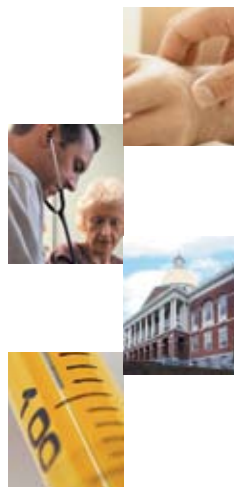




VITAL SIGNS



- 2 PRESIDENT'S MESSAGE**
The Physician–Patient Relationship
- 3 YOUR PRACTICE**
Health Plans' GIC Products
Patient Safety Week
Surgery-Volume Stats
- 4 THE PUBLIC'S HEALTH**
Flu Vaccine Summit
Preventing Homelessness
Conference on Aging
Website of the Month
- 5 GOVERNMENT AFFAIRS**
Regulatory: BRM Reg Update
Federal: More on Medicare
- 6 PROFESSIONAL MATTERS**
Physician Suicide
Asset Protection
Women's Heart Health
- 7 INSIDE MMS**
IMANE Collaborations
Residents Receive AMA Grants
Poster Symposium
Across the Commonwealth
- 8 MMS EDUCATION PROGRAMS**

2006 Annual Meeting —
See Brochure Inside for Preview

Smooth Adoption of Electronic Health Records Requires More than Hardware and Software

BY TOM WALSH

Patrick Barbier, M.D., runs a solo family practice in Newburyport that will be one of the first to “go live” with electronic health records (EHRs) this month as part of a much-anticipated pilot program. He and his two staffers are both enthused and apprehensive at the prospect of going paperless.

“Everyone’s excited — and a little frightened,” said Dr. Barbier. “I think it will help in the future, but I think it will be hard to get used to. There will be a learning curve. At the beginning, it will slow us down.”

Like most practices today, Dr. Barbier’s already has a computer for billing. He’s also done some e-prescribing. “But with this,” he said, “we’ll be hooked up to the hospital. We’ll be able to download lab work, x-rays. Everything will be right in

the computer and it will make things much easier. I’ve been waiting for this for many years.”

First Pilots Ready to Launch

That vision of health care connectivity is supported by a \$50 million grant from Blue Cross Blue Shield of Massachusetts. The grant has fueled the pilot program now moving forward in physician practices and hospitals in Brockton and North Adams, as well as Newburyport. The hope is that these early programs will demonstrate the benefits of linking doctors and hospitals technologically so they can share information smoothly, reduce medical errors, better control costs, and create a more efficient health care system statewide.

“For doctors, this means that their whole office will be based on an elec-



Massachusetts eHealth Collaborative President Micky Tripathi (inset), leads the nonprofit organization that coordinates EHR implementations like this one at Newburyport Family Practice.

tronic workflow, not a paper record,” said Mickey Tripathi, president of the Massachusetts eHealth Collaborative (MAeHC), the non-profit organization formed to coordinate the pilot programs. “Doctors will document all of their encounters in an electronic record — phone consults, e-prescribing, prescription refills, patient notes, complaints, histories. We hope we will get efficiency. For certain, it will change the way the physician’s office works.”

The Barbier practice is one of eight practices in Newburyport that began choosing technology vendors back in December. The program covers the cost of technology and provides hands-on support from an 11-person MAeHC practice service team, whom Tripathi describes as “facilitators and navigators” for the practices. “We’re hoping that

with a little bit of hand-holding, we can get the practices into this more easily,” he explained.

Dr. Barbier is grateful for the help. “Doing it on my own would be more difficult,” he said, adding that he also welcomes the program’s financial assistance. “Although the technology is getting better and better, it is not getting cheaper,” he said.

More Complex Than It Seems

Getting doctors on their way in the pilot program is not as simple as it may seem. Says Tripathi, “Each office has its own way of doing things. What we provide is relatively standard, but the implementation process is different based on what the practice has. The task is to take all the automation they are using now, such

Reporting Goes Public with MHQP’s Patient Experience Survey Results

BY DANA COOPER

This month, the Massachusetts Health Quality Partnership (MHQP) plans to publicly release physician practice site results from its 2005 patient experience survey. The report is entitled “Quality Insights – Healthcare Performance in Massachusetts: Patient Experiences in Primary Care.” MHQP shared practice site data with participating physicians in November 2005 to give them a chance to review the results.

From July through September of last

year, MHQP surveyed patients from 497 adult and pediatric primary care practice sites in Massachusetts. The survey collected patients’ experiences with physicians and other practice staff in terms of communication quality, health promotion, interpersonal treatment, trust, access, and continuity and integration of care.

Additionally, MHQP conducted six focus groups across Massachusetts. The key finding: patients want more office-visit time with their physician. This correlates directly with a near-universal de-

continued on page 3

continued on page 2

PRESIDENT'S MESSAGE



We Must Resuscitate Primary Care

Physicians in Massachusetts have operated under financial and work-environment stress for many years. Nowhere is the workforce more squeezed — and practice viability more threatened — than in the primary-care arena. The number of medical school graduates choosing primary care is plummeting, and many in the field are leaving it or retiring. Waiting times for new appointments with PCPs in Massachusetts are among the longest for any specialty.

The American College of Physicians (ACP), the nation's largest specialty society, recently issued a report on the impending collapse of primary care. The report calls for four major reforms that would help ensure enough highly trained PCPs to meet the rapidly growing health care demands of an aging population. The following four proposals from the ACP dovetail nicely with many MMS principles and our advocacy agenda.

The first proposal cites the need for so-called “advanced medical homes” — practices that provide comprehensive, coordinated, evidence-based care to ensure high levels of quality, accessibility, and efficiency. One hallmark of the advanced medical home is health information technology (see related article on page 1).

