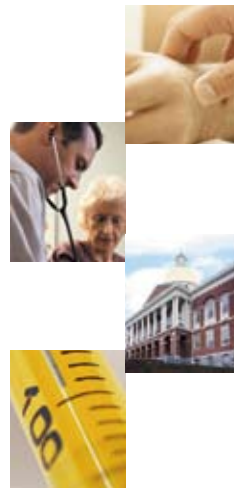




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## Society Taps State's Medical Directors to Help Physicians Address Health Care Cost Problem

BY TOM WALSH

In a bid to bring Massachusetts doctors to the center of deliberations on how to improve patient care and curb rising health care costs, the MMS has enlisted medical directors from several physician practice groups to join a unique advisory board that will confront these issues.

At an initial meeting in May 2007, the medical directors chose the cost of health care as their initial project. The MMS then held a workshop in December that convened experts from around the country to begin identifying the tools physicians will need to more directly impact the quality-and-cost debate.

Said B. Dale Magee, M.D., MMS president, "If physicians are not driving the initiatives to improve cost and quality, others will try, as we've seen with recent attempts by health plans and purchasers. Physicians have to take the lead in this and work with all the parties involved."

Spurred at least in part by physician dissatisfaction with the push by the state Group Insurance Commission (GIC) to rate doctors individually and by questions about the data and methodology used in the ratings, the MMS initiative signals the Society's resolve to have physicians spearhead the quest for higher quality and

cost containment. "To do that," Dr. Magee said, "we have to look at the data physicians are working with."

### Data Is the Hub

What constitutes good, useful data, and how should it be used to improve quality and cost? Michael van Duren, M.D., vice president of Hill Physicians Medical Group, the largest IPA in northern California, and one of several physicians who addressed Massachusetts medical directors at the December workshop, has for years confronted these questions.

"The situation in American health care is that we haven't been looking under the hood enough. The more we do look, the more we see a lot of variability in quality and cost. Right now, we're beginning to sort out what that means.

Some have rushed out narrow networks and public report cards. That's what happened in New York and Massachusetts." Using data in that way, Dr. van Duren said, is "unhelpful," and New York Attorney General Andrew Cuomo recently mandated changes to his state's physician rating system that reflect MMS principles (see *Vital Signs*, December 2007/January 2008, page 2).

Nevertheless, "there is a lot of unexplained variation" in how doctors treat patients, Dr. van Duren observed. "What we've learned is that even people who

practice in the same building have very different ways of ordering diagnostic studies. Often they don't realize how different they are from their colleagues. The right kind of data can make this very visual."

### Don't Rush to Judgment

Just how visual became apparent when Dr. van Duren presented data used by his own IPA. In one instance, "drilling down" through physician-specific data concerning glaucoma treatment found that "high-cost" providers frequently ordered computerized diagnostic testing. A cursory judgment might conclude that these tests were unnecessary. However, closer review revealed that the tests en-

abled doctors to see glaucoma-related changes in patients sooner rather than later. The extra cost of the tests resulted in higher quality care — and potentially lower treatment costs down the road.

In another instance, though, the data revealed a physician ordering too many refraction exams for a cataract patient. In this case, the extra testing did nothing to improve the quality of care and the tests were deemed unwarranted.

"The point is, you can't just take the data out of the box and say 'that's a good doctor or a bad doctor,'" Dr. van Duren said. "It's hard work to unpack these tools and see what they are really

*continued on page 2*



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## MMS-Led Coalition Succeeds in Adding Regulation and Oversight to Limited Service Clinics

In January, the state's Public Health Council approved new regulations governing limited-service medical clinics. The move paved the way for CVS Corp. to open MinuteClinics in its Massachusetts stores, and it also makes feasible limited service clinics in outlets affiliated with hospitals and community health centers.

The council's approval came with strict patient safety and public health provisions urged by a coalition led by the MMS and organizations representing pediatricians, family physicians, hospitals, and community health centers.

Thanks to these efforts, "an appropriate, open process occurred for reviewing the potential benefits and risks of incor-

porating this form of health care into the Massachusetts health care delivery system," said Karen McAlmon, M.D., president of the Massachusetts Chapter of the American Academy of Pediatrics. Added MMS President-Elect Bruce Auerbach, M.D., "The revised regulations are certainly improved from their original version."

Among the council-approved regulations are the following:

- Oversight of clinical issues by the medical director of the Department of Public Health (DPH)
- DPH review of all applications for such clinics and monitoring of their planning and operation

*continued on page 2*

## PRESIDENT'S MESSAGE



### Containing Health Care Costs Calls for Collaboration

**F**or health care reform to succeed in Massachusetts, we have to get costs under control. The

enormous scope of that challenge became apparent at a recent meeting of the Health Care Quality and Cost Council. We in Massachusetts spend as much on health care every four months (about \$15 billion) as was spent over the entire two-decade Big Dig project. At approximately \$46 billion annually, health care is our state's largest industry, accounting for about one-sixth of the Massachusetts economy.

During the council meeting, Don Berwick, M.D., president and CEO of the Institute for Healthcare Improvement and an elected member of the prestigious Institute of Medicine, cautioned that slowing the growth of the health care sector could be financially painful for some of the very same stakeholders charged with the task of doing so.

Dr. Berwick also estimated that as much as 30 percent of the health care dollars we spend are wasted through low- or no-value practices such as duplication, poor care coordination, or unnecessary administrative processes. He issued a challenge to all medical specialties to find 10 things that their practitioners could do to cut waste out of the system. I think this challenge should extend to everyone in the health care system — all providers, payers, purchasers, and even patients. As doctors, we have to

impress on our patients that more care does not necessarily mean better care, despite the bombardment of drug advertising and other messages to the contrary.

