

THE GREEN MOUNTAIN PHYSICIAN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

"Not for ourselves do we labor"

Jan./Feb.
2010

In This Issue:

Page 1

• Vermont Physicians
Provide Critical Medical
Care in Haiti

Pg. 2

• From the EVP
• Practice Variation
Report Issued

Pg. 3

• Practice Variation
Cont'd

Pg. 4

• VMS Expresses
Opposition to New APRN
Rules

Pg. 5

• Haiti Cont'd

Pg. 6

• 10 Questions With.....
• Practice Variation
Cont'd

Pg. 7

• HITECH Act's Breach
Notification
Requirements Explained

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Burlington physician Patty Fisher, M.D., cares for a young child in earthquake-ravaged Haiti.

VERMONT PHYSICIANS PROVIDE CRITICAL MEDICAL CARE IN HAITI EARTHQUAKE AFTERMATH

When the news of the devastating earthquake in Haiti reached physician Patty Fisher, M.D., she knew exactly what she had to do.

"As soon as it happened I couldn't stand watching it on TV," said Dr. Fisher, the director of the Community Health Center in Burlington. "I couldn't stand hearing that there weren't enough docs and supplies when I knew I could somehow get there and bring supplies with me. I knew I needed to get there somehow."

Dr. Fisher wasn't the lone Vermont physician who felt a calling to help the international relief effort. Fletcher Allen's Bill Charash, M.D., and Richard Salerno, M.D., Middlebury Family Health's Jean Andersson-Swayze, M.D., Porter Hospital's Michael Kiernan, M.D., and Green Mountain Orthopaedic Surgery's Chris Meriam, M.D., all went to Haiti shortly after the earthquake to provide badly needed medical assistance.

For Dr. Fisher, her interest in helping Haitians preceded the earthquake by about ten years, as she had been on nearly a dozen previous medical missions to the country. That familiarity, and the knowledge that even in the best of times Haitians' medical needs were immense, made her desire to help in the aftermath of the earthquake even stronger.

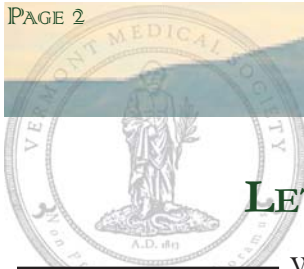
"I needed to go," said Dr. Fisher. "It is kind of my home-away-from-home. I know the people. I know the language."

Upon his return, Dr. Charash described the scene on the ground as overwhelming.

"I had a lot of feelings that while we did so much to help, it seemed like it was so little in the overall scope of things," said Dr. Charash. "We made the best of a terrible situation and at times it seemed almost inconsequential. But we made some systemic improvements. Sometimes even if you make one person feel better, makes it all worth it."

Dr. Andersson-Swayze also experienced the power of focusing on one patient, a technique that she used to block out the scale of the tragedy.

Continued on Page 5



LETTER FROM THE EXECUTIVE VICE PRESIDENT



Welcome to the latest edition of *The Green Mountain Physician*. Two of the stories we cover in this issue highlight the excellent care that Vermont physicians provide, both in their every day practice and in the most extreme circumstances.

A report recently released by BISCHA (see story on page three) shows that Vermont's utilization rates for advanced imaging, physician visits, inpatient hospital use, back surgery and Medicare spending were lower than the national average, and generally lower than regional averages. Whenever physician reimbursement cuts are proposed, I routinely tell lawmakers that Vermont's physicians do an excellent job of providing top-quality health care, as evidenced by our nearly annual position atop national health rankings, at lower than average costs. Studies like the one conducted by BISCHA only reinforce the message that Vermonters received excellent care for their health care dollars and that the state's physicians are already doing their part to keep costs down.

It is hard to be farther removed from a Vermont physician's day-to-day life than going on a medical mission to post-earthquake Haiti. In our front-page article, we feature a handful of Vermont physicians who put their personal and professional lives on hold in order to help the people of Haiti in the aftermath of that country's devastating earthquake. VMS salutes Drs. Patty Fisher, Bill Charash, Richard Salerno, Jean Andersson-Swayze, Michael Kiernan, M.D., and Chris Meriam for their commitment to patient care, no matter where it takes them.