Development of such practices would depend partly on new reimbursement models. Consequently, the ACP's second proposal calls for fundamental reform in how payers determine “value” of physi-

cian services. Primary care physicians spend much time and energy providing evaluation and management (E&M) services and coordination of care activities that are chronically undervalued and poorly reimbursed. The ACP proposes that payers begin to pay for the extensive “non-encounter” activities essential to continuity and coordination of care, including telephone discussions and e-mail contact. Payment for primary care should reflect the full extent of the effort it entails and the value it creates.

The third proposal addresses financial incentives. Any Medicare pay-for-performance program, says the ACP, should:

- be nonpunitive
- prioritize the “top 20” conditions as identified by the Institute of Medicine
- be sufficient to offset physician investment in IT and other innovations
- NOT be grafted onto already flawed payment methodologies.

The fourth and final proposal calls upon Congress to scrap the sustainable growth formula method of calculating reimbursements, which has put many physicians out of business while failing to curtail the volume of inappropriate services.

Our adult and pediatric patients desperately need access to effective, high quality primary care. We cannot let this part of our system implode, lest the state of the entire health care system deteriorate further into higher costs, lower quality, and reduced access.

Alan M. Harvey MD, MBA
— Alan M. Harvey, M.D., M.B.A.

EHR Implementation

continued from page 1

as electronic practice management systems, and reorient them to the electronic health record.”

The sheer scope of the project also adds complexity. In all, the eHealth Collaborative pilot program covers 160 practices in the three regions. That's 450 physicians — 300 in the Brockton area, 90 in Newburyport, and 60 in North Adams — as well as 150 nurse practitioners and physician assistants.

Partners Aggressively Promoting EHRs

Meanwhile, Partners Community Healthcare, Inc. (PCHI) — a physician network of more than 4,500 primary care physicians and specialists that cares for more than 1.5 million patients in eastern Massachusetts — is moving aggressively to bring participating physicians into its own EHR program.

“We think of electronic medical records as being really critical,” said Jeffrey K. Levin-Scherz, M.D., PCHI's chief medical officer. “It's the way to coordinate care better and to offer better quality of care.”

Dr. Levin-Scherz said that at Partners' academic medical centers, Massachusetts General and Brigham and Women's Hospitals in Boston, 89 percent of primary care physicians and 82 percent of specialists were using EHRs as of the end of last year. EHR use is significantly lower (43 percent) in Partners' community medical groups, and at its physician-hospital organizations, EHR rates are 34 percent for primary care doctors. Overall, 53 percent of the network's primary care doctors have gone electronic, as have 52 percent of the network's 3,500 specialists.

With EHRs, everyone's long-term goal is “interoperability” — that is, the ability of all the state's care providers, hospitals, and patients to appropriately share information. Dr. Levin-Scherz is confident that interoperability will happen despite multiple initiatives using various vendors across the state. However, he said patient privacy issues and system nuances may thwart 100-percent interoperability.

MMS to Help Small Practices

Dale Magee, M.D., a Shrewsbury gynecologist and MMS vice president, has chaired the Society's Information Technology Clinical Advisory Committee, which has been an important driver of EHR progress. Dr. Magee thinks the em-

brace of technology may be the most important health care development in a generation. “It's going to change things in ways we haven't even thought of yet,” he said. A hundred years ago, he added, doctors thought the advent of the automobile would change medicine because it would expedite physician house calls. “But the real benefit occurred when patients got cars and could drive themselves to their doctors' offices,” he said.

In late January, the MMS Board of Trustees approved recommendations from Dr. Magee's committee that are designed to help smaller physician practices across Massachusetts adopt EHR systems. “One of our great concerns is that physicians in small groups will be left out and not able to compete without interoperable systems,” said MMS President Alan M. Harvey, M.D., M.B.A.

“What we are trying to do is level the playing field and make sure that when it comes to EHRs, we have a way to include all physicians for the greater good.”

Dr. Magee said the most important of his committee's recommendations is the plan to provide smaller practices with a suite of services that will include office analysis, consultation, and continuing EHR education. “We intend to piggyback on the eHealth Collaborative experience,” Dr. Magee said. “They are making recommendations, and we are trying to track with them. We're also cosponsoring education programs with them.”

The Society trustees also agreed with a consultant's recommendation that the MMS work with four EHR vendors. At the same time, the MMS will focus on a single vendor — eClinical Works — for added education and support. The MMS will also offer enhanced member service in this area — beyond that described by Dr. Magee — for an appropriate fee.

Dr. Magee said that busy physicians need as much help as they can get to upgrade their practices to EHRs. MAeHC's Tripathi is optimistic that his organization's pilot programs will eventually help get most of the state's doctors to use electronic health records. His group has already assembled a capital funding committee to look at ways to pay for widespread implementation, which Tripathi said could cost \$750 million to \$1 billion. “But doing hardware and software is not enough,” Tripathi added, echoing Dr. Magee. “Physician offices need our consulting and educational support.” **VS**

*Statewide implementation
of EHRs could cost
\$1 billion.*

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MMS Contributes to National Patient Safety Awareness Week

National Patient Safety Awareness Week, March 5 to 11, is a good time to highlight the Society's continued commitment to improving patient safety and reducing medical errors.

To acknowledge this important awareness-building effort, the Society will release updated references and resources on its website (www.massmed.org/xxxxxxxxxx), covering patient-safety topics such as health care quality and safety, medication safety, evaluating information on the Web, and surgical safety.

Our Committee on the Quality of Medical Practice is keeping us at the forefront of patient safety initiatives throughout the Commonwealth and the country. These include:

- **100k Lives Campaign** — Developed by the Institute for Healthcare Improvement, the 100,000 Lives Campaign strives to get hospitals nationwide to implement changes proven to improve patient care and prevent avoidable deaths. The MMS has joined with other health care leaders to support this initiative. You can obtain more information about the 100k Lives Campaign at www.ihl.org.
- **Ambulatory Medication Safety** — Our Committee on the Quality of Medical

Practice is providing input into a program developed by the Massachusetts Coalition for the Prevention of Medical Errors that provides an easy-to-use tool to help patients track their current medications. The information can then be shared with physicians and other providers along the continuum of care. Additional information on the program is available at www.macoalition.org.

