WYOMING Medicine

A Legacy of Quiet Faithfulness:

Dr. Richard Hillman

PHYSICIAN OF THE YEAR

Physician Call Coverage Obligations Under Wyoming and Federal Law

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Wyoming Medicine

Fall 2014

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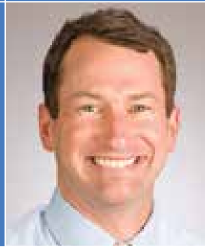

EDITOR'S PAGE

A Tax to Help Your Patients' Health

By Robert Monger, MD

This year marks the 50th anniversary of the first surgeon general's report of the health hazards of smoking. And while much progress has been made since 1964 in the effort to reduce smoking, tobacco use remains the leading cause of death in the United States. In the five decades since the surgeon general's report was published, a stunning 20 million Americans have died as a result of smoking, and 5.6 million of today's Americans are projected to die prematurely from a smoking-related illness.

Here in Wyoming, we have a higher-than-average rate of tobacco use and a lower-than-average tax on cigarettes. Those facts are important because we know that increasing the cost of cigarettes is one of the most important tools we have to prevent smoking, and in 2015 the Wyoming legislature will consider a bill to raise the state tobacco tax.

Wyoming's current state cigarette tax rate of 60 cents per pack is ranked 40th in the nation and is well below the national average state cigarette tax of $1.54 per pack. Many states have cigarette taxes of more than $3.00 per pack, and in some parts of the country it's not uncommon for cities and counties to have their own cigarette taxes on top of the state taxes. In Chicago, the total state and local taxes add up to more than $6.00 per pack.

The national average adult smoking rate is 18 percent, but in Wyoming approximately 22 percent of adults smoke—a total of more than 96,000 people. This includes more than 5,000 Wyoming high school students. It's estimated that each year 500 kids (i.e., those under the age of 18) in Wyoming become new daily smokers.

The toll of tobacco in Wyoming is high: it's estimated that 700 adults in the state die each year from their own smoking (which doesn't include deaths from secondhand smoke), and the healthcare costs in Wyoming directly caused by smoking are more than $250 million per year.

The Joint Interim Labor, Health and Social Services Committee is drafting a bill that would raise our state's cigarette tax by at least a dollar per pack, which would bring Wyoming's cigarette tax up to the national average. And while the increased tax would generate more revenue for the state (at least $20 million dollars per year), the real benefit of the tax increase is that it would lead to a decrease in Wyoming's high smoking rate.

Based on data from when other states have increased their cigarette tax, a tax increase of $1 per pack in Wyoming would prevent 5,000 people under the age of 18 from becoming adult smokers, and an estimated 5,000 current adult smokers would quit. A $1 per-pack tax increase would prevent close to 3,000 premature smoking-related deaths in Wyoming.

What can you do to help? It's important to talk to your legislators and let them know that this is an important issue for you and for our state. Tobacco lobbyists are well funded and well connected, and the legislators need to hear from you.

Two excellent websites you can go to for more information are those of the Wyoming Cancer Action Network and the Campaign for Tobacco-Free Kids. Of course, the Wyoming Medical Society will also be heavily involved in this fight, and information will be available on the WMS website.

Be an advocate for your patients and talk to your legislators about the importance of raising Wyoming's cigarette tax.

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FROM THE DIRECTOR

An Appeal for WYOPAC

By Sheila Bush

Let's talk about a tough subject. Do you ever wonder about ways to make the voice of the Wyoming physician better heard at the state capitol? WMS works hard to advocate effectively and represent the positions of our board and membership with respect. We strive to protect the profession and educate about the nuances that influence practicing medicine in Wyoming today.

But it's important to remember that advocacy is so much more than just a strong voice at the capitol while the legislature is in session. Advocacy is building quality relationships throughout the year and taking an active role in electing upstanding, respectable statesmen and women to office so that when the time comes for serious discussion, we can be confident that physicians will be listened to.

As hard a pill as it might be to swallow, it's time we all take a close look at physician participation and engagement in the Wyoming Medical Political Action Committee (WYOPAC). Donations have dropped, and as a result WYOPAC's ability to act on your behalf has also lessened. We currently have 20 members in WYOPAC and our account balances at $10,056.04.

> *"We currently have 20 members in WYOPAC and our account balances at $10,056.04."*

Your membership in the Wyoming Medical Society alone is not enough to make the difference that you want to make. While the WMS advocates for you on policy issues, the PAC is involved in the election process. We need WYOPAC to endorse and financially support political candidates who are open minded, thoughtful, and friendly to physicians' perspectives on medical issues.

So let's clear up some misconceptions about WYOPAC that may be influencing your decision.

First, 100 percent of donations stay in Wyoming and a board composed of Wyoming physicians decides whom to support. Several years ago, we severed the relationship with the American Medical Association's PAC, which primarily handles federal races. Today, the WYOPAC board decides whom to support after gathering information about all candidates during the primary and general elections. We also review input from physicians and other sources on candidates' backgrounds and their positions on medical issues. Candidates who receive WYOPAC support and funding are "friends of medicine."

As part of the process, we send a short healthcare-specific political opinion survey to every filed candidate and then post their responses to our website for members to review. Our 2014 survey includes questions on their top three priorities if elected to office, Medicaid reimbursement updates, liability reform, general scope of practice, psychologist prescribing rights, optometrist surgery privileges, patient-physician relationship protection, Medicaid expansion, and universal vaccine support.

Second, we're not buying votes. Contributions to individual candidates are minimal—mostly around $100—with the main value tied to endorsement. In fact, we have contributed to candidates in the past who voted against policies that the WMS supported. Why would we do this? We want to ensure that legislators who serve this state are willing to have a conversation with us.

This year, especially, we are concerned that some potential candidates could completely shut physicians out of future policy discussions. Because of this, WYOPAC participated in 17 primary races by either endorsing a candidate, as was the case with the governor, or providing financial support and endorsement. We typically hold out until the general election, but so many important races were decided on Aug. 19 this year that we decided to take action.

Third, a donation from WYOPAC carries more weight than an individual donation, due to its association with WMS and its membership. The WYOPAC Board takes their role in vetting candidates and identifying key races very seriously. A dollar donated to WYOPAC in the southwest corner of the state might be used to influence a key race in the northeast part of the state. Supporting and donating to WYOPAC is the best way to support the only organization in the state watching races strictly for the impact those future legislators may have on state healthcare policy decisions. This is why WYOPAC is so important—we have a statewide reach and have more resources to build relationships. The WMS name has a strong reputation that's respected; candidates are proud when we endorse them.

In order to remain vital in the process, WYOPAC desperately needs your contributions. Election season is not over yet. We have three levels of donation—$100 as a basic member, $250 for Capitol Club, and $500 for Inner Circle. Please keep in mind that contributions by individuals should be made from a personal credit card only. WYOPAC cannot accept corporate funds. Visit www.wyomed.org/WYOPAC for more details.

Please donate to WYOPAC to help us ensure strong physician engagement in the political process. Together we can make a difference!

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Project ECHO

By Ashley Grajcyk

Extension for Community Healthcare Outcomes (ECHO) is an educational program that utilizes telehealth technology to bring Wyoming providers together in a virtual "clinic." The program allows healthcare professionals to discuss challenging cases with a team of specialists while also obtaining Continuing Medical Education credit.

The Wyoming Department of Health has partnered with the University of Utah and the University of Washington to provide ECHO services to Wyoming's providers. The collaborative ECHO program is part of Wyoming's Resource Integration for the Behavioral Health Network Project, which was initiated in 2012 to define and quantify current behavioral health resources within Wyoming, identify what resources are lacking, and promote the development of the resources needed to achieve improved care and a healthier population at a lower cost.

Current telehealth ECHO clinics are available through the University of Utah and the University of Washington and include medical topics on HepC, HIV/AIDS, diabetes and cardiovascular care, dementia care, chronic pain and headache management, integrated addiction, and general psychiatry.

Here are some of the benefits of Project ECHO:

- Expanded support for Wyoming providers. In contrast to conventional telemedicine programs that connect individual patients with individual doctors, ECHO simultaneously connects up to 80 provider sites with a team of specialists to discuss challenging cases and best practices in treatments for those cases. In doing so, it quickly expands the capacity of the providers to treat patients with like illnesses in their local communities.
- Improved quality of care. ECHO provides a way to bring nationally recognized specialty care and best practices to underserved and rural communities.
- Accessible education and CMEs. In addition to providing added support and educational opportunities to Wyoming providers, ECHO offers continuing education credits for participants.
- Well-connected provider networks for public health preparedness. ECHO offers a rapid-response mechanism for mobilizing the healthcare workforce and disseminating standardized best practices for chronic illness care and public health emergencies (like the H1N1 outbreak in 2009).

To learn more, visit www.uwyo.edu/wind/echo.

Wyoming Professional Assistance Program

By Rachel Girt

The Wyoming Professional Assistance Program (WPAP) was founded in 1997 to offer a confidential resource to professionals with chemical dependency or substance abuse issues. WPAP is not a treatment organization per se; rather, the program provides initial triage or intervention, referral into treatment, treatment quality monitoring, and long-term care through a monitoring plan for addiction disorders and their related problems. WPAP intends to expand the program this fall to provide services for mental health issues.

