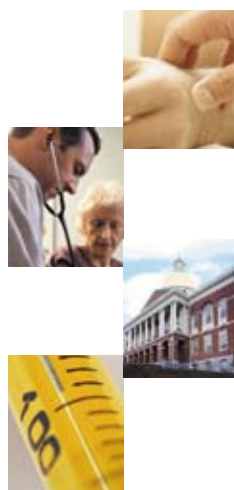




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What's on the Web?

Business and Labor Communities Determined to Move Ahead with Individual Tiering

MMS Continues to Insist on a Higher Standard

BY TOM WALSH

Massachusetts business and labor leaders say they sympathize with physicians about the need for better data to rate individual physician performance. But they do not express enthusiasm about slowing or halting current initiatives until better data can be used.

Interviewed separately by *Vital Signs*, top business and labor figures felt strongly that current initiatives to "tier" doctors individually rather than by physician group should go forward. They emphasized that something has to be done to curtail rising health care costs.

"We could sit around talking about this, trying to get the perfect measurement, and it might take us 20 years," said Richard C. Lord, president and CEO of Associated Industries of Massachusetts (A.I.M.). "There will always be some disagreement from doctors and hospitals over what the perfect metric should be. But I do think we owe consumers some information so they can make choices now."

"This train is moving, and I agree we can't wait for the perfect set of data," added Michael J. Widmer, president of the Massachusetts Taxpayers Foundation. At the same time, though, Widmer said doctors should not be unfairly hurt by the process. "I'm not comfortable with

data that will unfairly tarnish anyone's reputation."

Last year, the state Group Insurance Commission (GIC) unveiled its two-tiered assessment of the state's physicians. The GIC — which provides health insurance to more than 267,000 Massachusetts state workers, retirees, and their dependents — is seeking to better control health care costs while enhancing quality of care by offering employees lower copayments when they select tier-one doctors rather than those rated tier two.

Data Sources and Usage Could be Inaccurate

Concerned about the appropriateness of the GIC's two-tier format — especially

given numerous complaints from physicians soon after the initiative rolled out (see box on page 2) — the MMS commissioned Focus Medical Analytics (FMA) of Rochester, N.Y., to assess the program.

The FMA report recommended tiering physicians only at a group level "until data accuracy is improved and the methodology is further validated." The report also cited inaccuracies caused by the program's reliance on claims data. Further, the report stated that using this data for individual tiering "exacerbates the impact of accuracy issues. Pharmacy prescribing and radiology ordering information, for example, will be more accurate within a group than for an individual."

To identify systematic accuracy problems with this data, the FMA report recommended "a formal feedback and correction mechanism so that errors uncovered by physicians, plans, and other analysts can contribute to improving the evaluation system."

Kenneth R. Peelle, M.D., MMS president, said doctors understand that rising costs exert considerable pressure on employers, who pay the bulk of health insurance premiums. "We don't oppose transparency," Dr. Peelle said. "We think the biggest problem in tiering physicians is that the reliability of tiering them at the individual level is low. As we try to find a solution to the cost problem, we have to make sure we don't disrupt the physician-patient relationship."

continued on page 2

Society's EHR Resources Can Help Any Practice

Looking back, Dale Magee, M.D., says the decision five years ago to invest in an electronic health record (EHR) system for his two-doctor OB/GYN practice in Shrewsbury was good for patients and for business. "It paid for itself in two years,

and now we have an office that runs much better than it otherwise would," said Dr. Magee, MMS president-elect.

The MMS now has a suite of online resources and services that can help members learn what they need to know about EHRs and better handle cost issues. According to Ari Alpert, MMS health information technology manager, the Society's EHR services include:

- A Web-based EHR "readiness assessment tool." Doctors complete a short survey to learn where their practices stand in terms of EHR adoption.
- Member discounts with four vendors — eClinical Works, e-MDs, NextGen, and Allscripts

- A Web "sandbox" that allows members to get hands-on exposure to EHR systems before buying
- Information on how other doctors view various systems from KLAS, an independent health care technology rating service
- Consultants who can provide timely help to members who need assessments of how to improve office workflow and implement IT

"What we offer can help our physicians thrive in this changing environment," Dr. Magee concluded.

To access these EHR resources, go to www.massmed.org/ehr. **VS**

— Tom Walsh



Illustration by Chris Twichell

PRESIDENT'S MESSAGE



EHRs: Get Started Now

Members frequently ask me whether they should convert to electronic health records (EHRs).

The page 1 article about the Society's growing EHR resources answers some of the "hows" of this important question, but I'd like to address the "when" and "why" of EHRs.

The answer to "when" is simple: start now. Learn as much as you can about these systems — their capabilities, infrastructure requirements, and how they can change the way you run your practice. I recommend the MMS resources because we've weeded out a lot of the hype in the EHR marketplace. Use the online EHR assessment tool, even if you've already started the journey, to see which step your practice should take next.

Many physicians are waiting for results from the Massachusetts eHealth Collaborative pilots. The Collaborative will no doubt have important information to share over the next few months, but I urge you not to wait for any "final answers," because there won't be a one-size-fits-all solution. Get started with the education and planning process even if you're not ready to purchase anything.

