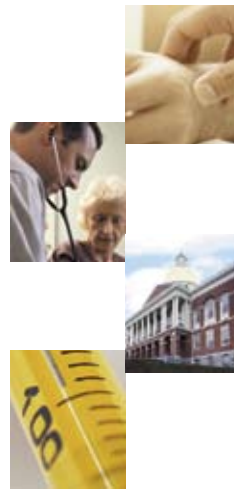




# VITAL SIGNS



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What's on the Web?

## Workforce Study Confirms Shortage of Primary Care Physicians

BY TOM WALSH

Patricia Sereno, M.D., had not yet seen the findings of the 2007 MMS Physician Workforce Study. But Dr. Sereno, president of the Massachusetts Academy of Family Physicians, already knew intuitively what the study had found — physician shortages in primary care and numerous specialties (see sidebar on page 2).

"It's going to be a crisis," predicted the Malden family practitioner. "I don't think our patients are aware of how bad the crisis is going to be, but they are going to start figuring it out."

### Still, Patients and Physicians Are Satisfied

On a much more positive note, the 2007 results show that Massachusetts residents remain satisfied with the care they receive. Nearly two-thirds, 65 percent, are "very satisfied" with their care, and 26 percent said they are "somewhat satisfied." However, the surveys also shows that fewer respondents (42 percent) are able to schedule a primary care doctor's appointment within a week of calling than they were a year ago (53 percent).

From the physician perspective, the 2007 study found that:

- Despite a "harsh" practice environment, 83 percent of Massachusetts physicians find their medical careers either "very rewarding" or "rewarding."
- About three-quarters plan to continue to practice here. At the same time, however, about 25 percent are contemplating a career change or are thinking of leaving the state unless practice conditions improve.
- One-third of medical directors say physician supply problems have required them to alter patient services.

- More than half of resident physicians leave the state after completing their residencies.
- 83 percent of the state's community hospitals and 67 percent of teaching hospitals report problems filling physician vacancies. Further, more than two-thirds of community hospitals reported a need to adjust service delivery patterns to meet patient demand. This is up from the 50 percent of community hospitals that made the same observation between 2003 and 2006.

### Primary Care Is a Primary Concern

"We're very concerned about the primary care situation," said B. Dale Magee, M.D., M.S., MMS president. Dr. Magee said shortages of primary care physicians (PCPs) cause problems that spill over to specialists because of the unique role PCPs play in managing individual patient care.

He said the problem begins when medical students who are initially interested in primary care hear that traveling that path will diminish both earning power and prestige within the profession. "A good many internal medicine residents emerge with a sub-specialty rather than primary care," Dr. Magee observed.

To address this problem, Dr. Magee said the MMS, led by President-Elect Bruce S. Auerbach, M.D., is working on student loan forgiveness for new doctors who opt for PCP careers. The Society is also promoting the "advanced medical home" concept of delivering primary care, which has been put forth by the American College of Physicians.

"We need to reconfigure the way primary health care is delivered and change the way primary care physicians are paid," Dr. Magee said. "We are also

working to put together a group of primary care physicians who have found a way to be successful and happy in their work. We want to work with the medical schools and these mentors to demonstrate that doctors can be very satisfied with primary care practice."

The 2007 Workforce Study makes several recommendations for reducing medical school debt and improving the overall physician practice environment.

### Burden of Practice Cost Cited

What fuels the deteriorating physician workforce situation?

Earlier this year, another MMS-sponsored study (see *Vital Signs*, May, page 1)

identified several culprits — high professional liability rates and the high costs associated with running a practice in Massachusetts. The continuing practice environment deterioration in Massachusetts has exacerbated physician shortages in specialty and primary care, made it difficult to recruit and retain physicians, and reduced patient access to care.

Another concern is that Massachusetts' landmark health care reform law will heighten demand for physician services. This year's Workforce Study observes that "the inevitable increase in patient demand is occurring in the midst of an increasing physician shortage. Newly

*continued on page 2*

## Smoothing the Transition to Adult Care for Adolescents with Special Needs

BY TOM WALSH

To borrow a well-known phrase, the MMS is looking for a few good men and women — in this case, physicians to care for the thousands of Massachusetts adolescents with special health care needs who turn 18 every year and must transition from pediatric to adult care.

"We are trying to develop more physician capacity and figure out where the needs are for more physician education," said Matthew D. Sadof, M.D., a Springfield pediatrician and adolescent medicine specialist who serves on the Committee on Disabilities for the Massachusetts Chapter of the American Academy of Pediatrics. Dr. Sadof recently discussed this transitioning predicament during a meeting of the MMS Inter-specialty Committee.

"Across the country, half a million kids with special health care needs turn 18 every year," Dr. Sadof said. According to



federal government figures, Massachusetts is home to nearly 222,000 children with special health care needs.

Those needs vary according to the type and extent of disability. "Some need wheelchairs, some need a ventilator at night at home, some have mental health issues," Dr. Sadof noted.

*continued on page 2*

## PRESIDENT'S MESSAGE



### Quality = Standards + Wisdom

I recently had the privilege of speaking to the Massachusetts Health Care Quality and Cost Council, the multi-disciplinary body

formed by the state to establish health care quality-improvement and cost-containment goals. The Society has a seat on the council's advisory board.

