

VITAL SIGNS



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Payment Reform Becomes Mass. Law

BY ERICA NOONAN

With the Legislature's passage of a 349-page payment reform bill on July 31, Massachusetts once again made health care history by unveiling an ambitious roadmap to reduce costs, improve transparency, and promote innovation.

No other state promotes alternative payment methodologies as vigorously as does this bill. However, it also reflects two central tenets of MMS policy on payment reform: Physicians will be free to decide whether they want to adopt an alternative payment methodology; and traditional fee for service arrangements may still exist alongside, or even within, a global payment structure.

"Global payments aren't a one-size-fits-all solution, and fee-for-service still has a vital role to play in our system," said MMS President Richard V. Aghababian, M.D.

To control health care costs, the law sets targets equal to or slightly below the annual growth in the state's economy, with some ability to adjust the targets in future years. Lawmakers decided not to penalize providers that exceed the targets, but require them to file a corrective action plan.

The Society cheered the legislation's inclusion of the Disclosure, Apology and Offer model of medical liability reform that it has championed for many years. This alternative to traditional litigation will foster a climate of safety and openness in all health care settings, especially when a patient is harmed by an adverse medical outcome, Dr. Aghababian said.

Initiatives to foster transparency of reliable cost and quality information will not only benefit patients, but will also assist providers in recommending the most effective and affordable tests, drugs, and procedures for their

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The Medical Home of the Future: Friendly, Focused, and Forward-Looking

BY VICKI RITTERBAND

One day in the not-too-distant future, a typical "medical home" will likely look something like this:

The patient comes into the office with an itchy abdominal rash. She is greeted with a warm hello by the receptionist, who asks after her new grandson. The receptionist hands her a clipboard with a depression screening tool in Spanish, her preferred language, and explains its purpose.

Once in the exam room, the medical assistant tells her she is due for a mammogram and bone density exam. Would she like to schedule them now?

The patient's care team — a physician, nurse, and medical assistant — conferred earlier about her difficulty sticking to her medication regimen, so the nurse will do a quick educational session at the end of the visit.

The physician enters the room and is able to start her work, said Kirsten Meisinger, M.D., medical director of Cambridge Health Alliance's Union Square Family Health in Somerville.

"I am now in the incredibly happy circumstance of turning to my patient and asking her what she needs and meaning it," said Dr. Meisinger, describing such a scenario. "I have nothing else on my to-do list. All the non-urgent things she needs have been done by my team."

Post-visit, the patient exits the waiting room, waving to her medical assistant who is busy calling a list of diabetic patients who are overdue for their HbA1c test, and her nurse, who is checking in on a patient recently discharged from the hospital. Looking on from a comfortable

cushion in the reception area is the therapy dog, a yellow Lab mix named Ginger. The patient pats her head on the way out.

This scenario — an amalgam of elements from eight practices that consider themselves medical homes — may sound like a fantasy to many Massachusetts physicians.

So far, only 107 Bay State practices have been recognized by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes.

But in the coming years, an increasing number of the state's primary care physicians will find themselves practicing in a similar environment. Most likely their reimbursement rates will also be tied to NCQA recognition.

Proponents say the medical home model is good medicine and ultimately cost-saving because it emphasizes preventive care and better management of chronic disease.

Becoming a medical home requires a practice to make

profound changes in its technology, work flow, and culture, but the benefits can be huge.

What follows are a few of the most common challenges practices have faced during the transformation as well as lessons learned along the way.

Creating a Team-Based Approach

The team-based approach not only improves the efficiency and effectiveness of the visit, but also keeps things from falling through the cracks, said Laura Zucker, M.D., of Family Practice Group in Arlington.

"Previously, if I needed an administrative assistant's help, I would walk into the administrative area and of course everyone would be on the phone. It was catch-as-catch-can," she said. "Now I can assign a task to the dedicated person, and there's accountability."

For many primary care offices, practicing more collaboratively

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Tufts Medical Student Competes in Olympic Rowing



AP Photo/Armando Franca

MMS medical student member Gevvie Stone reached the semifinals of the women's single sculls at the London Olympic Games this summer. Stone, a native of Newton and a medical student at Tufts University School of Medicine, took two years off from medical school to dedicate time to training and competitive rowing. She returns to her studies at Tufts this fall with an anticipated graduation date of June 2014.

PRESIDENT'S MESSAGE



MMS on the Front Lines of Change

As we report on Page 1 of this issue of *Vital Signs*, Massachusetts has an ambitious new health care law outlining a legal framework for today's evolving health care system. It's a complex bill, and will affect many aspects of the physician practice, from finances to daily interactions with patients.

We are continuing to study the fine print, and will produce special advisories for you throughout the rest of the year. That's part of our job — to serve as your resource and advisor in this changing environment.

