Interim Meeting 2012
Delegates Set Policy on EMR Use, Prior Authorization, and Health Plan Coverage Decisions

BY ERICA NOONAN

The House of Delegates voted on nearly 30 resolutions at the 2012 Interim Meeting, passing resolutions on medical marijuana, electronic medical records, issues of prior authorization, and health plan coverage decisions.

The House directed the MMS to work with the Board of Registration in Medicine (BRM) to define the nature of the physician-patient relationship required under the law and advocate for the development of appropriate standards for medical marijuana certification by physicians, among other actions (see accompanying story, “MMS Medical Marijuana Policy Expanded”)

The HOD also determined that the MMS would research their impact on patient metrics.

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White Coats and iPhones: Mobile Technology
Part One of a Two-Part Vital Signs Series on Physicians and Technology

BY VICKI RITTERBAND

When a 2011 Halloween nor’easter knocked out power for more than a week in western Massachusetts, physicians’ practices were paralyzed. Pioneer Valley Pediatrics in Longmeadow was the exception.

“There were no phones, no computers. The only thing we had were cell phones and because of my cell phone, I was the only physician in the area who was able to access patient data, schedules, all sorts of information,” said Sally Ginsburg, M.D., who used athenahealth’s iPhone application to connect to her electronic health record (EHR).

“I knew early on my cell phone would be a powerful way to access any type of medical information at any point in time.”

Dr. Ginsburg is one of the growing number of physicians using mobile devices as extensions of their office computers, enabling them to work from anywhere at any time of the day or night. In addition to accessing their EHRs with smartphones and tablets, they’re consulting reference material, drug formularies, and clinical calculators on the fly. They’re reviewing their schedules on soccer fields, earning CME credits on cross-country flights, viewing test results and imaging studies while sipping coffee at Starbucks, and calling up vivid anatomical renderings of hip joints to share with patients pre-surgery.

“Physicians don’t want to be tethered to anything — whether it’s the EHR on their desktop or whatever,” said Danny Sands, M.D., a Beth Israel Deaconess Medical Center (BIDMC) internist. “They’re on the go, running between patients and with their family. Mobile technology has really allowed doctors to untether themselves.”

While every physician interviewed for this article was enthusiastic about the ways mobile devices have enabled them to work in more flexible ways, several raised concerns about two issues related to the use of personal devices for job-related activities: the security and privacy of patient information and the risk of being distracted from medical tasks when their work worlds coexist with their personal lives on their devices.

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White Coats and iPhones continued from page 1

How They’re Using Them
The reputation of physicians as Luddites no longer applies: doctors love their electronic gadgets. Eighty-five (85) percent of U.S. physicians own or use a smartphone professionally, while 62 percent own a tablet — nearly double the number from 2011, according to Manhattan Research’s study, Taking the Pulse® U.S. The iPhone and iPad are by far the most popular models among physicians. In a recent survey conducted by the MMS, American College of Rheumatology, and ICF Ironworks, 56 percent of physicians reported they use a smartphone for work and 25 percent said they use a tablet.

And unlike in the general population, it’s not just the younger doctors who are bullish on mobile technology. “There is not as strong an age correlation as you’d expect,” said Manhattan Research’s principal analyst, James Avallone. “Tablet use is across the board. And when you get a number as high as 85 percent for smartphone penetration, you’re seeing uniform use across all ages.”

Physicians tend to use their smartphones for activities that take three minutes or less, such as checking their schedule or looking up a discrete piece of information, said Avallone. “Tablets play better to situations where they’re spending more time — researching something more in depth,” said Avallone. “We found that one in two tablet owners use their device at the point of care. Because of the larger screen, it’s ideal for patient education activities. You can share that screen with a patient much more easily than you can with a smartphone.”

Dr. Sands follows that pattern. He uses a handful of reference applications on his iPhone, including a clinical calculator that determines everything from body mass index to creatinine clearance. Another app provides him with the recommended evidence-based preventive health measures for patients, based on their age. “The apps are convenient and they help eliminate mistakes,” said Dr. Sands.

But when it comes time to give a patient a medical primer, he pulls out his iPad. “I can teach them anatomy, or call up an X-ray, I might use it to show someone why they’re having acid reflux. I can show them an image and mark it up. The patients really like it.”

In the MMS survey, physicians’ top use of tablets was for reading news, articles, or abstracts and accessing patient records and the EHRs. Smartphones were most commonly used for reading news, articles, and abstracts and accessing drug reference databases and clinical reference material.