As an organization, the Vermont Medical Society responded to the disaster in Haiti as well. VMS, along with the Chittenden County Medical Society, made a combined donation of \$3,500 to Doctors Without Borders in support of their Haiti earthquake relief effort. With the scale of tragedy in Haiti so extraordinarily high, I'm sure that the Vermont medical community will be called upon to help for years to come. If you take part in that effort, I encourage you to share your experiences with VMS as we'd like to share them with your colleagues as well as the broader community.

In the meantime, please enjoy this issue of *The Green Mountain Physician* and do not hesitate to contact me or other VMS staff if you have any questions, concerns or comments.

Sincerely,

Paul Harrington
Executive Vice President

PRACTICE VARIATION REPORT ISSUED

Enacted last spring, Act 49 charged the commissioner of the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) with: analyzing data on geographic variation in utilization of health care services in Vermont, recommending a process to improve the appropriateness of utilization in treatments or procedures across Vermont to improve patient outcomes and potentially reducing costs and recommending solutions to change significantly low or high utilization.

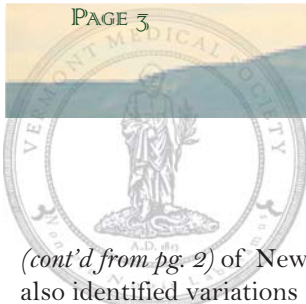
In response to the legislation, BISHCA recently released its report on "Recommendations to Improve Utilization and Variation in Health Care Services in Vermont." Norman Ward, M.D., and VMS's Paul Harrington were actively involved in the development of the process.

BISHCA retained the Dartmouth Institute (TDI) to perform the initial data analysis on geographic variation in utilization of health care services in Vermont. TDI analyzed Vermont Medicare data and collaborated with Onpoint Health Data's analysis of commercial insurance data through BISHCA's multi-payer data base.

The report includes an analysis of utilization and spending by Vermont Medicare beneficiaries across the state's 13 hospital service areas (HSAs) and it recommends a process to reduce variation or positively impact utilization. It's important to note that the report examined variations in utilization based upon where the patient lived as opposed to where they received their care.

The analysis focused on the use of advanced imaging (CT and MRI scanning), physician visits, inpatient hospital use, back surgery and Medicare spending. For all the measures examined, Vermont's utilization rates were lower than those found in the rest of the United States and they were generally lower than those observed in the adjacent Hospital Referral Regions (HRRs)

Continued on Page 3



PRACTICE VARIATION

(cont'd from pg. 2) of New York, Massachusetts and New Hampshire. However, the report also identified variations in both utilization rates and spending within Vermont, after accounting for possible differences in health or socioeconomic status.

Among the different health care services examined, the report presents CT events per 100 Medicare beneficiaries in each of the 13 Vermont HSAs. The report found that between the years of 2003-2007, the rate of CT events increased nationally (7.3 percent growth rate), in the New England region (7.5 percent) and in the state of Vermont (5.7 percent). And while the rates of CT events increased in Vermont over five years, the report concludes that the state has much lower rates than the nation and the adjoining HRR's. The national average for CT events was 63.8 events per 100 people while the Vermont state average was just 41.8.

CT (Rates per 100 beneficiaries)			
Year	VT Mean	National Mean	Adjoining Region
2003	38.94	47.83	46.47
2004	42.07	52.17	50.90
2005	41.59	56.63	55.98
2006	45.68	61.21	59.67
2007	49.53	64.56	64.11
5-Year Mean	43.63	56.48	55.43
Mean Change per Annum	5.70%	7.50%	7.80%

Though rates are lower in Vermont than in the rest of the nation, the report found that there are large, statistically significant variations in the rates of utilization of CT scans within Vermont. Some Vermont HSAs, like Bennington with 51.5 CT events per 100 people, approach the rate of the national average, while other HSAs fall well below the national benchmark, such as Brattleboro (33.6), Middlebury (34.0) and Morrisville (35.0).

In addition to the TDI and Onpoint analysis, the report recommends a BISHCA-directed process to improve utilization and variation in health care services in Vermont.

It recommends that an advisory body be established by the commissioner of BISHCA to perform three essential functions: identify preliminary areas of focus from the data analysis described above, develop methods for disseminating information on variation, and monitor progress in the areas of focus. An analytic organization would address the question of how to determine whether there is significantly low or high utilization.

