitted data that demonstrates performance that meets the Program's key diabetes measures. These include regular eye exams, optimal

blood pressure, and glucose and cholesterol control, among others. When people with diabetes receive quality care as outlined by these measures, they are less likely to suffer complications such as heart attacks, stroke, blindness, kidney disease and amputation.

"I have a long-standing interest in the treatment of diabetic patients. Working with Vermont's Blueprint for Health chronic care initiative, I implemented a registry for all of my diabetic patients which helped me provide an organized system of care. This ensured that my diabetic patients received regular diabetic check-ups with appropriate care and best practice treatment," stated Dr. Williams. "Primary care physicians are challenged by seeing a wide spectrum of patients with multiple chronic illnesses every day. The number of diabetics is increasing exponentially around the world and is certainly a phenomenon we are experiencing in central Vermont. I have enjoyed the personal and professional challenge involved in achieving this recognition."

2008 PQRI Educational Sessions

For 2008, eligible professionals who meet the criteria for satisfactory submission of quality measures data for services furnished during the reporting period, January 1, 2008 - December 31, 2008, will earn an incentive payment of 1.5 percent of their total allowed charges for Physician Fee Schedule (PFS) covered professional services furnished during that same period (the 2008 calendar year). It is not too late for those who have not started reporting to begin participation. For more information, go to: <http://www.cms.hhs.gov/PQRI/>

The VMS will be holding two fall educational sessions on the PQRI - Watch your mail for more details!
Oct. 16th from 4:45 - 6:15 p.m., Vermont Interactive TV (VIT) and Oct. 21st from 12:45 - 2:15 p.m. - VIT

UVM TEAM COUNTERS INFLUENCE OF DRUG MARKETING

Pharmaceutical companies are spending big money to market drugs to physicians across the country. In Vermont alone, more than \$3.1 million was spent on marketing drugs to physicians in 2007, according to a recent report from the Vermont Attorney General's office. Two programs offered through the University of Vermont Office of Primary Care aim to educate prescribers, and future prescribers (UVM medical and nurse practitioner students), to ensure they stay above the influence of slick marketing tactics.

Together, the UVM Office of Primary Care and Area Health Education Centers (AHEC) operate the Vermont Academic Detailing (AD) Program, one of the first such programs in the country. The term "detailing" refers to one of several strategies used by pharmaceutical companies to influence the prescribing behavior of physicians, nurse practitioners and physician assistants. The detailing strategy, which is based on theories of social marketing and behavior change, involves person-to-person education and discussion by a pharmaceutical representative "expert". Pharmaceutical companies spend millions of dollars each year on a sales and detailing workforce. Borrowing the successful format of expert, person-to-person or small-group education used by pharmaceutical representatives, academic detailing or counter-detailing is university-based educational outreach that focuses on educating prescribers using an evidence-based approach for safe, effective, and well-established treatments, rather than promoting a specific product.

Since 1999, the Vermont AD Program has been helping healthcare providers translate prescribing guidelines into practice. The one-hour, condition-specific (e.g., treatment of hypertension, depression, insomnia), case-based

interactive sessions are delivered at practices by members of the AD team, including Charles MacLean, M.D., associate professor of medicine; Richard Pinckney, M.D., assistant professor of medicine; Amanda Kennedy, Pharm.D., research assistant professor of medicine; and Fletcher Allen Health Care pharmacists Michele Corriveau, RPh, and Gary Starecheski, RPh. The program presents an objective overview of what evidence from studies shows about various drugs used to treat a medical condition, and where appropriate, emphasizes the importance of lifestyle change and non-drug therapies as the building blocks upon which drug therapies may be added. This program is funded by multiple sources, but there are no drug company sponsorships, nor do any of the team members have any ties to the pharmaceutical industry. For more information or to schedule a session for your practice, please contact Laurie McLean at 802-656-2179 or lmclean@uvm.edu.

Launched in 2007, a second program called the Program in Wise Prescribing is a UVM Office of Primary Care initiative funded by the Attorney General Consumer and Prescriber Grant Program. The impact of drug company marketing strategies on consumer and prescriber behavior is well understood. However, the proper approach for limiting marketing's negative impact on inappropriate and needlessly expensive use of medications remains controversial. The Program in Wise Prescribing is not condition-specific; instead, its approach centers on raising awareness about the general methods and effectiveness of pharmaceutical marketing. Dr. Pinckney is the principal investigator on the grant. The Wise Prescribing educational program will be disseminated nationally in 2009 through a partnership with AHEC.

TOBACCO CESSATION PROGRAMS SAVE LIVES

by John Hughes, M.D.



Over the last decade, our legislature has saved thousands of Vermonters' lives and saved the state millions of dollars by increasing the tax on cigarettes, passing smoke-free policies, and funding the Vermont Tobacco Control Program. As a result, the percentage of youths who smoke has decreased dramatically from 31 percent in 2000 to 16 percent in 2007, and in adults from 22 percent to 18 percent.

These actions will save thousands of Vermonters from early deaths due to tobacco and will save the state millions

of dollars in health care costs. No initiative the state has taken has had a greater public health benefit for Vermonters.

There is room for progress. Most of the adult smokers we have convinced to quit have been the less-addicted smokers, leaving us the challenge of the more "hard-core" smokers. For these remaining smokers, although motivation via taxes, etc., is important; it's just not enough. That's because for most of these smokers quitting is not just an issue of motivation. In the past, many thought that if someone was depressed or had

TOBACCO CESSATION

Continued from Page 3

alcohol problems, they just needed to be motivated to change. We now know that many such persons require treatment to overcome their problem.