Your Two Cents
Vital Signs welcomes letters to the editor. Letters should be 200 words or fewer, and all are subject to editing. Send to the MMS Department of Communications, 860 Winter Street, Waltham, MA 02451-1411; vitalsigns@mms.org; or fax to (781) 642-0976.

VITAL SIGNS is the member publication of the Massachusetts Medical Society.
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PRODUCTION AND DESIGN: Department of Premedia and Publishing Services; Department of Printing Services
PRESIDENT: Richard V. Aghababian, M.D.
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DIRECTOR OF COMMUNICATIONS: Frank Fortin

Vital Signs is published monthly, with combined issues for June/July/August and December/January, by the Massachusetts Medical Society, 860 Winter Street, Waltham, MA 02451-1411. Circulation: controlled to MMS members. Address changes to MMS Dept. of Membership Services. Editorial correspondence to MMS Dept. of Communications. Telephone: (781) 434-7110; toll-free outside Massachusetts: (800) 322-2303; fax: (781) 642-0976; email: vitalsigns@mms.org.

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Care Coordination through Communication

On Friday, February 8, 2013, the Massachusetts Medical Society will host a CME program titled, “The Impact of Effective Communication on Patients, Colleagues, and Metrics.”

The program will feature three experts in the field of health communication discussing their research on health communication within the context of recently passed health care legislation.

Helen Riess, M.D., director of empathy research and training in psychotherapy research in the Department of Psychiatry at Massachusetts General Hospital, will discuss physician-to-patient communication with a special focus on physician empathy. David Longworth, M.D., a physician at the Medical Institute of the Cleveland Clinic, will discuss the importance of patient engagement in relation to prospective payment systems. And Ronald Epstein, M.D., professor of family medicine, psychiatry, oncology, and nursing at the University of Rochester Medical Center, will discuss effective physician-to-physician communication, and how clear communication can enhance patient outcomes within integrated delivery systems.

Many physicians and health care administrators do not have specific training in communicating with colleagues or patients, and the issue of engaging patients in their medical care is a relatively new topic.

In 2011, the Institute of Medicine (IOM) identified patients and providers as the groups who must be fully engaged to reform the current health system infrastructure.

Many physicians engage and physician-to-patient and physician-to-physician communication all rely on similar principles. Patient engagement includes working together with patients to select appropriate treatments or management options, understanding and acting on health information, and providing feedback on health care processes and outcomes. Physician-to-patient communication utilizes healing relationships, grown on principles of adaptability to the patient’s needs, growth of both parties, and commitment to the healing process. Physician-to-physician communication hinges on direct, concise information-sharing. In all three concepts, the importance of teamwork, care, and precision is highlighted.

Coordinated health care emphasizes the key role of clear, concise communication at all levels. In our upcoming CME program, providers will gain a better understanding of best practices and necessary steps for enhanced patient engagement, as well as new techniques for communicating with their colleagues and their patients. This knowledge will be necessary for physicians to operate a successful practice under the new coordinated care models.

For more information on the program, please visit www.massmed.org/IEC2013.

— Leif Brierley and Melissa Higdon
Preventing Falls in Older Patients

Falls are among the most common and serious health problems facing older adults today, according to the CDC. One out of three Massachusetts residents over age 64 experiences a sudden fall each year.

Falls caused 408 deaths in Massachusetts in 2009. In FY2010, falls caused 21,331 acute care hospital stays and 40,091 emergency department discharges, at a cost of more than $511 million in inpatient charges and more than $100 million in ED charges, according to state officials.

Falls are not an inevitable part of aging; they result from a combination of intrinsic and extrinsic risk factors, such as certain chronic conditions or medications and hazards in the home environment. This year, the U.S. Preventive Services Task Force, a group of national experts in prevention and evidence-based medicine, recommended at-risk older adults receive an in-depth examination to identify specific fall risk factors.

CMS has supported fall risk assessment during initial Medicare and annual wellness exams since 2011. Yet, many clinicians report they do not feel confident assessing or addressing fall risk.

The MMS, in collaboration with Blue Cross Blue Shield of Massachusetts and MDPH, will host a live webinar on February 6, 2013, to provide clinicians with the knowledge and tools to assess and prevent falls in older patients.

Participants will receive a free copy of the CDC’s STEADI (Stopping Elderly Accidents, Deaths and Injuries) Tool Kit.

