

THE GREEN MOUNTAIN PHYSICIAN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

"Not for ourselves do we labor"

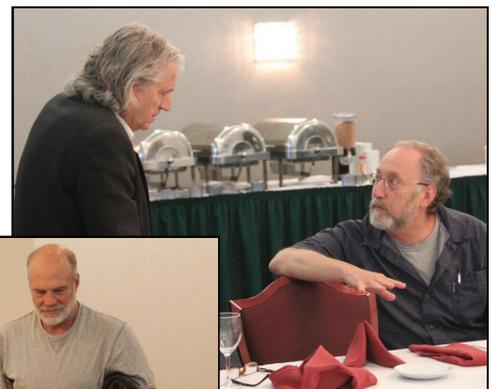
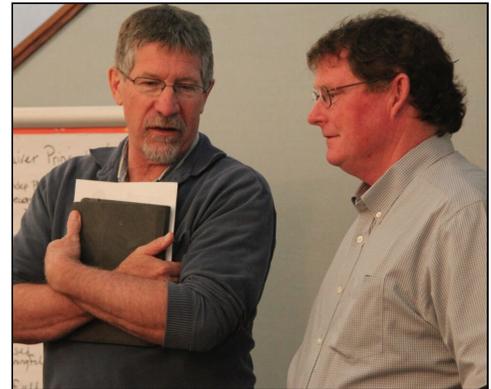
Aug./Sept.
2015

ANNUAL PLANNING RETREAT HELD

The Vermont Medical Society held its annual planning retreat July 11th at the Capital Plaza Hotel and Conference Center in Montpelier, Vt.

Topics raised during the retreat focused on a number of health policy issues, including concerns about EHRs and how to make them more user friendly and useful, physician wellness, tort reform and how it impacts recruitment, communication between physicians, and mid-level scores of practice. The conversation was in part informed by the results of the 2015 VMS member survey, the results of which can be found on page four.

The retreat is the Society's annual moment to thoughtfully consider the strategic opportunities and challenges facing it as an organization and profession. Many of the issues raised during the brainstorming session will become resolutions that members will vote on during the Nov. 7th annual meeting at Topnotch Resort in Stowe. The annual meeting is open to all Society members. For more information about the annual meeting, see page eight.



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FROM THE PRESIDENT'S DESK

By David M. Coddaira, M.D.



Welcome to the latest issue of the Green Mountain Physician.

Many are aware of the high-profile legislative activity that the Vermont Medical Society influences. I wish to talk about some of the quieter, but very important, VMS activities that happen weekly.

As a result of the Vermont Health Connect fiasco, a substantial number of claims were paid by Blue Cross/Blue Shield for patients who were not really enrolled. As a result the insurer is recouping close to \$514,000 from physicians. Due to the efforts of Paul Harrington, the company will not pursue another \$4.5 million.

Paul is also meeting weekly with some of the major players to discuss payment reform in anticipation of the proposed "all-payer waiver" that has been submitted to the Center for Medicare and Medicaid Services by the Green Mountain Care Board. The principles of the potential future payment system are being fleshed out in these meetings.

Atty. Madeleine Mongan communicates with the Board of Medical Practice about the proposed multi-state licensure compact as well as the Board's investigative practices. Council members and I will continue to convene with representatives of the Board around these topics.

Stephanie Winters continues her work as executive director of several specialty societies and Colleen Magne coordinates the good work of the Vermont Practitioners Health Program, which assists our colleagues whose health challenges impair their work.

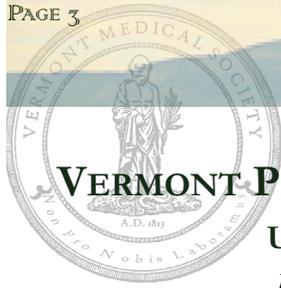
Please keep in mind two public health concerns:

- The plague of distracted- and impaired-driving continues to take lives. Let's talk to our patients about driving safety, and
- Secondly, let us do our part to ameliorate the opioid epidemic. We should "follow the evidence" in our use of these medications.

Finally, reserve Nov. 6-7 for the VMS Annual meeting at Topnotch Resort in Stowe. It will be combined with meetings of the surgeon, psychiatrist, internist and family physician associations.

Thank you all for your good clinical work!