Cost is often cited as the number-one barrier to EHR adoption. But cost is now less of an insurmountable impediment. Dale Magee, M.D., MMS president-elect and one of the Society's many EHR champions, estimates his two-physician OB/GYN practice spent \$40,000 up

front and pays about \$5,000 per year in maintenance costs. Dr. Magee's practice installed its system five years ago (without the benefit of health plan incentives or vendor discounts that are now available), and it paid for itself in two years. Increased office efficiency has led to cost savings in filing and phone management and less wasted time hunting for patient information.

The cost barrier is less formidable now that Massachusetts health plans have offered EHR-based incentives. Also, many members of the new U.S. Congress support providing federal money to help doctors buy health information technology.

The obvious answer to the "why" question is also simple: improved patient outcomes and patient safety. But there's more. EHRs are becoming essential in today's environment of transparency and pay for performance. With EHRs, it's easy to prove that your patients received appropriate care, and EHR-generated reports can help you pinpoint your quality-improvement efforts. Moreover, the decision support embedded in many of these systems will go a long way toward eliminating the hassle of prior notification and precertification.

We know that the practice of medicine is always changing, and EHRs are one example. As long as physicians lead this change and embody it in their practices, our patients will receive the best possible care.

Kenneth R. Peelle

— Kenneth R. Peelle, M.D.

Business and Labor on Tiering

continued from page 1

Not a Single Phone Call

Richard Waring, vice chair of the GIC who represents the National Association of Government Employees, said the cost of medical care "is a big, complicated issue, and we can't solve it without working with everybody. I think what the commission is doing right now is the right way to go... If the medical society finds something in the data that doesn't make sense, the appropriate response is that we will examine it."

Waring added that his members — 12,000 of whom are Massachusetts state workers — have said nothing to him about physician concerns regarding tiering. "There's not been a single phone call yet," he observed.

Karen Hathaway of Local 93 of the American Federation of State, County, and Municipal Employees and a GIC commissioner, said her organization has supported the GIC program "right down the line." Added Hathaway, "We're in favor of anything that can lead to better quality of care and cost effectiveness for employees." Further, she said she sees little value in tiering doctors by groups. "When you go to the doctor, you see an individual, not a group," Hathaway said.

Hathaway echoed Waring in saying that her membership has been silent so far about tiering.

Alan G. Macdonald, executive director of the Massachusetts Business Roundtable, said the business community is "very focused" on health care transparency and that "defensiveness" on how to measure

performance or obsessing about perfection "may lead to no measurement at all." He said he can appreciate doctors' concerns, "but from a system-wide point of view, if the system does not get pushed, there will always be a reason to put it off."

Macdonald said physician tiering per se is not a focus for the business community. "The issue is the need for more consumer awareness," he said. "You don't

have a market if all the products look the same. If you assume every provider is the same in skill, there's not a market. The whole issue is how to identify the market for value."

Eileen McAnneny, A.I.M. director of legislative services and a point person for the association on health care issues, said, "More information is a good thing, and rewarding doctors who are efficient and not reward-

ing those who are inefficient makes sense." As for physician concerns about using flawed data, McAnneny concluded, "The data may not be perfect, but you can't let the imperfect get in the way of the good." **VS**



Richard C. Lord,
President and
CEO, Associated
Industries of
Massachusetts



Michael J. Widmer,
President,
Massachusetts
Taxpayers
Foundation

Some Observations that Raised Concerns about Tiering

- Physicians were evaluated on the cost of conditions that do not occur in their specialty.
- A neurosurgeon was profiled as a general surgeon.
- A difference of 0.01 units (from 1.00 to 0.99) resulted in a non-preferred tiering.

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LETTER TO THE EDITOR

A Call for a Single-Payer System

Commonwealth Connector head Jon Kingsdale rightly says, "We have a contract... that we don't just let people collapse on the street," and that we should "share the burden of paying for it" (*Vital Signs*, Dec. 2006/Jan. 2007, page 1). He didn't define "we," but I suggest that "we" means our entire society — that we *all* should share the burden.

Physicians, hospitals, and related groups should not let themselves be singled out for paying for health care. We should fix our broken and fragmented health care system by adopting a single federally paid and run system, one place

to handle forms, claims, payments in and out, and everything else.

The "NPI Now" article on page 3 of the same issue says physicians are supposed to obtain a national identifier code, the NPI, and then submit it to each insurer using a different method and/or form for each one. All of that should and could be handled transparently by a single responsible federal health agency. This should be a goal for voters in the 2008 federal election cycle.

— John D. Leith, M.D.
Auburndale, MA

Blue Cross Revises Tiering Methodology

Blue Cross Blue Shield of Massachusetts recently announced a change to its tiering methodology for primary care physicians for whom it does not have sufficient data to make a definitive tier determination.

Originally, Blue Cross assigned physicians without sufficient quality-measurement data (typically those newly in practice) to Tier 2, the nonpreferred tier. Based on physician feedback and MMS input, Blue Cross will now geographically group physicians with insufficient data and move all Tier 2 physicians in that category to Tier 1 until sufficient data

are collected. As a result, 98 percent of all Blue Cross physicians are now classified as Tier 1.

