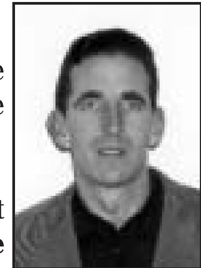
Vermont Chapter
GOVERNOR'S NEWSLETTER

ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

Summer 2005

Frank J. Landry, MD, MPH, FACP
Governor, Vermont Chapter

GOVERNOR'S CORNER



I want to thank all who attended the annual meeting in San Francisco, April 14-16 2005. I believe we had the largest Vermont contingent yet! Our combined Vermont, New Hampshire and Maine reception was a great success with over 30 participants!

As usual, our University of Vermont Associates had a huge success in the Associate Abstract Competition. Four Vermont residents were selected to present their scholarly activities. **Diane Hakey**, MD was a national winner for her oral presentation, "Sarcoidoisis and Calciphylaxis with Interferon Therapy". Other presenters were **Eric Gauthier**, MD, **Carolyn Lyons**, MD, and **Jennifer Wolfson**, MD. Congratulations to all of our Associates and students for their support of the ACP.

Three new Vermont ACP Fellows participated in the Convocation exercise in San Francisco. The Convocation of the ACP is a yearly ceremony whereby the College recognizes and applauds new Fellows. New Fellows attending included **Bonita Libman**, MD, **Mark Pasanen**, MD, and **Jonathan Cohen**, MD. Other new Vermont Fellows include **Christopher Grace**, MD and **William Hopkins**, MD. I want to congratulate all of our new Fellows and I encourage many others to consider becoming Fellows of the ACP!

Once again our Vermont Chapter received the "Chapter Excellence Award". This award reflects on our continued success with our Student and Associate Program and our annual Vermont Meeting. I want to thank our entire membership for your support of Vermont ACP activities!

Mark your calendars for next our next **Vermont Chapter Meeting**. It will be held on **Friday October 21st** at **Trapp Family Lodge**. More details will be coming soon.

SUPPORTING YOUR CHAPTER THROUGH CHAPTER DUES

Chapter dues are the backbone of local activities and vital to the success of our chapter. While we are provided some financial support from the national office, the chapter dues collected provide the majority of financial support for local activities. Educational meetings, mentoring programs for medical students, local Associates' research competitions, advocacy with state legislators, and participation by chapter leaders in Leadership Day on Capitol Hill are just some of the activities supported by your chapter dues. Many of these activities are orchestrated by unpaid volunteer leaders in our chapter. However, the increase in activities at the local level has created the need for additional staff support to help manage the day to day operation of the chapter. Your chapter dues help support the cost of local staff and provide funding for new and existing chapter initiatives. When you receive your dues notice, please remember to include the chapter dues in your payment. You will be contributing to the success of many grass roots activities happening right here at home.

VIRGINIA HOOD NAMED TO BOARD OF REGENTS

Virginia L. Hood, MBBS, MPH, FACP, and previous Vermont Chapter ACP Governor, was elected to the Board of Regents of the American College of Physicians. This is a great honor for our chapter and recognizes the great work Dr. Hood has done for the ACP, both on a local and national level. Dr. Hood received her medical degree at the University of Sydney, NSW, Australia and a Master of Public Health from the Harvard School of Public Health in Boston, Massachusetts. After residency in internal medicine and fellowship in nephrology at the University of Sydney she joined the faculty at the University of Vermont in 1977 where she currently holds the rank of Professor in the Department of Medicine. Virginia served as the Vermont Chapter ACP-ASIM Governor from 1999-2003. In addition, she has served the College well by participating in a number of committees to include: member, ACP-ASIM Foundation Program Development Committee, 2002-2004;Vice Chair, ACP-ASIM Publications Committee, 2002-2002 and member 2002-2004; Chair, Books Program Evaluation Subcommittee 2002-2004; member, 2004 Scientific Program Subcommittee, 2002-2004; and member, Ethics and Human Rights Committee, 2003-2005. Dr. Hood remains very active in our local chapter and serves on our council and program committee. She received recognition during her tenure as Governor for Chapter Management and received the ACP, Vermont Chapter Laureate Award in 2003. Congratulations, Virginia!

ACP SERVICES, INC. FORMS PAC

ACP Services, Inc. has formed a political action committee to help promote internists' participation in the political process. A PAC is an entity permitted under federal law to make contributions to political candidates running for office at the state and/or federal level. More and more national medical specialty societies are forming political action committees to enhance their government relations activities and increase their political influence.