Additionally, under the direction of the Committee on Quality of Medical Practice, the MMS Health Policy and Health Systems Department is developing an online audio CME program with Jerome Grossman, M.D., coauthor of the recent Institute of Medicine report, *Building a Better Delivery System: A New Engineering/Health Care Partnership*. The program will demonstrate how minor modifications in processes can have significant impact on patient safety. The lecture will be followed by a one-on-one conversation between Dr. Grossman and MMS President Alan M. Harvey, M.D., M.B.A., to reinforce how physicians can implement such changes into their practices.

For more information about this program, please check the Society's website at www.massmed.org. **VS**

— David Huffman

Patient Experience Survey

continued from page 1

sire among physicians to be able to spend more time with patients. Focus group participants noted that having the survey information will empower them to make health-related decisions. They also expressed hope that the measurements and data analysis will be valid enough to prompt physicians to make improvements in their practices.

How Should Physicians Respond?

The MMS is helping physicians in both leadership and practitioner roles respond to patient or media inquiries about the results (see box).

The MMS encourages physicians to use the results to identify opportunities for improvement. Do the data provide benchmarks relevant to your practice? Have you experienced other incidents (complaints or compliments) that validate the measures reported? Can your practice conduct focus groups with patients and staff to create solutions?

For more information on the MHQP, the patient experience report, and clinical quality reporting, visit www.mhqp.org. **VS**

Responding to the Results

Here are some tips you can use and traps you should avoid when patients or the media ask you about MHQP's patient experience survey:

DO

- Assign a single person to speak with the media.
- Train every physician, nurse, and staff member in basic responses to patient questions.
- Assert your commitment to continuous improvement. Ask patients for further feedback.

DON'T

- Disparage survey results.
- Minimize or try to justify shortcomings cited in the survey.
- Express disapproval of the survey's methodology.

Avoiding these don'ts will help convince your patients that you are committed to continuous improvement.

GIC Plans Announce New Tiered Products

Beginning July 2006, state workers whose health insurance is administered by the Group Insurance Commission (GIC) will be charged lower out-of-pocket costs when they use physicians who rate most favorably on certain resource measures. Health plans that contract with the GIC have started detailing their product offerings as noted below. At press time, the design of the products was not final, but the GIC has outlines of the preliminary designs. Final details of all products can be found on the GIC website at www.mass.gov/gic/gicplans.htm.

Harvard Pilgrim Health Care (PPO)

Patients will pay the lowest (tier 1) copay of \$15 for primary care physicians, psychiatrists, OB-GYNs, and allied professionals. The copays (tier 1 or tier 2) for specialists in GI, general surgery, cardiology, dermatology, and orthopedics will depend on the practitioner's cost efficiency score (based on analysis of episode of treatment groups, or ETGs). Tier 2 copays (\$25) will apply for all other specialists.

If a physician changes local-care units (LCUs), the initially assigned tier will not change, even if the specialty group of the new LCU has a different tier assignment. There is no hospital tiering or gatekeeper/PCP referral requirement. Members who use specialists affiliated with tier 1 hospitals will maintain an office visit copayment of \$15.

Fallon Community Health Plan

Under this plan, primary care physicians will be rated by contracted group based on aggregated ETGs across the health plans. Fallon will continue to offer Fallon Direct Care — a preferred network of hospitals and doctors — with no changes. The Fallon Select plan will use output from ETG analyses, internal quality measures, and physician fee schedules to develop select networks of PCPs. Fallon Select members who use more efficient and effective PCPs will pay lower copays and deductibles.

Tufts Health Plan

Tufts will maintain its current Navigator product for GIC enrollees but will change pediatric hospital tiering from three tiers to two. Navigator groups Massachusetts hospitals into different copayments for obstetric and adult medical/surgical care. The copays are based on the quality of care the hospitals provide and the real cost per admission to Tufts Health Plan for the services.

Tufts has established a preferred tier of surgical specialists based on a surgeon's primary hospital affiliation. Surgeons primarily affiliated with tier 1 adult medical/surgical hospitals will have lower office visit copays (\$15) than all other specialists. Nine surgical specialties will be tiered: general surgery; hand surgery; orthopedic surgery; neurological surgery; thoracic surgery; general vascular surgery; plastic and reconstructive surgery; colon and rectal surgery, and urological surgery. Office visit copayments will increase to \$25 for all other specialists.

Health New England and Neighborhood Health Plan (NHP)

HNE will use output from ETG cost-efficiency analysis, internal quality measures, and physician fee schedules to develop tiered networks of PCPs. PCP office visit copayments will vary by tier: Tier 1 = \$10 copay; Tier 2 = \$15 copay (no change); Tier 3 = \$25 copay. Specialist office visit copays will remain at \$15.

NHP will offer a new plan, Neighborhood Community Care Plan, with lower copays than the standard NHP HMO.

The MMS recommends that physicians contact the health plans to see and understand their ratings. While the process is moving faster than the MMS thinks appropriate, the GIC postponed the release of this information until July 2006, and ratings will not evaluate individual physicians as originally expected, but rather physician groups or risk units. **VS**

— Dana Cooper

State Website Tracking Surgical Volume

On January 31, the state published 2004 volume data online for 10 surgical procedures for physicians who practice at acute-care hospitals in Massachusetts. Due to MMS advocacy, the website does not provide data for physicians who have fewer than 10 procedures. The MMS is also working with the state to develop a process to rectify errors following the publication of the

data. If you find errors, contact the state at quality.cost@hcf.state.ma.us.

