

VITAL SIGNS



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GIC Plans Issue New Tier Designations, Focusing on Costs

In January, physicians throughout Massachusetts started receiving their tiering information from the six health plans that offer coverage to state and local employees through the Group Insurance Commission. The new tiering designations take effect in July 2010.

In a major change from last year, three health plans are rating more specialties on cost data alone if there is insufficient data to rate them on quality. In previous years, except for a handful of specialties, the predominant practice was to assign physicians to the middle tier if the amount of quality data was insufficient.

The MMS urges physicians to review all GIC mailings immediately. The appeals period expires on January 29, except for Fallon, whose appeal deadline is two weeks after receipt of the notice.

What You Should Do

- Review your profile and the tiers into which you've been placed.
- Contact each of the health plans and ask each one for details on how your tier designation was calculated — whether it was based on cost, quality, or both.
- Ask for detailed cost and quality information about each of your patients.
- For a complete list of questions you can ask the health plans, go to www.massmed.org/tiering.

Meanwhile, the Society's lawsuit against the GIC and its tiering program is still in state Superior Court. There are no updates to report at this time.

Please e-mail us at mdfeedback@mms.org with your concerns and questions. Your experiences will help us advocate with the health plans. **VS**

Quality and Cost Council's Roadmap Calls for "Shared Responsibility"

BY TOM WALSH

It's being studied inside the White House and around the United States. Even European health care policymakers are looking at it. Nearly 100 pages long, the Massachusetts Health Care Quality and Cost Council's *Roadmap to Cost Containment*, made public last October, "might eventually be a pathway to actual health care reform," said Jack T. Evjy, M.D., the past MMS president who chairs the council's advisory committee.



contain health care costs and "to reduce care that is unnecessary, duplicative, and of no or marginal benefit."

"Given the pieces we need to achieve cost containment, we now recognize that it can't happen overnight."

— JudyAnn Bigby, M.D.,
chair of the Health Care Quality
and Cost Council and secretary
of the Executive Office of Health
and Human Services

- Comprehensive payment reform
- Support of system-wide redesign efforts
- Widespread adoption and use of health information technology
- Implementing evidence-based health insurance coverage informed by comparative effectiveness research

Sustainable Containment Sought

"Effective cost control will require a shared responsibility by all who deliver, use, and pay for care," the *Roadmap* document states. It adds that the following 11 strategies are intended to "sustainably"

- Implementing further health insurance innovations to promote high-value care

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Ten Years after *To Err Is Human*: How Far Have We Come with Patient Safety?

BY LLOYD RESNICK

Just 10 years ago, the Institute of Medicine (IOM) published *To Err Is Human*, its groundbreaking report that pushed patient safety to medicine's center stage.

Today, most patient safety experts agree that there's been a lot of progress, but significant gaps remain. For example, an essay published in January by the policy journal *Health Affairs* gives medicine's patient safety efforts an overall grade of B-.

Systems Approach Meets Payment Reform

Paula Griswold, executive director of the Massachusetts Coalition for the Prevention of Medical Errors and a member of the state's Health Care Quality and Cost Council's Patient Safety Workgroup, believes that payment reform is a crucial element in fixing systems to improve patient safety. She thinks payers — especially Medicare — have to get beyond predominantly punitive measures such as refusals to reimburse providers for so-called "never events."

"We need payment systems that don't just declare what providers *won't* get paid for, but one that pays providers for coordinating care and ensuring safe transitions from one health care setting to another," Ms. Griswold said. "It's not surprising that physicians, who are predominantly reimbursed for procedures but not for serving on safety committees or for ensuring safe patient transfers, may not be as involved as they could be in systematic efforts to improve patient safety."

Ms. Griswold also said that the systems approach to patient safety helps account for the fact that blaming individuals for system failures or predictable imperfections in human behavior does more to harm patient safety than to promote it. But as more effective safety practices came on line, many in the patient safety community acknowledged that intentionally reckless provider behaviors or repeated refusals to follow accepted procedures should have consequences. "But," Ms. Griswold said, "I still feel we can

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Organized Medicine and Health Reform

As I write this message, the differences in the House and Senate versions of health care reform legislation are being resolved. By the time you read this, it's possible that a compromise bill will have passed through Congress and been signed by President Obama.

Whatever the final legislation looks like, constant and effective advocacy from state and national physician groups, including this Society, helped ensure that lawmakers jettisoned many ill-conceived proposals that would have harmed rather than improved patient care. We thank the entire Massachusetts congressional delegation for listening to and fighting for us.

