

Green Mountain Physician

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Jessa Barnard, Esq., named VMS VP for Policy

The Vermont Medical Society (VMS) has announced the hiring of Jessa Barnard, Esq., as its vice president for policy. In the position Barnard will help represent the interests of VMS' 2,000 physician members and their patients before the Vermont General Assembly, governor's administration, and regulatory and public policy boards throughout the state.

"I'm very excited to be a part of the VMS team working on behalf of the state's committed and hard-working doctors," said Barnard, a native of Bennington. "Vermont enjoys some of the best health care in the world and I look forward to working with doctors across the state to continue that success, as well as look for ways to make patient care even better."

Barnard is no stranger to VMS or health care in Vermont and New England. She previously served as policy specialist at VMS from 2002 to 2005, and spent four years with the Maine Medical Association, most recently as their associate general counsel, representing physicians in Augusta and addressing their legal and regulatory concerns.

"From her first stint with us we knew that Jessa was extremely diligent, talented and committed to quality health care for Vermonters," said Paul Harrington, VMS' executive vice president. "Ever since she left VMS to go to law school we've been hopeful that someday we'd be able to get her back. We are very excited that we have. She is going to be a tremendous asset to Vermont's doctors and their patients."

Barnard also has a familial familiarity with medical practice in Vermont, as she is the daughter of retired orthopedic surgeon Robert Block, M.D. She says that growing up around the profession deeply influenced her view of doctors as well as her career choices.

"I was so proud of my dad as I grew up," said Barnard. "I could see how much his patients loved him and how deeply he was committed to his work. Sometimes this meant that I didn't see him on the weekend or at bedtime. But it also meant that patients would come up to thank him in the grocery

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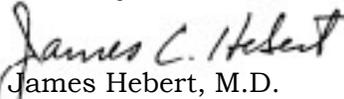
From the President's Desk

Welcome to the latest edition of the *Green Mountain Physician*, an issue that is in large part dedicated to discussing opioids and prescribing controlled substances.

I don't have to tell you that controlled substance abuse is emerging as one of the key challenges facing our state, region and country. It is the Vermont Medical Society's hope that the information presented within this issue – coupled with some of its parallel efforts including its Opioid Task Force and the well-received work of the VMS Foundation – will help individual physicians and the profession as a whole better understand and respond to the challenge.

To that end, I encourage all members to let the VMS leadership know if there is anything that it could or should be doing to better help the state's doctors battle this dangerous trend.

Sincerely,


James Hebert, M.D.
President

Prescription Drug Testing: What You Need to Know

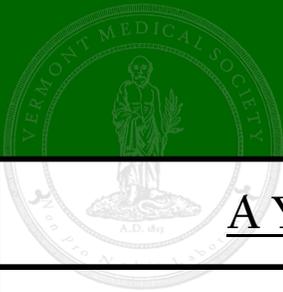
As the full scope of Vermont's opiate and addiction crises continues to reveal itself, many physicians in the state are increasingly concerned about how to provide their patients the pain control medication they need, without contributing to the growing problem.

To help physicians who have questions and concerns about prescription drug testing, the Green Mountain Physician asked Jill Warrington, M.D., Ph.D., what physicians in the state need to know. Dr. Warrington is the Assistant Director of Clinical Chemistry in the Department of Pathology and Laboratory Medicine at UVM Medical Center and Laboratory Director of Burlington Laboratories, a Vermont-based drug-testing laboratory,

Green Mountain Physician: How can physicians who are prescribing controlled substances for their patients select the proper lab and test for particular circumstances?

Dr. Warrington: Selection of a laboratory centers on matching one's needs with the labs' offerings. Some aspects of a lab one might consider include: the types of tests offered, the amount of customer support, the turnaround

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A Year Later: Protocol for Prescription Opioids

Last year the Green Mountain Physician reported on a new protocol (available and developed by the UVM Medical Center and UVM College of Medicine)recommendations for treating non-cancer chronic pain sufferers.

