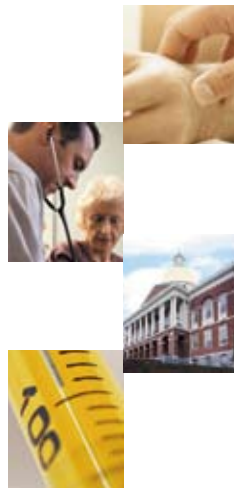




# VITAL SIGNS



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## MMS Strengthens Its Preauthorization Guidelines

### Task Force Continues Work with Health Plans to Preserve Physician-Patient Relationship

BY TOM WALSH

Signaling its continued support of physicians who object to health plans' imaging-study preauthorization requirements, the MMS Board of Trustees voted recently to strengthen the Society's previously adopted "principles" for these situations.

"We're still out there fighting to support our members who have hassles with preauthorization," said Kenneth R. Peelle, M.D., MMS president. "We're keeping the insurers' toes to the fire regarding what they told us they would do."

Many Massachusetts doctors assert that health plans' preauthorization requirements for imaging studies can hinder patient care and damage doctors' relationships with patients. Health plans maintain that these programs can help improve quality of care and control costs.

The MMS strongly believes in the need to improve care and control health care costs, but Dr. Peelle maintained that health plans need not require preauthorization for physicians who have strong records of ordering imaging studies appropriately. "We keep trying to find ways to make it easier on the physicians who have a good record," Dr. Peelle said.

#### Tougher Denial Criteria

The Board of Trustees, working with the MMS Task Force on Medical Cost Control, approved the following changes to principles that were first approved by the MMS House of Delegates in 2005:

- Prior-authorization requirements should be suspended when a patient needs urgent care.

- If an imaging request is denied, documentation that includes the reason for denial and the name of the physician making the denial decision should be sent to the clinician.
- Denials should be issued by a licensed, board-certified, actively practicing physician who regularly treats patients in a clinical setting and who would typically manage the medical condition under review.
- Health plans conducting prior authorization programs should track patients who have been issued denials and monitor their subsequent care for the health problem that prompted the imaging request.

#### Paper Trail Needed

B. Dale Magee, M.D., MMS president-elect and chair of the Task Force on Medical Cost Control, said only two plans that require preauthorization — Tufts Health Plan and Health New England — actually issue denials. Blue Cross and Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Neighborhood Health Plan require preauthorization but do not deny physician imaging requests. Fallon Community Health Plan makes preauthorization decision support available but does not require its use.

Dr. Magee said preauthorization is one way the plans gather data, much of which they have shared with the MMS. Ideally, he said, health plans and physicians should work together to analyze this information to improve quality. "Improving the quality of health care is the top priority of the Medical Society," Dr. Magee emphasized.

The MMS Board of Trustees added to its preauthorization principles the stipulation that health plans should track subsequent care of patients for whom they deny imaging studies. "Our assertion to the plans is that we need a good paper trail," Dr. Magee said. "If modern medicine means tracking results and understanding the consequences of what you do, it means that the plans should do that as well."

#### Denial Prompted Board's Action

Dr. Magee said the original impetus to strengthen the Society's preauthorization principles came from John W. Sullivan, M.D., a Longmeadow neurologist whose frustration turned to inspiration after a patient was denied an MRI. As his patient's symptoms worsened, Dr. Sullivan persisted in his demand for the test.

*continued on page 2*

## From Boston to Bangladesh, the *Journal* Expands Its Electronic Reach and Impact

BY TOM WALSH

The e-mail came from a physician in Nepal, and it underscored one of the many innovations the *New England Journal of Medicine* (NEJM) and the MMS Publishing Division are responsible for these days.

"This physician was working in a very poor setting," recalled Edward W. Campion, M.D., senior deputy editor and online editor at the *New England Journal of Medicine*. The physician had trained in Europe's major economic cen-

ters, but had eventually moved out to the fringes, where he was working when he contacted NEJM. In his e-mail, he credited having electronic access to the *Journal* with helping him feel part of the professional mainstream and connected to the center of medicine.

One of many programs ushered into being by Web-based technology, this one makes NEJM available free online to physicians in 120 low-income countries around the world. "We now have servers programmed to recognize users from one of

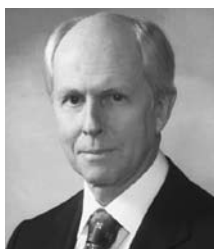


Innovations at the *New England Journal of Medicine* have led to expanded website offerings including instructional videos, 3-D animation, and podcasting.

*Photo montage by Chris Twichell*

*continued on page 2*

## PRESIDENT'S MESSAGE



### Networking with Other States' Health Care Leaders Helps Everyone

As Massachusetts physicians, we are understandably focused on the

health care environment in our own state. But among the many privileges MMS presidents have are opportunities to represent our Society at gatherings of health care leaders outside Massachusetts. I've found that the cross-pollination of ideas that takes place between leaders of different states can contribute to the improvement of health care here and across the country.

People outside Massachusetts always want to know about our "universal coverage" law. Many of the questions are about the so-called "individual mandate" that requires all residents to have some form of health insurance. The Commonwealth Health Insurance Connector Authority has worked hard to make sure that premiums for non-subsidized plans are affordable, deductibles are manageable, and that reasonable choices are available. Our Massachusetts program is a work in progress, for sure, but other states will continue to see us as an example to emulate.

Another area in which people look to Massachusetts for health care leadership is information technology (IT). With the ongoing positive impact of the Massachusetts eHealth Collaborative, Masspro's successful management of the federally funded DOQ-IT program, and our own Society's efforts to help small- and medium-sized practices adopt electronic

health records (see *Vital Signs*, February 2007, page 1), our colleagues in other states are learning from us how to tackle thorny IT issues such as cost and interoperability.