The results of the advisory body's assessment would be provided to the commissioner as recommendations for areas of focus. The commissioner may use these recommendations to contract with a performance improvement organization tasked with further exploration and improvement in the areas of focus. For each area of utilization, there are two issues that would need to be addressed by the improvement organization: whether there are authoritative resources and research studies on causes of variation for the particular utilization area, and what factors should be considered in determining causation.

The Vermont Program for Quality in Health Care (VPQHC), because of its experience in working with Vermont hospitals and health care professionals on quality improvement initiatives, and TDI, because of its role in performing the data analysis, have been identified in the report as the best organizations to communicate the initial analyses to the entities that provide direct patient care. BISHCA would direct and coordinate a communication



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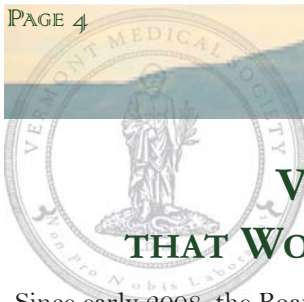
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VMS EXPRESSES OPPOSITION TO NEW RULES THAT WOULD ALLOW APRNs TO PRACTICE INDEPENDENTLY

Since early 2008, the Board of Nursing (BoN) has been working on new rules that essentially would allow APRNs to practice independently. VMS has expressed its concerns about the rules orally and in writing on various drafts of the rules, and did so again at a public hearing held by BoN on Feb. 12 at the National Life Building in Montpelier.

Key among VMS's concerns about the new rules are provisions that would remove the currently in effect collaborative practice requirement and would permit APRNs to practice medicine independently with full prescribing authority.

In his comments during the public hearing, Vermont Medical Society Executive Vice President Paul Harrington stressed that the current rules have been working well for Vermont.

"Physicians who have had the opportunity to work with advanced practice registered nurses believe this collaborative system of care has been helpful to both professions, offering APRNs and physicians an opportunity to learn from each other, to improve the care they provide to their patients, and to coordinate care in complex cases," said Harrington. "The current requirements also are designed to ensure that patients receive the same standard of medical care whether they receive treatment from an APRN or a physician, something most patients believe to be the case."

Harrington also expressed VMS's concern that the new rules go beyond the legislature's intent.

"While the legislative intent focused on nurse practitioners providing primary care, the draft APRN Rules extend independent practice to nurse midwives, nurse anesthetists and clinical nurse specialists in psychiatric and mental health nursing, and other clinical nurse specialists," said Harrington.

In concluding his testimony, Harrington asked BoN to consider five VMS recommendations, which the Vermont Board of Medical Practice voted to generally support on Feb. 3. They were:

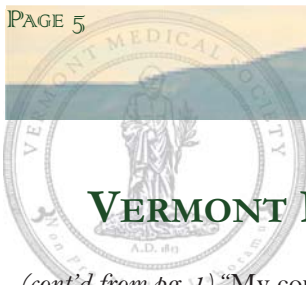
- That the proposed amendment for APRNs conform fully to the six recommendations made by the Vermont Board of Medical Practice in January 2008 – which included monitored and supervised clinical experience under a formal collaborative agreement prior to independent practice, a multi-disciplinary formulary for prescribing, regulation by medical professionals with at least the same level of training as the APRNs, and a prohibition on use of the term "doctor" in ways that could lead to patient confusion – to ensure a meaningful standard of training and regulation.
- That the draft amendment to the Board of Nursing Rules for APRNs be limited to nurse practitioners providing primary care and chronic care.
- That the standard of regulation, education, training and oversight for APRNs in Vermont be comparable to the standard for other clinicians performing similar work.
- That a statute be enacted that would include requirements for APRNs' education, training, scope of practice, professional conduct and patient disclosure, which would provide legislative oversight comparable to other professions.
- That the requirements for collaboration with physicians, and for guidelines that are acceptable to both physicians and APRNs in the current Board of Nursing rules, be maintained in the draft APRN rules.

Joining Harrington in commenting at the hearing was a doctor with unique insight into care delivered by physicians and APRNs, and the ways in which they work together to provide care. William Roberts, RN, CRNA, M.D., PhD, was a certified nurse anesthetists before becoming an anesthesiologist.