Dr. Berwick's most profound point was that unless all the players in the health care system get beyond self and group interest and work together for the common good, health care reform could crumble. Stakeholders managed to put aside self interest when they came to agree on the landmark legislation in 2006 and during the first year of implementation, but this challenge will be even greater going forward as we tackle cost issues.

The lead story on page 1 describes how the Medical Society is working with the state's medical directors to identify tools physicians can use to reduce waste and improve quality in health care delivery. But physicians can't do it alone, and the need for everyone to collaborate with one another in such efforts is paramount. As just one example, physicians and health plans must work together to generate actionable data for the "drill-down" analyses that will expose less-than-best clinical practices.

The stakes in this cost-containment struggle are huge. We need to re-engineer the health care delivery system from top to bottom and side to side. As physicians, we need to do our part and help others do theirs.

— B. Dale Magee, M.D.

#### Medical Directors

*continued from page 1*

saying. Sometimes people use the data too quickly."

Once physicians have sufficiently drilled-down data to work with, they can improve quality and reduce costs by coming up with the best treatment regimens, condition by condition, Dr. van Duren said. "Colleagues should get together and determine how their practices differ and whether there is a best practice among them," he recommended. "If a best practice exists, then they should all use it."

If that sounds easy, it's not. "Telling doctors to do something different can be hard and awkward," Dr. van Duren said. "Rather than having 'the teacher' handing doctors their grades and telling them how they must change or improve, it's more effective to let them look at their own grades and determine what they must do to improve."

In another presentation at the workshop, George Isham, M.D., and Thomas Marr, M.D., from HealthPartners health plan in Minnesota discussed how physicians and health plans can establish the trust needed to collaborate on successful performance evaluation programs. They also emphasized the important role of a statewide quality-improvement organization to establish uniform measurement guidelines and reporting formats across all health plans.

#### Doctors Ready to Get Involved

Richard Parker, M.D., medical director of the Beth Israel Deaconess physician organization and a participant in the MMS initiative, said, "In the next year to two, we're going to see doctors agreeing that we need to choose a set of conditions and determine what is reasonable variation and measure ourselves according to those standards. But it's going to

be a gradual process. It won't happen overnight."

Barbara Spivack, M.D., medical director at Mount Auburn Cambridge IPA, is also involved in the MMS initiative. "The MMS has taken on a critical role in speaking for doctors on this issue," she said. "We're not arguing about whether data should be publicly available, but we are saying that data should be accurate and reasonable. It has to have some reliability."

There was general agreement among the medical directors that the GIC's objectives of controlling costs and improving quality are valid. But there was also consistent criticism of how the commission has gone about it.

"I'm not sure the information the GIC is giving me is helping me give better care to my patients," Dr. Spivack said. "It's telling me how I'm doing on efficiency and cost, but it doesn't tell me what I need to do to provide better care."

Dr. Magee added, "I think the GIC has the potential to be a driver toward this end. But at some point, it would help for them to see what they can do as purchasers to drive the [health] plans to work with physicians more constructively." Ideally, Dr. Magee said, the result of such cooperation would be "a professional portal for physicians to access and use health plan information."

#### Work in Process

Getting this all done right will take time. In California, Dr. van Duren's group has been using data for four years. "We're still learning how to make it meaningful," he said.

Dr. Magee concluded that the MMS medical director initiative represents the first important step of a journey. "I'd like to say the end is in sight and we have a great solution," he said. "I *do* think we've found a good path to follow." **VS**

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#### Minute Clinics

*continued from page 1*

- Tighter requirements for sanitation, handicapped accessibility, and interpreter services
- Improved infection-control guidelines
- Stepped-up provider credentialing
- Improved processes for referral of serious conditions
- Regular reporting of clinic status to the Public Health Council

Approving the clinics "under the license and oversight of established primary care providers will go a long way in

supporting the long-standing reputation Massachusetts has built for providing top-notch health care," said James W. Hunt, president and CEO of the Massachusetts League of Community Health Centers.

What effect such clinics will have on the state's health care system remains to be seen. Dr. Auerbach advocates a more comprehensive and coordinated "medical home" approach to primary care (see *Vital Signs*, September 2007, page 1). "The best care will come from patients having a long-term relationship with a primary care provider," he concluded. **VS**



## Health Plan Programs Follow Some — but Not All — MMS Guidelines

A new study that evaluates health plan-driven physician tiering, prior authorization, and pay for performance (P4P) programs compared with MMS guidelines found that the health plans meet some of the standards, while not complying with others. The study was conducted by consultants John D. Freedman, M.D., M.B.A., and Bruce E. Landon, M.D., M.B.A.

Most significantly, the study found that “several aspects of the tiering methodologies used by the health plans do not conform to the MMS guidelines and raise concerns about the potential for these programs to adversely affect patients and physicians.”

Specific findings of the study regarding tiering include the following:

- For many specialties, the data used are not representative of actual practice.
- For both primary and specialty care, “Individual tiering is of concern based on both practical and analytic grounds,” the study reported.
- Because physicians in the same practice group can be tiered differently, individual tiering adds complexity for both practices and patients.
- Tier cutoffs are often arbitrary and could lead to misclassification.
- Feedback sent to physicians is often inadequate for improvement purposes.

The authors concluded that most prior authorization programs for high-cost radiology “are implemented so as to conform to MMS guidelines,” although they represent “an additional administrative burden” for which physicians are not compensated.

Noting that some health plans provide the “timely and actionable” P4P data called for in MMS guidelines, the authors pointed out that many physicians “may not receive direct individualized feedback on their performance” because most results are reported at the group level.

