

CONFERENCES

<p>COLLEGE OF ST. JOSEPH ANNUAL GALA "CELEBRATING EXCELLENCE"</p> <p>April 25, 2008 - 6:00 p.m. Holiday Inn Rutland, VT</p> <p>For more information call 802-773-5900 ext. 3264</p>	<p>AMERICAN ACADEMY OF PEDIATRICS VERMONT CHAPTER SPRING MEETING</p> <p>May 9, 2008 Gifford Medical Center Randolph, VT</p> <p>For more information call Stephanie Winters at 802-223-7898.</p>	<p>4TH ANNUAL DARTMOUTH CONFERENCE ON ADVANCES IN HEART FAILURE</p> <p>May 19, 2008 Dartmouth-Hitchcock Medical Ctr. Lebanon, NH</p> <p>For more information call 603-653-1531 or visit their website at http://ccehs.dartmouth-hitchcock.org</p>
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**Vermont Psychiatric Association
Annual Meeting**

April 12, 2008
Three Stallion Inn, Randolph, Vermont

For more information call Valerie Lewis: 802-223-7898.

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195th Annual Meeting**

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*"Not for
Ourselves do
we labor"*

VMS motto

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Society**

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**MY TURN: THE COMING CRISIS IN
PRIMARY CARE IS SOON UPON US**

By John Matthew, MD

Vermonters were pleased recently to have been told we live in the healthiest state in the nation. The State launched the new Catamount health plan, an ambitious effort to reduce the number of persons without health insurance in the state. The UVM School of Medicine was rated very highly for its education of primary care physicians. The past two years have seen the expansion in Vermont of Federally Qualified Health Centers chartered to serve all persons in their geographic area, regardless of their ability to pay.

But these recognitions, innovations, ratings, and successes have occurred in circumstances that, beneath the radar of most of the public and many policy makers, threaten to undermine our collective efforts to make health care available to all, especially in rural areas. In fact, the very structure of our health care system, if it should be called a system, is threatened by the coming collapse of primary care, which is the foundation of quality and any hope of economy in this realm.

There is a substantial and worsening lack of physicians and dentists to work in primary care nationwide, with rural areas suffering disproportionate shortages. While our need for these essential professionals is projected to grow by as much as forty percent in the coming decade, the number of medical students moving on to primary care residencies after graduation has fallen by about fifty percent in the last ten or twelve years. Our cadre of primary care providers, both medical and dental, is aging and not being replaced. If this trend continues – and it appears to be accelerating – we will find ourselves in a circumstance with 50% of our present supply trying to provide care for 140% of our present demand. This may understate the problem, since the aging population, in little more than twenty years, will need about seven times the present number of geriatric physicians, a group already available at half of current need.

About half of the estimated fifty-six million Americans who now have no primary care doctor have health insurance but still can find no source of primary care. We are already seeing many practices in Vermont closed to new patients and the professionals working longer hours to take care of those enrolled in their practices. In Vermont, and across the nation, increasing numbers of patients are being seen and experiencing worsening delays in our emergency rooms. This trend has been aggravated in other states by the closure of many ERs by for-profit hospitals which have discovered that these services lose money, particularly as they attract the uninsured and the down and out. The care that people without a regular source of primary care receive, if they do receive care, is almost certain to be much more costly, in both the short and the longer run, in financial and in human terms.

Primary care is one of the most challenging disciplines in medicine, requiring broad scientific knowledge and exceptional interpersonal "soft" skills. It is also one of the

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most rewarding, involving long-term relationships with individuals and families which many other specialties do not offer. It is also the most cost-effective component of our system. But primary care is in trouble.

Many primary care physicians, feeling under appreciated and under reimbursed compared to their professional colleagues in other fields, report diminished satisfaction with their professional work. After working more and more unreimbursed hours contending with Medicare pharmacy program companies and an unending stream of prior approval forms, changing formularies, and barriers to care; some are getting out of practice. They are not recommending similar careers to their children or others and increasingly report feeling undervalued, overworked, and taken for granted.

There are many disincentives to choosing primary care that devolve from our medical education system, including what sort of person is chosen to be admitted to medical school, how they are influenced by the role models and practice organizations in academic medical centers, and the great costs they confront to get through college, medical school, and residency training before starting practice.

