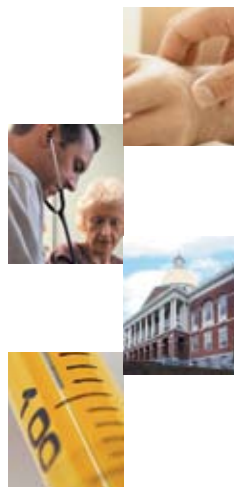




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A Physician-Guided Approach to Transparency and P4P

BY TOM WALSH

New physician performance ratings from the state's Group Insurance Commission (GIC) are just around the corner (see *Vital Signs*, October 2005, page 1). Doctors in Massachusetts continue to maintain that that initiative — and related pay-for-performance (P4P) incentive programs or public reporting efforts — must be based on accurate patient data if they are to help improve care and curb rising health care costs.

"Physicians recognize the urgent need to address the soaring cost of health care," said Alan M. Harvey, M.D., M.B.A., MMS president. However, Dr. Harvey added, the methodology and raw data that go into quality and cost measurements must be "transparent" — that is, the information must be made available to physicians in a timely way.

"Physicians need to be involved in this," Dr. Harvey declared. "Physicians determine health care quality, not payers or employers. Physicians working with their patients will define what constitutes the best care."

Survey Finds Physicians Skeptical

The findings of a statewide physician survey by the MMS, made public in December, demonstrated that an overwhelming majority of the state's doctors remain skeptical or unsure about the accuracy and usefulness of cost- and quality-measurement programs now under development.

When asked about the quality measures being developed by health plans and others to rate physician performance, 65.5 percent of respondents said the measures were either inaccurate (42.9 percent) or only somewhat accu-

rate (22.6 percent). An additional 30.5 percent said they did not know enough about the measures to gauge accuracy. Conversely, more than half of the respondents said they'd use *validated* quality and cost measurements to improve their practices.

"Physicians are not opposed to good measurement programs that help us improve care," Dr. Harvey reiterated. "But we have legitimate concerns about the accuracy, usefulness, and timeliness of the data, and how that data will be used."

New Ratings Loom

As 2006 unfolds, new cost and quality ratings will debut. Among these are:

- Massachusetts Health Quality Partners (MHQP), a broad-based coalition that aims to improve health care, will release quality data at the medical-group level (about 150 groups). That will be followed later by release of data from surveys of patient experiences at the practice-site level (about 500 practices).
- The GIC, which handles health insurance for the state's 250,000 workers and their families, expects by mid-year to charge lower out-of-pocket costs to employees who use physicians with the most favorable ratings. These ratings are based on "Episode of Treatment Group" measures (see *Vital Signs*, October 2005, page 2). The GIC is also readying a rating system based on a proprietary set of quality measures.
- Using its website, the state government will publish information on individual physicians, starting with the volume of procedures performed by individual doctors at each hospital to which they admit patients for procedures such as angioplasties and hip and knee replacements.

- The state's health plans, responding to employer demands to curtail annual health insurance premium increases, have already introduced incentive programs based on measures such as mammogram rates. So far, they have mostly rewarded primary care physicians for meeting certain measurement thresholds.

- At the national level, the Centers for Medicare and Medicaid Services has implemented a few voluntary incentive initiatives, but legislation to make P4P mandatory in the Medicare system didn't survive a Congressional conference committee.

What "Transparency" Really Means

Elaine Kirshenbaum, MMS vice president of policy, planning, and member services,

said physician performance ratings are transparent "only if physicians are able to review the data to understand it and make sure it's accurate. Physicians have to be able to suggest changes where necessary. That's the right way to reach everyone's goal — improved health care." Kirshenbaum added that the published literature makes her wary of using procedure volume to measure quality. "With the exception of a few high-risk procedures, there is still limited evidence about the relationship between volume and outcomes," she said. "Therefore, surgical volumes should be used cautiously when choosing a physician or hospital."

Rich Parker, M.D., medical director of the 1,400-physician Beth Israel Deaconess physician organization, appreciates the

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Vital Signs Turns 10

Much has changed in the decade since *Vital Signs* debuted in



March 1996. While we now publish a weekly, e-mail version of *Vital Signs* (*Vital Signs this Week*) to keep up with the increased volume of health care news, the inaugural edition of *Vital Signs* published a story entitled "What is the Internet?"

As mutable as the world is, some things don't change — such as *Vital Signs'* support for the Society in its myriad efforts to ensure quality health care for individuals and the public, physician-practice viability, and excellence in medical education. "The

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PRESIDENT'S MESSAGE



Three Goals for Health Care Reform

There are many “interested parties” in the drive for meaningful health care reform: physicians, patients, hospitals, insurers, employers, and elected officials. The fact that each group has vested interests in the reform process and outcome means that one group often comes into conflict with one or several others. When stakeholders square off and squabble, it becomes difficult for meaningful reform to emerge. This is especially true when the issues are as complex as those surrounding health care reform.

So, how can we all work together effectively? One way is to identify goals that all stakeholders can agree on — and to remember these objectives always, especially when partisan interests threaten to derail negotiations. Recent conversations with leaders from the hospital and health-insurance communities have led me to the following three goals on which I think all stakeholders can agree:

- Improving patient safety
- Continuously improving the quality of medical care
- Carefully controlling costs

The use across all 50 states of weight-loss surgery guidelines developed in Massachusetts is a great example of what happens when stakeholders put aside their individual agendas and place patient safety and quality first.