WPAP is designed to encourage professionals to seek a recovery program before their condition harms a client or damages their career through disciplinary action. The program currently has contracts to serve the licensees of the Boards of Medicine, Dental Examiners, Veterinary Medicine, Pharmacy, Wyoming Supreme Court–Judicial Branch, and Wyoming State Bar.

[CONTINUES ON PAGE 10]

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[CONTINUED FROM PAGE 8]

WPAP is committed to:

1. Receiving information from many sources about individuals who may be having difficulties with substance abuse disorders and its related conditions.
2. Referring such individuals into a properly structured evaluation and/or treatment if indicated.
3. Monitoring the initial treatment and assisting the professional in planning for his or her return to work.
4. Managing the chronic nature of addictive disorders in professionals through drug screen monitoring, self-help group attendance, psychotherapy (as needed), and general health and wellness.
5. Educating licensing agencies, specialty boards, malpractice insurance carriers, and other professionals across the state about the risks of substance abuse and the services offered by WPAP. The program also provides education to the general public.

In a larger sense, WPAP builds a community of support that ensures the health and wellness of professionals across our state.

The program's board and staff are committed to WPAP's reputation as an effective and reliable support and monitoring program for professionals coping with substance abuse and mental health issues. For additional information about WPAP, contact Candice Cochran at (307) 472-1222 or candicec@wpapro.org.

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POLST-Physician Order for Life-Sustaining Treatment

PO

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physicians Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders. **THEN** contact physician, nurse practitioner, or PA-C. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name / First / Middle Initial

Date of Birth | Last 4 #SSN | Gender ❑M ❑F

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

❑ CPR / Attempt Resuscitation ❑ DNR / Do Not Attempt Resuscitation (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in **B, C and D.**

B MEDICAL INTERVENTIONS: Person has pulse and / or is breathing.

❑ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer:** EMS contact medical control to determine if transport indicated to provide adequate comfort.

❑ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care if possible.

❑ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. **Transfer** to hospital if indicated. Includes intensive care.

Additional Orders (e.g. dialysis, etc.) ______

C ANTIBIOTICS:

❑ No antibiotics. Use other measures to relieve symptoms.
❑ Determine use or limitation of antibiotics when infection occurs, with comfort as goal
❑ Use antibiotics if life can be prolonged

Additional Orders ______

D ARTIFICIALLY ADMINISTERED NUTRITION:

Always offer food and liquids by mouth if feasible

❑ No artificial nutrition by tube
❑ Trial period of artificial nutrition by tube (Goal ______)
❑ Long-term artificial nutrition by tube

Additional Orders ______

E MEDICAL CONDITION / GOALS:

F SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences, and best known information

Discussed with: ❑ Patient ❑ Parent of a minor ❑ Legal Guardian ❑ Health Care Agent (DPOAHC) ❑ Spouse / Other

PRINT Physician / NP / PA-C Name | Phone Number

Physician / NP / PA-C Signature (mandatory) | Date | Time

Patient or Legal Surrogate Signature | Date | Time

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

A sample POLST form

The POLST panel at the June 2014 Wyoming Medical Society Annual Meeting

Putting POLST into Practice

BY CYNTHIA WORKS, MD

At the end of life comes death…but what tools do we have in the medical profession to help our patients make choices as they face progressive chronic illness and death? In an effort to provide choices to patients as they approach the end of life, many states have adopted versions the Physician Orders for Life Sustaining Treatment (POLST) form. This form takes patients' goals of care in advance directives and makes them actionable in the medical system in the form of medical orders.

In the state of Wyoming, several practitioners and healthcare systems began to use the POLST form as they saw a need to document the end-of-life goals of care for patients in the form of medical orders. At the annual meeting of the Wyoming Medical Society (WMS) in June 2014, a panel presented the POLST concept to the medical community.

The panel included Jim Little, MD, from Jackson, who was instrumental in creating the only formal POLST policy in Wyoming at St. John's Hospital; Kelly Davis, JD, an elder law attorney from Cheyenne who works with creating advance directives for his clients; Dr. Cindy Works from Casper, who has used the POLST form informally in her geriatric practice and in training family medicine residents for the last five years; and Tim Summers from AARP, who works with legislative policy. The objectives of the panel were to increase knowledge of the POLST process within the medical community and to initiate exploring the adoption of a single POLST form for the state of Wyoming.

The panel addressed many of the medical and legal issues surrounding the use of the POLST form and the history of POLST both in the nation and in Wyoming. Davis felt that the form would be a valuable addition to his advance directive planning for his clients, as advance directives are not easily actionable in the medical setting. Several audience members voiced that they had used or were planning to use some adaptation of the POLST form.

[CONTINUES ON PAGE 14]

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[CONTINUED FROM PAGE 12]

From left: Kelly Davis, Tim Summers, Dr. Cindy Works, and Dr. Jim Little

Since at least six different towns within Wyoming have made some attempt to create and utilize a POLST form, it became clear that the need for such a form existed and that it would be timely to create a single accepted form for the state of Wyoming to ensure the portability and familiarity of the form within the state. Summers and Dr. Little both described the previous unsuccessful attempt to pass legislation for the POLST form.

After the panel presentation, an ad hoc working group met with representation from the WMS leadership and administration, an interested legislator, and the panel members to envision next steps for the adoption of a POLST form and policy for Wyoming. Since then, the working group has communicated their thoughts about POLST in Wyoming to the Wyoming Medical Board, the various healthcare institutions who have experimented with the use of the POLST form, and other medical providers who have promoted POLST usage around the state. The group has also planned a webcast to present both the medical and legal perspective on POLST to the Wyoming State Bar.

The working group hopes to propose a suggested POLST form with the support of the WMS to pilot within the state before the end of the year. If the reception within the medical community is favorable and the POLST form is found to be useful for patients facing end-of-life decisions, then they would like to approach the legislature and go through the formal process of adopting a Wyoming POLST form.

On a personal note, the elders of Wyoming raised me and I feel compelled to offer them as much autonomy and power as possible within our healthcare system—in particular, the ability to say "yes, please" and "no, thank you" and to have those choices honored by the medical profession. I have found the conversation with my patients when we complete a POLST form to be humbling and empowering as they share their wisdom on life and death and what I can do to align their goals with what the healthcare system has to offer.

Please send any comments for the working group to the WMS.

For more information on POLST, please visit www.polst.org.

Cynthia Works, MD, is a family medicine doctor at the University of Wyoming's Family Medicine Residency Program in Casper.

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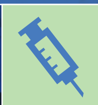
The Integrated Pharmacist Model: Connecting Patient Medication Information with Primary Care

BY BETH YOUNG, PHARMD



Medication adherence issues cost the United States nearly $290 billion annually. These issues include under- or over-prescribing, missed doses, and untimely medication refills or pick-ups.

The Integrated Pharmacist model has proven to be a key component in the development of medical neighborhoods throughout Wyoming by enhancing a practice's interdisciplinary care team.

Integrated Pharmacists are a resource to support primary care physicians, not replace them. Two years ago, an effort began to build a collaborative network of comprehensive medication therapy management-trained pharmacists and primary care providers. The energy that went into the development of this network resulted in 12 trained pharmacists working with multiple primary care providers in four Wyoming communities. Further, 20 patients were enrolled and have provided a wealth of pilot data to the model. We aim to far exceed the original enrollment numbers as we work toward full integration of this model in Wyoming medical neighborhoods.

> *"Medication adherence issues cost the United States nearly $290 billion annually."*

Pharmacists complement and reinforce the care plan developed by the primary care providers. The pharmacists and providers involved in this effort experience the excitement of patients who achieve their health outcomes and become empowered to self-manage their care. This success positively impacts the primary care practice as their patient populations become healthier.

Communication problems between primary care providers and pharmacists should not stand in the way of patient healthcare. The Integrated Pharmacist model is a system of care developed by the School of Pharmacy at the University of Wyoming to help providers ensure patients receive comprehensive medication therapy management. It also creates a space where the dialogue begins about patient medication behaviors.

Pharmacists conduct one-on-one patient visits to drive discussions about medication and health behaviors. Prior to joining the network, the pharmacist is trained in motivation, behavior change, health efficacy, and self-health management techniques and strategies that help impact health knowledge, with the goal of impacting achievable behavior change for patients. The pharmacists and providers invested in the Integrated Pharmacist model are experiencing the benefits from increased patient communication and therefore the enhancement of the continuum of care. With this model, the patient emerges with a more robust care team and all health professionals are more aware of patient behaviors.

Practice workflows are increasingly challenged by external factors such as Meaningful Use requirements and the desire to achieve NCQA recognition as a Patient-Centered Medical Home. We all continually strive to meet optimal health outcomes for patients while also achieving reimbursement metrics, heeding best practices, and critically thinking about healthcare solutions. Everyone involved in the Integrated Pharmacist model believes in doing whatever possible to encourage efficient communication between patients, pharmacists, and providers.