Medical students graduate with substantial debt after four years of college and four of medical school, so they are apt to opt for specialties that provide higher incomes after residency training. For the same time in training and no less work, primary care incomes are often half or a third of what other specialists earn.

We not only have half as many graduating doctors choosing primary care post-graduate training but also find that half of the new residents in family medicine programs are graduates of foreign medical schools, half of whom are foreign nationals. We do not seem to be able to manage to attract and educate enough of our own bright young people to take care of our own population.

Unlike attorneys, physicians can not bill for telephone work or most paperwork, so roughly 35% of the regular working hours of primary care physicians are not reimbursed. The average family physician, prior to the extra hours demanded by managed care and pharmacy benefits management companies, worked a 54 hour week, not including the hours on call with a beeper on their belt or a phone on the bedside table.

More and more “free” work is the result of companies, often for profit companies, requiring physicians and their staff to complete forms, answer questionnaires, or make telephone calls to justify their decisions in order to have their patients receive care.

The private physicians still attempting to survive in unsubsidized situations are trying to make ends meet with increasing numbers of persons in the expanded Medicaid program, which nickels and dimes providers at every turn. Medicaid also has its own formulary program, which adds to the difficulty of caring for these patients. Quite a number of these physicians are limiting or ceasing enrollment of Medicaid patients in their practices because of the poor reimbursement.

One of the great ironies of our present circumstance is that governmental entities and companies choose insurers that cut costs by reducing payments to health care professionals. The employers appear to be surprised and even mystified by the shrinking supply of doctors for their beneficiaries and employees, but some simple accounting would solve the mystery. (It’s the reimbursement, stupid).

The public, where primary care is still available, seems unaware of the accelerating crisis in access that faces all of our citizens. If they knew the true situation, there might be a clamor for solutions; but any of these, when adopted, will take years to change the supply of doctors for the population. Things are virtually certain to get much worse before getting better, if that is going to happen. The primary care system, with dwindling numbers of providers contending with increasing patient loads and expanding mandates, dictates, expectations, and demands, including those of such laudable quality initiatives as the Vermont Blueprint for Health, is much closer to breaking down than most people realize.

Those leading the march to health care reform run the risk of turning around to discover that there are no primary care physicians and dentists behind them in the parade. Those who do continue in the work – some would say the calling – of taking care of the sick will all be entirely too busy with patients who are aging and have more complex illnesses. At the same time, they must try to get pharmaceuticals and tests approved by companies which increase their profits – or non-profit insurers which must try to compete with those companies – by reducing access to care. *–Continued on Page 3*

MEDICARE PQRI PROVISIONS FOR 2008

CMS will again provide up to a 1.5 percent bonus for physicians who voluntarily report on quality measures during 2008. Physician Quality Reporting Initiative (PQRI) reporting begins January 1, 2008 through December 31, 2008. Physicians that did not participate in PQRI during 2007 are still eligible to participate in 2008. Complete details of all PQRI 134 measures can be found as a download at: http://www.cms.hhs.gov/PQRI/35_2008PQRIInformation.asp

The bonus is contingent on (a) achieving 80 percent success for patients that have a disease/diagnosis that a quality measure you selected is being reported and (b) achieving that success rate for three quality measures (or fewer measures if less apply).

The bonus will be paid out as a lump sum in mid-2009. The bonus will be applied to 100 percent of Part B billings for the period except for drugs, other biologics and durable medical equipment. There is a cap, which ensures that a physician who only reports a few cases doesn’t get the same size bonus as a physician who reports quality measures frequently on his/her patients. No dollar amount is listed in the Medicare Fee Schedule for the Category II or G codes, but the charge box should not be left blank. If the billing system won’t accept a zero charge, post 0.01.

Not everyone in the practice has to select the same measures. Nor does everyone in the practice need to participate. Since the individual reporting is based on the NPI, only those patients treated by that physician will count towards the 80 percent and the bonus calculation. However the more participating physicians in the practice, the greater the total bonus.

PQRI Modifiers

There will be situations when a modifier is appropriate in addition to the Category II or G code to explain why a measure could not be completed.