As this issue of *Vital Signs* went to press, the state was scheduled to send its 2005 surgical volume data to hospitals for comment. Physicians are urged to contact their hospital administrators to verify the accuracy of the 2005 data before it is released to the public. **VS**

National Flu Vaccine Summit Tackles Distribution, Supply Problems

On January 24 and 25, the MMS participated in the 2006 National Influenza Vaccine Summit convened by the AMA and the Centers for Disease Control and Prevention (CDC). The summit came one month after the MMS Interim Meeting, where members and delegates expressed great concern about delays and shortages in the vaccine supply, and the impact on patients.

In opening the summit, AMA President J. Edward Hill, M.D., recommended a special pre-booking period for small vaccine orders. He also called on the CDC to shift its post-season vaccine stockpile to an early next-season stockpile to enable providers without vaccine to serve high-risk patients in the event of a vaccine shortage or delay.

Attendees' perceptions of inequitable distribution of vaccine focused on mass vaccinators, such as clinics in retail stores, which seemed to get preferential distribution.

Attendees at the summit included representatives from the vaccine suppliers — Sanofi pasteur, Chiron, GlaxoSmith-Kline, and MedImmune — along with distributors, physician groups, and public health officials.

Sanofi pasteur's representative, Phil Hosbach, reported that Sanofi instituted a policy to ship partially to all customers. He reported that only 10 percent of Sanofi vaccine went to mass vaccinators, a group that includes the Visiting Nurse Association of America. One-third went to private physicians, one-third to the public sector, and the remainder went mostly to hospitals and medical centers. Manufacturers hope to produce 120 million doses of vaccine for the 2006–2007 season.

Attendees generally agreed that communication to health care providers and the public about the status of vaccine must be improved. Chiron acknowl-

edged communication weaknesses and announced plans to create an electronic communication tool for its customers.

Participants also recommended improved education for physicians and other providers regarding priority groups and the need to order vaccine early. Patient education about the efficacy of vaccination also needs improvement, many participants suggested.

CDC Director Julie Gerberding, M.D., M.P.H., noted some successes coming out of the 2005–2006 flu season: the number of flu vaccine manufacturers increased, as did supplies of vaccine. She also cited better collaboration among partners and the dissemination of more information about vaccine distribution.

The summit executive committee will use the summit's conclusions to make recommendations to manufacturers, distributors, the CDC, and the Advisory Committee on Immunization Practices early this year. **VS**

— Robyn Alie

Avian Flu and Pandemic Preparedness: Practical Information and Strategies for Physicians

A Risk Management Program

**Thursday, March 9
6–9 p.m.**

MMS Headquarters, Waltham

This event will offer practical resources and strategies for preparing your practice, treating patients, and protecting yourself during a pandemic.

For more information, contact the MMS Department of Public Health and Education at dph@mms.org or (781) 434-7371.

MMS and Alliance Foundation Support Boosts Homelessness Prevention Initiative

According to the Center for Social Policy at UMass Boston, Massachusetts is currently the third least affordable state in the nation for rental housing, a reality that contributes to the problem of homelessness in the Bay State.

The Homelessness Prevention Initiative (HPI), an MMS and Alliance Charitable Foundation-supported program, continues to facilitate new models that aim to make significant changes in the lives of individuals and families at risk of becoming homeless.

The HPI has distributed \$1 million in grants each year since 2003 to 18 Massachusetts nonprofit organizations, including the Family Health Center of Worcester, the Mental Health Association of Springfield, Bridge Over Troubled Waters, and Rosie's Place. The grants — made possible by the MMS and Alliance Charitable Foundation, the Boston Foundation/Starr Foundation, and Tufts Health Plan — have enabled grantee organizations to implement a comprehensive variety of homelessness-prevention strategies throughout Massachusetts.

The Center for Social Policy survey collected data from individuals and families who accepted services from HPI grantee organizations. Nearly 2,500 individuals and families were surveyed at three different times: immediately after receiving assistance, six months after receiving assistance, and 12 months after receiving assistance.

Among households surveyed, homelessness was prevented for 85 percent of individuals and families immediately following assistance. Of those for whom follow-up information was available six months post-assistance, nearly 85 percent reported "positive housing outcomes" (meaning that homelessness was prevented), with 75 percent retaining their initial housing and almost 10 percent relocating to other residences. Twelve months post-assistance, more than 70 percent reported positive housing outcomes, with more than 60 percent retaining their housing and slightly more than 10 percent relocating to other residences. **VS**

— Jennifer Lorrain

Conference on Aging Spotlights Health Care for Baby Boomers

In December 2005, 1,200 advocates for the elderly met in Washington, D.C., for the fifth White House Conference on Aging (WHCoA). Per legislative mandate, the delegates, largely appointed by governors and congressmen, were charged to "focus on ... the 78 million baby boomers born between 1946 and 1964." As chair of the MMS Committee on Geriatric Medicine, I attended the conference as a nonvoting observer.

In a compelling keynote address about an imminent "tsunami" of retiring Baby Boomers, starting in 2011, David Walker, U.S. Comptroller General, observed that the increasing demands on the health care system by that group could bankrupt the United States unless action is taken immediately.

The delegates considered 72 resolutions, from which they prioritized the "top ten." These included reauthorization of the Older Americans Act (which awards grants to local agencies to provide health-related services to elders), improving the Medicaid and Medicare programs (for which both the MMS and AMA have advocated strongly), and im-

proving treatment of mental illness and depression among older Americans. For the full listing of resolutions, visit www.whcoa.gov.

The sixth most important resolution was one to support geriatric education and training for all health care professionals, paraprofessionals, health profession students, and direct care workers. Ironically, several days prior to the WHCoA, Congress approved a spending bill that eliminated funding for geriatric health profession education programs.

Physicians Must Act Now

One of my biggest concerns about this conference was the apparent dearth of physician representation. My WHCoA experience convinced me that physicians must act *immediately* to influence policies being developed by politicians regarding the health care of maturing baby boomers. I encourage the MMS to join with the 29 Massachusetts delegates who attended the WHCoA to ensure that the conference's health care resolutions are reasonably implemented.

— Janet Jankowiak, M.D.

