The Green Mountain Physician

A Publication of
the Vermont Medical Society

March/April
2009

"Not for Ourselves do we labor"

VMS motto

Vermont Medical Society

134 Main Street
PO Box 1457
Montpelier, Vermont
05601-1457

800-640-8767
802-223-7898

Fax 802-223-1201

Online at:
www.vtmd.org

Ever-Changing Pharmacy Formularies Risk Patient Health, Over Burden Practices with Time Consuming Paperwork

With he and his staff spending a growing amount of time keeping track of, and complying with, ever-changing prescription formularies, Plainfield's Dr. John Matthew has a modest proposal for managed care organizations (MCOs). How about getting paid for the countless hours of work they do on behalf of the companies?

"If pharmacy benefit management companies use our nurse practitioners, physician assistants and other staff (to comply with re-issued regulations), they should be paying for the service," says Dr. Matthew. "It ties up many hours of our time each week. We've become involuntary unpaid employees."

Dr. Matthew is not alone in his frustration over how formulary changes not only consume valuable employee time, but also put patient health at risk by often forcing those who have been stabilized on one medication to try others that may or may not be the best clinical options for them.

"I've talked to many of my colleagues and everyone is getting barraged with these requests," says Dr. Bob Tortolani, a Brattleboro family practitioner and president-elect of the Vermont Medical Society. "In a one-week period alone I received 14 different requests for prescription changes."

It would be one thing, says Dr. Tortolani, if the reasons behind switching medications were related to the patient's health.

"This isn't about better patient care, it is about money," says Dr. Tortolani. "I don't mind looking at every new drug choice, but I think changing people from a drug for no reason is not only difficult it is dangerous. If it goes against the best interests of patients, why should we do it?"

Barre's Dr. Anthony Williams also has much more experience wrestling with insurance companies than he'd care to have. He has recently had six interactions with an MCO in a struggle to keep a patient on Starlix.

"I wrote a letter stating that the patient clearly needed it and it still gets denied," says Williams. "I can't get through to someone at the insurance company that can resolve the issue and in the meantime my patient's blood sugar keeps rising."

It is the experiences described by Drs. Tortolani and Williams that concern Dr. Matthew, who feels that his expertise and individual knowledge of the patient's circumstances are being undermined.

"I did four years of college, four years of medical school, a residency and a fellowship," says Dr. Matthew. "I'm board certified in two specialties and I've been practicing to get better for 30 years and I have to justify myself to someone at a computer terminal who works for a company who just wants to make more money."

Continued on Page 3

Letter from the Executive Vice President

Welcome to the latest edition of *The Green Mountain Physician.* In it I hope you'll find insight and information that both interests and informs you. Topics covered in this issue include the frustrations physicians face over ever-changing prescription formularies (page 1), federal stimulus package incentives for physicians adopting Health IT (this page), an improved methadone prescribing process at Fletcher Allen Health Care (page 4), a new feature called 10 questions with.....(page 6), and Vitamin D deficiency (page 7).

In addition to developing this edition of *The Green Mountain Physician*, we've also recently been hard at work representing members' interests on a number of issues at the Vermont Statehouse. A few examples include:

- Opposing Gov. Douglas' proposed Medicaid reimbursement cuts, which could potentially reduce reimbursement to physicians by 8 percent;
- Engaging key legislators and the Vermont Board of Nursing on the board's proposal to end the requirement that APRNs have a written collaborative agreement with physicians; a move we do not support; and,
- Working with the Department of Health, the UVM College of Medicine, and the Vermont Board of Medical Practice to ensure that physicians have access to education about palliative care and pain treatment that would be helpful to them and patients, instead of adopting a one-size fits all approach of mandating palliative care CME for all physicians, regardless of specialty.

Last month, VMS Vice President Dr. Paula Duncan joined Gov. Douglas at a capitol press conference announcing the VMS's initiative for physicians to assess patients' basic needs and when necessary direct them to available resources (for more information about referring patients to social services, see the 2-1-1 article on page 6). Dr. Duncan highlighted the role physicians play in the overall health and well being of Vermonters and Gov. Douglas expressed his deep appreciation for Vermont physicians' willingness to go the extra mile to serve their communities in a time of need. The event received wide media coverage as the Burlington Free Press, Brattleboro Reformer, Bennington Banner, Rutland Herald and WCAX all favorably reported on the efforts of the state's physicians to help their most vulnerable patients.