I'm writing this message on the same day the Centers for Medicare and Medicaid Services reported that total U.S. health care spending in 2004 (\$2 trillion) accounted for 16 percent of the gross national product. I refer to *careful cost control* in the third goal because it is unreasonable to expect the national tab for health care to decline from present levels any time soon. Baby boomers are becoming Medicare beneficiaries, new medical technology continues to emerge, and the price tag of new prescription drugs keeps rising.

Cost control requires cooperation and compromise among all stakeholders. But that does not mean the imposition of draconian reimbursement cuts on the provider side or “cost shifting” that makes health care unaffordable for consumers. Keeping the goals always in our sights can help us overcome this stubborn dollars-and-cents dilemma regarding health care reform.

Physicians must lead the way in determining what “quality health care” means. We must continue putting patients first and never flinch from our commitment to continuous improvement and sensible, evidence-based utilization of resources.

Whenever anyone asks you what physicians stand for regarding health care reform, simply say, “Improved patient safety, continuous improvement of quality, and careful cost control.” No one in their right mind will disagree with you!

Alan M. Harvey MD, MBA

— Alan M. Harvey, M.D., M.B.A.

Transparency and P4P

continued from page 1

efforts to control rising costs and promote higher quality care. However, he remains skeptical of current health plan efforts to rate physician performance using claims data.

“I'd like to understand the methodology, see it in action, see that it works,” Dr. Parker said. “I'd like to see how the data from my own organization is going to be used. So far, my colleagues and I have not seen adequate data.”

Health Plan Perspectives

Marylou Buyse, M.D., president of the Massachusetts Association of Health Plans, said pay-for-performance programs are “a way for health plans to recognize the good work doctors do and reward them for meeting standards and benchmarks.”

Claiming that pay for performance “is a quality issue, not a cost issue,” Dr. Buyse said she is “puzzled” by physician reluctance to embrace P4P — especially since she says it could be a significant source of new revenue for practices.

Dr. Harvey emphasized that “we want to create an environment in which we can continuously improve the medical care we deliver. But we can't allow large-scale implementation of an experiment, such as the one the GIC is about to embark on, that hasn't been adequately vetted through smaller, well-designed pilot projects.”

There is mutual agreement that using medical records rather than insurance claims information is the long-term answer. However, until physicians, hospitals, health plans, and *electronic* patient records are all connected in a usable fashion, completely realizing that goal will be difficult.

Do It Right

In the months ahead, MMS leaders will endeavor to explain the Society's position on pay-for-performance and transparency issues to opinion leaders across the Commonwealth.

In December, the Boston Globe published an opinion article on the topic authored by Dr. Harvey. “Physi-

Evaluating the Ratings

In 2005, the MMS adopted a comprehensive new set of principles, summarized below, to guide the collection and reporting of physician performance data. The MMS encourages physicians to contact their plan representatives for information about how performance data was obtained and to use these guidelines to evaluate the data.

1. **Data Quality.** Programs should use objective, well-validated, and clinically important measures of quality.
2. **Overcoming Technical Barriers.** Technical barriers to accurate and timely measurement must be overcome. Uniform availability of electronic health records is central to improved measurement.
3. **Physician-Patient Relationships.** Quality measurement programs should support and improve these relationships and should protect and improve access to high-quality care for all patients.
4. **Public Reporting of Physician Performance.** Such reports must be accurate, statistically valid, and avoid arbitrary cut points when comparing physicians and practices.
5. **Paying for Performance.** Incentives rewarding superior physician performance must contribute to higher quality and more cost-effective care.

icians support quality measurement and transparency,” Dr. Harvey wrote. “We want accurate and meaningful information provided publicly for our patients as they make decisions about their care. We want this information for our own use, as well, to continue to improve our own performance and provide higher quality care based on this feedback.”

While “perfection is not a prerequisite to implementation,” Dr. Harvey continued, whatever is done to measure performance “has to be done right.” The MMS president concluded, “The crush of rising health care costs requires decisive action, but all of us — physicians, providers, insurers, employers, and policymakers — must be careful that the cure isn't worse than the disease.” **VS**

Vital Signs

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continued success of *Vital Signs* as a key resource for physicians and the health care community is testimony to the outstanding team of editors, writers, designers, physician advisors, and production staff,” said MMS Executive Vice President Corinne Broderick.

Vital Signs is your publication. We invite you to participate by e-mailing us at vitalsigns@mms.org. As MMS President Alan M. Harvey, M.D., M.B.A., emphasized at a recent meeting of the *Vital Signs* Physician Advisory Board, “Communication is a two-way street.” **VS**

VITAL SIGNS is the member publication of the Massachusetts Medical Society.

EDITOR: Lloyd Resnick **STAFF WRITER:** Tom Walsh

EDITORIAL STAFF: Charles Alagero, Office of General Counsel; Robyn Alie, Public Health; Dana Cooper, Managed Care; Stephen Phelan, Membership; Cathy Salas, West Central Regional Office; Stephen Shestakofsky, Government Relations; Jessica Vautour, Physician Health Services

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PRODUCTION AND DESIGN: Lisa Salvo & Sylvia Sziklas, layout & design; Marissa Mathieson, quality assurance; Department of Printing Services, print production

PRESIDENT: Alan M. Harvey, M.D., M.B.A. **EXECUTIVE VICE PRESIDENT:** Corinne Broderick

DIRECTOR OF COMMUNICATIONS: Frank Fortin

Vital Signs is published monthly, with combined issues for June/July and December/January, by the Massachusetts Medical Society, 860 Winter Street, Waltham, MA 02451-1411. Circulation: controlled to MMS members. Address changes to MMS Dept. of Membership Services. Editorial correspondence to MMS Dept. of Communications. Telephone: (781) 434-7110; Toll free outside Massachusetts: (800) 322-2303; Fax: (781) 642-0976. E-mail: vitalsigns@mms.org. Letters to the editor should be no longer than 200 words; all are subject to condensation.