The MMS appreciates the responsiveness of Blue Cross regarding this issue. In a letter sent to physicians affected by the change, Blue Cross said it would continue to work with the provider community in 2007 and review its tiering methods every two years. For more information, contact your Blue Cross provider relations manager at (800) 316-BLUE (2583). **VS**

— Dana Cooper

Reminder: HCAS Begins Initial Credentialing February 1

Beginning February 1, 2007, Health-Care Administrative Solutions (HCAS) will be conducting initial credentialing through a new process. As with the recertifying efforts in January, HCAS plans (Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, Network Health, and Tufts Health Plan) will use Ingenix Inc. and the Council for Affordable Quality Health Care (CAQH) to allow physicians to apply for credentials verification and submit common credentialing information to one source.

"Providers can complete one credentialing application on behalf of the HCAS participating plans and other insurers that utilize the CAQH system," explained Lori Burgiel, executive director of HCAS.

When a request for affiliation is received by the health plan, Ingenix will provide complete credentialing instruction packets to physicians who are credentialing for the first time. Each health plan will make independent decisions about credentialing new providers.

Kelly Glynn of Harvard Vanguard Medical Associates says the Ingenix/CAQH process "is user friendly and easy to maneuver." She adds that building relationships with CAQH representatives and area credentialing contacts is a key to success.

Providers should continue to communicate changes in contracting, billing, and enrollment directly to the specific health plan involved.

For more information, visit the HCAS website at www.hcasma.org. Physicians who experience problems with the HCAS process should contact Dana Cooper at (781) 434-7218 or dcooper@mms.org. **VS**

— Dana Cooper

MMS to Help MHQP Implement Physicians' Foundation Grant

The Physicians' Foundation for Health Systems Excellence recently awarded a nearly \$500,000 grant to Massachusetts Health Quality Partners (MHQP) — in partnership with the MMS and Masspro — to develop, implement, and evaluate an innovative approach to improving clinical quality and the patient experience in physician office practices.

The two-year project, which began in January 2007, integrates a newly devel-

oped patient-experience improvement curriculum with new and existing approaches to clinical care management. The program will be implemented through a pilot intervention with 20 to 25 physician groups and will be evaluated using clinical quality, patient experience, and physician practice satisfaction measurements. The final report will assess the impact of the pilot and make recommendations for broader implementation. **VS**

— Dana Cooper

LAW AND ETHICS

Clinical Trials: The Rewards and Risks for Private Practice Physicians

Increasingly, private practice physicians are considering participating in clinical trials that test drugs, devices, and other technologies among outpatients. The need for physicians in private practice to serve as clinical investigators is increasing as the trials require larger numbers of research subjects.

Many practicing physicians who act as clinical investigators have improved the care provided to their patients, increased their professional satisfaction, and contributed to the advancement of medical knowledge. Additionally, these physicians sometimes receive compensation, which may offset decreasing reimbursements from more traditional revenue sources. The rewards, however, are not without potential risks.

Clinical research is heavily regulated by the federal government. Complex laws govern the conduct of the research and specify protections accorded to research subjects, including informed consent and privacy. Clinical trials are based on pre-approved protocols that investigators must follow to the letter, and investigators must meet the requirements of the trial's institutional review board, which helps protect the rights and welfare of human subjects.

Regulations and requirements notwithstanding, the investigator and anyone assisting with the research must maintain the highest ethical standards to uphold the integrity of the study and protect the safety of the research subjects.

Until now, few legal actions have been brought against investigators, but this may be changing. Indeed, failure to comply with regulations can theoretically expose investigators to a laundry list of liability: strict product liability, common law fraud and intentional misrepresentation, constructive fraud, battery, lack of informed consent, violation of the FDA "Common Rule" and other clinical trial regulations, violation of the research subject's civil rights or right to be treated with dignity, breach of fiduciary duty, conflict of interest, and violation of confidentiality. Investigators could even face potential liability to the sponsor of the clinical trial.

If you are considering becoming a clinical investigator, you should confer with experienced colleagues and your insurance carrier. Then carefully review the trial's protocol, making sure reimbursement arrangements are proper and ethical and that these details and all others are set forth in a clinical trial agreement. Also, have an attorney experienced with clinical research review all study documents, including any confidentiality agreements, before you sign.

With careful preparation and attention to compliance, you may find the risks of participation manageable and the rewards multiple. **VS**

— Sarah Elisabeth Curi, J.D., M.P.H.

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.

SAVE THE DATE

2007 MMS Annual Meeting

May 17–20, 2007

Seaport Hotel and World Trade Center — Boston

Thursday, May 17

House of Delegates
Annual Awards Luncheon
Annual Oration
Ethics Forum
Physician Volunteer Fair

Friday, May 18

House of Delegates (continued)
President's Reception and Dinner

Saturday, May 19

Annual Educational Program
Shattuck Lecture Luncheon
International Medical Graduates Reception
Member Art Exhibit
Annual Banquet and Entertainment

Physicians Influence Breastfeeding Decisions among New Mothers

Recent data from the Centers for Disease Control and Prevention show that Massachusetts has met the Healthy People 2010 goals for early breastfeeding, with 77.5 percent of Commonwealth mothers starting out nursing in 2005. However, only 16.6 percent were giving only breast milk at six months, falling short of recommendations established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. With appropriate guidance, clinicians can help families meet recommendations for six months of exclusive breastfeeding.

Not breastfeeding is associated with higher rates of acute illnesses in infants. Not being breastfed is also linked with chronic conditions such as obesity and type 1 diabetes. Breastfeeding positively impacts maternal health as well: studies have associated short-duration or absent lactation with increased risks of breast cancer, ovarian cancer, osteoporosis, and type 2 diabetes.