By staying engaged throughout the painstaking reform debate, by refusing to "just say no," organized medicine convinced lawmakers to make significant improvements to both bills as they were being crafted and amended. Similarly, during the House-Senate reconciliation process, we continued to advocate for certain key provisions in the legislation, such as strong insurance reforms, closing the so-called "donut hole" in Medicare Part D, and making sure that necessary increases in reimbursement for primary care and general surgery did not come by robbing Dr. Peter to pay Dr. Paul.

We categorically opposed the proposal for an independent Medicare payment commission, and if that appears in the final legislation, we will continue to oppose it or any other approach that circumvents meaningful congressional oversight of Medicare.

And we will continue to try to convince federal legislators that health care reform can't truly succeed without a permanent fix of the SGR-based Medicare formula. We will continue to work vigorously for a long-term solution to that fundamental problem.

Mario Motta, MD

— Mario E. Motta, M.D.

Patient Safety

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do a lot more to improve patient safety from a systems perspective and to develop incentives to support a provider's ability to improve."

Setting-Specific Tools

Since the IOM report, many state and national organizations, both private and governmental, have promulgated tools and best practices aimed at improving patient safety. There have also been more "stick"-like approaches from government and accrediting agencies that involve legal and regulatory requirements. And payers have gotten involved with incentives and disincentives they claim are related to patient safety.

But according to James Feldman, M.D., an emergency physician and chair of the MMS Committee on Quality of Medical Practice, some of these well-intended tools and rules have led to unintended consequences, and there's a potential risk to applying them across the board in all settings.

"We're still far from where we need to be with patient safety, and part of that is because we haven't vetted all the tools, metrics, reporting requirements, and regulations to make sure they actually improve patient safety," he said.

Noting that a single hospital is really a collection of "subsystems," Dr. Feldman said he's experienced the challenge of having a patient safety tool or metric thrust upon his colleagues in the emergency department before ground-level providers in that environment have had the chance to prove that it will work.

"I think there's a need for different patient safety tools and metrics in different settings within the same facility," Dr. Feldman said. He credited the MMS with being effective both in advocating for patient safety improvements and in expressing legitimate physician concerns regarding the inappropriate application of patient safety metrics and reporting requirements.

No Proxy for Doctors

One of the goals of the Patient Safety Workgroup of the Health Care Quality and Cost Council is to encourage the development and implementation of a "patient safety program in all [Massachusetts] settings in which patient care is delivered" by January 2012.

But the workgroup is also committed to helping ensure that physician concerns about unintended

consequences and meaningful metrics are addressed.

"The physician community cannot cede safety and quality issues to anyone else," maintained Jack Evjy, M.D., medical affairs advisor for the MMS and chair of the council's Patient Safety Workgroup. "We can't let anyone be a proxy for doctors when it comes to patient safety and quality."

The opportunity for lapses in patient safety can occur in any health care setting, so the workgroup is focusing on establishing patient safety programs for non-hospital settings, including ambulatory surgical centers, dialysis centers, long-term care facilities, and even solo and group physician practices.

The workgroup's goal statement, which received a favorable response from Dr. Feldman's Committee on Quality of Medical Practice, relies on voluntary, nonregulatory, and nonpunitive approaches to patient safety based on widely accepted standards established by national organizations. "We want to help develop patient safety practices customized to various health care settings that can be embedded in the delivery system of the future," said Dr. Evjy.

Integration versus Fragmentation

And that future delivery system, being shaped in Massachusetts by the Health Care Quality and Cost Council and in Washington, could impact patient safety quite a bit. "Integrated, coordinated systems like the models proposed in most health care reform plans are those most likely to excel in patient safety," said Ms. Griswold. "Fragmented, siloed systems, like the ones that currently predominate, are least likely to promote patient safety."

Dr. Evjy agreed. "Integrated health systems like Geisinger and Mayo have the tools and resources embedded in the culture to help providers achieve patient safety excellence," he observed. "Most physicians in Massachusetts are not part of such integrated systems, but the hoped-for proliferation of accountable care organizations and medical homes should provide the framework for more well-coordinated care. That in itself should solve some important patient safety issues."

Systemic improvement aside, the safety and well-being of patients remains the core of the patient-physician relationship. "Patient safety really means doing the right things by our patients," Dr. Evjy concluded. "It's fundamental to everything we do as physicians." **VS**

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CMS Proposes Three Stages of “Meaningful Use” Criteria for Health IT

As part of recently released proposed rulemaking regarding the electronic health record (EHR) incentive, the Centers for Medicare and Medicaid Services (CMS) outlined provisions related to the requirement that professionals must be “meaningful users” of “certified” EHRs.

