

# THE GREEN MOUNTAIN PHYSICIAN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

*"Not for ourselves do we labor"*

March/April

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## VERMONT HOUSE PASSES LEGISLATION REQUIRING PRESCRIBERS TO REGISTER WITH, USE VPMS

In late March, H. 522 a bill relating to Strengthening Vermont's Response to Opioid Addiction and Methamphetamine Abuse, was passed by the Vermont House. The version of the bill passed by the House included the following requirements for prescribers to check the VPMS database:

- The first time a practitioner prescribes an opioid controlled substance for a patient with chronic pain;
- Annually following the initial prescription of an opioid;
- When starting a patient on a controlled substance for long-term opioid therapy of 90 days or more;
- Prior to writing a replacement prescription;
- When a patient requests a prescription renewal for an opioid prescribed to treat acute pain; and,
- As otherwise required by the Commissioner of Health by rule after consulting with the Unified Pain Management System Advisory Committee.

VMS is particularly concerned by the new requirement added on the floor of the House to check the database for a renewal of a prescription to treat acute pain. The committee did not take testimony on this amendment and it was not recommended by the Report of the Commissioner of Health's Unified Pain Management Advisory Council. Provisions in the report recommended that prescribers check the VPMS "at least annually for patients who are on chronic opioid therapy" and "when starting a patient on a controlled substance for long-term opioid therapy (defined as more than 90 days)." VMS believes that this new requirement will impose an undue burden on physicians who are dealing with administrative mandates.

Several of the requirements for checking the database in the version of the bill passed by the House are narrower than the requirements in the bill as introduced by the House Human Services Committee which had required checking the VPMS the first time any controlled substance on Schedule II, III or IV was prescribed for any condition or illness, not just opioids prescribed for chronic pain. While VMS believes that narrowing the requirement to check the database is helpful, we do not support legislating the practice of medicine.

Consistent with the resolution adopted by the membership in October of 2012, <http://bit.ly/10hFPhq>, VMS supported a provision in last year's VPMS bill that would have authorized licensing boards such as the Vermont Board of Medical Practice (VBMP) to adopt evidence-based standards addressing the frequency and circumstances licensees are required to query the VPMS. VMS supports requiring prescribers and dispensers to register to use the VPMS if they prescribe or dispense controlled substances. Registration for use of the VPMS should be streamlined and incorporated in the re-licensure process.

### The VPMS system should include real time data

VMS believes that requirements to check the VPMS database should be linked to improvements in the functionality of the database. The bill does not mandate that the prescription data be reported to VPMS in real time. Instead, the bill requires the VPMS advisory committee to report on the feasibility of obtaining real-time information and to evaluate whether increasing the frequency of reporting from every seven days to every 24

*Continued on Page 6*



## FROM THE PRESIDENT'S DESK

*By Norman Ward, M.D.*



This is certainly an exciting time to be involved with the Vermont Medical Society; ACOs, a huge dollar State Innovation Model (SIM) grant, tort reform, prescriptive authority for naturopathic practitioners, and more! Our two hundredth year is proving to be filled with more potential for change than perhaps any other. This issue of the Green Mountain Physician will touch on several of those issues.

Our VMS Executive Committee phone call earlier this month was opened up to Council participation to discuss the proposed expansion of state statutes to add APRNs to virtually every citation of the word "physician" in state law (see page 3). The extensive feedback from membership will be crafted into a cogent response to stop the train and permit detailed analysis of the wisdom of each point.

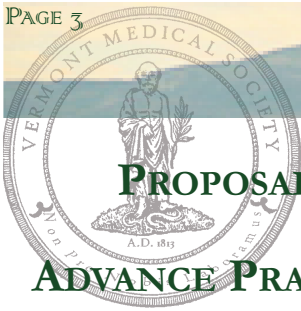
Our cover includes an article about how a bill passed by the Vermont House attempts to address the very important issue of opioid addiction and misuse by encouraging, and in some cases requiring, the use of the Vermont Prescription Monitoring Program. It is important to note that while VMS strongly supports efforts to combat this problem that is doing harm to so many communities, it continues to work with the legislature to find ways to do so without adding undue burdens to physicians or legislating the practice of medicine. This is an important issue to stay tuned to for the rest of this legislative session, especially when the bill is taken up by the senate in coming weeks.