WEBSITE OF THE MONTH

Disease Risk Assessment Tool

The Center for Cancer Prevention at the Harvard School of Public Health has developed a site (www.YourDiseaseRisk.harvard.edu) that provides easy-to-use question-and-answer "quizzes" to help individuals assess their risks for cancer, diabetes, heart disease, osteoporosis, and stroke. By answering a few lifestyle questions on dieting, exercise, and family histories, patients can view their risk for each disease in a colorful graphic. In addition to delivering personalized risk results, the site helps patients identify simple, risk-reducing lifestyle changes they can make.

REGULATORY UPDATE

Back to the Drawing Board for Revised BRM Regulations

The Massachusetts Board of Registration in Medicine (BRM) is restarting the process it began last fall of completely revising its regulations related to discipline, licensing, and patient-care assessment. In response to comments from the MMS, the Massachusetts Hospital Association, Partners HealthCare, the Massachusetts Association of Health Plans, the Council of Boston Teaching Hospitals, and others, the board pulled back its original proposal and issued a statement in November promising that “the public hearing process will be restarted.” You can read detailed testimony of the MMS and other concerned parties at www.massmedboard.org/public/reg_changes.shtm.

Board Chair Martin Crane, M.D., and Executive Director Nancy Audesse expressed concerns about the first draft of the regulations and a willingness to work with the medical community to craft practical regulations that will provide the framework for the board’s activities for many years to come. At a working session with its legal staff on January 18, the board planned for new hearings in late February and discussed many points from the aforementioned testimony, in-

cluding an MMS suggestion to revise the BRM’s definition of the “practice of medicine.” We anticipate that this issue of *Vital Signs* will be distributed just as the board’s public hearing process and comment period are concluding.

The initial draft of the regulations seemed to lack consideration of the practical impact the proposals would have on hospitals and physicians. For example, the draft regulations required an increase in the mandatory minimum levels of malpractice coverage from the current \$100,000 to \$1,000,000. According to the board attorney overseeing the original redraft, fewer than 300 physicians carry \$100,000 coverage, making the impact minimal. The MMS testimony pointed out both the logical reasons for such a low-coverage decision and the rights of physicians themselves to choose their own levels of coverage to protect their assets. The MMS has received assurances that the board will scrap this proposed regulatory change.

Other areas of concern included provisions that would affect teaching hospitals by requiring that:

- All physicians supervising residents be employed by the hospital

- Billing for residents’ services take place only when “direct personal supervision” occurs
- Temporary licenses be limited to services essential to teaching
- Minimum postgraduate training for a full license be increased by one year

Also of concern were proposed changes to disciplinary standards and processes, such as the discretion to review medical records without patient consent and summary suspension power for posing a “serious threat to the public” (as opposed to “presenting an imminent danger”).

In fairness to the board, it should be pointed out that the BRM regulations are lengthy and complex, with both positive and negative implications for physicians. The MMS applauds the board for not adopting wholesale the proposals presented last fall. The MMS is working hard to have meaningful dialog with the board. The final regulations, scheduled for implementation on July 1, will prove how successful we have been in this endeavor. **VS**

— William J. Ryder, Esq.

LEGISLATOR OF THE MONTH

Representative Robert K. Coughlin (D)

District: Dedham, Walpole (part), Westwood

Committees: Health Care Financing, Financial Services, Revenue



QUOTE: My son Bobby was born with cystic fibrosis. As a result, I have learned a lot more about the health care system than I ever imagined I would.

I have come to recognize that children are not little adults; they need expert care delivered by clinicians with specialized pediatric training. When children are in the hospital, they have a whole range of developmental and emotional requirements. Bobby spends a lot of time in the playroom with child life specialists when he is an inpatient. When he’s home, he depends upon a network of trained providers, including my wife Christine and me.

At the end of the day, Bobby’s health depends on several interlocking parts: good clinical care, well-trained clinicians and caregivers, and a research agenda that is responsive to pediatric patients and that will, I believe, continue to deliver advances in care that will improve Bobby’s life and the lives of other cystic fibrosis patients.

As a businessman and elected official, I understand that nothing in life is free, that the hidden costs of care need to be recognized, and that providers need to be adequately reimbursed. I have committed to that basic idea in my State House work, and I look forward to continued collaboration with the state’s physicians and health care providers in the future.

FEDERAL UPDATE

Second-Session Congressional Agenda for Health Care Looks Familiar

Upon its return for the second session, the U.S. House of Representatives passed the 2006 reconciliation bill, which stops the 4.4 percent cut in physician Medicare reimbursements for one year. Instead, physician reimbursement levels for 2006 will be frozen at 2005 levels. The Centers for Medicare and Medicaid Services will automatically reprocess claims submitted on or after January 1 to restore the necessary funds to physicians. Unfortunately, the bill also includes a number of other provisions of great concern to Medicaid beneficiaries and Medicare providers.

In the second session, both President Bush and Congress are expected to focus on quality measurements for physicians as part of the ongoing debate about Medicare reimbursement. There is also significant bipartisan support for the final passage of health information technology legislation that would promote electronic health-information standards, foster interoperability, and help providers acquire necessary technology. The

Senate has already passed Sen. Edward Kennedy’s “Wired for Health Care Act,” and action is pending before the House.

Part D Difficulties

The January 1 launch of the Medicare Part D drug program revealed a number of problems. Many patients seeking to make choices among the numerous options available found the system to be too complicated. The MMS offers several resources to help physicians help their patients navigate the new benefit. For example, the Society’s website includes links to all Massachusetts formularies as well as contact numbers and forms needed to file an appeal for drugs not covered. The MMS is also offering a one-hour educational program designed to give physicians a general overview of the program, including information for patients. For more information, contact www.xxxx@xxxx.

The CMS website, www.cms.hhs.gov, also provides useful information to help physicians and their patients, including a

free download of Epocrates Rx® software, which provides physicians and other practitioners with Part D formulary information.