The CMS proposed a three-stage approach to achieving meaningful use by eligible professionals between 2011 and 2015, with each of the three stages entailing escalating requirements.

Stage 1 Criteria

The meaningful use criteria proposed for stage 1 focus on the following:

- Electronically capturing health information in a coded format
- Using that information to track key clinical conditions and communicating that information for care coordination purposes
- Implementing clinical decision support tools to facilitate disease and medication management

- Reporting clinical quality measures and public health information

For stage 1, which begins in 2011, the CMS proposed 25 meaningful use objectives/measures for eligible professionals and 23 objectives/measures for eligible hospitals. In 2011, the results for all objectives and measures, including clinical quality measures, will be reported to the CMS (or to states for Medicaid providers and hospitals) through “attestation.”

In 2012, the CMS proposed requiring the *direct submission* of clinical quality measures to CMS or to the states through certified EHR technology. The CMS says it recognizes that the administrative burden of reporting must be reduced.

Beyond Stage 1

Through future rulemaking, the CMS intends to propose two additional stages of meaningful use criteria. Stage 2 will expand upon stage 1 criteria in the areas of

disease management, clinical decision support, medication management, support for patient access to health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies.

Consistent with other provisions of Medicare and Medicaid, stage 3 will focus on achieving improvements in quality, safety, and efficiency; decision support for national high-priority conditions; patient access to self-management tools; access to comprehensive patient data; and improving population health outcomes.

The proposed stage 1 rules are subject to a 60-day public comment period. The MMS is studying the proposals and will submit suggestions for improvement. **VS**

— Adam Shlager

For ongoing updates on all health IT adoption issues, sign up for the free *MMS ARRA Advisor* newsletter at www.massmed.org/newsletters.

CMS Tosses Medicare Consult Codes

In late December, the Centers for Medicare and Medicaid Services (CMS) announced that it would not delay the implementation of a change in Medicare consult codes that could significantly reduce consult income for subspecialists. The AMA and other health care groups urged the CMS to delay implementation of the change.

The 2010 Medicare fee schedule proposes the elimination of the use of inpatient and outpatient consultation codes for various sites of service, with the exception of telehealth consultation G-codes.

The change is offset by an increase in the work relative value units (RVUs) for new and established office visits by approximately 6 percent and an increase in the work RVUs for initial hospital and facility visits by approximately 0.3 percent.

Because of Medicare admitting-physician payment policies, the CMS will also develop a modifier to differentiate the admitting physician of record for hospital inpatient and nursing facility admission from physicians who furnish specialty care.

Although this coding change is “budget-neutral” for Medicare, it will not be for most practices. The following are among the considerations for physicians:

- Will a 2 to 6 percent increase in work RVUs for new/established patient codes offset the 12 to 40 percent differential Medicare now pays for consultations?
- What is the estimated impact of the changes on your bottom line?
- What are the CMS-provided “cross-walks” between consultation and new/established patient codes?
- When should new/established patient codes be used?
- What changes might be necessary to document these codes accurately and optimally?

The MMS will keep members abreast of the latest developments on this issue as they occur. **VS**

— Adam Shlager

Streamlining Medical-Office Workflows

It has been somewhat problematic to apply quality and efficiency analyses to medical practices. The core element of a medical practice — individualized relationships with patients — does not lend itself well to traditional examinations.

But creating a smoother, tighter workflow in office procedures can result in more time for and enhancement of the patient-physician encounter. Improvements can typically be made in the following areas:

- Establishing clear rules for how appointments can be made for each physician, and clearly communicating those rules to office staff
- Reducing the number of “hands” that “touch” the prescription and refill process
- Making it clear at the time the appointment is made that patient insurance information

must be confirmed and copays must be made on the day of an appointment

Efficiency is a game of aggregates. For example, let’s assume that a quarter of the patients seeking appointments in a two-provider office require a call back because the person making appointments needs to confirm the provider’s schedule. Assuming 100 appointment calls per day, 25 would need call backs. The provider would waste 12.5 minutes per day to confirm (one-half minute per call), and up to 50 minutes of staff time would be required to call patients back. With improved appointment-making processes, over a week, the providers would free up almost an hour (time for two to three additional patients), and staff could save as much as four hours.

Payment and Collections

Billing is another process often in need of streamlining. If insurance information is not confirmed on the front end at check in, hours of unnecessary work and write-offs on the back end may result.

The same goes for failing to collect copayments. One uncollected copay means generating a bill. Anecdotally, monies billed are slower to collect and are often never collected. An inconsistent collections policy is confusing to patients and increases the risk for lost revenue.