Another role is advocacy — to represent your interests to lawmakers, regulators, and the general public. This issue has been very challenging for the MMS from the beginning, when Past President Alice Coombs was named to a special payment reform commission in January 2009. Given the affordability crisis, we had to be serious about bending the curve of health care costs. But as physicians, we also had to ensure that health care quality, access, and equity were not compromised in efforts to improve efficiency.

Your officers were in frequent communication with elected and appointed officials on this issue, and are on a first-name basis with most of the key players. They want our advice and counsel, and understand that we provide a unique perspective.

Will this legislation achieve its goals? Due to its groundbreaking nature, only time will tell us for sure. I can assure you the MMS will continue to work on the front lines, advocating and educating as energetically as always.

Our work has only begun.

Richard V. Aghababian

— Richard V. Aghababian, M.D.

Medical Home

continued from page 1

has required that nurses, medical assistants, and even receptionists take on much more responsibility. At Harvard Vanguard Medical Associates in Medford, nurses now adjust medication dosages based on protocol and the physician's orders. That new responsibility is one example of what Harvard Vanguard's Thad Schilling, M.D., refers to as "functioning at the top of their license," a critical element of team-based care, he says. At Boston Health Care for the Homeless Program, high-risk patients — identified through a computerized stratification tool — now meet alone with nurses for clinical care management visits, intended to engage them more in their own health care.

Fostering Collaboration

This highly collaborative model of care can be difficult for physicians at first, said several physicians. "Doctors aren't used to being team players," said Harvey Bidwell, M.D., medical director of Bowdoin Street Health Center in Dorchester.

"Sometimes it's because you have a sense of responsibility and you're not sure whether that other person is asking the question in way that will elicit the real answer — for example, screening for depression," he said. "Until you have that level of confidence, you're going to repeat the questions yourself."

Regular communication is important for building team solidarity as well as improving patient care, said several practices. At Family Practice Group in Arlington, every morning begins with a quick care team huddle, when the physician, medical assistant, and administrative assistant meet to talk about

their patients for that day. It's when they discuss who needs what preventive screenings; review big things going on in patients' lives that may affect their health; work out scheduling snafus; and distribute phone messages.

Providing Proactive, Coordinated Care by Knowing the Patient

The patient-centered medical home model requires that practices track patient health to a greater degree than ever before. Information technology that allows caregivers to identify needed care for individual patients, gain insight into the health of specific groups, and communicate with other care settings is a must, but not always easily attainable. Often, the practice will have to customize its existing electronic medical record system, yet even then, pulling out actionable information is not simply a matter of pressing a button.

"If you have additional resources, putting that toward data analysis can be really helpful, because you need to extract a lot of clinical information," said Jessie Gaeta, M.D., medical director of Boston Health Care for the Homeless. "On Monday morning we're able to email a report that tells clinicians who they'll be seeing, what they need, and what they've been able to accomplish with the patient so far. Seeing the data in black and white is a powerful facilitator of change for clinicians who may think they are regularly doing things like medication reconciliation, but aren't."

Patients Must Do Their Parts

Atkinson Family Practice in Amherst requires that patients get a regular physical, as one important way for the office to keep apprised of their health status. If

patients are more than two years overdue, they have 30 days to make an appointment or they're dropped from the practice.

"I need to know what's going on with that person," said Kate Atkinson, M.D., who added that most patients respond to the warning. "Are they smoking, exercising? Has their job or marriage status changed? These are all things that affect their health. ... I never get a call on a weekend from someone who has stepped on a nail because everyone is up to date on their vaccinations."

Auburn-based Grove Medical Associates has prioritized keeping better tabs on high-risk patients post-hospitalization. The practice has urged hospitals where its physicians don't round to notify it when a Grove patient visits the emergency room or is hospitalized.

Once discharged, a nurse from the practice — whose hours were increased for this sole purpose — aims to do a follow-up call to the patient within 24 hours, and encourages him or her to visit the office within three days. "We've done a good job, but haven't been able to do this across the board," said David Weinstock, D.O. "Sometimes that last call on the list may not get made."

Creating a patient-centered medical home can be onerous, expensive, and time-consuming. Yet, the physicians interviewed by *Vital Signs* agree it's been well worth it.

"I'm working as hard, or harder, than ever, but I have great job satisfaction," said Dr. Meisinger of Union Square Family Health. "I know I'm taking better care of my patients in 2012 than I was in 2002. That's why I come to work happy every day, in spite of going home tired." **VS**

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The Importance of Using Data in Your Practice

Changing payment models are forcing physicians to meet quality metrics and maintain targeted levels of performance in order to be reimbursed. As a result, understanding and utilizing practice data is becoming extremely important. Many physicians are already using electronic health record (EHR) data in innovative ways to manage patient health and maximize quality and efficiency. For those practices not as far along in the process, the good news is that EHRs provide a wealth of information that practices can use to get a solid, fact-based snapshot of how they are performing and which areas can be improved.