Conversely, we're learning a lot from other states about professional liability reform. We recently hosted an event focused on how the University of Michigan Health System drastically changed its approach to malpractice. And the MMS Task Force on Medical Liability Reform, chaired by past president Alan Woodward, M.D., is studying alternative strategies, including apology, that have yielded impressive results in states such as Colorado.

Finally, we're just starting to learn from other states how to fairly and effectively implement a skills-assessment and remediation program for physicians who are changing specialties or returning to practice after a hiatus. California, Colorado, Oregon, and Texas are the leaders in this regard. With their help and the cooperation of the Board of Registration in Medicine, we hope to develop a sound program in Massachusetts.

I am very grateful to the health care leaders from other states who have shared their ideas and listened to ours. To keep moving forward in Massachusetts, we must continue to evaluate viable ideas for health care improvement, wherever or whomever they come from.

*Kenneth R. Peelle*

— Kenneth R. Peelle, M.D.

#### Preauthorization Principles

*continued from page 1*

Finally, the test showed that his patient had a tumor that was impinging on a nerve.

"That patient was treated and today is doing well," Dr. Magee said. "But the fact is that the plan stood between Dr. Sullivan and a prompt diagnosis for his patient." Dr. Magee added that this episode demonstrates the need for health plans to track care and outcomes after denials.

Barbara Rockett, M.D., MMS past president, told of how, on a Saturday, a patient with back problems came to the office she shares with another MMS past president, her husband, Francis Rockett, M.D. "Fran said the patient needed an MRI right away because the symptoms pointed to an acute ruptured disk," she said. "But when we called the health plan, they told us they were only available for preauthorizations Monday through Friday." The Rocketts knew a senior executive at that health plan and called him. Only after that was the preauthorization granted and did the patient receive timely care.

#### "Bar Not Terribly High"

Thomas Ebert, M.D., vice president and chief medical officer at Health New England, which serves Western Massachusetts,

said his plan's four-year-old preauthorization program "has had a direct impact on trying to slow the rate of premium increases." He added that "when tests are not necessary and they are not ordered, it is good for the health system and good for our members. It makes money available to provide services of other kinds."

Dr. Ebert maintained further that when it comes to getting imaging approvals, "the bar is not terribly high."

*"We're still out there fighting to support our members who have hassles with preauthorization."*

— Kenneth R. Peelle, M.D.  
MMS President

And, he said, preauthorizations are a rational response to what he sees as "enormous variations" in physician ordering patterns for imaging studies.

Dr. Magee said the Task Force on Medical Cost Control

continues to meet regularly with the plans to discuss all issues surrounding imaging studies, including variability in ordering. "What has evolved is a template of data on utilization compliance," he said. Technology and continuing medical education will help improve the system, he added.

Meanwhile, the MMS continues to watch preauthorization practices closely. "We are working with the plans to decrease inappropriate burdens on physicians," Dr. Magee concluded. "Inasmuch as plans do anything inappropriate, we are advocating for doctors and their patients." **VS**

#### NEJM's Electronic Impact

*continued from page 1*

these 120 countries," Dr. Campion said. "They get everything for free, right from the moment it's published."

Bolstering NEJM's online presence while continuing to support the venerable print publication make this and many other ventures possible. "Being online helps us to do more easily what we always wanted to do in print — encourage dissemination of medical information and support physicians and health care development," Dr. Campion explained.

Added Kent Anderson, NEJM executive director of international business and product development, "Our online version has become dominant. More people now see us online than in print."

Among other "electronic" innovations at NEJM are the following:

- Online audio and video clinical features that are of educational relevance to physicians and other health care professionals. One of the first videos

showed techniques for placing an arterial line. Among the thousands who accessed that video were viewers from more than 100 foreign countries.

- "Physician's First Watch," an early morning e-mail briefing on the day's medical news
- An enhanced online presence for the *Journal Watch* family of newsletters. Similar to the digital evolution of NEJM, *Journal Watch's* five-year plan will move it from a print publication with an online presence to an online enterprise that includes print.

"What we're trying to do is to get out information in as many different forms as possible," Anderson concluded. "Long term, all of this is going to be digital and multimedia. Now's the time to marshal all of our skills and get this done." **VS**

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## SPOTLIGHT ON SUCCESS

### Vendor Selection Tips from Brookline Village Dermatology

The time had come for Brookline Village Dermatology to move to electronic health records (EHRs). The two-and-one-half physician practice recognized that their paper recordkeeping system was archaic and that EHR systems were improving. They also realized that while seeing 90 to 100 patients a day, the practice spent \$5 per chart whenever someone touched a patient record.

#### Basic Research

Office manager Leah Arteaga investigated six EHRs based on references from colleagues and familiarity with the companies. The practice ruled out two of the vendors based on price. As Steven Shama, M.D., noted, "In vendor selection, price is still the bottom line; all practices have investment limitations." However, he cautioned physicians not to be myopic about financial recoupments. "If your office staff and patients are happy, you will keep them longer," he observed.

#### Keys to Successful Vendor Selection

**Wish List.** Establish a wish list of problems you need to solve. Share it with vendors in advance of any sales presentation or demo.

**Time.** Brookline Village Dermatology's vendor-selection process lasted six months. They recommend not rushing vendor presentations. Take the time to digest what the vendors have laid out for you, and don't let them force you into a decision deadline.

**Education.** Good vendors don't just sell; they educate. By listening closely to each presentation, office staff realized which functions their practice truly needed. This allowed them to ask vendors if a modular approach or lower-cost systems were available.