Demands at primary care practices limit the availability to provide appointment-driven, focused medication consultation with patients. Engaging the Integrated Pharmacist network allows providers to spend more time treating their patients and less time providing medication consultation or medication reconciliation. As we developed this network, we found the model operates most effectively when providers give input to pharmacists about how they wish to receive information about a patient visit and when to conduct follow-up appointments. Also, primary care providers can actively review patient care notes that are provided by the pharmacist and then follow up on any issues with the pharmacist.

Outcomes data from the model are being gathered to quantitatively determine its clinical and financial impact. The goal is to determine if the model is cost effective over the next two years. Reimbursement models will also be developed and proposed as more data is gathered about patient success.

The Integrated Pharmacist model is actively being offered to patients in Jackson, Riverton, Casper, and Cheyenne. An aggressive yet achievable expansion strategy is in place for other communities throughout Wyoming. The feedback from patients far exceeds original expectations: 9 out of every 10 appointments result in the identification of a potentially serious adverse drug reaction, and nearly all patients feel empowered to follow through with their primary care provider's recommendations about further tests, taking a medication, or undergoing a procedure.

Pharmacists connect into this network by contacting Beth Young. Following contractual agreements, the pharmacist will receive robust training. Primary care providers can become involved in this network and the development of this network by also contacting Young and by visiting with participating pharmacists. Finally, patients can experience the benefits of this model through a referral at a primary care office or at the pharmacy. Pharmacists are able to access drug histories for patients who fill prescriptions at their pharmacy. If a pharmacist identifies a patient who may be a great candidate for these services, the patient will be made aware of the program at that time.

Contact Beth Young at byoung22@uwyo.edu for further information about expanding this opportunity in your community.

Beth Young, PharmD, is the team leader for the Virtual Pharmacist Program at the University of Wyoming School of Pharmacy.

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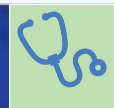


A Legacy *of Quiet Faithfulness:*

Dr. Richard Hillman, Physician of the Year

BY SCOTT HUBBARD

Looking at Dr. Richard Hillman's resume, you might think it was a catalog of potential careers for physicians rather than the experience of a single doctor.

He began as the managing physician at the Cheyenne Children's Clinic and finished as the clinical dean for Wyoming's WWAMI program. In between sit a couple seven-to-ten year stints as the administrator of public health for the Department of Health and an emergency physician in Cheyenne and Casper—not exactly entry-level positions, you might say.

On the side, Dr. Hillman served in a military reserve unit, led the state's medical community as the Medical Society president, and volunteered his expertise at Cheyenne Frontier Days.

Now, he has another bullet point to add under the "Accomplishments" section of the CV: Wyoming Physician of the Year.

> *"I found practicing to be 100 times more rewarding than research. So I decided to stick with it."*

The Road to Medicine

"I had no interest in medicine early on," Dr. Hillman said in a recent interview with the Medical Society. His undergraduate career at Colorado State University corroborates the claim: entering his freshman year as an industrial arts major, he eventually switched focuses and graduated with a degree in Wildlife Management, perhaps revealing a waxing interest in the sciences but still far from a commitment to medicine.

The four years Dr. Hillman spent earning that degree contributed more toward his future path than the words on his diploma might indicate, however. The coursework developed the diligence he would exhibit throughout the rest of his schooling and career, turning him from a mediocre student to one headed toward a PhD.

"Wildlife Management was more difficult than medical school," he remembered. Of the 300 students who began the program, a mere 17 donned mortarboards four years later.

From there, Dr. Hillman's academic career curved gradually toward medicine. Graduate and doctoral work in anatomy gave way to a position in Maryland with the Army, where for two years he performed clinical duties and conducted research on kidney problems. By then, one of his professors from CSU had moved to Texas Tech and needed help launching the school's anatomy department. Dr. Hillman headed south.

At the time, Texas Tech sponsored PhDs to attend medical school so they could be more clinically oriented. In the midst of going to school full time, teaching half time, and conducting research, medical practice rose above the tumult and awakened Dr. Hillman's ambitions like a clarion call.

"I found practicing to be 100 times more rewarding than research. So I decided to stick with it," Dr. Hillman said.

A family medicine residency clarified his path further. "I was originally going to do orthopedics, but I liked the families and the kids," he continued. "I decided I wanted to practice in a small town doing pediatrics.

"And I wouldn't change anything."

> *"You're dealing with all ages, all demographics, and all walks of life—the people who live under the bridge as well as state government officials. The people are the best part of medicine. That's what it's all about."*

Pediatrics, Public Health, and More

Now, about that resume.

As part of his pediatrics residency at the University of Colorado Denver, Dr. Hillman had the opportunity to spend a month practicing at the Cheyenne Children's Clinic. When the residency ended, he ventured to ask the clinic if they wanted another pediatrician.

"They said, 'Not really,'" Dr. Hillman recalled. "But we liked each other and I did end up getting a job at the clinic and there actually turned out to be a real need. It was a fabulous practice and the position was a perfect fit."

About a decade later, he transitioned to the Department of Health where he worked in family services and public health. While there, Dr. Hillman helped to streamline the Medicaid process, increase

> *We don't have gigantic cities and you have to depend on each other to get things done. The colleagues and the medical community have made practicing worth it.*

statewide immunizations, and attract more physicians to the state. He would continue to advocate for adequate numbers of Wyoming physicians throughout the rest of his career.

Emergency medicine came next. "They needed someone to work in the emergency department who knew pediatrics," he said. The experience encapsulated for Dr. Hillman the best parts of being a physician. "You're dealing with all ages, all demographics, and all walks of life—the people who live under the bridge as well as state government officials. The people are the best part of medicine. That's what it's all about."

Finally, he rounded out his career as the Wyoming representative for WWAMI. As he looks to the future of Wyoming medicine, WWAMI is what gets Dr. Hillman excited. "The program puts young, well-trained, Wyoming-oriented physicians back to the state to practice. It's a real boon for the state and important for the future of healthcare."

Talk of a favorite position is a bit of moot point for Dr. Hillman. "If I didn't enjoy it, I didn't do it. I look back on everything with fondness."

Sharing the Honor

When he first found out about the Physician of the Year award, Dr. Hillman was a bit ambivalent. "I just did what a lot of other people in other professions do. You leave the publicity aside and just do your job."

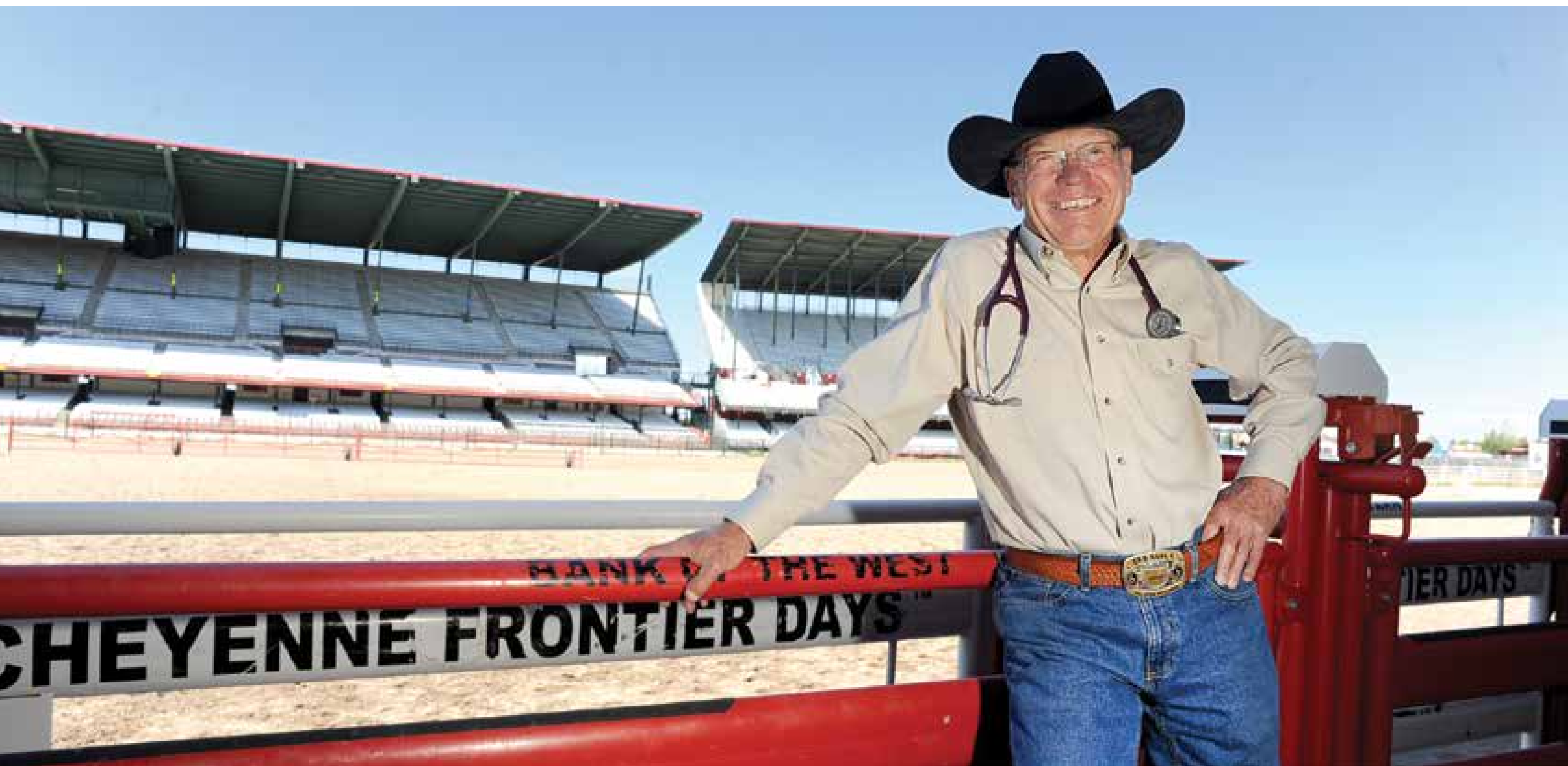
Mostly, Dr. Hillman is quick to recognize the network of physicians and other professionals who contributed to his successful career. "We don't have gigantic cities and you have to depend on each other to get things done. The colleagues and the medical community have made practicing worth it," Dr. Hillman said.