- 1P Documentation of medical reason(s) for not performing a measure.
- 2P Patient declined for economic, social, or religious reasons.
- 3P Performance measure exclusion modifier due to system reasons. Insurance coverage/payer-related limitations or resources to perform the services not available.
- 8P Reasons not otherwise specified.

VHIMA’S PERSPECTIVE ON THE REVISED HOSPITAL CONDITIONS OF PARTICIPATION REQUIREMENTS FOR HISTORY AND PHYSICALS

By Angela Guyette, RHIT, CCS, CPC, President, VT Health Information Management Assoc.

In 2007, the Center for Medicare and Medicaid Services (CMS) published some revisions to the Hospital Conditions of Participation requirements to clarify the timeframe requirements for the medical history and physical examination and its update. The short version is as follows:

- H&P must be completed and documented for each patient no more than 30 days prior to or 24 hours after hospital admission or registration, but prior to surgery or a procedure requiring anesthesia services; regardless of whether inpatient or outpatient
- An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The

updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician or other qualified individual. . . .

This regulation is now consistent with the JCAHO element of performance PC.2.120 (2) and (6). You can find the complete revision of Conditions of Participation and survey advice at the following web address: <http://www.cms.hhs.gov/surveycertificationgeninfo/downloads/SCLetter08-12.pdf>

The Vermont Health Information Management Association (VHIMA) is comprised of Directors, Managers, Coders, Transcriptionists and other professionals whose primary purpose is to facilitate the management of patients’ health information in our Vermont hospitals and other health care settings.

CHANGES TO DEATH REPORTING

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certificate, the Preliminary Report of Death will be the official document used by the funeral director or other authorized person to obtain burial-transit and cremation permits.

This spring, the Vermont Department of Health will distribute copies of the Preliminary Report, and will provide support and guidance as you transition to the new death certificate and reporting process. Additional information and updates related to the coming changes to death reporting can also be found on the VDH web site at: <http://healthvermont.gov/hc/EDRS/index.aspx>.

If you have specific questions about the EDRS, or would like to discuss any of the changes in death reporting, please contact Dawn Anderson at EDRS@vdh.state.vt.us at 802-652-2070.

CHANGES TO THE MEDICAL CERTIFICATION SECTION

New Questions for Medical Certifiers

- IF FEMALE:
 - Not pregnant within past year
 - Not pregnant, but pregnant within 42 days of death
 - Not pregnant, but pregnant 43 days to 1 year before death
 - Pregnant at time of death
 - Unknown if pregnant within the past year

This information is important in determining the scale of mortality amongst this population and will be of assistance to maternal mortality review programs. The level of detail in this item reflects the information needed for better cause of death coding, using ICD-10.

- WAS MEDICAL EXAMINER CONTACTED
 - Yes
 - No

This question comes from the U.S. Standard Certificate of Death and records whether the Medical Examiner was informed when circumstances warrant this, including cases that should be referred for certification.

- IF TRANSPORTATION INJURY, SPECIFY:
 - Driver/Operator
 - Pedestrian
 - Passenger
 - Other (specify) _____

Because all non-natural deaths, including those that are the result of injury, must be reported to the Office of the Chief Medical Examiner, most physicians will not

address this question. However, the data collected here will help assign deaths to categories that may be used to assess trends and effectiveness of public safety programs.

○ VT LICENSE NUMBER - Physicians will now be asked to provide their license number as part of the reporting process. Some of you already provide this information (thank you!), although there is not a field for it on the current Vermont death certificate. With the introduction of the EDRS this number will be important in establishing an electronic signature. The license number will not appear on the death certificate.

Revised Questions for Medical Certifiers

- ACTUAL OR PRESUMED DATE OF DEATH (formerly "Date of Death")
- ACTUAL OR PRESUMED TIME OF DEATH (formerly "Hour of Death")

These two questions have been revised to be more comprehensive.

- TITLE OF CERTIFIER:
 - Physician
 - Pathologist
 - Medical Examiner

The categories "Attending Physician" and "Staff Physician" have been replaced by "Physician".

