

## SAVE THE DATE

# Vermont Medical Society

## 201st Annual Meeting

October 24 & 25, 2014

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VERMONT MEDICAL SOCIETY  
PO Box 1457  
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# THE GREEN MOUNTAIN PHYSICIAN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

"Not for ourselves do we labor"

Jan./Feb.  
2014

## VMS FOUNDATION CONDUCTS WELL-RECEIVED RESEARCH FOR GREEN MOUNTAIN CARE BOARD

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### Contact Us

PO Box 1457  
Montpelier, VT 05601  
800-640-8767 or 223-7898  
Fax 802-223-1201  
Online at:  
[www.VTMD.org](http://www.VTMD.org)

The VMS Foundation has significantly increased its visibility and utility to state health care policy makers by presenting a pair of whitepapers to the Green Mountain Care Board that addressed ways to optimize hospital-based and rural care in the state of Vermont.

The Board asked the Foundation to conduct qualitative research aimed at eliciting physician opinion on topics relevant to the Board's activities including health resource planning, the measurement of health care outcomes, and payment reform.

"The Board realizes the wealth of knowledge practicing physicians have about the Vermont's health care system, and to their credit, they are very interested in their input and ongoing evaluation," said Dr. Cyrus Jordan, the Foundation's Director. "Many Vermont physicians recognize that the health care reform efforts underway are an opportunity to rethink the way they do business and re-build a system of care that better serves their patients. These reports capture their thoughts on how to go about doing that."

To say that the Board was receptive and appreciative of the Foundation's work – and the physician input that it represented – is an understatement as explained by VMS' Executive Vice President Paul Harrington.

"[Board] Chairman Al Gobeille described a business strategy that only focused on those things that deserved a standing ovation," recalled Harrington. "At the conclusion of the presentation of the second whitepaper, Mr. Gobeille stood up and asked everyone to give Dr. Cy Jordan and his physician colleagues a standing ovation for the insightful and pragmatic suggestions these physicians leaders had made to advance healthcare reform in Vermont."

### Optimizing Hospital-based Care

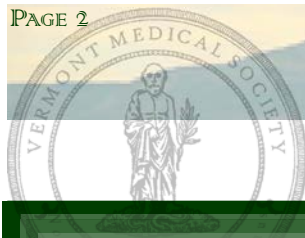
A number of physicians who contributed to the whitepaper *Optimizing Hospital-based Care in the Vermont Region* joined Dr. Jordan in discussing its findings and recommendations with the Board during a Dec. 5th presentation.

The 60-page whitepaper is the result of detailed interviews with 17 physicians who collectively direct and provide inpatient care at the majority of the state's hospitals.

The whitepaper makes nine physician recommendations for optimizing hospital care in Vermont:

1. Construct a health resource allocation plan for the state as a whole;
2. Health care reform should be patient centered;
3. Plan three levels of hospital resources: Community based care; Regional centers of excellence; and Tertiary care.
4. Care for patients at the right level of care through coordination of resources;
5. View the direct patient care workforce as the key resource for health care reform;
6. Push hard for a seamless integrated information technology;
7. Encourage more meaningful and efficient accountability measurement;
8. Align payment reform with providing high quality care; and,
9. Include direct care givers in ongoing policy discussions and evaluation efforts.

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## FROM THE PRESIDENT'S DESK

By Daniel B. Walsh, M.D.



Welcome to the latest edition of the Green Mountain Physician.

The legislative season is heating up in Montpelier, and as has been the case in recent years, health care policy is a major priority in the statehouse. Policy must be constructed before cost can be estimated.

The Governor and the legislature are keenly aware that paying for the 2017 Green Mountain Care Plan, AKA, the single-payer system will be a significant challenge. The Society is helping shape that debate with its role in the Vermont Partners for Health Care Reform, a group of organizations who all have a stake in health care reform. Partners released a report that raised questions about the Shumlin Administration's cost estimates and how those estimates included significant decreases in reimbursement for physicians and hospitals under the plan. So far the Society has been successful at shifting the cost estimate from 1.6 to 2.1 billion dollars. Some legislators seem to understand the cost may be even higher. For more info, please see the story on page 5.