In addition to the physicians who have practiced beside him, Dr. Hillman's eyes are on the incoming generation—those doctors, physician assistants, and others who are the future of Wyoming medicine.

"I'd like to let the young people take over in the medical community. Your profession is like a bucket of water. When you're there it's like having your hand in it; when you're gone, things still go on and you're not as important as you might have thought," he said.

Still, there is something to being named Wyoming's Physician of the Year. And among all the sideways and forward looking, Dr. Hillman recognizes that. "I was very pleased and honored," he said. "It does feel good."

> *If I didn't enjoy it, I didn't do it. I look back on everything with fondness.*



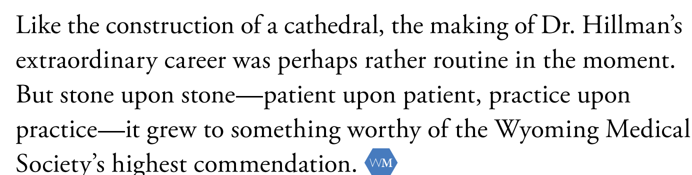
Stone Upon Stone

Perhaps the most striking feature of this year's physician of the year is the cumulative impact of his career.

Although Dr. Hillman remembers some unique and noteworthy moments from his history as a physician, the overriding tenor of his decades of professional experience is one of quiet faithfulness throughout the regular patterns of medical practice.

Isolated acts of courage and self-sacrifice are not what contributed to Dr. Hillman's nomination, nor did occasional, publicized gestures of community engagement. Rather, it grew from a steadfast, humble commitment delivered over the course of years and directed to a place and its people.

Like the construction of a cathedral, the making of Dr. Hillman's extraordinary career was perhaps rather routine in the moment. But stone upon stone—patient upon patient, practice upon practice—it grew to something worthy of the Wyoming Medical Society's highest commendation.



> *I was very pleased and honored, he said. It does feel good.*

Scott Hubbard is a writer and editor for Wyoming Medicine.

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2. What undergraduate institution did you attend?
3. What was your major?
4. What do you like most about Wyoming?
5. What is an interesting fact about you?
6. What are you most looking forward to as you start medical school?

JASON JACK REYNOLDS

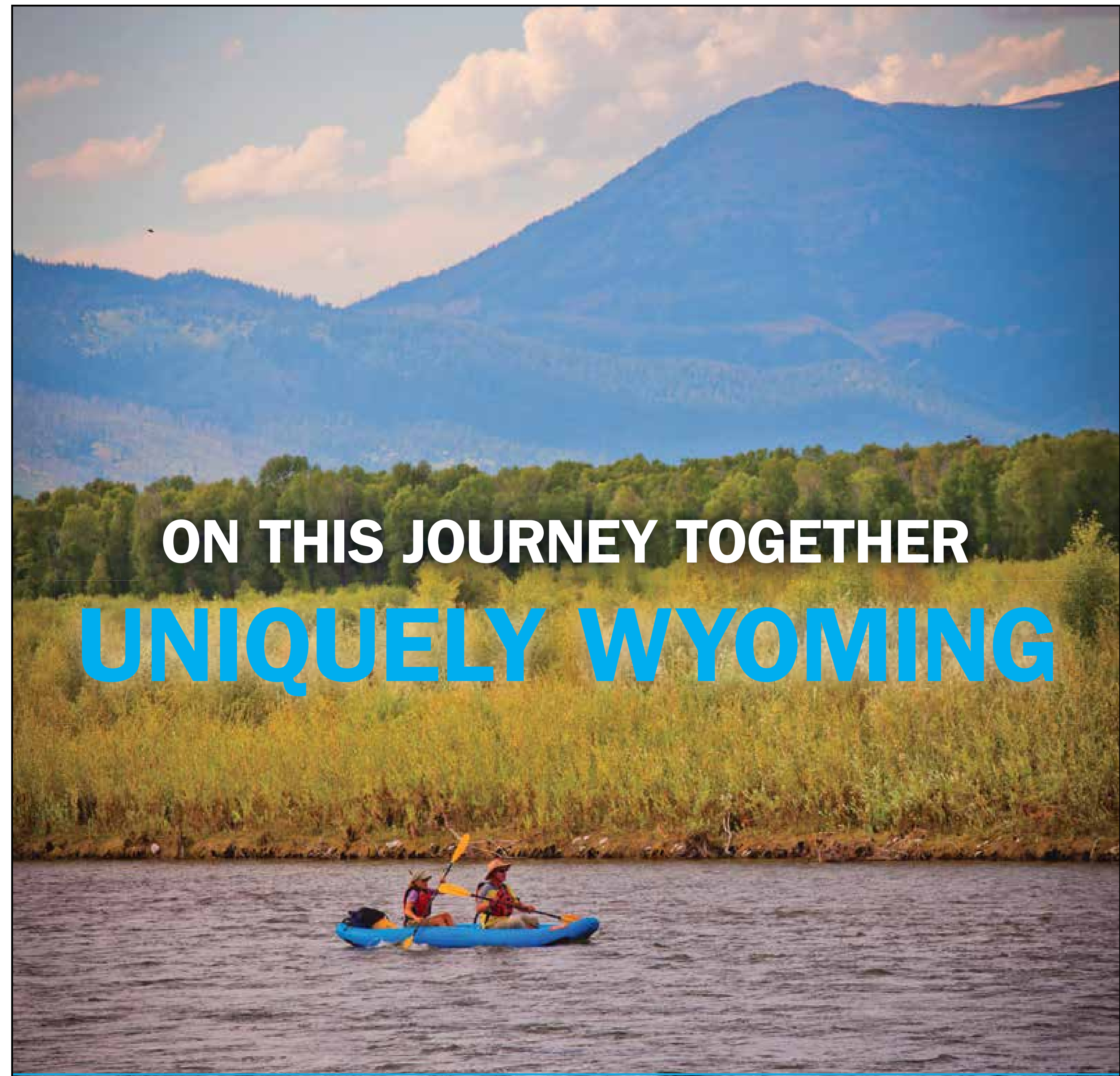
1. Worland
2. Idaho State University
3. Microbiology
4. I like the outdoor opportunities and the sense of community shared by the citizens.
5. I am named for my grandfather, the only other scientist in my large family.
6. Joining a group of highly motivated people and being in a position to challenge myself.

DANIELLE BORIN

1. Cheyenne
2. Brandeis University in Boston
3. Neuroscience
4. I love how beautiful and quiet it is in Wyoming.
5. I know all the lines of "Friends" episodes.
6. I am really excited to get to learn more about the human body and its complicated beauty!

CASEY SLATTERY

1. Gillette
2. University of Denver
3. Biology
4. Everyone involved with the Wyoming program was genuinely excited to meet me and I felt wanted more at Wyoming compared to the other schools I interviewed with.
5. I won a car when I was 18.
6. I am looking forward to all of the new challenges and experiences that medical school will offer.



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BRYAN FEINSTEIN

1. I grew up outside of Syracuse, NY, and have lived in Jackson for the last nine years.
2. Dartmouth College
3. Molecular Biology
4. I enjoy the open space and diversity of the landscapes throughout the state.
5. Before deciding on a career in medicine, I spent two years in the US Navy pursuing my other dream of becoming a pilot.
6. I am looking forward to the challenge of returning to the classroom and meeting my 19 other WWAMI classmates.

LEVI HAMILTON

1. Gillette
2. University of Wyoming
3. Chemistry
4. I like the mountains and forests.
5. I have eaten a scorpion.
6. Learning the material I need to become a doctor, and building relationships with my classmates.