Called the Management of Chronic Opioid Protocol and available at <http://bit.ly/1PJbNN8>, the protocol defines step-by-step practices that doctors and staff should engage in when dealing with a patient suffering from chronic pain. They are meant specifically for use when starting patients on Schedule II and III opioid use that will be lasting for or exceeding 90 days. The document calls for standardizing a prescription agreement between the provider and patient, the discussion and signing of informed consents, and other practices such as urine drug screenings, pill counting, refills and patient assessments, among other recommendations.

To check on the progress and use of the protocol the Green Mountain Physician recently talked with Alicia Jacobs, M.D., a member of the task force that created the protocol and Vice Chair of Family Medicine at UVMCC.

Green Mountain Physician: How is UVM MC expanding its capacity for buprenorphine replacement both in medical homes and expanded services at Day One?

Dr. Jacobs: We now have capacity at every UVMCC Medical Home; 11 sites in total. We have an opioid replacement protocol to use with the Hub and Spoke model. The expanded services at Day One have commenced. Patients have moved out of the Hub for Day One evaluation and have begun moving to their medical homes.

We continue to train physicians for their buprenorphine waivers and will run one or two more waiver training session in conjunction with the CHCB this year.

Green Mountain Physician: The protocol has been in effect for about a year and a half - are you planning or developing any updates or additions?

Dr. Jacobs: For the complex pain/chronic opioid protocol, we have done additions to respond to new legislative guidelines. We also have done brand updating and have new recommendations on how to do functional assessments at follow up visits.

Green Mountain Physician: Do you have any information about the effect of the protocol on practice so far?

Dr. Jacobs: This protocol has improved the management of this type of care. It has improved access for patients while decreasing the overall numbers of patients receiving chronic pain treatment by helping to identify patients that have a primary opioid use disorder rather than chronic pain. It has been an improvement for patients and how they are treated as well as the providers who feel more confident in providing this care.

Green Mountain Physician: How about practitioners' response to the protocol?

Dr. Jacobs: We did a survey of providers last fall and received some useful suggestions for improvements. Overall the protocol was welcomed.

Green Mountain Physician: If physicians from other parts of the state are interested in reviewing or adopting all or part of the UVM-MC protocol, what steps would you suggest that they take?

Dr. Jacobs: We are happy to send copies of our comprehensive protocol including all the tools needed (agreements, informed consent, functional assessments, recommended drug screening, withdrawal protocol, etc.).



Dartmouth-Hitchcock Research Improves Outcomes, Lowers Costs for NAS Babies and Moms in Opioid Crisis

In 2015, one in 10 newborns in the Upper Valley region had been exposed to opioids in utero and many had neonatal abstinence syndrome (NAS) – moderate to severe symptoms of physical dependence at the time of delivery.

This crisis led to the development and adoption of a new model of care at the Children’s Hospital at Dartmouth-Hitchcock (CHaD) for newborns exposed to opioids before birth, a model that is receiving national recognition in a journal article published this spring in *Pediatrics*.

The article “Rooming-in to treat neonatal abstinence syndrome: Improved family-centered care at lower cost” was based on a nearly three-year project conducted by an interdisciplinary quality improvement team at CHaD. The project improved the experience of care for the babies and families, appropriately reduced the use of medications for treating NAS symptoms, trimmed five days from the average length of stay, and more than halved the cost of care.

Basing their project on prior work from Canada and Europe, the CHaD team moved the site of care for the opioid-exposed newborns from the open bay neonatal intensive care unit to a rooming-in model on the calmer pediatric ward. They also sought to increase family participation in care, preparing families for the hospital stay with prenatal education and teaching the importance of skin-to-skin contact with the baby.