COMING CRISIS IN PRIMARY CARE

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Also missing from the parade will be the numerous Physician's Assistants and Nurse Practitioners who are essential and capable components in our primary care efforts. They too will be overwhelmed as more and more need confronts our shrinking numbers, physicians and "physician extenders" alike.

There will be increasing numbers of foreign medical graduates filling out the ranks of America's primary care providers, but leaving their native lands with even less care in a global brain drain to the more affluent United States. Hospitals will increasingly employ primary care providers, subsidizing their practices by shifting income from imaging and surgery services to attract and retain primary care doctors, whose value is not as obvious until they are not available in their communities.

President Bush may be proven to have been inadvertently prescient when he stated recently that all Americans have access to health care because they can go to the emergency room. More and more, this will be the health care entry point of necessity: crowded, expensive, and poorly suited to attend to the tasks of primary care. It is a chaotic and worrisome picture to contemplate.

VITL ANNOUNCES PRE-SCREENED EHR PRODUCT LIST

To assist Vermont physician practices with the process of selecting an electronic health record (EHR) system, Vermont Information Technology Leaders, Inc. (VITL) has released a Pre-Screened EHR Product List.

VITL has been authorized by the Vermont Legislature to conduct a \$1 million EHR Pilot Project. As part of the pilot, VITL will work with selected physician practices to develop requests for proposals, which will be sent to vendors of products on the pre-screened list.

The products on the list are certified by the Certification Commission for Healthcare Information Technology (CCHIT) and have met VITL's criteria in functionality, service and support, technology, the vendor's vision for the future, and the company's ability to execute that vision. However, it is important to note that interoperability with the VITL health information exchange network is not necessarily limited to the products on this list.

The six products on VITL's Pre-Screened EHR Product List are:

- Allscripts HealthMatics
- Allscripts TouchWorks
- eClinicalWorks EMR
- GE Healthcare Centricity EMR
- McKesson Practice Partner
- NextGen EMR

Why The List Was Developed

The market for ambulatory EHR systems is very robust, with more than 200 products currently on the market. The sheer number of available products makes the task of choosing one to implement very difficult for physicians. When faced with this prospect, some physicians have opted to put off selection of an EHR system, hoping that the market will shake out and leaders will emerge.

Limited resources also slow the adoption of an EHR solution. The research necessary to choose the "best fit" product for a practice can be daunting, given the lack of resources available to practices to do that research. The VITL Pre-Screened EHR Product List should serve as a source of basic research.

Recognizing that physicians need impartial sources of information to help them choose a system with confidence, CCHIT created an annual testing and certification process. CCHIT has developed an extensive list of criteria, and invited vendors of EHR systems to submit their products for testing. If a product passes, it is certified. To date, there are more than 70 certified ambulatory EHR systems. (For more information, see www.cchit.org)

Narrowing the field via certification has made the selection process somewhat easier for physicians, but it still leaves a lot of systems to choose from. VITL decided to embark on an effort to pare the list of systems even further. A request for information (RFI) was issued to all the companies marketing CCHIT-certified ambulatory

PRE-SCREENED EHR PRODUCT LIST

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EHRs. VITL received 27 responses, which were scored by VITL staff and a group of advisors. Vendor finances were independently reviewed. The result of this process is the Pre-Screened EHR Product List.

How to Use the List

The VITL Pre-Screened EHR Product List is meant to be a good starting point for Vermont physician practices considering the acquisition of an EHR system. VITL believes the systems on this list are the market leaders for physician practices, and should be given consideration. However, this is not meant to be a purchase list.

While VITL hopes that the existence of the Pre-Screened EHR Product List helps shorten the selection process, and speeds up the adoption rate for EHRs in Vermont, it is imperative that physician practices take the time to assess their specific needs, develop a request for proposal (RFP), and send it to vendors of some or all of the EHR systems on the VITL Pre-Screened EHR Product List. An accepted industry guideline is to invite three to five vendors to compete. Choosing an EHR system is a very important business and strategic decision and practices must perform due diligence. The VITL Pre-Screened EHR Product List is not meant to be a replacement for a thorough assessment and selection process.