Based on the findings, the study offered numerous recommendations, including the following:

- Because of “substantial limitations” to measuring the performance of individual physicians, consideration should be given to restricting measurement to physician practice sites or groups, with individual feedback provided internally for quality improvement purposes.
- Adopt formal appeals processes for physicians rated in tiering programs
- Exclude high performing physicians from prior authorization programs
- Change prior *authorization* programs to prior *notification*
- Review health plan initiatives regularly, and modify or eliminate those that do not meet cost or quality goals **VS**

— Tom Walsh

## Fallon Imaging Prenotification Becomes Mandatory

As of February 1, Fallon Community Health Plan (FCHP) is implementing new notification requirements for outpatient elective CT, MR, nuclear cardiac, and PET imaging studies. Physicians are required to notify MedSolutions via a secure Web portal, toll-free telephone, or fax when ordering these tests. At this time, no service denials will be issued. Prior notification is not required for imaging studies in conjunction with an inpatient stay or emergency room visit.

**Physicians are now required to notify MedSolutions via secure Web portal, toll-free telephone, or fax when ordering these tests.**

This is a significant change from Fallon’s original program, introduced in 2006, which was a voluntary physician-to-physician radiology consultation offering.

The Society has begun discussions with FCHP to better understand this program and the health plan’s reason for moving from a voluntary to a mandatory program. We will also examine

the program’s alignment with the MMS *Principles for the Use of Prior Authorization Programs* as more details about the program become available. **VS**

— Dana Cooper

## New Behavioral Health Screening Regimen for Kids Enrolled in MassHealth

Since December 31, 2007, primary care providers serving MassHealth children under the age of 21 (except for MassHealth Limited members) have been required to offer behavioral health screens using a standardized screening tool at each Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/Pediatric Preventive Healthcare Screening and Diagnosis visit required by the EPSDT medical protocol and periodicity schedule.

### Bill with Code 96110 and Modifier

Primary care providers who conduct behavioral health screens according to the EPSDT periodicity schedule will receive a payment separate from and in addition to payment for the visit. Primary care providers should bill using CPT code 96110 — “developmental testing; limited, with interpretation and report.”

Modifiers are required when billing with CPT code 96110, and as of July 1,

2008, failure to include a modifier will result in denial of the claim. First, billers and billing intermediaries should check the patient’s medical record or ask the provider or office staff whether the provider identified a behavioral health need.

From there, the modifiers vary by provider type, as shown in the table below. With CPT code 96110, the midlevel modifiers for nurse practitioners (SA), nurse midwives (SB), and physician assistants (HN) are not used.

— Louise Bannister  
and Lana Miller  
MassHealth Office of Acute  
and Ambulatory Care

For more information, go to [www.mass.gov/masshealth/childbehavioralhealth](http://www.mass.gov/masshealth/childbehavioralhealth). This site has information on the Children’s Behavioral Health Initiative, announcements of training opportunities, and additional resources. To view the MassHealth EPSDT protocol and periodicity schedule, go to [www.mass.gov/Eeohts2/docs/masshealth/providermanual/appx-w-all.pdf](http://www.mass.gov/Eeohts2/docs/masshealth/providermanual/appx-w-all.pdf).

Modifiers for Use with CPT Code 96110

Servicing Provider	When No Behavioral Health Need Identified	When Behavioral Health Need Is Identified*
Physician, Independent Nurse Midwife, Independent Nurse Practitioner, Community Health Center (CHC), Outpatient Hospital Department	U1	U2
Nurse Midwife employed by Physician or CHC	U3	U4
Nurse Practitioner employed by Physician or CHC	U5	U6
Physician Assistant employed by Physician or CHC	U7	U8

\*Needs include those regarding behavioral health, social/emotional well-being, or mental health.

### PRACTICE MANAGEMENT TIP OF THE MONTH

#### e-Prescribing Off Limits for Controlled Substances

Electronic prescribing is a solid first step toward an electronic health record system, but it has some limitations. For example, although Massachusetts recognizes electronic signatures, the federal Drug Enforcement Administration (DEA) does not acknowledge their validity for controlled substances. This means that prescriptions for all Schedule I-V drugs still require a “wet” signature and may not be electronically prescribed.

SureScripts, the provider of the portal that processes electronic prescriptions, acknowledges that some vendors may have allowed electronic transmission of Schedule I-V prescriptions, and that some pharmacies may have filled them. However, in cooperation with the DEA, SureScripts is blocking this ability at the portal level, and will no longer allow such prescriptions to be processed.

For more information, contact Adam Shlager, practice management consultant at the MMS Physician Practice Resource Center, at (781) 434-7702 or [ashlager@mms.org](mailto:ashlager@mms.org).

## For State-Supplied Vaccine, 2008 Brings New Distribution System

In 2008, the process by which physicians receive state-supplied vaccine will change. Currently, Massachusetts providers receiving state-supplied vaccines pick up the vaccine at the local board of health or a local vaccine depot. But now, the Centers for Disease Control and Prevention has initiated the Vaccine Management Business Improvement Project (VMBIP), a nationwide, centralized vaccine distribution system with direct delivery of vaccine to providers.

The VMBIP is an effort to simplify processes for ordering, distribution, and management of vaccines to facilitate effective responses to disease outbreaks, vaccine shortages, and supply disruptions. The new system affects only state-supplied vaccine, not privately purchased vaccine. State-supplied vaccine will continue to be provided free of charge, with no shipping costs to providers.

In Massachusetts, centralized vaccine distribution through McKesson is expected to begin in June 2008. Here are some procedural details:

- All orders will be centrally processed through the Massachusetts Department of Public Health (MDPH) Vaccine Unit and shipped directly to your office from the national distributor (similar to the current process for varicella vaccine).