"I am not against the increased autonomy of my nursing colleagues; I actually embrace an expanded role for nursing to support the delivery of healthcare needs," said Dr. Roberts. "I am, however, against the administrative redefinition of what is essentially the defined acceptable entry mechanism for a nurse to enter into the practice of medicine ... The public wants a single set of expectations to be met. Everyone who performs acts of medical diagnosis and prescribes medical, therapeutic or corrective measures should have a single standard of care by which they are evaluated."

In addition to Dr. Roberts, Joel Mumford, M.D., also testified and supported VMS's recommendations and Dr. David Clauss, immediate past chair of the Vermont Board of Medical Practice and William Wargo, executive director of the VBMP also attended the hearing.

For more information about the APRN rules and VMS's stance, visit <http://www.vtmd.org/APRN/APRN%20Index.html>.



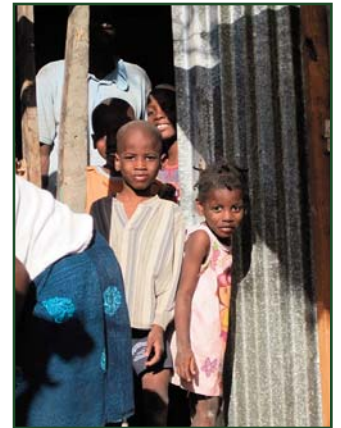
VERMONT PHYSICIANS PROVIDE CRITICAL MEDICAL CARE IN HAITI

(cont'd from pg. 1) "My coping method was to focus on one patient at a time," said Dr. Andersson-Swayze, who joined Dr. Fisher on a previous mission to Haiti just last October. "Anything else would have deprived that patient of what they need and then the magnitude of everything would have immobilized you."

Doing everything from running an emergency room and delivering babies, to treating critical patients and wounds, her experience in Haiti gave Dr. Andersson-Swayze an even greater appreciation for her training as a family physician.

"It was really great to be a family doctor," said Dr. Andersson-Swayze. "Never have I appreciated my training more because I was thrown into every situation imaginable. It felt good to be able to do a little bit of everything."

Dr. Charash's time in Haiti may even lead to better care of patients here in the United States. He noticed a peculiar difference in Haitians responses to injuries that differed from Americans that in his mind has rich potential for research.



"The Haitian people from a purely medical standpoint had a different response to injuries," said Dr. Charash (pictured to the left), who in addition to his duties at FAHC is also a member of the faculty at the University of Vermont College of Medicine. "Their response was far superior. While crush injuries produce a lot of renal failure and cause a high rate of kidney damage, the Haitian kidney is somehow more resilient than others. Is this genetic or an environmental adaptation? There may be physiological principles that could we could apply to the treatment of our own patients. These unanswered questions need to be investigated."

The experience left lasting impressions on Drs. Fisher, Charash and Andersson-Swayze.

Dr. Fisher worries about how the country's legacy of corruption will impede recovery, while Dr. Charash was deeply moved by the strength showed by Haitian families.

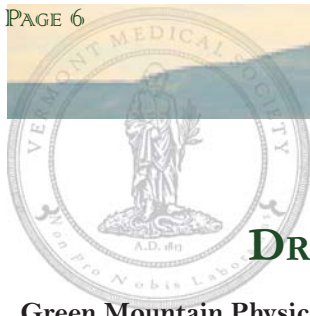
"They were very instrumental in care and were amazing at getting patients to react well," said Dr. Charash, who taught families how to do basic post-op care such as wound treatment and range of motion exercises. If there was one family member injured, the whole family wouldn't leave. The Haitian people have so little yet the thing that matters most to them are family, church and education. They have enormous pride for having so little. I found that to be a very powerful statement about human culture."

And for Dr. Andersson-Swayze, the experience was like seeing a glimpse of Dante's Inferno only to be lucky enough to escape.

"Coming back to Vermont is like visiting hell and being able to get out of it but you have to leave most people behind because they can't get out," said Dr. Andersson-Swayze, who is continuing to help those affected by the earthquake by raising funds for the charity SolidHaiti.org. "For people living here day to day who have no roof over heads, drinking water that other people use as a latrine, having no electricity, it is a way of life that here in Vermont you can't even fathom. It really makes you appreciate all that you have."