Because of the short timeframe for compiling this list, VITL was not able to validate the responses that vendors gave to the RFI, nor was VITL able to view demonstrations of the EHR products on the list. The practice management portion of the system was not evaluated, but VITL strongly recommends that practices consider an integrated solution. VITL cannot guarantee the performance of the products on the list. VITL strongly recommends that as part of a RFP process, physician practices see demonstrations of each of the systems they are considering. Vendors of the products on the list will be invited to exhibit at the VITL Summit '08 on Thursday, Sept. 25, 2008 at the Killington Grand Hotel in Killington, Vt.

In addition to seeing demos, VITL urges practices to ask each vendor for names of other similar practices using the product, and then call and/or visit those practices to find out how satisfied they are with the product. Ask if they have experienced any problems with the system, and if so, ask how responsive the vendor was. Also ask what the practices like about the system. Site visits should be made for only those one or two vendors under final consideration. Because vendors tend to give out references that they know are satisfied, VITL also recommends trying to contact practices using the product whose names have not been supplied by the vendor. Local, state, and national physician and practice manager organizations may be helpful in identifying practices using the product(s) under consideration.

As the market continues to mature, VITL intends to update the Pre-Screened EHR Product List on a periodic basis. VITL will also work with physician practices receiving grants through VITL's EHR Pilot Project to develop site-specific RFPs, which will be issued to vendors of products on the list. This RFP process will provide a deeper level of review, and in the future VITL may provide additional information about the EHR systems on the list.

About VITL

Vermont Information Technology Leaders, Inc., is a non-profit, public-private partnership that is facilitating the adoption of electronic health records systems by physician practices in Vermont and implementing a secure health information exchange network.

For more information, contact:

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CHANGES TO DEATH REPORTING IN VERMONT EFFECTIVE JULY 1, 2008

By Dawn Anderson, EDRS Outreach and Training Coordinator

Death reporting in Vermont will undergo two important changes this year. Beginning with deaths occurring on July 1, 2008, the Vermont Department of Health (VDH) will begin to use a new death certificate which is based on the 2003 revision of the U.S. Standard Certificate of Death. At the same time, we will begin to roll out Vermont's Electronic Death Registration System (EDRS). The EDRS is a secure web-based application, with user verification and tracking, for reporting deaths and producing death certificates. The initial roll out, or "pilot" phase will begin with internal VDH users, including the Office of the Chief Medical Examiner, and key town clerks. Most physicians and funeral directors will continue to use a paper process during this first phase. The Department of Health plans to make the system available to these users, in subsequent phases, beginning later in 2008. When the EDRS is fully implemented, it will bring improvements to the death reporting process, as well as result in more accurate and timely information about Vermont deaths and their causes.

Changes to the Death Certificate

Death certificates are a critical source of information for state, federal, and even international public health programs; therefore, the changes to the death certificate were designed to elicit more specific data, which will in turn guide and enhance public health planning. The revised death certificate includes seven new questions along with modifications to some existing questions. One new question which we anticipate will result in data of particular interest to the medical community (although it will be completed by funeral directors or the family) is whether the deceased received hospice care in the 30 days prior to his or her death. The changes on the medical certification section are shown on page 6.

New Form and Reporting Process

Eventually, all deaths in Vermont (as well as in all other US states and territories) will be fully reported on-line. In the meantime, we will continue to rely on a paper process for death reporting. This paper process will be especially important as we make the transition to electronic reporting. The transitional paper process for death reporting will be very close to the current process of death reporting, with a few important differences.

From July 1, 2008 forward, instead of using an actual death certificate for reporting, you will be using a form known as the Preliminary Report of Death. It is NOT the same Preliminary Report of Death you may have used or seen at a hospital. The Preliminary Report will contain all of the fields on a death certificate, and is organized so as to be user-friendly: one side covers the medical information to be provided by the certifier; the other side covers the demographic information of the decedent which is typically completed by a funeral director.

Preliminary Reports will not go directly to a town clerk for processing. Instead, the funeral director, (or other authorized person in the case of a home burial), will fax the completed Report to VDH Vital Records (VR). VR staff will enter the data into the EDRS, register it, and notify the appropriate town clerk when the record is available for printing certified copies for the funeral director, or for the family. In addition to collecting the information which will be used to produce the death



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