The makeup of the council — payers, providers, government officials, and consumers — suggests that no single health care stakeholder can solve the dual challenge of improving quality and containing cost. We must work together.

During my presentation, I noted that meaningful standards are key elements in quality improvement and cost containment. Each player in the health care arena can do its part to develop and adhere to such standards.

Physicians need to follow evidence-based clinical guidelines, and they need the systems that deliver protocol information to the point of care. Physicians also have the challenge of applying clinical best practices and the wisdom to know when to make an exception for a particular patient's well-being. For their part, researchers need to design and implement more evidence-based studies that examine clinical efficacy *plus* cost efficiency.

The public needs to heed nutritional and exercise guidelines, and school systems need to support those recommendations by serving more nutritious meals and continuing to fund health and physical

education programs. The biggest bang for the buck in cost containment — not to mention improved quality of life — comes with reducing the need for treatment by preventing disease. We need to urgently address conditions like obesity, which can lead to chronic, high-cost complications such as diabetes, cardiovascular disease, and arthritis.

Payers — the health plans — need to standardize and improve the timeliness, accuracy, and type of information sent out to physicians. Right now, the health plans hold a wealth of information that, if usefully packaged, physicians could use at the point of care to make quality improvements and reduce cost. More importantly, the health plans tend to use this information "after the fact" to issue public report cards which, so far, have contributed little to quality-of-care improvement efforts and may mislead patients about both quality and cost. Physicians need to review this data prior to public release to confirm its accuracy.

I have faith that the Health Care Quality and Cost Council will help us tackle the bedeviling issues facing health care today. I have equal faith that the physicians of Massachusetts will do their utmost to change the things they can to move the physical and fiscal health of the Commonwealth forward. I welcome your ideas.

— B. Dale Magee, M.D.

### Workforce Study

*continued from page 1*

insured residents may find it difficult to get timely appointments with physicians due to these shortages."

### Negative Patient Impact

Dr. Sereno, who practices family medicine in Malden as an employee of Hallmark Health, is dismayed when she thinks about how today's health care reality affects patients. "For acute medical problems, most doctors' offices are still very accommodating," she said. "But for things like routine physicals, some patients are waiting months to be seen. At my office, when patients are leaving they often say, 'I'm booking my annual physical on the way out because it takes so long to get an appointment with you.'"

Many still remember the television program *Marcus Welby, M.D.*, in which the paternally friendly Dr. Welby provided personalized patient care. "He was the guy who held your hand and came out to the house with his black bag," Dr. Sereno said. "Now, the system pushes you to see a patient every 10 to 15 minutes. Get them in, get them out. The system works on volume. It tarnishes the esteem of the profession."

### New Role for PCPs

Dr. Magee said the primary care setting idealized by Norman Rockwell paintings is changing. With the "medical home" concept, he said, "PCPs will become managers as well as direct caregivers, referring patients to others for care or specific advice, measuring outcomes, and overseeing a process. It will be a field that not only includes the traditional view of primary care, but also another layer of management that is much more sophisticated."

The 2007 Workforce Study compiled data from surveys of practicing physicians, medical staff presidents in community hospitals, department chiefs in

teaching hospitals, medical directors of medical groups, and resident program directors. It also includes data from a telephone survey of physician offices in Massachusetts and a telephone survey of the public regarding health care issues, including patient access to care. **VS**

To download the executive summary of the 2007 Workforce Study, go to [www.massmed.org/workforce](http://www.massmed.org/workforce).

### Urology Lands on List of Specialist Shortages

According to the 2007 Workforce Study, anesthesiology, cardiology, gastroenterology, and neurosurgery face either "critical" or "severe" labor shortages — as they have since the study began such ratings in 2002. Family practice was found to be in a severe shortage situation, and internal medicine was critical. These same two primary care components were similarly rated a year ago. Vascular surgery eroded from severe to critical. Psychiatry was rated severe for the second straight year. And urology, first evaluated this year, was found to be facing a severe shortage.

"Recruitment and retention in Massachusetts are difficult," said Peter N. Tiffany, M.D., past president of the Massachusetts Association of Practicing Urologists. "Young physicians who are sitting on a bunch of debt from medical school are hesitant to come to a state where the cost of living is pretty steep."

Dr. Tiffany's Stoneham practice is now fully staffed with five physicians and one physician assistant. However, he recalled without fondness a prior situation when the practice had but two doctors. "Never again," Dr. Tiffany said. "You're on call every other night, taking care of five hospitals. It was craziness."

### Smoother the Transition

*continued from page 1*

Dr. Sadof hopes Massachusetts doctors will step up to help ease this transition, which is made especially difficult by health care financing issues and the need to establish trust among practitioners, patients, and their families. The first step will be a statewide e-mail survey this summer, which the MMS is helping Dr. Sadof coordinate. The survey results will be used to build physician capacity to take care of this population.

The American Academy of Pediatrics, among other societies, maintains that "physicians have an important role in fa-

cilitating transitions to adulthood and to adult health care for young people who are least likely to do it successfully on their own." Among other things, the Academy recommends that the parents and caregivers of such patients develop a written transition plan by the time the patient is 14 years old.