This information is key for practices participating in accountable care organizations, contracting with health plans offering performance-based pay, or participating in federal programs that provide bonuses for meaningful use of technology.

The bad news is that many practices lack the resources to determine what data should be

used, how to interpret it, and more importantly, how to use it in the practice. Regardless of where you may be in the process, here are some points for consideration for using data in your practice:

- **Data collection and reporting.** Unlike paper records, an EHR system can aggregate and report data in ways that are easily searchable and organized. The type of data that practices need to capture is often dictated by the reimbursement programs that the practice participates in or its specific health plan contract requirements. Either way, practices should become familiar and comfortable with creating and running reports based on their practice data. In some cases, EHRs are set up to generate predefined reports that can be accessed within the EHR.

- **Using data to provide better care and expand your practice.** Data analytics can be used to identify at-risk patients who fall outside the normal benchmarks and may require some special attention and/or follow-up clinically. By having such data in hand, physicians are able to target these specific patients and develop programs to better manage their care. Data not only improves patient outcomes, but also opens the door to opportunities for practice expansion in different areas, including disease or condition centered program development.
- **Data will soon become bigger and better.** The emergence of health information exchanges will only expand the scope of analytics and provide physicians with access to regional and national data, providing a more holistic view of patient information. **VS**

—Talia Goldsmith

For more information on data analytics visit: www.massmed.org/data2012.



New Member Benefit: Physician Fact Book

The new MMS *Physician Fact Book* is now online. Find out how you compare to other physicians in Massachusetts and across the United States.

The *Physician Fact Book* reviews physician supply, physician demographics, current and past physician shortages, as well as average physician compensation within the state. It also reviews the rate of change in medical school applications in Massachusetts, as compared to the United States.

The fact book notes the percentage of Massachusetts physicians accepting new patients by specialty, physicians accepting Medicare and Mass Health by specialty, average patient wait times, and much more.

—Melissa Higdon

The *Physician Fact Book* is available for download at www.massmed.org/factbook.

Adding Value to Practice: Being Ready for a Billing Audit

We are no longer operating in a world of “if we get audited,” but rather “when we get audited.” Your practice can successfully survive an audit with preparation, education, and a well-outlined internal plan.

Recently, the North Carolina Medical Society released a YouTube video highlighting inefficiencies in the audit process and the dangers of not being prepared or not understanding a practice’s role in billing audits.

While viewing the video, I found myself cringing because the featured practice was assessed a \$1 million fine by CMS. The practice then spent over four years and \$300,000 fighting the audit findings.

I often consult with MMS members about proper compliance techniques. In speaking with practices, I routinely encourage them to prepare in advance for audits rather than simply waiting for the day when a letter arrives from a health plan requesting

medical records. Education, understanding, and proper planning can save your practice significant time and money.

- **Educate yourself.** Know what each health plan requires as part of its integrity program or claims review process. Information can be found on health plan websites or by reading your contracts.

Understand what the time period is for records review, whether or not an auditor is allowed to visit the practice site, and the frequency with which auditing can occur for each plan.

- **Know where you are at risk.** Improper documentation or processes that do not support billing levels are often the source of error or risk. Consider engaging an external auditor on an annual basis to perform a mock audit and discuss the findings with your practice. Don’t forget to involve key staff in the mock audit. Consider it

a test run for the day you receive a letter from a health plan requesting records. Use this as an opportunity to outline the internal process your practice will take.

- **Identify a designated staff member to manage the process.** It is important to have a designated full-time person responsible for managing an audit. Do not have a temporary staff member make photocopies of charts and drop them in the mail. That person may not be familiar with what the audit is looking for and may not be familiar with how the physicians in the practice document their charts.

Choose someone familiar with the practice, how the physicians work, and where things are located within the chart. This person will be able to see if something important is missing or highlight the location of

key information for the audit reviewer.

- **Organize the information and flag important pieces for the auditors.** Practices that take this step often have high levels of success. If things are hard to find, the auditor may miss them. In most cases, the auditor is not on site and you will not have an opportunity to point out where pertinent information is located.
- **Make copies of submission materials.** Make copies of everything you submit, so if something accidentally goes missing, it’s easy to provide to the auditor. Also, if your practice questions or disputes an audit finding, knowing exactly what records were sent will help speed response time. **VS**

—Kerry Ann Hayon

For more information on the auditing process, visit: www.massmed.org/audits.

International Health Studies Grant Recipient Travels to Liberia

Julia von Oettingen, M.D., a resident at Massachusetts General Hospital for Children, received an International Health Studies grant from the Massachusetts Medical Society and Alliance Charitable Foundation to help defray the costs of her global health trip to Liberia.

"To be continued..." I thought to myself when I left Liberia in February 2011, following a month of work abroad and many months of preparation beforehand. One year later I have returned from my second HEARTT pediatric global health trip to Liberia.