David Coddaira, M.D.
President



VERMONT PRESCRIPTION MONITORING SYSTEM UNDERGOES TRANSITION

By the Vermont Department of Health

The Vermont Prescription Monitoring System (VPMS) has transitioned vendors from Health Information Designs (HID) to Appriss, Inc., in order to provide registered users with a more robust and functional system to assess and monitor scheduled II-IV controlled substances dispensed to Vermont patients.

For providers that are registered with the VPMS, please be assured that your registration status will not be affected by the transition. When you log in for the first time after the transition, you will be asked to update your account information to ensure that the VPMS program has the most accurate and up-to-date contact information. As DOH moves closer to the transition date you will receive an email with login instructions for the new website.

DOH anticipates online registration will be available for new users including residents and delegates on Sept. 15, 2015. For delegates and residents who mailed in paper registration forms, please register online to ensure that we have the most accurate and up-to-date information on all of our registrants. New registrants may register for access to the VPMS by going to the VPMS homepage and clicking on “register now” located here: <http://www.healthvermont.gov/adap/VPMS.aspx>.

DOH hopes that you will find the new VPMS to be a more user friendly and efficient tool to assist you in providing the best care for your patients. More information will follow as the transition date approaches. Thank you for your patience and please do not hesitate to contact the program with any questions, comments or concerns.

THE FUTURE OF PRIMARY CARE IN VERMONT

By Allan Ramsay, M.D., Green Mountain Care Board Member

When Governor Shumlin announced on December 17 that he would not move forward with Vermont’s publically financed Green Mountain Care plan, there was both surprise and a collective groan. The Green Mountain Care Board (GMCB) had many vocal protestors at our public Board meeting the following day. Rather than conduct a regular agenda we decided to open the entire meeting to public comments. Anyone present could sign and record their concerns. We heard about Vermonters who delayed starting a family because of health care costs, farm foreclosures, lack of access to health care, and many other heartfelt stories.

Many of my primary care colleagues also felt a sense of loss. Some had been supportive of a single payer system their entire careers, even though few actually understood what Act 48 would accomplish in Vermont. Green Mountain Care would not include Vermonters in self-insured plans, Medicare, or those with primary VA benefits. It was never made clear what entity, public or private, would actually be the payer.

I knew that many primary care professionals in Vermont were always concerned that nothing would change for them as a result of the state’s health care reform efforts. The loss of Green Mountain Care became an “I told you so” moment in their minds. The overwhelming administrative burdens in the current system would continue, measurement fatigue would still be a reality, and increased cost sharing by patients would compromise their decisions about needed health care.