Dr. Sadof said he hopes that by the end of 2007, results from the MMS survey will uncover many physicians who will welcome young adults with special health care needs into their practices. "If most physician practices took on just one or two of these new patients, the problem would be solved," Dr. Sadof concluded. **VS**

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# Blue Cross Announces Fee Increase and Program to Measure Psychiatric Outcomes

Physicians contracting with Blue Cross Blue Shield of Massachusetts (BCBSMA) will see an aggregate 3 percent increase in BCBSMA payments for services rendered, beginning September 1. The new reimbursement rates will be implemented across all coverages, including indemnity, HMO, point of service (POS), and preferred provider organization (PPO) services.

Specialty-specific fee schedules will be mailed to individual physicians this summer, according to John Fallon, M.D., senior vice president and chief physician executive of BCBSMA.

In addition, Blue Cross's performance-based quality programs offer eligible primary care physicians the opportunity to earn an extra 3 to 15 percent above fee-for-service payments. The state's largest insurer also offers additional incentives to eligible multispecialty organizations.

Physicians with payment-related questions or suggestions should contact their Blue Cross provider relations manager at (800) 316-BLUE (2583).

## Psychiatric Outcomes Measurement

On May 1, BCBSMA launched an outcomes measurement program for behavioral health providers. To participate, psychiatrists register with Behavioral

Health Laboratories, Inc. (BHL) and administer the Treatment Outcomes Package (TOP) to their qualifying Blue Cross members. Completion of the tool is voluntary for patients; however, future fee schedule revisions for psychiatrists will be linked to participation in the program.

For the January 1, 2008, fee update, psychiatrists who registered with BHL by August 1, 2007, will be paid higher fees than nonregistered physi-

cians. January 1, 2009, fee updates will be based on achievement of provider and member participation rate targets.

The MMS is currently talking with Blue Cross about this program. At its 2007 annual House of Delegates meeting, the Society adopted policy opposing insurance company collection of sensitive mental health information directly from patients. The adopted policy also calls for appropriate action to prevent insurance companies from using personal health surveys to determine provider compensation or patient coverage and eligibility.

For more information about the TOP process, go to [www.bhealthlabs.com](http://www.bhealthlabs.com) or call (800) 329-0949. Physicians with comments related to this program can contact Dana Cooper at (781) 434-7218 or [dcooper@mms.org](mailto:dcooper@mms.org). **VS**

— Dana Cooper

# Outpatient Formulary Guide, 10th Edition

The Massachusetts Medical Society recently published the 10th edition of the *Massachusetts Outpatient Formulary Guide*. The guide is a collaborative effort between the MMS and nine Massachusetts health plans: Aetna Health, Inc., Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, MassHealth, Neighborhood Health Plan, Network Health, and Tufts Health Plan.

The 10th edition of the *Formulary Guide* was redesigned and offers a more effective compilation of the participating health plans' commonly prescribed outpatient

formulary drugs. The easy-to-read, pocket-size guide includes information on 17 categories of drugs. It specifies each plan's preferred formulary drugs, medications requiring prior authorization/notification, step therapy procedures, and medications with dispensing limitations.

The guide was mailed to more than 23,000 physicians and 1,300 pharmacies in Massachusetts. It will also be available on the MMS website in both PDF and searchable-text formats. To purchase additional hard copies, contact the MMS Customer Service

Department at (800) 843-6356. **VS**

— Dana Cooper



# Clear Up Your Claims Problems

Throughout August and September, the MMS regional offices will once again host claims problem-solving work sessions for Massachusetts physicians in order to adjudicate troublesome claims. In recent years, these sessions have proven successful in resolving various claims issues.

According to the schedule shown below, insurer representatives from National Heritage Insurance Company (Medicare Part B), MassHealth, Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health

Care, Health New England, and Tufts Health Plan will be available to review claims with physicians and their office staff and answer questions regarding claims processing.

Thirty-minute appointments for each plan can be scheduled between 9 a.m. and 4 p.m. Physician offices are eligible for one appointment per plan, but more than one person from an office may attend. **VS**

For further information, please contact your Regional Office (see listing in "Across the Commonwealth" on page 7).

Calendar of Claims Problem-Solving Workshops

Insurer	Waltham Aug. 22	Lakeville Aug. 23	Holyoke Aug. 29	Worcester Sept. 12
BCBSMA	X	X	X	X
FCHP			X	X
HPHC	X	X	X	X
Health New England			X	
MassHealth	X	X	X	X
Medicare/NHIC	X	X	X	X
Tufts Health Plan	X	X	X	X

# MHQP Releases 2007 Quality Report on Medical Groups

Recently the Massachusetts Health Quality Partners (MHQP) released its Web-based report, titled *2007 Quality Insights: Clinical Quality in Primary Care*. The 2007 report gives consumers and providers Web access to comparative quality information for approximately 150 medical groups comprising more than 5,000 physicians.

The latest MHQP results show that Massachusetts physicians score at or above the national 90th percentile on 12 of 17 measures of clinical quality. But the report also found group-to-group variation in performance and identified areas in need of statewide improvement.

The report uses measures developed by the National Committee for Quality Assurance. The measures selected by MHQP include appropriate use of depression and asthma medications; breast, cervical, and colon cancer screening; chlamydia screening in young women; overall diabetes care; and pediatric care. Areas that showed a need for improvement included management of adult asthma and depression medication.