Cy Jordan's testimony (detailed on page 6) to the legislature about the VMS Education and Research Foundation's white paper study of opiate prescribing really tells what it is like in the trenches for physicians. This is a small example of the potential for his work with the Foundation to provide pathways for physician leadership training and Communities for Vermont.

Hold on to your hats ...

Sincerely,

Norman Ward, M.D., VMS President



## PROPOSAL UNDER CONSIDERATION WOULD EXPAND AUTHORITY OF ADVANCE PRACTICE REGISTERED NURSES (APRNs)

VMS has received a legislative draft that would expand the scope of practice of Advanced Practitioner Registered Nurses (APRNs) by adding the words “and advanced practice registered nurse” to all Vermont statutes that reference physicians or doctors. This proposal was initiated at the request of the Nurse Practitioner Association and the Vermont Association of Nurse Anesthetists, and builds on a legislative council study identifying all the instances in the Vermont laws where “physicians” or “doctors” were specifically referenced. This study was done in late fall and subsequently the CRNAs and NPs developed the legislative draft adding APRNs to laws that reference physicians or doctors.

VMS is highly supportive of team-based care and the medical home model. While VMS supports increasing patient access to safe and high-quality care by increasing team-based care, VMS opposes the draft legislation in its current form. VMS has numerous objections to the proposed legislation, among them:

- The proposal is not consistent with the current rules for APRNs which require a transition to practice period during which APRNs may not practice independently;
- Adding the term APRN may imply that the legislature intended to expand the scope of practice of all APRNs to enable them to perform all of the activities listed in the proposed bill;
- The proposal is not consistent with the Board of Nursing rules which require APRNs to practice in specified roles such as Nurse Practitioner, Certified Nurse Midwife, Certified Registered Nurse Anesthetist and with specified population focuses such as pediatric, adult, family.

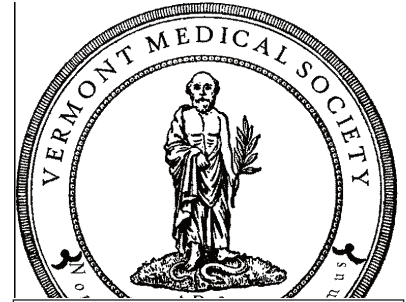
VMS staff has asked that the committee delay consideration of the bill until 2014. In the meantime, VMS asked the committee to direct the Vermont Board of Medical Practice (VPMB) and the Board of Nursing to study the proposed legislation and report their recommendations regarding the bill to the legislature by Nov. 1, 2013. Prior to finalizing their recommendations, the VBMP and the Board of Nursing would be required to hold at least one public hearing and receive written comments on their draft recommendations.

As noted by VMS President Norm Ward, M.D., in this issue’s “From the President’s Desk” column, the response from membership is being diligently gathered by VMS staff and will be very useful as VMS works on this initiative.

### WINTERS ELECTED TO AAP CHAPTER EXECUTIVE DIRECTORS’ STEERING COMMITTEE

Stephanie Winters, who as part of her VMS duties serves as executive director of several state specialty societies, has been elected to the American Academy of Pediatrics’ Chapter Executive Directors’ Steering Committee.

The Chapter Executive Directors’ Steering Committee (EDSC) is a leadership body of seven executive directors elected by all chapter executive directors. The committee’s purpose is to share and discuss challenges, concerns, and ways to improve communications and collaboration in order to build a stronger relationship between chapter executive directors, chapters and the national AAP. The ultimate goal of the committee is to support successful chapter development by way of the chapter EDs, chapter volunteer leadership, and the national office.



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VMSERF Administrator



## TO KEEP OR DROP INSURANCE COVERAGE – CONSIDERATIONS FOR VERMONT SMALL EMPLOYERS IN 2014

*Editor's note: The op-ed below was authored by a number of Act 48 Progress Assessment Working Group members, including former VMS President and current Fletcher Allen CEO John Brumsted, M.D., and VMS Executive Vice President Paul Harrington. It appeared in numerous publications statewide.*

Small employers in Vermont have a decision to make before January of 2014 – whether to keep their employer-sponsored insurance or drop it altogether and direct their employees to the state's new Health Insurance Exchange as individual purchasers. The Administration is recommending that small employers drop their health insurance coverage. Instead, we encourage businesses to evaluate their options and consider the implications on not only their own bottom lines, but the impact on working Vermonters. We believe there is no single right answer for employers and we feel that many Vermonters may be better off keeping their current employer-based insurance plan.