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Patient Communication: Hearing Through the Patient's Ears

(Part 2 of a series)

Communicating with your patients is critical to their well-being and your ability to successfully treat them. But what do they really hear when you talk to them in the exam room? Understanding patient perceptions of your communication is an important part of ensuring the patient understands your diagnosis and treatment of their condition.

Research with patients has classified physician speech during an exam into six categories of communication: information giving, information asking, social talk, positive talk, negative talk, and partnership building. These categories are structured as a nested hierarchy, with each level representing an increased level of involvement in the interaction, and each successive level capable of incorporating the previous level. At the highest level of involvement, physicians are perceived as working to build a partnership with and actively involve the patient in health care.

Is there a magic combination of communication elements or categories that will meet your patients' expectations and ensure understanding and satisfaction? Unfortunately there isn't. Every patient is unique — not only medically, but also from the perspective of communication.

Communication only works effectively when it is a two-way process, with shared intent and mutual meaningfulness.

That means physicians need to be thoughtful in their communication with their patients, assessing the individual patient's intent and ability, and working to create meaningfulness in the interaction. Simply asking the patient what's wrong and providing information is not enough in most cases to meet patient expectations. Conversely, too much social talk potentially removes the medical context from the interaction, and too much negative feedback could alienate the patient.

Also, a patient's eagerness to be involved will not necessarily guarantee an increase in meaningfulness for the patient. Patients may sincerely want to be involved in their health care, but without enough of the lower levels of interaction, they may be unable to thoroughly understand what involvement in their care entails.

For more information on creating meaningful interactions with your patients, contact Adam Shlager, practice management consultant at the MMS Physician Practice Resource Center, at (800) 322-2303, ext. 7702. **VS**

— Adam Shlager

LAW AND ETHICS

Guidance for Providing Interpreters

Title VI of the Civil Rights Act of 1964 prohibits those who receive federal funding, including providers of Medicaid or Medicare services, from discriminating on the basis of a person's national origin, including the language he or she speaks. Consequently, physicians who participate in Medicaid, Medicare, or any other federally funded program must ensure meaningful access to those programs for *all* individuals with limited English proficiency ("LEP individuals") by providing oral language assistance. Additionally, hearing-impaired patients may be considered disabled under the Americans with Disabilities Act (ADA), such that physicians are required to make reasonable modifications to provide those patients with meaningful access to health care.

Informal Interpreters

The U.S. Department of Health and Human Services (HHS) suggests several options for providing oral language assistance, including hiring bilingual staff, hiring staff interpreters, contracting for in-person or telephonic interpreter services, and engaging community volunteers. Another option is to enlist family members or friends of patients as informal interpreters. This is allowed under Title VI, as long as (a) the LEP individual has already been made aware of the right

to receive free interpreter services from a neutral person and has declined that offer, and (b) the informal interpreter's vocabulary, facility with both languages, and cultural competence allow for accurate translation. Family members (especially children) or friends may not be competent to provide quality and accurate interpretations. Also, if an LEP individual has chosen an informal interpreter and the physician later determines that the informal interpreter is not competent or appropriate, the physician should provide competent interpreter services to the LEP individual in place of, or in addition to, the informal interpreter.

Privacy Issues

Under HIPAA, a physician is not generally required to obtain the patient's authorization to use or disclose personal health information to an interpreter. Where the interpreter is a member of the physician's staff, the interpreter is part of the covered entity and is bound by HIPAA to the same extent as the physician. If a physician has an ongoing contractual relationship with an interpreter, either through a commercial service or a community-based organization, the physician should have a business-associate agreement in place with the interpreter. If the patient chooses to use an informal interpreter who is not a business associate or staff member, the patient's presence during the disclosure of health information creates a reasonable inference that the patient does not object to such disclosure.

HHS allows significant flexibility in the implementation of oral language assistance. The steps a particular physician or entity must take depend on (1) the number or proportion of LEP individuals served, (2) the frequency with which LEP individuals access the physician's services, (3) the nature and importance of the physician's services, and (4) the resources available to the physician and the costs of those resources.

The Office of Civil Rights (OCR) Region One office is available to help physicians determine which steps might be reasonable given individual practice situations. For more information, call the OCR at (617) 565-1340. **VS**

— Liz Rover Bailey, 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.

MMS Adopts Principles for Prior Authorization Programs

As reported in *Vital Signs* last September, Tufts Health Plan and Blue Cross Blue Shield of Massachusetts implemented prior notification/pre-certification programs regarding imaging studies. The Society has engaged in constructive dialogue with both plans to inform them of our members' points of view.

The principles summarized below regarding the implementation of prior authorization programs were developed by the MMS Task Force on Medical Cost Control and adopted by the Society at its 2005 House of Delegates Interim Meeting:

- **Prior authorization programs should be implemented only upon a showing of substantial variation in the targeted practice and good evidence of overutilization** among those providers the proposed prior authorization program would affect. Such data should be shared with the physician community before any action is taken. Physicians

who meet criteria should be excluded from the program.

- **Prior authorization requirements should never apply in a medical emergency**, or when a patient could be harmed by the delay caused by such programs.
- **Prior authorization programs should actively seek input from practicing physicians** in development and maintenance of the programs.
- **Prior authorization programs should be entirely transparent to patients and physicians.** Transparency should include a list of all procedures and relevant codes subject to prior authorization.
- **Prior authorization programs should be operated in a manner that avoids administrative burdens for physicians and their office staffs and incremental costs** to physicians, other providers,

and patients. Streamlining should include electronic communications and an efficient appeals process. Providers should be paid for incremental work effort of prior authorization programs.