As a member of MHQP, the MMS supports the use of accurate, meaningful data to help providers improve the quality of care and reduce costs and to help the public make informed choices.

"With trusted information, physician groups can target areas where better systems are needed to improve the rates of appropriate preventive screening, well-child visits, and chronic disease management," said B. Dale Magee, M.D., M.S., president of the MMS.

However, the Society also maintains that the claims data some reports rely on have accuracy and timeliness limitations for assessing quality of care. Therefore, patients must use good judgment when interpreting the results. Clinical information derived directly from medical records would provide more robust data for evaluating physician quality, but using medical records for such purposes is currently expensive and time-consuming. The MMS thus continues to emphasize the need for a statewide electronic medical record-keeping system. **VS**

— Dana Cooper

## MMS to Join in "National Night Out Boston"

On August 7, the MMS will host a tent at "National Night Out Boston" at the Franklin Park Zoo. The theme for this year's event is "Unity Through Community," which echoes the theme of the MMS youth violence prevention ad campaign launched earlier this summer. The campaign messages encourage parents to get their children involved in community activities to help keep them out of dangerous situations.

National Night Out was first introduced by the National Association of Town Watch (NATW) in 1984 to

increase community participation in anticrime efforts. In 2006, National Night Out was celebrated in more than 11,000 communities and involved more than 35 million people nationwide.

Boston residents are invited to the event on August 7 from 5 to 8 p.m., which includes free admission to the zoo, family-friendly entertainment, and Neighborhood Crime Watch awards presentations to recognize efforts to prevent crime and promote safe neighborhoods. **VS**

— Nneka Ufere

## WEBSITE OF THE MONTH

### Prepare Your Patients for Extreme Heat

As this issue of *Vital Signs* went to press, the nation was experiencing a scorching heat wave, a stark reminder that in the heat of summer, measures need to be taken to prevent heat-related deaths and illness. Approximately 400 people in the U.S. die each year from heat exposure. The elderly, the very young, and those suffering from mental illness and chronic disease are most at risk for succumbing to heat.

The best defense against extreme summer heat is prevention. The Centers for Disease Control and Prevention provides summer health and safety resources at [www.bt.cdc.gov/disasters/extremeheat/index.asp](http://www.bt.cdc.gov/disasters/extremeheat/index.asp). The website includes a comprehensive guide outlining tips for preventing heat-related illness during the summer months. Other available resources include information on heat stress in the elderly, how to recognize the symptoms of heat disorders and provide first aid treatment for them, and personal preparation for summertime blackouts and other hot weather health emergencies. The website also provides weekly reports for health professionals documenting heat-related morbidity and mortality in various cities across the nation.

## Congratulations to Poster Contest Winners



Photo by Lee Hollenbeck

MMS Alliance President Mary Kay Albert (far left) and David Crandell, M.D. (far right) of the MMS Committee on Student Health and Sports Medicine recognized the 12 young winners of the MMS Anti-Tobacco Poster Contest at the State House in June.

## Foundation Grant at Work



Photo by Peter Wrenn

In April, the Massachusetts Medical Society and Alliance Charitable Foundation awarded \$15,000 to support the DotWell Diabetes Initiative. The funds enhance DotWell's community-based component through educational outreach materials and diabetes screening for at-risk individuals. Pictured is Ivy Brackup, M.D., consulting with a patient during a diabetes program support group.

## Homelessness Prevention Initiative Gets Results

Investing in efforts to prevent homelessness is more effective and less expensive than current strategies that direct resources to emergency shelters and services. Those findings come from a three-year study released in late June by the Boston Foundation and the Center for Social Policy at UMass Boston.

The report, *Preventing Homelessness and Promoting Housing Stability: A Comparative Analysis*, is the result of the Homelessness Prevention Initiative (HPI), a joint project of the Boston Foundation, the Starr Foundation, Tufts Health Plan, and the MMS and Alliance Charitable Foundation.

The organizations launched the HPI in December 2003. From 2004 through 2006, 19 Massachusetts nonprofit organizations serving families and individuals at risk for becoming homeless received \$3 million in HPI grants. Those 19 organizations served a total of 4,315 households. In some cases, the HPI provided direct assistance to families and individuals at risk of becoming homeless. Other programs addressed the needs of individuals with mental health or substance abuse issues or inmates about to be released from prison.

"This study goes a long way to end the all-too-common hunch that some people are simply doomed to homelessness regardless of how they are helped," said Paul S. Grogan, president and CEO of the Boston Foundation. "In fact, many incidents of homelessness happen because of a one-off economic event that pushes a financially fragile family or individual out onto the street."

### Prevention Costs Less

A startling 27 percent of the Massachusetts population is at high risk of becoming homeless. Nevertheless, the vast majority of the state's resources to fight homelessness have been directed toward bolstering the emergency shelter system rather than prevention. In 2002, 80 percent of state resources addressing homelessness were allocated for emergency shelter and related services, while only 20 percent went to homelessness prevention.

Providing emergency shelter to a single homeless adult in Massachusetts costs the state about \$1,000 a month on average, not including case management or health-related expenses. Of the roughly 2,900 homeless families in Massachusetts, one-fifth to one-quarter stay in shelters for 15 months, costing the state nearly \$50,000 per family. That adds up to \$250 million in annual state spending on emergency shelter and related services.