To receive updates on these and other important legislation issues in the coming months, please look for our weekly legislative bulletins in your incoming mail (or on your fax machines if you've previously requested delivery in this manner).

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

Stimulus Package Incentivises Health IT Adoption

If you've been thinking about adding electronic health records (EHR) to your practice's IT operations but wondered where the money would come from to implement them, the federal stimulus package signed last month by President Obama may be the answer.

The American Recovery and Reinvestment Act of 2009 provides up to $19 billion in incentives to physicians and other health care providers who adopt EHRs in a "meaningful" way.

In his speech to a joint session of Congress on Feb. 24, President Obama said the recovery plan "will invest in electronic health records and new technology that will reduce errors, bring down costs, ensure privacy, and save lives."

According to the American Medical Association's analysis of the package, providers that take advantage of the incentives could receive yearly payments for up to five years, with those who adopt the technology the earliest receiving the largest and most numerable incentives (please see the accompanying AMA-developed chart for further details about the tiered payment schedule). Total incentives from Medicare could reach as high as $44,000 per physician.

Many of Vermont's rural physicians could see even higher incentives. Those in designated rural health professional shortage areas who adopt EHRs are eligible to receive a 10-percent increase in incentive payments.

Continued on Page

Pharmacy Formulary Changes Risk Patient Health

(Cont'd from Page 1) Both physicians and patients bear the brunt of financial costs associated with the often-occurring formulary changes. When a plan's formulary is altered, physicians who feel that the current drug is best for the patient must go through an extensive documentation process – often entailing sifting through medical records that go back many years – in order to show why a patient shouldn't be forced to take a different, less expensive drug. When MCOs are not satisfied with the physician's reasoning, medications must be switched in order for the patient's insurance to continue covering the cost of prescriptions.

In addition to the adverse side affects switching medications can often create, if patients pay a co-pay or out-of-pocket fees for office visits, the sometimes numerous visits required by switching medications (visits to prescribe new medication, follow up visits to monitor the patient, treatment of bad reactions or decreased efficacy, additional visits if a third or fourth medication must be tried, etc.) can really add up. In essence, these additional fees for patients mean that they are subsidizing savings for the MCOs.

BISHCA's Rule 10 Revisions Provide an Opportunity to Address Physicians' Concerns Regarding Formularies

However, there may be some hope for improvement. VMS is engaging the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) as it currently revises Rule 10, which establishes consumer protection and quality requirements for MCOs.

"We understand why our members are so frustrated," said Paul Harrington, VMS executive vice president. "These new requirements significantly impact physicians' ability to treat their patients. We've received a lot of feedback from our members on this issue and we will aggressively advocate on their behalf." Harrington says that VMS understands the importance of reducing drug costs, however, it cannot by done in a manner that jeopardizes patient health or creates an undue administrative burden for physicians.

VMS has already provided extensive suggestions in response to several working drafts of the regulation and will provide formal comments to Rule 10 as it goes through the rulemaking process. New to Rule 10 is Part 4, which establishes additional requirements on MCOs if pharmaceutical benefit management mechanisms are used. Of particular interest to VMS are new requirements imposed upon MCOs if procedures are used regarding changes to pharmaceutical benefits, as well as utilization management procedures, such as prior authorization and step therapy.

Given the time consuming prior authorization requirements that have recently been adopted by MCOs in Vermont, VMS anticipates making extensive recommendations to BISHCA on Rule 10 in order to ensure that patients are able to receive prescriptions that are best for them and that prior authorization and step therapy requirements do not create an undue administrative burden on physicians. In addition, the VMS has asked MCOs to revise their policies in order to grandfather medications for existing patients, reduce the documentation requirements and to maintain their formularies for as long as possible.

Free Software Puts Drug Information at Physicians' Fingertips

Keeping up to date with ever-changing prescription formularies (see related article on page 1) – not to mention dosings, recalls, contraindications and interactions – can be a daunting task, but technology is making things a little easier by putting this important information at your fingertips.