Physicians are uniquely positioned to empower and encourage women to breastfeed. Studies have found a strong correlation between how long a mother breastfeeds and what her physician tells her. In addition, one study found that among mothers who are uncertain about how to feed their baby, breastfeeding information offered in physician offices that is sponsored by baby-formula makers significantly increased the likelihood of a mother to wean.

Despite their potential influence, physicians receive little formal training in breastfeeding management. For exam-

ple, physicians may not be familiar with medication use in nursing mothers and may mistakenly advise mothers who are taking medication to wean. LactMed, a website sponsored by the National Library of Medicine, reviews guidelines and supporting data on thousands of medications. Using these materials and consulting with the infant's pediatrician can help physicians of new mothers make informed decisions about medication use while nursing. In addition, the Massachusetts Breastfeeding Coalition (www.massbfc.org) is a resource for professional and patient information.

Baby Friendly Hospital Initiative

Hospital practices are also critically important. Through its Baby Friendly Initiative, the World Health Organization recommends that every facility providing maternity services implement certain steps for successful breastfeeding. These include showing mothers how to breastfeed and how to maintain lactation if they are separated from their infants.

Physicians who deliver babies can also incorporate baby-friendly practices. For example, at delivery, healthy infants should be placed skin-to-skin on the mother's chest for the first hour of life. In a Cochrane meta-analysis, such contact increased breastfeeding duration by 42 days.

— Alison Stuebe, M.D.
Brigham and Women's Hospital

For more breastfeeding resources, visit www.massmed.org/breastfeeding.

Health Care Reform Aims to Improve Public Health, Curb Disparities

The landmark Massachusetts health care reform law should not only expand health insurance coverage, but also improve public health. As the 2003 Institute of Medicine report *Unequal Treatment* noted, insurance coverage alone does not guarantee access to high-quality health care. Comprehensive policies to improve public health must also address social factors that extend beyond the biology of disease. Currently, many forces within and outside the medical system widen health disparities and lead to suboptimal health outcomes.

Will Wellness Work?

The new law has the potential to improve public health in many ways. Two provisions in particular focus on reducing underlying disparities through policy change. The first, a new MassHealth Wellness Program, will provide incentives for low-income Medicaid patients to utilize specific preventive services. MassHealth enrollees who participate in one or more wellness activities — such as smoking cessation, cancer screenings, or stroke education — will pay reduced premiums and copayments. Encouraging such preventive behaviors could lead to improved outcomes for those at higher risk.

However, given that MassHealth premiums and copayments are already low, only time will tell if these incentives will encourage healthy behaviors in this target population. While the concrete details of operationalizing the program, including monitoring and tracking, are currently being developed, the Massachusetts experience could provide valuable data to inform implementation of wellness programs in other states.

Third Annual Public Health Leadership Forum

April 26, MMS Headquarters

Topic: Public Health and Health Care Reform

For more information, call (800) 322-2303, ext. 7372.

Disparity Reduction and P4P

A second innovative component of the Massachusetts law establishes a Medicaid pay-for-performance plan for hospitals that is linked in part to disparities reduction. The specified quality standards and performance benchmarks that hospitals must meet by fiscal year 2009 include the reduction of racial and ethnic disparities. Massachusetts is among the first to explicitly use disparity reduction as a performance indicator.

Successful implementation of the pay-for-performance component of the health care reform law will rely partly on establishing effective systems for race and ethnicity data collection, which in itself is a challenging task. To make a difference for the people of Massachusetts, these innovations will require further development and coordination among many stakeholders.

In addition, Health Care For All's Disparities Action Network plans to advocate for omnibus legislation that will propose a new Office of Health Equity to coordinate all state agency efforts dedicated to disparities elimination.

All in all, the promise of improving public health is a tantalizing aspect of the new Massachusetts law.

— Howard K. Koh, M.D., M.P.H.,
and Amber Johnson, M.S.
Harvard School of Public Health

“Go Red” Empowers Women to Reduce Risk for Heart Disease

Heart disease is the number-one killer of American women. Nearly half a million women die of cardiovascular disease annually, more than the total number of cardiovascular disease-related deaths in men. A recent study showed that one-third of women underestimate their personal risk of developing heart disease, and the majority doesn't know what cholesterol, blood pressure, and blood sugar levels are healthy for them. This lack of awareness is especially prevalent among Afri-



can American and Hispanic women.

Proactive leadership of health care professionals is greatly needed to advance the fight against heart disease and stroke in women. Through “Go Red For Women,” the American Heart Association provides health care professionals with tools to help them work with patients to combat serious cardiovascular health risks.

The program offers women patients information on healthy eating, exercise, and risk-factor reduction, such as smoking cessation, weight maintenance,

blood pressure control, and cholesterol management. The Go Red Heart Checkup — an online tool that provides a comprehensive evaluation of overall heart health — helps women understand the numbers that are most important to them.

“We created the Go Red For Women Heart Checkup to motivate women to take action and encourage them to open a dialogue with their doctors about their long-term heart health,” said Nieca Goldberg, M.D., Go Red For Women spokesperson and chief of Women's Cardiac Care at Lenox Hill Hospital in New York. The tool can be used by patients on their

own or in conjunction with their physicians.