- **Prior authorization programs should be conducted using up-to-date, evidence-based clinical criteria.** Any proposed denials should be issued by a licensed, actively practicing physician who regularly treats patients and who would typically manage the medical condition under review.

For more information on the full set of prior authorization principles, contact the Physician Practice Resource Center at pprc@mms.org or (800) 322-2303, ext. 7702. The Society will continue to voice physician concerns regarding prior notification policies and work to reduce all administrative barriers to practicing medicine. **VS**

— Dana Cooper

March Public Health Forum to Examine Health Care Disparities

When compared to whites, minority groups in the United States have higher rates of chronic diseases and mortality — and poorer health outcomes. Asked by Congress to assess the extent of racial and ethnic disparities in health care, the Institute of Medicine (IOM) published a study entitled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” in 2003. The IOM study committee reported that “disparities exist in a number of disease areas, including cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness, and are found across a range of procedures.”

The report concluded that “although myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care.” Economic, social, and environmental factors also contribute to health disparities. For example, limited health insurance or lack of income can have a profoundly negative impact on access to care.

The IOM report recommends the following steps to help eliminate disparities in care:

- Increase awareness of racial and ethnic disparities in health care among the general public, key stakeholders, and health care providers
- Promote the consistency and equity of care through evidence-based practice guidelines and enhanced patient-provider communication and trust

- Structure payment systems to ensure adequate services to minority patients
- Implement patient education programs to increase patient knowledge of how to best access care and participate in treatment decisions
- Integrate cross-cultural education into the training of health professionals

In 2004 the Massachusetts Legislature created the Commission to Eliminate Racial and Ethnic Health Care Disparities to “examine the racial, ethnic and

linguistic disparities in health and provide an action plan for the state to address these disparities.” The report, scheduled for release in the next couple of months, will provide recommendations that will foster the design, implementation, and improvement of new or existing health programs and services. Alice

Coombs, M.D., chair of the MMS Committee on Diversity in Medicine, is serving as the Society’s representative to the Commission.

In conjunction with the Harvard School of Public Health’s Division of Public Health Practice, the Massachusetts Medical Society’s 2nd Annual Public Health Leadership Forum will address health disparities (see above). “Given the increasing emphasis on this topic, we believe it is the number-one public health issue for us to explore,” said Howard Koh, M.D., M.P.H., chair of the MMS Committee on Public Health. **VS**

— Susan Webb

2nd Annual Public Health Leadership Forum

“Examining Health Disparities”

Thursday, March 23, 8 a.m.–3 p.m.
MMS Headquarters, Waltham

Featuring a presentation by Ichiro Kawachi, director of the Harvard Center for Society and Health

For more information, contact the MMS Department of Public Health and Education at (781) 434-7372 or dph@mms.org.

Hospitals, Physicians Must Provide Emergency Contraception to Rape Victims

This past fall, Massachusetts passed legislation that mandates that hospital emergency rooms provide information about and access to emergency contraception for rape victims. Facilities must also provide written information about emergency contraception to all those who provide care to victims of sexual assault. These materials, developed by the state Department of Public Health, are available at www.mass.gov/dph/dhccq/emergency_contraception.htm.

The legislation went into effect on December 14, 2005, and was endorsed by the MMS and many other organizations and individuals.

“This legislation is an important public health measure,” said Elaine Alpert, M.D., M.P.H., of the MMS Committee on Violence. “Sending the victim to another location for medication increases the chance of pregnancy and the patient’s anxiety.”

Also, regulations developed jointly by the Board of Registration in Pharmacy, the Board of Registration in Medicine, and the Drug Control Program now allow a pharmacist to dispense emergency

contraception with a standing order from a physician with prescribing privileges. The licensed pharmacist must first complete training accredited by the Accreditation Council on Pharmacy Education or offered by an approved college or school of pharmacy. The training, still in development, will include instruction on referring patients for additional services and follow-up.

Six other states (Alaska, California, Hawaii, Maine, New Mexico, and Washington) also have emergency contraception pharmacy-access programs.

David Norton, M.D., a pediatrician and vice chair of the MMS Committee on Public Health, states, “Physicians and other health care professionals should initiate discussion about contraception with their patients of childbearing years and their partners. We can assist our patients in making informed choices about routine contraception, as well as raise their awareness and educate them about emergency contraception.” **VS**

— Candace Savage

Sign Up for MMS Flu Advisories

Although the 2005–2006 flu season is not over yet, it’s time to plan for next year’s flu season. Physicians are strongly encouraged to order flu vaccine early. Vaccine manufacturer sanofi pasteur, which sells direct, and Chiron Corp., which sells through distributors, have announced that

vaccine will be available for pre-booking beginning January 31. At press time, MedImmune had not announced a pre-book date for FluMist, its nasal flu vaccine.

Visit www.massmed.org/flu for updated vaccine-ordering information and to sign up for the MMS Flu Advisories listserv. **VS**

Duffy Center Receives Foundation Grant



Photo by Doug Bradshaw

John Crowe, M.D., chair of the MMS and Alliance Charitable Foundation, presents a check to Arthur F. Bickford, M.D., medical director of the Duffy Health Center. The funds will support the E.P. Duffy Practice at Highpoint, which serves the medically underserved, uninsured, and at-risk patients from Plymouth County and greater Brockton, New Bedford, and Fall River. Also pictured are Edith M. Jolin, M.D., president of the Plymouth District Medical Society, and Richard S. Pieters Jr., M.D., Plymouth District treasurer.