KATELYN MILLER

1. Jackson
2. University of Montana
3. Social work
4. I love the feeling of coming home. Whenever I am in Wyoming I feel like I am surrounded by family, even if they are all strangers.
5. I had a serious rafting accident in early July and almost died. That was interesting!
6. I am looking forward to meeting my class! Also, I'm excited to finally get started on accomplishing my biggest dream in life! I can't wait to be a medical student!

ALLISON DAWSON

1. Cheyenne
2. University of Wyoming
3. Physiology
4. The kind people, and the many varieties of outdoor activities available.
5. While living in Kauai, Hawaii, my family and I lived through a category 4 hurricane (Hurricane Iniki) as it passed directly over the island.
6. I look forward to continuing my education and gaining important and practical skills while being surrounded by a group of inspiring and intelligent individuals.

LAUREN MILLET

1. Newcastle
2. University of Wyoming
3. Microbiology
4. I love the open spaces, the mountains, the wonderful attitude of the people living here, and the sense of community.
5. I was born and raised on a cattle ranch in northeastern Wyoming and have been riding horses since before I was able to walk.
6. Starting medical school is the beginning step to fulfilling a long-held dream and I am looking forward to a career doing what I enjoy the most, which is helping people.

MORGAN JOHNSON

1. Casper
2. University of Wyoming
3. I have two bachelor's degrees in physiology and kinesiology and one master's degree in kinesiology and health.
4. The open spaces, outdoor opportunities, and friendly people.
5. I shot a six-point bull elk at 549 yards.
6. I am most excited about the vast new experiences, gaining applicable knowledge, and meeting some amazingly intelligent and talented classmates and professors.

ANDREA "ANNIE" HABEL

1. Rock Springs
2. University of Wyoming
3. Medical Microbiology and Molecular Biology
4. I love the small town feel and the ability to drive to beautiful outdoor recreation [areas] in minutes.
5. When I first joined the Army, part of my job was to refuel helicopters while the engine was running and the rotors turning.
6. I'm excited to learn from experienced physicians who have for years practiced the art of medicine and are pleased to share their knowledge with students.

GALEN MILLS

1. Powell
2. Carroll College in Helena, MT
3. Biology
4. What I like most about Wyoming is how much money the state puts into education.
5. I have an identical twin brother who is also in medical school (Loma Linda University).
6. I have worked entry-level jobs my whole life, and now I am finally starting my education that will enable me to become a qualified specialist where I can offer others professional-level help.

AISLINN ESTHER LEWIS

1. Star Valley
2. University of Wyoming
3. Physiology
4. How different each part of the state can be in surroundings, people, and activities, and yet we still feel like one cohesive state.
5. I am a Hog Wrestling champion.
6. Finally being a part of helping people, and getting to study the things that interest me every day.

JUSTIN ROMANO

1. I was born in Santa Rosa, California, and lived there until I was 11, but my home is Wyoming and my hometown is Cheyenne.
2. University of Wyoming
3. Physiology
4. I like the sense of community and the general feeling of camaraderie.
5. I am a descendant of Benjamin Franklin's oldest brother, so every time I walk past the Benjamin Franklin statue on the Wyoming campus I feel like I am amongst family.
6. The thing I am looking forward to as I start medical school is learning about the thing that interests me most: the human body (more specifically the cadaver lab).

BRITTANY MYERS

1. Cody
2. Rocky Mountain College in Billings, MT
3. Biology
4. I like how the whole sate of Wyoming exudes a small-town feel and supplies its residents with such a strong sense of community.
5. With the help of poorly structured knees and my college basketball career, I have actually had four ACL reconstruction surgeries!
6. I can't wait to meet my classmates, professors, and doctors that I will be interacting with and learning from this year.

LYDIA CLARK

1. Lander
2. Reed College in Portland, Oregon
3. Biology with a humanities bent
4. The open spaces and how nice the people are.
5. I've been a llama wrangler.
6. Getting to know my classmates and having my first formal anatomy class!

RAGE GERINGER

1. Glendo
2. Sheridan College and the University of Wyoming
3. Physiology
4. The laid back atmosphere of the rural communities.
5. My name on my birth certificate is actually Rage.
6. Learning all the new material and getting to know my 19 other classmates.

BRANDON DOUGLASS

1. Casper
2. University of Wyoming
3. Physiology
4. I love the people in Wyoming; they make it easy to form lasting connections.
5. I ran track for the University of Wyoming.
6. I am most looking forward to total science exposure and the challenge of learning so much information.

TRICIA JENSEN

1. Douglas
2. University of Wyoming
3. Molecular Biology and Physiology
4. I love the spacious outdoors and friendly people.
5. I grew up involved in archery and fly fishing and still enjoy those activities.
6. I am excited to learn more about medicine and to begin the next step in my education, advancing me toward my career goals.

COULTER NEVES

1. Otto
2. Brigham Young University
3. Exercise science
4. The wide-open spaces.
5. I hold the Neves Family Farm continuous tractor drive record at 12 hours, set in the spring of 2008.
6. The opportunity to expand my knowledge of the human body and use that knowledge to help others.

SARAH KOCH

1. Cheyenne
2. University of Wyoming
3. Physiology
4. The wide-open spaces and outdoors lifestyle.
5. I am allergic to all antibiotics.
6. Being a student again, meeting my classmates, and working with physicians in a community that I love.

WHO YOU Gonna Call?

Physician Call Coverage Obligations Under Wyoming and Federal Law

BY NICK HEALEY, JD

Wyoming physicians have for many years regarded call coverage as a public service, a practice-building mechanism. Call coverage has been a minor inconvenience for some specialties and in some hospitals, but for others it has been a major imposition on physicians' quality of life. Increasingly, call coverage is being regarded (particularly by newer physicians) as something they simply will not do (at least not for free).

Many Wyoming physicians still regard a reasonable amount of call coverage as a public service, and are happy to do it without compensation to serve their community. More and more, however, physicians are finding themselves squeezed between time pressures (such as family obligations) on one hand and perceived state and federal legal obligations on the other.

Increasingly (and unfortunately), those physicians are simply opting out, resigning medical staff membership and clinical privileges solely to avoid hospital call coverage burdens. This article provides general guidance on state and federal law requirements for physician call coverage, both in the physician's private practice and in the hospital. With a better understanding of these obligations, it may be easier to find middle ground between the competing demands on physicians' time.

1 Wyoming Board of Medicine Rules and Regulations, Ch. 3, Section 6, Practice Coverage (http://wyomedboard.state.wy.us/PDF/Rules/BOM%20New%20Rules.pdf)

2 Although the "practice coverage" rule is written in "advisory" terms (using language such as "should" and "recommended" rather than "shall") it also states that "failure to adequately address coverage needs of physician's patients" may serve as the grounds for disciplinary action by the board, potentially as "unprofessional conduct."

I. Wyoming law requires physicians to provide private practice on-call coverage, but not for hospital emergency departments.

Wyoming physicians will not be surprised to learn they are required to provide call coverage for their private practices. The Wyoming Board of Medicine's Rules and Regulations require Wyoming physicians to "make reasonable efforts to arrange adequate and appropriate coverage for their practices and patients" when the physician is unavailable.[1] The rules require that these coverage arrangements take into account the "general nature, complexity and severity of illnesses and the care and treatment in the patient population regularly seen by the physician." Physicians must also take into account the availability of other qualified, available providers to respond to their patients when developing a coverage plan.

The rules do not require a physician to be on call at all times. The board's rules recognize that "physicians cannot be continuously available to respond to patients and their emergencies," but recommend that the physician instruct patients about what to do in case of unavailability. The rules indicate that directing patients to simply go to the local hospital's Emergency Department should be a last resort; if physicians do so, they should confer with the Emergency Department's medical director to ensure those providers "are able to communicate with the physician, or another provider qualified and available to respond to the patient's needs, about the care of their patients who may present for care at the facility."[2]

Unfortunately, the rules do not answer an important question: can a Wyoming physician ever be completely unavailable? The rules require the physician to always be available to the emergency department, at least by phone, unless he or she has made arrangements with another appropriate provider to cover his or her patients. In many small Wyoming towns, arranging for another provider for call-coverage is difficult, particularly for specialties with few practitioners. In many cases, the only alternative is to pay for locums coverage, which is often prohibitively expensive for many Wyoming practitioners. In the absence of other arrangements, however, it appears that Wyoming physicians must always be available for call coverage, at least by phone.

Wyoming hospitals are, however, legally required to provide emergency and trauma services. Wyoming's hospital licensing statutes require Wyoming-licensed hospitals that operate emergency departments to provide emergency care for "any condition in which the person is in danger of loss of life, or serious injury or illness at the regularly established charges of the hospital."[3]

The Wyoming Department of Health's (WDH) hospital licensing regulations provide simply that the hospital shall meet the emergency needs of patients in accordance with acceptable standards of practice.[4] The rules also provide that "services" (not further defined) shall be available 24 hours per day, and emergency room staff coverage shall be adequate to ensure that a patient for treatment will be seen within a reasonable time relative to his or her illness or injury. The rules contain a catch-all requiring all hospitals to receive a trauma center designation, and the Department of Health's Trauma Rules (chapter 4) require most Wyoming hospitals to have specific specialists on call and promptly available for traumas.