A major glitch with the new program occurred when a number of dually eligible patients (those qualifying for both Medicare and Medicaid) who should have been automatically enrolled in a Part D drug plan were denied medications or asked to pay high copayments. Massachusetts and many other states stepped in to cover the costs of the drugs to ensure seniors received their medication. In response to growing outrage from Congress and governors, the Bush Administration agreed to reimburse states that paid for medications for low-income seniors who had problems with the launch of the program. Congressional Democrats have agreed to give the Administration time to work out these and other issues before pushing for new legislative solutions. **VS**

— Alex. Calcagno

PIAM Offering Program on Asset Protection Planning

In today's difficult professional liability climate, physicians need to reduce the extent to which their assets are exposed to malpractice allegations and other lawsuits. In response to this need, PIAM, a subsidiary of the Massachusetts Medical Society, has developed a special approach to create added financial protection for physicians.

As an introduction to this new approach, PIAM will hold a series of seminars across the state on asset protection planning for physicians (see box for dates and locations). The seminars, starting later this month, will address a variety of topics on creditor protection for employed and nonemployed physicians, including insurance coverage, real estate ownership, retirement and education plans, and the use of trusts.

Seminar speakers will include attorneys from law firms across the state, including Mintz Levin, Bowditch & Dewey, and McManus Norton & MacNamee, as well as advisors from PIAM Financial Services. Updated information will be

available on the PIAM website at www.piam.com. You may also arrange for an in-house workshop for your group or hospital by calling Chip Moynihan at PIAM at (781) 434-7398. **VS**

Basic Asset Protection Planning (6 to 7:30 p.m.)

March 22	Danversport Yacht Club, Danvers
March 28	Best Western Sovereign Hotel, West Springfield
April 6	MMS Headquarters, Waltham
April 11	Coonamesett Inn, Falmouth
April 25	Hawthorn Country Club, Dartmouth

Advanced Asset Protection Planning (6 to 7:30 p.m.)

April 4	Danversport Yacht Club, Danvers
May 2	MMS Headquarters, Waltham
May 16	Beechwood Inn, Worcester
May 23	Lombardo's, Randolph

MMS to Host Women's Conference on Cardiac Health

According to the American Heart Association, cardiovascular disease claims about 500,000 women's lives in the U. S. each year — more than the next six most common causes of death combined. Yet, surprisingly, women do not frequently visit their physicians due to concerns about heart disease.

In April, the MMS Committee on Women in Medicine will host the 2006 Women's Cardiac Health Conference: *Updates in Prevention, Diagnosis, and Management* (see box). This conference will address a variety of topics, including cardiac imaging, the influence of obesity and diet on cardiac health, and an update on target levels for various heart disease risk factors such as body mass index, blood pressure, cholesterol, and triglycerides.

Keynote speakers will include JoAnn E. Manson, M.D., Dr.P.H., and Paula Johnson, M.D., M.P.H. Dr. Manson will discuss current guidelines related to hormone replacement therapy, and Dr. Johnson will highlight gender differences in heart disease prevention. During

the luncheon, Aram V. Chobanian, M.D., will deliver the MMS Annual Oration, an examination of the effects of race/ethnicity and socioeconomic status on cardiovascular outcomes.

Since cardiovascular disease is largely preventable, it is valuable for physicians to gain the most up-to-date information about strategies for identifying and managing women patients who may be at risk.

— Erin Tally

2006 Women's Cardiac Health Conference *Updates in Prevention, Diagnosis, and Management*

Thursday, April 6, 8 a.m.–4 p.m.
MMS Headquarters, Waltham
7.5 AMA PRA Category 1 Credits™
(2.5 credits approved for risk management)

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

PHYSICIAN HEALTH MATTERS

Physician Health Programs Help Stem the Tide of Suicide

During my residency in psychiatry at a Massachusetts hospital in 1973, one of my fellow residents committed suicide using injectable potassium chloride. It was one of the most distressing incidents of my training years. Back then, the residency program had no guidelines for dealing with faculty or resident suicides.

The physician who killed herself suffered from major depression, so attending physicians and the chief resident checked in with the other residents to see if they, too, suffered from depression. While we generally appreciated the effort, at times the approach lacked empathy and was perceived as an accusation of having depressive illness, rather than a concern for our well-being.

Advent of PHPs

The very next year, 1974, the AMA encouraged states to develop programs to address impairment in physicians. But it was not until the 1990s

that these programs matured into formal state physician health programs (PHPs). We are fortunate to have these programs as invaluable resources to help identify debilitating illnesses early, and to provide interventions that can save lives. However, we still need to learn to better identify the candidates for services and to improve access to the appropriate resources.

Male physicians have a suicide rate approximately 50 percent higher than that of men in the general population. Women physicians have a suicide rate approximately two to four times the suicide rate of women in the general population.

Stress and Suicide

Major depression and substance use disorders are the illnesses most commonly associated with suicide. Although there are clear genetic components to these illnesses, it is well known that life stress also contributes. The long hours many physicians are required to work are stressful, cutting into time spent with supportive family and friends. The increased threat of liability suits and decreased practice autonomy contribute additional stress. Thankfully, with the assistance of state PHPs, physicians can access social support systems — formal

peer-support groups, individual therapy, collegial mentoring, and job coaching.

Suicide Prevention

I have been privileged to be part of a multidisciplinary group of interested experts addressing suicide among physicians. Our goal is to prevent suicide by increasing recognition of depression and decreasing the stigma and negative consequences of seeking treatment for it. Now that we have a resource in each state for providing physicians with confidential services, we need to overcome all barriers that prevent physicians from accessing the services.

To improve recognition of depression, we need to increase education about the illness at all levels, from medical school

to continuing medical education. We also need to mitigate the stigma surrounding depressive illness by eliminating discrimination by regulatory, credentialing, and insurance enti-

ties against physicians who seek treatment.