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Deadline for Foundation Grants: January 15

The MMS and Alliance Charitable Foundation is accepting letters of inquiry for its Community Action and Care for the Medically Uninsured/Underinsured grants until January 15, 2013.

These grants support physician-led volunteer initiatives that provide free care to uninsured patients and increased access to care for the medically underserved, as well as community health initiatives that target public health issues such as infectious disease, obesity, and domestic violence. Last year, the Foundation awarded 13 grants, ranging from $5,000 to $30,000.

Those submitting successful letters of inquiry will be invited to submit full grant proposals by March 1. For more information, visit www.mmsfoundation.org.
MMS and AMA Working Together on National Scope of Practice Issues
Concern over Nurse Practitioners Cited

The Federal Trade Commission (FTC) has emerged as an advocate for independent nurse practitioners in a handful of states. Recently, the FTC sent letters to Missouri and Tennessee legislators and to state medical boards stating that nurse practitioners provide care that is at least equivalent to physicians for safety and quality. Citing “available evidence” in making their clinical judgments, the FTC appears to intend to assert its authority in the area of preventing restraint of trade by eliminating public safety and clinical quality issues from the rational basis for decisions by legislators and regulators to require physician supervision of nurse practitioners.

The most chilling example of the FTC’s apparent intent comes from an enforcement action brought by the FTC against the North Carolina State Board of Dental Examiners. In this action, the FTC asserted the position that dentists serving on the board are private actors subject to antitrust rules rather than agents of the state performing their duties concerning oversight of rules governing the practice of dentistry by allied health professionals. The AMA has weighed in directly by meeting with the FTC commissioners and questioning the FTC’s expertise in weighing clinical evidence comparing physicians and non-physicians. The FTC has since modified its communications in this area to include disclaimers citing its lack of expertise in patient care and safety. The FTC also has promised to reach out to state medical societies before taking positions on similar issues in the future.

The Litigation Center of the AMA, of which the MMS is a member along with other state medical societies, has filed an amicus brief in the North Carolina case and the MMS looks forward to a positive outcome. However, the evolution of practice standards should not occur in court. Rather, legislative changes should reflect solid practice standards developed in the medical community. The AMA continues to work to support the physician-led team as the gold standard in patient care. Recent AMA-supported legislation in Virginia created such a statutory standard of collaborative practice for physician-led teams.

The MMS is proud of its work in the Scope of Practice Partnership and the Litigation Center and applauds the AMA for its effective and reasonable advocacy.

— William Ryder

FEDERAL UPDATE

The 113th U.S. Congress: Possibilities for Compromise on Sequester, SGR, and ACA?

Now that the election is over, President Obama and members of Congress are keenly focused on cutting spending and raising revenue to avert the formidable and so-called “fiscal cliff.”

The stakes are high. The Congressional Budget Office released a report two days after the election stating that should Congress fail, the resulting $600 billion in automatic cuts would send the country into a recession.

There is reason to hope that the dynamic of stalemate among legislators may change in the coming year.

The most hopeful scenario involves President Obama and Congress striking a short-term deal that would avert the fiscal cliff, forestall sequestration, and stop the Medicare physician payment cut.

More permanent and long-term solutions to these inherent problems will surely dominate the agenda of the newly constituted 113th Congress. There is reason to hope that the dynamic of stalemate among legislators may change in the coming year.

With some conservatives losing their seats in the November elections, House Speaker John Boehner (R-Ohio) may now have more leverage to lead his party in negotiating compromise with the Democrats and White House.

Senate Majority Leader Harry Reid (D-Nevada) also acknowledged the need for compromise.

For those in health care, the election does resolve at least two issues. We can expect implementation of the Affordable Care Act at the federal level to continue relatively on track, although states still have much power to undo its promise, particularly with respect to Medicaid expansion.

We expect a flurry of regulations detailing the provisions of the federal law to be issued within the next month. Though the unsuccessful vice presidential candidate Rep. Paul Ryan (R-Wis.) supported changing Medicaid from an entitlement program to a "premium support plan," such a transformation is not expected to be on the president’s agenda.

— Alex Calcagno
Many medical professionals tend to delay or avoid the responsibility of guiding reluctant students into treatment and/or monitoring.

Students in the health professions are held to a very high standard and without adequate support; this can lead them to be critical of themselves. Fears of stigma can lead to isolation from academic support. There might be fears of potential jeopardy if a supervisor were to discover a student’s personal health issue, and these fears tend to be strongest for problems centering around drugs and alcohol.