Nothing in these statutes or rules obligates the physician to provide hospital call coverage. Legally, they only describe the hospital's obligation, since the hospital is the licensee under the WDH's licensing statutes and rules. Under the hospital licensing statutes, the hospital must provide such emergency services when it "has appropriate facilities and qualified personnel available."[5] Physicians are not required, as "personnel," to make themselves available to provide emergency care at the hospital. Likewise, the hospital receives the Wyoming Trauma Program designation, not the physician. Although the hospital may be required to make sure certain specialists are available for traumas, it is up to the hospital, not the physician, to make those arrangements. There is, therefore, nothing under Wyoming's statutes or rules and regulations requiring physicians to provide call coverage for hospitals.

II. The Emergency Medical Treatment and Active Labor Act requires the hospital to provide call coverage for its emergency department, but it does not require individual physicians to provide that call coverage.

Under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), also called the Patient Anti-Dumping Statute, Medicare-participating hospitals must provide persons coming to the emergency department with an appropriate medical screening exam, and stabilizing treatment for any emergency medical condition revealed by the exam, before discharging or transferring the patient.[6] EMTALA requires that hospitals provide these services without regard to payer source (or lack thereof), and "regardless of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured, Medicaid), race, and color, national origin (e.g., Hispanic or Native American surnames), and/or disability, etc."[7]

EMTALA also requires that the hospital have a list of physicians who are on call for duty after the medical screening exam to provide further evaluation and treatment necessary to stabilize an individual with an emergency medical condition.[8] A hospital must provide adequate medical personnel to meet its emergency needs by using on-call physicians to either staff or to augment its emergency department, during which time the capabilities of its emergency department include the services of its on-call physicians. The on-call list identifies and ensures that the emergency department is prospectively aware of which physicians, including specialists and subspecialists, are available to provide care.

3 Wyo. Stat. §35-2-115(a)

4 Wyoming Department of Health, Rules and Regulations for Licensure of Hospitals, Chapter 12, section 8.

5 Wyo. Stat. §35-2-115(a)

6 42 U.S.C. §1395dd

7 Medicare State Operations Manual, Appendix V, Responsibilities of Medicare Participating Hospitals in Emergency Cases, Section 489.24.

8 42 C.F.R. §489.20(r)(2)

A. CMS will review "all relevant factors" to determine how much specialty call coverage a hospital must provide.

1. CMS does not use a "Rule of 3."

CMS does not require any physician to be on call at all times, and EMTALA does not state how frequently physicians are expected to be available to provide on-call coverage.[9] CMS has stated there is no pre-determined ratio for determining how much call coverage a hospital is required to provide in a particular specialty. Before CMS's 2003 revisions to the EMTALA regulations, it was widely believed that CMS used a "rule of 3": hospitals must provide "full" call coverage (24 hours a day, 365 days a year) for a specialty with three or more practitioners. CMS, however, specifically repudiated a "rule of 3" in 2003, declining to create a "safe harbor" for the appropriate amount of call under EMTALA.[10] Instead, CMS stated that hospitals should have flexibility in determining the appropriate amount of call,[11] and that it will "consider all relevant factors in determining whether a hospital has met its obligations for providing call coverage, including:

- the number of physicians on staff,
- other demands on these physicians,
- the frequency with which the hospital's patients typically require services of on-call physicians,
- the provisions the hospital has made for situations in which a physician in the specialty is not available (vacations, conferences, days off) or the on-call physician is unable to respond."[12]

2. It is up to hospitals and physicians to decide what level of call coverage is adequate.

Under EMTALA, hospitals are ultimately responsible for ensuring adequate call coverage, not individual physicians.[13] CMS specifically addressed its expectation of how frequently a medical staff member expected to provide call coverage in a memorandum dated June 13, 2002, stating,

> Medicare does not set requirements on how frequently a hospital's medical staff of on-call physicians is expected to provide on-call coverage. Hospitals are expected to provide services based upon the availability of physicians required to be on-call. We are aware that practice demands in treating other patients, conferences, vacations, and days off must be incorporated into the availability of staff. **We are also aware that there are some hospitals that have limited financial means to maintain on-call coverage all of the time. CMS allows hospitals flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability.**[14] (emphasis added)

CMS has also emphasized that it has not set a "full coverage" requirement, as that might establish an "unrealistically high standard that not all hospitals could meet,"[15] and that

> [W]e do not believe it would be practical or equitable to attempt to adopt more prescriptive rules on such matters as the number of hours per week physicians must be on-call or the numbers of physicians needed to fulfill on-call responsibilities at particular hospitals…[T]hese are local decisions that can be made reasonably only at the individual hospital level through coordination between the hospitals and their [medical staff].[16]

This has been interpreted as requiring those specialties with many physicians or with high patient volume to be "well-represented" in the call coverage schedule.[17] Those with fewer physicians or with low patient volume may be represented in proportionately lower amounts. Gaps in the on-call coverage may be permitted, but back-up arrangements must be made and documented in writing for any gaps. CMS recognized, however, that, "[g]iven the wide variation in the size, staffing, and capabilities of the institutions that participate in Medicare as hospitals, we do not believe it is feasible for us to mandate any particular minimum level of on-call coverage that must be maintained…"[18]

> *Patients will probably always need assistance at odd hours that are not convenient or desirable for physicians.*

Wyoming physicians should understand, however, that they may have call coverage obligations under their hospital's medical staff bylaws, rules, or policies, or under employment or call coverage agreements. Those obligations are still enforceable even though EMTALA does not impose them. Moreover, serious penalties can be also assessed against individual physicians under EMTALA if a physician is scheduled to provide emergency department call coverage under the medical staff bylaws, and does not respond.[19] If the physician fails to respond to a request to provide stabilizing treatment, and the patient is transferred to another facility, the physician's name and address will be included with the patient's medical records sent to the receiving facility.[20] Therefore, Wyoming physicians may still have hospital call coverage obligations and should take them seriously, even if they do not arise under federal or state law.

III. Conclusion

Physician call coverage obligations are not going away. Patients will probably always need assistance at odd hours that are not convenient or desirable for physicians. Few physicians would argue that they were not aware of those burdens when they made the decision to pursue a career in medicine. But it is important to understand what burdens are legal and what burdens are chosen so that Wyoming physicians can make educated decisions with respect to how much of that burden they are willing to shoulder.

Nick Healey is a partner at Dray, Dykeman, Reed & Healey, P.C. and a member of the Wyoming Medical Society General Counsel.

9 68 Fed. Reg. 53,251; See CMS Memorandum to regional offices and State Survey Agencies, May 13, 2004, regarding the revised EMTALA Interpretive Guidelines ("CMS Memorandum"), p. 21.

10 68 Fed. Reg. 52,251; CMS Memorandum dated June 13, 2002.

11 68 Fed. Reg. 53,224.

12 68 Fed. Reg. 53,251 (2003); CMS Memorandum, June 13, 2002.

13 68 Fed. Reg. 53,250; See CMS Memorandum to regional offices and State Survey Agencies, dated May 13, 2004, regarding the revised EMTALA Interpretive Guidelines , p. 20-21; CMS Manual, §489.24(j). "Hospitals have an EMTALA obligation to provide on-call coverage for patients in need of specialized treatment if the hospital has the capacity to treat the individual…On-call coverage should be provided for within reason depending upon the number of physicians in a specialty." CMS Memorandum, p. 21; Manual.

14 CMS Memorandum; 68 Fed. Reg. 53,251, C.

15 68 Fed. Reg. 53,252

16 Fed. Reg. at 53,253.

17 On-call Obligations under EMTALA, Physician's Digest News, July 2006.

18 Fed. Reg. at 53,253.

19 Civil penalties of not more than $50,000 per violation may be assessed directly against a physician for certain EMTALA violations, and the physician faces potential exclusion from participating in federal healthcare programs. 42 U.S.C. §1395dd(d).

20 42 C.F.R. §489.24(e)(2)(B)(iii

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"A Unique Blend of Law & Medcine": Wyoming's Workers' Comp Medical Commission

BY JAMIE BROOMFIELD, MD

Can doctors serve as judges? Yes! In our state, the Wyoming Workers' Compensation Act provides that physicians who serve on the Medical Commission of the Wyoming Workers' Compensation Division be empowered by law to make judicially binding and appealable decisions in certain types of medically contested workers' compensation cases.

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This statutorily created model, with doctors serving as administrative law judges (i.e., hearing examiners) is unique to Wyoming in the United States. Although some other states use medical panels for advisory purposes, the Wyoming model provides that the final legal decision be made by a medical hearing panel made up of three healthcare providers who make decisions based upon evidence and testimony that is presented to them in a contested case hearing.

The law that created the Medical Commission limited the jurisdiction of the commission to medically contested cases defined by rule to include a percentage of physical impairment under the AMA Guides, claims for permanent total disability, and eligibility for temporary total disability benefits. Additional issues may also be heard, whose resolution is primarily dependent upon the evaluation of conflicting evidence as to medical diagnosis, prognosis, or the reasonableness and appropriateness of medical care.

