
**Clinical Utilization Review Board (CURB)
Meeting Minutes
November 19, 2014**

PRESENT:

Board: Michel Benoit, MD, David Butsch, MD, Ann Goering, MD, William Minsinger, MD, Norman Ward, MD

DVHA Staff: Daljit Clark, Aaron French, Jennifer Herwood, Nancy Hogue, Susan Mason, Thomas Simpatico, MD (moderator), Scott Strenio, MD,

Guests: Jay Persico

Absent: Patricia Berry, MPH, Delores Burroughs-Biron, MD, John Matthew, MD, Paul Penar, MD, Richard Wasserman, MD

HANDOUTS

- Agenda
- Draft minutes from 10/1/2014
- 2015 Meeting Schedule

CONVENE: Dr. Thomas Simpatico convened the meeting at 6:30 pm.

1.0 Introductions

2.0 Review and Approval of Minutes

The minutes were reviewed and approved with a minor change.

3.0 Updates:

Meeting Schedule 2015

The meeting schedule for calendar year 2015 was handed out to the board.

Patricia Berry Resignation

Dr. Simpatico informed the board that Patricia Berry will be retiring from her position at University of Vermont (UVM) in early 2015. She will be resigning from the Clinical Utilization Review Board. Patricia plans to attend the meeting in January and that will be her final meeting. There will be a process to select a replacement for her. If anyone wants to recommend someone to the board please send recommendations to Dr. Simpatico.

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4.0 Old Business:

Hub and Spoke Continued

Dr. Simpatico presented on the Hub and Spoke program.

Hubs are intake portals and methadone clinics to stabilize un-stabilized individuals. Once the patient is stabilized they are passed on to the Spoke and their primary care providers. There are 5 Hubs: Chittenden Center, Bay Area Addiction Research and Treatment (BAART) Central Vermont, Habit, West Ridge and BAART Northeast Kingdom. All of the current Hubs have waiting lists of 23 to 86 patients. Chittenden Center can assimilate 10 new people per week. There is a gradual increase in the number of people being served. Some of the hubs have met their maximum capacity.

In the Spokes some see up to 100 recipients, most see 10 or less. We want to try to remove the barriers for the Spokes to allow them to see a greater number of people.

The spoke deterrents are the following:

- The perception is that the Vermont Board of Medical Practice (VBMP) has a higher likelihood of scrutiny and severe sanctions.
- Use of Vermont Prescription Monitoring System (VPMS) system

VBMP - Dr. Simpatico met with VBMP to explain the concerns: Their response was that it is probably true that there is a high level of scrutiny due to the increase in complaints. They even have to look into frivolous assertions. VBMP would be happy to speak to any groups about their obligations and what if any changes in practice are possible. They report a low rate of findings, 12 findings per 350 cases. They are aware of the issues of frivolous cases and are able to discern them when they occur.

VBMP is willing to engage and do more drill downs on the work they do to dispel unwarranted opinions about them.

VPMS –Everyone agrees in principle of its utility. Vermont is viewed in the vanguard; however, there are a number of issues including:

- It is a difficult system to access.
- A disproportionate share of the risk falls on the Physician.

Can DVHA use push reports to share the risk?

Dr. Simpatico spoke to DVHA's Attorney and they felt that push reports should be able to go out to MDs to prevent bad outcomes, including death. DVHA has a subset of the information in the VPMS data base; they will pull reports based on triggers such as:

- >16 mg of Buprenorphine/day
- > 5 Emergency Department (ED) visits within the preceding year
- > 90 days without a urine toxicology screening
- Concurrent use of opiates and benzodiazepines.

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- Multiple opiate prescribers per patient.

Nancy Hogue, DVHA Pharmacy Director reported that the new Pharmacy Benefit Manager (PBM) will start on 1/1/15. The new PBM has a more robust system and more technical capacity to pull reports. With the new PBM, DVHA will be able to look at dosing and concurrent use. DVHA is interested in knowing how they can best communicate this information to the MDs. There will be thresholds and criteria. We are looking at best practice, and the bell curve to identify outliers.