Editor's note: Members who went to Haiti, or will do so in the future, are encouraged to share their stories with VMS by contacting Justin Campfield at jcampfield@vtmd.org or (802) 223-7898, ext. 12. Doctors mentioned in this story but not quoted were not available for an interview at press time either because of illness or because they were still in Haiti.



10 QUESTIONS WITH ... DR. VICTOR PISANELLI, JR., VMS VICE PRESIDENT



Green Mountain Physician: Where do you practice and how long have you been practicing there?

Dr. Pisanelli: I practice in Rutland, Vermont and have for the past 32 years.

GMP: You became VMS's Vice President at last October's annual meeting. What made you interested in taking on the role of vice president of the Vermont Medical Society?

Dr. Pisanelli: There are a lot of things happening politically with regard to health care and I felt it would be wise to add a general surgeon's perspective to the Society's activities. It is good to have as much diversity as possible.

GMP: What do you hope to accomplish during the year?

Dr. Pisanelli: I hope to be able to work with other members of the Society and its leadership to ensure that we, as providers in the state, can continue to provide for our patients the way we see best while knowing that we have to work around financial constraints. We want to retain our physicians, attract new ones and work with our state and federal representatives to ensure that there is adequate reimbursement for our services.

GMP: You practiced medicine along side your father for many years. What was that like?

Dr. Pisanelli: My father had a surgery practice for many years and I joined him in 1977 and we practiced along side each other until he passed. I was very fortunate to be able to do it. He served as a very good mentor and role model. We never had any conflicts; we knew each other's strengths and weaknesses. He also realized and acknowledged that I was bringing new skills and techniques into the practice. We worked very well together.

GMP: If you were awarded a full year's sabbatical to study any medical issue, what would it be?

Dr. Pisanelli: I'd like to study health care delivery systems in other countries just to see how they go about doing it. As our country is embarking on a more socialistic system I think I'd like to see if there is anything they could teach us.

GMP: Complete this sentence. I like practicing medicine because ...

Dr. Pisanelli: It is very gratifying to help patients with their surgical problems, helping them to relieve their pain and getting on with their lives.

GMP: If you were named U.S. Secretary of Health and Human Services, what would be your first policy enactment?

Dr. Pisanelli: A lot of our health care system's issues are based on lifestyle issues. I'd try to enact a more widespread and comprehensive program to get in schools and teach our kids about a healthy lifestyle. That's where we'll get the biggest payoff down the road.

GMP: How do you relax and unwind?

Dr. Pisanelli: I enjoy working out in the gym and in the last year have participated in two half marathons with my children. In the summer time I like to play golf although I don't get to do that as much as I'd like to.

GMP: If you weren't a doctor, what would you be?

Dr. Pisanelli: I always liked math and science and I thought in my earlier years about the engineering field. But medicine interested me at such an early age that I didn't really spend a lot of time looking at other choices.

GMP: Why are you involved with the VMS?

Dr. Pisanelli: I feel that physicians, because of the nature of our work being so one-on-one with our patients, tend not to spend as much time together as other professions do. We really need to get together and pool our resources to make sure that the practice of medicine isn't damaged. We should focus on trying to maintain the practice of medicine as the art and science that it is ... maintaining that foundation that has been built over generations. I think the hurdles to doing that are getting larger and larger and I'm fearful that the next generation will not be as eager to jump into the profession.

PRACTICE VARIATION

(cont'd from pg. 5) process to be implemented by these two organizations. Potential mechanisms for communicating with health care professionals include hospital medical staff and community meetings.

The report recommends that VPQHC would convene the meetings and facilitate discussions of the analytical findings. TDI would be available to review methods, statistical considerations and other technical issues related to data analysis and reporting.

In the report, BISHCA recommended proceeding with the plan and providing a progress report to legislative committees on Jan. 15, 2011, and providing a report evaluating the effectiveness of the plan to the same committees on Jan. 15, 2012. Should the plan move forward, VMS plans to be actively involved. The full report may be found at <http://tinyurl.com/vtpracticevariation>.