By comparison, the average homelessness-prevention cost per household served by HPI programs was \$737. Seventy-five percent of families and 63 percent of individuals assisted by HPI programs had positive housing outcomes 12 months after intervention. Achieving positive housing outcomes was most challenging among those leaving prison, runaway youth, and families escaping domestic violence.

These findings underscore how effective homelessness prevention can be, especially if agencies working with people at risk have the flexibility to address the specific needs of individual clients, which can vary greatly. **VS**

## DPH Commissioner Auerbach Outlines State Public Health Agenda

*Editor's Note: John Auerbach, the former executive director of the Boston Public Health Commission, was appointed state commissioner of public health in March. During a recent interview with Commissioner Auerbach, Vital Signs learned about his public health goals.*

**Q:** How can the MMS and the Massachusetts Department of Public Health (DPH) best work together on public health issues?

**A:** The ideal way would be both formally and informally. It would be beneficial for me and other departmental leaders to meet on a regular basis with the Massachusetts Medical Society, and do some planning for the kinds of activities we see as necessary over the next few years. We also need to have continuing informal relations so that as issues arise unexpectedly, we are able to be in communication with each other and address those quickly. I suspect that will be the case.

**Q:** What are some of those necessary activities?

**A:** There are several. One is understanding health care reform and what we think will change with health care delivery as more people acquire health insurance. Problems may arise from pockets of individuals who should be enrolled in the programs but aren't. We can work together to try to reach

them. They may also arise in terms of services that are covered. They may arise with reimbursement rates. This is a unique moment in history.

**Q:** Which other specific public health issues are you targeting for action?

**A:** One of them is the significant increase in the percentage of the population that is overweight. More than 50 percent of the adult population in the Commonwealth is overweight, and that's gone up in just 10 years. It's matched by the increase in the prevalence of diabetes and certain other health conditions. Paying attention to that, particularly in terms of the promotion of healthy eating and exercise, is important.

To have an impact, the messages that go out about these topics must be multifaceted. People have to hear it from their doctors

and from their schools. They have to see advertisements and have ready access to exercise that is enjoyable. Parents need help in terms of selecting foods that promote good health.

We must also focus on the troubling issue of racial and ethnic disparities. We have consistently found that across the state the burden of poor health rests more heavily on black and Latino populations. This includes conditions ranging from prostate cancer and hypertension to infant mortality, diabetes, and HIV/AIDS. While we need population-wide campaigns, we also need to pay particular attention to the populations that have been disproportionately affected. I think we can do that very well as a partnership. We'll also see some changes as a result of health care reform, because historically there's been a disproportionate number



John Auerbach, Massachusetts Commissioner of Public Health

*Formal and informal relations between the DPH and the MMS are necessary for both long-term planning and to address issues that arise unexpectedly.*

of black, Latino, and Asian residents who have lacked health insurance. Now we'll see more and more folks seeking primary care providers.

**Q:** Are you concerned that there may not be enough primary care doctors to handle the influx?

**A:** You bet. The shortage of health care professionals is quite troubling. It's physicians but it's also nurses, physical therapists, and even home health aids. We're hearing these complaints across the board.

**Q:** Before you became state DPH commissioner, you worked in public health for the city of Boston. How did this urban experience prepare you for your current position?

**A:** The city of Boston is a microcosm of what happens across the Commonwealth as a whole. Virtually all the issues that I'm working on now, with the exception of rural health, are issues I worked on in Boston. One of the advantages of working in Boston was that I worked for a mayor who was very farsighted and brave with regard to developing health care initiatives. With Gov. Patrick, I believe I'll have the same relationship. **VS**

— Tom Walsh

### FEDERAL UPDATE

## House and Senate Expected to Move on SCHIP and Medicare Physician Payment Reform

Congress is expected to advance legislation this summer that would reauthorize the State Child Health Insurance Program (SCHIP) for five years and stop the scheduled Medicare physician payment cuts for 2008 and 2009. While the House and Senate are discussing different approaches to deal with these crucial programs, both issues are considered priorities for this legislative session.

Most of the activity is in the House, where key committees are proposing to move a single bill that would address both SCHIP and Medicare at an estimated cost of \$100 billion. Among the major provisions under discussion is one that would stop the pending 10 percent Medicare physician payment cut and provide a slight, positive increase for the next two years. Consideration is also being given to creating volume performance targets

for various services. For example, separate spending targets might be set for primary and preventive care, other evaluation and management services, major procedures, imaging services, and anesthesia and minor procedures. According to press accounts, the House Democrats said their legislation would also lay out steps for a long-term change to the Medicare physician payment system.

Of equal importance, the House wants to reauthorize the SCHIP program for five years with an estimated \$50 million funding mechanism. The proposed legislation makes a number of programmatic changes, including improving the formula whereby states are allocated funds and making it easier to enroll SCHIP-eligible children in the program. In Massachusetts, future SCHIP funding is extremely important to the ultimate success of the state's health reform law

(Chapter 58). The MMS worked closely with Sen. Kennedy's office on the creation and passage of the original SCHIP legislation, and we continue to be a persuasive participant in the regional SCHIP coalition, the New England Alliance for Children's Health.