Because of its tax status as a charitable organization, ACP cannot establish a PAC. However, ACP Services, Inc., a separate and distinct organization from ACP established in 1998 to provide advocacy, practice management, and other services for internist-members, has a different tax status that allows it to establish a PAC. Members of ACP automatically are also members of ACP Services, Inc.

ACP Services PAC is governed by an 11-member Board of Directors that researches and analyzes the voting records of congressional candidates and determines who should receive contributions from the PAC. Chaired by William Golden, MD, FACP, from Little Rock, Arkansas, the board is composed of internal medicine leaders selected from various areas of the country by the ACP Services Board of Directors. The PAC board considers candidates' record of support on issues important to the profession, membership on key health committees, and leadership positions in the Congress, among other criteria, when deciding whom to support.

The PAC will begin making donations to congressional candidates running in the 2006 election cycle, which starts in Jan. 2005.

For more information on the PAC, contact **Laura Allendorf**, ACP Services PAC Director, at Lauraa@acponline.org.

ACP Services PAC Board of Directors
Chair: William Golden, MD
Dawn E. Clancy, MD, St. Johns Island, SC
John F. DeCarli, DO, Wilmington, DE
Larry Faltz, MD, Sleepy Hollow, NY
Mark Friend, EVP of ACP Services, Inc., Washington, DC
Paul A. Gitman, MD, New Hyde Park, NY
Robert A. Gluckman, MD, Portland, OR
Edward D. Harris, MD, Menlo Park, CA
Mark E. Mayer, MD, University Heights, OH
Richard L. Neubauer, MD, Anchorage, AK
Frederick E. Turton, MD, Sarasota, FL

GOVERNORS TACKLE FLAWED PAYMENT SYSTEM
NEWS FOR THE GOVERNORS MEETING IN SAN FRANCISCO, APRIL 2005

By Janet Colwell

No payment for coordinating care. Claims that take three months to process. No incentives to invest in information technology.

These are just a few of the symptoms that the Board of Governors noted about the dysfunctional payment system. That issue topped the Board of Governors meeting agenda earlier this week as Governors, Regents and invited speakers met to discuss the flawed reimbursement system and ways to reform it.

The dysfunctional payment system is a reflection of deeply held cultural values, observed **Glenn M. Hackbarth**, JD, former chief executive officer of Harvard Vanguard Medical Associates and current chair of the Medicare Payment Advisory Committee (MedPAC), one of the speakers who addressed the Governors. Those values include the idea that clinician autonomy is more important than accountability and that all possible interventions must be done, regardless of cost.

There is also a widespread belief in this country that medicine and science can triumph over any illness or disability, he added. That belief drives higher spending on health care-often to the detriment of education, the environment and other important areas. As several of the Governors pointed out, these beliefs also adversely affect the way physicians are paid.

Three perspectives

In a series of workshops in which Mr. Hackbarth and other speakers participated, the Governors looked at the issue from the perspective of physicians, payers and patients.

"The dysfunctional payment system is oppressive, Byzantine and discriminatory," said **Cecil B. Wilson**, MACP, who led the discussion from the physician's perspective. Dr. Wilson, who has a solo practice in Winter Park, Fla., said he has more than 1,300 insurer addresses in his computer and that three-to-four month payment delays are common whenever a patient switches plans.

Patients often expect their physicians to know the details of all of these plans, he added, while insurers expect doctors to be 100% accurate in their filings or face payment delays. Fear of denied or delayed payments, he added, encourages physicians to adopt tactics such as down coding to avoid denials.

Dr. Wilson listed other problems of the flawed payment system from physicians' point of view; those include administrative hassles and poor communication between physicians and insurers.

From patients' vantage point, the flawed payment system doesn't work either, said MedPAC's Mr. Hackbarth. Patients' concerns include coverage availability, affordability, administrative complexity and a fragmented system that rewards complex, technological solutions over quality of care.

A third speaker, **Reed V. Tuckson**, MD, senior vice president of consumer health and medical care advancement at UnitedHealth Group, provided the payers' perspective. While payers want to work with physicians, he said, they are facing relentless pressure from big employers, who are "terrified" about how rising health care costs are affecting their bottom line. At the same time, he said, consumer and quality groups continuously point to credible studies on medical errors and the gap between cost and quality.

UnitedHealth has taken steps to improve communication with physicians, said Dr. Tuckson. For example, it has introduced an insurance card that can be swiped in any card-reading terminal, giving physicians instant access to a patient's benefits and eligibility information. Soon, he said, that information will be merged with payment information.