“By doing in-depth interviews with families at the start of our project, we saw the hospital course from their eyes, learned more about what they desired, and discovered how much they as parents and families could do by being the main care providers for their newborns in a physical environment where they could room-in,” said lead author Alison Holmes, MD, MPH, MSc, associate professor of pediatrics at the Geisel School of Medicine at Dartmouth and a pediatric hospitalist at the Children’s Hospital at Dartmouth Hitchcock.

Another goal was to decrease the proportion of opioid-exposed infants treated with medications. This was achieved by modifying physician responses to withdrawal symptom scores, paying less attention to the score number and more attention to how the newborns were feeding and sleeping, and how easily they could be consoled.

With the new care model, the CHaD team decreased the percentage of opioid-exposed newborns treated with medications from 46 percent to 27 percent, decreased the length of stay of those treated with medications from 17 to 12 days, and more than halved the costs of care, while improving the family experience of care.

Holmes notes that while it may seem obvious that newborns want to be held and comforted by family members, “in a hospital environment, we can unfortunately become overly focused on the medication management aspect of newborn opioid-dependence, and overlook the importance of the environmental aspects of care. We were not alone in this—in looking at the national data on neonatal abstinence syndrome, most newborns with withdrawal symptoms are still managed with medications and stay for close to a month in an intensive care environment without the continuous presence and support of their families.”

By replicating the CHaD model at other centers across the U.S., Dr. Holmes says that close to \$2 billion in hospital charges could be saved (using 2012 rates for opioid use in pregnancy), while simultaneously improving the birth hospitalization experience for the newborns and their families. At CHaD, mean hospital costs for newborns requiring pharmacologic treatment declined from \$19,737 to \$8,755 while costs for all opioid-exposed newborns also decreased, from \$11,000 during the study’s baseline year to \$5,300 during the second year.

Thanks to a \$127,000, three-year grant from the March of Dimes New England Chapter, D-H will soon be facilitating the regional delivery of comprehensive care services for pregnant women with substance use disorders.



AMA Corner

*Robert Block, M.D.
AMA Alt. Delegate*

Who is the AMA? That was my first question when asked to serve as VMS' alternate delegate to the AMA. I pictured a group of retired physicians decrying every change that has occurred starting with Medicare and Medicaid.

I developed that perception when attending the 1996 AMA annual meeting as your president. I guess that shows my age and lack of attention to AMA modernization.

Upon arriving at the 2013 annual meeting, I found myself surrounded by representatives of the medical student, resident and fellow sections, as well as those like myself of a certain age. All ages and both genders were well represented.

Intense debate of numerous issues occurred at the level

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Vivitrol in the Office Setting

*Written by Katie Marvin, M.D.
Stowe Family Practice*

Injectable naltrexone (Vivitrol) is one of several tools we use in conjunction with our Medication Assisted Treatment (MAT) team to treat addiction in our outpatient family medicine clinic.

Offered to help treat alcoholism, or as an alternative to buprenorphine for opiate addiction, naltrexone is a mu opiate receptor antagonist and blocks the "high" from using a drug. The monthly shot is given in our office and has better rates of compliance than the daily oral formulation. With concurrent counseling and treatment of mental health issues, our patients report a significant reduction in cravings, as well as a desire to continue treatment.

Patients must be opiate free for seven to ten days prior to the first dose, and we usually give an oral dose in the office prior to the injection to ensure tolerance. We have found that it is a good option for someone who has recently completed inpatient rehab, or who abuses short-acting narcotics and is able to stop for a week. You may offer short-term non-narcotic medications to help them through this period of time if they experience significant withdrawal.

As with all medications, we provide upfront counseling regarding the risks and benefits. Risks include liver function test changes and the possibility of overdose if a patient attempts to overcome the medication. A patient wears identification (dogtags, bracelet or card for the purse) in the event they are in a car accident or have other trauma and end up in the ER. Local ER physicians and anesthesiologists are aware that these patients will need close monitoring and alternative medications for pain in the event of emergency surgery. But, these are risks that many relapsing alcoholics or opiate addicts are willing to take.