This could be accomplished if such entities carefully limited their questions regarding a physician's depression or substance use to those that specifically relate to the current ability to practice. Procedures should allow physicians and medical students to answer "no" to questions that ask if they have sought treatment when they are actively participating in or have successfully completed a PHP monitoring contract or program. Sending a confirmation letter from that state program along with the application would both confer physician confidentiality and protect the public by ensuring successful physician participation in a PHP.

Our group hopes to help prevent the tragedy of physician suicide and increase access to care and confidentiality for physicians to the level available to all other patients.

For more information, contact Physician Health Services at (800) 322-2303, ext. 7404, or www.physicianhealth.org.

— Peter A. Mansky, M.D.

Executive Medical Director, Nevada PHP

Women physicians have a suicide rate two to four times higher than that of women in the general population.

ACROSS THE COMMONWEALTH

District News and Events

Berkshire – District Meeting. Tues., Mar. 14, 6 p.m. Location: Pittsfield Country Club, Pittsfield. Speaker: Aaron Lazare, M.D. Topic: “On Apology.” For more information, contact the West Central Regional Office.

Bristol South – Executive Committee Meeting. Wed., Mar. 1, 6 p.m. Location: Candleworks Restaurant, New Bedford. **District Meeting.** Wed., Mar. 22, 6 p.m. Location: Venus de Milo, Swansea. Speaker: Sen. Jack Reed of Rhode Island. For more information, contact the Southeast Regional Office.

Essex South – Winter Meeting. Wed., Mar. 8, 6 p.m. Location: MMS Headquarters, Waltham. Speaker: Jerri Nielsen, M.D. Topic: “Polar Challenge.” For more information, contact the Northeast Regional Office.

Hampden – Legislative Breakfast. Fri., Mar. 10, 7:30-9 a.m. Location: Best Western Sovereign Hotel & Conference Center, West Springfield. **H.S. Doctor for a Day Program.** Thurs., Apr. 6. Breakfast 7:30-8:30 a.m.; debriefing 5:30-6:30 p.m. Location: Main Conference Center, Holyoke Medical Center, Holyoke. For more information, contact Suzanne Skibinski at (413) 736-0661.

Hampshire – H.S. Doctor for a Day Program. Wed., Mar. 29, 7:30 a.m.-5 p.m. Location: Cooley Dickinson Hospital, Northampton. For more information, contact the West Central Regional Office.

Hampshire/Franklin – District Meeting. Thurs., Mar. 2, 6 p.m. Location: Chandler’s Restaurant, Deerfield. Speaker: Marc Abrahams, editor of the *Journal of Improbable Research*. Topic: The Ignoble Prize. For more information, contact the West Central Regional Office.

Middlesex North – Membership Meeting. Wed., Mar. 1, 6 p.m. Location: Vesper Country Club, Tyngsboro. Speaker: Alex. Calcagno. Topic: Medicare Part D. For more information, contact the Northeast Regional Office.

Norfolk South – District Meeting. Tues., Mar. 28, 6 p.m. Location: Neighborhood Club of Quincy. Speaker: Alan M. Harvey, M.D., M.B.A., MMS president. For more information, contact the Southeast Regional Office.

Suffolk – District Meeting. Thurs., Mar. 16, 6 p.m. Location: Mass. General Hospital, East Garden Room, White Basement. Speakers: Charles Alagero, Esq., MMS VP and General Counsel, and Alex. Calcagno, director of Federal Relations. **Legislative Breakfast.** Fri., Mar. 31, 7:30-9 a.m. Location: Mass. General Hospital, East Garden Room, White Basement. For more information contact Thelma Malafey at (617) 236-5864.

Worcester – Medical Education Conference. Wed., Mar. 15, 5:30 p.m. Location: Beechwood Hotel, Worcester. Speaker: B. Dale Magee, M.D., MMS president-elect. Topic: “Pay for Performance.” For more information, contact Joyce Cariglia at (508) 753-1579.

Statewide News and Events

MINs News – Arts, History, Humanism, and Culture Member Interest Network – Digital Photography. “How to Buy a Digital Camera.” Tues., Mar. 21, 6-8 p.m. Location: MMS Headquarters, Waltham. For more information, contact the West Central Regional Office.

Members’ Art Exhibit: Deadline for Artists – The Arts, History, Humanism, and Culture MIN is again sponsoring an art exhibit in conjunction with the MMS Annual Meeting. Deadline for registering is March 6. For additional information, contact Cathy Salas at (800) 322-2303, ext. 7715 or csalas@mms.org.

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

Residents Receive Policy Promotion Grants

With some help from the AMA Resident and Fellow Section (AMA-RFS), Lloyd Fisher, M.D., and Richard Urman, M.D., will be able to carry out a health policy curriculum for residents and a community-based health literacy program, respectively. The AMA-RFS has awarded each resident’s project a policy promotion grant of \$500.

Grassroots advocacy is typically not a skill taught in residency programs. To help fill that gap, Dr. Fisher, a third-year pediatric resident at UMass Memorial Health Care, designed a series of monthly lunchtime conferences to give residents a general understanding of how the U.S. health care system works. Dr. Fisher plans to demonstrate “how an individual or a group of individuals can have a role in shaping health care policy.”

Dr. Urman, a third-year anesthesia resident at Beth Israel Deaconess Medical Center, plans to use the grant to conduct health literacy tutor workshops.



AMA Grant recipients Lloyd Fisher, M.D., (left) and Richard Urman, M.D. (right)

“Improving health literacy education is one of the major priorities of the AMA and our state’s medical society, and one of my professional passions,” Dr. Urman said.

The MMS Resident and Fellow Section congratulates both Drs. Fisher and Urman on their achievements. **VS**

– Emily H. Richardson

MMS and IMANE Collaborate

Recognizing their similar interests, the Indian Medical Association of New England (IMANE) and the MMS have recently collaborated on some worthwhile endeavors.