The Administration has cited the individual market exchange as a more affordable option for the employees of small businesses than their current employer-sponsored coverage. While this may be true for some people, it is most likely not true for all. Some employees could face significantly higher health insurance costs that will make it very challenging to maintain their health insurance coverage. The result? Less affordable coverage for middle-income Vermonters and an increase in the number of uninsured Vermonters.

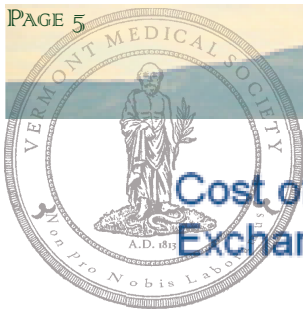
The impact of losing employer sponsored insurance will vary depending on the employee's household income. Only those individuals with incomes below 200 percent of the federal poverty level (\$22,980 annual income) are likely to experience reduced health insurance costs using the new subsidies available in the exchange rather than employer-sponsored coverage. Vermonters with higher incomes could pay significantly more for insurance than they do under their employer-sponsored coverage. For example, individuals earning over \$45,960 a year will receive no subsidies and will be expected to pay 100 percent of the premium cost. This increased cost could mean a number of these Vermonters may not purchase insurance, preferring to pay the relatively small tax penalty of \$95 a year, per person.

National estimates indicate that about 30 percent of employers could drop their coverage, even without any encouragement. If these estimates hold true for Vermont, about 12,000 of these dropped Vermonters will likely choose not to buy health insurance. Dropped employees could choose to forego health coverage for economic reasons creating a new class of uninsured, although previously insured, middle-income Vermonters. Those individuals who do purchase coverage via the Exchange will have to buy insurance with after-tax dollars, further lowering their purchasing power. As a result, the more small employers who continue to provide coverage, the more Vermonters will be insured.

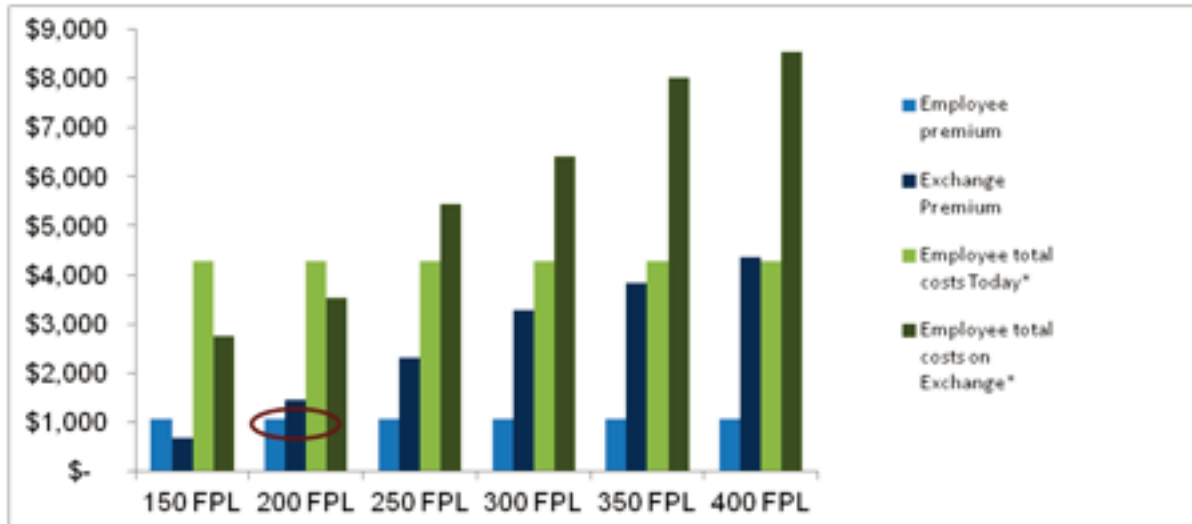
In addition to the changes employers face resulting from the Affordable Care Act cited above, Vermont businesses will still pay if they drop their coverage. The Administration is recommending that the so-called "Catamount tax" continue in 2014 after the Catamount program is replaced by the Exchange. This would impose a state tax penalty of \$476 per employee on small employers who drop coverage on full-time workers. Encouraging small businesses to drop insurance dismantles the existing financing mechanism, before the new and long-term financing mechanism is known, potentially leading to increased supplemental state financing to support previously insured individuals.