Visit http://goredforwomen.org/healthcare_professionals to access more resources and free downloadable tools such as the most up-to-date evidence-based guidelines for cardiovascular disease in women, online continuing education courses, and patient materials.

For more information, contact Shannon Melluzzo at (413) 735-2104, or Shannon.Melluzzo@heart.org.

— Jennifer Natoli
American Heart Association

STATE UPDATE

MMS Continues Fight to Protect Practice Environment

The newly elected 2007–2008 state Legislature convened on January 3. When the deadline for pre-filing bills came a week later, the MMS was ready with a package of 16 separate bills, most of which were focused on improving the viability of physician practices in Massachusetts. Pre-filing bills assures their full consideration at a public hearing.

Building on last year's first of three scheduled escalating increases in Medicaid rates, the Society will continue to vigorously advocate for reforms aimed at professional liability and the relationship between physicians and insurers. New measures were also filed in the areas of hospital staff relations, physician workforce development, sharing pharmacy data, and peer review. The MMS will also continue its efforts to expand health care access and restore adequate funding for public health.

The following bills focus on the practice environment:

- **Professional Liability:** In addition to re-filing omnibus legislation incorporating an array of proven "MICRA" reforms, the MMS drafted four new bills. Two of the new bills would make it harder for unqualified expert witnesses to ply their trade in Massachusetts,

while the other two are aimed at forestalling litigation itself — one requires a six-month notice before a claim could be filed, and the other exempts statements of regret or apology from admission into evidence in litigation.

- **Managed Care:** New legislation would establish standards for the Group Insurance Commission and health insurers to build greater integrity into the "transparency" process. The legislation, which is based on an independent report by national experts that contained 34 recommendations to improve current practices (see *Vital Signs*, Dec. 2006/Jan. 2007, page 1), would specify in detail the standards to be used. The Society also re-filed bills aimed at leveling the playing field between physicians and insurers, including legislation that addresses unilateral amendments of contracts, "All Products" clauses, timely payment, and the data used in determining year-end bonuses and withholds. In addition, the MMS re-filed legislation to create an antitrust exemption so physicians can collectively negotiate with insurers, and a bill to mandate uniform credentialing forms and timeliness standards.

- **Medicaid Reform:** The Society re-filed a bill to eliminate many of the administrative hassles burdening physicians in the Medicaid program and to allow billing for all medical services rendered in a single day. The legislation would also give Medicaid managed care patients the same rights granted to other managed care patients.

Other new bills filed by the Society include measures to provide for greater autonomy of hospital medical staffs (mirroring a recently approved California law); to prevent pharmaceutical marketing to physicians based on individual prescribing activity; to promote physician recruitment and workforce development in Massachusetts; to repeal separate written consents for HIV testing (per new federal and state requirements); to shield volunteer health professionals from civil suits when called upon in public health emergencies; and to allow the MMS to extend its peer-review protection to any clinical skills assessment program it may operate.

The text of all MMS-filed bills is at www.massmed.org/mms_legislation_2007. VS

— Stephen Shestakofsky

LEGISLATOR OF THE MONTH

Representative
Jay R. Kaufman (D)

District: Arlington (part), Lexington (part), Woburn (part)

Committees: Public Service (chair)



QUOTE: The passage of sweeping health care legislation last year was an important step toward good, affordable health care for all. But there is still much work to be done. Delivering on the promise of the new law will be our greatest challenge in 2007. We need the political will and financial resources to address unanswered questions about the law. Physicians and policymakers who came together to pass the law must stay together to implement it.

Our public health system, too, needs serious attention in 2007. In recent years, the state's public health budget has stagnated, while needs have ballooned. Without critical state support, we will not be prepared for a flu pandemic or for potential manmade emergencies such as a bioterrorist attack.

I also see a continuing need for state laws and regulations to address the expanding marketplace of health care providers. More than ever, consumers are seeking out naturopathic, homeopathic, and other nontraditional practitioners and treatments. We must respond by facilitating the availability only of those alternatives that are non-harmful, and by ensuring that such services are provided in ways that protect the public from fraud, malpractice, and unqualified providers.

FEDERAL UPDATE

Beyond Stopping Medicare Cuts: More Details on Health Care Bill

The health care bill passed in the closing moments of the 109th Congress stopped the pending 5 percent cut in physician Medicare payments (see *Vital Signs*, Dec. 2006/Jan. 2007, page 1). The measure also included several other important provisions that affect physicians and their patients.

The new law established a voluntary quality reporting program for physicians and other eligible health care providers that begins in July 2007. Physicians who report on quality measurements currently posted on the Centers for Medicare and Medicaid Services (CMS) website as part of the Physician Voluntary Reporting Program can receive up to a 1.5 percent bonus for reportable services provided between July 1 and December 1, 2007. The law allows CMS to update the measures if the changes are based on a consensus meeting in January and published on the CMS website by April 1, 2007. In addition, the secretary of

Health and Human Services (HHS) can further refine the measures, without notice, until July 1, 2007.

To qualify for the bonus payments, physicians must report on at least three measurements for their specialty 80 percent of the time. Bonuses for reportable quality measurements will be paid in one lump sum, probably in 2008. The law also established a cap on the bonus payments and stipulated that HHS can change the quality measures in 2008 by a consensus process with public comment. Changes may include the addition of structural measures such as the use of electronic health records.