The company is also trying to align its reimbursement policies with Medicare whenever possible, Dr. Tuckson said. "The goal is to achieve consistency so there is less confusion."

Sellable solutions?
The Governors discussed the idea of the primary care physician's office as the patient's "medical home," with the internist acting as care coordinator and being reimbursed accordingly. Dr. Tuckson said health plans are interested in the idea, but must first see proof that such a system would reduce costs.

Several Governors also suggested changes to the insurance industry, including standardizing benefits across plans and mandating individual coverage. By simplifying communication among insurers, doctors and patients, the Governors said, additional savings would be realized. Selecting an insurance plan should be more like buying a car, allowing consumers to select from a standard menu of options, said Board of Governors Chair **Frederick E. Turton**, FACP, in his summary of the workshop sessions.

According to Mr. Hackbarth, pay-for-performance programs could hold some answers by rewarding doctors for efficiently using technology and for following evidence-based guidelines.

"Now we are rewarding more care and advanced care instead of quality or right care," Mr. Hackbarth said. "The current payment system discourages doctors from trying to think of innovate ways to meet patient needs."

The Board of Governors also approved a number of resolutions related to reimbursement that will be considered by the Board of Regents. Those resolutions included:

- Funding pay-for-performance rewards with new dollars created from cost savings, separate from inflationary updates in physician fee schedules.
- Increasing compensation for cognitive services by exploring changes to the current payment system. Suggested changes included changing the Medicare formula of tying fee increases to the sustainable growth rate and revising the fee-for-service-based payment methodology, which is based on acute episodic care.
- Working with the AMA to advocate for an increase in physician fees for visits to Medicare beneficiaries in nursing homes.

RESEARCH CORNER

Announcing an innovative program now available to patients being treated for depression. The prevalence of depression is increasing, and the offspring of a parent who has had depression has a 35-40% risk of developing major depression. Over the past five years, a program was developed in Vermont to reduce this very high risk to the child of a depressed parent. The University of Vermont's Departments of Psychology and Psychiatry, numerous community agencies, private mental health practitioners, insurance companies and most recently, the Vermont Department of Health, have cooperated to develop a program for the primary prevention of depression.

One hundred Vermont families have already attended The Raising Healthy Children program. The program is for families in which one parent has been depressed. The intervention is designed to reverse children's high risk for depression and other mental health problems. The program teaches better coping skills and parenting skill training, combining cognitive-behavioral and family techniques. Families consistently are "highly satisfied," and it is free with compensation provided. The group (**Rex Forehand**, Ph.D. and **Gary Keller**, M.D. at UVM and **Bruce Compas**, Ph.D. at Vanderbilt University.) have recently received National Institutes of Mental Health funding for a 5 year randomized, controlled study of the program in two states. Families are randomly assigned to one of two arms: a group-based curriculum or an individual-based curriculum.

Families are presently being recruited for participation. Inclusion criteria include: a parent who has previously had major depression or dysthymia, and one child in the family who is 9-15 years old. Contact **Gary Keller** directly for more information or brochures (gary.keller@uvm.edu or 802-951-2089 x109), or to refer a patient call 888-350-7659 or raisinghealthychildren@uvm.edu.

UPDATE ON MAINTENANCE OF CERTIFICATION
APRIL 2005

Over the past year, a collaborative working relationship between the American College of Physicians (ACP) and the American Board of Internal Medicine (ABIM) has resulted in ABIM's granting credit for an attractive new option for ACP's Medical Knowledge Self-Assessment Program 13 (MKSAP 13) to fulfill part of the requirement for maintenance of certification. In addition, starting in January 2006, a modified overall framework for Maintenance of Certification will be instituted by the ABIM, motivated by a desire to increase flexibility, reduce redundancy, emphasize assessment of performance in practice, and simplify the process for physicians recertifying in both Internal Medicine and one or more of its subspecialties. This update of the Maintenance of Certification process will provide a summary of the following specific topics: 1) the new MKSAP option; 2) the modified ABIM framework for January 2006; and 3) reduction of anxiety for candidates taking the closed-book examination. Additional information about the new MKSAP option can be found on the ACP website: http://www.acponline.org/mksaprecert/, and further description of the new ABIM framework can be found on the ABIM website: http://www.abim.org/moc/moc_new.shtm

The New MKSAP Substitution Option

The MKSAP substitution option was designed to offer recertifying physicians an alternative method to the ABIM Self-Evaluation Process (SEP) modules for fulfilling the maintenance of certification requirement for self-assessment of medical knowledge. By using MKSAP, candidates can simultaneously fulfill this requirement while studying for the closed book examination. In addition, the MKSAP substitution option has been designed to incorporate immediate feedback as well as education (and links to educational resources) into the self-evaluation process.