In keeping with recent Congressional "pay-as-you-go" principles, significant discussion has focused on financing the SCHIP/Medicare proposal through an increase in the federal tobacco tax and reduced payments to Medicare Advantage plans. MedPac, an independent federal body that advises Congress on Medicare, recommended cutting payments to Medicare managed care plan products. While managed care plans are currently paid between 12 and 19 percent more than fee-for-service, MedPac concluded that these products do not warrant the sizeable increase in dollars. Particularly

controversial were "private" fee-for-service products, newly marketed under Medicare Part D, which receive the highest reimbursement rate. Several national organizations agreed to stop marketing those products in response to allegations that the advertising was misleading and the products did not always offer Medicare's basic benefits. MedPac also noted that seniors in fee-for-service Medicare programs paid, on average, about \$2 more per month in premiums to support the managed care products.

On the Senate side, the Senate Finance Committee plans to approve a free-standing SCHIP reauthorization bill, with separate action on a Medicare physician payment proposal to follow. Eventually, the proposals from both houses of Congress will end up in a conference committee for finalization. **VS**

— Alex. Calcagno

## ASC Commission Issues Final Report

The Commission on Ambulatory Surgical Centers and Medical Diagnostic Services recently issued its final recommendations. The commission was charged with investigating the impact of single and multispecialty ambulatory surgical centers (ASCs) and medical diagnostic or therapeutic services on the health care delivery system. Representing the MMS on the commission was B. Thomas Hutchinson, M.D., an ophthalmologist and cofounder of Ophthalmic Consultants of Boston.

The commission made no recommendation to change the physician practice exemption, as currently defined, or the exemption from statutory and regulatory clinic licensure requirements. The Society strongly supported retaining both exemptions.

Regarding medical imaging, the MMS expressed concerns about commission recommendations that would favor one medical specialty over another. The MMS followed the lead of the AMA in "opposing limitations to restrict reimbursement for imaging procedures

based on physician specialty." Instead, we continue to support the reimbursement of imaging procedures based on the proper indication and the qualifications of the imaging specialists, regardless of medical specialty. The MMS also opposed the commission's recommen-



dation of a blanket prohibition against "leasing arrangements."

The commission chose not to submit legislation, but its recommendations will drive future discussion and legislative direction. For copies of the commission's final report, contact the MMS Government Relations Department at (781) 434-7215. **VS**

## PHYSICIAN HEALTH MATTERS

### Resident Health and Well-Being a Big Concern

Successful residents know their patients come first. They arrive on time for all shifts, are always prepared to report on their patients, ready to undertake the responsibilities of their colleagues, and willing to ask questions of the attending when they don't know something. But with all that pressure and responsibility, what happens when a resident becomes ill or needs to see a doctor for a wellness visit?

The culture of medicine today promotes and rewards commitment and dedication to patients, but it also makes it difficult for residents to acknowledge that they are ill or need time to keep their own medical appointments. When a resident gets sick, he or she often struggles with guilt: "Am I sick enough to call in and not care for my patients?" they ask themselves. Then they worry about their fellow resident who will have to pick up the extra patient-care workload.

#### Dual Responsibility

The ultimate responsibility for resident health and well-being lies with each individual. But residency programs can and should educate residents about the risks of working when they are feeling less than optimal, and resident training should encourage residents to care for themselves as needed. Residents should know their program's protocol for getting time off to see a primary care physician, attend eye doctor appointments, or participate in prenatal care. For their part, residency programs could implement protocols that enable flexible coverage adjustments when a resident is "out of commission" with a cold,

flu, or virus, or more substantially incapacitated with depression or a major illness or injury.

#### Beware Curbside Care

Loath to miss a shift for an outside health care appointment, many residents turn to one another for medical care. This simple expedient of asking a colleague for a quick consult or prescription (commonly referred to as "curbside care") is risky for both physicians involved. Objectivity is often compromised when a physician treats a friend who's also a doctor. Full physical exams tend to be short-cut, medical histories are glossed over, and updating medical records is often forgotten.

Consequently, residency programs should educate their charges about these risks and ideally would develop clear, written parameters regarding the medical treatment of fellow residents, attendings, chiefs, or other hospital staff by residents to avoid conflicts, interpersonal discomfort, and suboptimal care.

While residents need more education geared toward improving self-care and, when appropriate, utilizing sick days, residents themselves should take advantage of self-care opportunities offered by their institutions. These may include health screenings, flu immunizations, and weight-loss programs. The organizational culture should be one of understanding, not criticism, when residents seek and use such resources. Ultimately, improved health practices among residents will translate into improved patient care. **VS**

For more information, visit [www.physicianhealth.org](http://www.physicianhealth.org) or call (781) 434-7404.

## Bedside Advocacy Project Seeking Volunteers to Help Patients Navigate the Health Care System

The Bedside Advocacy Project is a nonprofit organization currently inviting semi-retired or retired physicians to serve as volunteer advocates and facilitators for fragile elderly and other high-risk patients in a variety of settings. The volunteers will help alleviate patient anxiety, enhance comfort, facilitate improved communication and continuity of care among the patients' providers, and identify threats to patient safety. Of equal importance, they will help patients and their families navigate the health care environment and educate patients and families about how to speak up, get answers, and make their needs

known. Physician volunteers will help solve problems, but will *not* practice medicine.