None of the workflow issues discussed here directly intrudes on the patient/physician relationship. They are designed to enhance it by giving patients a consistent, smooth experience and by making physicians more available to patients. **VS**

— Adam Shlager

Leadership Forum to Focus on Energy and Health

On April 28, the MMS will host its Sixth Annual Public Health Leadership Forum. Titled "Clearing the Air: Energy Practices and Human Health," the forum will present the science that links energy practices to health effects.

The forum will also discuss state and federal energy policies and steps forum participants can take to reduce the harmful health effects of pollution. **VS**

EPA: Greenhouse Gases Threaten Health

In December 2009, the U.S. Environmental Protection Agency (EPA) announced that greenhouse gases (GHGs) threaten the public health and welfare of Americans. The EPA also found that emissions from on-road vehicles contribute to that threat.

The EPA's "endangerment" finding comes after a thorough examination of the scientific evidence. Greenhouse gases — including carbon dioxide, methane, nitrous oxide, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride — are the primary drivers of climate change. In turn, climate change leads to increases in ground-level ozone levels that are linked to asthma and other respiratory illnesses.

Scientific consensus shows that human activities have pushed GHG concentrations in the atmosphere to record-high levels. On-road vehicles contribute more than 23 percent of the total greenhouse gas emissions in the U.S.

"Business leaders, security experts, government officials, concerned citizens, and the U.S. Supreme Court have called for enduring, pragmatic solutions to reduce greenhouse gas pollution," said EPA Administrator Lisa P. Jackson. **VS**

Helmets Cut Risk of Winter Sport Head Injuries

For skiers and snowboarders, head injury is the leading reason for emergency department visits and inpatient hospital admissions. It is also their most common cause of death.

Helmets do not prevent all concussions, but they do decrease the risk of a concussion and other head trauma, and they decrease the severity of head injury.

Helmets are not only for elite athletes. Among alpine skiers and snowboarders, helmet use is associated with a 60 percent reduced risk of head injury. In children under the age of 13, failure to use a helmet while skiing or snowboarding was associated with an almost two-fold increase in risk for head, neck, and facial injury. The U.S. Consumer Product Safety Commission stated that "helmet use by skiers and snow-

boarders could prevent or reduce the severity of 44 percent of head injuries to adults and 53 percent of head injuries to children under the age of 15."

Despite these statistics, helmet use among recreational skiers and snowboarders is generally low. A 2003 study reported that only 12 percent of skiers and snowboarders wore helmets. Although helmet use today may be as high as 50 percent, it is still well below the goal of 100 percent.

Some have argued that skiers and snowboarders who wear helmets are more likely to engage in the sport aggressively. However, a 2005 study did not find helmet use to be associated with riskier activities resulting in injuries, and a 2002 study showed no significant increase in the incidence of

collisions among those wearing helmets.

So, wear a helmet, and encourage other winter-sport enthusiasts to do the same.

— Alan Ashare, M.D.

Chair, MMS Committee on Student Health and Sports Medicine



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MMS Supports Expansion of Smoking-Cessation Benefits

In December, the MMS provided written testimony before the Joint Committee on Financial Services in strong support of two bills that would further increase health-plan coverage for smoking cessation.

House Bill 890 would require the state's Commonwealth Care program to provide comprehensive smoking-cessation treatment, and House Bill 951 would require coverage for smoking-cessation products by the Group Insurance Commission, Blue Cross Blue Shield of Massachusetts, and managed care plans.



The deadline for submissions to the MMS and Alliance Anti-Tobacco Poster Contest is Friday, February 12. For more information, go to www.massmed.org/tobacco.

MassHealth Tobacco Cessation Benefit Yields Positive Results

In July 2006, MassHealth began offering coverage for smoking cessation as part of the state's health care reform initiative. The Massachusetts Tobacco Cessation and Prevention Program (MTCP) worked closely with MassHealth to design a barrier-free benefit that includes access to all FDA-approved medications to quit smoking, behavioral counseling, and very low copays.

In November 2009, the Patrick Administration announced an unprecedented drop in heart attacks, asthma, and birth complications associated with the MassHealth smoking-cessation benefit.

In the first two and a half years of the benefit, more than 75,000 MassHealth members used it to try to quit smoking. That represents an impressive 40 percent of MassHealth enrollees who smoke.

Researchers from the MTCP found that up to 38 percent fewer cessation benefit users were hospitalized for heart attacks in the first year after using the benefit

than prior to using it. Similarly, 17 percent fewer benefit users visited emergency rooms for asthma symptoms, and researchers found a 17 percent reduction in claims for adverse maternal birth complications since the benefit was implemented.