- Providers will order monthly, every two months, every three months, or twice a year. Practices using more vaccine will order more frequently.
- Office staff will need to accept, open, and properly store vaccine shipments immediately to ensure that the cold chain is maintained.
- Providers should allow two weeks for delivery of ordered vaccine.
- Providers need to provide vaccine information statements to those being vaccinated or their parents.

The MDPH is encouraging providers to have at least a six-week supply on hand as orders are placed — sufficient to hold you over between orders, plus a one-month reserve. It is also critical to have sufficient refrigeration capacity to store the largest volume of vaccine you might need at the busiest time of year, such as flu season.

— Kathleen Shattuck, M.P.H.  
Massachusetts DPH

For more information on the VMBIP, ordering frequency, and assessing your current vaccine storage capacity, go to [www.mass.gov/dph/cdc/epii/imm/vac\\_management/vmbip.htm](http://www.mass.gov/dph/cdc/epii/imm/vac_management/vmbip.htm) or call the MDPH Vaccine Management Unit at (617) 983-6828. The MDPH will also hold a one-hour Web-based seminar with more detailed information on February 13. To register, call (781) 434-7373 or e-mail [dph@mms.org](mailto:dph@mms.org).

## MMS Unveils Tools to Encourage Healthy Weight and Physical Activity

During our 2007 Interim Meeting, the MMS unveiled a number of tools to help physicians lead by example in promoting physical activity and healthy weight. These tools include patient-centered prescription pads for physical activity, a patient handout on how to lose weight and keep it off, and waiting-room posters encouraging healthy eating and physical activity.

To help physicians themselves become more physically active, the tools include an online physical activity tracker, which is accessible at [www.massmed.org/YourHealthFirst](http://www.massmed.org/YourHealthFirst) or [www.massmed.org/activity\\_tracker](http://www.massmed.org/activity_tracker). This tool allows users to log daily physical activity by minutes or pedometer steps. The tracker also has a weight-tracking option, can calculate body mass index, and provides tips on setting weight goals. Users can have an automated e-mail sent to them weekly to remind them to log their activity.

"Tracking your physical activity helps you see your progress over time and helps you identify specific barriers that may be preventing you from making progress," said Caroline Apovian, M.D., vice chair of the MMS Committee on Nutrition and Physical Activity, which oversaw development of the tools.

### President-Elect Issues Challenge

On behalf of the MMS officers, MMS President-Elect Bruce Auerbach, M.D.,

issued a physical activity challenge to members and districts. The individual member with the most physical activity logged online and the district with the highest activity tracking participation rate by the time of the MMS Annual Meeting in May will receive an award.

### Public Health Forum to Focus on Obesity

Many efforts are under way throughout the country to address the problem of obesity. In March, the MMS will bring together leaders in public health, health care, industry, and government to examine some of these efforts and identify additional ways to slow the obesity epidemic. The fourth annual Public Health Leadership Forum, jointly sponsored by the MMS and the Harvard School of Public Health's Division of Public Health Practice, will take place at MMS Headquarters on Thursday, March 27. **VS**

— Robyn Alie

For more information about the Public Health Leadership Forum or to register, e-mail the MMS Department of Public Health and Education at [dph@mms.org](mailto:dph@mms.org). For more information about the tools for physician offices or the online physical activity tracker, visit [www.massmed.org/YourHealthFirst](http://www.massmed.org/YourHealthFirst) or call (781) 434-7371.

## MMS Joins Partnership for Healthcare Excellence to Engage Consumers in Improving Care

A new statewide effort launched last fall aims to motivate consumers to improve the safety and effectiveness of their own health care. The Partnership for Healthcare Excellence (PHE), a coalition with participants from every segment of the health care community, is the first statewide effort of its kind to focus specifically on helping patients play a greater role in improving the quality of their health care.

The goals of the partnership are as follows:

- To educate the public about variations in health care quality
- To provide consumers with information and tools to improve the quality of their own care
- To motivate consumers to advocate for overall health care system change

The PHE Leadership Council — which includes the MMS, consumer associations, advocacy organizations, insurers, business groups, labor, public health advocates, and other health care leaders — advises the partnership in achieving its mission. "Most of the work currently being done to improve health care quality is focused on health care staff and providers," said PHE Chair Jim Conway, who is also senior vice president of the Institute for Healthcare Improvement. "The partnership wants to help make consumers part of that conversation."

In November, the partnership launched a public education campaign that includes advertising, a website (see "Website of the Month" on this page), and grassroots outreach focused on promoting patient medication safety, safe hospital stays, and better communication between patients and physicians.

"The most critical step in finding good health care is to ensure that the source of the information is credible, authoritative, and trustworthy," said MMS President B. Dale Magee, M.D. "The PHE is one of those sources."

Dr. Magee was quick to add, however, that a patient's primary care physician and other reputable information sources should also influence the decision-making process. **VS**

— Robyn Alie

### WEBSITE OF THE MONTH

#### Site Empowers Patients to Improve Quality of Care

The Partnership for Healthcare Excellence website, [www.partnershipforhealthcare.org](http://www.partnershipforhealthcare.org), provides practical, reliable information on what patients can do to improve the quality, safety, and effectiveness of their health care. The site's "One Stop Guide to Quality Healthcare" links patients to information about how to choose and compare hospitals and how to choose a doctor, prepare for a doctor's appointment, take medications safely, and prepare for a hospital stay.

The site also provides reports, research papers, and public opinion surveys on health care and how consumers make health care decisions in Massachusetts. A separate "Fact Sheets" section itemizes practical steps patients should take when selecting a physician, preparing for a doctor's visit, preparing for surgery, and taking medications. All fact sheets are downloadable in both English and Spanish. The site also allows users to receive an e-mail notification when new information is added.