There will be criteria which have not yet been determined and the thresholds need to be developed.

DVHA and Vermont Department of Health (VDH) will work together on this initiative. The new Pharmacy contractor has shown DVHA some methods for the push notifications that they can provide. The push notices will only reflect what DVHA pays for. The email would go to the prescribing providers. If there are multiple providers they would all get the notification.

Plainfield Federally Qualified Health Center (FQHC) –
Dr. Simpatico met with Plainfield FQHC. They are currently seeing 4 spoke patients. They have the potential to see many more, but have concerns in doing so. The impediments they are experiencing include:

- Lack of counseling
- Lack of communication between the Hub and Spoke
- Lack of effective handoff
- Lack of confidence that hub will take unstable patients back
- Lack of standardized transition protocols
- High turnover in hubs so patients can “play the system”
- Need access to addictionologists for case consultation
- Loop in parole offices and tolerance level with spokes

DVHA will join forces with State of Vermont’s Alcohol and Drug Abuse Program (ADAP) to do a focused intervention to assist the FQHCs and then disseminate it across the state. We put in the proposal for two addictionologists to help UVM Healthcare system feel comfortable absorbing stabilized patients. We also want to include any Physicians in a “coalition of the willing”.

We can undercut the opiate trade by absorbing and stabilizing opiate users. If we don’t they will continue to go into the corrections department.

Discussions

- If someone is paying cash we will not have their data.

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- The push email may be competing for the limited attention of busy providers. Need to bring attention to this notification.
- Educational outreach to the pharmacies is a good idea.
- Private practitioners need more financial support.
- Abstinence is not a goal for the patients, great if it happens but the expectation is problematic.

Action Item:

DVHA will have an update and hopefully a demo during the first quarter of calendar year 2015.

5.0 New Business:

Gender Reassignment Protocol

Dr. Strenio presented a case study that challenged our guidelines.

The current guidelines for gender reassignment surgery are:

- Patient must be at least 21 years old
- The request must be submitted via paper or fax
- One year of living in the gender role after the onset of dysphoria
- One doctoral level provider recommendation.

The World Professional Association for Transgender Health (WPATH) guidelines suggest:

- Patient must be age of consent in culture
- Does not require hormones, but must have gender dysphoria for a number of years.

The individual in the case presented was initially denied the procedure due to not being 21 years old. The patient appealed the decision and came in person to present the case with the support from family members. The in-person request is important as well as long term gender dysphoria and having two doctoral level evaluations.

Should the following new criteria be added?:

- Assessment of Harm vs. Benefit Deferred documented. What is the harm in waiting until age 21 and what is the benefit in having the surgery earlier. Those who know with certainty that they are born into the wrong body vs someone with a more fluid sexuality such as borderline personality is an easy distinction, to show a sustained improvement and happiness.

Should the age on the guideline be changed to age 18? The world guidelines state that the patient must be age of consent in your culture. What is the age of consent in our culture? Is it 18 or 21?

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Currently DVHA will review cases on an individual basis for recipients under 21 years. Wanted to discuss the issue and then come up with a reasonable recommendation, but have some latitude within the recommendation.

Discussion:

- Recommend age 21, then case by case basis
- Flexibility is key
- Flexibility may result in complexity
- What are the age guidelines for other elective surgeries?
- Age of consent for surgery is 18 years
- What do other states do?
- We can look at the regional norms
- A long relationship with the professional is important
- The current criteria came from published literature.
- There is limited information in the literature
- We are studying post-op satisfaction surveys

Action: DVHA will do more research on this topic and will look at what other states are doing. They will bring back to the group any formal recommendation or suggestion for any policy changes.

Adjournment – CURB meeting adjourned at 8:35 PM

Next Meeting

January 21, 2015

Time: 6:30 PM – 8:30 PM

Location: Department of Vermont Health Access, Williston, VT