The first pilot project was launched in June. Each participating volunteer physician will serve a single client on a one-on-one basis and will be backed up by another volunteer. The volunteer advocates will support one another by participating in support teams of four to six individuals. Each team member will share his or her own professional experience and



insights for the benefit of the patients served by the other volunteers on the team.

The Bedside Advocacy Project was featured on page 1 of the February 25, 2007, *Boston Sunday Globe*. The U.S. Congress is now considering a pilot project based on this initiative for veterans returning from Afghanistan and Iraq. The need for advocacy for high-risk members of the military and veterans has reached crisis proportions, especially for those with

traumatic brain injuries and post-traumatic stress disorder.

For more information, visit the organization's website at [www.bedsideadvocates.org](http://www.bedsideadvocates.org). Applications will be provided to those who wish to consider serving, and periodic orientation and get-acquainted sessions are scheduled for prospective volunteers.

You can also contact Jonathan E. Fine, M.D., executive director of Bedside Advocates, by e-mail at [JonathanFine@bedsideadvocates.org](mailto:JonathanFine@bedsideadvocates.org), by phone at (617) 547-0023, or by mail at 10 Walden Mews, Cambridge, MA 02140-3335.

— Jonathan E. Fine, M.D.

ACROSS THE COMMONWEALTH

## District News and Events

**Plymouth – District Executive Meeting.** Wed., Aug. 15, 6 p.m. Location: Southeast Regional Office. **Family Event.** Sat., Sept. 8, 2 p.m. Location: Plimoth Plantation, Plymouth. For more information, contact the Southeast Regional Office.

**Worcester – 16th Annual Women in Medicine Breakfast.** Fri., Sept. 21, 7:30 a.m. Location: Beechwood Hotel, Worcester. Speaker: Alex. Calcagno, director of federal and community relations for the Massachusetts Medical Society. For more information, contact Joyce Cariglia at (508) 753-1579.

## Statewide News and Events

**Art, History, Humanism & Culture Member Interest Network – Tower Hill Event.** Sat., Sept. 29, 6 p.m. Location: Tower Hill Botanical Gardens, Boylston. 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 June and July 2007. We also note member deaths on the MMS website at [www.massmed.org/memoriam](http://www.massmed.org/memoriam).

**Kenneth M. Frankel, M.D.**, 66; Longmeadow, MA; University of New York College of Medicine, 1965; died June 17, 2007.

**Samuel Klibanoff, M.D.**, 90; Springfield, MA; Harvard Medical School, 1941; died June 23, 2007.

**Jess B. Weiss, M.D.**, 90; Pompano Beach, FL; Middlesex University School of Medicine, 1943; died June 28, 2007.

**Edmund P. Wiker, M.D.**, 66; Fall River, MA; University of New York College of Medicine, 1966; died June 19, 2007.

## Pri-Med East Returning to Boston

October 11–14, Boston Convention and Exhibition Center

The MMS is once again partnering with Pri-Med East, a three-day medical conference that provides extensive continuing medical education opportunities. Focused on diagnosis and treatment, Pri-Med's core program, *Current Clinical Issues in Primary Care*, is developed and presented by nationally recognized faculty from Harvard Medical School.

An expansive exhibit area will provide opportunities to view the latest in pharmaceuticals, medical devices, and technologies. Be sure to stop by the MMS, *New England Journal of Medicine*, and *Journal Watch* booths. For more information and to register, visit [www.pri-med.com/east](http://www.pri-med.com/east).



Two additional Pri-Med events are also coming to the Boston area:

### Updates in Cardiology

**October 12–13, The Colonnade, Boston**

This two-day event will address cutting-edge topics and current research in cardiovascular medicine. *Journal Watch* and the *New England Journal of Medicine* are Pri-Med partners for this program.

### Updates in Neurology

**September 8, Hyatt Regency, Cambridge**

This intensive one-day conference will feature the latest scientific advances as well as case-based sessions that focus on real-world clinical practice. **VS**

For more information about any of these programs, call (877) 4PRI-MED.

## Lecture to Probe Link between Medical Liability and Women's Access to Health Care

Steadily rising professional liability insurance rates have adversely affected women's access to a wide range of health services. Expensive and sometimes unaffordable insurance premiums cause specialists to limit their practices, leave high-liability states, or retire early.

To help physicians understand the ramifications of the current malpractice environment on the delivery of women's health services, the next Women's Lecture Series, sponsored by the MMS and its Committee on Women in Medicine, will shine a light on this important subject (see box). The program will offer proactive solutions to minimize risk and foster reform.

Presenters will include Ellen Epstein Cohen, J.D., a partner at Adler, Cohen, Harvey, Wakeman & Guekguezian,

LLP; and Kathleen Finnerty-Schroth, CIC, vice president of Physicians Insurance Agency of Massachusetts.

Established more than 25 years ago, the MMS Committee on Women in Medicine provides a valuable forum to identify, address, and educate fellow professionals about topics of concern to women in medicine.

For more information, contact Erin Tally at (800) 322-2303, ext. 7413, or [etally@mms.org](mailto:etally@mms.org). **VS**

– Erin Tally

### Who Pays the Price? The Influence of Medical Liability on Women's Access to Health Care

September 26  
5:45–8:00 p.m.