**Trust.** Brookline Village Dermatology eventually went with a company that seemed genuinely interested in what was best for the practice. Their selected vendor, LighthouseMD, wanted to "fill a need instead of create a need," said Dr. Shama.

#### Other Considerations

Dr. Shama and Ms. Arteaga cited other factors practices should consider when they select an EHR vendor:

- **Staff Input:** The selection process should be a partnership between a physician leader and the office manager and should include broad staff input.
- **System Interoperability:** Does the system work with other systems in your office? Does the vendor offer integrated products that would eliminate the need for multiple vendors? How smoothly will your current system transition to the new one? Will there be additional conversion costs?
- **Security:** Are you protected from system downtime? Do upgrades occur automatically, or does the office need to install them? If remote access is involved, is that protected?
- **Training and Support:** Select a vendor with a good national reputation but local office support. Ideally, training will be included in the upfront cost of the system.

Satisfied with its vendor selection, Brookline Village Dermatology realized a savings of \$60,000 during the first year after implementing its new billing and EHR system. **VS**

— Dana Cooper

If your practice is interested in being featured in Spotlight on Success, contact Dana Cooper at (781) 434-7218 or [dcooper@mms.org](mailto:dcooper@mms.org).

### Harvard Pilgrim Fees to Rise 3.5 Percent

Harvard Pilgrim Health Care's updated standard physician fee schedule will take effect on April 1. The new fee schedule incorporates Medicare's 2007 national Relative Value Units and will result in an aggregate increase of 3.5 percent for physicians.

Physicians will be able to determine the effect of the new fee schedule on

their individual practices after reviewing specialty-specific information and by referring to sample fee schedules, which are available upon request.

Physicians with questions regarding fee schedules should contact the HPHC Provider Service Center at (800) 708-4414, option 5. **VS**

— Dana Cooper

## LAW AND ETHICS

### Making Apology Work in Medicine

In our personal lives, many of us place great value on apology as a way of redressing wrongs. When we act in a way that results in harm to another, we often see apology as the appropriate ethical response.

In the context of medical adverse events and unanticipated outcomes, however, apology has not been seen as a realistic option, largely because of the fundamental change from a clinical environment to a legal environment that often occurs in the wake of an adverse event.

Historically, physicians have been advised, and sometimes are even required, to stay silent. In the absence of laws that shield doctors, there may be good legal reasons for such advice, because an apology in which the physician admits fault is considered an "admission against interest" and, as such, may be admissible in a malpractice proceeding as evidence of acknowledgment of fault.

Fortunately, laws making an apology following an adverse event inadmissible in a court proceeding are growing in popularity. Physician apology laws enable candid communication between a physician and his or her patient following an unanticipated medical outcome and appear to reduce overall medical malpractice liability costs by reducing the number of lawsuits and consequent attorney fees and claim costs.

Additionally, research shows that physician apology laws encourage effective assessment, thereby improving opportunities to prevent future adverse events. Such laws also remove obstacles that may discourage physicians from engaging in the moral and humane act of apologizing.

Although Massachusetts was the first state to adopt a physician apology law, the current rule only protects a narrow subset of physician apologies. The Massachusetts statute provides that benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to such person or to the family of such person are inadmissible as evidence of an admission of liability in a civil action (Massachusetts General Laws, Chapter 233, Section 23D). But this law does not protect a physician who takes responsibility for a medical error. It merely renders inadmissible apologies that are passive expressions of sympathy (e.g., "I am sorry that you were hurt."), and does not clearly address the admissibility of apologetic expressions that also take responsibility for the injury-causing incident (e.g., "I am sorry that I hurt you.").

To fully realize the benefits of physician apology, the MMS has proposed An Act Relative to Health Care Providers' Statement of Regret. This legislation prevents any gesture expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of concern from being used as evidence of acknowledgment of fault.

At the Society's Annual Meeting in May, both the Annual Oration and the Ethics Forum will address the issue of apology. **VS**

— William Frank, Esq.

The "Law and Ethics" column is provided for educational purposes and should not be construed as legal advice. Readers with specific legal questions should consult with a private attorney.

### CMS Mandates Use of Revised 1500 Form

As of April 2, physicians who submit paper claims to the Center for Medicare and Medicaid Services (CMS) will be required to use the revised CMS-1500 form (version 08-05). Medicare, health plans, clearinghouses, and other information-support vendors have been accepting the revised forms since January 2. After March 30, CMS will no longer accept claims on the current 1500 form (12-90).

Physicians should contact their forms vendor to order the updated CMS-1500 forms, or they can order them from the AMA by calling (800) 295-9895.

#### Billing Guidelines

In addition, effective May 23, claims containing billed services that require a National Provider Identifier (NPI) will be rejected if the NPI is not entered in items 24J, 17B, 32a, and 33a on the revised 1500 form.

Physicians can apply for an NPI online at <http://nppes.cms.hhs.gov>, or they can receive a paper application by calling (800) 465-3203. In addition, physicians can authorize the Massachusetts Board of Registration in Medicine or another electronic file interchange-approved organization to acquire NPIs for them. **VS**

— Dana Cooper

## Third Annual Public Health Leadership Forum

**Public Health and Health Care Reform**  
**Thursday, April 26, MMS Headquarters, Waltham**

*Jointly sponsored by the MMS and the Harvard School of Public Health's Division of Public Health Practice*

**For more information, call (781) 434-7372, or e-mail [bsird@mms.org](mailto:bsird@mms.org).**

## Thimerosal — Autism Link Does Not Exist

A bill to restrict the use of vaccines containing thimerosal (an ethylmercury-based preservative) nearly passed the full House of Representatives in Massachusetts last summer. A similar bill has been introduced in the 2007 session.