"It is clear from these latest findings that the Commonwealth's efforts to help people quit smoking are a sound investment," said JudyAnn Bigby, M.D., secretary of the Executive Office of Health and Human Services.

Still, smoking remains the number one preventable cause of illness and death in the Commonwealth and in the U.S.

More than 8,000 Massachusetts residents die annually from the effects of smoking, and tobacco use is associated with \$4.3 billion in excess health care costs in Massachusetts each year.

— John Bry

Massachusetts Tobacco Cessation and Prevention Program

REGULATORY UPDATE

Health Insurers Scrutinized during State Probe of High Premiums

In late fall and early winter, the state Division of Insurance (DOI) held an unprecedented eight-week series of hearings. The hearings were initiated by Gov. Deval Patrick and implemented by acting insurance commissioner Joseph Murphy to respond to concerns of the small-business community about the growth in health insurance premium costs and to investigate potential solutions.

The hearings were sparsely attended but created reams of documents crafted in response to specific questions directed at invited witnesses. (A list of questions and other information is available at www.mass.gov.doi.) The questions, directed by a panel of DOI officials, were developed by the state through a process that solicited public input. The most

frequent witnesses were representatives of the state's health care plans, who have each appeared multiple times.

As reported in the *Boston Globe* on December 10, 2009, responses from the insurance industry have been varied. The record includes some assertions that key information sought by the division — mostly fee schedules — is proprietary or subject to contractual restrictions on disclosure. The record also includes specific data on relative costs of small-group and large-group premiums, rates of increase for such groups, and the disparity in reimbursements to different providers for the same services.



Testimony from the business community has raised concerns about the impact of existing laws and regulations on premiums. Most notably, businesses are concerned about their inability to join purchasing collectives, the inclusion of nongroup insurance in the same risk pool as that of small business, the lack of choice among products and benefits, and the inability to bargain for coverage with the same impact as large groups.

Insurers have cited strong bargaining positions by large provider groups and hospitals as a major cost driver of increasing premiums, but much of the spe-

cific payment information has not been disclosed.

Insurers are resisting demands from regulators for the most sensitive and valuable information, while acting commissioner Murphy insists that the authority of the division to obtain such information is essential to providing meaningful oversight and regulation of the industry. The Patrick Administration is expected to file legislation clarifying the authority of the division to intervene when premiums do not reflect the legitimate costs of insurers.

As this edition of *Vital Signs* went to press, the provider community, including the MMS, was invited to testify. **VS**

— William Ryder, Esq.

To read the MMS testimony, go to www.massmed.org/DOItestimony.

Roadmap

continued from page 1

- Developing health resource planning capabilities
- Enacting liability reform and peer review statutes
- Implementing administrative simplification measures
- Consumer engagement
- Emphasis on illness prevention and good health promotion
- Increased transparency

Deliberate Pace, Alternate Routes

Mario E. Motta, M.D., MMS president, cautioned that some cost-containment strategies cannot be rushed. "The process has to go slowly, and in a number of steps," Dr. Motta said. "And it has to be voluntary."

The MMS president observed that some physician practices are more ready than others to embrace the *Roadmap* strategies. "Those who can and want to do it have the infrastructure in place to do it," he said. "For those who are thinking about it, we'll teach them how to get there. Those who do not have the needed infrastructure in place need to take

preparatory steps before they even try to do it. And some practices may never get there."

Dr. Motta emphasized administrative simplification and liability reform as two of the most important *Roadmap* strategies.

Overall, the Society supports the goals of the *Roadmap*, although it will continue to address concerns with certain strategies, such as ensuring that the "health insurance innovations" do not include a flawed tiering program like the one the Group Insurance Commission thrust upon physicians. "All stakeholders, not just physicians, need to be accountable," said Dr. Evjy. "But the system for accountability has to be meaningful, accurate, and fair. Arbitrarily breaking the trust between patient and physician is not acceptable."

Achievable Cost Reduction

At one point, the council had hoped to limit annual health care cost growth in Massachusetts to no more than the annual growth of the state's gross domestic product. However, JudyAnn Bigby, M.D., chair of the council and secretary of the Executive Office

of Health and Human Services, told *Vital Signs*, "Given the pieces we need to accomplish to get to cost containment, we now recognize that that can't happen overnight." The next step to implementing the *Roadmap*'s 11 strategic initiatives will begin, she said, by "developing action plans with defined outcomes and a timeline. That's a lot of work."