## STATE UPDATE

## Health Disparities Council Holds Inaugural Meeting

While disparities in the health outcomes of racial and ethnic minorities have long been documented, until now no entity in state government has ever been charged with overseeing and addressing the problem. The Massachusetts Health Reform Law (Chapter 58 of the Acts of 2006) not only expanded health insurance coverage to hundreds of thousands of previously uninsured patients, it also established an independent Health Disparities Council within the Executive Office of Health and Human Services. The council's charge is to "make recommendations to reduce and eliminate racial and ethnic disparities in access to quality health care and in health outcomes within the Commonwealth." The MMS is represented on the council by Assistant Secretary-Treasurer Alice A. Tolbert Coombs, M.D., a South Shore anesthesiologist.

Much of the impetus for the creation of the council came from the research and early draft recommendations of the Massachusetts Commission on the Elimination of Racial and Ethnic Disparities

in Health Care, which issued its final report last August (see *Vital Signs*, October 2007, page 5). While some of the disparities in health outcomes are attributable to a disparity in health insurance coverage, the commission pointed to other factors, such as cultural and language barriers, individual bias and stereotyping, lack of patient trust in the health care system, low levels of health literacy, and poor communications by all parties.

The council, which is co-chaired by Rep. Peter Koutoujian (D-Waltham) and Sen. Dianne Wilkerson (D-Boston), will make an annual report to the governor, the Legislature, and the Health Care Quality and Cost Council. The annual report will include data on disparities in health care access and health outcomes, as well as on the diversity of the health care provider workforce. The council will also provide recommendations regarding statutory or regulatory changes that would promote the reduction and eventual elimination of those disparities,

as well as proposals for improving workforce diversity and cultural competency. Both council co-chairs previously served as co-chairs of the commission.

At the initial meeting of the council, Dr. Coombs informed the group that the work of the commission had an impact that extended far beyond Massachusetts' borders. Dr. Coombs credited the work of the commission as the inspiration for the unanimous passage of a resolution presented by the Massachusetts delegation at the AMA House of Delegates. The resolution calls upon the AMA "to develop model legislation and encourage and assist state and local medical societies to advocate for creation of state-wide commissions to eliminate health disparities in each state."

For its part, the MMS adopted a policy in 2004 declaring that the elimination of racial and ethnic disparities in health care is "an issue of high priority." **VS**

— Stephen Shestakofsky

LEGISLATOR  
OF THE MONTHRepresentative  
Peter V. Kocot (D)

**District:** Hatfield, Montgomery, Northampton, Southampton, Westhampton

**Committees:** Health Care Financing; Environment, Natural Resources, and Agriculture (Vice Chair); Economic Development and Emerging Technologies



**QUOTE:** Western Massachusetts is facing a crisis in health care access, and local legislators are working to find a solution. As Charles Joffe-Halpern, president of Health Care For All, wrote in the *North Adams Transcript*, "Only 50 percent of primary care physicians in Massachusetts are accepting new patients...only 43 percent of patients (who have a physician)... could be seen within a week."

What happens when people can't get in to see a doctor? They end up in emergency rooms, paying higher co-pays, seeing a health care professional that may not know their health care history, and tying up emergency room services that should be used for real emergencies.

Daniel Levy, M.D., writing in the *Daily Hampshire Gazette*, concluded that less than 5 percent of new medical students end up as traditional primary care physicians. Under the leadership of Vice Chairman Stephen Kulik, the Committee on Health Care Financing recently held a hearing at UMass-Amherst to discuss legislation filed by Sens. Steven Buoniconti and Gale Candaras and Reps. Angelo Puppola and Sean Curran to address this crisis. Rep. Chris Donelan recommended economic incentives to keep good doctors in western Massachusetts.

As we expand health insurance coverage in Massachusetts, doctors and legislators are working together to offer their constituents the best health care in the nation.

## FEDERAL UPDATE

## President Signs Medicare Payment Patch and SCHIP Extension

## Legislators to Debate More Comprehensive Action in 2008

Immediately before adjourning for the holidays, the U.S. House and Senate passed legislation that halted a looming 10 percent 2008 Medicare physician payment cut for six months and replaced it with a 0.5 percent increase. The legislation also extends the State Children's Health Insurance Program (SCHIP) through March 31, 2009, at current levels. President Bush signed the legislation, which does not include cuts to Medicare Advantage plans.

The legislation is a significantly scaled-down version of the bill passed by the House and the package contemplated by the Senate Finance Committee. In Washington's "pay-as-you-go" legislative environment, funding sources for programs must be identified upfront. Consequently, the President's unyielding opposition to Medicare Advantage cuts paralyzed even moderately ambitious Medicare reform proposals.

Without additional Congressional intervention, the 10 percent physician payment cut will be reinstated on July 1, 2008.

The bill includes several other provisions that will affect physicians. It extends the Physician Quality Reporting Initiative program and — by six months — funding for bonus payments for physicians working in shortage areas. A full summary of the legislation is available at [www.massmed.org/medicare\\_summary](http://www.massmed.org/medicare_summary).

The bill does not include any changes to SCHIP, but there is nothing in it to prevent the Bush Administration from implementing new regulations that would make it difficult for states to provide coverage for families with incomes greater than 200 percent of the federal poverty level (FPL). Massachusetts is one of four New England states that currently provides coverage for families earning up to 300 percent of the FPL. The SCHIP extension through March 2009 was strongly supported by Republicans to prevent the issue from becoming a political hot potato during the 2008 Presidential election. Democrats noted, however, that the legislation does not stop them from considering full SCHIP reauthorization in 2008.

Supporters of more comprehensive measures in both the House and Senate expressed disappointment with the limited scope of the package. Rep. Pete Stark (D-CA), chair of the House Ways and Means Committee and principal author of the House package, reiterated his commitment to passing a more comprehensive bill in 2008. Senate Finance Committee Chair Max Baucus (D-MT) noted that negotiators will face the same roadblocks in crafting a broader Medicare bill in 2008. With the 2008 election on the horizon, Sen. Baucus said he hopes "members of Congress will be listening more to their constituents than to the White House."