HEARTT (Health Education and Relief Through Teaching) was founded in 2005 to help rebuild the country's health infrastructure after more than a decade of civil war.

HEARTT works with the Liberian Ministry of Health to improve clinical care and medical education. The organization is based out of Liberia's largest academic teaching hospital, John F. Kennedy Memorial Hospital in Monrovia, and collaborates with major academic institutions in the U.S.

My second time around I understood the difficulties ahead and the dramatic needs of this small country of four million on

Africa's western coast, surrounded by conflict-ridden Sierra Leone, Guinea, and the Ivory Coast.

Taking care of a child with a foot infection, who lives in a dirt-floor shelter without access to clean water, food, or electricity had given mere statistics real meaning. I also knew the rewards that came from helping build a successful juvenile diabetes program that has been quite successful.

Through HEARTT, I attempted to address a lack of resources, training, and access by leading daily bedside teachings with students, residents, and mid-level providers. Also, together with a Liberian senior resident, I engaged in modeling teaching rounds, and organizing formal teaching sessions.

Most importantly, I worked with Liberian residents, learning from them, teaching them, and creating a culture of mutual exchange of medical knowledge.

Despite the challenges, this approach has led to huge successes. Liberia has gone from having no pediatricians in the whole country to having two

Liberian pediatricians heading the pediatric department at JFK.

And there are little, but important, successes every day. A septic newborn can be treated in time with the right antibiotic. Nurses now use glucometers to detect a child in diabetic ketoacidosis; and residents now start their pre-rounds with the most critically ill child.

I very much hope that this chapter of the story, is also "to be continued..."

— Julia von Oettingen, M.D.

Applications for 2012 International Health Studies grants are due September 15. Visit www.mmsfoundation.org for information.



Julia von Oettingen, M.D., visiting a patient's family at their home.

CDC Announces New Lead Screening Policy

In May, the CDC announced a change in policy in order to promote the identification of, and earlier intervention for, children exposed to lead. Previously, the CDC set a "level of concern" at 10 micrograms of lead per deciliter ($\mu\text{g}/\text{dL}$).

The new policy sets a "reference value" currently at 5 $\mu\text{g}/\text{dL}$. This value is based on the population of U.S. children ages 1 to 5 with the highest blood lead levels. This means that physicians can expect to see more tests requiring follow-up.

State guidelines calling for testing of children between the ages of 9 and 12 months, and again at ages 2 and 3, remain unchanged.

Sean Palfrey, M.D., clinical professor of pediatrics and public health, Boston University School of Medicine, and medical director of the Boston Lead Poisoning Prevention Program, praised the change.

"Any exposure to lead is a problem," he said. Even low-level increases in blood lead levels in children are associated with distractibility and hyperactivity, and a 2- to 3-point decrement in IQ for each blood lead level increase of 10 $\mu\text{g}/\text{dL}$, said Palfrey. Increases in level from 0 to 10 $\mu\text{g}/\text{dL}$ have been shown to cause greater relative harm than increases in levels between 10 to 20, 20 to 30, and so on, he added.

Approximately 250,000 U.S. children have blood lead levels 10 $\mu\text{g}/\text{dL}$ or higher and an additional 200,000 children have blood lead levels between 5 $\mu\text{g}/\text{dL}$ and 10 $\mu\text{g}/\text{dL}$. Lead poisoning often has no obvious symptoms, but can affect nearly every system in the body. Lead damage is permanent, and there are currently no options for treating the cognitive and behavioral effects of lead exposure, nor for treating low to moderate lead exposure, notes the American Academy of

Pediatrics, though individual educational activities at home and at school clearly provide some counterbalance.

The new CDC policy "should serve as a powerful reminder that children and (pregnant) women are still at risk from their environment," Palfrey said.

Lead paint was banned from household paint in the United States in 1978. While houses built or gut-renovated after 1978 should not have lead, those built before — even if they've been deleaded — may still contain lead. Physicians and parents should be aware that, even if the child's residence does not contain lead, he or she may be exposed to lead in the homes of relatives or child care providers and outdoors.

Palfrey recommends that physicians screen children annually beginning at 9 to 12 months, and at 18 months of age, as well as at-risk children annually until age 6 using venous

testing, which provides more accurate results than fingersticks. He also recommends that obstetricians alert mothers to the risks of lead, and advise parents not to renovate old homes themselves before their baby's birth. Palfrey puts children with poor dietary iron and lead levels above 10 $\mu\text{g}/\text{dL}$ on small amounts of iron as it can compete for intestinal absorption and enzyme action in the body.

Parents should be made aware of the importance of cleaning everything in the home with soap to remove dust and of trying to prevent the child from putting objects (from inside or outside the home) in his or her mouth.

The Massachusetts Childhood Lead Poisoning Prevention Program, www.mass.gov/dph/clppp, and the CDC, www.cdc.gov/lead, have information for parents and homeowners. **VS**

— Robyn Alie

Payment Reform*continued from page 1*

patients, he said.