That challenge is especially tough in a difficult economic climate. "We're looking for efficiencies where we can find them," Dr. Bigby said, emphasizing that promoting wellness and disease prevention "is not only a long-term strategy, but could also, new data suggests, save money in the short term as well."

Disciplined, Collaborative Approach

James B. Conway, senior vice president at the Cambridge-based Institute for Healthcare Improvement, said the *Roadmap*'s cost-containment strategies are "aimed at driving out the cost of poor quality." He added that the aspect of this report that has piqued the interest of so many

people outside Massachusetts is its "disciplined approach."

Lynn Nicholas, Massachusetts Hospital Association president and CEO, sees the *Roadmap* as further evidence that all elements of the state's health care system are willing to collaborate. "It will probably get implemented because the rationale for doing it is coming from more than one source," she said.

Doctors Not Singled Out

The *Roadmap* cautions that achieving cost containment "will likely reduce the income and profitability of the health care sector, which employs 15 percent of the Massachusetts population."

According to Dr. Bigby, "It would be impossible to expect that we can contain health care costs without changing the revenue streams." She was quick to add, however, that the *Roadmap* does not target physicians as a primary source of savings. Rather, she said, prevention, averting duplicate services, and ensuring that care is provided in the right setting are the *Roadmap*'s key goals. **VS**

To read the *Roadmap* in its entirety, go to www.mass.gov/healthcare.

IMG Workshop to Address Licensing, Residency, and Immigration

On Saturday, February 6, the MMS will host its 18th Annual Career Day/Job Fair for Massachusetts physicians. The event will take place from 9:00 a.m. to 1:00 p.m. at Society headquarters in Waltham.

During this event, a workshop specifically geared toward international medical graduates (IMGs) will take place from 11:00 a.m. until noon. The workshop will serve as an open forum for IMGs to discuss immigration, residency, and licensing issues. Speakers will include attorney Samia Chandraker and IMG Section Chair Anil Chandraker, M.D.

The workshop is free, and all member and nonmember IMG residents and physicians are welcome to attend. **VS**

To learn more about the MMS Career Day/Job Fair, e-mail chennessy@mms.org, or call Colleen Hennessey at (800) 322-2303, ext. 7315.

MMS Legislative Workshop

**Tuesday, February 9,
7:00–9:00 p.m.**

**Massachusetts General
Hospital's Ether Dome, Boston**

This event will provide excellent preparation for anyone interested in getting involved in future MMS legislative advocacy and for anyone planning to attend the AMA Lobby Day and/or National Advocacy Conference in Washington, D.C., later this year. Dinner will be provided.

The event is sponsored by the MMS and its Committee on Young Physicians and the Resident and Fellow Section. **VS**

**RSVP by Tuesday, February 2,
to chennessy@mms.org
or (781) 434-7315.**

PHYSICIAN HEALTH MATTERS

Despite Decriminalization, Marijuana Is Still Medically Problematic

In the last issue of *Vital Signs*, we featured a poignant description of a physician's struggle with marijuana abuse that adversely affected his relationships and work. He came to Physician Health Services on referral, agreed to monitoring, and now, in recovery, is leading a substance-free life and practicing well in medicine. This article will focus on the current trends regarding marijuana and the medical consequences of using it.

In recent months, there have been widespread efforts to decriminalize and increase the medicinal prescribing of marijuana. Beginning January 1, 2009, a new Massachusetts law went into effect that decriminalizes the possession by adults or adolescents of one ounce or less of marijuana.

Although marijuana remains illegal, possession of these small amounts is now a civil offense — not a criminal one. For adults, possession carries a fine of \$100 and confiscation of the marijuana. If the person in possession is less than 18 years old, there is an additional requirement of four hours of education and ten hours

of community service, all of which must be completed within one year. Parents are also being held responsible for ensuring the follow-through of their minor children.

Recently, a local newspaper article described an urban housewife who grows substantial amounts of marijuana in her home and sells it surreptitiously to those with medical problems (especially pain) for which it presumably provides relief. This person mentioned that she was able to support her children through college through the sale of marijuana.

In addition, it is well known that the flow of marijuana from Mexico and other countries is posing enormous economic and criminal threats to citizens of our nation and others.

Remember the Consequences

Despite this nationwide movement to decriminalize and increase the availability of marijuana, there are several potentially not-so-pleasant consequences of its use that physicians need to be aware of. Use of marijuana can:

- Progress to abuse and dependence, with all of the attendant complications
- Impair judgment, decrease motivation, and add to the effects of other substances, both prescribed and illicit
- Cause pulmonary or medical side effects if large amounts are inhaled
- Deepen anxiety and depression and exacerbate panic attacks

In addition, the percentage of tetrahydrocannabinol (THC) in marijuana is increasing as production techniques become more refined to enhance the substance's mood-altering effect.