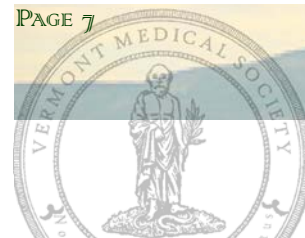
Another way the Society is helping to reshape health care in Vermont is through the efforts of Cy Jordan, M.D., and the VMS Foundation. Recognizing Dr. Jordan's expertise and the committed group of physicians he has assembled, the Green Mountain Care Board has increasingly turned to the Foundation for help with the many policy initiatives they are undertaking. Read about two whitepapers the Foundation recently presented to the Board – and the amazing reception they received – on page 1.

Finally, I'd like to call your attention to an important resolution the VMS Council passed at its February 8th meeting that addresses two increasingly critical topics in mental health care: a shortage of acute psychiatric beds and long delays in the delivery of non-emergency involuntary medications. Please see page 3 for more information.

This new resolution is a good example of how, through the VMS, members can impact health care delivery in the state. If you don't normally attend Council meetings, I encourage you to do so. Personally, I find them rich with information and very rewarding as the actions of the Vermont Medical Society make a real difference for physicians and our patients. The next Council meeting will be held April 26th in Waterbury. I hope to see you there!

Sincerely,

Daniel B. Walsh, M.D.  
President



## VMS FOUNDATION

(Cont'd from pg. 1) **Optimizing Rural Care**

A week later Dr. Jordan and a team of physician leaders responsible for the majority of the care in several contiguous communities in the rural central eastern part of the state presented Recommendations for Optimizing Rural Care in Vermont to the Board.

Developed through detailed interviews with 22 Vermont clinicians who practice in the rural settings in eastern central Vermont, the whitepaper made seven recommendations:

1. Center the care system on patient needs;
2. Design three levels of care;
3. Coordinate clinical services;
4. Dovetail clinical and social services;
5. Measure meaningful and actionable metrics;
6. Anticipate the workforce; and,
7. Partner with those clinicians at the leading edge of care.

For more information about the whitepapers, including PDF copies and PowerPoint summaries, please visit [VMSFoundation.org](http://VMSFoundation.org).

## MALPRACTICE CLAIMS

(Cont'd from pg. 6) 4. Increasing complexity of managing health care systems of hospitals and physicians has created more hand-offs and potentially more physicians involved in complex cases.

5. The development of system guidelines and protocols which may be judged to be standards of care and used against physicians, even when appropriate exceptions are made.

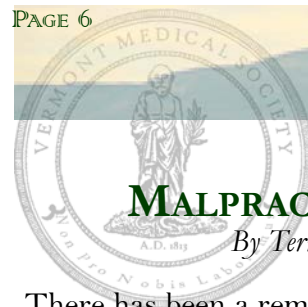
Changes that have the potential to decrease claims:

1. The consolidation of hospitals and physicians will lead to health care systems and large physician groups that have the capacity to address patient safety and quality of care standards. They have more time, more money, and more people to develop protocols and guidelines devoted to lessening inappropriate variability and medical errors.
2. Electronic medical records: a well-functioning electronic medical record has an enormous potential to tie together all the components of the health care system. Providers have the ability to access patient information from any site, at any time.
3. The current pay-for-performance and pay-for-outcome initiatives will create additional incentives to continue the focus on improved care.

Trying to predict how these countervailing forces will play out, of course, is difficult. If you look back into the future it doesn't always work. But here's my opinion backed by experience and maybe a little hope: the current favorable claims trend starting in 2003 will continue.

We are at a new set point. There will be some year-to-year variability but we will not go back to the 2003 claims frequency. We have learned too much and have worked too hard to improve care to slip back in a significant way.

Without your efforts over the past decade to improve care, patient outcomes would be much worse and claims frequency would be greater. So, keep up the great work and let's look to a bright future in health care.



## MALPRACTICE CLAIMS ARE DOWN, BUT WHERE ARE WE HEADED?

By Terrance J. Sheehan, M.D., President/CEO, Medical Mutual Insurance Company of Maine

There has been a remarkable claims frequency trend in Vermont over the past 10 years. Since the high watermark in 2003, yearly claims for physicians and hospitals insured by Medical Mutual Insurance Company of Maine have decreased, on average, 42.6 percent. For the five years following 2003 (2004-2008), the yearly decrease, on average, was 25.5 percent; over the past five years (2009-2013), the average yearly decrease was 61.7 percent.