Epocrates Rx is a free mobile and Web-based drug and formulary reference that, according to the company that supplies it, is used by one in four U.S. physicians. The software can be downloaded for use on smartphones or PDAs such as BlackBerry, Palm and Windows Mobile devices, as well as Apple's iPhone. The software can also be used via the Internet.

Epocrates Rx's database includes vital information on more than 3,000 medications. To learn more about the software, or download it, visit www.epocrates.com.

Stimulus Package Incentivises Health IT Adoption

(Cont'd from Page 2) While the incentives are a carrot, the stimulus package also included a stick. Penalties for practices who do not implement EHRs will be assessed, beginning with a 1-percent reduction in the Medicare fee schedule in 2015, and subsequent reductions of 2 percent in 2016 and 3 percent in 2017 and thereafter.

The Vermont Medical Society says that it will work hard to make sure that its members take advantage of the incentives provided by the federal government.

"This is a great opportunity to not only make our health care system more efficient, flexible and error free, but also to get financial support for doing it," says John Brumsted, M.D., VMS's president. "VMS will do all it can to make sure that Vermont physicians are well positioned to receive that support."

1st Payment Year	1st Payment Amount and Subsequent Payments in Following Years	Reduction in Medicare Fee Schedule for Non-Adoption/Use
2011	$18k, $12 k, $8 k, $ k, and $2 k.	$0
2012	$18 k, $12 k, $8 k, $4 k, and $2 k.	$0
2013	$15 k, $12 k, $8 k, and $4 k.	$0
2014	12 k, $8 k, and $4 k.	$0
2015	$0	-1 percent of Medicare Fee Schedule
2016	$0	-2 percent of Medicare Fee Schedule
2017 and therafter	$0	-3 percent of Medicare Fee Schedule

While plans are still being formulated and depend largely upon how the stimulus package's Health IT provisions are finalized during the rule-making process, VMS expects its assistance to include regular updates on the issue and guidance on how to navigate the application and implementation process.

FAHC Develops Tool that Facilitates Appropriate and Safe Methadone Prescribing

Methadone is a valuable part of physicians' prescription toolbox in the treatment of pain, drug detoxification and opioid abuse, but it doesn't come without risks. Chief among them are its lack of cross-tolerance with other opioids, which can lead to life-threatening adverse events caused by incorrect conversion of morphine doses to methadone doses.

In 2006, the FDA encouraged physicians who prescribe methadone to exercise caution, but didn't provide specific dosage recommendations. Last year, Fletcher Allen Health Care (FAHC) began looking for ways to provide guidance on the issue to its health care practitioners.

After reviewing a number of options, FAHC's Medication Safety Subcommittee of the Pharmacy and Therapeutics Committee developed a physician order form that provides the prescriber and pharmacy with all of the necessary information needed to prescribe methadone safely. The working group consisted of pharmacists and physicians from palliative care, anesthesia pain service and addictive medicine. Required information on the order form includes: indication for use, history of use, verification of home dose and time of last dose taken prior to hospitalization. The form also includes dosing restrictions for new initiations and patients who haven't taken methadone within the last 72 hours based on recommendations from the Institute of Safe Medication Practices. The maximum dose allowed is 20 mg/day and a frequency of no more often than every eight hours. Additional guidelines on methadone use as well as the contact information and hours of operation for all Vermont methadone clinics are included on the form. To view the form, visit *www.vtmd.org/methadoneform.pdf*

Once it was approved by FAHC's Medication Safety and Pharmacy and Therapeutics committees, education was provided on the form's usage with in-services to pharmacists and pharmacy technicians. Physician staff, nurse practitioners, nurse educators, and physician assistants received detailed information about the form and the rationale behind its development via hospital email.

The use of the form at FAHC began on December 1st. The form has been a tool for educating prescribers on methadone use and making it safer for all patients at FAHC.

Proposed Medicaid Cuts Compound Previous Reductions Borne by Vermont's Physicians

By Dr. Ted Shattuck

To understand the full impact of the proposed cuts to Medicaid reimbursement on non-evaluation and management procedures being discussed in Montpelier, the recent history of Medicaid in Vermont should first be reviewed.