Throughout this contentious debate, the MMS worked closely with the AMA, our state's Congressional delegation, and other medical societies and specialty groups. All members of the delegation supported efforts to permanently fix the Medicare physician payment formula and reauthorize SCHIP. These efforts will be renewed — and revitalized — in the coming months. **VS**

— Alex. Calcagno

## Women's Cardiac Health Conference to Highlight Motivational Interviewing

Annual Conference to Be Held Feb. 29 in Waltham

Motivational interviewing (MI) is an evidence-based, client-centered, directive method for enhancing change using intrinsic motivation. MI is especially effective in addressing the behavior changes necessary for effective treatment of illnesses that have strong lifestyle components, such as diabetes, cardiovascular disease, obesity, eating disorders, renal disease, HIV, and addictive disorders.

Motivational interviewing provides an alternative to the traditional "top-down," didactic approach to health behavior change. With MI, the practitioner is not the only expert, and the patient is not merely a passive "student." Instead, MI assumes that both the client and the practitioner are experts in the counseling relationship, which is collaborative in nature. Careful listening to the patient is therefore essential.

MI techniques are designed to enhance the client's motivation for and

commitment to change. MI integrates an empathic, non-confrontational style of interviewing with powerful behavioral strategies for helping clients convince themselves that they ought to change. As a result, patient resistance is minimized, self-motivation is enhanced, and behavior change is more likely.

— Ellen R. Glover, Ph.D., R.D., L.D.N.

To learn more about motivational interviewing techniques and other topics related to women's cardiac health, attend the 3rd Annual Women's Cardiac Health Conference on February 29 at MMS Headquarters in Waltham. For more information, call (800) 843-6356 or visit [www.massmed.org/cmecenter](http://www.massmed.org/cmecenter).



## Survey of International Medical Graduates Yields Interesting Results

The number of American medical school graduates has not kept pace with the explosive growth of the American health care system since the 1960s. Fortunately, graduates of foreign medical schools have helped fill this void.

Findings from a recently concluded survey of international medical graduates (IMGs) by the Society's International Medical Graduate Section offer interesting insights into IMG makeup, aspirations, and their level of professional fulfillment.

The survey revealed that the number of IMGs has grown almost exponentially during the past 50 years. However, that growth trend reversed significantly in recent years, probably due to the stringent immigration restrictions implemented since the terrorist attacks in 2001.

Among the survey respondents, almost 80 percent completed their residency training in the U.S. Approximately 30 percent said they are self-employed in private practice, while approximately 70 percent are employed by hospitals, medical groups, or medical schools. One of

the survey's most significant findings is that more than 90 percent of IMGs are practicing in the area of medicine in which they originally hoped to work.

When the survey asked IMGs about discrimination, about two-thirds of the

respondents felt that it existed, and one-third said they had encountered discrimination in their workplace. Despite evidence of discrimination, almost 80

percent of respondents said they would advise recent international graduates to come to the U.S. to practice medicine, and about 90 percent would want to come to the U.S. to practice if given the choice again.

The IMG contribution to the American health care system should not be discounted or underestimated. We would like to thank everyone who contributed to this important survey.

— Joseph Grisanzio, M.D.  
Vice Chair, MMS IMG Section

To view the complete survey results, go to [www.massmed.org/img\\_survey](http://www.massmed.org/img_survey).

## PHYSICIAN HEALTH MATTERS

### Gambling: Recreation or Compulsion?

With the possibility of legalized casino gambling in Massachusetts, physicians may be more likely to face compulsive gambling disorders in their patients — and also potentially in themselves and their colleagues. Compulsive gambling is classified as an impulse control disorder rather than an addiction, but in both cases, those afflicted can't resist the temptation to act in ways they know could lead to severe personal or social consequences.

The symptoms of compulsive gambling include the following:

- A preoccupation with gambling or obsessive thinking about it
- Gambling increasing amounts of money to feel excitement or make back losses
- Taking time from work or family life to gamble
- Gambling to escape problems or negative feelings
- Concealing gambling from others or lying about the amount of time or money spent gambling
- Feeling guilt or remorse after gambling
- Borrowing money or stealing to gamble
- Failing in efforts to cut back or quit gambling, or feeling restless or irritable when trying to do so
- Losing a job, relationship, or educational or career opportunity due to gambling

The particular challenge with a gambling disorder is the cyclical nature of the compulsion and the power of intermittent reinforcement. Gamblers are tempted not only by the "rush" of the bet, but also by the potential of a major windfall that they believe will make everything better. When the win fails to materialize, the gambler is driven deeper into debt and, potentially, into despair. However, when the occasional windfall does arrive, the compulsive gambler often becomes intensely euphoric and is reinforced to keep gambling.

Although it is not clear why certain individuals become compulsive gamblers,

neurotransmitters (serotonin, norepinephrine, and dopamine) do play a role in the susceptibility. The aroused, euphoric state experienced by compulsive gamblers is accompanied by changes in brain chemistry similar to those caused by alcohol or drugs in substance abusers. Similarly, compulsive gamblers develop "tolerance" to gambling and must increase the size of their bets or the odds against them to create the same amount of excitement, akin to the tolerance that develops among substance abusers and leads to increased consumption.

Men are more likely than women to develop a gambling compulsion, as are those who began to gamble at a younger age. Also, those who live within 50 miles

of a casino are more likely to develop the problem than those who live further away, emphasizing the importance of local physician awareness of this disorder if casinos enter Massachusetts.