In general, this is a national trend although there is a considerable amount of variability by state and there has been some modest increase in claims numbers in some states over the past several years.

The cause of this trend is most likely multi-factorial, including tort reform in some states, concerns of physician access, and better communication between physicians and patients when things go wrong. However, I believe much of the credit goes to physician and hospital initiatives in patient safety, quality and risk management.

In 1999, the Institute of Medicine stated in its seminal report, "To Err Is Human" that between 44,000 and 98,000 people die in hospitals each year due to medical errors. This report sent shockwaves through the healthcare industry and although the exact number of deaths was debated, what was not debated was that hospitals and physicians needed to improve their care of patients.

Following this report, providers responded by forming quality committees which reported to Boards of Directors, hired risk and quality managers, developed guidelines and protocols that reduced surgical infections, catheter-related bloodstream infections, and ventilator-related pneumonia. Using evidence-based medicine, providers improved care of heart attacks, congestive heart failure and pneumonia. In 2004, the results of these efforts and many others started to make a difference, which continues today with a focus on pay-for-performance and outcomes.

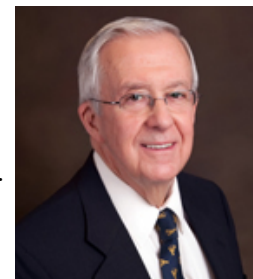
This impressive claims frequency trend has led to stabilization and reduction of premium rates, the payment of dividends to our policyholders in six of the past seven years and improved the financial strength of Medical Mutual. As of 2013, about 70 percent of states have higher average physician malpractice premiums than Vermont.

But despite the good news of the past ten years, the question remains: where are we headed? The health care system is in constant change with new physicians, a changing, aging population, new technology and an increased ability to treat vulnerable patients who are more prone to complications.

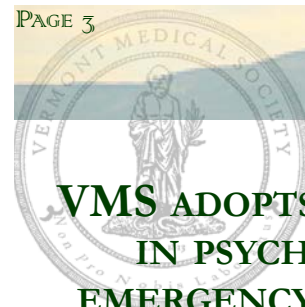
Here are some of the considerations I feel will affect medical errors and subsequent claims over the next three to five years.

New risk with a potential to increase claims:

1. 32,000,000 additional insureds starting in 2014 which may overwhelm the physician workforce and increase the use of nurse practitioners and physician assistants, requiring an increased focus on physician supervision and a clear delineation of scope of practice standards to mitigate medical errors such as failure to diagnose and delay in diagnosis.
2. Electronic Medical Records: interoperability and ease of use issues need to be addressed.
3. Pressure to control costs with incentives to do less. Which services to reduce becomes clear sometimes only in retrospect.



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## VMS ADOPTS RESOLUTION CALLING FOR INCREASE IN PSYCHIATRIC BEDS, STREAMLINED NON-EMERGENCY INVOLUNTARY MEDICATION ORDERS

Responding to two burgeoning mental health issues, the VMS Council adopted a new resolution at its Feb. 8th meeting that aims to increase the number of psychiatric beds in the state and speed up the legal process for non-emergency involuntary medication orders.

Titled "Acute Inpatient Mental Health Care," the resolution calls "sufficient capacity and overflow capacity to ensure that no acutely psychiatrically ill patient waits for a Level 1 Acute Involuntary Psychiatric bed at an emergency department or correctional facility for more than 24 hours."

In support of its position, the resolution cites a shortage of psychiatric beds in Vermont. According to the Journal of the American Academy of Psychiatry and the Law, 50 beds per 100,000 people are needed to sustain a minimum level of care. In Vermont's case, that would be 300 beds. The state currently has 169 spread across six designated hospitals, a number that will increase by 10 when the Vermont Psychiatric Care Hospital opens in Berlin.

The resolution also cited anecdotal evidence of a bed shortage, such as instances in which patients at one community hospital emergency department waited 13 days for admission to an Acute Level 1 involuntary Psychiatric bed while another waited seven days.

The resolution also calls for legislation to streamline the timing of the legal process for non-emergency involuntary medication orders. It recommends policy changes that will "prioritize admission and treatment for the most severely ill and behaviorally symptomatic patients, consistent with a recommendation in the Act 114 Report to create a "fast track" for those patients whose symptoms manifest in extreme violence to themselves or others, so that judicial review could take place in days, not weeks."