From the late 80s to early 90s, the number of patients enrolled in Medicaid in the state grew from just 13,000 to 120,000 people. Medicaid fees, however, were not adjusted during this period of rapid growth, so Vermont physicians in essence subsidized this expansion. This adversely impacted physicians across the state, especially primary care physicians, many of whom either left the state or became employees of their local hospital system.

While Vermont's physicians protested through the Vermont Medical Society, these untenable reimbursements continued unabated. For example, the cost of seeing a level III Medicaid established patient was $15 and yet the physician was only reimbursed $9. Things came to a head in 1993 and 1994 when the District VII Federal Court ruled that the State of New York's refusal to pay the Medicaid portion of "dual eligible" (patients covered under both Medicaid and Medicare) was a violation of federal law. Vermont, which had also violated the same Federal Law and is also in the same District, eventually conceded this point and capitulated.

As a result, in 1995 the State of Vermont provided a one-time adjustment in Medicaid spending of $20 million, in which all fees (E&M and procedural) were included. All in all this was a pretty good deal for the state as it by then owed an estimated $60 million to Vermont physicians, of which only $20 million was actually paid for future work. For the next ten years, the VMS – with full support of its entire membership, two-thirds of which were specialists – battled to raise the payment of Vermont's evaluation and management codes to national Medicare levels (since Medicare rebased the E&M codes in 2007, many of these codes are no only at 88 percent of Medicare 2009).

Specialty or procedural fees had been frozen, therefore, at 1995 levels until Gov. Jim Douglas instituted a 7.5-percent cut in 2005. Thus the 4-percent cut being proposed in 2009 would constitute an additional cut on top of an already reduced and unsustainable reimbursement rate.

Compounding the negative impact of the proposed cuts is a reimbursement landscape that has changed since 1995. Procedural physicians can no longer afford to work at a further discount of the 1995 Medicaid reimbursement levels. Medicare increases are political footballs and decreases usually forecasted are stopped by Congress at the last hour. Private insurers, some of whom based their reimbursement levels on the discredited Ingenix database owned by United Health Care, have not even kept pace with the consumer price index, much less the higher medical index. Currently Vermont ranks No. 1 nationally in the overall quality of its health care. This lofty standing is at risk due to the state's inability to attract and retain fairly paid physicians. Clearly there has been neither a financial reward nor thanks for being first in the nation.

It is my hope that upon being made aware of the recent history of Medicaid reimbursements, the governor and state legislature will do the necessary work to maintain Vermont's infrastructure of dedicated, quality physicians by rejecting further Medicaid spending decreases and working to restore and increase procedural fees.

Editor's note: If there is a topic you'd like to address in an upcoming issue of Green Mountain Physician, please contact VMS's Justin Campfield at jcampfield@vtmd.org.

10 Questions with ...
Dr. Bob Tortolani, VMS Presdient-Elect

Green Mountain Physician: Where do you practice and how long have you been practicing there?
Dr. Tortolani: I practice Brattleboro and I've been practicing family medicine since 1974.

GMP: What got you interested in a career in medicine?
Dr. Tortolani: My father was a general practitioner in a small town in Connecticut. He really enjoyed his work and he inspired me to follow in his footsteps.

GMP: If you weren't a doctor, what would you be?
Dr. Tortolani: I believe that as physicians we are ultimately teachers, we teach health. I enjoy being a teacher, especially teaching students and residents, so I might in some way be involved in teaching.

GMP: Is there one thing from your residency that you still think of often today? If so, what is it?
Dr. Tortolani: As a resident at UVM I remember how much I enjoyed the beauty of Vermont and the hardiness of the Vermont people I worked with. That is what really got me interested in staying in Vermont.

GMP: If I only had one afternoon to sight see in your town, what is an absolute must see?
Dr. Tortolani: I would say go up to Kipling Road, which is near where the School of International Training is. From the road you can see the campus. About two miles past that you can see Rudyard Kipling's home, which he built in 1896. Then another mile or so after that you can see the Scott Apple Farm, which has been there for more than 150 years and was where the movie Cider House Rules was filmed.