Possible benefits include sobriety, lack of withdrawal if a dose is a day or two late, and the lack of diversion possibility. The injection has been covered by insurance plans, and is mailed directly from a pharmacy to our office. A helpful video of an injection being given can be found at: <https://www.youtube.com/watch?v=lZBaDCIWSwg>.

I would encourage other family medicine prescribers to consider using injectable naltrexone for the right patients, and our MAT team would be happy to share our experiences in developing our protocol for the medication. Feel free to contact us at kmarvin@chslv.org.



Department of Health Calls for “All Hands on Deck” to Keep Vermonters Covered

Earlier this year, the Department of Vermont Health Access launched its Medicaid renewal project. Every Medicaid and Dr. Dynasaur enrollee in Vermont should receive a letter in the next few months, if they haven't already, telling them what they need to do to maintain health coverage. The “what to do” is actually quite simple. They can either mail back the enclosed form or they can call DVHA's toll-free number ([1-855-899-9600](tel:1-855-899-9600)). The phone option is generally faster and easier.

DVHA's goal is to help every Vermonter access the health care they need by enrolling in the public or private health plans for which they qualify. It wants to help Vermont families avoid a gap in coverage. Toward this end, it is sending three notices and reminders to each household over a two-month period before we terminate their coverage. In the event that they don't respond and their coverage is terminated, the department encourages them to call and apply for new coverage as soon as possible.

Here are three ways physician practices can help spread the word:

1. In pre-appointment communication with Medicaid enrollees, ask if they've recently received a Medicaid renewal letter.
 - If so, encourage them to respond ASAP (if they haven't already done so).
 - If not, ask them to watch their mailbox – it will come between now and fall.
 - If they've moved recently, they should call Vermont Health Connect to make sure their mailing address is correct.
2. At the appointment, ask the same question.
 - If they need in-person help, tell them about our statewide network of <http://info.healthconnect.vermont.gov/find>
 - In external communication, call attention to Medicaid renewals.
 - Post an announcement (see <http://info.healthconnect.vermont.gov/materials#Post>) in newsletters and invite staff to post in their local Front Porch Forum.

Health care providers can also download the posters and handouts from: <http://info.healthconnect.vermont.gov/materials> or use our materials request form found on the website to request materials be sent to you.

If you have questions or ideas, please contact the department at: <https://apps.health.vermont.gov/VHCFForm/family>.

**Barnard...***(Continued from page 1)*

store or around town and explain how he had allowed them to walk again.

“I also have many fond memories of playing with the model skeletons, casting supplies and wheel chairs after hours when the office was closed. My dad has a lot to do with my interest in health law as a profession.”

Barnard, a graduate of Dartmouth College and Stanford University School of Law, has nearly ten years of experience in health care policy and regulation and is a frequent speaker on topics including health reform, advocacy and issues in health law. Following her graduation from law school, she founded a program in San Jose, Calif., to address the legal barriers to health stability facing low-income individuals living with diabetes.

Barnard lives in Montpelier with her husband and two children.

Prescription Drug Testing...*(Continued from page 2)*

time for testing, support on pre-analytical collections and specimen handling, interfacing of results, or service innovations such as randomization of collections.

The relationship between the laboratory and the physician can be very useful in supporting treatment. Physicians should feel empowered to reach out to their laboratories and request meetings or even a laboratory tour.

Green Mountain Physician: What steps can prescribing physicians take to have confidence in the test results and address false positives, false negatives or unusual metabolic pathways?

Dr. Warrington: The most challenging aspect of urine drug testing in particular is the post-analytical interpretation of test results. Screening by immunoassays are known to have common, but predictable false positives and false negative results. Confirmation testing by mass spectrometry tend to have fewer false positives and false negative results, but remain challenging to interpret. Some factors that make urine drug testing particularly difficult include: timing since last use and drug half life, genetic variability in metabolism, and known interfering substances such as poppy seeds or secondhand marijuana smoke.