But the good news is that institutional support for aspiring physicians begins early on in medical school. Data indicates that medical schools are heeding the call and providing programs that are convenient and accessible with costs reduced by economies of scale, while maintaining confidentiality.

This is especially important for medical students, because the advent of their clinical training in the third year of medical school coincides with the increase in care-seeking through informal consultation with colleagues, half of whom (residents and physicians) write prescriptions for themselves, and often seek informal treatment from colleagues.

Having strong, formal, school-based programs for treatment serves as a bulwark against such self-defeating care. Statistics from the University of Massachusetts Medical School’s counseling services show that among the 2012 graduating medical school class, 46 percent of the students had sought out the student counseling services sometime during their medical school enrollment.

The Federation of State Physician Health Programs’ public policy statement on physician illness emphasizes early identification and treatment of illness. Many physician health programs (PHPs) extend their services to medical students and in some states to other health professionals. PHPs often work very closely with their respective states’ medical boards, smoothing the path to initial licensure for monitored students. In Massachusetts, PHS runs support and 12-step groups limited to health professionals and students; these are free of charge and available regardless of involvement with monitoring contracts.

Peer-assistance models, such as Active Minds, also exist. Its website (www.activeminds.org) emphasizes student-run mental health awareness, education, and advocacy on campuses.

Additionally, the American Foundation for Suicide Prevention (www.afsp.org) supports a Web-based tool for anonymous entry into communication with school-based counseling services. A pilot of this program has recently been extended to a few medical school campuses.

By beginning these efforts at the student level, health professionals may be empowered to maintain optimal care of themselves just as they begin the endeavor to provide optimal care for their patients.

— Ruthann Rizzi, M.D.

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For more information, please contact Physician Health Services, Inc., at (781) 434-7404 or visit www.physicianhealth.org.
2013 Member Benefits Guide Now Available

The 2013 MMS Member Benefits Guide is available now! The 25-page, easy-to-read guide is a comprehensive reference of the many valuable benefits exclusive to MMS members. You will also find a section devoted to the various benefits accessible online. Current members will receive their copy along with their membership card as they renew their 2013 membership. It will be sent to new members as part of their welcome packet.

The guide is your one-stop resource for information on MMS advocacy, educational services, practice management and professional resources, patient education, and public health campaigns. The contact information section provides phone numbers, email addresses, and websites for all the benefit programs and services.

Through the members-only section of the MMS website, www.massmed.org, the online version of the guide provides direct links to more in-depth descriptions of particular benefits and services. If you have questions about your benefits, call the Member Information Center at (800) 322-2303, ext. 7311, or email info@massmed.org.

New Benefit for MMS Members: Online Data Backup and Recovery

The MMS is pleased to announce that a partnership has been formed with VaultLogix to provide an online backup and recovery solution at exclusive discounted rates for members.

In today’s world of technology, HIPAA requirements, and personal information protection compliancy, it is more important than ever to safeguard your business and patient information.

VaultLogix is the premier provider of business class online backup and recovery services that exceed government data security requirements. It offers an easy to use, reliable, and customizable backup service to encrypt your critical business and patient data and secure it in offsite redundant data centers. VaultLogix has built a worldwide business clientele, including customers in the health care fields ranging from single practices to large health centers and hospitals.

To learn more about VaultLogix and the exclusive MMS member benefit, visit www.dataprotection.com/massmedical.

ACROSS THE COMMONWEALTH

District News and Events


Franklin — Social Event. Tues., Jan. 29, 6:00 p.m. Location: Maggie, Greenfield. For more information, contact the West Central Regional office.

Plymouth — Executive Committee Meeting. Thurs., Jan. 17, 6:00 p.m. Location: Southeast Regional Office, Lakeville. For more information, contact the Southeast Regional Office.


IN MEMORIAM

The following deaths of MMS members were reported to the Society in October and November 2012. We also note member deaths on the MMS website at www.massmed.org/memorial.

Frederick H. Levine, M.D., 69; Amherst, MA; Harvard Medical School, 1968; died September 2012.

Robert E. Scully, M.D., 91; Boston, MA; Harvard Medical School, 1944; died October 2012.

Robert A. Seidel, M.D., 79; Scituate, MA; New Jersey Medical School, 1963; died September 2012.

John D. Sweeney, M.D., 92; Newton, MA; Tufts University School of Medicine, 1944; died August 2012.

Robert Orator: Michael F. Collins, M.D., University of Massachusetts senior vice president of health sciences and UMass Medical School chancellor and professor of quantitative health sciences and medicine. For more information, contact Joyce Cariglia at (508) 753-1579.