"We are also pleased to support the wellness programs that are outlined in the legislation," said Dr. Aghababian. "Prevention is the best medicine of all."

At the same time, the MMS is concerned that the law may impose undue burdens on smaller practices, particularly with its new reporting and registration requirements. The Society will look to clarify how small practices will be impacted by the costs and burdens associated with reporting to new entities established by the legislation.

In addition to the financial burdens the new legislation could levy on physicians, the MMS said the new law could go too far in expanding the scope of practice of some non-physician providers. Society officials said they would monitor the developments closely and would be prepared to advocate for corrective measures in the event of unintended consequences.

"The Massachusetts Medical Society remains committed to working with all stakeholders, as we strive for a health care system that is effective, affordable, and accessible to all," said Dr. Aghababian. **VS**

Key Elements of the Legislation

The following is our current reading of the key points of Senate 2400. However, we caution that some sections could be subject to different interpretations in the future by state agencies, the courts, or other parties.

- No provider is required to become an accountable care organization (ACO).
- The state sets standards for ACOs and certifies them. Providers of free-standing services may appeal if an ACO declines to contract with them.
- Sets statewide targets for annual increases in health care costs:
 - **2013 to 2017:** Equal to the potential annual growth rate of the gross state product (GSP).
 - **2018 to 2022:** One-half percentage point below the annual growth in the GSP.
 - **Starting in 2018,** there is limited ability to modify the target.
- Provider groups whose spending exceeds the target may be required to file a performance improvement plan.
- The state may conduct a "market impact review" of any provider whose costs exceed the state target. The attorney general may investigate to determine if the provider is engaging in anti-competitive behavior.
- Provider groups who carry downside financial risk must register with the state. Appears to exempt groups without financial risk who have fewer than 15,000 patients or less than \$25 million in net patient service revenue.
- The state will collect and publicly report cost and quality data provided by provider groups.
- Providers must report their cost and quality information to the state annually. Requirements for who reports will be determined by regulation.
- The state will certify groups that carry downside financial risk, to determine if they are likely to meet their financial obligations.
- Reasserts that physicians must demonstrate competency in the use of EHRs as a condition of licensure. Expands requirements for the implementation of EHRs for a wide range of contracting entities. Every patient must have access to his or her EHR data.
- Malpractice reform: Patients must give 182-day notice before filing a claim following an unanticipated medical outcome. Apologies are not admissible as evidence in a judicial proceeding.
- Reinforces state mental health parity laws, and promotes patient access to such care.
- Establishes various loan repayment, loan forgiveness, and primary care training programs to address health care workforce shortages.
- Creates tax incentives for small businesses that establish employee wellness programs.
- Health plans and large hospitals assessed \$225 million to establish new funds for distressed hospitals, prevention and wellness programs, and health information technology adoption.
- Allows patients to designate physician assistants as primary care providers. Removes limits on the number of PAs that a physician can supervise.
- Allows nurse practitioners to sign forms that physicians must currently sign, as long as they are still practicing within the scope of their license.
- Directs the state to rewrite the regulations of limited service clinics, to eliminate many of the current public health requirements for their operation.

FEDERAL UPDATE**What the Supreme Court's ACA Ruling Means for Massachusetts**

Perhaps it is fitting that the most significant health care law of our times should also be the most controversial and dramatic. And the drama is far from over.

With the Supreme Court's decision to uphold the constitutionality of the law, the focus now turns to the states for implementation and the November 2012 elections.

In upholding the Affordable Care Act (ACA), the court also ruled that Congress overreached in its effort to expand Medicaid and struck down the provision that states that did not comply with the new Medicaid expansions would lose all of their state Medicaid matching funds.

In practical terms, many predict it will be difficult for states to

leave this money on the table. Nevertheless the court's ruling strikes at one of the essential elements of the ACA.

The Massachusetts health reform law was never in jeopardy from the court's ruling. However, the ruling will allow more federal funds to come to the Commonwealth. For example:

- More moderate-income Massachusetts adults and children will be eligible for state-subsidized health insurance. Currently, Massachusetts allows people whose income is up to 300 percent of the federal poverty level to obtain subsidized coverage. Federal law will expand that to 400 percent.
- Additional federal Medicaid funds are expected to bring \$2 billion to the state over six years for childless adults, and another \$100 million annually between 2016 and 2019 to cover children.
- Approximately 62,000 Massachusetts seniors and persons with disabilities see significant savings in prescription drug costs from subsidies and the closing of the so called "donut hole."
- Primary care doctors will see higher Medicare reimbursements.
- Massachusetts residents will be able to purchase a low-cost health insurance option if the work-provided insurance costs 9.5 percent or more of the worker's income.
- Uninsured Massachusetts residents will pay lower penalties. The federal \$95 annual fine is lower than the state's penalty, which ranges from \$228 to \$1,212 per year.
- Starting in 2016, Massachusetts residents who are covered by expensive insurance plans will be taxed on their coverage, as part of the controversial "Cadillac" insurance tax.
- Community health centers, could receive millions in additional funding.