GMP: Which colleges/universities did you attend? What campus activities were you involved in?
Dr. Tortolani: Brown University and Rochester Medical School. I played college baseball and a lot of intramural basketball, but more than anything else I just enjoyed all the great conversations.

GMP: How do you relax and unwind?
Dr. Tortolani: I tend to be very physically active. In the summer I play in a softball league and I also bike, kayak, swim, canoe, walk. In the winter I cross country ski and snowshoe.

GMP: Complete this sentence. I like practicing medicine because …
Dr. Tortolani: … the people. I also really enjoy the collegiality of our hospital. We've always had a good collegial group here. It is fun to practice medicine in our hospital.

GMP: If you were awarded a full year's sabbatical to study any medical issue, what would it be?
Dr. Tortolani: I might not something medicine. I might do something different like literature, art or music. But if I did something in medicine it would have to do with communication in medicine and trying to find a way to improve how we interact with our patients.

GMP: Why are you involved with the Vermont Medical Society?
Dr. Tortolani: I really like the motto of the medical society, not for ourselves do we labor. The absolute center of the organization's attention is focused on the care of the people in Vermont and I really like that. Why wouldn't I be involved in an organization like that?

Refer Patients to 2-1-1 for Assistance

In February, the Vermont Medical Society joined Gov. James Douglas in announcing a member-supported initiative that enlists members in helping to assess patients' heating, food, transportation and other basic needs. If a patient is found to have a social service need, physicians are encouraged to refer them to Vermont's 2-1-1 system.

Vermont 2-1-1 is a simple number your patients can dial to receive information about numerous health and human services, including:

- *Child Care Resource and Referral*
- *Domestic and Sexual Violence Services*
- *Employment Services*
- *Food Shelves and Nutrition Programs*
- *Health Care Services*
- *Alcohol and Drug Programs*
- *Mental Health Care and Counseling*
- *Transportation*
- *Utility Assistance*
- *Housing (Homeless Prev., Shelter, Tenants' Rights)*
- *And much more ...*

To learn more about 2-1-1, please see the brochure enclosed in this newsletter or visit *www.Vermont211.org*. To request additional brochures, call 2-1-1.

Vitamin D Deficiency: Common, Damaging, and Simple to Remedy

By John Matthew, M.D., FACP, The Health Center, Plainfield, Vt.

Editor's note: This is an abridged version. A more comprehensive article including clinical notes and PowerPoint slides can be found at www.vtmd.org.

Most physicians think of Vitamin D as necessary to building and maintaining a strong skeleton, with rickets or osteomalacia the consequences of inadequate intake. But it is now known to be necessary to the transcription of hundreds of genes and to influence crucial processes in virtually every tissue in the human body, not just in bone. Understanding this aspect of physiology is important to all of us as we try to do what is best for our patients.

Vitamin D has been part of cellular physiology since the phytoplankton. So it's not surprising that this ancient compound has an important role in many basic cellular processes. Most tissues contain the enzyme for producing the 1-25 Dihydroxy active form, cytoplasmic Vitamin D receptors, and intra-nuclear Retinoid Receptors. The Vitamin D/Vitamin D Receptor/Retinoid Receptor triad then acts like an ignition key in the "Vitamin D Response Elements" that are adjacent to hundred of genes, activation of which is necessary to the initiation of transcription to produce proteins critical to cell, tissue and organ function.

Deficient levels of Vitamin D are surprisingly prevalent. Roughly eighty-five percent of people tested in central Vermont in 2007, and a similar percentage of persons in a practice in Boston and of adults in Framingham, Mass., have 25 Hydroxy Vitamin D levels below 40 ng/ml – the lower limit of the preferred or optimal range – with roughly 50 percent below 30 ng/ml. Some rather large subgroups of the population have very low levels, rated as severely deficient (<10) or deficient (<20). Deficient levels are roughly three times more common in the winter/spring interval than in the summer/fall part of the year. Our Vermont sunlight contains negligible UVB levels from November through March, thus there are no realistic means of achieving adequate levels except with supplements.