Other provisions of the legislation are as follows:

- A three-year, eight-state demonstration project for "medical homes" for people with multiple chronic conditions
- An extension of direct payment for the technical component for pathology services provided in 2007

- A study by the HHS Office of the Inspector General of Medicare payments for events that should never happen to patients in hospitals
- Expansion of the Recovery Audit Contractor Program, which employs independent contractors to find under- and over-payments in Medicare
- A redistribution of unused State Children's Health Insurance Program funds to help Massachusetts and 13 other states ensure that funding will not run out before May 4, 2007

Working with a new Democratic leadership in the 110th Congress, the physician community will once again have to fight a new round of mandated cuts to Medicare payments and advocate for changing the physician payment formula to better address the needs of physicians and Medicare beneficiaries. VS

— Alex. Calcagno

Early Career Physicians to Learn Grassroots Advocacy

Medical students, residents, and young physicians will convene in the nation's capital on Monday, February 12, to help shape the future of medicine during the AMA's Lobby Day for students and residents. Lobby Day activities will include educational sessions on effective advocacy and lobbying techniques, briefings on health care-related legislative issues before Congress, and opportunities to meet with legislators and their staff.

Often the best lobbying "technique" is for members to convey their individual experiences with medical education, debt management, and patient care. Personal anecdotes provide legislators with information they do not receive from research or staff briefings. Young physicians will also learn that they do not need

Personal anecdotes provide information legislators don't receive from research.

a complete working knowledge of current bills to become effective advocates.

Lobby Day will be followed immediately by the AMA National Advocacy Conference on February 13 and 14, also in Washington, D.C. Political insiders will talk about the changes in the new Congress and what to expect in the near future. Additional events, including a forum for state and specialty society presidents, will be held in conjunction with the conference.

For more information on Student/Resident Lobby Day, visit www.ama-assn.org/ama/pub/category/12118.html. For more information on the National Advocacy Conference, visit www.ama-assn.org/ama/pub/category/14350.html. **VS**

— Emily Richardson

Second Resident/Student Poster Symposium Slated for April 21

Abstract Deadline: March 6; Notification by March 16

Sponsored by the MMS and its Resident and Fellow and Medical Student Sections, the Second Annual Research Poster Symposium for Residents, Fellows, and Medical Students will be held on Saturday, April 21, from 12 to 5 p.m. at MMS Headquarters in Waltham.

Abstract Guidelines

- Abstract text should be a maximum of 400 words and should include introduction, methods, results, and discussion sections.
- Submissions should be made in Microsoft Word format, using 11-point Arial font and 1-inch margins.
- Indicate abstract category (see below) and include title, authors' names, and institution affiliations.

Abstract Categories

Basic Research — Clinical Research — Clinical Vignettes — Health Policy/Medical Education

Additional Guidelines

- All research must be original work and not published previously in a journal or other copyrighted publication.

Works previously presented at another poster symposium or similar event will be considered.

- Primary author must be a resident, fellow, or medical student member of the MMS.
- Primary authors must be able to attend the symposium on April 21 to present their work.
- Limit of two submitted abstracts per primary author

Prizes Awarded in Each of the Four Categories

- First Prize — \$100
- Second Prize — \$50
- Honorable Mention — \$25

Prizes will not distinguish between medical students and residents/fellows.

To Submit

Please e-mail questions or abstract submissions to Emily Richardson at erichardson@mms.org. **VS**

— Emily Richardson

PHYSICIAN HEALTH MATTERS

Maintaining a Drug-Free Workplace

Physician Health Services (PHS) often receives inquiries regarding drug and alcohol use in the workplace. PHS recommends that you become familiar with your organization's policies and practices regarding such matters. Generally, those policies stipulate that a physician and/or employee should arrive for work free from the effects of alcohol and drugs and without impairment from prescribed medications.

Such policies are usually developed by the organization's human resources department and published in an employee manual. Although physicians are not always technically "employees" of an organization, the organization, the Board of Registration in Medicine (BRM), and other regulatory bodies typically expect doctors to adhere to the standards established for employees.

Noteworthy provisions of your workplace policy may include the following:

- Employees are not permitted to work under the influence of alcohol or when impaired by a controlled substance.
- Unlawful manufacturing, distribution, dispensing, use, sale, purchase, transfer, or possession of a controlled substance during work hours or on workplace property is prohibited.
- Employees who take controlled substances as a medical treatment must use them in accordance with a valid prescription.

Violations of these policies may result in required participation in a drug rehabilitation program, participation in the PHS program, disciplinary action by the BRM, or possible termination and loss of privileges.

An American Medical Association (AMA) policy urges physicians who are available for patient care to refrain from ingesting alcohol in an amount that has the potential to cause impairment or create a "hangover" effect. The policy also states that medical staff must be involved in developing an organization's substance-abuse policy, standards, and testing methods.

Many organizations offer employee assistance programs for drug- and/or alcohol-related problems. The Joint Commission on the Accreditation of Healthcare Organizations requires that accredited hospitals implement a process for their medical staff to identify and manage matters related to the individual health of licensed independent practitioners. The process must be *separate* from medical staff disciplinary functions, because the purpose is to assist and rehabilitate affected individuals, not discipline them. PHS can provide guidelines to assist hospitals in establishing such a process in addition to providing support for physicians whose substance-related problems become identified.