Supporters of the bill feel that the increase in autism rates reported in recent years is related to the increase in pediatric vaccinations during the past several decades. However, a series of recent biological and epidemiological studies have shown this concern to be unfounded. Moreover, restricting the use of vaccines containing thimerosal would have an adverse impact on vaccine supplies in Massachusetts, the cost of vaccines, and the public perception of vaccine safety in general. Following is a summary of evidence that mercury in vaccines is *not* one of the causes of autism.

### All Mercury Isn't the Same

Mercury is a naturally occurring element found in the earth's crust, air, soil, and water. Certain types of bacteria in the environment can change mercury into methylmercury. Methylmercury makes its way through the food chain in fish, animals, and humans. At high levels, methylmercury can be toxic to people.

Thimerosal — a preservative still used in influenza vaccine — contains a different form of mercury called ethylmercury. Studies comparing ethylmercury and methylmercury suggest that they are processed differently in the human body. Ethylmercury is broken down and excreted much more rapidly than methylmercury. Therefore, ethylmercury (the type of mercury in influenza vaccine) is much less likely than methylmercury to accumulate in the body and cause harm.

### Mercury Doesn't Cause Autism

Five large studies have now compared the risk of autism in children who

received vaccines containing thimerosal to those who received vaccines without thimerosal. The studies were consistent, clear, and reproducible: the incidence of autism was the same in both groups. Denmark, a country that abandoned thimerosal as a preservative in 1991, actually saw an increase in autism that began several years after 1991.

Because water, infant formula, and breast milk contain small quantities of methylmercury, an infant who is exclusively breastfed will ingest more than twice the amount of mercury than is contained in vaccines and 15 times the quantity of mercury contained in the influenza vaccine.

### What Does Cause Autism?

Although autism clearly has a genetic basis, environmental factors can also cause the disease. For example, children whose mothers took thalidomide during pregnancy had a significantly greater incidence of autism than babies born to mothers who never took thalidomide — but only if the mothers took it early in pregnancy. Similarly, babies born to mothers who suffer from rubella early in their pregnancies also are at greater risk of developing autism, but as with thalidomide, only if the baby is exposed to rubella early during pregnancy. During the second and third trimesters of pregnancy and after the child is born, the window for environmental factors causing autism apparently closes.

Children in the United States whose mothers received thimerosal when they were pregnant (as a preservative in a drug used to prevent complications from blood-type mismatches between mother and baby) did not have a greater risk for autism than babies whose mothers never received the drug.

— Paul Offit, M.D.

*Director of the Vaccine Education Center,  
 Children's Hospital of Philadelphia*

## Committee on Violence Program to Examine Suicide Prevention

Suicide claims the lives of more than 30,000 people annually in the United States, according to the American Foundation for Suicide Prevention (AFSP). The Centers for Disease Control and Prevention (CDC) lists suicide as the third leading cause of death among young people between 15 and 24 years of age. It is the eighth leading cause of death for men in the United States, although women report attempting suicide during their lifetime about three times as often as men. Further, suicide rates increase with age and are notably high among those 65 and older. The CDC reports that most elderly suicide victims see their primary care provider a few weeks prior to a suicide attempt.

Studies have also shown disproportionately high rates of suicide among physicians and physicians in training when compared to those the same age and gender in other professions. On average, death by suicide is approximately 70 percent more likely among male physicians in the United States than among other professionals, and 2½ to 4 times more likely among female physicians, the AFSP reports.

Risk factors associated with suicide include a history of mental disorders, particularly depression; a previous suicide attempt; chronic illness; alcohol and substance abuse; isolation; loss (relational, social, work, or financial); and cultural and socioeconomic barriers to accessing mental health treatment.

The AFSP says protective factors that mitigate suicide include effective clinical care for mental, physical, and substance abuse disorders; easy access to a variety of clinical interventions and support for help-seeking; and support from ongoing medical and mental health care relationships.

Concerned about these statistics and their implications for physicians, the MMS Committee on Violence will host a program on April 23 at 7 p.m. to examine suicide in physicians and patients, and best practices for physicians in screening patients for depression as a means of reducing suicide risk.

The Committee on Violence program is free of charge and is open to MMS members and others. For more information, contact Candace Savage at (781) 434-7017 or [csavage@mms.org](mailto:csavage@mms.org). **VS**

— Robyn Alie

## WEBSITE OF THE MONTH

### National Public Health Week Focuses on Vulnerable Populations and Public Health Emergencies

April 2 through April 8 marks National Public Health Week. This year's theme is "Preparedness and Public Health Threats: Addressing the Unique Needs of the Nation's Vulnerable Populations."

A September 2006 poll found that only 31 percent of Americans have emergency plans in place, and preparedness is an even greater challenge for many of the nation's most vulnerable populations. During National Public Health Week, the American Public Health Association (APHA) will launch a national campaign to close the gap and ensure that all Americans have a plan.

The APHA's resources are specifically tailored to vulnerable populations, including mothers with young children, hourly wage workers, and people with chronic health care needs. Resources will also be promoted to local food banks and elementary and secondary schools.

Resources and information can be found at APHA's recently improved website, [www.apha.org](http://www.apha.org), which features updated content, enhanced search functionality, and improved navigation.





## REGULATORY UPDATE

### MassHealth to Pay Retroactive Reimbursement Increases

MassHealth announced in February its intention to reprocess claims for payment for services rendered during the summer of 2006. Those payments should have included increases of 3 to 5 percent as part of a \$13.5 million increase in fees for fiscal 2007. The increase was mandated as part of the health care access legislation passed in 2006.

The precise rates were set on time by the Division of Health Care Finance and Policy, but the MassHealth claims processing system was not fully updated until September. Because of this delay, physicians were not paid the increases for claims submitted for services provided in July, August, and parts of September. Upon our inquiry, the MMS was told that physicians could resubmit the claims and the increase would be paid. In most cases, though, the cost of reprocessing individual claims to receive a 3 to 5 percent increase would be impractical.