Free Health Programs

This past fall, IMANE and the India Society of Worcester opened the Free Health Stop in Shrewsbury. This site provides acute care for nonemergency medical problems and information on health and nutrition topics.

IMANE also partners with the Waltham Area Free Health Center to help deliver free health services to patients lacking health insurance in greater Waltham.

Keep It Simple, Doc! CME Program

On March 25, IMANE and the MMS International Medical Graduates Section will cosponsor “Keep It Simple, Doc!”

Volunteers Get Help with Liability Coverage

The MMS Committee on Senior Volunteer Physicians’ Health Center Program funds professional liability insurance for volunteer physicians.

For more information, contact Erin Tally at (800) 322-2303, ext. 7413, or etally@mms.org.

This program will focus on the simple clinical aspects related to irritable bowel syndrome, overactive bladder, oral cancer detections, and tongue pathology.

For more information about IMANE and its activities, contact Julie Kealey at (800) 322-2303, ext. 7317, or visit www.imanemd.org. **VS**

Call for Abstracts

First Annual Research Poster Symposium for Residents, Fellows, and Medical Students

Deadline for Abstract Submission: Tuesday, March 7
Notification by: Friday, March 17

Abstract Guidelines: Abstracts should be a maximum of 400 words, including title, authors’ names, and institution affiliations, and introduction, methods, results, and discussion sections. E-mail abstract submissions to Emily Richardson at erichardson@mms.org. First prize of \$100 and honorable mention of \$50 will not distinguish between medical students and residents/fellows.

For more details, visit www.massmed.org/postersymposium.

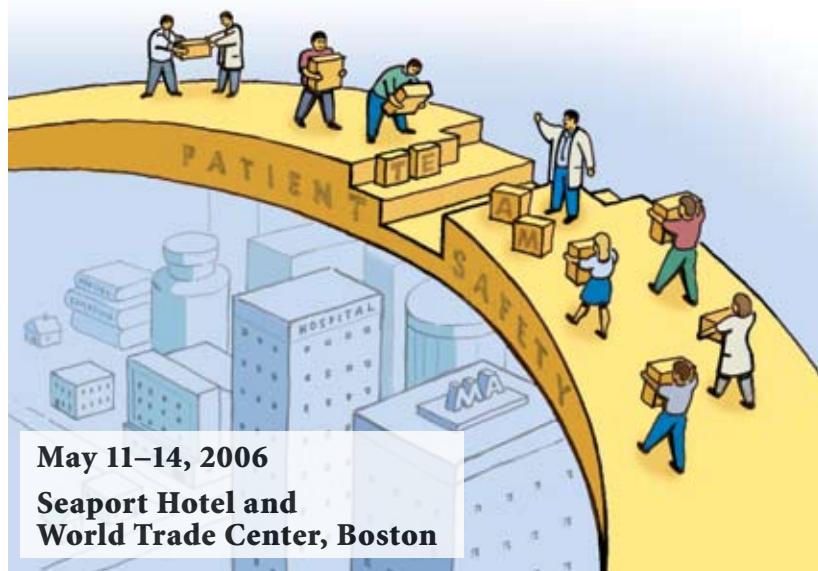


MMS Annual Meeting 2006

Patient Safety is Teamwork

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Bridging the Gap



May 11–14, 2006

Seaport Hotel and
World Trade Center, Boston

See inside for details and visit www.massmed.org/annual2006.

MMS Education Programs

To register for any of these programs, call (800) 843-6356. For more information on these programs, contact the MMS Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to www.massmed.org.

NOTE: (RM) indicates that the program or a portion of the program meets the Massachusetts Board of Registration in Medicine criteria for risk management study.

Onsite CME Programs

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

March 29, 8 a.m.–12 noon, MMS Headquarters, Waltham. Sponsored by the MMS. CME Credit: 4 AMA PRA Category 1 Credits™ (RM)

Women's Cardiac Health Conference: Updates in Prevention, Diagnosis, and Management

April 6, 8 a.m.–4 p.m. MMS Headquarters. Sponsored by the MMS and its Committee on Women in Medicine. CME Credit: 7.5 AMA PRA Category 1 Credits™ (2.5 RM)

Early Warning Disease Threats: Public Health Preparedness through Surveillance

April 25, 6–9 p.m., MMS Headquarters. Sponsored by the MMS and supported by the Massachusetts Department

ment of Public Health. CME Credit: 2.5 AMA PRA Category 1 Credits™ (RM)

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

April 28, 9 a.m.–3:15 p.m., MMS Headquarters
May 5, 9 a.m.–3:15 p.m., Beechwood Hotel, Worcester
May 19, 9 a.m.–3:15 p.m., MMS Headquarters
Sponsored by the MMS. CME Credit: 6 AMA PRA Category 1 Credits™ (RM)

Fourth Annual Symposium on Men's Health: Working with Men in Your Daily Practice

June 23, 8 a.m.–4 p.m. MMS Headquarters. Sponsored by the MMS and its Committee on Men's Health. CME Credit: 7.5 AMA PRA Category 1 Credits™ (2.5 RM)

Online CME Programs

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

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

- The Electronic Health Record in the Office Practice*
- Medical Malpractice Litigation: The Attorney's Perspective*
- Nonsurgical Cosmetic Procedures: Risk Issues in the Quest for Youth*
- Difficult Patients
- Closing a Practice
- Terminating the Professional Relationship With a Patient
- Patient Satisfaction
- The Telephone as an Instrument of Risk

- Nurse Practitioners and Physician Assistants: Some Risk Management Concerns*
- Cultural Diversity*

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

The following online programs are sponsored by the MMS. Each program is awarded 2 AMA PRA Category 1 Credits™ (RM).

- Clinical Aspects of Bioterrorism
- Medical Perspectives on Impaired Driving
- Medical Errors and Perspectives on Patient Safety
- Patient Safety: Conducting a Root Cause Analysis of Adverse Events
- Medication Safety, Systems and Communication