MMS Headquarters, Waltham

CME Credit: 1.5 AMA PRA  
Category 1 Credits™ (RM)

To register, call (800) 843-6356.

## Society Stands Out at AMA Annual Meeting

The Society's AMA Delegation spent June 22 through 27 in Chicago advocating for Massachusetts physicians at the 2007 AMA Annual Meeting. At Saturday's opening session, AMA President William G. Plested III, M.D., asked delegates to join hands, reminding them that they draw strength from unity. The many tasks facing organized medicine — steering reform in America's health care system, continuing to lead quality improvement efforts, and advocating for equitable reimbursement — are "daunting," Dr. Plested said. "However, I have absolute faith in our ability to do what needs to be done."

- Samantha Rosman, M.D., was re-elected as the resident member of the Board of Trustees.
- Barbara A. Rockett, M.D., was elected president of the AMA Foundation.



Barbara A. Rockett, M.D.



Joseph Heyman, M.D.

### Meeting Highlights

Several MMS members were elected to important AMA posts during the meeting:

- Joseph Heyman, M.D., was elected by the Board as chair-elect of the Board of Trustees.
- Jana Montgomery, M.D., was elected to be the resident member of the Council on Medical Service.
- David Rosman, M.D., was elected speaker of the RFS Assembly.

AMA advocacy on two priorities — reauthorization of the State Children's Health Insurance Program (SCHIP) and preventing steep cuts in Medicare physician payments — is dialing up the pressure on Washington lawmakers to pass legislation to protect the health of America's children and seniors. Delegates received a packet of advocacy materials that spells out the facts about SCHIP and the looming Medicare cuts and provides a checklist of grassroots activities in which physicians can participate.

Empowering patients, achieving true transparency, and focusing quality improvement efforts on patients' rather than payers' needs were among the themes that emerged at the AMA's annual forum on national health care policy. **VS**

– Michele Boutin



MASSACHUSETTS MEDICAL SOCIETY  
EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

MMS  
eCommunities  
*Connect. Collaborate. Learn.*



WHAT'S ON THE WEB?

eCommunities Enhancements

New site enhancements make it easier for first-time users to start communicating with their colleagues. Also, online polling functionality has been added for each community. Visit <http://ecomunities.massmed.org>.

Blue Cross Settlement Resources

Maximize your return from the recent settlement of litigation against Blue Cross health plans by accessing these online resources. Go to [www.massmed.org/bluecross](http://www.massmed.org/bluecross).

Your Health First

Resources and background information relating to the award-winning MMS public health education campaign. Topics include violence prevention, healthy weight activities, and flu prevention. Visit [www.massmed.org/yourhealthfirst](http://www.massmed.org/yourhealthfirst).

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

Who Pays the Price? The Influence of Medical Liability on Women's Access to Health Care

Sept. 26, 5:45–8:00 p.m. MMS Headquarters, Waltham. Sponsored by the MMS and its Committee on Women in Medicine. CME Credit: 1.5 AMA PRA Category 1 Credits™ (RM)

Unmasking Depression in Primary Care Practice

Sept. 28, 8:15 a.m.–12:30 p.m. MMS Headquarters, Waltham. Sponsored by the MMS in collaboration with the Massachusetts Health Quality Partners and the Massachusetts Psychiatric Society. CME Credit: 4.0 AMA PRA Category 1 Credits™ (RM)

Online CME Programs

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

The following 10 online programs are sponsored by the MMS and developed and funded by ProMutual Group. Each program is awarded 1 AMA PRA Category 1 Credit™ (RM).

- Let the Record Show\*
- Nursing Home Malpractice Litigation: Physician-Focused Risks\*
- Terminating the Physician-Patient Relationship\*
- The Electronic Health Record in the Office Practice\*
- Medical Malpractice Litigation: The Attorney's Perspective\*
- Nonsurgical Cosmetic Procedures: Risk Issues in the Quest for Youth
- Patient Satisfaction
- Cultural Diversity
- Closing a Practice
- Difficult Patients

\*Asterisked programs are also available in print. For a copy, call the Department of Continuing Education and Certification at (800) 322-2303, ext. 7306.

New Online Audio and Slide Presentation: Cost Performance Ratings: What You Need to Know about Episode Treatment Groups (ETGs)

CME Credit: 2.5 AMA PRA Category 1 Credits™ (RM)

Electronic Health Record (EHR) Program — EHRs in Your Office — Let's Get Started!

Jointly sponsored by the MMS, Healthcare Information & Management Systems Society (HIMMS), and Massachusetts e-Health Collaborative (MAeHC). CME Credit: 1 AMA PRA Category 1 Credit™ (RM) for each of the following:

- Module 1: EHRs 101
- Module 2: Provider Daily Life
- Module 3: Workflow Redesign
- Module 4: Managing Change

2nd Annual Public Health Leadership Forum: Examining Health Disparities.

Jointly sponsored by the MMS and Harvard School of Public Health, Division of Public Health Practice. CME Credit: 1 AMA PRA Category 1 Credit™ (RM) for each of the following modules:

- Health Disparities: A Social Determinants Approach
- A National Perspective on Disparities in Health Care Quality
- Boston's Campaign to Reduce Racial and Ethnic Health Disparities
- Public Health Preparedness
- Panel Presentation on Health Disparities and the Homeless, Children and Elderly