The MMS raised this issue several times with MassHealth officials and in testimony before the Division of Health Care Finance and Policy, arguing that delays deprive physicians of a significant percentage of the appropriated \$13.5

million increase for fiscal 2007. Another MMS concern was that the claims processing delays might be repeated in the projected increases for fiscal years 2008 and 2009.

In February, MassHealth initiated its own process to review claims from this period and retroactively issue reimbursements for the unpaid but mandated increases. We thank the MassHealth staff and leadership for undertaking this project.

#### MassHealth P4P?

MassHealth is also in the process of investigating pay-for-performance (P4P) mechanisms. Preliminary thoughts were rolled out at a meeting in late January before a clinician advisory committee. Attendees candidly discussed the difficulties of identifying valid quality measures and the importance of not financially penalizing small practices that may be ineligible for incentives if they see an insufficient number of patients for whom a particular measure might be appropriate. It seems unlikely that MassHealth will implement a P4P plan in the coming fiscal year, which begins in July, but we anticipate further meetings and discussions.

#### BRM Looking at Medical Spas and Credentialing

The Board of Registration in Medicine (BRM) recently convened two task forces: one on medical spas and the other on credentialing standards. Created by the Legislature, the medical spa task force will review medical spa practices, including the use of lasers, botulinum toxin, and other treatments by personnel with different training and licensing. Further information is posted on the BRM website at [www.massmedboard.org/public/med\\_spa.shtm](http://www.massmedboard.org/public/med_spa.shtm).

The credentialing task force will review issues associated with uniform credentialing standards in hospitals and other settings. MMS President Kenneth R. Peelle, M.D., addressed the task force in January. Dr. Peelle expressed the Society's support for a uniform credentialing form and a willingness to work with the BRM task force.

Finally, as this issue of *Vital Signs* went to press, there was no word on when the BRM will again revise its proposed regulations or hold public hearings to discuss them. The most current version of the proposals was approved by the board for public hearing in December 2006 and is available on the BRM website. **VS**

— William Ryder, Esq.

## FEDERAL UPDATE

### Mental Health Parity and Other Reforms Advance in Congress

For the first time in decades, Congress is poised to pass federal mental health parity legislation. On February 14, the Senate Health, Education, Labor, and Pensions (HELP) Committee approved a federal mental health parity bill. Sponsored by Sens. Edward Kennedy (D-Massachusetts), Pete Domenici (R-New Mexico), and Mike Enzi (R-Wyoming), The Mental Health Parity Act of 2007 (S. 558) would prohibit insurance plans that offer mental health and substance abuse benefits from imposing tighter restrictions on those benefits than they do on medical and surgical benefits. The bill also would expand an existing law that requires annual and lifetime dollar limits for mental health coverage to be no less than those for medical and surgical coverage.

In addition, S. 558 would prohibit co-payments, deductibles, coinsurance, and out-of-pocket expense requirements for

mental health benefits from exceeding those for other benefits. Plans would also be prohibited from establishing restrictive limits on the scope or duration of mental health treatment.

A compromise measure, the bill would not apply to employers with 50 or fewer employees. And if the new parity requirements drove up coverage costs more than 2 percent in the year after they took effect — or 1 percent thereafter — they would not apply the following year. The bill would also preempt some provisions of state mental health parity laws.

More than 100 organizations supported the bill, including the American Medical Association and the American Psychiatric Association. The AMA and MMS were in contact with Sen. Kennedy's office regarding the impact of the bill's preemption provisions on Massachusetts state law, and we will continue to review these issues prior to final passage.

#### Tobacco Regulation and Genetic Non-Discrimination

On February 15, Sens. Kennedy and John Cornyn (R-Texas) and Rep. Henry Waxman (D-California) introduced The Family Smoking Prevention and Tobacco Control Act of 2007. The legislation (S. 625/H.R. 1108) would give the FDA authority to regulate the manufacture, sale, distribution, and marketing of tobacco products. The Senate HELP Committee, chaired by Sen. Kennedy, is expected to hold a hearing and vote on the bill in the near future.

Both the House and Senate have also introduced legislation to protect patients from genetic discrimination by employers and insurers. This legislation has already been approved by the relevant House and Senate committees, and passage is expected during the 110th Congress. The MMS supports both measures. **VS**

— Alex. Calcagno

## LEGISLATOR OF THE MONTH

### Representative Mary E. Grant (D)

District: Beverly

Committees: House Ways & Means; Children, Families & Persons with Disabilities; Public Health



QUOTE: Before running for office in 2002, I spent almost 30 years in the health care field as a child and adolescent clinical nurse specialist. I hold B.S. and M.S. degrees from Boston College. For 14 years I worked for the Department of Mental Health. Seven of those years were spent in children's services at Wes-Ros-Park Mental Health Center as a clinician and administrator. And my seven years at the Mental Health Center of Greater Cape Ann included a long stint as co-director of the sexual abuse treatment service. In 1990, I opened a private practice. While I have always been active in civic affairs, I waited to run for public office until my family was older and my husband and I were able to balance the demands of office.

My professional background has been a rich resource to bring to bear in the Legislature at this pivotal time. I believe that in the public debate on health care, all of us who are direct clinical providers have to practice with our heads up, and speak up. We bring a necessary clinical perspective. I invite you to join me in this endeavor. I believe we will all be better served.