Further northerly or southerly latitude, lower UVB light exposure and Vitamin D deficiency are associated with a great number of diseases, including our most common chronic disorders and our most prevalent causes of death. There is a bimodal distribution of many of these illnesses, with progressively higher prevalence as people live further north or south away from the equator, where the prevalence is lowest. Many experts in this burgeoning area of medical science believe that correction of low Vitamin D levels may lead to substantial reductions in disease and disability and great improvements in health and life expectancy.

Low Vitamin D levels are associated with increased risk for coronary artery disease and winter is also associated with worse peripheral vascular and cerebral vascular disease; perhaps because lack of D increases inflammation, a strong risk factor for these illnesses. Low D levels predict a substantially increased risk of dying in the coming years. They are also associated with decreased myocardial contractility, elevated Renin and high blood pressure, age-related macular degeneration, pre-eclampsia, elevated triglyceride levels, insulin resistance, reduced insulin production, periodontal disease and tooth loss, and reduced activity of Tyrosine Hydroxylase, the rate limiting step in the synthesis of Central Catecholamines (Serotonin, Norepinephrine, and Dopamine). Other associations include neuromuscular deficits, autoimmune and inflammatory disorders and impaired defenses against infections.

There are some tantalizing reported effects of Vitamin D supplements. Finnish infants given 2000 units daily for the first year of life had, over the next thirty years, an 80-percent reduction in childhood onset diabetes. Nebraska women given 1100 units of Vitamin D daily had a 60-percent reduction in new cancers in four years. The 95 percent confidence limits for this study were 40- to 90-percent reduction. There are also reports of supplements reducing tooth loss and falls in the elderly, as well as supplements providing impressive relief to people with fibromyalgia, poor sleep, chronic pain, and depression.

A total of 18 cancers have reported increased prevalence, and some with decreased survival rates, associated with lower D levels. There is a logical possible mechanism of action for this relationship, since Vitamin D dependent processes are involved in cell differentiation and maturation, growth arrest of cells with abnormal DNA, apoptosis, and the inhibition of angiogenesis. There is a 17 percent lower risk for all cancers (and 43 percent for GI cancers) associated with each 10 ng/ml increase of Vitamin D serum level. One Vitamin D expert projects that if all Americans' levels were at least 55 ng/ml we would have 60,000 less colon cancers and 85,000 less breast cancers yearly.

Of course "correlation does not mean causation" and "the plural of anecdote is not data". Information concerning Vitamin D deficiency ranges from observed correlations to intervention studies. Some matters are proven, while others are at the stage of strong correlations and compelling anecdotes. But taken together, there is a large body of information developing on this topic with more and more firm conclusions being reported in a veritable cascade of studies and publications.

Conferences

Vermont Medical Society Council Meeting

April 4, 2009
10:00am - 12:00pm
Best Western, Waterbury, Vt.

For more information
Call Stephanie at 802-223-7898 or swinters@vtmd.org

Vermont Geriatrics Conference

April 7, 2009
Capitol Plaza, Montpelier, Vt.

PRESENTED BY Vt. Area Health Education Centers (AHEC) Network

For more information call 802-656-2292 or go to the website at http://cme.uvm.edu

Regional Urologic Cancer Update Symposium

April 17, 2009
Hilton Hotel
Burlington, Vt.

For more information call 802-656-2292 or go to the website at http://cme.uvm.edu

Unite for Sight 6th annual Global Health and Innovation Conference

April 18, 2009
Yale Univeristy
New Haven, Conn.

For more information, please visit www.uniteforsight.org/conference.

Women's Health Perception, Prevention & Practice

May 6 - 7, 2009
UVM Conference Center at the Sheraton
South Burlington, Vt.

For more information, please visit http://cme.uvm.edu or call (802) 656-2292

SAVE THE DATE!

Vermont Medical Society 196th Annual Meeting
Oct. 3, 2009
Basin Harbor Club, Vergennes, Vt.

Vermont Medical Society
PO Box 1457
Montpelier, Vermont 05601

Pre-Sorted Standard
U.S. Postage
PAID
Montpelier, Vermont
Permit No. 97