In Wyoming, the decisions of the panel of three physicians who sit on these cases are reduced to written opinions, signed by the chairperson of the hearing panel. All Medical Commission opinions can be appealed through the Wyoming court system, all the way to the Wyoming Supreme Court in many cases. The Wyoming Workers' Compensation Act provides the statutory framework under which the Medical Commission operates, and the Wyoming Supreme Court opinions and case law direct the interpretation of the statutes and the application of the law.

"Many of the physicians on the Medical Commission have requested reappointment more than once because they enjoy the work."

The Medical Commission consists of 22 healthcare providers who are located throughout Wyoming. Physicians appointed by the governor serve staggered three-year terms. Many of the physicians on the Medical Commission have requested reappointment more than once because they enjoy the work.

Doctors on the Medical Commission represent a wide cross-section of medical specialties with chiropractors, general practitioners, orthopedic surgeons, neurologists, rheumatologists, general surgeons, psychologists, and neurosurgeons currently composing the majority of members in the commission. Pulmonologists; ear, nose, and throat physicians; and other specialists have been on the commission in the past. The Workers' Compensation Act only requires that the physicians on the commission be licensed, which has been interpreted by Wyoming's attorney general to mean having a valid license issued by the Wyoming Board of Medicine.

The Wyoming Medical Society was involved in the appointment of the original Medical Commission by submitting a list of nominees to the governor who then appointed the full panel.

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Formalizing the Process

The Wyoming Legislature created the Medical Commission in 1994 to add an element of medical professionalism to the administrative hearing process in the burgeoning workers' compensation field. The legislature understood that workers' compensation cases often present medically challenging issues, including decisions on medical causation, which can be complex and are driven largely by expert medical opinion. The majority of workers' compensation cases that are not medically contested cases continue to be heard by the Office of Administrative Hearings, a separate government agency which provides a variety of hearing services to citizens of the state regarding a wide range of issues.

Hearings before the Medical Commission are conducted as full evidentiary hearings and are tried under Wyoming's Administrative Procedures Act, which is designed to ensure that all participants get a timely and fair hearing. Injured workers are represented by attorneys who are paid through the workers' compensation fund, and the Workers' Compensation Division is represented by legal counsel at every stage of the proceedings. Employers can choose to have their own separate legal counsel for the proceedings, but often choose not to participate at all and leave the battle to the Workers' Compensation Division.

Scott Smith, a practicing attorney for over 30 years and formerly the executive secretary of the Medical Commission, pointed out that the cases are "full blown litigation. Witnesses, doctors—including treating and independent experts—are routinely deposed with their written deposition testimony submitted to the hearing panel. Independent Medical Examinations (IMEs) are often conducted by the parties as well and are provided to the hearing panel in the form of written and bound disclosure statements, which are provided to the hearing panel before a hearing commences." Cases can be very time consuming, depending on the issues that are presented.

Smith also indicated that the "doctors are great hearing examiners. They are thorough…ask great questions, and they are committed to making all participants in the process comfortable. Training is vital as Medical Commission members must undergo regular and comprehensive legal training to ensure that they understand the status of the law and the concepts of due process for administrative hearings as directed by courts."

Now semi-retired, Smith serves as an occasional hearing officer for the Medical Commission and enjoys the challenges and the interaction with the commission's physicians.

Depositions, Deliberations, and Decisions

The hearing is conducted by video, teleconference, or in person before a hearing panel consisting of three Medical Commission members and the presiding hearing officer. Medical Commission members have the right to question any live witness who may testify, and panel members have vigorously used their ability to ask questions to get additional information from witnesses or to clarify areas of confusion.

Members of a workers' compensation medical hearing panel (from left): Jamie Broomfield, MD, John Renneisen, Esq., Reed Shafer, MD, Jerry Post, PhD

"The Medical Commission is a unique blend of law and medicine that works to the benefit of all who appear before it…"

Most cases are heard in three to four hours, with many more hours spent reviewing the sometimes lengthy disclosure statements that are prepared and presented by the parties in the case. After the evidentiary hearing concludes, the parties to the hearing are excused and the medical hearing panel retires into confidential deliberations to make their decision. After a decision is reached by majority rule, the hearing officer prepares a written decision, setting forth the specific findings of fact and the conclusions reached by the panel based on those findings. Written opinions are issued within 45 days of the close of the evidence.

The Office of the Medical Commission is a busy place, with referrals for contested cases showing a steady increase over the years.

Shawna Goetz, who has been the office manager, scheduler, and go-to person for the commission for 16 years, indicated that current trends show the commission will be busy for many years to come. Goetz enjoys her contact with the physicians on the commission and she takes care of most of their needs as cases move forward through the system. She also handles the appeals that go to the district court and supreme court. She acknowledged that keeping such a massive amount of paper moving forward is sometimes daunting, but it is also rewarding because the process is comprehensive and provides all parties a full and fair hearing in a timely manner.

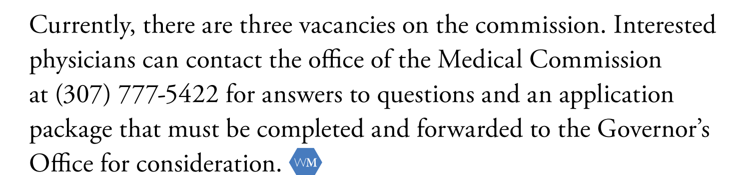
The Office of the Medical Commission and its employees are a part of the Wyoming Workers' Compensation Division, but the Medical Commission maintains a large amount of independence in order to avoid any appearance of bias or prejudice in the hearing process procedure.

Judicious Doctors

I am the current president of the Medical Commission, having twice been elected to this position by my fellow physicians. I have also been a member of the commission since 2003, so I have acted as a panel member on hundreds of medically contested cases and have seen firsthand how the process works.

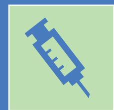
In my experience, the Medical Commission involves a unique blend of law and medicine that works to the benefit of all who appear before it. The process is fair and expeditious. Participants receive detailed written decisions in a timely manner, and the doctors on the Medical Commission enjoy their special status as judges and work very hard at their "judicial" duties.

Members of the Medical Commission are compensated for their time spent in preparation and attendance of hearings and the annual meeting. The Medical Commission meets in a different Wyoming community each year for a two-day annual meeting that provides training and fellowship with other members. This year's annual meeting will be held in Sheridan.



Currently, there are three vacancies on the commission. Interested physicians can contact the office of the Medical Commission at (307) 777-5422 for answers to questions and an application package that must be completed and forwarded to the Governor's Office for consideration.

Jamie Broomfield, MD, is the president of the Wyoming Medical Commission and the vice president of the Laramie County Medical Society.



Altered Regulations for Physicians and Physician Assistants

BY KEVIN BOHNENBLUST, JD

The Wyoming Board of Medicine recently completed a review of its entire body of regulations governing the licensure of, practice by, and discipline of physicians and physician assistants. The action was initiated upon Governor Matt Mead's directive to state agencies to reduce their regulations by one-third, and the need to speed up the temporary licensing of physician assistants. The board also wanted to consolidate separately codified—and sometimes inconsistent—rules for investigations and discipline for physicians and PAs.

The Process

In response to the governor's directive, in January the board requested authority to make changes to its existing six chapters of rules and to add a seventh to combine the investigation and disciplinary processes for physicians and PAs. The governor granted authority to proceed, and later that month the board published notice of intent to promulgate rules and opened a 45-day period for public comments.

After the legislature adjourned in March, I met with Sheila Bush, WMS's executive director, to discuss the draft rules. She asked questions about the proposed changes and offered suggestions to improve the rules. After our meeting, she and WMS legal counsel, Nick Healey, followed up with additional questions and concerns. Ms. Bush then submitted written comments on behalf of WMS. Steven Platz, PA-C, the president of the Wyoming Association of Physician Assistants, also submitted comments from his organization.

> *"The biggest concern arose from a proposed rule requiring that all PA supervisory relationships include a minimum 10 percent chart review by the supervising physicians."*

At the board's next meeting on April 11, 2014, upon a request from WAPA, a hearing was held on the proposed rules. In addition to representatives from WMS and WAPA; Valerie Goen, PA-C; and Bob Cummings, PA-C; members of the Board's Physician Assistant Advisory Council attended and provided comments. The biggest concern arose from a proposed rule requiring that all PA supervisory relationships include a minimum 10 percent chart review by the supervising physicians.

Those at the hearing spoke against a fixed minimum chart review. They said that the elements of supervisory relationships—and especially the frequency of chart review—should not be "one size fits all." Instead, they should take into account the individual physician/PA relationship, including the experience levels of both

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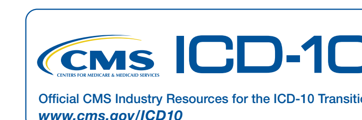

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licensees; the nature and specialty of the practice; method(s) of supervision; and other relevant factors.