Similarly, there are many smokers who are very unlikely to quit without treatment. To get these smokers to quit, we need to continue to fund our state tobacco program so it can provide counseling and medication to these smokers. In addition, if we raise the price of cigarettes with taxes, it seems only humane that we couple it with free help for smokers who now want to quit.

Finally, some Vermonters have the misperception that the smoking problem has been fixed. Every year 900 Vermonters die early due to tobacco. Preventing youths from starting and helping the remaining smokers to quit will require continued and even stepped-up efforts, but it's worth it. Every time three youths decide not to smoke or three adults quit, we save one early death. As a physician, I can tell you there are few things I do that have such a great benefit.

Dr. John Hughes is the former chairman of the Vermont Tobacco Evaluation Board

NEW 2009 JCAHO GUIDELINES FOR CONFLICT MANAGEMENT IN HEALTHCARE ORGANIZATIONS

by Gerhild Bjornson Ph.D, M.D.

On Jan. 1, 2009, the Joint Commission on Healthcare Organizations (JHACO) will start incorporating three new performance criteria into its credentialing process, which address health care personnel behavior and communication styles. They are:

1. The hospital has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
2. Leaders create and implement a process for managing disruptive and inappropriate behaviors.
3. The organization manages conflict between leadership groups to protect the quality and safety of care.

Many studies have confirmed the link between poor "bedside manners" and patient safety. Good listening and communication skills result in better outcomes and fewer liability suits. Hospitals, however, rarely offer training in these skills to their personnel. Instead of recording, reporting, and studying how to prevent inappropriate behavior and unresolved conflict, most health care organizations wait till a lawsuit forces them to take a closer look at what happened.

The entire field has been remarkably resistant to address problems resulting from lack of interpersonal skills. Fifty percent of physicians and other health care workers report having witnessed unprofessional behavior and

ongoing conflict. Most of them did nothing to intervene or to report the situation.

JHACO issued the new mandates in response to this situation. Both protests and applause have greeted the new performance criteria. "How can 'disruptive behavior' be defined in an objective and fair way?" ask critics who fear the new measures will result in more, rather than less, conflict and potential litigation. Many healthcare workers, however, as well as patients and families, welcome increased accountability for counterproductive behavior as well as lack of adequate communication.

The task to plan and implement processes which will ensure compliance with the new JHACO mandates is not unique to medicine. It will, however, require extensive training of all personnel in the areas of behavior, communication, and conflict management skills.

The goals of the new mandates are:

- a healthier working climate;
- increased safety and satisfaction for patients; and
- the future accreditation of the organization.

Dr. Bjornson, a physician with a master's degree in conflict resolution, teaches communication and conflict management skills to healthcare professionals. She can be reached at gerhildbjornson@yahoo.com.

MEDICAID "TAMPER-RESISTANT" PRESCRIPTION REQUIREMENT UPDATE

By October 1, 2008, all handwritten and computer-generated printed prescriptions for Medicaid recipients must be fully compliant with federal guidance for prescription tamper resistance. While the first phase of prescription tamper-resistant guidance (effective April 1, 2008) required prescriptions to contain at least one feature from one category of tamper resistance, this second phase requires that prescriptions contain at least one industry-recognized feature from each of the three categories of tamper resistance. Prescriptions for Medicaid patients that are telephoned, faxed or ePrescribed are exempt from these tamper-resistant requirements.

Prior guidance for electronically generated printed prescriptions stated that special copy-resistant paper would likely be required to be in compliance as of October 1, 2008. The Centers for Medicare and Medicaid Services (CMS) has since provided new guidance that states that, while special paper may be used to achieve tamper resistance, it is not necessary. Electronically-generated prescriptions may be printed on plain paper and be fully compliant with all three categories of tamper resistance provided they contain at least one feature from each of the three categories of tamper resistance.

Additional information on Vermont's tamper-resistant prescription pad requirements for Medicaid recipients, including recommended best practices, is available on the Office of Vermont Health Access website: http://ovha.vermont.gov/for_providers (scroll down the Pharmacy list to "Tamper-Resistant Prescription Drug Pads").

MULTIPLE PRESCRIPTIONS FOR SCHEDULE II DRUGS NOW PERMITTED (Separate prescription forms required for each fill date)

An amendment to the Vermont pharmacy laws allowing physicians to write multiple separate prescriptions for Schedule II Controlled Substances became effective July 1, 2008. These multiple prescriptions are not considered to be refills by the DEA. Prior to this change, prescriptions for Schedule II drugs were required to be filled within 10 days and multiple prescriptions for Schedule II drugs were not permitted.

As of July 1, 2008, multiple separate prescriptions for Schedule II drugs may be written for multiple fill dates; but all prescriptions with multiple fill dates must be filled within 90 days. For example, a physician could write three separate Ritalin prescriptions on July 1, the first to be filled in 30 days, the second authorizing a future fill after August 1 and the third authorizing a future fill after September 1. Each of the three separate prescriptions would be dated July 1, the date they were written. The two prescriptions with future fill dates would have to be filled by September 28 -- 90 days after the prescription was written on July 1. The two future fill prescriptions would include fill instructions on the prescription, such as "Do not fill before August 1" or "Do not fill before September 1."

Prescriptions for Schedule II drugs written without a future fill date must be filled within 30 days from the date the prescription is written. (Note: The DEA prohibitions against refilling and postdating prescriptions for Schedule II drugs remain in effect.)

More information about multiple prescriptions for Schedule II controlled substances is available at: www.vtmd.org or http://www.deadiversion.usdoj.gov/faq/mult_rx_faq.htm



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