WEBSITES OF THE MONTH

Help with the New Emergency Contraception Law

You can find information about the new emergency contraception law by visiting www.mass.gov and searching for “emergency contraception.” You can also go directly to the Department of Public Health’s site, www.mass.gov/dph/dhccq/emergency_contraception.htm, which has fact sheets for patients and providers, links to hospital regulations and guidelines for standing orders, and links to information on family-planning services for low-income patients. The Massachusetts Emergency Contraception Network’s site, www.massecnetwork.org, has news and information for providers, pharmacists, and women and their partners. The Network also offers provider training.

DPH Commissioner Paul Cote Sees Broad Benefits from Pandemic Preparedness

When Gov. Mitt Romney appointed Paul J. Cote Jr. as commissioner of the Department of Public Health (DPH) in October 2005, he described Cote as “the ideal candidate to help foster a healthier society through prevention, treatment, and education.” Although the DPH is charged with addressing numerous public health issues including substance abuse and strengthening the state’s public hospitals, improving emergency preparedness is at the top of Cote’s priority list. Bill Ryder, MMS counsel for state legislative and regulatory affairs, recently interviewed Commissioner Cote.

Q: How is the DPH balancing the need for preparedness with other public health priorities?

A: Clearly the issue of pandemic preparedness is one that is timely, of enormous public concern, and has great potential impact on the Commonwealth. Our task is to respond to a specific issue such as avian flu in a way that maximizes the value of the response for the benefit of public health preparedness in all areas.

The question that seems to be foremost in people’s minds is whether our planning for pandemic flu will entail a diversion of public health personnel and resources toward a single activity that might detract from other priorities in public health. Again, the challenge we have is to focus our attention on preparedness in ways that will have a broader benefit.

Q: What’s the role of vaccination in pandemic preparedness?

A: On the national front, the President’s push for new vaccine-manufacturing technology is very exciting, as is the broader research into antivirals. The advent of cell-based technology could make a huge difference for public health across the country and across the world.

One fringe benefit of the attention being paid to the avian flu is the fact that we can leverage people’s desire for a bird-flu vaccine into educational opportunities that prompt people to think about getting vaccinated for the regular flu season. To the extent that we bring attention to the utility of vaccination in general, we are raising consciousness — not in a fearful way, but in a productive way that encourages people to become educated health care consumers.

Q: What is the current status of surge capacity in Massachusetts?

A: Massachusetts hospitals have very fine margins regarding capacity. We have only 13,000-plus acute-care beds. That is why we are looking at how we can create surge

capacity by taking advantage of the resources of our physician offices and group practices. We’re pleased to work with the MMS on very detailed issues surrounding surge capacity, including issues of professional liability coverage for volunteer physicians. We are working together effectively in many areas.

Q: How important is clear communication during a pandemic?

A: In times of public health crisis, the public needs to hear a unified message. We have established relationships and procedures within the medical community and with first responders that will allow information to be shared effectively. Consequently, the leaders of the MMS, the Governor, and Al DeMaria, M.D., our director of communicable disease control can all deliver the same message to the public regarding responses to medical emergencies and threats.

Clear communication will also enable us to most effectively assign and utilize health care volunteers in a time of crisis.



Paul J. Cote Jr., Commissioner of the Massachusetts Department of Public Health

Q: Speaking of volunteers, please comment on the Volunteer Surveillance Corps.

A: The MMS and the DPH are working together to establish a network to increase awareness about the importance of prompt reporting that could indicate the emergence of a new infectious disease outbreak. Surveillance is also critical when responding to an established outbreak. New electronic medical records systems are giving us instant identification of outbreaks, and we need to continue investing in technology that will keep us ahead of fast-moving developments.

Dialogue *now* in areas of ethics and standards of care is also critical to insure that we make decisions and establish protocols based on sound advice. It is hard to obtain and integrate good advice in the midst of a crisis.

Q: Any final thoughts?

A: As with health care reform in Massachusetts, there is a real urgency around maintaining and improving our infrastructure to respond to the threats we face. We are on the frontier of many ethical and philosophical issues in care as well. We need to promote dialogue, identify best practices based on outcomes, and promote understanding about effective public health activities. I value the opportunity to work with the MMS on these challenges. **VS**

FEDERAL UPDATE

Stopping Medicare Reimbursement Cut Will Require Full House Vote

Final action to stop the 2006 Medicare physician reimbursement cut will wait until the U.S. House reconvenes. Although both chambers passed a reconciliation bill that replaced the cut with a reimbursement freeze, the Senate version included other changes that require House approval. Since the House had formally adjourned by the time of the Senate vote, and because House Speaker Dennis Hastert and House Minority Leader Nancy Pelosi could not agree to move the bill along during a pro forma session (where few members are present), passage of the bill will require a full House vote when Congress reconvenes.

Because Congress did not act, the 4.4 percent cut is now in effect until the bill is finally passed. However, after House

approval, the Centers for Medicare and Medicaid Services has agreed to automatically process claims at the frozen levels, retroactive to January 1.

The 4.4 percent cut in Medicare reimbursement will remain in effect until Congress reconvenes.

Unfortunately, the bill also includes several provisions objectionable to physicians. For example, the legislation increases cost sharing for Medicaid beneficiaries — allowing states to reduce benefits — and decreases spending on prescription drugs by \$3.9 billion. The bill also would make it more difficult for people to qualify for

long-term care coverage, saving the federal government an estimated \$2.4 billion. In addition, the bill reduces Medicare payments for multiple images on contiguous body parts in 2006 and 2007, ensuring that payment for imaging services delivered in physician offices does not exceed payment rates for the same services delivered in hospital outpatient departments.