How does the MKSAP substitution option work?

The MKSAP substitution option is available to MKSAP 13 subscribers (either print or CD-ROM subscribers) as a no-cost benefit. The entire process is completed electronically. Candidates use their MKSAP subscriber privileges to access up to four question modules via the Internet, download them to their computer, answer the MKSAP question sets, and, using their ABIM candidate number, submit their responses via the Internet for ABIM recertification credit. MKSAP 13 subscribers who have registered with ABIM for maintenance of certification can initiate the process by accessing the following: http://www.acponline.org/mksaprecert/

Each question is presented in a way that combines self-assessment with education, and provides immediate feedback to the candidate. After the candidate reads the question, (s)he first selects and enters an answer choice for “grading” by the computer. If the submitted answer is correct, the candidate receives immediate feedback from the computer that the answer is correct, and is presented with the critique and discussion of the question. There is also an opportunity to link immediately to the relevant text from MKSAP 13 in order to obtain further educational material relevant to the question.

If the candidate answers the question incorrectly, (s)he receives that feedback immediately from the computer, and is provided with the link to the relevant MKSAP 13 text. After reading the text, the candidate has a second opportunity to answer the question. Following the second answer, the candidate receives immediate feedback about whether the answer is correct, and is presented with the critique and discussion of the question. Candidates are not required to complete each set of 60 questions at a single sitting, but can do so at whatever schedule is convenient for the candidate.

Following completion of each 60 question module, the candidate receives two scores: a) a score based on the first answer provided for each question; b) a score based on the second answer provided for each question. Because each of the questions has been pre-tested, candidates are provided feedback about how their score compares with the scores of others who have pre-tested the examination. This information is useful to the candidate in allowing him/her to identify areas for further study in preparation for the closed book, secure examination.

Although candidates immediately receive scores based on their completion of the questions, all candidates who complete the MKSAP question sets receive the appropriate amount of maintenance of certification credit (the equivalent of 1 module of credit for each set of 60 questions). Thus, there is no threshold score that one must obtain before receiving credit. The ACP is responsible for processing the information related to completion of the MKSAP questions, and for providing ABIM with the name of each candidate who has completed the MKSAP questions for credit.

The Modified ABIM Framework

Starting January 2006, the previous requirement for completion of five ABIM SEP modules will evolve into a "point system" requirement that incorporates flexible options for self-assessment of knowledge and practice performance. Each candidate will need to complete 100 self-evaluation points as part of the maintenance of certification process. The same points are applicable to all certificates and are valid for 10 years (i.e. extra points are not needed if a candidate is applying for both internal medicine and a subspecialty within the 10 year period during which the points are valid). The required 100 points are divided in the following way: a minimum of 20 points must relate to self-evaluation of medical knowledge; a minimum of 20 points must relate to self-evaluation of practice performance; and 60 points are elective and can relate to either category of self-evaluation. Each ABIM SEP module counts as 20 points relating to self-assessment of medical knowledge, as does each MKSAP question module.

How Do I Get Credit for Self-Evaluation of Practice?

A variety of options will be available for fulfilling the 20 point minimum requirement for self-evaluation of practice, and the number of points given for each option will depend upon the amount of work involved. There are three basic components to this self-evaluation of practice: 1) measuring practice performance from data that the physician collects or receives from another source; 3) developing and implementing a plan for improvement; and 3) assessing the impact of the improvement plan. The types of options that will be available for assessing practice performance include: 1) ABIM Practice Improvement Modules (PIMs); 2) ABIM survey modules (Peer, Patient, and Practice Inventory); 3) established quality measurement and improvement programs; and 4) self-directed quality measurement and improvement. Credit for performance assessment is given with completion of one of these options; there is no grade given and thus no "passing" score. The ABIM's PIMs will count as 40 points and the survey modules will count as 20 points. The ABIM will assign points to new modules as well as tools and programs developed by others according to pre-established standards and criteria.

What is Happening During the Transition Period Before January 2006?