In support of the streamlined legal process and prioritized admissions, the resolution cites numerous factors, including a doubling of involuntary medication petitions filed with courts since 2010, the dangers to patients and the communities resulting from continuing psychosis and an average time from admission to medication of 72 days.

To view the full resolution, visit <http://bit.ly/1gOYqZP>.

## MY VMS DUES IN ACTION

By Joseph Nasca, M.D.

Earlier this month I had the opportunity to meet with Mr. Don George, CEO of Blue Cross Blue Shield Vermont (BCBSVT) to discuss how he views the role of small, private practices in the delivery of health care to Vermonters. This meeting was made possible through the efforts of our executive vice president, Paul Harrington.

In December of last year I reviewed the reimbursement for my solo pediatric practice in Franklin County. I realized that BCBSVT had not provided an increase that year. With BCBSVT looking like the likely single payor this trend was not reassuring. Paul suggested we set up a meeting with Mr. George, along with a few other primary care docs from around the state. Hence, Joe Haddock M.D., Eileen Fuller M.D., Peter Gunther M.D., Paul and I met with Mr. George on a snowy day in Berlin.

I am happy to report that Mr. George was interested in what we had to say about the financial realities primary care docs face right now. He went on to assure us that



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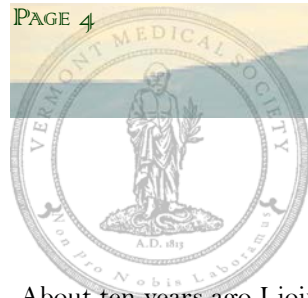
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## IT'S ALL HOW YOU LOOK AT IT

By Rebecca Jones, M.D.



About ten years ago I joined a group of neighbors fighting to protect farmland from development in a rural part of Massachusetts. We were fighting to protect the few remaining large tracks of open land, much of which is suitable to fostering farming and the local food movement.

An issue that we became very active in was our town's consideration of a big box store. Among the most popular topics of debate in the town was how to reduce the impact of the store visually, through requirements such as a pitched roof to make the building look less enormous, demanding that certain colors be used on the building, or perhaps limiting the overall size of the structure—a big store, but perhaps not a megastore.

What wasn't discussed nearly as much were things that are not addressed by a pitched roof or pleasing exterior paint color. Like how they tend to pay low wages and provide part time jobs. The damage they wreak on smaller, locally based stores by underselling them and at times driving them out of business. Or the tax breaks they ask for while at the same time requiring – and not paying for – infrastructure improvements such as wider roads and more traffic lights. And of course the effect they have of lowering property values of the houses in the area.

When decisions are being made that involve everyone, it is important to have the broadest perspective possible. So it is with town development, and so it is with healthcare.

We are wrangling right now with who can afford access to what health insurance plan, as if an insurance plan, like yet another big box business, is what anyone wants or needs. Just because a big box store is big and powerful, doesn't mean we need to let them take over our communities. And, just because the health insurance industry has a stranglehold on our medical system, doesn't mean we have to pretend to like it.

Asking ourselves how much we want to pay for health insurance is like asking what we want our big box store to look like. It's fine if that is really what we want, but maybe we need to be asking ourselves something entirely different. Do we only want well-controlled diabetes, or do we want the healthy food and walkable communities that would lower obesity rates and thereby prevent and control diabetes? Access to breast cancer treatment is important, but shouldn't we also be assuring protection from carcinogens known to cause breast cancer?

As we watch the bitter haranguing over the insurance exchange roll-outs, food stamps are being cut, obesity is rising, and so are carbon emissions. These are all serious health issues, yet no amount of health insurance is going to address them.

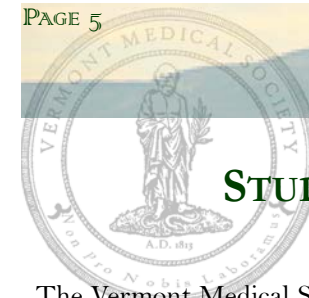
There has been a lot of press, finally, about how much more we spend on medical care in this country, compared to other countries and, how much poorer our outcomes are.