In response, the board deleted the proposed 10 percent chart review, acknowledging WMS's and WAPA's position that chart review requirements should be set on a case-by-case basis. It asked that WMS, WAPA, the PA Advisory Council, and board of medicine staff "confer and develop a set of guidelines for chart review and co-signature, to be reviewed by the Board at a future meeting."

The board then approved the proposed rules, as amended in response to the public comments. The rules were submitted to the attorney general's office, then to the legislature's Management Council. While approving the rules, the council recommended that the governor direct the board to ensure that future rule making reflects that the board may only delegate to a subset of the board, or to board staff, as specifically allowed by the Medical Practice Act.

On June 24, 2014, Governor Mead signed the rules, making them effective. In the letter reporting his action, the governor asked the board to review its rules in light of the legislature's concerns.

What's Next?

In response to legislation passed this year, the State's Office of Administrative Hearings is promulgating uniform rules for the conduct of hearings before state agencies, including licensing boards. This will render some of the board's new rules on disciplinary process inoperable, so the board will need to conduct another rulemaking to delete them. At that time, the board will review the remainder of its rules in light of the delegation concerns raised by the legislature and the governor. This may begin as early at the board's next scheduled meeting this October.

Kevin Bohnenblust, JD, is the executive director of the Wyoming Board of Medicine.

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Dianne Kirkbride
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Don't Waste Time When Your Life is on the Line

MISSION: LIFELINE WYOMING AIMS TO SAVE LIVES

By the American Heart Association

It was just before midnight in June 2007 when Gary Keimig woke up nauseated and soaking in sweat. A week earlier, the 66-year-old landscape artist had brushed off chest pain, but now he knew something was definitely wrong.

"My daughter told me to call 9-1-1," says Keimig.

By sunrise, Keimig was nearly 200 miles from his Dubois home and lucky to be alive. Keimig had suffered the most deadly type of heart attack and was airlifted from a Lander hospital to Casper, which was the nearest PCI-capable facility equipped to treat an ST-elevation myocardial infarction, or STEMI.

Due in part to the state's rural landscape and sparse healthcare resources, cardiovascular disease remains the leading cause of death in Wyoming. Mission: Lifeline Wyoming (M:LW), an American Heart Association (AHA) initiative launched in 2012, is working to save lives by quickly getting STEMI patients to specialized care.

"Time equals muscle," says Michael Eisenhauer, MD, a Casper-based cardiologist and project co-chair. The goal is to reduce "living room to balloon" time to two hours or less.

The first phase of the initiative centered on streamlining the system of care among participating hospitals, clinics, EMS agencies and first responders through equipment, training, and protocols. To date, M:LW has invested approximately $3 million in new and upgraded equipment, outfitting nearly 200 ambulances with mobile 12-lead electrocardiograms. These ECGs are capable of transmitting patient data to hospitals, where doctors can prepare to treat or transport the patient upon arrival.

A recent survey revealed one in seven Wyomingites couldn't name any signs of a heart attack. Further, only 52 percent of Wyoming adults said they would call 9-1-1 first if they suspected a heart attack. The second phase of M:LW is focused on raising awareness of heart attack warning signs and symptoms and the importance of immediately dialing 9-1-1. A series of PSAs, ads, and education materials featuring Keimig and other Wyoming survivors is currently in rotation through mid-2015.

The $7.1 million program is funded through a $5.9 million grant from The Leona M. and Harry B. Helmsley Charitable Trust with additional funding from First Interstate Bank and the Wyoming Community Foundation's Working for Wyoming Fund.

Visit www.heart.org/mlwyoming to learn more about the initiative.

Gary Keimig, Dubois resident and heart attack survivor

Vital Records Important to Wyoming

By Kim Deti

The Wyoming Department of Health's Vital Statistics Services Office (VSS) collects and stores data on Wyoming's vital events. VSS serves the state by maintaining accurate, secure information on key milestones with a focus on births, deaths, marriages, and divorces.

In some ways, VSS operates just as it did in the 1930s. In others, operations are far more modern.

On a typical day, VSS receives about 200 pieces of mail. Each must be opened and processed just like in 1930. However, behind the scenes there is a secure, dynamic electronic system that contains almost 2 million data points.

As children are born, physicians and other hospital personnel log in and initiate a birth record. Nearly 100 percent of births are reported electronically. When there is a death, physicians, coroners, or funeral homes can log in and initiate a death record. Just over 80 percent of Wyoming deaths are recorded electronically.

While the staff processes requests, the secure system continues to grow and change.

The State and Territorial Exchange of Vital Events System (STEVE) exchanges data with other jurisdictions. If a Wyoming resident dies in another state, the information is automatically imported to the VSS secure database. STEVE replaced the less secure practices of exchanging paper copies and entering data manually.

Similarly, the Electronic Verification of Vital Events System (EVVE) allows sanctioned users to verify various vital events. EVVE allows authorized federal and state agency users to generate an electronic query to any participating vital records jurisdiction throughout the country to verify the contents of a paper birth certificate or to request an electronic certification.

In 2013, 7,617 Wyoming residents gave birth and 4,467 residents died. As life and death goes on in our state, both the modern and somewhat ancient activities of VSS will continue.

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WyHealth

By Kellie Moser

WYhealth…Get Plugged In! is a Medicaid program offered through Xerox Care and Quality Solutions, Inc. Providers and their patients who are Medicaid clients can benefit from a wide array of programs offered by WYhealth. The organization hopes to partner with all Medicaid-approved providers to improve patient outcomes and assist providers where needed through additional care coordination and care management services for their patients.

A partnership with WYhealth provides access to initiatives like:

- Due Date Plus mobile app, available for all pregnant women
- Weight management programs—one designed for children and one for adults—with technology devices
- Incentive Diabetes program coming this fall
- 24/7 nurse line
- Disease and case management for chronic conditions
- Readmission Reduction Initiative
- Appropriate Care Site Initiative to reduce ER admissions
- Collaborative Development of Medication Adherence mobile app

Providers receive additional reimbursements through the Pay 4 Participation (P4P) program for Medicaid patient referrals to the WYhealth program and the use of certain disease management, screening, and education billing codes.

To learn more about the programs and services WYhealth offers, visit WYhealth.net. The section of the website for providers includes a WYhealth provider manual, referral forms and policies, and much more.

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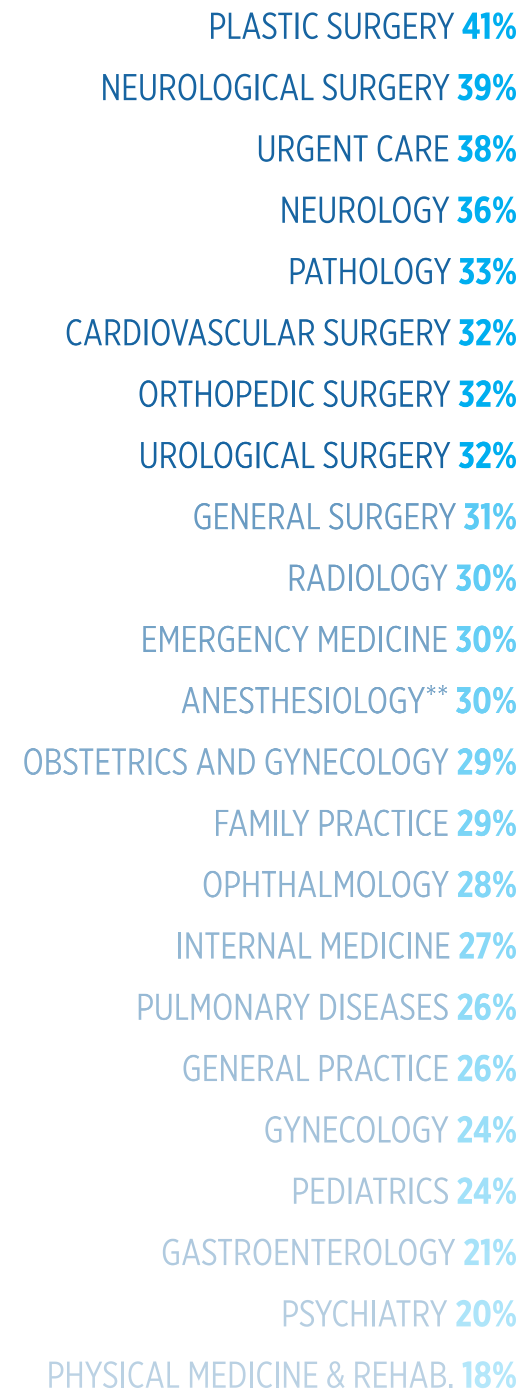

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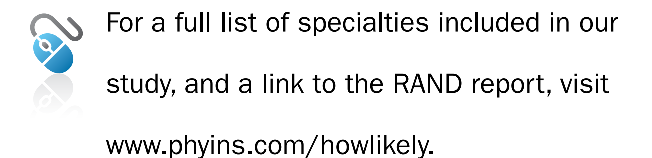

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* *Figures reflect Physicians Insurance claims data over a ten-year period from 2003 to 2012 and indicates the percentage of all claims, by specialty, that ended up as lawsuits.*

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