The new point system framework (and the need to include self-evaluation of practice) will not apply to physicians who complete the current self-evaluation module requirement (including the option for substituting up to 4 modules of MKSAP) before January 2006. If a physician still has one or more SEP modules to complete after January 2006, then the new guidelines will be in effect, and 20 Practice Evaluation points will be needed to complete the Self-Evaluation process.

Reducing Anxiety About the Secure Examination

Although a closed book examination can elicit anxiety, a better understanding of the examination and the types of questions on the examination can help allay that anxiety. As a result, the ABIM is committed to increasing communication about the examination to recertification candidates, and to clarifying what are sometimes misconceptions about the examination.

An important point of clarification is that the maintenance of certification examination is different from the examination used for certification of residents who have recently completed house staff training. Residents typically are exposed to specialized types of inpatient problems that are primarily handled by subspecialists, and are therefore not part of the "core" practice or experiences that cut across general internal medicine as well as most subspecialties. Therefore, the maintenance of certification examination focuses on topics that are relevant and of clinical importance to all internists. At the same time, the maintenance of certification examination questions are designed to test clinical judgment, not recall of obscure facts. A Board-certified clinician should be able to answer these questions without using additional resources, since the questions are testing judgment rather than factual recall.

The pass rate for the examination is generally approximately 89 percent on the first try, whereas approximately 97 percent of candidates ultimately pass the maintenance of certification examination. The passing score is set as an absolute threshold, and is not based on a curve. Thus, there is no intent to fail a specified percentage of candidates taking the examination.

Perspective About the Recent Collaboration Between ACP and ABIM

Over the past year, ABIM has clearly demonstrated a commitment to a collaborative, cooperative working relationship with ACP. ABIM is also committed to ongoing improvement in the process for maintenance of certification, with specific goals of reducing redundancy and adapting the program for relevance and usefulness in the practice environment. And finally, ABIM and ACP are both committed to continuing to work together for the best interests of our physicians, our patients, and the discipline of internal medicine.

PICTURE GALLERY

New Fellows Attend Convocation in San Francisco
L to R: Jonathan Cohen, MD, FACP; Frank Landry, MD, FACP, Governor; Mark Pasanen, MD, FACP; and Bonita Libman, MD, FACP

At the Associate Poster Competition
L to R: Steve Grant, MD; Carolyn Lyons, MD; Jennifer Wolfson, MD; and Mark Pasanen, MD, FACP

Relaxing during an ACP Break
UVM Internal Medicine Residents Adam Chodosh, MD and Caroline Lyons, MD.

---VISIT OUR CHAPTER WEBSITE---

http://www.acponline.org/chapters/vt

VERMONT CHAPTER COUNCIL

David Babbott, MD, MACP
(Past Governor)
Burlington, VT
Phone: (802) 864-4647
E-mail: david.babbott@vtmednet.org

Chris Holmes, MD
(Chair of Associates Activities)
Burlington, VT
E-mail: chris.holmes@vtmednet.org

Virginia Hood, MD, FACP
(Past Governor)
Burlington, VT
Phone: (802) 847-3572
Email: vhood@zoo.uvm.edu

Sundip Karsan
(Student Representative)
Burlington, VT
Email: sundip.karsan@uvm.edu

Marvin F. Klikunas, MD, FACP
(Chair of Membership Committee)
Williston, VT
Phone: (802) 872-1470
E-mail: marvin.klikunas@vtmednet.org

Frank Landry, MD, FACP
(Governor)
1205 North Avenue
Burlington, VT 05401
Phone: (802) 863-1313
Email: frank.landry@vtmednet.org

Mark Levine, MD, FACP
(Director, IM Program)
Shelburne, VT
Phone: (802) 847-4959
Email: mark.levine@vtmednet.org

Keith W. Michl, MD, FACP
(Past Governor)
Dorset, VT
Phone: (802) 867-5534
E-mail: kmichl@adelphia.net

Mark Pasanen, MD
(Chair of Scientific Program)
Burlington, VT
Phone: (802) 847-8300
E-mail: mark.pasanen@vtmednet.org

Harvey S. Reich, MD, FACP
(Chair of Public Policy)
Rutland, VT
Phone: (802) 747-3851
E-mail: hreich@rrmc.org

Erik Rufa, MD
(Associate Representative)
Burlington, VT
Email: Erik.Rufa@vtmednet.org

Thomas Ziobrowski, MD, FACP
St. Johnsbury, VT
Phone: (802)748-5174
E-mail: tomz@nchcvt.org