On a more positive note, the bill does not include any pay-for-performance provisions for physicians, although it does require expanded quality data reporting by hospitals starting in 2008.

In a separate but related measure, a bill introduced by Rep. Pete Stark (R-CA), H.R. 4520, would increase physician reimbursement by 1.5 percent in 2006 and

2007, and would require MedPAC (an independent federal body that advises Congress on issues affecting Medicare) to report back to Congress on a permanent change to the current physician reimbursement formula by 2008. The bill would also require that beneficiaries not bear the cost of reimbursement increases and that the cap on Medicare spending imposed by the Medicare Modernization Act be lifted. Massachusetts Reps. Markey, Frank, and Capuano are original co-sponsors of this measure. **VS**

— Alex. Calcagno

Women's Lecture Series to Address Popular Diets

Of the many Americans dieting today, most are women. In addition, the majority of those dieters are trying to lose weight without a physician's or dietitian's supervision. Instead, they're relying on popular diet books and other merchandise.

The next program in the Committee on Women in Medicine Lecture Series will address the benefits and risks of popular diet fads (see box). The program will include a discussion of some of the most well-known diets, including the Atkins diet, Sugar Busters, the South Beach diet, and the Ornish diet.

The past popularity of the Atkins diet prompted several investigations into the effects of low-carbohydrate, Atkins-like diets on body weight and other health parameters. This educational program will focus on those studies and help attendees understand the similarities and differences between many of the popular low-carb/high-fat and high-carb/low-fat diets.

This program will discuss which approaches are best for weight loss and weight maintenance, based on both epidemiological data and results from the Weight Loss Registry, a database of several thousand people who have lost at least 50 pounds and have kept it off for at least three years. **VS**

— Caroline M. Apovian, M.D.

The Benefits and Risks of Popular Diet Fads

Wednesday, February 15
6:30–8:00 p.m.
MMS Headquarters

Speaker: Caroline Apovian, M.D., associate professor of medicine at Boston University School of Medicine and director of the Nutrition and Weight Management Center at Boston Medical Center

CME Credit: 1.5 category 1 credits (RM)
To register, call (800) 843-6356.

MMS Committee Appointments 2006–2007

Deadline for Consideration: March 3

If you would like to become more involved in the MMS, consider participating on a committee or the Member Interest Network (MIN) Executive Council.

The listing below includes all MMS committees and the MIN Executive Council. For committee descriptions and an application form to be considered for a committee, contact Sandra Manchester at the MMS Executive Office, (800) 322-2303, ext. 7012 or smanchester@mms.org. If you would like to join the MIN Executive Council, contact Cathy Salas at the West Central Regional Office, (800) 522-3112 or csalas@mms.org.

Standing Committees

Appointed by the President-elect (limited openings in accordance with bylaws)

- Bylaws • Ethics and Grievances • Inter-specialty • Judicial • Medical Education
- Membership • Public Health • Publications • Quality of Medical Practice
- Recognition Awards

Special Committees

Appointed by the President-elect

- Accreditation Review • Communications • Diversity in Medicine • Environmental and Occupational Health • Geriatric Medicine • Global Medicine • History • Information Technology • Maternal and Perinatal Welfare • Men's Health • Nutrition • Professional Liability • Senior Volunteer Physicians
- Sponsored Programs • Violence • Women in Medicine • Young Physicians

District Appointed Committees

Contact your district medical society for more information.

- Legislation • Nominations

Member Interest Network (MIN) Executive Council

- Arts, History, Humanism & Culture **VS**

Communication and Performance Improvement

A three-session, three-day program to assess and improve physician communication skills
Sponsored by Tufts University School of Medicine and the Tufts Health Care Institute, in collaboration with UMass Medical School

Where: Conference Center at Marlborough, Marlborough, MA
When: Sat., April 22, Sat., May 6, and Sat., June 10
Course Director: Robin Richman, M.D.

Fees: \$6,000 regular program fee • \$3,000 for ProMutual clients
For more information, call (617) 636-1000 or visit www.thci.org.

PHYSICIAN HEALTH MATTERS

Caring for the Caregivers Conference Focuses on Changing Culture of Medicine

Due to the increasing number of physicians seeking support and assistance with stress, workplace changes, and interpersonal relationships, Physician Health Services, Inc. (PHS) held its fifth Caring for the Caregivers Conference. Conducted by PHS and the MMS, this year's conference addressed the increasing challenges among physicians to comply with changing professional and behavioral standards.

PHS speculates that the increase in referrals in this area is a result of numerous new stressors among today's practicing physicians. These include continuous changes in the practice environment, new technology, increasing expectations from more informed patients, less tolerance for distressed physician behavior in the workplace, and limited opportunities for feedback to and from physicians.

Loring Flint, M.D., of Baystate Health Systems (BHS) spoke of his organization's creation of a culture of professionalism in which trust, respect, integrity, collaboration, and communication are emphasized to physicians during orientation and departmental meetings. A series of interventions for noncompliant physicians substantiates the practices. To ensure a successful program, Dr. Flint



Photo by Linda Quain

Conference Highlights:

Anthony Whittemore, M.D., of Brigham & Women's Hospital (BWH) spoke on some newly implemented professionalism standards at BWH. The BWH Program for Medical Professionalism consists of 33 professionalism officers, 26 trainers, and 3,600 physicians and Ph.Ds. The officers document facts when allegations arise, facilitate appropriate referrals, conduct investigations, interview witnesses, and meet with the physicians who are the subject of concern. After a six-hour training session, trainers go on to educate the 3,600 MDs, residents, and investigators.