— Alex. Calcagno

Some Improvement in Wait Times for New Appointments

Now in its eighth iteration, the 2012 MMS Health Care Wait Times Study found stable or shorter wait times for new patient appointments in all specialties, with the exception of family medicine where the trend toward longer wait times continues. A trend toward shorter wait times in internal medicine also continues. Since this study was initiated, internal medicine and family medicine have exhibited the most volatile wait time changes year-to-year, with an average year-to-year change of 8 days.

Other findings from the study include the following:

- The number of offices accepting new patients did not change significantly since last year in any specialty.
- Orthopedic surgeons and gastroenterologists remain the most likely to be accepting new patients, while

internists and family medicine specialists remain the least likely.

- Starting in 2011 this study began measuring acceptance of Medicare products among providers. As was recorded last year, Medicare remains almost universally accepted in each specialty.

The study examines the availability of and access to non-emergency, new patient appointments in seven specialties: cardiology, internal medicine, family medicine, gastroenterology, OB/GYN, orthopedic surgery, and pediatrics. In addition, the survey examines the types of insurance accepted by these specialists. Approximately 830 physicians' offices were called for the purpose of scheduling an appointment for a new patient when collecting the data for this study. **VS**

— Melissa Higdon

The full report is available at www.massmed.org/waittimes.

New Workforce Study: Continued Shortages in Seven Specialties

The 11th annual MMS Physician Workforce Study found that physician labor markets continued to be tight in 2012. Seven physician specialties — dermatology, family medicine, general surgery, internal medicine, psychiatry, urology, and neurosurgery — satisfied the statistical criteria of operating in either critical or severe labor markets.

Other findings include:

- Fewer physicians reported seeing an increase in recruiting time for physicians in their practice specialty.
- Fewer physicians reported seeing an inadequate pool of applicants for physician positions in their specialty.
- The percentage of physicians having difficulty filling vacant positions in their specialty declined slightly from 2011 to 2012.
- More physicians expressed dissatisfaction regarding time spent on administrative tasks.

While access to care has improved under Chapter 305, it can only be sustained if there is a strong physician workforce. To accomplish this, a number of changes to the health

environment must take place. Health care stakeholders must work collaboratively on key issues in order to secure a strong physician workforce that will deliver coordinated, high-quality, and cost-effective care.

The MMS, with the assistance of prominent labor economists, completed this year's study that builds upon the results of the previous ten years of Physician Workforce Studies. Given the wide scope of the project, primary and secondary data were used to examine issues affecting the Massachusetts physician workforce.

The MMS Physician Workforce Study provides current and trend data on physician shortages, physician recruitment and retention. The study examines Massachusetts physician satisfaction, career plans, and opinions on health care reform, and professional liability. **VS**

— Melissa Higdon

The full report can be downloaded at www.massmed.org/workforce.

PHYSICIAN HEALTH MATTERS

Doctor: Care for Thyself

It is ironic that we commit our professional work to the care of others, yet often fail to care for ourselves as well as for the significant others in our lives. The disturbing reasons that underlie this reality are many, but the “final common pathway” carries the potential for burnout, impacting ourselves, those close to us, and the care we provide.

Burnout, as characterized by Dr. Christina Maslach, is marked by emotional exhaustion, detachment, and a lack of fulfillment. Burnout is pernicious because of the dysfunction and disability it leaves in its wake, making its prevention vital for a personal and professional life that is balanced and fulfilling.

Recalibrating this reality demands that we step back, reflect, and commit ourselves to reengage the commitment that brought us to medicine. Much like our advocacy for prevention in health care, we ought to be focused on initiatives that deal with wellness and forestall burnout before it materializes.

Framework for Well-Being

As Craig Irvine puts it, “We are ethically obligated to care for ourselves.” Linda Clever, M.D., a prominent physician leader in renewal initiatives, issues a similar reminder. “Taking care of yourself is not selfishness, it is self-preservation,” she writes.

Accomplishing this requires attention to advice we liberally dispense to others: getting enough rest, eating sensibly, exercising, cultivating interests outside of medicine, avoiding “chemical coping” as a strategy for dealing with problems, taking regular vacations, and many other beneficial “interventions” well-known, but often ignored, by us.

Without the framework for personal wellness in our own lives, we are not in a position to afford aid others.

Caring for Significant Others

How often do we discuss our life priorities with those close to us? How often do we ask for their

validation about our plans? We need to remain connected to our family, significant others, colleagues, and friends — connections requiring an appreciation of the centrality of others in our lives.

Work

Our well-being is intimately connected with our work and comes from remembering and valuing the joy inherent in caring for others. Joy that comes from the daily application of our scientific skills and our talents for listening and caring.