Because the impact on employers and employees will vary, we encourage employers to consider the following questions when deciding whether to keep their coverage or to drop it:

- What are the household incomes of my employees and will they be eligible to receive subsidies on the Exchange and what level of subsidization ([healthreform.kff.org/Subsidycalculator.aspx](http://healthreform.kff.org/Subsidycalculator.aspx))?
- Will my employees be able to afford health insurance if I drop my employer-sponsored coverage?
- If I drop my coverage, how much of an increase in wages will I need to make to ensure that employees can still afford insurance?
- If I drop my coverage and increase the wages of my employees, how much in additional taxes will I pay (due to losing the corporate tax exemption for providing health insurance and paying additional payroll taxes) and my employees pay (due to paying taxes on higher wages and paying for insurance with after-tax dollars)?
- Is my business eligible for a financial incentive to sponsor group healthcare coverage such as the small group tax credit (see [irs.gov](http://irs.gov))?
- Will there be a penalty for dropping coverage such as the Catamount tax?



## Cost of Insurance Coverage, employer-sponsored vs Exchange



\*Total costs include premium plus OOP maximum

Source: Kaiser Family Foundation, Hickock and Boardman, Vermont Silver plan OOP maximum as approved, ACA data on OOP percentage reduction, team analysis

(Cont'd from pg. 4) • How does the decision to keep or drop your health insurance coverage affect employee recruitment, retention and employee wellness?

Very soon, Vermont employers must address these questions and make a choice. We hope when they do, they will consider all the facts they need to choose the best path forward for their company and employees.

Representing Act 48 Progress Assessment Working Group Organizations:

*John Brumsted, M.D., Pres. & CEO, Fletcher Allen Health Care*

*Betsy Bishop, Pres., Vermont Chamber of Commerce*

*Don George, Pres. & CEO, Blue Cross Blue Shield of Vermont*

*Bea Grause, Pres. & CEO, VT Assoc. of Hospitals & Health System*

*Paul Harrington, EVP, Vermont Medical Society*

*Lisa Ventriss, Pres., Vermont Business Roundtable*

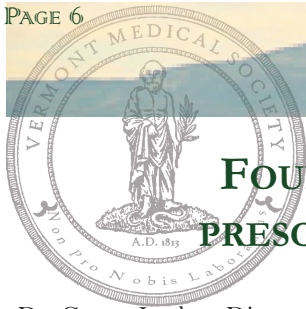
## PHYSICIAN ASSISTED SUICIDE BILL PASSES VERMONT SENATE

The Vermont Senate has voted 22 to 8 to pass legislation allowing for physician assisted suicide. The bill, S.77 would create a program similar to the one that has been in effect in Oregon for about 15 years and in Washington State since 2009.

It is anticipated that the bill will be quickly taken up by the House of Representatives where it has the support of House Speaker Shap Smith. Governor Peter Shumlin has also expressed his support for the legislation as a civil rights issue.

VMS testified against the legislation before both the Senate Health and Welfare Committee and the Senate Judiciary Committee based on its current policy on physician assisted suicide, adopted in 2003, stating there should be no laws for or against physician assisted suicide due to a concern that such laws could hinder the provision of high quality end-of-life care. The policy was reaffirmed by the VMS Council in February of 2011.

In its testimony, VMS indicated the uncertainty around making a diagnosis of a terminal illness which would result in death within six months. It cited a study indicating that 17 percent of individuals diagnosed with a terminal illness for purposes of the hospice benefit live longer than the six months. This uncertainty has been cited as one of the reasons why the measure failed to pass through public referendum in Massachusetts last November.



## FOUNDATION DIRECTOR DELIVERS CHRONIC PAIN AND PRESCRIPTION ABUSE TESTIMONY TO JOINT COMMITTEES

Dr. Cyrus Jordan, Director of the Vermont Medical Society Education and Research Foundation (VMSERF) recently testified to a joint hearing of the House Judiciary Committee and the House Human Services Committee about Safe and Effective Treatment of Chronic Pain in Vermont, a revealing report he authored on chronic pain care and prescription drug abuse in the state.

Dr. Jordan was joined by several physicians, most of whom had contributed to the report, including: Dr. Trey Dobson, an emergency physician and the Chief Medical Officer at Southwestern Vermont Medical Center; Dr. Carlos Pino, Director of the FAHC Pain Medicine Center; Dr. Gilbert Fanciullo, Director of the Pain Management Center at DHMC; and Dr. Zail Berry, a pain specialist in private practice.