Therefore, physicians should include questions about the use of marijuana when taking screening histories of patients. The frequency of use, amount, and its effects on the person using should be noted and discussed. Its potential interactions with prescribed medication(s) should also be noted.

Adolescent patients should be queried as to their understanding of the new Massachusetts law. If they have been cited for possession, discuss their mandatory follow-up with them. Additionally, discussion of marijuana use with all patients should include the reminder that the substance is still illegal.

If applicable, physicians should also consider whether their own use of marijuana is worth the risks of adversely affecting themselves, their medical practices, and their family lives.

In the face of a growing movement to minimize the risks of marijuana use, physicians should be more concerned than ever about its potential deleterious medical effects if abused or used additively. **VS**

For more information, contact Physician Health Services at (781) 434-7404 or www.physicianhealth.org.

Students Get Primer on Federal Health Reform



Photo by Colleen Hennessey

Joseph Heyman, M.D., past MMS president and recent chair of the AMA Board of Trustees, addressed nearly 90 medical students at a health reform briefing at Tufts University School of Medicine on November 30, 2009.

March 5 Deadline for MMS Committee Consideration

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

Committee appointments are usually three-year renewable commitments. For those with limited time, we have resources for distance participation.

The listing that follows 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. Applications must be received by March 5.

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

Board of Trustees Committees Appointed by the Board

(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, Grievances, and Professional Standards • 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 • Lesbian, Gay, Bisexual and Transgender Matters • 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 Executive Council

Arts, History, Humanism, and Culture **vs**

IN MEMORIAM

The following deaths of MMS members were reported to the Society in December 2009 and January 2010. We also note member deaths on the MMS website at www.massmed.org/memoriam.

Carl E. Cassidy, M.D., 85; Lynnfield, MA; Case Western Reserve University School of Medicine, 1948; died December 11, 2009.

David J. Cohen, M.D., 99; Davis, CA; Tufts University School of Medicine, 1934; died December 27, 2009.

Carmen R. Goldings, M.D., 81; Needham, MA; Harvard Medical School, 1954; died November 23, 2009.

Herbert J. Goldings, M.D., 80; Needham, MA; Harvard Medical School, 1954; died November 23, 2009.

Arthur G. Hill, M.D., 92; Yarmouth Port, MA; Temple University School of Medicine, 1942; died November 20, 2009.

Olga F. Szabo, M.D., 75; New York, NY; University of Juarez Medical School, Mexico, 1981; died July 25, 2009.

Walter F. Tauber, M.D., 83; Barrington, RI; University of New York College of Medicine, 1952; died December 18, 2009.

Isidor S. Tolpin, M.D., 97; Newton, MA; Middlesex University School of Medicine, 1942; died December 20, 2009.

Thomas G. Webster, M.D., 85; Concord, MA; Wayne State University School of Medicine, 1949; died July 1, 2009.

Robert D. B. Williams, M.D., 88; West Harwich, MA; Vanderbilt University School of Medicine, 1945; died December 27, 2008.

ACROSS THE COMMONWEALTH

District News and Events

Berkshire — Annual Social Event. Sat, Feb. 27, 2:00 p.m. Location: Colonial Theatre, Pittsfield. For more information, contact the West Central Regional Office.

Bristol South — Executive Committee Meeting. Tues., Feb. 11, 6:00 p.m. Location: Waterfront Grille, New Bedford. For more information, contact the Southeast Regional Office.

Charles River — Executive Committee Meeting. Tues., Feb. 9, 6:00 p.m. Location: MMS headquarters, Waltham. For more information, contact the Northeast Regional Office.

Essex South — Delegates Meeting. Wed., Feb. 24, 6:00 p.m. Location: Beverly Depot, Beverly. For more information, contact the Northeast Regional Office.

Middlesex Central — Executive Committee Meeting. Thurs., Feb. 18, 7:45 a.m. Location: Emerson Hospital, Concord. For more information, contact the Northeast Regional Office.

Hampden — District Winter Meeting. Tues., Jan. 26, 6:00 p.m. Location: Clarion Hotel, West Springfield. Speaker: Alice T. Coombs, M.D., MMS president-elect. **Zumba Party.** Tues., Feb. 9, 6:30 p.m. Location: Baystate Conference Center, Holyoke. \$10.00 fee. For more information or to register, contact Suzanne Skibinski at hdms@massmed.org or (413) 736-0661.