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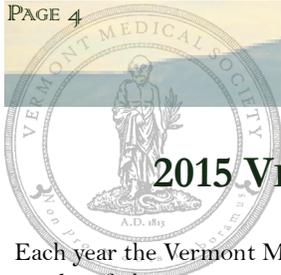
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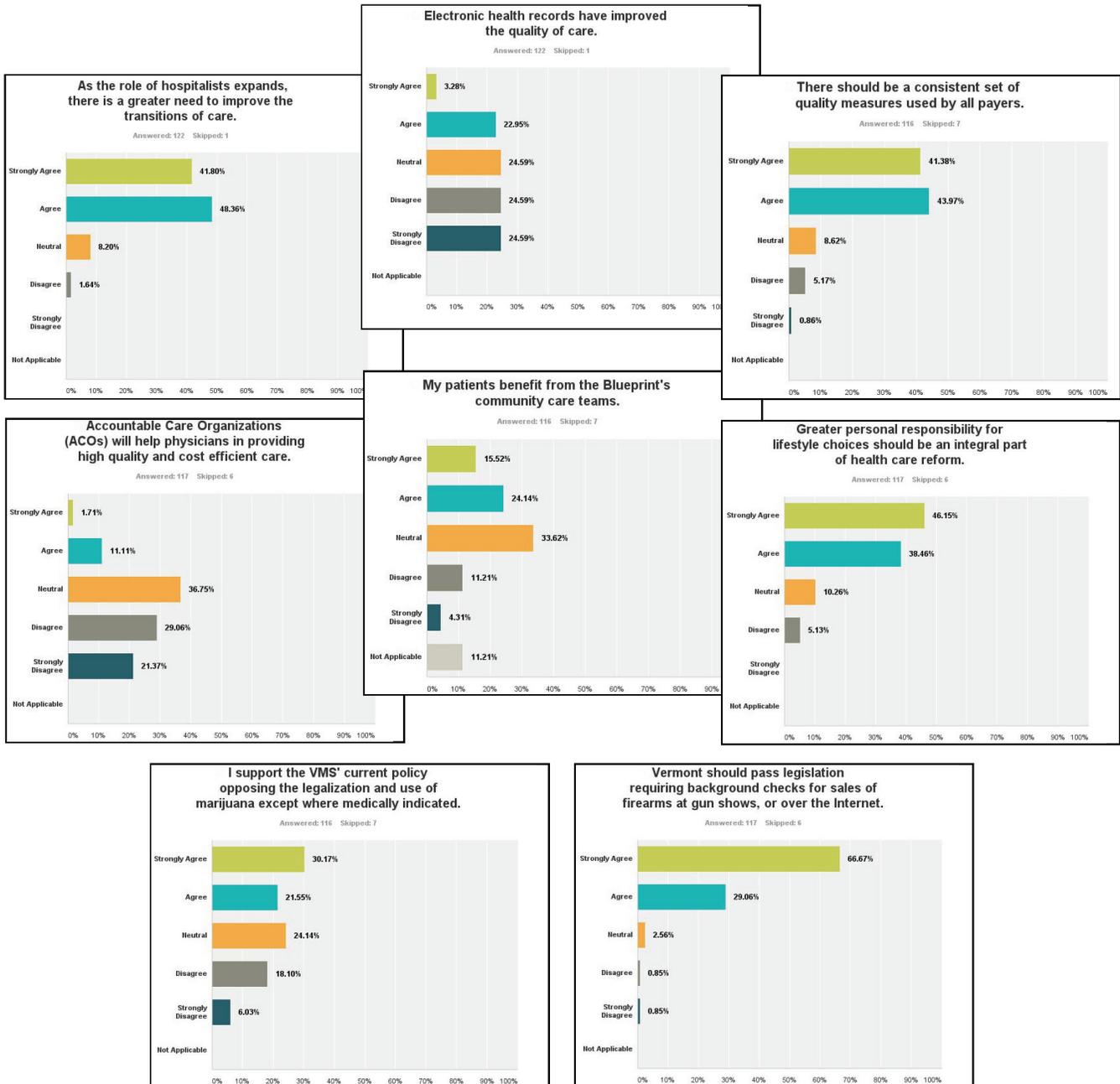


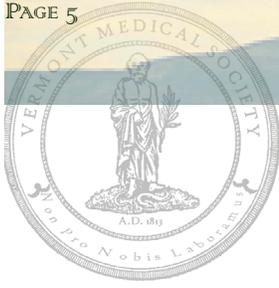
2015 VERMONT MEDICAL SOCIETY MEMBERSHIP SURVEY

Each year the Vermont Medical Society surveys its membership on a variety of health care and public policy issues. The results of the survey are used in part to determine the Society's priorities for the following year.

Below are eight survey questions and results that are particularly informative. They include issues addressed by resolutions that are currently being drafted by VMS staff based on member input at the annual planning retreat and will be presented to membership at the Nov. 7th annual meeting at Topnotch Resort in Stowe.

For results of the full survey, visit www.vtmd.org/2015-vms-member-survey.





GMP SPOTLIGHT: HOSPICE CARE

(note: three articles in this section)

A CONVERSATION WORTH HAVING

By Christine Werneke

Too often families struggle with the care and needs of a loved one at the end of life. In many cases, they may not understand the options that are available to them. Palliative care and hospice offer an extra layer of support that helps individuals and families maintain their quality of life. Talking about these options for care at the end of life can offer families comfort and support. Yet many have trouble getting this conversation started.

A study done by the California Health Foundation in 2011 found nearly 80 percent of people would like to talk with a doctor about end-of-life care, but only seven percent have had this conversation. For cancer patients, 95 percent thought discussing advance directives issues was very or somewhat important, yet only seven percent had discussed this with their oncologist.

To help people understand their options and start what can be a difficult discussion, the VNAs of Vermont created Start the Conversation, a program to encourage families to learn and talk about end-of-life care before a health crisis or serious diagnosis. The program helps increase the understanding of palliative care and hospice and encourages individuals to have conversations with their loved ones and their physicians. VNAs of Vermont also partners with Vermont Ethics Network to offer information and resources to support the advance care planning process.

Communities across the state have responded positively to learning about options for end-of-life care and hearing about advance care planning and the tools available to help

them get started. After learning about Start the Conversation one woman commented, "I am a single mother with a chronic disease and I've wanted to take care of this for quite a while, but it all seemed so complicated and I didn't know where to start."