Dr. Jordan suggest a number of practical things that can be done tomorrow that will make a big difference in the way Vermonters are treated for chronic pain and potentially reduce prescription drug abuse, including:

- Creating a single set of recommendations for treating pain in Vermont;
- Improving the Vermont Prescription Monitoring System;
- Educating the public to expect best medical practices;
- Evaluating the approach of professional oversight;
- Differentiating the role of law enforcement from the role of care giver; and,
- Discouraging payment policies that encourage pill prescribing.

All of the physicians who testified at the hearing praised the Vermont Prescription Monitoring System (VPMS) and spoke about how helpful it was in their practices. At the same time they noted that it was somewhat difficult and time consuming to use, although improving. Additional areas of concern included its lack of coordination with EMRs, the potential risk to patient confidentiality when delegates access the database, and the need for pro-active alerts sent to prescribers when suspect prescribing patterns are detected.

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## VERMONT PRESCRIPTION MONITORING SYSTEM

(*Cont'd from pg. 1*) hours would yield substantial benefits. VMS encourages the Department of Health to improve the VPMS database, which physicians report is not easy to log into and use and does not work well with electronic medical records. VMS encourages the Department of health to ensure that the data in the VPMS is current and available real-time.

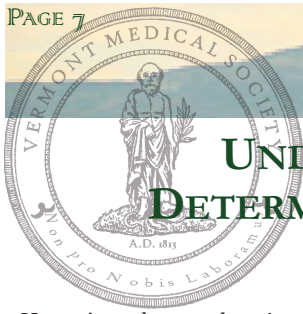
### Provisions in H. 522 supported by VMS

There are many provisions in the bill that VMS supports, some of which include:

- A requirement that individuals picking up prescriptions at the pharmacy show identification;
- A provision authorizing physicians to appoint delegates to check the VPMS database (Note: the rules permit this now.);
- Authorization for the DVHA Medical Director and the Chief Medical Examiner to query the VPMS database;
- Authorization for interstate agreements that would enable physicians to check monitoring systems in bordering states;
- Authorization for the Department of Health to perform trend analyses on the VPMS data, post information about trends on its website, and send alerts to health care providers and dispensers by email;
- A requirement that licensing authorities, such as the VBMP develop evidence-based standards to guide health care professionals in the appropriate prescription of Schedule II, III, or IV controlled substances;
- Establishment of a Pain Management Advisory Council that will advise the Commissioner of Health concerning rules for the appropriate use of controlled substances;
- Creation of a statewide disposal program for unused drugs; and
- Immunity for physicians who prescribe opioid antagonists to persons at risk of experiencing an opioid-related overdose and to their families, friends or others in a position to assist a person at risk of experiencing an overdose.

VMS has not taken a position on whether law enforcement should be permitted to access the VPMS database without a warrant or court order. VMS members' opinions vary on this issue.

H. 522 has moved to the Senate where it will be reviewed by the Senate Health and Welfare and Judiciary Committees.



## UNDERSTANDING WORKERS' COMPENSATION, PART IV: DETERMINATION OF CAUSATION IN WORKERS' COMPENSATION

By Nelson S. Haas, M.D.

Knowing the workers' compensation system will prepare physicians for caring for patients who claim workplace injury or illness. This fourth in a series of articles about the workers' compensation system covers the determination of causation. Previous articles describe the history of, Vermont statutes and rules governing, and ethics as applied to the workers' compensation system. Forthcoming articles will suggest improvements in the system.

Misunderstanding cause in workers' compensation may misplace blame, condemn the innocent, deprive people of the opportunity to understand and take responsibility for their health or the health problems they create in others, and foster aversion to work. This article defines cause, describes barriers to depending on our perception to determine cause, and describes a hierarchy of medical evidence and approaches to determining cause.