Although BWH's program is still in its early stages, hospital officials have already noted enhanced awareness of the consequences of inappropriate behavior, increased incident reporting by staff, and an appreciation that liability in this arena is personal and is not covered under institutional or malpractice policies.

Thomas Lee, M.D., of Partners HealthCare System spoke about creating a culture of collegiality. Creating such a culture entails developing new skills among physician leaders, teaching that cooperation is a critical part of modern medicine and that physician autonomy is not the highest value in health care, and recognizing organizational dysfunction.

More than 100 health care professionals attended the fifth Caring for the Caregivers Conference at MMS Headquarters.

advocates developing physician behavioral codes and policies, training all physicians on those policies, and providing consistent enforcement.

Additional take-aways from the conference included the ongoing need for physician health support and intervention and the need for an increased focus on prevention and wellness.

As a resource for those challenged by these new standards, PHS has developed a course entitled "Managing Workplace Conflict: Improving Personal Effectiveness." Designed to provide physicians and administrators with the tools to guide effective workplace interactions, this course is offered twice a year, in June and December. In addition, PHS offers guidelines to assist hospitals with setting up physician health committees, which develop nondisciplinary methods to assess physicians whose behaviors may have health-related origins.

For more information on PHS programs and services, visit www.physicianhealth.org or call PHS at (781) 434-7404. **VS**

— Jessica Vautour

ACROSS THE COMMONWEALTH

District News and Events

Essex South – Delegates Meeting. Wed., Feb. 15, 6 p.m. Location: Danversport Yacht Club, Danvers. For more information, contact the Northeast Regional Office.

Franklin/Hampshire – District Social. Fri., Feb. 3, 6 p.m. Location: Mullins Center, UMass, Amherst. For more information, contact the West Central Regional Office.

Hampden – Legislative Breakfast. Fri., March 10, 7:30-9 a.m. Location: Best Western Sovereign Hotel & Conference Center, West Springfield. For more information contact Suzanne Skibinski at (413) 736-0661.

Norfolk South – Executive Committee Meeting. Wed., Feb. 8, 6:30 p.m. Location: Alba Bar & Grill, Quincy. For more information, contact the Southeast Regional Office.

Plymouth – Executive Committee Meeting. Wed., Feb. 15, 6 p.m. Location: MMS Southeast Regional Office, Lakeville. For more information, contact the Southeast Regional Office.

Suffolk – District Meeting. Thurs., Feb. 9, 6 p.m. Location: Mass General Hospital, East Garden Room, White Basement. For more information, contact Thelma Malafey at (617) 236-5864.

Worcester – 210th Annual Oration. Wed., Feb. 8, 5:30 p.m. Location: Beechwood Hotel, Worcester. Orator: Harvey Kowaloff, M.D., chief medical officer, Jordan Hospital, Plymouth. Topic: “Do No Harm – Hippocrates to the IOM.” For more information, contact Joyce Cariglia at (508) 753-1579.

In Memoriam – With respect and sympathy, we note member deaths on the MMS website at www.massmed.org/memoriam.

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; Nancy Caron, West Central Regional Office, at (800) 522-3112 or ncaron@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

DecisionHealth Discounts Available to MMS Members

The *New England Journal of Medicine* and advocacy for issues concerning physicians and their patients are two well-known benefits of MMS membership. Another, lesser-known membership benefit is an exclusive discount on publications from DecisionHealth.

DecisionHealth provides practical and timely publications on reimbursement, coding, and compliance matters. For example, the *Part B Answer Book* with CD-ROM is a useful tool to obtain assistance with reimbursement issues, denial, and delayed payments. The *Answer Book* has more than 150 chapters organized alphabetically that explain Medicare’s billing rules. The book’s 1,200 pages are packed with plain-English explanations to help physician practices file clean claims quickly. The free companion CD-

ROM gives you keyword search capability for more than 3,500 pages of official Medicare documents to help you make sure you and your billing staff follow the rules your Part B carrier will use to review your claims.

To obtain the *Part B Answer Book* today with an exclusive MMS member discount, call DecisionHealth at (877) 602-3835 and mention code PBA06001 and your MMS membership.

Other DecisionHealth publications include *Part B News*, *HIPAA Answer Book* (with CD-ROM), *HIPAA Compliance Alert*, *CorrectCodeCheck*, and *Fraud & Abuse Answer Book* (with CD-ROM). Visit the DecisionHealth website at www.decisionhealth.com to learn more. **VS**

– Carolyn Maher

Group Enrollment Saves Time and Money

MMS members can realize significant savings if their practice group takes advantage of the Society’s new group-enrollment option. With this dues option a group can save in either of two ways:

- 20 percent off the total state dues (with 100 percent group participation as new/current MMS members)
- 5 percent off the total state dues (with 80 percent group participation as new/current MMS members)

Your group administrator will also benefit from group enrollment. The advantages are as follows:

- A single dues invoice, with savings displayed for each member
- Information that permits “one stop”

updating for critically important contact and demographic information

- Application packets for physicians joining the MMS as part of the group enrollment
- Centralized communications with the MMS concerning your group’s dues status and updates

Groups with five or more physicians who are members or who will become members as a result of this enrollment option are eligible for the group discount. To begin your group enrollment, contact MMS Membership Services at (800) 322-2303, ext. 7321 or groups@massmed.org. **VS**

– Catherine Cronin

Membership Satisfaction Levels Remain High

Each year the MMS conducts a satisfaction survey of a representative sample of members. The four-page survey not only examines member satisfaction, but also determines how the MMS is performing on key strategic initiatives.