While there is no research to demonstrate the susceptibility of physicians to gambling, certain

personality traits not uncommon among physicians create a greater likelihood of developing compulsive gambling. These include extreme competitiveness, workaholicism, and thrill seeking. As with other compulsive behaviors, it is important to identify this disorder promptly so treatment can take place sooner rather than later.

Treatment options for compulsive gambling include psychotherapy, medications, and self-help groups such as Gamblers Anonymous. The principles that have been successful with other addictive disorders have also been helpful in treating pathological gambling.

If you, a patient, or a colleague are experiencing the effects of compulsive gambling, there is help. For physicians facing this disorder, Physician Health Services, Inc. (PHS) can be a valuable resource. Other resources include Gamblers Anonymous [(800) 287-8670 or [www.gamblersanonymous.org](http://www.gamblersanonymous.org)], the National Council on Problem Gambling [(800) 522-4700 or [www.ncpgambling.org](http://www.ncpgambling.org)], and the Harvard Medical School Division on Addictions at Cambridge Health Alliance ([www.divisononaddictions.org](http://www.divisononaddictions.org)). VS



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## ACROSS THE COMMONWEALTH

### District News and Events

**Berkshire — Winter District Meeting.** Wed., Feb. 27. Location: Frankie's Restaurant, Lenox. For more information, contact the West Central Office.

**Charles River — Executive Committee Meeting.** Tues., Feb. 26, 6 p.m. Location: MMS Headquarters, Waltham. For more information, contact the Northeast Office.

**Franklin — Executive Committee Meeting.** Fri., Feb. 22, 7:30 a.m. Location: Baystate Franklin Medical Center, Conference Room A, Greenfield. For more information, contact the West Central Office.

**Hampden — Legislative Breakfast.** Fri., March 28, 7:30 to 9 a.m. Location: The Clarion Hotel, Route 5, West Springfield. For more information, contact Suzanne Skibinski at (413) 736-0661.

**Hampshire — Executive Committee Meeting.** Wed., Feb. 13, 6 p.m. Location: Butter-nuts, Hadley. For more information, contact the West Central Office.

**Norfolk South — Executive Committee Meeting.** Tues., Feb. 12, 6:30 p.m. Location: Reggio Ristorante, S. Weymouth. For more information, contact the Southeast Office.

**Suffolk — Membership Meeting.** Thurs., March 13, 6 p.m. Location: East Garden Room, White Basement, Massachusetts General Hospital. Speaker: Stephen Porter, M.D. Topic: How Important Is Patient Satisfaction? For more information, contact the Northeast Office.

**Worcester — WDMS 212th Annual Oration.** Wed., Feb. 13, 5:30 p.m. Beechwood Hotel, Worcester. "Profiles in Medical Courage — A Message of Hope, Survival and Transcendence." Orator: Michael Hirsh, M.D., F.A.C.S., F.A.A.P., chief, Division of Pediatric Surgery, UMMHC. For more information, contact Joyce Cariglia at (508) 753-1579.

**Worcester North — Executive Committee Meeting.** Tues., Feb. 12, 6:30 p.m. Location: Sonoma, Princeton. For more information, contact the West Central Office.

### Statewide News and Events

**Arts, History, Humanism & Culture Member Interest Network — The Nancy N. Caron Annual Art Exhibit.** Calling all artists! Registration deadline is February 8. For more information, contact the West Central Office.

If you have news for Across the Commonwealth, contact Florence Keefe, Northeast Regional Office, at (800) 944-5562 or fkeefe@mms.org; Linda Howard, Southeast Regional Office, at (800) 322-3301 or lhoward@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

### In Memoriam

The following deaths of MMS members were reported to the Society in December 2007 and January 2008. We also note member deaths on the MMS website at [www.massmed.org/memoriam](http://www.massmed.org/memoriam).

**James G. Boyd Jr., M.D.**, 65; Ashland, MA; George Washington University School of Medicine, 1969; died November 26, 2007. **Richard J. Broggi, M.D.**, 83; Worcester, MA; Tufts University School of Medicine, 1948; died April 16, 2007. **Mortimer J. Buckley, M.D.**, 75; Osterville, MA; Boston University School of Medicine, 1958; died November 24, 2007. **Charles L. Easterday, M.D.**, 86; Gloucester, MA; Harvard Medical School, 1949; died December 19, 2007. **Paul J. Hannaway, M.D.**, 70; Salem, MA; Albany Medical College, 1963; died November 22, 2007. **Alfonso C. Mandrachia, M.D.**, 94; Melrose, MA; Middlesex University School of Medicine, 1939; died December 18, 2007. **Andrew V. Mason, M.D.**, 90; Mashpee, MA; Tufts University School of Medicine, 1943; died July 19, 2007. **Edward A. Mason, M.D.**, 88; Cambridge, MA; Washington University School of Medicine, 1944; died December 26, 2007. **William F. McKeon, M.D.**, 74; West Springfield, MA; New York Medical College, 1959; died December 4, 2007. **Robert B. Orr, M.D.**, 96; Sanibel, FL; University of Virginia School of Medicine, 1938; died December 14, 2007. **Arthur S. Parker Jr., M.D.**, 95; Needham, MA; Georgetown University School of Medicine, 1938; died November 20, 2007. **Richard R. Pastorello, M.D.**, 81; Auburn, AL; Tufts University School of Medicine, 1954; died October 19, 2007. **Joseph Ross, M.D.**, 73; Cochrane, MA; Yale University School of Medicine, 1962; died December 27, 2007. **Joseph H. Schaffer, M.D.**, 87; Chestnut Hill, MA; University of Pennsylvania School of Medicine, 1946; died December 9, 2007. **Robert Shapiro, M.D.**, 94; Canton, MA; Tufts University School of Medicine, 1937; died November 23, 2007.