#### CLARIFICATION

Due to editing, the last paragraph of the February Legislator of the Month column differed from the text that Rep. Jay R. Kaufman submitted. The originally submitted text is as follows:

I also continue to see a need for state laws and regulations to respond to the growing marketplace of health care providers. More than ever, consumers are expressing a desire for choice, seeking out naturopathic, homeopathic, and other non-traditional practitioners and treatments. We must respond by both facilitating the availability of options that do no harm and ensuring that they are provided in a way that protects the public from fraud, malpractice and unqualified providers.

## Multiple Generations Address Disparities



Photo by Fay Photo

Alice Coombs, M.D., MMS assistant secretary-treasurer, demonstrates a mock anesthetic induction for interested youngsters at the Bethel AME Church in Jamaica Plain on March 4. The demonstration was part of the Doctors Back to School program, a grassroots effort to increase the number of minority physicians nationwide, and it coincided with a meeting of the AMA Commission to End Health Care Disparities at MMS Headquarters.



Photo by Linda Quain

The Society hosted the American Medical Association's Commission to End Health Care Disparities meeting on March 4 and 5. During the meeting, the Honorable Louis W. Sullivan, M.D. — former U.S. secretary of Health and Human Services, president emeritus of Morehouse School of Medicine, and chair of the Sullivan Alliance — discussed how increasing diversity in the health professions will reduce racial and ethnic health disparities.

## Free Cancer Screening Slated for April

For the third consecutive year, the Massachusetts Society of Otolaryngology — Head & Neck Surgery (MSO-HNS) will participate in the Yul Brynner Head and Neck Cancer Foundation's Oral, Head & Neck Cancer Awareness Week from April 16 to April 20.

As part of this effort to increase awareness about these diseases, many Massachusetts ear, nose, and throat physicians will provide free screenings for cancer of the mouth, pharynx, and larynx. The

MSO-HNS hopes to exceed the approximately 400 screenings conducted in 2006.

A list of the screening sites can be found on the Yul Brynner Foundation website at [www.yulbrynnerefoundation.org](http://www.yulbrynnerefoundation.org). If you would like more information on the MSO-HNS Oral, Head & Neck Cancer Screening Week or are interested in hosting a screening site, contact Julie Kealey, MSO-HNS chapter administrator, at (800)322-2303, ext. 7317. **VS**

— Julie Kealey

## Preventing the Preventable: Women and Heart Disease



Photo by Linda Quain

On February 16, more than 150 people attended an educational program on women and heart disease sponsored by the MMS Committee on Women in Medicine, in collaboration with the American Heart Association. The conference focused on prevention and practical risk-reduction strategies. During the event, Health and Human Services Secretary JudyAnn Bigby, M.D., (left) addressed cultural competency in women's health and its implications for cardiac risk factors.

## PHYSICIAN HEALTH MATTERS

### Proposed JCAHO Standard Addresses Disruptive Behavior

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently developed a new standard on disruptive behavior. The standard is currently under review and is scheduled for approval this spring. The new disruptive behavior standard, LD.3.15, is contained within the proposed new "Culture of Safety" section of the chapter on leadership.

#### Behavior Linked to Safety

Personal interactions are a critical component of a culture of safety and quality, and the proposed JCAHO standards ask leaders to set expectations for behavior among those who work in the organization. Because safety and quality thrive in an environment that supports teamwork and mutual respect, the standard calls for leaders to impose expectations upon everyone, regardless of their position. Management, clinical and administrative staff, volunteers, licensed independent practitioners, and governing body members will all be held to certain behavioral expectations.

#### "Disruptive" Defined

JCAHO generally identifies disruptive behaviors as those that have the capacity to intimidate staff, affect staff morale, or lead to staff turnover. Behavior deemed disruptive may be verbal or nonverbal, and could involve the use of rude language or facial expressions, threatening manners, or even physical abuse.

The proposed behavioral standards call for leaders to take the following action:

- Develop a professional code of conduct that is applicable to everyone in the organization and that specifically defines desirable and disruptive staff behaviors
- Educate staff about both desirable and disruptive behaviors
- Develop processes for managing disruptive staff behaviors that include steps for identifying and reporting concerns and fair hearings

- Provide management training on addressing disruptive staff behavior at its earliest stages

For background information and to view the proposed JCAHO standard, visit [www.jointcommission.org/AccreditationPrograms/BehavioralHealthCare/Standards/FieldReviews/disruptive\\_behavior\\_bhc\\_std.htm](http://www.jointcommission.org/AccreditationPrograms/BehavioralHealthCare/Standards/FieldReviews/disruptive_behavior_bhc_std.htm).

#### Remedial Resources

If you are concerned about the behavior and workplace interactions of a medical student, resident, or physician, Physician Health Services (PHS) can provide an assessment and support to the individual while your organization conducts an appropriate review. PHS will confidentially evaluate whether the staff member in question is facing a health-related concern or condition and consider additional resources for the individual. A formal PHS assessment is most effective when it includes input from several individuals at the health care organization involved, documentation of the situation, and clarity regarding the reasons for and requirements of the referral.

Although PHS consultation and assessment services are free to all Massachusetts health care organizations, residents, students, and physicians, fees are often associated with independent evaluations and other referral resources that may be indicated. PHS

encourages the referring health care organization to remain involved and ask for a written summary of conclusions reached by PHS.

To help your organization satisfy the JCAHO standard's educational component, PHS can provide lectures and/or grand rounds to your medical staff. **VS**

For more information about PHS or about any of the resources mentioned in this article, please call (781) 434-7404 or visit [www.physicianhealth.org](http://www.physicianhealth.org).

#### Managing Workplace Conflict: Improving Personal Effectiveness

June 21 and 22, 8 a.m.–4 p.m.

MMS Headquarters, Waltham

To register, call (800) 843-6356, or visit [www.massmed.org/cme](http://www.massmed.org/cme).