Resources for you and your patients

The program offers an array of resources to encourage conversations about end-of-life care, such as care preferences questionnaires, conversation guides, helpful facts, and a dedicated website to help patients and families access palliative and hospice care for themselves or a loved one.

While these materials can stand alone, they are most helpful when they are part of a conversation. Trained facilitators from VNAs of Vermont agencies can lead group discussions to help answer questions on palliative care and hospice and support the advance care planning process. Discussions are often held at local libraries, community or senior centers, or have been done in partnership with a local hospital or primary care practice.

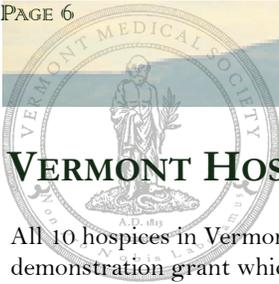
You can learn more by visiting www.StartTheConversationVT.org or by contacting your local VNAs of Vermont agency. If you would like to schedule a Start the Conversation presentation and discussion with members of your community or specifically for your patients or practice, please contact your local VNAs of Vermont hospice agency. A directory of agencies and contact information can be found at www.starttheconversationvt.org and at www.vnavt.org.

MADISON DEANE IS STUDYING HOSPICE IN VERMONT

If the vast majority of people say they would rather die at home than in a hospital or nursing facility, why are only 30 percent of Vermonters receiving hospice care at the end of life? That question is the driving force behind a statewide study examining Vermonters' current experiences with end-of-life care.

The research is being commissioned by the VNA Madison-Deane Initiative (MDI), with support from the VNAs of Vermont, and Coverys Community Healthcare Foundation. MDI is the education arm of VNA End-of-Life Care services and has a mission to transform end-of-life care through education, collaboration and inspiration.

The study, being conducted by the University of Southern Maine, Muskie School of Public Service, will gather input from every region of Vermont and will take a comprehensive view of perspectives, including state administrators and lawmakers, advocacy organizations, nursing homes, hospitals, health care providers, hospice agencies, and the Vermonters who live in our communities. For more information, contact VNA at mdi@vnares.org.



VERMONT HOSPICES SELECTED FOR PALLIATIVE CARE DEMONSTRATION

All 10 hospices in Vermont have been selected as pilot agencies for the Medicare Care Choices Model (MCCM) demonstration grant which will allow the agencies to provide extensive palliative care and care management services to patients who qualify for hospice care but chose not to enroll in the hospice program. This model will allow them to receive select hospice services while continuing to receive curative care services concurrently, which is prohibited under current hospice rules.

The program will provide home-based care management, care coordination, and palliative care services to eligible beneficiaries with emphasis on patients with Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and diabetes.

The Center for Medicare and Medicaid Innovations plans to phase in program starting Jan. 1, 2016. Sixty-five of the 140 approved for the program were randomly selected for the first round. The 75 agencies not selected in the first round will start their programs Jan. 1, 2018. Eight of the 10 Vermont hospices were selected for the first round.

The patients who will be served in this program are at highest risk of repeated medical crises, hospitalization, symptom distress, family caregiver stress, and unnecessary medical expenditures.

The goal of the Medicare Care Choices Model is to test a new model of care for hospice-eligible Medicare and dual eligible beneficiaries. By allowing patients to receive this supportive care typically provided as part of the Hospice benefit while still pursuing curative care, CMS hopes that this will eliminate a common barrier to choosing hospice services earlier in the disease cycle. Patients enrolled in the model will get help with pain and symptom management, patient-centered goal planning, care coordination, case management and shared decision results for this patient population.

Expected outcomes are increased patient and family satisfaction, and lower utilization of hospital and emergency department, and diagnostic services.

Eligible Patients

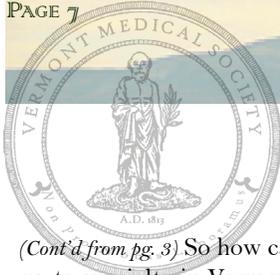
- Medicare or dual eligible beneficiary
- Hospice-eligible (prognosis of 6 months or less, signed hospice consent)
- Not a current hospice patient or have not had hospice care in the last 30 days
- Has a qualifying diagnosis of cancer, CHF, COPD or AIDS/HIV
- Has had at least 2 hospitalizations in the past 12 months related to the qualifying diagnosis
- Has had at least 3 office visits within the last 12 months related to the qualifying diagnosis
- Lives in a traditional home
- Is not part of a managed care program

Supportive Services (Covered by a PMPM payment)

- Patient-centered goal planning (assessment, patient and family education, plan of care, interdisciplinary care team review)
- Home visits by an RN and LNA as needed
- Counseling and family support
- 24/7 access to hospice

Curative Services (Billed under current system)

- Physician
- Hospital
- Diagnostic
- Imaging
- Therapies
- Pharmaceuticals
- DME



FUTURE OF PRIMARY CARE

(Cont'd from pg. 3) So how can I be so sure primary care is the go-to specialty in Vermont? Let's explore the evidence.