Norfolk South — Executive Committee Meeting. Tues., Feb. 9, 6:30 p.m. Location: Peppercorn Restaurant, Weymouth. For more information, contact the Southeast Regional Office.

Suffolk — District Winter Meeting. Thurs., Feb. 11, 7:00 p.m. Location: Clery's Bar, Boston. For more information, contact the Northeast Regional Office.

Worcester — 214th Annual Oration. Wed, Feb. 3, 5:30 p.m. Location: Beechwood Hotel, Worcester. "You Have Saved Our Lives: The Making of a Doctor." Orator: Guenter L. Spanknebel, M.D. For more information, contact Joyce Cariglia at (508) 753-1579.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — Eagles in Winter. Sun., Feb. 28, 10:00 a.m. to 1:00 p.m. Location: Joppa Flats, Newburyport. **Executive Council Meeting.** Wed., March 3, 6:00 p.m., Location: MMS headquarters, Waltham. **The Nancy N. Caron Annual Art Exhibit.** Fri., May 14, 6:30 p.m. Location: Lighthouse Room, Seaport Hotel, Boston. Due to publishing deadlines, please register no later than Mon., Feb. 8. For more information, contact the West Central Regional Office.

If you have news for Across the Commonwealth, contact Michele Jussau, Northeast Regional Office, at (800) 944-5562 or mjussau@mms.org; Sheila Kozlowski, Southeast Regional Office, at (800) 322-3301 or skozlowski@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

**Save the Date
Monday, April 12**

**Controversies and
Advancement of Human
Papillomavirus (HPV)**

**MMS Headquarters, Waltham
8:00 a.m. to 12:00 p.m.
3.75 AMA PRA Category 1
Credits™ (RM)**

This program will cover a variety of topics related to HPV, including the latest Pap smear guidelines, HPV typing, different screening strategies, and head and neck cancers in relation to HPV.

To register, call (800) 843-6356 or visit www.massmed.org/cme_events.



What's on the Web? Understanding Global Payments and ACOs

► Tune in to three short videos.

Local physician leaders explain how different practice types can succeed under a global payment system (www.massmed.org/global).

► Read a white paper.

Learn about the issues physician practices must consider when either establishing or joining an accountable care organization (www.massmed.org/aco).

INSIDE ►

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- **"Meaningful Use" of HIT Defined Page 3**
- **Expanded Stop-Smoking Benefits Paying Off Page 4**



MASSACHUSETTS
MEDICAL SOCIETY

VITALSIGNS

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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.

Live CME Activities

Go to www.massmed.org/cme/events.

5th Annual Women's Cardiac Health Conference — Conquering Cardiovascular Disease: Integrating the Latest Research into Your Practice

February 5, 8:00 a.m.–12:30 p.m. MMS headquarters, Waltham. Sponsored by the MMS in collaboration with the American Heart Association. 4.0 Credits

Effectively Managing Pain: Strategies for Clinical Practice

March 12, 8:00 a.m.–12:30 p.m. MMS headquarters, Waltham. Jointly sponsored by the MMS and the Massachusetts Pain Initiative. 4.0 Credits

Online CME Activities

Go to www.massmed.org/cme.

Improving the Patient Experience and Clinical Outcomes in the Office Practice Setting

Four modules. 1.5 Credits (RM) per module

Massachusetts Medical Law Report Quarterly Risk Management CME Series. Each module is 1.0 Credit (RM).

NEW Social Networking 101 for Physicians*

Doctors Worry about New Liability Concerns for Prescriptions

Electronic Health Records Surge Despite Barriers*

Reducing Errors and Liability in Patient Handoffs

Dealing with Difficult Patients

Office Compliance 101*

How to E-mail Patients without Worrying about Liability*

**Also available in print. Call (800) 322-2303, ext. 7306.*

Defining What to Include in a Minor Patient's Chart — Treating Minors without Parental Consent 1.0 Credit (RM)

Reporting Patients to the RMV 1.0 Credit (RM)

Advanced Directives 1.0 Credit (RM)

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Public Health Courses

Disaster and Primary Care 2.5 Credits (RM)

UPDATED Pandemic Flu: Practical Strategies for Preparedness 2.0 Credits (RM)

Save the Dates

April 12
Controversies and Advancement of HPV

May 13
Annual Meeting Ethics Forum

May 15
Annual Education Program and Shattuck Lecture

June 17
Men's Health Symposium

CME CREDIT: Unless otherwise noted, each activity is designated for AMA PRA Category 1 Credit™. 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.