Physicians need to stay educated in this field and partner with their laboratorians. Most laboratories should be able to provide customer support that can highlight some of the common trends or known pitfalls in urine drug testing. Through this dialogue, physicians will be able to gain confidence in the testing and better understand the nuances in interpreting these tests.

Green Mountain Physician: What steps can prescribers take to avoid tampering with or adulterating a sample?

Dr. Warrington: There are a number of ways to both reduce the chance of a patient altering a urine sample and to help identify when a sample has been manipulated. The first step is in scheduling the patient's collection. If a provider is monitoring buprenorphine compliance, for example, the patient might take the drug immediately before his or her visit. Instead, randomization of the collection can be a powerful tool to support abstinence and compliance. This can be done through scheduling at the doctors' office and is a service offered by some laboratories. Another useful tool is arranging for or performing observed collections. Patients employ a number of tactics to avoid having to provide their own urine at collections including using others' urine, adding products that will mask the drug in question, bringing in heat packs to avoid drops in temperature and use of devices to hold synthetic or borrowed urine. Correctly performed observed collections will identify or minimize most of these strategies.

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AMA...

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of the New England Delegation composed of MD's from our region and brought forward to the House of Delegates.

The AMA proved to be a dynamic, strong and growing organization. It welcomes input from both the delegates and members using the recently initiated members forums (located on the AMA web site), which allows us to discuss proposals to be reviewed and vetted before the meetings. Amendments to the Bylaws or Constitution can be submitted in this fashion. The AMA supports both patient's needs as well as us physicians. It is definitely worthy of our support.

In future AMA corners, I will address more specific activities of the AMA, including the amazing transformation of medicine activities of the AMA forum, the philanthropic arm of the AMA.

Prescription Drug Testing...

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Testing is also available to help determine whether or not a sample has been altered.

Green Mountain Physician: Do you have suggestions for how to deal with the variability of different tests?

Dr. Warrington: There are a number of sources of variability in urine drug testing. Some variables are inherent to the day-to-day variability seen in a patient's life including timing of dose to collection, dilutional effects due to hydration status, or concomitant medications or food. Other variables are due to specimen collection, shipping and handling including time from collection to processing, storage conditions, or the presence of bacteria in urine. Analytical variability can also contribute a small degree of differences.

Perhaps one of the most confusing sources of variability is relying on multiple laboratories for testing. Differences in methodology, sensitivity and specificity can significantly impact the interpretation of results. Immunoassays on different instruments can yield significantly different results as the antibodies used to detect the drug have different sensitivities from one drug to another. Although confirmation testing can be more specific and sensitive, the interpretation can vary from one laboratory to another due to differences in methodology and cutoff values, for example. Familiarizing oneself with the laboratory and the limits to the method being used can mitigate incorrect interpretations.

Green Mountain Physician: How will a prescriber know what substances will or won't be detected by a test?

Dr. Warrington: Navigating the world of urine drug testing and understanding the limitations of a test can be very confusing. The laboratory can serve as an important partner in supporting what tests can detect what substances. There are a number of ways in which the laboratory can support the provider's work. Providers can work with sales representatives to optimize the testing panels to support the patient's use and abuse patterns. In addition, customer service or the laboratory staff can help the provider understand what substances can or cannot be detected by that laboratory's specific methodology. Details may be available on the laboratories' websites. Most laboratories are willing to provide educational literature or presentations to staff to further support the communication between providers and the laboratory. Finally, the laboratory report itself is a wealth of information, often listing out what can be detected and the level of quantitation used to determine a drug's presence.

Green Mountain Physician: Would you recommend *Urine Drug Testing in Clinical Practice: The Art and Science of Patient Care*, a reference cited by the UVM MC protocol (www.pharmacomgroup.com/udt/udt5.pdf)?

Dr. Warrington: Yes, it is a professional, well-organized reference that I recommend.