**Definition of Cause** – A cause is a factor that provides the generative force for something<sup>1</sup> or that produces an effect or action<sup>2</sup>. In medicine, we may consider cause of disease:

1. Its pathology, or change in structure or function from that which we view as normal to that which creates unpleasant symptoms and/or dysfunction;<sup>3</sup> and
2. Personal characteristics or exposures that increase the likelihood of unpleasant symptoms and/or decreased function.<sup>4</sup>

**Occupational Injuries and Illnesses** – An occupational injury or illness is any harmful work-related change in the body, whether occurring instantaneously or gradually,<sup>5</sup> “arising out of and in the course of employment.” In the case of a violent workplace accident with immediate and visible effects, cause and effect are usual clear. An illness arises out of employment when it is caused by “conditions characteristic of and peculiar to a particular trade, occupation, process or employment, and to which an employee is not ordinarily subjected or exposed outside or away from the employment.”<sup>5,6</sup> In the case of occupational illnesses, where cause and effect are not immediate and visible, our approach to determination of causation must be analytical to be valid.

**Fallibility of Perceptions: Cognitive Pitfalls** – Human perceptions are fallible. Humans have thought that the earth was flat<sup>7</sup> and at the center of the universe,<sup>8</sup> that higher forms of life occurred spontaneously without descent from similar organisms,<sup>9</sup> and that disease was caused by demonic possession.<sup>10</sup> Our perception and performance are limited by cognitive pitfalls, for example, by structured biases known as schema,<sup>11,12</sup> a subcategory of which is stereotyping.<sup>13,14</sup> A list of cognitive pitfalls is contained in Appendix A.

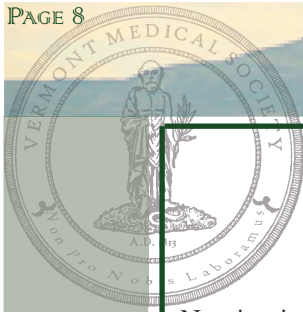
The impact of schema can be seen in performance on mathematics tests: When persons from groups who are perceived to do less well in mathematics than white males, such as African Americans,<sup>15,16</sup> Latinos,<sup>17</sup> and females,<sup>17-20</sup> are reminded of their race or gender before taking math tests, they do worse than if not reminded. The effect is particularly strong when the test is challenging and when the examinees are reminded that persons from their group are expected not to perform as well on math tests as white men.

Stereotypes may manifest themselves physically as well as academically. African Americans who are under stereotype threat exhibited larger increases in blood pressure during tests than African Americans who are not under stereotype threat,<sup>16</sup> and their blood pressure was higher blood pressure when they perceived racism.<sup>21</sup>

**Placebo and Nocebo Effects** – Our expectations of the effect of an exposure shape our reactions to an anticipated exposure. Positive outcomes based on expectation are seen in the placebo effect, which has been documented in many circumstances, including in treatment of chronic pelvic and abdominal pain,<sup>22,23</sup> osteoarthritis,<sup>24,25</sup> headache,<sup>26</sup> fibromyalgia and other body pain,<sup>27-29</sup> diabetic neuropathy,<sup>29</sup> Parkinson's disease,<sup>30</sup> and acne.<sup>31</sup>

The nocebo effect – perception of harm in the absence of harmful exposure – has been documented with treatment of disease and from anticipated exposure to environmental phenomena such as electromagnetic fields. The nocebo effect has been identified during treatment of: fibromyalgia,<sup>28,29,32-34</sup> diabetic neuropathy,<sup>29</sup> Parkinson's disease,<sup>30,37</sup> headaches,<sup>35,36</sup> and other conditions.<sup>38-41</sup> More nocebo complaints occurred among those who expected than those who did not expect harm from exposure to electromagnetic fields with application of sham electromagnetic fields<sup>42,43</sup>; and in trials where the anticipated, untoward effects of the intervention were reinforced (told more frequently to participants).<sup>44</sup>

The remainder of the article, including many other sections, can be viewed online at [VTMD.org/workerscomp4](http://VTMD.org/workerscomp4).



## NOMINATIONS OPEN FOR SCHWARTZ CENTER COMPASSIONATE CAREGIVER AWARD

Nominations are open for the 15th annual Schwartz Center Compassionate Caregiver Award. This prestigious award honors caregivers (physicians, nurses or other caregivers) in the New England region who display extraordinary compassion in caring for patients. The recipient will receive \$5,000 and four finalists will receive \$1,000 each. Nominations are due May 3, 2013.

The Schwartz Center for Compassionate Healthcare will present the award at its annual Kenneth B. Schwartz Center Compassionate Healthcare Dinner on Nov. 21, 2013 at the Boston Convention and Exhibition Center in South Boston, Mass.

For more information visit [www.theschwartzcenter.org](http://www.theschwartzcenter.org) or call (617) 724-4746.

### Vermont Medical Society 200th Annual Meeting

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