## Annual Poster Symposium Set for April 26

Building on the success of the past two research poster symposia, the MMS Resident and Fellow and Medical Student Sections will host the 2008 Research Poster Symposium on Saturday, April 26, at MMS Headquarters in Waltham.

The symposium offers residents, fellows, and medical students the opportunity to display their research, meet other members, and learn what their peers are working on. First-time participants have found the event to be a great way to learn how to create a compelling poster and present research results.

Poster presenters compete in one of four categories: basic research, clinical research, clinical vignettes, and health policy/medical education.

Three individuals in each category will be awarded cash prizes — \$100 for first place, \$50 for second, and \$25 for third.

### Submission Guidelines

- Deadline for abstract submission: March 17

- Abstracts should be a maximum of 400 words, submitted in a Microsoft Word document with one-inch margins and should include introduction, methods, results, and discussion sections. References should be in standard format.
- Notification by March 24
- All research must be original work and not published previously in any copyrighted publication. Work previously presented at another poster symposium or similar event will not be excluded.
- Primary author must be a resident/fellow/medical student member of the MMS.
- Primary authors must be able to attend the symposium on April 26 to present their work.
- One primary author may submit a maximum of two abstracts.

E-mail questions or abstract submissions to Emily Richardson at [erichardson@mms.org](mailto:erichardson@mms.org). **VS**

## MMS Committee Appointments

### 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. Committee appointments are usually for three-year renewable commitments. We have opportunities for distance participation, including conference calls, online meetings, and videoconferencing.

The listing below includes all MMS committees and the MIN executive council. For committee descriptions and an application form to be considered, 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 • Gay, Lesbian, Bisexual and Transgendered Issues • Geriatric Medicine • Global Medicine • History • Information Technology • Maternal and Perinatal Welfare • Men's Health • Nutrition and Physical Activity • Preparedness • Professional Liability • Senior Volunteer Physicians • Sponsored Programs • Student Health and Sports Medicine • Violence Intervention and Prevention • Women in Medicine • Young Physicians

### District Appointed Committees

Legislation • Nominations

### Member Interest Network (MIN) Executive Council

Arts, History, Humanism & Culture

SAVE THE DATE

2008 MMS Annual Meeting

Lead by Example — Choices for a Better Health Care System

May 8–11, 2008

Seaport Hotel and World Trade Center — Boston

Thursday, May 8

- House of Delegates
- Annual Awards Luncheon
- Ethics Forum

Friday, May 9

- House of Delegates
  - President's Reception and Dinner
- Boston Public Library

More information to come!

Saturday, May 10

- Annual Education Program
- Lead by Example —  
Choices for a Better Health Care System
- Shattuck Lecture and Luncheon
  - International Medical Graduates Reception
  - Member Art Exhibit
  - Annual Banquet
- Featured Entertainment:  
Vonda Shepard

MMS Sponsored & Jointly Sponsored CME Activities

To register for any of these activities, call (800) 843-6356.

For additional information, contact the Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to [www.massmed.org/cmecenter](http://www.massmed.org/cmecenter).

Live CME Activities

Go to [www.massmed.org/cme/events](http://www.massmed.org/cme/events).

3rd Annual Women's Cardiac Health Conference: Wellness Strategies for a Healthy Heart

February 29, 8:00 a.m.–3:15 p.m.  
MMS Headquarters, Waltham.  
Sponsored by the MMS and its Committee on Women in Medicine.  
6.0 Credits (2.5 RM)

Perinatal Aspects of HIV

April 16, 6:30–9:00 p.m.  
MMS Headquarters, Waltham.  
Sponsored by the MMS and its Committee on Maternal and Perinatal Welfare.  
2.5 Credits (RM)

Know the Response: Disaster Management and Communication for the Health Care Provider

April 30, 5:30–9:00 p.m.  
MMS Headquarters, Waltham. Sponsored by the MMS in collaboration with the Massachusetts DPH.  
2.5 Credits (RM)

Online CME Activities

Go to [www.massmed.org/cme](http://www.massmed.org/cme).

The following audio and PowerPoint activities are available online:

Physician-Hospital Relationships: Where Do You Stand?

3.0 Credits (RM)

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

2.5 Credits (RM)

Recognizing and Preventing Youth Violence

3.0 Credits (RM)

Avian Flu and Pandemic Preparedness

2.5 Credits (RM)

Cost Performance Ratings: What You Need to Know about Episode Treatment Groups (ETGs)

2.5 Credits (RM)

Health Disparities:

A Social Determinants Approach

1.0 Credit (RM)

A National Perspective on Disparities in Health Care Quality

1.0 Credit (RM)

Health Disparities: Public Health Preparedness

1.0 Credit (RM)

The following online activities are co-developed with Adler, Cohen, Harvey, Wakeman & Guekguezian, LLP. Each activity is designated as 1 Credit (RM):

Legal Advisor: Mandated Reporting

Legal Advisor: Hearing-Impaired Patients and the Americans with Disabilities Act

Legal Advisor: New Guidance — Patients with Limited English Proficiency

Save the Dates

May 10

Lead by Example: Choices for a Better Health Care System  
Seaport/World Trade Center, Boston

May 10

2008 Shattuck Lecture: Health of the Nation — Coverage for All Americans  
Seaport/World Trade Center, Boston

June 4

6th Annual Men's Health Symposium  
MMS Headquarters, Waltham  
Sponsored by the MMS and its Committee on Men's Health

CME CREDIT: Unless otherwise noted, each activity is designated for AMA PRA Category 1 Credits™. RM indicates that the activity or a portion thereof meets the Massachusetts Board of Registration in Medicine criteria for risk management study. CME ACCREDITATION: The Massachusetts Medical Society is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.