As wonderfully stated by Christine Cassel, president and CEO of the American Board of Internal Medicine, “Medicine is, at its center, a moral enterprise grounded in a covenant of trust ... dedicated to something other than its own self-interest. Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it.”

Our role as physicians is demanding and asks us for a measure of equilibrium as we confront economic and regulatory pressures. Yet, we are afforded the privilege of caring for others in moments of health and in times of struggle and death.

Values

This most vital and sustaining life lesson, interwoven with a pursuit of kindness, mindfulness, humor, curiosity, a desire to learn, and daily lessons of humility that the practice of medicine brings, all serve to encourage the wellness essential to our lives as practitioners and individuals striving to lead a full life. Without the emphatic attention to all of these issues we cannot sustain our caring for others and ourselves.

— Charles J. Hatem, M.D.
Chair, Department of Medical Education, Mount Auburn Hospital

For more information, please contact Physician Health Services, Inc. at (781) 434-7404 or visit www.physicianhealth.org.

MMS Celebrates Women in Medicine Month

In honor of Women in Medicine Month, the Committee on Women in Medicine will be hosting the program "Effective Team Leadership."

The program is designed for women physicians who wish to increase their influence as team members and achieve greater inroads into leadership positions.

Featured speakers include Karen Antman, M.D., dean of Boston University School of Medicine, and Luanne Thorndyke, M.D., vice provost for faculty affairs, University of Massachusetts Medical School.

At this event, the Committee will present the first annual Woman Physician Leadership Award to Barbara Rockett, M.D., in celebration of her outstanding leadership accomplishments.

EFFECTIVE TEAM LEADERSHIP
Monday, September 24, 2012
8:00 a.m. to 10:00 a.m.
MMS headquarters
1.75 AMA PRA Category 1 Credits™

For more information or to register, visit www.massmed.org/womensleadership2012.

The Committee offers lectures for women physicians three to four times per year. If you are interested in learning more about the Committee on Women in Medicine, or would like to suggest a topic or speaker for a future lecture, please contact Erin Tally at (800) 322-2303 ext. 7413 or via email at etally@mms.org. **VS**

Interim Meeting Resolution Deadline: October 16

The 2012 Interim Meeting of the MMS House of Delegates will be held Friday and Saturday, November 30 and December 1, 2012, at MMS Headquarters and the Westin Waltham-Boston Hotel.

The deadline for submitting resolutions is Tuesday, October 16. Members may submit resolutions online (preferred

method) at www.massmed.org/resolutions, via email to resolutions@mms.org, or via fax to (781) 434-7589.

The deadline for hotel reservations at the Westin Waltham-Boston Hotel is October 22. Please call the hotel directly at (781) 290-5600 to make your reservations.

ACROSS THE COMMONWEALTH

District News and Events

Berkshire — Young Physicians, Residents and Students Luncheon. Wed., Sept. 12, noon–1:30 p.m. Topic: Financial planning seminar for young physicians, residents, and students. Location: Berkshire Medical Center, Medical Arts Building, 5th Floor Classroom, Pittsfield. For more information, contact the West Central Regional Office.

Essex South — Clambake. Sat., Sept. 8, 1:00 p.m. Location: Coffin/Wingaersheek Beach, Gloucester. For more information, contact the Northeast Regional Office.

Middlesex — Family Jazz Brunch and Magic Show. Sun., Sept. 30. Featuring the Riverboat Stompers and brunch from 11:00 a.m.–1:00 p.m. and magician Bonaparté from 11:45 a.m.–12:15 p.m. Location: MMS headquarters, Waltham. Note: The Middlesex Executive Committee will meet prior to the event from 10:00–11:00 a.m. For more information, contact the Northeast Regional Office.

Middlesex North — Golf Outing and Clambake. Wed., Sept. 12. Golf at 1:00 p.m. Tennis, 3:00 p.m., Brickapalooza (Lego Building) 5:45–7:15 p.m. Cocktails 5:45–7:15 p.m. and clambake at 7:15 p.m. Location: Vesper Country Club, Tyngsboro. For more information, contact the Northeast Regional Office.

Suffolk — Students, Residents, and Young Physician Reception. Thurs., Sept. 13, 7:00–9:00 p.m. Location: Clery's, Boston. For more information, contact the Northeast Regional Office.

Worcester — Individual Claims Consultations. Fri., Sept. 14, 9:00 a.m.–4:00 p.m. Location: Mechanics Hall, Worcester. Problem-solving work sessions to help MMS physicians adjudicate troublesome claims. **21st Annual Women in Medicine Breakfast.** Fri., Sept. 28, 7:30 a.m. Location: Beechwood Hotel, Worcester. Topic: Is Work-Life Balance Possible? Speaker: Julia Johnson, M.D., professor and chair of obstetrics and gynecology, UMass. For more information, contact Joyce Cariglia (508) 753-1579.