For the third consecutive year, the survey revealed a high overall member satisfaction rate of more than 90 percent. Even more outstanding was the fact that 98 percent of those polled said they were “likely to renew this year.” That near-perfect result is extraordinary for any membership association.

Additionally, members identified challenges to providing quality care to their patients. The two issues that stood out as most challenging were administrative burdens on physicians and staff and limited prescription drug benefits for some patients. Notably, one-third of the members surveyed cited the need for better information technology (IT) as very challenging.

Many of the respondents’ personal goals and values as physicians dovetail with those challenges. Members assigned the highest value to improving the IT capabilities of their practices and reducing time spent in administrative management. Respondents also placed high value on increasing income, career advancement, and professional development. These responses suggest that most members remain committed to patient-care careers, but that they seek solutions to improve practice efficiency and reduce the hassles of health care delivery.

The Health Systems and Policy Department is preparing to mail the 2006 member satisfaction survey. If you receive the survey, please complete it and return it to the MMS as soon as possible. Your participation is key to a successful process.

For more information on the survey, the process, or the results, contact the Health Systems and Policy Department at (800) 322-2303, ext. 7222. **VS**

– David Huffman

2006 Annual Meeting of the House of Delegates May 11–12

Dates to Remember

- March 27 Deadline for resolutions and reports
- April 14..... Deadline for reservations at Seaport Hotel, Boston
- April 20 Delegates Handbook issued and posted on website
- April 27 Deadline for late resolutions and reports (please note adjusted date)
- May 11-12 House of Delegates Meetings

You can submit a resolution online at www.massmed.org/resolutions or by e-mail at resolutions@mms.org.

(See page 8 for more Annual Meeting information.)



MMS Annual Meeting 2006

Patient Safety is Teamwork

Bridging the Gap

May 11-14, 2006

Seaport Hotel and
World Trade Center, Boston



Thursday and Friday, May 11 and 12

Annual House of Delegates Meeting

Friday, May 12

President's Reception and Dinner — New England Aquarium, Boston

Saturday, May 13

Annual Education Program — Patient Safety is Teamwork
Shattuck Lecture Luncheon

Featured Speaker: Ferid Murad, MD, PhD, Nobel Laureate
Presidential Ceremony and Annual Banquet

Entertainment by *Canadian Brass* and dancing to *Horns in the House*

For more information, visit www.massmed.org/annual2006

MMS Education Programs

To register for any of these programs, call (800) 843-6356. For more information on these programs, contact the MMS Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to www.massmed.org. NOTE: (RM) indicates that the program or a portion of the program meets the Massachusetts Board of Registration in Medicine criteria for risk management study.

Onsite CME Programs

Benefits and Risks of Popular Diet Fads

February 15, 6:30–8 p.m., MMS Headquarters, Waltham. Sponsored by the MMS and its Committee on Women in Medicine. CME Credit: 1.5 category 1 credits (RM)

It's Not Just a Paper Chase: Making the Case for Documentation

March 29, 8 a.m.–12 noon, MMS Headquarters. Sponsored by the MMS. CME Credit: 4 category 1 credits (RM)

Early Warning Disease Threats: Health Preparedness through Surveillance

April 25, 6–9 p.m., MMS Headquarters. Sponsored by the MMS and supported by the Massachusetts Department of Public Health. CME Credit: 2.5 category 1 credits (RM)

Healing Words: The Benefits of Apology — 2006 Literature and the Professions Series

April 28, 9 a.m.–3:30 p.m.,
MMS Headquarters
May 5, 9 a.m.–3:30 p.m.,
Beechwood Hotel, Worcester
May 19, 9 a.m.–3:30 p.m.,
MMS Headquarters
Sponsored by the MMS. CME Credit:
6 category 1 credits (RM)

Online CME Programs

To access the following programs,
go to www.massmed.org/cme.

*The following online CME programs are jointly
sponsored by the MMS and ProMutual Group.
Each program is awarded 1 category 1 credit (RM).*

- **Medical Malpractice Litigation:
The Attorney's Perspective***
- **Nonsurgical Cosmetic Procedures:
Risk Issues in the Quest for Youth***
- **Difficult Patients**

- **Closing a Practice**
- **Terminating the Professional
Relationship With a Patient**
- **Patient Satisfaction**
- **The Telephone as an
Instrument of Risk**
- **The Electronic Health Record
in the Office Practice***
- **Nurse Practitioners and Physician
Assistants: Some Risk Management
Concerns***
- **Cultural Diversity***

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

*The following online programs are sponsored by
the MMS. Each program is awarded 2 category
1 credits (RM).*

- **Clinical Aspects of Bioterrorism**
- **Medical Perspectives
on Impaired Driving**

- **Medical Errors and Perspectives
on Patient Safety**
- **Patient Safety: Conducting a Root
Cause Analysis of Adverse Events**
- **Medication Safety, Systems and
Communication**

*The following three online CME programs are based
on the 2005 Patient Safety Forum. Each program is
awarded 1 category 1 credit (RM).*

**Communication:
Meeting the Challenge**
James P. Bagian, M.D.

**AHRQ Initiatives to Improve the
Quality and Safety of Health Care**
Carolyn M. Clancy, M.D.

**Patient Safety and Communication:
An IOM Perspective**
Harvey Fineberg, M.D., Ph.D.
CME Credit: 1 category 1 credit per
exam. New exams available every week.