HITECH ACT'S BREACH NOTIFICATION REQUIREMENTS EXPLAINED

By Anne Cramer, J.D., Primmer Piper Eggleston & Cramer PC

Passed into law as part of the American Recovery and Reinvestment Act of 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act mandates how health care providers must respond when patients' personal information is breached.

Under the rules issued by the U.S. Department of Health and Human Services (HHS) implementing the law, which took effect on September 23, 2009, health care providers and other covered entities are required to notify an individual whose unsecured protected health information (PHI) has been accessed, acquired or disclosed as a result of a breach of privacy or security within 60 days of the discovery of the breach, and perhaps sooner if feasible.

The content and methodology of notification is well outlined in the HITECH Act and slightly modified by rules HHS released last August. In most instances, notification must be in writing and mailed directly to the individual, unless electronic mail has been specified as a preferable means of communication by the individual. If the PHI of 500 or more Vermont residents is involved, then notification to a prominent media outlet is also required along with contemporaneous notice to the secretary of HHS. The rules implementing the law make clear that health care providers must keep a log of any breaches and annually report them to HHS not later than 60 days after the end of each calendar year.

For practices, perhaps the most difficult aspect of the notification requirements is the breadth of the definition of "breach":

The term "breach" means the acquisition, access, use, or disclosure of protected health information in a manner not permitted by Subpart E [of the HIPAA Privacy rule] which compromises the security or privacy of such information.

There are however, exceptions. They include:

- Any unintentional acquisition, access or use of protected health information by a workforce member or individual acting under the authority of a covered entity or business associate if:
 - Such acquisition, access, or use was made in good faith and within the scope of his/her authority; and,
 - Does not result in further use or disclosure in a manner not permitted by Subpart E.
- Any inadvertent disclosure from a person who is otherwise authorized to access protected health information at a covered entity or business associate to another person authorized to access protected

health information at same entity; and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted by Subpart E; and,

- A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Note that the breach notification requirement does not apply if the PHI is considered "secured" such that it is rendered unusable, unreadable or indecipherable to an unauthorized individual through a methodology specified by guidance from the secretary of HHS. While HHS has stated that securing PHI in such a manner is not required, the rule conveys that it is best practice to do so.

The definition of "compromises the security or privacy" of PHI means "poses a significant risk of financial, reputational, or other harm to the individual." Thus to determine if an impermissible use or disclosure is a breach, health care providers must engage in a risk assessment that should be fact specific – and documented.

Further, covered entities must train all members of its workforce on these matters, provide a process for individuals to make complaints, refrain from taking retaliatory acts against those who do complain and to develop and impose appropriate sanctions for members of its workforce who fail to comply with the HIPAA Privacy Rule provisions.

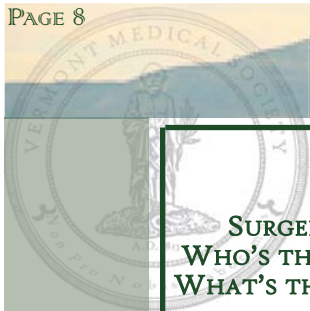
Additional Changes Took Effect Feb. 17, 2010

Important HITECH provisions which became effective on Feb. 17, 2010, include:

1. Access in an electronic format must be provided to individuals whose PHI is part of an EHR.
2. An individual has a right to request that no disclosure of PHI be made to a Payer, and have it honored, if the individual self paid for the relevant medical care.
3. Business Associates are directly subject to the HIPAA Privacy and Security Regulations and the civil and criminal penalties for non-compliance.
4. The secretary of HHS is required to periodically audit Covered Entities and Business Associates for compliance with the HITECH Act and the HIPAA Privacy and Security Regulations.

For questions or clarifications, please contact Anne Cramer at acramer@ppeclaw.com.

CONFERENCES



SURGERY FOR DIABETES? WHO'S THE RIGHT CANDIDATE, WHAT'S THE RIGHT PROCEDURE?

March 22, 2010
DHMC
Lebanon, NH

For more information call 603-653-1531 or go to the website at <http://ccehs.dartmouth-hitchcock.org>

UPDATE ON THE PREVENTION, DIAGNOSIS AND MANAGEMENT OF PATIENTS WITH VASCULAR DISEASE: 2010

April 5, 2010
Radisson Hotel Manchester
Manchester, NH

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April 30, 2010
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