Worcester North — Fall District Meeting. Wed., Sept. 19, 6:00 p.m. Location: Fay Club, Fitchburg. Topic: Two Hundred Years of Medical Advances. Speaker: Jeffrey Drazen, M.D., editor-in-chief, NEJM. For more information, contact the West Central Regional Office.

Statewide News and Events

Art, History, Humanism, and Culture Member Interest Network — Bird Banding. Sat., Sept. 29, 11:00 a.m.–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.

IN MEMORIAM

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

Gerald G. Bousquet, M.D., 79; Tyngsboro, MA; Laval University Faculty of Medicine, Quebec, 1959; Died February 24, 2012.

Robert V. Dandrow Jr., M.D., 87; Milton, MA; Tufts University School of Medicine, 1951; Died August 26, 2011.

John L. Doherty Jr., M.D., 79; Wellesley, MA; Tufts University School of Medicine, 1958; Died February 25, 2012.

Bellenden R. Hutcheson, M.D., 89; Roseburg, OR; Northwestern University Medical School, 1947; Died April 14, 2012.

I. Charles Kaufman, M.D., 92; Ventura, CA; University of New York College of Medicine, 1943; Died October 22, 2011.

Edward C. Olchowski, M.D., 59; Acton, MA; Brown University Medical School, 1976; Died January 16, 2012.

Joan Peterson, M.D., 83; Dedham, MA; Medical College of Pennsylvania, 1958; Died April 17, 2012.

Boris Senior, M.D., 89; Dedham, MA; University of Witwatersrand Medical School, South Africa, 1946; Died April 26, 2012.

William C. Sheehan, M.D., 71; Dartmouth, MA; Harvard Medical School, 1964; Died July 11, 2011.

Julius Sozanski, M.D., 93; Lynn, MA; Loyola University School of Medicine, 1944; Died April 14, 2012.

Carlos P. Valle-Santana, M.D., 65; Pittsfield, MA; University of Havana, 1970; Died August 20, 2011.

Samuel L. Winer, M.D., 93; Medford, MA; Kansas City University of Physicians and Surgeons, 1942; Died May 24, 2012.

Linked in

Link In with MMS

Connect with your peers by joining our members-only LinkedIn group at www.massmed.org/linkedin.

NEJM 200th "Dialogues in Medicine"



Photo by Richard Cashin

Prominent medical experts, including physicians Paul Farmer, Tony Fauci, Joe Loscalzo and Eugene Braunwald, gathered in Boston on June 22 for a day-long symposium with four panel discussions on HIV/AIDS, maternal and fetal health, breast cancer and cardiology. Watch the presentations online at nejm200.nejm.org.

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MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES

Go to www.massmed.org/cme/events. Unless otherwise noted, all events are held at MMS headquarters, Waltham.

PubMed: How to Search Like a Librarian

Wed., Sept. 5, 3:00 p.m. to 4:00 p.m.

Women's Leadership Forum: Effective Team Leadership

Mon., Sept. 24, 8:00 a.m. to 10:00 a.m.

Management of Carotid Artery Stenosis and Acute Stroke

Jointly sponsored with the Massachusetts General Hospital Academy and Vascular Center, Sat., Sept. 29, from 7:45 a.m. to 3:45 p.m., MGH, Starr Center Auditorium, Boston.

CME Accreditation Orientation

Tues., Oct. 16, 8:30 a.m. to 11:45 a.m.

Controversies in the Screening and Management of Breast Disease

Wed., Oct. 24, 8:00 a.m. to noon.

Managing Workplace Conflict

Nov. 1, 8:00 a.m. to 4:00 p.m., and Nov. 2, 8:00 a.m. to 3:00 p.m.

SAVE THE DATE

Federal Funding Opportunities

Thurs., Oct. 18, Harvard Medical School, Boston.

Directors of Medical Education Conference

Thurs., Nov. 8.

ONLINE CME ACTIVITIES

Risk Management CME

Go to www.massmed.org/cme.

End-Of-Life Care

- The Importance of Discussing End-of-Life Care with Patients*
- The Unintended Consequences of DNR Orders*
- Legal Advisor: Advance Directives*

Pain Management

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

Public Health

- MA Responds Orientation Course

Other Risk Management CME

- Acid Suppression Therapy: Neutralizing the Hype
- The Importance of Data Analytics in Physician Practice
- Seven Steps to Better Health Literacy*
- A Path to ACOs
- Legal Duties When a Patient Raises Suicide
- Dealing with the Changing Dynamic of Medical Staff
- The Changing Nature of Informed Consent: Informing Patients and Avoiding Litigation
- Avoiding Failure to Diagnose Suits
- Physician Practices Scramble to Comply with New Privacy Regulations
- Social Networking 101 for Physicians
- Terminating the Doctor-Patient Relationship
- Boundary Issues in the Physician-Patient Relationship

* 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.