However, engagement in such a process or program may not exempt a person from a disciplinary review, which could take place simultaneously.

To promote awareness of such policies, some hospitals require that each medical staff member review and sign an agreement to abide by the provisions. Organizations are also developing programs to promote awareness of drug and alcohol policies and assistance programs. Additionally, some organizations request PHS to provide information to their medical staffs about the risks of drug and alcohol addiction and how to get help.

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

2nd Annual Women's Cardiac Health Conference

**Preventing the Preventable:
Women and Heart Disease**

Friday, February 16, 7:30 a.m.–2:30 p.m.
MMS Headquarters, Waltham

The first 50 paid registrants will receive a free *Go Red For Women* cookbook from the American Heart Association.
5.5 AMA PRA Category 1 Credits™ (1.5 RM)

For more information, call (800) 843-6356, or visit www.massmed.org/cardiac_conference.

ACROSS THE COMMONWEALTH

District News and Events

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

Norfolk South – District Meeting. Tues., March 6, 6 p.m. Location: Neighborhood Club of Quincy. Speaker: Kenneth Peelle, M.D., MMS president. For more information, contact the Southeast Regional Office.

Suffolk – District Meeting. Thurs., March 8, 6 p.m. Location: East Garden Room, Massachusetts General Hospital. For more information, contact Thelma Malafey at (617) 236-5864.

Worcester – WDMS 211th Annual Oration. Wed., Feb. 14, 5:30 p.m. Location: Beechwood Hotel, Worcester. Topic: “The Class of 1980: Reflections on Medical Education Then and Now.” Orator: Michele Pugniare, M.D., vice dean, undergraduate medical education, University of Massachusetts Medical School. **First Annual Louis A. Cottle Medical Education Conference.** Wed., March 21, 5:30 p.m. Location: Beechwood Hotel, Worcester. For more information, contact Joyce Cariglia at (508) 753-1579.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network – Photoshop Elements. Tues., Feb. 6, 6 to 8 p.m. Location: MMS Headquarters. For more information, contact the West Central Regional Office.

China Tours 2007 – April 9 to 27 and Sept. 22 to Oct. 6. Dr. Bernard Huang is organizing two more trips to China. The number of travelers per trip is limited to 32, and the approximate cost per person (double occupancy) will be \$3,650, plus round-trip airfare. Interested individuals should e-mail Cathy Salas at csalas@mms.org or Dr. Huang at bernardhuang@comcast.net for more information.

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 between November 2006 and January 2007. We also note member deaths on the MMS website at www.massmed.org/memoriam.

John A. Atchley, M.D., 86; West Newbury, MA; Columbia University College of Physicians and Surgeons, 1944; died August 7, 2006. **Robert T. Barry, M.D.**, 85; North Eastham, MA; Columbia University College of Physicians and Surgeons, 1946; died October 10, 2006. **Lawrence Churchill Jr., M.D.**, 89; Townsend, MA; Kansas City University of Physicians and Surgeons, 1942; died September 9, 2006. **Jay D. Coffman, M.D.**, 78; Boston, MA; Boston University School of Medicine, 1954; died December 12, 2006. **Pauline PM Cooke, M.D.**, 90; Cambridge, MA; Medical College of Pennsylvania, 1941; died December 21, 2006. **Leonard S. Gottlieb, M.D., M.P.H.**, 79; Brookline, MA; Tufts University School of Medicine, 1950; died December 7, 2006. **Hermes C. Grillo, M.D.**, 83; Boston, MA; Harvard Medical School, 1947; died October 14, 2006. **Alfredas Kriškiūnas, M.D.**, age unknown; Milton, MA; Boston University School of Medicine, 1953; died October 27, 2006. **Robert W. Liming, M.D.**, 85; Hanover, NH; University of New York College of Medicine, 1945; died July 7, 2006. **Philip P. McGovern Jr., M.D.**, 72; Cambridge, MA; New York Medical College, 1959; died October 20, 2006. **Charles J. Okstein, M.D.**, 61; Tempe, AZ; Tufts University School of Medicine, 1970; died March 25, 2006. **John K. Pearce Jr., M.D.**, 71; Cambridge, MA; Yale University School of Medicine, 1961; died October 31, 2006. **Albert M. Pearson, M.D.**, 89; Middlebury, VT; Tufts University School of Medicine, 1943; died November 10, 2006. **Vincent P. Perlo, M.D.**, 86; Belmont, MA; Tufts University School of Medicine, 1945; died October 25, 2006. **David H. Reid, M.D.**, 90; Idyllwild, CA; Tufts University School of Medicine, 1943; died October 5, 2006. **John P. Remensnyder, M.D.**, age unknown; Exeter, NH; Harvard Medical School, 1957; died October 14, 2006. **Earl S. Seale, M.D.**, 94; Boston, MA; Tulane University School of Medicine, 1935; died December 17, 2006. **Francis P. Tally, M.D.**, 66; George Washington University School of Medicine, 1966; died October 1, 2006.

MMS Committee Appointments 2007–2008

Deadline for Consideration: March 2

If you would like to become more involved in the MMS, consider participating on a committee or on the Member Interest Network (MIN) Executive Council. Committee appointments are usually for three-year renewable terms.