We will start approaching the lower price other countries pay for medical care if we follow their leads: countries like Britain, Canada and Sweden all provide universal access to medical care, but they also commit significantly more funds than we do for the things people need to live healthy, productive lives—things like family leave for new parents, subsidies for healthy food, and bicycle lanes on roads. Where other countries spend twice as much on social services as they do on medical care, our numbers are reversed: twice as much on medical care as social services.

The correlation between social spending and health can be seen at *OECD.org*. How much we spend to help keep people healthy seems like the kind of choice we should be making, rather than how much to pay for health insurance. Vermont is at least taking the first step toward seeing the big picture.

Having a single-payer medical system gets rid of health insurance, places medical spending in the hands of the entity—the state—that is responsible for infrastructure and policy, and aligns the interests of government with the interests of we, the people—that is, to keep medical costs down not by denying people care, but by keeping people healthy.

*Dr. Jones practices medicine in Brattleboro, Vt.*



## STUDY EXAMINES KEY ASSUMPTIONS IN COST ESTIMATES FOR 2017 GREEN MOUNTAIN CARE PLAN

The Vermont Medical Society has joined the Vermont Partners for Health Care Reform (VPHCR), a coalition of organizations committed to health care reform in Vermont.

The group's first act was to commission a study examining key assumptions used in estimating the cost of providing all Vermonters with health care coverage.

Authored by Avalere Health, LLC, a Washington-based analytical group, the study was presented to the Health Care Oversight Committee on November 14th and focused primarily on a report issued to the Legislature earlier this year in compliance with Act 48, the state's over-arching health care reform law.

That report, prepared by the University of Massachusetts and called the "Financing Plan," provided lawmakers with their first estimates of the amounts necessary to finance Green Mountain Care, the proposed single-payer system that would provide all Vermonters with health care coverage in 2017.

Key findings of the Avalere study included:

- The state's initial \$1.6 billion revenue estimate to publicly fund Vermont's health care system is probably too low.
- The Financing Plan proposes to generate revenue by cutting provider payments by nearly one dollar in six. This proposal would likely create a disincentive for health care practitioners to work in Vermont and could lead to less access to health care services.

In conducting its analysis, the Avalere group interviewed the Financing Plan's authors and state officials, and noted that both the analysts who modeled the plan and the State officials who commissioned the analysis said that all figures used in the Financing Plan are planning assumptions, not definitive policy.

VPHCR is comprised of Fletcher Allen Health Care, the Vermont Association of Hospitals and Health Systems, the Vermont Medical Society, the Vermont Business Roundtable, the Vermont Chamber of Commerce, the Vermont Assembly of Home Health and Hospice Agencies, Dartmouth Hitchcock Medical Center and Blue Cross and Blue Shield of Vermont.

"Our goal was to advance this work by having a qualified third party make an independent assessment of the State's health care reform financing plan's cost estimate and key assumptions, and report on their findings," said VMS' Paul Harrington. "We look forward to participating in a robust, data-driven process on this critically important issue."

"Our group formed earlier this year to bring additional perspective and analysis to Vermont's pioneering health care reform initiatives," explained Lisa Ventriss, President of the Vermont Business Roundtable.

"We believe this study provides valuable context to this ongoing work. Regardless of how Vermont's health care system ultimately is financed, understanding the drivers of health care spending remains an essential component of our reform efforts."

"Consistent with Act 48, whatever reform path we jointly construct, we have a responsibility to ensure that our efforts lead to an affordable, high-quality health care system for all Vermonters," agreed Bea Grause, president and CEO of the Vermont Association of Hospitals and Health Systems.

For more information about the VPHCR and Avalere report can be found at [VPHCR.org](http://VPHCR.org).

## DUES IN ACTION

*(Cont'd from pg. 3)* BCBSVT values the role we play in the efficient, reliable care we provide for our patients – who are also his beneficiaries. To this end, he promised a mid-year pay boost to validate our efforts. We all recognized the importance of maintaining a strong primary care infrastructure and how important it is for us to continue our work and be able to recruit younger physicians to our practices.

This meeting opened up a dialog that is, and will be, very important as we move into whatever health care reform is coming. I am grateful for the organizational help VMS provides me as a member. I see my dues as an investment in the future of my ability to continue to practice independently in Vermont.

*Dr. Nasca practices in Milton, Vt.*