ACROSS THE COMMONWEALTH

## District News and Events

**Berkshire – High School Doctor for a Day.** Tues., April 10, 7:30 a.m. to 4 p.m. Location: Berkshire Medical Center, Pittsfield. **Annual Meeting.** Tues., April 24, 6 p.m. Location: Spice Restaurant, Pittsfield. For more information, contact the West Central Regional Office.

**Bristol North & Plymouth – Joint Spring Annual Meeting of the District Societies.** Tues., April 24, 6 p.m. Reception followed by dinner and a presentation. Location: Tuscan House, Middleboro. Featured Speaker: Bruce Auerbach, M.D., MMS vice-president. For more information, contact the Southeast Regional Office.

**Bristol South – Annual Meeting.** Wed., April 11, 6 p.m. Location: Venus de Milo, Swansea. For more information, contact the Southeast Regional Office.

**Essex South – Annual Meeting.** Wed., April 25, 6 p.m. Location: Danversport Yacht Club, Danvers. Guest Speaker: Dale Magee, M.D., MMS president-elect. For more information, contact the Northeast Regional Office.

**Hampden – Annual Meeting.** Wed., April 11, 6 p.m. Location: The Munich Haus, Chicopee. Topic: “Now that the Democrats Have the Majority Vote, What Are They Going to Do about Health Care?” Speaker: Honorable Congressman Richard E. Neal. **High School Doctor for a Day Program.** Thurs., April 12, breakfast 7:30 to 8:30 a.m. and debriefing 5:30 to 6:30 p.m. Location: Baystate Health Learning Center, Holyoke. For more information, contact Suzanne Skibinski at (413) 736-0661.

**Middlesex North – Annual Meeting.** Wed., May 2, 6 p.m. Location: Vesper Country Club, Tyngsboro. For more information, contact the Northeast Regional Office.

**Norfolk – Annual Meeting.** Wed., April 18, 6 p.m. Location: Sheraton Hotel, Needham. For more information, contact the Northeast Regional Office.

**Norfolk South – Legislative Breakfast.** Fri., Apr. 27, 7:30 to 9 a.m. Location: Emerson Conference Room at South Shore Hospital, S. Weymouth. For more information, contact the Southeast Regional Office.

**Southeast Regional Caucus –** Wed., May 9, 6 p.m. Location: LeBaron Country Club, Lakeville. Delegates from Barnstable, Bristol North, Bristol South, Plymouth, and Norfolk South District Medical Societies will meet to review and discuss resolutions prior to the annual meeting. For more information, contact the Southeast Regional Office.

**Suffolk – Legislative Briefing.** Wed., April 11, 9:30 a.m. Location: The State House. For more information, contact Thelma Malafey at (617) 236-5864.

**Worcester – 2007 Annual Business Meeting and 211th Annual Oration.** Tues., April 10, 5:30 p.m. Location: Beechwood Hotel, Worcester. For more information, contact Joyce Cariglia at (508) 753-1579.

## Statewide News and Events

**Art, History, Humanism & Culture Member Interest Network – Digital Photography Workshop.** Sat., April 28, 10 a.m. Location: MMS Headquarters, Waltham. For more information, contact the West Central Regional Office.

If you have news for “Across the Commonwealth,” contact Florence Keefe, Northeast Regional Office, at (800) 944-5562 or fkeefe@mms.org; Linda Howard, Southeast Regional Office, at (800) 322-3301 or lhoward@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 February and March 2007. We also note member deaths on the MMS website at [www.massmed.org/memoriam](http://www.massmed.org/memoriam).

**Richard M. Abbott, M.D., 88;** Gilmanton, NH; Yale University School of Medicine, 1943; died January 26, 2007. **Richard A. Gleckman, M.D., 72;** Worcester, MA; Tufts University School of Medicine, 1960; died February 22, 2007. **Joshua J. Hurwitz, M.D., 85;** Chestnut Hill, MA; Harvard Medical School, 1946; died February 18, 2007. **Martin B. Murray, M.D., 96;** Springfield, MA; New York University Medical School, 1937; died February 13, 2007. **Robert K. Osborne, M.D., 76;** Dedham, MA; Virginia Commonwealth University School of Medicine, 1956; died February 25, 2007. **Calvin H. Plimpton, M.D., 88;** Westwood, MA; Harvard Medical School, 1943; died January 30, 2007.

## MMS Participation Opportunities Include Time-Limited Activities

The MMS has many opportunities for physicians to share their expertise or interest. In addition to formal committee work, the Society convenes special time-limited task forces, advisory groups, and expert panels to review specific issues, make recommendations, or oversee the implementation of projects.

The Society also has opportunities for physicians to represent the MMS on commissions, special panels, and other appointed groups in the public and private sectors.

If you have a special interest or expertise in the areas listed below and would like to be considered for any of these time-limited opportunities, please contact Sandra Manchester at (781) 434-7012 or [smanchester@mms.org](mailto:smanchester@mms.org). **VS**

### Participation Opportunities

Public Health • Physician Credentialing  
• Office Management • Electronic Health Records • Quality Improvement  
• Professional Liability • Continuing Education • Clinical Competencies

## MMS Receives Highest Rating from National CME Accreditor

The Accreditation Council for Continuing Medical Education (ACCME) recently announced that the MMS is “recognized with commendation” as an accreditor of CME providers. According to ACCME standards, this highest-attainable rating is “reserved for programs which are truly exceptional.” Consequently, the ACCME granted the MMS a maximum six-year accreditation period.

The MMS received “exemplary compliance” in two specific areas: development and implementation of appropriate policies governing CME, and the significant wealth of experience and expertise of its staff and committees.