For those with limited time who wish to participate, we have resources for distance participation, including conference calls, online meetings, and video-conferencing at regional offices.

The list 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 (800) 322-2303, ext. 7012 or smanchester@mms.org. If you would like to join the MIN Executive Council, contact Cathy Salas at (800) 322-2303, ext. 7715 or csalas@mms.org.

Committees Appointed by the Board of Trustees

Limited openings in accordance with bylaws

- ☐ Administration and Management
- ☐ Finance ☐ Member Services
- ☐ Recognition Awards ☐ Strategic Planning

Standing Committees

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

- ☐ Bylaws ☐ Communications ☐ Ethics and Grievances ☐ Interspecialty
- ☐ Judicial ☐ Medical Education
- ☐ Membership ☐ Public Health
- ☐ Publications ☐ Quality of Medical Practice

Special Committees

Appointed by the President-Elect

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

District-Appointed Committees

Contact your district medical society.

- ☐ Legislation ☐ Nominations

MIN Executive Council

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

Online Communities Come to MMS

This month, the MMS is launching an experiment with online communities called “MMS eCommunities.”

This new Internet-based member service is accessible directly from the home page of massmed.org and will allow MMS members to participate in Society activities and connect and collaborate with other members on a range of topics — without having to travel.

The project launches with three pilot communities: Residents and Fellows, Electronic Health Records, and the Board of Trustees. The resident/fellow and EHR communities are available to any member. The trustees community is available only to trustees, alternates, and designated staff.

After a few months in the pilot phase, members will be able to suggest and launch additional eCommunities. Most will be open to any MMS member, though others could be limited to specific groups for privacy or confidentiality reasons.

An eCommunity will help you work with your colleagues on your favorite projects, on your own time, without having to commute to meetings. It expands your

options for participating in the Society, supplementing all traditional forms of participation.

Each eCommunity will have online discussions, documents, calendars, surveys, blogs, podcasts, and other features. Community members create the discussions and maintain them, with as little structure as possible.

How do you join? As an MMS member, you already have a username and password to access massmed.org. This same password will give you immediate access to all public eCommunities, as well as to any invitation-only communities in which you participate. First-time users will only have to set up a basic profile to start using the service.

eCommunities is modeled on a number of online communities in the non-profit and business sectors, such as LinkedIn and Yahoo Groups. Several state medical societies and many professional associations have also launched successful online communities.

To learn more or to start using the service, visit ecomunities.massmed.org. **VS**

– Frank Fortin



MASSACHUSETTS MEDICAL SOCIETY
EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

WHAT'S ON THE WEB?

Physician Focus

If you're looking for timely, accurate, unbiased patient information on topics ranging from Lyme disease to obesity, check out the **Physician Focus** section of the MMS website (www.massmed.org/physicianfocus).

Physician Focus articles contain patient-centered health information delivered by MMS member physicians on nearly 40 different subjects. The print articles are supplemented by the monthly *Physician Focus* TV program, which reaches close to 1.5 million households in Massachusetts via public-access stations.

For more information about Physician Focus, contact Richard P. Gulla, MMS media relations manager, at (781) 434-7101.

Easier Login

We've **improved login** functions on the MMS website. The login boxes have moved to the middle of the page, and we've made it easier to retrieve your username or password in case you forget.

LOGIN

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.

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

Preventing the Preventable:

Women and Heart Disease

Feb. 16, 8:00 a.m.–2:30 p.m.

MMS Headquarters, Waltham.

Sponsored by the MMS and the American Heart Association. CME Credit:

5.5 AMA PRA Category 1 Credits™

(1.5 RM)

Balancing Your Practice: Protecting the Public Health and Preserving Your Patients' Privacy

March 7, 6:30–9:30 p.m.

MMS Headquarters. Sponsored by the MMS and its Volunteer Surveillance Corps, in collaboration with the Massachusetts Department of Public Health. CME Credit: 3.0 AMA PRA Category 1

Credits™ (RM)

2007 Literature and the Professions

Seminar: Management of End-of-Life Care

April 20, 9:00 a.m.–3:15 p.m., Beechwood Hotel, Worcester. April 27, 9:00

a.m.–3:15 p.m., MMS Headquarters, Waltham. May 11, 9:00 a.m.–3:15 p.m.,

Southeast Regional Office, Lakeville. Sponsored by the MMS. CME Credit:

6.0 AMA PRA Category 1 Credits™ (RM)

Online CME Programs

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

Avian Flu and Pandemic Preparedness

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

2nd Annual Public Health Leadership Forum: Examining Health Disparities

CME Credit: 5 AMA PRA Category 1 Credits™ (RM)

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

- Nursing Home Malpractice Litigation: Physician-Focused Risks*
- Terminating the Physician-Patient Relationship*
- Hospitalists*
- 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
- Difficult Patients
- Closing a Practice
- Terminating the Professional Relationship With a Patient
- Patient Satisfaction

- The Telephone as an Instrument of Risk
- 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 AMA PRA Category 1 Credits™ (RM).

- Medical Errors and Perspectives on Patient Safety
- Patient Safety: Conducting a Root Cause Analysis of Adverse Events
- Medication Safety, Systems and Communication
- Building a Better Delivery System: A New Engineering/Health Care Partnership