First, Vermont does not have enough primary care physicians. There are good jobs available in every part of the State. This year more University of Vermont College of Medicine graduates chose family medicine residency positions than ever before. Pediatrics, the other specialty most likely to produce a primary care physician, did equally as well. Within the next two years the UVMC Family Medicine Residency Program will have a second residency site at the Champlain Valley Physicians Hospital in Plattsburgh, New York. This is the first expansion of family medicine training in our region in twenty years.

Second, the primary care professionals in Vermont have shown they have the leadership skills to take responsibility for improving the health care system. The Blueprint for Health is a perfect example. Primary care practices throughout the state have done the arduous work to become certified Patient Centered Medical Homes (PCMH) for their patients. This delivery system is demonstrating both improved quality and reduced costs. The evidence shows that the longer the PCMH model is supported, the better it performs. Primary care physicians in Vermont are the only ones who can integrate the care of those with multiple physical and mental health conditions. The organizational framework of the PCMH and community health team makes this integration possible. Blueprint payments are increasing as a result of its success.

Third, payers and the Green Mountain Care Board are working to slowly change some of the administrative burdens that can add to our frustrations. A pilot study designed to eliminate prior authorization for some drugs and advanced imaging has begun. As the shift of financial risk moves from the payer (fee-for-service) to the provider of health care (capitation), the tools used to control utilization by the payer become unnecessary. On the other hand, generic prescribing, shared decision making about procedures or tests, and applying sound evidence when discussing treatment plans becomes more necessary. Exactly what primary care physicians are trained to do.

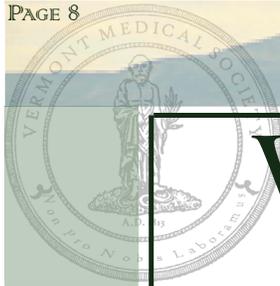
Fourth, many of my colleagues agree that electronic health records have not reached their potential to improve the flow of meaningful information and improve health

outcomes in the office setting. In Vermont we have Vermont Information Technology Leaders (VITL). VITLAccess is a provider portal to information about patients wherever they are seen. Since July 2014 there have been 1,424 authorized users making over 91,000 patient queries on VITLAccess. I suspect many of these are in primary care. VITL is building a health information exchange that really works for us no matter what kind of electronic medical record system we use.

Lastly, I know full well that continued growth of primary care in Vermont cannot continue without meaningful payment reform. At the close of this year's legislative session lawmakers did agree to small Medicaid and Blueprint payment increases. Primary care practices in Vermont have been exemplary in their willingness to care for those with Medicaid. This has held true even as the numbers of new Medicaid patients have increased and the enhanced payment of the first two years of the Affordable Care Act went away. It is time for the Vermont legislature and payers to understand the increase in health care costs in Vermont will not moderate without much greater investment in primary care services.

The Administration and GMCB are now engaged with the Centers for Medicare and Medicaid to develop creative new payment models for Vermont. This effort could reduce complexity in our payment system by aligning the rules for federal, state, and private payers in Vermont. Achieving the goal of an "all-payer model" is technically complicated. I know it will not succeed unless primary care is better rewarded for what it does.

During the late stages of my career I practiced as a specialist in Palliative Care at UVMC. I did consultations on specific conditions using a focused knowledge base. My relationships with patients, though intense, were usually short. I often thought of how different this was from being a family physician. As a family physician I developed personal and family relationships over a long period of time, it was the complete care of the whole person. It sometimes even gave me a better understanding of myself. Primary care offers this profound opportunity for self-discovery. No other discipline comes close (LaCombe, Ann Intern Med 1993; 118:384). That will always be the real reason I believe so strongly in the future of primary care.



Vermont Medical Society

202nd Annual Meeting

in Collaboration with

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Vermont Chapter, American College of Physicians

Vermont Chapter, American College of Surgeons Vermont

Chapter, Vermont Academy

of Family Physicians, Vermont Psychiatric Association

November 6 & 7, 2015

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