Statewide News and Events

Art, History, Humanism, and Culture Member Interest Network — Executive Committee Meeting. Wed., Jan. 9, 6:00 p.m. Location: Mechanics Hall, Worcester. Winter Eagles Program. Sat., Feb. 2, 10:00 a.m. to 1:00 p.m. Location: Joppa Flats, Newburyport. For more information, contact the West Central Regional office.

If you have news for Across the Commonwealth, contact Michele Jussaume, Northeast Regional Office, at (800) 944-5562 or mjussaume@mms.org; Sheila Kozlowski, Southeast Regional Office, at (800) 322-3301 or skozlowski@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

LGBT Healthcare Equality Index Now Available

On October 11, a unique resource was offered to hospitals in Massachusetts and throughout the country: the LGBT Healthcare Equality Index (HEI). This online survey, available at www.hrc.org/hei through January 2013, allows assessment of policies and practices related to lesbian, gay, bisexual, and transgender (LGBT) individuals. HEI responders who meet criteria are then designated “Leader in Healthcare Equality” by the HEI.

LGBT health concerns are receiving increasing attention in health care. In January 2011, CMS issued regulations requiring hospitals to guarantee equal visitation. This requirement was mirrored by a Joint Commission standard mandating equal visitation, which was accompanied by a standard requiring accredited hospitals to prohibit discrimination based on patients’ LGBT status. Additionally, in March 2011 the Institute of Medicine issued a landmark report, The Health of LGBT People, which led U.S. Health and Human Services (HHS) Secretary Kathleen Sebelius to create an HHS LGBT-working group, which has issued a host of LGBT health recommendations.

To be an HEI Leader, a hospital must not only ensure equal visitation and forbid discrimination against LGBT patients, but also ban discrimination against LGBT employees and provide senior managers with LGBT health training. This training, available free online from HEI staff, reviews key LGBT health issues. For example, a recent study revealed that 56 percent of lesbian, gay, and bisexual patients and 70 percent of transgender patients have experienced discrimination in healthcare because of their LGBT status. Also, the LGBT community experiences a number of health disparities — most rooted in stigma and social stress.

The HEI is a highly effective way for hospitals to ensure that their policies meet LGBT-related CMS and Joint Commission requirements. Equally important, it shows hospitals how to provide an equitable and welcoming environment for LGBT patients and their families.

— Shane Snowdon, M.A.
Director, Health and Aging Program Human Rights Campaign Foundation
MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES
Go to www.massmed.org/cme/events or call (800) 843-6356. Unless otherwise noted, all events are held at MMS headquarters, Waltham.

8th Annual Women’s Cardiac Health Conference
Fri., Feb. 1, 8:00 a.m. to noon

Preventing Falls in Older Patients: A Provider Tool Kit Webinar
Wed., Feb. 6, noon to 1:30 p.m.

The Impact of Effective Communication on Patients, Colleagues, and Metrics
Fri., Feb. 8, 8:00 a.m. to noon.

How to Prepare for ACOs
Wed., Feb. 27, 6:30 p.m. to 9:00 p.m.

Managing Workplace Conflict: Improving Personal Effectiveness
Thurs., March 7, 8:00 a.m. to 4:00 p.m. and Fri., March 8, 8:00 a.m. to 3:00 p.m.

ONLINE CME ACTIVITIES
Go to www.massmed.org/cme.

Risk Management CME

End Of Life Care
• The Importance of Discussing End-of-Life Care with Patients*
• Legal Advisor: Advance Directives*

Pain Management
• Legal Advisor: Identifying Potential Drug Dependence and Preventing Abuse*
• Managing Risk When Prescribing Narcotic Painkillers for Patients*

Other Online CME
• Bullies and Victims: Can You Tell the Difference?
• Acid Suppression Therapy: Neutralizing the Hype
• Antitrust Considerations for Physicians in Massachusetts
• Legal Advisor: Legal Duties and Options When a Patient Raises Suicide
• Medical Mistakes: Learning to Steer Clear of Common Ones
• Incorporating Meaningful Use in the Specialty Practice
* Also available in print. Call (800) 322-2303, ext. 7306.

TO REGISTER FOR ANY OF THESE ACTIVITIES, CALL (800) 843-6356.

CME CREDIT: These activities have been approved for AMA PRA Category 1 Credit™.

For additional information, contact the Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to www.massmed.org/cmecenter.