The MMS is proud to have achieved this status and looks forward to continued work with its accredited providers throughout the current six-year accreditation term. **VS**

– Danna Muir

## Medical Student Mentoring Night Planned

On May 1, the Committee on Women in Medicine will host a mentoring night for MMS-member medical students. A panel comprised of physician committee members who represent a broad range of work experiences and specialties (including obstetrics and gynecology, psychiatry, and gastroenterology) will discuss career options in medicine, how to match medical specialties to personality type, and different work settings.

“Students have expressed interest in hearing a more personal account of life in medicine beyond the training years,” explained Edith M. Jolin, M.D., chair of the Committee on Women in Medicine.

Students who attend the mentoring program will receive a free copy of the Committee’s book, *When You Don’t Fit the Mold, Make a New One*.

Medical Student Mentoring Night is free to medical student Society members. To join the Society or for more information, contact Erin Tally at (800) 322-2303, ext. 7413. **VS**

### Medical Student Mentoring Night

Sponsored by the Committee on Women in Medicine

**Tuesday, May 1, 6:30 p.m.**  
**MMS Headquarters**  
**Dinner will be served.**



### MASSACHUSETTS MEDICAL SOCIETY

EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

#### MMS eCommunities

Connect. Collaborate. Learn.



## WHAT'S ON THE WEB?

### eCommunities

The MMS Internet service, **eCommunities**, officially launched in March with three pilot groups — medical residents and fellows, the MMS Board of Trustees, and those interested in electronic health records. To learn more, visit [www.ecommunities.massmed.org](http://www.ecommunities.massmed.org).

### MMS Annual Meeting

The theme of the **2007 MMS Annual Meeting** is *Patient-Centered Medicine: Bringing Health Care Home*. For more details, including registration information, visit [www.massmed.org/annual2007](http://www.massmed.org/annual2007).

### Podcasting

We now offer **podcasting**. You can listen to audio files while visiting [www.massmed.org](http://www.massmed.org), or download them to your computer or to a portable media device. Starting with audio excerpts of *Physician Focus* TV shows, offerings will soon include interviews with health care leaders.

### Electronic Health Records

For online resources and services that can help you get a better handle on **electronic health records**, go to [www.massmed.org/ehr](http://www.massmed.org/ehr).

**WWW.MASSMED.ORG**

## MMS Education Programs

To register for any of these activities, call (800) 843-6356. For more information on these activities, contact the MMS Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to [www.massmed.org](http://www.massmed.org).

NOTE: (RM) indicates that the activity or a portion of the activity meets the Massachusetts Board of Registration in Medicine criteria for risk management study.

### On-Site CME Programs

#### 2007 Literature and the Professions Seminar: Management of End-of-Life Care

April 20, 9:00 a.m.–3:15 p.m., Beechwood Hotel, Worcester. April 27, 9:00 a.m.–3:15 p.m., MMS Headquarters, Waltham. May 11, 9:00 a.m.–3:15 p.m., Southeast Regional Office, Lakeville. CME Credit: 6.0 *AMA PRA Category 1 Credits*<sup>TM</sup> (RM)

#### Caregivers as Patients: Transforming Personal Experiences into Better Care

April 25, 5:30–7:00 p.m. The Inn at Longwood Medical, Boston. CME Credit: 1.5 *AMA PRA Category 1 Credits*<sup>TM</sup> (RM). For more information, visit [www.RMF.Harvard.edu](http://www.RMF.Harvard.edu).

#### Family and Childhood Obesity: Evaluation and Treatment Methods

April 25, 6:30–8:00 p.m. MMS Headquarters, Waltham. CME Credit: 1.5 *AMA PRA Category 1 Credits*<sup>TM</sup> (RM)

#### 5th Annual Symposium on Men's Health

**A Field Coming of Age: Evidence and Opportunity**  
May 23, 8:00 a.m.–4:00 p.m. MMS Headquarters, Waltham. CME Credit: 7.5 *AMA PRA Category 1 Credits*<sup>TM</sup> (5.0 RM)

*The following four Annual Meeting education programs will be held at the Seaport Hotel and World Trade Center, Boston, May 17–19.*

#### 2007 MMS Annual Oration: Apology in Medical Practice — An Emerging Skill

**Aaron Lazare, M.D.**  
May 17, 3:00–4:00 p.m. CME Credit: 1.0 *AMA PRA Category 1 Credits*<sup>TM</sup> (RM)

#### 2007 MMS Ethics Forum

**Apology: Many Voices, Many Perspectives**  
May 17, 4:00–6:00 p.m. CME Credit: 2.0 *AMA PRA Category 1 Credits*<sup>TM</sup> (RM)

#### 2007 MMS Annual Education Program Patient-Centered Medicine: Bringing Health Care Home

May 19, 8:30 a.m.–12:30 p.m. CME Credit: 3.75 *AMA PRA Category 1 Credits*<sup>TM</sup> (RM)

#### 2007 Shattuck Lecture and Luncheon We Can Do Better: Improving the Health of the American People

May 19, 1:00–2:30 p.m. CME Credit: 1.0 *AMA PRA Category 1 Credits*<sup>TM</sup> (RM)

### Online CME Programs

To access the following programs, go to [www.massmed.org/cme](http://www.massmed.org/cme).

**Avian Flu and Pandemic Preparedness**  
CME Credit: 2.5 *AMA PRA Category 1 Credits*<sup>TM</sup> (RM)

**2nd Annual Public Health Leadership  
Forum: Examining Health Disparities**  
CME Credit: up to 5 *AMA PRA Category 1 Credits*<sup>TM</sup> (RM)

*The following online CME program is new and is awarded 1 AMA PRA Category 1 Credit*<sup>TM</sup> (RM).

**Cultural Competence in Women's  
Health: Implications for Cardiac Risk  
Factors and Disease**